Auditor of State
Betty Montgomery

OHIO MEDICAID PROGRAM PERFORMANCE AUDIT

DECEMBER 19, 2006

Auditor of State
Betty Montgomery

To the General Assembly, Governor's Office, Participating Medicaid agencies, and Interested Citizens:

In response to the authorization granted in Amended Substitute House Bill 66 (2005), the Auditor of State's Office conducted a performance audit covering select areas of the Ohio Medicaid program. This audit provides an independent assessment of the organizational issues within the program, methods of service provision, managed care and care management practices, technology and its role in program management, and program integrity activities within the Medicaid program. These areas were selected to provide a comprehensive review of the program and identify opportunities for increasing efficiency and effectiveness, as well as reducing fraud, waste and abuse.

The performance audit contains recommendations which, if implemented, could provide both service, and operational improvements. While the recommendations contained within the performance audit are resources intended to assist the General Assembly and State Medicaid agency in strengthening select areas, State lawmakers, the Agency, sub-recipient agencies and stakeholders are also encouraged to independently assess overall program operations for the purpose of identifying additional areas for improvement. The performance audit report also suggests several areas for future study.

An executive summary has been prepared which includes the project history, audit conclusions, and summaries of the key recommendations. The contents of the summary have been discussed with appropriate State and agency officials.

Additional copies of this report can be requested by calling the Clerk of the Bureau's office at (614) 466-2310 or toll free at (800) 282-0370. In addition, this performance audit can be accessed online through the Auditor of State of Ohio website at http://www.auditor.state.oh.us/ by choosing the "On-Line Audit Search" option.

Sincerely,

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December 19, 2006

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Ohio Medicaid Program

Table of Contents

Organizational Issues – Section 3

Medicaid Service Provision – Section 4

Managed Care and Care Management – Section 5

Technology and Program Management- Section 6

Program Integrity – Section 7

Issues for Further Study – Section 8

Appendix 1: Selected Resources

Appendix 2: Summary of Objectives

Appendix 3: Glossary

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EXECUTIVE SUMMARY

Executive Summary

Executive Summary Table of Contents

Project History

The Auditor of State's Office (AOS) was authorized to undertake a performance audit of the Medicaid program (the program) in Amended Substitute House Bill 66 (HB 66), passed by the General Assembly on June 21, 2005 and signed by the Governor on June 30, 2005. According to HB 66, the Auditor of State may, during SFY 2005-06 and 2006-07, conduct a single performance audit of the Medicaid program, as defined in Ohio Revised Code (ORC) § 5111.01[1] to determine ways of reducing or eliminating fraud, waste, and abuse in the program, making the program more efficient, and enhancing the program's results (ORC § 206.66.49). The impetus for the performance audit came from the Ohio Commission to Reform Medicaid report issued in January 2005 and was one of several Commission recommendations adopted by the Ohio General Assembly in this bill.

[1] Under Ohio Revised Code § 5111.01, the "medical assistance program" or "Medicaid" means the program that is authorized by ORC Chapter 51 and provided by ODJFS under Title XIX of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C.A. 1396, as amended, and the waivers of Title XIX requirements granted to ODJFS by the health care financing administration of the United States Department of Health and Human Services. ODJFS acts as the single State agency to supervise the administration of the Medicaid program. As the single State agency, the Department is required to comply with 42 C.F.R. 431.10(e). Likewise, under ORC § 5111.01, ODJFS' rules governing Medicaid are binding on other agencies that administer components of the Medicaid program. The law states that no agency may establish, by rule or otherwise, a policy governing Medicaid that is inconsistent with a Medicaid policy established, in rule or otherwise, by the Director of ODJFS.

Based on a review of the Commission's work and the organization and operations of the program in Ohio, AOS identified the following five broad areas for study in the performance audit:

- **Organizational Issues,** including the State organizational structure, county level organization, and budgeting processes;
- **Medicaid Service Provision,** including waiver usage, eligibility, long-term care, prescription drug provision, and rate setting;
- **Managed Care and Care Management,** including the use of third party administrators, and the use of managed care and care management models;
- **Technology and Program Management,** including the system architecture and system functionality; and
- **Program Integrity,** including fraud, waste, and abuse prevention and recovery methods and the interrelationship between State agencies to ensure integrity.

Audit Conclusions

Introduction

A number of broad programmatic issues were identified that effect Ohio Medicaid's ability to serve recipients in an efficient and effective manner. These issues are illustrative of fundamental flaws in Ohio's Medicaid program and include Medicaid's excessive complexity, both from an organizational and implementation perspective, State and county-level inconsistencies, inadequate information and program systems, as well as fragmented and redundant monitoring and oversight functions.

Ohio Medicaid is extremely complex, involving 256 individual State, County, and regional agencies and departments that administer approximately $13 billion[2] from federal, State, and local sources. In addition, the extensive laws and regulations that govern Ohio Medicaid are contained in numerous chapters and sections of both the ORC and Ohio Administrative Code (OAC).[3] Because of the length of the rules and the arcane legal language used to frame them, it is extremely difficult to interpret the intent of these legal requirements. In some cases, the rules are conflicting or produce multiple layers of overlapping responsibilities and redundancies. The Ohio Department of Job and Family Services (ODJFS), in its capacity as the State Medicaid agency, and the sub-recipient agencies[4] have been unsuccessful in streamlining Ohio Medicaid-related laws and regulations by working to eliminate complicated, redundant, or out-dated

[2] Estimated cost for 2004.
[3] Ohio Medicaid is also regulated by federal laws.
[4] Ohio Department of Mental Health, Ohio Department of Alcohol and Drug Addiction Services, Ohio Department of Mental Retardation and Developmental Disabilities, Ohio Department of Aging.

language. Often, at the State level, the program's complexities impede external involvement or assessment.

Because of the frequency of change in the program, ODJFS tends to be unable to implement a proactive approach. This contributes to the perception that ODJFS is unable to conduct and implement future planning or innovations. In some cases this has also alienated ODJFS from the sub-recipient agencies that remain focused on specific population-based programs[5] and are averse to changes that might reduce their involvement or control over their respective funding for portions of the program.

Contributing to Ohio Medicaid's complexity are inconsistencies that exist at every level in the program. The U.S. Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS), as well as providers and recipients, regularly criticize the lack of statewide consistency as it pertains to services and access. In interviews with local agencies, providers, and recipient stakeholder groups, it was revealed that inconsistencies exist between counties and between sub-recipient agencies within counties. This can be attributed, in part, to Ohio's "Home Rule" philosophy, which grants extensive financial and decision-making authority to county-level and regional agencies.[6] While the state-level Medicaid agencies are aware of the concerns over county-level inconsistencies, their efforts have been largely unsuccessful in resolving the inconsistencies. The Ohio Department of Mental Retardation and Developmental Disabilities (ODMRDD) recently attempted to address some of CMS' concerns on statewideness by instituting statewide rates for select services; however, county-level MRDD agencies have expressed strong negative reactions to the plan because it impacts their ability to maximize services for their recipients.

Another obstacle is the relative age and inadequacy of Ohio Medicaid's information technology systems and the absence of program-wide information sharing. There is no comprehensive information system to track provider claims or recipient use of resources, nor is there a common information system used to communicate among agencies. The Medical Management Information Systems (MMIS) is antiquated and, in some instances, unable to generate sufficient information for decision-making. State-level sub-recipient agencies maintain separate data systems which communicate only through claims processing and eligibility information modules. Similarly, there is limited effort to communicate between agencies at the local level to ensure more effective coordination of care.[7]

[5] For example, ODMH and its program component covering community mental health services or ODMRDD and its program component which serves mentally retarded and developmentally disabled Ohioans.

[6] Ohio's strong "Home Rule" government philosophy is not common among other states and creates several programmatic problems that are unique to Ohio.

[7] Informal coordination of care occurs at the local level in some small counties, particularly where county DJFS offices and county-level sub-recipient agency personnel are housed in the same facility.

Ohio Medicaid is fragmented across the agencies involved in the program and among participating providers. Since there is limited information sharing about recipients, it is questionable whether many recipients receive the best services available. At the State level, there has not been a concerted effort to review and prioritize services to determine if they are the most effective or the best type for the populations served. In some cases, for example, covered treatments fund the beginning and end of a treatment process but leave out critical midpoints.

Finally, the performance audit noted that Ohio Medicaid receives significant and sometimes redundant oversight from a variety of governing bodies. In HB 66, the Legislature also commissioned the Medicaid Administrative Study Council to determine how to reorganize Ohio Medicaid at the State level into a single stand-alone agency. Additional committees have been formed to examine technology use, as well as oversee the implementation of managed care and identify practices to enhance care management. It should be noted that Ohio lawmakers have only begun to delineate the intent of the program in Ohio and the philosophical underpinnings governing its implementation. Without defining and clarifying the aims of the program, the Governor and Legislature cannot effectively communicate Medicaid-related expectations to providers, recipients, and the public agencies that oversee service delivery, or Ohio taxpayers.

Despite the shortcomings identified in the program's implementation in Ohio, Medicaid provides an irreplaceable service to some of the State's most vulnerable populations. Through numerous stakeholder interviews, the performance audit identified a common theme of appreciation for the program's assistance by recipients and their advocates. Many recipients lauded the assistance they received through the program and contrasted the potential bleakness of their circumstances if they were unable to access Medicaid services. Similarly, providers, although troubled by the low rates paid for their services, often went far beyond the requirements of the program to help recipients access quality care and to ensure the well-being of their patients and clients.

The lives of many Ohioans and their future prosperity are markedly affected by their ability to receive quality services and consistent care through Medicaid. From the very young enrolled in children's health insurance programs, to the elderly using PASSPORT and PACE[8], Medicaid services have the potential to substantively and favorably alter individuals' quality of life. However, the enormous and increasing expense of Ohio Medicaid gives lawmakers pause and requires a critical examination of the program and its ability to achieve unstated goals for intended recipients.[9] Like many states, Ohio has reached a cross-road where social responsibility

[8] PASSPORT (Pre-Admission Screening System Providing Options and Resources Today) is a waiver program administered by the Department of Aging for individuals age 60 and over, who meet income eligibility requirements. The waiver provides community based care to the eligible population. PACE (Program of All-inclusive Care for the Elderly) is a managed care program, usually for individuals age 55 and over, who meet income eligibility requirements. Under PACE, Medicare may pay a portion of the capitated rate.

[9] Although recent cost reductions have been realized through a reduction in eligibility and the implementation of state-wide managed care, long term national forecasts indicate that costs will continue to increase.

and fiscal resources require intensive system-wide examination and radical change to ensure the future continuation of these vital services.

Organizational Issues

In operating the Ohio Medicaid program, State and local decision-makers are presented with critical but limited choices related to policy design and administrative processes. Federal regulations control the framework for the program, but State elected officials are responsible for the design and deployment of the program within the State, so long as it conforms to federal guidelines. Medicaid, unlike other state programs, is subject to a far greater and more influential range of environmental factors, from the rising costs of medical care to change in social perceptions about healthcare. Similarly, its significant and growing consumption of State financial resources makes the program very visible and subject to criticism. Finally, in Ohio, the program has been subjected to frequent change which has not enhanced the stability of the State Medicaid agency or its ability to develop a more forward-looking approach to program implementation.

Ohio has had only limited success in forging relationships to support a unified vision and culture for its Medicaid program. No clear purpose has been defined for the program and program priorities have not been identified. The absence of clear vision and purpose for the program has resulted in a cumbersome and fragmented system marked with inefficiencies. Because of the structural arrangement in Ohio, key contract management functions – design and monitoring, implementation, and payment administration, occur at the State and local levels in multiple agencies, creating a high rate of redundancy and impacting federal compliance. Eleven other states have county-based Medicaid systems but none reported contract management issues similar to Ohio.

Ohio Health Plans (OHP), the office within ODJFS that administers Medicaid, has organized its bureaus based on a divisional framework with sub-components arranged according to function. This organizational structure encourages a narrow view of issues among less senior staff and leads to high job specialization centered on a specific population group. Overall, highly efficient state Medicaid programs tend to be more flexible and aligned with the functional basis of organization.

While HB 66 includes a mandate to create a stand-alone Medicaid agency, the program would further benefit through the Governor and General Assembly identifying the purpose and priorities of the Ohio Medicaid program. The purpose of the program could then be used to develop a final organizational structure for the program based on the stand-alone model selected in HB 66. Understanding the program and determining the organization based on purpose is essential to the program's long-term success. Whether the single State agency authority in Ohio is ultimately organized as an umbrella human services agency, is combined into a public health

oriented agency, or remains as a stand-alone agency, a systematic and strategic approach to program design and implementation is fundamental to success. Structural design and organizational design are of critical importance because the chosen structure affects the organization and operation of all network agencies involved in delivery of Medicaid services.

As Medicaid exists in a rapidly changing, complex financial and political environment, reducing the rate of change and buffering the agency from the effects of these changes is important in providing a stable foundation for program operations. First and foremost in reducing the rate of change and creating a more stable program is the need to change how Medicaid is perceived in Ohio. This requires transparency on the part of leaders at all levels and a greater degree of cooperation among participating agencies. Without a cohesive purpose and coordinated efforts within the State Medicaid agency and among sub-recipients, as well as local partners, Ohio Medicaid will fall further behind the programs in other states in terms of its level of innovation and modernity.

Medicaid Service Provision

The Ohio Medicaid program provides basic eligibility to low income and disabled Ohioans. Although the eligibility requirements within the State are within the average range for most states, the program, as a whole, has not examined the populations served or opportunities to expand or restrict eligibility to achieve programmatic goals. The program also has engaged in very limited experimentation. Waivers, which allow states flexibility in administering their Medicaid programs by testing innovative policies and practices, have been implemented in a conservative manner. Ohio Medicaid offers seven waiver programs administered by three state agencies, each of which provides home and community based services to distinct populations. Other states have used waivers, especially demonstration project waivers, to implement innovative programs to reach target groups, improve service outcomes, or reduce costs.

In February 2006, President George W. Bush signed the Deficit Reduction Act of 2005 (DRA), which will affect the amount of federal and state Medicaid spending and will change health care access and coverage for low-income beneficiaries. The DRA provides states new options that allow them to develop alternative benefit packages for certain groups of children and adults, and to require premiums and higher enforceable co-pays. As of August 2006, several states had used the increased flexibility allowed in the DRA to redesign their Medicaid programs. Ohio Medicaid has not been aggressive in exploring and implementing innovative programs allowed under the DRA, even though states are now able to do so without having to obtain waiver approval from CMS.

In other states, premium assistance and buy-in programs are being used to help control increasing Medicaid costs and expand coverage. However, Ohio Medicaid has not piloted or implemented programs of this type, although legislation has been recently introduced to allow a

buy-in program. Premium assistance programs help individuals on Medicaid pay for employee sponsored insurance programs that they otherwise can not afford. Fourteen states have premium assistance programs and another five states received approval in 2005 to implement such programs. Similarly, buy-in programs provide Medicaid coverage to employed individuals with disabilities whose income is too high to qualify for Medicaid. Individuals "buy-in" to the Medicaid program by paying premiums or otherwise sharing costs. Eleven states have implemented buy-in programs and another four states have passed legislation or granted budgetary authority to create such programs. Because Ohio has not implemented these types of programs, Ohio Medicaid continues to cover disabled individuals who are eager to work and contribute by paying for a portion of their care.

The long-term care delivery system in Ohio includes a range of environments including facility-based care in nursing facilities (historically the most common type of care) and intermediate care facilities for the mentally retarded (ICF/MR), assisted living facilities, and home and community based services. Efforts to deinstitutionalize the long-term care setting began several decades ago and received greater prominence with the U.S. Supreme Court decision, *Olmstead v. L.C.*, 527 U.S. 581 (1999). Olmstead requires states to move individuals who are determined able to live in the community to a least restrictive setting. In response, Ohio issued the *Ohio Access for People with Disabilities 2001* report, and its 2004 follow-up, which is regarded as a blueprint for other states to follow. While Medicaid is only one of many tools Ohio uses for implementing it blueprint, it is a key funding source for long-term care services. However, because of statutory parameters for institutional nursing home reimbursements, Ohio Medicaid has been unable to financially support a greater level of rebalancing in long-term care options and has not implemented more systemic changes that are occurring in state Medicaid programs elsewhere in the U.S.

Ohio continues to control the supply of nursing facility and ICF/MR beds by limiting the number of beds that can be certified to provide Medicaid services through certificates of need and a moratorium on the expansion of new certified nursing facility beds. Although the number of beds has remained constant, the average number of residents per day and the nursing facility occupancy rate have steadily declined since 1997. Certificates of need limit competition and remove market incentives for nursing facility owners to adjust their bed supply to meet changes in demand. Yet, Ohio has not repealed the certificate of need or permitted nursing facility owners to reallocate beds from rural counties to more populous areas of the State.

The State's Medicaid prescription drug program has adopted several best practices by using a preferred drug list and implementing a cost-sharing requirement. However, other states have implemented additional cost saving initiatives, including the use of medication therapy management programs, outsourcing the retrospective drug utilization review, and joining multi-state purchasing pools. AOS was not able to conduct detailed comparisons of the cost of drugs or

the cost effectiveness of rebates because 42 USC §1396r-8(b)(3)(D) imposes strict confidentiality requirements for the Medicaid drug rebate program.

Provider reimbursement rate adjustments are often made during the budget process because the Medicaid program in Ohio does not have a defined process in place to periodically review Medicaid reimbursement rates for appropriateness and make necessary adjustments. Providers are concerned that rate setting is not transparent or clearly communicated. Stagnant rates have contributed to declining provider participation in the program, particularly in specialty areas. Because nursing home reimbursement rates are set in the ORC, nursing facilities receive annual increases while other providers have accepted stagnant or reduced rates to accommodate the maintenance of service levels within budgetary constraints. If rates continue to fall far short of the costs of treatment for many providers, the State Medicaid agency may face shortages of qualified providers throughout the State.

Managed Care and Care Management

In the past decade, participation in managed care has increased seven-fold. HB 66 required ODJFS to implement statewide managed care and enroll all Covered Families and Children and portions of the Aged, Blind, and Disabled population into managed care throughout the State by December 31, 2006. This will include over 90 percent of Covered Families and Children and 20 percent of the Aged, Blind, and Disabled population. However, Ohio Medicaid expanded managed care without strong empirical evidence that the expected cost savings will result. Statewide managed care will require the implementation of managed care in rural regions of the State where providers are already at a premium and access to care is limited. The U.S. Department of Health and Human Services noted that managed care implementation is most difficult in states with diverse populations (e.g., very rural and very urban) like Ohio.

Strong performance monitoring and widely accessible data for decision-making are not recognized as attributes of Ohio Medicaid. As a result, the State Medicaid Agency may remain unaware of complications in implementation during and after the transition to statewide managed care. Past program initiatives have, in some cases, been terminated before results could be evaluated and, in the case of implementing service models with untried populations or in untried regions of the State, this may leave recipients with limited alternatives for health care.

Provider and recipient concerns over statewide managed care may compound provider access issues. National studies conducted by Health Services Research in 2004 and 2005 found that Medicaid recipients were far more vulnerable, experience more substantial access problems, and have a lower capacity to exercise choice than insured Americans. Furthermore, low levels of provider participation by both physicians and dentists have plagued the Medicaid program since its inception. Access to care issues are highlighted in high cost services like emergency room care—as much as $18 billion a year is spent in the U.S. on avoidable emergency room visits and

one third of all emergency room visits are non-urgent or could be treated in primary care setting. However, 36 million people reportedly do not have a regular source of care. In Ohio, a majority of the counties report a shortage of providers, especially dentists, pediatricians, and specialists. Low reimbursement rates, high rates of "no shows", and claim submission problems are often the stated causes for limited provider participation. Access to services, particularly primary care services, could be enhanced through the addition of Medicaid covered specialty types, such as physician assistants and advanced nurse practitioners.

Care management in Ohio, at best, is fragmented and inconsistent between the State's separate systems of care. Practices vary between participating agencies and, as these systems are designed to treat populations with particular clinical conditions (e.g., mental heath, mental retardation, drug addiction, etc.), the case management activities used in these systems are structured to meet the unique needs of the populations served. Enhanced Care Management, a program targeted at the Aged, Blind, and Disabled population, was terminated by ODJFS less than a year into implementation without evaluation. Managed care companies could expand their role in care management, but outcome-focused incentives have not been offered to the contracted companies and their expertise in this area is often overlooked. Furthermore, programs operated by the sub-recipient agencies were carved out of the managed care expansion (mental health and alcohol and drug addiction services), limiting the managed care plans ability to effectively coordinate treatment among providers. Because of the narrow focus on care management and the limited populations involved in these programs, the Ohio Medicaid program does not effectively promote preventive, coordinated, or well-managed care. This may lead to over-utilization and higher costs, and may result in ineffective treatment for the recipient.

As technology is not used to bridge communication gaps in care management activities, the program may pay for services that are duplicative or unnecessary. The program also has not used technology-based solutions to improve health outcomes and reduce the use of Medicaid services in high-risk populations. Improved case management activities, particularly for high cost populations, and better intra-system coordination could result in cost savings and have a substantial positive impact on Ohio Medicaid recipients' long-term health outcomes. However, the reticence of the participating agencies to work in concert and share information on recipients reduces the likelihood of substantial progress in this area.

While Medicaid serves one-sixth of Ohioans, up to 1.2 million Ohioans within the State do not have any form of health insurance. In Ohio, over 60 percent of the individuals classified as uninsured are working citizens. Recent studies find that uninsured Americans are typically sicker during their life span and die younger than those with health insurance. Individuals without insurance tend to put off preventive and even necessary care, until they require emergency attention. As lower income Ohioans avoid preventive measures because of the costs, their long-term health costs to the State can skyrocket, eventually placing a larger burden on the Medicaid and Medicare programs. For lower to middle income individuals and families, the uninsured are

often faced with choosing between seeking medical attention and paying basic expenses such as rent and groceries. Waiting to seek medical attention may worsen medical conditions or cause longer and more acute suffering.

Despite intense recent attention on the uninsured, Ohio has not opened a public debate on options to extend health care coverage to uninsured persons within the State. Some options have been suggested, like health savings accounts and requiring people to buy employer-sponsored insurance; however, these have limited feasibility and overlook the high rate of poverty associated with the uninsured populations. Several other states have developed buy-in programs for the uninsured which provide limited coverage – with varying degrees of success. Ohio has recently made limited efforts to introduce legislation developing some form of health coverage for the uninsured.

Technology and Program Management

The healthcare industry has experienced dramatic change in the last several years, much of which can be attributed to significant advancements in technology. While Ohio's State agencies have started to incorporate new technologies into the Medicaid program, the program has not developed coordination between State agencies, efficient eligibility and claims payment processes, or the ability to effectively integrate with provider-based technologies.

Ohio has not engaged in a formal, comprehensive multi-agency planning process for Medicaid technology. ODJFS has not worked with sub-recipient agencies and stakeholders to develop technology related goals and objectives. While all State agencies submit a two-year technology plan to the Office of Information Technology (OIT), at no point in this process is there a leadership presence which ensures that the system as a whole is efficient and agencies are leveraging each other's competencies. As a result, the technology used to administer Medicaid is antiquated, insufficient, and dispersed throughout several State agencies or contracted third-party vendors whose systems may not fully meet the needs of the program. Improved coordination in implementing program-wide technology could be accomplished by establishing a State Coordinator for Health Information Technology or some other position designed to fill this leadership void.

The poor level of cohesion is evident in the eligibility determination and claims payment systems. The majority of County Departments of Job and Family Services (CDJFS), who perform Medicaid eligibility determinations, still require face-to-face meetings with applicants and maintain paper documentation. Frequently, this process results in frustration for applicants who often experience lengthy waits upon arrival at the office, only to find out they do not have the proper documentation and must reschedule. Other states have begun piloting or using web-based enrollment systems and electronic documentation standards, practices which Ohio could adopt. Electronic eligibility information would also permit caseworkers to have real-time access

to the records maintained by every county, improving the case worker's ability to serve populations who may relocate within the State. Furthermore, a reduction in the time dedicated to processing documentation would allow county caseworkers to focus more time and attention on assisting recipients in gaining independence and becoming self-sufficient rather than verifying and archiving paperwork.

Ohio is also less efficient than other states in its claims payment process, as claims from the sub-recipient State agencies are processed two and three times (from the local board to the sub-recipient agency, to the State Medicaid agency). Other states, such as New York and Pennsylvania, have implemented claims processes which accept claims at a single source and pass them through a single adjudication process – a process that draws information from each relevant agency. This ensures that all payees are reimbursed in a timely and accurate manner. Consolidating claims adjudication could serve as a catalyst to eliminate paper claims submissions.

In 2004, President Bush issued Executive Order 13335, requiring the use of electronic health records by 2014. Because of this order, health plans will now have access to more clinical data than ever, allowing for better coordination of care and cost control. Florida, which has been proactive in developing a strategy to capitalize on electronic health records, has implemented a state planned framework for linking clinical information obtained from physicians, pharmacies, hospitals, and laboratories to databases maintained by State and federal programs. Central to this network is the use of Regional Health Information Organizations, groups composed of multiple stakeholders with integrated systems which share information with one another through a central source. Indiana has implemented a similar program. However, Ohio has not begun planning how to exchange and use this data in its Medicaid program nor will the information systems in use or under design capitalize on health records data.[10]

Another related key initiative is the expansion of e-prescribing. E-prescribing provides physicians more information on a patient at the point of contact. Rather than relying on a pharmacy to detect adverse drug interactions, physicians can perform this critical check before they complete the prescription. Several states have implemented pilot e-prescribing program and a few have implemented statewide e-prescribing for Medicaid. In these cases, Medicaid has been used to encourage providers to adopt systems which will meet set standards for interoperability with state systems and encourage physicians to engage in more efficient prescribing practices. Ohio has not planned a pilot of e-prescribing through the Medicaid program.

In moving forward, the technology-related challenge for Ohio's Medicaid program is finding a way to work with private providers, as they select systems to meet their own needs, so that those systems can integrate with State operated systems and databases. All parties involved understand

[10] ODJFS has incorporated these concepts into a recent grant proposal. However, the impact of the grant on the sub-recipient agencies and the Program is unknown at the time of reporting. See also *subsequent events*.

the high cost of investing in information technology and that establishing a culture of interoperability will help to maximize their investment. Ultimately, Ohio needs a comprehensive vision for healthcare technology which reaches beyond agency lines and seeks to provide efficient, customer friendly service to both providers and recipients.

Program Integrity

Program integrity focuses on reducing and eliminating fraud, waste, and abuse within the Medicaid program. Improper payments attributable to Medicaid fraud, waste, and abuse typically fall into several groups and the nature and magnitude of fraud, waste, and abuse in Ohio Medicaid is not fully known. However, the estimated risk of loss in SFY 2004-05 is about $1.2 billion. Of this, the Ohio Commission to Reform Medicaid suggested that between $105 and $525 million was recoverable. During this same period, ODJFS processed approximately 63.5 million Medicaid claims for nearly 2 million recipients. ODJFS – through Ohio Health Plans and the Office of Research Assessment and Accountability – is ultimately responsible for coordinating and monitoring program integrity internally and externally as well as within State sub-recipient and regional/county-level agencies, managed care plans, and fee-for-service providers. Program integrity functions are conducted in conjunction with the Attorney General and Auditor of State.

In Ohio, the agencies responsible for overseeing Medicaid have not worked together to assess or mitigate program risks. No comprehensive risk assessment planning process exists to identify and measure risks and establish Medicaid program integrity-related goals and objectives for the program on a statewide basis. In addition, Medicaid agencies do not effectively include input and feedback from provider and recipient advocacy groups in planning and evaluating program integrity activities.

Although Ohio recently began identifying and measuring Medicaid program integrity risks, ODJFS does not effectively coordinate with sub-recipient agencies to implement the preventive and detective controls necessary to ensure Medicaid program integrity. ODJFS also does not employ all control activities that are available. For example, it has not established a consistent procedure for processing Medicaid provider background/fingerprint checks and does not effectively track and monitor the results. It also does not require that providers who have been investigated for fraud in the past obtain surety bonds.

Unlike other states, the Ohio State Medicaid agency does not require that all Medicaid providers periodically re-enroll, and it has not purged all inactive provider numbers from the Medicaid system. Medicaid program integrity personnel also are not actively involved with managed care plans. Lastly, Ohio does not participate in the Public Assistance Reporting Information System (PARIS) – a voluntary, federally-administered project for states to share public assistance data to maintain Medicaid program integrity and detect and deter improper payments to recipients.

These factors limit the State's ability to implement sufficient, targeted enforcement strategies (e.g., recovery audits/reviews, managed care plan monitoring, etc.) and minimize fraud, waste, and abuse. Moreover, compared to other state and federal practices, Ohio's audit recovery function remains fragmented, negatively impacted by out-dated technology and duplicative legal and audit authority between the State Medicaid agency and the sub-recipients. This weakens Medicaid program integrity by creating inefficiency and waste, as well as fostering discord among State-level sub-recipient agencies and providers as a result of inconsistent auditing methodologies used by the participating agencies.

Conclusions

Ample opportunities exist for improvement in the Ohio Medicaid program. Initially, stakeholders at all levels – the Governor and General Assembly, the participating State and County agencies, providers, and recipients – should focus on the intentions of the program and work to design a cohesive system for the future. Incremental changes, made in the past three decades, have not resolved flaws in the program, and instead have magnified the division between agencies and populations. In order to achieve the desired efficiency while maintaining access and eligibility, the program will require all invested parties to compromise and be willing to share responsibility and programmatic control. Without substantive changes in the manner in which short and long-term decisions are promulgated about Ohio Medicaid, the program will continue to leap, poorly prepared, from partial solution to partial solution. However, a concerted effort to overcome past differences in interests and develop a mutual vision for the future of the program will help State and local program participants to achieve a greater degree of efficiency while accentuating the social safety-net aspects of the program.

Objectives, Scope, and Methodology

This performance audit was conducted in accordance with Generally Accepted Government Auditing Standards. Audit field work was conducted between October 2005 and July 2006. The goals of the performance audit process, as defined in HB 66 were as follows:

- Determining ways of reducing or eliminating fraud, waste, and abuse in the program;
- Making the program more efficient; and
- Enhancing the program's results.

The Auditor of State further defined the objectives of the performance audit to focus on five broad areas – Organizational Issues, Medicaid Service Provision, Managed Care and Care Management, Technology, and Program Integrity. A summarized list of objectives can be found in **Appendix A-2**.

As the language enabling the performance audit of the program was defined under ORC § 5111.01, the performance audit includes evaluations of the roles, responsibilities and operations of the single State agency, ODJFS, as well as the following sub-recipient agencies:

- The Ohio Department of Mental Retardation and Developmental Disabilities (ORMRDD);
- The Ohio Department of Mental Health (ODMH);
- The Ohio Department of Alcohol and Drug Addiction Services (ODADAS); and
- The Ohio Department of Aging (ODA).

The Ohio Department of Health (ODH) was included to a small degree as their role in Medicaid is limited. Similarly, the Ohio Department of Education (ODE) was only included to a limited degree because of the small amount of funding received by the Department under Medicaid Administrative Claiming. AOS further included in its analysis the roles of the County Departments of Job and Family Services; the County Boards of Mental Health, Alcohol and Drug Addiction Services, and combined boards; the County Boards of Mental Retardation and Developmental Disabilities; and the Area Agencies on Aging. Finally, provider groups and recipients were included in the performance audit process through a series of targeted stakeholder meetings. A selected bibliography, including the agencies and stakeholder groups interviewed, is included in **Appendix A-1.** Some information provided by groups is paraphrased or quoted in the report; however, all input provided in the stakeholder meetings was considered in developing the audit conclusions and recommendations.

Since Medicaid claim data can be delayed as long as 18 months from the date of service, the performance audit drew on national and state-by-state data on claims and costs from 2003. Additional data from 2004, 2005, and 2006 was included in the report where possible. Through

conversations with CMS and the various state agencies, it was determined that the available data was often incomplete (in the case of data reported by the states to CMS) or was of questionable validity (in the case of data obtained from both CMS and some of the Ohio agencies). To a large extent, the poor quality of data and the inability of some Ohio agencies to provide comparative reports are attributable to the archaic information system used by ODJFS for claims and recipient information. Also, the scale of the program and the limited edits used in the information system make the data more prone to errors. On several documents provided by ODJFS, the data was qualified and the Agency stated that it should be used for informational purposes only. Furthermore, many of the national study groups, such as the Kaiser Foundation, rely on self-reported data which may be erroneous or incomplete. For these reasons, most data in the report is used to illustrate conditions within the Ohio Medicaid program, and not as the basis for recommendations.

During the audit process, ODJFS undertook several initiatives to implement portions of HB 66, and to remedy internal processes identified as problematic by the Ohio Inspector General (January 26, 2005) and an internal study (Medicaid Internal Management Review, July 27, 2005). Several of the sub-recipient agencies also had ongoing initiatives that caused changes in the program and its management during the audit period. Furthermore, the Ohio Medicaid Administrative Study Council fulfilled it mission under HB 66 and developed organizational frameworks for a stand-alone Medicaid agency. Finally, the federal government made substantial changes to program integrity requirements and funding processes for Medicaid and Medicare which affected the Ohio Medicaid program. Whenever possible, these changes have been identified and their impact on the evaluation included in the analysis.

AOS generally received information in a timely manner from ODJFS and the sub-recipient agencies. Sub-recipient agencies were cooperative in allowing access to personnel during the interview process. Likewise, the county agencies were accessible and cooperative in sharing information with the auditors. Most interviews were held in group settings to ensure the most complete information was obtained. However, requests to ODJFS to individually interview members of ODJFS staff were not granted, and a representative of ODJFS management and/or Agency legal staff participated in all formal interviews. The inability to conduct individual interviews may have tainted the reliability of information obtained. Where possible, AOS has supplemented data and printed materials in support of processes and procedures within the Agency. Because of the large number of data requests from AOS and Legislative committees authorized under HB 66, ODJFS established a liaison who was instrumental in ensuring that all requested information was obtained.

Auditors used best practices and comparative data to complete the analyses in this report. State best practices were selected based on the recommendations of CMS, other states, State and county agencies, stakeholder groups, and the availability of information. As a sizeable body of literature exists on aspects of the program and health care industry initiatives, auditors accessed

this information to support process improvement recommendations. Also, in an effort to obtain value adding information from other states, each state was ranked by common efficiency indicators, and information was more heavily sought from states with high efficiency indicators.

Stakeholders and agency personnel (at the State and county level) were also instrumental in highlighting areas for improvement and making suggestions for process change. Auditors also attended committee meetings for the numerous committees addressing Medicaid issues within the State. Most analyses focused on high-level processes within the program as the breadth of program operations required a selective audit approach. As the auditors began the audit process, areas identified as requiring substantial attention by the participating agencies and the General Assembly were chosen as the focal points for this report.

Because of the large number of parties involved in the audit process, preliminary information sharing was constrained to ODJFS, participating State agencies and selected members of the General Assembly. AOS also shared information with selected members Medicaid Administrative Study Council and reported on audit progress, on occasion, to the Committee on Medicaid Technology and Reform. As the number of involved parties exceeds 250 agencies, departments, and committees, ODJFS, the sub-recipient agencies, and county/regional agencies were not invited to provide written comments in response to the various recommendations for inclusion in the final report.

Subsequent Events

Fieldwork for this performance audit was concluded in August, 2006, and prior, to the release of this report, several events occurred which are important to the reader in understanding the issues presented in this report. A summary of these events is included below:

Organizational Issues

In October 2006, the Kaiser Commission on Medicaid and the Uninsured reported that across all states, total Medicaid spending increased by 2.8 percent in FY 2005-06, which is the lowest rate of growth since 1996. Slowing program enrollment, the shift of prescription drug spending for dual eligibles from Medicaid to Medicare, and frozen or reduced reimbursement rates to providers were contributing factors. Other program changes in other states included 26 states that plan to restore cuts from previous years or expand to new populations; a handful of states that plan to change benefits or implement cost sharing under the Deficit Reduction Act of 2005; 38 states plan to expand home and community based services; several states are expanding disease management programs and implementing pay-for-performance and enhanced program integrity programs.

In October 2006, the GAO released a report *Strategies to Help States Address Increased Expenditures during Economic Downturns* which provides strategies for Congress to use in developing a legislative response that would assist states to better cope with Medicaid cost increases.

In November 2006, the Ohio Medicaid Administrative Study Council (OMASC) adopted recommendations for a new cabinet-level Ohio Department of Medicaid. The recommendations include a proposed new organizational structure along with a new mission that focuses on containing cost and ensuring that care provided is medically necessary. The Council also recommends the establishment of an Ohio Health Care Advisory Committee which would have a broad health care focus, as well as the adoption of a unified long-term care budget. OMASC calls for the new Medicaid Department to have a consolidated budget for Aged, Blind, and Disabled recipients. The Council is completing work on additional recommendations and is in the process of preparing its final report.

In an update provided on November 27, 2006, ODJFS indicated that both the Office of Budget and Management (OBM) and the Legislative Service Commission (LSC) have access to de-identified Decision Support System (DSS) data. ODJFS provided training for staff from both agencies on using DSS during the spring and summer of 2006.

Service Provision

In August, CMS announced plans to reduce the maximum allowable tax on Medicaid beds from a rate equal to 6 percent of a provider's total revenues to 3 percent. ODJFS estimates that as of SFY 2008-09, the reduced revenues and federal draw-downs would total $116.2 million in all funds. That includes $35.2 million for nursing facilities, $11.2 million for ICF/MRs and $69.8 million for managed care plans.

In September, new legislation (SB 369) was introduced which would establish a Medicaid buy-in program. The program would allow anyone between 16 and 64, with a disability (as defined by the Social Security Administration) to work if they wanted to do so. The measure would increase the Medicaid asset limit for eligible working Ohioans with disabilities from the current $1,500 to $10,000, increase maximum income levels to 250 percent of poverty, and exclude the first $20,000 of earned income. Among other provisions, the bill would replace the Medicaid spend down formula with a premium system based on income, limit premiums at no more than 10 percent of gross earnings, and charge no premiums until earnings of the disabled worker exceeded 150 percent of the federal poverty level. The State share cost of the program when fully implemented was estimated at $14 million, although the figure does not take into account taxes that the newly employed disabled would pay to the State.

On October 1, 2006, new rules went into effect that restrict Medicaid access for individuals who give away their property to become eligible for the benefit. ODJFS restrictions on the Medicaid hardship waiver process were in place for some time, but were rarely used until Congress changed the penalty period in the Deficit Reduction Act of 2005. The law also extended the look-back period for asset transfers from three to five years and changed the beginning of the penalty period for asset transfers from when the transfer occurred to when the individual applies for Medicaid long-term care coverage.

Also in October, New York was granted a waiver from CMS to assist the state in achieving Medicaid costs reductions, while improving programs and facilities. Under the waiver, the state will improve its health information technology; modernize facilities; increase fraud and abuse recovery efforts; implement a preferred drug list; explore options to provide health coverage for the uninsured; and provide better guidance for providers of long-term care services. The New York waiver is the only one of its kind; however, CMS officials encouraged other states to consider such reforms.

On November 1, 2006, ODJFS submitted a proposal to CMS for a Money Follows the Person grant. The proposal outlines a program titled *Rebalancing Ohio's System for Long-Term Care*, the goal of which is to transition 2,200 elderly and individuals with disabilities from institutions to home and community-based alternatives. The preliminary budget for the five-year program is $248.7 million.

Also in November, ODJFS reported to auditors that in SFY 2005-06 its generic dispensing rate increased to 60.2 percent. Based on this increase, the State should set a goal of increasing the use of generics above the 62 percent recommended in this report. As CMS has strongly encouraged states to maximize the use of generic drugs, ODJFS may want to request assistance from CMS to target differences in the use of generic drugs by therapeutic classes and increase the use of generic drugs to a level more commensurate with that of high performing states and the U.S. Veterans Administration.

Managed Care and Care Management

In September, 2006, Ohio was selected as one of seven states to participate in a new Center for Health Care Strategies' initiative develop and implement provider incentive programs aimed at improving care for Medicaid beneficiaries. The initiative is supported by the Commonwealth Fund with additional funding from the Robert Wood Johnson Foundation. ODJFS's proposal outlined the Agency's objective to implement a pay-for-performance system. This program is linked to the Medicaid Transformation Grant application submitted by the Agency to request funding for a new Medicaid Electronic Patient Management and Assessment System.

As of November 2006, the Medicaid Care Management Working Group was in the process of completing its report. The group developed a draft report issued on October 16, 2006 which contained preliminary recommendations which included full adoption of HEDIS standard methodology, implementation of outcome measures based on evidence, development of a strategy to focus on at-risk individuals, implementation of pay-for-performance, establishment of case management performance measures, and a continuation of the behavioral health services carve-out from managed care.

Technology

On September 29, 2006, ODJFS submitted an application to CMS for a Medicaid Transformation Grant to develop a Medicaid Electronic Patient Management and Assessment System. The Agency requested funding for a consumer self-assessment form; a consumer interface for access to customized educational material and the "Rewards for Health" program; an on-time Medicaid management system; data interfaces with other pharmacy benefits managers, and the exchange of clinical information, including data from electronic medical records, through at least one regional health information organization.

In October, the National Committee on Vital and Health Statistics approved a set of minimum functional requirements for the Nationwide Health Information Network, laying out a framework for exchanging medical records among doctors, hospitals and other health care providers. The requirements are included in the committee's report *Minimum but Inclusive Functional Requirements Needed for the Initial Definition of a Nationwide Health Information Network*, which will be submitted to the U.S. Department of Health and Human Services.

In addition, the Department of Health and Human Services awarded a $2 million contract to the National Governors Association to establish the State Alliance for e-Health, the purpose of which is to share lessons learned among states who are implementing health information technology. The contract is part of the effort by HHS to spur the adoption of electronic health records and other health information technology.

Also in October, 2006, ODJFS shared with AOS its plan to improve provider network management, which included requiring all fee-for-service providers to submit claims in an electronic format. Additionally, the Agency plans to establish performance metrics for trading partners and to post the performance of these entities on its website. Benchmarks suggested by ODJFS include: timely submission of claims; number of claims needing adjust due to error; and any incident of massive incorrect data submissions.

As of November 27, 2006, ODJFS staff reported that the proposals for the MITS project were in the scoring phase and the timeline for vendor selection was February, 2007.

Program Integrity

In October, ODJFS released *Focus on Performance: Provider Network Management Fee-for-Service Deliver System* which outlines the Agency's vision for improved provider network management. The report outlined a number of planned actions to improve program integrity including:

- Requiring background checks for all providers;
- Implementing a closed-ended provider contract for all fee-for-service providers;
- Requiring new provides to serve a probationary period;
- Implementing a pay-for-performance model;
- Implementing a web portal for use in enrolling providers;
- Developing a provider directory; and
- Developing a process to sanction those providers who do not comply with Agency rules.

On November 27, 2006, ODJFS officials indicated that the Agency is taking steps to implement the performance audit recommendation to participate in the Public Assistance Reporting Information System (PARIS). During the same meting, ODJFS officials noted that the Agency has worked with AOS and the Ohio Attorney General's Office to develop a process that they call a risk assessment to identify high risk service categories which may be appropriate for the surveillance and utilization review process. In addition, ODJFS indicated that it has initiated meetings with the other State Medicaid agencies to centralize the recovery/review process within ODJFS.

Summary of Recommendations

The recommendations within this report could result in savings of up to $403.5 million.[11] Of the 109 recommendations in the report, 13 recommendations contain quantified cost savings. An additional four recommendations could lead to savings but the effect could not be quantified. Also, 17 recommendations would likely have additional costs of varying degrees associated with implementation, although the magnitude of these costs could not be quantified. Twelve recommendations would yield savings but would require an expenditure of funds for implementation. Finally, several additional recommendations could be implemented within existing resources or by redirecting and streamlining current business practices. The performance audit recommendations are summarized below. References to the full recommendations are contained in the table.

No.	Recommendation
	Organizational Issues
General Assembly	
R3.1	**Develop a long-term perspective:** The General Assembly should evaluate its role in establishing Medicaid policy and establish a long term perspective for the program. It should seek to establish long-term direction and goals and allow the participating agencies to implement strategies to achieve those goals. Also, the Medicaid agencies should develop budgets with output measures and should plan future information systems to allow outcome measures to be collected.
R3.4	**Use an intermediary reporting agency:** The General Assembly should consider requiring the State Medicaid agency to provide access to the Decision Support System for the Office of Budget and Management, the Legislative Services Commission, or another existing body. One of these entities could serve as a separate and objective body to gather, interpret, and disseminate relevant information to ensure that the program is transparent and agencies are providing reliable and relevant information. This would likely require the allocation of additional resources to these organizations to offset the added duties. (See also **R3.11**).
R3.5	**Establish an intermediary oversight body:** The General Assembly should evaluate if a second tier of reporting structures or processes, would help future elected officials maintain an appropriate scope of decision-making. The General Assembly may wish to establish a Council (similar to the Ohio Retirement Study Council) which could provide independent advice to the Legislature on Medicaid program and policy decisions, and their financial effects and health care impact. This would allow Medicaid program operations to be buffered from short-term political pressures and initiatives.
R3.6	**Prioritize program goals:** The General Assembly and the Governor's Office should devise a process to prioritize the goals of Medicaid to provide guidance and direction to decision makers. The goals and purpose of the program should be clearly articulated and criteria established to help prioritize goals when they are in conflict for policy decisions. These priorities should not be subject to short-term fluctuations or changes; they should be the foundation for long-term planning efforts. Finally, they should develop guiding operating principles with clearly articulated assumptions and limitations so that these can be recognized and accepted without continuous revitalization of the debate.

[11] This equates to about 3.1 percent of program expenditures based on SFY 2004-05 expenditures of $13 billion.

R3.7	**Centralize claims:** The General Assembly should provide the State Medicaid agency authority to centralize claims processing so that it has additional control over the level of claims within the program. (See also **R6.9**).
R3.10	**Capture all program costs:** The State of Ohio should improve its information management practices to better capture the costs of publicly funded health care and, more narrowly, the Medicaid program. In particular, all costs associated with the Medicaid program, including those expended at the local level and administrative costs not reimbursed by the federal government, should be captured so that the true and complete cost of the program is known. In order to accurately capture the local funding component of Ohio Medicaid expenditures, the General Assembly should direct county agencies to track and report local funding used for Medicaid by type (both levy and county funds), State funding used for Medicaid, and any unpaid administrative costs. These costs should be reported to OBM and the State Medicaid agency.
R3.11	**Grant information access to independent bodies:** The Legislative Service Commission (LSC) and Office of Budget and Management (OBM) should be granted access to the Decision Support System (DSS). As independent servants of public officials, the involvement of LSC and OBM in gathering information using DSS will engender improved public trust and enhanced decision-making. State-level decision-makers will be able to make more proactive policy decisions based on output and outcome data, and be able to better evaluate the impact of these decisions. (See **R3.4**).

R3.12	**Reorganize based on a clear purpose for the program:** The General Assembly should base any final Ohio Medicaid reorganization decisions on a clear purpose for the State's publicly funded health care system and social safety net programs. As the purpose and priorities of Medicaid are difficult to identify, the General Assembly should set aside sufficient time for a group to be convened which represents all stakeholders involved in the final determination.[12] If desired, the Legislature should take initial steps to implement the designated stand-alone agency but set a firm date for the submission of recommendations for a long-term, final organizational design. The General Assembly should seek to have the purpose of Medicaid defined and the most appropriate structure to meet the defined purpose identified within the next biennium (SFY 2006-07 to 2008-09). The General Assembly may determine that the stand-alone agency is the best option or may, based on the purpose of the program, consider selecting from one of the two other organizational structures described below. • If the General Assembly and Governor identify the purpose of Medicaid as a payer of medical claims for economically disadvantaged individuals (specifically those meeting Medicaid eligibility), the State Medicaid agency would be best arranged within a stand-alone Medicaid agency. In this arrangement, the relationship with local agencies could remain as it is. • If the General Assembly and Governor identify the purpose of Medicaid as a component of a comprehensive health strategy, the State Medicaid agency would be best organized as a component of a super health agency. In this arrangement, the local agencies could remain as is, but the system would probably benefit from combining portions of the program at the county or regional level. • If the General Assembly and Governor identify the purpose of Medicaid as an integral component of the social safety net for poor and disabled Ohioans, the State Medicaid agency would be best organized within an umbrella health and human services agency. In this arrangement, the organization would benefit from a consolidation of local agencies, on either a county or regional basis. Any of these choices will require redesigning the current system of relationships. However, the purpose of Ohio publicly funded health care under Medicaid should be the basis of selecting one of the three organizational structures. Reorganization of the program and reducing associated administrative duties could save the State up to $156.5 million.
R3.13	**Permit the program to stabilize without additional near-term changes:** Once a structure for publicly funded health care is selected and implemented, the General Assembly should cease Medicaid redesign efforts for an extended period of time, perhaps at least three to five biennia. As these changes cause significant organizational and programmatic strain and the implementation of these changes can be costly, the General Assembly should permit time for the new organizational structure to stabilize and begin to measure and track its performance.

[12] The General Assembly may wish use existing studies or may wish to commission studies to determine what areas of public health in Ohio are most in need of attention and which strategies are most likely to resolve them. The General Assembly might consider using the Ohio Medicaid Administrative Study Council as a base for the development of such a committee as the participants will be versed in the current program and the selected stand-alone design. Several other recent committees, including the join committee on Medicaid Technology and Reform, might also be appropriate to involve in the process.

R3.14	**Centralize contract management within the State Medicaid agency:** The General Assembly should centralize the core functions of Medicaid contract management within the State Medicaid agency. This will help the Medicaid agency better design contracts that are consistent with clearly specified and prioritized long-term goals of the Governor and the General Assembly, as well as help it coordinate contracts with other State agencies and local entities. • The General Assembly, with the assistance of the State Medicaid agency and sub-recipient agencies, should evaluate if local contracts can be consolidated based on the final organizational structure selected, geographic responsibility, and service type or population served.
State Medicaid Agency	
R3.2	**Use service strategies:** The State Medicaid Agency should use service provision strategies such as care management or consumer driven models to help stabilize the program and reduce market and environmental effects on the program.
R3.3	**Improve state-level relationships:** The State Medicaid Agency and the sub-recipient agencies should improve and develop transparent, positive, and proactive relationships with all political oversight bodies to improve informed and effective decision-making. • The agencies should enhance long-term trust and cooperation among the executive and legislative representatives involved in program policy-making through increased responsiveness to requests and compliance with legislative mandates. • The State Medicaid agency should better educate elected officials about the program and assist elected officials in interpreting and placing information in the proper context to enhance legislative decision making.
R3.8	**Revise interagency agreements:** Once clearly prioritized goals and principles are established, the State Medicaid agency should seek to revise its interagency agreements to strengthen its ability to oversee Medicaid within the sub-recipient agencies. The State Medicaid agency should outline desired outcomes and seek to establish an improved contract monitoring relationship with the sub-recipient agencies for non-compliance or the inability to meet agreed upon outcomes.
R3.9	**Improve relationships with sub-recipients:** The State Medicaid agency should improve its relationships with sub-recipient and stakeholder organizations and seek to broaden collaborative opportunities and go beyond the current oversight relationships. Likewise, the sub-recipient agencies should work to be more responsive to the State Medicaid agency's requests for information, cooperation, and assistance.
R3.15	**Decentralize authority within State Medicaid agency:** The State Medicaid agency should decentralize authority to individuals with the necessary technical expertise to successfully deal with the complexity of issues so that it is sufficiently flexible to respond to its operating environment.
R3.16 & R3.17	**Involve program participants, stakeholders and internal staff in planning:** The State Medicaid agency should seek feedback on its mission, vision, values, strategies, and strategic objectives from the other Medicaid program participants when revising (or developing) its strategic plan, particularly sub-recipient agencies and groups advocating for impacted populations to enhance cooperation and a establish a common understanding of programmatic priorities. The State Medicaid agency should also seek additional feedback and input from its own staff to encourage positive impacts on organizational performance.
R3.18	**Select an appropriate strategic management** The State Medicaid agency should revise its approach to strategic management and select an approach that is more closely aligned to the nature of its operations. It should consider using a strategic architecture or strategic design approach to ensure that the required flexibility and empowerment of employees who exhibit core competencies are assured.
R3.19	**Implement appropriate information technology to measure program outcomes:** The State Medicaid agency should manage its information needs based on its desired end goals, outcomes, and clinical measures. It should implement the information collection infrastructure that would be required for outcome measurement. This may include the implementation of electronic medical records or internal labor intensive methods to estimate outcome measures.

R3.20	**Manage employee skills within participating agencies:** The State Medicaid agency should actively engage in skill set management and succession planning by identifying the technical skills and knowledge for critical positions and soft skills for recipient oriented positions, as well as identifying key personnel approaching retirement. The identification of high potential employees and implementation of employee development programs will ensure the long-term development of staff for future organizational roles. These activities should be extended to the State sub-recipient agencies and local agencies to ensure that these parties approach provider and recipient services in a consistent and professional manner.
R3.21	**Improve human resources support:** The State Medicaid agency should strengthen its human resources support structures in order to enhance capacity for performance management, succession management and influence on organizational goals. By heightening the level of human resources support, the State Medicaid Agency can increase opportunities to achieve measurable organizational efficiency and effectiveness through improved management of critical core competencies required at the organizational, group and individual levels.
	Medicaid Service Provision
General Assembly	
R4.8 & R4.10	**Eliminate certificates of need, lift nursing home bed moratorium, and continue to revise reimbursement system to better rebalance long-term care options in Ohio:** Ohio should eliminate certificate of need and lift the moratorium on beds in Ohio. Removing certificate of need will allow the market to adjust itself to a balance point in the long term care market. Likewise, the banking industry and loan approval processes for development include several controls for market entry. Ohio's move to a pricing system should further lessen the State's need for supply controls. Additionally, the new reimbursement formula should not overly reimburse capital and the State should move toward a system that allows for contracting services with providers on an as needed basis. In the event Ohio continues to use certificate of need to control construction and remodeling of nursing homes, then it should update its certificate of need process to include an evaluation of State and county needs; the use of alternative long term care services such as home health, assisted living, and hospice; and occupancy and use of nursing homes in the area. Additionally, Ohio should either develop regions or open bed shifting statewide so it can more effectively meet the changing demographics across county lines.
R4.9 & 4.11	**Implement consumer comparison process and use incentive payments or penalties to ensure higher occupancy levels and quality of care:** With the removal of certificate of need, Ohio should take steps to ensure quality standards are met and readily available for comparison by consumers. Ohio may also consider quality of care fines similar to Indiana's to focus on inspections to maintain the standard of care. Additionally the State should implement an incentive payment similar to Indiana, which rewards occupancy levels greater than 90 percent with all quality standards met. If Ohio continues to use certificate of need, the State should work with the industry to implement policies that reduce the number of beds in the system and redistributes them to a level that provides access to Medicaid and meets the needs of the State. Additionally the State should implement an incentive payment similar to Indiana's which is added to the formula for occupancy levels greater than 90 percent with quality standards met. Ohio may also consider that facilities with a low occupancy should forfeit a number of beds so that average occupancy is 90 percent. If Ohio continues to allow bed banking, it should consider policies that take a number of beds out of service for a given number of beds banked.
R4.14	**Place nursing home reimbursement formula in OAC:** The nursing home reimbursement formula should be removed from ORC and included in the OAC, which is consistent with other payment methodologies. Any changes to rate in OAC must go though the JACCR process and ORC §119.03 process which provides opportunities for stakeholder and public hearings on rule changes. By removing the formula from ORC, nursing home reimbursement can be more readily considered as one piece, or a component, of Medicaid long term care service delivery.

R4.15	**Require notice to the State upon death of a recipient:** Ohio should follow the Attorney General's recommendation and add language in statute requiring that beneficiaries of assets from anyone who has been on Medicaid must give notice upon death of the recipient. Additionally adding to the notice provision in ORC § 2117.061 that notice be given if the decedent or the predeceased spouse was on Medicaid would assist in recovery in cases where recovery is deferred due to surviving spouse who is not on Medicaid. With additional notice requirements on non-probate assets, Ohio should realize an increase in yearly collections.
State Medicaid Agency	
R4.1	**Align eligibility with program goals:** In order for Ohio to maintain a cost efficient yet effective program for Medicaid eligibility, it should review its eligibility coverage for all recipients of its Medicaid program in relation to program goals. The State Medicaid agency should determine whether its goals will align with maintaining a cost efficient program, or expanding eligibility to serve the largest population and maintaining an effective program. Additionally, the Single State Medicaid agency should ensure that it balances eligibility requirements and human costs. This would allow the State to provide more targeted services while managing the program in a way that prevents sweeping cuts in the future.
R4.2	**Reshape coverage using Deficit Reduction Act flexibility:** The State Medicaid agency should use the flexibility of the Deficit Reduction Act to reshape the Ohio Medicaid Program coverage, while ensuring that crucial services are still provided. The Agency has the ability to make changes such as reducing the number of services offered, limiting benefit packages, requiring cost-sharing, increasing premiums and co-payments, restricting enrollment, and increasing penalties for enrollment abuse. Although the State Medicaid Agency intends on implementing changes to it benefit packages during the SFY 2008-09 budget period as allowed under the DRA, it should consider creating different benefit packages tailored to specific populations, similar to Kentucky or implement different levels of benefit packages, similar to West Virginia's Basic Plan and Enhanced Plan. However, it is imperative that the State Medicaid Agency implement adequate consumer protections and quality benchmarks to ensure that access to health services is not limited.
R4.3	**Implement the Disability Determination Consolidation Study Council recommendations:** The State Medicaid agency should implement the Disability Determination Consolidation Study Council's recommendation for greater efficiency in its Medicaid State eligibility status, as well as administration and application processes. The State should reduce application and administrative duplication by allowing the Rehabilitation Service Commission to determine disability for Supplemental Security Income or Social Security Disability Income and Medicaid at the same time. Additionally, the State Medicaid Agency should monitor its 209(b) status, to determine if the eligibility status remains the most cost effective eligibility measure for the State. Based on the Study Council's recommendations, ODJFS could save about $2 million annually.
R4.4 & R4.5	**Implement an employer-sponsored premium assistance program and Medicaid buy-in program:** The State Medicaid agency should strive to reduce the costs of its Medicaid program by opting to implement an employer-sponsored premium assistance program and use Medicaid funds to purchase employer- sponsored group health insurance on behalf of Medicaid-eligible individuals if such insurance is available and cost effective. The State Medicaid agency should also develop and implement a Medicaid buy-in program which would enable working individuals with disabilities to buy into the Medicaid program. Annual savings from a premium assistance program, assuming that Ohio can enroll 15 percent of employed Medicaid recipients, could reach $10 million.

R4.6	**Improve consistency and process for Medicaid spend-down:** The State Medicaid agency should implement a review of CDJFS spend-down eligibility practices to ensure that all counties are following consistent rules and procedures. In addition the agency should implement training to enable pertinent members who distribute or access Medicaid spend-down eligibility, consistent and accurate spend-down service provision information related to eligibility. The Agency should also ensure that the administrative provisions related to spend-down provisions are not creating barriers to care for its recipients. Additionally, the State Medicaid agency should track recipient receipts to better serve its spend-down population and ensure access to Medicaid eligibility cards. The Agency should investigate the feasibility of online application, receipt collection, and training systems.
R4.7	**Expand community-based long-term care services to enhance long-term care rebalancing efforts:** The State Medicaid agency should consider more proactive strategies toward diverting nursing home residents from nursing homes while expanding community based services through pooled funding for long-term care budgets; demonstrated savings over institutional care; support for community residences; and case management across all service categories. Ohio should set system-wide goals for long term care service delivery which may include estimated growth projections within budgeted dollars.
R4.12	**Publish quarterly occupancy levels by county:** Regardless of whether or not Ohio maintains the certificate of need program, the State should collect and publish quarterly occupancy by levels by county. If Ohio maintains certificate of need, this will show redistribution efforts both by county and region. Furthermore, tracking changes in occupancy and availability by county would help future policy review of access to the nursing homes by recipients.
R4.13	**Monitor nursing home facility quality and condition:** With the implementation of a new pricing system, the single State Medicaid agency should monitor the nursing home industry for quality and the condition of it facilities. As the pricing system moves toward full implementation, State Medicaid agency should consider a move toward contracting services based on appropriate placement in a range of long term care service options.
R4.16	**Implement a medication therapy management program for fee-for service recipients:** The State Medicaid agency should work with major stakeholders including pharmacy providers, recipients, and physicians to develop a medication therapy management pilot program for aged, blind and disabled Medicaid recipients that will not be enrolled into a managed care plan. The pilot program may want to focus on a specific chronic disease or a group of diseases, depending upon the State's most recent utilization data. Additionally, during future contract negotiations with managed care plans, the State Medicaid agency should include a medication therapy management program requirement. If the State Medicaid agency implemented a MTM program for individuals diagnosed with diabetes, the State could save approximately $450 per person, or a total of $45 million.
R4.17	**Contract out the retrospective drug utilization review program:** The State Medicaid agency should contract with a private vendor, state medical or pharmacy association, or state university for its retrospective drug utilization review (DUR) program. In the interim, the single State Medicaid agency should proceed with plans to hire a contract employee to serve as the DUR Program Director. The DUR Program Director should resume sending notifications to providers and ensuring follow-up is completed. Furthermore, the State Medicaid agency should complete the project with Comprehensive Neurosciences. If the program results in positive health outcomes and cost savings, the State Medicaid agency should seek funding to continue the program indefinitely or fund the program through cost avoidances.

R4.18	**Monitor the effect of Medicare Part D on supplemental prescription rebates and increase generic substitution:** The State Medicaid agency should monitor the impact of Medicare Part D and statewide managed care on the Medicaid prescription drug program, specifically its supplemental rebates from manufacturers. If Ohio Medicaid experiences a loss in purchasing power, it should explore opportunities to join a purchasing pool for prescription drugs. Furthermore, the Agency should work with CMS to have the Comptroller General or Director of the Congressional Budget Office review and compare states' drug costs, after supplemental rebates, on a routine basis. If the State Medicaid agency were to experience savings through joining a multi-state purchasing pool at a level similar to Michigan, the Agency could avoid costs of $2 million. If the State Medicaid agency were to increase the use of generics to 62 percent, the State could save $57 million annually in prescription drug costs. (Assuming that 75% of costs are shifted to Medicare Part D).
R4.19	**Use waiver programs to implement pioneering approaches to services and coverage:** The State Medicaid agency should actively pursue pioneering approaches, through federal waivers, to improve services to existing recipients and expand coverage. The Agency should use limited populations to pilot the projects but should ensure that, throughout the duration of the initial waiver, appropriate input, output and outcome data is maintained so that the efficacy and cost effectiveness of the program can be determined.
R4.20	**Implement a Cash and Counseling or Independence Plus program:** The State Medicaid agency should work with the sub-recipient agencies, specifically ODA and ODMRDD, to develop and implement a Cash and Counseling or Independence Plus program in Ohio. These programs would grant Ohio Medicaid participants greater flexibility and direction over their care. The new waiver currently under development by ODJFS and ODA could serve as a method to pilot these programs before implementing them statewide.
R4.21	**Implement a regular process to evaluate rates and rate setting methodologies, and set rates to achieve program purposes:** The State Medicaid agency should implement a regular process for the periodic evaluation of all Medicaid service rates and should examine each of its rate setting methodologies separately as it undertakes rate adjustment strategies. Furthermore, the State Medicaid agency should set rates to achieve specific public policy objectives, such as access to primary care, well-child care, or prenatal care. The overall goal of the State Medicaid agency's rate reimbursement cost reduction activities should be to ensure that all Medicaid recipients are provided access to necessary care, as well as high quality services. When determining rate setting cost reductions, the State Medicaid agency should establish a more rational process for periodically reviewing and adjusting payment rates, use Medicare rates as a benchmark, perform a comprehensive analysis of access to physician services and the quality of care provided, and offer proposals for periodic future adjustments to rates based on analysis. Although modifying the design of a state health care payment system presents risks, ignoring inequities and inefficiencies in Ohio's Medicaid payment approach also endangers the well-being of the overall health care system.
R4.22	**Improve the transparency of the rate-setting process:** The State Medicaid agency should make its rate setting process more transparent by consistently keeping stakeholders and providers informed of pending rate reimbursement changes and seeking their input. To ease stakeholder concerns about the nature and timing of rate changes, the State Medicaid agency and the sub-recipient agencies should establish a more formal schedule of rate reviews and include ample opportunity for stakeholder comment.

R4.23	**Document the rate setting process and prioritization goals:** The State Medicaid agency should develop a documented policy containing detailed goals for setting reimbursement strategies and rate reductions. The Agency should routinely determine if access and quality of care to Medicaid services are compromised when rate setting cost reduction strategies are proposed and implemented. Additionally, the State Medicaid agency should document service prioritization goals when determining rate setting cost reduction strategies to be implemented to ensure the most appropriate service rates are reviewed. The State Medicaid agency should use recommended rate reimbursement criteria including ensuring that payment rates are high enough to encourage program participation by efficient providers, payment rates are low enough to minimize taxpayer burden and enable the provision of program services and enrollee coverage; and payments rates are appropriate to the overall market and individual submarkets to sustain program viability across and within a state's market areas and to avoid under and over provision of care, recognizing practice variation from one market to the next.
	Managed Care/Care Management
General Assembly	
R5.26	**Implement a High Risk Pool program for uninsured Ohioans:** The General Assembly and the Governor, with the assistance of appropriate State agencies, should implement a High Risk Pool program for uninsured Ohioans. Ohio should also access funding available under U.S. Senate Bill 288.
R5.27	**Implement a Premium Assistance/Covered at Work program for uninsured Ohioans:** The State Medicaid agency should apply for a federal demonstration waiver to implement a Premium Assistance/Covered at Work program for uninsured Ohioans. The State Medicaid agency should design the program with the goal to make preventive and primary care services available to a portion of the uninsured population
R5.28	**Pilot and test programs for the uninsured in Ohio:** The State Medicaid agency should use Ohio state-funded universities to examine current programs for the uninsured in Ohio, their financial impact, and the impact of the uninsured on Medicaid. Using this data, the State Medicaid agency should develop pilot programs to test the viability of alternative programs for the uninsured and study the cost/benefit of these programs. Based on evaluation of the pilot programs, the State Medicaid agency should take a proactive approach and make recommendations, supported by data-driven evidence, to the General Assembly concerning the addition of programs for the uninsured in Ohio.
State Medicaid Agency	
R5.1	**Develop and use a meaningful system to monitor managed care and fee-for service delivery systems:** The State Medicaid agency should develop and use a robust and meaningful evaluation system to monitor managed care and fee-for service delivery systems. To assist in developing and collecting this information, State universities have expressed an interest and capability in forming a joint venture with the State to promote health services research. Also, the Care Management Working Group, developed as a result of HB 66, could assist in determining specific measures and criteria for defining positive health outcomes.
R5.2	**Pilot alternative care models and implement effective models in Ohio:** The State Medicaid agency should pilot and evaluate alternative care models to determine which programs would be most effective in Ohio, both under fee-for-service and managed care. In particular, those Medicaid recipients having multiple, chronic healthcare needs should be targeted as they may benefit the most from an enhanced care management plan or a primary care case management program. Furthermore, the State Medicaid agency should identify cutting-edge service delivery models and apply the lessons learned through evaluations of these models to Ohio Medicaid. Finally, the State Medicaid agency should be prepared to support decisions to continue or eliminate programs through data centered empirical evaluations.

R5.3	**Implement pay-for-performance:** The State Medicaid agency should implement pay-for-performance programs within the Ohio Medicaid Program and encourage the adoption of pay-for-performance within the sub-recipient agency programs. The State Medicaid Agency should also examine program implementation and effectiveness in other states and use the lessons learned from other programs to focus Ohio Medicaid on quality outcomes.
R5.4	**Develop performance standards for the Aged, Blind, and Disabled managed care plans:** The State Medicaid agency should strengthen oversight of the Aged, Blind and Disabled (ABD) managed care program by developing performance standards for providers and health plans; collect, measure, and publicly report fee-for-service and managed care performance for the ABD and other populations; and improve coordination across many State programs that serve the ABD population.
R5.5	**Incorporate greater case management components for ABD managed care plans and implement non-medical case management:** The State Medicaid agency should, in its expansion of managed care to the ABD population, incorporate greater case management components as a condition of service for the managed care plans. Furthermore, it should seek to implement non-medical case management services on a pilot basis and consider additional case management services based on the outcome of the pilot. Finally, the State Medicaid Agency should enhance management of the complex medical needs of the ABD population thorough evaluating pilot and traditional service delivery systems.
R5.6	**Pilot forms of behavioral health "carve in" managed care programs:** The State Medicaid agency should closely examine other states' practices of managing behavioral health and pilot different types of "carve in" and behavioral health managed care programs to determine the efficacy of these programs for Ohio behavioral health services recipients. The State Medicaid Agency should also investigate alternative solutions, such as those using a specific managed care organization exclusively for behavioral health services.
R5.7	**Collect data for all HEDIS indicators of managed care clinical performance and collect fee-for-service performance measures:** The State Medicaid agency should immediately begin collecting data for all HEDIS indicators to monitor managed care plan clinical performance. It should also collect clinical performance data for the populations who will remain in fee-for-service and seek additional measures for use within the sub-recipient State agency services or compile existing measures used by these agencies into a comprehensive annual report.
R5.8	**Improve the use of consumer surveys:** The State Medicaid agency should improve the use of the consumer survey (CHAPS) to monitor recipients' access to care, customer service concerns, and perceptions of unmet medical needs.
R5.9	**Enforce prompt payment of provider claims by managed care plans and review pending and denied claims:** The State Medicaid agency should enforce the requirements surrounding the prompt payment of individual claims by each managed care plan to encourage provider confidence in Medicaid managed care plans and ensure access to care for recipients. It should enforce its standards for pending and denied claims and require managed care plans to submit aging accounts data to it on a monthly basis to better monitor pending claims. In particular, the agency could monitor the volume of claims in pending status. The State Medicaid agency should also review denied or pending claims. As a high number of denials or pending claims could result in providers canceling contracts causing a decrease in access to care, it should work with the managed care plans to improve the pending and denied claims payment process.

R5.10	**Include services provided by additional specialty types under Medicaid:** The State Medicaid agency should seek approval from the General Assembly to include services provided by additional specialty types, such as physician assistants and advanced nurse practitioners, as primary care services covered by Medicaid to increase access to care. ODJFS indicated that this recommendation could have cost implications; however, the long-term financial implication for this recommendation could not be quantified. While the recommendation could increase costs in the short-term it is possible that improved health outcomes as a result of increased preventive care and better coordinated health care could yield savings over a longer time frame.
R5.11	**Ensure physician access standards are appropriate for Ohio Medicaid managed care plans:** The State Medicaid agency should examine the time and distance standards, as well as the usefulness of its ratios, in determining appropriate numbers of physicians and dentists required under contract with its managed care plans. Using appropriate standards and ratios will help ensure access to critical services for all recipients.
R5.12	**Improve access to providers through diversifying delivery system partners, using risk-sharing models, and improving administrative processes:** The State Medicaid agency should take steps to implement processes to improve access. First, it must make a commitment to meeting the community's health care needs in its mission. The State Medicaid agency should include diverse delivery system participants, including "mainstream" providers, safety net clinics, nurse practitioners, and other specialties by developing collaborative partnerships between physicians, clinics and hospitals. Finally, communication by the State Medicaid agency to providers should be improved and administrative processes streamlined as discussed in this and other portions of the report. Implementing these recommended steps would help the State Medicaid agency ensure improved access through the availability of providers to Ohio Medicaid recipients.
R5.13	**Offer alternatives, incentives, or increased rates to ensure access to hard to find specialists:** The State Medicaid agency should consider offering alternatives to joining a managed care plan to hard-to-find specialists and dentists. Similarly, where access issues become critical in a certain field, the State Medicaid agency should consider increasing rates or offering incentives for practitioners to treat rural recipients.
R5.14	**Implement community-based low birth weight programs and seeks to expand community-based programs into other areas:** The State Medicaid agency should seek to implement low birth weight programs throughout the State. Based on the data provided by the program for the low birth weight program, Ohio could save approximately $19 million annually by reducing the low birth weight rate by 25 percent. Although the State Medicaid agency may need to focus the community-based program initially on pre-natal care, it should seek to expand the program to immunizations and other areas of preventive care. If the program can not be implemented statewide, the State Medicaid Agency should ensure its implementation in areas where access to care issues have been observed.
R5.15	**Lengthen redetermination periods to reduce churning:** The State Medicaid agency should examine the redetermination schedule and strongly consider lengthening the time between redetermination periods, particularly for the ABD population. Furthermore, the State Medicaid Agency should enhance performance measurement by soliciting the feedback of managed care plan members who may not have been enrolled for a full year in the HEDIS data collection process.
R5.16	**Implement case management for fee-for-service programs:** The State Medicaid agency should implement a case management program for all Medicaid recipients remaining in fee-for-service and not enrolled in a waiver program in which case management is already a component.
R5.17	**Ensure consistent case management services between managed care and fee-for-service:** The State Medicaid agency should mandate the managed care plans to expand their case management programs to include the same diseases as the fee-for-service case management model. Medicaid recipients often move from managed care to fee-for-service. If both managed care and fee-for-service focus on the same diseases then the recipients would have minimal interruption in their case management services.

R5.18	**Develop program-wide case management:** The State Medicaid agency should work with sub-recipient agencies to develop a program-wide case management system. At a minimum, the Agency should seek to ensure that new information systems and data warehouse structures are able to communicate plans of care from among the participating agencies. The adoption of electronic health records, as described in the technology and program management section, would expedite this process and may make it unnecessary for the State to invest in additional information systems.
R5.19	**Implement disease management for fee-for service recipients:** The State Medicaid agency should implement a disease management program for Medicaid fee-for-service recipients. In addition, the Agency should work with sub-recipient agencies to ensure that their clients are enrolled in appropriate disease management programs. Assuming similar results as other states that have implemented disease management programs, Ohio could save up to $54 million by implementing such programs for 20 percent of its Medicaid fee-for-service recipients.
R5.20	**Require managed care plans to expand the focus of disease management programs:** The State Medicaid agency should encourage the managed care plans to expand their focus of disease management and case management to include: well child, pregnancy, asthma, diabetes, congestive heart failure, chronic kidney disease, hypertension, hyperlipidemia, cancer, HIV/AIDS, chronic obstructive pulmonary disease, and sickle cell. The agency should also ensure that all appropriate managed care plan enrolled recipients are included in and use these programs.
R5.21	**Develop and use benchmarks to measure improvements in health outcomes due to disease management programs:** The State Medicaid agency should develop benchmarks that would measure each disease and the improvements in health outcomes due to the expanded disease management program. These benchmarks would help the Agency better communicate the utility and potential cost savings of the programs to stakeholders and the General Assembly. Similarly, an expansion of the use of disease management benchmarks would help the Agency better track the effectiveness of programs – allowing it to enlarge successful programs and alter those with more marginal performance.
R5.22	**Develop means to provide disease management continuity as Medicaid recipients transition off Medicaid:** As Medicaid recipients frequently lose and gain eligibility, the State Medicaid agency should investigate means to assist its transitioning recipients in continuing their disease management program. When recipients lose Medicaid eligibility, the State Medicaid agency should consider extending disease management programs through transitional care, through the fee-for-service model, or through the recipient's selected primary care physician.
R5.23	**Enhance utilization review and utilization management:** The State Medicaid agency should begin evaluating Medicaid health care expenditures through enhanced utilization review and/or utilization management. The State Medicaid agency would benefit from conducting utilization reviews on all health care services. The State Medicaid agency should coordinate with the sub-recipient agencies to ensure that utilization review and utilization management data is used in agency decision—making processes.
R5.24	**Track and report participation in the Primary Alternative Care and Treatment (PACT) program:** The State Medicaid agency should track and, at least annually, report participation in PACT, the program used to manage recipients with a history of over-utilization of services, and the potential cost avoidance generated by member participation in the program.
R5.25	**Expand the use of State universities to research and administer related programs:** The State Medicaid agency should expand its use of State universities to research and administer Medicaid-related projects.

	Technology
General Assembly/Governor's Office	
R6.1	**Create a State Coordinator for Health Information Technology position to improve health information leadership:** Ohio should create the position of State Coordinator for Health Information Technology to provide leadership in creating a single statewide consumer-centric health information technology infrastructure. This position should report to the State Chief Information Officer within the Office of Information Technology and should serve to ensure that health information technology policy and programs are coordinated with all relevant agencies as well as private industry.
R6.2	**Develop a long-term health information technology plan:** The State Coordinator for Health Information Technology should facilitate a long-term strategic plan which identifies the state's technology needs for the next five years.
State Medicaid Agency	
R6.3	**Solicit feedback from stakeholders when implementing Medicaid technology changes:** The State Medicaid agency should solicit input from stakeholders when implementing changes to Medicaid technology and should facilitate an on-going workgroup which represents the needs of all provider groups and agencies that submit claims or have a role in the claims process.
R6.4	**Require electronic storage of recipient eligibility information at county offices:** The State Medicaid agency should adopt a policy requiring the electronic storage of recipient eligibility verification information in county-level offices. Storing information electronically will reduce the reliance on paper storage, allow for better document management, and make information more easily accessible for caseworkers. The cost savings generated by this recommendation could not be quantified because the document storage costs for each county are not available.
R6.5	**Allow Medicaid applicants to complete eligibility determination forms on-line:** The State Medicaid agency should allow Medicaid applicants to complete eligibility determination forms on-line. This would reduce case worker workload and streamline the eligibility determination process. Appropriate documentation would still be submitted to by mail, fax, e-mail or by hand-delivery.
R6.6	**Install kiosks at high volume county offices to allow applicants to apply for services without meeting with a caseworker:** The State Medicaid agency should pilot an initiative to streamline the eligibility process by installing kiosks at county offices with high caseloads. Kiosks would allow applicants to apply for services without meeting with a caseworker. Information could be entered into the web application and appropriate documentation could then be submitted and reviewed at a later time.
R6.7	**Implement e-prescribing for the Medicaid program in Ohio:** The State Medicaid agency should pilot an e-prescribing program and develop a plan to implement e-prescribing statewide. The Agency should consider subsidizing providers who participate in the pilot program and who participate in rural areas and offer financial incentives to ensure statewide adoption. In additional to achieving cost-savings (estimated at up to $5 million dollars monthly or $62.2 million annually) through improved prescribing methods, implementation of e-prescribing would have an additional benefit to patients through reduced adverse reactions.
R6.8	**Pilot pre-emptive benefits coordination:** The State Medicaid agency should pilot an automated pre-emptive coordination of benefits process. The State Medicaid agency should review the results to determine if the automated system would have identified those same recoveries and if the product would produce greater savings for the State. If the pilot program is successful and can be carried over to ongoing operations, the automated coordination of benefits could serve to eliminate the need for pay and chase collections with potential savings of about $6 million. This potential savings does not include the cost to develop or implement this process.

R6.9	**Centralize claims acceptance within the State Medicaid agency:** As part of the implementation of the new Medicaid Information Technology System, the State Medicaid agency should design a workflow model which centralizes claims acceptance with the State Medicaid agency but pulls information from systems used by ODA and ODMRDD. The role of ODA and ODMRDD should be to reconcile claims with service plans and report discrepancies to the State Medicaid agency. Claims would continue be paid by ODA and ODMRDD and these agencies should also monitor the timeliness of payments to providers to ensure that existing levels of service are maintained or improved. This consolidation should also be designed with considerations for any unique requirements related to securing and sharing ODMRDD and ODA data. Moving to a centralized system would result in savings of about $1.3 million.
R6.10	**Use electronic file transfer to reduce manual entry of eligibility data by ODA:** ODA and the State Medicaid agency should review the processes which results in the manual entry of Medicaid eligibility data and should seek to transfer this information through electronic file transfer. The potential savings from this recommendation could not be determined from available data.
R6.11	**Consolidate and centralize data warehousing activities:** The State Medicaid agency should consolidate the data warehousing activities of various State agencies and centralize the data warehouse environment to reduce the duplication that exists between ODJFS and sub-recipient agencies. Although a consolidation of data warehousing would result in cost savings by reducing the resources needed to maintain separate systems, the amount could not be quantified.
R6.12	**Develop regional health information organizations (RHIO) to collect clinical outcome data and create a statewide health information network:** The State Medicaid agency should develop RHIOs which will collect clinical outcome data as it becomes available and then link RHIOs thereby creating a statewide health information network. Ultimately, the Office of Information Technology should oversee the coordination and implementation of a statewide health information network.
R6.13	**Encourage the adoption of electronic health records:** The State Medicaid agency should encourage the adoption of electronic health records. The State should minimize the risk to providers by promoting electronic health record systems which fit its needs and long term goals.
R6.14	**Reduce paper claims submissions:** The State Medicaid agency should identify the reduction of paper claims submissions as a formal strategic objective. The agency should monitor paper claims submissions, and implement formal performance goals which target reduction.
R6.15	**Require electronic claims submission:** The State Medicaid agency should adopt a formal policy requiring all providers to submit claims electronically unless explicitly permitted to submit paper claims by the State Medicaid agency. If all claims were electronically submitted, the savings would be approximately $4.2 million.
R6.16	**Change State statute to allow the State Medicaid agency to regulate claims submission processes:** The State Medicaid agency should pursue changes to the OAC to emphasize the change to electronic processes and allow the State Medicaid agency to regulate claims submissions as most appropriate to ensure efficient business practices.
R6.17	**Create an Office of Information Security to centralize participating agencies response to information security:** The State Medicaid agency should include an Office of Information Security, which is charged with developing a centralized response to information security and privacy needs. In addition, this Office should develop a business plan which identifies the Office's mission, vision, key objectives, programs, services, and initiatives.
R6.18	**Organize a privacy review committee:** The Office of Information Security should also be charged with organizing and chairing a privacy review committee. The focus of this committee should be to provide direct support and policy recommendations on issues such as Health Insurance Portability and Accountability Act (HIPAA) compliance and electronic health records.

R6.19	**Develop a coordinated strategy for communicating with providers:** The State Medicaid agency should develop a coordinated strategy for communicating with providers. The Help Desk should serve as a gatekeeper, providing one number that providers can call to ensure that inquiries are routed to the appropriate operating units. In addition, the Help Desk operation should not refer callers to third-party vendors for technical assistance.
	Program Integrity
R7.1	**Develop and implement a comprehensive risk assessment planning process:** The State Medicaid agency should develop a comprehensive, risk assessment planning process to identify and measure risks and establish goals and objectives and performance measures. A formal risk assessment planning process will help to ensure compliance with new federal guidelines and may also help to ensure that all Medicaid providers undergo prioritized, risk-based audits/reviews in compliance with audit standards and with minimal duplication of effort. Potential savings from these efforts could approach $29 million.
R7.2	**Track and monitor the results of provider background and fingerprint checks:** The State Medicaid agency should track and monitor the results of provider background and fingerprint checks and require State sub-recipients agencies to ensure that all Medicaid providers obtain State and federal-level checks.
R7.3	**Link surety bonds to provider risk levels:** The State Medicaid agency should link surety bond-related requirements to a formal risk assessment plan and accompanying risk measures and should require that any provider who has ever been investigated for fraud obtain a surety bond. Combined with State and federal-level background and fingerprint checks, stringent surety bond requirements will discourage potentially fraudulent providers from doing business in Ohio.
R7.4	**Require providers to reenroll in Medicaid at least once every three years:** The State Medicaid agency should require that all providers, regardless of the State sub-recipient agency to which they report, periodically re-enroll in Medicaid at least once every three years. This will ensure program-wide uniformity and consistent provider scrutiny across all systems and sub-recipient agencies.
R7.5	**Purge inactive providers from the Medicaid information system:** As Ohio moves to implement national provider identifiers, the State Medicaid agency should purge all inactive provider numbers from the Medicaid Management Information System, as recommended by the Commission and GAO. Specifically, the independent program integrity manager or Medicaid Chief Inspector should collaborate with technical staff to correct technology-related deficiencies and monitor and report progress in this area by means of comprehensive performance measures and annual reports.
R7.6	**Become an active participant in the Public Assistance Reporting Information System (PARIS):** The State Medicaid agency should work with US Department of Health and Human Services and neighboring states to join and participate as an active member of the PARIS program, a voluntary, federally-administered project for states to share public assistance data to maintain Medicaid program integrity and detect and deter improper payments to recipients. Potential savings based on peer state is approximately $7.3 million per year in improper Medicaid payments. This figure excludes additional potential savings and cost avoidances that could be achieved by linking PARIS to other federal programs.
R7.7	**Centralize Medicaid program integrity related training, education and monitoring activities:** The State Medicaid agency should centralize Medicaid program integrity-related training, education and monitoring activities with a program integrity manager or Medicaid Chief Inspector who is independent of OHP. Specifically, this position should work with OHP and State sub-recipient agencies to assess stakeholder training needs, develop accompanying goals and objectives, and monitor progress through performance measures that can be reported in online annual reports.

R7.8	**Provide explanation of benefit statements to all Medicaid recipients**. Although ODJFS's EOB survey process has been recognized as a best practice, the State Medicaid agency may wish to consider providing explanation of benefits to all Medicaid recipients when it issues monthly Medicaid cards.[13] Providing recipients with an explanation of benefits enhances consumer responsibility as the recipient has a better understanding of the types and associated cost of care billed to the State on their behalf.
R7.9	**Publish State-disciplined and federally-excluded providers on a central, public web site:** The State Medicaid agency should publish State-disciplined and federally-excluded providers on a centralized, public website. This serves as an additional deterrent against those providers who would seek to join Medicaid and act inappropriately. During the course of the performance audit, ODJFS updated its website to include information on excluded providers.
R7.10	**Centralize coordination and monitoring of the recovery audit/review process:** The State Medicaid agency should centralize coordination and monitoring of the recovery audit/review process with a program integrity manager or Medicaid Chief Inspector who is independent of OHP. Specifically, this position should collaborate with other entities to minimize duplication of effort and target recovery audits and utilization reviews to high-risk providers, based on the results of a joint risk assessment planning process.
R7.11	**Ensure that provider recovery audits/reviews are conducted under consistent procedures, in accordance with standard auditing practices.** The program integrity manager or Medicaid Chief Inspector should work to ensure that provider recovery audits/reviews are conducted consistently, in accordance with standard auditing procedures. The State Medicaid agency can better ensure consistency by consolidating and centralizing the recovery audit/review function rather than delegating and fragmenting these responsibilities to sub-recipient and other State agencies.
R7.12	**Centralize post-payment and cost reconciliation auditing:** If centralization and improved oversight are ineffective at resolving the identified issues, or, if all Medicaid-related claims processing is encompassed under a single agency, the State Medicaid agency should consider encompassing all post-payment and cost report reconciliation auditing under its auspices.
R7.13	**Consider using neural networking to identify fraudulent providers:** The State Medicaid agency should examine the use of neural networking as a means of identifying fraudulent patterns from large volumes of medical claims and historical provider/recipient data. The State Medicaid agency should consider collaborating with the Texas Health and Human Services Commission, which was one of the first Medicaid agencies to implement neural technology and has been recognized by GAO as an innovator in program integrity.
R7.14	**Update managed care contracts to allow the Surveillance and Utilization Review Section (SURS) and Auditor of State (AOS) to audit/review all data related to a claim:** The State Medicaid agency should update its contracts with managed care plans to formally stipulate that SURS and AOS personnel may periodically audit/review all data related to a claim.
R7.15	**Establish a Medicaid Chief Inspector position wholly responsible for Medicaid program integrity functions:** The State Medicaid agency should consider establishing a Medicaid Chief Inspector position that is wholly responsible and accountable for all program integrity functions. If the Medicaid program remains within ODJFS it should, at a minimum, make the current program integrity manager independent of internal program and policy functions (OHP), in line with Ohio Inspector General recommendations. Specifically, the State Medicaid agency should reorganize the program integrity manager's responsibilities under the Office of Chief Inspector, rather than within the bureaus of OHP.

[13] If ODJFS implemented EOB for all Medicaid recipients, it might consider also providing the information on-line in a manner similar to Blue Cross and Blue Shield of Michigan. This could be done in conjunction with information on eligibility and recipient redetermination.

R7.16	**Develop and publish a comprehensive program integrity annual report:** The State Medicaid agency should develop and publish one annual report that provides operational and financial statistics on efforts to minimize fraud, waste, and abuse. This report should also reflect the mission and vision of Ohio Medicaid program integrity efforts, incorporate mutually agreed-upon goals and objectives, and include performance measures for monitoring all State and local activities.
R7.17	**Establish and monitor program integrity related goals and measures, and adjust program integrity efforts based on outcomes;** The State Medicaid agency should establish specific goals and measures for reducing improper payments and periodically monitor the progress in achieving the established performance measures, using baseline information for comparison. It should the make the results of performance reviews widely available to permit independent evaluations of the success of efforts to reduce improper payments and ensure timely resolution of problems identified by audits and other reviews. Last, it should adjust prevention/detection control activities as necessary, based on the results of monitoring activities.
R7.18	**Develop universal and comprehensive performance measures for Medicaid program integrity:** The State Medicaid agency should develop universal and comprehensive performance measures for Medicaid program integrity. Examples include, but should not be limited to, provider enrollment/termination measures (fee-for-service and managed care plans); provider monitoring (pre- and post-payment) measures; recipient monitoring and third party liability measures; and program integrity training/education measures.

Source: AOS Performance Audit Recommendations

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PROGRAM OVERVIEW

Program Overview, History and Current Status

Program Overview Table of Contents

Introduction

This section provides a brief overview of the history of the Medicaid program at the federal and State of Ohio levels. Some of the basic tenets of the program, such as means testing, are discussed, as are trends in enrollment and costs. This section also provides a brief overview of the organizational relationships between the single State Medicaid agency, the State sub-recipient agencies, the county agencies and boards, and providers and recipients in Ohio. Because of the complexity of the program, generated by ambiguity in federal statutes and the program's implementation in the State, this section only comprises a very high level overview to acquaint the reader with the basics of the program and its functioning in Ohio. As such, the diagrams and descriptions are by no means complete in their representation of the program's functioning in Ohio. For additional detailed references, readers may wish to refer to **Appendix 1: Selected Resources** section of this report.

Medicaid Program Overview

Medicaid (Title XIX) is a federal/state entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. The adoption of Medicaid in 1965 represented a critical peak in the long struggle to adopt universal health insurance in the United States. In 1964, three alternative approaches to improving health care access were before United States Congress: (1) a universal hospital insurance program based on Social Security; (2) a voluntary physician services program supported by beneficiary premiums; and (3) an expansion of the means tested Kerr-Mills [1] program which offered a wide range of health care benefits to the elderly.

After lengthy national debate, Congress passed legislation in 1965 establishing the Medicare and Medicaid programs as Title XVIII and Title XIX, respectively, of the Social Security Act which combined all of the proposed approaches to improving health care access into a single package. The first component (universal hospital insurance) was encompassed in Medicare Part A. The Second component, voluntary physician services, was encompassed in Medicare Part B. Finally, the third component, Medicaid (originally termed Part C), broadened the health care protections offered to the elderly and poor. The original Kerr-Mills means test [2] was expanded to cover a broader population including additional elderly citizens, the indigent, blind, and permanently disabled, and adults – mostly of single headed families – and their dependents.

By 1965, 40 states had already implemented a Kerr-Mills program which provided health care coverage for medically indigent persons. In most cases, these programs provided nursing home coverage and prescription drugs. Therefore, Medicaid was perceived as being a relatively minor piece of the 1965 Social Security Legislation. By 1967, 37 states had implemented Medicaid. The whole point of the Medicaid shared financing arrangement was to give states the capacity to tailor their individual programs to their particular circumstances and goals. Without such policy flexibility, states would become supplicants, rather than partners, of the federal government. However, fiscal concerns, evident as early as 1967, clearly outweighed federalists' sentiments as the federal government's projections of costs were drastically under actual expenditures. Therefore, beginning in 1967, the federal government has, in turn, restricted benefits and pushed a greater portion of the cost sharing to the states, and increased eligibility for vulnerable populations (e.g., State Children's Health Insurance Program expansion). As a result of the federalist nature of the program, though, there are now essentially 56 different Medicaid programs – one for each state, territory and the District of Columbia.

[1] The Kerr-Mills program was drafted in 1959 in response to the Forand Bill (which proposed universal health care for the elderly) and included means testing to ensure that the program would efficiently serve the most needy citizens. Eligibility was restricted to the medically indigent – a term distinguished from totally indigent by its emphasis on the cost of large medical bills in relation to income.

[2] Ways and Means Committee Chairman Wilbur Mills proposed the means tested approach to forestall universal health care coverage, which he feared would be massively expensive and endanger the actuarial soundness of the Social Security System.

Two crucial concepts were embedded in the 1965 legislation – medical indigence and comprehensive benefits. However, the ambiguity of these concepts and subsequent interpretation has left the program open to controversy over the generosity of eligibility and benefits, and its relationship to welfare and cash assistance. The original Medicaid act mandated the coverage of certain categorical groups but allowed the states broad discretion in defining the parameters of these groups. The 1972 creation of the Supplemental Security Income (SSI) Program[3] clearly divided eligibility with the elderly, blind, and disabled gaining Medicaid eligibility under federal standards, and poor mothers and children gaining eligibility under often more restrictive state standards.

Since its adoption and implementation in 1965, Medicaid has evolved into a program of immense size, significance, and impact. Medicaid is the largest source of funding for medical and health-related services for America's poorest people. Based on the history of changes to the program and the politics surrounding those changes, Medicaid has always been controversial and vulnerable. All aspects of the program -- eligibility, benefits, payment mechanisms, and federal and state responsibility for the program -- have been hotly debated.

Within broad national guidelines established by Federal statutes, regulations, and policies, each state (1) establishes its own eligibility standards; (2) determines the type, amount, duration, and scope of services; (3) sets the rate of payment for services; and (4) administers its own program. Medicaid policies for eligibility, services, and payment are complex and vary considerably, even among states of similar size or geographic proximity. Thus, a person who is eligible for Medicaid in one state may not be eligible in another, and the services provided by one state may differ considerably in amount, duration, or scope from services provided in a similar or neighboring state. In addition, state legislatures may change Medicaid eligibility, services, and/or reimbursement during the year.

The Medicaid program is the federal government's largest health care program in terms of enrollment. Total federal and state Medicaid spending is comparable to the amount paid by Medicare. As the largest program in the federal "safety net" of public assistance programs, Medicaid provides essential medical and medically related services to the most vulnerable populations in society. The significance of Medicaid's role in providing health insurance cannot be overstated. Medicaid covered 12.0 percent of the total U.S. population in 1998, compared to 9.1 percent in 1978. In the five-year period from 1998 to 2003, total enrollment in Medicaid increased by 30 percent. According to figures presented by the Centers for Medicare and Medicaid Services (CMS), Medicaid enrollment is expected to increase from 54 million in 2003 to 65 million in 2015, a 21 percent increase.

[3] SSI consolidated five separate state-run cash assistance programs for the aged, blind and disabled into a single federal means-tested program.

Consistent with the rapid rise in enrollment, Medicaid expenditures increased at a faster rate than other insurance coverage types between 1998 and 2003. Overall, Medicaid expenditures increased by 62 percent from $153 billion to $248 billion, with spending on adults increasing by 77 percent, the greatest increase among all enrollment categories. By comparison, private insurance expenditures increased by 51 percent, and Medicare by 36 percent over the same time period.

Projections by CMS's Office of the Actuary indicate that total health care spending will continue to increase at over 7 percent per year for the next 10 years while Medicaid spending is expected to increase at a rate of nearly 8 percent per year. Additional estimates from CMS indicate that total Medicaid spending will increase from $275 billion in 2003 to $685 billion in 2015, an overall increase of almost 145 percent over the 12-year period (7.9 percent per year). Federal spending will have increased from $161 billion to $390 billion and state spending from $114 billion to $295 billion, increases of approximately 7.6 percent per year and 8.2 percent per year, respectively.

Since the Medicaid program was enacted, the federal government has made significant changes in eligibility criteria, services provided and financing of the program. In addition, states have made administrative changes (e.g., use of managed care delivery systems). Many of the changes to the Medicaid program have been in response to the growing number of low-income individuals in need of medical assistance, the need to improve access to care, and the need to contain the rising costs of providing medical assistance. **Table 2-1** shows some of the legislative changes made to Medicaid since the program was established.

Table 2-1: Major Federal Program Changes

1960's	**1965** The **Medicaid Program**, authorized under **Title XIX of the Social Security Act**, is enacted to provide health care services to low-income children deprived of parental support, their caretaker relatives, the elderly, the blind, and individuals with disabilities.
	1967 Early and Periodic Screening, Diagnostic, and Treatment (**EPSDT**) comprehensive health services benefit for all Medicaid children under age 21 is established.
1970's	**1972** States are provided the opportunity to **link Medicaid eligibility** for elderly, blind and disabled residents to eligibility for the newly enacted federal **Supplemental Security Income program (SSI).**
1980's	**1981 Freedom of choice waivers** (1915b) and **home and community-based care waivers** (1915c) are established; states are required to provide additional payments to hospitals treating a disproportionate share of low-income patients (**DSH hospitals**).
	1986 Medicaid coverage for pregnant women and infants (up to 1 year of age) to 100 percent of the federal poverty level (FPL) is established as a state option.
	1988 Medicaid coverage for pregnant women and infants (up to 1 year of age) to 100 percent FPL is mandated; special eligibility rules are established for institutionalized persons whose spouse remains in the community to prevent "spousal impoverishment;" Qualified Medicare Beneficiary group is established (QMBs).
	1989 Medicaid coverage of pregnant women and children under age 6 to 133 percent FPL is mandated; expanded EPSDT requirements are established.
1990's	**1990** Phased in **coverage of children** ages 6 through 18 under 100 percent FPL is established; Medicaid **prescription drug rebate program** is established; **Specified Low-Income Medicare beneficiary eligibility** group is established (SLMBs).
	1991 Disproportionate Share Hospital (DSH) **spending controls are established**; provider donations are banned and provider taxes are capped.
	1996 Welfare Reform — The Aid to Families with Dependent Children (AFDC) entitlement program is replaced by the Temporary Assistance for Needy Families (TANF) block grant. Welfare link to Medicaid is severed; enrollment/ termination of Medicaid no longer automatic with receipt/loss of welfare cash assistance.
	1997 Balanced Budget Act of 1997 (BBA) — State Children's Health Insurance program (S-CHIP) is created; limits on payments to disproportionate share hospitals are revised; new managed care options and requirements for states are established.
2000's	**2005 Deficit Reduction Act of 2005 (DRA)** – Made several revisions to Medicaid, allowing states to reduce benefits, increase cost sharing; limit payments for certain drugs, and tighten rules related to asset transfers.

Source: AOS compilation of various sources

Medicaid Eligibility and Services

Medicaid is a means-tested program and covers about 60[4] million people across the country, including children and families, persons with disabilities, pregnant women and the elderly. Although the program is targeted at low-income individuals, not all low income individuals are eligible, and not all of those covered are poor. To qualify for Medicaid, an individual must meet both categorical and financial eligibility requirements. Categorical eligibility requirements relate to the age or characteristics of an individual. Aged persons, certain persons with disabilities, children and their parents, and pregnant women are among the eligible categories. Financial requirements limit the amounts of income and assets individuals may have to become eligible for Medicaid (thresholds) and provide guidelines for how these amounts are calculated. The specific income and asset limitations that apply to each eligibility group are set through a combination of federal parameters and state definitions. Consequently, those standards vary considerably among states, and different standards apply to different population groups within a state. To qualify, applicants' income and assets must be within specified limits. There are three general ways in which applicants meet these requirements:

1. Income and assets equal to or below state-specified thresholds;
2. Spend-down income and assets on the costs of their care; and
3. Divest their assets to qualify for Medicaid sooner.

States have flexibility in the services offered; however, some services are mandatory if Federal matching funds are to be received.[5] Mandatory services include the following:

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[4]The Congressional Budget Office estimates that for federal fiscal year 2005-06, Medicaid will cover 60 million individuals or about 20 percent of the U.S. population.

[5] Starting on March 31, 2006, the Deficit Reduction Act (DRA) allows states to scale back the Medicaid benefits provided to a limited group of enrollees, mainly adults who are not disabled or pregnant and have income that exceeds the eligibility standard under the old Aid to Families with Dependent Children program. States can offer reduced benefit packages only to enrollees who are in eligibility categories the state established before the date of enactment, not to new categories of enrollees. Additionally, states can not reduce benefits for children, pregnant women, certain poor parents, disabled individuals, individuals eligible for both Medicare and Medicaid, and certain other aged and disabled enrollees who receive long-term care services, or are medically frail or have special medical needs. States choosing to restrict benefits must offer packages of benefits that meet certain minimum standards. The package of benefits must include certain basic services, such as physician and hospital coverage, and, with some exceptions, would be required to be actuarially equivalent to coverage provided under one of the specified "benchmark" benefit packages. The benchmark benefit packages are the standard Blue Cross/Blue Shield preferred-provider option in the Federal Employees Health Benefit program, a health benefit plan that is offered and generally available to state employees, and the benefits offered by the health maintenance organization with the largest commercial enrollment in the state. The act allows states to offer less than actuarially equivalent benefits for certain services, such as prescription drugs and mental health services, and permits states to offer wrap-around coverage for other health insurance. States are permitted to enroll children in a benchmark benefit plan but are required to provide supplemental coverage for all other Medicaid benefits, including early and periodic screening, diagnostic, and treatment services.

- Inpatient and outpatient hospital services;
- Prenatal care and nurse-midwife services;
- Vaccines for children;
- Physician services;
- Nurse facility services for person aged 21 or older;
- Family planning services and supplies;
- Rural health clinic services;
- Home health for persons eligible for skilled-nursing services;
- Laboratory and x-ray services;
- Pediatric and family nurse practitioner services;
- Federally qualified health-center (FQHC) services, and ambulatory services of an FQHC that would be available in other settings; and
- Early and periodic screening, diagnostic and treatment (EPSDT) services for children under age 21.

States may also receive federal matching funds to provide certain optional services. The following are the most common of the 34 currently approved optional Medicaid services:

- Diagnostic services;
- Clinic services;
- Intermediate care facilities for the mentally retarded (ICF/MR);
- Prescribed drugs and prosthetic devices;
- Optometrist services and eyeglasses;
- Nursing facility services for children under age 21;
- Transportation services;
- Rehabilitation and physical therapy services; and
- Home and community-based care to certain persons with chronic impairments.

Within broad Federal guidelines and certain limitations, states determine the amount and duration of services offered under their Medicaid programs. States may limit, for example, the number of days of hospital care or the number of physician visits covered. Two restrictions apply: (1) limits must result in a sufficient level of services to reasonably achieve the purpose of the benefits; and (2) limits on benefits may not discriminate among beneficiaries based on medical diagnosis or condition.

In general, states are required to provide comparable amounts, duration, and scope of services to all categorically needy and categorically related eligible persons.[6] There are two important exceptions: (1) Medically necessary health care services that are identified under the Early and

[6] The Deficit Reduction Act of 2005 allows states increased flexibility in establishing benefit packages for select Medicaid recipients.

Periodic Screening, Diagnostic Treatment program for eligible children, and that are within the scope of mandatory or optional services under Federal law, must be covered even if those services are not included as part of the covered services in that State's Plan; and (2) states may request "waivers" to pay for otherwise uncovered home and community-based services for Medicaid-eligible persons who might otherwise be institutionalized. As long as the services are cost effective, states have few limitations on the services that may be covered under these waivers (except that, other than as a part of respite care, states may not provide room and board for the beneficiaries). With certain exceptions, a State's Medicaid program must allow beneficiaries to have some informed choices among participating providers of health care and to receive quality care that is appropriate and timely.

Payment for Medicaid Services

Medicaid operates as a vendor payment program. States may pay health care providers directly on a fee-for-service basis, or states may pay for Medicaid services through various prepayment arrangements, such as health maintenance organizations (HMOs). Within federally imposed upper limits and specific restrictions, each State typically has broad discretion in determining the payment methodology and payment rate for services. Generally, payment rates must be sufficient to enlist enough providers so that covered services are available at least to the extent that comparable care and services are available to the general population within that geographic area. Providers participating in Medicaid must accept Medicaid payment rates as payment in full. States must make additional payments to qualified hospitals that provide inpatient services to a disproportionate number of Medicaid beneficiaries and/or to other low-income or uninsured persons under what is known as the "disproportionate share hospital" (DSH) adjustment.

States may impose nominal deductibles, coinsurance, or co-payments on some Medicaid beneficiaries for certain services. The following Medicaid beneficiaries, however, must be excluded from cost sharing: pregnant women, children under age 18, and hospital or nursing home patients who are expected to contribute most of their income to institutional care. In addition, all Medicaid beneficiaries must be exempt from co-payments for emergency services and family planning services.

The federal government pays a share of the medical assistance expenditures under each state's Medicaid program. That share, known as the Federal Medical Assistance Percentage (FMAP), is determined annually by a formula that compares the state's average per capita income level with the national income average. States with a higher per capita income level are reimbursed a smaller share of their costs. By law, the FMAP cannot be lower than 50 percent or higher than 83 percent. In federal fiscal year (FFY) 2004-05, the FMAP varied from 50 percent in 12 states to 77 percent in Mississippi. The average FMAP was 56.8 percent.

Medicaid in Ohio

Ohio's Medicaid system was established in 1968 and, like other states and the federal program, has undergone numerous changes in the four decades since it was established. In 2004, Ohio's Medicaid program ranked 6th in the nation in size and 5th in the amount of claims paid.[7] Ohio uses county agencies to administer its Medicaid program, a practice used in only 11 other states.[8] Also, Ohio uses locally generated dollars (property tax levy funds) to pay the non-federal share of claims and draw down additional FMAP. Ohio is one of a handful of states that uses this practice.[9]

Federal regulations governing the Medicaid program require each state to designate a "single state agency"[10] responsible for the Medicaid program. Under Ohio law, the Ohio Department of Job and Family Services (ODJFS) is that agency for the Medicaid program. Within ODJFS, the program is overseen by the Office of Ohio Health Plans (OHP). OHP's direct administration of Medicaid includes all of the functions of any major health plan, including: member services; provider network management; quality assurance and improvement; claims payment; benefit design and pricing; information services; utilization review and management; program integrity; and marketing. Various administrative responsibilities are performed by county agencies, particularly the county departments of job and family services which establish eligibility for all Medicaid recipients. In 2004, Medicaid represented almost 24 percent of Ohio's total expenditures (including federal and State funds), making it and education the two largest expenditure categories in the State budget. Over the years Medicaid has undergone many improvements and changes that have allowed more people to become eligible to receive services.

[7] Ohio ranks seventh in population based on the 2000 census.

[8] The 12 states using a locally administered program, including Ohio, are California, Colorado, Georgia, Maryland, Minnesota, New York, North Carolina, North Dakota, Pennsylvania, Virginia, and Wisconsin. Of these, only Ohio and two other states use substantial local levy dollars to draw down federal matching funds.

[9] States using local funding for non-federal Medicaid shares include Ohio, New York and North Carolina (whose local contributions are classified as "significant"), Wisconsin and Washington (which use the funding for mental health services), Oregon (for AAA programs), and Virginia and West Virginia (for Medicaid funded services in schools). Many states use intergovernmental transfers and certified public expenditures to contribute public funds for the non-federal share. Such local funding has enabled these states to enhance payments to safety net providers to ensure access to care for low-income individuals. The financing mechanisms have become an essential element of many state Medicaid programs. However, these methods for financing Medicaid expenditures have come under increasing scrutiny from the Centers for Medicare and Medicaid Services in recent years and it has attempted to impose restrictions on their use.

[10] In many of the report recommendations "single state agency" is used to indicate the future Medicaid organizational structure in Ohio. By this term, the auditor is using the federal definition of a designated agency responsible for the program within a given state, not necessarily indicating that a stand-alone Medicaid agency is the best organizational option.

Like other states, several agencies participate in the Medicaid program. ODJFS acts as the single state Medicaid agency while sub-recipient agencies, each of which has county or regional branches, include the following:

- Ohio Department of Mental Retardation and Developmental Disabilities (ODMRDD);
- Ohio Department of Mental Health (ODMH);
- Ohio Department of Alcohol and Drug Addiction Services (ODADAS); and
- Ohio Department of Aging.

These sub-recipient agencies serve specific population groups. Additionally, the Ohio Department of Health serves as a provider for some public health services (immunization tracking and lead poisoning screenings), conducts all inspections for licensure and certification of long-term care facilities, and manages the certificate of need program. The Ohio Department of Education (ODE) performs some administrative claiming, originally related to the Community Alternative Funding System, a Medicaid program administered through participating school districts.[11] School districts that participate in the Medicaid administrative claiming program are reimbursed for outreach and referral and linkage activities where potential recipients are linked with county DJFS offices. In addition, the Ohio Attorney General's Office performs Medicaid fraud investigation and prosecution functions as Ohio's Medicaid Fraud Control Unit, while the Auditor of State performs claims audits through its Fraud and Investigative Audit Group. Lastly, the Ohio Office of Budget and Management is heavily involved in advising the Governor's Office of funding availability for the program and working with ODJFS to set reimbursement rates and program funding levels. In all, ten distinct State-level agencies are participants in the program.

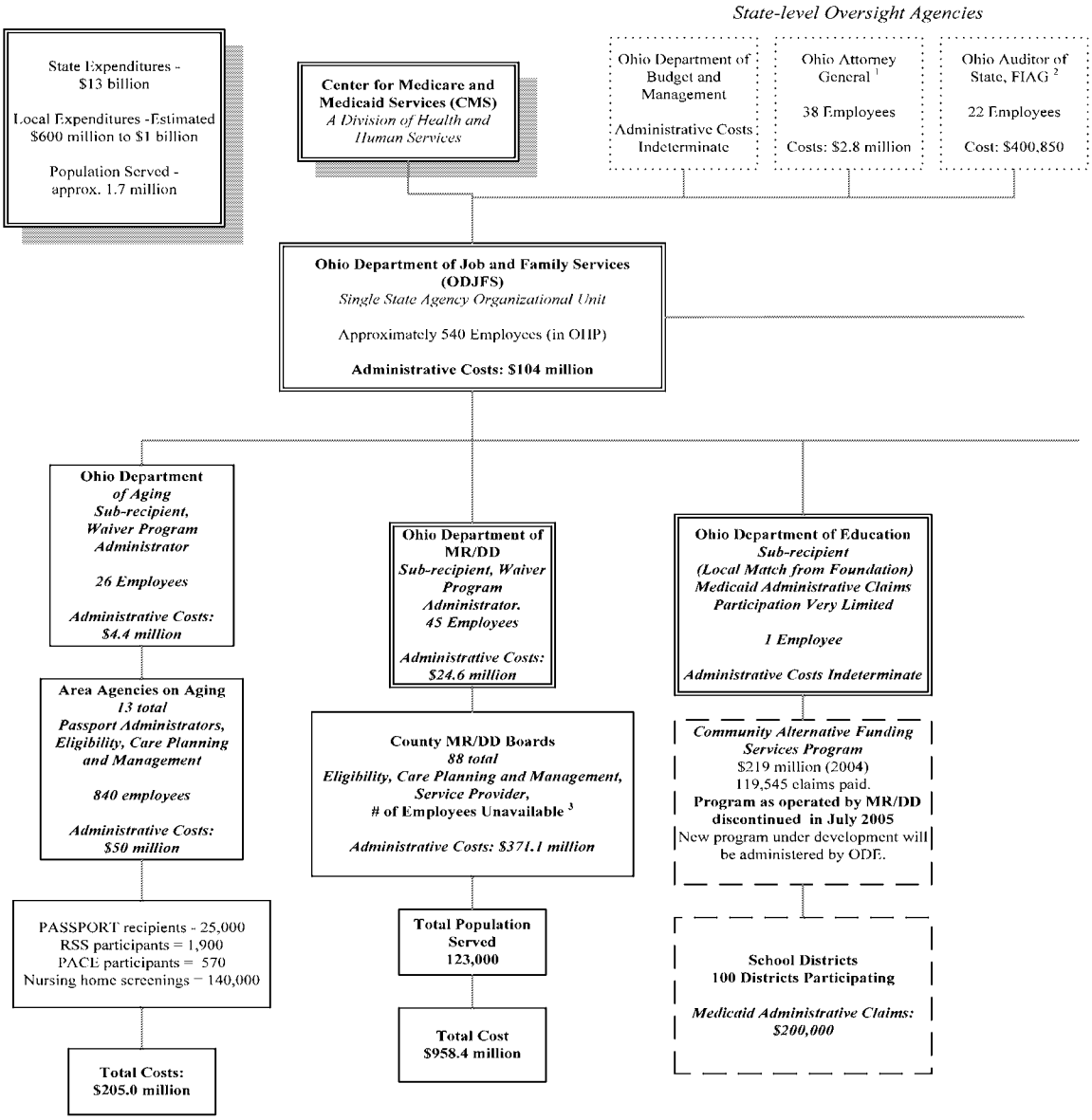
At the county level, Departments of Job and Family Services are responsible for eligibility determination.[12] The County boards of MRDD perform service coordination, some service provision, and act as local funders for MRDD Medicaid recipients. County boards of Mental Health and Alcohol and Drug Addiction Services serve as local funders as well, but have no service coordination or provision authority. Area agencies on Aging perform service coordination and have some funding responsibilities. In all, 245 county-level agencies play some role in the provision, funding, monitoring or eligibility determination aspects of Ohio Medicaid.

[11] The Community Alternative Funding System was discontinued by the federal Center for Medicare and Medicaid Services because it lacked "state-wideness." The program paid for certain services to special needs students and was used to varying degrees by participating districts. Over 1/6th of Ohio school districts participated in the program. ODE, ODMRDD, and ODJFS are working with the federal Center for Medicare and Medicaid Services to re-implement the program in a manner designed to meet federal requirements.

[12] Eligibility determination for Medicaid is performed in conjunction with determinations for other ODJFS administered programs like Temporary Assistance for Needy Families (cash assistance) and food stamps.

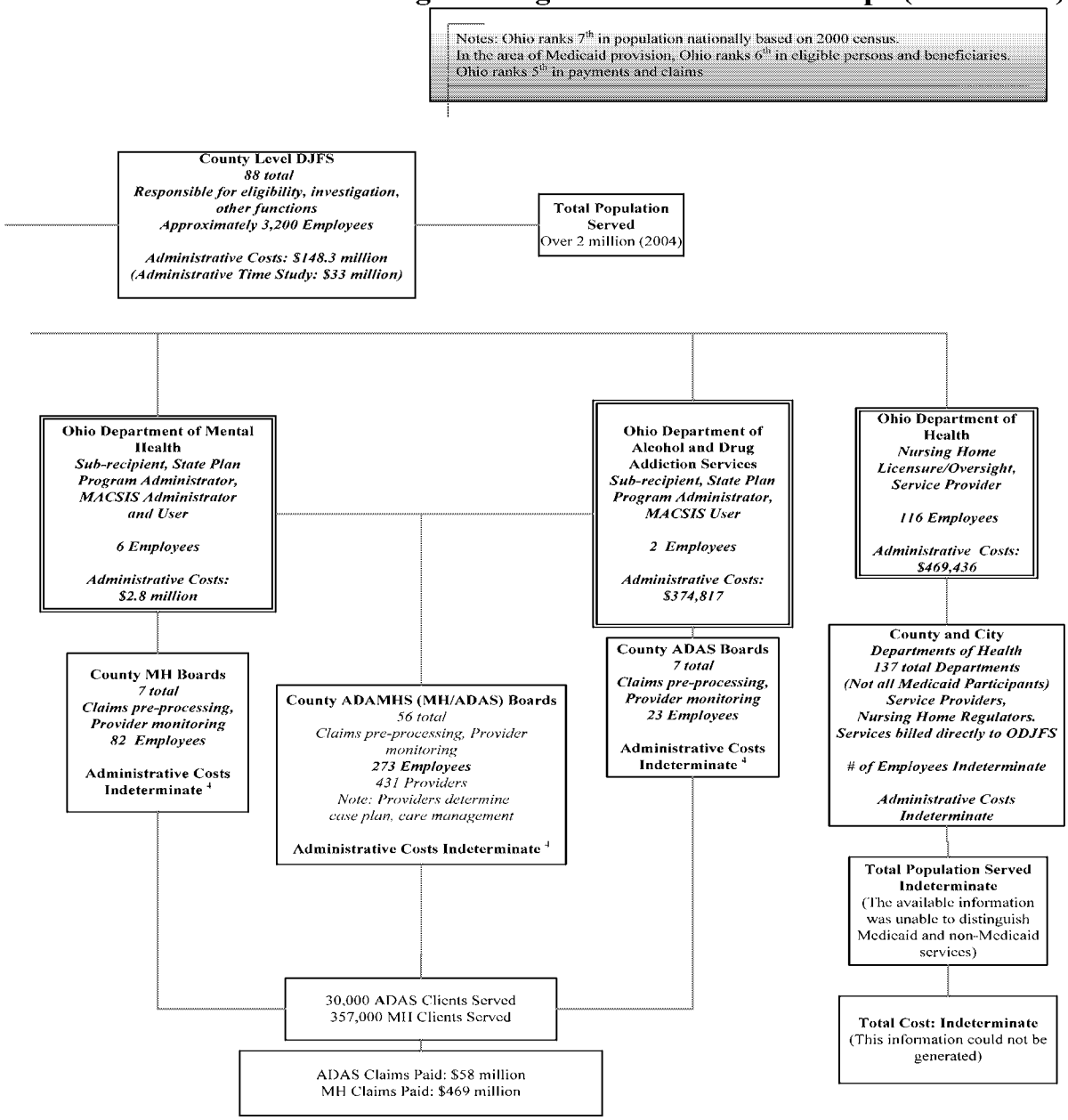
Chart 2-1 shows the organization of agencies involved in Ohio Medicaid, along with expenditure levels and populations served. The funding and program relationships between these agencies are shown in greater detail in **Charts 2-6** to **2-11**.

Chart 2-1: Ohio Medicaid Program Organizational Relationships



Source: Financial Data from OBM ALI 600-655, also ODMRDD, ODMH, ODADAS, ODJFS, and ODA, Self-reported Agency data on employees compiled by AOS. These employees represent those with Medicaid responsibilities. Population served self-reported by agencies. In some cases, employee and recipient figures have been estimated. 2004 data unless otherwise noted.
Note 1: In several instances, information was not available from the county-level offices because of data collections methods used by the counties and State-level agencies. State-level costs do not include $400,000 transferred to the Board of Regents.
Note 2: State and local administrative costs often include technology-related costs, local administrative costs often include transportation for recipients and other functions.
[1] Based on 2003 data
[2] Does not include charge-backs to auditee
[3] County-level MRDD agencies do not track staff time in a manner that differentiates between Medicaid administration and Medicaid direct services.
[4] ADAS, MH, and ADAMH boards do not track administrative time because it is not reimbursed. These boards' agreements with the state-level agencies do not include a provision for reclaiming administrative costs through Medicaid.

Chart 2-1: Ohio Medicaid Program Organizational Relationships (Continued)



Like the federal system, Ohio Medicaid has undergone changes to improve services and expand eligibility, or to meet the requirements of federal changes. In 1975, ODMRDD received Medicaid funding for the first time. In 1978, managed care began to be implemented in various parts of the program in a limited fashion to enhance system accountability for access and quality, and to achieve greater cost predictability. In the same year, nursing facilities and Intermediate Care Facilities for the Mentally Retarded (ICF/MR) began receiving retrospective reimbursements from Medicaid.

During the early 1980's, Ohio began to enroll certain Medicaid populations into managed care plans under the 1915b federal waiver program.[13] In addition, Ohio began to cover home and community based long-term care to elderly and disabled populations who would otherwise be institutionalized in 1981. In 1982, Ohio expanded Medicaid coverage by permitting ODMH to begin receiving Medicaid dollars to fund community mental health services. In 1984, Ohio began implementation of the PASSPORT demonstration project and, in 1988, permitted ODA to begin receiving Medicaid funds for PASSPORT program administration. Finally, in 1989, Ohio began implementation of the Healthy Start Program which allows children up to age 19 and pregnant women to obtain medical coverage.

The 1990's was a decade of extensive change in the Medicaid program in Ohio. In the area of elder-care, Ohio expanded PASSPORT services statewide in 1990, and in 1997, under the Balanced Budget Act of 1997, it added the program of All Inclusive Care for the Elderly (PACE) as an optional state plan service for Medicaid. PACE sites provide participants with all of their needed healthcare, medical care, and ancillary care in acute, sub-acute, institutional, and community settings. Ohio implemented the program with two PACE programs, located in Cuyahoga and Hamilton Counties.[14]

ODADAS treatment coverage under Medicaid began in 1991. Then, in 1993, Ohio began using 1115 waivers[15] to expand managed care for Medicaid recipients. Eligibility was expanded in 1997 when Ohio enacted the State Children's Health Insurance program (SCHIP) to provide medical care to the growing number of children without health insurance. SCHIP represented the single largest expansion of health insurance coverage for children since the introduction of Medicaid in 1968. One year later, Ohio expanded Medicaid coverage in the Healthy Start program to 150 percent of Federal Poverty Level (FPL). Finally, in 1996, ODJFS entered into a

[13] Section 1915(b) Managed Care/Freedom of Choice Waivers provide the Secretary of Health and Human Services authority to grant waivers that allow states to implement managed care delivery systems, or otherwise limit individuals' choice of provider under Medicaid.
Section 1915(c) Home and Community-Based Services Waivers provide the Secretary authority to waive Medicaid provisions in order to allow long-term care services to be delivered in community settings. This program is the Medicaid alternative to providing comprehensive long-term services in institutional settings.

[14] In November 2002, the two Ohio PACE programs moved from demonstration status to full provider status and, in 2005, these programs were moved to ODA for oversight and administration.

[15] Section 1115 Research & Demonstration projects provide the Secretary of Health and Human Services broad authority to approve projects that test policy innovations likely to further the objectives of the Medicaid program.

publicly bid contract to establish, maintain and operate the Medicaid Consumer Hotline. The agency received 19,689 calls in its first year of operation and 447,277 in 2002.

The expansions in eligibility and services occurred in most states during the 1990's, reflecting the economic prosperity of most state governments and the increased attention to the rising costs of health care and the impact of limited access to care on the uninsured. Like many states, Ohio further expanded Healthy Start under SCHIP in 2000. This expansion raised the income limit for eligibility to 200 percent of FPL, but children are eligible only if they are uninsured, as a federal match was not offered for this expansion.

The 2000 expansion of SCHIP was the last program expansion in Ohio and the following six years have been marked with program changes intended to control costs and reduce State financial liability for the program. In 2003, ODJFS implemented a preferred drug list (PDL) that includes both generic and trade-name drugs that do not require prior authorization. This has resulted in some savings within Ohio Medicaid's pharmacy benefit program. In an effort to reduce the use of more costly medications, a $3 co-payment was enacted on January 1, 2004 for medications that require prior authorization.

In 2004, ODJFS phased in a new initiative called Enhanced Care Management to expand care management for eligible aged, blind, or disabled (ABD) Medicaid consumers. Enhanced Care Management targeted adults who had been diagnosed with certain diseases or conditions and children under age 21 with asthma. This program was terminated in June 2005, when the General Assembly made the decision to expand full-risk managed-care statewide.[16] Lastly, in 2005, Ohio implemented several changes to the disability determination process to increase efficiency and timeliness. Changes include the establishment of a Case Tracking System, improvements in the workflow documentation process, and upgrades to ODJFS's mainframe eligibility system (CRIS-E).

On December 13, 2003, the Ohio Commission to Reform Medicaid was formed. The purpose of the Commission was to conduct a complete review of the State Medicaid program and make recommendations for comprehensive reform and cost containment. A report was submitted to the Governor, Speaker of the House, and Senate President in January 2005. Several of the recommendations of the Commission were addressed through Amended Substitute House Bill 66, effective June 30, 2005.

Table 2-2 shows the recommendations made by the Ohio Commission to Reform Medicaid and how these issues have been addressed through HB 66 by category. Items in italics were not addressed in HB 66. Items with a check mark have been implemented or are in process.

[16] According to the Ohio Health Plans Section Chief, ODJFS elected to terminate the Enhanced Care Management program and use its limited personnel resources to enact state-wide, full-risk managed care.

Table 2-2: Actions on Ohio Commission to Reform Medicaid Recommendations (HB 66)

Long-Term Care (LTC):
LTC-1: ***Offer cost effective long-term care and eliminate the established bias towards nursing homes.*** √ (LTC-1.1) Remove the nursing home reimbursement formula from Ohio statute…. **(HB 66 § 206.66.22** revises formula**)** *(LTC-1.2)Phase out the current Certificate of Need for Ohio's nursing homes*
LTC-2: ***Ensure access to and information about long-term care service options and expand those options.*** *(LTC-2.1) Create a comprehensive pre-admission screening process for Medicaid-funded long-term care….* *(LTC-2.2) Establish Long-Term Care Resources Centers in each Area Agency on Aging service area.* √ (LTC-2.3) Offer assisted living as a Medicaid option. **(HB 66 § 5111.893)** *(LTC-2.4) Increase the clinical capacity of home care options to care for consumers.*
LTC-3: ***…Modify estate and asset recovery… [and] state funding policy.*** √ (LTC-3.1) Modify Ohio's estate recovery process to the maximum extent allowed under federal Medicaid estate recovery law. In addition, use waivers to create incentives through an estate recovery model for consumers to select the lowest cost care options. **(HB 66 § 5111.11)** √ (LTC-3.2) Establish a long-term care "voucher system" **(HB 66 § 206.66.38)** *(LTC-3.3) Increase assets that may be retained by income-eligible Medicaid waiver applicants to avoid premature admission to an institutional setting* *(LTC-3.4) Increase coordination between state agencies, adopting nationally recognized quality performance standards, and requiring managed care entities to purchase surety bonds to strengthen financial solvency.* √ (LTC-3.5) Establish a Managed Care Working Group (referred to as the *Medicaid Care Management Working Group*) including representatives from […list follows] **(HB 66 § 5111.161)**
LTC-4: Withhold payment of the hospital Graduate Medical Education (GME) Medicaid subsidy from those hospitals that fail to participate in expansion of care management. (HB 66 § 206.66.51)
Pharmacy (Ph):
Ph-1: ***Secure the best prices for drugs (brand, generics and over-the-counter medications) through expansion of buying power and creation of a more competitive market for price negotiation*** (Ph-1.1) Consolidate all drug purchasing by the state and other Ohio public entities with Ohio Medicaid through administrative streamlining for the purposes of negotiating rebates and better overall prices for individual drugs **(HB 66 § 5111.082)**. At the same time, analyze the financial benefits of expanding the pool further through participation in newly emerging multi-state drug purchasing pools **(HB 66 § 5111.0114)**. *(Ph-1.2) Remove bureaucratic obstacles to accessing Home and Community-Based Services as quickly as nursing facility care.*
Ph-2: ***Create a cost-efficient long-term care system with consolidated budgets, data collection and planning*** *(Ph-2.1) Create a unified long-term care budget ….* *(Ph-2.2) Establish a long-term care policy coordinating body ….*
Care Management (CM):
CM-1: ***Establish a statewide care management program for all Medicaid recipients.*** √ (CM-1.1) Expand the full-risk managed care to all covered families and children **(HB 66 § 5111.661 and 5111.16(B)(1)).** √ (CM-1.2) Apply care management to the Aged, Blind and Disabled consumers as appropriate….**(HB 66 § 5111.661 and 5111.16(B)(2)).** (CM-1.3) Implement outcome-based protocols that offer incentives… to constrain cost and improve health status …. **(HB 66 § 5111.17)** (CM-1.4) Lift restrictions in the current rebate system, which exclude certain Medicaid purchases from negotiated cost recovery….. **(HB 66 § 5111.082)** *(CM-1.5) Create a transparent pharmacy program that allows for open, prospectively negotiated and publicly disclosed individual drug discounts, based on competitive pricing*
CM-2: ***Restrict drugs eligible for payment under Medicaid program using a more limited formulary …*** *(CM-2.1) Limit the number of preferred drugs and require documentation and prior authorization (PA) for off-formulary use* *(CM-2.2) Regularly evaluate … evidence-based research on the use of prescription drug therapies, and … ensure their practice* (CM-2.3) Set …time specific goals for increasing the use of generic … as percent of all drug expenditures **(HB 66 § 5111.083)**
CM-3: ***Reduce State expenditure at the point-of-purchase of Medicaid drugs.*** *(CM-3.1) Bring Medicaid pharmacy reimbursement into parity with commercial insurers.* √ (CM-3.2) Create a system of modest patient cost sharing for all drug purchases…. **(HB 66 § 5111.0112(A))** *(CM-3.3) Implement a mail-order program for Chronic Care Maintenance Medications.*

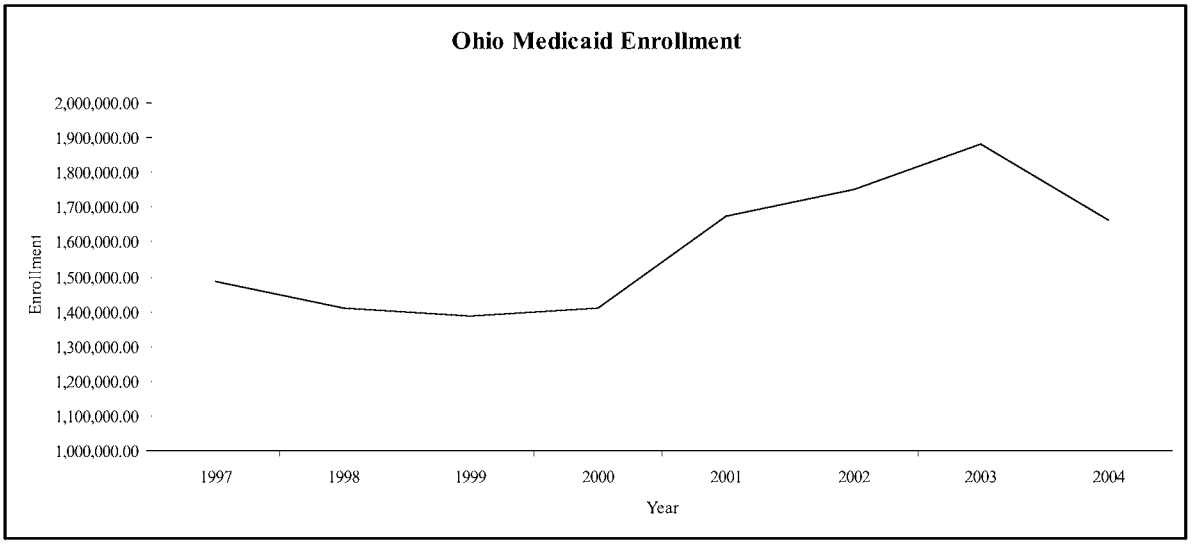
CM-4: ***Establish systems to monitor cost effective management of drugs by …prescribing physicians and health plans***
(CM-4.1) Initiate Medication Therapy Management
(CM-4.2) Provide incentives for physicians and hospitals to move toward electronic prescribing supported by evidence-based research, practice guidelines and step therapy **(HB 66 § 5111.084)**
CM-5: *State financial liability in the shift to Medicare Part D*
(CM-5.1) Monitor the shift to the Medicare Part D formulary for the dual eligible population….
Eligibility(E):
E-1: ***Terminate, effective July 1, 2005, the duplicative disability determination process administered by the ODJFS***
E-2: ***Further develop data and policy alternatives for aligning ABD eligibility ….***
E-3: ***Ensure Medicaid is the payer of last resort***
(E-3.1) Modify the current benefit coordination practices to ensure that Medicare and private sources are the first payers ….
Structure and Management (SM):
SM-1 : ***Design and implement a comprehensive program of fiscal compliance audits and performance audits to improve effectiveness and overall operation of the Medicaid program***
√ (SM-1.1) Provide the Auditor of State with statutory and independent budgetary authority to conduct performance audits of the Medicaid program and provider audits **(HB 66 § 206.66.49)**
(SM-1.2) Strengthen, formalize and validate audit-sampling techniques to determine levels of fraud, waste and abuse
(SM-1.3) Reposition the Surveillance Utilization Review Section (SURS), as an independent entity within ODJFS
SM-2: ***Update the Medicaid information systems and integrate financial, program management and patient care functions***
(SM-2.1) Develop a comprehensive business case analysis for the entire Medicaid information technology system….
(SM-2.2) Implement an Enterprise Data Warehouse System for the purposes of eliminating redundant reporting systems, exposing operational inefficiencies and modeling solutions **(HB 66 § 5111.915)**
SM-3: ***Expand overall health care coverage through a better-defined relationship between Medicaid and employer-based health plans***
(SM-3.1) Collect premiums from persons receiving transitional Medicaid benefits
(SM-3.2) Require certain employed Medicaid recipients to enroll in private insurance.
(SM-3.3) Establish a Medicaid Buy-In Program … after implementing Commission recommendations….
Finance (F):
F-1: ***Establish firm annual spending targets for Medicaid***
(F-1.1) Beginning with the SFY 2006-07 biennium, annual appropriations to the Ohio Department of Job and Family Services' 525 line-item 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
(F-1.2) Provide program administrators flexibility and authority to manage costs within the budgeted amounts….
F-2: ***Freeze or limit institutional payment for the SFY 2006-2007 biennium.***
√ (F-2.1) Freeze hospital inpatient rates at SFY 2005 levels **(HB 66 § 206.66.22)**
√ (F-2.2) Reduce by up to 3% payment for nursing facilities and intermediate care facility/mental retardation (ICF/MR services)…. **(HB 66 § 206.66.22 and 206.66.23)**
F-3: ***Optimize cash flow by paying all bills no sooner than the end of the month, consistent with prompt pay laws***
(F-3.1) Establish a real-time, paperless, cost-claiming system and streamline and establish an integrated eligibility determination process for Medicaid …. Establish capacity for electronic prescribing…. **(HB 66 § 5111.084)**
F-4: ***Restructure Ohio Medicaid through a multi-step process over the SFY 2006-2007 biennial budget.***
(F-4.1) Appoint a Medicaid Transition Council to oversee the implementation plan to transform the Medicaid System ….
(F-4.2) Create a new Medicaid Department by July 1, 2007. **(HB 66 § 206.66.52)**
F-5: ***Leverage Medicaid's buying power through …use of care management and contracting linked to quality performance***
F-6: ***Increase Medicaid's access to clinical and analytical resources for the improvement of health care delivery and financing through independent and cost-effective collaborations with the state's Academic Medical Centers (AMC)***

Source: Commission to Reform Medicaid Report and HB 66 (AOS Compilation).
Note: Several items recommended by the Commission that were not addressed in HB 66 were implemented by ODJFS.

Although HB 66 addressed several areas raised as concerns by the Ohio Commission to Reform Medicaid, it did not address all the recommendations. In addition, some changes promulgated by HB 66 have been stalled within the State Medicaid and sub-recipient agencies. Others have been sidetracked by disagreements over which agency should control aspects of the program within the sub-recipient systems. Finally, some have been modified because of the implementation or committee process, or because of lawsuits filed by provider groups.

Despite concerns about the cost of Medicaid, substantial changes have not been made in eligibility for the most costly Medicaid consumers. In State Fiscal Year (SFY) 2005-06, the General Assembly modified eligibility for adults in the covered families and children category, dropping eligibility levels to 90 percent of the federal poverty level.[17] This change is not reflected in **Chart 2-2**, which only shows Ohio Medicaid enrollment from 1997 to 2004. In addition, the criteria for eligibility for the ABD population has remained unchanged.

Chart 2-2: Ohio Medicaid Enrollment 1997-2004



Source: ODJFS and US Census Bureau

17

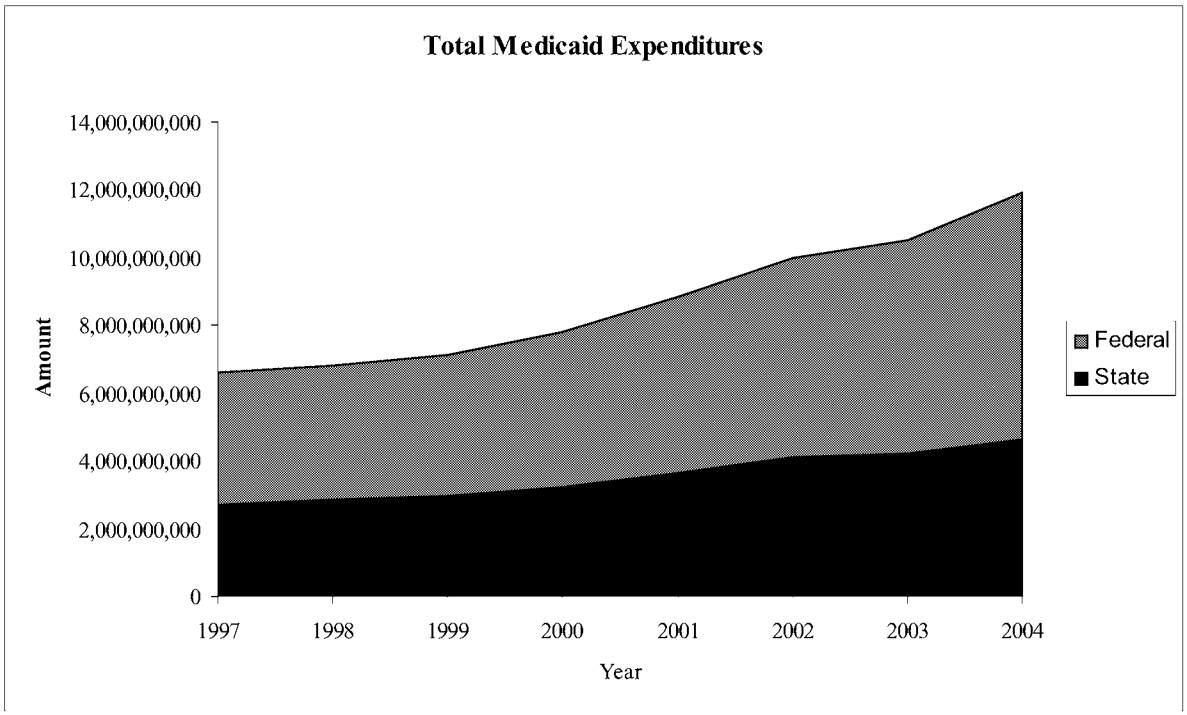
2005 HHS Poverty Guidelines

Persons in Family Unit	Poverty Guideline	Persons in Family Unit	Poverty Guideline
1	$ 9,570	2	$12,830
3	$16,090	4	$19,350
5	$22,610	6	$25,870
7	$29,130	8	$32,390
For each additional person, add			$3,260

Source: *Federal Register*, Vol. 70, No. 33, February 18, 2005, pp. 8373-8375.

In SFY 2004-05, the Medicaid program was budgeted to spend $5.4 million in State funds and draw down a federal match of $7.8 billion for a total expenditure amount of $13.2 billion.[18] **Chart 2-3** shows Medicaid expenditures for 1997 through 2004.

Chart 2-3: Total Ohio Medicaid Expenditures



As shown in **Chart 2-3**, Ohio Medicaid expenditures have almost doubled since 1997. The steepest increases have been in FFYs 2000-01 through 2003-04, despite recent declines in the population served. This reflects the increasing costs of medical care in the United States.

[18] Because Medicaid claims may remain open for 365 days from the date of service, SFY 2004-05 final expenditures were not available as of March 2006 when this section was compiled.

Overall Trends in the Cost of Health Care in the United States and its Impact on Ohio Medicaid

> "The problem with Medicaid [is] -- not the problem with Medicaid. They're the problems of the American health care system. People are saying 'Medicaid's going up so much' -- well, yeah, health care is going up. What do you expect?"
>
> *Medicaid Stakeholder*

According to *Health Spending Projections Through 2015: Changes on the Horizon* (Journal of Health Affairs, 2006), written by members of the National Health Statistics Group within CMS, health spending is expected to consistently outpace gross domestic product (GDP) over the coming decade, accounting for 20 percent of GDP by 2015. **Table 2-3** appeared in the article and presented national health care expenditure growth rates by spending category, as well as projections for 2005 through 2015.

Table 2-3: National Health Expenditure Growth Rates for 1993-2015

Spending Category	1993	2002	2003	2004	2005	2006	2010	2015
National Health Expenditures (NHE)	11.5	6.4	8.2	7.9	7.4	7.3	7.4	7
Health Services and Supplies:	11.7	6.5	8.4	7.9	7.4	7.3	7.4	7
Personal Health Care	11.5	6.3	7.8	7.9	7.5	7.4	7.3	7
Hospital Care	11.2	4.9	7.5	8.6	7.9	7.5	7.4	6.9
Professional services:	12	6.7	8	8.1	7.5	7.7	7.4	6.9
Physician and clinical services	12.3	5.9	8.6	9	7.5	7.8	7.2	6.8
Other prof. services	16.4	7.2	7.5	7.4	5.9	6.9	7.1	6.9
Dental services	9.7	7.3	4.8	6.1	7.2	7.9	7.3	6
Other PHC	11.8	12.4	8.7	5.8	9.1	7.9	9.2	8.6
Nursing home and home health:	14.3	5.4	6.1	6.6	7.7	6.4	6.4	6.6
Home health care	22.1	5.1	11.1	13.3	13.2	8.6	8	7.5
Nursing home care	12.9	5.5	4.5	4.3	5.6	5.5	5.7	6.2
Retail outlet sales of medical products:	9.7	10.1	9	6.7	6.6	7	7.3	7.5
Prescription drugs	10.2	13.4	10.2	8.2	8	7.7	8.1	8.3
Durable medical equipment	9.6	4.9	6.4	4	3.3	5.1	4.3	4.1
Nondurable medical products	9	2.9	4.2	0.4	1.1	3.5	4.1	3.4
Program admin. And net cost of private health insurance	13.7	8	17.7	9.4	4.2	6.4	8.6	6.6
Government public health activities	13.7	7.6	4.4	4	10.5	8	7.9	7.6
Investment	9.4	6.3	6.7	7.3	7.4	7.3	7.4	7
Research	9.7	7.9	9.5	9.3	7.9	7.7	7.4	6.1
Structures and equipment	9.3	5.6	5.5	6.5	7.1	7.2	7.5	7.5
NHE per capita	**10.4**	**5.2**	**7.2**	**6.8**	**6.4**	**6.4**	**6.5**	**6.1**
Population (millions)	1	1.1	1	1	0.9	0.9	0.8	0.8
GDP, billions of dollars	**8.4**	**5.2**	**4.8**	**7.0**	**6.1**	**5.5**	**5.1**	**4.7**
Real NHE	5.9	4.5	6.1	5.1	4.7	4.9	4.9	4.4
Chain-weighted GDP index	5.2	1.9	2	2.6	2.6	2.3	2.4	2.5
Personal Health Care Deflator	7.3	3.2	3.7	4.1	3.5	3.8	3.8	3.8

Source: CMS Office of the Actuary, National Health Statistics Group

Several factors on the demand side and supply side will continue to drive growth in health care spending. On the demand side, demographic shifts, declining insurance coverage, and changes in the nature of insurance, such as the rise of health savings accounts, will influence demand for public health services. The aging population will account for a small, but accelerating portion of expenditure growth at 0.4 percent in 2004 and increasing to 0.6 percent of growth in 2015, as the leading edge of the baby boom generation becomes eligible for Medicare. The cost containment strategies of changing insurance models are expected to have a very modest impact. On the supply side, growth in input prices and medical price inflation are expected to be the primary drivers of expenditure growth. New medical innovations and technology are expected to continue to drive spending upward, contributing 1.2 percentage points to growth in real per capita private personal health care spending over the period, according to the author's projection model.

By health care market segment on a national basis, total hospital spending is expected to remain at 37 percent of total personal health care spending, with a slight deceleration in spending growth in public hospital spending as enrollment growth in Medicaid slows. Prescription drug cost growth is expected to slow from historical periods to range from 8.0 to 8.4 percent going forward from 2007 after the effects of Medicare part D are incorporated. These growth rates are the result of conflicting factors such as a greater propensity to prescribe drugs to a larger portion of the population and high cost specialty drugs being prescribed for rare conditions. These conditions are offset by the increased use of generic drugs as current patents expire and an increase in cost sharing by consumers. Nationally, long-term care spending growth is expected to accelerate slightly in the short-term and stabilize in later periods. However this category is comprised of two sub-categories; home health care and nursing home care. Home health care is projected to be the main driver of long-term care spending growth. This is caused by a shift in care setting preferences, both by beneficiaries and payers, away from institutional care toward home care. Within Medicaid, the home health spending growth rate is expected to accelerate in the short-term and stabilize at an average of 10.7 percent through 2015. Medicaid's share of home health spending is expected to increase 10.9 percentage points by 2015. Nursing home spending growth is also expected to accelerate slightly during the projected period. Public spending drives this acceleration with faster growth rates in Medicare and Medicaid. Medicaid spending is expected to grow faster, averaging 7.0 percent per year during the projection period. By the end of the period, Medicaid is expected to pay for nearly half of all nursing home spending compared with less than 45 percent in 2004. Finally, physician and clinical services are expected to grow at a decelerating rate due to an expected slowing in physician fees. **Table 2-4** illustrates expectations for national health expenditures by source of funds for selected years from 1993 through 2015.

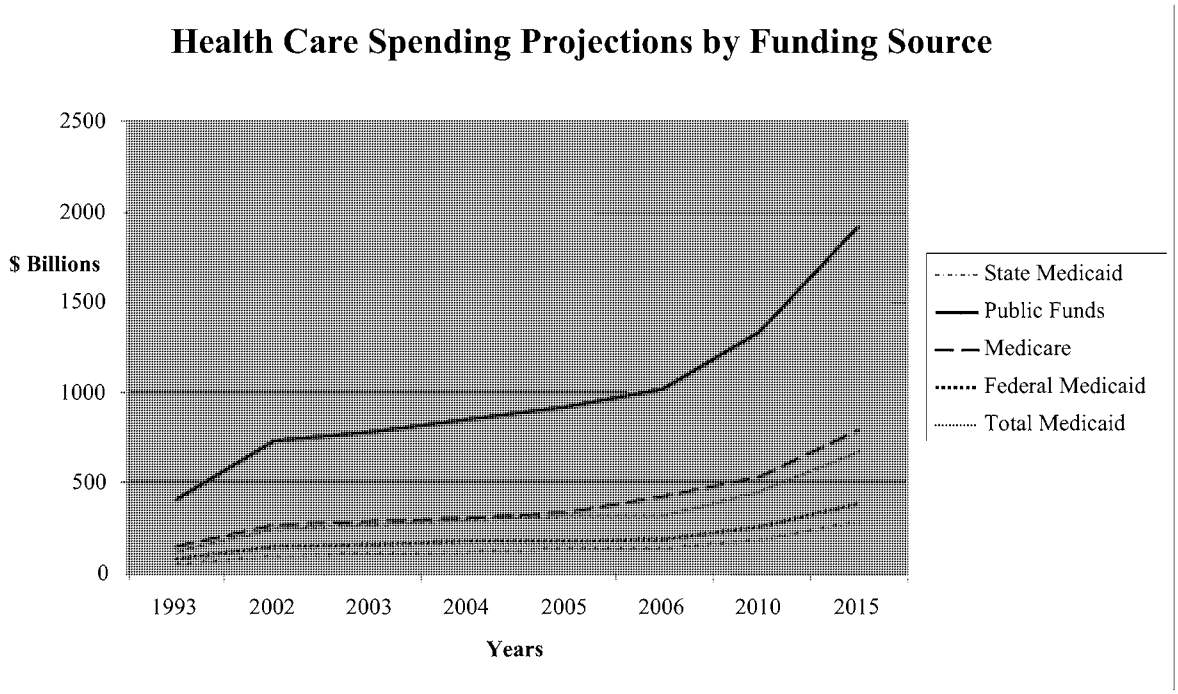
Table 2-4: National Health Expenditures by Source of Funds for 1993-2015

Source of funds	**1993**	**2002**	**2003**	**2004**	**2005**	**2006**	**2010**	**2015**
NHE (billions)	916.5	1,607.9	1,740.6	1,877.6	2,016	2,163.9	2,879.4	4,031.7
Private funds	514.2	881.4	957.2	1,030.3	1,101.4	1,148.4	1,544.7	2,116.4
Consumer Payments	442.3	763	829.7	894.2	955.2	991.2	1,334.1	1,818.1
Out-of-pocket payments	145.3	210.8	223.5	235.7	248.8	246.2	316.3	421
Private Health Insurance	297	552.2	606.3	658.5	706.4	745	1,017.7	1397.1
Other private funds	71.9	118.4	127.5	136.1	146.2	157.1	210.6	298.3
Public Funds	***402.3***	***726.5***	***783.4***	***847.3***	***914.6***	***1,015.5***	***1,334.7***	***1,915.3***
Federal	277.7	509.5	554.4	600	645.9	742	971.4	1,407.8
Medicare	148.4	266.3	283.8	309	335.5	420.1	536	792
Federal Medicaid	76.8	147.3	162.5	173.1	181.5	184	258.9	384.4
Other federal	52.5	95.8	108.1	118	128.9	137.8	176.5	231.3
State and local	124.7	217.1	229	247.3	268.7	279.2	371.2	519.4
State Medicaid	45.6	101.7	108.7	119.6	133.6	136	191.5	285.3
Total Medicaid	122.4	249	271.2	292.7	315.1	320	450.4	669.7
Other state and local	79.1	115.4	120.3	127.7	135	143.2	179.7	234.1
Average annual growth	**1993**	**2002**	**2003**	**2004**	**2005**	**2006**	**2010**	**2015**
NHE (%)	11.5	6.4	8.2	7.9	7.4	7.3	7.4	7
Private funds	11	6.2	8.6	7.6	6.9	4.3	7.7	6.5
Consumer payments	11	6.2	8.7	7.8	6.8	3.8	7.7	6.4
Out-of-pocket payments	8	4.2	6	5.5	5.6	-1	6.5	5.9
Private Health Insurance	13.7	7.1	9.8	8.6	7.3	5.5	8.1	6.5
Other Private funds	11.1	5.7	7.7	6.8	7.4	7.5	7.6	7.2
Public Funds	12.2	6.8	7.8	8.2	7.9	11	7.1	6.5
Federal	12.7	7	8.8	8.2	7.7	14.9	7	7.7
Medicare	13.7	6.7	6.6	8.9	8.6	25.2	6.3	8.1
Medicaid	15.4	7.5	10.3	6.6	4.9	1.4	8.9	8.2
Other federal	9	6.9	12.8	9.1	9.2	6.9	6.4	5.6
State and local	11.3	6.4	5.5	8	8.7	3.9	7.4	7
Medicaid	13.6	9.3	6.9	10	11.8	1.8	8.9	8.3
Other state and local	10.4	4.3	4.3	6.1	5.8	6	5.8	5.4

Source: CMS Office of the Actuary, National Health Statistics Group

Chart 2-4 graphically presents the selected national health expenditures illustrated above.

Chart 2-4: National Health Expenditures by Source of Funds for 1993-2015



Source: CMS Office of the Actuary, National Health Statistics Group

It is expected that combined state and federal Medicaid spending growth in 2005 will slow for the fourth consecutive year. Growth in real per enrollee Medicaid spending is projected to increase from 1.0 percent in 2004 to 2.8 percent in 2005. Enrollment growth is expected to decelerate, falling to 2.1 percent in 2005 from 4.2 percent in 2004, primarily because of improving economic conditions. Also, because of the changes in matching rates, state Medicaid spending growth is expected to outpace its federal counterpart. States are pursuing strategies that focus on cost containment, the most popular being negotiated rebates on prescription drugs, frozen or reduced provider payment rates, and new restrictions on enrollment. With the implementation of Medicare Part D, it is expected that Medicaid prescription drug spending will decrease as people eligible for both Medicaid and Medicare will shift to Medicare Part D.[19] Finally, in 2005, a temporary enhanced federal match rate expires and it is expected that the state Medicaid spending growth rate will be greater than the federal share as the burden shifts back to the states.

[19] However, states must reimburse the federal government for these costs. Although the payment period is set for ten years, many states are contesting the manner in which the payment rate was determined. In the case of Ohio, the rate was set based on SFY 2002-03 prescription drug costs and did not include many of the rebates the State has since negotiated. This payment is colloquially called the "claw-back."

The increases in national and state Medicaid costs are part of a much larger trend for health care costs in general. In fact, Medicaid costs compare somewhat favorably to general national health care costs. According to the Center on Budget and Policy Priorities, from 2000 to 2003 Medicaid costs per person have grown at 6.9 percent nationally, while private per person insurance costs have increased 12.6 percent.[20] Some of the environmental factors contributing to Medicaid cost increases are within Ohio's control, while others will require resolution at other levels to address fundamental economic and structural inefficiencies in the health care market.

Program Implementation and Structure in Ohio

In SFY 2004-05, the Medicaid program in Ohio encompassed approximately $13.2 billion dollars. The following were participants in the program:

- 10 major State agencies, 6 of which are directly responsible for an aspect of program implementation,
- 88 County Department of Job and Family Services (CDJFS) agencies
- 88 County Mental Retardation and Developmentally Disabled (CBMRDD) boards,
- 43 county and area Alcohol, Drug Addiction, and Mental Health Services (ADAMH) boards,
- 7 Alcohol and Drug Addition Services (ADAS) boards,
- 7 Community Mental Health (CMH) boards,
- Approximately 43,000 health care providers, and
- About 1.7 million beneficiaries.

The Ohio program is primarily designed to act as a vendor payment program; however, in some instances, it also provides case management and direct service to consumers, as in the case of the MRDD system. The following six State agencies[21] are primarily responsible for the administration of Medicaid services:

[20] On the other hand, CMS data examines overall increases and finds that, in overall cost trends, the increases in Medicaid exceed those of the general industry.

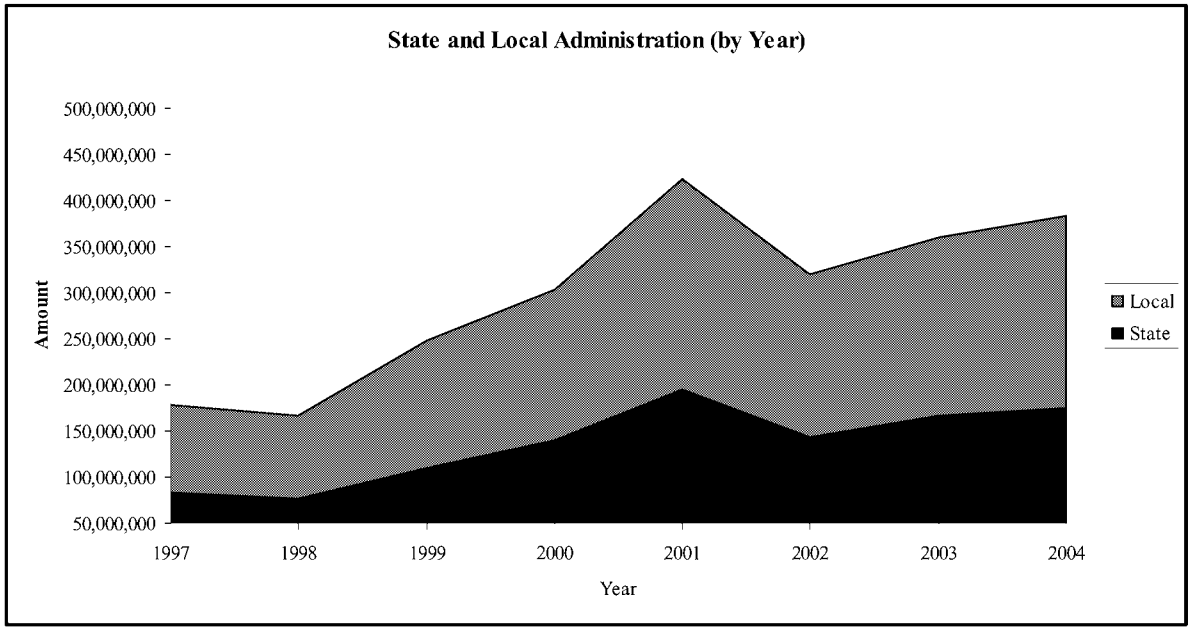
[21] The Ohio Department of Education (ODE) is also a sub-recipient agency. The Ohio Attorney General (AG) serves as the states Medicaid Fraud Control Unit (MFCU), the Ohio Auditor of State (AOS) conducts post-payment claims audits, and the Ohio Office of Budget and Management (OBM) provides assistance to ODJFS in rate setting and budget preparation.

- Ohio Health Plans (OHP) within the Ohio Department of Job and Family Services (ODJFS),
- The Ohio Department of Mental Retardation and Developmental Disabilities (ODMRDD),
- The Ohio Department of Mental Health (ODMH),
- The Ohio Department of Aging (ODA),
- The Ohio Department of Alcohol and Drug Addiction Services (ODADAS), and
- The Ohio Department of Health (ODH).

These agencies, with the exclusion of OHP, are "sub-recipients" that receive Medicaid funding under contract with ODJFS. The sub-recipient agencies are generally organized by population and their services are targeted in a similar manner. Some overlap of services exists among the State sub-recipient agencies and individuals may be using services from more than one agency.

In SFY 2003-04, the Medicaid program in Ohio had administrative costs of approximately $382 million. However, these costs represent only those reported to CMS and the federal government.[22] **Chart 2-5** shows the administrative costs in Ohio from 1997-2004.

Chart 2-5: Medicaid Administrative Costs 1997-2004



Source: CMS

[22] Community Mental Health boards and Alcohol and Drug Addiction Services boards do not capture all administrative costs as they are not authorized to conduct Medicaid administrative tasks. Likewise, some of the State sub-recipients and CDJFS do not capture all administrative costs.

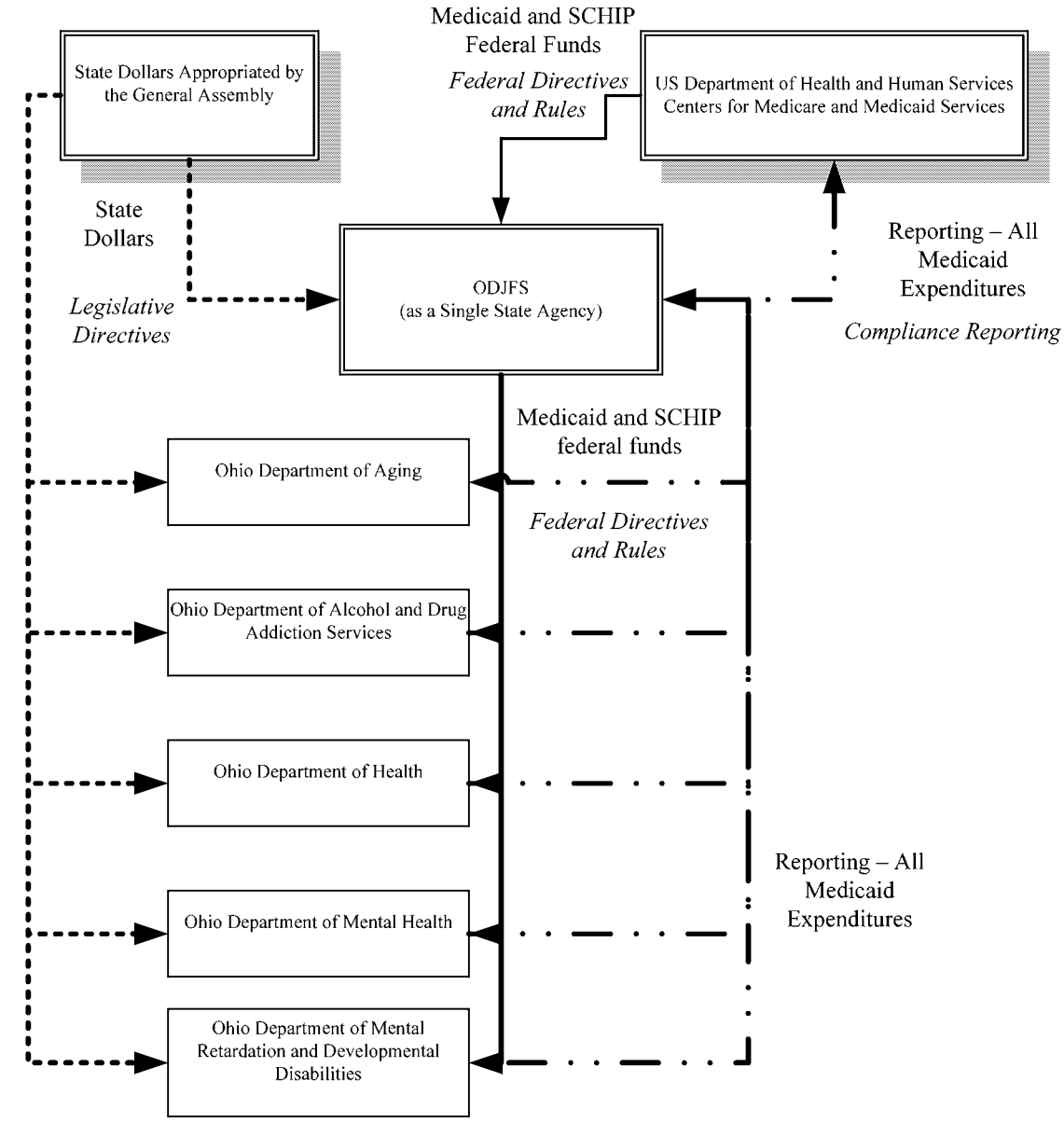
Charts 2-6 to **2-11** show the structural implementation of Medicaid within Ohio on an overall and agency-by-agency basis. The series of charts includes funding flow, rule and directive promulgation, and payment relationships. The charts and descriptions encompass the six major state agencies participating in Ohio Medicaid.

ODJFS as Single State Medicaid Agency

ODJFS is designated by the federal Centers for Medicare and Medicaid Services (CMS) as the single State Medicaid agency authority and is accountable to the federal government for supervising the administration of Medicaid grant funding by local political subdivisions. Ohio Health Plans (OHP) is the division within ODJFS responsible for Medicaid administration and is responsible for maintaining and updating the State Medicaid plan.[23] OHP provides funding for services such as nursing homes, private intermediate care facilities for people with mental retardation or developmental disabilities (ICF/MR), inpatient hospital services, outpatient hospital services, physician services, prescription drugs, ODJFS waivers,[24] physical therapy services, Medicare Buy-in, home health, dental, hospice, and other services. It also serves as the liaison between CMS and the sub-recipient agencies. **Chart 2-6** shows the relationship between CMS, the General Assembly, ODJFS, and the sub-recipient agencies.

[23] The State plan is a federally required document that outlines the State's Medicaid program.
[24] ODJFS administers the Ohio Home Care Waiver and the Transitions Waiver.

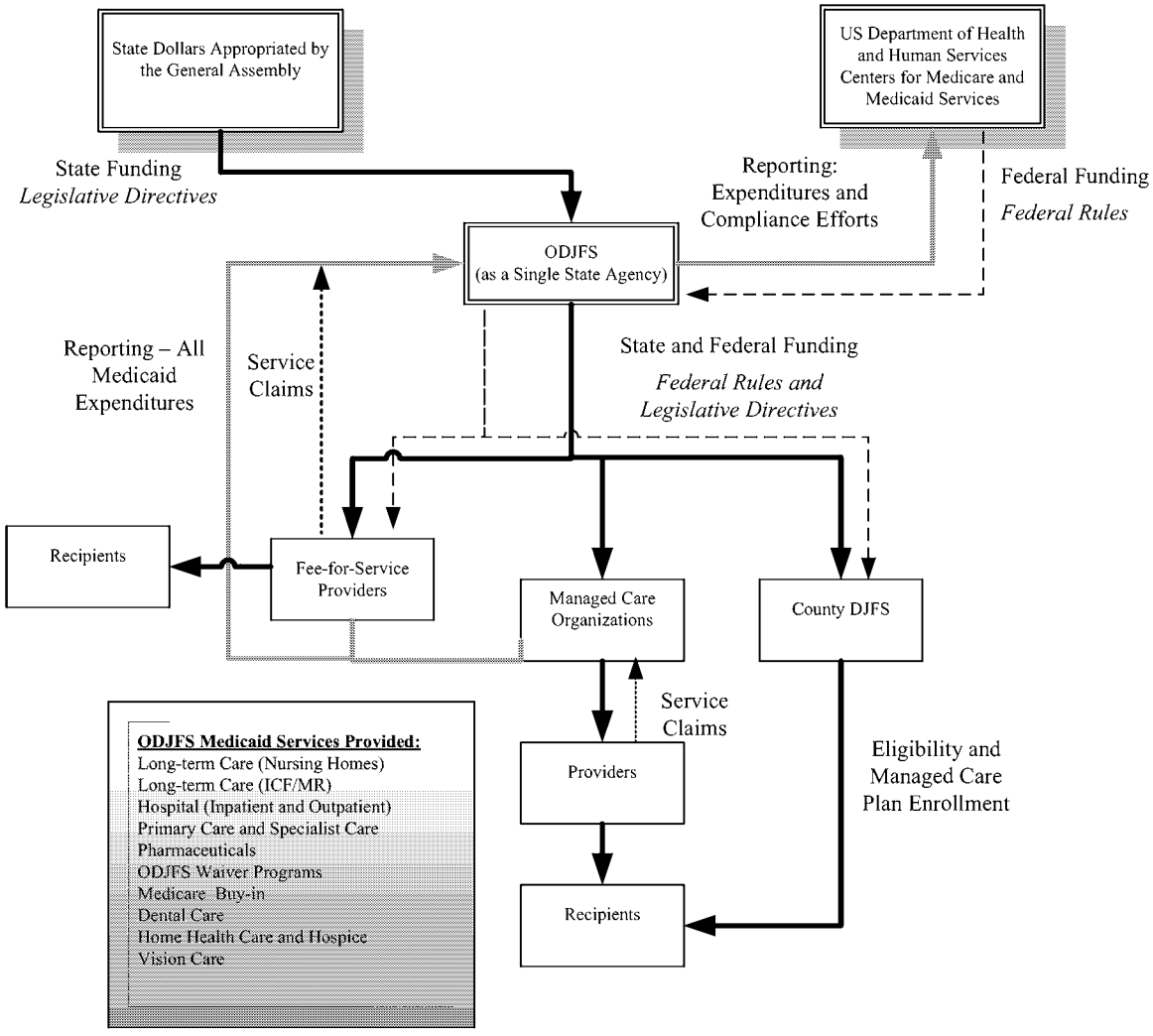
Chart 2-6: Process Flow - Ohio Department of Job and Family Services as Single State Agency



Source: AOS, Ohio Medicaid Administrative Study Council

Chart 2-7 shows the relationship between ODJFS, the County departments of Job and Family Services (CDJFS), providers and recipients. The roles of CMS and the General Assembly are also highlighted in the chart. The role of the CDJFS is also described in detail below.

Chart 2-7: Process Flow - Ohio Department of Job and Family Services



Source: AOS, Ohio Medicaid Administrative Study Council

Role of County Departments of Job and Family Services

Ohio has 88 County Departments of Job and Family Services (CDJFS) agencies which are the local representation for all of ODJFS' services. Within the Medicaid program, the CDJFS are responsible for intake of applications for eligibility determination. In addition, the agencies facilitate local transportation services to needed medical care. The Bureau of Consumer and Program Support within Ohio Health Plans is the primary area that links State and local functions. According to the Bureau Chief, the Bureau of Consumer and Program Support is responsible for providing technical assistance to counties with regard to their key function which is eligibility determination.

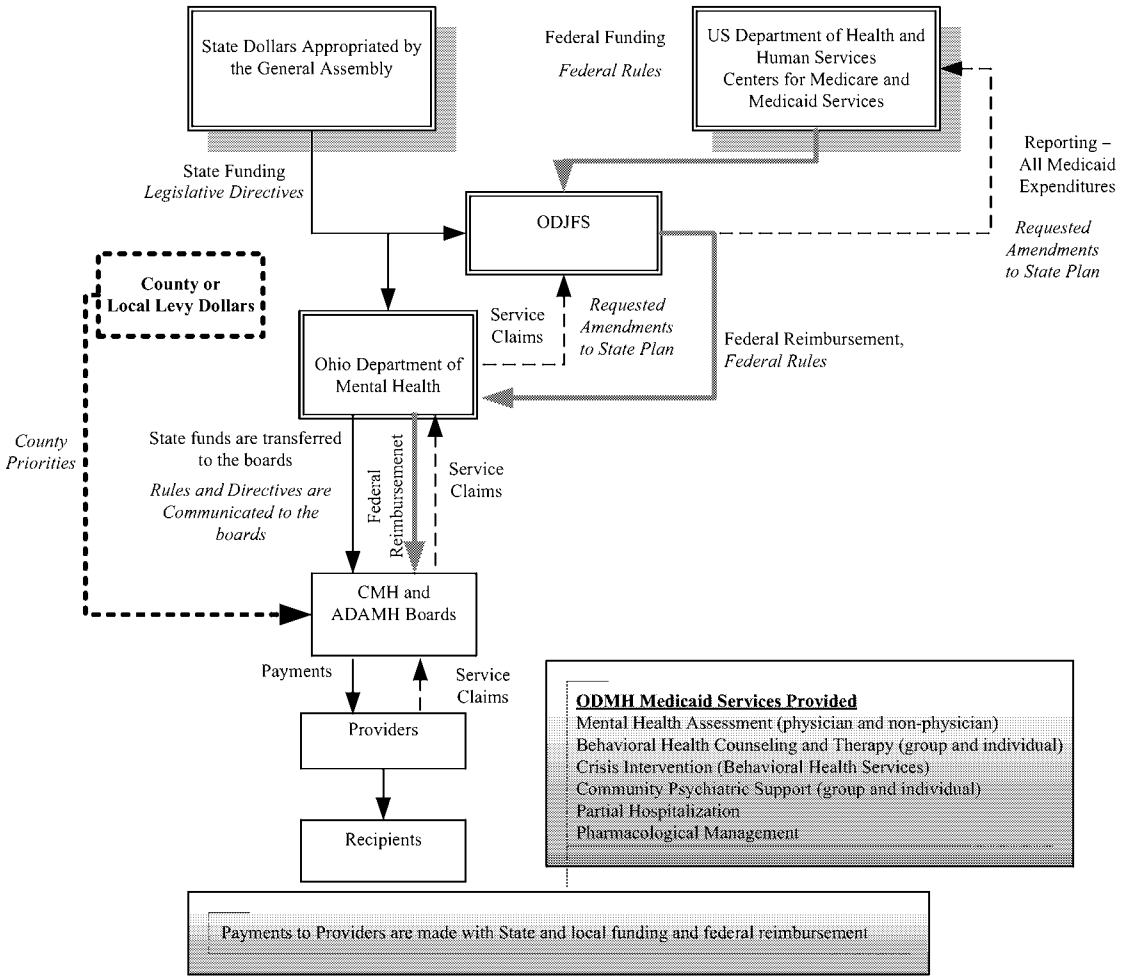
Ohio Department of Mental Health

The Ohio Department of Mental Health (ODMH) is the agency responsible for ensuring that quality mental health services are available in all communities in Ohio. ODMH employs approximately 2,760 personnel and oversees 23 community-based services,[25] such as pharmacological management, mental health assessments, and behavioral health counseling and therapy. In addition, ODMH licenses private psychiatric hospital inpatient units and community residential programs, and operates five Behavioral Healthcare Organizations that provide intensive inpatient treatment at nine campuses across the state. It also has approximately 400 staff that provide community-based services through its Community Support Networks. ODMH is the only State agency participating in Medicaid that is a service provider at the State level. With the passage of the Mental Health Act of 1988 (Ohio Amended Substitute Senate Bill 156), Ohio successfully transitioned to a State-managed, locally administered mental health system. ODMH works with local mental health boards to ensure the provision of mental health services.

Over the past decade, community mental health Medicaid expenditures in Ohio have grown from approximately $60 million in SFY 1989-1990 to $242 million in SFY 2003-04 and now accounts for about 35 percent of all community mental health spending in Ohio. According to ODMH, the growth of Medicaid funding in Ohio is attributed to two primary factors. First, the implementation of the Mental Health Act increased the need for, and availability of, resources to serve adults returning to the community, as well as those already living in the community who are underinsured. Second, Ohio's broad Medicaid coverage for mental health services permitted the dollars transferred to local communities through the implementation of the Mental Health Act to be used as State and local matching funds to draw down the federal Medicaid reimbursement. A majority of the county administrative bodies for alcohol, drug addition and mental health services are joint boards. Therefore, the role of these local organizations is discussed following the discussion of ODADAS. **Chart 2-8** shows the placement of ODMH in the organizational relationships surrounding Medicaid in Ohio.

[25] See ORC Chapter 5122-29 for a complete list of the requirements and procedures for mental health services provided by agencies.

Chart 2-8: Process Flow –
Ohio Department of Mental Health



Source: AOS, Ohio Medicaid Administrative Study Council

Ohio Department of Alcohol and Drug Addiction Services

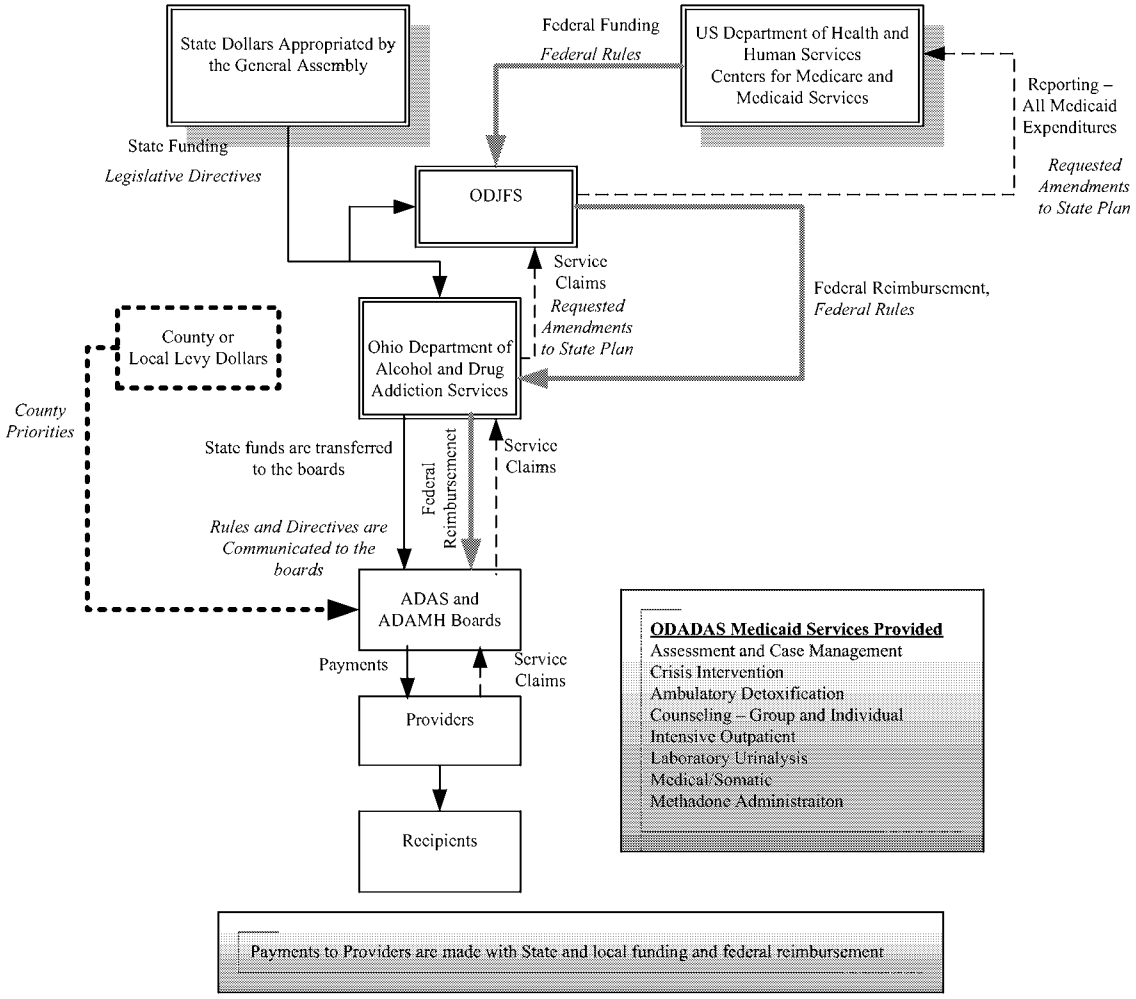
ODADAS was established in 1989 with the enactment of House Bill 317. Ohio Revised Code (ORC) § 3793.02 requires ODADAS to develop and coordinate educational and research programs that aid in the prevention and intervention of addiction to alcohol and other drugs and the coordination of treatment programs for persons who abuse alcohol and other drugs. Some of the treatment programs include ambulatory detoxification, assessments, case management, crisis

intervention, individual and group counseling, and intensive outpatient services.[26] Additional services include methadone programs and residential treatment. To meet the requirements for coordinating these programs, ODADAS has organized itself into five distinct program series: (1) Prevention Services, (2) Treatment and Recovery, (3) Planning, Outcomes, and Research, (4) Quality Improvement, and (5) Program Management. Approximately 77 percent of ODADAS funding is spent on treatment programs and Medicaid accounts for about 24 percent of total expenditures. Federal funds account for approximately two-thirds of total funding, with the largest source being the Substance Abuse Block Grant.

ODADAS community alcohol and drug program expenditures paid through Medicaid have experienced moderate growth since SFY 2000-01 (5 percent annually compared to double-digit growth for all of Ohio's Medicaid services) and were estimated at about $57 million in SFY 2004-05. The Medicaid program pays for covered services to approximately one-third of all Ohioans accessing publicly funded alcohol and other drug treatment and prevention services in any given State fiscal year. Primary factors contributing to the increasing cost of the Medicaid program include increases in the number of Medicaid eligible Ohioans accessing alcohol and other drug treatment programs, increases in the number of Medicaid participating alcohol and other drug treatment programs, and increases in the general costs of doing business. **Chart 2-9** shows the organizational relationship between ODADAS and the other State, county and stakeholder organizations in the Medicaid program.

[26] Terms are defined in OAC 3793:2-1-08. See OAC Chapter 7393:2 for a complete list of alcohol and drug addiction services.

Chart 2-9: Process Flow - Ohio Department of Alcohol and Drug Addiction Services



Source: AOS, Ohio Medicaid Administrative Study Council

Role of County Alcohol, Drug Addition and Mental Heath Boards

Ohio has 43 Alcohol, Drug Addiction, and Mental Health Services (ADAMH) boards, 7 separate Alcohol and Drug Addiction Services (ADAS) boards, and 7 separate Community Mental Health (CMH) boards.[27] Each Board has a signed agreement with its respective State agency (ODMH or ODADAS) outlining its responsibilities respective to Medicaid.[28] The boards are responsible for planning, funding, monitoring, and evaluating the service delivery systems within their geographic areas. The community mental health boards contract with local service providers to deliver mental health services in the community, including crisis intervention, partial hospitalization, and community psychiatric support. ADAS boards contract with local service providers who operate about 680 certified community programs. ODADAS certifies all alcohol and other drug addiction treatment programs and driver intervention programs. CMH, ADAS, and ADAMH boards supplement state funding for services through local levies, a portion of which is typically used as the non-federal portion for Medicaid.

Ohio Department of Mental Retardation and Developmental Disabilities

ODMRDD serves Ohioans with mental retardation or other developmental disabilities. It manages 10 developmental centers, provides protective services, administers two Medicaid waiver programs (Level 1 and Individual Options), and provides oversight of providers and facilities. The developmental centers are State-operated intermediate care facilities for the mentally retarded and developmentally disabled (ICF/MR) that serve individuals requiring comprehensive program, medical, and residential services including skills development, behavior support, and therapy. According to the Deputy Director of Medicaid Policy and Administration for MRDD, the developmental centers currently serve approximately 1,500 residents.

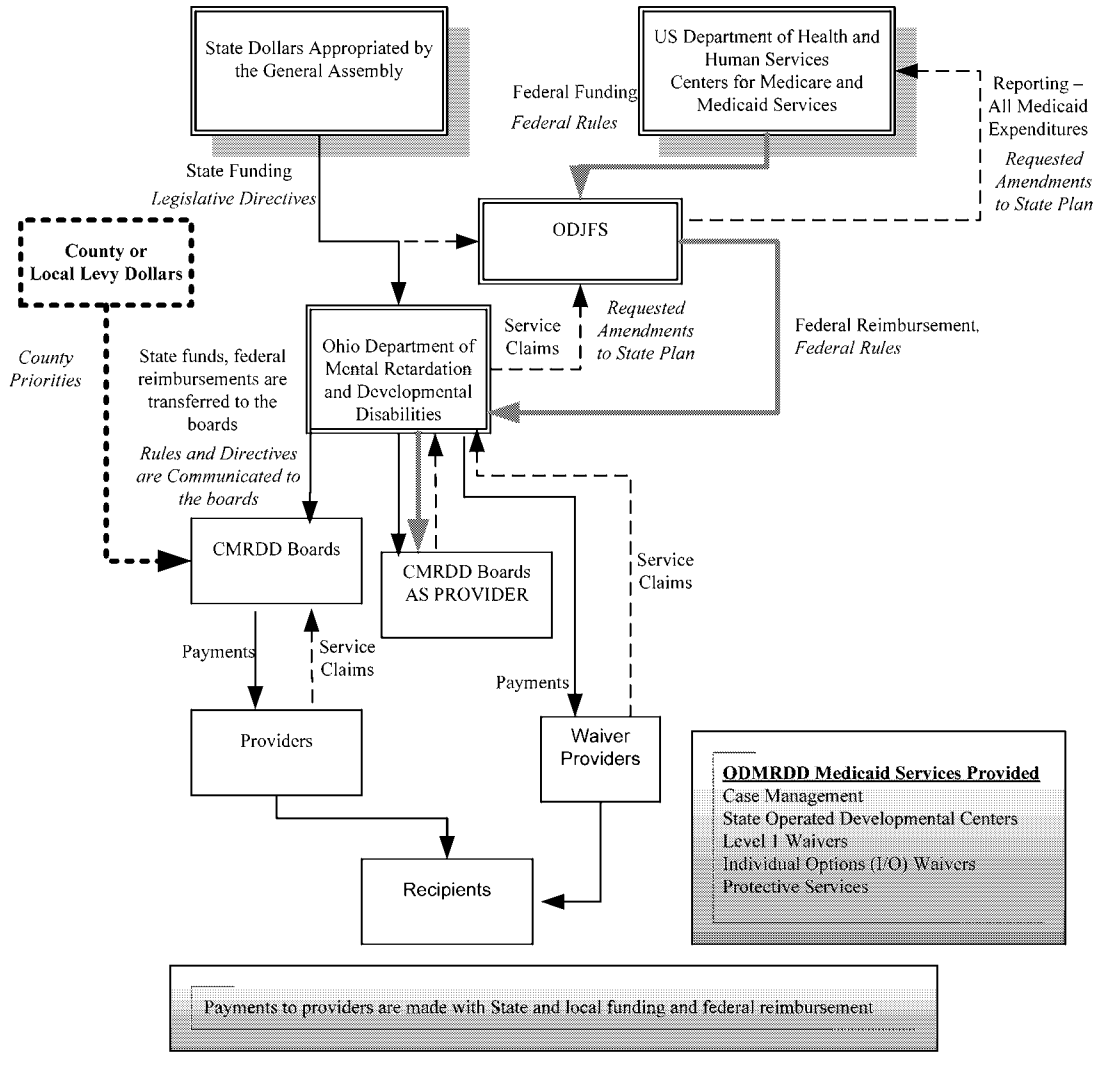
ODMRDD is charged with establishing standards, certifying providers and residential facilities against those standards, and continually monitoring the providers' and facilities' compliance with those standards. This is accomplished by conducting onsite reviews of facilities and programs to ensure compliance on a continuing basis and monitoring corrective actions in response to past findings. Finally, ODMRDD must accredit all County boards of MRDD based on standards developed by the Department consistent with federal and State regulations.

[27] In July 2006, the Lucas County Mental Health Board and the Alcohol and Drug Addiction Services Board of Lucas County merged into one agency, and as a result, there are now only six counties with separate boards.

[28] Under the mental health system, local boards entered into agreements with the Ohio Department of Mental Health for the provision of community mental health services. Initially, these contracts were in the form of a community plan. The agreements in place in SFY 2005-06 are extensions of an agreement that became effective July 1, 2002 (original) between the board and State agency. In the Alcohol and Drug Addiction Services system, local boards entered into annual agreements with ODADAS beginning in 1991 (upon the inclusion of ADAS in Medicaid). The annual agreements were changed to open ended agreements in 2000.

In the MRDD system, Medicaid funding is used for two waiver programs and the State-operated developmental centers. Medicaid funding represents a significant portion of ODMRDD's operating budget. In SFY 2004-05, Medicaid expenditures comprised almost 90 percent of the total ODMRDD budget. **Chart 2-10** shows the relationship between ODMRDD, the county boards of MRDD, and other Medicaid participants.

Chart 2-10: Process Flow – Ohio Department of Mental Retardation and Developmental Disabilities



Source: AOS, Ohio Medicaid Administrative Study Council

Role of County Boards of MRDD

County MRDD boards are unique in that they are both a service provider and are responsible for the administration of waiver services provided by private entities. In addition, county boards provide targeted case management (TCM) services. County boards must perform comprehensive evaluations, habilitation services, relocation management, and ongoing monitoring of Medicaid recipients. Boards also conduct assessments based on statewide guidelines to determine eligibility for services provided within their system. In theory, this allows the county boards to direct resources more effectively and control access to services. After these assessments, individuals may use the county board services or those of a private provider. However, county boards cannot provide waiver services, only day services. Some boards have joined together to form Councils of Governments (COGs) to fulfill some of their responsibilities in administering the waivers. As outlined in the interagency agreement with ODJFS, county boards provide the State and local match and fulfill administrative functions (which are matched by federal funding). County boards also recruit providers and enter them into the waiver payment system.

Ohio Department of Aging

The Ohio Department of Aging (ODA) serves and advocates for Ohioans age 60 years and older. ODA administers programs emphasizing community-based care as an alternative to institutional (nursing home) settings. The goal of these programs is to improve the quality of life for older Ohioans by providing services that allow individuals to live in their own homes for as long as possible. Traditionally, over 90 percent of ODA's budget is subsidy distributions for community-based care.

ODA administers programs such as Pre-Admission Screening System Providing Options and Resources Today (PASSPORT), the Choices waiver, and the program for All Inclusive Care for the Elderly (PACE). In addition, ODA began administering an Assisted Living program in 2006. The PASSPORT program is a Medicaid waiver program that helps low-income seniors obtain assistance with daily activities in their homes as an alternative to nursing home care. The program accounts for the majority of ODA's expenditures, and, in SFY 2003-04, approximately 75 percent of ODA's budget was expended on this program. In 1995, PASSPORT began receiving funding from horse racing taxes. The amount received from this funding source has gone up 121 percent since inception (from $1.9 million to $4.2 million). A portion of nursing home franchise fees also go toward the PASSPORT program. In SFY 2003-04, ODA received approximately $33.3 million from this funding source.

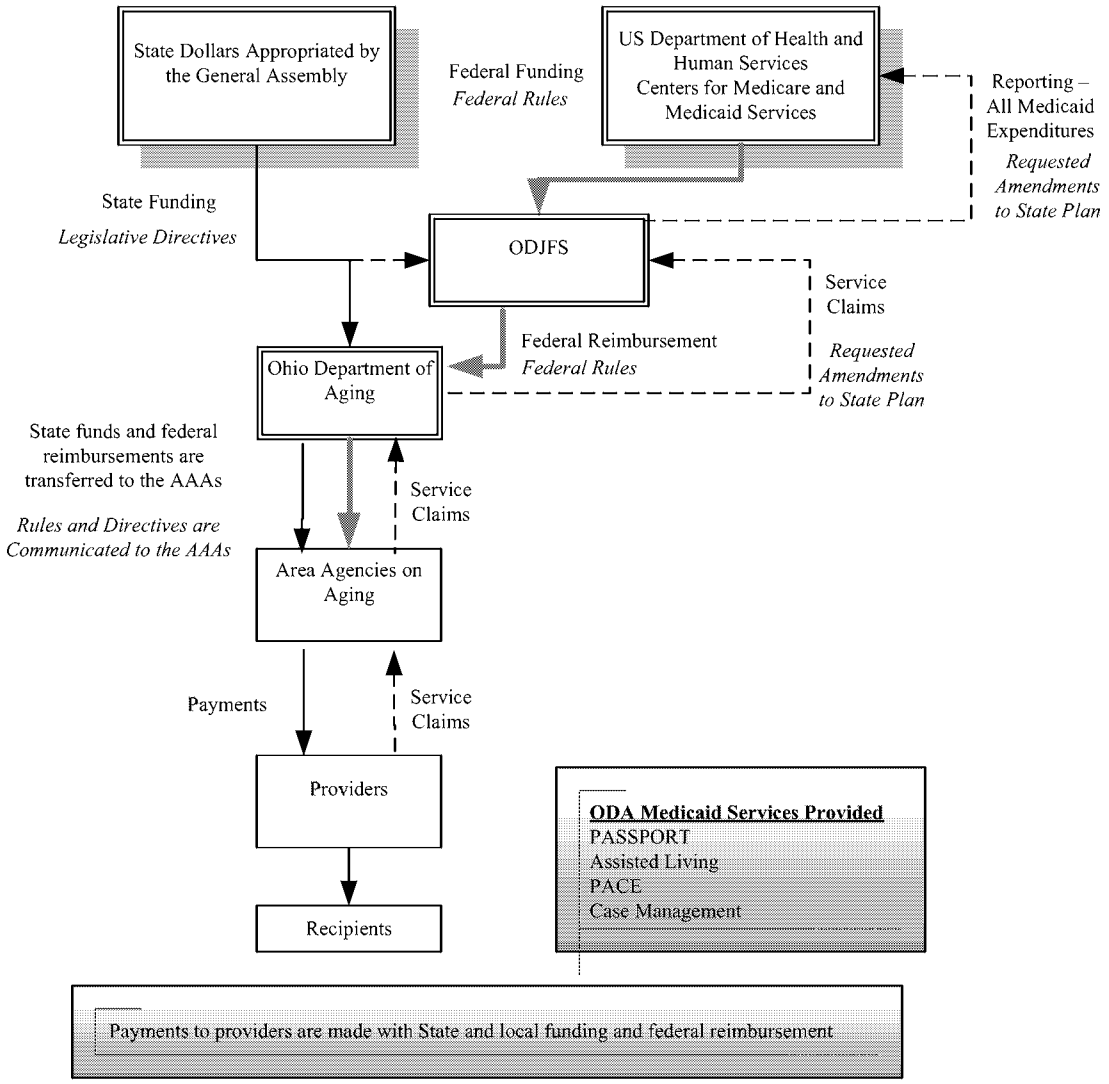
ODA also offers "Choices," a consumer-directed waiver program, in which enrollees take an active role in directing their own care by hiring their own caregivers, including family members, friends, or other individuals. The choices waiver program served 157 central Ohioans in 2004 and received authorization to expand into two additional regions in southeastern Ohio next year.

HB 66 transferred the "day-to-day" administrative duties for the PACE program to the ODA. However, appropriation authority had not been transferred to ODA pending federal approval, and therefore, historical data reflect these expenses in ODJFS. The program of All-Inclusive Care for the Elderly (PACE) is a Medicaid component based on a managed care model through which certain sites provide frail, older adults with all of their needed health care and ancillary services in acute, sub-acute, institutional, and community settings. Enrollment is voluntary, and once enrolled, PACE becomes the sole source of all Medicare and Medicaid covered services as well as other medical, social, or rehabilitation items or services the PACE interdisciplinary team determines an enrollee needs.

Assisted living services are defined as home and community-based services providing personal care, homemaking, chores, attendant care, medication oversight, and therapeutic social and recreational programming. This program is intended to move individuals with intermediate needs from nursing facilities to residential care facilities.

Chart 2-11 shows the relationship between ODA, the Area Agencies on Aging (AAAs), and other Medicaid stakeholders.

Chart 2-11: Process Flow - Ohio Department of Aging



Source: AOS, Ohio Medicaid Administrative Study Council

Role of Area Agencies on Aging

ODA also provides technical and financial assistance to the State's 12 Area Agencies on Aging (AAAs) which were created by the federal Older Americans Act of 1965. The AAAs administer most State and federal aging programs in Ohio. Over 300,000 Ohioans receive services through ODA programs and local AAAs.

Ohio Department of Health

ODH provides preventive medical services, public health education, and health care services in support of its mission to protect and improve the health of all Ohioans by preventing disease, promoting good health, and assuring access to quality health care. ODH has a total annual budget of approximately $561.6 million (SFY 2005-06). However, ODH has a relatively minor role (in terms of funding) within the Medicaid program. ODJFS contracts with ODH to certify skilled nursing facilities, nursing facilities, and MR/DD ICF/MR facilities. It also conducts public health lead poisoning investigations and tracks immunization data involving Medicaid eligible children. Additionally, ODH administers the certificate of need program. Any nursing home capital improvement project over $2 million must be approved by ODH.

ODH's activities are governed by the Public Health Council. However, the Council does not have administrative or executive duties. ODH employs approximately 1,372 employees. In addition to its central office operations, there are 137 local health districts that are governed by local boards of health and health commissioners. The local health departments receive funding from many sources including ODH line items earmarked for specific purposes and subsidy moneys which are allocated according to a formula developed by the Public Health Council. Services provided by local health districts that are eligible for Medicaid reimbursement are paid for by ODJFS in the same manner as other medical services.

Conclusion

The Ohio Medicaid program may, like the program in many other states, need to make substantial changes to its services, eligibility, and administrative structure. Because of factors like the complex administrative environment resulting from multiple agency involvement and the need to balance services with available resources, the Ohio program is likely to undergo a substantial evolution to ensure future viability, and improved coordination and efficiency. Furthermore, the inclusion of non-indigent persons in state or federal health insurance is a recurring topic subject to political debate that may drive future decisions about how medical care is provided to Ohioans.

The following report sections explore several central issues within the Ohio Medicaid program. The topics researched and addressed in this report, while highly important within the program, are not exhaustive as the scale of the program does not permit a comprehensive review of all aspects within a reasonable time frame. Materials within the report focus on processes and conceptual approaches rather than a high degree of detail for the same reasons. A detailed explanation of the audit scope within each report section is included in **Appendix 2: Summary of Objectives**.

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ORGANIZATIONAL ISSUES

Organizational Issues

Organizational Issues Table of Contents

Background

This section of the performance audit of Ohio's Medicaid program reviews aspects of the management and implementation of the program including: strategic planning, support functions, and budgetary and performance measurement processes. In addition, it evaluates organizational structure options for future Medicaid administration. The issue of organizational structure for the program comprises three critical components. First, the organizational design of publicly funded health care and the role of Medicaid must be considered within the larger context of health care in general. Second, the roles of Medicaid participating State agencies, or sub-recipients, must be examined for appropriateness and value. Third, the operating structure of the primary Medicaid agency must be evaluated to determine if the current structure promotes positive organizational characteristics and capabilities relative to the operating environment.

As part of the review of organization structure and other organizational issues, this analysis included an environmental assessment of Ohio's Medicaid program. This assessment involved input from the State agencies participating in the Medicaid program, local administrative bodies, provider stakeholder groups, and recipient stakeholder groups. As the Ohio Department of Job and Family Services (ODJFS), and more specifically its Office of Ohio Health Plans (OHP), is the single State Medicaid agency and the only Medicaid administrator that has duties solely dedicated to Medicaid,[1] this review is more heavily focused on the operations of this organization. Furthermore, OHP has direct control over approximately 85 percent of the program resources and has at least indirect control over, or input into, the remaining 15 percent of the resources (see **Illustration 3-1**). Furthermore, if the General Assembly creates a new stand-alone Medicaid agency, OHP's functions and, perhaps, its personnel, will form the core of this agency.

The information from OHP and other State agencies participating in the Medicaid program was compared to other states' practices, as well as to literature providing standards and best practices for organizational design and management. The various service provision relationships between State agencies, providers and recipients of service are explained in detail in the **Medicaid program overview, history and current status** section of this report.

[1] OHP is also responsible for two programs closely tied to Medicaid - the State Children's Health Insurance Plan (SCHIP) which is linked to Medicaid eligibility and Disability Medical Assistance (DMA) which is provided to disabled individuals who often become Medicaid eligible.

Ohio Department of Job and Family Services

ODJFS is designated by the federal Centers for Medicare and Medicaid Services (CMS) as the single State Medicaid agency and is accountable to the federal government for supervising the administration of Medicaid funding. It allocates State and federal resources directly to providers, and managed care plans while serving as a pass-through to sub-recipient agencies and, by extension, their local representatives for federal reimbursement funds. Ohio Health Plans (OHP) is the division within ODJFS responsible for Medicaid administration. OHP is responsible for maintaining and updating the State Medicaid plan. The plan is a federally required document that outlines the State's Medicaid program. OHP pays for services such as nursing homes, private intermediate care facilities for people with mental retardation or developmental disabilities (ICF/MR), inpatient hospital services, outpatient hospital services, physician services, prescription drugs, ODJFS waivers,[2] physical therapy services, Medicare Buy-in, home health, dental, hospice and other services. **Chart 3A-1** (in **Appendix 3-A**) shows the placement of OHP within the ODJFS organizational structure.

There are eight bureaus within OHP,[3] with three reporting to the Assistant Deputy for Long Term Care: the Bureau of Long Term Care Facilities, the Bureau of Community Access and the Bureau of Home and Community Services. Three bureaus report to the Assistant Deputy for Benefits: the Bureau of Health Plan Policy, the Bureau of Consumer and Program Support and the Bureau of Managed Health Care. The remaining two, the Bureau of Clinical Management and the Bureau of Plan Operations report to the Assistant Deputy for Operations. Organizational changes have been frequent in the past due to various external and internal management reviews. **Chart 3A-2** in **Appendix 3-A** illustrates the organizational structure of OHP.

OHP appears to have generally organized its bureaus based upon service types, service delivery models, and functions. Service types are generally correlated to certain populations served by the Medicaid program. Service types that are reflected within the organizational framework include the following:

- Long-term care (coordinated by the Bureau of Long-term Care Facilities);
- Home and community based services (coordinated by the Bureau of Home and Community Services); and
- Liaison services between sub-recipient agencies and CMS (facilitated by the Bureau of Community Access).

[2] ODJFS administers the Ohio Home Care waiver that provides home and community services for people with serious disabilities and unstable medical conditions eligible for Medicaid coverage in a nursing home or hospital, and the Transitions waiver that provides home and community services for people eligible for Medicaid coverage in an intermediate care facility for people with mental retardation or developmental disabilities (ICF/MR).

[3] The organizational structure presented in this report is a new structure that is not fully in place until October, 2006. OHP previously had seven bureaus and a different management structure. The Bureau of Clinical Management was spun off from the Bureau of Plan Operations.

In contrast, three bureaus are organized on a functional basis to support the fee-for-service model and overall program including:

- Fee-for-service reimbursement (coordinated by the Bureau of Plan Operations);
- Clinical, development, and support functions such as disability determination, prior authorization, and breast and cervical cancer services (coordinated by the Bureau of Clinical Management);
- Interaction and support of County Departments of Job and Family Services (CDJFS) and the intake function (coordinated by the Bureau of Consumer and Program Support); and
- General health plan policy for developing, revising, or implementing health plan design features (coordinated by the Bureau of Health Plan Policy).

The Bureau of Managed Health Care is the only bureau within OHP that is organized solely on a service delivery model alternative to the fee-for-service system. Each of these bureaus then is further organized by functional responsibilities, which at times overlap. In general, functional based bureaus have duties that are more narrowly defined, while those organized by service type or service delivery model have more comprehensive responsibilities with some functional overlap. The organization and duties of each bureau is presented in further detail in **Appendix 3-A**.

Role of County Departments of Job and Family Services

Ohio has 88 County Departments of Job and Family Services (CDJFS). These agencies are the local representation for all ODJFS services. Within the Ohio Medicaid program, these organizations are primarily responsible for eligibility determination and enrollment of Medicaid recipients. Their role and structure within the program is described in detail in the **Medicaid program overview, history and current status** section of this report.

Sub-recipient Agencies

The other State agencies that administer portions of the Medicaid program in Ohio are primarily organized based upon population groups and the services required by those groups. The six sub-recipient State agencies include:

- Ohio Department of Aging (ODA);
- Ohio Department of Alcohol and Drug Addiction Services (ODADAS);
- Ohio Department of Education (ODE);
- Ohio Department of Health (ODH);
- Ohio Department of Mental Health (ODMH); and
- Ohio Department of Mental Retardation and Developmental Disabilities (ODMRDD).

Within these organizational structures, the population-specific Medicaid programs are arranged with functional tasks and duties very similar to those highlighted above for OHP. Generally, these organizations have created small Medicaid units or identified a Medicaid point person. However, most Medicaid-related duties are diffused throughout the organization and housed in support services, like IT and finance, or population-based units, like child-oriented services. Throughout this report, sub-recipient agencies collectively refers to the abovementioned agencies. The structure, roles and responsibilities of the sub-recipient State agencies and their local boards and agencies are further described in the **Medicaid program overview, history, and current status** section and **Appendix 3-B** within this section of the performance audit.

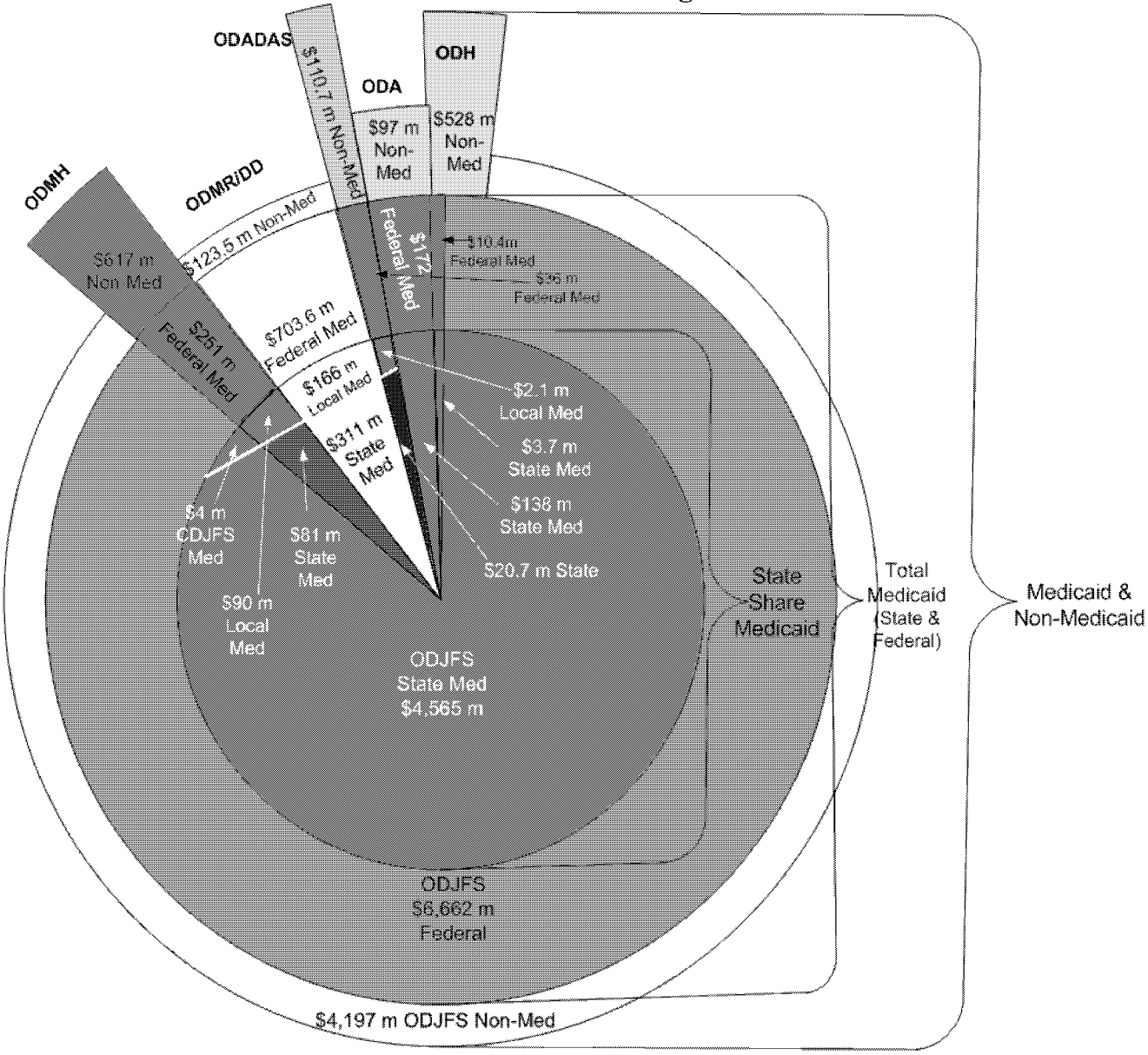
Oversight Agencies

In addition to the oversight and monitoring duties performed by ODJFS and the sub-recipient State agencies, three other State agencies have a role in Medicaid oversight functions. The Office of Budget and Management (OBM), the Attorney General's Office (AG), and the Auditor of State's Office (AOS) also have roles in the Ohio Medicaid program in an oversight capacity. OBM is the primary representative of the executive branch and has an oversight role in determining appropriate budgetary appropriations, tracking expenditures against the State budget, advising on rate setting, and other policy issues. AOS and AG provide audit and program integrity related roles, with a focus on accurate reporting and identification of fraud, waste, and abuse (see **program integrity**).

Financial and Statistical Data

When discussing Medicaid in Ohio, the term refers more to a funding source or program rather than to an entity. Therefore, Medicaid exists within a complex network of several State agencies and a multitude of local organizations. To add further complexity to this arrangement, Medicaid is funded jointly by the federal and State government. Ohio's share of Medicaid funding comes from State taxes and local funding sources. For each dollar spent on Medicaid services, Ohio receives a federal reimbursement of about 59 cents, which is Ohio's FMAP (or federal medical assistance percentage). **Illustration 3-1** presents SFY 2004-05 Medicaid and non-Medicaid expenditure estimates, by funding source, for each State department administering the Medicaid program.

Illustration 3-1: Overview of Medicaid Funding Structure for SFY 2004-05



Source: AOS, Ohio Medicaid Administrative Study Council, ODJFS, sub-recipient agencies, and the Ohio Legislative Service Commission
Note 1: Figures are self reported and unaudited from March 30, 2006 and do not include an entire year's expenditures as claims can be submitted up to one year after the date of service.
Note 2: The illustration is not drawn to scale.
Note 3: ODE and the oversight agencies are excluded due to their minor role in terms of overall funding and because they are not involved in providing direct services to recipients. Although the Community Alternative Funding System (CAFS) was terminated in 2005, ODJFS, ODE and ODMRDD are working to develop a program to replace it which would, in the future, make ODE a significant participant in the Medicaid program.

Illustration 3-1 presents Ohio's Medicaid expenditures both by funding source and by administering State agency. Each circular portion of the pie chart indicates a distinct funding source, while each slice of the pie chart indicates the administering State agency.

The inner-most circle represents Medicaid expenditures that are funded by State generated resources (the State match). In total, the State contributed approximately $5.4 billion in SFY 2004-05. Ohio is in a limited group of states in that a portion of the State match actually comes from local funding sources at the county level.[4] This is represented by the area positioned on the upper left outer edge of the inner circle. In SFY 2004-05, the Medicaid Administrative Study Council estimated that the local funding sources contributed approximately $260 million or about 5 percent of the State match while the Ohio Provider Resource Association estimated that local contribution – for the MRDD system alone – ranged from $131 million (2 percent of state match) to $347 million (6 percent of state match). In any instance, these figures are merely estimates as no agency – ODJFS, OBM, ODMRDD, ODMH, or ODADAS included – have a complete accounting of the amount of local funding used for Medicaid match within their systems. Estimates used in the illustration - $262 million - assume that all State distributions were directed toward Medicaid uses and the remainder was contributed by the county systems. However, State distributions are apportioned to specific programs, so the entire amount could not be used as Medicaid match. As such, these figures substantially understate the county contribution. A further discussion of this issue is contained in the ***Medicaid budgeting practices*** assessment in this section of the performance audit.

The next ring of the pie chart represents Medicaid expenditures reimbursed by federal resources. In total, these distributions approximated $7.8 billion in SFY 2004-05, or 59 percent of the overall program costs. Finally, the outer-most ring represents each State department's non-Medicaid expenditures. This information is important to reflect how large a role Medicaid funding plays in each State department's total budget. While Medicaid funding plays a minor role in the ODH budget, it is a significant portion of the other state Medicaid and sub-recipient agencies, particularly ODMRDD and ODJFS.

Table 3-1 presents the detailed financial data depicted in **Illustration 3-1.**

[4] County funding that is used to meet the State's match requirement comes from the county departments of job and family services, county boards of mental retardation and developmental disabilities, and alcohol, drug addiction and mental health boards, and can be comprised of allocations from the county general fund or special levy funds.

Table 3-1: Overview of Medicaid Agencies Funding Structure for SFY 2004-05

Agency	Funding Source	Total State Department Funding	Medicaid	Funding Source as Percent of Medicaid Sub-total	Funding Source as Percentage of Total Medicaid	Medicaid Expenditures as Percent of Department Expenditures
ODADAS	Federal	$113,657,964	$35,982,609	61.2%	0.3%	31.7%
	State	$53,781,339	$ 20,713,204	35.2%	0.2%	38.5%
	Local Levies	N/A	$ 2,100,000[1]	3.6%	0.0%	N/A
ODADAS Total		**$167,439,303**	**$ 58,795,813**	**100.0%**	**0.4%**	**33.9%**
ODA	Federal	$236,101,577	$ 172,001,335	55.4%	1.3%	72.9%
	State	$171,578,515	$138,306,960	44.6%	1.0%	80.6%
ODA Total		**$407,680,092**	**$ 310,308,295**	**100.0%**	**2.3%**	**76.1%**
ODMH	Federal	$300,999,156	$ 250,583,068	59.5%	1.9%	83.3%
	State	$647,517,891	$ 80,976,077	19.2%	0.6%	12.5%
	Local Levies	N/A	$ 89,583,468[1]	21.3%	0.7%	N/A
ODMH Total		**$948,517,048**	**$ 421,142,613**	**100.0%**	**3.2%**	**35.0%**
ODMRDD	Federal	$718,762,334	$703,596,865	59.5%	5.3%	97.9%
	State	$419,525,090	$311,208,855	19.2%	2.4%	74.2%
	Local Levies	N/A	$165,956,543[1]	21.3%	1.3%	N/A
ODMRDD Total		**$1,138,287,424**	**$1,180,762,263**	**100.0%**	**8.9%**	**65.8%**
ODH	Federal	$405,856,749	$10,375,386	73.9%	0.1%	2.6%
	State	$135,986,085	$3,664,874	26.1%	0.0%	2.7%
ODH Total		**$541,842,834**	**$14,040,260**	**100.0%**	**0.1%**	**2.6%**
ODJFS	Federal	$9,745,221,444	$ 6,662,160,577	59.3%	50.4%	68.4%
	State	$5,679,290,834	$ 4,565,763,587	40.6%	34.5%	80.4%
	Local Levies	N/A	$4,319,266[1]	0.0%	0.0%	N/A
ODJFS Total		**$15,428,831,543**	**$ 11,232,243,431**	**100.0%**	**85.0%**	**72.8%**
Grand Total		**$18,628,831,543**	**$ 13,217,292,676**	**N/A**	**100.0%**	**69.5%**

Source: AOS, Ohio Medicaid Administrative Study Council, Medicaid State agencies, and Ohio Legislative Service Commission
Note 1: Figures are self reported and unaudited from March 30, 2006 and do not include an entire year's expenditures as claims can be submitted up to one year after the date of service.
Note 2: ODE and other oversight agencies are excluded due to their minor role in terms of overall funding and because they are not involved in providing direct services to recipients.
[1] Local funding is estimated and, because of the methodology used, may understate the contribution of local dollars into the program.

Table 3-1 illustrates that ODJFS, through OHP, administers the majority of Medicaid expenditures. In SFY 2004-05, it administered approximately 85 percent of total Ohio Medicaid expenditures. The next largest administrator is ODMRDD, which administered almost 9 percent

of Medicaid funds. **Table 3-1** also illustrates the funding sources for each of the Medicaid administering agencies. The Medicaid program requires states to contribute a portion of the program's funding. However, in the State of Ohio, a portion of the "state match" is provided from local funding sources such as county tax levies. Local funding sources are most prevalent in the ODMRDD and ODMH systems. Based on the estimates in **Table 3-1**, local funds in these systems represent at least 21 percent of their Medicaid expenditures, and in many cases, substantially more. Finally, **Table 3-1** demonstrates the relative importance of Medicaid within each State department by evaluating Medicaid funding as a percentage of total department funding. In SFY 2004-05, Medicaid represented over half of the total funding to ODMRDD, ODA, and ODJFS.

Table 3-2 summarizes historical growth rates within each State department for total departmental expenditures, departmental Medicaid expenditures, and departmental non-Medicaid expenditures, by funding source.

Table 3-2: Medicaid Agencies' Expenditure Growth Rates SFY 2000-01 to SFY 2004-05

Agency	Funding Source	2001-2005 Avg. % Change in Medicaid Expenditures	2001-2005 Avg. % Change in Total State Department Expenditures by Fund Source	State Department Non-Medicaid Expenditures by Fund Source Avg. % change 2001-2005
ODADAS	Federal	10.5%	2.8%	0.1%
	State	12.1%	(0.2%)	(5.3%)
	Local Levies[2]	(3.8%)	N/A	N/A
ODADAS Totals		**9.8%**	**1.7%**	**(1.7%)**
ODA	Federal	12.4%	10.1%	5.0%
	State	13.0%	7.1%	(7.6%)
ODA Totals		**12.4%**	**8.5%**	**(0.5%)**
ODMH	Federal	8.5%	7.1%	5.5%
	State	8.0%	1.1%	0.3%
	Local Levies[2]	8.1%	N/A	N/A
ODMH Totals		**8.3%**	**2.8%**	**0.4%**
ODMRDD	Federal	16.2%	15.7%	6.2%
	State	13.1%	3.6%	(9.0%)
	Local Levies[2]	16.5%	N/A	N/A
ODMR Totals		**14.2%**	**10.4%**	**(8.6%)**
ODH	Federal	7.7%	9.4%	9.5%
	State	7.8%	(2.0%)	(2.2%)
ODH Totals		**7.3%**	**5.9%**	**5.9%**
ODJFS	Federal	11.2%	12.5%	16.4%
	State	10.8%	5.6%	(6.3%)
	Local Levies[2]	17.5% [1]	NA	N/A
ODJFS Totals		**11.0%**	**9.6%**	**6.2%**
Grand Total		**11.2%**	**9.0%**	**4.7%**

Source: AOS, Ohio Medicaid Administrative Study Council, Medicaid State agencies, and Ohio Legislative Service Commission
Note: Figures are self reported and unaudited.
[1] The average growth rate for local levy source expenditures for ODJFS reflects SFY 2002-03 through SFY 2004-05.
[2] Local funding is estimated and, because of the methodology used, understates the contribution of local dollars into the program.

Table 3-2 illustrates that overall Medicaid expenditures grew by an average of 11.2 percent from SFY 2000-01 through SFY 2004-05 per year, which outpaced department total expenditures and non-Medicaid expenditures during the same time period. The most rapid growth rates in Medicaid expenditures were experienced by the ODMRDD and ODA, which grew at average annual rates of 14.2 percent and 12.4 percent, respectively. In addition, ODJFS Medicaid expenditures experienced an average annual growth rate of 11.0 percent during this time period. This is in contrast to non-Medicaid expenditures, which grew at a more modest rate of 4.7 percent when examined in aggregate for all of the Medicaid administering State agencies. ODJFS experienced the highest rate of growth in non-Medicaid expenditures, averaging 6.2 percent from SFY 2000-01 to 2004-05; however, this is explained by increases in federal monies, rather that State resources. In contrast, ODMRDD experienced the largest overall decrease in non-Medicaid expenditures among these agencies. Medicaid expenditures for all departments are presented in more detail in **Appendix 3-C**.

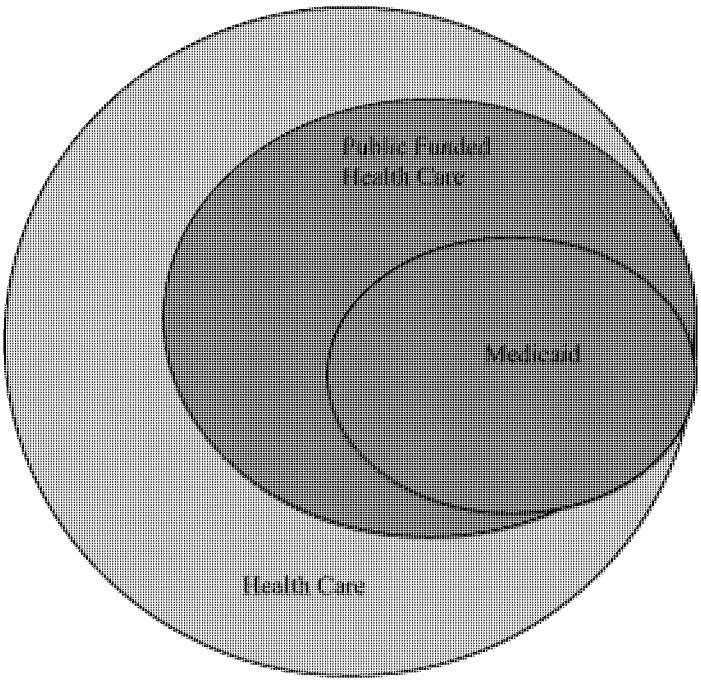
Operating Environment

The Ohio Medicaid program operates within a complex financial and political environment that exerts pressure on its operations and affects its implementation. Such environmental factors influence all organizations. While the intensity of these pressures varies among industries, it is the organization's ability to respond to its environment, or at least mitigate controllable negative factors that impacts its ability to successfully achieve its mission. The organization's operating environment provides the context for developing organizational structures and strategic management approaches. A critical part of this process is to ensure the environment has been appropriately defined.

Ohio Medicaid operates within the national and global health care environment and many of the same pressures found in the larger health care system are exerted on the Ohio Medicaid program. "Public health care" refers to health care administered and/or financed by governmental entities (as a subset of health care) and more specifically defines the Medicaid environment. The ***responding to the operating environment*** subsection examines the Ohio Medicaid environment and the program's response to external factors in the context of the larger health care and the public health care environments.

Illustration 3-2 represents a systems perspective of the environments in which the Ohio Medicaid program must exist.

Illustration 3-2: The Medicaid Operating Environment



Source: AOS depiction

As depicted above, Medicaid is part of a larger universe of publicly funded health care and health care in general. Environmental factors can be further grouped into economic factors, social and demographic factors, technology factors, and political or legal factors. This framework allows for the identification of issues and indicates the intensity of environmental pressures on an organization's operations. **Table 3-3** summarizes environmental factors grouped in these categories for Ohio Medicaid and presents those also identified by OHP in *italics*.

Table 3-3: Summary of Environmental Factors in Ohio Medicaid

Economic Factors:	**Political Factors:**
• Market inefficiencies -- poor consumer information and separation of payment responsibility from the benefit recipient ("moral hazard") ○ *High rates of health care cost inflation* • *State and Federal revenue growth is unlikely to keep pace with expected Medicaid spending growth* • *Rural and local hospitals struggle financially*	• Historical federal expansion of eligibility and services • Federal allowance for increased State flexibility in administering their Medicaid programs to achieve efficiencies • Federal pressure to curtail Medicaid spending • Federal pressure to have centralized authority under the federally required single State Medicaid agency • *High levels of litigation initiated by stakeholders* • High Levels of involvement from the General Assembly • *Information confidentiality concerns in relation to HIPAA*
Social & Demographic Factors:	**Technology Factors:**

• Shift of attitudes to view health care as a "right"
• *Rising "consumerism" driving demand increase for home & community based care options*
  ○ *When supply is insufficient, legal action ensue*
• The US population is aging
  ○ Age is correlated with disabilities
  ○ Disabilities are correlated with poverty
  ▪ Medicare recipients do not receive long-term care, these services are provided by Medicaid
• *Smaller employers expressing interest in public Health Plan buy in programs*
	• *Advances in procedures, practices, devices, and pharmaceuticals are expected to continue at their rapid pace further impacting health care cost increases*
	• *Increased use of internet technology for e-commerce, e-government and e-health*

Source: AOS analysis, OHP 2001 environment assessment, other industry literature

Table 3-3 summarizes and categorizes material environmental factors that impact the Medicaid program in Ohio. These factors are evaluated to a greater extent in the **recommendations** section of the report. However, in each case, these factors represent issues that the State Medicaid agency and sub-recipients must consider in planning and implementing the program.

Market Inefficiencies

Like all exchanges of goods and services, individuals' demand and supply curves for health care can be aggregated into market demand and supply curves that apply to all free-market transactions. While these transactions comply with general economic theory, they are somewhat unusual in their application. For instance, consumers in general will not be as responsive to changes in prices relative to other goods and services because in many instances health care is perceived as a necessity. Furthermore, due to the high educational requirements for

practitioners, product and service differentiation, and legal incentives for technology advancements, such as patents, there is less competitive pressure from substitute goods compared to other industries. However, health care is abnormal in that there are market inefficiencies resulting from basic assumptions regarding competitive markets that do not apply to the health care market.

According to *The Economics of Health Reconsidered* (Rice, 1998), competitive markets require the following:

- There is an absence of positive and negative external impacts of consumption;
- Consumer tastes are predetermined;
- Consumers are the best judge of their own welfare;
- Consumers know with certainty, the results of their consumptions decisions;
- Individuals are rational;
- Individuals reveal their preferences through their actions;
- Social welfare is based solely on individual needs, which are in turn based on the goods and services consumed;
- Supply and demand are independently determined;
- Firms do not have any monopoly power;
- Firms maximize profits;
- There are not increasing returns to scale;
- Production is independent of the distribution of wealth; and
- The distribution of wealth is approved of by society.

A number of these assumptions are not valid in today's health care markets. According to *Abnormal Economics in the Health Sector* (Hiaso, 1995), there are five main health care market segments for health services and goods: financing, physician services, institutional services, input factors, and professional education. Each of these markets is interconnected. For instance, insurance plans (financing) influence consumer demand and physician fees. In turn, physicians impact demand for hospital and institutional services, which impact input factors such as labor, capital, and pharmaceuticals. Using this framework, the Ohio Medicaid program is most closely related to a financing organization, which then must interact with the other segments of the health care market. Hiaso identified market inefficiencies and common responses to these inefficiencies. These factors and Hiaso's perception of the effectiveness of the responses are presented in **Table 3-4** as they apply to the Medicaid program.

Table 3-4: Health Care Market Inefficiencies & General Responses

Market Failure	Cause	Effects	Mitigating Strategies	Effectiveness of Strategies
Insurance Effect/ Moral Hazard	A third party payer for services separates the beneficiary of services from responsibility for payment. Patients' demand is increased beyond where marginal cost exceeds the marginal benefit, which tends to increase the rate of inflation in health expenditures.	Overuse of services by patients, "moral hazard"	Deductible coinsurance Gatekeepers Waiting Lines	Moderately effective Moderately effective Patient dissatisfaction
Hospitals as Monopolies	In local markets, hospitals tend to have monopolistic powers due to the large capital investment and economies of scale.	Excess profit, poor quality, expansion of expensive technology	Retrospective cost reimbursement Prospective price or hospital budget	Ineffective Effective
Physicians as Monopolies	Consumers lack sufficient medical knowledge to make their own choices, instead they employ physicians as their agents to advise them about needed medical treatments. However, they also are service providers with profit motivation. This creates a corrupted relationship. Monopolistic power is strengthened by delivery of services for life threatening or emergency situations.	Induced demand, price discrimination, excess profit, poor quality, expansion of expensive technology	Monitoring and claim reviews Payment by capitation, salary or global budget Consumer education Promote physician substitutes	Expensive & ineffective Effective Ineffective Ineffective
Incomplete Information	Technical and customized nature of health care.	High search costs, high monitoring costs	Consumer information	Expensive & moderately effective
Price Uncertainty	Due to incomplete consumer information, and the inability of physicians and other providers to give advance price guidance before a diagnosis and the individual's recovery rate, a basic prerequisite of market competition, advance price information, is not present.	Weak competition, expansion of expensive technology	Post prices on standard services	Moderately effective for physician services, ineffective for hospital services

Source: *Abnormal Economics in the Health Sector* (Hiaso, 1995)

Market inefficiencies result from two primary factors: poor consumer information and health financing that separates beneficiaries from the responsibility for payment. According to *Coordinated Agency Versus Autonomous Consumers in Health Services Markets* (Dowd, 2005),

managed care and consumer driven service models attempt to mitigate these factors. Managed care was a response to poor consumer information. Managed care firms collected and analyzed data on provider price and quality and studied the effectiveness of medical and surgical treatments. They then built that information into the design of provider networks. Managed care responded to the difficulty experienced by consumers attempting to obtain reliable information on the price and quality of complex technical services and the disincentives for price shopping inherent in insurance coverage, by acting as the consumer's representative. Finally, managed care plans were able to better substitute health care professionals' services, particularly when they could hire their own personnel for substitution.

Dowd's assessment of consumer-driven health care models indicates that they primarily seek to address price distortion resulting from insurance or third party payers for services that reduce the out-of-pocket price of care that could otherwise decrease consumer demand (also known as the *moral hazard*). These plans use large, up-front deductibles to reduce frivolous or less urgent care usage. However, these models face challenges in their ability to address failures caused by uninformed consumers. Dowd proposes that the combination of managed care and consumer-driven plans may better address health care market challenges. These issues are examined in greater detail in the **Medicaid service provision** and **managed care and care management** sections of this report.

Projected Growth in Governmental Revenues and Medicaid Expenditures

The Congressional Budget Office's (CBO) *Budget and Economic Outlook: Fiscal Years 2007-2016* suggests that federal revenues will grow by an average of 5.7 percent from 2006 to 2010. While revenues are expected to increase in 2011, these increases are due to scheduled phase outs of tax provisions that temporarily decreased tax rates, and therefore are less than certain. The CBO's expectations for revenue growth are contrasted by their expectations for Medicaid expenditures. Medicaid is expected to grow at an average annual rate of 8.0 percent for the next 10 years. CBO notes that over the long-term, if these trends are maintained, the increasing resource demands of Medicaid, as well as Medicare and Social Security, will exert such pressure on the budget as to make current fiscal policy unsustainable. As a result, Medicaid is likely to be subjected to future policy and programmatic changes as illustrated below in the political factors discussion.

According to the Ohio Department of Taxation's figures for total State of Ohio tax collections, revenues increased an average of 3.1 percent annually in the past five years, 5.3 percent annually in the last 10 years, and 5.2 percent annually in the last 15 years. The Legislative Service Commission's revenue figures, which incorporate other non-tax revenues but exclude federal grants, indicate an average annual growth rate of 2.8 percent from 2001 to 2004 and an average annual growth rate of 5.8 percent from 1997 to 2000. Contrasted with Medicaid expenditure growth expectations, expenses will continue to grow at faster rates than the rate of increase in State revenues, even during prosperous periods. Assuming historic revenue trends continue,

Medicaid, if left unchanged, will continue to consume an ever increasing portion of the State budget.

Ohio's rising Medicaid costs (and national Medicaid cost increases) are part of a much larger trend of health care costs in general. In fact, there is some evidence that Medicaid costs compare somewhat favorably to general national health care costs. According to the Center on Budget and Policy Priorities, from 2000 to 2003, Medicaid costs per person have grown at 6.9 percent nationally, while private insurance costs have increased 12.6 percent per person. Some of the contributing environmental factors to Medicaid cost increases are within Ohio's control, while others will require resolution at other levels to address fundamental economic inefficiencies in the health care market. However, it is important for Ohio to take actions to mitigate the negative impacts to the extent possible, especially given the contrasting economic profile of State and federal government revenue growth.

During stakeholder interviews, several participants commented on the impact of Medicaid on the State budget and the political discussion surrounding Medicaid expenditures. A member of the Ohio Family Services Council spoke to advocates' concerns about the impact of expenditures on the program noting that, due to its size, the Medicaid budget is a constant target for cuts which hampers efforts to make long-term improvements in the program. The member noted that Medicaid is often referred to as the "budget monster" and that because the federal matching funds are also shown in the budget as General Revenue funds, the program size is exaggerated and it "stands out like a red flag".

Public Opinion and Attitudes

Over time, the population's attitudes have changed from viewing health care as a privilege versus viewing it as a right. As people increasingly view health care as a right, social pressure has been exerted to change the original intent of the Medicaid program (see the **federal political environment** discussion). While opinion trends do not exist for the entire time period Medicaid has been in existence, the National Data Program for the Social Sciences has administered its General Social Surveys from 1972 through 1998. It includes general population attitudes toward government involvement in health care for 1985, 1990, and 1996. **Table 3-5** presents the survey results.

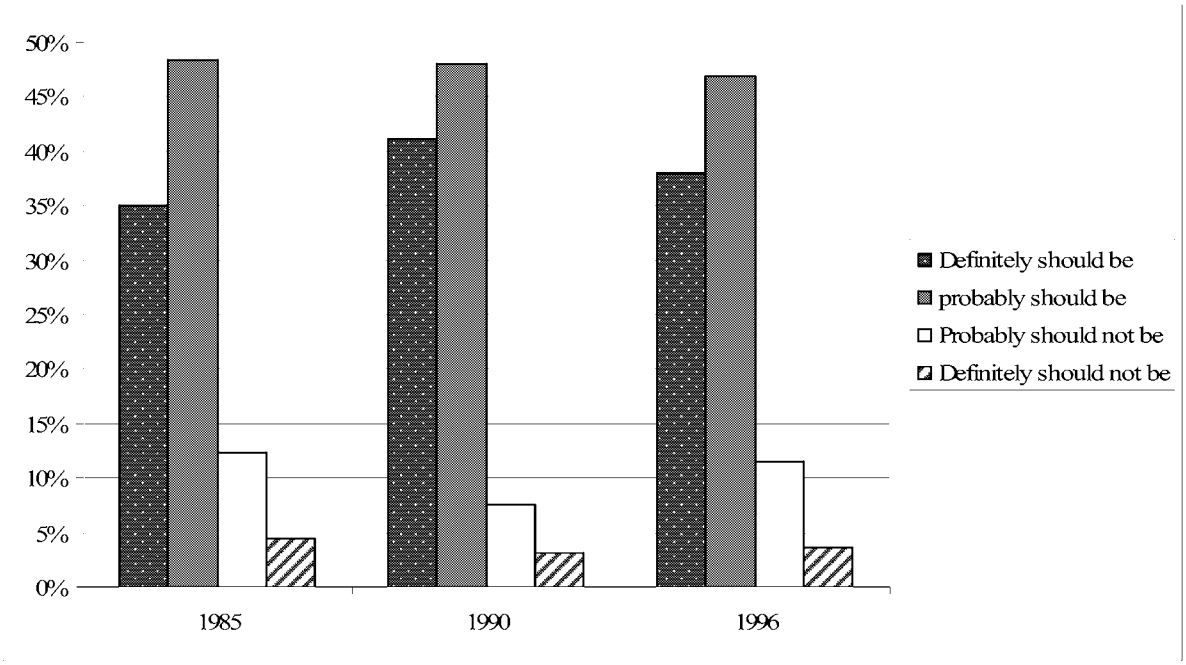
Table 3-5: Historical Attitudes Toward Government Health Care

Response:	1985	1990	1996
Do you think it should or should not be the government's responsibility to provide health care for the sick?			
Definitely should be	35.0%	41.2%	38.0%
Probably should be	48.3%	48.1%	46.9%
Sub-total	*83.3%*	*89.3%*	*84.9%*
Probably should not be	12.3%	7.5%	11.5%
Definitely should not be	4.4%	3.2%	3.6%
Sub-total	*16.7%*	*10.7%*	*15.1%*
Would you like to see more or less government spending on health? Remember that if you say "much more," it might require a tax increase to pay for it.			
Spend much more	12.5%	20.2%	17.2%
Spend more	45.7%	52.3%	49.7%
Sub-total	*58.2%*	*72.5%*	*66.9%*
Spend the same as now	33.8%	24.5%	26.5%
Spend less	6.2%	2.2%	4.9%
Spend much less	1.8%	0.8%	1.6%
Sub-total	*8.0%*	*3.0%*	*6.5%*

Source: University of Michigan's General Social Surveys

Chart 3-1 illustrates the above information in bar-graph form.

Chart 3-1: Historical Attitudes Toward Government-Funded Health Care

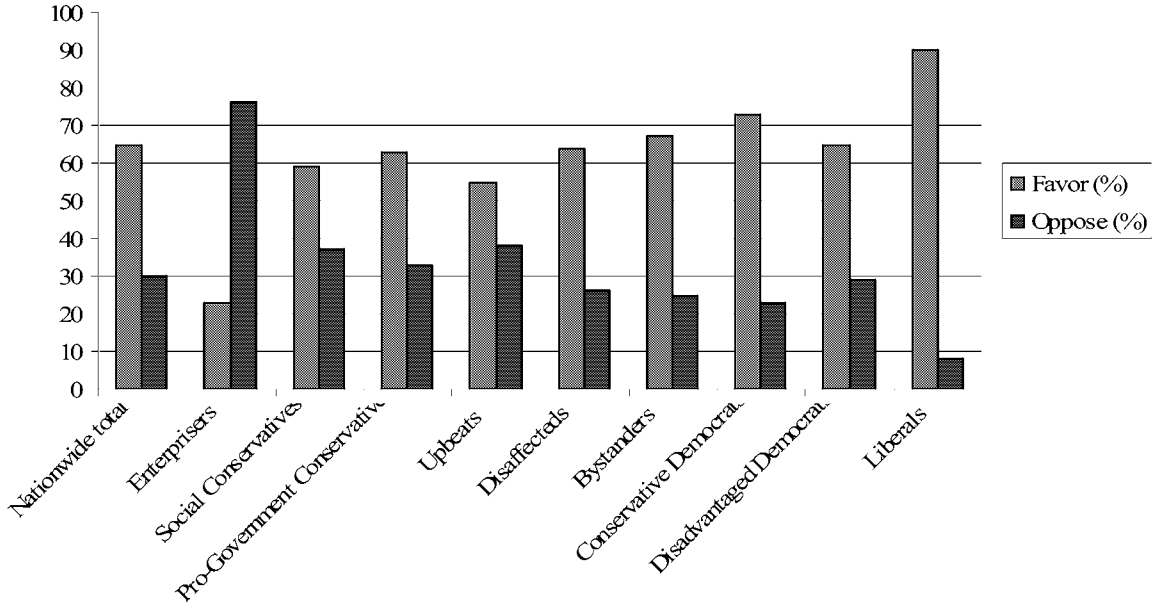


Source: University of Michigan's General Social Surveys

In both 1990 and 1996, larger portions of the population favored government sponsored health care and would support increases in spending on health care. Furthermore, according to a January 2004 survey released by Community Voices, 77 percent of Americans believed health care should be a right, with 48 percent strongly agreeing and 28 percent agreeing somewhat.

Likewise, a survey released in 2005 by the Pew Research Center indicated 65 percent of the nation's population would support government guaranteed health insurance for all citizens even if it meant raising taxes. Furthermore, there appeared to be moderately strong support by several more conservative subgroups. The results of this survey are illustrated in **Chart 3-2**.

Chart 3-2: Survey Results for Guaranteed Health Care



Source: Pew Research Center
Note: The statement posed for agreement or disagreement was, "The US government should guarantee health insurance for all citizens, even if it means raising taxes."

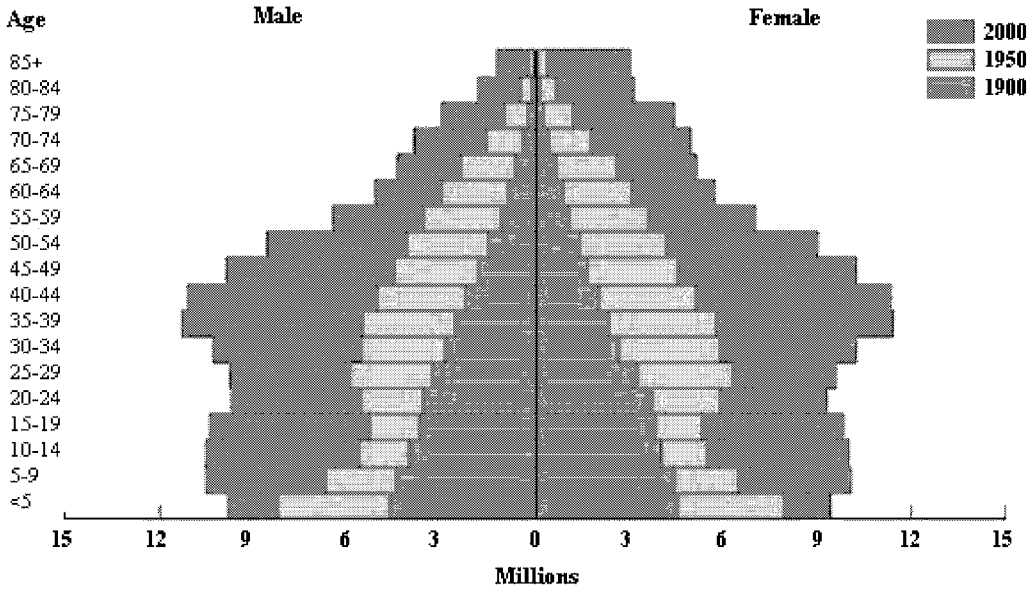
Demographics

Demographic shifts within the general population have a substantial impact on the cost of the Medicaid program. As a whole, the U.S. population is aging. This is particularly challenging for the Medicaid program because there exists a relationship between age, disability, and poverty. Because poverty and disability are prerequisites for Medicaid eligibility, and Medicaid is responsible for the long-term care needs of Medicare recipients, these demographic trends will increase Medicaid spending.

According to a special report prepared by the US Census Bureau, entitled *Demographic Trends in the 20th Century,* the general population is aging. This trend is the result of fertility trends with relatively higher fertility at the start of the century. There tended to be lower fertility in the late 1920's and during the 1930's, and higher fertility during the "baby-boom" period. This was followed by lower fertility during the "baby-bust" period. **Chart 3-3** summarizes the age distribution for the United States at 1900, 1950, and 2000.

Chart 3-3: Age Distribution of the US Population

Population by Age and Sex 1900, 1950, and 2000



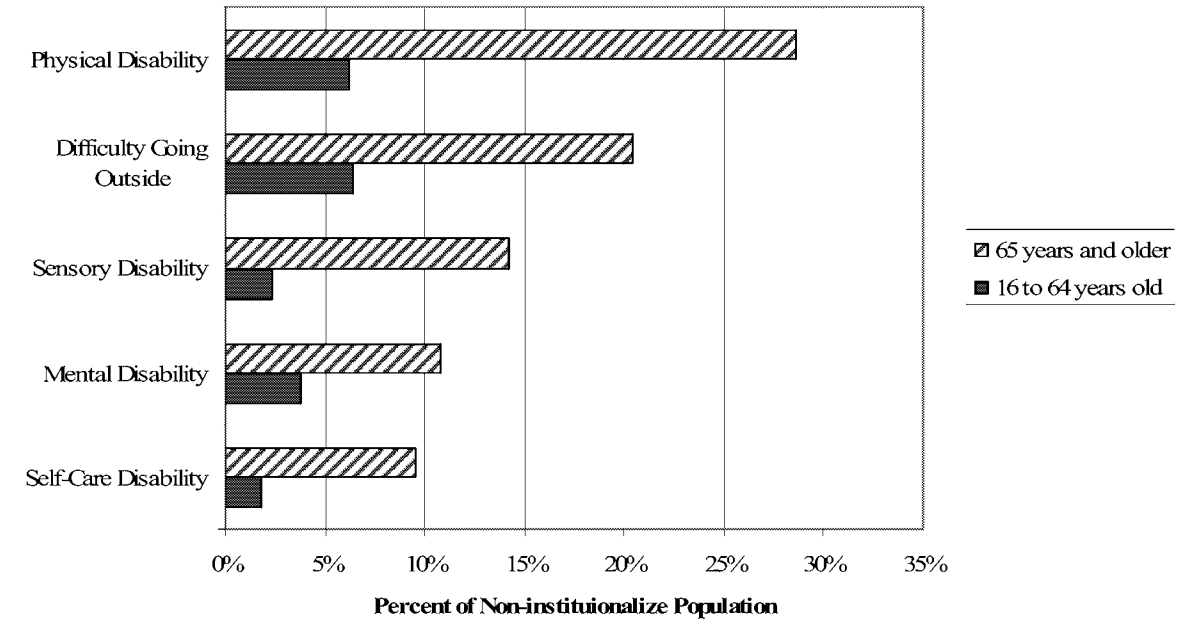
Source: US Census Bureau, decennial censuses 1900, 1950 and 2000.

In addition, to a larger distribution among various age groups, the shape or proportions of age groups has changed. In the past, age distributions indicated a "cone-like" shape at the top of the pyramid compared to more recent distributions. This change is likely the result of combined factors including lower fertility rates in key demographic groups and decreasing mortality rates (or delaying mortality to older ages) due to advances in medical technology.

The Congressional Budget Office's *Long-term Outlook for Medicare and Medicaid* states that the aging population will impact Medicaid expenditures, not only because an aging Medicaid population requires more frequent and more expensive services, but also because the program covers services not offered by Medicare (such as long-term care) and pays a portion of Medicare premiums for those with moderately low incomes.

Furthermore, an increase in a population with an elderly demographic is also characterized by higher rates of disability. According to the U.S. Census Bureau, disability rates rise with age. **Chart 3-4** illustrates the portion of the population with disabilities by age group.

Chart 3-4: Disability Rates by Age Group



Source: U.S. Census Bureau

Finally, there exists a correlation between disability and poverty. According to the U.S. Census Bureau, families with disabled members were more likely than other families to live in poverty. Among families with one or more members with a disability, the poverty rate was 12.8 percent compared to 7.7 percent for families without disabled members. In Ohio, families without disabled members had a poverty rate of 6.6 percent, while 11.1 percent of families with members having disabilities were considered impoverished. By disability type, families with members having mental disabilities, physical disabilities, and sensory disabilities had 16.2, 12.6, 11.0 percent poverty rates, respectively. However, it should be noted that families with children with disabilities and single parent families with disabled children had a much higher correlation to poverty than families with disabilities as a whole.

Although Medicaid covers many individuals with disabilities, a member of the Ohio Developmental Disabilities Council discussed concerns about the program's focus on assisting low-income families in becoming self sufficient. According to the member, the program was not designed for providing long-term health care services, as it has historically been linked with other public assistance programs which are often only needed for short periods of time. In contrast, the member described the Medicaid program for the disabled population as "their lifeline, period" and stressed that for some disabled individuals, their need for the Medicaid program will extend over a longer time period, possibly their lifetime.

Federal Political Environment

Every organization is subject to external pressures and mandates imposed by federal, state, and local laws. Furthermore, these laws are determined by political bodies whose members are motivated by various priorities and goals. For public entities, not only do these political bodies establish restrictive standards of conduct or require prescriptive actions, they also determine funding and to some extent, they establish goals, policies, and practices. Federal legislative changes result from two competing influences; the changing perception of health care as a right and the rising cost of health care discussed above. However, the result of these pressures can be illustrated through federal legislative changes. **Appendix 3-D** presents a time line of federal legislative changes categorized by changes to eligibility, changes to benefits, and the flexibility States have to administer their programs.

While changes in federal legislation were less frequent during the 1960's and 1970's, a trend of expanding eligibility and benefits emerged in the 1980's and early 1990's. Another trend emerged in the 1990's of increased state flexibility in administering their programs for improved efficiency. These trends were also reflected in conversations with ODJFS legal staff who interpreted changes in federal legislation as reflecting a re-evaluation of the core purpose of Medicaid. The original intent was understood to be that of a health care provider of last resort with minimal medical coverage. However, ODJFS legal staff indicated that this definition appears to be expanding. The federal government appears to be reducing the level of flexibility at the State level in regards to the level of service. For instance, the *any willing provider* language prevents negotiation with service providers for more efficient purchasing of services. However, the federal government has provided flexibility in expanding coverage to different groups and in using some alternative service provision models such as managed care. Finally, the tables in **Appendix 3-D** indicate that in recent years, increasing health care costs have prompted more definitive efforts to curtail Medicaid spending. For instance, a December 2005 CBO study, *The Long-term Budget Outlook,* indicated the challenge to funding Medicaid at current spending growth rates given expected revenue growth rates. It suggests options such as reducing the overall federal contribution, conversion of federal reimbursement into a block grant, reducing mandatory benefits, restricting coverage, increasing costs shared by beneficiaries, or encouraging the use of lower cost services.

According to the ODJFS liaison with CMS, this increased focus on cost containment has also intensified the pressure to ensure adequate oversight and control over Medicaid resources. A review of CMS management reviews of Ohio Medicaid programs for the past three years indicated CMS' preference for centralized administrative authority. The CMS reviews were of components of the ODJFS, ODMRDD, and ODA Medicaid operations, and excluded financial reporting audits. A categorization of their comments by subject matter showed that findings pertaining to oversight and interagency issues were most pervasive. Almost 34 percent of the 62 findings reviewed indicated insufficient oversight of various parties or insufficient coordination of Medicaid agencies. While ODMRDD programs had the greatest number of findings of the

three agencies that had segments of operations reviewed, ODJFS had more findings pertaining to oversight and interagency issues, comprising nearly 48 percent of the CMS findings for ODJFS. ODJFS legal staff is aware of the federal preference for centralized administration of Medicaid programs and indicated that it was a point of contention given Ohio's decentralized organization and funding structure, and strong home rule history. (See the **program integrity** section for additional information on oversight and coordination issues between ODJFS and the sub-recipient agencies.)

Finally, the national Medicaid political environment is also contentious, with frequent and far reaching litigation in the judicial system. In some instances, this litigation prevents efficient and effective administration of health care and Medicaid. According to *A Quiet Revolution: Law as an Agent of Health System Change* (Bloche and Studdert, 2004, Health Affairs), legal conflict is the catalyst not only for changes to rules, but also through its influence on market actors' perceptions and expectations. This article presents a case study of the evolution of managed care law, which initially provided managed care plans immunity from State law through provisions of the Employee Retirement Income Security Act, and the effects of the erosion of this immunity through judicial decisions. It is the authors' contention that these plans ended their aggressive cost management strategies, responsible for much of the lower spending growth in health care markets of the early 1990's, in response to increased litigation risk and the perceived uncertainty of these risks by investors. Due to these changes, the managed care companies reduced the intensity of cost management strategies such as utilization management, selective contracting with providers, and financial incentives to physicians, for less expensive health outcomes and treatments.

The ODJFS legal staff also indicated that litigation was prevalent in their operating environment. Throughout the history of the Ohio Medicaid program, several court decisions have affected program implementation and oversight. These are reflected in several portions of Ohio Revised Code and Ohio Administrative Code as well as in the attitudes and initiatives of the Department. According to ODJFS executive staff, a number of federal regulations also prevent efficient and effective administration of the Medicaid program. These legal and regulatory barriers to efficiency, as identified by ODJFS, include:

- **Provider Rate Legislation -** Rate-setting code language was revised in an attempt to reverse the Boren Amendment,[5] which had been used by nursing facility providers to

[5] Prior to 1980, Medicaid and Medicare reimbursed nursing facilities on a retrospective reasonable cost basis. In the Omnibus Reconciliation Act of 1980 (section 1902(a)(13)(A)), the Boren Amendment changed the reimbursement method for nursing facility services. Under the Boren Amendment, a State plan for medical assistance was required to provide for payment of nursing facility services through the use of rates which were reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated providers in order to provide care and services in conformity with applicable State and Federal laws, regulations and quality and safety standards. In 1997, the Balanced Budget Act repealed the Boren requirements and replaced them with a requirement that States implement a public process when changes in payment rates or methodologies are proposed. The new public process requirement applies to rates established on or after the October 1, 1997 effective date.

challenge reimbursement rates. However, the new code language, while intended to prevent litigation, is still being used in litigation to challenge rate schedules due to vague standards that require rates to be consistent with efficiency and quality care standards. Combined with "every willing provider" legislation, this may result in too onerous a standard whereby OHP must fund every provider regardless of their efficiency. This also puts the burden on the State to solicit public input in order to set rates. The ability of service providers to file suit over changes in rates and administrative oversight protocols often results in legal injunctions. This delay compromises OHP's ability to have sufficient flexibility in rate setting and oversight. OHP staff believes that statutes should provide states more flexibility in rate setting and allow them to use market pressures to establish rates and provider participation.

- **Estate Recovery -** OHP would like to expand its powers to collect service costs from the estates of deceased beneficiaries. Currently, there is insufficient clarity in statutes regarding collectible assets. As a result, aggressive collection efforts often result in successful legal challenges.

- **60 - Day Rule -** These statutes require states to repay CMS within 60 days of discovering any overpayment for services or incorrect reimbursement for services, regardless of the state's success in recollecting these funds. These rules result in a cash flow problem for states. In those states with lower federal shares, there already exists a sufficient motivation for collection of these errors in payments. OHP would prefer that CMS use each state's payment error rate (PERM) to evaluate its efforts to recover errors. By using this measure, CMS could impose either the 60-day rule or a more collaborative time frame.[6]

- **Eligibility** - Eligibility standards are too complicated for effective and efficient administration.

- **Access to Medicare Data and Collaboration -** The dual-eligible population represents a small portion of the Medicaid population but a large portion of expenditures. Currently, OHP simply gets a bill from Medicare and is largely excluded from the decision making process. OHP would prefer to have access to Medicare data so that it can evaluate the quality and efficiency of care and have involvement in setting capitation rates.

The Ohio Medicaid program operates within a turbulent, dynamic, and complex environment. Factors like environmental pressures, demographics, and the federal political environment have a profound impact on how the program could best implement strategic management and organizational design. However, there are also other difficult environmental factors created by

[6] The 60-day rule does not apply to situations of fraud.

Ohio's own public officials and administrators that exacerbate an already challenging environment.

Organizational Issues Evaluation Approach

Because of the wide array of factors that influence Medicaid policy, at both the State and federal levels, the following findings and recommendations are based upon an evaluation of common interrelated organizational components. Each of these issues is presented separately, but assessed in a holistic manner. As such, this discussion first presents a model of strategic management to both define terms and illustrate the optimal relationships between these interrelated issues in contrast to the relationships observed in the Ohio Medicaid program. However, the issues discussed in this section are not presented in the same order as the model, because the assessment also includes organizational structure, which should be driven by aspects of strategic management. Therefore, the examination of Ohio's Medicaid program taken as a whole is presented in the following manner:

- Responding to the operating environment;
- Defining the purpose of Ohio's Medicaid program;
- Medicaid budgeting practices;
- Organizational design of publicly funded health care; and
- Medicaid high level organizational structure.

Following this analysis, the focus narrows to an examination of the State Medicaid agency (ODJFS) and will largely concentrate on OHP operations as it is the only organization solely devoted to Medicaid administration in Ohio. As organizational management and design functions reflect all duties and operations of an entity, a comprehensive review of Medicaid within the sub-recipient agencies, would also require an examination of the inter-relationship between the sub-recipients' Medicaid and non-Medicaid programs. This analysis was determined to be secondary to the central questions surrounding the purpose and best organizational arrangement for the program. The role of the sub-recipients and the effect of changes on their Medicaid services should be examined once the purpose of the program has been defined and the best organizational structure identified.

According to *The Role of Political Ideology in the Structural Design of New Governance Agencies* (Bertelli, Public Administration Review, July/August 2006), structural design and organizational design present politicians with critical choices regarding the delegation of authority to quasi-governmental entities to deliver public services. Bertelli says, "They may design agencies for a single policy task, even if it means committing assets that are non-recurrent and task specific." Policy uncertainty creates an incentive for legislatures to delegate vague powers to administration. Furthermore, government attitudes, particularly those regarding administrative efficiency, affect the structural design of governmental organizations (like ODJFS). As advocates for efficiency and reform, legislatures are keenly interested in

governance structures and processes. Public management reforms specific to the deployment of the Medicaid program will likely involve deliberate changes to the structures and processes of numerous public sector organizations. These decisions for change are made with the objective of getting those organizations (in some sense) to perform more efficiently and effectively. Therefore, issues identified within OHP and the current structure will likely continue to have an impact on program operations. Several agency or department level issues were also examined and are presented as follows:

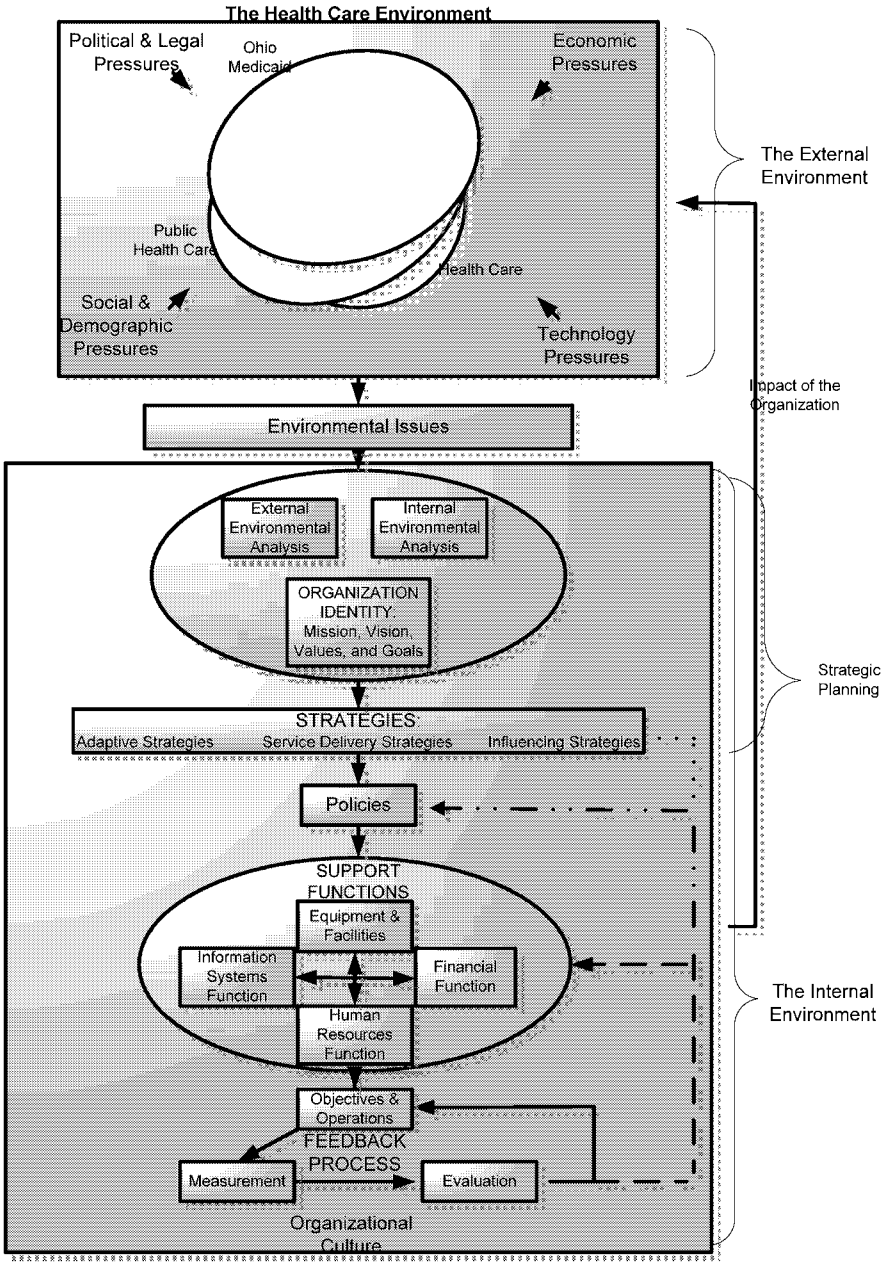
- Operating structure of the Medicaid agency;
- OHP's strategic planning implementation process;
- OHP's strategic management and planning framework and content;
- Information management and performance measurement; and
- Human resources management.

These issues -- planning, management, performance measurement, and human resources management -- are central to the operations of all organizations. Areas of weakness identified during the evaluation process and the corresponding recommendations are therefore applicable to any new organizational array that might be implemented for the program. Similarly, the recommendations may have applicability within the sub-recipient agencies and could have a beneficial impact on their ability to provide Medicaid and non-Medicaid services to their constituents.

Explanation of Key Strategic Planning and Management Terms

As a wide variety of terms are used to define organizational and management theory, the terminology for the subjects included in this section of the performance audit is particularly important. Terms are often applied inconsistently and organizational and management issues have an interdependent and interconnected nature. Because the strategic management of the Medicaid program has a high impact on its effectiveness and efficiency, the use of strategic management in program management is key to the effective organization and deployment of Medicaid in Ohio. This review first presents a common terminology for further discussion of strategic planning and management, and defines the optimal relationship between various functions. In this manner, the reader is able to view each issue in the context of an optimal arrangement and with a common understanding of the terminology. **Illustration 3-3** represents optimal relationships between various functions of strategic management as adapted from several strategic management models.

Illustration 3-3: Strategic Management Outline



Source: AOS depiction

Illustration 3-3 represents optimal relationships between fundamental strategic management elements. However, it does not necessarily correlate to an organizational structure, or even singular or multiple structures. While a fragmented structure may complicate the coordination of the functions, it does not preclude these relationships, nor does it prohibit the organization(s)[7] from operating in this manner if there is a high level of collaboration and cooperation.

Strategic management, the process outlined in **Illustration 3-3**, involves an assessment of the operating environment, definition of the organization's purpose and identity, strategy formulation, implementation of strategic initiatives with support functions and objectives, and, finally, monitoring of progress and revision of implementation approaches. *Strategic planning*[8] is a subset of strategic management. Strategic planning involves the evaluation of both the external and internal environments to define the organization's "identity," and then the "strategies" or approaches it will use to achieve its goals. Defining an organization's identity requires an evaluation of its mission, values, vision, and goals. *Mission* describes an organization's purpose for existence, while *values* represents the principles an organization collectively believes have merit. In many ways, these should reflect the organization's culture, which is the unseen force that influences decisions and actions. Values also help an organization prioritize among competing goals and factors. *Vision* refers to how an organization would like to change the world or society. It is, in essence, the organization's desired legacy. Finally, an organization's *goals* are what the organization would like to do or accomplish with an outcome focus. Collectively, these ideals represent an organization's identity. They answer the questions: Why are we here? What do we believe in? What do we want our legacy to be? What outcomes do we want to accomplish?

Once the program's identity is established, it can evaluate how it will achieve its goals, or the approach it will use to accomplish its goals, or service delivery (strategies). However, strategies may also seek to adapt the internal realities to external pressures (adaptive strategies). On the other hand, strategies may seek to allocate resources in a manner to influence external parties or external conditions to facilitate achievement of goals (influencing strategies).

The remaining aspects of *strategic management* entail the establishment of policies, support functions, actionable objectives, and a feedback process that facilitates monitoring of how well objectives have contributed to goal attainment. *Policies* are the established rules and operating procedures that support the strategic approach of an organization. They may apply to internal and/or external parties. In this analysis, *programmatic policies* refer to those policies impacting the administration of the Medicaid program. Policies may be restrictive or prescriptive in nature.

[7] The following discussion uses the term *organization* for convenience and incorporates all possible organizational structures.

[8] Within the discussion of OHP's ***strategic planning and management framework and content***, research is presented that refers to "strategic planning" with a specific intent. "Strategic planning" in the context of this discussion is a general term (unless otherwise noted) that incorporates each of the "schools of thought" for strategic management expressed in this research.

Restrictive policies prevent internal or external parties from certain actions because they are deemed to expose the organization to risk or are contrary to goals, strategies, or values. Prescriptive policies require action on the part of individuals or describe the appropriate process for action. These policies should support the goals and strategies of the organization. *Support functions* are those crucial ancillary functions that allow an organization to achieve its goals, but are not directly tied to service delivery. *Objectives* refer to actionable resource allocation or steps to be taken by the organization to reach its goals. Finally, the *feedback process* refers to a cycle that allows an organization to assess the effectiveness and efficiency of its objectives and operations in achieving its goals. Effectiveness refers to the correlation between outputs and the achievement of desired outcomes (goals). Efficiency refers to the ratio of resource inputs to outputs. Cost effectiveness refers to the ratio of outputs to inputs. Evaluating these aspects of operations is crucial in operational planning and achieving incremental improvements over time as it allows adjustments to operational level objectives in the future or even occasional adjustments to strategies or support functions.

Findings and Recommendations

A. Responding to the Operating Environment

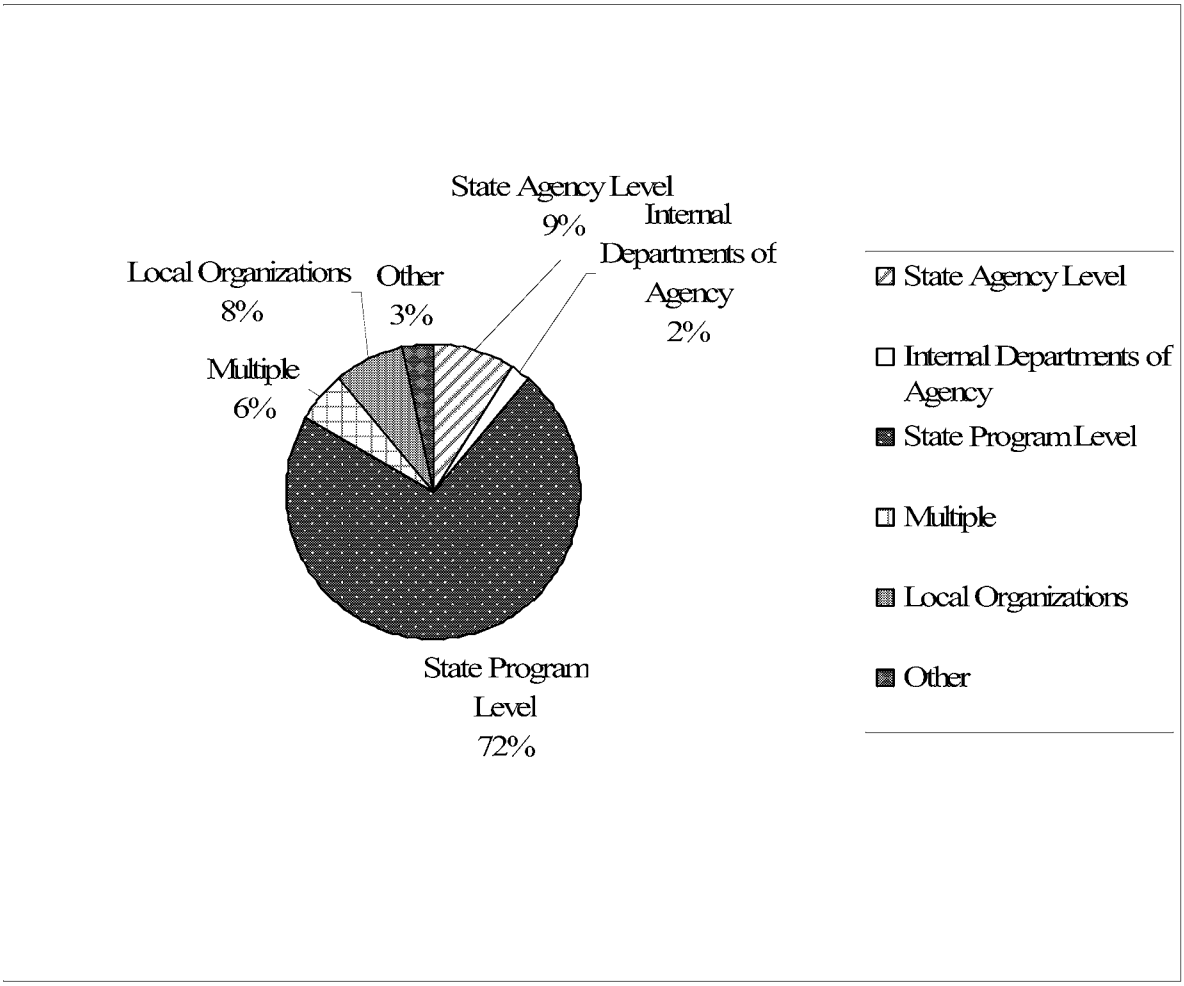
Given the environmental pressures impacting Ohio Medicaid and health care in general, those factors that can be controlled, such as the State political environment, are particularly important to manage. The environment in which Ohio Medicaid operates appears to be characterized by a general absence of trust between the General Assembly and State agencies; among Medicaid agencies; between State agencies and local administering organizations; and between providers and public organizations.[9] Key General Assembly members indicated a low degree of confidence that complete and comprehensive information was provided to them by the Ohio Medicaid agencies. Members' impressions included the perception that agencies, at times, appeared to have contrary agendas, were resistant to being held accountable, and were not proactive in their contact with the General Assembly. However, it should also be noted that General Assembly members indicated their relationships with these agencies has recently improved. To that end, the ODJFS liaison to the General Assembly discussed a number of proactive steps ODJFS has taken to inform the General Assembly of events and issues within ODJFS and Ohio Medicaid including: providing required episodic reports, quarterly reports, and press releases; and responding to information inquiries within six days. ODJFS indicated that the negative perceptions of the General Assembly members on the quality of information provided were likely caused by the Agency's antiquated computer system which does not allow for immediate responses to information requests. However, this review noted improvements in the information system that allows better summarization of claims data with the Decision Support System which thereby permits more timely responses (see ***information management and performance measurement***). Similarly, term limits have reduced ODJFS' ability to build relationships and educate legislators on the nuances of the Medicaid program and compressed the time allotted for legislators to achieve their desired goals.

A member of the Ohio Job and Family Services Directors' Association described the potential frustration that members of the General Assembly may experience with the Ohio Medicaid program because of historic unresponsiveness from ODJFS and the complex nature of the program. The member acknowledged that this frustration over the unresponsive nature of ODJFS appears to have been translated into the idea "if you take it out of ODJFS, then it will be fine". The member added that pulling OHP out of ODJFS "isn't going to help them." The members of this association advocated that services at the local level should not be negatively impacted by this proposed change and that Medicaid eligibility determination should remain with the county DJFS to ensure centralized eligibility for public assistance programs.

[9] During the course of this audit, representatives of the executive branch (the Governor's Office) were also contacted for their input and concerns about the program; however, the representatives declined participation in the audit.

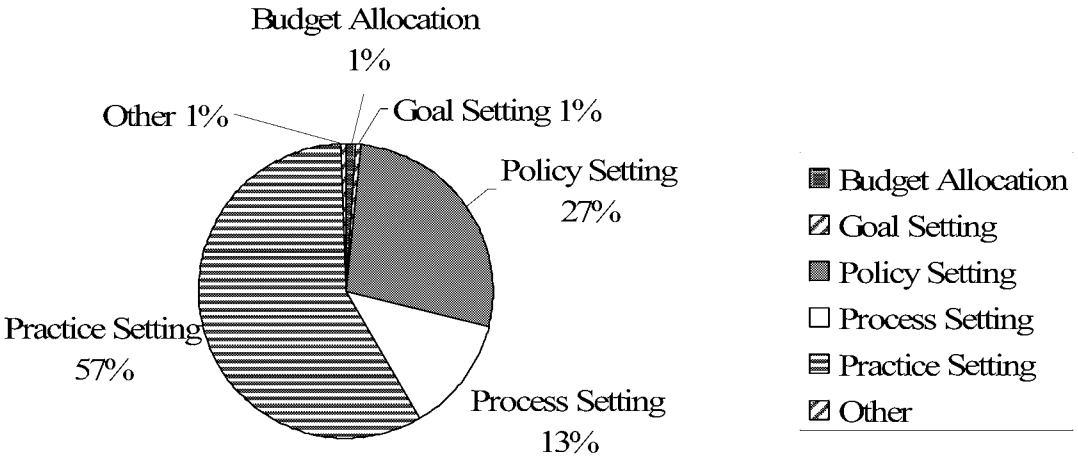
The absence of transparency in Ohio Medicaid processes at ODJFS erodes the General Assembly's trust in ODJFS and, by extension, the sub-recipient agencies. This erosion of trust is compounded by the high rate of expenditure growth. Partially as a result of low levels of trust in the Medicaid agencies, the General Assembly has become active in Medicaid strategy -- setting policy and implementation practices for various programs. One legislator indicated that the General Assembly uses prescriptive legislation to ensure that its directives will be implemented fully or in a manner consistent with the "spirit" in which they were passed. **Charts 3-5** through **3-7** summarize a sample of Ohio legislative changes to the Medicaid programs and the level of the General Assembly's involvement in the process during the last three biennial budget cycles.

Chart 3-5: Summary of Characteristics of General Assembly Legislation Impacting Medicaid Programs by Level of Impact



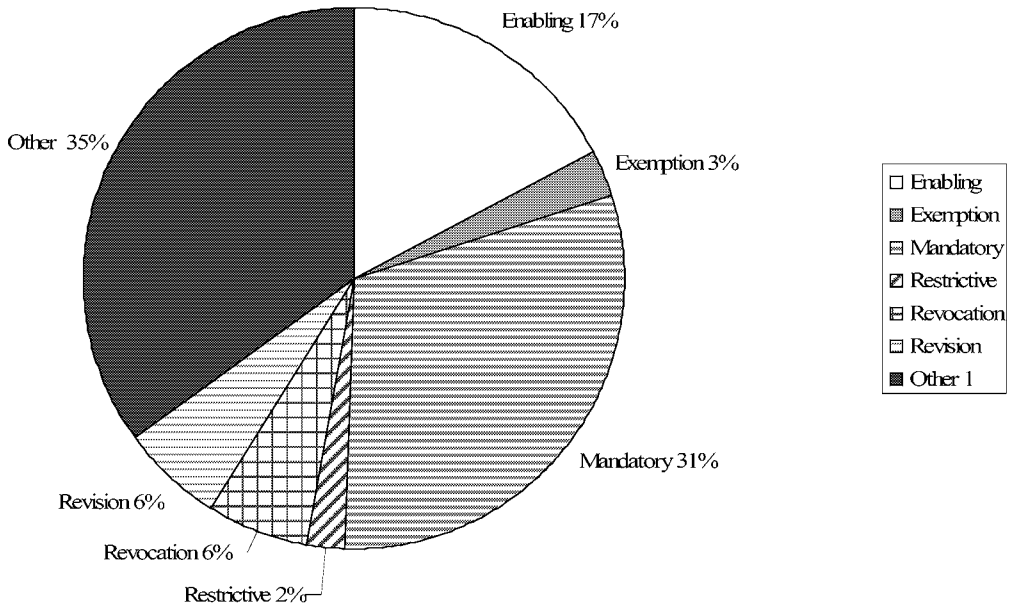
Source: Legislative Service Commission Bill analysis for HB 66, HB 95, and HB 94

Chart 3-6: Summary of Characteristics of General Assembly Legislation Impacting Medicaid Programs by Level of Involvement



Source: Legislative Service Commission Bill analysis for HB 66, HB 95, and HB 94

Chart 3-7: Summary of Characteristics of General Assembly Legislation Impacting Medicaid Programs by Type of Language



Source: Legislative Service Commission Bill analysis for HB 66, HB 95, and HB 94
Other 1: "Other" legislative language combined attributes of two or more categories.

A sample of legislative changes as summarized by the Ohio Legislative Service Commission (LSC) indicates that the Ohio General Assembly has a tendency to establish detailed legal changes to the Ohio Medicaid program that establish practices for various Medicaid programs. Provisions were subjectively categorized and almost 58 percent of legislative changes established detailed practices and 72 percent impacted specific Medicaid programs. These changes primarily impact ODJFS and providers. Furthermore, many of these changes are mandatory. Of those provisions reviewed, almost 31 percent were entirely mandatory and almost 55 percent were at least partially mandatory. Finally, legislative involvement accelerated in the last biennium's budget as evidenced by the number of changes to the Medicaid program in Amended Substitute House Bill 66 relative to prior budget bills.

This involvement is completely within the General Assembly's power; however, frequent and substantial legislative changes can result in unintended negative effects. While some of these policies may have input from OHP, other State agencies, county administrators, or other stakeholders, they are not all necessarily guided by a common perception of goals or by priorities

of a long-term nature. Therefore, it is likely that this level of involvement will result in increased programmatic and organizational instability. For instance, conversations about the strategic management process between auditors and ODJFS executive staff revealed fundamental differences in basic perceptions of how strategic planning and management should operate. During this discussion, it became clear that OHP does not have sufficient consistency of operations to allow this traditional cycle of strategic planning and management that includes a cycle of planning, implementation, measurement, and evaluation. The OHP Chief of Staff described her staff as project managers as, every biennium, new policies from the legislature require implementation by OHP staff. Furthermore, as a portion of these changes were driven by budget constraints, some policies and general direction of the Medicaid program were inconsistent because budget cycle concerns took precedence over long-term priorities. OHP's approach implied that environmental change pressures were so intense that staff was unable to establish proactive strategies and policies, and instead, simply reacted to changes required of the organization.

In the current biennium, the high degree of Medicaid program involvement within the General Assembly may inhibit an emerging organizational culture of ownership and responsibility developing within ODJFS and OHP, which is a prerequisite for accountability. Policies made external to the organization inhibit organizational "buy-in." The deficiencies in responsibility and accountability are both contributing factors to, and result from, the ill-defined and inconsistent purpose in the Ohio Medicaid program (see further discussion in ***defining the purpose of Ohio's Medicaid program***).

It is important to note that the Ohio General Assembly is not alone in its interest in the operations of state Medicaid agencies. Conversations with other state Medicaid directors revealed that they too must implement initiatives originating from their legislative bodies. It is very difficult to compare the effects of legislative changes among States as their frequency does not necessarily indicate the scope or scale of changes. However, the Director of the Arizona Medicaid program indicated that legislation results in three to four operational changes annually in the Arizona program compared to 94 legislative changes impacting Ohio's Medicaid program in the last budget bill (HB 66). The Director of the Arizona Medicaid program indicated that lesser involvement by his State's legislature was primarily due to the agency's continual outreach efforts with the community and legislators. The Oklahoma Medicaid program has buffered itself from some political pressures by reporting to a seven member board comprised of appointees of the Governor, as well as the House and Senate. Board members serve three-year terms and are responsible for selecting and hiring the director of the Oklahoma Medicaid Agency. According to the Oklahoma Medicaid Director, this has provided more stability and continuity since the director is not appointed or otherwise serving at the discretion of elected officials. Finally, Oregon also has a separate policy-making body that has voting members appointed by the governor and non-voting legislative members. The Oregon Medicaid Director stated that political pressures within his State are somewhat negated due to the well defined long-term vision and purpose of their Medicaid program (see also ***defining the purpose of Ohio's***

Medicaid program: prioritization practices in other states). This purpose and identity drove an effort to prioritize services and guides decisions at the goal, strategy, policy, and programmatic levels. Furthermore, the prioritized services provide the Oregon legislature with guidance during difficult periods of rationing of required funding for particular services.

In Ohio, the Ohio Retirement Study Council (ORSC) functions as an independent advisor to the General Assembly on matters concerning the State retirement plans. The Council is governed by fourteen members: three members of the House, three members of the Senate, three appointed by the Governor, and the five executive directors of the State retirement systems who are nonvoting members. The Council was formed to serve as a buffer between competing interest groups and to insulate the General Assembly—and the plans—from these forces. The Council is able to provide the General Assembly sound advice, fiscally and policy-wise. Also, because pensions are increasingly complex, requiring specialized knowledge and continuous supervision to keep up with changes, the Council is able to contract for specialized services and monitor changes to federal laws. The Council's duties include impartially reviewing all Ohio laws governing the State retirement systems and making recommendations to the Legislature, reporting to the Governor and Legislature on its evaluations and recommendations with respect to the operations of the public retirement systems, and studying all proposed changes to Ohio retirement system law and reporting on probable cost and actuarial implications, and the desirability as a matter of sound public policy.

Ohio Medicaid is also complex and constantly in change. Federal changes require constant monitoring and evaluation. Medicaid also requires a degree of expertise and knowledge to understand the effect of policy and rule changes which may have serious financial and public policy consequences. Also, several interested parties compete for funding and program access. A greater degree of continuity of policy would enhance the program and reduce the patchwork effect created by special interest groups. Because of these factors and the program's need for long-term, consistent policy, a separate body, formed in a manner and consistent in mission with the ORSC would potentially be beneficial to Ohio Medicaid.

Because ODJFS, OHP, and the State sub-recipient agencies are continually responding to required changes, the agencies suffer from inconsistent approaches and fragmented program implementation. As changes are required with such regularity, there is insufficient time to gauge the effectiveness of a program or approach. Through improved relationships with legislative and executive leaders, the Medicaid agencies could reduce controllable change and focus on mitigating the impact of environmental factors beyond the agencies' control. Likewise, the General Assembly and Executive branch could focus on broader policy and purpose-related issues. A member of the Ohio Association of County Behavioral Health Authorities advocated for systemic change (over the incremental change process that has been used in the past) because of the limited progress in achieving changes within the Medicaid behavioral health system.

R3.1 The General Assembly should evaluate its role in setting Medicaid policy and establish a long-term perspective for the program. The use of legislation to guide program operations can be cumbersome and difficult to change when flexibility is required. Similarly, legislative mandates have increased program instability and inconsistency by limiting the participating agencies' ability to evaluate the outcomes of program operations. Instead, the General Assembly, with assistance from the State Medicaid agency, sub-recipient agencies, and Governor's Office, should seek to establish long-term direction and goals and allow the participating agencies to implement strategies to achieve those goals (see the discussion of Defining the Purpose of the Medicaid program). Future legislative directives should reflect these long-term initiatives.

Furthermore, the executive branch and the General Assembly should consider their information needs in relation to their decision-making authority. The State Medicaid agency and sub-recipient agencies should supplement budgetary information with output measures generated from the current claims based system for members of the General Assembly. Likewise, the agencies should plan future information systems to allow outcome measures (see the discussions of Information Management and Performance Measurement and the discussion of Medicaid Budgetary Practices).

R3.2 In order to better overcome negative environmental factors, the single State Medicaid agency should use the recommendations in this report, as well as other best practices identified by the Agency, to mitigate health care competitive market failures, such as using service provision strategies like care management or consumer driven models (see the managed care and care management sections for further analysis of the managed care option).[10] These market failures are outlined in the overview of the operating environment discussion of market inefficiencies within the background section.

R3.3 The State Medicaid agency and the sub-recipient agencies should improve and continue to foster transparent, positive, and proactive relationships with all political oversight bodies to ensure informed and effective decision-making. Furthermore, the agencies should seek to enhance the long-term trust and cooperation among the executive and legislative representatives involved in program policy-making through increased responsiveness to requests and compliance with legislative mandates. Finally, the State Medicaid agency should use available information sources to better educate elected officials about the program and assist elected officials in refining their information requests. The State Medicaid agency should also assist

[10] For example, using a consumer driven model and care management might alleviate some of the problems associated with the "moral hazard" associated with a third party payer.

elected officials in interpreting and placing this information in the proper context to enhance legislative decision making.

R3.4 The General Assembly should consider requiring the State Medicaid agency to provide access to data to the Decision Support System to the Office of Budget and Management, the Legislative Services Commission, or another existing body. One of these entities could serve as a separate and objective body to gather, interpret, and disseminate relevant information. In this manner, members can be assured that agencies are transparent and providing reliable and relevant information. This would likely require the allocation of additional resources to these organizations to offset the added duties. Further discussion of granting access to the Decision Support System (DSS) is included in *budgeting practices* and *information management and performance measurement.*

R3.5 The General Assembly should evaluate if a layer of reporting structures or processes between the General Assembly and the State Medicaid agency would help future elected officials maintain an appropriate scope of decision-making. The General Assembly may wish to establish a Council (similar to the Ohio Retirement Study Council) which could provide independent advice to the Legislature on Medicaid program and policy decisions and their financial effects and health care impact. A Council or separate reporting structure should allow Medicaid program operations to be buffered from short-term political pressures and initiatives. Another strategy would be to establish a separate and objective body to set health policy for Ohio, similar to those used in Oregon or Oklahoma.

B. Defining the Purpose of Ohio's Medicaid Program

Competing Goals among Participating Ohio Medicaid Agencies

Ohio has failed to clearly define the purpose and identity of its Medicaid program. According to the Centers for Medicare and Medicaid Services (CMS), the purpose of the federal Medicaid program is to provide medical benefits to groups of low income populations who may have no medical insurance or inadequate medical insurance. Although the federal government establishes general guidelines and options, states must interpret the program's role within the larger context of their respective health care systems and establish specific Medicaid program policy. For instance, Ohio's Medicaid program includes services mandated by the federal government as well as optional services Ohio has elected to provide (also see the **Medicaid service provision** section). While Ohio's policy is established within the ORC and OAC, these policies do not appear to be driven by a central purpose for the program. Furthermore, there appears to be differences in the interpretation of policy among various administrators at all levels of government.

The difficulty in establishing a social service's identity is that it involves balancing competing, if not contradictory, goals. Public social service programs seek to provide the highest quantity and quality of services to the largest possible number of eligible beneficiaries. However, as a public entity, these agencies are also entrusted with public resources to be conserved and spent in the most efficient manner possible. While expansion of the scope, scale, or quality of services does not always result in greater costs, these instances are unusual and expansion is very highly correlated with higher expenditures. In essence, defining "success" for a public social service organization is nebulous and difficult, but it is also a prerequisite first step toward effective operations. The private sector has a more concrete and quantifiable definition of success, and as a result, research about the identities of private sector companies is able to determine the impact of clear high level goals on organizational performance.

A Model of the Impact of Mission Statements on Firm Performance (Bart, Bontis, and Taggar, 2001) found empirical evidence that while establishing goals, or "ends," within mission statements had a positive relationship with organizational performance, a much stronger relationship existed with mission statements that clearly indicated the "means" of accomplishing the goals. This study surveyed a number of individuals within large North American private companies and compared the results of the survey to financial performance indicators. The companies surveyed included a number of health organizations, such as hospitals, and the study found that both clearly defined goals and ways to prioritize among these goals are required. Therefore, criteria are needed to assist public officials and administrators in prioritizing competing interests.

These differences in interpretation of goal priorities are best illustrated by a comparison of each participating Medicaid Agency's strategic planning documents, which are summarized in **Tables 3-6 to 3-7**. The emphasis on key words in the tables was added by AOS. A complete listing of competing goals and strategies can be found in **Appendix 3-E**.

Table 3-6: Summary of Agencies' Competing Missions, Visions and Values

	Mission
ODJFS/OHP	**Mission:** Support the quality of life of Ohioans through coverage of high quality, cost effective, accessible health care and related services. **Vision:** Be a leading public sector health plan by demonstrating excellence throughout the organization and leadership in health system reform. **Values:** Treating our diverse consumers, colleagues, and stakeholders with dignity, integrity, and respect. Exemplifying pride in public services. Leading through innovation, flexibility, and teamwork. Pursuing fiscal integrity, accountability, and outcome-based decision making. Communicating promptly and effectively.
ODMRDD [1]	**Mission:** Continuous improvement of the quality of life for Ohio's citizens with developmental disabilities and their families. **Vision:** N/A **Values:** Self-determination principles of freedom, support, authority, responsibility, and confirmation.
ODMH	**Mission:** Pursue clinical excellence through progressive treatment, education, research, and advocacy. Promote the recovery of people with mental illness and the support of their families. Work in partnership to respect the rights of people and the safety of the community while honoring unique local, cultural, and special population needs. **Vision:** Establish mental health and recovery from mental illness as cornerstones of health in Ohio, assuring access to quality mental health services for Ohioans at all levels of need and life stages. Be a community of mentally healthy people who lead fulfilling and productive lives. **Values:** *Integrity*- honest and ethical, accountable for actions. *Dedication*- committed to helping every Ohioan with mental health needs; exceed the expectations of those we serve. *Quality*- provide the highest quality services; clinically and culturally competent services and interventions in a manner that is acceptable to consumers and that help them achieve the outcomes they desire. *Teamwork*- Promote partnerships that reach across system and organizational boundaries.
ODADAS	**Mission:** Provide statewide leadership for alcohol and other drug addiction prevention and treatment services for the health, safety and productivity of all Ohioans. **Vision:** To provide nationally recognized leadership in establishing, brokering, and marketing quality alcohol and other drug addiction prevention and treatment services accessible to all Ohioans. **Values:** Innovation, accountability, and value
ODA	**Mission:** Advocate for the needs of older citizens. **Vision:** The emphasis is on improving the quality of life for older Ohioans, helping senior citizens live active, healthy, independent lives, and promoting positive attitudes toward aging and older people. **Values:** Be highly visible, accessible, well-managed, and cost effective.
ODH	**Mission:** To protect and improve the health of all Ohioans. **Vision:** N/A **Values:** Leadership, excellence, accountability, partnership, and citizenship

Source: Medicaid agency planning documents
Note: The presentation of planning initiatives was interpreted and formatted for the best comparison with other Ohio Medicaid departments and consistency with AOS interpretations of strategic planning terminology.
[1] ODMRDD did not have a comprehensive strategic planning document; however, excerpts from the RFP requesting outside assistance in designing a quality management system were used to the extent possible.

Table 3-7 outlines the competing goals of the various agencies. Emphasis on key words was added by AOS.

Table 3-7: Summary of Agencies' Competing Goals

	Goals
ODJFS/OHP	A. Continually improve the effectiveness of publicly funded health care systems and expand integrated community service options for adults and children with disabilities. B. Improve the effectiveness and agility of OHP's business operations through performance and project management. C. Continually improve cost management of OHP and responsibly slow the rate of growth in ODJFS all-funds spending for Medicaid medical services to a level that is more sustainable with existing State revenues.
ODMRDD [1]	Provide leadership in the development of public policy
ODMH	A. Increase access to mental health services by individuals in need. B. Enhance patient outcomes in a way that increases recovery and resilience of consumers in the mental health system. C. Increase the quality of life of individuals in the mental health system. D. Increase consumers' satisfaction with their interaction with the mental health system. E. Improve the internal processes to reduce the level of administrative burden in the service systems to increase the level of resources available for direct care.
ODADAS	A. Increase the number of consumers returning to the workforce and contributing to Ohio's economy. B. Reduce the stigma of addiction so that it is recognized as a chronic illness and a legitimate health care issue with an appropriate and necessary continuum of care that includes prevention, treatment and recovery services. C. Improve access to effective services that meet the needs of customers. D. An accessible, effective, seamless continuum of care from childhood through adult. E. Continue to improve business performance.
ODA	A. Provide choice and quality long-term care services and supports for consumers. B. Respond to disparate needs (e.g., health, social isolation, poverty) of older adults who may be diverse in race, ethnicity, culture, linguistics, disability, and sexual orientation. C. Address the shortage of professional and paraprofessional health care workers to meet the current and future needs of older Ohioans. D. Foster, develop, and enhance programs and services for active seniors and baby boomers. E. Improve aging network program efficiency, integration, and coordination.
ODH	A. Encourage healthy choices B. Prevent chronic, environmental, genetic and infections diseases C. Eliminate health disparities D. Assure public health preparedness and security E. Assure quality and safety of health care services F. Improve business performance

Source: Medicaid agency planning documents
Note: The presentation of planning initiatives was interpreted and formatted for the best comparison with other Ohio Medicaid departments and consistency with AOS interpretations of strategic planning terminology.
[1] ODMRDD did not have a comprehensive strategic planning document; however, excerpts from the RFP requesting outside assistance in designing a quality management system were used to the extent possible.

Tables 3-6 and **3-7** illustrate cultural differences among the agencies administering Ohio's Medicaid program. An analysis of these agencies' missions, visions, and values reveals that OHP identifies itself more as a health financing agency, while each sub-recipient agency generally conceptualizes itself as an advocate for its constituent population and views Medicaid as a funding source. For instance, OHP's stated mission is to be a "leading public sector health plan." In contrast, ODMH seeks to make "mental health a cornerstone of health in Ohio." One of ODADAS' goals is to "reduce the stigma of addiction" (see **Table 3-7**) and it seeks to accomplish this with multiple strategies of educating citizens and professionals in various manners. ODA explicitly states that its purpose is to "advocate for the needs of older citizens" and it desires a "visible" aging network. This perception of the agency's role likely contributes to differences in how these agencies prioritize the competing goals of cost containment versus improving the quality of life of recipients. While different agencies are expected to have different, even competing missions and goals, the divergence of approach in the area of Medicaid policy and application is a barrier to increased coordination and cooperation among the agencies.

Increasing the scope of services, quantity of services, quality of services, utilization of services, or eligibility for services are all strategies to improve recipients' quality of life. However, while each agency has some level of concern for controlling costs and being a frugal administrator of public funds, OHP appears to have more narrowly defined its strategies for improving the quality of life for its recipients relative to other Medicaid agencies and has more robust and numerous strategies to contain costs as reflected in **Table 3-7**. For instance, OHP identifies improving the quality of life for Ohioans as part of its mission, but its goals are limited to improving the effectiveness of services and expanding the flexibility of service options. Therefore, OHP seeks to better match its services and resources to recipient needs and provide additional options to its recipients.

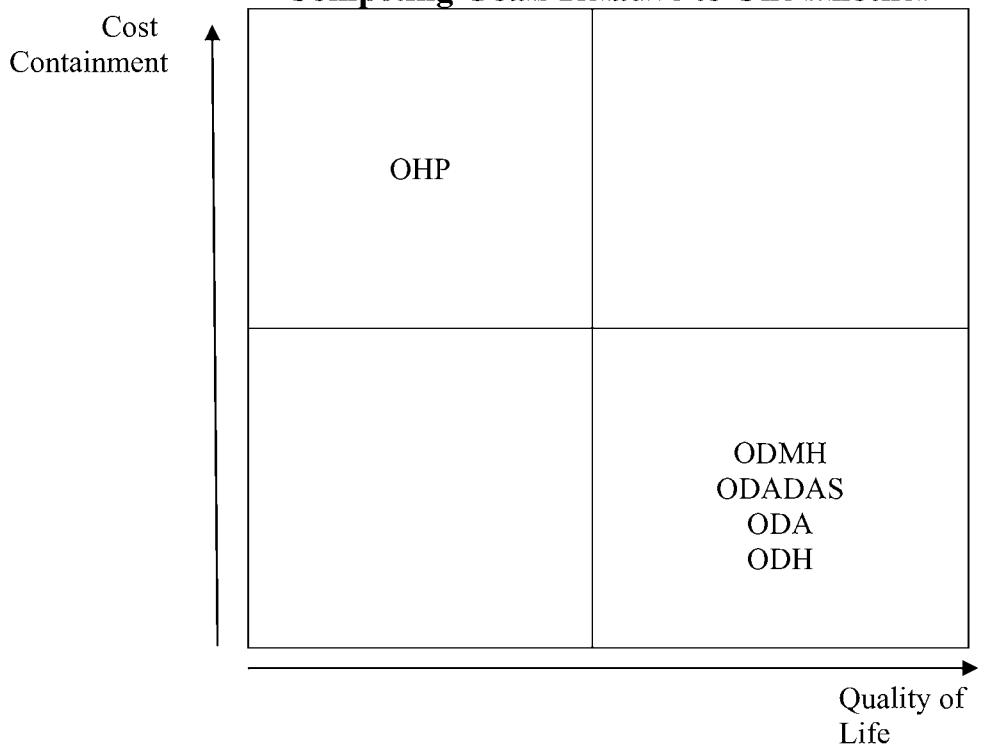
In contrast, ODMH defines dedication as "helping every Ohioan with mental health needs" and defines quality as "achieving outcomes the client desires." Furthermore, its goals include expanding the quality of life, expanding access, and increasing consumers' satisfaction. While ODMH identifies reducing administrative costs, this is solely for the purpose of expanding services. Furthermore, ODMH identifies increasing the financial capacity of its system and direct care dollars as a strategy for achieving its goals (see **Appendix 3-E**, **Table E-3**). Overall, it appears that ODMH prioritizes service delivery at a higher level than OHP relative to cost considerations.

ODADAS, like ODMH, appears to place service issues higher than OHP relative to cost considerations. Within the ODADAS strategic planning document, cost containment strategies are limited to more effective utilization of resources. However, ODADAS seeks to make alcohol and other drug addiction services "accessible to all Ohioans." Furthermore, it identifies expanding the financial capacity of local boards and providers to seek additional revenue as a strategy.

Finally, ODA, like the other sub-recipient agencies, defines quality of life in a more inclusive manner than OHP and includes meeting individuals' health, social interaction, and poverty needs. It defines cost containment more narrowly than OHP, generally focusing on better allocation of resources.

Illustration 3-4 summarizes the competing values of the Medicaid agencies in Ohio in graphical form and shows the relative priorities as interpreted from their respective missions, visions, and goals.

Illustration 3-4: Medicaid Agencies' Priority of Competing Goals Relative to One Another



Source: AOS depiction based on participating Medicaid agencies' planning documents
Note 1: As these administrating agencies were placed in the chart above based upon an interpretation of their strategic planning documents, ODMRDD could not be included because at the time of this review, the agency did not have such a document. Furthermore, ODE was not included due to its relatively minor role in the program in terms of resources expended.
Note 2: The term "Quality of Life" is used because it is a more comprehensive term that incorporates aspects such as service expansion, access to care, eligibility expansion, preventive services, as well as advocacy services.

Illustration 3-4 shows the relative position of the state agencies' priorities. For instance, the illustration does not indicate that OHP does not value quality of life issues. Many of OHP's activities seek to improve the quality of life for its recipients. The illustration simply depicts that, relative to other agencies, it values cost containment more and quality of life issues less than

other agencies. It should also be noted that each agency's perspective may be very appropriate given its legislative mandate. For the sub-recipient agencies, Medicaid is simply one of several funding sources to be used to the extent possible to support services to individuals in need. Though subtle, these fundamental differences in each agency's culture, perceptions of roles, and prioritization of competing goals have a profound impact on its interpretation of Medicaid and its efforts to change its environment.

A member of the Ohio Association of Area Agencies on Aging explained that there are several challenges associated with the implementation of Medicaid. Fragmentation and programmatic silos make consumer access difficult. The member questioned if this was caused by the fragmentation of funding and mentioned that there were several barriers preventing more efficient care. Finally, the member noted that the size of ODJFS does not allow for flexibility in the implementation of new programs.

A member of the Ohio Provider Resource Association described the impact that competing goals and values have on providers in their organization. While ICR/MR services are reimbursed by ODJFS, ODMRDD is involved in rule development and oversight. As a result "the rules kind of get jumbled because it's not the single State agency that's dealing with the program directly." When programs are delegated to ODMRDD, the member reported that discussions around the Medicaid rules and reimbursement become difficult and the two State agencies "may not always agree on things."

At the local level, administrators interpreted the role of Medicaid in a slightly different manner than their respective State agencies. This contributes to different cultures among the various administrators of segments of the programs, and contributes to the poorly defined identity of Ohio's Medicaid program. Furthermore, these competing factors are responsible, in part, for the active involvement of the General Assembly and the resulting systemic instability within the Medicaid program.

A member of the Ohio Job and Family Services Directors' Association explained the tension between the competing goals and layers of the program describing the system as "entrenched bureaucratic nonsense." Members of this association indicated that the need for accountability and openness was the driving factors to establish a new separate State Medicaid agency but noted that the Medicaid is "integrated into the county operation" and "if you create a department and call it just by another name and you don't have a different type of accountability system, you don't have a different type of leadership, you're not going to do anything but disrupt the entire system."

As a result of different priorities and competing goals, policies of various State agencies can be in conflict. Discussions with county MRDD boards revealed that 36 percent believed that ODJFS and ODMRDD goals were in concert. In contrast, 57 percent of county MRDD boards believed that they were in conflict. However, it should be noted that these organizations indicated some

progress and improvements recently over past practices. More telling, however, is that 71 percent of boards indicated that no formal communication of program goals had been received by them, while the remaining 29 percent indicated that they had received conflicting communications about the program's goals. Conversations with county boards in the ODMH and ODADAS systems indicated that 35 percent of the boards perceived that the goals of the State agencies were generally in conflict, while 33 percent believed that they conflicted on a situational basis. Furthermore, conversations with Area Agencies on Aging (AAAs) in the ODA system revealed that half of these agencies believed that ODA and ODJFS policies were in concert, while the other half believed they conflicted at least occasionally. Twenty percent believed that they were in conflict on a consistent basis.

The different organizational and cultural perspectives between State agencies and county boards are allowed to flourish due to a fragmented program and now pose operational challenges for local administrators, providers, and recipients. In part, the fragmentation has been encouraged by an organizational design and legislation that precludes OHP from effectively exerting Medicaid program operational influence over sub-recipient State agencies. In contrast, OHP, as the single State Medicaid agency, is typically held responsible for all aspects of the program by the General Assembly, CMS, and stakeholders. Interagency agreements outline duties and rights of parties, but do not clearly establish direct lines of authority; rather, the relationship is more akin to a contract that allows the contractor (sub-recipient agencies) discretion in fulfilling a given task. While changes to the terms for performing a task require ODJFS approval, the actual administrative duties are largely delegated. Furthermore, OHP and the other agencies have not developed sufficiently cooperative relationships to allow the single State Medicaid agency to provide more effective guidance and oversight.

The fragmented nature of the program and the issues created by inconsistency was reiterated by stakeholders in several interviews. These concerns highlighted their inconsistencies in the Medicaid program and variations from county to county resulting in 88 different versions of the program in Ohio.

A member of the Ohio State Legal Services Association spoke to inconsistency in the CDJFS offices and the need for the State Medicaid agency to "take its enforcement role seriously." The member also noted that ODJFS is the single State Medicaid agency responsible for the Medicaid program "but doesn't act as if it is – it acts as if there are 88 counties, 88 state agencies." The need for improved accountability to ensure that counties are administering the program appropriately was also expressed by a representative of the Universal Health Care Action Network who added that "it has been good to have counties having incentives to do a better job, and, if it goes to a statewide system, it would be good for counties to still have the flexibility to do better than the minimum. But we sure do need more accountability than we have."

A member of the Ohio Coalition for Healthy Communities also spoke to this concern noting that each of the 88 counties has its "own way of doing it, …You have to understand what the

eligibility requirements are in county A versus county B versus county C." The result of the differences between counties for agencies working with Medicaid recipients is that it is doubly difficult trying to understand and train staff "who are trying to assist the client in getting the access to benefits that they need." This concern was echoed by a representative of the Arc of Ohio who stated that the program allows 88 counties to interpret how they are going to provide services which "impacts the way care and access to services happens.... It's just not statewide." The results of this inconsistency leads to inequity noted a member of the Ohio Coalition for Healthy Communities. As a result, families seek out information on which counties provide the best services for their loved ones. In addition, a member of the Ohio Advocates for Mental Health noted that there may be a potential for savings if some of the county entities merged noting that "there is nothing logical about 50 mental health boards. There has to be some savings of money by merging some of those boards."

Not only is the program fragmented by structural design (as outlined in **Medicaid program overview, history, and current status** section and **Appendix 3-B**), it is also fragmented by funding source. Medicaid funding reaches the sub-recipient State agencies by several paths. Only the federal share of Medicaid funding passes through ODJFS to the sub-recipient agencies. In effect, ODJFS maintains a contractual relationship with outside parties without the effective ability to control payment for services. This hampers OHP's ability to coordinate and control services provided by other State agencies and their local administrators through the Medicaid program. A key control in any contractual arrangement is the ability to withhold payment for services that are not consistent with the client's expectations. While ODJFS has established interagency agreements with each of the sub-recipient agencies that define general roles and responsibilities, they are prescriptive in nature and do not appear to outline desired outcomes or incentives to achieve these outcomes. Differing and competing priorities, along with OHP's insufficient oversight powers caused by fragmented State and local programs, contribute to inconsistent organizational cultures and prevent implementation of Medicaid programs with a common purpose. However, OHP's historically poor communication and meager collaborative efforts have also contributed to the inconsistencies of purpose.

According to the Director of ODMH, ODJFS has historically had very little communication or collaboration with his Department. He did note that this relationship has improved recently, but ODJFS was not involved in formulating ODMH's strategic direction relative to Medicaid, nor was ODMH asked to comment on the OHP strategic plan relative to Medicaid. In contrast, ODMH and ODADAS have collaborated to create a common Medicaid business plan which ODJFS approved. The Deputy Director of Medicaid Policy at ODMRDD also noted past communication failures with ODJFS which she perceived to be caused by a lack of trust between the agencies. She also indicated that this had prevented an advancement of policy between their agencies. However, she noted recent improvements with the appointment of the new Deputy Director of OHP. The Director of ODADAS also perceived communication as inadequate. She noted that, in the past, ODADAS was included in discussions but was not provided a role in decision making. Furthermore, in the past she felt that ODJFS would air grievances with the

executive branch without presenting a balanced report of the issues. However, she also noted that in prior administrations she only met with the ODJFS Director once. She noted that she meets with current ODJFS leadership on a quarterly basis. External stakeholders also remarked on the apparent communication problems at the State level. A member of the Ohio Coalition for Healthy Communities said, "The other issue that we have is a lack of communication from ODJFS to the sister agencies and then on down to the providers and then to the ultimate end user, the consumers and their families in terms of changes made."

Local administrators of CDJFS, CBMRDD, and Alcohol, Drug Addiction, and Mental health Services boards[11] (ADAMH boards) reported poor communication with ODJFS. Conversations with CDJFS' revealed general dissatisfaction with guidance provided by OHP and ODJFS. A majority of the CDJFS stated that they did not receive sufficient guidance, with 56 of 62 CDJFS' respondents indicating dissatisfaction with the guidance from ODFJS on Medicaid.[12] CDJFS participants stated that when they called OHP for assistance or direction, they were frequently referred to manuals rather than provided an interpretation of the manuals. CBMRDD directors indicated, during a stakeholder interview, that they did not receive accurate or timely information from ODJFS. County boards within the ODMH and ODADAS systems also reported difficulties in communication, with only a few boards reporting good communication with their respective State-level agencies. However, their concerns seem to be a lack of input into policy decisions and the lack of a relationship with ODJFS. AAAs reported generally positive communications and guidance from ODA and commented that ODA was the "right size" to be able to respond to their inquiries and requests for assistance in a timely manner. AAA directors also remarked on the collaborative relationship with ODA and the opportunities that were created for trying new programs. However, they emphasized that no relationship existed with ODJFS and attributed this to differing missions and limited trust between the organizations. A member of the Ohio Job and Family Services Directors' Association commented about the problems in building a relationship with ODJFS. One example of these problems was limited technical assistance and the limited information provided by ODJFS. The member added "they don't give any kind of additional information. I'm not sure -- I mean they're a mystery to us."

A member of Arc of Ohio remarked that the "other challenge is that…on a local level, it is such a bureaucratic nightmare that the local JFS offices aren't getting the information." In contrast, a member of the Ohio Job and Family Services Directors' Association explained that they "are kind of the broker, the communicator between all the other systems…even though we may not deliver a Medicaid health service…and it's going to be hard to capture the communication and coordination that is done on a day-by-day basis in each county between all of those participants…."

[11] Throughout this report, ADAMH boards is used to collectively refer to combined boards, as well as stand alone Mental Health boards and Alcohol and Drug Addiction Services boards.
[12] Eighty three CDJFS boards were interviewed during the audit.

In contrast, OHP has very different perceptions of its communication efforts with external parties. A survey of OHP executive staff, bureau chiefs, section chiefs, unit chiefs, and policy staff revealed a strongly held self-perception that OHP proactively sought positive relationships with external parties.[13]

In particular, external stakeholders (providers, recipients, and advocates) expanded on communication issues among the State and local agencies and between the governmental entities and the non-governmental participants in the system (providers and recipients). One area for improvement repeatedly noted was in training. The Ohio Provider Resource Association recommended training providers and county administrators together so that there is improved consistency. Improved training of county caseworkers was also suggested by a member of the National Multiple Sclerosis Society who added an additional suggestion to review the training materials saying "the educational materials are not always understandable."

A member of the Ohio Academy of Nursing Homes noted that internal communication within ODJFS does not always occur, which results in providers having to resubmit documents and creates delays in resolving issues. A member of the Ohio Council for Home Care further spoke on the impact on providers adding:

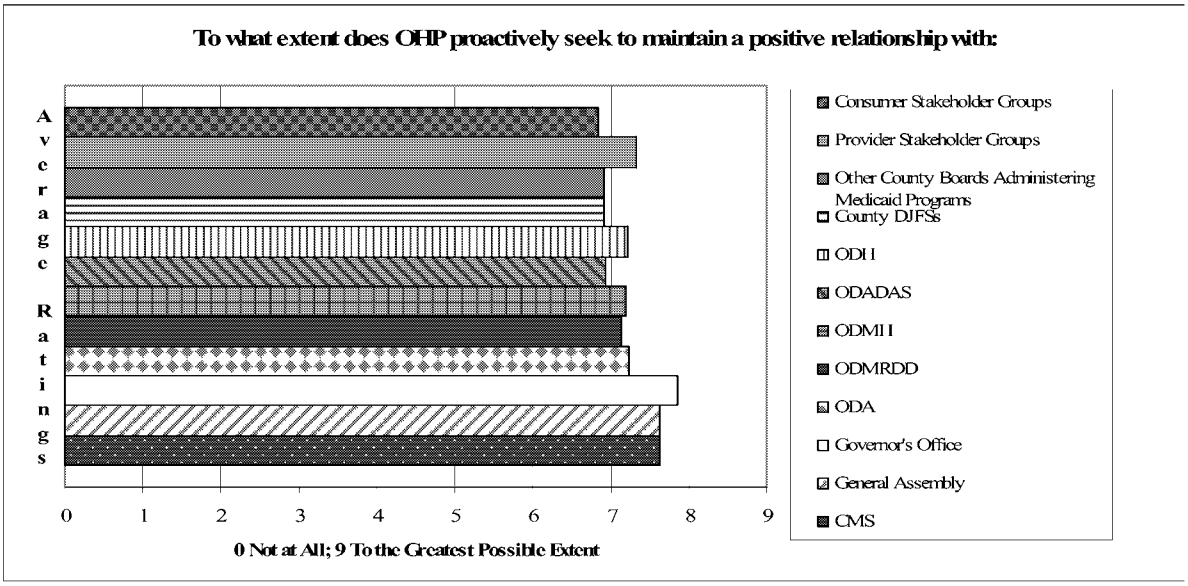
> "From a standpoint of qualifying your people, your staff, the approval for services, there's a whole different series of people and hoops and whatever that you have to go through, so organizationally it's not efficient…its very difficult and very resource intensive to try to comply within the same program with different rules all the time. And when you put multiple programs together, it's very costly and very resource intensive."

A member of the Arc of Ohio summed up the concerns saying "the only aspect of Medicaid in Ohio that has state-wideness is confusion…. We shouldn't have to spend five years down here in Columbus trying to figure it out and trying to get your questions answered. …Then when it gets answered, it's changed the next week…."

Chart 3-8 illustrates OHP's internal perceptions of its efforts to maintain positive relationships with agencies, boards, and other stakeholders involved in the Medicaid program. The chart is scored based on a Likert scale with 0 meaning not at all and 9 meaning to the greatest possible extent.

[13] During the audit, a survey was sent by AOS to all OHP employees by email. In total, 543 OHP employees were invited to participate in the survey and there were 309 total respondents, or about a 60 percent rate of return. Although some survey questions were designed specifically for this audit, several questions were also drawn from survey instrument used in an academic study on high performing organizations. A core set of questions was given to all employees, and additional questions were asked of 165 employees who responded to the survey and indicated having management or policy-related responsibilities. Management staff included executive staff, bureau, section and unit chiefs. The rate of return for questions to management and policy staff was based on these 165 individuals.

Chart 3-8: OHP's Self Perception of its Relationship Building



Source: AOS survey of OHP staff
Note: This question was only posed to OHP executive staff, bureau, section and unit chiefs and policy staff. This question had a response rate of 67 percent, although respondents may have opted to answer only a portion of the questions in this series.

These survey results are in stark contrast to the experiences related to auditors by external parties. This might be explained by the recent improvement in relations noted by other State department representatives, or perhaps it is reflective of differing expectations. It also reflects the confusion concerning goals within OHP itself (see **Chart 3-9**), which may impact its ability to effectively communicate its priorities to sub-recipient agencies. Regardless of the cause of this discrepancy, it is the perception of those external partners in the Medicaid program that are the true reflection of the sufficiency of OHP's efforts to build relationships and come to a common understanding of the program's priorities and goals. The factors mentioned above prevent Ohio's Medicaid program from clearly communicating a common purpose or desired outcome. Furthermore, there appears to be disagreement within OHP as to the priorities of the program.

Competing Goals within OHP

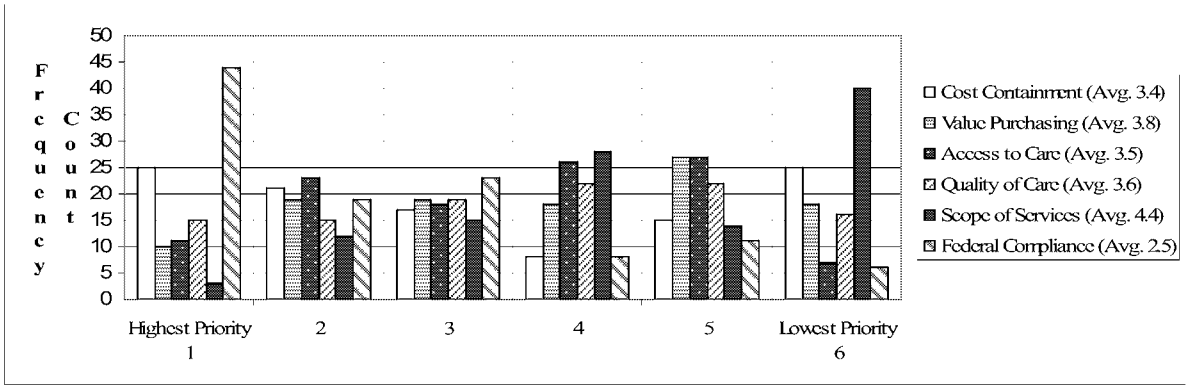
Not only are the program's goals not clearly prioritized among the administering organizations, but goals are also not clearly prioritized within OHP. According to an internal management review,

> "Without clear direction for state financing efforts or the prioritization of needs and requests from other state agencies, the system becomes overwhelmed and bogged down amid multiple and competing interests and constituencies. The level of resources available within one state agency to meet all the needs and requests from other state agencies will likely always be insufficient. As

> OHP strives to "be all things to all people," work efforts tend to move in one direction, only to be halted and either redirected or reversed. New priorities take precedence either because of an impending crises or for other reasons including circumstances such as work plan being placed in statute thus creating an altered, if not unclear overall priority work plan."

These issues were also reflected in a survey of all OHP staff. Respondents were asked to rank six OHP high level goals by priority: cost containment, value purchasing, access to care, quality of care, federal compliance, scope of services, and any other goal the respondent wished to specify. It should be noted that the sub-recipient agencies were not surveyed because of their more limited role in the program. **Chart 3-9** illustrates the frequency with which respondents ranked each goal in numerical order, with 1 being the highest priority and 6 being the lowest priority relative to the other goals.

Chart 3-9: OHP Prioritization of Goals



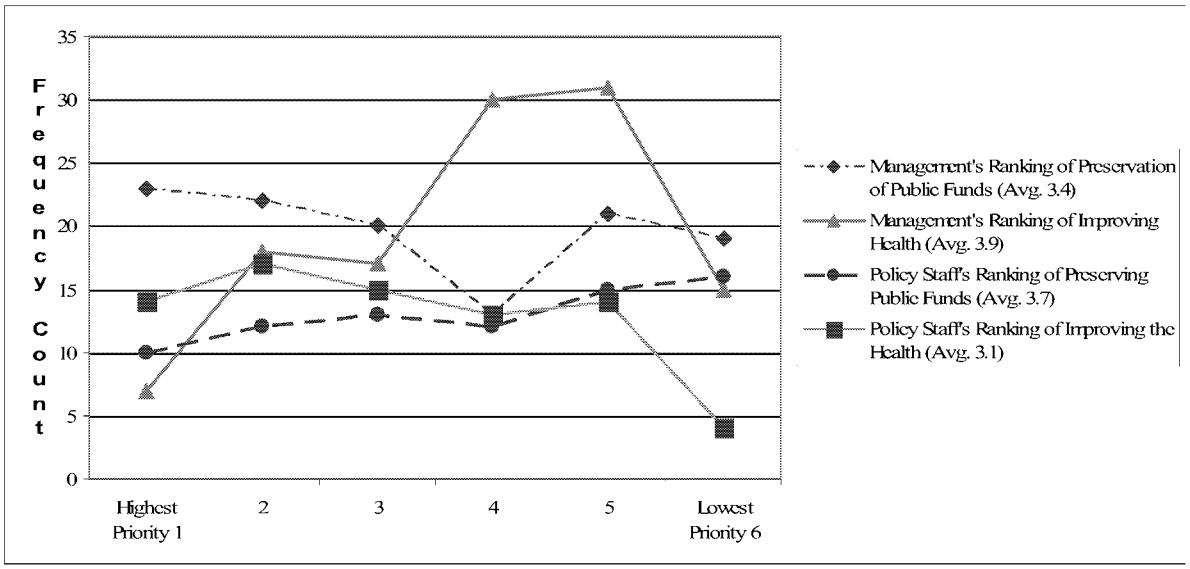
Source: Survey of OHP staff
Note: This question was only posed to OHP executive staff, bureau, section and unit chiefs and policy staff and had a response rate of 68 percent.

The absence of clear distribution curves is evidence that OHP has not communicated a clear ranking of its competing goals internally. Federal compliance was generally ranked as the highest priority of these goals. However, by its nature this is a basic requirement, rather than a goal within OHP's discretion. Likewise, scope of services is often dictated by the legislators. This goal was generally ranked as the lowest priority. The remaining goals have very similar central tendency measures (average rankings), indicating that no clear priority exists. Furthermore, lack of a clear slope to the cost containment distribution curve indicates a polarized perception of priority. There is a group of individuals that perceives it as being a high priority, and group of individuals that perceives it as being a low priority.

These goals have a direct correlation with the two competing goals/outcomes outlined in ***information management and performance measures***. Cost containment and value purchasing are intermediate outcomes of preserving public funds. Quality of care and access to care are intermediate outcomes of improving the health and well being of Ohioans. When the rankings of

these two outcomes are combined it becomes clear that these two goals/outcomes are in conflict and have not been clearly prioritized. **Chart 3-10** illustrates the prioritization of these outcomes as ranked by OHP management and OHP policy staff.

Chart 3-10: OHP's Prioritization of Preservation of Public Funds versus Improving Health of Recipients by Position Type



Source: AOS survey of OHP staff
Note: This question had a 68 percent rate of return; however, the rate counted (employees with more than one year tenure) was 59 percent. Management staff included executive staff, bureau, unit and section chiefs

In **Chart 3-10**, the downward sloping curve of OHP management's ranking of the goals related to preserving public funds indicates that it is a higher priority than the upward sloping curve of its ranking of goals related to improving the health of recipients. In contrast, policy staff ranked improving the health of recipients as a higher priority than conserving public funds as evidenced by slope of its ranking distributions. This highlights the fact that even within OHP, its goals and outcomes are in conflict among its members because Agency leadership has not clearly prioritized these through the strategic management process. This is in the context of conflicts in prioritization among several sub-recipient Medicaid agencies.

Prioritization Practices in Other States

In contrast to the confusion of prioritized goals among participating Ohio Medicaid agencies, the State of Oregon was able to prioritize the aspects of improving the quality of life of recipients. It decided that broad coverage was a higher priority than a broad scope of services. It was then able to prioritize its services when cost containment became a more pressing priority. Oregon uses a separate Office for Health Policy and Research for the development and analysis of health

policy which serves as the policy making body. The Oregon Health Policy Commission advises the Office for Health Policy and Research and is comprised of 10 voting members appointed by the governor and four non-voting legislators. This organization has a number of guiding principles for reform, but most notably, it includes a provision that explicitly states the Commission should strive to achieve access for all Oregonians through rational coverage decisions, but that should it become necessary to alter services to stay within budget constraints, it is better to place limitations on the services covered rather than deny people insurance coverage. Furthermore, it states that policies should seek to align incentives so that consumers and providers make health care decisions that drive quality and control costs.

Oregon underwent a process by which legislative oversight bodies enabled advisory committees, such as the Oregon Health Services Commission, to prioritize health services. The enabling statute had two important attributes. It mandated the group prioritize services and it provided general criteria or guidance on how to prioritize. The statute established that services should be prioritized based upon the comparative benefits of each to the entire population to be served and it required that such determinations consider both clinical and cost effectiveness.

According to the Director of the Oregon Medicaid Department, the State has generally expanded coverage to non-Medicaid recipients, but it has reduced benefits. These reductions were made using evidence-based medicine and other criteria. For instance, it stopped services that did not conclusively result in better health outcomes. It also stopped services for conditions that would rectify themselves without medical intervention. While the legislature made funding level decisions, the use of those funds and the approaches used in delivering service were largely determined by service priority and policy makers. Service priorities are continuously updated; however, Oregon has added stability to the system because as budgetary constraints became more pervasive, the system and the legislature knew that its strategy was to reduce services, rather than change eligibility, and it knew which services would be reduced. This is reinforced by the fact that the legislature is not able to change the order of service priorities and, therefore, cannot cut services except in order of priority.

It should be noted that Oregon's priorities may not be appropriate for Ohio, but the process used may assist Ohio in establishing priorities that guide decision makers at all levels in their choices between competing goals. Oregon's process was facilitated by an external policy-making body that could objectively review priorities without experiencing substantial pressure from constituent populations.

In contrast to the Oregon process, administrators from CDJFS who participate in the Ohio Health Plans Executive Leadership Committee expressed their concerns with Ohio's process reporting that "…political groups drive decisions rather than administrators familiar with the issues. Decisions should be made based on a continual improvement basis, based on management information." They added that any recent increases in funding have not been made with health

outcomes in mind and, in those cases when funding is not allocated based on health outcomes, service will suffer and people die.

Additional comments were provided by stakeholders on the priorities for Medicaid services. A representative from the Ohio Council for Home Care suggested looking at the system from "the perspective of the service that's being provided instead of the payer source". Other providers expressed frustration over the lack of innovation in making changes to the program. A member of the Ohio Association of County Behavioral Health Authorities noted that ODJFS manages the Medicaid program but it does not provide leadership. The member said, "they're always managing to the problem instead of trying to articulate longer-term strategic solutions." ODJFS' focus on short-term problem resolution and on cost containment was highlighted by a member of the Ohio Developmental Disabilities Council who stated that the State continues to patch its problems. The member concluded saying, "What we really need to do is get rid of the current system and start from scratch. When people are patching a bad system, it still continues to be a bad system."

Outside the realm of social services or health care, other administrative and rulemaking bodies have struggled with similar issues. Agencies that also deal with extremely technical and complex issues that are subject to ambiguous or competing goals have developed equally effective strategies to achieve policy implementation. One example is the Financial Accounting Standards Board (FASB). Prior to the establishment of FASB, financial accounting standards were established by the American Institute of Certified Public Accountants (AICPA) Accounting Principles Board (APB). The APB was disbanded due to perceived internal political conflicts caused by its affiliations with stakeholder groups and limited progress on the most fundamental accounting issues. It is generally agreed that the perceived political motivations may have been caused by divergent basic principles and a definition of terms. In *the Project to Revisit the Conceptual Framework* (Johnson, 2004), FASB concluded that it needed a framework to provide direction and structure to financial accounting and reporting. The Board's mission could not be fulfilled without a sound and unified conceptual underpinning that provided direction and the means for deciding whether one solution to a financial reporting issue was better than the others. Without the guidance provided by the framework, standard setting becomes based on the (unstated) concepts held by individual board members. As a result, standard setting becomes more or less ad hoc. Learning from the example of the APB, FASB developed a conceptual framework.

FASB provides a clear model of the procedures required for establishing prioritized goals. FASB's conceptual framework is a coherent system of interrelated objectives and fundamentals that prescribes the nature, function and limitations of financial reporting. Three main steps were taken to create the conceptual framework. These steps are as follows:

1.) **Establish objectives and goals** - Answer the questions, "Why are we doing this activity?" "What do we hope to accomplish?"

2.) **Define the qualitative criteria used to decide between the competing goals and objectives.** These criteria are based upon descriptive characteristics of policy that achieve the given goals of financial accounting. The criteria serve as a formalized, consistent, and logical method of making policy decisions that require compromising one goal to an extent for the achievement of another and when that is appropriate.

3.) **Establish guiding principles to use in practice** - These general approaches and methodology should also clearly state assumptions in forming these principles, and the limitations of these assumptions.

In the realm of Medicaid, the State of Oregon provides an example of how these principles can be applied to Medicaid administration. Oregon's process generally mirrored the one used by FASB. The process was as follows:

1.) **Establish objectives and goals** - Oregon began by defining its objectives for publicly funded health care and Medicaid. Oregon defined a successful publicly funded health care system as one that achieved broad coverage (eligibility); and a breadth and depth of services (covered services).

2.) **Define qualitative criteria** - Because Oregon recognized that funding was a constraint that largely was outside its control, it developed qualitative criteria to aid in choosing among compromise policy solutions. Oregon explicitly chose to prioritize broad coverage over maintaining the scope and scale of services. Furthermore, when these compromises in policy were necessary, it provided further criteria that scope of services should be reduced; rather than the scale or depth of services.

3.) **Establish guiding principles to use in practice** - Service priorities were established with very specific guiding principles. First, prioritization would be accomplished through evidence-based medicine with a focus on the relative impact of the services on the health and well being of recipients. For instance, services for ailments that will resolve themselves are of a lesser priority than other services.

While Oregon's prioritization may or may not be appropriate for Ohio, much can be learned from the process they employed. Perhaps the most important action elected officials can take in improving the Ohio Medicaid program is to provide long-term direction to Ohio's publicly funded health strategy, and implement a process that clearly prioritizes goals for the program. This is the foundation for any long-term improvements in the program as it can act as the guiding principles for a multitude of decisions made by administrators at every level. This will also clarify the appropriate organizational structure for publicly funded health care and the Ohio Medicaid program at a high level (see the ***organizational design of publicly funded health care*** and the ***Medicaid high level organizational structure*** discussions).

R3.6 The General Assembly and the Governor's Office should devise a process to prioritize the competing goals of Medicaid (and other social service programs) to provide guidance and direction to decision makers. Like Oregon, they should first clearly articulate the goals and purpose of the program. Secondly, they should develop criteria to help prioritize goals when they are in conflict, similar to the process used in Oregon. These priorities should not be subject to short-term fluctuations or changes; they should be the foundation for long-term planning efforts. Finally, they should develop guiding operating principles with clearly articulated assumptions and limitations so that these can be recognized and accepted without continuous revitalization of the debate.

R3.7 Regardless of the final organizational structure selected for the Medicaid program, the General Assembly should provide the State Medicaid agency authority to centralize claims processing so that has additional control over the level of claims within the program. See also *Medicaid budgeting practices* and the technology and program management section.

R3.8 Once clearly prioritized goals and principles are established, the State Medicaid agency should seek to revise its interagency agreements to strengthen its ability to oversee Medicaid within the sub-recipient agencies.[14] The State Medicaid agency should outline desired outcomes and seek to establish an improved contract monitoring relationship with the sub-recipient agencies for non-compliance or the inability to meet agreed upon outcomes. By using sound contract management techniques, it will clearly articulate expectations and strengthen coordination.

R3.9 The State Medicaid agency should improve its relationships with sub-recipient and stakeholder organizations by broadening collaborative opportunities and going beyond the current oversight relationships. Furthermore, it should enhance its ability to provide input into policy and decision making. Likewise, the sub-recipient agencies should work to be more responsive to the State Medicaid agency's requests for information, cooperation, and assistance.

[14] If **R3.14** is not implemented.

C. Budgeting Practices

According to the executive budget proposal for SFY 2005-06 and 2006-07, the objective of budgetary control is to manage the State's finances within limitations set forth in its approved budget. Budgetary control allows the State to keep its expenditures within limitations of available appropriations and available revenues[15] and, under the State constitution, Ohio is required to have a balanced budget. In essence, the State budget represents a statement of priorities and sets a strategic policy direction for the activities of State government.

As part of the budget proposal for SFY 2005-06 and 2006-07,[16] State departments were required to implement program budgeting, which groups budget line items by program series and program. This helps show more clearly what the costs of services or activities were for each program. However, these programs are defined generally by the type of service or activity, rather than actual funding programs such as Medicaid. Therefore, Medicaid funding is contained in several program codes within each participating Medicaid agency's budget. OBM representatives reported that Medicaid will be billed as one whole unit in future ODJFS budgets. This change in practice resulted from stakeholder concerns that political considerations could have a greater effect if the budget was recorded on a program basis. Also, spreading the Medicaid program among various activities reduced the usefulness of the information. Responsibility for actually preparing the budget rests with the State agencies. The ODJFS Medicaid budget is actually comprised of several component budget documents.

As part of the State Medicaid budget process, ODJFS develops an administrative budget, a Hospital Care Assurance Program (HCAP)/Supplemental Inpatient Payments budget, and a Subsidy Budget Projection Model comprised of separate documents for Medicaid, SCHIP, and Disability Medical Assistance. In addition, it submits a budget to OBM for interagency transfers to sub-recipient agencies developed by those agencies. The most material of these budgets are the interagency transfer budgets and the subsidy budget projection model.

Interagency transfer budgets are prepared by all of the State sub-recipients, including ODH and ODE. OBM and ODJFS use these documents to establish appropriation levels within the ODJFS budget as a transfer to the other agencies for the federal match share of services. The sub-recipient agencies provide the State match from their resources, or in some cases, local resources. According to OBM representatives, only ODA has a budget that includes a structure specific to Medicaid. This is attributed to its use of waivers as the sole Medicaid function within the Agency. ODMRDD, ODMH, and ODADAS each receive a general allocation of funding, which is then remitted by the State agency to its respective county boards. These funds may or may not be categorized by source or use of funds, and include both Medicaid and non-Medicaid funds. In the case of ODMRDD, ODMH, and ODADAS, Medicaid eligible services are funded

[15] Revenues and expenditures are tracked using the State's Central Accounting System (CAS).

[16] Budget request limitations were implemented for the majority of State agencies during this biennium, holding appropriations to no more than to 100 percent of SFY 2004-05.

by the county boards (ADAMH boards pay these claims directly).[17] Although all county and regional agencies were contacted, program-based budgeting was not used in a manner that would easily allow Medicaid expenditures to be extracted from aggregate financial data. Similarly, the source of the non-federal match payment for Medicaid services (at the local level) was not tracked in a manner that allowed the source (or percentage) of funds to be distinguished as State, County, or local levy funds.

The ODJFS subsidy budget projection model predicts expenditures for the Medicaid program based on the biennial policy at the time the model is created. This base-line cost estimate is used to identify policy changes required to achieve the executive budget funding level. This estimate is prepared using caseload projections; fee-for-service, managed care, and institutional long-term care models; and Medicare buy-in estimates. These are described in detail below:

- **Case load projections** are prepared for two populations; the Aged, Blind and Disabled, and the Covered Families and Children. Within these two large groups, several sub-populations are estimated separately. These estimates are based on regression, time series, and staff estimate methodologies.

- **Fee-for-service models** are calculated on a per member per month basis by service category for each eligibility category. Per member per month category estimates are based upon estimates of utilization multiplied by the estimated cost per claim. Each of these factors is comprised of approximately 400 smaller estimates and is based on a scenario analysis using over 30 different circumstances.

- **Managed care budget model** is based upon an estimate of penetration rates into managed care plans stated as a percentage of the Covered Family and Children caseload. This estimate is based on historical trends adjusted for specific county plans. From this data, an estimated number of enrollees is calculated and multiplied by the per person cost as determined by an outside actuary.

- **Institutional long-term care budget model** is based on the estimated number of days of care multiplied by the estimated per-diem rate. This is reduced by expected recipient contributions. The number of days of care is based on projections of eligible individuals who are then categorized in age groups. The per-diem rate is based on historical cost report data for direct, indirect, and capital costs; which are then adjusted for inflation factors and cost growth estimates. Finally, recipient contributions are based on historical trends.

[17] In the ODMRDD/CBMRDD relationship, the State agency identifies the State allocation for each county board and, based on the County board's direction, holds a portion to pay the Medicaid claims related to MRDD Medicaid recipients in the county. If the amount held back is not sufficient, the county must send additional funds to ODMRDD to cover additional match needs.

- **Medicare buy-in budget estimates** are for the Medicare premiums of low income Medicare eligible individuals. These estimates are based on historical trend analysis of the number of claims and the cost per claim.

While the ODJFS budget development and modeling process appears rigorous, it is too complicated to allow the lay-person (stakeholders, taxpayers, members of the General Assembly) to understand.

The budget document is based upon Appropriation Line Item (ALI) codes. These codes are six digit numeric codes (xxx-xxx), with the first three characters identifying the administering agency, division, or activity. The second set of three characters indicates a specific purpose. However, these purposes are not aligned with funding sources or programs such as Medicaid. OBM and the State departments use the more detailed Reporting Category Codes (RCAT), which are generally organized by type of services within funding source. These codes are aggregated into the ALI codes which then become the basis of the budget. Often, a single ALI code for a participating agency will contain both Medicaid and non-Medicaid appropriations.

These codes are part of the CAS system, which does not capture the total cost of the Medicaid program due to the administrative and funding structure of Ohio's Medicaid program. The challenge of the Medicaid program for accounting purposes is that a single entity is not completely responsible for the program. While OHP expenses and allocated expenses from other departments within ODJFS are captured as program costs, sub-recipient agencies and their respective county agencies submit their direct service expenses through the claims system (administrative costs are submitted through cost reports). However, portions of administrative costs are not captured in the CAS system. While the sub-recipient agencies submit administrative costs, these do not capture the full cost because the documentation requirements to track some activities are too onerous. Within the county board systems, CDJFS also submit their administrative costs based upon time studies to allocate salary costs to the program. ODE and participating school districts follow a similar process. However, no similar activity is conducted by the local boards in the Medicaid systems administered by ODMH and ODADAS.

In addition, Ohio's funding structure for the State share of the Medicaid program also presents accounting challenges. At the State level, Ohio includes federal Medicaid reimbursements as a component of State General Fund revenues. While this is legally permissible as the federal Medicaid match is a retroactive reimbursement for activities consistent with Medicaid purposes, it creates confusion on how large a percentage of State General Fund revenues are used for Medicaid purposes and causes difficulties in identifying expenditures by funding source. Although the federal reimbursement is generally deposited into specific accounting funds, this requires knowledge of fund uses that is not common knowledge among State decision-makers. According to OBM, the practice of including the federal reimbursement in the State General Fund was implemented to simplify accounting and to enhance the State's General Fund balance

which is used as the basis for bond ratings and debt capacity limits.[18] Therefore, depositing the federal reimbursement funds within general purpose State funds allows Ohio to expand its debt capacity.

Funding structure is also a challenge to accounting for the State share of the Medicaid program. Within the ODMRDD, ODMH, and ODADAS Medicaid systems, the State agencies remit funds to, and pass through claims payments or make claims payments on behalf of the county boards[19] without specifying the funding source. The counties are able to use State and local funds for payment of Medicaid services. In addition, within each of these Medicaid systems, the local administrators contribute a portion of their local funding to meet the state match requirements. This allows local administrators to leverage federal funding with local funding. However, as payment funding is not segregated by type at the State or claims payment level, the county portion can only be indirectly estimated by subtracting State and federal contributions from total Medicaid expenditures. This methodology, however, assumes that all State funding to local and regional boards was used for Medicaid purposes. This significantly understates the local contribution and overstates the State's contribution to the Ohio Medicaid program because a portion of the State funds are allocated to specific programs and populations and can not be used for Medicaid claims payment.

According to the Government Finance Officers Association (GFOA), the budgeting function in governmental operations has followed an evolutionary pattern. These are described as follows:

- **Line-item Budgeting** (1920s through the 1930s): Characterized as being control oriented and primarily focused on inputs.

- **Performance Budgeting** (1940s through the mid 1964): Increased its focus on management of operations, used outputs as well as inputs with an efficiency focus (outputs per input), organized the budget by programs, and linked performance levels to budget amounts.

- **Planning/ Programming Budgeting** (1965-1971): Establishes long-range planning goals and considers inputs, outputs, and effects of alternatives using a cost/ benefit approach;

- **Management by Objectives** (1972-1977): Centralized top down approach that organizes budgets by goals and objectives using inputs, outputs, and outcomes with a cost effectiveness orientation;

[18] These bond issues are used to fund a large portion of the State's capital improvement projects.
[19] ODMRDD holds a portion of the CBMRDD state allocation to make payments on behalf of these entities.

- **Zero-based Budgeting** (1977-1980): Periodically re-evaluates the programs of an agency, prioritizing each program and thereby identifying programs for elimination or modification;

- **Target-based Budgeting** (1980-1992): Limits are placed on budgets driven by available revenues with a focus on inputs and outcomes; and

- **Budgeting for Results** (1993-Present): Links allocations of funds to performance measures, focusing on efficiency, cost effectiveness, and accountability seeking to promote better service delivery methods.

The budgeting process for the Ohio Medicaid program most closely resembles target-based budgeting as it is limited by a given level of resources. However, the program based approach used by OBM appears to be focused on outputs, rather than outcomes, as it centers on what the funding buys rather than the impact of the investment. For instance, within the ODJFS executive budget proposal for program series 05.01: Fee-for-service, it states that the funding provides health care coverage for 1,056,028 citizens per month in SFY 2005-06 and 661,932 in SFY 2006-07. It also states that it funds Ohio's share of the Medicare Part D prescription drug payment to the federal government in the amount of $155.3 million in SFY 2005-06 and $339.6 million in SFY 2006-07. These measures focus on outputs, rather than outcomes specifying the results of these expenditures in terms of their impact on the health of Ohioans. The implementation of more advanced budgeting approaches that use outcome data to make allocations is largely limited by the lack of outcome based information sources maintained by some of the Medicaid agencies (most notably OHP). The *Budgeting for Results* and *Management by Objectives* approaches use effectiveness criteria in addition to traditional efficiency measures. Effectiveness measures require outcome data as a component of these measures as discussed in the **information management and performance measurement** discussion. In many ways, financial data is a subset of performance measurement data, which can be supplemented by other performance information. The lack of this information limits the budgeting function to using input and output based data. Allocations are not able to be made based on quantifiable health outcomes or program performance.

Recommended Budget Practices: A Framework for Improved State and Local Government Budgeting (National Advisory Council on State and Local Budgeting, 1999) states that a high quality budget has a broadly defined process that has political, managerial, planning, communication, and financial dimensions. It is characterized by the incorporation of a long-term perspective; establishing linkages to broad organizational goals; focuses budget decisions on results and outcomes; involves effective communication with stakeholders; and provides incentives to management and employees. The *Recommended Budgeting Practices* goes on to present the following framework for effective budgeting:

- Principle 1: Establish Broad Goals to Guide Government;
  - Assess community needs, priorities, challenges, and opportunities;
  - Identify opportunities and challenges for government services and management practices;
  - Develop and disseminate broad goals;

- Principle 2: Develop approaches to achieve goals;
  - Develop programmatic, operating and capital policies and plans;
  - Develop programs and services that are consistent with policies and plans;
  - Develop management strategies;

- Principle 3: Develop a budget consistent with approaches to achieve goals;
  - Develop a process for preparing and adopting a budget;
  - Develop and evaluate financial options;
  - Make choices necessary to adopt a budget;

- Principle 4: Evaluate performance and make adjustments:
  - Monitor, measure, and evaluate performance; and
  - Make adjustments as needed.

Each of the above elements of the framework is supported by specific best practices in the budgeting process. Most notably, in principle one, *Recommended Budgeting Practices* suggests governments identify and assess the programs and services provided, their intended purpose, and factors that could affect their provision in the future. This might involve a process that inventories and evaluates programs and services to determine their relationship to the needs of the community. This requires an assessment of purposes, beneficiaries, needs fulfilled, and the program's success in achieving goals. Another practice supporting this principle is to identify broad goals based on an assessment of the community the government serves and the environment within which the government operates. These goals should define the priorities and the preferred future state of the community; thereby providing a basis for allocation decisions. Principle two is supported by a practice that translates broad goals into strategies for achieving goals. The strategies may address items such as population groups served, service delivery issues, standards of performance, expected costs, time frames for goal achievement, and priorities for service provision. Principle two is also supported by a practice that recommends governments should develop and use performance measures for functions, programs and/or activities. These are used for evaluating how efficiently and effectively functions, programs, or activities are provided as a means for determining whether program goals are being met. These measures should be linked to specific goals and should be valid, reliable, and verifiable in quantifiable terms. They also should include aspects of inputs, outputs, and outcomes, which then translate into ratios or measures of efficiency and effectiveness. The measures then require benchmarks to provide context to measures which may come from external sources or historical

data. Benchmarks are used to support the practices in principle four, which articulates a process of implementation, evaluation, and adjustment for the next time period.

Best practices in governmental budgeting generally assume a process that is guided by prioritized long-term goals - a concept not commonly shared by parties within the Ohio Medicaid program (see ***defining the purpose of Ohio's Medicaid program***). It also assumes a results-based approach with the expectation that inputs will have measurable outputs and outcomes. However, the supporting information systems do not offer complete measures of outcomes for the Medicaid program (see **in*formation management and performance measures***). These issues reinforce the importance of clearly prioritized goals and a supporting information management system for the program.

The issue of an appropriate budget model largely depends upon the role of legislators in the decision making process. More detailed legislation and policy decisions require more detailed information sources. As discussed in the ***operating environment*** discussion, the General Assembly has taken an active role in the decision making process for the Medicaid program. The budget model is generally focused on the program's inputs and only broadly provides output data. This information is insufficient for programmatic policy decision making. OBM representatives also reinforced that by itself, the budget document was likely insufficient to make policy decisions.

Furthermore, the basis of organization of the budget document should reflect the high level perspective of policy maker's collective definition of the purpose of publicly funded health care as discussed in the ***organization design of publicly funded health care*** portion of this section. A state system that defines the purpose of publicly funded health care (and Medicaid's role within that definition) as part of a broader social policy will result in a budget document organized differently than one that defines it as part of public health care. Each of these will organize the document differently than a state that narrowly defines public health care closely aligned with Medicaid's minimalist approach to providing only a minimal level of service to the most economically disadvantaged populations. Likewise, the organizational structure for publicly funded health care would also impact the State's ability to track and measure costs. For instance, consolidation of Medicaid entities would improve the State's ability to collect and measure Medicaid expenditures. Furthermore, public health umbrella or social service umbrella organizational models would likely better facilitate collecting the total cost of publicly funded health care to Ohio over and above the cost of the Medicaid program. For instance, an OBM representative indicated[20] that a unified long-term care budget would be a positive change, but also believed this was a more holistic definition than making a Medicaid budget. The representative believed that while a Medicaid budget might simplify OBM analysts' duties and that of policy makers, it may not be appropriate to organize a budget around sources of service

[20] This representative's opinion does not necessarily reflect that of OBM or the governor's office.

funding. These issues reflect basic assumptions that must be consciously resolved prior to changing the organization of the budget documents.

During stakeholder meetings, several county-level representatives and providers discussed the impact of the current funding process on services. Of particular concern is the use of local levy dollars for the State Match and the impact of this on the willingness of county administrators to place levies on the ballot and the support of voters for these levies. A representative of the County Commissioners' Association of Ohio expressed concern that county residents who are not eligible for Medicaid may be unable to receive county-funded services because county resources are being directed into Medicaid match. A representative of the Ohio Council of Behavioral Healthcare Providers also commented that "the State needs to look at it in terms of where is the obligation for these very needed services." Finally a member of the Ohio Family Services Council stated that it appeared that the State departments were not focused on assisting the systems in retaining non-Medicaid service delivery.

The ODJFS Decision Support System (DSS) allows queries and summaries of claims data, which is capable of categorizing costs and service units by service type, population, and diagnosis – information that may be sufficient to meet the needs of State and local decision-makers without large scale changes to the State's accounting system. To utilize this information, decision makers would likely require trained staff to assist in interpreting and analyzing it in a pertinent manner. The most likely organizations to fulfill this role would be the Legislative Service Commission (LSC) for the General Assembly and the OBM for the executive branch. Currently, the executive and legislative branches do not have access to the Decision Support System. However, OBM indicated plans to acquire this access. This will allow OBM and the LSC to more proactively identify policy initiatives and to independently evaluate the implications of these initiatives. Furthermore, it will facilitate improved transparency and an environment of trust. However, it should be noted that these organizations may require additional resources or staff to perform the additional duties.

R3.10 The State of Ohio should improve its information management practices to better capture the true costs of publicly funded health care and, more narrowly, the Medicaid program. In particular, all costs associated with the Medicaid program, including those expended at the local level that are not currently attributed to Medicaid administration and administrative costs not reimbursed by the federal government, should be identified so that the true and complete cost of the program is known. Any changes to the current organization of the Medicaid budget should be guided by a conscious decision concerning the larger purpose of Medicaid in publicly funded health care. The scope of this purpose will drive the basis of categorization of funds. Once this is firmly established, goals for the Medicaid program can be more clearly articulated and prioritized, including fiscal goals. Supporting strategies can then be developed and supported by the budgeting function.

In order to accurately capture the local funding component of Ohio Medicaid expenditures, the General Assembly, through the State Medicaid agency, should direct county agencies to report local funding used for Medicaid by type (both levy and county funds), State funding used for Medicaid, and any administrative costs not compensated under Medicaid reimbursement. These costs should be reported to OBM and the State Medicaid agency.[21]

R3.11 The Legislative Service Commission (LSC) and Office of Budget and Management (OBM) should be granted access to the Decision Support System (DSS). Furthermore, these agencies should be provided sufficient resources to fulfill a research function for public officials and constituents. Increased staffing levels and training programs are likely required for successful implementation. As independent servants of public officials, the involvement of LSC and OBM in gathering information using DSS will engender improved public trust and enhanced decision-making. State-level decision-makers will be able to make more informed policy decisions based on output and outcome data, and be able to better evaluate the impact of these decisions. Should the State Medicaid agency develop additional measures of performance related to health outcomes, LSC and OBM should be provided access to this data.

D. Organizational Structure

Form Follows Function: Purpose Drives High Level Organizational Structure

A critical examination of the organizational structure of the Ohio Medicaid program was prompted by its fragmented and dispersed administration. HB 66 called for the formation of a stand-alone Medicaid agency, authorized this performance audit, and formed several Legislative committees to examine various issues surrounding the program.[22] Among others, HB 66 established the Ohio Medicaid Administrative Study Council to examine the following:

- Structuring the Medicaid program's administration in a manner that optimizes its fiscal and operational objectives;

[21] This could be accomplished by a variety of means. One method would be to use a special fund, like a rotary fund, to capture transfers-in from local levy, local general fund, and State fund sources; and expenditures for Medicaid services. Counties may, with the approval of the Auditor of State, establish additional special funds under ORC § 5205.12. On the other hand, the State could adopt a practice similar to New York whereby county contributions rise on a fixed percentage (the remaining inflationary increases to be made up by the state). This allows New York counties to better plan their annual expenditures and local revenue needs.

[22] HB 66 did not provide funding for this agency and, in discussions with members of the General Assembly, the vision of what this agency would be was unclear.

- Centralizing financing and information technology functions to coordinate the new (stand alone) department's activities with other State agencies, if any, that assist in its administration;
- Creating a unified budget for Medicaid-funded long-term care services;
- Identifying the fiscal and operational impact that a new (stand alone) administrative structure for the program would have on ODJFS and other State agencies that currently assist in the program's administration; and
- Identifying the role of government entities that administer the program at the local level and the fiscal and operating impact that a new administrative structure for the program would have on those entities.

Although the Ohio Medicaid Administrative Study Council goals encompass relevant issues surrounding the direct administration of the Ohio Medicaid program, the areas under examination do not include several critical issues that frame the role of Medicaid in Ohio's publicly funded health care. Instead, the focus was narrowed to consolidating administrative functions into a stand-alone agency. Examining only a future organizational structure for Ohio Medicaid overlooks larger questions like:

- What is the purpose of publicly funded health care in Ohio?
- How should Ohio Medicaid fit into the larger vision for publicly funded health care?

The resolution of these questions directly impacts the decision of where to place the single State Medicaid agency and how it should be structured.

Organization Design of Publicly Funded Health Care

In redesigning the Ohio Medicaid program, it is imperative to define the organization's purpose in a clear and prioritized manner so the mandate can guide the new organization's culture. Although HB 66 includes language creating a separate Medicaid agency and allocates resources to study the design of this organization, the Legislature neglected to allow time to determine, first and foremost, the purpose of publicly funded health care in Ohio, how Medicaid fits into that purpose, and then the best Medicaid organization to implement that vision in the State. Organizational design is the natural by product of a core purpose and desired identity.

In *Re-engineering Public Administration in Developing Countries* (Saxena, 1995), three levels of process re-engineering are discussed. *Process improvement* is the most focused and easiest change management approach to implement in public administration. It usually entails improvement of a part of a process which falls within a particular function rather than improvement of the entire end-to-end process. The focus tends to be on streamlining tasks. *Process design* involves the total redesign of an end-to-end process, and may provide radical process improvement in terms of cost, perceived quality and cycle time. This requires the analysis of high levels of organizational hierarchy.

Organizational Transformation is the broadest type of re-engineering with the broadest scope, and is the most difficult to implement in public administration. As it is the most difficult to implement, it also has the highest risk of failure. It seeks to change the structure and culture of the organization itself in order to improve its processes. It starts with a fundamental self-evaluation of the organization by asking why the organization exists and what it is trying to achieve. Only then can it examine how the organization reviews how it performs its processes to achieve its goals and how these processes can be improved.

Though very risky and expensive, the successful transformation of a public organization might result in radical improvement in overall organizational performance; organization-wide clarity of purpose, direction, capabilities, and true mission; and a high degree of public satisfaction. Saxena states,

> "Strategy is the critical element in public administration re-engineering, as it gives a purpose and sets the direction for the pubic administration....discussion of public administration re-engineering would be meaningless in the absence of strategy."

In redesigning the Ohio Medicaid program, the General Assembly has embarked upon the most difficult of public administration re-engineering tasks, or organization transformation. In effect, by mandating an organizational structure prior to establishing and prioritizing the fundamental goals and the priority of those goals, the selected organizational design may not be consistent with the underlying purpose for publicly funded health care in Ohio. Or, the purpose of the Medicaid program and other programs may be altered to fit an organization without due consideration of the ramifications.

Similar parameters for organizational change are reflected in *Changing the Organization but Maintaining the Culture* (McMahon, 1999), which provided a case study of the United States' Environmental Protection Agency (EPA) and Great Britain's Environment Agency (EA). This case study examined the success of the archaically organized EPA contrasted against the poor performance of the innovatively organized EA; somewhat contradictory to intuitive perceptions among organizational theorists. McMahon notes,"

> The institutional structure, while important, cannot deliver the culture one wants, and the mission-commitment an organization needs, when the cultures combined in an organization do not share a baseline of agreement as to the goals of the agency and value of pursuing these goals."

Therefore, regardless of the high level public health organizational structure, it is imperative to define the organization's purpose in a clear and prioritized manner so the mandate can guide the new organization's culture.

The options to define the purpose and structure of publicly funded health care are virtually endless. However, in practice, most states have structured their publicly funded health care along four general organizational categories. A 2003 review of State structures conducted by the

National Governors Association (NGA), categorized high level organization structures into these four categories:

- **Traditional Public Health Agencies:** a state health agency that oversees public health and primary care only. While it may also administer one other health-related program (i.e., environmental health, alcohol and drug abuse, etc.), its responsibilities are usually limited to improving or protecting the overall health status of the public. Medicaid is not usually included in these agencies.

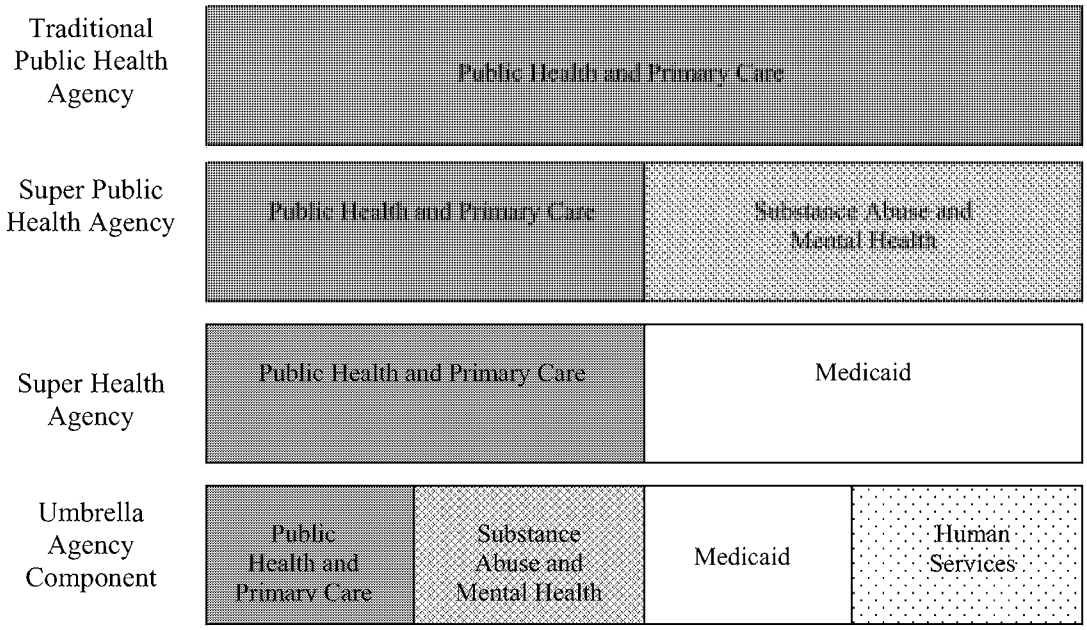
- **Super Public Health Agencies**: a state health agency that oversees both (a) public health and primary care and (b) substance abuse and mental health. This would likely include administering services supported by the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant and the Community Mental Health Services (CMHS) Block Grant programs. Similarly, Medicaid is not usually included in this structure.

- **Super Health Agencies:** a state health agency that oversees (a) public health and primary care and (b) the State Medicaid program

- **Umbrella Health and Human Services Agencies (Umbrella Agency)**: a state health agency that oversees (a) public health and primary care, (b) substance abuse and mental health, and (c) the Medicaid program, as well as (d) other human services programs.

Illustration 3-5 summarizes the differences in definitions between these models.

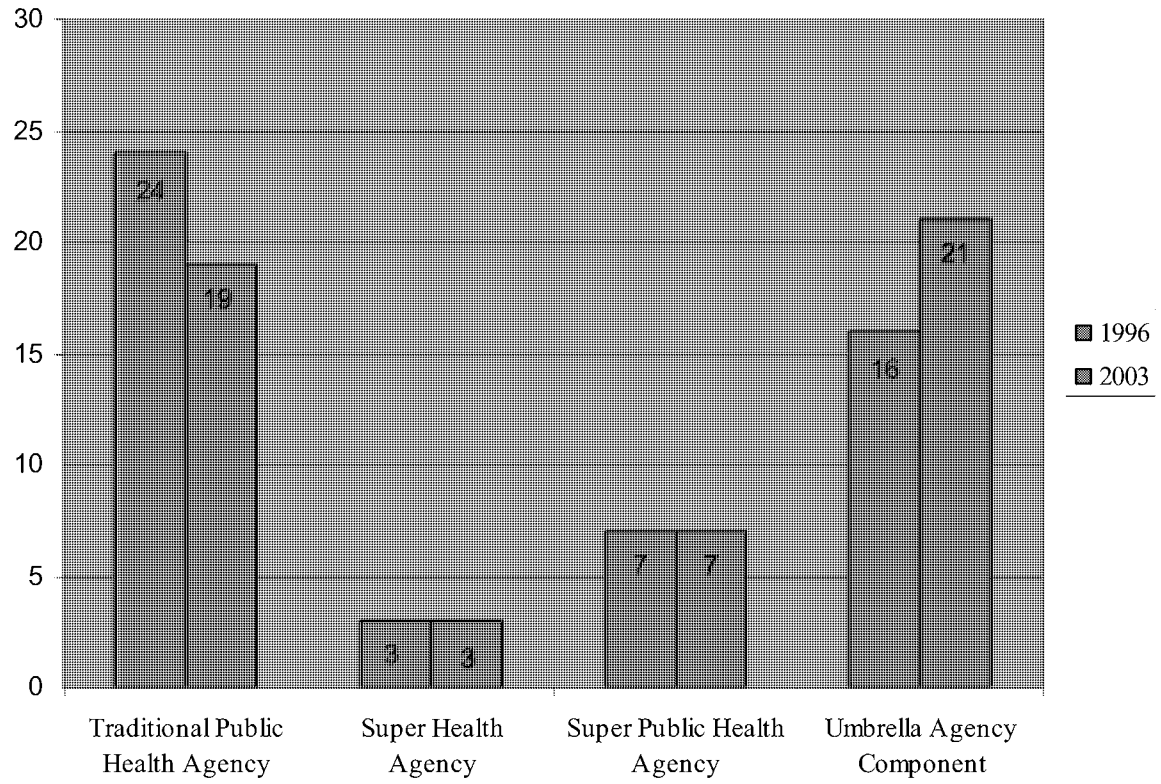
Illustration 3-5: Summary of Organizational Structure Categories



Source: National Governors Association

Chart 3-11 summarizes the distribution of states' organizational structures within these categories.

Chart 3-11: Summary of State Public Health Organizational Structures



Source: National Governors Association
Note: The numbers within the bar graph represent the number of states that use a particular organizational structure.

While these structures reflect publicly funded health care, only the super health agency and the umbrella agency models include Medicaid as a component of their mandates. Those states that are traditional public health agencies and super public health agencies have separated Medicaid in some manner, often as a stand alone agency unconnected to the other health and social programs. With respect to the administration of the Medicaid program, there are only three models: a stand-alone Medicaid agency, a super health agency, or an umbrella agency.

NGA labeled Ohio's organizational structure as an umbrella agency. However, this does not take into consideration the fragmented administration of the Medicaid program. In practice, it resembles a network structure between several State agencies. *Network Structures: Working Differently and Changing Expectations* (Keast, Mandell, Brown, and Woolcock; 2004) explains that a network structure exists when individuals or organizations come together to achieve a broad common mission and join strategically interdependent action. These structures require a high level of cooperation and a strong commitment among members to overriding goals.

Chart 3-11 illustrates that states are polarized between stand-alone Medicaid agencies and Medicaid agencies that are part of an umbrella agency. In 1996, there were 27 states with Medicaid agencies not incorporated into one of the four models and 16 states where Medicaid was part of an umbrella agency predominate. However, a general trend toward the umbrella agency model is evidenced by a decrease in the number of states using a stand alone Medicaid structure, and an increase in the number of states using an Umbrella Agency structure. The NGA report noted a general movement to consolidate services within a single organization.

To determine the efficiency of the organizational categories, the organizational structure of state Medicaid programs was examined against efficiency indicators. Of the 10 most cost efficient[23] states in 2003, no discernable difference existed in the prevalence of one organizational structure over another. However, there does appear to be a difference in the extent of organizational change between highly efficient and less efficient states. Eight of the ten states with the highest efficiency profiles noted no recent organizational change. Efficiency levels could be attributed to greater stability, or stability could be a result of higher levels of efficiency. However, correlation between efficiency and stability illustrates that public administration re-engineering may have high costs and risks if improperly implemented. Furthermore, this indicates that organizational design alone will not result in an efficient and effective organization, but must be implemented in concert with a clearly defined purpose to support organization performance.

The ultimate organizational design of the single State Medicaid agency in Ohio should be based on the purpose of public health care and Medicaid within Ohio as interpreted and agree-upon by the General Assembly, the Governor, State and county agencies, and stakeholders. This will require decision-makers to review, in broad fashion, the responsibilities and missions of many separate State and county agencies that provide services related to public health care. The ramifications of these decisions will likely result in one of three organizational structures: a stand-alone Medicaid Agency, a Super Health Agency, or an Umbrella Agency. Also, beyond the program purpose driving the choice of structure, there are concrete and practical strengths and weaknesses associated with each organizational option. Although HB 66 included provisions for the formation of a stand-alone Medicaid agency, this structure, as researched by the Ohio Medicaid Administrative Study Council, could serve as the foundation for any of the three potential structures. To ensure that the General Assembly's desire to improve the control and coordination of the program in the short-term is achieved, the stand alone agency can fulfill this purpose. However, in the long-term, a broader perspective and agency structure may be needed to meet Ohio's Medicaid and public health goals.

[23] Efficiency was evaluated using the most recent expenditure, claims, and eligibility counts available from CMS (2002 and 2003). Various ratios of cost per participant, cost per claim, and other adjusting information such as state population, state GDP, and expenditure growth rates were used for efficiency determinations. The top ten states ranked by this review's efficiency methodology included: California, Oklahoma, Virginia, Georgia, Utah, Florida, Michigan, Arizona, Oregon and Texas. The ranking used to categorize states based on Medicaid expenditure efficiency ratios did not take into account total publicly funded health care expenditures; rather, it only reviewed Medicaid expenditures.

Stand-alone Medicaid Agency: If the State determines that the role of Medicaid is to provide a defined level of care to those who are eligible according to federal Medicaid standards, a stand-alone Medicaid agency would be the most appropriate organizational structure. In this model, the stand-alone agency serves as a funding source and designs coverage policy and protocols, like a commercial health insurance company. The stand-alone Medicaid agency has the most narrowly defined scope, and therefore, would most likely be the least cumbersome to implement and administer. However, the agency would face challenges in leveraging several funding sources and consolidating supporting or administrative functions to eliminate duplication and redundancy. Furthermore, it would not achieve a comprehensive strategy for publicly funded health care in Ohio and overlapping care patterns would persist. This could also be costly because administrative functions that exist within ODJFS to support OHP would need to be replicated in the new agency.[24]

Super Health Agency: If the State adopts a broader health focus and desires a comprehensive strategy to improve health conditions for the citizens of Ohio, then the most appropriate organizational structure would be to consolidate Medicaid and other health programs in one agency. The breadth of the definition of public health care would determine the scope of the duties of the new organization. The super health organization would allow moderate leveraging of funding and a more comprehensive strategy for health care. However, it would potentially be more cumbersome to manage than a stand-alone Medicaid agency and could be difficult to integrate into a larger vision for social services in Ohio.

Umbrella Health and Human Services Agency: If the State determines that Medicaid is integral to a social safety net designed to assist the poor and disadvantaged, to keep them healthy and productive members of the community, then the most appropriate model would be an umbrella health and human services agency. This model leverages Medicaid funding with other health and social funding. In this model, all agencies providing public health services would be amalgamated into a single agency. The umbrella organization would potentially be the most difficult to administer and would likely face a difficult transition. However, it would support a comprehensive vision to provide a seamless social service safety net. It would also consolidate administrative and support functions at the State level.

In many ways, the restructuring of publicly funded health care or Medicaid shares procedural characteristics with mergers, acquisitions or divestitures of corporations. Research regarding these activities indicates that restructuring in the private sector has, in many cases, not resulted in expected efficiencies or improved value. The comparison to private sector organizational combinations is particularly telling because there are objective and comprehensive financial measures of success. According to *Consulting in mergers and acquisitions: Interventions spawned by recent trends* (Marks, 1997) a 1995 study of large private sector combinations

[24] While the General Assembly called for the formation of a separate agency to administer Medicaid, this audit encourages decision-makers to consider the purpose of the program as a defining factor in the organizational structure.

revealed that less than 20 percent of these combinations resulted in achieving their desired financial or strategic results. Half of the combinations destroyed shareholder value, 30 percent had a minimal impact, and 17 percent created shareholder value. Furthermore, these failings were largely the result of subtle but pervasive "soft" issues such as culture and the impact of uncertainty on morale and employee productivity or retention. Organizations with operations that derive their value from highly skilled, analytical, or knowledge-based activities are particularly susceptible to suffer a loss of value. The nature of the contract management operations in the Ohio Medicaid program is consistent with a knowledge-based organization (see ***Medicaid high level organizational structure***).

Mergers and Acquisitions in the Private Sector: What are the Lessons for Health and Social Services (Field and Peck, 2003) evaluates the experiences of merging health and social service organizations in the United Kingdom. Field and Peck warn of the difficulties in implementing mergers of these types of organizations. However, in public entity mergers, the results showed no improvement in the satisfaction of service recipients and a decrease in employee morale. The authors recommend developing transitional structures; paying adequate attention to cultural issues; and establishing clear, consistent, and frequent communication.

The selection of an organizational structure to support a specific purpose has substantial implications for the management of Medicaid and other social services in Ohio. A member of the Ohio Job and Family Services Directors' Association spoke to the organizational quandary stating that "picking up OHP and moving it" is insufficient and, with the need to add staff to this new organization, "you haven't accomplished anything but your costs have skyrocketed because there's no scale involved anymore." A representative of the County Commissioners' Association of Ohio stressed the need for a strong management team to set priorities noting "it's all about relationships and management teams that are empowered to make things happen." However, a member of the Ohio State Legal Services Association remarked that the idea of a separate Medicaid agency was not the best structure as individuals' needs are not segregated in silos for health care, cash assistance, food stamps, unemployment compensation, and other services. The member said separating "all of the pieces would be less efficient. It would be more expensive to operate each of those programs. It would also miss the connections between them…."

R3.12 The General Assembly should base any final Ohio Medicaid reorganization decisions on a clear purpose for the State's publicly funded health care system and social safety net programs. As the purpose and priorities of Medicaid are difficult to identify, the General Assembly should set aside sufficient time for a group to be convened which represents all stakeholders involved in the final determination.[25]

[25] The General Assembly may use existing studies or may wish to commission studies to determine what areas of public health in Ohio are most in need of attention and which strategies are most likely to resolve them. The General Assembly might consider using the Ohio Medicaid Administrative Study Council as a base for the development of such a committee as the participants will be versed in the current program. Several other recent committees,

The Legislature should take initial steps to implement the designated stand-alone agency but set a firm date for the submission of recommendations for a long-term, final organizational design. The General Assembly should seek to have the purpose of Medicaid defined and the most appropriate structure to meet the defined purpose identified within the next biennium (SFY 2006-07 to 2008-09). The General Assembly may determine that the stand-alone agency is the best option or may, based on the purpose of the program, consider selecting from one of the two other organizational structures described below:

- **If the General Assembly and Governor identify the purpose of Medicaid as a payer of medical claims for economically disadvantaged individuals (specifically those meeting Medicaid eligibility), the State Medicaid agency would be best arranged within a stand-alone Medicaid agency. In this arrangement, the relationship with local agencies could remain as it is.**

- **If the General Assembly and Governor identify the purpose of Medicaid as a component of a comprehensive health strategy, the State Medicaid agency would be best organized as a component of a super health agency. In this arrangement, the local agencies could remain as is, but the system would probably benefit from combining portions of the program at the county or regional level.**

- **If the General Assembly and Governor identify the purpose of Medicaid as an integral component of the social safety net for poor and disabled Ohioans, the State Medicaid agency would be best organized within an umbrella health and human services agency. In this arrangement, the organization would benefit from a consolidation of local agencies, on either a county or regional basis.**

Any of these choices will require redesigning the current system of relationships. However, the purpose of Ohio publicly funded health care under Medicaid should be the basis of selecting one of the three organizational structures.

Although the financial implications of redesigning the Ohio Medicaid organizational structure are difficult to determine, the estimated cost associated with the sub-recipient agencies' administrative functions is about $25 million, based on an average from 2002-2004. If the General Assembly decided to consolidate all state-level Medicaid administrative functions in a single State agency, and if it could save 50 percent in State administrative costs through a reduction in duplicative tasks and

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including the Commission on Medicaid Technology and Reform, might also be appropriate to involve in the process.

improved technology, the cost savings would be about $12.5 million annually. Similarly, if the General Assembly decided to consolidate local agencies and the consolidation resulted in a 50 percent savings, local administrative costs of about $144 million annually could be avoided.

R3.13 Once a structure for publicly funded health care is selected and implemented, the General Assembly should cease Medicaid redesign efforts for an extended period of time, perhaps at least three to five biennia. As these on-going changes cause significant organizational and programmatic strain and the implementation of these changes can be costly, the General Assembly should permit time for the new organizational structure to stabilize and begin to measure and track its performance.

Medicaid High Level Organizational Structure

Although the Medicaid program serves a broad range of stakeholders and offers a variety of services, in essence, the program constitutes a series of contracts between parties – from CMS through the State Medicaid agency to providers. The nature of the program largely defines the organizations' identity as a contract manager. Organizational identity encompasses the nature of the work performed and how the organization adds value. It also encompasses the mission, vision, goals, and values of an organization. According to *Organizational Identity in Nonprofit Organizations: Strategic and Structural Implications* (Young, 2001),

> "Organizational identity is what is central, distinctive, and enduring about an organization. …Identity reflects how members perceive their organization. …Identity is also related to organizational role or function. ….clarity and consensus about organizational identity are essential elements in setting successful long-term strategy and making structural choices in a nonprofit organization. In short, nonprofit organizations must know who they are to make successful strategic and structural choices." Identity answers the questions "Who are we?" "What kind of business are we in?" or "What do we want to be?"

As the organization's identity should drive operations; conversely, the organization's operations should reflect the organization's identity. In the case of the Medicaid program and the organization(s) that administer it, the identity and associated operations should reflect those of a contract manager.

ODJFS and OHP Core Functions and Organizational Identity [26]

ODJFS (through OHP), as the single State Medicaid agency in Ohio, has activities that are varied and complex, but these activities could generally be grouped into three categories: (1) policy/rule/contract writing, (2) compliance monitoring and oversight, and (3) various support functions related to the payment administration system. In examining its operations, OHP does not associate its identity with that of a contract manager, except in limited instances like the Bureau of Managed Health Care. In response to a request by the Ohio Medicaid Administrative Study Council, OHP identified staff that performed each of the following functions:

- **Contract design** including policy research and development, and legal code and rule revision and promulgation;
- **Contract implementation** including financial eligibility determinations, clinical eligibility determinations, and enrollment of providers;
- **Contract support** including relationship management with federal, State, and local authorities;
- **Payment administration** including claims processing, and benefits coordination;
- **Oversight and monitoring** including auditing financial data and claims; and
- **General support functions** such as financial information collection/reporting, human resources management and information technology.

Almost all of the State Medicaid agency's core activities (not including support functions such as human resources, information technology, etc.) support the elements of contracting: the determination/dissemination of an appropriate offer, support activities related to transacting the consideration, or evaluating the performance of service providers activities to determine if they constitute an acceptance according to the terms of the offer.[27]

Policy research and development, rule writing, and contract development are functionally separate tasks, but are conducted for a common purpose of making an appropriate offer. Likewise eligibility determinations are completed to specify qualified individuals to receive services; another component of the offer. Provider enrollment is completed to disseminate the offer to service providers.

Claims processing activities represent necessary transaction costs to facilitate the consideration for providers. Part of this process is providing technical support to providers to ensure appropriate billing procedures are implemented.

[26] The following discussion refers to all offices of ODJFS that have duties pertaining to the Ohio Medicaid program, such as OHP and Office of Research, Assessment, and Accountability (ORAA).

[27] These three categories of activities closely mirror the phases of contracting identified in *Contract-Management Capacity in Municipal and County Governments* (Brown & Potoski, 2003). According to Brown, the three phases of the contracting process are a feasibility assessment, the contracting implementation process, and monitoring and evaluation of vendor performance.

Last, audits of financial reporting and claims; and oversight and monitoring of service provision are done in an effort to determine if the terms of the contract were fulfilled, or accepted, by the medical service provider. The billing process also serves as a record of past performance to be summarized and analyzed in the performance measurement cycle. This can then be used to evaluate performance and make incremental process improvements. Terms of the offer are analyzed and used in an effort to make more appropriate offers in the future and are supported by this information. A more complete list of OHP activities organized by contract development activities; contract oversight and monitoring; and payment system administration activities is presented in **Appendix 3-A**.

Technically OHP's identity could best be described as a contract manager. However, some members of OHP's leadership identified themselves as a *health care financing agency* and others have used the term *value purchaser*. Yet, it is difficult to determine how widely that organizational self perception is held by members of OHP. When OHP policy and management personnel were asked, "To what extent has OHP clearly defined the organization's 'identity' and role in terms of how it adds value to the Ohio Medicaid system?", roughly 30 percent responded in a negative manner, while 70 percent responded in an affirmative manner that OHP had defined its identity to some extent. But this does not indicate whether they share the same perception of identity or if that perception is accurate.

Within OHP's strategic planning documents, it identifies a vision of becoming a leading *public sector health plan*. While the difference in terminology may be a semantic issue, *contract manager* implies a more active role that involves determining rates, covered services, eligibility, care management procedures/matching of services to needs, access standards, care procedures, etc. Furthermore, the term *contract manager* clearly identifies the core functions for both internal and external parties." *Value purchaser*, *health care financing agency,* and *public sector health plan* imply a more passive and reactive role involving accepting contracts primarily on the basis of price.

Identity and Core Functions of Sub-recipient Agencies

The ODMH component of the Medicaid program is largely administered through County ADAMH boards and County MH boards. The local-level agencies do not provide direct services but directly contract with service providers and provide monitoring and oversight functions such as compliance reviews, audits, and budget reviews. ODMH's role in this arrangement includes assisting ODJFS in development of OAC rules and state plan amendments, establishing requirements for Boards and providers, ensuring that providers are certified and private psychiatric hospitals meet licensure requirements, providing an appeals process for disputes between boards and providers, and completing several fiscal, information technology, and administrative duties related to claims processing and payment. ODMH also provides a range of direct services oriented to the behavioral health field.

ODADAS also administers its portion of the Medicaid program through ADAMH boards and County ADAS boards. These boards directly contract with alcohol and other drug treatment programs. ODADAS' role includes assisting ODJFS in the development of OAC rules and State plan amendments pertaining to ODADAS Medicaid programs, certifying alcohol and other drug treatment programs, providing arbitration for grievances of alcohol and other drug treatment programs against county administrators, and establishing guidelines, standards, and audit protocols for its local boards and its provider system, as well as undertaking other financial administrative functions.

ODMRDD has a role very similar to the other State sub-recipient agencies but, at the local level, CBMRDDs provide direct care services and this system, like ODA, operates under a waiver. ODMRDD also provides direct services in its developmental centers. ODMRDD's role includes making eligibility determinations for developmental center residents and for waiver applicants, working with ODJFS in developing rules and State plan amendments, grievance arbitration, establishing guidelines and regulations governing CBMRDD and provider operations, and completing several fiscal, information technology, and administrative duties related to claims processing.

With the exception of administering waiver programs rather than a State plan service, ODA maintains essentially the same relationship with ODJFS and its local agencies as the other sub-recipients. ODA administers its portion of the Medicaid program through Area Agencies on Aging (AAAs), who then directly contract with and oversee providers. ODA is responsible for establishing standards for its programs, usually managed by AAAs, and program staff employed by these organizations. In addition, ODA is responsible for establishing standards for providers and certifying providers under those standards. The Agency also manages information technology systems and is involved in claims processing and payment.[28]

ODH is the State health standard setting authority and State health survey agency, which entails certifying and determining compliance of skilled nursing facilities, nursing facilities, and ICF/MRs for the mentally retarded with requirements for participation in the Medicaid program.[29] It is also charged with certifying nursing facilities for the Medicare program, which according to ODH, has substantially similar certification requirements. Therefore, it is able to achieve economies of scale and improved efficiency of operations. ODH reviews new and existing facilities and also investigates complaints alleging non-compliance with Medicaid standards for participation or conditions posing a hazard for the health and safety of long-term care residents. Part of this process is to ensure that residents are in fact eligible for Medicaid services. ODH is also charged with enforcement of deficiencies noted in reviews and can impose remedies such as termination of Medicaid participation, appointment of temporary managers, applications to the courts for injunctions, denying Medicaid payments for all Medicaid

[28] The financial audit function for federal cost reports is conducted by ODJFS for ODA and the AAAs.

[29] ODJFS has several contracts with ODH under which ODH provides services like the immunization registry and lead testing.

eligible new admissions, or the imposition of fines. ODH also approves or disapproves plans of correction submitted by facilities. Finally, ODH provides ODJFS with necessary data for the calculation of the nursing home franchise fee.

In effect, ODJFS, through OHP, is a manager of contracts with ODMRDD, ODMH, ODADAS, and ODA. The sub-recipient agencies, in turn, manage contracts with their local agencies. The local agencies are directly responsible for contracting with health service providers. This system of administration is likely the result of Ohio's historically strong home rule system, the desire for local funding sources to be used and controlled locally, and a desire to delegate responsibilities to State departments with advocacy roles for improving the quality of care. **Table 3-8** presents functions performed by each participating Medicaid agency at the State level. Consistent with the role of a contract administrator, the functions listed in **Table 3-8** support contract design, implementation, oversight and monitoring, and payment administration.

Table 3-8: Functional Duties of Major Sub-recipient Agencies

	ODJFS	ODMH	ODADAS	ODMRDD	ODA	ODH
Contract Design:						
Policy Development and Rule Writing	√	√	√	√	√	√
Contract Implementation:						
Recipient Eligibility Determination through local or regional office	√	--	--	√	√	--
Service Provider Certification and/or Enrollment	√	√	√	√	√	√
Utilization Review/Care Coordination	√	√	√	√	√	--
Contract Support:						
Technical Assistance and Outreach	√	√	√	√	√	√
Payment Administration:						
Claims Processing and Adjudication	√	√	√	√	√	--
Oversight & Monitoring:						
Audit (financial, clinical, or compliance)	√	√	√	√	√	√
Eligibility Determination Oversight	√	√	--	√	√	--
Service Standard Compliance	√	√	√	√	√	√
Data Collection and Evaluation	√	√	√	√	√	--
Direct Care Services:						
Advocacy(individual/system)	√	√	√	√	√	--
Operator of Care Facilities/Direct Service Provider	--	√	--	√	--	--
General Support Functions:						
Financial & Budgeting	√	√	√	√	√	√
Information Technology	√	√	√	√	√	√

Source: Medicaid State Agencies, OMASC, and Medicaid Interagency Agreements

As shown in **Table 3-8**, Ohio's design has several redundancies in the roles at the State and local levels. Because of the structural arrangement in Ohio, key contract management functions – design, monitoring/oversight, implementation, payment administration -- are performed more than once. Furthermore, additional layers of hierarchical decision-making reduce efficiency, flexibility, federal compliance, and the effectiveness of these activities. As flexibility and effectiveness are components of quality, this system may reduce, rather than enhance, quality and responsiveness.

The impact on efficiency can not easily be determined due to the multiple roles of individuals in State agencies and in local administering organizations. The cost of these services is dispersed among multiple programs/funding sources and is not generally recorded or estimated as it is not reimbursed or required (see ***Medicaid budgeting practices*** and the ***overview*** for further discussion of required reporting practices). However, the impact on federal compliance is evident. A review of CMS management reviews of Ohio Medicaid programs for the past three years indicates CMS' preference for centralized administrative authority. The CMS reviews were of components of the ODJFS, ODMRDD, and ODA Medicaid operations, and excluded financial reporting audits.

In general, CMS findings pertaining to oversight and interagency issues were most pervasive. Almost 34 percent of CMS findings indicated insufficient oversight of various parties or insufficient coordination of Medicaid agencies. Furthermore, almost 18 percent of the CMS findings pertained to the adequacy of client care or case management practices. While ODMRDD programs had the most findings of the three agencies that had segments of operations reviewed, ODJFS had the most findings pertaining to oversight and interagency issues, comprising nearly 48 percent of the CMS findings for ODJFS.

Perhaps most troubling are comments from the reviews pertaining to care issues in the ODMRDD system. The following were contained in CMS's review of Home and Community Based Services waivers in the ODMRDD administered systems from 2001 through 2005:

- **Quality of care** - 43 percent in 2001 and 39 percent in 2002 of a sample of Individual Options (IO) waiver recipients indicated issues with preventative health management, continuity of care, medical follow-up, and medication administration.

- **Matching services with needs** -23 percent in 2001 and 22 percent in 2002 of a sample IO waivers indicated that the individual service plans did not match needs.

- **Documentation of care** - 24 percent of a sample of IO waiver recipients indicated problems with implementation and documentation of behavior practices, presence of behavior support when warranted, and staff training on behavioral antecedents and prevention.

- **Major unusual incident procedures** - 41 percent in 2001 and 39 percent in 2002 of a sample of IO waiver recipients had problems in reporting major unusual incidents, staff ability to identify major unusual incidents or tracking patterns of major unusual incidents, and providing preventative measures.

- **Consistency of practices and documentation** - CMS found that individual plans varied in time period from county to county and consistently, the service documentation did not support that the services identified in the consumers' individual plans were being provided.

- **Communication with ODJFS** - Concern was expressed that there was not consistent communication between ODJFS and ODMRDD in the sharing of information from the compliance reviews, incident reports, and communication with providers as a whole.

- **Separation of duties** - CMS expressed its desire that Ohio redefine the role of CBMRDDs in the Residential Facility Waiver program.[30] For example, CMS noted that it was a direct conflict of interest for the routine monitoring of waiver recipients, their plans of care and their services to be conducted by the same entity providing the waiver services.

- **Consistency of access to waiver services** - CMS stated the State should ensure that distribution of waiver slots is decided at the State level. It must be based on criteria that are applied consistently throughout the State. Lack of local funding should not be a consideration.

Although these findings are not sufficient to draw conclusions regarding the quality of care on a system-wide basis and the reviews were limited to specific HCBS programs, the findings call into question the practice of delegating contract management responsibilities to sub-recipients to achieve higher quality of care. Furthermore, the comments from these reviews on ODJFS oversight clearly indicate CMS's preference for centralization. The comments also highlight the difficulties involved in managing a contract through two additional layers of agencies. ODJFS legal staff is aware of the federal desire for centralized administration of Medicaid funded programs and indicated that it was a point of contention given Ohio's decentralized organization and funding structure.

On the issue of ODMRDD and CBMRDD compliance, members of the Ohio Provider Resource Association (OPRA) highlighted the large number of federal citations as reasons for deep concern. One member reported:

[30] Enrollees in the Residential Facility Waiver program were converted to the Individual Options Waiver and the Residential Facility Waiver program ended on June 30, 2005.

> "What I find most troubling is the pattern that we're starting to see of the noncompliance. In 1988 the feds came in and did a survey…and found many areas of noncompliance. …After seven years and 13 extensions, Ohio, instead of trying to fix the problem, just did away with it. Same thing happened with CAFS [Community Alternative Funding System]. After about 10 years of noncompliance with CAFS, Ohio, instead of trying to fix the problem, just said "We'll send the money back.""

An OPRA member spoke of one of the letters issued by CMS after conducting a review in Ohio and said that in her experience of working with Medicaid for over two decades, "I never saw one letter-- not one letter-- that was this explicit from CMS on any topic. They don't write letters like this." Another OPRA member went on to say that many of the concerns centered on the conflict of interest in the MRDD system around the county boards serving as the "funder, the contractor, the service planner, the quality manager, the major unusual incident monitor, investigative agents, others, and doing service provisions at the same time.…That is a tremendous conflict of interest. …That is an abuse of the system."

These examples underscore the substantial problems associated with the redundant contracting process and delegated oversight in use in Ohio Medicaid. Beyond the monetary costs associated with the redundant administrative functions, across the program and to varying degrees the fragmented system results in gaps that affect access to services, service oversight, and the quality of care delivered to Medicaid recipients.

Contract Management Forms and Practices

The fragmentation and redundant functions are symptomatic of overlapping contract management responsibilities among the State Medicaid agency, the sub-recipient agencies, and the local agencies. The myriad of problems identified in the redundant systems raises the question whether these agencies have adequately developed the capacity to effectively manage Medicaid-related contracts. Brown and Potoski (*Contract-management Capacity in Municipal and County Governments*, 2003) identified three basic components for capacity to manage contracts:

- **Feasibility assessment capacity:** the capacity to determine whether to make or buy the good or service;
- **Implementation capacity:** the capacity to bid the contract, select a provider(s), and negotiate a contract; and
- **Evaluation capacity:** the capacity to evaluate the contractor's performance.

As a contract manager, OHP (as the State Medicaid agency) adds value to the Ohio Medicaid system through its ability to identify the feasibility of certain ranges of Medicaid services (feasibility assessment capacity), write and implement contracts (with the sub-recipients and providers); and evaluate the performance of contracted parties in accordance with those contracts. This is particularly difficult given the lack of prioritized goals discussed in ***identifying***

the purpose of the Medicaid program. Without prioritized goals, a contract administrator can not create, implement and monitor contracts which are designed to achieve a desired outcome.

State Social Services Contracting: Exploring the Determinants of Effective Contract Accountability (Romzek and Johnston, 2005) defines effective contract management and accountability as,"…where the state is able to design, implement, manage, and achieve accountability for its social service contracts. This includes the state's ability to obtain timely and accurate reporting from the contractor and use that information to evaluate performance and correct deficiencies." Romzek and Johnston state that contract specifications are theoretically a key component of contract accountability. These components include the contract specification and the clarity of accountability relationships; contract design; and accountability design. In particular, the presence of multiple competing and shifting performance expectations held by diverse, legitimate, and often conflicting sources is a challenge for public managers in administering contract relationships.

Contracting for Major Projects: Eight Business Levers for Top Management (von Branconi & Loch, 2003) also identified several key drivers to successful contracting for services, each of which are related to adequately defining the terms of the contract. These items include technical specifications, price, payment terms, and performance guarantees. The client defines the technical basis of every contract and the quality of those specifications is the result of the adequacy, completeness, clarity of scope, and executable descriptions of the contractor's deliverables. Furthermore, price should be perfectly consistent with technical specifications. Performance guarantees refer to the contractor's duty to prove that delivered services are within defined parameters. If performance aspects are not explicitly defined in the technical specifications of the contract, this weakens the ability to ensure compliance. In essence, contract performance monitoring is largely dependent upon the adequacy of the contract. Each of these aspects is dependent upon a clear and adequate specification of the contract. This in turn is dependent upon the contract/policy writer(s) adequately understanding the priorities of the program or contract. This is why defining the priorities of the Medicaid system is crucial to effective management of OHP's two value adding activities: contract development and oversight of contract performance. Likewise, the priorities of the program and its role in public health care are critical to determining the final role of the State Medicaid agency.

Saxena notes that the most important element for successful organizational change is the creation or maintenance of an organizational mission and purpose. Therefore, allowing State agencies with advocacy roles – roles which could be in conflict -- to act as contract managers does not promote a clear organizational role or direction with which to make operational decisions. Similarly, decentralized contract administration reduces the State Medicaid agency's focus on its role as contract administrator and diminishes its ability to require contract compliance.

OHP's ambiguity over its role in contract management and its ineffectiveness in managing contractual relationships can be traced back to its conflicting mission and structure. *A Model of the Impact of Mission Statements on Firm Performance* (Bart, Bontis, and Taggar, 2001) states,

> "The results...further substantiate the long established conclusion from previous research that a powerful relationship exists between an organization's internal structure and its strategy. The findings demonstrate that specification of both mission ends and means influence the way in which an organization will set up its organizational design, rewards, hiring practices, etc. Or, to paraphrase an old theorem, structure follows mission."

These ideas are echoed by the director of the Arizona Medicaid program. The director generally believed that fee-for-service health plans should steer clear of including any social service aspects in their core purpose. He stated that social service agencies have problems, largely because they attract staff with mindsets that are overly focused on societal needs rather than business processes. As such, these organizations lack the expertise and skills to focus on operations of financing services and value purchases, or, more simply, contract management. The director believed this cultural disconnect with operational and business oriented skill sets was a real barrier to systematic performance improvement.

In addition to Ohio, 11 other states (California, Colorado, Georgia, Minnesota, New York, North Carolina, North Dakota, Pennsylvania, Virginia and Wisconsin) have county-administered systems for Medicaid. In comparison to these states, the administrative costs for Ohio Medicaid[31] (3.3 percent) were the second lowest of the states, surpassed only by New York (3.2 percent). California, Georgia, and Virginia were also among the cost effective states identified for benchmarking purposes within this audit. When compared to the cost effective states in the area of administrative costs, Ohio administrative costs as a percentage of total medical assistance was the lowest of the cost effective states. Of the county-administered, cost effective states, California's administrative costs were 9.2 percent, Georgia's were 5.2 percent, and Virginia's were 6.4 percent. Therefore, the primary concern in Ohio Medicaid administration at the State and local levels is consistency rather than costs. However, the reported Ohio Medicaid administrative costs do not capture some selected administrative functions at the local level that are not tracked. Ohio's low administrative costs may indicate that, in the past, the State has not put adequate resources into the administration of this large program, which could be a factor in some of the program's weaknesses.

The county-administered states generally use the same interagency agreement relationship to manage Medicaid at the local level. Georgia reported having seven interagency agreements similar to Ohio's agreements with sub-recipient agencies. However, these states generally reported having fewer interagency agreements (usually because they have fewer state agencies participating in Medicaid) or contracts. None reported having individual contracts between the single state Medicaid agency and county agencies. In addition, none of the states reported

[31] Ohio Medicaid administrative costs were 3.3 percent in 2004 when administrative costs are calculated as a percentage of total medical assistance payments. In Ohio, administrative costs were $383 million out of total medical assistance payments of $11.5 billion.

problematic issues associated with contracts management, yet a number of them emphasized that coordination and partnership were key to successful administration of the program and required additional efforts because of the complexities of a county-based system.

Consequences of Contract Management Practices in use in Ohio Medicaid

Dividing administrative responsibility among several separate entities reduces programmatic flexibility and, more importantly, oversight effectiveness. First and foremost, as previously discussed in ***defining the purpose of Ohio's Medicaid program***, a lack of consistent goals and priorities among administrators creates conflict and prevents decisive action. In addition, by fragmenting the administration of the program, functional expertise in contract management is not shared across the system. Furthermore, separating State funding sources and using local funding sources as part of the state match implies a level of control over the program by subordinate parties that exceeds that of normal contractual relationships (see the discussion of ***Medicaid budgeting practices*** in this section of the report for further discussion of funding sources).

The impact of the decentralized arrangement was evident in stakeholder and recipient feedback. Issues with multiple delegations, levels of bureaucracy, and inefficiencies in administering the program where highlighted. A member of the Ohio Association of County Behavioral Health Authorities noted that ODJFS may, at times, not have a complete understanding of services administered by the sub-recipient agencies, which can impact its ability to be an effective broker in discussions with CMS.

Additionally, members of the Ohio Council of Behavioral Healthcare Providers noted that the complexities, multiple levels of bureaucracy, and the competing goals result in an inefficient, inconsistent system that does not adhere to sound business practices. A member of the Ohio Provider Resource Association summed this up saying "Get the smartest people in the land, put them in this room, and defy them to come up with a system that's more complicated than this one. …They couldn't because the right side of their brain would force them to improve it. You couldn't come up with a more complicated system."

Finally, members of the National Alliance for the Mentally Ill note that the "bureaucracy in our system is tremendous." A representative of the Ohio Advocates for Mental Health spoke to how the inefficiencies in the system impact services:

> "…You have got the dollars being spent from the Department of Mental Health to 50 mental health boards to 450 providers and they control the dollars now not the client…. And we get more complaints from mental health clients that are being pressured to take services they don't want. At the same time we get denied services for people who need services….Medicaid has gotten away from treating the people and more and more mental health treatment is pharmaceutical treatment."

Consolidating Medicaid contract management core functions: contract design; contract implementation; oversight/monitoring; payment administration; and other contract support functions into a single State department would alleviate many of the contract management issues identified by CMS, stakeholders, and recipients. However, local administrators' understanding of local needs and their effectiveness in addressing these needs may offset the loss of efficiency caused by multiple layers of administration. It is unlikely that intermediary State department administrators -- the sub-recipient agencies -- are required in the Medicaid program. The State Medicaid agency could contract directly with CBMRDDs, ADAMHs, and AAAs and increase consistency across the Medicaid program in Ohio. The roles of ODMRDD, ODA, ODMH or ODADAS could revert to advocacy for their populations, provider of direct services, administrator of non-Medicaid programs, and advisor to the State Medicaid agency. ODH's current role of certifying long-term care facilities could be retained as this expertise is not housed elsewhere in the program and it is already performing these duties for the Medicare program. In this manner, the system would become less fragmented and key contract management services would be more consistent and centralized.

Changes to the contract management relationships in place at the time of this audit would require substantial changes to processes and resources to deal with the additional workload. Likewise, restructuring the Ohio Medicaid program will require significant time, effort, and resources. The State Medicaid agency may require additional staff and a reallocation of all State match Medicaid funding (see the discussion of ***Medicaid budgeting practices*** in this section of the report). Finally, it would require negotiation of new interagency agreements between the Medicaid agency and local administrators.

Stakeholders expressed varying degrees of support for consolidation of functions, either at the contract or agency level. A member of the Ohio Council of Behavioral Healthcare Providers supported a stand-alone agency, saying "from a provider perspective that direct link to that one entity in terms of that payment relationship and those administrative responsibilities, it ought to be much more efficient, much more direct, and much more flexible." A member of the Ohio Council of Speech and Hearing Administrators had a similar viewpoint but was concerned about the focus of any reorganization effort, remarking "I don't think we talk so much about the models. I think we spend a lot of time talking about reimbursements, the specifics…."

A member of the Ohio Association of Medical Equipment Services took an even more narrow view, seeing a new State Medicaid agency as only a fiscal agent focused on claims payment with policy decisions and standards of care being developed by another State agency. However, members of the Ohio State Legal Services Association emphasized that the relationships or organization was not the root cause of the problem. Instead, they focused on the county administration of the program and the need for "enforcement capacity" at the State level. A member stated that the problem was the "lack of meaningful oversight" and "meaningful quality assurance."

Finally, a member of the Ohio Association of County Behavioral Health Authorities raised concerns about separating Medicaid services from non-Medicaid services as clients move in and out of Medicaid adding that having separate systems could create "perverse incentives, which financially end up driving us in ways that would be very damaging both for clients and for the infrastructure that you're trying to build." The impact of a divided system was illustrated by a member of the Ohio Job and Family Services Directors' Association who noted that, if recipients have to go to multiple places to get assistance, "that's a huge disadvantage to many low income families, including low income elderly and disabled individuals."

R3.14 The General Assembly should centralize the core functions of Medicaid contract management within the State Medicaid agency. This will improve the Medicaid organization's ability to clearly and strongly identify itself as a contract management organization. Furthermore, it can design contracts consistent with the clearly specified and prioritized long-term goals of the Governor and the General Assembly. Also, this will help the State Medicaid agency better coordinate contracts with other State agencies and local entities.

To streamline the contracting process, the General Assembly, with the assistance of the State Medicaid agency and sub-recipient agencies, should evaluate whether local contracts can be consolidated based on the final organizational structure selected, geographic responsibility, and service type or population served.

E. The Single State Medicaid Agency

Medicaid Operating Structure

Structure refers to: 1) the way the organization segments its work into discrete activities, 2) how the organization coordinates these activities, and 3) who is empowered to make decisions and how decisions are made. According to *In Search of Structural Excellence* (Martinsons, 1994) structure can also be categorized on the basis of organization. Traditionally, organizations have used functional structures, divisional structures, or hybrid structures at an operational level.

The functional structure is based on a group's function or dedicated activities in an organization such as finance or information technology (IT). The advantage of these organizational groupings is that they provide a division of labor that allows for specialization within the functional areas and allows for cooperation within the function. However, the functional design weaknesses can allow individuals within the function to become isolated from the larger organizational purposes and lead to coordination problems.

The divisional operating structure includes all functions, but is organized around discreet segments by line of service, geography, or customer type. In effect, the organization is divided into separate smaller organizations. The components may share some corporate resources, but

are relatively autonomous. This basis of organization allows more cooperation within the larger organization for interrelated functions and allows accountability to be maintained for a final product or process. However, it does not allow for specialization in function. Each division may have duplicative operations that do not leverage information or improved methodology from other divisions.

Sub-recipient agencies have very similar functional tasks and duties as they relate to Medicaid. Generally, these organizations have created small Medicaid units or identified a Medicaid point person. However, most Medicaid-related duties are diffused throughout the organization and housed in support services, like IT and finance, or population-based units, like child-oriented services. ODJFS, as the single State Medicaid agency, has generally organized its OHP bureaus in a divisional framework. The sub-components of the bureaus themselves are generally divided around functional lines, with several exceptions. The eight bureaus are organized as follows:

- **Bureau of Health Plan Policy (BHPP) -** is a function-based grouping that is the primary policy research and implementation body. It is generally sub-divided into two divisional sections; one for hospital benefits and another for benefits management. These sections are supported by two separate functional organizational units -- one for strategic planning and one for researching and analyzing health services data. Within the benefits section, there are divisional groups for types of services or programs. Within the hospital benefits section, individuals are grouped by function with the exception of two units organized around service/program type.

- **Bureau of Long-term Care Facilities (BLTC)** - is a division organized around a population and their associated services. It is generally responsible for developing policy regarding nursing homes and other long-term care services. This bureau is comprised of subordinate groups organized by function. There are two sections; the financial operations section, and the reporting/analysis section. Each of these sections is further divided into function-based units.

- **Bureau of Managed Care (BMHC)** - is a division-based organizational unit responsible for contract design, contract implementation/solicitation, and monitoring the performance of managed care contracts, and is generally organized around these functions. It has a section responsible for contract administration; financial management and development; performance improvement and clinical management; and premium administration and membership services. Each of these are functional tasks necessary for the management of managed care contracts.

- **Bureau of Consumer and Program Support (BCPS)** - is a function-based unit for the purpose of supporting county intake functions, county oversight and support, program development, and consumer services/relations.

- **Bureau of Home and Community Services (BHCS)** - is responsible for specific service types consistent with a divisional format. However, internally, the bureau is organized around three functions: data management and analysis; provider standards and services; and consumer standards and services.

- **Bureau of Community Access (BCA) -** is a division responsible for facilitating changes to the programs specific to populations or services administered by other State agencies. It is internally organized first into policy and monitoring functions. However, it is further divided on a division basis for each external Medicaid agency in the policy section. This bureau does, however, maintain a functional structure in the group responsible for fiscal monitoring, quality assurance, and program services.

- **Bureau of Plan Operations (BPO) -** has functional duties related to operating the payment administration system and is organized around the following function-based sections: clinical reviews for disability determinations and quality assurance; benefit coordination and recovery; provider network management; claims processing; claims services; and contract administration. It should be noted that OHP has indicated that it will reorganize to have an eighth bureau entitled the Bureau of Clinical Management to separate the duties of the medical operations section from BPO.

- **Bureau of Clinical Management (BCM) -** is a new bureau that will include the functions currently included in the BPO Medical Operations Section. These duties include ensuring that all Medicaid services requiring prior authorization are medically necessary and appropriate, as well as pricing prior authorization requests for medical, transportation, durable medical equipment, organ transplantation, supplies, and dental and vision services. This section will also provide technical assistance to Ohio's 88 counties in developing processes for reviewing clinical information for individuals applying for assistance due to a disabling condition.

In this reorganization, OHP will revise the reporting structure to include a third assistant deputy position to oversee payment administration operations and the new bureau. This new arrangement will organize bureaus into groups involved in operations, long-term care, and benefits.

At a high level, four of OHP's eight bureaus are organized on a divisional basis. This basis of organization is best exhibited by an identification of functional duties at the unit level. Those groups organized by division will likely be responsible for performing several functions. **Table 3A-1** in **Appendix 3-A** illustrates the functional duties of each section within the OHP's bureaus.

According to the Chief of Staff and the Chief of the BHPP, portions of OHP's operational structure (such as establishing the BCA) was a conscious decision and was implemented in response to a management process assessment conducted by AMS consulting. However, other

aspects were a natural evolution in response to the system becoming more complex and requiring additional policy analysis capacity within each bureau, organized around populations or service types. The AMS management process assessment makes no specific recommendations regarding operational structure, but it does recommend incorporating a "new product development" approach for the Governor's Office. Furthermore, it identifies difficulties working across bureaus and identifies common functions across bureaus. It also highlights a lack of formal mechanisms for coordination and sharing of best practices across bureaus and recommends a best practices program and increased use of cross-bureau groups.

Over the past few years, OHP has developed a project management approach that resulted in another informal internal structure comprised of task-specific work groups in addition to its formal structure. These groups can have inter-bureau membership. Several bureau chiefs noted that policy analysis and formulation was done in a collaborative manner. However, it remains uncertain if this collaboration on policy is restricted to senior bureau staff or if it is also a common practice among middle managers within bureaus. OHP's Chief of Staff and the bureau chief of BHPP recognize that the structure has fragmented functional duties. However, they use centralization of authority to ensure that changes in one aspect of the program do not have unintended consequences in other portions of the program. The Chief of Staff feels this function is critical because of the interrelatedness of the system. Cross-bureau teams which meet to discuss programmatic policy changes then make recommendations to the OHP Chief of Staff or another executive staff member. This cross-bureau team approach is an effective response to the interrelatedness of policy decisions within the Medicaid program and may speak to the poor fit between the program and divisional-based internal operating structures. However, it also results in a bottleneck at the executive level and in delayed responsiveness to critical issues.

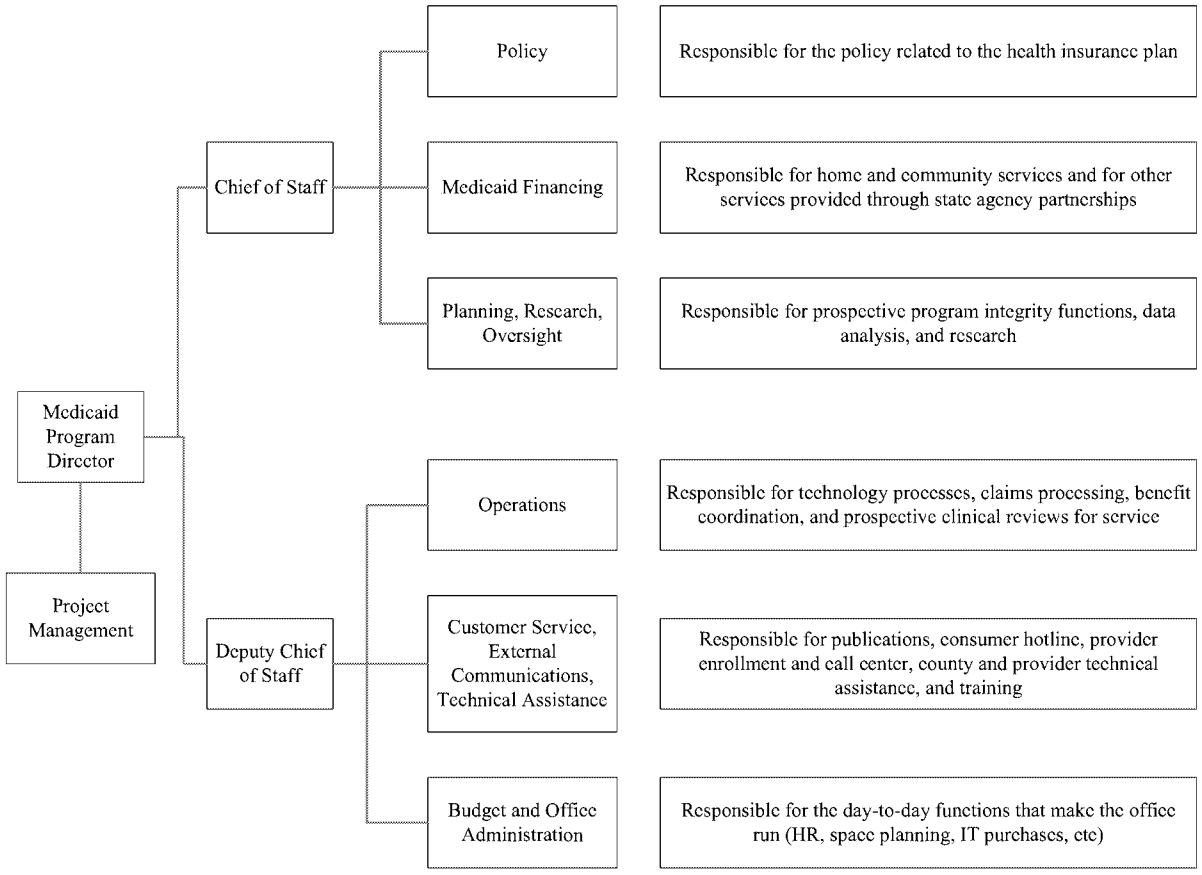
On July 27, 2005, OHP completed an internal management review that investigated business philosophy, organizational structure, business processes, resource alignment, and culture. The management review noted that although most staff reported an adequate scope of authority, these individuals also stated that they generally do not proceed without expressed consent or permission from their superiors. It noted that the same core group of people is involved in almost every decision. This contributes to a centralized command and control decision-making process. Although organizationally, groups are established based upon services or recipient populations in a division structure, the organizational culture appears to inhibit decision making ability at the operational level. The report stated that some managers expressed frustration at the length of time it takes to move an idea from concept to actual implementation because of numerous meetings in which decisions needed to move the work forward are revisited again and again. The report noted a number of duplicative functions performed in the various bureaus related to program integrity and policy/data analysis. As discussed above, these are the primary value-adding activities of a contract management organization.

The management review notes that the Office of Research, Assessment, and Accountability (ORAA), which is not in OHP, is responsible for retroactive audits, reviews, and quality assessments for all ODJFS programs. In OHP, each programmatic area (bureau) is responsible for its own prospective reviews and quality control/quality assurance efforts. Reviews were defined as examination and validation of financial and program activities such as approval of sub-recipient budgets and review or approval of invoices from other State agencies. Quality control and quality assurance were defined as activities that appraise program implementation on a prospective basis (before the work is performed); such as the hold and review program that holds claims submitted by suspect providers for review by program staff prior to payment. The management review notes that assigning the responsibility to each programmatic area violates professional independence standards, as well as the Ohio Inspector General's recommendations for program integrity and audit resolution (see the **program integrity** section).

In addition, the management review identified duplicative research, reporting, and data analysis activities spread throughout the bureaus of Health Plan Policy, Long Term Care Facilities, Community Access, Home and Community Services, and Managed Health Care. It found that these efforts were varied, uncoordinated, and lacked standardized methodology and processes. It recommended centralization of these activities that it believed would facilitate a consistency in approach, quality work products, create economies of scale, and maximize the expertise of existing staff. Furthermore, consolidation would foster knowledge transfer and ongoing communication. Finally, the management review identified inequitable spans of control at the assistant deputy level. Five of the seven bureaus in place at the time of the review, or four-fifths of all OHP staff, report to the Chief of Policy and Operations; while the remainder report to the Chief of Disability Policy.

Chart 3-12 presents the internal management review's recommended organizational structure, largely based on functional groupings of policy; Medicaid financing; planning, research and oversight; operations, customer service, external communications and technical assistance; and budget and office administration.

Chart 3-12: Internal Management Review Proposed Operating Structure

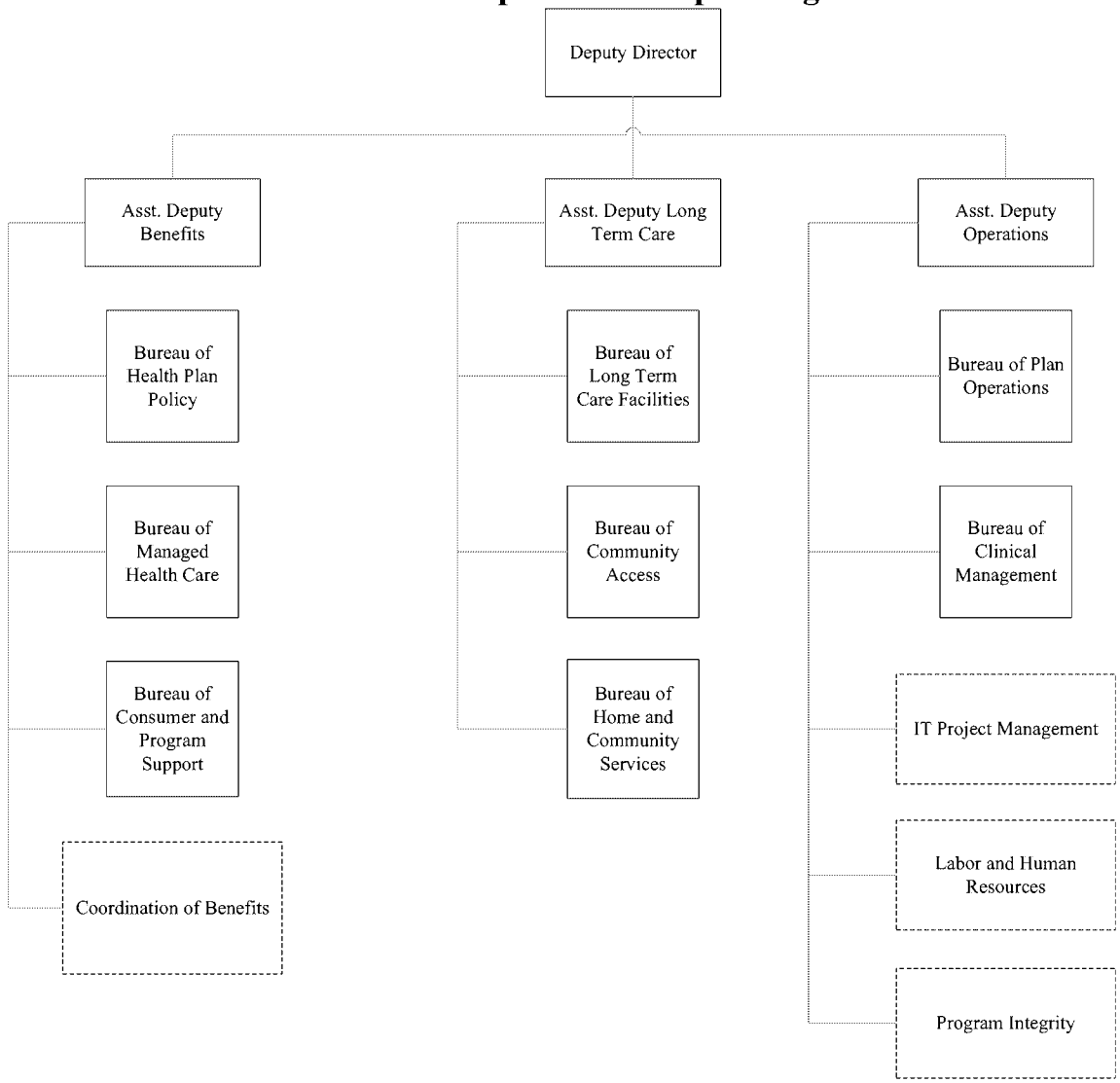


Source: Internal Management Review

The internal management review recommended a function-based organizational structure, centralizing all contract development and implementation functions under the Chief of Staff, while centralizing all payment administration, technical assistance, and support functions under the Deputy Chief of Staff. Partly in response to the management review, OHP has proposed the following operating structure which is expected to be fully implemented by October of 2006.

Chart 3-13 illustrates OHP's proposed revised operating structure.

Chart 3-13: OHP's Proposed New Operating Structure



Source: OHP as of May 30, 2006
Note: The above table does not include support functions within the Deputy Director's Office.

Chart 3-13 conflicts with the recommendation of the internal management review report. The chart illustrates that OHP will retain its division-based operating structure, while the management review recommended a function-based organizational design. OHP's new organizational structure has also created an eighth bureau -- the Bureau of Clinical Management. The proposed operating structure will still require informal coordination between the policy development groups reporting to the Assistant Deputy of Benefits and those reporting to the Assistant Deputy of Long-term Care.

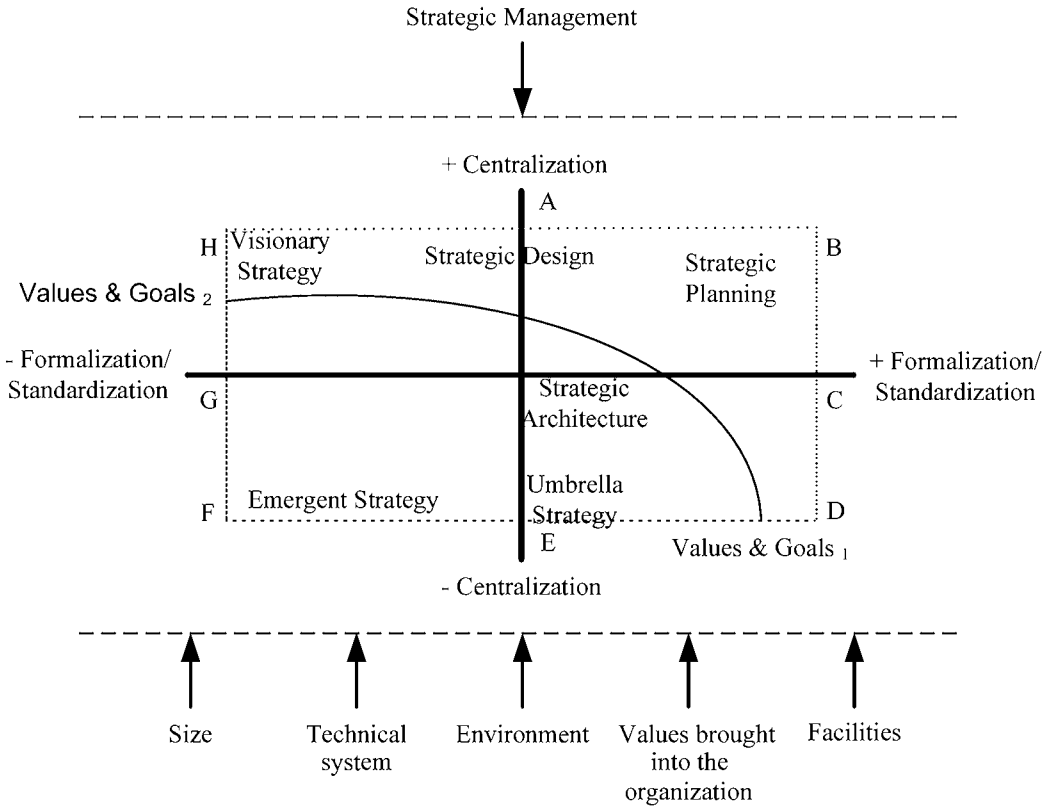
No single approach to organizational design is superior to other approaches in every circumstance. This is largely explained by the inter-related nature of external pressures, purpose, organizational culture, and the fundamental nature of an organization's operations. *Strategic approaches, organizational design and quality management: Integration in a fit and contingency model* (Moreno-Luzon and Peris, 1998) presents a conceptual model that is intended to assist organizations in determining what a particular organizational structure will achieve. The model differentiates between external and internal organizational characteristics, strategic management, organizational design, and methods of evaluating operational performance and highlights the theoretical importance of these items. The model has three basic descriptive organizational characteristics that can be consciously designed and implemented in response to the operating environment and nature of the organization's tasks. These descriptive characteristics are as follows:

- The level of decision making centralization in the organization;
- The level of formalization or standardization in the organization; and
- The level of common or shared values in the organization.

Illustration 3-6 illustrates the relationship of the above characteristics in the contingency framework.[32]

[32] Or the school of thought that recommends different kinds of organizational structures for different types of organizations based on the organizational function and needs.

Illustration 3-6: Contingency Model of Strategic Management Frameworks



Source: Moreno-Luzon and Peris. 1998. "Strategic Approaches, Organizational Design and Quality Management." International Journal of Quality Science.

An organization can be described by the level of intensity or absence of the three basic characteristics. For instance, an organization may have very centralized authority and very standardized processes, or it may be very centralized without standard processes. Centralization is the first of these descriptive characteristics. It should be noted, that this definition does not pertain to structural relationships, rather, it is the *de facto* decision-making authority, not merely what appears on an organizational chart. The level of centralization is comprised of three variables: the level of delegation of decision making power down the chain of authority, the level of consensus of the policies that serve as the framework of the decision making, and the level of autonomy with respect to the direct control of the members of the organization in their spheres of influence.

Standardization or formalization refers to the extent that procedures are always carried out in a methodical way and may be indicated by the extent that instructions for procedures are written

down. Finally, shared values refer to the extent that members of the organization adopt the set of values which are congruent with the principles behind the strategy of the organization. If common values are pervasive and deeply held, this will be evidenced by high levels of job commitment and personal responsibility. It is in effect an aggregation of the values of the individual members of the organization. This aggregate curve shows how as a whole the organization substitutes formalization for centralization.

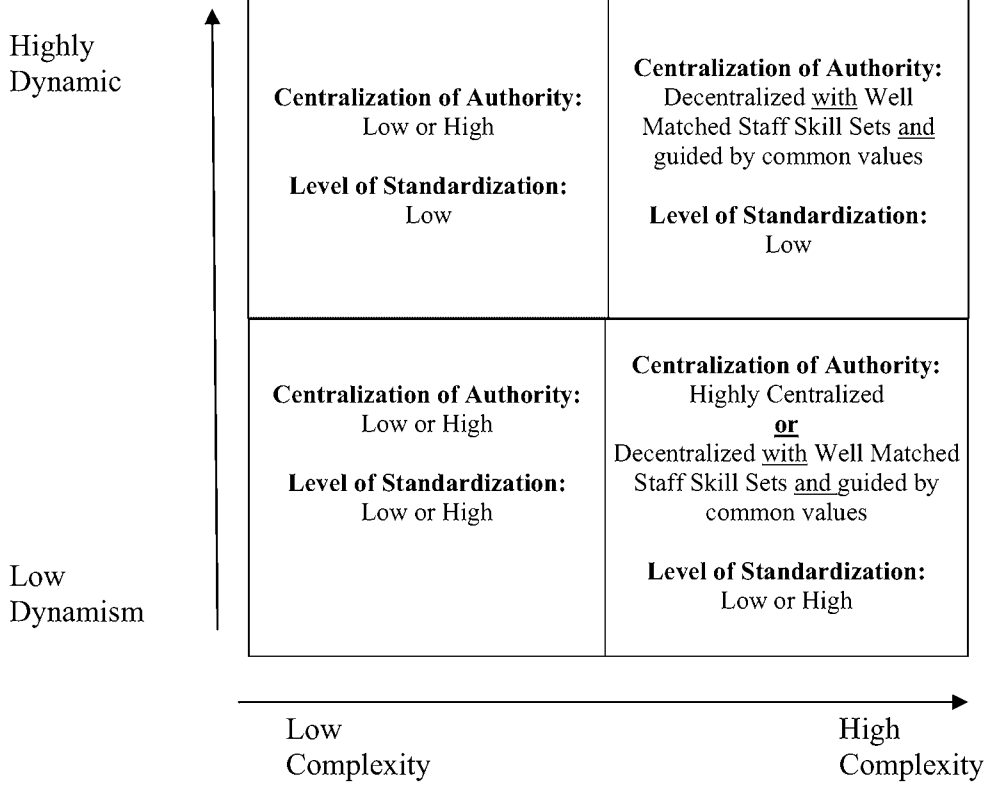
An organization's culture or values are represented by the *position* of the curve on the axis and by the *shape/slope* of the curve. The position represents the extent to which organizational culture promotes or is resistant to centralization and formalization. The *shape* indicates the relationship between centralization and formalization. For instance, if higher levels of formalization result in lower levels of centralization, then the slope of the curve will be downward sloping. Also, if it is not a one to one relationship, the shape of the curve will be convex, rather than a straight line. Common values are unique in this framework as both a descriptive characteristic of an organization, and an influencing factor, or contingency factor, of the model.

This framework also presents five contingency factors that influence an organization's positioning on this framework or should be considered when designing an organization. These factors include: size, technical system, environment, and the values brought into the organization by its members. It should be noted that the contingency factors can have different strengths or importance in different organizational sub-units. Furthermore, these factors may act simultaneously upon an organization, but require contradictory responses. However, each of these influences, except for the environment, is at least partially under the control of the organization as they are internal characteristics of the organization. Therefore, it is important to make conscious decisions when designing an organization's internal characteristics to meet the needs of its environmental pressures.

There are two aspects of the environment: dynamism and complexity. Dynamism refers to the rate of change in an operating environment. Consequently, it limits the maximum level of formalization/ standardization that is acceptable in a given situation. Highly dynamic situations require flexible organizations that can adjust to new environmental pressures. Complexity refers to the intricacy of operations and specialization required for effective operations. Highly complex operations require highly-skilled individuals. Complexity requires matching the specialization required for operations with individual's skills and training. If there is a poor match between an organization's required skills and the current skills of its individuals, generally this requires an increased level of centralization to allow those individuals with the best skill set to make more of the decisions. The more skilled the individuals; the less centralization is necessary to cope with complexity. The values of the members of an organization can be used as an alternative control and coordination mechanism. If the inclination is toward cooperation and commitment among individuals is high; then the culture can be used as a substitute for

standardization and centralization. **Illustration 3-7** presents the appropriate organizational design in response to given environmental factors.

Illustration 3-7: Organizational Design Responses to Operating Environments

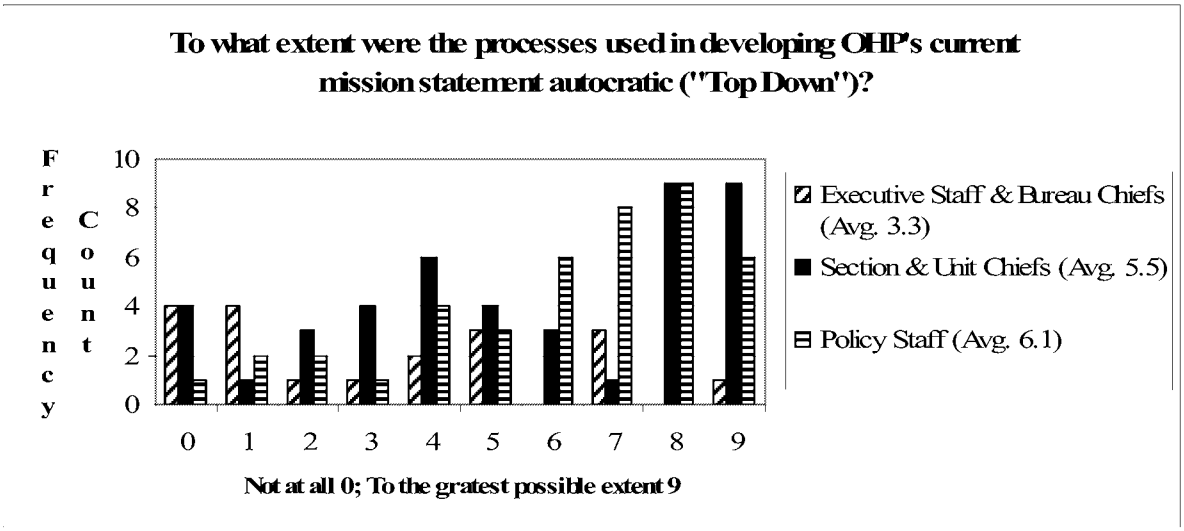


Source: Moreno-Luzon and Peris (1998). "Strategic Approaches, Organizational Design and Quality Management," International Journal of Quality Science.

OHP is a large organization, with a highly complex and turbulent environment. An organization of this kind should seek highly skilled individuals, guide their actions with clear and prioritized strategic direction through prioritized goals, decentralized decision making authority, and seek moderate levels of standardization or formalization. Given these desired organizational characteristics, the optimal design would include an operating structure that facilitates a flexible organization with decentralized decision making authority and only moderate levels of standardization or formalization. In contrast, the management review report indicated that OHP exhibited a high level of centralization and reflected a command and control approach with the same individuals involved in most decisions. Furthermore, it noted OHP's difficulty in dealing with its dynamic environment and noted several instances where managers expressed frustration

over the length of time required to implement programmatic concepts. Finally, consistent with the traditional weaknesses of a divisional structure, the management review noted difficulties in coordination between divisions. Consistent with the management review's findings, a non-statistical survey of OHP staff indicated that authority was centralized within OHP. For instance, the strategic planning process in OHP was construed as being an autocratic process by most groups surveyed, with the notable exception of the executive staff and bureau chiefs. **Chart 3-14** illustrates survey results pertaining to OHP management and policy staff perceptions regarding the strategic planning process and their involvement in developing the mission statement. Where applicable, the responses of OHP personnel are compared to those of executives in private sector health-care organizations.

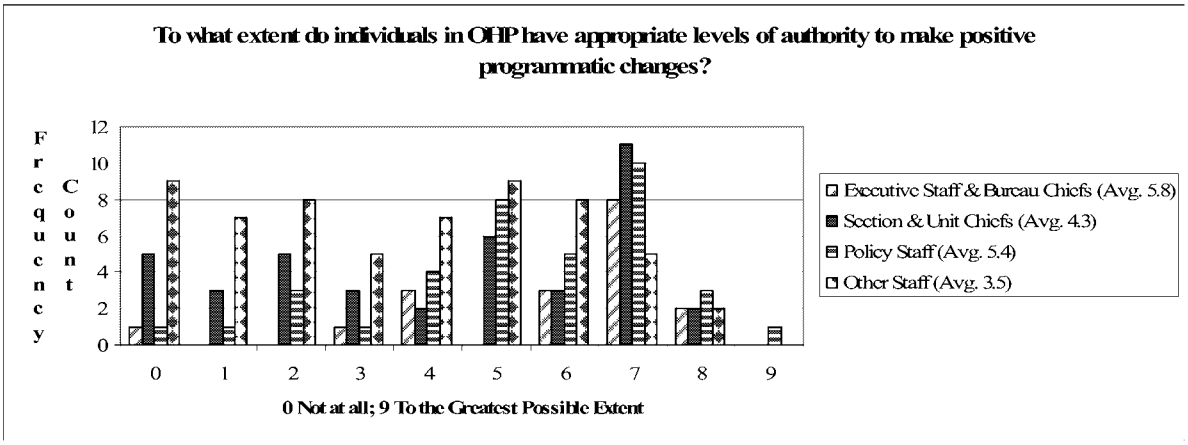
Chart 3-14: OHP's Perceptions of Strategic Planning Process



Source: Survey of OHP staff
Note: This question had a rate of response of 64 percent.

Chart 3-14 shows that section chiefs, unit chiefs, and policy staff perceive the strategic planning process to be autocratic. Conversely, the executive staff and bureau chiefs perceive the process to be relatively inclusive. The same survey question administered in connection to *Mission Statement Content and Hospital Performance in the Canadian Not-for-Profit Health Care Sector* (Bart, 1999) to senior managers of 129 health care organizations revealed an average response of 3.8, while the top performing quartile had an average response of 3.56. While OHP's executive staff and bureau chiefs' perceptions indicate a decentralized environment similar to other high performing health care organizations, other OHP staff's perceptions differ greatly. This indicates that not only is authority centralized within OHP, but that there are polarized opinions regarding the centralization of authority. Furthermore, OHP staff members do not perceive that they have appropriate levels of authority to make programmatic changes. **Chart 3-15** presents responses to a survey administered to all OHP staff.

Chart 3-15: Perceptions of Authority to make Programmatic Changes



Source: Survey of OHP staff
Note: This question had a response rate of 29 percent.

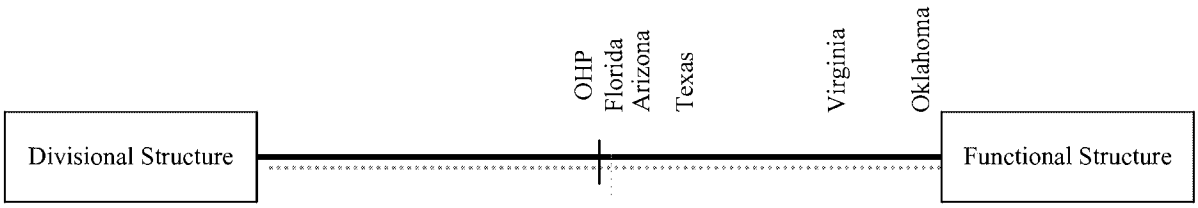
While executive staff and bureau chiefs perceive that they have authority to make programmatic changes, these views are shared in lesser degrees by other positions within OHP. Naturally, more senior staff will have additional authority; however, 60 percent of other staff and 45 percent of section and unit chiefs did not believe they had authority to make positive programmatic changes.

Even under a new organizational structure, centralized decision-making will continue if the culture of the organization does not change. The current operating structure encourages centralized decision-making by separating OHP on a division basis, thereby arbitrarily dividing contract development and implementation functions, which should be housed in the same organizational unit, into service or customer groups. However, State plan services are interrelated; therefore, a change to one service group (like long-term care) will likely impact another service group (like home and community based services). Therefore, additional layers of coordination are required for each change and these occur at the executive level.

Naturally, as each bureau is equal in its authority and may have different perspectives on the appropriate courses of action, it forces decisions to be made at higher levels in the organization and encourages centralized decision-making. Policy decisions will always require executive staff or senior management involvement (regardless of whether it is really necessary) because authority is fragmented across an artificial population basis, rather than a functional basis. Therefore, no one is able to effectively comprehend the impact of policy changes except senior staff, who have the benefit of multiple subordinates reporting to them and providing a comprehensive view of the system. The current organizational structure encourages a narrow view of issues among less senior staff because they are focused on their population group's needs. This is inappropriate for a dynamic environment which requires rapid changes to programs which may result from pressures exerted by outside parties and limited funding.

Medicaid agencies in other states have developed more functional organizational responses to the operating environment. Five of the ten most efficient states'[33] operating structures were reviewed to determine if a trend in internal organization existed among highly efficient Medicaid programs. **Illustration 3-8** summarizes each state's organizational structure on a continuum of divisional and functional structure.

Illustration 3-8: Relative Operating Structures of Peer Medicaid Programs: Divisional vs. Functional



Source: Peer states' organizational charts and organizational unit descriptions

Illustration 3-8 shows that some of the most efficient Medicaid program operation structures are based upon a hybrid or functional design concept. This was defined by the proportion of organizational units reporting directly to the executive staff level, organized on a functional versus divisional basis. OHP, on the other hand, is slightly more aligned with divisional organizational structure, but is generally evenly split between a divisional and functional structure at the bureau level. However, division-based organizations are misaligned with the central identity of OHP and, as such, they promote a centralization of authority and inhibit the organizational flexibility required in the dynamic and turbulent operating environment of Medicaid.

R3.15 The single State Medicaid agency should have an organization that is sufficiently flexible to respond to its operating environment. It should decentralize authority when possible to individuals with the necessary technical expertise to successfully deal with the complexity of issues. This can best be accomplished through operating structures that are based on functional tasks as most Medicaid issues are interrelated. Divisional/population-based organizations can be maintained within the functional alignment to the extent that population-specific expertise is relevant and value adding.

[33] As part of this analysis, peer state Medicaid programs were ranked based upon SFY 2001-02 and SFY 2002-03 (the most recent data available at that time) claims costs, claims count, and recipient count data available from CMS and ranked each of the states based on several efficiency indicators.

The State Medicaid Agency's Strategic Planning and Implementation Process

In response to a report issued by AMS Consulting in 2000, OHP implemented a Balanced Scorecard (BSC) approach for strategic planning and management. ODJFS created the position of Director of Strategic Planning and recruited an individual from outside the Department. This position reports directly to the OHP Chief of Staff. The Director of Strategic Planning noted wide acceptance in the private sector with the Balanced Scorecard framework.

The BSC strategic planning approach was developed in the early 1990's by Dr. Robert Kaplan and Dr. David Norton of the Harvard Business School. BSC provides a more holistic view of organizational performance that includes cultural aspects of the organization such as employee learning and growth, internal business processes, and aspects of customer satisfaction to balance the traditional focus on financial measures. It uses this basic tenant and seeks to make strong formalized links between high level mission, vision, and values; strategies; and a measurement feedback loop. The feedback loop assumes a cause and effect relationship between the four areas of business performance. Internal processes, internal culture, and customer satisfaction are assumed to be leading indicators of financial performance. The goal of this system is to make management decisions based on fact and to adjust strategies or practices on an incremental improvement basis. It should be noted that the BSC strategic planning approach was designed with private sector organizations in mind.

According to the Balanced Scorecard Institute,[34] a leader in applying the balanced scorecard to governmental operations,

> "The key metric for government (or nonprofit) performance … is not financial in nature, but rather mission effectiveness. But mission effectiveness is not a definite and static thing. …At any given time, some departmental missions may be more important than others for the needs of the country. The selection of the departmental mission priorities is an ongoing strategic planning responsibility. … Success is thus defined specifically to the agency's charter. "Performance" in this context means, "How well is the agency doing its mission?" Metrics of performance answer the question "How do you know how well the agency is doing?" … But in addition to mission work, every agency also contains a support workforce that does the same kinds of tasks… essentially the same in all agencies. Criteria or metrics for government or nonprofit agency performance can thus be broken down into the following three categories:
>
> 1. Strategic need (current and in the foreseeable future)
> 2. Mission-specific effectiveness metrics (uniqueness and viability)
> 3. Generic efficiency metrics."

From inception in April 2001 to implementation, OHP's strategic planning process took approximately 11 months. The process began with meetings with the bureau chiefs to review past planning efforts and begin educating the bureaus on strategic planning concepts. In June of

[34] This source was also recognized by the ODJFS Director of Strategic Planning as a best practice resource.

2001, 75 staff were taken off-site to begin developing basic mission, vision, and value statements. Two teams were formed – the first, a strategy design team was charged with crafting the actual mission and vision statements; the second, the guiding team, was comprised of senior staff to review and comment upon the strategy design team's submissions. In mid July, the design team submitted the initial draft of OHP's mission, vision, and value statements and began receiving feedback and discussion from all staff. Under BSC processes, revised drafts are prepared and used to solicit input from the strategy guiding team and all staff. Also during the month of August, an environmental analysis, an internally prepared Strength, Weaknesses, Opportunities, and Threats (SWOT) analysis, and an external stakeholder prepared SWOT analysis were submitted for inclusion in the strategic planning process. While the environmental assessment reviewed initiatives of other state Medicaid agencies, it did not seek to identify areas of contention or differences in goals as identified in the analysis of ***purpose and goals of Medicaid and public health care in Ohio***. Furthermore, the SWOT analysis prepared using feedback from stakeholders included: consumer/family groups, long-term care consumer/ advocate groups, Medical Care Advisory Committee, provider groups, and CDJFS groups. However, OHP was unable to receive feedback from managed care providers (though an attempt was made) and they did not seek feedback from other State departments participating in Medicaid programs or their respective local agencies.

OHP's balanced score card strategic plan has five strategies that have subordinate strategic objectives. Strategic objectives in turn are measured by performance metrics. More detailed strategic initiatives are used to drive progress, which should be reflected in the performance metrics. During September of 2001, an external consultant was engaged to facilitate the guiding team and strategy design teams identification of strategies. During September, October, and November, the teams developed five strategies:

1.) Use value purchasing strategies to afford consumers health plan accessibility, network management, quality, and improved outcomes;
2.) Continually improve the effectiveness of publicly funded health care, expand integrated community service options for adults and children with disabilities;
3.) Improve the effectiveness and agility of OHP's business operations performance and project management;
4.) Continually improve cost management of OHP; and
5.) Continually enhance OHP's workforce excellence through proactive staff development, support, and recognition.

Throughout this process the strategies were reviewed and revised against the SWOT analysis documents and with feedback from the guidance team. In November, the guidance team and strategic design team conducted a "reality check audit" of the strategic planning documents produced to date. The consultant provided BSC education to 80 OHP employees. In addition, a measurement task force was created to identify appropriate measurements for strategic objectives and review current measurements to identify gaps. At the end of November, the consultant

provided measurement education to the measurement task force. However, the measurement task force continued to work through May of 2002.

In January and February of 2002, a communications planning group was chartered and developed a communications plan to introduce the strategic planning efforts to staff. In March of 2002, the implementation phase of the strategic plan began with a two hour strategic plan presentation and discussion with each bureau's employees. The communication campaign included the active involvement of the prior Deputy Director of OHP. Mission, vision, and values posters were placed in visible areas and the strategic plan was placed on the Agency's intranet. Furthermore, strategy champions were identified to advance strategies on an on-going basis. Updates on strategy achievement are periodically communicated through the annual report and other methods.

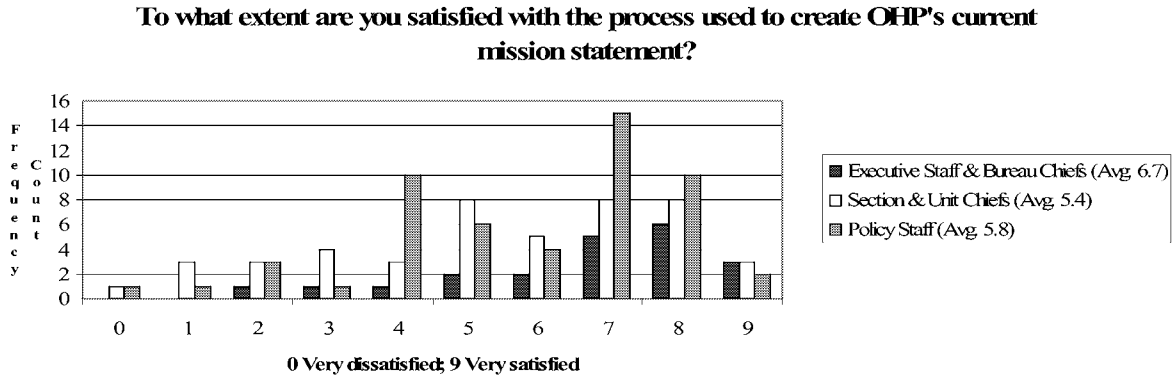
OHP continues to develop subordinate work plans and even strategic plans for the bureaus. At the time of this review, OHP provided documentation indicating how goals within the Bureau of Plan Operations are linked to the larger strategies of OHP and are linked further to meet goals defined by ODJFS.

Application of the Balanced Score-card Concept to Develop a Conceptual Framework to Measure Facilities Management Performance within NHS Facilities (Amaratunga, Haigh, Sarshar, and Baldry; 2002) provides the following procedural guidelines for implementing a balanced scorecard:

1.) Establish and confirm the organization's vision based on shared vision and communication;
2.) Establish the perspectives;
3.) Break the vision down according to each aspect of performance and formulate overall strategy goals;
4.) Identify critical success factors - moving on from the descriptions and strategies outlined above to discuss what is required for the vision to succeed and which factors will have the greatest effect on outcome;
5.) Develop relevant key measures to satisfy the critical success factors and study the feasibility of taking such measurements, and simultaneously check the structure for logical consistency (cause and effect);
6.) Establish the comprehensive scorecard;
7.) Break down the scorecard and measures by organizational unit;
8.) Formulate goals - goals must be set for every measure, as the company needs both short- and long-term goals, so that it can check its course continually and take the necessary corrective action in time;
9.) Develop action plans aligned to the goals and vision; and
10.) Implement the scorecard. It is necessary to follow it up on a continuous basis, so that it fulfills its intended function as a dynamic tool of management.

Generally, OHP appears to have followed a similar process. Procedurally, OHP has done a very thorough job in designing an implementation process, with the one exception that it did not include the sub-recipient agencies, or any other stakeholders, in the process. This critical factor is listed as the first step in the process, primarily because a common vision can be difficult to achieve with competing goals and multiple administrators and stakeholder groups. Furthermore, OHP is still developing performance measures and still seeking to link the overall plan to more detailed organizational units (see the discussion of ***strategic planning content***). The success of OHP's strategic planning process is evident in a survey of OHP staff. It should be noted that this survey used the term mission statement in a holistic manner that included aspects of strategic management and planning for consistency and comparability of results with research conducted by a third party. This definition was communicated to respondents several times throughout the survey. **Chart 3-16** illustrates OHP management and policy staff's satisfaction with the process used to create OHP's mission statement.

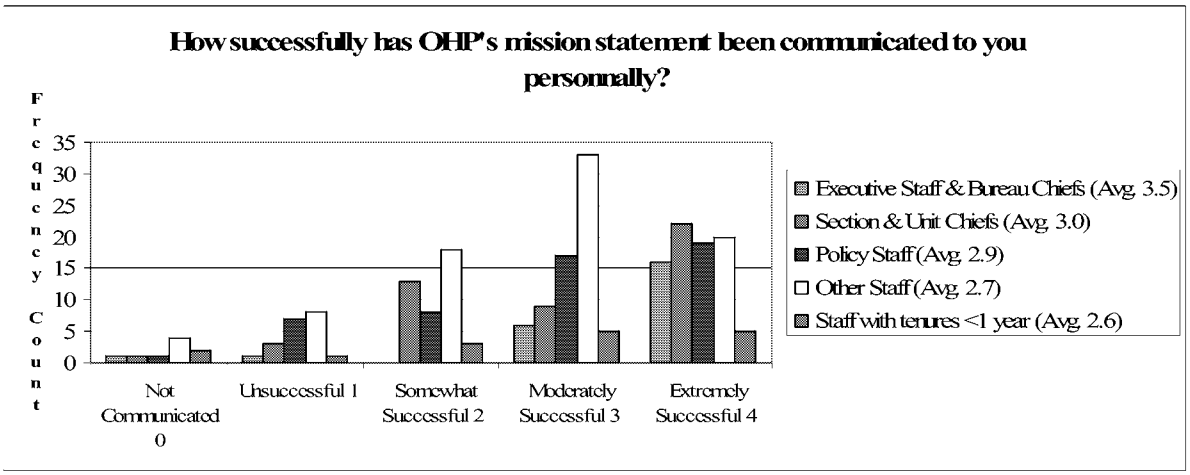
Chart 3-16: OHP Management and Policy Staff Satisfaction with Strategic Planning Process



Source: Survey of OHP staff
Note: This question had a response rate of 73 percent.

Chart 3-16 illustrates that OHP management and policy staff are largely satisfied with the process used in formulating the strategic planning documents. In comparison, the same survey question administered in connection to *Mission Statement Content and Hospital Performance in the Canadian Not-for-Profit Health Care Sector* (Bart, 1999) to senior managers of 129 health care organizations, revealed an average satisfaction score of 6.7, while the top performing quartile reported an average satisfaction score of 7.3. OHP's executive staff and bureau chiefs had comparable levels of satisfaction at 6.7 when compared to the survey's average, but less satisfaction than top performing health care organizations. **Chart 3-17** illustrates how effectively OHP was able to communicate its strategic plan to individuals within the organization.

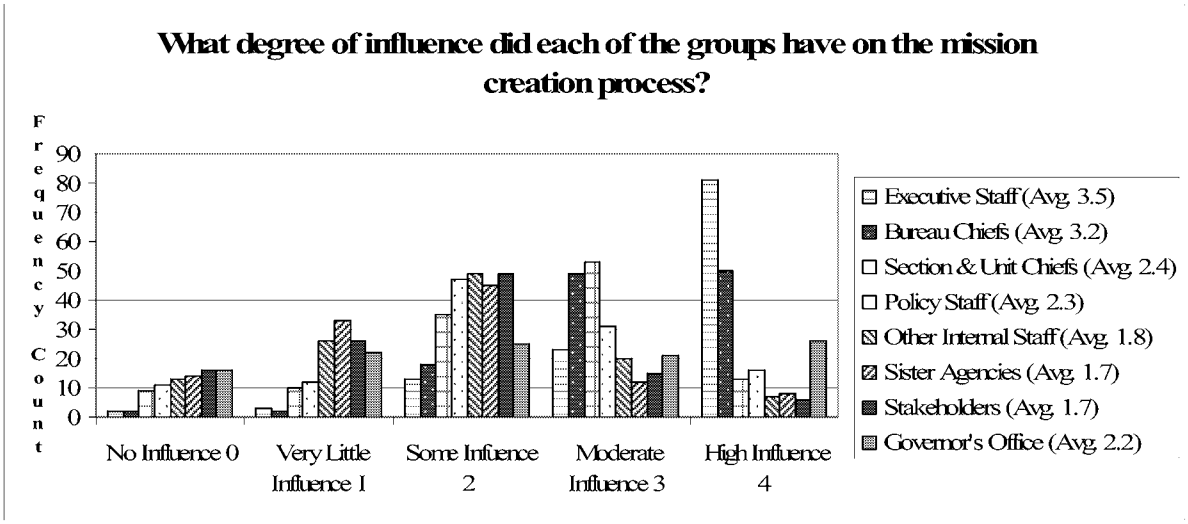
Chart 3-17: OHP Staff Perceptions of Effectiveness in Communicating the Strategic Plan to Internal Groups



Source: Survey of OHP staff
Note: This question had a response rate of 41 percent.

Generally, respondents were satisfied with the process employed to implement the strategic planning process. Furthermore, OHP has successfully communicated this plan to its employees given that it is a relatively recent document. It is particularly impressive that OHP has successfully communicated this document to its employees with tenures of less than one year with the organization. However, the process also was dictated from senior managers to the organization. **Chart 3-18** illustrates OHP's staff perceptions regarding the level of input each group had on strategic planning formulation.

Chart 3-18: OHP Staff's Perceived Influence on the Strategic Planning Process



Source: Survey of OHP staff
Note: This question had a response rate of 66 percent.

Chart 3-18 illustrates that the strategic planning process was generally a top-down process. Executive staff and bureau chiefs had a larger influence on formulation of the plan than section chiefs, unit chiefs, and policy staff, which in turn, had a stronger influence than other OHP staff. Furthermore, external parties had very limited influence on the strategic plan. The same survey question administered in connection with *Mission Statement Content and Hospital Performance in the Canadian Not-for-Profit Health Care Sector* (Bart, 1999) to senior managers of 129 health care organizations showed the survey's top performing quartile scoring between 3.4 and 4 for the senior managers, CEO, and Board of directors, similar to the results for OHP executive staff and bureau chiefs. Health care organizations scored the influence of middle managers (2.96) to be greater than that of OHP (2.4). External bodies' influence was comparable at about 1.7. The results, particularly for middle managers, indicate that the process may not have created a sense of ownership in the program among these parties, even though success is dependent upon the acceptance by these groups.

During stakeholder meetings, providers and recipients discussed their impressions of external options in decision-making within OHP. Stakeholders interviewed, including the Ohio Federal of the Blind, Arc of Ohio, the Brain Injury Association, and the Ohio Developmental Disabilities Council stressed the need for the State Medicaid agency to have increased interaction with and input from recipients and other stakeholders to enhance the agency's understanding of the program's impacts. One member of the Arc of Ohio noted that "it has not been the practice of Medicaid to actually talk with the people that they serve." A member of the Brain Injury Association questioned how familiar ODJFS staff is with the needs of different populations. A member of the Ohio Developmental Disabilities Council recommends that the Medicaid program

"…be required to develop a consumer advisory committee" and noted that in other states it is a fundamental part of the program to involve stakeholders, although "we have not had that kind of environment here."

Members of the Ohio Association of Health Plans noted that the Ohio Medicaid program has been reactionary and not proactive in "reaching out and trying to do new and creative things to improve efficiencies." Rather the Medicaid agency reacts "to individual situations by creating broad-brush program requirements that just add on layers of the bureaucracy that really don't make sense." A representative from AOPHA noted:

> "Much of what has happened with the State has been as a result of litigation. It shouldn't have to be that way. But if there were a change of attitude at the State, if we all said, look, we understand there's a budget. Let's honestly talk about what you want to reward…."

R3.16 The single State Medicaid agency should seek feedback on its mission, vision, values, strategies, and strategic objectives from the other Medicaid program participants when revising (or developing) its strategic plan, particularly sub-recipient agencies and groups advocating for impacted populations. This will help the State Medicaid agency develop collaborative efforts and improve the alignment of activities. In this manner, cooperation and a common understanding of programmatic priorities can be established.

R3.17 The State Medicaid agency should seek additional feedback and input on its mission, vision, strategies, and strategic objectives from its own internal staff when revising (or developing) its strategic plan. While it may have been necessary to establish the foundation of the strategic plan at executive or management levels in OHP, future revisions to the Agency's mission, vision and strategies should be based on the purpose of the program and should include input from all levels of the organization to engender a common commitment to the mission. Consistent with the model of mission impact, increased input and commitment have positive effects on organizational performance.

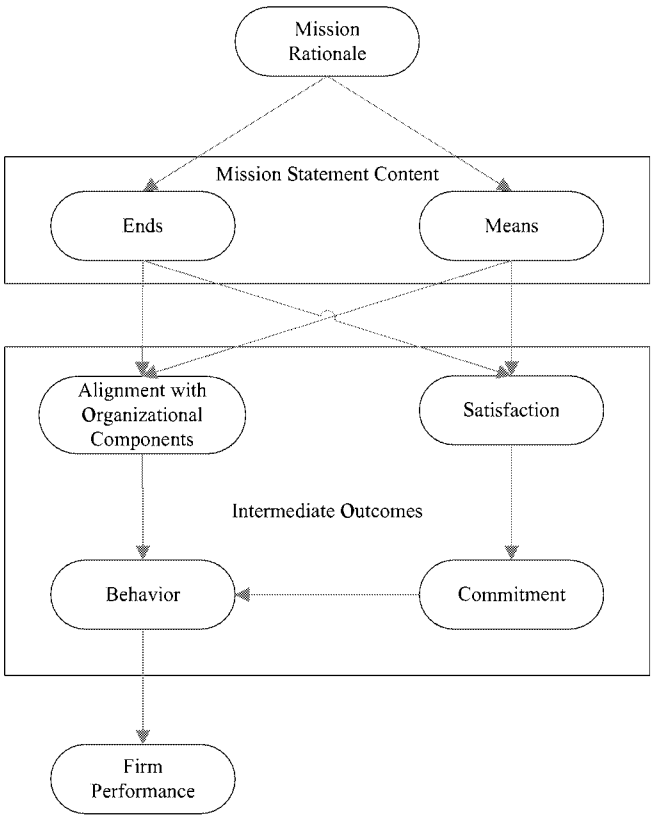
State Medicaid Agency Strategic Planning and Management Framework

Strategic Plan Content

During the audit, a survey was administered to OHP employees which contained questions identical to those used in *A Model of the Impact of Mission Statements on Firm Performance* (Bart, Bontis, and Taggar; 2001). This work identified a statistical link between aspects of the strategic planning and management process and organizational performance in the private sector. While performance is more difficult to define in public sector entities, there are objective financial measures in the both sectors. Furthermore, the drivers of performance identified in

private entities also apply to public entities. This model is unique in that it theorizes that mission statements by themselves have a poor correlation to an organization's performance. However, it is the mission statements' rationale, content, and its ability to influence individual's attitudes and behaviors that is predictive of an organization's performance. **Illustration 3-9** shows a conceptual model of how these factors are related to each other and to an organization's performance.

Illustration 3-9: Conceptual Model of Mission Impact on Performance



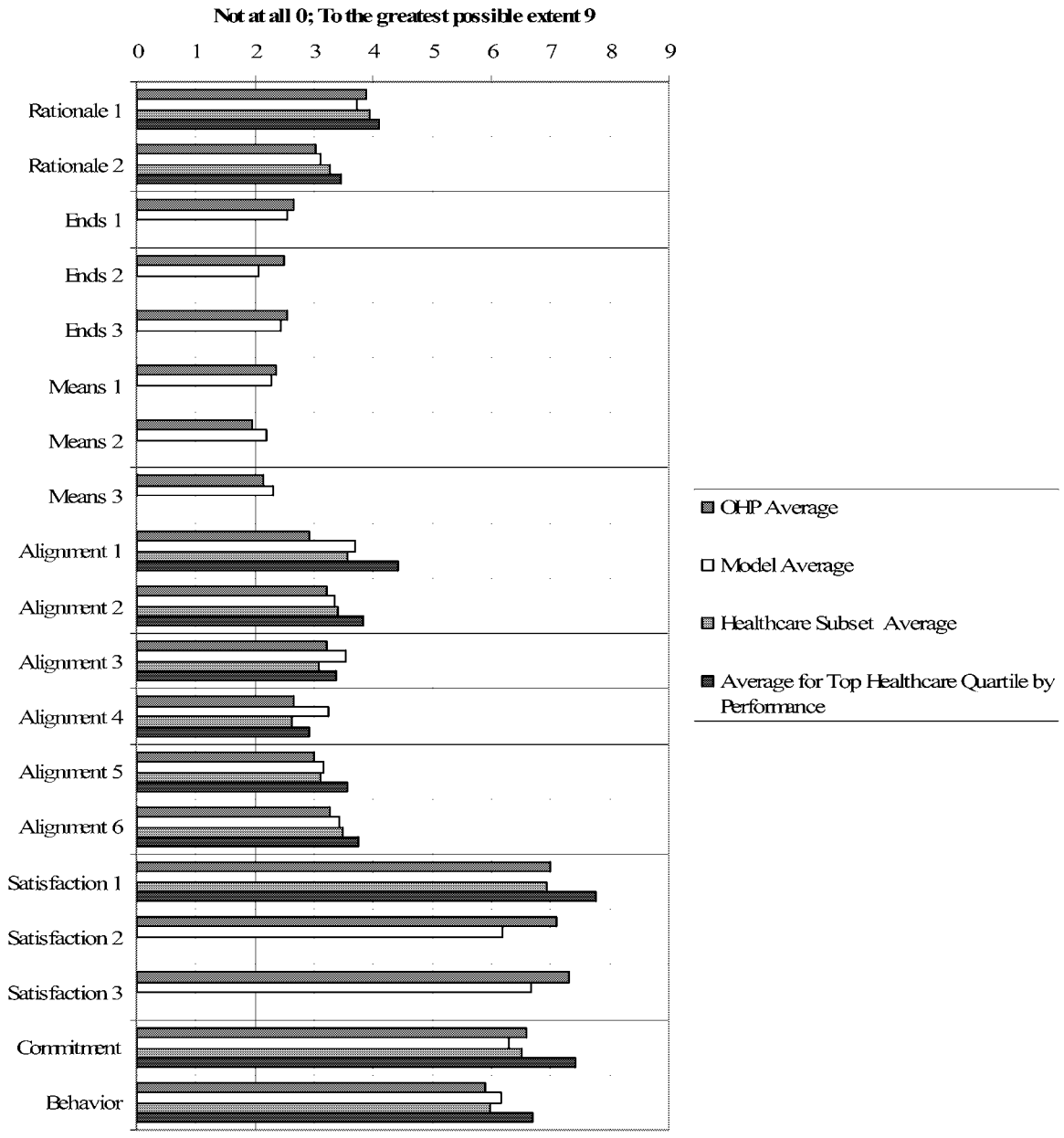
Source: *A Model of the Impact of Mission Statements on Firm Performance* (Bart, Bontis, and Taggar; 2001)

The model shown in **Illustration 3-9** defines mission in a broad sense which encompasses the terminology including mission, vision, values, purpose, goals, and identity. The model; however, illustrates the indirect manner in which these items influence performance. The dimensions of the mission model begin with a clearly articulated rationale for the mission statement that should translate into a mission statement that both identifies the end goals of the organization and the means by which it seeks to achieve these goals.

If organizational characteristics and management systems are aligned with both the ends and means of the mission, there is a direct link between this alignment and behavior. "Management systems" refers to items such as: organizational structure, procedures, human resources functions, budgeting and financial functions, or performance measurement and reporting. These systems have direct influence on individuals through both positive reinforcement of rewards systems and negative reinforcement through punitive controls such as individual performance feedback. Therefore, these management systems can have a direct influence on employee behavior and, therefore, firm performance.

If management systems are not aligned, mission statements can still influence an individual's behavior, as well as firm performance, through the psychological affects of organizational culture. This route requires both an aggregated satisfaction with the mission content and commitment by individuals of the organization. It is theorized that if both satisfaction and commitment exist, the behavior of individuals in the organization will be influenced. Through its aggregated influences on individual behavior, ultimately firm performance is impacted by its mission. **Chart 3-19** presents the results of the survey of OHP executive staff and bureau chiefs in comparison to the results from the model.

Chart 3-19: OHP Mission and Strategic Planning Effectiveness Indicators



Source: AOS survey of OHP staff and *A Model of the Impact of Mission Statements on Firm Performance* (Bart, Bontis, and Taggar; 2001)
Note 1: The survey questions and results are the intellectual property of professors Bart, Bontis, and Taggar. No reproduction or use of this information is permitted without their express permission. Two questions were altered slightly from the original survey so that it would better match the realities of government organizations.
Note 2: The questions on Ends and Means were rated on a 3 point scale and the questions on Rationale and Alignment were rated on a 5 point scale.

As shown on the chart:

- **Rationale** indicators generally sought feedback if strategic planning documents were developed to motivate staff and provide guidance for decisions such as resource allocation.

- **Ends** indicators generally questioned the extent that clear organizational goals were included in planning documents.

- **Means** indicators asked respondents if competencies, values, and strategies were clearly stated within strategic planning documents to indicate how goals would be accomplished.

- **Alignment** indicators asked respondents if human resources management, budgeting, operations planning, and other factors were aligned with organization strategic plans.

- **Satisfaction** indicators asked respondents to rank their satisfaction with strategic planning documents including aspects of clarity and if the right mission was selected.

- **Commitment** indicators asked if individuals in the organization were committed to achieving the mission.

- **Behavior** indicators ask if individuals' actions were influenced by the mission statement.

Chart 3-19 illustrates that while OHP's strategic planning efforts are generally consistent with the indicators of average organizations, its indicators fall short of high performing organizations. High performing organizations appear to communicate the rationale for their strategic management initiatives more effectively than OHP. Furthermore, high performing organizations have aligned their organizations more consistently with their strategic management efforts and, as a result, they have achieved more commitment and have influenced behavior to a greater degree than OHP. OHP communicates the desired ends and means of its strategic management efforts better than an average organization. Furthermore, when compared to average organizations, it appears to have achieved a higher level of satisfaction. When comparable data was obtained for satisfaction indicators, high performing organizations appear to have achieved greater satisfaction with strategic management initiatives than OHP.[35] In contrast, the discussion of ***defining the purpose of Ohio's Medicaid program*** highlights the discrepancies in OHP's prioritization of competing goals. The implication of these results taken comprehensively is that OHP's strategic management and strategic planning efforts are not harnessing the full benefits of

[35] It should be noted that the results obtained from other organizations was obtained without any potential repercussions of responses, while OHP staff were surveyed in an environment with additional scrutiny. It is unclear if this may have skewed results, but this assessment assumes the impact of this factor likely would influence results to reflect more positive perceptions than reality; rather than cause an incorrect assessment of their efforts in a negative manner.

these activities. The model presented indicates the indirect manner in which these activities can enhance organizational performance. If any one of these causal relationships is disconnected, strategic management and planning is unlikely to have an impact upon the organization's overall performance as it does not influence its individuals' behavior and decision making. This may in part be explained by OHP's selection of a balanced scorecard approach to strategic management, which is not aligned with the pressures exerted upon the organization by its operating environment.

Comments made by stakeholders during interviews underscored the potential disconnect between OHP and the agencies, providers, and recipients it serves. A member of the OHP Executive Leadership Committee stated that the State level does not coordinate very well with the county because the State believes it knows the issues and fixes them on their own. The member went on to describe that the counties want to be "customers" within the system so they can get answers. In addition, the member expressed a desire for more local decision making in, for instance, disability determinations which they said should be made at a county or regional level. At one time, the member said, this was the process; however, legal issues arose after audits revealed inconclusive forms. In response, the State made wholesale changes rather than improving the process.

One representative from AOPHA described the relationship with the State Medicaid agency as "adversarial" adding that "there is missing a certain cooperative collegiality that exists in other contexts and in other states." Other stakeholders interviewed, including the Ohio Association of Community Health Centers and the Ohio Association of County Behavioral Health Authorities, spoke to a desire to be involved in planning to allow for input in developing program requirements so that "everyone understands how rules are to be applied." This would also give each stakeholder an ability to get their issues and priorities on the "radar screen" at the State Medicaid agency.

Strategic Planning and Management Framework

Despite the success of OHP's implementation process for the strategic plan, the strategic management format[36] is insufficiently detailed in content and misaligned with performance metrics and strategic initiatives required under the principles of the BSC strategic planning framework. No single approach to strategic planning is superior to other approaches in every circumstance, largely because of the inter-related nature of external pressures, purpose, organizational culture, and the fundamental nature of an organization's operations.

Because Ohio Medicaid exists in a complex and dynamic environment, it needs to be able to respond to its environment, even though the responses can be contradictory. A dynamic

[36] Within the discussion of OHP's ***strategic planning and management framework and content***, research is presented that refers to "strategic planning" with a specific intent. "Strategic planning" in other discussions of this report use this term in a general sense that incorporates each of the "schools of thought" expressed in this research.

environment requires customized tasks and keeps standardization to a minimum. However, the nature of contract management in the health care field is extremely complex. Complexity can be managed through centralized authority, but this will inhibit the flexibility required by the organization to deal with the dynamic nature of the operating environment.

The best method of addressing complexity and dynamism is through the provision of decentralized authority to staff who have a good skill sets and are guided by strong common culture. Under these circumstances, strategic management becomes a very important tool to reinforce the common values driving empowered staffs' decisions. The strategic management approach should also reflect the need to respond to the environment.

Given the complexity of operations and the dynamic nature of the operating environment of the State Medicaid agency, the BSC is too formalized and too centralized to support efficient and effective operations. Using a BSC approach assumes a consistency of operations that allows tracking of metrics over time. In contrast, conversations with senior staff at OHP revealed that little consistency exists. When asked if there were traditional static processes that involved a cycle of implementation, monitoring, and feedback, the OHP Chief of Staff indicated that the State Medicaid agency component of ODJFS did not have sufficient consistency of operations to allow this traditional feedback cycle of strategic planning and management. Rather, she indicated that OHP staff used a project management approach that, in the Agency's assessment, had been fairly successful.

Furthermore, the BSC approach fundamentally assumes relationships that do not exist in government operations. BSC assumes a clear goal of profitability that has a correlation with the organization's ability to improve customer relations, internal business operations, and the culture of learning and growth. While government operations have sought to adapt these measures to focus on mission achievement, OHP, as the State Medicaid agency, is subject to competing goals and missions as discussed in the ***purpose of the Ohio Medicaid program*** analysis in this section of the report.

Furthermore, OHP's defined strategies are general and do not appear to focus on or be well matched to the stated goals.[37] Last, BSC's basic premise -- that performance has a clear link with customer relations -- is faulty in its implementation within Ohio Medicaid. As a contract manager of Medicaid purchased services, taxpayers, the General Assembly, the Governor, and recipients are all customers. These parties have competing goals for the Medicaid program,

[37] BSC does not list quality of life issues as a separate goal. Rather, it is included as part of strategy one which generally states that quality of life goals will be achieved with value purchasing strategies. OHP's BSC indicates that this will be primarily achieved through consumer education, enhanced care management, and interagency collaboration. Its BSC also has a strategy to improve the effectiveness of publicly funded health care systems, but this appears to be defined as expansion and revision of waivers, implementation of Medicaid administrative claiming programs, creation of interagency agreements, and reform of long-term care financing systems.

which negates the ability of OHP to achieve its mission through improvement of customer satisfaction.

The poor fit of the strategic management approach is evidenced by OHP's inability to fully implement BSC. The BSC plan and the underlying performance metrics and reported performance measures were not supported by quantifiable measures of strategic impact. Output measures were defined as those that measure the immediate result of operations or efforts. However, outcome measures have a direct relation to the core goals of the Medicaid program as identified in the ***purpose of Ohio's Medicaid program***. Alternatively, they refer to the core purpose of a support function. For instance, the core function of human resource management is to recruit, retain, or develop the skill sets of staff to meet the organization's value adding mission (see the discussion of ***information management and performance measurement*** for additional information of input, output, and outcome measures). **Appendix 3-E** presents a more detailed summary of OHP's strategic planning document and its subordinate strategic objectives and supporting performance metrics. It also presents a summary of the other Medicaid administering state agencies' strategic management and planning documents.

While OHP has been able to establish five strategies and several subordinate strategic objectives, it has not been able to adequately define quantifiable performance metrics on a consistent basis. As part of its strategic plan, OHP has identified 57 performance metrics. However, only 17, or 30 percent of these metrics are quantifiable and related to outputs or outcomes. Fifteen of those measure an aspect of output and two measure an aspect of outcome. OHP has identified the following strategies and supporting strategic objectives:

- Use value-purchasing strategies to afford consumers health plans that provide accessibility, network management, quality, and improved outcomes.
    - This strategy is supported by five subordinate strategic objectives measured by 9 performance metrics. However, none of these metrics were both quantifiable and related to output or outcome.

- Continually improve the effectiveness of publicly funded health care systems and expand integrated community service options for adults and children with disabilities.
    - This strategy is supported by three subordinate strategic objectives measured by 15 performance metrics. However, only one of these metrics was quantifiable and directly measured an output of the organization.

- Improve the effectiveness and agility of OHP's business operations and information technology through performance and project management.
    - This strategy is supported by six subordinate strategic objectives measured by 15 performance metrics. However, only one of these metrics directly measured an output of the organization.

- Continually improve cost management of OHP.
  - This strategy is supported by three subordinate strategic objectives measured by six performance metrics. Two of these measures were both quantifiable and measured an output of the organization. Another two of these measures were both quantifiable and measured an outcome of the organization.

- Continually enhance workforce excellence through proactive management, staff development, support, and recognition.
  - This strategy is supported by four subordinate strategic objectives measured by 12 performance metrics. Six of these performance metrics were both quantifiable and measured an output of the organization.

Strategies four and five appeared to have the most clearly defined performance measures. Only those items that had more clearly defined goals, or were of a more standardized and common nature (such as human resources management) were able to be measured. The nature of the operations of a contract manager is very complex and dynamic, which does not allow sufficient stability and standardization for measurement of operations as is required in the BSC strategic planning approach. Value adding activities such as policy or contract development are customized by nature and are very difficult to measure. Furthermore, several fundamental changes to the Medicaid program were incorporated into the BSC and implementation of new programs or fundamental redesign is difficult to measure. The current information management system also does not adequately collect information that is pertinent to the needs of a contract management organization's desired outcomes.

The inability of OHP to fully implement the BSC strategies does not negate the appropriateness of the strategies identified by OHP. Rather, the BSC approach to strategic planning is poorly aligned with the organization's needs and characteristics. It is the equivalent of the colloquial "square peg in a round hole." BSC is too centralized and too standardized to be implemented fully, therefore, in practice it was only loosely interpreted. Furthermore, the American Society for Training and Development (ASTD) notes that the primary disadvantage is the time and resource consuming nature of the BSC. Scorecard development requires the continuous identification of drivers and establishment of connections between financial and non-financial measures. Benchmarking comparisons must be made using reliable data with standard data definitions. This process is time consuming and creates an additional workload. In addition, the scorecard process is complex and, therefore, may take several training session or reiterations for employees to understand the approach. Top management must be supportive of the process, the costs, the time, and the workload involved, despite the cost of implementation.

Stakeholders commented during interviews on the limited use of metrics and the limited core competencies within Medicaid staff at OHP, the State sub-recipient agencies, and local agencies. A member of the Ohio Association of Health Plans remarked, "I think that theme of process versus outcome permeates the entire way they run the business. It's not just health outcomes. It's

provider directories. It's enrollment. You name it, it's the process that they are focused on." The member went on to say there was a need for ODJFS to examine industry best practices as it is not maximizing "the clinical expertise that the plans bring to this program."

A representative of a Federally Qualified Health Center and member of the Ohio Association of Community Health Centers said that few of the staff in OHP is familiar with federally qualified health centers which resulted in delays in enrollments as "there was no one who could answer our questions". For example, applying for a Medicaid provider number became a lengthy process "trying to get people to answer your questions before you could even complete the application, or knowing which application was applicable to what we had to do."

Concerns about the skill set within Medicaid were reiterated by a member of the Ohio Health Care Association who noted "there has been a lot of turnover of what I would consider key seasoned people at the state and at the JFS level …and they lack the knowledge base because they have not been there for the last 10 or 15 years."

A member of the Ohio Association of Medical Equipment Services expressed concern about the attitude encountered by saying:

> "At one of the meetings the message came down to this industry saying, "We're going to ratchet your costs down until you get out of the business and that's where we know the baseline is." So what message does that send as far as what kind of working relationship you are going to develop?"

During the interviews, several recipients and advocacy groups also commented on the level of skill and appropriateness of assistance efforts that they had encountered, particularly at the county level. The issue of staff turnover was also identified as an issue at the county level, particularly with the CDJFS offices. A member of the National Multiple Sclerosis Society shared "one of the biggest things I've seen is the rapid turnaround in the local levels of all the job and family services departments in each county and the knowledge of the services that are provided…they don't provide us information about the services that are available. They pretty much wait for you to ask for them." A mental health advocate with the National Alliance for the Mentally Ill shared the same assessment as to the "uneven quality in the training and in the expertise" of CDJFS staff. An advocate with the Universal Health Care Action Network reiterated these observations noting that "as long as the law is complicated, there will always be infinite training issues because there will always be turnover of case workers. The system shouldn't be dependent on experts."

The contingency framework (**Illustration 3-6**) presents alternative approaches to strategic management that may better match the needs of the State Medicaid agency's need to be less centralized and less standardized. One of these approaches is the strategic architecture approach. This school of thought is characterized by a concept of core competencies, and holds that strategic management should be pursued for the purpose of proactively developing these

organizational competencies. Core competencies are the collective learning in the organization, and an organization is conceived as a portfolio of organizational skills. Core competencies are a bundle of skills and technologies, rather than a single, discrete skill or technology. They make a disproportionate contribution to customer/stakeholder perceived value. This concept may be altered to a disproportionate contribution toward mission/goal achievement for public entities. The primary types of core competencies applicable to public entities are integrity-related competencies and functionality-related competencies. Integrity-related competencies refer to quality and cycle time management, to allow more flexibility and quality of end product or service. Functionality-related competencies refer to product or service match to customer/ stakeholder benefits or needs. One note of caution is that this approach requires a constancy of effort to assure the development of these competencies over a period of time. This, in turn, requires stability of personnel and wide acceptance of the identified core competencies.

Another strategic management approach, the strategic design approach, is of comparable or increased centralization, but less formal than strategic planning in that it defines strategies as patterns of decisions in a company and is largely determined by the chief executive. The patterns of decisions reveal the organization's objectives, purposes, or goals and produce the principal policies and plans for achieving those goals. They also define the range of activities the organization is to pursue, and the kind of economic and non-economic contribution it intends to make to stakeholders and society. It generally encompasses mission, vision, values, purpose, and goals and is a process that involves formulation and implementation of strategy, as well as evaluation of progress and results. Strategy is defined by the evaluation of the external environment for opportunities and risks, determination of the organization's internal resources and competencies, and filtered by the decision makers' or organization's values. One distinguishing difference between strategic management and strategic architecture is that the latter focuses on developing internal competencies as the end goal of strategy, while the former evaluates present competencies as a given for determining the plausibility of strategic options. The implementation process of strategic design involves aligning organizational aspects with strategy and includes: determining division of tasks, coordination of divided responsibilities, information systems design, standards and measurement, control systems, and human resources management. Evaluation of the effectiveness of the strategy formulation and implementation is continuous and is used to revise both implementation and formulation activities in the future. However, the evaluation is often based on measurements of operating and implementation activities, rather than direct measures of strategies as is customary in the BSC approach.

Although no model will result in a perfect fit with the State Medicaid agency, the agency can evaluate its needs and develop its own hybrid approach. This approach should reflect more decentralized spheres of authority to promote flexibility and responsiveness. Similarly, it should emphasize the customized nature of the services and required procedures of the State Medicaid agency and the rate of change involved. The strategic management approach selected should reflect these desired organizational characteristics.

R3.18 The State Medicaid agency should revise its approach to strategic management and select an approach that is more closely aligned with the nature of its operations. This will help mitigate the dynamic operating environment and the complex nature of its work. This does not negate the work already performed for strategic planning and may be used as a starting point for further strategic management efforts. The State Medicaid agency should consider using a strategic architecture or strategic design approach to ensure the required flexibility and empowerment of employees who exhibit core competencies.

Information Management and Performance Measures

OHP has limited data available for decision making as described in **technology and program management**. Similarly, the sub-recipient agencies use claims-driven information as the source of performance data which does not lead to effective outcome measures. A claims-based information system does not collect direct measures of outcomes related to improving the health of program recipients, and cannot indicate what benefit Ohio has purchased through its Medicaid program.

The concept of performance measurement, and therefore information management, is not a new concept in government operations. The Government Finance Officers Association (GFOA) recommends that financial, service, and program performance measures be developed and used as an important component of decision making and incorporated into governmental budgeting. These performance measures should:

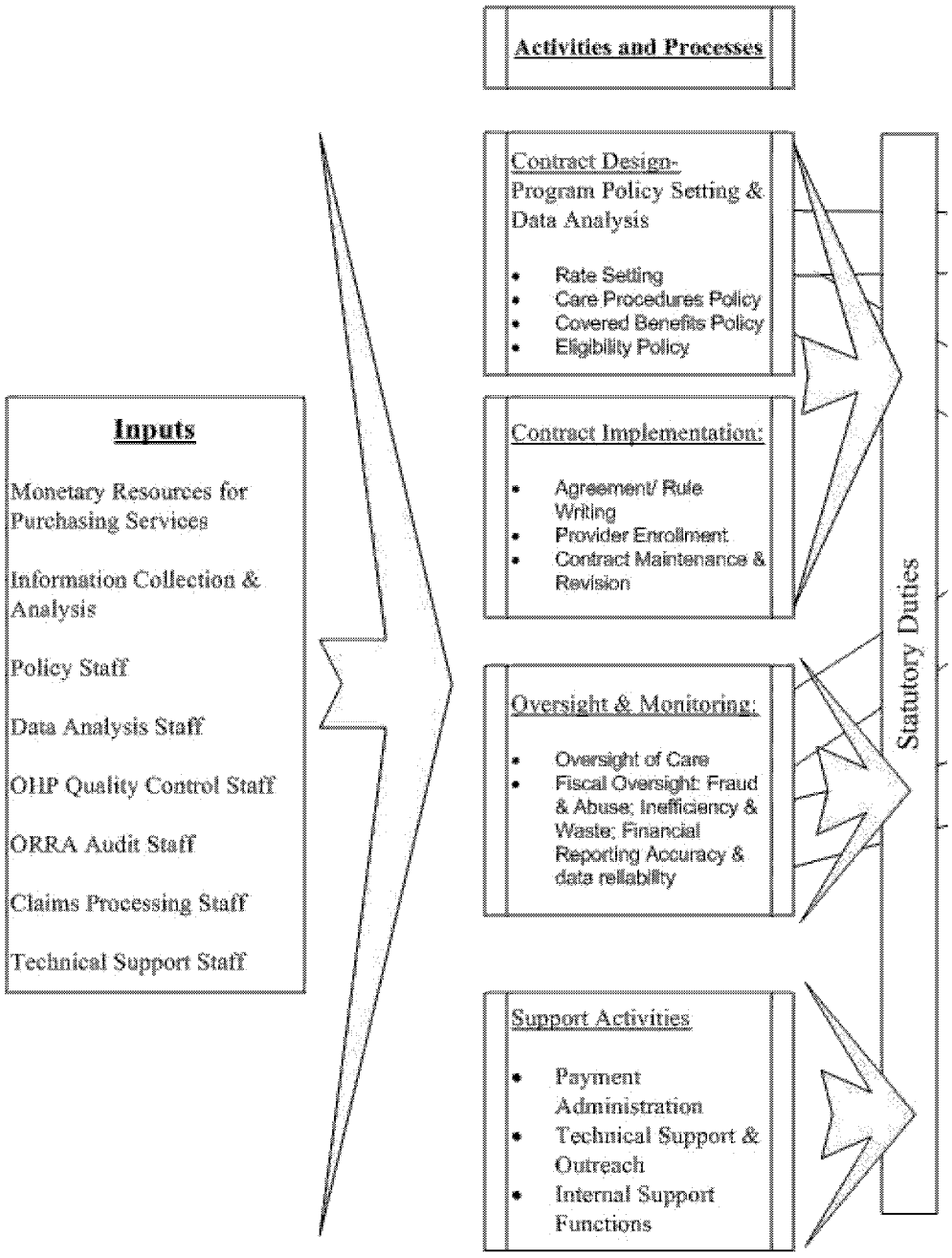
- Be based on program goals and objectives that tie to a statement of program mission or purpose;
- Measure program results or accomplishments;
- Measure efficiency and effectiveness; and
- Be reliable, verifiable, and understandable.

Implementing Performance Measurement in Government: Illustrations and Resources (GFOA, 1997) categorized performance measurements as measurements of inputs, outputs, and outcomes. Measures of input indicate the volume of resources that are used in the delivery of a program or service. Inputs may be both monetary and non-monetary allocations of resources. Monetary resources are measured in dollars, while non-monetary resources are measured in other appropriate units of measurement, such as full-time equivalent staffing allocations. Output indicators measure the quantity or volume of products/services provided by the program. Outcome measures indicate the results, accomplishments, or quality of the items produced or services provided by the program. Some measurement systems may further divide outcome measures into intermediate outcomes and long-term outcomes. For instance, a decrease in utilization may be an intermediate outcome for the long-term outcome of decreasing Medicaid costs. The terms efficiency and effectiveness indicate the relationships between inputs, outputs,

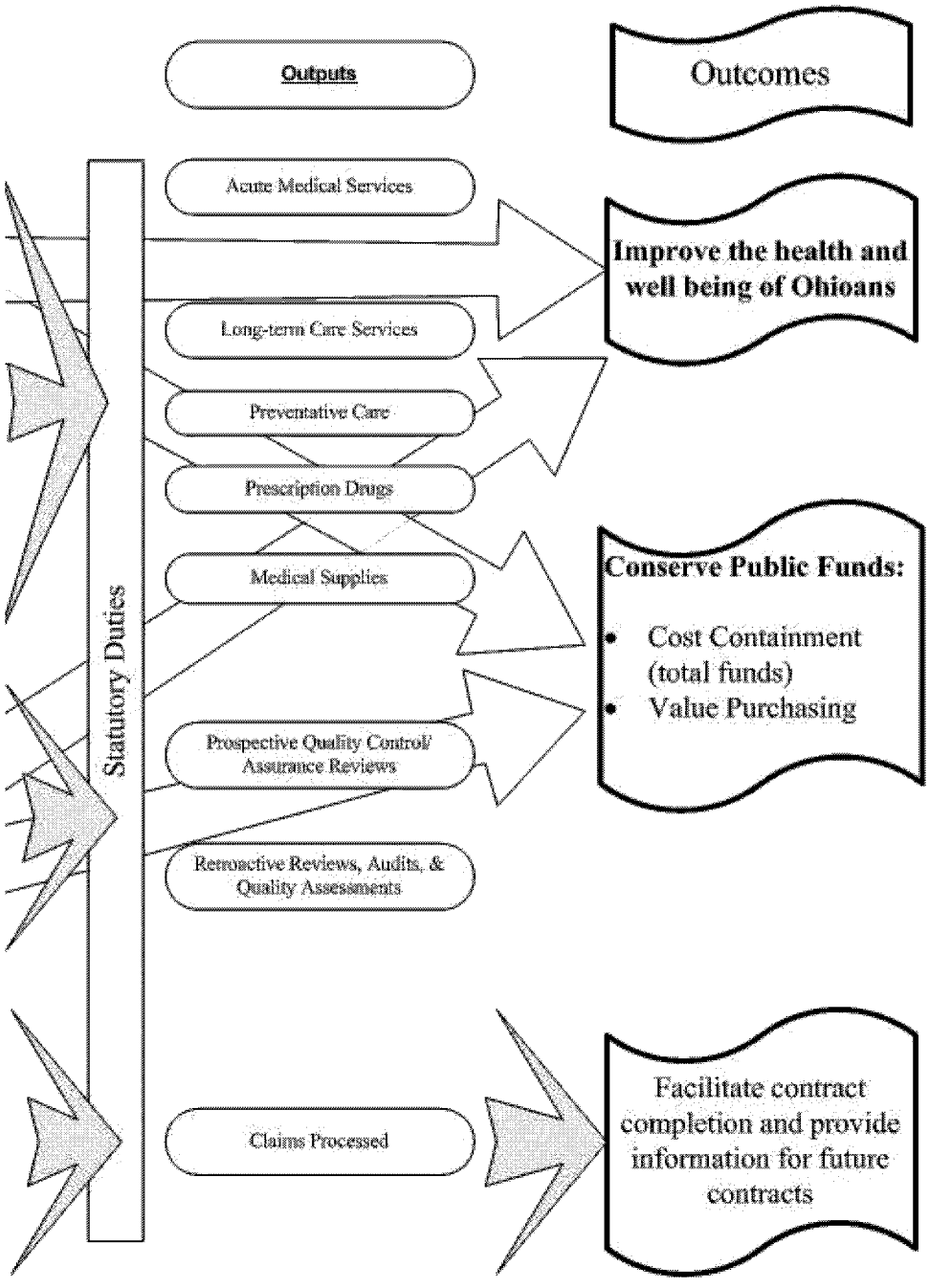
and outcomes. Efficiency refers to the ratio of inputs to outputs. Effectiveness refers to the correlation between outputs and outcomes, while cost effectiveness refers to the ratio of outcomes to inputs.

Design of a Corporate Performance Management System in a Devolved Government Organization (Lawrie, Cobbold, and Marshall; 2003) presents the response of the Environment Agency in the United Kingdom (UK) to difficulties it had in implementing a balanced score card strategic management approach that required a sophisticated performance measurement system. It provided an illustration of cause and effect relationships between inputs, outputs, and outcomes to assist the agency in developing a performance measurement system. This same approach is presented below to illustrate the State Medicaid agency's (OHP) inputs, outputs, and outcomes and is used to contrast against the current data sources used by the organization to measure its impact and track its progress for operational feedback purposes. **Illustration 3-10** presents ODJFS's Medicaid program inputs, activities, outputs, and outcomes consistent with the concepts described above.

Illustration 3-10: OHP Performance Measurement Model



Source: AOS interpretation of a strategic linkage model for OHP


Outputs
Outcomes
Acute Medical Services
Long-term Care Services
Preventative Care
Prescription Drugs
Medical Supplies
Prospective Quality Control/ Assurance Reviews
Retroactive Reviews, Audits, & Quality Assessments
Claims Processed
Statutory Duties
Improve the health and well being of Ohioans
Conserve Public Funds:
• Cost Containment (total funds)
• Value Purchasing
Facilitate contract completion and provide information for future contracts

As reflected in **Illustration 3-10**, ODJFS and OHP primarily add value to the Ohio Medicaid program by designing and implementing contracts for health care services and by fulfilling an oversight and monitoring role to ensure the contract is completed. While **Illustration 3-10** shows program administration inputs, such as OHP staffing, it should be noted that these are relatively insignificant in comparison to total program expenditures. The outputs of these activities are actual health care procedures, as well as reviews and audits pertaining to both fiscal integrity and quality assurance. Each of these activities is conducted for the purpose of achieving a long-term outcome of either improving the health of Ohioans or conserving public funds. However, as noted above, these outcomes can be further divided into intermediate outcomes. Outcome components of improving the health and well being of Ohio Medicaid recipients include:

- Improving access to health care;
- Improving the quality of health care; and
- Increasing the scope of health services.

Conversely, intermediate outcomes for conserving public funds might include cost containment with a focus on total expenditures, or value purchasing with a focus on improving the number or quality of outputs for a given amount of input. If one were to further explore cost containment strategies, one could further focus outcomes related to cost drivers such as utilization, price of services, and total enrollment. Decreasing the utilization of services would be a specific outcome that contributes to cost containment efforts. Value purchasing might be more narrowly focused to evaluate aspects of cost effectiveness, quality of services for a given cost, or even price control for commodity services.

The basic prerequisite for any performance measurement system is adequate data relating to inputs, outputs, and outcomes. This requires an active and conscious information management focus. The Medicaid Data Warehouse is the primary information system which supports goal setting and decision making for OHP. The Data Warehouse is a repository which collects data from other internal ODJFS systems and uses relational databases to manage the Medicaid program. OHP staff can access this repository of data through the Decisions Support System (DSS). The data contained in this system comes primarily from the eligibility system and claims or encounter data.

Claims Coding

Professional and facility claims forms and online instructions for completing them were reviewed to gain an understanding of the types of information collected through the claims submission process which may be analyzed and used for decision-making purposes. Each dollar spent in the Medicaid system is coded in several ways for categorization and summary of activities. The primary methods for coding claims are Current Procedural Terminology (CPT) codes, which identify the procedures and supplies doctors and other practitioners provided to

patients, and the diagnosis of the patient's ailment through International Classification of Diseases (ICD-9).

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) required CMS to adopt standards for coding systems that are used for reporting health care transactions. Thus, a standardized coding system called the Health Care Common Procedural Coding System (HCPCS) was developed by the American Medical Association to ensure that Medicare and other health insurance program claims are processed in an orderly and consistent manner. The HCPCS coding system comprises three unique levels of coding to identify items and services. The first of these levels refers to CPT codes, which are a list of descriptive terms and identifying codes (CPT codes) for reporting medical services and procedures performed by physicians and other health care providers. Inclusion of a descriptor and its associated five-digit code in the CPT book is based on whether the procedure is consistent with contemporary medical practice and is performed by many practitioners in clinical practice in multiple locations. The main body of the material in the CPT book is divided into six sections. Each section is divided into subsections with anatomic, procedural, condition, or descriptor subheadings. The main headings for procedures and services are as follows:

- Evaluation and Management;
- Anesthesiology;
- Surgery;
- Radiology;
- Pathology and Laboratory; and
- Medicine.

While this information does provide a detailed and logical system for coding services and medications, these are service volume and type measures (or outputs), rather than measures of health outcomes.

The International Classification of Diseases (ICD-9) is used to classify morbidity and mortality information for statistical purposes. The classification system is also used to index hospital records by disease and operation for easier data storage and retrieval. ICD-9 codes are used for coding and reporting the diagnosis and procedures for an encounter. Coding is a complex activity that involves transforming descriptions of diseases, injuries, conditions and procedures into numerical designations. Appropriate coding is a critical part of the claiming process. The ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) is divided into sections containing codes with either 3, 4, or 5 digits. Diagnosis and procedure codes are to be used at the highest level of detail possible. Codes with three digits are included in the ICD-9-CM as the heading of a category of codes that may be further subdivided by the use of a fourth and/or fifth digit which provides greater detail. The categories are generally based on ailment category or by the affected body system. The major categories are as follows:

- Infectious and Parasitic Diseases;
- Neoplasms;
- Endocrine, Nutritional and Metabolic, Immunity;
- Blood and Blood-Forming Organs;
- Mental Disorders;
- Nervous System and Sense Organs;
- Circulatory System;
- Respiratory System;
- Digestive System;
- Genitourinary System;
- Complications of Pregnancy, Childbirth, and the Puerperium;
- Skin and Subcutaneous Tissue;
- Musculoskeletal System and Connective Tissue;
- Congenital Anomalies;
- Conditions in the Perinatal Period;
- Symptoms, Signs, and ILL-Defined Conditions; and
- Injury and Poisoning.

ICD-9 codes provide a logical and detailed method for categorizing ailments and conditions requiring medical treatment. Taken together with CPT codes discussed above, claims based data can provide information on what services were provided and why. However, claims based data cannot provide information on the result or health outcomes of these services and, as the sole means of measurement, are insufficient to provide full decision-making data to program administrators.

Using Data to Analyze Program Operations

As the primary data collected for the Medicaid system is based upon claims and encounter submissions, OHP's ability to analyze revisions to programmatic policy or contract provisions can not be determined. Claims are primarily concerned with collecting the quantity and type of services charged, the cost of such services, and the condition of the recipient that precipitated such services. This allows OHP to track inputs into the Medicaid program in terms of monetary resources distributed for service charges. Furthermore, this allows OHP to count the number and type of services with CPT codes, which are congruent with **Illustration 3-10** output measures. Finally, it allows collection of information related to why the services were required through ICD-9 codes. This information would allow OHP and other oversight organizations to review the appropriateness of services in relation to recipient conditions. This might be used to evaluate if fraud, abuse, waste, or inefficiencies exist in matching services to recipient needs. It might also be used to group individuals into ailment populations. This would be valuable in combination with service (output) data and health indicator (outcome) data to evaluate treatment effectiveness. However, outcome data is not included with this information.

In addition to claims based data, OHP uses normative benchmarks from other sources for policy analysis, including:

- Medicare fee schedules and pricing methodology;
- Health Care Cost Review- a publication presenting economic indices;
- Global Insight Inpatient Hospital Market Basket- provides inflation factors for a variety of payers;
- MarketScan- a database of claims, encounter, and eligibility data for the privately insured population over time;
- Health Plan Employer Data (HEDIS)- standard quality of care and access measures;
- Diagnostic Cost Grouper- provides measures used to evaluate providers and/or health plans adjusting for differences in underlying risk of patient populations and supports predicting future health care costs;
- Disease Staging Methodology- method of measuring the severity of specific diseases and the stages of those diseases based on clinical characteristics of the disease without considering the treatment or resources consumed; and
- Episodic Grouper- condition focuses grouping of related health care services over a specified period of time to provide a picture of cost and treatment.

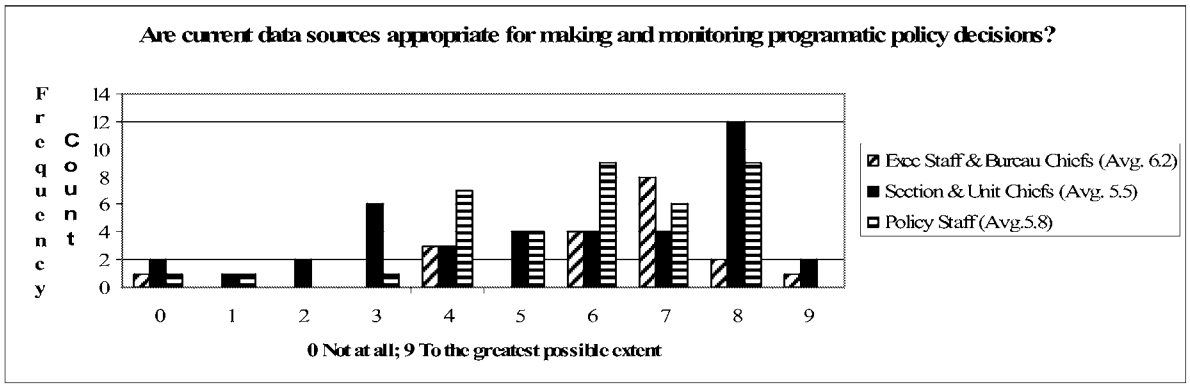
The above information sources provide some measures of outcomes related to conserving public funds, but long-term measures of outcome are incomplete. For instance, cost containment can be evaluated from current claims data as it is related to limiting the total cost of Medicaid. But value purchasing goals pertain to achieving value for a given input. This cannot be evaluated because the cost effectiveness (outcome/input) relationship cannot be established without health outcome data.

No direct measures of health are maintained beyond reactive measures of service usage. For example, morbidity may be evaluated based on claims data, but this is a lagging indicator of health and well being. Leading indicators such as blood pressure, blood sugar, or other measures are not collected. With the exception of HEDIS measures and outcome data collected by the behavioral healthcare system, there are few information sources employed by Ohio Medicaid that directly measure the desired outcome of improving the health of Ohioans. But the nature of this rating system is based upon the assumption of effectiveness of select inputs, such as diabetes care, with long-term health outcomes. But this does not firmly link the assumed health outcomes with the inputs related to the cost of services. However, it should be noted that a portion of the intermediate outcome measures might be evaluated. For instance, access to care could be evaluated based on the number of recipients and the number of providers maintained in the Data Warehouse. Similarly, utilization data could be calculated based on the number of claims per eligible recipient. However, since direct measure of health outcomes are not maintained in this system, the available measures of inputs and outputs allow for an assessment of programmatic efficiency indicators, but limit management's ability to assess effectiveness and cost effectiveness of its operations.

Making programmatic policy decisions is information intensive and highlights the importance of actively managing information collection, data reliability, and data analysis efforts. Conversations with policy staff in bureaus with contract development or programmatic policy development duties revealed an inconsistent use of data for decision making, likely the result of insufficient data being collected and maintained. Although OHP conducts impact analysis for proposed changes to the Medicaid plan, these assessments appear to have a greater focus on the estimated cost effects. According to the Bureau of Community Access, impact analysis is focused on providing feedback to the legislature about the estimated dollar impact of policy changes. This could be explained by heightened interest in cost containment strategies given current fiscal conditions, but it might also be explained by the lack of current and historical health indicator data that might allow an analysis of health effects. Furthermore, while prospective impact analysis is considered, there appears to be a lesser emphasis on a formal methodology for tracking actual program impacts against expected impacts. The Bureau of Home and Community Services stated that there generally is not a formal evaluation process, because it is based around the biennium budget which is too short a time period for evaluation. The bureau tries to evaluate results on an on-going basis and quarterly, but this is an informal process focused on problems with immediate implementation, rather than long term issues. In effect, because it does not have outcome data, the State Medicaid agency is unable to make policy decisions that incorporate information regarding the program's effectiveness and cost effectiveness. It is essentially unable to evaluate the extent to which it can improve health outcomes and well-being for the efforts and resources invested. However, OHP's internal perception is that it has sufficient information for programmatic policy decisions despite having no direct measures of health outcomes.

Chart 3-20 presents OHP management and policy staff survey results to questions pertaining to the adequacy of current information sources.

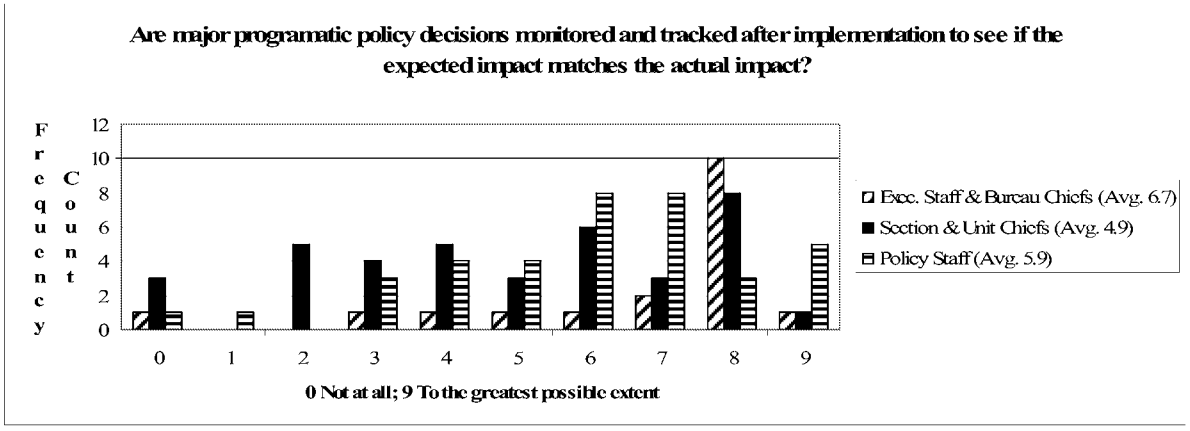
Chart 3-20: OHP Management and Policy Staff Perceptions Regarding Sufficiency of Information Sources



Source: Survey of OHP staff
Note: This question had a response rate of 59 percent.

Chart 3-21 illustrates OHP management and policy staff survey results relating to its ability to track expected programmatic change effects against actual effects.

Chart 3-21: OHP Management and Policy Staff Perceptions of Monitoring the Impact of Programmatic Changes



Source: Survey of OHP staff
Note: This question had a response rate of 56 percent.

Chart 3-20 shows that executive and policy staff feel that information sources are sufficient to monitor the program and make decisions. Executive staff was skewed more positively while policy staff rated these areas lower. However, section and unit chiefs were widely distributed in their answers Similar results were obtained for monitoring and tracking program impacts after changes (**Chart 3-21**), with section and unit chiefs being widely distributed on this issue as well. Policy and executive staff answered in a manner similar to **Chart 3-20**.

It should be noted that OHP and some parts of Ohio Medicaid are not alone in their lack of outcome-based information. Public health care as a whole has not fully embraced an outcome-based approach, largely because of the difficulty and time periods involved in collecting such data. Perhaps that explains OHP's internal perception that its current information sources are sufficient for decision making purposes. This might also be explained by OHP's greater focus on cost containment outcomes than health outcomes.

The Florida Agency for Health Care Administration has attempted to incorporate outcome measurement into the State Medicaid program. Currently, Florida issues an annual performance report publishing the results of 58 outcome based measures covering five populations including:

- Pregnant women and women seeking family planning services;
- Children;
- Non-disabled, working-age adults;
- Disabled, working-age adults; and
- The elderly.

However, Florida also relies primarily upon claims data without supplementing it with direct leading indicators of recipient health condition. Therefore, its outcomes generally involve measures of mortality and morbidity.[38] However, Florida is moving toward maintaining electronic health records for its recipients. In June of 2004, the Health Information Advisory Board was appointed by Florida's Governor to advise on the implementation of the Florida Health Information Network. The primary goal of this initiative is to provide additional information at the primary point of care on past treatments. Its applications could also be used to support policy decisions. Florida plans to collect information from physicians and providers, hospitals and institutions, laboratories, and pharmacies.

Indiana is in the early stages of developing an information management program entitled Quality Health First. Quality Health First tracks health care results, lab notes, general health information, and several thousand health-related pieces of information for Medicaid, Medicare, and private insurance agencies. The information collected by Quality Health First is used for research, patient care, health center operations, and payment (and aligns with HIPAA requirements, thereby complying with Federal privacy requirements). At the doctor's office, hospital, or participating data source, patient consent forms explain how the information will be used. The goal of the Quality Health First work is to improve health care through incremental quality improvement. It provides clinical observations from laboratories, radiology centers, hospitals,

[38] The morbidity rate is the incidence or prevalence of a disease or of all diseases in a population (incidence rate or prevalence rate). The mortality rate is the percentage of deaths associated with a disease or medical treatment (death rate).

and other providers with clinical data from physician offices and claims data from payers. This is accomplished with Logical Observation Identifier Names and Codes (LOINC) which allow for common coding of laboratory results. With this foundation of information collection, it is then able to develop quality measures that seek to make a clear and compelling evidence-based link between the process measured and patient outcome. The manager of the program, Indiana Health Information Exchange, collects membership and primary care provider information, medical and pharmacy claims, and relevant clinical data which is matched to patients. It then produces reports or databases for health plans (both private and public) and physicians using metrics and definitions approved by participant representatives. Health plans use this information to develop quality incentive payment plans. The Indiana Health Information Exchange also collects incentive payment information from health plans to provide quarterly reports to each physician and physician group, summarizing the incentives paid under the pay for performance initiative. With this data, the program director hopes to enhance the quality performance measurement of health care providers by assessing incremental improvements and enhancing data sharing among providers.

Israel's national health program also presented innovative information management practices at the 18th Annual National Managed Health Care Congress held in Washington D.C. in April of 2006. The Israeli system lists information such as the patient's historical symptoms, sensitivities, laboratory results, diagnoses, medications, and other health information. This has allowed their health system to increase patient safety through lower risks of medical errors while increasing the efficiency of the care cycle. It has also reduced the cost of the medical program by allowing an increased focus on preventive care and reducing unnecessary testing, treatments, and medications. Finally, it allows for more data-driven policy making.

Health outcome data can be obtained in a number of ways. The most complete, but most costly to implement would be the retention of electronic medical records (EMR) for every Medicaid recipient in Ohio. An EMR is defined as the set of databases (or repositories) that contain the health information for patients within a given institution or organization. Thus, an EMR contains data gathered from a variety of clinical service delivery processes, including laboratory data, pharmacy data, patient registration data, radiology data, surgical procedures, clinic and inpatient notes, preventive care delivery, emergency department visits, billing information, etc. OHP and other participating Medicaid agencies have not developed a method of obtaining EMR information from providers with those capabilities. (See **information technology and program management** for additional information on EMRs and EHRs.)

EHR (electronic health record) extends the notion of an EMR to include the concept of cross-institutional data sharing. Thus an EHR contains data from a subset of each institution's EMR (that is agreed upon by the institution). An EHR may also reside "entirely within one institution" and link the various affiliated practice sites together. The EHR is generally patient focused and

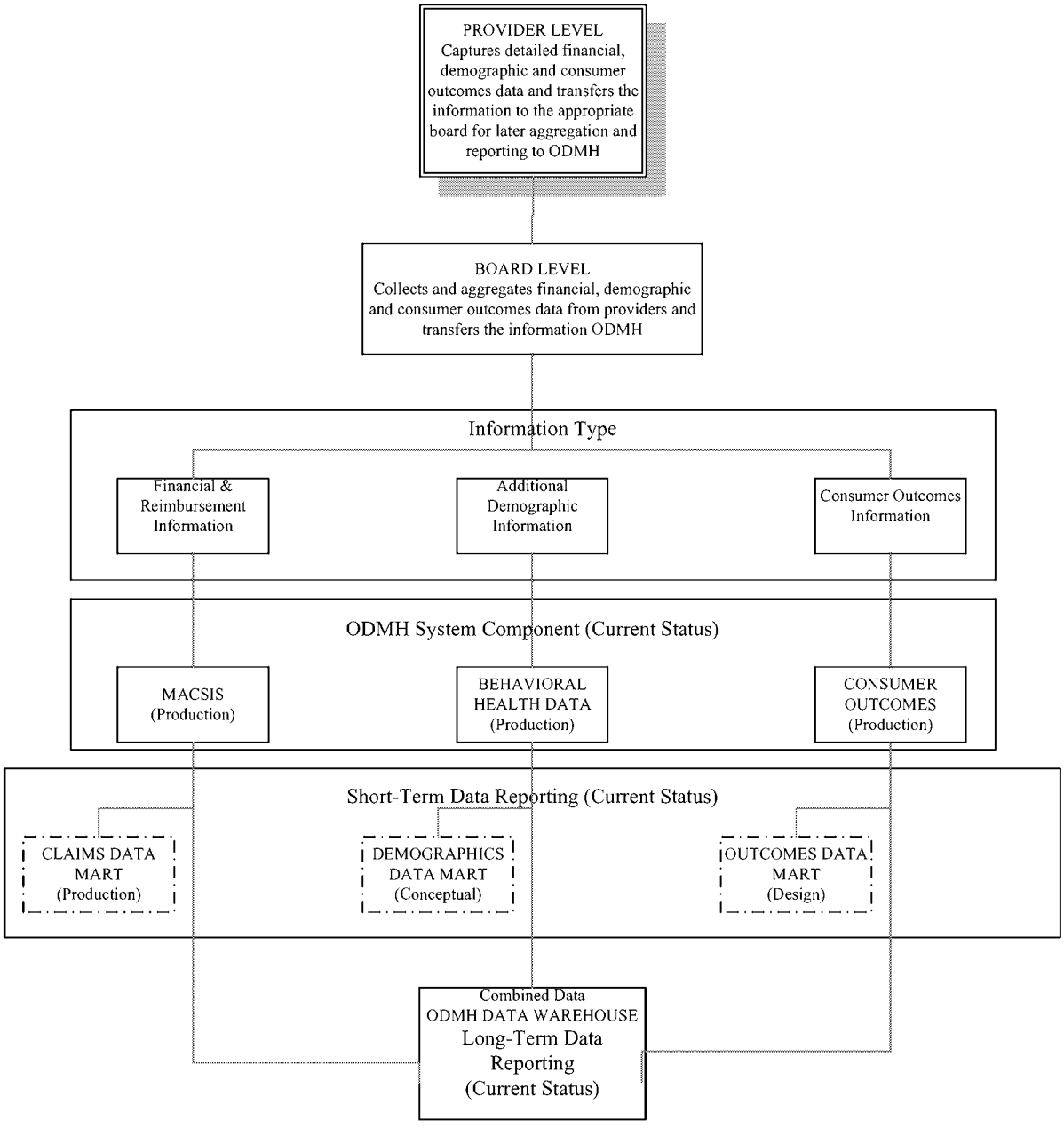
spans episodes of care rather than a single encounter. An EHR can only be present if the participating sites all have EMRs in place that are interoperable.[39]

The State Medicaid agency should also evaluate other less extensive information management improvements based upon an assessment of its needs for programmatic policy development/ contract design activities. Its needs are both prospective (forward looking) and retrospective. OHP, the sub-recipient agencies, the Executive Office, and the General Assembly require information to evaluate the expected impact of programmatic changes as well retrospective information to determine the actual impact. The actual impact is important, not only to temper future decision making with experience, but also to evaluate the prospective methodology used in policy analysis. The State Medicaid agency might alternatively seek to use statistical sampling techniques to evaluate a material change in programmatic policy on the sample prior to full scale implementation. Or, it might seek to compare the outcome measures of health and well being of a sample of the entire population for comparison against a placebo group. While these techniques would require significant additional staff with specialized skills, it is important to note that administrative costs are a very small portion of the total cost of the Ohio Medicaid program. The cost to make improvements in contract design provisions may be offset by widespread small incremental improvements due to the scale of the program.

Perhaps the best example of alternative methods of collecting outcome data is right within Ohio. ODMH has implemented an outcome based performance measurement system designed to measure the clinical status, quality of life, functional status, and health and safety of its service recipients. This information is used to manage consumer care, improve the service delivery system and to account for public resources. Clinical status measures are based on a self-reported instrument that attempts to measure the level of distress of the individual on a 15 point scale based on the severity of the psychiatric symptoms. Quality of life measures are based on a questionnaire to recipients pertaining to physical health, medication concerns, and perceived stigma of their afflictions in the agency and the community. The functional status measures ask the provider's staff to rank the individual's ability to function within society based on measures of perceived social interest, social network, ability to manage money, independence in daily life, housing stability, participation in meaningful activities, the effect of any addictive or compulsive behaviors on function, criminal justice system involvement, and general overall role performance. Finally, safety measures are based on questions to the clinician's perceptions of the individual's propensity to harm themselves, others, or victimization. While ODMH's measures reflect goals that are more advocacy driven than may be appropriate for the State Medicaid agency, these practices serve as an example of how information can be gathered through alternative methodologies, which may be less information architecture intensive than electronic health records. **Illustration 3-11** presents how this information is incorporated into ODMH's other information sources such as claims data.

[39] It should be noted that if an EHR approach is implemented, that it will be limited to current recipients. Therefore, if information is needed regarding the health impact of reductions in eligibility, additional data collection may be required.

Illustration 3-11: ODMH Information Management System



Source: ODMH Consumer Outcomes System Procedural Manual

Because it does not collect data on comprehensive health outcome measures, the Ohio Medicaid program does not have data to measure the benefits of various services, nor can it support its efforts to make incremental improvements in the quality of the health of its recipients. Similarly, it is unable to evaluate the correlation of service expense to the benefit of those services. Therefore, its information is limited to measures of efficiency that use only the relationships of inputs (funding) and outputs (units of service). However, the Ohio Medicaid program, and more specifically the State Medicaid agency, is unable to measure the results of these services in relation to their cost (cost effectiveness) or correlation of outputs to outcomes (effectiveness). The limited pool of measures is likely related to the antiquated information system and changes in the past two decades to the types of information used for decision-making. As the State Medicaid agency and many of the sub-recipients and local agencies have not progressed in their measurement efforts, data driven decision-making is limited at best.

R3.19 The State Medicaid agency should evaluate and manage its information needs based on its desired end goals and outcomes. It should seek to implement the necessary information collection infrastructure that would permit outcome measurement. This may include the implementation of electronic medical records or internal labor intensive methods to estimate outcome measures. The State Medicaid agency should ensure that it implements future information systems that can achieve its desired outcomes and clinical measures.

Human Resources Management

> "In the end, agencies are people and you can have four different agencies or you could have one agency, you could have it under the same configuration, but in the end, it's about people. If you don't have the right people running agencies, it really doesn't matter. You could have whatever structure you want, but it's the people that you recruit. It's the values that they bring. It's the vision that they have that really matters."
>
> *Member, Ohio County Behavioral Health Authorities*

> "You would have thought they put that [their 1-800 number for customer service] on a letter: They don't, they don't want to be questioned. They don't want that. They don't want a bunch of mad people calling them and cussing them out because you know a lot of them would."
>
> *Member, Ohio Federation of the Blind*

> "And they [caseworkers] act like the money is coming out of . . . their own personal pocket".
>
> *Member, Ohio Federation of the Blind*

This assessment reviews human resource management from the perspective of the contingency framework discussed in the ***operating structure of the Medicaid agency*** and ***strategic planning and management framework*** discussions. This framework indicates that the State Medicaid agency's (OHP) operations are extremely technical and complex. These factors either require significant centralization of decision making authority into individuals with sufficient expertise, or a close match of employee skills with position skill requirements to allow decentralized

decision making. Given that the environment is also dynamic, which requires a flexible organization, it is imperative that OHP effectively manages its skill sets to ensure that it meets its operational needs in a manner that enables management of the competing pressures of dynamism and complexity. In contrast, a survey of OHP staff appears to indicate that OHP has relatively centralized decision making authority residing primarily with senior managers and policy staff.

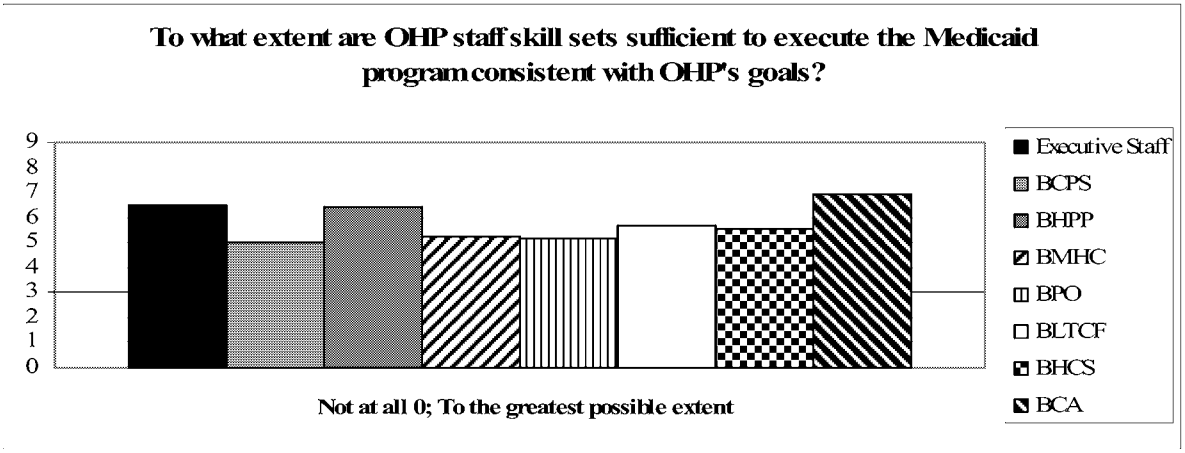
Based on **Chart 3-15**, executive staff, bureau chiefs, and policy staff perceive the centralization of decision making within OHP to be appropriate. While it is natural for some levels of authority to be centralized at more senior levels, the survey question asks if this centralization is appropriate, rather than if it is centralized. Section chiefs, unit chiefs, and other staff scores are below the midpoint and much more diverse, indicating that centralization limits their input. Overall, 46 percent of those surveyed were dissatisfied with OHP's centralization of authority. Sixty percent of other staff and 45 percent of section and unit chiefs expressed some dissatisfaction, and 27 percent of policy staff and senior staff expressed dissatisfaction.

According to *How Organizations Create Social Value* (Salls, 2005), obtaining the right people with the right skills to enhance economic and social value creation includes the following activities:

- Recruiting and retention processes should be centered on closely-held values;
- Organizational learning should be promoted in a manner that bridges individual and organizational development (many successful organizations use advisory boards as sources of critical skills); and
- Excellence in management should be integrated with mindfulness of social values.

According to the Human Resources (HR) Director, ODJFS has one of the most complex Human Resources offices in State government with 269 employee classifications. OHP had, at the time of reporting, 489 staff with a fiscal ceiling or authorization level of 494 positions. ODJFS has changed from a key hiring practice of assessing primarily knowledge, skills, and abilities to more competency-based testing. The identification of core competencies for each classification was the result of a job analysis that identified favorable personality characteristics and soft skills needed for the position. According to the HR Director, the Agency uses test instruments from Lominger Limited, a leading research and experience company specializing in leadership development tools and applications designed to improve organizational systems. Although more emphasis is placed on competency requirements, ODJFS has not evaluated the necessary technical/analytical skills needed for each position within OHP. The HR Director reported that no formal assessments have been performed to identify gaps between current skill sets and those needed for job success within OHP. **Chart 3-22** summarizes the perceptions of OHP management and policy staff by bureau concerning their perception of internal skill sets relative to those needed.

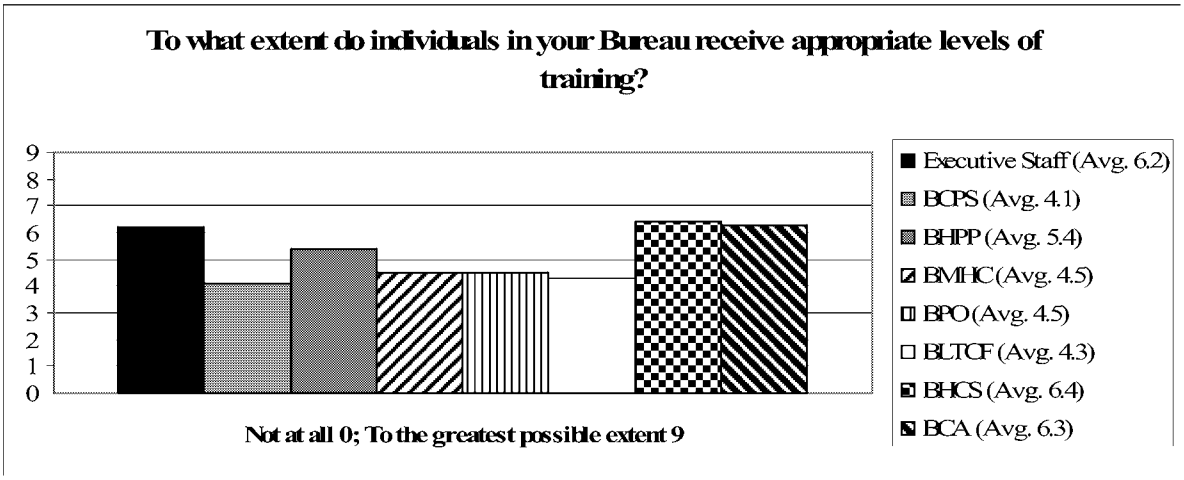
Chart 3-22: OHP Management and Policy Staff Self Perception of Skill Set Adequacy by Bureau



Source: Survey of OHP staff
Note: This question had a response rate of 57 percent.

While OHP's average perceptions are slightly above the scale's midpoint, a significant portion of respondents did not feel that skill sets were adequate. Overall, 23 percent of respondents did not feel skill sets were adequate to some degree. However, there is a wide degree of variance between bureaus. While executive staff, Bureau of Health Plan Policy, Bureau of Home and Community Services, and Bureau of Community Access reported relatively high levels of satisfaction; 43 percent of Bureau of Consumer and Program Support respondents, 50 percent of Bureau of Managed Health Care respondents, 46 percent of Bureau of Plan Operations respondents, and 40 percent of Bureau of Long-term Care Facilities respondents indicated dissatisfaction with current skill sets. Furthermore, respondents indicated that they were not receiving sufficient training to rectify any skill set deficiencies. **Chart 3-23** presents responses from a survey of all OHP staff concerning the sufficiency of training activities.

Chart 3-23: OHP Staff Self Perception of Training Adequacy



Source: Survey of OHP staff
Note: This question had a response rate of 28 percent.

Chart 3-23 illustrates a mild dissatisfaction with current training efforts. While executive staff, Bureau of Home and Community Services, Bureau of Community Access, and Bureau of Health Plan Policy exhibited average responses indicating moderate satisfaction exceeding the rating scale's midpoint (4.5); the remaining bureau's average satisfaction rating was below the scale midpoint. Overall, 37 percent of respondents expressed dissatisfaction with employee training to some extent; while 64 percent of respondents with Bureau of Consumer and Program Support, 47 percent of respondents within the Bureau Managed Health Care, 50 percent of respondents within the Bureau of Plan Operations, and 53 percent of respondents within the Bureau of Long-term Care Facilities expressed dissatisfaction with training efforts. In contrast, the Bureau of Home and Community Services and Bureau of Community Access expressed high levels of satisfaction. Training is particularly important given that almost 38 percent of survey respondents reported tenures with OHP of less than two years, and 50 percent of survey respondents reported tenures with OHP of less than five years.

Finally, OHP historically has been restricted from recruiting qualified individuals due to its inability to make hiring decisions on a timely basis. One of the primary human resource management problems with regard to OHP has been hiring time. The lack of priority placed on selection, coupled with high turnover rates, can lead to cascading issues of employee instability and low morale. In recent years, OHP has consistently operated with approximately 70 to 80 vacant positions; although recently that figure has dropped to below 50. In 2005, OHP posted and filled 151 positions.

According to the HR Director, in the past, OHP hiring managers required up to 90 days to fill vacancies after receiving applicant information from the HR Department This was particularly problematic since the Agency only retains applications or résumés for four months. If no action

has been taken in that time, applications are discarded. In the past, long processing times and delays would often result in lost candidates. However, this appears to be improving with efforts underway to streamline the process. The HR Director stated the average hiring time is now 47 days.

In response to these shortcomings, ODJFS created a new Talent Development Unit. The HR Director said this unit will hire at least two career development counselors. The Agency has also added two organizational development consultants. Based on the job posting, duties for these positions will include workforce planning to guide and assist the agency in improving organizational productivity, culture and overall performance. The organizational development consultants will be responsible for assessing future workforce needs and leading efforts to design and implement workforce strategies, change initiatives, reorganization, staff deployment, succession management and systemic issues driving workforce change. It is unclear how the role of the Agency's newly hired organizational development consultants will intersect or overlap with changes currently underway in OHP. This represents a key manifestation of the larger systemic issues surrounding what appears to be a failure to base effective decision-making on sound planning and on the important principles of human capital management and organizational transformation.

Recent changes in human resources practices within ODJFS have largely been the result of an employee survey which was administered approximately a year and a half ago. The purpose of the survey was to gauge employee perceptions of human resources management within the Agency. The survey was created in response to OHP's strategic plan that incorporated aspects of human resources management.

This assessment uses the term succession planning in a holistic manner which encompasses not only the traditional meaning of top executive succession, but also more general organizational skill set management. Recruitment and retention practices are critical elements of good succession management - an area that the HR Director stated ODJFS would like to enhance. This will be one of the duties of the internal organizational development consultants. The HR Director further indicated that the HR Department has identified the employees within OHP who are eligible for retirement in each of the next five years. However, there is little evidence to suggest that comprehensive succession planning takes place, particularly with regard to leadership positions. For example, no one was being groomed to take over the Deputy Director position at the time the former OHP Deputy Director departed. Once the Assistant Deputy Director, Chief Operations Officer was named as interim Deputy Director, a nationwide search was conducted for a permanent replacement. The search ended with her permanent appointment as Deputy Director which represented a shift in thinking on the part of Agency leadership.

According to the American Society for Training and Development (ASTD), a good replacement planning program is a key component of continuous improvement efforts. Succession, or replacement planning normally focuses on replacements for specific top positions. Organizations should be asking two key questions about succession planning:

- Do we have qualified people ready to fill key positions and grow or sustain business operations in the next three to five years? (Short-term emphasis); and

- Will we have a sufficient number of qualified candidates ready in five to 10 years to fill key positions? (Long-term emphasis)

While there is no one system which meets every need, every organization should develop and practice its own well-constructed and meaningfully executed succession management program. According to ASTD, a good succession planning program is part of any continuous improvement effort. Succession planning is a dynamic process too often given curt or dismissive treatment when regarded as a function of HR alone. However, high-impact succession planning is a continual leadership optimization process with the goal of avoiding costly mistakes in hiring the wrong person for a key position. Effective succession planning results in a talent pool with the skills, attributes, and experiences needed to fill specific leadership positions, as well as the cultivation of a talent pipeline to meet emerging leadership needs. Succession and development processes that are rooted in best practice principles that contain the following components:

- All levels of management, from the Director/CEO to the front-line supervisor are accountable for ensuring a strong leadership bench. Given that strong leadership is a strategic driver of success, many organizations link a manager's demonstrated ability to develop others to their compensation package.

- Development of the next generation of leaders is achieved primarily through sculpting challenging assignments and "stretch jobs" supported by coaching, mentoring and action learning (such as bringing high-potential individuals together to work on a pressing issue). This forces emerging leaders to look beyond their functional silos to solve strategic problems and, in the process, learn more of what is required of a general manager.

- Investment of resources differentially among high-performing employees in order to develop a talent pool with the appropriate skill sets and experiences. While all talent is valued and affirmed, money and time are limited resources that need to be invested where the greatest return can be leveraged. Attention is paid to poor performers with the intention of improving them or moving them out of the organization.

- Identification of young promising leaders is equally focused through the provision of experiences of increasing scope and responsibility.

- Managers are informed where they stand on the performance and potential continuum as well as what is needed in order to advance.

- Succession and development processes are simple and tailored to the organization's unique needs. They are constantly being improved to fit the strategic business challenges, aligning talent needs with business requirements.

- There is a clearly defined leadership success profile that articulates the skills and behaviors necessary for success in specific jobs at specific levels. There should be three or four non-negotiable aspects of talent, know-how and experience that are critical to meeting the organization's strategic needs.

- Jobs that are critical to overall organizational success are often found in established parts of the business and have clearly developed performance and experience criteria, as well as a pool of potential successors whose experience and track record would make them viable contenders for the position.

- The inclusion of outside third-party assessments is often incorporated into succession and development processes to provide a complete and accurate profile of a candidate's readiness for a specific position.

According to *Succession Planning* (ASTD, 2000), a comprehensive succession planning program can be implemented by conducting the following five basic activities surrounding succession planning:

- **Replacement Planning** – The primary component of a succession planning system is the identification of replacement personnel. Replacement identification should include an evaluation of the quality and readiness of named successors.

- **Human Resources Audit** – The second component in a succession planning system is the human resources audit. This builds on the identification of successors and addresses assessment of employee mobility to various positions. The human resources audit is conducted by each manager wherein each direct report is reviewed in terms of time in current position, performance, readiness for advancement, potential to move to a new position, and development required. This plan ensures that all employees are reviewed whether they are successors or not, alleviating management's concerns that succession planning is an elitist program that ignores the development of all employees.

- **High Potential Employee Identification** – Experts recommend including a high-potential identification process for selecting next generation leaders. The definition of a high-potential employee is someone who can move into and perhaps above a particular level in the organization. This definition becomes increasingly selective by identifying

necessary competencies associated with certain positions. The following are considered critical competencies of high-potentials: results driven, people skills, mental ability, lifelong learning, integrated thinking, flexible, and energy.

- **Employee input** – The fourth component of a succession planning program is employee input via a career development process. Succession planning must respond to workforce demands and this includes employee input. Such responsiveness is a vital link between HR planning and business strategy. Employees list career interests, qualifications, and willingness to relocate on an input form. The form should then trigger a career development discussion between the manager and employee.

- **Development programs** – The fifth component of succession planning is the design and implementation of career development programs. As a result of the accelerated rate of change, development is becoming increasingly critical. Organizations need more people faster who are ready to fill key positions. The skills needed for positions are changing so rapidly that people cannot keep up without having planned development. Many organizations use leadership development programs to fast track high-potential employees.

Turnover and limited opportunities to cultivate the skill of workers was reflected in a high number of stakeholder comments surrounding communication, attitude, level of assistance, and basic knowledge. The comments were not restricted to OHP and covered the State sub-recipient agencies and local agencies as well. Provider comments shared during stakeholder interviews centered on concerns over incorrect information and unprofessional customer service. A member of the Ohio Council of Speech and Hearing Administrators said, "I think the issue in general seems to be the reliability and accuracy of the information you get when you call someone and how that information jives with regulations, written authorities." Other members of the Council described customer service issues and reported reporting a lack of responsiveness by OHP:

> "[It] is very frustrating … to direct a staff member to call Medicaid provider relations and they sit on the phone. That line is active for an hour, two hours only to be followed by "click" because it was lunchtime. "Click" because it was 4:30. And they just never get to you…. Call it uneven or inconsistent guidance. ..So I could take information from here and take it back to my place and it's wrong for me. For the type of center you are. We don't really have access to a "frequently asked questions" [document]."

Stakeholders noted confusion on who to contact for assistance, and frustration over receiving contradictory directions. A member of the Ohio Association of Community Health Centers (OACHC) noted "I'm not sure what it is but you never get the same answer." Other members of the OACHC included, "…Then the people that you speak to get attitudes … they don't want to be told that they're giving you the wrong answer but after they look into it, they really are not giving you the… correct answer, and I'm getting denial from Medicaid… denials that are not our errors."

A member of the Ohio Association of Nursing Homes remarked:

> "The Department of MRDD seems to be very, very small. It takes a long time for a further review to get done to allow someone to come into a nursing home. …[For MR patients] there is nowhere for them to go…. So there is this poor younger MR person who was living with an elderly parent, and the elderly parent recently passed away. She has no one. Now, she's stuck in the hospital until they can discharge her to someplace. "

Two members of the Ohio Health Care Association also commented on policy and attitude:

> "There are too many policy changes. It's a cost to the provider. It's a cost to the system. …At one time they did a newsletter, which was very helpful, but I think what they found was that sometimes they would put information in the newsletter and we would use it against them at final settlements, so they stopped issuing it. But even a newsletter would have been good to let us know that they were changing the policy."

> "…Things have changed somewhat with the Department, especially JFS in terms of their attitude….These people are very dependent on what you do and just to have that flip attitude -- like the other day we were talking to the State about the need to change prices to reflect better or more adequate capital reimbursements. And their attitude was, "Well, let's institute this pricing system, just see what happens. " … It's really almost outrageous to hear that, and that's been a change. It wasn't always like that. It's almost like the more aggressive stance I can take particularly about nursing homes, the more points I score with somebody."

And, last, a member of the Ohio Association of Nursing Homes expressed significant frustration with the service levels in the State agencies participating in the Medicaid Program stating "…no one will make some …bureaucrat responsible for his conduct or lack of conduct or lack of adherence to any standard of guideline or behavior. There is no effective management controls in place."

Recipients and advocates also indicated a number of negative experiences with employees in the Medicaid program. However, these remarks are most frequently focused at the county level where most recipients access the program. Several stakeholders and advocates discussed concerns with how recipients are treated and access to the system:

> "I think applying for Medicaid for families is not family friendly, and a huge example of that issue is kinship care families….There needs to be an emphasis on customer service in most departments. I can't even get our county to answer the phone, the Medicaid people to answer the phone. Their mailboxes are so backed up."
>
> *Member, Ohio Family Services Council*

> "They are treated terribly…. I mean they come out in tears because of the way they have been treated just trying to get something basic for their family so they can survive today, and it's awful. They are treated like they are trying to rip the system off. It's like they're taking money out of that caseworker's personal bank account, is how they are made to feel."
>
> *Member, Ohio Family Services Council*

A member of the Ohio Academy of Primary Care Physicians spoke of the importance of a single point of contact to help individuals, especially those eligible for both Medicare and Medicaid. Other stakeholders echoed the need to have strong customer service orientation and that the high staff turnover in some county-level organizations poses a challenge. One recipient from the Federation of the Blind noted: " for two years I went through about five different people and so I don't have too much respect for the system that way… I'm glad its there …but at the same time if you have to fight and claw to get anything and you have to beg them to do their job, what kind of help is that?"

Members of the Ohio Legal Services Association also commented on the problems recipients encounter in accessing the system explaining that the system is "too complicated for the caseworker to administer" and there is a need for a system "so that people can understand, going in, what they should get." And, last, a member of the National Multiple Sclerosis Society, Ohio Chapter discussed the complexities of the program and how they serve as a barrier to access:

> "…The rules are so complicated… you get dizzy by the time you try to read through everything and to get a grip of what they are trying to say and how it comes together …. It takes people being in the system and working the system to be aware of what's happening and how to work things and how to help people and sometimes, no matter how hard you try, you just can't get the things you need for your people. "

The preponderance of negative comments on direct contact with State and local employees serving as liaisons to providers or providing direct service to clients can be clearly linked with the rapid turnover at the State and local agencies and the inability of these agencies to then recruit and train qualified individuals. In particular, the comments of recipients resonate with advocacy groups who support access and fairness in the system. If the State Medicaid agency, along with the sub-recipients and local agencies, included stakeholders and providers in discourse on the program more frequently, many of these examples may have been avoided. However, without the appropriate personnel to carry out the General Assembly's vision of the purpose and goals of the program, the program is unlikely to reach its intended beneficiaries in a manner consistent with the expectations of Ohio policy-makers.

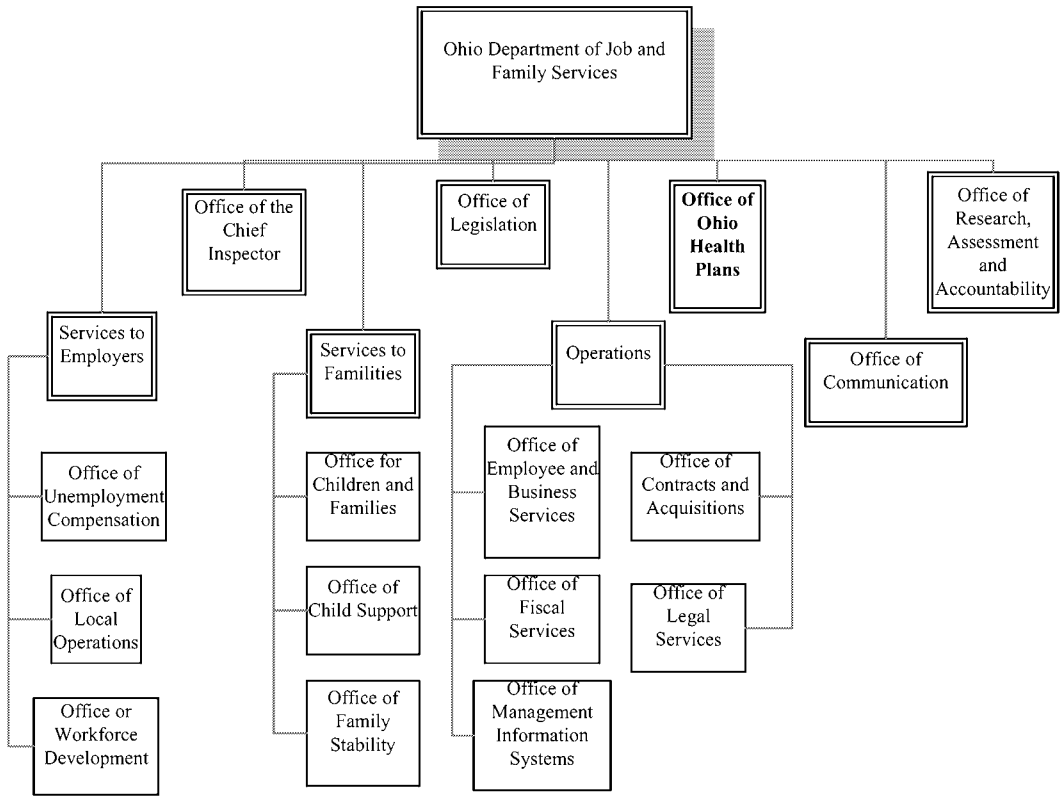
R3.20 The State Medicaid agency should actively engage in skill set management and succession planning. This will require the identification of technical skills and knowledge for critical positions, as well as soft skills (like those the ODJFS HR Department has identified) for recipient-oriented positions. Personnel key to operations, who are likely to retire, should be identified and succession planning should be implemented for these positions. Finally, identification of high-potential employees and implementation of employee development programs will help facilitate the long-term development of staff for future organizational roles. If the Medicaid program is relocated in a different organizational structure, these activities should be conducted for the personnel within the new agency. Likewise, these activities should be extended beyond the State Medicaid agency to its

contractors (the State sub-recipient agencies and local agencies), to ensure that these parties approach provider and recipient services in a consistent and professional manner.

R3.21 The State Medicaid agency should strengthen its human resources support structures in order to enhance capacity for performance management, succession management and influence on organizational goals. By heightening the level of human resources support, the State Medicaid agency can increase opportunities to achieve measurable organizational efficiency and effectiveness through improved management of critical core competencies required at the organizational, group and individual levels. If the Medicaid program is relocated in a different organizational structure, strong human resources structures should be implemented within the new agency.

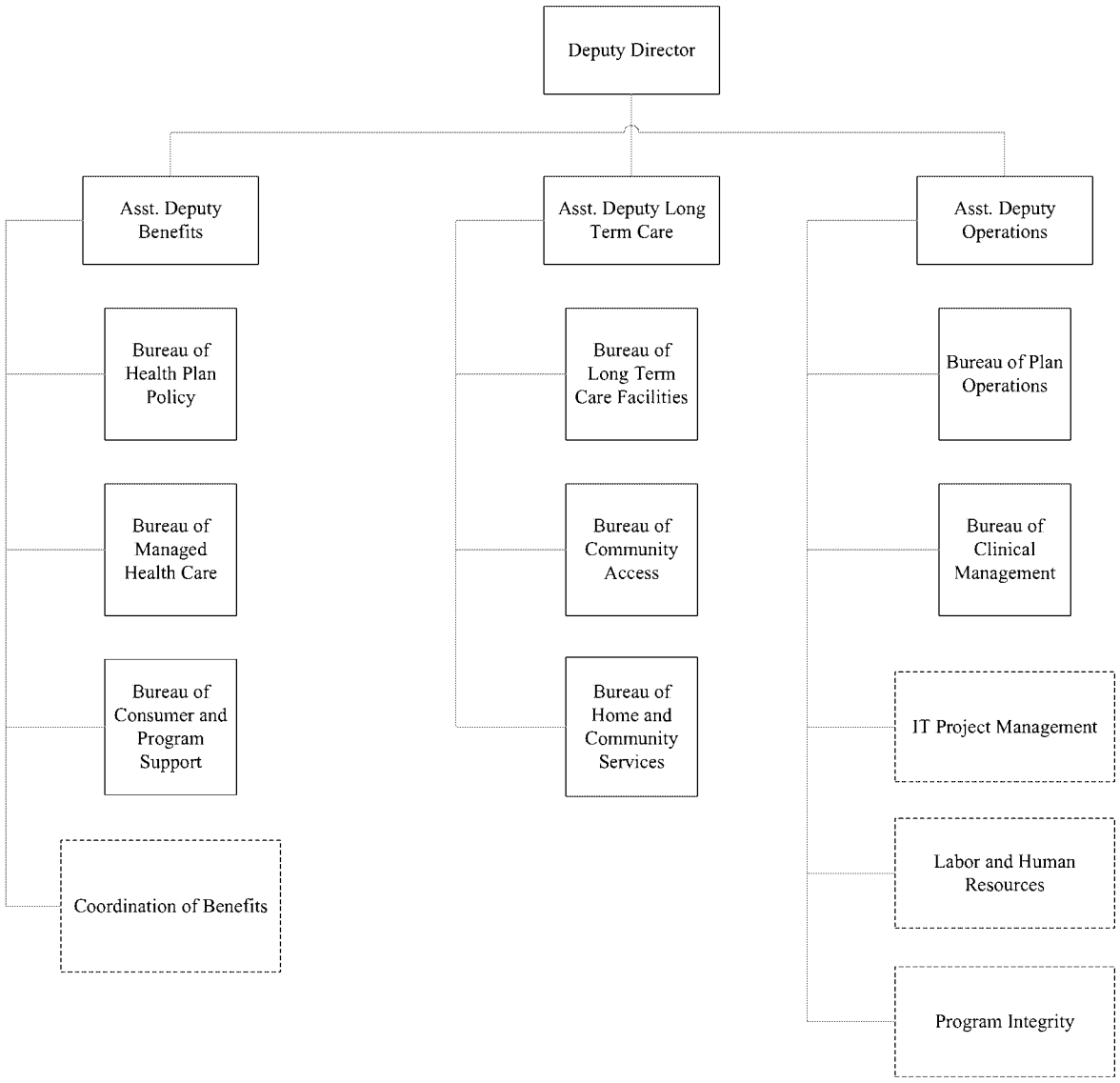
Appendix 3-A: OHP Organizational Charts

Chart 3A-1: ODJFS Organizational Structure[1]



Source: ODJFS
[1] The ODJFS Performance Center website has not been updated to reflect that OHP now reports directly to the ODJFS Director's Office.

Chart 3A-2: OHP Organizational Chart

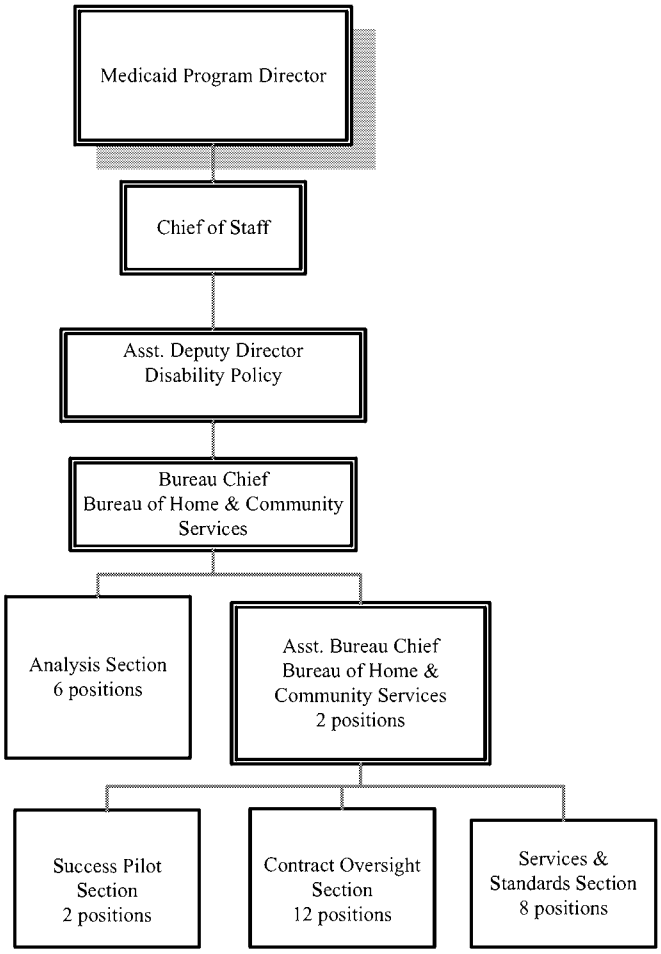


Source: ODJFS

Note: This organizational chart reflects planned organizational changes to be implemented in October 2006. However, at the time of this report, detailed organizational charts for each bureau were not available after this change. Therefore, **charts 3A-3** through **3A-9** differ slightly from this organizational chart. The Bureau of Clinical Management will not be reflected, and the Bureau of Plan Operation will not reflect the removal of the organizational units that currently perform the duties transferred to the Bureau of Clinical Management

Chart 3A-3summarizes the organization of the Bureau of Home and Community Services.

Chart 3A-3: Organizational Chart of the Bureau of Home and Community Services

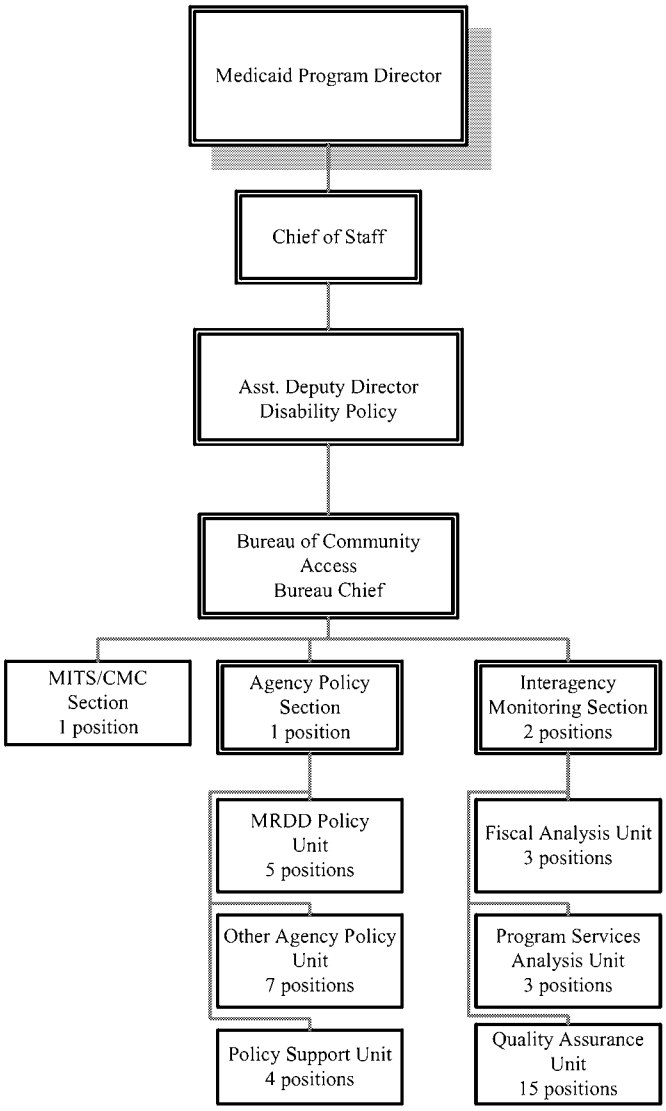


Source: ODJFS
Note: This organizational chart is as of March 2, 2006. However, restructuring will take place in October.

The Bureau of Home and Community Services operates several special programs called home and community-based services (HCBS) waivers. Under Section 1915(c) of the Social Security Act, the federal government waives certain Medicaid rules to allow a limited number of eligible people with severe disabilities and medically unstable conditions to live in their homes and in the community instead of in nursing homes, hospitals, or facilities for people with mental retardation/developmental disabilities (ICF-MR). This bureau administers the Ohio Home Care

Waiver and the Transitions Waiver. Ohio Home Care has approximately 8,300 slots and serves adults under 60 that do not have mental retardation or developmentally disabilities. The Transitions Waiver serves MRDD adults less than 60 years of age. However, interactions with other State departments that serve specific populations are conducted by another bureau. **Chart 3A-4** illustrates the organization of the Bureau of Community Access.

Chart 3A-4: Organizational Chart of the Bureau of Community Access



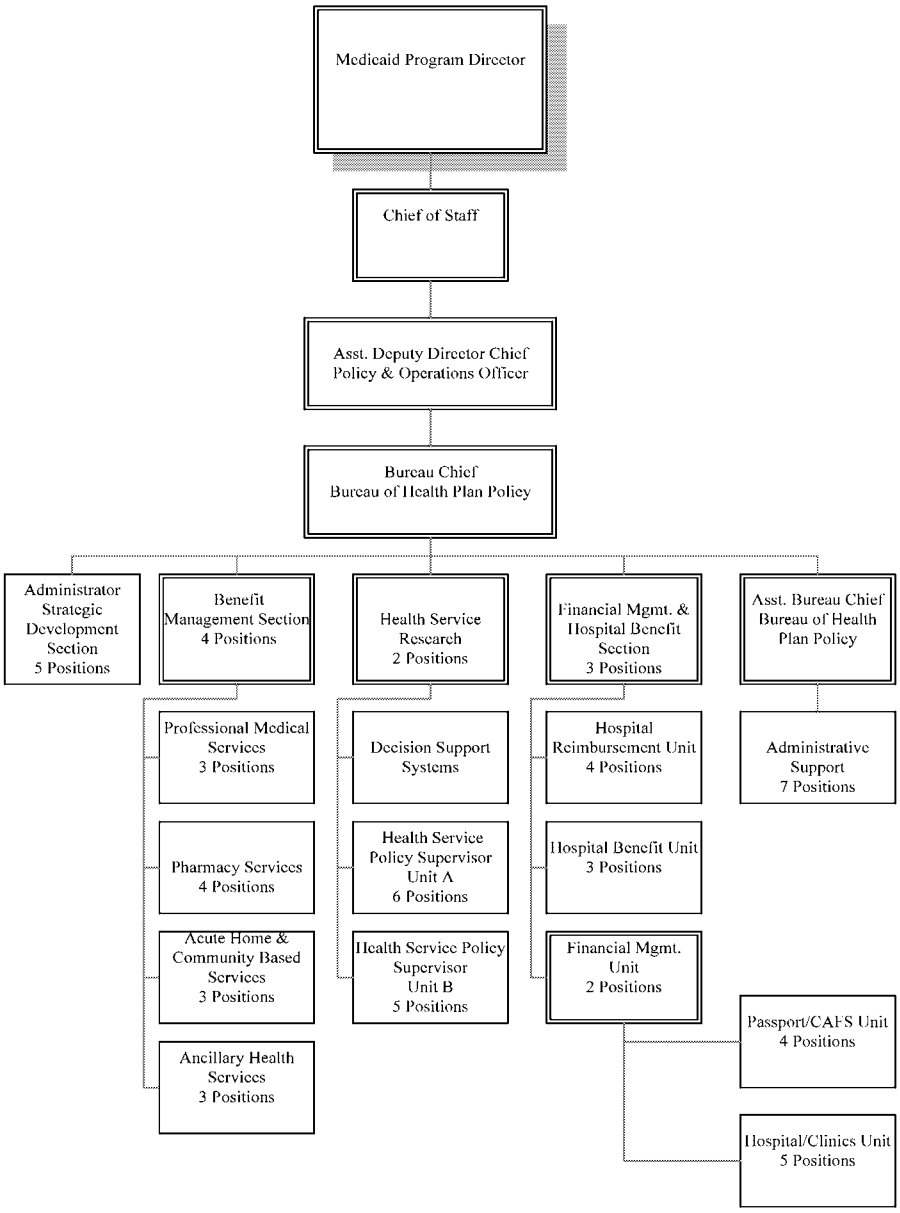
Source: ODJFS

Note: This organizational chart is as of March 2, 2006. However, restructuring will occur in October.

The Bureau of Community Access works with the other State agencies that are involved with Medicaid. This Bureau interfaces with sub-recipient agencies, acting as the liaison between these agencies and CMS. To ensure accountability, the federal government holds ODFJS ultimately responsible for oversight of all programs. As such, this bureau works with the sub recipient agencies to ensure that services provided in those programs meet all federal requirements.

Chart 3A-5 presents the organizational chart of the Bureau of Health Plan Policy.

Chart 3A-5: Bureau of Health Plan Policy Organizational Chart



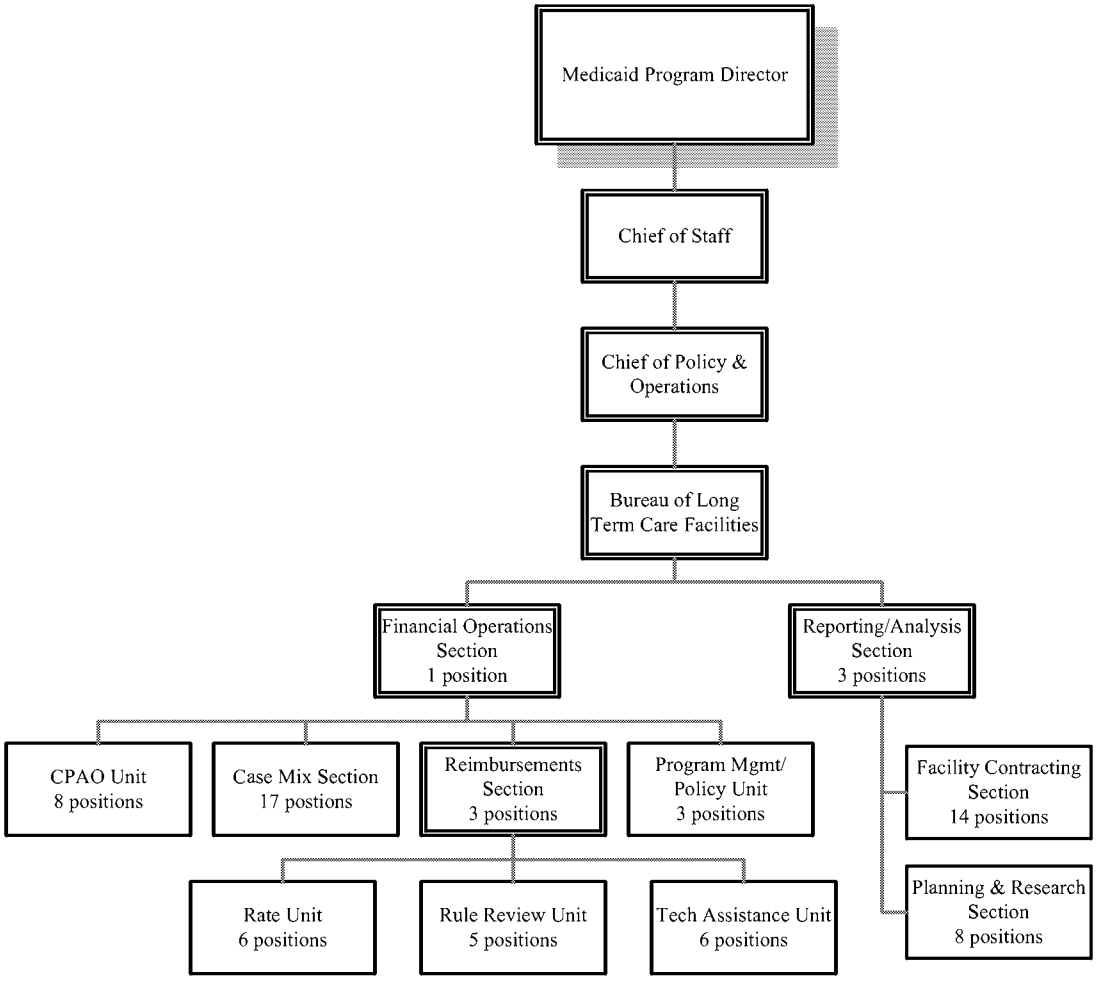
Source: ODJFS
Note: This organizational chart is as of March 2, 2006. However, restructuring will occur in October 2006.

The Bureau of Health Plan Policy (BHPP) is responsible for research, strategic planning, and policy development for most aspects of the Ohio Medicaid program. In addition, BHPP is responsible for creating and carrying out a research agenda for the Medicaid program. This includes analysis and evaluation of existing programs and new initiatives. Policies are translated into administrative rules that govern the types of services covered and the methods of provider reimbursement. They are responsible for Medicaid handbooks, policy and procedures manuals distributed to health care providers and for the Medicaid State Plan. Furthermore, BHPP negotiates and maintains various contracts and interagency agreements pertaining to the operation of the Medicaid program. Finally, BHPP is responsible for activities to assure the appropriateness of health care and develop cost containment and managed care strategies by administering the following utilization review programs:

- The Ohio Medicaid Drug program;
- The Medicaid Technical Assistance and Policy Program which is a partnership with the Board of Regents for research and data analysis; and
- The Hospital Care Assurance Program reimburses hospitals for uncompensated care. The Bureau assesses hospitals based on their book of business to obtain a federal drawdown.

Chart 3A-6 illustrates the organizational structure of the Bureau of Long-term Care Facilities.

Chart 3A-6: Bureau of Long-term Care Facilities Organizational Chart



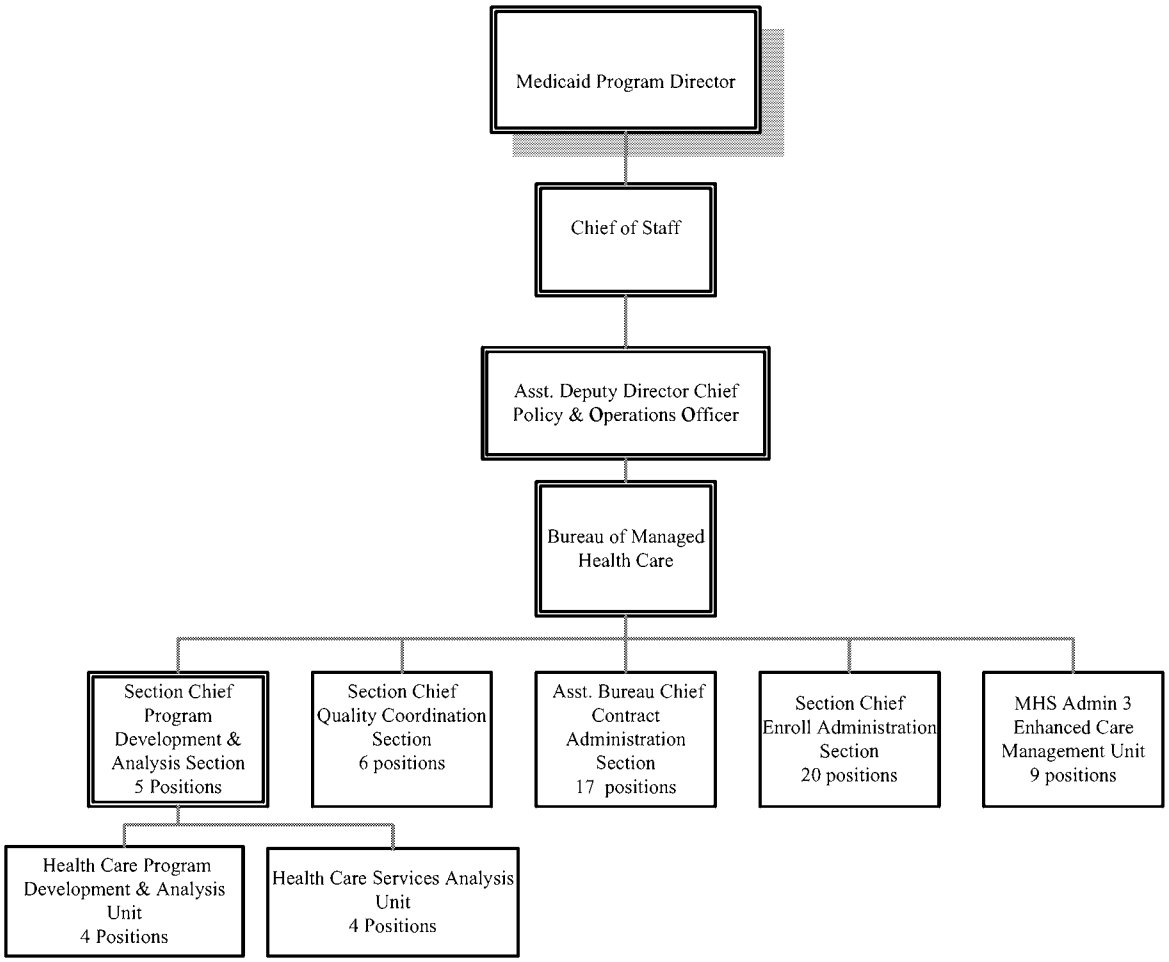
Source: ODJFS
Note: This organizational chart is as of March 2, 2006. However, restructuring will occur in October 2006.

The Bureau of Long-term Care Facilities is responsible for completing per diem rate-setting for all nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICF/MRs) participating in the Medicaid program. In addition it processes all nursing home rate reconsiderations, capital rate adjustments for change in provider agreements, and renovation approvals for nursing homes. In addition this bureau's responsibilities include maintaining provider agreements for nursing facilities and ICF/MRs, tracking changes to provider agreements, tracking nursing home complaints, franchise fee bed tax calculation, estate recovery

projects, surety bonds for nursing homes needed for personal needs allowance, and collection of fines for nursing homes. Finally, it operates a help desk for providers; works with Management Information Systems to design, test, and implement system changes; and conducts clinical and statistical studies.

Chart 3A-7 presents the organizational structure of the Bureau of Managed Health Care

Chart 3A-7: Bureau of Managed Health Care Organizational Chart

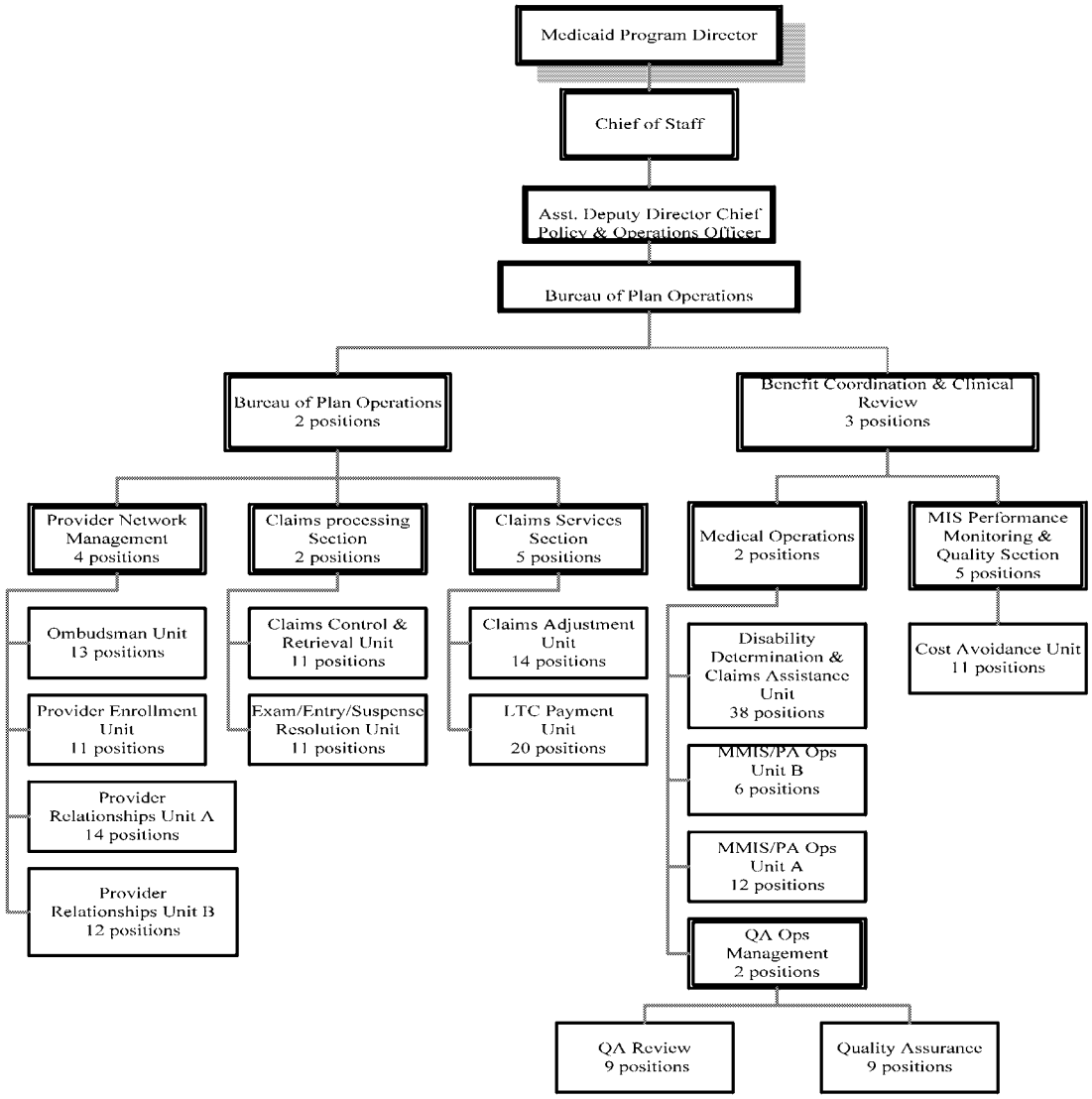


Source: ODJFS
Note: This organizational chart is as of March 2, 2006. However, restructuring will occur in October 2006.

The Bureau of Managed Health Care is responsible for the development, administration, and assessment of the Ohio Medicaid Managed Health Care. The bureau's work includes the design of purchasing specifications; selection of qualified managed care plans; contract monitoring; performance reviews; reporting; and development and implementation of new program initiatives. The bureau is also responsible for managed care enrollment policies and procedures, including the selection and oversight of enrollment services contracts. While OHP is moving toward further expansion of this service provision model, currently the majority of services are provided on a fee-for-service basis.

Chart 3A-8 summarizes the organization of the Bureau of Plan Operations.

Chart 3A-8: Bureau of Plan Operations Organizational Chart

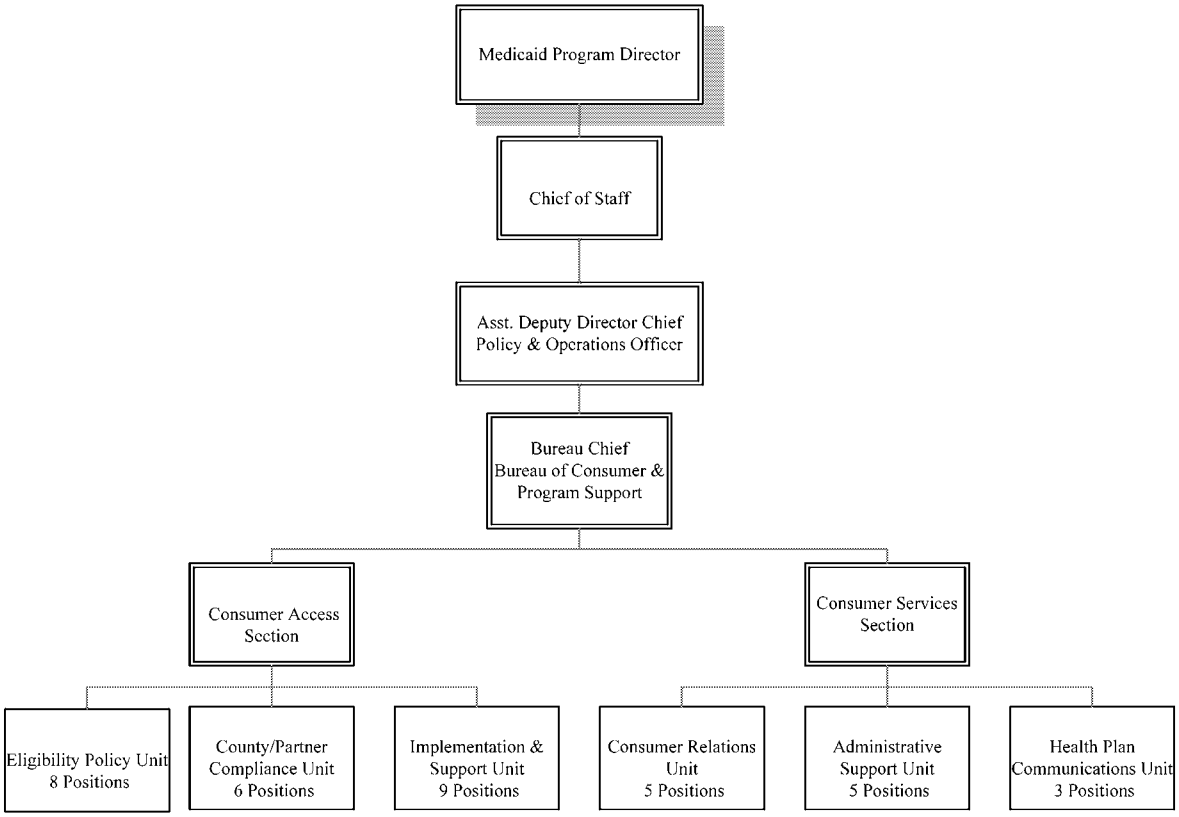


Source: ODJFS
Note: This organizational chart is as of March 2, 2006. However, restructuring will occur in October 2006.

The Bureau of Plan Operations is responsible for claims processing, claims services, provider network management, benefit coordination and recovery, and ensures that all Medicaid services requiring prior authorization are medically necessary and appropriately priced. Claims processing involves processing the hard copy Medicaid claims from providers and resolution of suspended claims for adjudication. Claims Services requires review and adjustments to previously paid claims to Medicaid and Long Term Care providers. Furthermore, this function processes provider liens and garnishments, and resolves billing errors and problems. The Provider Network Management section is the primary liaison between the medical provider community and the Medicaid fee-for-service program. The Provider Assistance unit answers telephone inquiries on billing, claim payment status, policy and coding. The Benefit coordination function processes client eligibility changes that cannot be processed through the eligibility system and ensures payment of Medicare premiums for certain groups of clients. The Medical Operations unit is expected to be become the basis for a new bureau entitled the Bureau of Clinical Management. Furthermore, portions of the Benefit Coordination and Clinical review section will become a section outside of any bureau structure but reporting directly to the Assistant Deputy of Benefits. At the time of this report, details regarding specific organizational structures were not available. This change is expected to be implemented in October of 2006.

Chart 3A-9 illustrates the organizational structure of the Bureau of Consumer and Program Support.

Chart 3A-9: Bureau of Consumer and Program Support Organizational Chart



Source: ODJFS
Note: This organizational chart is as of March 2, 2006. However, restructuring is anticipated in October.

The Bureau of Consumer and Program Support serves as a liaison with CDJFS agencies and is responsible for the following functions:

- Eligibility;
- Consumer hotline and information dissemination;
- Disseminating the Medicaid fact sheet;
- Healthy Start/Healthy Families;
- State Children's Health Insurance Program (SCHIP); and
- Joint advisory councils

Table 3A-1 summarizes the functional duties of each bureau within OHP and the subordinate sections with those bureaus.

Table 3A-1: Summary of Function Duties of OHP Organizational Units

	Contract Design/ Programmatic Policy Development	Rule Writing and Revisions	Research and Data Analysis	Contract Implementation	Oversight & Monitoring	Payment Admin.	Technical Assistance and Outreach
Bureau of Health Plan Policy							
Financial Management & Hospital Benefit Section	X	X	X	X	X	X	X
Strategic Development Section	X	X	X	X		X	X
Benefit Management Section	X	X	X	X	X	X	X
Health Services Research Section	X		X	X	X	X	X
Bureau of Long-term Care Facilities							
Case Mix Section	X	X	X	X	X		X
Program Management/Policy	X	X	X		X	X	X
CPAO Unit					X		X
Reimbursement Section	X	X	X				
Reporting/ Analysis	X	X	X				
Planning/ Research Section	X	X	X		X		
Facility Contracting Section				X	X		X
Bureau of Managed Health Care							
Contract Administration Section	X	X	X	X	X		X
Financial Management & Development Unit	X	X	X	X	X		X
Performance Review & Business Support Section	X	X	X	X	X		
Performance Improvement & Clinical Management Section	X	X	X	X	X		X
Premium Administration & Membership Services Section	X	X	X	X			X

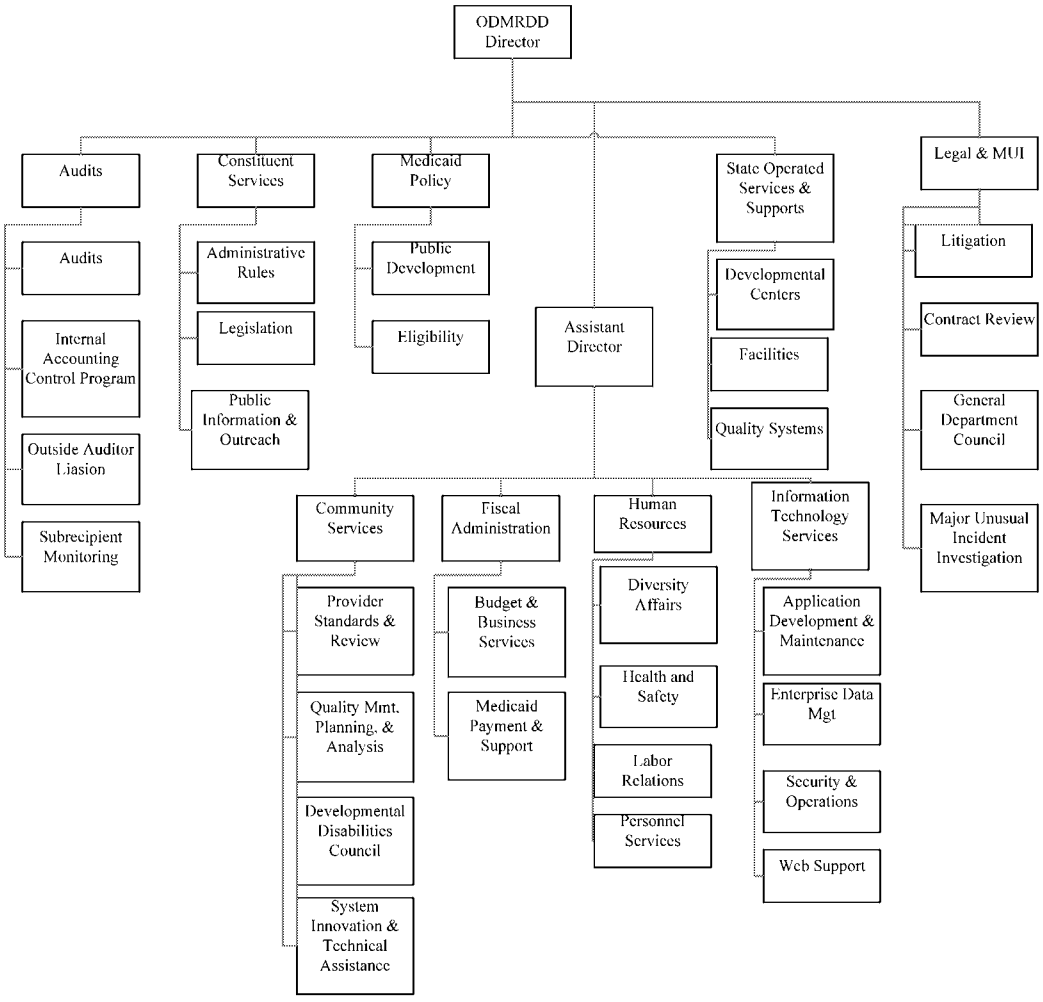
Bureau of Consumer and Program Support							
County Oversight & Support Section	X	X	X	X	X	X	X
Program Development Support Section	X	X	X		X		X
Consumer Services Section	X		X	X	X	X	X
Bureau of Home and Community Services							
Data Management & Analysis Section	X		X		X		
Provider Standards & Services Section	X		X	X	X		X
Consumer Standards & Services	X		X	X	X		X
Senior Policy Administrator	X	X					
Consumer Relations Manager	X						X
Management Analyst Supervisor	X		X				
BC/ABC	X		X	X			
Contract Management	X		X	X	X		X
Bureau of Community Access							
MITS/CMC Section	X		X			X	X
Agency Policy Section	X	X	X	X	X	X	X
Interagency Monitoring Section	X	X		X	X	X	X
Bureau of Plan Operations							
Medical Operations Section	X		X	X	X	X	X
Benefit Coordination & Recovery Section				X		X	X
Provider Network Management Section			X	X	X	X	X
Claims Processing Section			X	X	X	X	
Claims Service Section	X		X	X	X	X	X

Source: OHP Bureaus - self reported functional duties

Appendix 3-B: Sub-recipient Agency Organizational Charts

Table 3B-1 illustrates the organizational structure of the Ohio Department of Mental Retardation/Developmental Disabilities (ODMRDD).

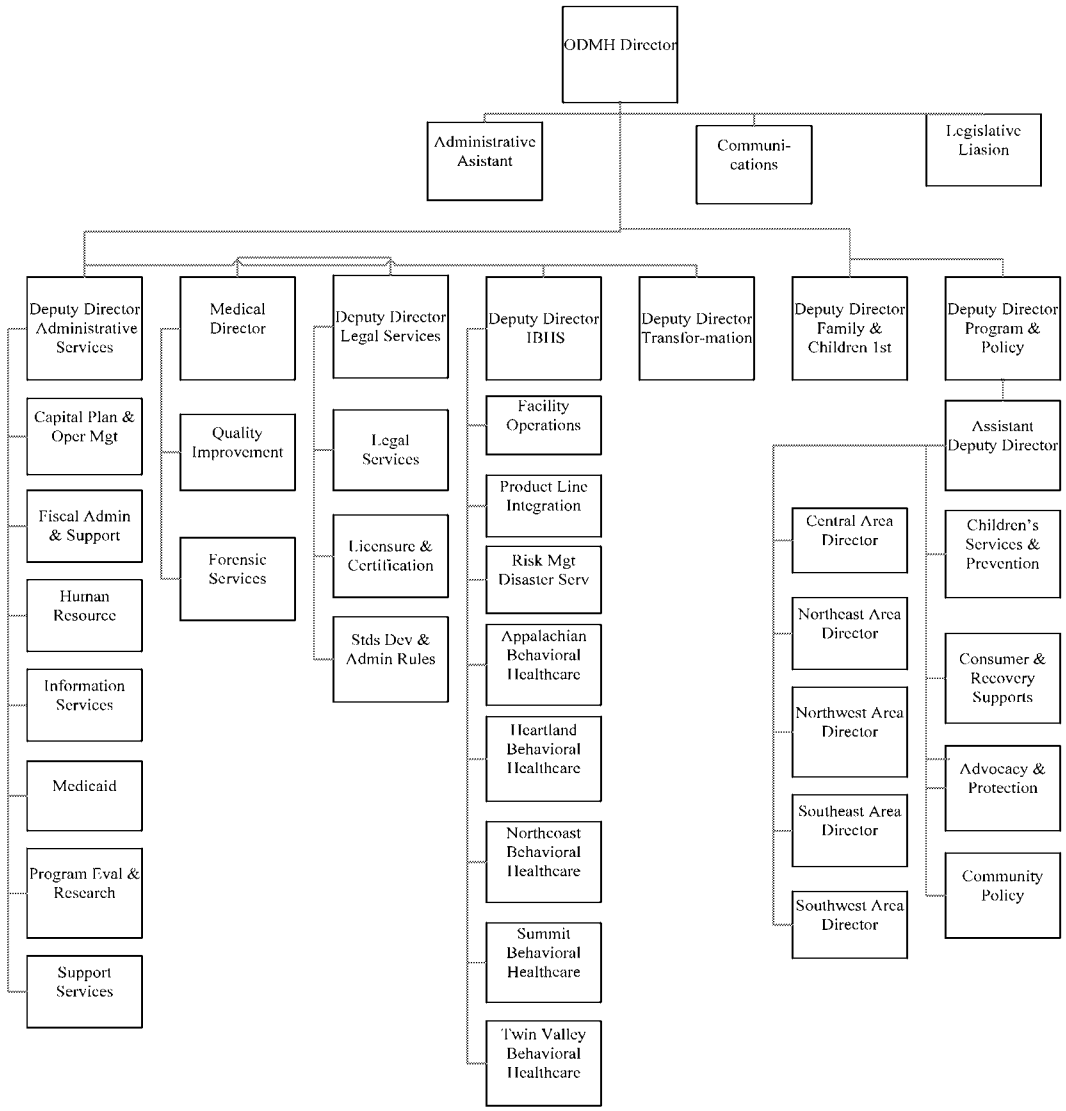
Chart 3B-1: ODMRDD Organizational Chart



Source: ODMRDD and the Ohio Medicaid Administrative Study Council

Table 3B-2 illustrates the organizational structure of the Ohio Department of Mental Health (ODMH).

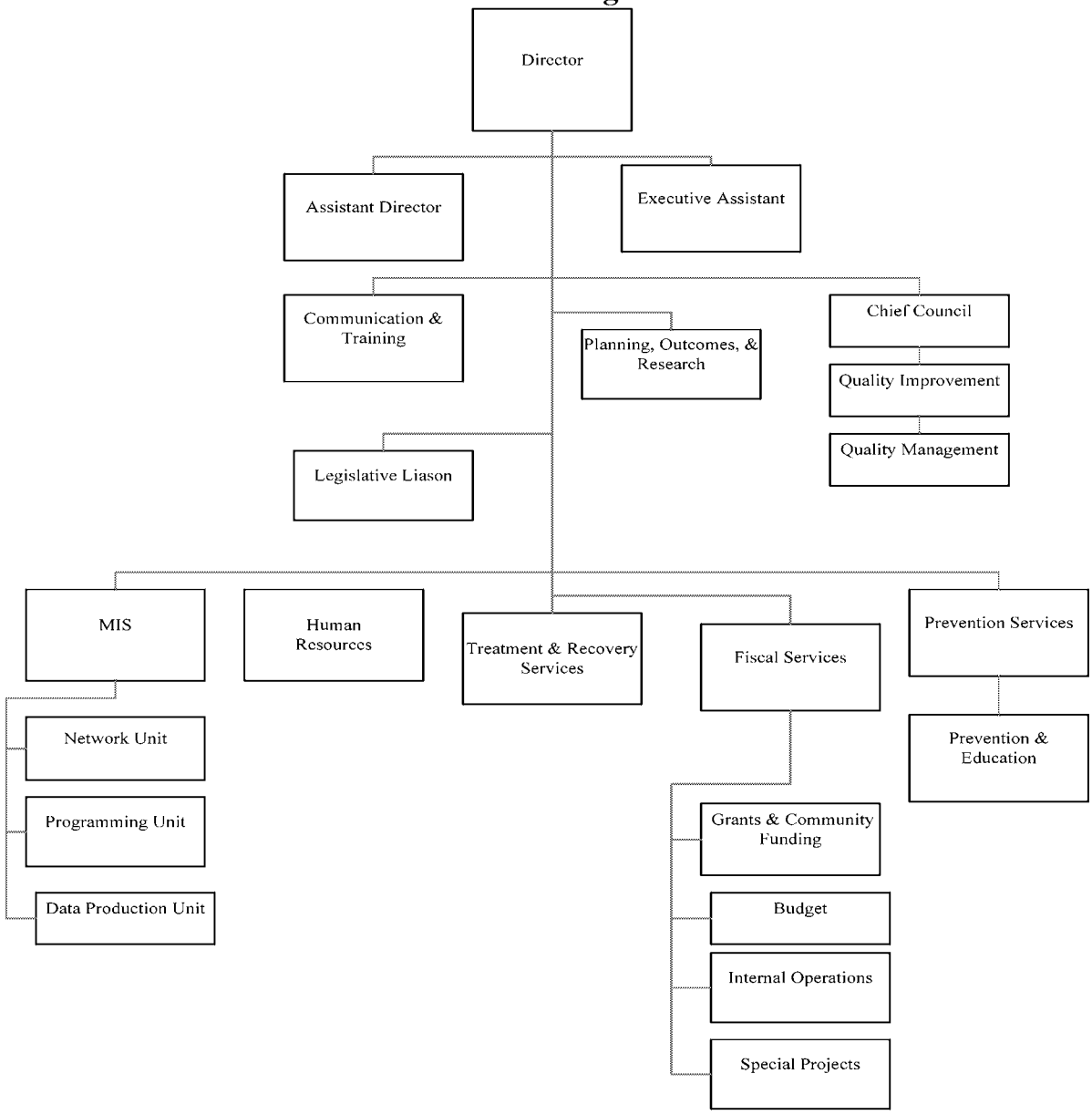
Chart 3B-2: ODMH Organizational Chart



Source: ODMH

Table 3B-3 illustrates the organizational structure of the Ohio Department of Alcohol and Drug Addiction Services (ODADAS).

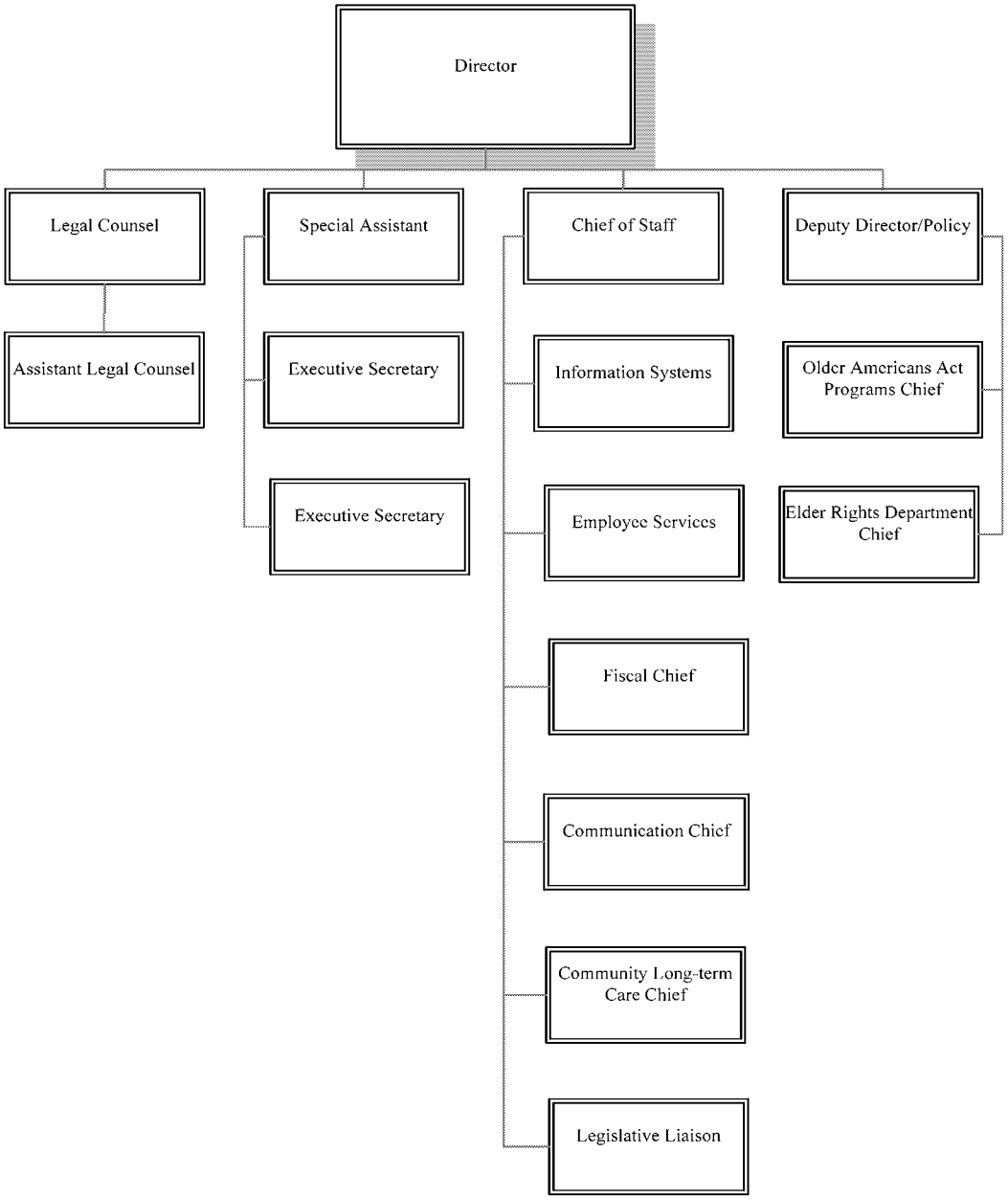
Chart 3B-3: ODADAS Organizational Chart



Source: ODADAS

Chart 3B-4 depicts the organizational structure of the Ohio Department of Aging (ODA).

Chart 3B-4: ODA Organizational Chart



Source: ODA

Appendix 3-C: Detailed Medicaid Expenditures by Agency

Table 3C-1 illustrates OHP Medicaid expenditures for SFY 2002-03 through SFY 2004-05.

Table 3C-1: SFY 2002-03 through SFY 2004-05 OHP Service Expenditures (000's)

	SFY 2002-03		SFY 2003-04		SFY 2004-05		Avg. Percent Change SFY 2002-03 to SFY 2004-05	
State Admin. Costs	$102,048		$121,754		$128,220		12.3%	
Local Admin. Costs	$136,128		$148,323		$133,031		(0.65%)	
Total Admin. Costs as % of total OHP Costs	**2.3%**		**2.4%**		**2.5%**		**N/A**	
Members	**1,934,547**		**2,011,021**		**2,086,608**		**3.9%**	
Member Months	**18,656,115**		**19,613,846**		**20,424,999**		**4.6%**	
Category of Service	**Total Cost of Coverage (000's)**	**Per Member Per Month Expenditures**	**Total Cost of Coverage (000's)**	**PMPM Exp.**	**Total Cost of Coverage (000's)**	**PMPM Exp.**	**Total Cost of Coverage**	**PMPM Exp.**
Skilled Nursing Facilities	$2,410,805	$129.22	$2,528,986	$128.94	$2,606,279	$127.60	4.0%	(0.6%)
Prescribed Drugs	$1,591,620	$85.31	$1,846,202	$94.13	$2,046,561	$100.20	13.4%	8.39%
Inpatient Hospital	$1,254,706	$67.25	$1,347,661	$68.71	$1,478,637	$72.39	8.6%	3.76%
Health Maintenance Services	$732,151	$39.24	$947,801	$48.32	$1,073,251	$52.55	21.35%	15.94%
Outpatient Hospital-General	$540,833	$28.99	$604,245	$30.81	$661,016	$32.36	10.6%	5.66%
Physician Services	$552,518	$29.62	$590,383	$30.10	$626,309	$30.66	6.5%	1.75%
ICF MR Private	$362,750	$19.44	$379,280	$19.34	$383,652	$18.78	2.9%	-1.71%
Core Services - Waiver Recip	$159,825	$8.57	$182,169	$9.29	$204,276	$10.00	13.1%	8.05%
Supplies & Medical Equipment	$143,828	$7.71	$165,575	$8.44	$161,446	$7.90	6.3%	1.6%
Home Health Svcs.	$115,058	$6.17	$132,871	$6.77	$149,047	$7.30	13.8%	8.8%
Dental Services	$107,155	$5.74	$121,592	$6.20	$127,272	$6.23	9.1%	4.2%
Private Duty Nursing Services	$103,642	$5.56	$107,052	$5.46	$112,465	$5.51	4.2%	(0.4%)
Hospice Services	$73,346	$3.93	$95,996	$4.89	$110,388	$5.40	22.9%	17.5%
ICF	$146,915	$7.87	$115,900	$5.91	$90,565	$4.43	(21.5%)	(25.0%)
ICF MR Public [1]	$73,376	$3.93	$71,714	$3.66	$80,253	$3.93	4.8%	0.2%
Clinic	$56,177	$3.01	$57,833	$2.95	$61,880	$3.03	5.0%	0.3%
Ambulance Services	$33,815	$1.81	$37,606	$1.92	$42,488	$2.08	12.1%	7.1%
Ambulette Services	$30,075	$1.61	$34,342	$1.75	$36,857	$1.80	10.8%	5.8%
Federally Qualified Health Center	$29,877	$1.60	$32,815	$1.67	$34,989	$1.71	8.2%	3.4%
Independent Lab.	$16,586	$0.89	$19,950	$1.02	$23,864	$1.17	20.0%	14.6%
PACE	$12,031	$0.64	$14,674	$0.75	$17,244	$0.84	19.7%	14.4%
Waivered Services	$11,613	$0.62	$12,022	$0.61	$14,169	$0.69	10.7%	5.8%
Optometic Services	$12,938	$0.69	$13,312	$0.68	$14,122	$0.69	4.5%	(0.1%)
Podiatrists Therapy	$10,391	$0.56	$11,499	$0.59	$12,789	$0.63	10.9%	6.0%
Ambulatory Surgery	$10,339	$0.55	$11,050	$0.56	$12,159	$0.60	8.5%	3.7%
Nursing Home Therapies	$7,275	$0.39	$10,130	$0.52	$11,145	$0.55	24.6%	19.1%

Advanced Practice Nurse Services	$6,384	$0.34	$8,218	$0.42	$10,366	$0.51	27.4%	21.8%
C R N A Services	$8,227	$0.44	$8,644	$0.44	$9,396	$0.46	6.9%	2.2%
Eyeglasses	$6,108	$0.33	$6,502	$0.33	$6,751	$0.33	5.2%	0.5%
Physiological Lab.	$3,073	$0.16	$4,062	$0.21	$4,684	$0.23	23.7%	18.2%
Rural Health Services	$2,353	$0.13	$3,748	$0.19	$3,897	$0.19	31.6%	25.7%
Home Care Case Management	$11,462	$0.61	$12,854	$0.66	$3,407	$0.17	(30.7%)	(33.9%)
Physical Therapy Services	$1,522	$0.08	$1,828	$0.09	$2,414	$0.12	26.1%	20.5%
Outpatient Health Services	$2,117	$0.11	$2,079	$0.11	$2,115	$0.10	(0.0%)	(4.5%)
Psychology Services	$2,969	$0.16	$2,294	$0.12	$1,992	$0.10	(17.9%)	(21.6%)
Chiropractor Services	$7,282	$0.39	$4,537	$0.23	$1,893	$0.09	(48.0%)	(50.3%)
Family Planning	$1,737	$0.09	$1,530	$0.08	$1,510	$0.07	(6.6%)	(10.7%)
Preferred Provider Services	$0	$0.00	$0	$0.00	$511	$0.03	N/A	N/A
EPSDT	($4)	$0.00	($11)	$0.00	($1)	$0.00	28.8%	22.5%
Total Ohio Health Plans	**$8,652,876**	**$463.81**	**$9,548,946**	**$486.85**	**$10,242,058**	**$501.45**	**8.8%**	**4.0%**
Total Other State Agencies	**$1,341,790**	**$71.92**	**$1,461,059**	**$74.49**	**$1,511,082**	**$73.98**	**6.2%**	**1.4%**
Total All Agencies	**$9,994,666**	**$535.73**	**$11,010,005**	**$561.34**	**$11,753,140**	**$575.43**	**8.5%**	**3.7%**

Source: ODJFS

Note: Financial figures are self-reported and unaudited. Discrepancy with figures in other tables in this section are primarily explained by the exclusion of the HCAP program, Medicare Buy-in, CDJFS administrative costs, Supplemental Inpatient Payments, CAS refunds, and Qualified Medicaid Beneficiary individuals receiving subsidies for Medicare premiums in this table, but inclusion of these programs in financial figures presented in **Table 3C-1**.

[1] Excludes developmental centers

The above table illustrates that the vast majority of expenditures administered by OHP are directly related to service expenditures. In each of the last three years, OHP's administrative costs ranged from 2.3 to 2.5 percent of total costs. However, a number of material service categories have increased at significant rates. The most notable of these service categories are prescribed drugs, health maintenance services, and core services waiver recipients. Prescribed drugs experienced an average growth rate of 13.4 percent from SFY 2002-03 to SFY 2004-05. Health maintenance services increased 21.4 percent on average from SFY 2002-03 to SFY 2004-05. From SFY 2002-03 to SFY 2003-04 these expenditures increased 29.5 percent, and increased an additional 13.2 percent in SFY 2004-05. Core services waiver services increased an average of 13.1 percent from SFY 2002-03 to SFY 2004-05. Inpatient and outpatient hospital services also experienced significant expenditure increases. These increases in total expenditures are evaluated against three primary cost drivers: number of consumers, utilization of services by consumers, and the price of services below.

Table 3C-2 presents the cost per claim, cost per consumer, and claims per consumer for each service category in SFY 2004-05 and the average percent change in these ratios for SFY 2002-03 through SFY 2004-05.

Table 3C-2: SFY 2004-05 OHP Service Expenditures Efficiency Ratios

	SFY 2004-05			Average Annual Percent Change SFY 2003-03 through SFY 2004-05		
Category of Service	**Cost per Claim**	**Cost per Consumer**	**Claims per Consumer**	**Cost per Claim**	**Cost per Consumer**	**Claims per Consumer**
Advanced Practice Nurse Services	$39.99	$101.35	2.5	(4.3%)	0.1%	5.1%
Ambulance Services	$101.41	$311.25	3.1	(0.3%)	2.7%	3.1%
Ambulatory Surgery	$314.72	$415.97	1.3	(5.6%)	(5.3%)	0.3%
Ambulette Services	$62.15	$737.95	11.9	(1.1%)	4.7%	5.9%
C R N A S ervices	$108.83	$135.25	1.2	0.3%	0.7%	0.4%
Chiropractor Services	$23.20	$144.32	6.2	(10.1%)	(10.5%)	0.3%
Clinic	$160.60	$636.06	4.0	3.9%	4.0%	0.1%
Core Services- Waiver Recip	$354.55	$22,460.22	63.3	(1.6%)	7.2%	9.0%
Dental Services	$127.42	$283.27	2.2	1.7%	3.8%	2.0%
Eyeglasses	$25.46	$32.50	1.3	1.3%	0.6%	(0.7%)
Family Planning	$50.24	$98.64	2.0	7.4%	1.2%	(5.3%)
Federally Qualified Health Center	$84.65	$286.34	3.4	1.6%	0.7%	(0.7%)
Home Care Case Management	$107.38	$302.43	2.8	(0.2%)	(37.4%)	(37.4%)
Home Health Services	$211.23	$3,597.30	17.0	(4.5%)	6.7%	11.8%
Hospice Services	$1,231.11	$10,173.11	8.3	(2.5%)	9.6%	12.4%
ICF	$2,737.49	$29,432.74	10.8	7.4%	5.6%	(1.7%)
ICF MR Private	$5,822.62	$72,469.25	12.4	5.7%	3.0%	(0.4%)
ICF MR Public [1]	$6,935.09	$84,299.28	12.2	6.1%	5.3%	2.1%
Independent Laboratory	$37.34	$111.96	3.0	6.2%	9.8%	3.4%
Inpatient Hospital	$4,475.27	$6,523.45	1.5	7.2%	5.6%	(1.3%)
Nursing Home Therapies	$397.44	$1,579.95	4.0	3.9%	9.1%	5.2%
Optometric Services	$40.90	$56.55	1.4	(1.5%)	1.1%	2.7%
Outpatient Health Services	$106.01	$287.26	2.7	6.6%	3.2%	(3.1%)
Outpatient Hospital- General	$175.55	$751.36	4.3	5.3%	7.2%	1.9%
PACE	$1,077.99	$21,473.93	19.9	11.2%	1.7%	(8.4%)
Physical Therapy Services	$48.94	$339.46	6.9	0.3%	3.9%	3.6%
Physician Services	$51.54	$542.53	10.5	1.6%	4.7%	3.1%
Physiological Laboratory	$179.21	$300.02	1.7	10.5%	11.6%	1.1%
Podiatrists Therapy	$32.37	$115.89	3.6	4.3%	6.3%	1.9%
Prescribed Drugs	$56.36	$1,835.15	32.6	6.4%	11.6%	5.0%
Private Duty Nursing Services	$900.49	$43,355.67	48.1	(0.3%)	4.7%	5.0%
Psychology Services	$33.44	$154.48	4.6	(8.4%)	(5.0%)	3.6%
Rural Health Services	$63.52	$195.25	3.1	24.2%	24.6%	(0.1%)
SNF	$2,769.69	$31,352.22	11.3	11.9%	3.2%	(7.7%)
Speech Therapy	N/A	N/A	N/A	N/A	N/A	N/A
Supplies & Medical Equipment	$87.76	$666.30	7.6	(3.1%)	0.7%	3.9%
Waivered Services	$166.21	$2,433,78	14.6	(1.2%	(4.6%)	(4.0%)
Health Maintenance Services	$169.68	$2,055	12.1	6.6%	6.7%	0.1%
EPSDT	($54.96)	N/A	N/A	0.8%	N/A	N/A
Total Ohio Health Plans	**$149.28**	**$1,788.01**	**12.0**	**2.1%**	**5.3%**	**3.4%**
Total Other State Agencies	**$353.67**	**$4,040.01**	**11.42**	**5.0%**	**3.6%**	**(0.4%)**
Total All Agencies	**$161.26**	**$1,926.05**	**11.94**	**2.0%**	**5.0%**	**3.1%**

Source: ODJFS

Note: Financial figures are self-reported and unaudited.

[1] Excludes developmental centers

Total expenditures for prescription drugs increased and average of 13.4 percent over the last three years. From SFY 2002-03 to FY 2003-04 the number of claims increased 11.8 percent, furthermore, the cost per consumer also increased while the cost per claim increased at a moderate pace, indicating potential increases in utilization per consumer rather than an increase in price. Total costs increased from FY 2003-04 to FY 2004-05 by 10.9 percent. However, during this same time period the number of claims and number of consumers were generally consistent with the prior period, with the cost per claim and cost per consumer increasing by approximately 9 percent each, indicating an increase in prices from FY 2004-05. According to ODJFS, the primary causes of growth in the drug program are new expensive prescription drugs and general medical inflation for prescription drugs experienced throughout the medical market. ODJFS does contend that these expenses are offset by standard CMS rebates and other supplemental rebates, which are not factored into the "out-the-door" expenses.

Health Maintenance Services increased 29.5 percent in SFY 2003-04 and 13.2 percent in SFY 2004-05. From FY 2003 to FY 2004 the number of claims increased 56 percent, but decreased by 17.5 percent in the following year. The number of consumers and the number of claims increased over 19 percent in SFY 2003-04 and an additional 7.7 percent in SFY 2004-05. During this time period utilization rates also remained flat. However, the cost per claim and cost per consumer increased 8.1 percent in SFY 2003-04 and 5.1 percent in SFY 2004-05, indicating a moderate increase in contractual prices. According to ODJFS, a rate increase was implemented in July of 2003 representing a half year of increased rates for SFY 2002-03 and a full year increase in SFY 2003-04.

Core Services for waiver recipients total costs increased almost 14 percent from SFY 2002-03 to SFY 2003-04 and increased an additional 12 percent in SFY 2004-05. In SFY 2003-04, both the number of claims and consumers increased 16.5 percent from the prior period. However, in SFY 2004-05, only the number of claims increased an additional 13.5 percent, while the number of consumers decreased 3.9 percent. This is also reflected in the number of claims per consumer. This ratio was flat in SFY 2003-04 from the prior period, but increased 18.0 percent in SFY 2004-05. As the cost per claim decreased slightly in SFY 2003-04 and SFY 2004-05 from the prior periods, increases in total costs in SFY 2003-04 appear to be explained by a general increase in the number of consumers served. However, total cost increases in SFY 2004-05 are explained by an increase in utilization which is evidenced by a 16.6 percent increase in the cost per consumer. According to ODJFS, these increases in expenditures are also explained by an increased percentage of consumers using nursing and daily living services, with no increase in cost per consumer for nursing/daily living services noted. BHCS currently accepts approximately 40 percent of individuals applying for waivers and has been focusing on pre-admission screening of applicants and restricting slots to individuals with high need for waiver services. For example, waiting list priorities targeting current nursing home residents and hospitalized pre-school children were initiated July 1, 2006. With this increased targeting of waiver services to high-need consumers, the trend of increasing percentages of consumers using nursing and daily living (personal care) services is expected to continue.

Outpatient hospital general costs increased 11.7 percent in SFY 2003-04 and 9.4 percent in SFY 2004-05. The number of consumers increased 3.4 percent while the number of claims increased 8.8 percent in FY 2003-04. The number of consumers increased 2.8 percent and the number of claims increased 1.3 percent in FY 2004-05. The growth in consumers relative to claims is reflected in utilization rates, which increased by 5.2 percent in SFY 2003-04, but declined 1.5 percent in SFY 2004-05. The cost per consumer rose in both SFY 2003-04 and SFY 2004-05 by 8.0 percent and 6.4 percent, respectively. However, SFY 2003-04 increases appear to be driven primarily by utilization rates as the cost per claim rose a modest 2.7 percent. In contrast, SFY 2004-05 increased primarily because of an increase in service costs as indicated by an 8.0 percent increase in the cost per claim. According to ODJFS, In SFY 2003-04, $8.9 million was added to the outpatient surgery fee schedule (for non-children's hospitals). While in SFY 2004-05, $10.7 million was added to outpatient surgery (for non-children's hospitals) per the state budget bill. These increases help explain the overall increase in outpatient costs, as well as cost per claim. Additionally, as with the inpatient observations, the cost per claim and utilization rate increases may also be attributed to the growth in Aged Blind and Disabled (ABD) caseload compared to non-managed care CFC. In both SFY 2003-04 and SFY 2004-05, the percentage growth in the ABD category was greater than the growth in non-managed care Covered Families and Children (CFC) eligible individuals. Relative to CFC, ABD consumers have a higher cost per claim, which would also help to explain the overall increase in cost per claim.

Inpatient hospital costs increased 7.4 percent in SFY 2003-04 and 9.7 percent in SFY 2004-05. The total number of consumers served increased a modest 3.4 percent in SFY 2003-04, while the number of claims increased 5.1 percent. In SFY 2004-05, the total number of consumers served increased 2.2 percent, while the number of claims decreased 2.2 percent. This is reflected in utilization rates, which increased a modest 1.6 percent in SFY 2003-04 and decreased 4.3 percent in SFY 2004-05. Therefore, it appears that increases in total costs are primarily the result of increases in the cost per claim, which increased 2.2 percent in SFY 2003-04 and 12.2 percent in SFY 2004-05. According to ODJFS, Children's hospitals received a 3.6 percent inflationary update to inpatient rates effective in January of 2004. In January of 2005, Non-children's hospitals received a 3.0 percent inflationary update, while Children's hospitals received a 3.3 percent update. In addition to the rate increases, the cost per claim increase may also be attributed to the growth in ABD caseload compared to non-managed care CFC. In both SFY 2003-04 and SFY 2004-05, the percentage growth in the ABD category was greater than the growth in non-managed care CFC eligible individuals. Relative to CFC, ABD consumers have a higher cost per claim, which would also help explain the overall increase in cost per claim. The changes in utilization rates for inpatient hospital services are more difficult to explain as utilization for this type of service varies due to the unpredictable nature of care provided in the inpatient setting.

Table 3C-3 summarizes ODMH Medicaid expenditures for SFY 2002-03 through SFY 2004-05.

Table 3C-3: ODMH Expenditures for SFY 2002-03 through SFY 2004-05

	SFY 2002-03	SFY 2003-04	SFY 2004-05	Average Annual % Change SFY 2002- 03 to SFY 2004-05
ODMH Administrative Costs	$510,700	$245,542 [1]	N/A	N/A
Medicaid Costs by Procedure:				
Behavioral Health Counseling and Therapy-Group	$9,923,064	$11,476,115	$12,357,492	12.2%
Behavioral Health Counseling and Therapy-Individual	$65,697,763	$73,022,963	$80,260,045	11.2%
Crisis Intervention Behavioral Health Services	$6,969,756	$6,666,120	$7,446,681	(2.7%)
Community Psychiatric Support Treatment-Group	$6,035,023	$6,893,293	$7,718,251	11.7%
Community Psychiatric Support Treatment-Individual	$137,689,909	$143,167,880	$150,030,330	4.5%
Cuyahoga Waiver	$4,576,914	$4,855,662	$4,700,268	4.1%
Mental Health Assessment- Physician	$17,734,879	$3,409,249	$4,141,957	(18.7%)
Mental Health Assessment- Non-Physician	N/A	$18,946,979	$21,579,333	13.9% [2]
Medical/ Somatic	$54,811,359	$55,188,738	$60,531,537	6.9%
Partial Hospitalization	$44,946,284	$47,511,390	$50,129,332	4.9%
Total Procedure Costs	**$348,384,950**	**$371,138,387**	**$398,895,227**	**7.1%**
Total Costs	**$348,895,650**	**$371,383,929**	**$398,895,227**	**7.1%**
Administrative Costs as a % of Total Costs	***0.14%***	***0.66%***	***N/A***	***N/A***

Source: ODMH and MACSIS

Note: Unaudited financial figures from claims system

[1] This figure does not represent a full year's administrative costs as ODMH has not yet submitted all of its administrative costs. These costs do not reflect any administrative costs from the CMH/ADAMH boards as these costs are currently not reported.

[2] As no expenditures were noted for this category prior to SFY 2003-04, the percent change figure represents the change from SFY 2003-04 to SFY 2004-05.

ODMH's Medicaid expenditures increased an average of 7.1 percent annually from SFY 2002-03 to SFY 2004-05. However, like ODJFS, identifiable administrative costs were negligible. While community psychiatric support treatment for individuals represents the most material service category, growth in Medicaid expenditures is driven primarily by individual behavioral health counseling and therapy and Medical/ Somatic services.

Table 3C-4 summarizes the ODADAS expenditures by service category for SFY 2002-03 through SFY 2004-05.

Table 3C-4: ODADAS Medicaid Expenditures for SFY 2002-03 through 2004-05

	SFY 2002-03	SFY 2003-04	SFY 2004-05	Average Annual Percent Change SFY 2002-03 2004-05
Total ODADAS Administrative Costs	$386,790	$350,913	$158,193 [1]	N/A
Medicaid Costs by Procedure:				
Ambulatory Detoxification	$80,025	$121,407	$116,337	21.9%
Assessment	$3,739,971	$3,984,155	$4,253,958	5.5%
Case Management	$6,375,143	$6,204,383	$6,799,101	2.8%
Group Counseling	$11,775,890	$13,674,091	$14,335,872	8.9%
Individual Counseling	$6,430,823	$6,617,465	$7,076,897	5.4%
Crisis Intervention	$269,521	$287,182	$415,234	37.6%
Intensive Outpatient	$12,712,303	$14,910,438	$16,072,765	11.8%
Laboratory Urinalysis	$1,492,860	$1,763,772	$2,162,794	20.3%
A-MARP	$462,000	$480,000	$540,000	3.8%
Medical/Somatic	$2,033,572	$2,349,100	$2,700,332	11.5%
Methadone Administration	$2,135,136	$2,532,721	$3,002,404	19.2%
Total Procedure Costs	**$47,507,244**	**$52,924,713**	**$57,475,693**	**9.1%**
Total Costs	**$47,894,034**	**$53,275,626**	**$57,633,886**	**9.1%**

Source: ODADAS and MACSIS

Note: Unaudited self-reported financial figures

[1] This figure does not represent a full year's administrative costs as ODADAS has not yet submitted all of its administrative costs. . These costs also do not reflect any administrative costs from the ADAS/ADAMH boards as these costs are currently not reported.

ODADAS's Medicaid expenditures are almost entirely comprised of direct service expenditures. The most material service categories include intensive outpatient and group counseling services. While the largest growth in expenditures was noted in crisis intervention services, the 9.1 percent increase in total Medicaid expenditures is driven by increases in laboratory urinalysis, methadone administration, and intensive outpatient services.

Table 3C-5 presents ODA Medicaid expenditures for SFY 2002-03 through SFY 2004-05.

Table 3C-5: ODA Expenditures for SFY 2002-03 through SFY 2004-05

	SFY 2002-03	SFY 2003-04	SFY 2004-05	Average Annual Percent Change SFY 2002-03 to SFY 2004-05
Aging Administration	$3,635,886	$4,381,731	$4,367,327	10.1%
AAA/PAA Administration	$46,732,600	$49,666,787	$53,586,271	7.1%
Total Medicaid Administrative Costs	**$50,368,486**	**$54,048,518**	**$57,953,598**	**7.3%**
PASSPORT Services:				
Personal Care Service	$141,550,998	$163,167,763	$193,043,126	16.8%
Home Delivered Meals	$21,327,710	$24,221,780	$27,585,715	13.7%
Adult Day Service	$11,270,297	$11,899,936	$12,832,603	6.7%
Homemaker Services	$4,354,960	$3,744,397	$3,576,186	(9.3%)
Emergency Response System	$4,830,993	$5,153,002	$5,728,914	8.9%
Medical Equipment	$5,200,230	$6,704,604	$8,178,409	25.5%
Medical Transportation	$2,702,838	$3,325,563	$4,621,193	31.0%
Minor Home Modification	$1,484,081	$1,799,939	$2,377,420	26.7%
Chore Services	$250,543	$297,602	$409,338	28.2%
Social/Work Counseling	$256,252	$288,294	$371,437	20.7%
Independent Living Assistance	$102,626	$104,119	$121,369	9.0%
Nutrition Consultation	$22,332	$33,235	$36,089	28.7%
PASSPORT Sub-total	**$ 193,353,859**	**$ 220,740,233**	**$ 258,881,800**	**15.7%**
Choices Services:				
Home Care Attendant Services	$1,050,517	$1,781,684	$1,957,728	39.7%
Meals Delivered: Home Delivered	$44,451	$66,431	$59,168	19.3%
Meals: Special	$0	$660	$2,032	N/A
Center Based Adult Day Services	$15,780	$27,017	$66,147	108.0%
Personal Emergency Response System	$13,574	$24,061	$26,249	43.2%
Specialized Medical Equipment & Supplies	$5,485	$11,370	$17,849	82.1%
Environmental Access Adaptations	$6,985	$0	$6,028	N/A
Choices Sub-Total	**$1,136,792**	**$1,911,222**	**$2,135,200**	**39.9%**
Total ODA Medicaid Expenditures	**$244,859,137**	**$276,699,973**	**$318,970,599**	**14.1%**

Source: ODA

Note: Unaudited self-reported financial figures

While ODA's administrative expenditures appear to be higher than the other Medicaid state agencies, it is important to note that ODA was able to supply the administrative costs of its local area aging agencies (AAA), while other state departments were unable to provide these expenditures. ODA's expenditures increased at an average annual rate of 14.1 percent from SFY 2002-03 to SFY 2004-05. ODA's primary waiver program is the PASSPORT program, which mirrored the overall average annual expenditure growth rate of 15.7 percent. While medical transportation services increased at an average rate of 31 percent, personal care services represents the most significant service category within the PASSPORT program. These expenditures increased by an average of 16.8 percent from SFY 2002-03 through SFY 200405.

Table 3C-6 presents ODMRDD Medicaid expenditures for CY 2003 through CY 2004. The expenditures in the table only include those reported by the county boards of mental retardation and developmental disabilities and administrative costs for ODMRDD. They do not include expenditures for the developmental centers operated by ODMRDD.

Table 3C-6: MRDD Expenditures for CY 2003 through CY 2004[1]

	CY 2003	CY 2004	Average Annual Percent Change CY 2003-CY 2004
ODMRDD Administrative Costs	$16,060,076	$20,610,574	28.3%
County General Administration	$93,796,671	$98,556,610	5.1%
Subtotal of Administrative Costs	$109,856,747	$119,167,184	8.5%
Total Admin. Costs as % of total ODMRDD Costs	9.9%	10.3%	N/A
Support Services	$204,585,868	$203,916,171	(0.3%)
Direct Services	$579,337,447	$614,879,721	6.1%
Physician Services	$208,775	$81,564	(60.9%)
Nursing Services	$22,665,882	$23,793,935	5.0%
Speech/Audio Services	$18,585,414	$19,601,359	5.5%
Psychology Services	$7,016,483	$7,914,923	12.8%
Occupational Therapy	$13,474,134	$14,271,374	5.9%
Physical Therapy	$11,722,347	$12,339,442	5.3%
Social Work	$2,115,170	$1,841,836	(12.9%)
Nutritional Services	$53,643	$49,855	(7.1%)
Transportation	$142,208,488	$140,793,564	(1.0%)
Total	**$1,111,830,397**	**$1,158,650,928**	**4.2%**

Source: ODMRDD

Note: Unaudited self-reported financial figures. In addition to services listed, ODMRDD operates developmental centers (ICF/MRs) which are eligible for Medicaid reimbursement; however, these expenditures were not available on a calendar year basis and are not included in **Table 3C-6**. Medicaid expenditures for developmental centers in SFY 2002-03 were $235,746,356 and in SFY 2003-04 were $230,024,140.

[1] Numbers reported in calendar year. 2005 figures were not provided.

ODMRDD administrative costs appear to be a larger component of total expenditures than other sub-recipient systems. These expenditures experienced a 28.3 percent increase from CY 2003 to CY 2004. County administrative costs jumped 5.1 percent which is primarily explained by a 22.7 percent increase of these costs within the case management program and an 11.8 percent increase in administrative costs within the community residential services program. Direct services costs experienced the most significant year to year increases of the material expenditure line items. This cost category increased by 6.1 percent from CY 2003 to CY 2004. This is primarily explained by a 19.0 percent increase in direct service costs within the case management program and a 15.5 percent increase in the community residential services program. However, these increases were offset by a 12.7 percent decrease in the ICF-MR program.

Appendix 3-D: Timeline of Federal Legislative Changes

Appendix 3-D illustrates a time line of federal legislative changes categorized by changes to eligibility, changes to benefits, and the flexibility States have to administer their programs. The arrows in the tables indicate increases in service levels (up arrows), decreases in service levels (down arrows), or changes that had no discernable financial or service impact (horizontal arrows).

Table 3D-1: Timeline of Federal Legislative Changes

Mandatory Eligibility Issues	
1960's & 1970's	**1965**: Established Medicaid by expanding the Kerr-Mills program. Participating States must cover "mandatory" populations (Aid to Families with Dependent Children (AFDC) and other cash assistance recipients). ↓**1967**: Concern about the growing federal costs of the Medicaid program led Congress to limit "medically needy" to those whose income was 133 1/3 percent of the AFDC income eligibility level in a State. ↔**1972**: Sates must either cover SSI ABD population recipients or use their 1972 Medicaid eligibility standards ("209(b) option").
1980's	↑**1984**: 1.)Mandated coverage of children under age 5 whose family incomes fall below State AFDC payment levels and pregnant women eligible for AFDC and for AFDC-UP after their children are born. 2.) Mandated coverage for one year for newborns born to women receiving Medicaid as long as their mothers remain eligible for Medicaid. 3.) Required transitional medical assistance by extended eligibility 12 months for persons losing AFDC and thus Medicaid benefits from increased earnings ↑**1985**: Mandate for coverage of all remaining AFDC eligible pregnant women. ↑**1986**: Required States to cover treatment of emergency medical conditions for illegal immigrants eligible for Medicaid. ↑**1988**: 1.) Mandated coverage of pregnant women, infants & QMBs with incomes up to 100 percent of the federal poverty level. 2.) Established special eligibility rules for institutionalized persons whose spouse remained in the community. 3.) Extended transitional medical assistance to families. ↑**1989**: Extended coverage of pregnant women and children < 6 to 133 percent of FPL.
1990's	↑**1990**: Mandated the phase-in coverage of children ages 6 - 18 to 100 percent of the FPL. ↓**1996**: 1.) Made eligibility for existing legal immigrants entering the US prior to 8/22/96 more restrictive. 2.) Barred new legal immigrants entering the US after 8/22/96 from receiving Medicaid for 5 years. 3.) Made the SSI disability definition more restrictive for children. ↔**1997**: Restored Medicaid eligibility changed by the welfare reform law to elderly, disabled, and children.
2000's	None

Mandatory Benefits Issues	
1960's & 1970's	**1965**: Medicaid program required services such as: physician, inpatient and outpatient hospital, laboratory and x-ray, skilled nursing facility, and supplemental coverage to low-income Medicare beneficiaries for services not covered by Medicare. ↑**1967**: Required Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program for children.
1980's	↑**1989**: Expanded EPSDT services, amount, duration, scope of services, requirements, and penalties for non-compliance. 2.) Mandated coverage and full cost reimbursement of federally qualified health centers (FQHCs).
1990's	↑**1990**: Required States to pay part B premium for Medicare beneficiaries with incomes up to 120 percent of the FPL. ↑**1997**: States must pay Medicare premiums for elderly and disabled with incomes between 120 and 135 percent of FPL.
2000's	↔**2003**: Establishes a new Medicare Part D prescription drug program transfers administration of drug purchasing dual eligible individual with incomes < 135 percent of FPL to Medicare effective January 1, 2006. States are required reimburse Medicare for their estimated transferred liability ("clawback"). ↓**2005 - Deficit Reduction Act of 2005 (DRA)** – Made several revisions to Medicaid, allowing states to reduce benefits, increase cost sharing; limit payments for certain drugs, and tighten rules related to asset transfers.

Optional Eligibility Issues	
1960's & 1970's	**1965**: States could cover "optional" populations such as the "medically needy" (ineligible for cash assistance but high medical expenses) ↑ **1967**: Permitted states to cover children in two-parent families.
1980's	**1986**: Option to cover pregnant women and infants <1 yr. old up to 100 percent of FPL and pay for Medicare premiums and cost-sharing for qualified Medicare beneficiaries (QMBs) with income at or below 100 percent of FPL. **1987**: Option of covering pregnant women and children <1 yr. old with income up 185 percent of FPL.
1990's	↑**1997**: Enacted the Children's Health Insurance Program (SCHIP) as a federal block grant to states. Allowed States to either expand Medicaid or create a separate program to cover more children. ↑**1999**: Allowed States to cover working disabled with incomes > 250 percent of FPL and impose income-related premiums.
2000's	↑**2000**: Allowed States to cover uninsured women with breast or cervical cancer regardless of income at enhanced SCHIP federal matching rate.

Optional Benefits Issues	
1960's & 1970's	**1965**: States could offer services such as: prescription drugs, clinic services, home health care, dental, physical therapy, and other diagnostic, screening, preventive, and rehabilitative services. ↑**1971**: States are given the option to cover services in intermediate care facilities (ICFs) for the those elderly, disabled, and mentally retarded individuals with lower care needs.
1980's	**1982**: Allowed States to extend Medicaid coverage to children under age 18 with disabilities requiring institutional care but living at home and waived SSI income restrictions for families.
1990's	**None**
2000's	**None**

Service Flexibility	
1960's & 1970's	**None**
1980's	↑**1981**: While section 1115 waiver authority predated the Medicaid program, OBRA 81 established two new types of Medicaid waivers 1915(b) freedom-of-choice waivers allowing mandatory managed care enrollment; and 1915(c) HCBS waiver, allowing coverage of home and community based services for ABD populations.
1990's	↑**1991**: Expanded use of Section 1115 Research and Demonstration waivers to extend coverage to non-traditional Medicaid populations and expand managed care. ↑**1993**: The Clinton Administration begins approving section 1115 waivers to States allowing more statewide expansion demonstrations. ↑**1997**: Permitted States to condition Medicaid coverage for nearly all enrollees on mandatory enrollment in a qualified MCO without a federal waiver.
2000's	↑**2000**: Streamlined approval of continuations of section 1115 waivers. ↑**2001**: Section 1115 waiver initiative, Health Insurance Flexibility and Accountability (HIFA), allows States to demonstrate comprehensive State approaches that will increase health insurance coverage using current-level Medicaid and SCHIP resources. ↑**2005 - Deficit Reduction Act of 2005 (DRA)** – Made several revisions to Medicaid, allowing states to reduce benefits, increase cost sharing; limit payments for certain drugs, and tighten rules related to asset transfers.

	Other
1960's & 1970's	**1972**: States were permitted to reduce expenditures on Medicaid from one year to the next.
1980's	**None**
1990's	**1990**: Established the Medicaid prescription drug rebate program requiring pharmaceutical companies to give "best price" rebates to States and federal government. **1996**: Replacement of AFDC welfare program with a block grant severed the automatic link between welfare assistance and Medicaid eligibility.
2000's	**2000**: Established upper payment limits for publicly (but not State) owned or operated health facilities and for outpatient & inpatient entities. **2005**: Resolution requiring $10 billion in cost savings from the Medicaid program & requiring advisory Medicaid commission to identify short & long-term savings. **Deficit Reduction Act of 2005 (DRA)** – Made several revisions to Medicaid, allowing states to reduce benefits, increase cost sharing; limit payments for certain drugs, and tighten rules related to asset transfers.

Source: Kaiser Foundation and National Governor's Association

Appendix 3-E: Medicaid Administering State Agency Strategic Management

Appendix 3-E presents more detailed summaries of strategic management and planning documents in a manner that allows comparison among the differing state agencies and assessment of the effectiveness of these documents.

Table 3E-1: Summary of OHP's BSC Supporting Performance Metrics

Strategic Objective	Number of Performance Metrics	Performance Measurement is Quantifiable and related to Output?	Performance Measurement is Quantifiable and Related to Outcome?
Strategy One: Use value-purchasing strategies to afford consumers health plans that provide accessibility, network management, quality, and improved outcomes			
1.1 Provide a regular source of primary care for consumers that coordinates care, as needed, emphasizes preventive health, guides consumers to appropriate care settings, and encourages consumers to participate.	1	No	No
1.2 Develop and implement a care management strategy for selected high cost populations.	1	No	No
1.3 Enhance OHP's Member Services to enable consumers to effectively utilize their health plan	3	No- 3	No- 3
1.4 Transform our provider network management to enhance accessibility, accountability, and the delivery of evidenced-based quality care.	0	N/A	N/A
1.5 Improve relationships and communication with stakeholders external to JFS to support value purchasing.	4	No- 4	No- 4
Strategy Two: Continually improve the effectiveness of publicly funded health care systems and expand integrated community service options for adults and children with disabilities.			
2.1 Continue to implement delivery system reforms and expansions to community care options covered by Medicaid and administered by other agencies through interagency agreements.	9	Yes- 1 No- 8	Yes- 0 No- 9
2.2 Improve the OHP Home Care Program to improve access, fiscal integrity and make service delivery system responsiveness to consumers.	5	No- 5	No- 5
2.3 Better align funding for institutional and community based long-term care services with consumer's choice and need.	1	No	No
Strategy Three: Improve the effectiveness and agility of OHP's business operations and information technology through performance and project management.			
3.1 To improve the administration of OHP's administrative budget and human capital resources	2	Yes- 1 No- 1	Yes- 0 No- 2

through automated reporting and streamlined hiring processes.			
3.2 As an early adopter of the CMS MITA architecture, OHP will implement the MITS project to develop human capital skills, reengineer business processes, and implement business drive information technology systems to enable OHP to meet the challenges and customer service needs of a 21st century health plan.	3	No- 3	No- 3
3.3 To deliver OHP priority business/IT projects on time, on budget and to business user requirements through implementation of project and change management methodologies.	2	No- 2	No- 2
3.4 To develop and implement a performance management framework to enable OHP to assess, benchmark and improve its performance through focus on organizational learning and accountability for business results.	1	No	No
3.5 Develop a human capital management plan to guide OHP future hiring.	1	No	No
3.6 To develop a comprehensive annual program integrity work plan which facilitates office wide coordination and alignment mitigates risk and documents results.	6	No- 6	No- 6
Strategy Four: Continually improve cost management of OHP.			
4.1 Invest in key administrative and system capacity.	1	No	No
4.2 Responsibly slow the rate of growth in ODJFS all-funds spending for Medicaid medical services to a level that is more sustainable with existing state revenues.	2	Yes- 0 No- 2	Yes- 1 No- 1
4.3 Develop innovative cost management approaches to achieve reasonable growth in average per member per month costs across Medicaid populations.	3	Yes- 2 No- 1	Yes- 1 No- 2
Strategy Five: Continually enhance workforce excellence through proactive management, staff development, support, and recognition.			
5.1 Improve talent development through staff learning, retention, promotion, and recruitment.	2	Yes- 2 No- 0	Yes- 0 No- 2
5.2 Improve staff morale and productivity through initiatives based on staff perceptions of the workplace.	6	Yes- 6 No- 0	Yes- 0 No- 6
5.3 Improve communication within OHP, between the Deputy Director's Office, Bureaus and OHP staff.	3	Yes- 3 No- 0	Yes- 0 No- 3
5.4 Improve employee recognition focusing on excellent performance.	1	Yes- 1 No- 0	Yes- 0 No- 1
Total	**57**	**Yes- 15 No- 42**	**Yes- 2 No- 55**
Percentage	**N/A**	**Yes- 26.3% No- 73.7%**	**Yes- 3.5% No- 96.5%**

Source: OHP BSC strategic plan

Table 3E-2: Summary of Agencies' Competing Strategies and Policies

	Strategies and Policies
ODJFS/OHP	A1. Continue to implement delivery system reforms and expansions to community care options covered by Medicaid and administered by other agencies through interagency agreements and waivers. A2. Better align funding for institutional and community based long-term care services with consumer's choice and need. B1. Continually enhance workforce excellence through proactive management, staff development, support, and recognition. B2. To improve the administration of OHP's administrative budget and human capital resources through automated reporting and streamlined hiring processes. B3. Improve information technology resources for policy development to support cost containment goals. In addition, OHP will implement the Medicaid Information Technology System (MITS) Project. B4. To develop and implement a performance management framework to enable OHP to assess, benchmark and improve its performance through focus on organizational learning and accountability for business results. B5. Develop a human capital management plan to guide OHP future hiring. B6. To develop a comprehensive annual program integrity work plan which facilitates office-wide coordination and alignment mitigates risk and documents results. B7. Continually enhance workforce excellence through proactive management, staff development, support, and recognition. This will be achieved through talent development through learning, retention, promotion, and recruitment. B8. Improve communication within OHP, between the Deputy Director's Office, Bureaus, and OHP staff. C1. Use value-purchasing strategies to afford consumers health plans that provide accessibility, network management, quality, and improved outcomes. This strategy seeks to better coordinate care, emphasize preventative health, matches consumers with appropriate care settings, care management for high cost populations, and seeks to educate consumers on health issues and available services for more effective self directed care. C2. Invest in key administrative and system capacity to discover and deter provider fraud, detect 3rd party resources, and bolster JFS capacity to oversee other State agencies who manage the day-to-day administration of Medicaid programs. C3. Identify high cost services or programs and design innovative cost management approaches or incremental program improvements to achieve reasonable growth in average PMPM.
ODMRDD	1. Develop sustainable resources that are consistently and equitably distributed and administered. 2. Increase the capacity of State and local systems to support individuals and families. 3. Work collaboratively with partners and stakeholders to establish statewide policy that positively affects the day-to-day lives of individuals and their families. 4. Communicate and promote, throughout the MRDD system, and environment of open dialogue about system issues and changes as they are developed and implemented.
ODMH	A1. Decrease disparities in access to service for diverse populations B1. Expand risk management procedures to non-forensic patients in Behavioral Healthcare Organizations. B2. Increase collaboration among entities that serve the mental health population. B3. Develop and disseminate administrative best practices to the mental health system B4. Increase the financial capacity of the mental health system & increase direct care dollars. C1. Increase school success of children with mental health ailments. C2. Increase employment for people with mental illness. C3. Reduce incarceration of mentally ill persons in the criminal justice system through diversion

	to treatment. D1. Increase consumer physical protections from abuse and neglect. D2. Decrease out of home care placements. D3. Increase responsiveness to consumer concerns. E1. Develop and disseminate evidence-based practices to the mental health system. E2. Retain qualified employees in the mental health system E3. Increase staff's capacity to do their job and the competence of employees in the mental health system
ODADAS	A1. Remove barriers to employment. B1. Educate Ohio citizens an systems about the benefits of an AOD system through publications and training programs. C1. Educate non-chemical dependency professionals about alcohol and drug issues. C2. Collaborate with medical schools in establishing curriculum pertaining to alcohol and drug issues. D1. Increase consumer awareness of prevention, treatment, and recovery services. D2. Diversify revenue sources to support Ohio's alcohol and other drug system. D3. Facilitate improvements in the capacity of local boards and providers to pursue revenue opportunities. D4. More effective utilization of current revenue sources and new revenue sources for the prevention and treatment system in Ohio. D5. Continue to provide effective and efficient communication with boards and providers to enhance partnership relationships. D6. Increase the number of prevention, treatment and recovery programs. E1. Utilize latest technologies to improve effectiveness and efficiencies. E2. Develop a highly effective workforce for the alcohol and other drug system (including ODADAS staff) that has the knowledge, values and skills to be effective in their roles. E3. Use an evidence based approach to develop policies, practices, strategies, and programs utilized in the AOD prevention and treatment and recovery system.
ODA	A1. Seeking to better match the supply of services to demand by rebalancing long-term care spending. A2. Integration of systems and programs to better match services with consumer needs. B1. Increase utilization of services by unserved and underserved populations through facilitating increased cultural competency among the ageing network staff and providers. B2. Increase utilization of services by unserved and underserved populations through educating these populations of programs and services. C1. Increase awareness of vocation options among graduating seniors and individuals entering health care careers. C2. Include care givers as partners in Ohio's home and community based care system and incorporate their basic needs into all aspects of the system. D1. Advocate for health, active lifestyles for older Ohioans to encourage communities to consider elders' needs in local planning and development and promote wellness programs for elders. D2. Advocate for older adults to ensure that their interests are represented in the legislative and policymaking process. E1. Use research methods to provide quality information for effective decision-making when developing and modifying programs and services. E2. Implement a joint ODA, AAA, and service provider process to review the effectiveness of current programmatic polices and practices to eliminate non-value adding functions, maximize coordination between programs, and enhance service delivery.
ODH	A1. Market healthy lifestyle choices to the community through the Healthy Ohioans program. B1. Use vaccinations to prevent diseases.

	B2. Train office physicians on effects of unhealthy lifestyle choices (ex. smoking cessation). B3. Collaborate with other governmental entities to prevent vector spreading of diseases (ex. establish MOU with the Ohio Dept. of Agriculture and Natural Resources to conduct animal surveillance). C1. Use all available funding sources (MAC) and coordinate funding sources to leverage current funding. D1. Monitor development of State & local hospital disaster plans. E1. Develop Abuse & Neglect prevention policies. E2. Facilitate self improvement of home health agency operators and nursing staff by developing management tools, education, and information programs F1. Increase automation and self service aspects of business processes through the use of web-based technology.

Source: Medicaid agency planning documents

Note: The presentation of planning initiatives was interpreted and formatted for the best comparison with other Ohio Medicaid departments and consistency with AOS interpretations of strategic planning terminology.

[1] ODMRDD did not have a comprehensive strategic planning document, however, excerpts from the RFP requesting outside assistance in designing a quality management system were used to the extent possible.

Appendix 3-F: Comparison of State Medicaid Program Efficiency Indicators

Appendix 3-E presents information used in evaluating other state Medicaid programs based on efficiency ratios. This comparison was conducted to help ensure that the Ohio Medicaid program was evaluated against the practices of other state programs that have achieved efficient operations.

Table 3F-1: State Comparison of Efficiency Indicators for the Medicaid Program

State Name	2002 Total Cost per Eligible:	2002 Total Cost per Claim:	2002 Total Claims per Eligible	2003 Total Cost per Eligible	2003 Total Per Claim	2003 Total Claims per Eligible	2003 Medicaid Payments as % of State GSP	2003 Medicaid Payments per State Resident	2003 Medicaid Claims per State Resident	2003 Medicaid Payments per Poor & Near Poor State Residents	Average annual Growth in Medicaid spending 1991-2001	Composite Relative Efficiency Score
California	$2,531.61	$84.75	29.9	$2,569.05	$86.99	29.5	1.66%	$727.08	8.4	$1,821.05	11.00%	25.0
Oklahoma	$3,302.23	$120.08	27.5	$3,193.45	$105.93	30.1	1.98%	$624.38	5.9	$1,561.20	10.00%	25.0
Virginia	$4,146.66	$141.88	29.2	$4,318.05	$141.29	30.6	0.97%	$434.90	3.1	$1,477.00	10.00%	22.0
Georgia	$3,285.77	$78.20	42.0	$3,265.80	$76.81	42.5	1.56%	$621.90	8.1	$1,705.84	11.00%	17.0
Texas	$3,472.96	$76.41	45.5	$3,420.92	$80.05	42.7	1.42%	$568.00	7.1	$1,300.56	13.00%	16.5
Florida	$3,651.12	$92.49	39.5	$3,908.20	$99.09	39.4	1.85%	$647.55	6.5	$1,725.53	12.00%	16.0
Michigan	$3,874.52	$156.44	24.8	$4,120.59	$118.57	34.8	1.74%	$651.98	5.5	$1,894.97	10.00%	15.0
Arizona	$2,735.25	$149.05	18.4	$2,568.91	$156.11	16.5	1.64%	$582.27	3.7	$1,458.15	15.00%	14.0
Oregon	$3,353.11	$83.22	40.3	$3,381.17	$90.95	37.2	1.65%	$593.51	6.5	$1,666.07	16.00%	14.0
Utah	$5,213.76	$140.05	37.2	$4,315.78	$125.62	34.4	1.45%	$506.76	4.0	$1,453.37	11.00%	13.5
Louisiana	$3,266.15	$82.51	39.6	$3,428.23	$75.28	45.5	2.36%	$819.74	10.9	$1,824.78	11.00%	13.0
South Dakota	$4,423.50	$110.31	40.1	$4,527.50	$110.25	41.1	1.84%	$723.25	6.6	$2,106.47	10.00%	13.0
Nevada	$3,561.89	$131.56	27.1	$3,731.08	$154.67	24.1	0.88%	$380.24	2.5	$1,072.30	15.00%	12.5
Indiana	$4,223.93	$87.73	48.1	$4,179.56	$90.07	46.4	1.74%	$643.73	7.1	$1,960.75	10.00%	12.0
Washington	$3,958.29	$124.41	31.8	$3,897.96	$127.36	30.6	1.73%	$745.92	5.9	$2,295.22	12.00%	10.5
Illinois	$4,393.58	$151.11	29.1	$4,312.46	$150.11	28.7	1.80%	$745.98	5.0	$2,178.35	11.00%	10.0
Arkansas	$3,314.77	$65.85	50.3	$3,274.29	$66.34	49.4	2.73%	$822.88	12.4	$1,909.26	10.00%	8.5
Wyoming	$4,017.82	$111.52	36.0	$4,227.73	$117.50	36.0	1.35%	$663.09	5.6	$2,093.72	13.00%	8.0
Colorado	$4,938.11	$100.97	48.9	$4,787.70	$102.31	46.8	1.13%	$507.14	5.0	$1,678.41	13.00%	7.0
Kansas	$4,920.42	$107.68	45.7	$4,965.74	$102.95	48.2	1.63%	$607.06	5.9	$1,829.99	12.00%	5.0
Missouri	$3,706.37	$75.44	49.1	$3,808.10	$83.52	45.6	2.17%	$785.33	9.4	$2,317.20	16.00%	5.0
Montana	$5,016.39	$95.91	52.3	$4,851.90	$89.42	54.3	1.95%	$589.93	6.6	$1,392.74	9.00%	5.0
South Carolina	$3,776.19	$110.33	34.2	$3,670.75	$108.28	33.9	2.68%	$891.39	8.2	$2,309.90	12.00%	5.0
Wisconsin	$4,642.50	$85.22	54.5	$4,338.26	$115.60	37.5	1.85%	$720.42	6.2	$2,300.39	8.00%	5.0
Alabama	$3,791.23	$82.30	46.1	$3,886.76	$88.06	44.1	2.48%	$779.58	8.9	$1,957.85	12.00%	4.0
Tennessee	$2,792.05	$69.10	40.41	$3,305.69	$52.12	63.4	2.51%	$931.54	17.9	$2,375.50	13.00%	3.5
Idaho	$4,031.77	$83.68	48.2	$4,154.10	$78.63	52.8	1.99%	$634.74	8.1	$1,700.25	15.00%	3.0
Pennsylvania	$4,981.84	$148.75	33.5	$5,288.03	$156.75	33.7	2.02%	$777.57	5.0	$2,315.39	12.00%	1.5
Mississippi	$3,530.64	$86.52	40.8	$3,515.45	$74.83	47.0	3.37%	$902.09	12.1	$1,952.26	13.00%	0.5
Nebraska	$4,713.85	$102.10	46.2	$4,762.05	$108.53	43.9	1.88%	$745.52	6.9	$2,422.91	13.00%	(1.0)
Iowa	$5,173.62	$97.20	53.2	$5,271.10	$91.37	57.7	1.80%	$686.21	7.5	$2,283.96	9.00%	(1.5)
Maryland	$4,869.38	$148.09	32.9	$5,328.09	$161.22	33.0	1.93%	$799.92	5.0	$2,789.49	10.00%	(2.0)
North Carolina	$4,347.76	$74.02	58.7	$4,496.76	$74.18	60.6	1.94%	$788.02	10.6	$1,961.29	14.00%	(2.5)
New Jersey	$5,594.20	$132.87	42.1	$6,186.74	$135.27	45.7	1.45%	$700.05	5.2	$2,528.31	11.00%	(3.0)
Hawaii	$3,553.07	$126.36	28.1	$3,582.04	$118.49	30.2	2.99%	$1,226.69	10.4	$3,493.84	11.00%	(3.5)
North Dakota	$5,902.70	$137.09	43.1	$5,801.00	$136.54	42.5	1.96%	$714.59	5.2	$2,235.87	7.00%	(4.0)
Ohio	$5,236.23	$96.58	54.2	$5,279.20	$96.91	54.5	2.44%	$910.61	9.4	$2,763.42	9.00%	(5.5)
New Mexico	$3,873.39	$199.76	19.4	$4,126.11	$192.57	21.4	3.33%	$1,082.28	5.6	$2,367.39	15.00%	(6.5)
Delaware	$4,425.26	$139.37	31.8	$4,787.18	$117.26	40.8	1.38%	$914.51	7.8	$2,973.77	15.00%	(7.0)
Massachusetts	$5,303.53	$119.89	44.2	$5,355.51	$101.42	52.8	2.01%	$1,005.01	9.9	$3,345.41	7.00%	(8.0)
Minnesota	$6,522.65	$179.35	36.4	$6,438.84	$179.66	35.8	2.10%	$922.84	5.1	$3,767.05	9.00%	(8.0)
Kentucky	$4,493.70	$65.99	68.1	$4,391.51	$62.03	70.8	2.61%	$875.08	14.1	$2,116.72	12.00%	(8.5)
New Hampshire	$6,455.80	$117.67	54.9	$6,060.95	$115.22	52.6	1.52%	$615.72	5.3	$2,726.38	13.00%	(10.5)
Vermont	$3,868.87	$87.25	44.3	$4,018.38	$87.87	45.7	2.93%	$1,047.38	11.9	$3,700.28	13.00%	(10.5)
West Virginia	$4,355.11	$85.93	50.7	$4,989.18	$91.29	54.7	3.70%	$1,023.86	11.2	$2,266.07	13.00%	(14.0

State Name	2002 Total Cost per Eligible:	2002 Total Cost per Claim:	2002 Total Claims per Eligible	2003 Total Cost per Eligible	2003 Total Per Claim	2003 Total Claims per Eligible	2003 Medicaid Payments as % of State GSP	2003 Medicaid Payments per State Resident	2003 Medicaid Claims per State Resident	2003 Medicaid Payments per Poor & Near Poor State Residents	Average annual Growth in Medicaid spending 1991-2001	Composite Relative Efficiency Score
Connecticut	$6,650.03	$149.57	44.5	$6,688.69	$162.31	41.2	1.81%	$974.03	6.0	$3,687.54	10.00%	(15.5
Rhode Island	$6,110.88	$185.80	32.9	$6,338.15	$200.50	31.6	3.21%	$1,270.92	6.3	$3,724.50	10.00%	(17.0
Maine	$4,954.79	$111.00	44.6	$5,482.41	$121.32	45.2	4.79%	$1,615.83	13.3	$4,614.26	11.00%	(20.5)
District of Columbia	$6,847.55	$172.52	39.7	$7,637.36	$185.77	41.1	1.56%	$2,188.93	11.8	$5,361.44	8.00%	(21.0)
Alaska	$5,657.29	$150.01	37.7	$6,600.32	$162.81	40.5	2.46%	$1,317.47	8.1	$4,271.77	13.00%	(28.0)
New York	$7,177.04	$106.19	67.6	$7,681.43	$109.53	70.1	3.93%	$1,853.72	16.9	$4,875.88	9.00%	(31.0)

Source: CMS and the Kaiser Family Foundation

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Service Provision

Service Provision Section Table of Contents

Background

This section focuses on service provision within the Ohio Medicaid program and includes covered services, eligibility, reimbursement methodologies, and the certificate of need program for nursing facilities. This section also analyzes specific services, such as the prescription drug program, waivers, and long-term care. Comparisons are made using data from the U.S. Department of Health and Human Services (HHS), the Centers for Medicare and Medicaid Services (CMS), the Kaiser Commission on Medicaid and the Uninsured (Kaiser Commission), the Pew Center on the States (Pew Center), Scripps Gerontology Center at Miami University (Scripps), and other state Medicaid programs. Each of the topics within this section is introduced below and described in greater detail in the associated findings and recommendations.

Services

Within broad federal guidelines, each state determines the amount and duration of services offered under its Medicaid program. The amount, duration, and scope of each service must be sufficient to reasonably achieve its purpose. States may place appropriate limits on a Medicaid service based on such criteria as medical necessity or utilization control.

Ohio's Medicaid program includes services mandated by the federal government as well as optional services the State has elected to provide. Once an optional service is identified in the state plan, it must be consistent with all federal requirements. According to the Ohio Department of Job and Family Services (ODJFS), Ohio's single State Medicaid agency, some services are limited by dollar amount, the number of visits per year, or the setting in which they can be provided. With some exceptions, all services are available, as medically necessary, to all Medicaid recipients (i.e., if a child is eligible for Medicaid under the Covered Families and Children category, all medically necessary services, mandatory or optional under federal law, must be covered).

Title 42, Part 440 of the Code of Federal Regulations (42 CFR 440), details the mandatory and optional Medicaid service requirements. **Table 4-1** illustrates Ohio's mandatory and optional Medicaid services, as outlined in the CFR.

Table 4-1: Ohio's Mandatory and Optional Services for 2006

Federally Mandated Services	Ohio's Optional Services
Inpatient hospital services	Ambulance/Ambulette[1]
Outpatient services, including rural health clinics and federally qualified health centers	Vision care, including eyeglasses[1]
Physician services	Community alcohol and drug addition treatment[2]
Nurse-midwife, certified family nurse practitioner, and certified pediatric nurse practitioner services	Community mental health services[3]
Lab and x-ray services	Dental services[1]
Medical and surgical dental services	Home and community-based services waivers[1]
Medical and surgical vision services	Hospice care[4]
Family planning services and supplies	Intermediate Care Facilities for people with Mental Retardation (ICF/MR)[5]
Nursing facility care	Physical therapy, occupational therapy, and speech therapy[1]
Durable medical equipment and supplies	Podiatry[1]
Home health services	Prescription drugs[1]
Screening and treatment services to children under age 21 under the health check (EPSDT) program	Chiropractic services for children
Transportation to Medicaid services	Independent psychological services for children
Medicare Premium Assistance	

Source: The Ohio Department of Job and Family Services
Note 1: ODJFS did not provide AOS with the implementation date of optional services.
Note 2: Chiropractic and Independent Psychologist services, both optional services, were no longer covered Medicaid services as of January 1, 2004.
Note 3: The Ohio Department of Mental Health covers psychology services when provided by community mental health centers.
[1] These services primarily administered by ODJFS; however, some of these are administered by multiple agencies.
[2] Ohio Department of Alcohol and Drug Addiction Service administered services.
[3] Ohio Department of Mental Health administered services.
[4] Ohio Department of Aging administered service.
[5] Ohio Department of Mental Retardation and Developmental Disabilities manages these services.

Based on a review of the CFR, the State of Ohio provides all of the federally mandated services and most of the optional Medicaid services. According to ODJFS, adding an optional Medicaid service begins with provider groups and populations that are seeking medical benefits. Of the optional services listed within the CFR, the single State Medicaid Agency's program includes all but chiropractic, independent psychologist, Christian Science school, and personal care optional Medicaid services. However, personal care services are provided under specified waiver programs. A representative from the Ohio Job and Family Services Directors' Association noted, "We have one of the most comprehensive service menus of any state, as I understand it. There are very few things that are on the list of ineligible services."

However, family members of Medicaid recipients noted that some optional services that are not covered could be beneficial. A member of the National Alliance for the Mentally Ill of Ohio remarked that respite care (instead of short-term inpatient care) would be very valuable to some

parents. Another member described how residential treatment would be a better alternative than long-term hospital treatment, but that Ohio does not offer residential treatment for severe psychological disorders under Medicaid. A waiver would be required to offer residential treatment under Medicaid in Ohio. Finally, a recipient spoke to the need for independent psychological services for adults, remarking that this option was removed from Ohio Medicaid recently and that the recipient's doctors had recommended the patient seeing a psychologist to assist in treating mental health issues. The recipient said, "…you can only do so much with medications."

As the single State Medicaid Agency, ODJFS has the option to implement new Medicaid services, or alter and delete current services. The State Medicaid Agency is required to use its state plan[1] to document all mandatory and optional services that are listed in Ohio Administrative Code (OAC) Chapter 5101:3.

Although there is no administrative or revised code pertaining to the process ODJFS uses when implementing new Medicaid services through its state plan, or altering services provided, the CFR provides requirements for initial review and amendment of state plans. Title 42, Part 430.12 of the CFR requires a Medicaid agency to submit a state plan and revised state plan amendments to the state governor or his/her designee for review and comment before submitting them to the CMS regional office.[2] The plan must provide that the governor will be given a specific period of time to review state plan amendments, long-range program planning projections, and other periodic reports on the Medicaid program, excluding periodic statistical, budget, and fiscal reports. Any comments from the governor must be submitted to CMS with the plan or plan amendment. The plan must provide that it will be amended whenever necessary to reflect changes in federal law, regulations, policy interpretations, or court decisions; material changes in state law, organization, or policy; or in the state's operation of the Medicaid program. CMS regional staff review state plans and plan amendments, discuss any issues with the Medicaid agency, and consult with CMS's central office staff on questions regarding the application of federal policy.

Every two years, the Governor of Ohio is required by State law to propose a new budget for State activities. The operating budget proposal must be submitted to the General Assembly not later than four weeks after its organization and is usually submitted to the legislature in early

[1] Ohio's State plan is in operation in accordance with all requirements of Title 42, Part 431.50. The plan is administered by the political subdivisions of the State.

[2] Although each state is responsible for the operation of its Medicaid program, CMS is the federal agency charged with administrative oversight of all Medicaid programs. In this capacity, CMS promulgates regulations, develops policy, and guides states in the operation of their Medicaid programs. CMS also must approve each state plan, all state applications for Medicaid waivers, and any amendments to either the plan or waiver programs. The state of Ohio is in CMS's region five; headed by its Chicago regional office, and includes the states of Indiana, Illinois, Michigan, Minnesota, and Wisconsin.

February of each odd-numbered year. The budget is more than a statutory requirement, it represents a statement of priorities. It sets a strategic policy direction for the activities of state government. Therefore, a detailed budget preparation process is necessary to generate information that will help the Governor and the General Assembly reach consensus regarding the priorities of the State and the most effective use of State resources. The process can be divided into the following components:

- Development of the Governor's Executive Budget;
- Enactment by the legislature; and
- Gubernatorial approval and vetoes.

The Office of Budget and Management (OBM) is the executive agency charged with preparing the Governor's budget recommendations. OBM is a cabinet-level agency within the executive branch of the Ohio State government. The mission of OBM is to provide financial management and policy analysis to help ensure the responsible use of State resources. OBM coordinates, develops, and monitors agency operations and capital budgets, and reviews, processes, and reports financial transactions made by state agencies. OBM also assists the Governor and other State agencies by providing policy and management support relative to the State's fiscal activities.

Changes in the Medicaid program usually involve changes to the Ohio Administrative Code as many of the regulations for the program are contained in these rules. Under Ohio Revised Code (ORC) §119.032, when a State agency proposes a new rule or amends a fully reviewed existing rule, that agency is required to assign a new review date to the rule that is not more than five years from the effective date. When a rule is reviewed by the Joint Committee on Agency Rule Review (JCARR) under the ORC § 119.032 process and a new review date has not been assigned by the agency, or the assigned review date exceeds the five year maximum, JCARR is required to assign a review date five years from the rule's immediately preceding review date.

On or before the designated review date, an agency shall file the rules with JCARR, thereby providing notice of the agency's review determinations. If the agency determines that no change to the rule is necessary, it must file with JCARR and the Legislative Services Commission (LSC) two complete sets and with the Secretary of State one set of the following: a cover letter which includes the rule numbers, a file copy of the rule, a complete and accurate rule summary and fiscal analysis, and the current and next review dates for the rule. The newly assigned review date and the previous review date should appear below the effective date on the rule. The new review date should not be greater than five years from the immediately preceding review date. If JCARR does not vote to invalidate a rule within the 90-day review period, the rule shall continue in effect until further amended or reviewed pursuant to the ORC 119.032 process.

Eligibility and Spend-down

In general, Medicaid eligibility is based on a combination of financial and categorical eligibility requirements. Each state determines income thresholds and resource standards for beneficiaries of the Medicaid program following federal guidelines. These thresholds and standards can vary by state and may differ for each Medicaid-eligible population within a state. The state cannot limit the number of eligible persons enrolled in Medicaid or deny access to medically necessary services in order to control costs.

Table 4-2 illustrates the Medicaid categorically needy eligibility groups mandated by Title XIX of the Social Security Act for which federal matching funds are provided. Additionally, states have the option of providing categorically related eligibility which is also illustrated in **Table 4-2.** According to CMS, these optional groups share characteristics similar to mandatory categorically needy eligibility categories; however, eligibility criteria such as income, resources, and assets, are somewhat more liberally defined.

Table 4-2: Federally Mandated Categorically Needy and Optional Categorically Related Eligibility Groups

Mandatory Categorically Needy	Optional Categorically Related
Meet requirements in CFR Title 45 Public Welfare for Aid to Families with Dependent Children (AFDC), effective 1996	Infants up to age 1 and pregnant women not covered under the mandatory rules whose family income is not more than 185 percent of the federal poverty level
Children under age 6 whose family income is at or below 133 percent of the federal poverty level [1]	Children under age 21 who meet criteria more liberal than the AFDC
Pregnant women whose family income is below 133 percent of the federal poverty level	Institutionalized individuals up to 300 percent of the federal poverty level
Individuals receiving Social Security Income in most states	Home and community-based services [3]
Recipients of adoption or foster care	Aged, blind, or disabled persons with family income less than 250 percent of the federal poverty level who would qualify for Supplemental Security Income if they did not work.
Special protected groups[2]	Recipients of Supplemental Security Income payments
All children born after September 30, 1983 who are under age 19, in families with incomes at or below the federal poverty level	Tuberculosis-infected persons
Certain Medicare beneficiaries	Certain uninsured or low-income women who are screened for breast or cervical cancer through a program administered by the Centers for Disease Control.
	State Children's Health Insurance Program (SCHIP) [4]
	Medically needy [5]

Source: CMS

[1] The federal poverty level was $9,310 for a single person and $15,670 for a family of three in 2004. The income eligibility level given for parents (42 percent of the federal poverty level) is the national median income threshold for non-working parents based on a family of three as of July 2004. The federal poverty level was $9,570 for a single person and $16,090 for a family of three in 2005. The current federal poverty level is $9,800 for a single person and $16,600 for a family of three in 2006.

[2] Special protected groups are typically individuals who lose their cash assistance due to earnings from work or to increased Social Security benefits, but who may keep Medicaid for a period of time.

[3] Home and Community Based services are optional services provided for individuals who would be eligible if institutionalized, but who are receiving care under home and community-based services waivers.

[4] Title XXI of the SCHIP program is a fairly new program proposed by the Balanced Budget Act of 1997. In addition to allowing States to craft or expand an existing State insurance program, SCHIP provides more federal funds for States to expand Medicaid eligibility to include a greater number of children who are currently uninsured. With certain exceptions, these are low-income children who would not qualify for Medicaid based on the plan that was in effect on April 15, 1997. Funds from SCHIP also may be used to provide medical assistance to children during a presumptive eligibility period for Medicaid. This is one of several options from which States may select to provide health care coverage for more children, as prescribed within the Balanced Budget Act's Title XXI program.

[5] Medically needy service options allow States to extend Medicaid eligibility to additional persons. These persons would be eligible for Medicaid under one of the mandatory or optional groups, except that their income and/or resources are above the eligibility level set by their State. Persons may qualify immediately or may "spend down" by incurring medical expenses that reduce their income to or below their State's medically needy income level.

As illustrated in **Table 4-2**, all states are required to provide Medicaid to eligible children and families, pregnant women, and the aged, blind, and disabled. The medically needy optional category allows states to extend Medicaid eligibility to additional persons. These persons would be eligible for Medicaid under one of the mandatory or optional groups, except that their income and/or resources are above the eligibility level set by their state. Persons may qualify immediately, or may spend-down to income, resource, and/or asset eligibility levels, by incurring medical expenses that reduce their income to meet their state's medically needy income level.

In addition to federally mandated mandatory and optional eligibility categories; under federal law, Ohio holds 209(b) status, which allows it to implement Medicaid income and resource criteria and a disability test that are more strict than those used to determine eligibility for Supplemental Security Income (SSI). Ohio, like all but one 209(b) state,[3] has opted not to use a more restrictive disability definition, and instead, adopted the Supplemental Security Income definition of disability. However, Ohio uses different income methodologies and more restrictive resource criteria than the Social Security Income program.

In providing Medicaid services to individuals who are receiving, or are in the process of being deemed to receive Supplemental Security Income,[4] states fall into one of three general categories:

- 1634: States have a contract with the Social Security Administration to determine eligibility for Medicaid at the same time a determination is made for receipt of Supplemental Security Income benefits. Thirty-two states plus the District of Columbia are categorized as 1634 states and use the same Medicaid eligibility criteria for determining their aged, blind, and disabled recipients as are used for the Supplemental Security Income program.[5]

- SSI: States that use the same Medicaid eligibility criteria for their aged, blind, and disabled recipients as are used for the Supplemental Security Income program, but require that these individuals apply to the state separately from their application for Supplemental Security Income to determine their Medicaid eligibility. There are seven states and the Commonwealth of Northern Mariana Islands that are categorized as Supplemental Security Income states.[6]

[3] New Hampshire uses are more restrictive disability definition.
[4] The approval of the application process has been received and the State is waiting to receive documentation.
[5] 1634 States are California, Maine, Massachusetts, Rhode Island, Vermont, New Jersey, New York, Delaware, District of Columbia, Maryland, Pennsylvania, West Virginia, Alabama, Florida, Georgia, Kentucky, Mississippi, South Carolina, Tennessee, Michigan, Wisconsin, Arkansas, Louisiana, New Mexico, Texas, Iowa, Colorado, Montana, South Dakota, Wyoming, North Carolina, Arizona, and Washington.
[6] Supplemental Security Income States are Alaska, Idaho, Kansas, Nebraska, Nevada, Northern Marina Islands, Oregon, and Utah.

- 209(b): States that use more restrictive Medicaid eligibility criteria for their aged, blind, and disabled recipients than are used in the Supplemental Security Income program in one or more eligibility areas. There are eleven states that are categorized as 209(b) states.[7]

Ohio, as a 209(b) state, uses at least one eligibility criterion more restrictive than the Supplemental Security Income program. States that have elected this option may not use more restrictive standards than those in effect in January 1, 1972 and must provide for deducting incurred medical expenses from income through Medicaid spend-down so that individuals may reduce their income to the income eligibility level. In Ohio, while the Medicaid program uses the same disability definition as the SSI program, the financial eligibility standard for Medicaid is stricter than that used in the SSI program.

In interviewing Medicaid stakeholders, providers, advocates, and service recipients voiced a number of concerns about the spend-down program in Ohio. A member of the Ohio Council of Behavioral Healthcare Providers described the spend-down program as "a disaster" and recommended extending the spend-down period to four or six months as has been done in other states. The member noted that this would result in a time savings for case managers and also help providers with issues of rebilling. Similarly, a member of the Ohio State Legal Services Association stated that, "…The Medicaid spend-down could have been… designed by a bunch of monkeys…. It's harmful to recipients, it's harmful to providers and it reduces access."

A member of the Ohio Pharmacists Association also expressed concern about the conflicting information recipients may get on the spend-down program. The member noted that recipients sometimes request an itemized printout of the cost of drugs to submit to the County JFS to satisfy spend-down requirements. Because a recipient may have been told they must incur the expense but do not actually have to pay it, the Association member was concerned that this may be contributing to Medicaid fraud.

Medicaid spend-down is an important concept not only to the 209(b) states, but also to all states with medically needy programs. Spend-down applies to individuals who have too much income to qualify under the state's income limits and takes into account incurred medical expenses during a budget period, from one to six months. In some cases, a state can also look at anticipated expenses, such as the cost of health insurance. The state then takes incurred costs for medical services covered under the state's Medicaid plan during the budget period and deducts them from the individual's countable income until the individual meets the state's income limit. Once the individual's income is at or below the limit, the person receives a Medicaid card and can access Medicaid services.

[7] 209(b) States are Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia

Long-Term Care Services and Eligibility

Medicaid long-term care services are those Medicaid funded, institutional or community-based, medical, health, psycho-social, habilitative, rehabilitative, and/or personal care services which may be provided to eligible individuals. Populations served by long-term care services are usually the aged, blind and disabled (ABD). Long-term care can take place at an individual's home, in senior centers, in community centers, in special retirement or assisted living facilities, intermediate care facilities for the mentally retarded (ICF/MR),[8] or in nursing facilities.

In addition to skilled medical needs, long-term care may include help with activities of daily living or instrumental activities of daily living. Activities of daily living means a personal or self-care skill performed, with or without the use of assistive devices, on a regular basis that enables the individual to meet basic life needs for food, hygiene, and appearance. Activities of daily living are grouped into the following six categories: mobility; bathing, grooming, toileting, dressing, and eating. Instrumental activities of daily living means a community living skill performed, with or without the use of assistive devices, on a regular basis that enables the individual to independently manage the individual's living arrangement. Instrumental activities of daily living are grouped into the following categories: shopping, meal preparation, environmental management, personal laundry, accessing community services, and medication administration.

Long-term care eligibility is determined for those individuals who meet the financial[9] and categorical basic Medicaid eligibility requirements, but may require institutional care for chronic conditions. Financial determination is performed by all 88 of the County Departments of Job and Family Services (CDJFS). To qualify, applicants' income and assets must be within specified limits. There are three general ways in which applicants meet these requirements:

- They have income and assets equal to or below state-specified thresholds;
- They deplete their income and assets on the cost of their care (i.e., spend-down); or
- They divest their assets to qualify for Medicaid sooner then they otherwise would.

In addition to the financial requirements, OAC 5101:3-3-15 sets forth the in-person assessment and level of care review processes for individuals seeking Medicaid payment for long-term care services. The assessment establishes a level of care used to determine if an individual is appropriate for admission to a nursing facility. The level of care process is the mechanism by which vendor payment to a nursing facility is initiated. The evaluation of an individual's level of

[8] ICF/MRs are facilities with that specialize in institutional care for the mentally retarded and developmentally disabled. They differ from nursing homes in staff training and requirements.

[9] With the exception of categories for recipients with children and spouses, recipients must meet the asset level of $1500; and income level of 64 percent or below the federal poverty level.

care needs determines the facility type for which Medicaid vendor payments can be made. To be medically eligible for Medicaid long-term care services, an individual must meet the intermediate or skilled level of care need required for nursing home placement. Some individuals must also undergo preadmission screening as outlined in rule 5101:3-3-151 of the Ohio Administrative Code.

The following summary details the levels of care used in determining appropriate placement and service options for Medicaid recipients:

- **Protective Care Level:** Protective care is assessed when all possible levels of care have been evaluated and an individual does not meet the criteria for skilled, intermediate or ICF-MR levels of care, but is unsafe remaining in their home without twenty-four-hour-a-day care. Determination is based on an individual's ability to perform activities of daily living or instrumental activities of daily living. The individual requires either supervision of one of the activities of daily living and assistance with three instrumental activities of daily living; or due to a cognitive impairment, including but not limited to dementia, the individual requires the presence of another person, on less than a twenty-four-hour-a-day basis for the purpose of supervision to prevent harm.

- **Intermediate Level of Care:** The intermediate level of care is assessed when the individual's physical and mental condition and resulting service needs have been evaluated and compared to all of the possible levels of care and it has been determined the individual requires services beyond the minimum required for a protective level of care; but, the individual's condition and/or corresponding service needs do not meet the minimum criteria for a skilled level of care; and the individual's condition and/or service needs do not meet the criteria for an ICF/MR level of care. To qualify for intermediate level of care at least one of the following applies:

    - The individual requires hands-on assistance with the completion of at least two activities of daily living;
    - The individual requires hands-on assistance with the completion of at least one activity of daily living; and is unable to perform self-administration of medication and requires that medication administration be performed by another person;
    - The individual requires one or more skilled nursing or skilled rehabilitation services at less than a skilled care level; or
    - Due to a cognitive impairment, including but not limited to dementia, the individual requires the presence of another person, on a twenty four-hour-a-day basis for the purpose of supervision to prevent harm.

- **Skilled Care Level:** OAC 5101-3-3-05 states in part that "skilled care level" means an individual receives at least one skilled nursing service at least seven days per week, and/or a skilled rehabilitation service at least five days per week. In order for an individual to meet skilled level of care, the individual's physical and mental condition and resulting service needs are evaluated and compared to all the possible levels of care (in accordance with OAC § 5101:3-3-151) and it has been determined that the individual requires services beyond the minimum of those of protective care, set forth in OAC 5101:3-3-08, intermediate care, set forth OAC 5101:3-3-06, and/or ICF-MR/DD level of care, set forth in OAC 5101:3-3-07. Additionally, at least one of the following must apply:

    - The individual's condition necessitates, and the individual's physician has ordered, that at least one skilled nursing service as defined in paragraph (B)(4) of this rule be provided at the skilled care level (as defined in paragraph (B)(3) of this rule); and/or
    - The individual's condition necessitates, and the individual's physician has ordered, that at least one skilled rehabilitation service be provided at the skilled care level (as defined in paragraph (B)(3) of this rule).

    However, an individual who meets the requirements of paragraphs (C)(1)(c) and (C)(2) of this rule may be determined to require a skilled level of care unless the individual has applied to a specific ICF/MR that is equipped to provide services at the skilled level of care (as defined in paragraph (B)(3) of this rule). AN individual who has applied to an ICF/MR that is equipped to provide services at the skilled level of care may be determined to require an ICF-MR/DD level of care if there is a written certification that the facility can meet the individual's skilled care needs.

    Skilled care level must be ordered by a physician and must be delivered by the licensed or certified professional due to the instability of the individual's condition; and the complexity of the prescribed service; or the presence of special medical complications.

- **Intermediate Level of Care – Mental Retardation/Developmental Disability (MRDD):** The intermediate level of care for individuals with mental retardation and developmental disabilities is assessed when the individual is seeking long-term care at the level of intermediate care facility services for the mentally retarded. This level of care determination is used for individuals seeking Medicaid coverage for either home and community-based services (HCBS) waivers or facility-based institutional long-term care services. An individual being assessed for intermediate level of care MRDD shall meet the minimum criteria for protective level of care and have substantial functional limitation resulting in the inability to independently, adequately, safely, and consistently perform age appropriate tasks as associated with the major life areas without undue effort

> and within a reasonable period of time. An individual who has access to and is able to perform the tasks independently, adequately, safely, and consistently with the use of adaptive equipment or assistive devices is not considered to have a substantial functional disability.

Area Agencies on Aging (AAAs) serve as the universal pre-screening agency using the pre-admission screening and resident review (PASRR) process to screen applicants. Applicants with possible mental health indications are referred to the Ohio Department of Mental Health (ODMH); individuals with mental retardation or developmental disabilities are referred to the Ohio Department of Mental Retardation and Developmental Disabilities (ODMRDD) for further screening and level of care determination. In complex cases, all three agencies or a combination thereof may be involved in the screening and level of care determinations.

Certificate of Need

Ohio is one of 37 states that maintain health services regulatory programs known generically as certificate of need. States maintain certificate of need programs to achieve a number of health policy goals. These goals differ somewhat from state to state, and from one health service to another, but all regulations and related planning are intended to compensate for observed or perceived market deficiencies. Historically, the overriding consideration has been to promote access, ensure quality, and help control costs by limiting market entry to those facilities and services that are found to be needed, appropriately sponsored, and designed to promote quality and equitable access to care. Each program implicitly incorporates these principles by predicating certification on the basis of community or public need.

The growth of certificate of need programs was spurred in part by the National Health Planning and Resources Development Act (PL 93-641) of 1974, which required states to operate certificate of need programs to be eligible for some federal funds available through the U.S. Public Health Service. Certificate of need programs were viewed as a vehicle to ensure the rational allocation of health care resources and control total health care spending. In the 1980s, certificate of need programs for acute care fell out of favor and were viewed as anticompetitive and unduly regulatory. The National Health Planning and Resources Development Act of 1974 expired in 1986 and was not replaced.

With the expiration of the National Health Planning and Resources Development Act, certificates of need were no longer required; however, several states retained certificates of need to regulate their health care markets. These states continued to use certificates of need to regulate long-term care services, focusing largely on nursing home beds. Because certificate of need programs usually determine only the need for additional beds with limited consideration of the budgetary impact, several states established a moratorium on the certification of additional nursing home beds.

According to the CMS *1998 State Data Book on Long Term Care Program and Market Characteristics*, the following policies on market control by certificate of need and moratorium applied to nursing homes.

- 24 states had certificate of need only,[10]
- 6 states had moratorium only,[11]
- 13 states had certificate of need and moratorium,[12] and
- 8 states had neither.[13]

In addition to limiting freestanding nursing home beds, most states limit conversions of hospital beds to nursing facility beds through the certificate of need process.

Prescription Drug Program

Medicaid prescription drug coverage is an optional service under the Medicaid program. The Ohio Medicaid Drug Program is a federal and State supported program that provides prescription drug coverage to eligible recipients and is administered by ODJFS. Ohio Medicaid spending on prescription drugs totaled $1.5 billion in SFY 2002-03 and is the single largest item of new Medicaid spending. Total prescription drug expenditures increased an average of 13.4 percent between SFY 2002-03 to SFY 2004-05 (see **Table 3C-2** in **Appendix C** of the **organizational issues** section).

In response to the increased spending, Ohio implemented a preferred drug list in 2003, which includes both generic and trade-name (brand name) drugs that do not require prior authorization. Effective January 1, 2004, Ohio Medicaid implemented a $3 co-payment for prescription drugs that require prior authorization for individuals 21 years of age or older. On January 1, 2006, a $2 co-payment was also implemented for select trade-name medications.

Ohio also participates in the federal Medicaid Drug Rebate Program and pursues supplemental rebates from drug manufacturers. The Medicaid Drug Rebate Program was created by the Omnibus Reconciliation Act of 1990 (OBRA 1990) and was translated into federal statute as Section 1927 of the Social Security Act. The law, which went into effect January 1, 1991, requires manufacturers to enter into a rebate agreement with CMS for their products to be eligible for federal Medicaid reimbursement. Section 1927(a)(4) of the Social Security Act

[10] Alabama, Arkansas, Delaware, District of Columbia, Florida, Hawaii, Illinois, Indiana, Iowa, Kentucky, Maryland, Montana, Nebraska, New Jersey, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Virginia, Washington, and Wyoming

[11] Colorado, Minnesota, North Dakota, South Dakota, Texas, and Utah

[12] Alaska, Connecticut, Louisiana, Maine, Massachusetts, Michigan, Mississippi, Missouri, New Hampshire, **Ohio**, Rhode Island, West Virginia, and Wisconsin

[13] Arizona, California, Georgia, Idaho, Kansas, Nevada, New Mexico, Pennsylvania

authorizes states to enter separate or supplemental rebate agreements as long as those agreements achieve drug rebates equal to or greater than the federal rebates with drug manufacturers. The Medicaid Drug Rebate Program and supplemental rebates are strictly confidential, as outlined in 42 USCS §1396r-8(b)(3)(D). Information disclosed by manufacturers and wholesalers under the federal rebate program or under an agreement with the Secretary of Veterans Affairs is confidential and shall not be disclosed by the Secretary of Health and Human Services, Secretary of Veterans Affairs, or a state agency or its contractor, in a form which discloses the identity of a specific manufacturer or wholesaler or prices charged for drugs by the manufacturer or wholesaler. The only exceptions are as follows:

- As determined by the Secretary of HHS to be necessary to carry out the drug rebate program;
- To permit the federal Comptroller General to review the information provided; or
- To permit the Director of the Congressional Budget Office to review the information provided.[14]

During a round-table interview with members of the Ohio Pharmacists Association, members of the Association expressed concerns over the State's use of generic drugs, the rebate program and Ohio's preferred drug list.[15] Member pharmacists remarked on Ohio lower rate of generic substitution and expressed concerns that the rebate program may shift costs to the pharmacist. The members reported that Medicaid requires the pharmacist to purchase and stock the brand-name drug which may have very limited use and be very high cost to the pharmacist. One member of the Association felt that, through therapeutic substitution, member pharmacists could increase generic use in Ohio Medicaid to 60 to 70 percent. The member noted that a one percent increase in the use of generics could save up to $19 million and that this might result in a greater savings than the rebates. Other member pharmacists described concerns that drug companies' rebates provided only marginal cost savings and might require the participating state to commit to using several other brand-name drugs not included on the rebate.

ODJFS contracts with ACS State Healthcare, LLC (ACS) to serve as its pharmacy benefit manager (PBM). ACS is responsible for the following functions:

- Providing a point-of-sale system that interfaces with the Medicaid Management Information System (MMIS) and existing networks;
- Processing, both manually and with automation, pharmacy claims, including point-of-sale and batch pharmacy claims;

[14] Because of these federal provisions, the information on drug rebates is restricted. In Ohio, the information is restricted to a very few individuals within ODJFS. This restriction is the same throughout the US.

[15] Due to the federal statutory confidentiality requirements on the pricing paid by Ohio for pharmaceuticals under the drug rebate program, concerns raised about the cost savings generated through the rebate program could not be addressed as a part of this audit.

- Providing prospective drug utilization review (DUR) services, including pharmacists who will attend all meetings of, and serve as advisors to, the Ohio DUR Board;
- Providing automated pharmacy claims processing and adjudication and prior authorization services;
- Operating a system help desk available 24 hours a day, 7 days a week and a prior authorization help desk available Monday-Friday from 7:00 a.m. to 7:00 p.m.;
- Analyzing and maintaining the preferred drug list by supporting the Ohio Medicaid Pharmacy and Therapeutics Committee and providing educational services regarding the preferred drug list;
- Providing drug rebate administration, to include the administration of supplemental drug rebates, including negotiation strategies, maintenance of rebate agreements, maintenance of supplemental and federal rebate invoicing, and collection and dispute resolution; and
- Providing educational services to help providers understand the pharmacy program, including the preferred drug list and prior authorization, and encourage cost-effective prescribing practices.

Effective January 1, 2006, the Medicare Prescription Drug Improvement and Modernization Act of 2003 (Medicare Part D), provided that individuals eligible for both Medicare and Medicaid, referred to as dual eligibles, would receive prescriptions through Medicare instead of Medicaid. As a result, states are required to make a monthly payment to the Medicare program intended to reflect a percentage of the expenditures a state would have made from its own funds had it continued to pay for outpatient prescription drugs for the dual eligibles through Medicaid. The state contributions, referred to colloquially as clawback payments, are based on the following factors:

- 2003 per capita drug spending for full benefit dual eligibles;
- Estimated growth in overall per capita drug spending nationally for all payers and populations between 2003 and 2006 as computed by the CMS Office of the Actuary in the National Health Expenditure Accounts;
- Number of full benefit dual eligibles reported by the state in the preceding month; and
- Phase-down percentage.

The phase-down percentage begins at 90 percent and declines to 75 percent by 2015 and thereafter. According to ODJFS, Ohio's clawback payment for 2007 will be $35 million more than if the dual eligibles were receiving prescription drugs through Ohio Medicaid because of the State's more recent participation in the supplemental rebate programs. As a result, Ohio is participating in a multi-state lawsuit against the federal government claiming the federal formula used to determine the claw-back does not take into account the negotiated manufacturer rebates for Medicaid drug purchases. In June 2006, the U.S. Supreme Court refused to take the case. The

Ohio Attorney General's Office is prepared to join other states' effort to continue the fight against the clawback.

Waivers

Several sections of the Social Security Act authorize the use of waiver and demonstration projects to allow states flexibility in operating Medicaid programs. Each section has a distinct purpose and requirements. Section 1115 Research and Demonstration Projects provide states with the opportunity to test policy innovations likely to further that state's Medicaid objectives. Section 1915(b) Managed Care/Freedom of Choice waivers allow states to implement managed care delivery systems, or otherwise limit individuals' choice of Medicaid providers. Section 1915(c) Home and Community-Based Services (HCBS) waivers allow states to waive Medicaid provisions in order to provide long-term care services in a community setting. These waivers are the Medicaid alternative to providing comprehensive long-term care services in institutional settings. Combined 1915(b)/(c) waivers allow states to simultaneously use section 1915(b) and 1915(c) program authorities to provide a continuum of services to disabled and/or elderly populations. States use the 1915(b) authority to limit freedom of choice and 1915(c) authority to target program eligibility and provide home and community-based services. With this type of program, states can provide long-term care services in a managed care environment or use a limited pool of providers. **Table 4-3** shows each of Ohio's seven waiver programs, as well as the administering State agency and a brief description.

Table 4-3 Ohio Medicaid Waiver Programs as of July 2006

Waiver	Administering Agency	Description
Ohio Home Care Waiver	ODJFS	Home and community services for people with serious disabilities and unstable medical conditions eligible for Medicaid coverage in a nursing home or hospital
Transitions Waiver	ODJFS	Home and community services for people eligible for Medicaid coverage in an intermediate care facility for people with mental retardation or developmental disabilities (ICF/MR)
PASSPORT Waiver	ODA	Home and community service for people 60 or older, eligible for Medicaid institutional care who require a nursing home level of care
Choices Waiver	ODA	Home and community services where the person becomes the employer of record and hires service providers
Assisted Living Waiver	ODA	Care in an assisted living facility for individuals residing in a nursing facility or enrolled in a home and community based waiver program with the individual responsible for room and board expenses
Level 1 Waiver	ODMRDD	Home and community services for people who live in family homes and receive voluntary family support, including those with aging caregivers
Individual Options Waiver	ODMRDD	Home and community services for individuals who, without such services, would require care at an ICF/MR

Source: ODJFS, ODA, ODMRDD

As illustrated in **Table 4-3**, Ohio has seven waiver programs, administered by three different state agencies. These waivers generally are targeted at individuals with mental retardation and developmental disabilities or who are aged. Other states have developed waivers for additional or more diverse populations – these options are discussed in this report section under ***G. waivers.***

Rate Setting

Medicaid costs fluctuate according to the number and type of participants (eligibility), what services are covered and the rates at which they are prescribed (utilization), and the amounts paid for these services (price). Some variations in these factors are beyond the control of policy makers and can cause both upward and downward cost pressures.

According to OAC 5101:3-1-60, the Medicaid payment for a covered service constitutes payment-in-full and may not be construed as a partial payment when the reimbursement amount is less than the provider's charge. The provider may not bill the recipients for any difference between the Medicaid payment and the provider's charge or request the recipient to share in the cost through a deductible, coinsurance, co-payment, or other similar charge, other than Medicaid co-payments as defined in rule OAC 5101:3-1-09.

For many years, states were required to pay institutional providers, hospitals and nursing homes, rates that were, in the words of the Boren[16] amendment (1980) "reasonable and adequate to meet incurred costs." The 1997 Balanced Budget Act (BBA) repealed the Boren amendment giving states more flexibility in setting provider reimbursement rates; however, states now are required to do the following:

- Use a public process for determining rates;
- Give interested parties a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications; and
- Publish proposed and final rates, the methodologies underlying the rates, and justifications for the rates.

[16] Prior to 1980, Medicaid and Medicare reimbursed nursing facilities on a retrospective reasonable cost basis. In the Omnibus Reconciliation Act of 1980 (section 1902(a)(13)(A)), the Boren Amendment changed the reimbursement method for nursing facility services. Under the Boren Amendment, a State plan for medical assistance was required to provide for payment of nursing facility services through the use of rates which were reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated providers in order to provide care and services in conformity with applicable State and Federal laws, regulations and quality and safety standards. In 1997, the Balanced Budget Act repealed the Boren requirements and replaced them with a requirement that States implement a public process when changes in payment rates or methodologies are proposed. The new public process requirement applies to rates established on or after the October 1, 1997 effective date.

Additionally, ORC §119.03 illustrates that if the State wants to adopt, amend, or rescind any rules, an agency shall give reasonable public notice in the register of Ohio at least 30 days prior to the date set for a hearing, in the form the agency determines. Furthermore, the public notice shall include:

- A statement of the agency's intention to consider adopting, amending, or rescinding a rule;
- A synopsis of the proposed rule, amendment, or rule to be rescinded or a general statement of the subject matter to which the proposed rule, amendment, or rescission relates;
- A statement of the reason or purpose for adopting, amending, or rescinding the rule; and
- The date, time, and place of a hearing on the proposed action, which shall be not earlier than the thirty-first nor later than the fortieth day after the proposed rule, amendment, or rescission is filed.

The Medicaid program offers two major benefit packages: long-term care services and primary and acute care services. The primary and acute care benefit packages are provided through either a traditional indemnity model, the fee-for-service system (FFS), or through a managed health care model.

Ohio Medicaid managed health care is used to provide primary and acute care services to most Medicaid recipients and is designed to assure access to appropriate services and quality of care for enrolled Medicaid members, to improve provider accountability, and to increase cost predictability. The Bureau of Managed Health Care within Ohio Health Plans is responsible for the development, administration, and assessment of the Medicaid managed health care program. (See **managed care and care management** section for further discussion.)

ODJFS contracted with Mercer Government Human Services Consulting (Mercer) to develop actuarially sound capitation rates for 2005 for the Healthy Families and Healthy Start[17] managed care populations. The Mercer contract outlines the changes to the historical rate-setting process, provides information on specific data adjustments, and includes summaries of data from historical fee-for-service claims and managed care plans. Mercer developed the final capitation rates paid to contracted managed care plans after the base data was developed and multiple years blended for each data source. Mercer applied trend analysis, programmatic changes, and other adjustments to each data source to project the program costs into the contract year. The various data sources were blended into a single managed care rate with an administrative component applied.

[17] Health Families and Healthy Start are Medicaid programs that provide eligible Ohio families, children, and pregnant women with comprehensive health coverage. This means families get coverage for all of the following: doctor visits, prescriptions, hospital care, immunizations, vision and dental care, substance abuse, mental health services, as well as other services.

Assessments Not Yielding Recommendations

In addition to the analyses presented in this report, assessments were conducted on several areas which did not warrant changes or yield any recommendations. These areas include the following:

- **Mandatory and Optional Medicaid Services:** Based on a review of 42 CFR 440, which illustrates the federal requirements for mandatory and optional Medicaid services, Ohio provides all federally required programs and offers optional Medicaid services consistent with other states. According to data collected and reported by the U.S. Department of Health and Human Services, Ohio, and every other state reporting data, provides several optional services: clinic, prescription drugs, case management, and extended pregnant women services. The one service that Ohio provides in addition to many other states is dental services, which are provided by 13 other states.[18] Amended Substitute House Bill 66 (HB 66) requires that the Medicaid program cover dental services for SFY 2005-06 and 2006-07. However, for Medicaid recipients age 21 or older, the coverage is to be less in amount, duration, and scope than that provided immediately before the effective date of this provision in HB 66. Additionally, HB 66 requires that a co-payment program be established for dental services.[19]

- **Managed Care Rate Setting:** ODJFS, as the single State Medicaid Agency designated to administer the Medicaid program under Title XIX of the Social Security Act and ORC §5111.02, obtained managed care plan (MCP) services for the benefit of certain Medicaid recipients. In so doing, the MCP provided, and will continue to provide, proof of its capability to provide quality services, efficiently, effectively, and economically during the term of the agreement.

  ODJFS reimburses MCPs in accordance with OAC 5101:3-26-09, which states that MCPs will receive a monthly premium payment for each member. According to ODJFS staff, the current average per member per month rate for covered families and children services is $198.03. During 2005, the minimum and maximum premium rates ranged from $71.43 to $611.61 depending on age, gender, service, and county. If the services to be provided or arranged by MCPs include maternity coverage, a separate payment is made for each reimbursable delivery. ODJFS contracted with Mercer to develop managed care capitated (per member per month) rates based on actuarial assessments. According to OAC 5101:3-26-09, these rates are to be reviewed, and may be modified, at least every two years to account for actuarial changes and experiences. The contract with Mercer calls for a review of the rates every two years.

[18] The 13 states that provide Medicaid dental services are Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Maine, Massachusetts, Minnesota, New Hampshire, Ohio, Rhode Island, Virginia, and Wisconsin

[19] ODJFS implemented a $3 co-payment for dental services which started January 1, 2006.

In deriving MCP rates, Mercer applied generally accepted actuarial principles that reflect the impact on fee-for-service experience of MCP programs. Mercer reviewed Ohio's historical fee-for-service experience, MCP CY 2002 and 2003 encounter data, and other state Medicaid MCP care experiences to develop MCP savings assumptions. These assumptions were applied to the fee-for-service data to derive the MCP rates. According to Mercer, the assumptions are consistent with an economically and efficiently operated Medicaid MCP.

Ohio's managed care rate setting practices were recognized as best practices compared to other states by the Michigan Association of Health Plans. According to the Michigan Association of Health Plans:

> "The managed care rate setting process in Ohio has an unusual feature: the Ohio Association of Health Plans engages an actuary to actively participate in the Medicaid rate-setting process. The actuary reviews the State's rate-setting methodology and generates questions and suggestions related to the rate-setting process. This process seems to work in Ohio and is likely successful since there is no competitive bidding process. Health plans in Ohio believe that the engagement of an actuary on their behalf has been helpful to the process. Health plans also believe that the State Medicaid Agency's (Ohio Department of Job and Family Services) commitment to complying with the actuarial soundness requirement was helpful in keeping rates adequate at a time when the State was experiencing budget difficulties."

A member of the Ohio Association of Health Plans noted that the reimbursement rate setting process is a strength in the Ohio program. The national Association of Health Plans reportedly has included Ohio's process in a best-practice summary for CMS. The member concluded saying, "Ohio has always had a strong commitment to mak[ing] these [rates] actuarially sound."

- **Long-Term Care Eligibility Determination:** In Ohio, the County Departments of Job and Family Services (CDJFS) perform the financial eligibility screening while the Area Agencies on Aging (AAA) serve as the universal prescreening agencies for level of care determination for nursing home placement. The pre-admission screening and resident review (PASRR) process is used to screen applicants for nursing home levels of care or home and community based waiver services.

  According to *Single Entry Point Systems: State Survey Results,* (National Academy for State Health Policy, 2003), single entry point systems are defined as systems that allow consumers to access long-term care and supportive service through one agency or organization. In their broadest forms, these organizations manage access to one or more funding sources and perform a range of activities that may include information and assistance; preliminary screening or triage; nursing facility preadmission screening; assessment of functional capacity and service needs; eligibility determination; care

planning, service authorization; and monitoring and reassessment. A comparison to states highlighted in this report showed that Ohio's level of care determination is consistent with many of the recommendations included in the report. Additionally, stakeholders and agencies reported that the level of care screening process (PASRR) functioned effectively.

- **Intrastate Prescription Drug Purchasing Pool:** Ohio Medicaid does not participate in an intrastate purchasing pool for its prescription drug benefit. A successful model for the incorporation of Medicaid prescription drug programs in an intrastate purchasing pool does not exist. Furthermore, the requirements of the Medicaid Drug Rebate Program do not make an intrastate purchasing pool a viable option for Ohio Medicaid at this time.

- **Prescription Drug Program in Long-Term Care Facilities:** Ohio Medicaid reimburses long-term care pharmacies for the ingredient cost and a dispensing fee, which is paid per prescription per member per month. The ingredient cost and dispensing fee are the same as those used in fee-for-service. The cost of prescription drugs is not included in the nursing facility reimbursement formula.

  According to the *State Medicaid Outpatient Prescription Drug Policies: Findings from a National Survey, 2005 Update (*Kaiser Family Foundation, 2005), states take different approaches to purchasing prescription drugs in long-term care facilities. Although costs that are bundled and paid on a daily basis may simplify administration, it prevents a state from taking advantage of Medicaid rebates. As a result, states are dependent on long-term care providers, or the pharmacies with which they contract, to ensure the most efficient purchase of prescription drugs. Of the 37 states that responded to the 2005 survey, 25 states, including Ohio, pay separately for, or carve-out, long-term care prescription drugs.

- **Preferred Drug List:** Ohio Medicaid implemented a preferred drug list in April 2003. At the time of reporting, there are 40 different classes of drugs on the list, which are looked at for volume and expenditures. The price that Ohio pays for prescription drugs on the preferred drug list is determined by Ohio Health Plan's (OHP) bottom-line pricing. OHP indicated that the prescription drugs that are placed on the preferred drug list are reviewed on both a clinical and economical basis. When a drug is subsequently placed on the preferred drug list, the prescribing physician does not have to obtain prior authorization before prescribing it to a patient. In July 2006, Ohio's Pharmacy Benefit Manager (PBM) changed from First Health to ACS, which recommends all bids and breaks them down. These recommendations as to which drugs should be selected are sent to ODJFS, which then determines which drugs should be on the preferred drug list (based on rebates, cost, and quality) and sends its selections to the Pharmacy and Therapeutic

Committee for approval. OHP's preferred drug list process is similar to that of other states' Medicaid programs.

Issues Requiring Further Study

Auditing standards require the disclosure of significant issues identified during an audit that were not reviewed in depth. Those issues may not be directly related to the audit objectives or may be issues that the auditor does not review within the scope of the audit. AOS has identified the following as an issue requiring further study.

- **Medicaid Services:** According to *Medicaid and Health Care Reform* (National Governors Association, 2005), Medicaid programs should allow for greater efficiencies without compromising quality of care, which would allow states to provide more targeted services while managing the program in a way that prevents sweeping cuts in the future. In Ohio, additional options for service benefit redesign may exist within the State's mandatory and optional Medicaid service benefit package which could reduce overall Medicaid expenditures in the future while ensuring access and quality care. During FY 2003-04, enrollment increased in several optional service categories, including adoption assistance; Qualified Medicare Beneficiary/Specified Low-income Medicare Beneficiary/Qualified Individual (QMB/SLBM/QI); and the Breast and Cervical Cancer Project. The Breast and Cervical Cancer Project was a new category in Ohio effective July 1, 2002. Due in part to the lack of outcome measures (see **organizational issues** section), the State Medicaid agency cannot fully determine if the benefits and health outcomes of the optional services outweigh the costs.

  Although the performance audit assessments compared Ohio's mandatory and optional Medicaid services to federal requirements and peer states, determining the appropriateness of mandatory and optional service benefit package levels (e.g., type of service and number of units) is outside the scope of this performance audit. Additionally, the performance audit reviewed the mandatory and optional Medicaid expenditures for SFY 2002-03 to 2004-05, but determining the appropriateness of the expenditure levels, which are related to medical necessity benefit design and a host of other factors, is also outside the scope of this performance audit. Refer to the **organizational issues** section for additional information on establishing a performance measurement system that reflects goals for the Ohio Medicaid program.

- **Mail-Order Prescription Drug Program:** Ohio Medicaid does not use mail-order for its prescription drug program. Several states have implemented mail-order programs for limited populations or diagnoses, but no state has implemented a mail-order program for its entire Medicaid prescription drug benefit. However, no evaluations have been

completed which document improved health outcomes for Medicaid recipients or cost savings for state Medicaid programs. Furthermore, literature regarding the cost savings associated with the implementation of mail-order programs is inconclusive.

The Ohio Public Employees Retirement System contracted with the Ohio State University College of Pharmacy to complete a study of its mail order program, which includes a determination of the program's cost effectiveness. The report is expected to be released by the end of 2006. However, the results of the Ohio Public Employees Retirement System study may not transfer to the Ohio Medicaid program given the different populations served.

A member of the Ohio Pharmacists Association spoke against the State pursuing a mail-order prescription drug program. The member pointed out that mail order companies usually send a 90 day supply to a recipient. However, in the case of behavioral health services recipients, medications may be changed frequently to address changes in health conditions which may defeat the cost savings generated through using a mail order service. The member explained that several other states permit pharmacists to provide mental health patients with a one-week supply of medication as this process results in a cost savings.

Findings and Recommendations

A. Eligibility

Covered Populations and Eligibility Guidelines

Eligibility for Medicaid is based on categorical (e.g., families and children, aged, blind, and disabled) and financial (e.g., income/resources) status. States must provide services to mandatory categorically needy and other required special groups. Additionally, states may provide coverage to members of optional groups and medically needy individuals who are eligible for Medicaid after deducting medical expenditures from their income.

To qualify for Medicaid, individuals must meet income and asset requirements and also fall into one of the categories of eligible populations. In order to receive federal matching funds, state Medicaid programs must cover certain mandatory populations. **Table 4-4** illustrates the federal minimum Medicaid eligibility levels and populations for 2004.

Table 4-4: Mandatory Income Eligibility Levels as a Percent of the Federal Poverty Level

Mandatory Population	Percentage of FPL
Pregnant Women	133%
Pre-School Children	133%
School-Age Children	100%
Parents	42%
Elderly and Individuals with Disabilities	74%

Source: The Kaiser Commission and the Health Policy Institute of Ohio, Centers for Medicaid and Medicare
Note 1: Populations include pregnant women and children under age 6 with family income below 133 percent of poverty ($21,400 a year for a family of 3 in 2005) and older children with family income below 100 percent of poverty ($16,090 a year for a family of 3 in 2005); most persons with disabilities and elderly people receiving assistance through the Supplemental Security Income program below 74 percent of poverty ($7,082 a year for an individual in 2005); and parents with income and resources below states' welfare eligibility levels as of July 1996, below 42 percent of the federal poverty level.

As illustrated in **Table 4-4**, mandatory income eligibility levels, as a percent of the federal poverty level (FPL), vary from 133 percent of the FPL for pregnant women and pre-school children to 42 percent of the FPL for parents (who have children also eligible for Medicaid). Many states have expanded Medicaid eligibility coverage over the mandatory income eligibility levels to optional populations. As a result, Medicaid eligibility above the federal requirements varies widely from state to state. Likewise, eligibility may be more restrictive in 209(b) status states. **Table 4-5** illustrates Ohio's covered populations and the 2003 qualifications for meeting these Medicaid eligibility categories.

Table 4-5: Ohio 2003 Medicaid Eligibility Coverage

Coverage Group/Program	Qualifications
Pregnant Women (Healthy Families)	150 % of federal poverty level (FPL)
Parents/Caretaker Relatives (Healthy Families) [1]	100 % of FPL
Breast and Cervical Cancer Medicaid	200 % of FPL
Immigrants	Arrived before 8/22/96 and is documented: he/she may qualify in any eligibility category as long as respective eligibility standards are met Arrived on or after 8/22/96: ineligible for Medicaid for five years, with certain exceptions (such as refugees) as long as respective eligibility standards are met
Children up to age 19 (Healthy Start)	200 % of FPL
Temporary Assistance for Needy Families (TANF) [2]	Families that participate in the Ohio Works First (OWF) cash assistance program are automatically covered by Medicaid
Spend-down Medicaid	If an individual's countable income exceeds the Medicaid need standard, but is otherwise eligible by meeting all other eligibility requirements such as citizen, residence, resources, etc
Aged, Blind, and Disabled (ABD) receiving SSI	Medicaid uses the Social Security Income (SSI) disability definition 64% of FPL
Institutional Level of Care	Income must be less than cost of care
Qualified Medicare Beneficiaries (QMBs), Specified Low-income Medicare Beneficiaries (SLMB), Qualified Individual (QI)	QMB: Income cannot exceed 100 % FPL and must be entitled to Medicare Part A SLMB: Income must be at least 100 % of FPL but cannot exceed 120 % of FPL QI: Income must be at least 120 % of FPL but cannot exceed 135 % of FPL
Children up to age 19 (SCHIP)	Income must be greater than 150 % of FPL but cannot exceed 200 % of FPL with no resource limit

Source: Health Resources and Services Administration, HHS.

[1] The Parents/ Caretaker Relative (Healthy Families) population income eligibility guidelines decreased to 90 percent from HB 66

[2] Welfare reform repealed the open-ended Federal entitlement program known as Aid to Families with Dependent Children (AFDC) and replaced it with Temporary Assistance for Needy Families (TANF), which provides States with grants to be spent on time-limited cash assistance. TANF generally limits a family's lifetime cash welfare benefits to a maximum of five years and permits States to impose a wide range of other requirements as well, in particular, those related to employment. Ohio Works First (OWF) is the financial assistance portion of Ohio's TANF program. OWF was established to provide time-limited assistance to eligible families. OWF provides cash benefits to eligible, needy families for up to 36 months.

As illustrated in **Table 4-5**, Ohio provides eligibility for all mandatory categories but does differ from the federal minimum standards for financial qualification. Ohio's pregnant women category is 150 percent of the FPL for 2003; whereas the 2005 mandatory FPL is 133 percent. Ohio's parent category is 100 percent of the FPL; whereas the 2005 mandatory FPL is 42 percent. Additionally, Ohio's children category ranges from 150 percent to 200 percent; whereas the 2005 mandatory FPL is 100 percent to 133 percent. Ohio, as a 209(b) state, is able to restrict eligibility for its aged, blind, and disabled recipients. Ohio Medicaid uses the same disability determination as Social Security Income (SSI) but has established a more restrictive financial eligibility. As a result, disabled populations are not automatically Medicaid eligible based only on their SSI disability determination.

The combination of categorical and financial eligibility was described as confusing by a number of stakeholders interviewed by AOS. A member of the Ohio American College of Emergency Physicians addressed eligibility from the provider standpoint explaining that addressing eligibility, dual coverage, and disenrollment was difficult, especially for emergency room physicians in a children's hospital. A member of the Ohio Hospital Association described the level of assistance on eligibility issues as depending on one's relationship with the county caseworkers. The member explained that large counties may be unresponsive because of volume and small counties may not have the resources to respond effectively. Last, a member of the Ohio Academy of Nursing Homes (OANH) expressed concern with the variation in how counties may assess resources for recipients prior to nursing home admission. The OANH member requested a manual on the subject but was told that the process of assessing resources was not available to the member in writing.

From the advocate's standpoint, a member of the Ohio Developmental Disabilities Council remarked on differing interpretations provided by the county-level case workers. A member of the Brain Injury Association of Ohio explained how difficult it was for a recipient to navigate the system. Finally, a member of the Ohio State Legal Services Association said, "One needs to be tenacious to … be a successful poor person, to really access and get the benefits you need. …The faint of heart, those who aren't sophisticated, have no end of trouble…" because of incorrect denials and terminations.

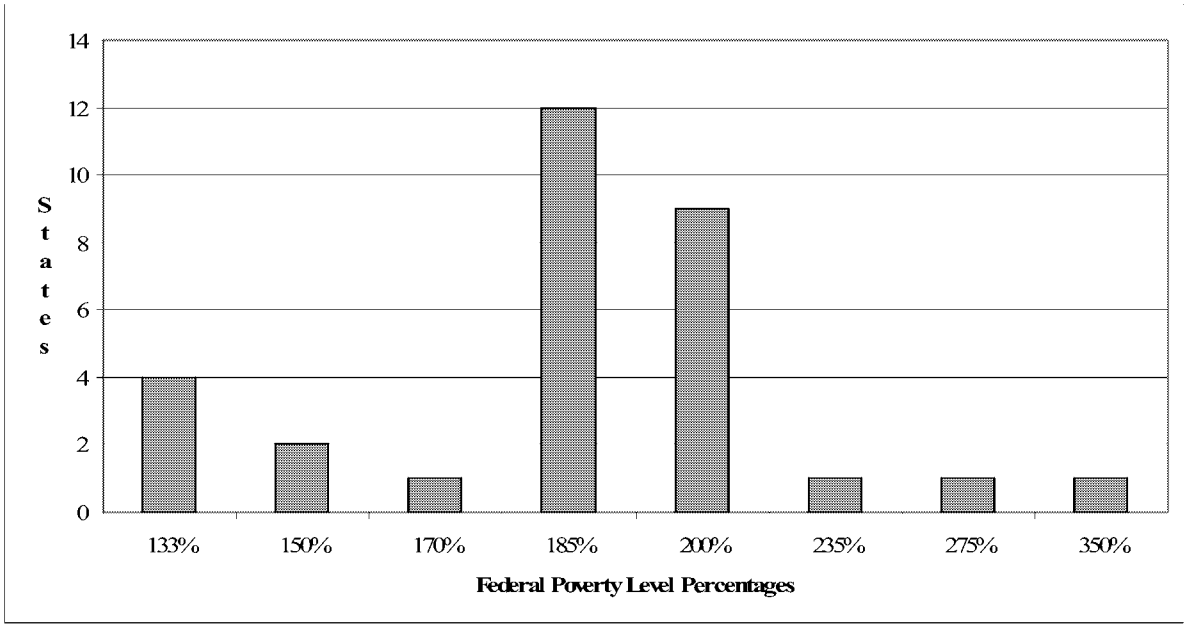
Other state Medicaid financial eligibility coverage[20], collected by HHS, was used for comparison with the State of Ohio.

Adult Coverage

Charts 4-1 through **Chart 4-8** illustrate Ohio and other states' (for which data was available) 2003 adult qualifications for Medicaid eligibility categories. The detailed information on eligibility for adult categories can be found in **Table 4A-1** in **Appendix 4-A**. **Chart 4-1** and **4-2** show income and asset restrictions for pregnant women.

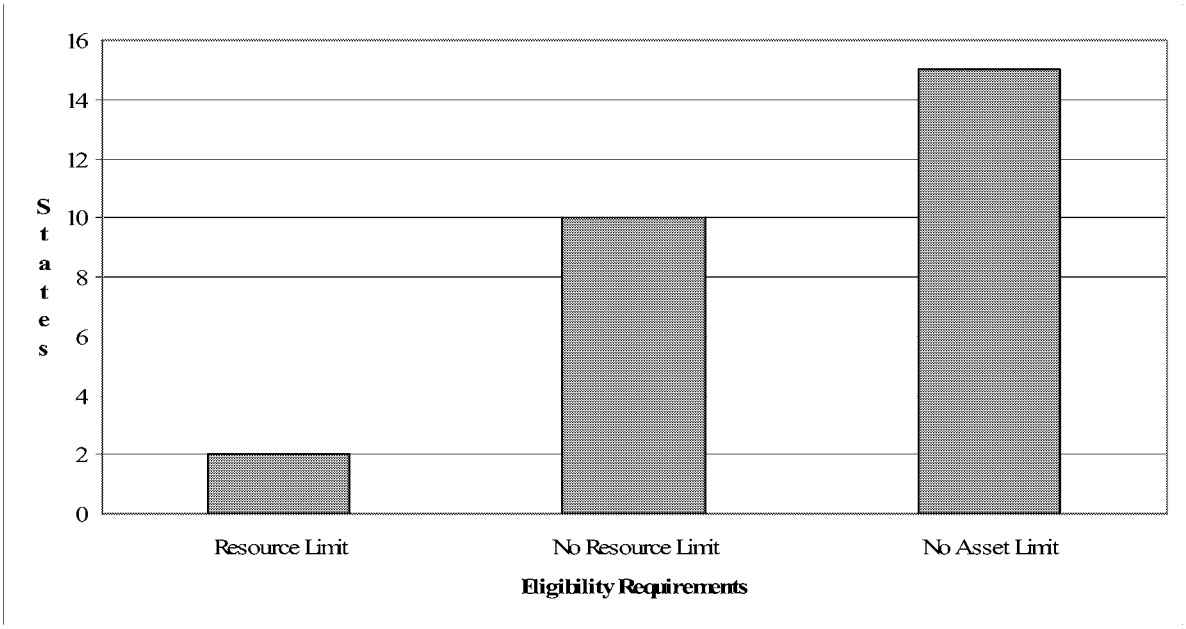
[20] To qualify for Medicaid, a person must meet income and resource requirements. Income is money that one gets from any source. Resources are things like cash, savings, stocks, bonds, and real property. Low income is only one test for Medicaid eligibility; assets and resources are also tested against established thresholds.

Chart 4-1: Ohio and Other States' 2003 Pregnant Women Medicaid Eligibility Coverage



Source: HHS (2003)
Note 1: HHS did not have information for Alabama, Alaska, District of Columbia, Idaho, Kansas, Kentucky, Maryland, Mississippi, Missouri, Montana, North Dakota, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, and Wyoming.

Chart 4-2: Ohio and Other States' 2003 Pregnant Women Asset, Income, and Resource Coverage



Source: HHS (2003)

Charts 4-1 and 4-2 illustrate that, during 2003, Ohio and other states had a range of FPL, asset, income, and resource requirements. The majority of states have income limits between 185 percent and 200 percent of the federal poverty level, while Ohio has an income limit of 150 percent of the federal poverty level. Twelve states [21] had eligibility at 185 percent FPL. Only four other states (Arizona, Colorado, Louisiana, and Nevada) listed in **Chart 4-1** had an eligibility level for pregnant women more restrictive than the state of Ohio. Ohio is more restrictive than the majority of states in its financial eligibility for this category, but is higher than the 133 percent federal minimum requirement. According to the U.S. Department of Health and Human Services, Ohio does not have a resource or asset limit, which is consistent with the majority of states' shown in **Chart 4-2.**

Parent/Caretaker/Relatives

Of the states reporting information in this category, only 12 states, including Ohio, define eligibility based on a percent of FPL. Of the 12 states, 7, including Ohio, set eligibility at 100 percent FPL, 2 states were more restrictive, and 3 states were less restrictive. HB 66 required

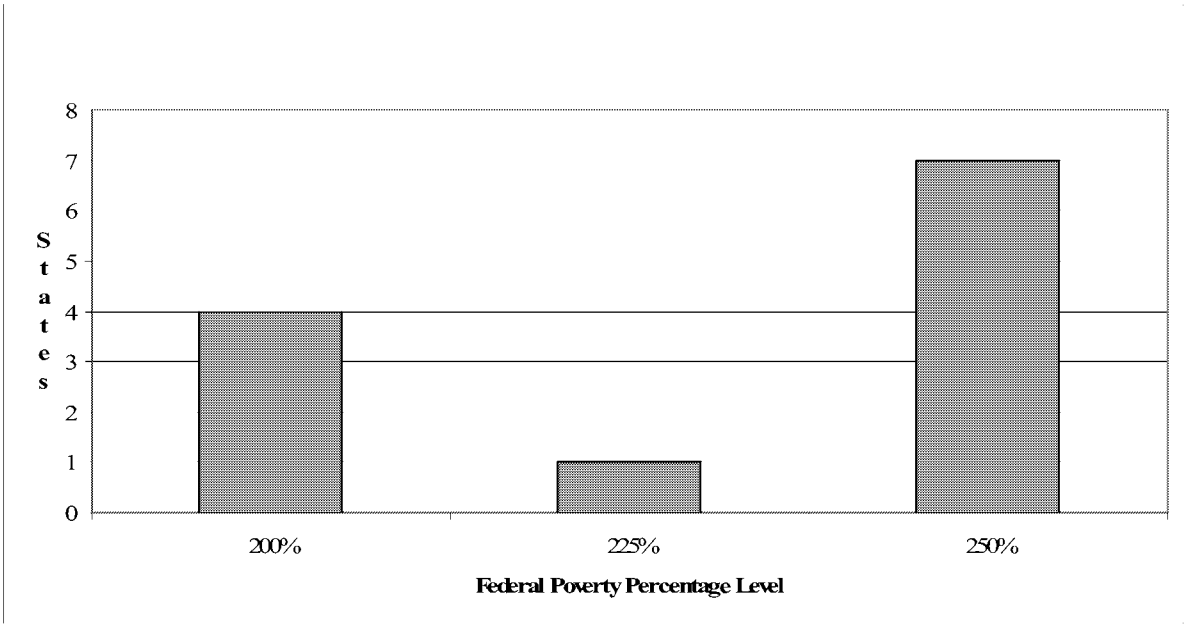
[21] Connecticut, Florida, Hawaii, Michigan, Nebraska, New Mexico, New Hampshire, New Jersey, North Carolina, Oklahoma, Pennsylvania, and Wisconsin

Ohio to reduce its income eligibility level to 90 percent FPL, down from the previous level of 100 percent of FPL. With the reduction of parent/caretaker percent FPL (90 percent), Ohio is more restrictive than the majority of the other states; yet higher than the federal percentage (42 percent). While Ohio bases eligibility only on FPL, other states use FPL and asset or resource limits or base eligibility on an income limit.

Breast and Cervical Cancer

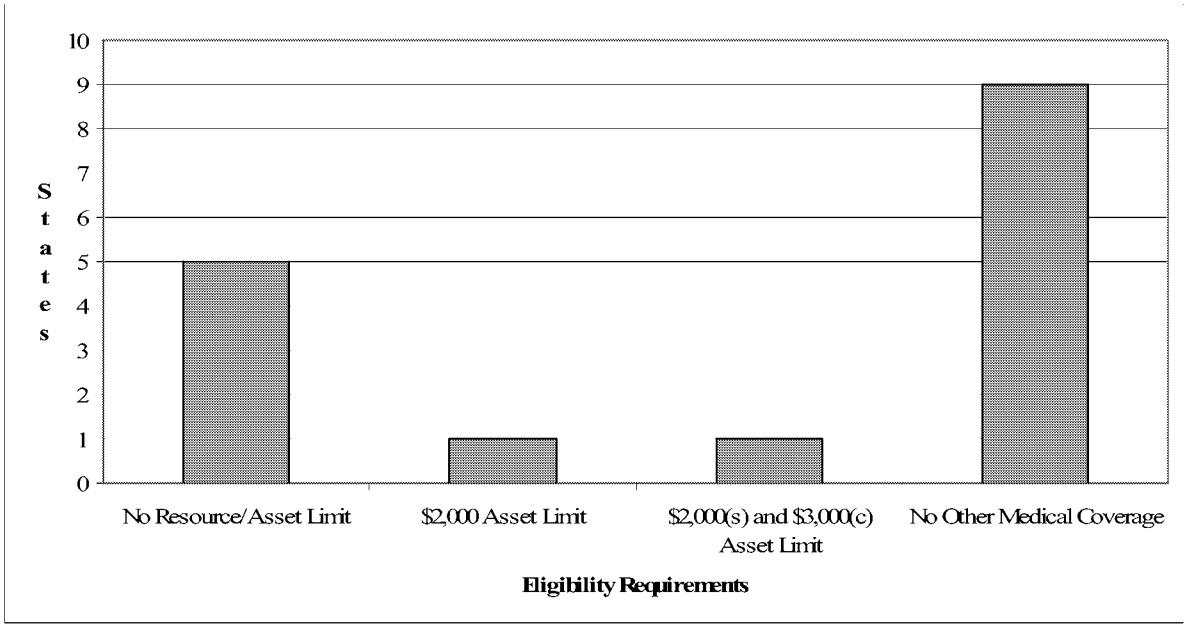
According to HHS's *Medicaid at a Glance 2005*, 50 states plus the District of Columbia provide some level of breast and cervical cancer Medicaid services. Income eligibility levels for these services are shown in **Chart 4-3**.

Chart 4-3: Ohio and Other States' 2003 Breast and Cervical Cancer Medicaid Eligibility Coverage



Source: HHS (2003)

Chart 4-4: Ohio and Other States' 2003 Breast and Cervical Cancer Asset, Income, and Resource Coverage



Source: HHS (2003)

Charts 4-3 and 4-4 illustrate that, during 2003, Ohio and other states had a range of FPL, asset, income, and resource requirements for individuals with breast and cervical cancer. Ohio, like Arkansas, Florida, Illinois, set eligibility at 200 percent FPL. Eight states, including Nebraska, Arizona, Hawaii, Indiana, Maine, New York, Pennsylvania, and Wisconsin, were less restrictive than Ohio with eligibility set at 250 percent of the FPL. Ohio was more restrictive in its income limit for this category than the majority of reported states. Additionally, only two states reported asset limits. Hawaii had an asset limit of $2,000 per individual or $3,000 for a family of two and Maine had an asset limit of $2,000. Ohio did not have asset limits.

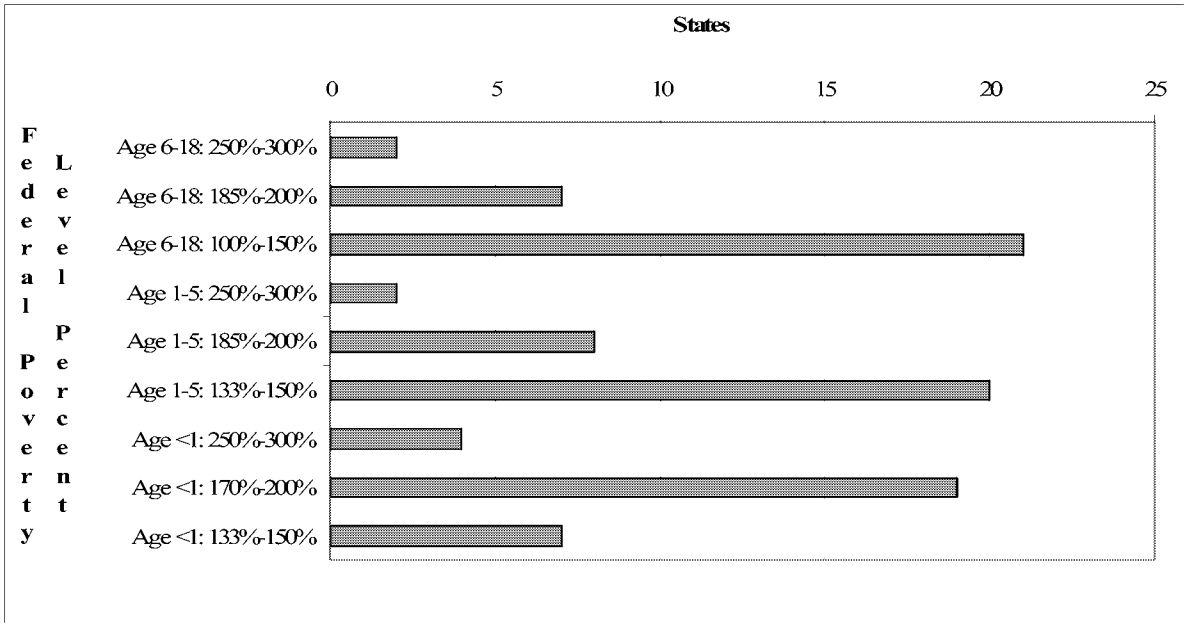
Immigrants

To be eligible for Medicaid, Ohio, like most other states, required that recipients meet the income, asset, and resource requirements for any eligibility category. California set an income limit of $600-$1,959 depending on family size. Within Ohio, if an immigrant arrived in the state after 1996, there is a five year federally required waiting period in order to be eligible to receive Medicaid. Several states have different standards for refugees and undocumented immigrants.

Families/Children

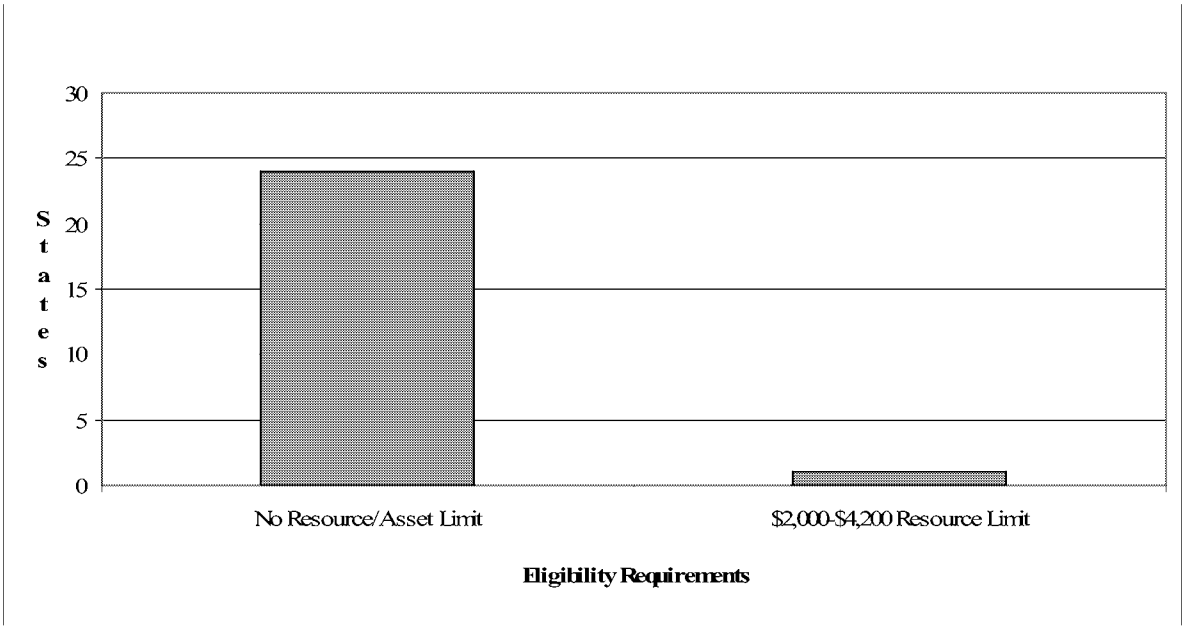
Charts 4-5 and 4-6 illustrate Ohio and other states' (for which data was available) 2003 families/children qualifications for Medicaid eligibility. The detailed information on eligibility for families/children categories can be found in **Table 4A-2** in **Appendix 4A.**

Chart 4-5: Ohio and Other States' 2003 Children up to age 19 (Healthy Start) Medicaid Eligibility Coverage



Source: HHS (2003)
Note: Some states have different FPL requirement for different age groups, while other states have the same FPL for all ages. States are organized by age group even if they reported one FPL for all ages.

Chart 4-6: Ohio and Other States' 2003 Children up to age 19 (Healthy Start) Asset, Income, and Resource Coverage



Source: HHS (2003)

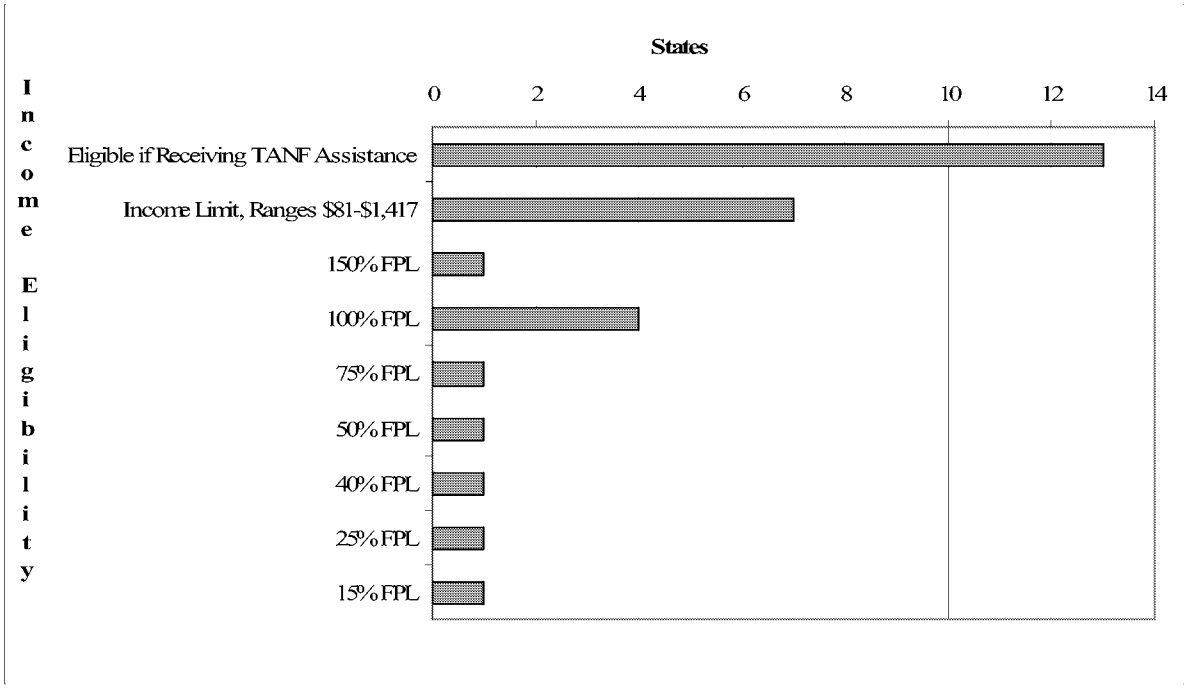
Charts 4-5 and 4-6 illustrate that for Ohio and the other states, there are multiple ranges of percent FPL for children up to age 19 (Healthy Start). The majority of reporting states provide coverage for children under age 1, at 170-200 percent of FPL; for children ages 1-5, at 133-150 percent of FPL; and for children ages 6-18, at 100-150 percent of FPL. Ohio provides families/children Medicaid eligibility coverage at 200 percent of FPL. Of the states reporting information for this category, 9 states, including Ohio, have one FPL requirement for all ages, while 22 states had different FPL requirements, depending on the age of the child. Furthermore, Connecticut, Florida, and Minnesota expanded coverage to include children through age 20.

Only Nevada had a resource limit, which ranges from $2,000-$4,200, depending on the number of eligible individuals. Ohio does not have an asset or resource limit for the families/children recipient category which may provide greater access to care and benefits.

Temporary Assistance for Needy Families (TANF)

Chart 4-7 shows Medicaid eligibility requirements for persons covered under Temporary Assistance for Needy Families (TANF).

Chart 4-7: Ohio and Other States' 2003 TANF Medicaid Eligibility Coverage



Source: HHS (2003)

Chart 4-7 illustrates that 13 of the responding states provide Medicaid to families receiving TANF, 10 states base eligibility on a defined FPL, and 7 states base eligibility on defined monthly income limits, which range from $81-$1,417. Similar to 12 other states, Ohio provides Medicaid to families participating in the OWF[22] cash assistance program. The states that do not link Medicaid eligibility to TANF, have established asset or resource limits, which range from less than $1,000 to $8,500, in addition to the income limits. Ohio does not have an asset or resource limit.

[22] Ohio Works First (OWF): is the financial assistance portion of Ohio's Temporary Assistance to Needy Families (TANF) program. OWF was established to provide time-limited assistance to eligible families. OWF provides cash benefits to eligible, needy families for up to 36 months. After 36 months, a family cannot receive additional cash assistance unless the County Department of Job and Family Services (CDJFS) approves an extension of benefits. There are two kinds of extensions; hardship, and good cause. A family can receive a hardship extension any time after the 36-month time limit has ended. A family can only receive a good cause extension after a 24-month waiting period following the 36-month limit.

Medically Needy and Spend-down Medicaid

Currently, 35 states[23] provide services for an optional medically needy population. The state of Ohio does not provide services for the optional medically needy population; however, it provides services for its spend-down[24] population. Only Arizona and Hawaii base eligibility for this category on a percentage of FPL. Furthermore, states have multiple ranges for asset, income, and resource requirements for their medically needy/spend-down recipients. Asset requirements range from $1,600 to $8,500; monthly income requirements range from $100 to $1,959; and resource requirements range from $2,000 to $100,000, with each criterion dependent upon the state and family size. Specifically, Iowa's resource limit cannot exceed $10,000 and Arizona's resource limit cannot exceed $100,000. The detailed information on eligibility for medically needy and spend-down categories can be found in **Table 4A-3** in **Appendix 4A.**

Aged, Blind, and Disabled

Ohio provides Medicaid services to the aged, blind, and disabled population at 64 percent of the FPL, which is more restrictive than the Supplemental Security Income level limit of 74 percent. Refer to the ***Medicaid eligibility guidelines*** section for additional information regarding Ohio's 209(B) status. The detailed information on eligibility for the aged, blind, and disabled categories can be found in **Table 4A-4** in **Appendix 4A.**

Only three states, including Ohio, base Medicaid eligibility on FPL and 14 states base it on an income range. An additional 12 states automatically provide Medicaid to individuals receiving Supplemental Security Income. Furthermore, 19 states have asset or resource limits.[25] While asset limits range from $1,600 to $6,000 and resource limits range from $1,500 to $3,800 (both dependent upon the state and family size), the majority of states had limits of $2,000 for an individual and $3,000 for a couple. Ohio's resource limits are more restrictive than most other states at $1,500/$2,250 (see **Table 4-7**).

[23] States that have Medically Needy programs include: Arkansas, California, Connecticut, District of Columbia, Florida, Georgia, Hawaii, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nebraska, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Pennsylvania, Puerto Rico, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin.

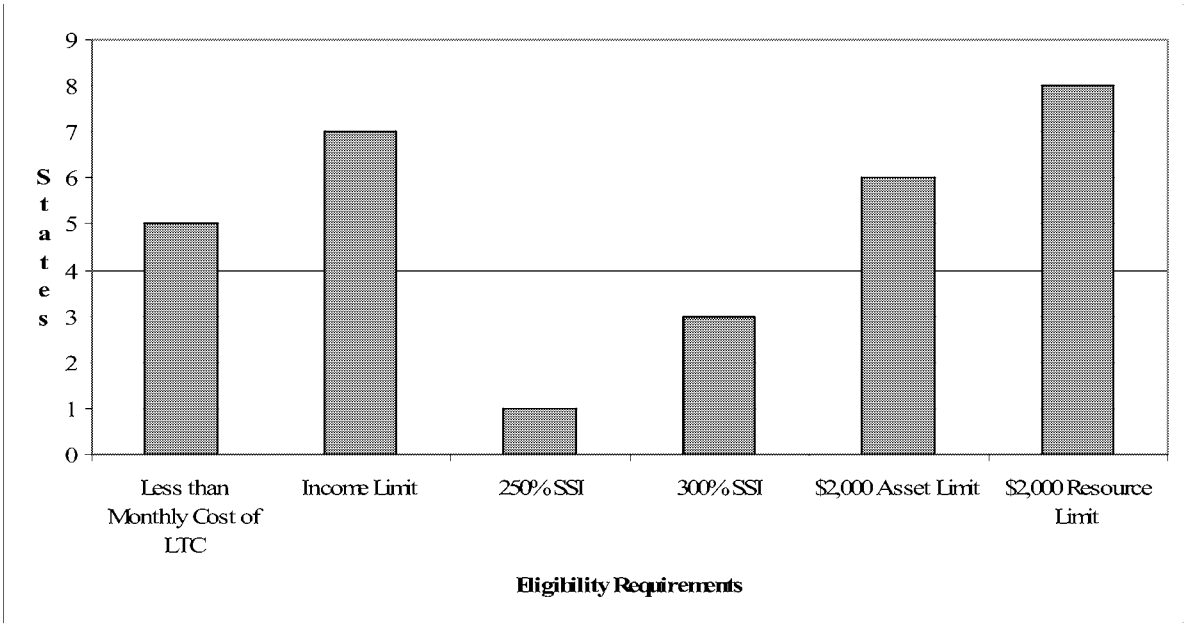
[24] Spend-down applies to individuals who have too much income to qualify under the state's income limits and takes into account incurred medical expenses during a budget period, from one to six months. In some cases, the state can also look at anticipated expenses, such as the cost of health insurance. The state then deducts incurred costs for medical services covered under the state's Medicaid plan during the budget period from the individual's countable income until the individual meets the state's income limit.

[25] Ohio did not report any resource limitation in the HHS document used for this analysis; however, ODJFS documents indicate the State does use resource limitations for this category (see **Table 4-7**). Adding Ohio brings the total to 20 states having an asset or resource limit.

Institutional Level of Care

Chart 4-8 illustrates Ohio and the other states' institutional levels of care, Medicaid eligibility coverage.

Chart 4-8: Ohio and Other States' 2003 Institutional Level of Care Asset, Income, and Resource Coverage



Source: HHS (2003)
Note: The asset and resource limits are based on individual levels only. Furthermore, Connecticut is not included in the chart because the State did not provide detail on its asset limits, other than to say it varies depending on marital status.

Chart 4-8 shows that during 2003, 14 states had asset or resource limits of $2,000 for an individual. Monthly income limits range from $600 to $3,312, dependent upon the state and family size. Arizona, Iowa, and Louisiana require income limits of less than 300 percent of the basic SSI benefit and Delaware requires income limits of less than 250 percent of the basic SSI benefit. Ohio's institutional level of care recipient income must be lower than the cost of care, which is similar to four other states. Of the 17 states reporting, only Ohio and Rhode Island do not have an asset or resource limit.

Qualified Medicaid Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), and Qualified Individuals (QIs)

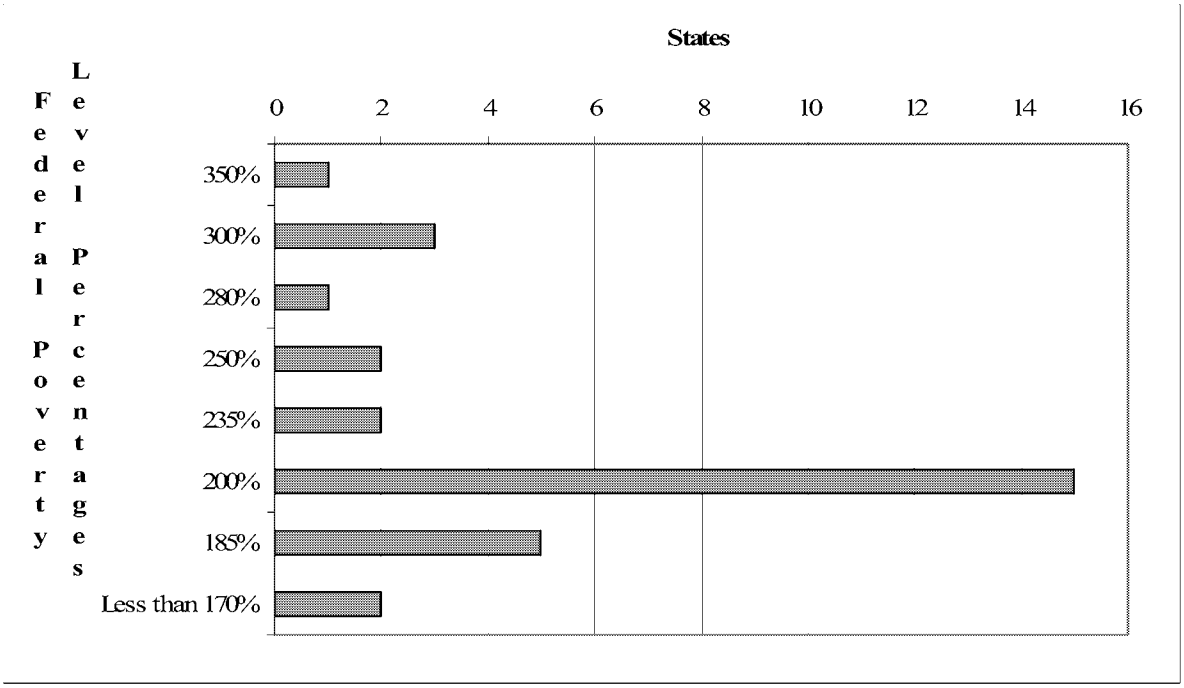
QMB individuals are entitled to Medicare Part A if they have income of 100 percent of FPL or less. SLMB individuals are entitled to Medicare Part A if they have income greater than 100

percent of FPL but less than 120 percent FPL. QI individuals are entitled to Medicare Part A if they have income at least 120 percent of FPL, but not more than 135 percent FPL. For each group, resources can not exceed twice the limit for Supplemental Security Income eligibility and individuals must not otherwise be eligible for full Medicaid benefits. The detailed information on eligibility for the aged, blind, and disabled categories, including QMB, SLMB, and QI, can be found in **Table 4A-4** in **Appendix 4-A.**

State Children's Health Insurance Program (SCHIP)

SCHIP provides coverage to children who exceed the maximum eligibility requirements and is an expansion program. **Chart 4-9** illustrates Ohio and other states 2003 SCHIP qualifications for Medicaid eligibility.

Chart 4-9: Ohio and Other States' 2003 SCHIP Medicaid Eligibility Coverage



Source: HHS (2003)

Chart 4-9 illustrates that the majority of reporting states provide SCHIP to children with a maximum FPL of 200 percent, which is consistent with Ohio's requirements. Additionally, Ohio does not have asset or resource requirements, which is also consistent with the majority of states. However, Oregon has a $5,000 resource limit.

The State of Ohio is using neither the most restrictive nor the most inclusive Medicaid eligibility requirements for a number of Medicaid eligible populations. Ohio is among the most restrictive in terms of eligibility for pregnant women and breast and cervical cancer services. Ohio also appears to be restrictive in eligibility for the aged, blind and disabled category; however, only two other states defined eligibility as a percent of FPL, so a clear comparison was difficult. Using less restrictive FPL, income, asset, and resource requirements enables individuals to receive Medicaid who would not be eligible under more restrictive eligibility requirements; but, in turn, greater immediate costs are incurred by the State. Ohio's middle-of-the-road approach allows flexibility in tailoring eligibility to certain goals and purposes. However, Ohio has not identified a purpose for its Medicaid program (see the **organizational issues** section) and, without defined goals and objectives for the Medicaid program, it can not be determined if the eligibility guidelines are achieving the program's purpose.

Stakeholders spoke to both the need to expand and contract Medicaid eligibility. Members of the Ohio Academy of Family Physicians spoke to restricting eligibility in Ohio's S-CHIP program explaining that Health Start provides coverage for up to 200 percent of the federal poverty level so many fully-employed parents take advantage of the service when commercial insurance may be available. Some members said that eligibility in this area should be examined by the State.

Other stakeholders spoke for the need to expand eligibility. Members of the Universal Healthcare Action Network described problems recipients face when they experience a non-medical emergency and have no resources to resolve the problem. Likewise, members highlighted concerns with restricting eligibility to disabled individuals and children or pregnant women saying that the "public health perspective is that you can't get help to stay healthy…we end up sicker [people] and much more expensive [care]…. we need to be providing disease management and primary care and prescription medication … coverage before [people] are totally disabled." A member of the Ohio State Legal Services Association commented on the need to restore eligibility to 100 percent of the federal poverty level saying, "…I think everyone agrees that the poverty level, in fact, understates the real needs of people… [Reducing the poverty level for eligibility] seems ill conceived and inappropriate."

Finally, a member of the Ohio Children's Hospital Association described a pilot program for presumptive eligibility in Cuyahoga County and recommended the program be examined for state-wide use. The member said that the pilot found self-reported incomes met federal thresholds and reduced barriers to accessing the program.

Medicaid State Budgets in 2004: Why Medicaid is so Hard to Cut (Rockefeller Institute of Government, 2004) shows an analysis on the reduction of eligibility and the effects on enrollment. The report assessed how Medicaid was treated in SFY 2003-04 in the budgets of 10 states: Arizona, Colorado, Kansas, Michigan, New Jersey, Ohio, Oregon, Texas, West Virginia, and Wisconsin. Drawing on a detailed analysis of state budgets, the Institute examined state

budget-balancing strategies, with particular attention to changes in Medicaid spending and eligibility compared to other government functions.

The rates of growth in Medicaid spending from 2000-2003 in the sample states were compared to the national average. While these states demonstrate a wide range over this period, Medicaid spending in these states grew at a slightly faster rate than the U.S. average. Ohio's total change in Medicaid spending from 2002 to 2003 averaged 37.8 percent, 10 percent greater than the U.S. average of 34.5 percent.

According to the Rockefeller Institute report, growth in the cost of Medicaid was seen as a problem in almost every state, but there was not substantial political sentiment that it was the major cause of state financial problems. Public discussion focused on revenue declines as a major cause of budget stress, and cuts to Medicaid were put forward as one of several possible means of addressing this problem.

Even in the environment of severe budget difficulties and significant spending cuts, Medicaid was not a major budget target in most of the sample states. Medicaid cuts were largest in dollar terms in Texas ($777 million) and Oregon ($167 million). In Kansas and West Virginia Medicaid spending cuts were not enacted. Ohio cut a total of $155 million in General Fund Medicaid expenditures during 2004.

Table 4-6 illustrates selected states' Medicaid cost controls during SFY 2003-04.

Table 4-6: Summary of Select States' Medicaid Cost Controls

State	Cut Eligibility	Eliminated/Slowed Expansion/ Enrollment	Cut Services/Limited Utilization	Cut or Froze Provider Rates
Arizona		x	x	
Colorado		x	x	x
Kansas	x			Minimal
New Jersey		x	x	
Ohio			x	x
Texas	x	x	x	x
West Virginia		X	x	
Wisconsin			x	x

Source: The Nelson Rockefeller Institute
Note: Data for Oregon and Michigan was unavailable during the time of the study

As illustrated in **Table 4-6**, states that cut or limited eligibility tended to target adults. Ohio eliminated a planned expansion of the SCHIP program to parents. Parents and adults may have been targeted for two reasons. First, it may be seen as politically easier to cut adults than children from government programs; second, most states had well-established programs for children and had only recently begun to consider eligibility expansions for adults; therefore, the most recent

expansions generally tended to be the first programs to be rolled back. Kansas cut adults receiving general assistance benefits from Medicaid if they had received services for a total of 24 months. Texas reduced eligibility for pregnant women from 185 percent of the FPL to 158 percent of the FPL and eliminated the Medically Needy Spend-down.

Although legislative and budget actions in 2003 and 2004 impacted Medicaid enrollment and services, administrative actions to increase enrollment remained largely unchanged. For instance, in Arizona, aside from the legislatively enacted tightening of the re-determination time frame, there were no efforts to limit enrollment and the state was still using a simplified application form. Colorado was still pursuing enrollment efforts despite the implementation of a cap on enrollment of children. State officials in Kansas continued support for sustaining enrollment as did those in New Jersey, Michigan, Ohio, Wisconsin, and West Virginia.

During SFY 2004-05, the Governor and General Assembly maintained most health care services and covered populations under Ohio's Medicaid program. Below is a listing of Medicaid policy issues followed by a brief description of their outcome in Amended Substitute House Bill 95 (HB95):

- Dental, podiatry, and vision were funded and specifically required to be maintained at current levels;
- Chiropractic and independent psychology services were not funded for adults;
- The General Assembly gave nursing facilities modest rate increases up to rate caps that were set in statute;
- ICF/MRs were allowed a 2 percent increase in their average aggregate daily payment during each year of the biennium;
- One consumer representative was added to the Joint Legislative Nursing Facility Reimbursement Study Council;
- The existing statute was removed which would have protected State fiscal liability when nursing facilities change ownership through increasingly common lease and sale agreements; and
- Medicaid payment rates for physicians and other community providers remained at SFY 2002-03 levels throughout the SFY 2004 - 2005 biennium.

According to the Rockefeller Institute report, eligibility reductions have a clear negative effect on access, as do such measures as the shortening of the enrollment period adopted in Arizona. In similar fashion, freezing or making detrimental cuts in the rates paid to providers may not have a large short-term effect on the availability of care; physicians may be unwilling to eliminate connections with established patients, although they may limit the number of new Medicaid patients they accept. In only three states, Colorado, Ohio, and Oregon, did cuts to Medicaid account for more than 10 percent of the state's total budget balancing package.

R4.1 In order for Ohio to maintain a cost efficient yet effective program for Medicaid eligibility; it should review its eligibility requirements for all recipients in relation to program goals. The State Medicaid Agency should determine whether its goals will align with maintaining a cost efficient program; or expanding eligibility to serve the largest population and maintaining an effective program. Specifically, the State Medicaid Agency should review the income, asset, and resource limits for its parents/caretaker relatives, immigrant, families and children (Healthy Start), spend-down, Qualified Medicaid Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), and Qualified Individuals (QI) eligibility categories. The State Medicaid Agency should also review the percent of federal poverty level for its immigrant; TANF; spend-down; aged, blind, and disabled receiving SSI; and institutional level of care eligibility categories. Additionally, the Single State Medicaid Agency should ensure that it balances eligibility requirements and human costs.

In addition to reviewing Medicaid eligibility requirements, the State Medicaid Agency should use the Budget Deficit Reduction Act to redesign the Medicaid benefit (covered services) for specific populations (see R4.2). The State Medicaid Agency should ensure that quality and access to care are not compromised, and Ohio's Medicaid program should allow for greater efficiencies without compromising quality of care. These steps will allow the State to provide more targeted services while managing the program in a way that prevents sweeping cuts in the future.

Budget Deficit Reduction Act

On February 8, 2006, the President signed the Budget Deficit Reduction Act of 2005 (DRA). The DRA includes net reductions of $4.8 billion over the next five years and $26.1 billion over the next 10 years from Medicaid. Many of the policy changes in the Budget Deficit Reduction Act would shift costs to beneficiaries and have the effect of limiting health care coverage and access to services for low income beneficiaries.

According to the Kaiser Commission on Medicaid and the Uninsured, there are many changes that will be made to a majority of Medicaid programs currently offered by the states due to the 2005 Budget Deficit Reduction Act. The Congressional Budget Office estimates that the provisions related to premiums and cost sharing in the DRA will reduce federal Medicaid spending by $1.9 billion over the next five years and by $9.9 billion over the next 10 years, with about 70 percent coming from increased cost sharing and the remaining 30 percent from premiums. For beneficiaries, including children, who have family incomes over 150 percent of the FPL, or $24,900 for a family of three in 2006, states may charge unlimited premiums and may charge co-payments up to 20 percent of the cost of medical services. Co-payment limits are

set at 10 percent of the cost of the service for beneficiaries, including children, with incomes between 100 percent and 150 percent of the FPL. However, states are prohibited from imposing premiums and cost sharing for services and preferred drugs on certain groups, including mandatory children and pregnant women. Certain services, including preventive services for children, pregnancy related services and emergency services, are also exempt from cost sharing. Additionally, families with incomes below 150 percent of the FPL could be subject to nominal cost sharing for non-preferred prescription drugs and families with incomes over 150 percent of the FPL could face co-payments up to 20 percent of the cost of non-preferred drugs.

The DRA requires states to provide wrap-around benefit coverage for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for children under 19, and ensure that affected beneficiaries have access to rural health clinic and federally-qualified health center (FQHC) services. The limited benefit options are only applicable to non-exempt eligibility groups covered under a state Medicaid plan prior to enactment of this option and are not applicable to new eligibility groups. States may also permit parents with disabled children to buy-in to the Medicaid program for their children if they have family income below 300 percent of the FPL. The Congressional Budget Office estimates that this provision would increase federal Medicaid spending by $1.4 billion over the next five years and $64 billion over 10 years and provide services to an additional 115,000 children.

Furthermore, the DRA requires new and current Medicaid beneficiaries to provide documentation of citizenship during enrollment or re-determination, tightens the definition of what qualifies as Medicaid targeted case management, and restricts provider taxes on managed care organizations. It also directs the Secretary of the U.S. Department of Health and Human Services to establish a demonstration program for Health Opportunity Accounts (HOAs) in which up to 10 states may participate during the first five years. These Medicaid demonstrations are a fundamental policy change, where states would set up accounts for individuals to pay for medical services. However, after the money in the account is exhausted, beneficiaries could face additional cost sharing requirements to meet a deductible before they have access to full Medicaid benefits.

The DRA includes additional spending for home and community based services for the elderly and disabled by allowing states to offer these services as an optional benefit instead of requiring a waiver. States are to cap the number of people eligible for the services. The Congressional Budget Office estimates that the provision would extend additional services to about 120,000 enrollees.

Kaiser indicated that while there remain opportunities to make Medicaid more cost effective, new proposals to reduce federal Medicaid spending should be assessed in conjunction with the effects of the changes enacted as part of the DRA. Additionally, careful monitoring tools should

be established to evaluate how these recent changes affect Medicaid spending and the adequacy of health coverage for low income beneficiaries.

The single State Medicaid agency indicated that it has not planned benefit level changes for the current fiscal year, but agency staff commented that benefit level changes will be requested from the legislature during the SFY 2008-09 budget cycle.

Kentucky and West Virginia are among the first states to redesign their Medicaid programs under new flexibilities granted by the DRA. As of March 31, 2006, the DRA provided states new options that allow them to develop alternative benefit packages for certain groups of children and adults, and to require premiums and higher enforceable co-pays. States merely need to amend their state Medicaid plans with CMS in order to institute changes to their Medicaid programs.

Kentucky's Medicaid reform initiative was previously structured as a Medicaid 1115 waiver. With the new flexibility provided by the DRA, the state repackaged its Medicaid reform initiative and submitted many of the changes to the federal government as a state Medicaid plan amendment. Kentucky is tailoring its Medicaid program to different populations by dividing it into the following four benefit packages:

- The Global Choices benefit package serves the general Medicaid population;
- The Comprehensive Choices benefit package serves elderly individuals in need of nursing-facility care and those with acquired brain injuries;
- The Family Choices benefit package serves children; and
- The Optimum Choices benefit package serves individuals with mental retardation and developmental disabilities in need of long-term care.

While Kentucky's reforms include positive initiatives to implement consumer directed care, there remain many unanswered questions about how to ensure that reforms do not create undue barriers to care.

West Virginia submitted a state Medicaid plan amendment and received federal approval in only eight days. The new benefit plan will primarily impact children and "healthy" parents. Under the new benefit package, certain Medicaid beneficiaries will choose between a Basic Plan and an Enhanced Plan, both of which provide fewer benefits than currently available. Mental health services are not covered in the Basic Plan. In order to access mental health services, beneficiaries must acquire the Enhanced Plan that requires individuals to sign a Medicaid Member Agreement. In signing the agreement, individuals agree to follow 12 requirements of the state's Medicaid program, including going to their medical home when sick, taking the medicines prescribed by their health care provider, and using the hospital emergency room only for emergencies. If beneficiaries fail to follow the requirements, they will be relegated to the Basic Plan and unable to access the Enhanced Plan for up to 12 months.

R4.2 The single State Medicaid Agency should use the flexibility of the DRA to reshape Ohio Medicaid Program coverage, while ensuring that crucial services are still provided. The Agency has the ability to make changes such as reducing the number of services offered, limiting benefit packages, requiring cost-sharing, increasing premiums and co-payments, restricting enrollment, and increasing penalties for enrollment abuse. Any changes should be made with ample stakeholder input, including the General Assembly, sub-recipient agencies, providers, and consumers. Changes should reflect the goals and priorities of the program as discussed in R3.3 and R3.6.

Although the Single State Medicaid Agency intends to implement changes to its benefit packages during the SFY 2008-09 budget period as allowed under the DRA; it should consider creating different benefit packages tailored to specific populations, similar to Kentucky, or implementing different levels of benefit packages, similar to West Virginia's Basic and Enhanced Plans. However, it is imperative that the State Medicaid Agency implement adequate consumer protections and establish quality benchmarks to ensure that access to health services is appropriate.

Medicaid Eligibility Guidelines

Under Federal law, Ohio holds 209(b) status, which allows it to implement Medicaid income and resource criteria and a disability test that are more strict than those used to determine eligibility for Supplemental Security Income. Ohio, like all but one 209(b) state, has opted not to use a more restrictive disability definition, and instead adopted the Supplemental Security Income[26] definition. However, Ohio uses different income methodologies and more restrictive resource criteria than the Supplemental Security Income program. **Table 4-7** illustrates Ohio's income and eligibility guidelines for Medicaid.

[26] Supplemental Security Income is a federal income supplement program funded by general tax revenues (not Social Security taxes). It is designed to help aged, blind, and disabled people, who have little or no income; and it provides cash to meet basic needs for food, clothing, and shelter.

Table 4-7: Ohio Medicaid Income Guidelines during SFY 2004-05 and 2005-06

Covered Population	Income Eligibility Guidelines	Gross Monthly Income Family Size 1	2	3	4
Children (Up to age 19)	200% FPL	$1,595	$2,139	$2,682	$3,225
Pregnant Women	150% FPL	$1,197	$1,604	$2,012	$2,419
Families	100% FPL[1]	$798	$1,070	$1,341	$1,613
	90% FPL[1]	$718	$962	$1,207	$1,451
		Income[2]		**Resources[3]**	
Ohioans age 65 or Older & Individuals w/ Disabilities	64% FPL	Individual $504	Couple $869	Individual $1,500	Couple $2,250

Source: ODJFS

Note: The income eligibility guidelines remained unchanged during SFYs 2004-05 and 2005-06. The gross monthly income chart is based on the federal poverty level (FPL) which changed during this time frame. The information shown in **Table 4-7** reflects the guidelines in effect on December 22, 2005.

[1]The covered family population income eligibility guidelines decreased to 90 percent on January 1, 2006.

[2]Some eligibility categories have various resource tests. Deductions and exceptions apply. This is a proxy amount. People with higher incomes may have medical expenses deducted from income calculations to spend-down to this level.

[3]Exceptions and calculations will affect the final amount counted toward eligibility. Actual determination of eligibility is performed by the CDJFS.

As illustrated in **Table 4-7**, income eligibility guidelines for each covered population vary. Ohio's income eligibility guideline for children is 200 percent of the FPL; with gross monthly income ranging from $1,595 to $3,225 (dependent upon family size). Ohio's pregnant women population income eligibility guideline is 150 percent of the FPL; with gross monthly income ranging from $1,197 to $2,419 (dependent upon family size). Ohio's family income eligibility guideline is currently 90 percent of FPL, due to the recent change brought about on January 1, 2006 in HB 66. Additionally, family gross monthly income ranges from $798 to $1,613 (dependent upon family size). Ohioans 65 or older and individuals with disabilities have income eligibility guidelines of 64 percent of FPL; which is more restrictive than the Supplemental Security Income level of 74 percent. Furthermore, individuals age 65 or older or with disabilities must have income of less than $504 per month and resources valued at less than $1,500. For couples, the monthly income standard is $869 and the resource limit is $2,250.

Stakeholders varied in their assessment of the State's 209(b) status. A member of the Ohio Job and Family Services Directors' Association spoke to the benefits of this status designation, explaining that it "…gives [Ohio] the opportunity to help and assist folks that are elderly [or] disabled, have higher medical bills and … fall under a spend-down." The member explained that, in other states where spend-down is not an option, medical care costs often are incurred by local, county and state governments.

On the other hand, a member of the Universal Health Care Action Network of Ohio spoke to the need for change in the State's eligibility status saying that Ohio should raise Medicaid eligibility for disabled individuals to at least the SSI threshold. The member said, " I find [it] so antiquated -- we have people that are so poor and they're disabled and they are living at the SSI level, and still have to spend down to 64 percent of poverty level…." This sentiment was echoed by members of the Ohio State Legal Services Association who said, "it's sort of an absurdity that we treat [aged, blind and disabled recipients] worse than we do parents …if you're 66 or blind or disabled, then you have to have income of 64 percent of poverty. That's ridiculous. It doesn't make any policy sense."

Other stakeholder concerns involved the impact of the State's more restrictive financial eligibility for aged, blind and disabled Medicaid recipients. A member of the Ohio Developmental Disabilities Council described how the MRDD population is heavily dependent on Medicaid to remain in the community and faces barriers in understanding the nuances of Ohio Medicaid law. The member went on to say that MRDD recipients "…have enough problems just trying to live in a dignified manner. …Medicaid regulations put insurmountable obstacles in the way of a Medicaid recipient." The member asked, "Why should a mentally retarded and/or developmentally disabled Medicaid recipient have to play unneeded, confusing bureaucratic games?" The member recommended abolishing the asset cap for MRDD recipients.

The Ohio Commission to Reform Medicaid (OCRM) and the Center for Community Solutions (Community Solutions) contracted with the Lewin Group to research the policy and programmatic implications of converting from Ohio's current 209(b) status to 1634 status.

The Lewin Group report describes the key steps necessary for such a conversion. A conversion from 209(b) status to 1634 status would require amending the Ohio Revised Code (ORC) and the State Medicaid plan, entering into an agreement with the Social Security Administration for eligibility determination, providing public notice, and amending the OAC and other state Medicaid policy documents. **Table 4-8** illustrates the complete process the State Medicaid Agency would need to conduct in order to convert to a 1634 state status.

Table 4-8: Key Steps and Estimated Timeframes in 1634 Conversion Process

Requirements	Timeframe
Obtain Statutory Authority	Unknown
Amend Medicaid State Plan	90 days
Enter into Section 1634 Agreement with SSA	Unknown
ODJFS Formal Clearance	50 days
Joint Committee on Agency Rule Review (JCARR)	65 days from filing of proposed rule
Final File of Rule	No sooner than the 66th day following filing of proposed rule
Effective Date of Final Rule	No sooner than the 76th day following filing of the proposed rule

Source: The Lewin Group

As illustrated in **Table 4-8**, the State of Ohio would have to conduct multiple changes to current law, administrative code, and state plan language to change State Medicaid status. Additionally, the State would also be required to consider whether individuals losing eligibility as a result of the conversion are eligible under other Medicaid categories. If the existing information is insufficient or indicates that the individual is not eligible under other eligibility categories, the individual must be provided an opportunity to submit additional information that may help establish eligibility. This would create a significant administrative and recipient paperwork burden.

The State would retain some of the financial responsibility for the Social Security Administration determining eligibility, particularly in the area of financial eligibility. If determining Medicaid eligibility costs the Social Security Administration more than determining SSI eligibility, or if the Social Security Administration collects additional information, the State is responsible for half the additional cost. The State must also pay the full cost of any statistical or other studies, as well as any other services not directly related to making Medicaid eligibility determinations. Furthermore, the State would share in some the of Social Security Administration's administrative and overhead costs.

The Lewin Group was commissioned to produce a second report, to examine Ohio's Medicaid coverage of the aged and disabled population. The report included the following primary components:

- Conducting statistical modeling of the enrollment and cost impacts of converting from 209(b) to 1634 status for the purposes of Medicaid eligibility determination for the disabled population;
- Researching other states' Medicaid disability determination processes and eligibility standards to provide points of comparison for Ohio; and
- Describing the process for making the conversion.

The Lewin Group reviewed three possible eligibility scenarios which are illustrated in **Table 4-9**. Two of these scenarios assume the State would implement a medically needy program and provide two levels for establishing a Medically Needy Income Limit (MNIL).

Table 4-9: Ohio 1634 Status Conversion Scenarios

	Scenario 1	Scenario 2	Scenario 3
1634 Status	Yes	Yes	Yes
Optional Medically Needy Group[1]	No	Yes, set MNIL at 100% of SSI	Yes, set MNIL at 64% of FPL
Special Income Rule Group for Long-Term Care Users	Yes, maintain at 300% of SSI	Yes, reduce to 200% of SSI	Yes, maintain at 300% of SSI

Source: The Lewin Group

[1] The Medically Needy Program is intended to provide medical coverage to individuals whose income or assets exceed the maximum to qualify for the Medical Assistance Program but have large medical bills. Eligible individuals receive Medical Assistance Program coverage either on a two-month, six-month, or 12-month basis, depending on the eligibility group to which they belong. Coverage varies from the full range of services available to other Medical Assistance Program clients (inpatient and outpatient services, prescribed drugs, etc.) to a limited benefit package.

As illustrated in **Table 4-9**, under each of the conversion scenarios, individuals who receive SSI benefits but are not eligible for Medicaid under Ohio's current standards would gain eligibility, thereby increasing overall Medicaid enrollment.

Under the three scenarios, Medicaid enrollment of individuals with disabilities is estimated to increase by 8,620 for scenario 1 and by 33,397 for scenarios 2 and 3. Under the first scenario, costs are estimated to fall by $251 million, to $8.0 billion by not including coverage through the mandatory 209(b) spend-down or the optional medically needy coverage groups. Medicaid costs under the other two scenarios would increase between $133 million and $155 million.

According to the Lewin Group, conversion to 1634 status under any of the three scenarios would result in 32,085 new Supplemental Security Income recipients gaining Medicaid coverage. The coverage gains could be offset to some degree by loss of coverage for certain individuals. Specifically, individuals who currently receive Medicaid coverage through spend-down would be adversely affected.

The Lewin Group indicated that conversion to a 1634 state would make Ohio's eligibility standards broader than under 209(b) status. Additionally, there would no longer be two application processes for Medicaid and disability which would reduce barriers to enrollment. The conversion would alleviate some work load for State and county Medicaid staff, because the Social Security Administration would make eligibility determinations for Supplemental Security

Income beneficiaries. The conversion would also allow Ohio to eliminate its spend-down process.

209(b) Disability Determinations

There are 10 additional states that maintain 209(b) eligibility status. Eligibility administration and application processes were collected and documented from those states to determine efficiency and effectiveness in processes.

The Commonwealth of Virginia's Medicaid program is a state supervised and locally administered program through its counties. Virginia contracts with the Department of Medical Assistance Services to conduct Medicaid eligibility determinations. In turn, the Social Service Agency contracts with 120 local county agencies to then determine eligibility. Virginia's county agencies determine eligibility at the local level; additionally, disability determinations are made by the State's Disability Determination Services (DDS), a division within the Department of Rehabilitation. However, Supplemental Security Income disability determinations are conducted by its Social Security Administration. The state of Virginia Medicaid staff indicated that it has maintained 209(b) state status due to the income transfer policy for long-term care recipients. If the state were to change status from 209(b) to 1634, it would have to abide by the 1634 and SSI requirements for contiguous property. If the State of Virginia was unable to include recipient's homes and $5,000 of income; a tremendous number of new enrollees would then be eligible, due to the number of rural areas and property within the state. The State has continually declined an eligibility status change due to the contiguous property Supplemental Security Income requirements.

In Minnesota, the Department of Human Services administers the State's Medicaid program through its county departments in a manner similar to Ohio. In Minnesota there is one application process for Medicaid and SSI, and Medicaid disability applications are processed through the county departments. Like Ohio, Minnesota does not use a more restrictive disability definition than SSI. Minnesota has implemented the optional medically needy group in addition to the mandatory spend-down group required of 209(b) states. The State of Minnesota has contemplated changing eligibility status; however, no decisions have been made to change due to potential enrollment increases.

The State of New Hampshire's Medicaid program is administered by its Department of Health and Human Services, Office of Health Planning and Medicaid. The Division of Family Assistance manages the financial side of Medicaid eligibility, and the Office of Medicaid Business and Policy oversees medical eligibility requirements. The State of New Hampshire indicated that although it has reviewed the potential to change eligibility status, it has never made the transfer due to the anticipated increase in enrollment from SSI individuals. The state indicated that there are separate application processes for Supplemental Security Income and

state Medicaid; which work well. New Hampshire Medicaid staff indicated that if there was one application process for both SSI and Medicaid, recipients would have a longer wait for assistance and determination. New Hampshire Medicaid has a four year disability standard (eligibility term before re-determination); whereas the Supplemental Security Income application process has a one year disability standard.

The State of Indiana's Medicaid program is administered by its Office of Planning and Medicaid Policy through county offices. Similar to Ohio, Indiana uses stricter income and resource standards and methodologies than SSI but uses the same disability definition. Indiana also has more restrictive methods than SSI for counting resources for the aged, blind, and disabled. Indiana does not cover the optional poverty-related or medically needy groups, or use the special income standard for institutionalized individuals. Indiana's State Medical Review Team, which is a unit within the Family and Social Services Administration, conducts disability determinations. Delays in disability determinations sometimes arise due to delays in receiving needed additional information. All individuals applying for Medicaid must complete the state medical team review even if they are current Supplement Security Income or Social Security Disability Insurance beneficiaries.

The State of Oklahoma's Medicaid program is administered by its Health Care Authority Board. The State does not use more restrictive methods than Supplemental Security Income for counting income; however, the State's resource methodology is more restrictive by limiting irrevocable burial fund principals. Oklahoma's optional medically needy group was eliminated due to budget constraints in February 2003. In Oklahoma, individuals with disabilities applying for Medicaid coverage are referred to the Social Security Administration for application for Supplemental Security Income benefits. The eligibility worker takes the information needed for the Medicaid application but does not determine final eligibility until the Social Security Administration renders a decision on the Supplemental Security Income benefits application. If the Social Security Administration determines that the individual is disabled, he or she is deemed disabled for the purposes of Medicaid. If the Social Security Administration denies the individual's application on the basis of disability, the Medicaid agency also denies eligibility.

Although each of the 209(b) states have different administration and application processes,[27] the majority do not have a single application process for Supplemental Security Income and Medicaid disability determinations. Additionally, none of the states indicated interest in changing to 1634 eligibility status due to the potential for increased enrollment from SSI recipients and less restrictive financial requirements.

[27] The states of Connecticut, Hawaii, Missouri, and North Dakota were contacted but did not provide information on their disability determination processes.

HB 66 (Section 206.66.46) required a study of the processes used by governmental entities that administer programs or services for which disability is an eligibility requirement. The purpose of the Disability Determination Consolidation Study Council (Study Council) report was to examine the feasibility of combining the disability determination functions within a single agency and to examine potential advantages or disadvantages of consolidating these functions.

In compliance with HB 66, ODJFS convened representatives of county departments of job and family services (CDJFS) and the Rehabilitative Services Commission (RSC) to examine 209(b) issues. Additionally, ODJFS invited representatives of the Disability Medical Assistance (DMA) council to participate in order to provide continuity with that group's discussions related to improving the number of and speed with which DMA enrollees complete a Medicaid disability determination.

The Study Council reviewed the application processes for Ohio's Medicaid program. The members of the Study Council agreed that Ohio could benefit from increased coordination of the current administrative processes used to determine the presence of disability for enrollment into several public programs for which a disability is required. The Study Council recommended that Ohio reduce some of the administrative duplication to reduce costs and continue the current disability eligibility criteria.

The Study Council recommended using the existing process and infrastructure of the RSC to perform the vast majority of disability determinations for Ohio Medicaid. Medicaid applicants would still apply at the CDJFS. However, if applicants were seeking Medicaid enrollment as a disabled person, they would also be required to apply simultaneously for SSI or Social Security Disability Income (SSDI) through the RSC.

The Council indicated that Ohio Medicaid could accomplish this change quickly and easily by using the same disability determination and medical release information forms that are currently used by Social Security. The end result would create an application process for Supplemental Security Income /Social Security Disability Income and Medicaid at the same location.

The Study Council indicated that CDJFS would retain the intake and enrollment functions for Medicaid. RSC would make the determination of disability status for Medicaid. As the State Medicaid Agency, ODJFS would retain the final eligibility determination for Medicaid, including both financial eligibility as well as disability status. CDJFS would be relieved of most of the administrative and financial burden of scheduling medical testing for Medicaid applicants who allege to have a disability.

The Study Council indicated that the benefits of the consolidated process include the following:

- Consolidation will result in an estimated $2 million in costs savings to ODJFS and CDJFS services;
- Applicants will have a single disability application form, a single release of information, and a single disability determination process for Medicaid and SSI or SSDI;
- Duplicate administrative functions for collection and review of medical documentation and determination of the presence of disability will be eliminated; and
- The process can be implemented within approximately 18 months and will build upon existing process improvements already underway within ODJFS and OHP.

Another option that was considered by the Study Council was changing Ohio's current Medicaid financial eligibility status so that it was the same for SSI. This option describes the change from Ohio being a 209(b) state to becoming a 1634 state. The Study Council found that although changing Ohio's Medicaid financial eligibility might result in some administrative savings, those savings would be dwarfed by the simultaneous increase in caseload costs associated with purchasing health care for thousands of newly eligible Medicaid enrollees. Thus, the Study Council rejected this option.[28]

During the course of the audit, stakeholders reported that the medical testing completed by the CDJFS was often delayed and procedures had to be repeated, creating increased costs for the county offices. Stakeholders expressed several frustrations with Ohio's current process for completing disability determination. A member of the Ohio Association of County Behavioral Health Authorities explained that the concern was with the expediency of the process – not who completes the determination. The member said that centralizing determination at the State level was supposed o increase efficiency but has, instead, led to long delays. A member of the Ohio Hospital Association said that once the paperwork is sent to the State, a recipient may have to wait six to nine months for a determination. The member went on to say that recipients and providers are "forever hearing, "We're working on a new process," or "We're short staffed,"" but that the process does not seem to improve.

A member of the Ohio Chapter of the National Multiple Sclerosis Society said that it is important for their members to be able to access some kind of medical care while waiting on a determination. The participant said, "they've got to have either more staff or they've got to be set up so that those determinations are made quicker" since some recipients are waiting 14 months to 30 months for a determination. Counties are also experiencing increasing delays and are often asked to repeat tests at the county's expense. A representative of the County Commissioner's

[28] As of February 2006, the ODJFS Director signed the Council's report and sent it to the Speaker of the House, the President of the Senate, and the Governor as required in HB 66. ODJFS is awaiting feedback in order to determine its next course of action. If the Council's recommendations are accepted, ODJFS estimates an 18 month implementation timeframe. As of June 2006, ODJFS had decided not to use the recommendations provided by the Council, per discussions with the RSC. Instead, ODJFS intends to work more closely with the RSC in sharing disability test information.

Association said, "improving efficiencies in disability determination would be greatly appreciated. …I'm hearing more six months to a year. 18 months on the tougher cases." The representative also said the counties are asked to provide irrelevant or duplicative information. As a solution, the County Commissioner's Association and Ohio Department of Job and Family Services Directors' Association reportedly recommended piloting disability determination through expert private providers at the regional level but the idea was discarded by ODJFS because it lacked state-wideness.

R4.3 The State Medicaid Agency and RSC should implement the Study Council's recommendation for greater efficiency in the Medicaid State eligibility determination, administration and application processes. The State should reduce application and administrative duplication by using the RSC to determine disability for SSI and Medicaid at the same time. Additionally, the State Medicaid Agency should monitor its 209(b) status to determine if it remains the most cost effective approach for the State. Based on the Study Council's recommendations, ODJFS could save about $2 million annually.

B. Premium Assistance Program

The State of Ohio does not have an employer-sponsored premium assistance program to reduce its General Fund Medicaid costs. Premium assistance[29] is a program for individuals on Medicaid that have employee sponsored insurance available but can not afford it. In this program, Medicaid pays the premium to the private insurance provider. This program shifts the costs to the private system. However, Medicaid may still cover services that are not covered by the employer's plan. Under current Medicaid law, states have the option of subsidizing the purchase of private group health plans for Medicaid beneficiaries if it is cost effective to do so. Additionally, states can pay premiums for non-Medicaid eligible family members and may make enrollment in a group health plan a requirement of Medicaid eligibility if it is cost effective to do so.

ODJFS uses the Medicare Premium Assistance Program, administered as part of the Medicaid program, for certain people eligible for Medicare. This program helps people who are eligible for Medicare and have limited income and assets pay the cost of Medicare premium(s), Medicare deductibles, and/or Medicare coinsurance. The Medicare Premium Assistance Program administered by ODJFS offers three types of assistance which include:

- Qualified Medicare Beneficiary (QMB)

[29] Premium Assistance is a health insurance purchasing strategy in which states use public funds, federal and state Medicaid and/or the State Children's Health Insurance Program (SCHIP), to pay for a portion of the premium costs of employer-sponsored insurance for eligible populations.

- Specified Low-Income Medicare Beneficiary (SLMB); and
- Qualified Individual (QI).

In 1997, the Ohio General Assembly enacted House Bill 408, which built on welfare reform provisions in the federal Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), which Congress enacted in 1996. The law eliminated the Aid to Families with Dependent Children program and replaced it with the federal Temporary Assistance for Needy Families (TANF) program. Ohio created two innovative programs from TANF: Ohio Works First (OWF) and Prevention, Retention and Contingency (PRC).

Consistent with PRWORA, Ohio provides Transitional Medicaid to certain families who are losing Medicaid as a result of employment or increased income for up to one year. If an individual receives Healthy Families/Low-Income Families (LIF) Medicaid and their income becomes too high to continue in the program, they may still be eligible for Transitional Medicaid.

Healthy Families/LIF Medicaid assistance groups are eligible for six months of Transitional Medicaid if:

- Loss of Healthy Families/LIF Medicaid was due at least in part to an increase in income from employment of the parent or caretaker relative or due to the expiration of certain time limits for Healthy Families earned income budgeting;
- Healthy Families/LIF Medicaid was received in three out of the last six calendar months;
- The assistance group includes a child under age 18 or a child under age 19 who is a full-time student in a secondary school or in the equivalent level of vocational or technical training; and
- No member of the assistance group has been convicted of Medicaid fraud during the last six months.

Transitional Medicaid assistance groups are eligible for a second six months of Transitional Medicaid coverage if:

- Transitional Medicaid was received during the entire initial 6-month period;
- The assistance group includes a child under age 18 or a child under age 19 who is a full-time student in a secondary school or in the equivalent level of vocational or technical training;
- The assistance group submits quarterly reports which include earnings for every month; and
- The average monthly earnings, less child care costs, of the assistance group does not exceed 185 percent of the federal poverty level.

Also, Senate Bill 5,[30] allowing small business to pool risks to obtain health insurance, was introduced in January of 2005; however, as of September 2006 there was no effective date and the bill had not been voted out of committee.

Although Ohio uses Medicare Premium Assistance and Transitional Medicaid, according to the Kaiser Family Foundation, there has been recent increased interest in using premium assistance programs to encourage low-income families' participation in private coverage, shore-up the private coverage market and prevent crowd-out, and achieve cost savings by bringing in employer contributions to help offset costs. This interest is partially due to the federal government's 2001 Health Insurance Flexibility and Accountability (HIFA) initiative, which encouraged states to seek waivers that included premium assistance components and loosened certain requirements for premium assistance programs.[31] (See also the **managed care/care management** section.)

CMS invited states to participate in the HIFA demonstration initiative, a Medicaid and State Children's Health Insurance Program (SCHIP) Section 1115 waiver approach. The primary goal of the HIFA demonstration initiative is to encourage new comprehensive state approaches that will increase the number of individuals with health insurance coverage within current-level Medicaid and SCHIP resources. CMS puts a particular emphasis on broad statewide approaches that maximize private health insurance coverage options and target Medicaid and SCHIP resources to populations with income below 200 percent of the FPL. States must systematically track the impact of their HIFA demonstration initiatives on the uninsured rate for individuals with incomes under 200 percent of the FPL. Through the HIFA demonstration project, CMS seeks to work with states to do the following:

- Encourage innovation to improve how Medicaid and SCHIP funds are used to increase health insurance coverage for low income individuals;
- Give states the programmatic flexibility required to support approaches that increase private health insurance coverage options;
- Simplify the waiver application process by providing clear guidance and data templates;
- Increase accountability in the state and federal partnership by ensuring that Medicaid and SCHIP funds are effectively being used to increase health insurance coverage, including substantially more private health insurance coverage options; and
- Give priority review to state proposals that meet the general guidelines of the HIFA demonstration project.

[30] State House Bill 5 permits small employers to offer health care plans that do not provide benefits otherwise required by law. Additionally, it provides for the operation of health savings accounts in a manner consistent with federal law; and places a limit on an insured's liability for co-payments and deductibles under a health benefit plan.
[31] The current average managed care premium paid to providers is $198.03

Another option is Section 1906 of the Social Security Act, which was enacted in the Omnibus Budget Reconciliation Action of 1990, and requires that states use Medicaid funds to purchase employer-based group health insurance on behalf of Medicaid-eligible individuals if such insurance is available and cost effective. States have the ability to use Section 1906 or 1115 waivers to provide low-income eligibles with health insurance, through premium assistance.

The National Academy for State Health Policy, during 2004, completed an assessment comparing states with premium assistance programs. **Table 4-10** illustrates the States that are operating premium assistance programs.

Table 4-10: States Operating Premium Assistance Programs in 2004

States	Program Authority
California	Section 1906
Georgia	Section 1906
Illinois	HIFA section 1115
Iowa	Section 1906
Massachusetts	Section 1906 and Section 1115
Missouri	Section 1906
New Jersey	Section 1906 and Section 1115 (w/HIFA amendment)
Oregon	HIFA section 1115
Pennsylvania	Section 1906
Rhode Island	Section 1906
Texas	Section 1906
Utah	Section 1115
Virginia	Section 1906 Title XXI
Wisconsin	Section 1906 and Section 1115

Source: National Academy for State Health Policy, 2004.

As illustrated in **Table 4-10**, 14 states operated premium assistance programs as of February 2004, and at least 10 other states were at various points in the planning process. Many states have expressed interest in pursuing premium assistance because they want to take advantage of the contributions that employers make toward the cost of employee health insurance coverage. According to the National Academy for State Health Policy, the states examined indicated that the savings that will result from leveraging employer contributions can help address tight state budgets and provide a mechanism to cover a greater number of the uninsured population. Some states also place value on using the private sector to provide coverage, rather than expanding public programs. During 2005, five additional states, Florida, Vermont, Iowa, New Mexico, and Oklahoma, received approval to implement section 1115 waivers.

According to National Council of State Legislatures (NCSL), Florida introduced greater benefit flexibility for providers and consumers with the passage of State Bill (SB) 838, which created the defined contribution managed care model, to be tested in two counties after federal approval of an 1115 demonstration waiver. SB 838 calls for the Florida Agency for Health Care

Administration to create a capitated (fixed payment) managed care program for all Medicaid recipients in fee-for-service or other managed care systems and in the MediPass (statewide primary care case management system) program.

New Mexico has recently initiated an employer-based public/private partnership program that is one of the first of its kind in the country. The program calls for New Mexico to provide a new insurance product for small businesses to offer to their low-income workers. Employers and employees pay part of the premium with state and federal funds picking up the remainder of the cost. Additionally, Oklahoma received federal approval in September 2005 for its Employer/Employee Partnership for Insurance Coverage, a premium assistance demonstration program aimed at addressing the state's high rate of uninsured persons. Oklahoma passed measures during 2005 increasing access to affordable health care coverage, particularly for small businesses and low-income workers.

Kentucky's new waiver requires beneficiaries to enroll in employer-sponsored private health insurance if it is available and if it is more cost-effective for the Commonwealth. According to NCSL, the Kentucky Health Insurance Purchasing Program will help enrollees pay premiums and wrap-around commercial coverage with Medicaid services. Additionally, the federal government recently approved a Section 1115 Demonstration waiver for Utah to carry out the Covered at Work program which uses employer, employee, state, and federal funds to provide private health insurance to recipients who are uninsured, not eligible to participate in the Utah Primary Care Network, and cannot afford to enroll in insurance plans offered through their employers.

The Kaiser Commission conducted a study on premium assistance programs implemented under section 1115 waivers in five states (Illinois, New Jersey, Oregon, Rhode Island, and Utah) to determine how they are financed; their eligibility, benefit, and cost sharing requirements; their methods for determining cost-effectiveness; and cost savings. These states used a variety of combinations of employer and enrollee contributions and subsidies to finance their premium assistance programs. Most relied on employer contributions to help offset costs, and they all required individual contributions from at least some families enrolled in the program. Illinois and Utah capped their subsidy amounts, shifting the risk of remaining premium costs to enrollees, while New Jersey, Oregon, and Rhode Island paid premium amounts remaining after employer and fixed individual contributions.

Additionally, the states varied in their benefit and cost sharing standards. New Jersey and Rhode Island provided "wrap-around coverage," meaning that they cover Medicaid benefits that are not covered by a private plan and any cost sharing in a private plan that exceeds the amounts allowed in Medicaid. In contrast, Utah and Illinois had very limited benefit and cost sharing requirements. Oregon required that subsidized coverage meet a minimum benchmark that is actuarially equivalent to federally mandated Medicaid benefits.

Furthermore, the examined states used several different approaches to determine cost-effectiveness, including assessing whether an employer contribution is sufficient to ensure cost-effectiveness on a case-by-case basis (New Jersey and Rhode Island), capping subsidy amounts (Illinois and Utah), and assessing aggregate program savings (Oregon). Among these states, there is limited data available regarding cost savings, but it is evident that Rhode Island and New Jersey are saving money on a per enrollee basis. New Jersey is saving approximately $204 per family per month (varies monthly); and Rhode Island is saving approximately $222 per family per month.[32] However, in order to achieve overall savings, enrollment must be high enough to generate sufficient savings to cover start-up and ongoing administrative expenses. How these programs are structured and whether they result in savings for states are considerations in assessing their impact.

Data from the RAND Health Insurance Experiment, the Medical Outcomes Study, and more recent studies suggest that requiring co-pays reduces both appropriate and inappropriate use of health care and medication, especially among people with low incomes or chronic conditions. Some of this may reflect voluntary opting out by families who believe they are healthy enough to do without insurance; however, findings from the National Survey of America's Families suggest that many simply cannot afford even modest cost-sharing arrangements. Access to affordable insurance is especially important for low-income populations.

While premium assistance programs enable states to use public funds such as federal and state Medicaid, and/or SCHIP, to pay for a portion of the premium costs of employer-sponsored insurance for eligible populations, the effect of recipient contribution could potentially impact Medicaid enrollment. However, the State Medicaid Agency could reduce a portion of Medicaid expenditures, by requiring employer/employee contributions through premium assistance programs.[33]

R4.4 The State Medicaid Agency should strive to reduce the costs of its Medicaid program by opting to implement an employer-sponsored premium assistance program by using Section 1906 or HIFA Section 1115 waivers. Section 1906 of the Social Security Act requires that states use Medicaid funds to purchase employer-sponsored group health insurance on behalf of Medicaid-eligible individuals if such insurance is available and cost effective. States have the ability to use Section 1906 or 1115 waivers to provide low-income eligibles with health insurance, through premium assistance. CMS encourages states to participate in the HIFA demonstration initiative. The primary goal of the HIFA demonstration initiative is

[32] All savings data represents federal/state savings.

[33] In February 2006, ODJFS issued a report identifying the number of employee assistance group members by employer. The report indicated that during SFY 2004-05 Wal-Mart had the highest monthly number of employee assistance group members (12,184). The employer with the lowest number was Custom Staffing with 542 monthly employee assistance group members.

to encourage new comprehensive state approaches that will increase the number of individuals with health insurance coverage within current Medicaid and SCHIP resources.

A number of states have implemented, or are in the planning stages of implementing employer-sponsored premium assistance programs. The State Medicaid Agency should ensure when implementing an employer-sponsored premium assistance program that enrollment in the program is high enough to generate sufficient savings to cover start-up and ongoing administrative expenses. When assessing the impact of these programs, the Agency should also review how they are structured and whether they result in savings for the State. Additionally, the Agency should continually review its employer-sponsored premium assistance program to ensure that participation rates are not dropping due to recipient contributions.

Financial Implication: **Assuming Ohio could enroll 15 percent of employed Medicaid recipients in a Premium Assistance program (based on 200,000 employed recipients as reported in 2005), and assuming Ohio achieved a cost savings of $30 per month, per participant, comparable to Utah, the annual savings would be about $10 million.**

C. Buy-in Program

Ohio does not currently have a Medicaid buy-in (MBI) premium assistance program for Medicaid eligible recipients. ODJFS considered the implementation of the program during SFY 2000-01; however, plans were not finalized or passed through legislation. During the course of this performance audit, ODJFS started budget preparation for SFY 2008-09, which includes reviewing the addition of a MBI program. ODJFS is seeking grants from CMS to conduct a study to determine what would be needed for the program.

According to the Ohio Access 2004 Report, recipients of Social Security Disability Income and Supplemental Security Income risk losing Medicaid coverage if they work. Eliminating barriers to health care and creating incentives to work can greatly improve financial independence and well being. To support this goal, Congress included a MBI option in the Balanced Budget Act of 1997 (BBA) and enacted the Ticket to Work and Work Incentives Improvement Act (TWWIIA) in 1999. The BBA allows states to provide Medicaid coverage to individuals with disabilities who are working and who cannot qualify for Medicaid because their income is too high. While the BBA imposes a maximum income and resource level to qualify, the Ticket to Work Act grants further flexibility to states by allowing them to establish their own income and resource standards.

Through MBI programs, states may elect to create an eligibility category through which such employed disabled people buy in to Medicaid coverage by paying premiums or sharing costs. When a state establishes a MBI program, it creates a Medicaid entitlement that serves as a supplement to any income and health benefits a person obtains by being employed.

The main features of a MBI program consist of the following:

- Devising an income eligibility limit;
- Determining an amount of earned income disregarded for income eligibility;
- Devising resource eligibility limits;
- Implementing premium amounts; and
- Developing income levels above which participants are required to pay a premium.

To implement MBI programs, states submit a Medicaid state plan amendment that describes the income, resource, and cost-sharing policies for the group. In addition to submitting state plan amendments to offer MBI programs, the Ticket to Work Act authorizes states to apply to the secretary of the Department of Health and Human Services for approval of a Medicaid buy-in demonstration project. Through the demonstration, states provide workers who have potentially severe disabilities with medical assistance equal to that provided to others participating in MBI.

Under the authority of the 1997 Balanced Budget Act, 11 states -- Alaska, California, Iowa, Maine, Minnesota, Mississippi, Nebraska, Oregon, South Carolina, Vermont, and Wisconsin -- have implemented MBI programs. Four other states -- Arkansas, Connecticut, Illinois, and New Mexico -- have passed legislation or provided budgetary authority for such programs and are now determining their implementation strategies and timetables.[34]

For a substantial percentage of MBI enrollees, states want their programs to serve as wrap-around coverage for employer-sponsored private health insurance. As a wrap-around plan, Medicaid will cover services not provided through the private plan. Some states design buy-in programs to be similar to state-administered health insurance programs for low-income families provided under Medicaid waivers or SCHIP. The use of a monthly premium based, at least in part, on projected health service costs for the insured group is consistent with the practices of many SCHIP programs.

[34] States can permit working individuals with disabilities with incomes at or above 250 percent of the Federal Poverty Level to buy into the Medicaid program. (The Balanced Budget Act limited Medicaid Buy-In coverage to persons with incomes below 250 percent of poverty.) A state providing Medicaid coverage to these individuals also may extend coverage to employed persons with disabilities aged 16 to 64 whose medical conditions have improved but who continue to have a severe medically determinable impairment as defined by federal regulations.

States believe they can use cost-sharing and premiums to control entry into the MBI program if initial fiscal estimates understate enrollment. States have discretion in setting premiums and can modify the cost-sharing arrangements as necessary to control costs. For example, some states require an initial cost-sharing of unearned income above specified levels to ensure that only those with significant work effort enroll in the MBI program. **Table 4-11** illustrates the characteristics of several state MBI programs.

Table 4-11: Characteristics of State MBI Programs

State	Financial Eligibility	Cost-Sharing Policies	Previous Medicaid Status of Enrollees	Start date and number of participants (as of March, 2000)	Legislation
Alaska	<250% of FPL	$20-$120 monthly premium[1]	First time enrollees	July 1, 1998; 47	House Bill 459 (1998)
California	<250% of FPL	$20-$250 (S) $30-$375 (F)	Medically needy	April 1, 2000; 2	Assembly Bill 155 (1999)
Iowa	<250% of FPL	Sliding pay scale at or above 150% FPL	Medically needy	March 1, 2000; 606	Senate File 211 (1999)
Maine	<250% of FPL	$10 -$20 per month[2]	Most current participants	August 1, 1999; 210	Legislation not identified in report
Massachusetts	No income eligibility maximum	Premiums for income at or above 200% FPL	60% of MBI previously on MCD; 40% had other insurance	1988; 3,624	Legislation not identified in report
Minnesota	No Income Limit	10% of gross income above 200% FPL	Most current participants[7]	July 7, 1999; 4000+	Legislation passed May (1999) but not identified in report
Mississippi	<250% of FPL	$51-$85 per month[3]	First time enrollees	July 1999; Less than 10	House Bill 403 (1999)
Nebraska	<250% of FPL	Varies[4]	Prior participants	June 1, 1999; 50	Legislative Bill 594 (1999)
Oregon	<250% of FPL	2%-10% of earning above 200% FPL	90% prior participants	February 1, 1999; 280	Legislation not identified in report
South Carolina	<250% of FPL	No cost sharing	Prior participants	October 1, 1998; 50	Appropriations Act (1998)
Vermont	<250% of FPL	Varies[5]	91% prior participants	January 1, 2000; 160	Vermont Act 62 Section 121H
Wisconsin	<250% of FPL	Varies[6]	72% prior participants	March 15, 2000; 53	Wisconsin Act 9 Assembly Bill 133 (1999)

Source: National Conference of State Legislatures, 2000

Note: Prior participants are recipients already receiving Medicaid prior to changing eligibility categories

[1]No premiums if net income is below 100 percent of Federal Poverty Level (FPL).

[2]Depends on income level.

[3]Fee assessed if income is at 150 percent of FPL.

[4]No cost-sharing up to 200 percent of FPL. Incomes between 200 percent and 210 percent of the FPL pay premiums of 2 percent of family net income above 200 percent. Incomes between 210 percent and 220 percent of FPL contribute 4 percent of family net income above 200 percent. Fees are graduated up to a maximum contribution of ten percent of income above 200 percent for those with incomes between 240 percent

[5]There is no premium for earning up to 185 percent of FPL. There is a $12 monthly premium for earning between 185 percent to 225 percent, and a $25 monthly premium for earnings between 225 percent and 250 percent. If a person has private insurance, that premium is $10 per month. No cost-sharing charges apply.

[6]Individuals with gross individual incomes of less than 150 percent of FPL are exempt from paying a monthly premium. Premiums for individuals with gross incomes at or greater than 150 percent of FPL are calculated as the sum of: 3 percent of individual's earned income minus some disregards (e.g. child care expenses).

[7]About 66 percent of enrollees had at least one month of Medicaid eligibility in FY 1999.

As illustrated in **Table 4-11**, other state buy-in programs contain multiple income and cost-sharing characteristics. Most of the states, except for Massachusetts and Minnesota, maintain financial eligibility of less than 250 percent of the FPL (monthly income of $3,340 for an individual and $4,500 for a couple). Cost-sharing policies vary across all states, from zero contribution to a $375 family contribution. Enrollment in the MBI programs, for programs in operation at least one year at the time of the NCSL report, ranged from 47 (Alaska) to more 3,624 (Massachusetts).

In addition to the states listed in **Table 4-11**, the following states have implemented or were in the process of implementing MBI programs during 2004:

- Arizona
- Arkansas
- Connecticut
- Illinois
- Indiana
- Kansas
- Louisiana
- Maryland
- Michigan
- Missouri
- Nevada
- New Hampshire
- New Jersey
- New Mexico
- North Dakota
- Pennsylvania
- Utah
- Washington
- West Virginia
- Wyoming

ODJFS contracted with The Lewin Group to develop several aspects of a MBI program, which generated five alternative designs for a MBI program in Ohio and one non-buy-in Medicaid expansion. **Table 4-12** illustrates the six potential scenarios.

Table 4-12: Ohio MBI and Non-Buy-In Scenarios

Scenarios	Financial Eligibility & Income Disregard	Cost-Sharing Policies	Asset Limits Single (S) Family (F)	Projected Enrollment	Total Program Costs (Millions)	Number of People Qualified	Program Costs per Eligible Person
Option 1 (Most Restricted)	≤200% of FPL, $10,000 income disregard	2.5%-7.5% (family income)[1]	$2,000 (S) $3,000 (F)	≤ 3,500	$20	333,249	$60
Option 2 Balanced Budget Act (BBA)	≤250% of FPL, 100% income disregard	≤10% (family income above 150% FPL)	$10,000 (S) $15,000 (F)	7,000	$50	400,219	$127
Option 3 (Parity with SSI)	≤294% of FPL, $20,000 income disregard	7.5% (family income above 150% FPL)	$10,000 (S) $15,000 (F)	7,000	$54	387,770	$140
Option 4 (Broader Eligibility)	≤400% of FPL, $40,000 income disregard	5% (family income above 150% FPL)	$20,000 (S) $30,000 (F)	9,000	$72	419,220	$172
Option 5 Ticket to Work Program (TTWP Recommendation)	≤250% of FPL, $20,000 income disregard	10% (family income above 150% FPL)	$10,000 (S & F)	7,000-9,000	$54	373,478	$145
Non-MBI[2]	100% of FPL 0% income disregard	N/A	N/A	63,000	$1,217	499,482	$2,437

Source: The Lewin Group
Note 1: The number of people qualified is based on disability and financial criteria (including those already on Medicaid)
Note 2: Ohio's Covered Families and Children Service eligibility requirement is 200 percent FPL.
[1]Individuals with family income below 100 percent of FPL would pay 2.5 percent of their income in premiums, those with income between 100 percent and 150 percent of FPL would pay 5 percent of income, and those above 150 percent would pay 7.5 percent of income.
[2] Non-MBI includes all individuals eligible under ABD category with incomes below 100 percent FPL. This option would increase Medicaid enrollment due to Ohio's eligibility requirement of 64 percent.

As illustrated in **Table 4-12,** the Lewin Group report reviewed multiple MBI options available to Ohio for providing coverage to individuals with disabilities. Enrollment and financial impacts vary greatly depending on the MBI program's design. The financial eligibility levels and income disregards range from 100 percent FPL to 400 percent FPL; and from 0 percent to 100 percent for the income disregard. Cost sharing polices range from 2.5 percent to 10 percent, dependent upon family income. Asset limits range from $2,000 to $20,000 for single coverage, and from $3,000 to $30,000 for family coverage. The program costs for the six options range from $20 million to $1.2 billion. Additionally, each option's total eligible population (number of people qualified in the table) ranges from approximately 333,000 to 500,000. The per eligible person program costs range from $60 to $2,437.

The main distinction in the scenarios is between individuals who already receive Medicaid and those who do not. Those not yet on Medicaid will generate new enrollment and Medicaid benefit costs, while those who shift from other Medicaid eligibility categories to Medicaid buy-in status will generate additional costs to Medicaid only to the extent that they use more services under the buy-in program than they would have used under their previous eligibility category.

According to the Lewin Group, the greatest number of new enrollees in the Medicaid program would come from the non-MBI option, which would expand Medicaid to the ABD populations without implementing a MBI program (from 64 percent FPL to 100 percent FPL). Under this option, there could be up to 63,146 new enrollees in Medicaid. This option would also have considerable financial implications, with the highest estimated program costs and over $180 million in lost spend-down offsets.

The greatest enrollment of individuals new to Medicaid through a MBI program would be realized through option 4. Under option 4, individuals aged 18 through 64 with income up to 400 percent of FPL and resources valued up to $20,000 would be covered. An estimated 9,056 individuals would enroll with a total program cost of 54 million, the highest program cost from among the five MBI options considered. Under the most conservative MBI program option (option 1), which would cover individuals with incomes up to 200 percent of FPL, limited income disregards, and resources up to $2,000, 1,968 new individuals would enroll in Medicaid. Programs costs for this option would be approximately $20 million.

The Lewin Group noted that conclusive comparisons regarding coverage across states cannot be made because states have varying eligibility standards for their Medicaid programs and use different types and levels of income and resource disregards, as evidenced in **Table 4-16**. States considering the implementation of a MBI program would achieve greater practical benefits from understanding how the program would fit within the context of their own current Medicaid coverage for individuals with disabilities.

Several factors affect the way Ohio might choose to provide coverage to working individuals with disabilities. These factors include enrollment potential, cost implications, ease of implementation, and the State's overarching policy goals related to Medicaid coverage and work incentives. A representative of the Ohio Council of Behavioral Health Care Providers offered support for MBI programs, "While we talk a good talk about consumers going back to work and many of us have programs to encourage that, this State still does not have Medicaid buy-in. States that have Medicaid buy-in can in good faith encourage people to go back into the job market, be successful and eventually leave Medicaid…."

According to *The Impact of Increased Cost Sharing on Medicaid Enrollees* (Health Affairs, July/August 2005), research suggests that changes to cost-sharing structures in public health insurance can affect participation in the system, along with access to and use of care. Evidence

from an analysis of Medicaid enrollment data in four states,[35] for example, found that as premiums rose from 1 percent to 5 percent of annual family income, estimated participation rates among the uninsured declined from 57 percent to 18 percent. Although cost-sharing is viewed as an incentive to the Ohio Medicaid program, it should be continually reviewed to ensure enrollment and accessibility are maintained.[36]

R4.5 The State Medicaid Agency should develop and implement a Medicaid Buy-in (MBI) premium assistance program. This program would enable and permit working individuals with disabilities to buy into the Medicaid program. This would reduce the State Medicaid Agency's total expenditures by allowing eligible recipients to contribute a portion of Medicaid costs.

Income limits, resources, earnings disregard, cost sharing, enrollment, and implementation costs are program characteristics that should be thoroughly reviewed by the State to control enrollment in the MBI program and ensure that the program furthers the goals of Ohio Medicaid. The Agency should look to the other states for financial eligibility and cost sharing levels to determine what is most financially appropriate for Ohio.

The Lewin Group provided six different options that illustrate an array of eligible populations and program costs. The State Medicaid Agency should review those options and determine which best fits the State's goals for the program. Potential sources of MBI participation consist of the following:

- **Individuals receiving SSI or SSDI, on Medicaid, and currently not working. Some of these individuals will begin working as a result of the MBI program, and move from their current Medicaid eligibility category to the Medicaid buy-in category.**

- **Individuals receiving SSI or SSDI, on Medicaid and currently working. Some of these individuals will move to the MBI program, enabling them to work additional hours or at higher paying jobs without losing their Medicaid coverage.**

- **Uninsured individuals not on Medicaid but with disabilities that make it difficult to work sufficient hours to obtain adequate health insurance through work. Many of these are individuals currently receiving SSI or**

[35] The four states include Hawaii, Minnesota, Tennessee, and Washington.

[36] Although no studies were identified, it is anecdotally known that when recipients are required to contribute to Medicaid costs; participation will decrease; potentially harming overall health status.

SSDI but are not eligible for Medicaid. Some, however, may not receive SSI or SSDI, and are therefore currently unknown to the system.

D. Medicaid Spend-down

In accordance with 42 CFR 435.121(B)(5), all 209(b) states that elect to provide medically needy coverage to aged, blind, and disabled individuals must permit individuals to spend-down to Medicaid income eligibility levels. Spend-down applies to individuals who have too much income to qualify under the State's income limits when they are SSI recipients. When an individual has too much income to qualify for Medicaid, the state Medicaid agency looks at the individual's incurred medical expenses during a budget period of from one to six months. In some cases, the state can also look at some anticipated expenses, such as the cost of health insurance. The state then deducts incurred costs for medical services covered under the Medicaid plan during the budget period from the individual's countable income until the individual meets the income limit.

Medicaid spend-down is also important to any state that has elected to cover the optional medically needy eligibility category, as permitted by Section 1902 of the Social Security Act. A medically needy program allows states to extend Medicaid eligibility to additional qualified persons with significant health care expenses who have income in excess of the mandatory or optional categorically needy levels. Such persons may spend-down to Medicaid eligibility by incurring medical and/or remedial care expenses to offset their excess income, thereby reducing it to a level below the maximum income allowed by that state's Medicaid plan. States may also allow families to establish eligibility for medically needy coverage by paying monthly premiums to the state in an amount equal to the difference between the threshold allowance for income eligibility, and a family's income, reduced by any unpaid expenses incurred for medical care in previous months. As of August 2002, thirty-five states plus the District of Columbia had elected to have a medically needy program and were providing services to at least some medically needy beneficiaries.

Ohio, as a 209(b) state, must provide for the deduction of incurred medical expenses from income through Medicaid spend-down each month (month specific) so that individuals may reduce their income to the eligibility level. However, Ohio does not have an optional medically needy eligibility category. OAC §5101:1-39-10 indicates that there are three ways an individual can meet spend-down, including the following:

- Recurring:
    - Ongoing: Covers a consumer with routinely occurring medical expenses (same type and amount each month), that are not covered by Medicaid;

- Pay-in: Covers a consumer who pays the spend-down amount to the CDJFS per month in advance; and
- Delayed: Covers a consumer with medical expenses that vary from month to month who must verify the incurred amount with the CDJFS each month.

According to county spend-down enrollment data for October 2005 provided by ODJFS, Ohio had a total of 132,624 recipients on spend-down. Of the 132,624 recipients, 73.7 percent, or 97,775, were recurring spend-down recipients.[37] ODJFS also provided Medicaid spend-down enrollment, months, and net payments amounts for delayed, reoccurring, and total unduplicated spend-down enrollment for FY 2002-03 to FY 2004-05. **Table 4-13** illustrates Ohio's spend-down enrollment and member costs.

[37] Recurring spend-down for the state of Ohio can be paid by going into the County Department of Job and Family Services and providing spend-down payment, or by providing recurring medical expenses (same type and amount each month of predictable incurred Medicaid costs).

Table 4-13: Ohio Medicaid Spend-down Enrollment, Member Months, and Costs

Spend-down Type	Measure	Time Period		
		SFY 2002-03	**SFY 2003-04**	**SFY 2004-05**
Delayed	Members	53,843	57,722	56,358
	Member months	370,880	393,908	345,139
	Cost to the Medicaid Program	$365,813,318	$417,562,992	$385,172,726
	Per member per month costs to Medicaid	$986.34	$1,060.05	$1,115.99
Recurring	Members	116,005	122,004	162,090
	Member months	1,082,209	1,132,288	1,254,170
	Cost to the Medicaid Program	$2,339,285,648	$2,526,807,156	$2,763,667,945
	Per member per month costs to Medicaid	$2,162	$2,232	$2,204
Total Unduplicated Spend-down	Members	160,359	169,277	175,772
	Member months	1,453,089	1,526,196	1,599,309
	Cost to the Medicaid Program	$2,705,098,967	$2,944,370,149	$3,148,840,671
	Per member per month costs to Medicaid	$1,861.62	$1,929.22	$1,968.88

Source: ODJFS
Note 1 Data information from ODJFS and was not tested for reliability.
Note 2: Pay-in spend-down enrollment will show up in either delayed or recurring spend-down member months and cost.

As illustrated in **Table 4-13**, Ohio's total unduplicated spend-down, members, member months, cost for Medicaid, and per member per month cost for Medicaid, increased from FY 2002-03 to 2003-04, and again in FY 2004-05. In general, the per-member, per-month spend-down is almost $200.[38] However, this calculation does not show the proportion of individuals with certain levels of spend-down. Anecdotally, stakeholders indicated that raising the income limit for spend-down by $100 would eliminate the spend-down requirement for many Medicaid participants.

[38] The per member per month spend-down for delayed spend-down recipients is based on November 2005 data as reported by ODJFS.

Ohio CDJFS administer the application process for Medicaid, including the collection of spend-down payments. According to ODJFS, recipients can pay their spend-down each month with a check or money order to their local CDJFS. If a recipient chooses this option, their Medicaid card will be good for the entire month. A recipient may also incur costs for medical services that equal the spend-down amount for the month. A recipient must provide proof (receipts) to the CDJFS that medical expenses were incurred or paid in the amount of the recipients pre-determined spend-down amount. Once a recipient's spend-down amount is met, he/she will receive the Medicaid card to use for the remainder of the month.

Ross CDJFS indicated that eligible Medicaid recipients can provide payment for spend-down at the county office through the cashier window or by mail. Once the spend-down payment has been made by the recipient, and information is entered into CRIS-E, the caseworker can release the recipient's Medicaid card. Additionally, recipients can also opt to send in a check or money order for spend-down. Ross CDJFS staff stated the Medicaid card release is slower due to the mailing process. Spend-down dollars are collected and recorded at Ross CDJFS, and are submitted to its fiscal department. Ross CDJFS commented that the spend-down dollars are used for county allocations.

Ross CDJFS indicated that there is an administrative time lag with the CRIS-E data entry system and the Medicaid Management Information System (MMIS). The data entered into CRIS-E takes approximately 24 hours to batch and show up in MMIS. As a result, it is difficult for a provider to see if the recipient is eligible in MMIS due to the time lag from the CRIS-E system (see the **technology** section).

During the course of the audit, stakeholder interviews reported that collection of spend-down payments was cumbersome and often resulted in lost receipts or delayed activation of the recipient's Medicaid card. Also, substantial variation in spend-down processes was noted. Concerns expressed by stakeholders about Ohio's spend-down process highlight the confusion, inconsistency, and frustration that surround this part of the Medicaid program. A member of the Ohio Advocates for Mental Health explained,

> "Incur means that it's charged against you. [For example], he goes to see a case manager and they charge $85. Then that $85 can go towards his spend-down, even though he didn't pay it....Part of the problem is that in 88 separate counties, there are 88 different opinions, 88 different understandings of what "incurred expense" is."

A member the Ohio Coalition for Health Communities expressed concern that they were unable to obtain a printed document listing the rules and procedures for spend-down and what can and can not be counted. A member of the National Alliance for the Mentally Ill of Ohio expressed that the spend-down process was impractical because,

> "…you have to incur the medical expense each month -- you either actually have to pay it out or incur it. Then you have to send in the receipts each month-- you have to either fax them in or mail them in, and that's fraught with hazards as to whether they're going to get them in a timely fashion. They often don't receive them. They get lost…. …often times your card will arrive after the end of the month or it won't arrive in time. It's very clumsy…."

The member went on to described how some counties have a process set up where recipients will go to their provider and receive a bill for an "incurred expense" so that the Medicaid card can be activated. A member of the Ohio Council of Behavioral Healthcare Providers stated that the spend-down process appeared to be designed to restrict access. Also, a member of the Ohio Coalition for Health Communities said understanding what counts toward spend-down is highly variable and different in each county – no guidelines appear to be applied state-wide.

The spend-down process is difficult for providers to understand as well. A member of the Ohio Dental Association described the difficulties in ensuring that records were received by the caseworker. The member called it a "paper bureaucracy-type thing." and said, "from a dentist's point of view, it's just and extra level of bureaucracy to deal with.", A member of the Ohio Association of County Behavioral Health Authorities stated that spend-down and what services are applicable is problematic to track. The member also said that it was hard for patients "philosophically when they see other people that don't have a spend-down."

Finally, members of the Ohio State Legal Services Association praised the concept of spending down to increase eligibility but called the process "administratively cumbersome". The member described a "ripple effect" of providers, caseworkers, and recipients all trying to navigate the system. "It's penny wise and pound foolish," concluded one member.

Other 209(b) states[39] were contacted to determine their respective administrative processes pertaining to spend-down, in addition to Medicaid spend-down duration. Virginia has a six month spend-down period[40] for aged, blind, and disabled, children under age 18, and pregnant women, and a three month retro-active spend-down provision for all potential recipients, excluding qualified Medicare beneficiaries. Virginia's long-term care Medicaid recipients are on a monthly spend-down provision. Virginia provides Medicaid benefits to its medically needy population. Staff from Virginia's Medicaid program indicated that it does not have administrative issues pertaining to spend-down.

Minnesota indicated that it also provides Medicaid to its medically needy population. Minnesota has a full-month coverage basis for Medicaid spend-down and, like Ohio, has never considered a date-specific Medicaid spend-down. Recipients have the option to meet a six month spend-down.

[39] Connecticut, Oklahoma, Missouri, North Dakota, and Hawaii were contacted but did not provide information on their spend-down programs.

[40] Virginia's eligible recipients are provided Medicaid coverage for a six month period due to constant and predictable incurred medical costs.

New Hampshire indicated that it has one and six month income spend-down. The six month spend-down time period was implemented in response to complaints from the State's advocacy groups. New Hampshire implemented date-specific eligibility versus full-month coverage because it was more cost effective and saves a half a month's Medicaid costs.

Illinois indicated administrative spend-down processes were not a burden due to automation. An individual's spend-down bills are entered into the state's Medicaid system and the automated system determines eligibility. Individuals can receive medical benefits for any month during which they provide proof of incurred medical expenses, whether paid or not, to their Department of Human Services (DHS) local office caseworker. Once an individual provides the proof, the caseworker completes a calculation and, if appropriate, authorizes medical benefits for each month spend-down is met. The majority of other 209(b) states have similar spend-down processes when compared to Ohio. However, some other states have differences in spend-down time periods for eligibility (Virginia and New Hampshire).

During the stakeholder focus groups conducted by AOS, ideas for improving the spend-down program included the following:

- Provide excellent training to providers who work with spend-down clients.(Universal Health Care Action Network of Ohio);
- Add permissible expenses like child support obligations and other items Ohio State Legal Services Association);
- Add spend-down provisions to PASSPORT (PASSPORT Directors Association;
- Extend the eligibility period for each spend-down to six or twelve months for permanently disabled individuals (Ohio Council of Behavioral Healthcare Providers);
- In crease the eligibility threshold to decrease the number of recipients on spend-down and lower administrative burdens (Ohio Council of Behavioral Healthcare Providers); and
- Clarify incurred versus paid expenses (Member, Universal Health Care Action Network of Ohio).

Although the CDJFS indicated spend-down is not an administrative burden, many stakeholder groups indicated the process was cumbersome and confusing for them. Providers and stakeholders indicated that many recipients, providers, and county offices have some level of difficulty knowing what services are applicable for spend-down eligibility. Additionally, multiple stakeholders felt that State spend-down provisions have increased barriers to good quality care and that incurred medical receipts are sometimes lost in mail transmittal to the county offices, which delays a recipient's spend-down eligibility.

R4.6 The State Medicaid Agency should take a number of necessary steps to improve consistency in the way the Medicaid spend-down program is administered. The

Agency should audit CDJFS spend-down eligibility practices to ensure that all counties are following consistent rules and procedures. Consistent statewide practices with spend-down should alleviate provider, stakeholder, and recipient concerns. Multiple stakeholders and providers indicated that there were numerous problems with Ohio's current spend-down provisions. Ohio should implement a provider, county, and recipient Medicaid spend-down training to enable all those impacted to have consistent and accurate information. The Agency should also ensure that the administrative provisions related to spend-down are not creating undue barriers to care for its recipients.

Additionally, the State Medicaid Agency should track recipient receipts to better serve its spend-down population and ensure access to Medicaid eligibility cards. The Agency should investigate the feasibility of online application, receipt collection, and training systems (see technology and program management section).

This recommendation will result in a cost savings for the State and the counties due to the reduction of county administrative time spent completing spend-down activities. The increased uniformity of CDJFS spend-down provisions will reduce administrative problem areas, inquiries, and complaints from uninformed recipients and stakeholders. However, the cost savings generated by this recommendation could not be quantified because the reduction in county administrative time could not be determined. Although there will be an initial cost to provide training, the savings produced from the reduction of county administrative time to manage spend-down will offset the costs.

E. Long-Term Care

Long-Term Care Services

According to CMS, long-term care includes a variety of services that help people with health or personal needs and activities related to daily living over a period of time. Long-term care can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities.

Several agencies in Ohio oversee long-term care options for qualified recipients. These include:

- Ohio Department of Job and Family Services Bureau of Long-Term Care Facilities which is responsible for establishing reimbursement rates of Medicaid certified facilities for both nursing facilities and intermediate care facilities for the mentally retarded. This Bureau maintains reimbursement rates, final settlements, provider agreements, and

annual calendar cost reports. The Bureau also files rules, state plans, and estate recovery projects for nursing facilities and intermediate care facilities for the mentally retarded.

- The Ohio Department of Aging works closely with statewide agencies, advocates and service providers to advocate for and serve older Ohioans. The Department of Aging administers home and community based programs providing long-term care services through waiver programs, including the Pre-Admission Screening System Providing Options and Resources Today (PASSPORT) program.

- The Ohio Department of Mental Retardation and Developmental Disabilities (ODMRDD) is responsible for overseeing a statewide system of supports and services for people with mental retardation or other developmental disabilities and their families. ODMRDD administers Medicaid programs for institutional, and home and community based waiver support for individuals who qualify.

- The Ohio Department of Mental Health also serves as a safety net, providing care for the uninsured and compensating for inadequate benefits in commercial health insurance plans. Most Ohioans have some insurance coverage for mental illness, but only five percent of policies will cover the costs of serious, crippling cases of schizophrenia, bipolar disorder, or depression. People with severe cases of these conditions often end up disabled, poor, and dependent on the public system and require long-term care.

- The Ohio Department of Health is contracted by ODJFS to inspect, license and certify skilled nursing facilities, nursing facilities, and ICF/MR facilities for Medicare/Medicaid. Additionally, the Department of Health administers the certificate of need program.

During the course of this audit, agencies were asked if combining each into one long-term care agency made sense for efficiency and budgeting purposes. All felt they had different strengths and the populations they served would lose some aspects the advocacy currently in place.[41]

Long-term care is the largest cost in Ohio's Medicaid budget. Currently, most long-term care is custodial care. Medicare does not pay for this type of care if it is the only kind of care needed by the recipient. Scripps Gerontology Center at Miami University (Scripps) notes that each person's use of long-term care is unique, depending on the person's individual needs and situation. Because people need differing types and amounts of assistance, long-term care is really a continuum of care ranging from infrequent assistance with one or two activities of daily living

[41] The Ohio Medicaid Administrative Study Council's Long-Term Care Budget subcommittee has made a preliminary recommendation to create a new division of aging and disabled within the State Medicaid Agency and to create a unified aging and disability budget.

to assistance with all activities. The population needing care includes the aged, blind, and disabled (ABD).

According to the National Care Planning Council, experts estimate at least 60 percent of all individuals will need extended help with home or personal care activities during their lifetime. The need for long-term care may only last for a few weeks or months or it may go on for years, and is dependent on the underlying reasons for needing care. Temporary long-term care, which lasts for only weeks or months, includes the following:

- Rehabilitation from a hospital stay;
- Recovery from illness;
- Recovery from injury;
- Recovery from surgery; and
- Care for a terminal medical condition.

In most cases, Medicare covers temporary long-term care requiring skilled services. Ongoing long-term care, which lasts for many months or years, is provided for the following conditions:

- Chronic medical conditions;
- Chronic severe pain;
- Permanent disabilities;
- Dementia;
- Ongoing need for assistance with activities of daily living; and
- Need for supervision.

The Medicaid long-term care benefit package provides services for persons who have chronic or disabling conditions and meet certain level of care criteria. Long-term care includes both community based and facility based long-term care services. The federal government requires state Medicaid programs to extend a broad range of mandatory services to Medicaid consumers. Nursing facility services for individuals age 21 or older is mandatory for consumers who are eligible for long-term care in Ohio.

If a state chooses to offer additional optional services, those services become entitlement services for all eligible consumers. States are allowed to seek waivers, or exemptions, for various regulations including entitlement institutional care settings. Intermediate Care Facilities for the Mentally Retarded and Developmentally Disabled operate under an exemption from the optional services provided for eligible recipients in Ohio. Additionally, in the community-based waiver process, the federal government essentially waives the comparability of services requirement in order to allow states to provide certain services to targeted individuals that enable them to live safely and successfully outside an institution. Under Ohio's waiver programs, certain consumers

can receive such services as personal care, adult day care, and home delivered meals, even though these services are not available to all Medicaid eligibles. See the ***waivers*** section for additional information.

The federal government requires that all home and community-based waiver services offered to individuals must be less expensive than the institutional entitlement options, either on a per person basis or in the aggregate. The formal marketplace for long-term care services has several options which are either facility-based or home-based. Some options are not accessible, or have minimal access, under Medicaid. Facility-based care options in Ohio's market place include:

- Nursing Homes;
- ICF/MR Facilities;
- Residential care facilities;
- Assisted living facilities; and
- Homes for the aged.

The Health Policy Institute of Ohio, in its report *Ohio Medicaid Basics (2005),* states that Medicaid is the leading payer of nursing facilities in Ohio and covers 70 percent of all nursing home care in the State. In SFY 2002-03, Ohio nursing home expenditures were $2.6 billion, or 5.5 percent of Ohio's total spending in all funds, and ICF/MR expenditures were $429 million. As a percent of Medicaid spending in SFY 2002-03, nursing home expenditures represented 29.5 percent, while ICF/MR expenditures accounted for 4.9 percent. Home and community-based services (HCBS) are provided through waiver programs to individuals who meet the eligibility requirements, have housing options available, and receive care provided by community–based services, family, or friends. These services comprised 2.0 percent of SFY 2002-03 Medicaid expenditures. For additional information on Ohio Medicaid expenditures, including nursing facility, ICF/MR, and waivers, refer to **Appendix 3-C** in the **organizational issues** section.

Several stakeholders spoke to Ohio's provision of institutional based care compared to home and community-based services. A member of the Ohio Developmental Disabilities Council described how the institutional bias affects recipients' ability to access occupational therapy. The member explained that Medicaid does not pay for occupational therapy in a community based setting, illustrating that the Medicaid rules have not been sufficiently modified to accommodate community-based care. Another member explained that there are great similarities between disabled individuals living in institutional settings and those living in the community. The severity of disability was less a predictor of placement in institutional care than availability of care types and services within the individual's community, according to the member. Also, members of the Ohio Job and Family Services Directors' Association described how the expansion of private living options was desirable and, though it might initially increase costs, it would prevent later admissions to institutional facilities.

Similarly, a member of Ohio State Legal Services Association said, "We need more waiver slots for home community-based services. To have limits on waiver slots is penny wise and pound foolish because you're taking people who could be served in the community in their homes at lower costs, and you're forcing them into nursing homes…." The member went on to describe how proposed rule changes to lower reimbursement rates for home care providers did not support the transition to home and community-based care and, instead, reinforced the emphasis on institutional care. Finally, a member of the Ohio American College of Emergency Physicians summed up the debate saying,

> "Everybody knows we've got too many people in nursing homes. We've got long waiting lists to get into PASSPORT, which costs about a quarter or a fifth of what it costs to be in a nursing home. Why aren't we doing more…?"

Before the 1970s, the elderly or disabled generally had one alternative to living with family, and that was to take up residence in a nursing home. Since then, there has been a move toward deinstitutionalization which had been slow, but received greater emphasis as a result of *Olmstead v. L.C.*, 527 U.S. 581 (1999).[42] The court ruled that, based on the Americans with Disabilities Act (ADA), unjustified institutionalization is a form of discrimination. As long as an individual wanted to transfer to the community and was judged to be qualified for community living, the state should work to move the individual to a less restrictive setting. The Court acknowledged that this may not be immediately possible if the move required "a fundamental alteration" of the state's programs. The Federal government continued to emphasize change by awarding "real system change grants" which provide money for states to experiment with alterations in the fundamental delivery of services. In 2001, President George W. Bush issued an executive order requiring federal agencies to "promote community living for persons with disabilities."

Historically, Ohio has provided long-term care services in an institutional setting such as nursing homes and ICF/MRs. Due to the Olmstead decision and federal initiatives, Ohio and other states are reviewing long-term care delivery in institutions and alternative home and community-based settings. The *Ohio Access for People with Disabilities (2001)* report was Ohio's direct response to the continued emphasis on providing community-based service alternatives for the aged and persons with disabilities. In addition to input gained through public forums, the Ohio Office of Budget and Management (OBM); the Ohio Department of Jobs and Family Services (ODJFS); the Ohio Department of Mental Health (ODMH); the Ohio Department of Mental Retardation (ODMRDD); the Ohio Department of Health (ODH); the Ohio Department of Aging (ODA); and the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) provided

[42] The Olmstead ruling stimulated lawsuits raising similar issues in other states on behalf of people who are institutionalized or at risk of institutionalization because of a lack of community-based services. These lawsuits often invoke two different sets of Federal laws; (1) civil rights laws (including the ADA, Olmstead ruling and the Rehabilitation Services Act 1973) and (2) Medicaid law (US DOJ 2002).

feedback that went in to formulating initiatives for Ohio that promote an array of home and community-based options that includes quality institutional care where it is clinically appropriate and cost efficient. ODJFS staff indicated that the *Access 2001* report has been serving as a blueprint for promoting change since it was published. In September 2003, the National Council on Disability stated that Ohio's *Access Report* has been widely regarded as a model for other states. It addresses most of the components of *Olmstead* planning recommended by United States Department of Health and Human Services (HHS). Despite its strengths, however, the plan did not address the pace of transition from institutions to community living, did not set timelines for movement, and did not look at the adequacy of the State's current system of assessing institutional residents.

The *Ohio Access Report* was updated in February 2004 with a new strategic framework that included statewide vision and goals, performance measures, and recommendations to achieve success. The updated report included expanded strategies for the services necessary for a person to live with dignity at home or in community settings, like housing, employment, transportation, education, and others. Specific strategies that were outlined in the report include expanding, redesigning or proposing waiver programs to give consumers meaningful choices; expanding behavioral health community-based services; improving quality and outcomes for individuals; ensuring that taxpayer investments net the best possible value; prevention strategies for some disabilities; and ways to support employment through Medicaid buy in programs. Much of the implementation of these plans is subject to legislative approval through statutory change or the biennial budget process.

Although the *Ohio Access Report* has been favorably received, a member of the Brain Injury Association of Ohio described concerns with how information was presented in the most recent update. The member related discussions with MR/DD representatives surrounding Ohioans with traumatic brain injuries (TBI) and how TBI recipients are not represented in the *Ohio Access Report*. The member was concerned that, if information on TBI-related disabilities was not included in the *Ohio Access Report*, the availability of appropriate settings might be limited and TBI patients would not be able to access appropriate services. The member said, "if you are talking about equal access regardless of disability, you have to factor in [the TBI] population. …Many young people are ending up in nursing homes where … they don't want to be … and that's costing much more than [using] community-based support groups….."

According to the *State Olmstead Plans and Alternative Strategies* (National Center for Personal Assistance Services, 2004), Ohio was one of nine states that issued reports and/or plans in 2001 that were included as Olmsted Plans in a National Conference of State Legislatures report. As of March 2004, 29 states had Olmstead Plans; 15 had alternative strategies to meet the intent of the Olmstead decision; and the remaining states had other strategies for increasing community based services. Although Ohio was one of the first to develop plans to expand services, other states have been more successful at implementing expanded home and community-based options by

diverting enrollment from nursing homes and investing the cost savings into home and community-based services.

Several states have been able to hold down long-term care costs by making sure that the nursing home option is used only when a participant's needs cannot be safely met by a less restrictive environment. This is only possible if a wide range of alternatives and a good system of triage is available. **Table 4-14** was taken from the *Special Report on Medicaid* (Pew Center on the States, 2006) and displays the states that are spending fewer Medicaid dollars on nursing home care than home health care in the community. Ohio ranks 48th out of 50 states in spending on home health care and is included for reference.

Table 4-14: States with Home Health Spending Greater than Nursing Facility Spending (FFY 2003-04)

	Nursing Facility	Home Health	Mental Health[1]
Oregon	25.0%	71.2%	3.8%
New Mexico	29.5%	66.7%	3.8%
Vermont	39.6%	60.0%	0.4%
Alaska	35.9%	58.9%	5.2%
Minnesota	33.9%	57.7%	8.4%
Washington	34.7%	55.1%	10.2%
Maine	32.4%	54.5%	13.1%
Kansas	37.3%	53.0%	9.7%
Wyoming	34.2%	50.8%	15.0%
Colorado	44.3%	50.6%	5.1%
Utah	33.4%	46.3%	20.3%
Texas	36.3%	45.1%	18.6%
New York	37.6%	43.8%	18.6%
Ohio (48th out of 50)	53.8%	21.9%	24.3%

Source: Pew Center on the States Special Report on Medicaid 2006 (sorted by AOS for ranking purposes)

[1] The Pew Center report stated that, after nursing facilities and home health care, the balance of long-term care spending was on mental health facilities and services. The percentage shown in this category was calculated by audit staff (100 percent minus nursing facility and home health percentage).

As shown in **Table 4-14**, the three states with the lowest spending percentages on nursing facilities were Oregon, New Mexico, and Vermont. *A Case of Negl*ect (Governing, 2004) cited Oregon and Vermont as success stories for strategies to control long-term care spending for the following reasons: According to *Governing*, Oregon "boasts the nation's lowest percentage of elderly people in nursing facilities. Its long-term care program provides incentives to the nursing home industry to develop home-care programs and diverts savings in institutional care into community and home care." Also, Vermont "has a very good track record for getting diverse groups involved with long-term care to work together. Patients are diverted from nursing homes

and the money saved goes into a trust fund, which is then used to develop more community and home care programs."

Strategies to Keep Consumers Needing Long-Term Care in the Community and Out of Nursing Facilities (Kaiser Commission on Medicaid and the Uninsured, 2005) indicates that as part of the effort to rebalance long-term care systems, states have used nursing home transition and diversion strategies. Nursing home transition generally refers to activities to move individuals from institutional settings to alternative community placements. Diversion refers to efforts to provide choices and assistance for consumers who are at risk of admission to nursing facilities unless alternate community-based care can be arranged quickly.

There is no best formula for implementing strategies to divert consumers from institutional care to home and community-based services. The strategies for the eight states in the Kaiser report included:

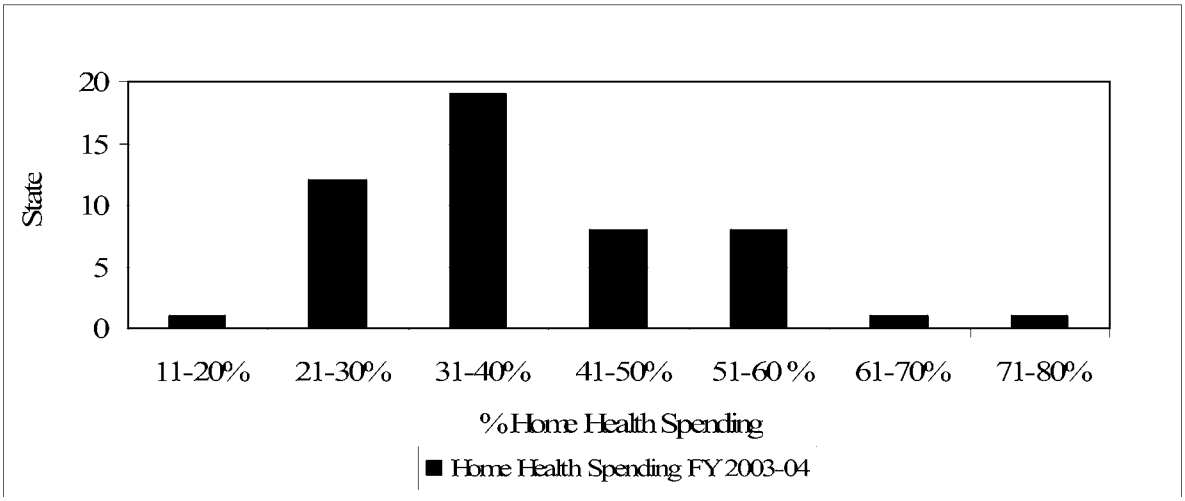
- Expediting program eligibility determinations with quick responses; fast tracking eligibility determinations; timely functional eligibility determinations; and streamlining procedures;
- Ensuring that community-based service providers are willing and able to provide immediate care with guaranteed payment for that care; and providing caregiver training in areas where skilled professionals or providers are limited;
- Developing procedures to track and manage placements to include case management for all applicants regardless of setting; promote shorter nursing facility rehabilitation stays; requiring notification to the state of nursing home placement after a hospital stay; limiting certification for nursing facility stay to promote community-based diversion evaluations during recertification; and establishing single entry point systems for eligibility;
- Assuring that financing arrangements support community-based care by demonstrating savings; pooling funds in long-term care budgets; and managing waiting lists;
- Providing support to maintain or obtain community residences by making provisions for home modifications or repairs; allowing for income and resources to support community living; increasing the supply of accessible and affordable housing; and
- Informing people about options for care through 24 hour hotlines, websites and publicity campaigns.

No state employed all of these strategies and there is no indication that the number of strategies employed enhanced the success of the program. Kaiser recommends that each state review the overall design of its Medicaid long-term care program and make changes to enrollment and service delivery processes to promote diversion.

According to Kaiser, state Medicaid programs that are most successful at keeping people in the community do not operate separate transition or diversion programs. Rather they have made systemic changes to increase the capacity for community-based care, to inform consumers about options for care, and to assist consumers as they make choices about care. The majority of state Medicaid programs has not completely revamped their long-term care systems, but has made changes to some of the established practices that favor institutional care. Maine, Oregon, Vermont, and Washington have made sweeping changes to their Medicaid long-term care systems and spend almost all or more than half of Medicaid spending on home and community-based services. Indiana, Nebraska, New Jersey, and Pennsylvania have made incremental changes to keep more people in the community, but still spend less on home and community-based care than institutional care.

Medicaid's Third Rail (Pew Center on the States, 2006) reported the FY2003-04 distribution of long-term care spending for Medicaid among all 50 states. **Chart 4-10** presents a summary of the data from *Medicaid's Third Rail*. The detailed information from the report is shown in **Appendix 4-B**.

Chart 4-10: Distribution of Long-Term Care Medicaid Spending on Home Health, FFY 2003-04



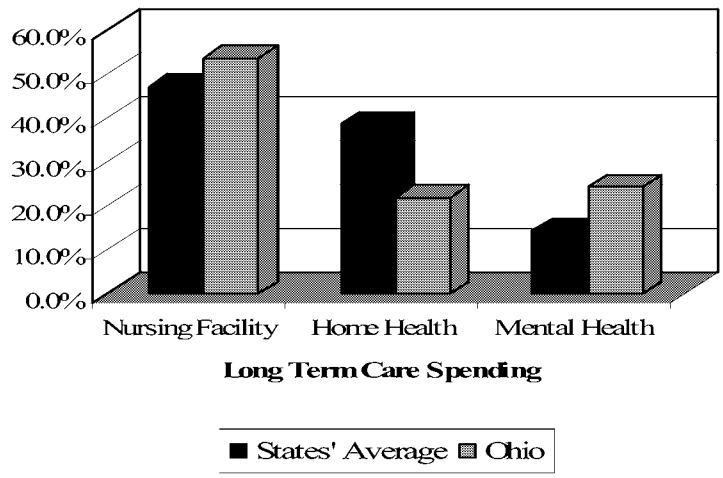
Source: Pew Center on the States Special Report on Medicaid 2006
Note: The nursing facility and home health costs were compiled from estimates by Urban Institute and Kaiser based on uninsured estimates from the CMS data.

Based on **Chart 4-10** and according to the Pew report, Ohio spent 21.9 percent of its Medicaid long-term care spending on home health and personal services in SFY 2003-04. Only Michigan and Mississippi spent less in FY 2003-04. The data used to develop **Chart 4-10** was sorted by

categories to determine the percentage of Medicaid long-term care money spent on nursing facilities, home health care, and mental health services, Ohio ranks 15th, 48th and 7th respectively.

Chart 4-11 compares Ohio's FFY 2003-04 spending for long-term care, by category, to the peer states' average.

Chart 4-11: Medicaid Long-term Care Spending by Category for FFY 2003-04



Source: AOS created with data from the Pew Center on the States Special Report 2006, *Medicaid's Third Rail*

As illustrated in **Chart 4-11**, in FFY 2003-04, Ohio spent more than the peer states' average in the nursing facility and mental health categories.

According to the National Academy of State Health Planning, first and foremost, a state has to have a goal. As an example, Vermont's goal is to serve 40 percent of eligible long-term care consumers in a community setting. Oregon does not have goal setting per se, but instead developed a priority list that is used in the budget and planning process. Minnesota has been very active is getting facilities to close so that monies can be shifted to home and community-based services. Ohio currently is focusing on balancing the Medicaid budget, but has not established goals for its Medicaid Program (see **organizational issues** section).

The Status of Long Term Care in Minnesota 2003 (2004), states the central theme of reform recommended by Minnesota's Long-Term Care Task Force is to reduce the reliance on the institutional model of care for older persons, and expand the supply of home and community-based options. These reforms reflect Minnesota's attempt to "rebalance" its long-term care

system after years of excessive reliance on the institutional model of care. In the past, the relative availability of nursing home beds made the development of services that helped older persons remain in their original homes less urgent, and fostered an acceptance of the nursing home as "the place" where elderly moved when they needed assistance.

Minnesota states that in order to rebalance its long-term care system, the informal, voluntary and formal components of the home and community-based services need to be expanded so that more elderly can remain in their homes and communities longer. In addition to expanding the capacity of the home and community-based system of services for older people in Minnesota, the 2001 long-term care reform called for a reduction in the state's reliance on nursing homes. The size of the nursing home bed supply was already declining due to market changes, and the state wanted to encourage that trend while ensuring that adequate numbers of beds were available to serve those who required nursing home care.

A philosophical commitment and legislative direction are important factors in facilitating change in Medicaid programs. In Vermont, community coalitions have been an integral part of the long-term care system since 1996, with the passage of Act 160, which required reductions in nursing home care and increases in community based care. Additionally, states with a mandate for change from the leadership have an advantage. In Pennsylvania, the Governor's Office of Health Care Policy considers the rebalancing of long-term care a priority and this fosters cooperation among state agencies. Original language in Oregon's legislation to promote community-based long-term care as a priority has instilled a philosophy that all program operations are geared toward diverting consumers from nursing homes and relocating nursing home residents who request care in the community.

According to Kaiser, states are demonstrating savings per recipient by shifting long-term care consumers to lower cost home and community-based services. To assure that financing arrangements support community-based care, states such as Oregon and Vermont have legislative mandates to reinvest cost-savings from reductions in institutional care into the development of home and community-based care. This approach has increased capacity of the community-based services over the years. A related approach -- "money follows the person" -- from nursing home to community can also enhance community capacity. For initiatives to be successful, institutional cost savings must remain in the budget or the enhancement to the state's Medicaid system will be temporary. Due to rebalancing initiatives, several states estimated the cost of providing long-term care in the community versus a nursing home:

- Washington estimates that the cost of caring for one nursing home resident equals the cost of providing care for two to four people at home,[43]

[43] Washington is recognized as an early implementer of policies aimed at balancing its long-term care system through transitioning from institutional care to home and community-based options.

- Pennsylvania estimates that 2.2 people can be served at home for the cost of one person in a nursing home; and
- Indiana cost estimates show that 3 people can receive services at home for every two people in a nursing home.

In addition to diverting institutional savings to home and community-based services, Oregon and Washington have pooled their respective funds for long-term care services. Most states separate funds between nursing home entitlement care and waiver services which can limit the success of diverting funds to community-based care.

Medicaid's Third Rail in the Pew Center on the States Special Report cautions that as states get better at offering sophisticated services in the new care anywhere model, costs and patient demands are climbing. In Vermont, the average cost of a community care slot has increased from half the cost of nursing home care to 80 percent of that cost. This trend has raised the question of what to do when community-based care exceeds the cost of nursing home care. The Director of Vermont Health Access attributed the increase in cost to a steadily rising capacity to handle more complex and costly cases in the community setting. This observation emphasizes the need for states to monitor the costs of providing services in each care setting where services are provided.

In an April 2006 report, the Kaiser Commission on Medicaid and the Uninsured *Nursing Home Transition Programs: Perspectives of State Medicaid Officials* reported on the experiences of Florida, Louisiana, New Jersey, Ohio, and Washington after receiving Federal grants for nursing home transition activities. According to the report, the states varied in their enthusiasm for nursing home transition programs. Washington and New Jersey are examples of states that give high priority to this issue by using state resources to employ care planners who identify and counsel nursing home residents on community care options. Both Washington and New Jersey had nursing home transition programs in place prior to the initiation of federal grant support for these activities. States such as Louisiana and Ohio represent a middle ground, with resources going toward efforts to inform people about options for transition which use toll free hotlines and statewide registries for individuals requesting home and community-based services. These approaches are primarily responsive to family members or nursing home discharge planners who contact care planners regarding individuals who want to transition, rather than being proactive. Florida is concentrating on transitioning individuals from nursing homes to assisted living, rather than to home and community-based services. Florida also has chosen to concentrate on nursing home diversion as its primary means of reducing unnecessary institutionalization.

There were several common views on nursing home transition that came from this study. The following were the states' considerations regarding nursing home transition:

- Individual and family motivation, and the availability of a community support system that could supplement formal services, were seen as key factors in who transitions back to the community from nursing homes;
- Policymaker attitudes on the need for nursing home transition programs as a remedy for perceived bias in favor of discharges to skilled nursing facilities for post-acute care influence legislative direction;
- States without the availability of residential alternatives such as adult family homes or assisted living placements have fewer options available to nursing home residents who want to transition; and
- State Medicaid officials were well aware that the nursing home industry has concerns about programs that could potentially reduce occupancy levels.

The states also noted the following obstacles to nursing home transition:

- Protections under the spousal impoverishment statute favor institutional care in some states;
- Requirements to liquidate assets in exchange for Medicaid coverage of nursing home care may prevent retention of community housing (i.e., lack of affordable community housing can be a major obstacle to leaving a nursing home);
- Barriers related to the use of Medicaid funds for community housing expenses are being addressed, but remain an issue;
- Uncertainties for nursing home residents about Medicaid eligibility and the extent of services they can qualify for if they return to the community;
- Eligibility for home and community-based services for nursing home residents who return to community settings often has to be re-established; and
- Waiting lists for community-based care are a significant problem in some states (but not all), and a potential barrier to nursing home transition.

Obstacles to the effectiveness of nursing home transition programs also were identified and included various disincentives that arise from Medicaid long-term care policies and limited community-based care options. States like Washington and New Jersey have invested in reducing these disincentives, by using state funds to assess service options and eligibility prior to discharge (thus removing uncertainties and eliminating potential gaps in services). The existence of a broad array of community-based service options in these states also makes transition from nursing home care a more viable option. The effectiveness of reducing unnecessary institutionalization depends on the extent to which disincentives are reduced or eliminated.

According to the National Academy for State Health Policy (NASHP) report *States in Action...Building Nursing Home Transition into a Balanced Long Term Care System: the Washington Model (*2003), Washington has been a leader in creating a comprehensive long-term

care system that combines policy development, regulation, licensing, payment and management of all services in one state agency. Washington's goal was to stay within a 3 percent growth curve of estimated nursing home costs assuming a 3 percent increase in both case load and reimbursement per case. The original projection for long-term care spending in 2002 was slightly over $1 billion. **Table 4-15** is shows the impact of Washington's transition from nursing home to HCBS from 1992 to 2002.

Table 4-15: Washington Long-term Care Spending 1992-2002

	1992 Clients	1992 Spending	2002 Clients	2002 Spending
HCBS	19,330	$89.7 million	32,213	$414.4 million
Nursing Home	17,353	$392.4 million	13,144	$489.4 million
Total	36,683	$482.1 million	45,357	$903.8 million

Source: The National Academy for State Health Policy (NASHP) *States in Action...Building Nursing Home Transition into a Balanced Long Term care System: the Washington Model November 2003*

As shown in **Table 4-15**, Washington's total spending on long-term care services increased by 87.5 percent or an average of 8.7 percent per year from 1992 to 2002. The 3 percent goal was based on a growth curve and increases in cost and case load in nursing homes. This trend line was not able to be replicated for the purposes of this study. However, Washington's total costs were less than estimated (by about $100 million) and the proactive approach to diverting recipients from nursing homes has resulted in positive financial outcomes.

The ability to manage all aspects of the system is an important factor in creating a balanced system by shifting funds from institutional to community services through a multi-year plan. Unlike community home care programs in some states, Washington nursing home residents receive case management services and relocation to the community is a continuing priority. In 1987, the Washington Aging and Adult Services Administration prepared a document that recommended policy and budget steps to expand in-home services and curtail institutional care. Ten years later, 63 percent of the agency's clients were served in residential and in-home settings. In 1995 Washington added a nursing home relocation program to divert residents in nursing homes back into the community. Washington a leader among states seeking to create and maintain a balanced long-term care system that offers real choices for consumers. Washington's success is due to the availability of a range of different settings, an array of services and funds to support transition expenses and ongoing services in the community. Ohio has taken the lead in developing strategies for transition to home and community-based waiver services, but other states have been more successful and timely in implementing transition strategies.

Long-term care was a significant concern for many stakeholders interviewed during this performance audit. A member of the Ohio Developmental Disabilities Council related a personal experience where the member had to enter institutional care because he and his wife could no longer be independent. Although they had accumulated a small savings and owned a home, they had to spend-down the saving and sell their house in order to access services. He

said that he was concerned many disabled working people would "get caught in the middle. " He concluded by saying, "[The] system sort of forces you into giving up all your assets, forces you into poverty."

A member of the Ohio Job and Family Services Directors' Association remarked that developing small community-based programs was difficult when expenses are driven by the nursing homes. A member of the Ohio Developmental Disabilities Council echoed this critique saying, "We certainly want to look at the nursing home statute and not prioritize one funding source which is less efficient and takes away individual choice, I think. It limits it very much." The member also elaborated on the institutional bias in Ohio Medicaid in the areas of co-pays (which are not required in nursing homes) and access to therapies (which are more widely available in a nursing home setting). Finally, a member of the Ohio Council for Home Care indicated that Ohio Medicaid did not financially support the concept of expanded in-home care. Drawing comparisons to Vermont, Oregon, and Iowa, the member explained how these states prioritize funding for home and community-based care. The member concluded saying, "Look, you've got three choices; institutional care, home care, or death. And most people don't chose option three. ….Most of them would choose … home care."

Although *Ohio Access for People with Disabilities* (2001) has been regarded as a model for other states, Ohio has been slow in making more systemic changes to increase the capacity for home and community-based services. The strategies for transitioning outlined in the *Access* report are regarded as a model plan; however, other states have been more timely and aggressive in implementing these efforts. According to *Ohio Access* (2004), Ohio received a three year nursing home transition Grant in 2002 based on the original *Access* report. Funding for an assisted living waiver for current nursing home residents took effect July 1, 2006, while states like Washington and Oregon have had community-based care initiatives as far back as 1987. The State has made incremental changes but still spends less on community-based care than institutional care when compared to other states (See **Chart 4-24**).

R4.7 With continued fiscal pressures and the emphasis on expanding services to the community while remaining budget neutral, the State Medicaid administering agencies should consider more proactive strategies for diverting nursing home and other institutional care residents from institutional care settings while expanding community-based services. Proactive strategies include those identified in the two *Ohio Access* reports and those activities being used in other states, which are discussed below. Additionally, programs designed to reduce the disincentives of transition should be reviewed and new strategies developed. New Jersey and Washington have used state funds to fill gaps in service during the transition and development of new programs.

Washington, Vermont, Oregon, and Minnesota are examples of states that have set goals to expand home and community-based services, all with slightly different strategies which include: pooled funding for long-term care budgets; demonstrated savings over institutional care; support for community residences; and case management across all service categories. The State of Ohio, through the State Medicaid Agency, should set system-wide goals for long-term care service delivery which may include estimated growth projections within budgeted dollars. The cost benefit analysis of this strategy should include tracking Medicaid's cost for all services provided to an individual at home on a daily basis versus the cost per day of caring for the individual institutionally.

Certificate of Need and Moratorium

According to the December 1998 Urban Institute report, *Controlling the Supply of Long-Term Care Providers at the State Level*, states have used certificates of need to shape the health care market for acute and long-term care for almost 30 years. A handful of states had programs before 1970, and almost all states had enacted such programs by 1979. The growth of certificate of need programs was spurred in part by the National Health Planning and Resources Development Act (PL 93-641) of 1974, which required that states operate certificate of need programs to be eligible for some federal funds available through the U.S. Public Health Service. Guiding the development of such programs was the hope of ensuring rational allocation of health care resources and controlling total health care spending. Certificate of need programs for acute care fell out of favor as the programs came to be viewed as anticompetitive and unduly regulatory in the 1980s. Following the lead of the Reagan administration, Congress let PL 93-641 expire in 1986. At the same time, other cost-control mechanisms, such as prospective payment and managed care, seemingly lessened the need for supply controls.

As of January 2005, 36 states maintained certificate of need programs to achieve a number of health policy goals. These goals differ somewhat from state to state, and from one health service to another, but all regulation and related planning are intended to compensate for observed or perceived market deficiencies where reimbursement includes the capital costs required to deliver services. Historically, the overriding consideration has been to promote access, ensure quality, and help control costs by limiting market entry to those facilities and services that are found to be needed, appropriately sponsored, and designed to promote quality and equitable access to care. Each program implicitly incorporates these principles by predicating certification on the basis of community or public need.

The *National Directory of Health Planning, Policy and Regulatory Agencies* (American Health Planning Association, 2005) summarizes 29 service categories that states and the District of Columbia control through certificates of need. The service categories include acute care, long-term care, outpatient care, and home health services. The District of Columbia and all 36 states,

including Ohio, have certificate of need requirements on long-term care nursing facilities. Fourteen states have eliminated certificates of need completely, they are: Arizona (1985); California (1987); Colorado (1987); Idaho (1983); Indiana (1999); Kansas (1985); Minnesota (1985); New Mexico (1983); North Dakota (1995); Pennsylvania (1996); South Dakota (1988); Texas (1985); Utah (1984); and Wyoming (1989). Of these states, Colorado, Minnesota, North Dakota, Pennsylvania, South Dakota, Texas, and Wyoming have moratoria on long-term care beds or nursing homes.

Ohio's Use of Certificate of Need and Moratorium

Certificate of need in Ohio is used to control entry into the nursing home and ICF/MR institutional market. Projects that require a certificate of need are evaluated by the Ohio Department of Health (ODH) based on the need, costs, and financial viability of the program. Ohio's use of the certificate of need began in 1975 with hospitals. In 1982, long-term care beds fell under certificate of need requirements. In 1992, Ohio deleted the hospital certificate of need and as a result, there has been a shift in the development of outpatient surgery and treatment centers and a redefining of hospitals based on market pressures. Ohio still controls nursing home capacity by limiting the number of beds that can be certified to provide Medicaid services.

In addition to controlling entry into the nursing home market through certificate of need, Ohio implemented a moratorium on the expansion of nursing home beds, effective July 1, 1993. The moratorium restricts bed capacity to the level as of July 1, 1993, by not allowing any additional beds. Although the number of beds can not be increased, beds can be transferred or sold. The moratorium was in direct response to the statutory formula in OAC 3701.12-23 used to determine bed need. The formula greatly overestimated bed need and exposed Ohio to huge financial burdens since capital was such a large part of reimbursement. This triggered the General Assembly to enact ORC § 3702.68, which restricted the Director of ODH from recalculating bed need in Ohio. Despite the moratorium, a certificate of need must still be obtained for replacement, relocation, or renovations affecting nursing home beds where project costs exceed $2 million. ODH has specific criteria for determining need and ensuring applicants meet all the requirements in the certificate of need section of OAC 3701.12.

According to ODH, the exact number of beds available for licensure is difficult to ascertain (because of beds in transition, banked,[44] etc.). There is an inherent discrepancy due to the administrative timing of the transfer and sale of beds, certificate of need determination, and the licensure process. Additionally, counties perform the licensure for county run homes which show up as zero beds licensed by ODH, but ODH performs the Medicare/Medicaid certification. A compilation of data from reports on nursing facilities from ODH showed that there were

[44] A "bed banking" concept allows facilities to set aside or "bank" beds to reduce their total bed complement. This is beneficial to providers in the rate formulation.

approximately 100,665 licensed beds and 95,256 Medicare/Medicaid certified beds as of February 27, 2006.

ODH states that certificate of need is designed to have a positive effect on access to nursing facilities by assuring access in all counties and ensuring no area has a shortage of beds (or is under-bedded). Due to restrictions that prevent moving beds across county lines, ODH is prohibited from addressing the shifting need of the population. Currently, the State has no ability to take back beds and redistribute them to those areas with a need. ODH has taken note of the shift in population from urban counties to contiguous counties and acknowledged the limitations of the current certificate of need process. Nursing homes with low occupancy can sell beds to homes with high occupancy. However, those facilities with higher occupancy may not need to build or renovate to accommodate relocated beds but may still incur the cost of obtaining the beds. One stakeholder noted that as a company, they owned several nursing homes in different counties. One home had a waiting list with the capacity to add more beds without renovation while the other home in another county had low occupancy. Instead of transferring beds, the stakeholder was forced to purchase 15 beds in the same county for $300,000 from another provider. Additionally, the sale of beds from one facility to another does not include a quality of care element. Another stakeholder spoke to this issue noting: "Years ago, there used to be a census done every other year to look at population shifts and bed needs. There haven't been any beds since 1993. You can't move beds between county lines. One of the problems we're having right now is population shifts. You can't get beds there to take care of them…." In contrast, representatives from OHP's Bureau of Long Term Care[45] state that certificate of need may no longer be effective and that changes in reimbursement decrease the need by reducing the State's exposure to capital payments experienced in the past.

Ohio's Bed Supply

Long-Term Care Utilization in Ohio 1993-2003 (Scripps Gerontology Center, May 2005) states that the number of nursing home beds in service in 2003 was 90,700, down from a high of 99,300 in 1997. Scripps representatives indicated that the data used for this study reflected only the certified beds in the system, which is not a true indicator of capacity because it does not account for banked beds or beds being transferred to another facility. **Table 4-16** shows the data Scripps presented in the brief.

[45] The Bureau of Long-Term Care Facilities is responsible for establishing reimbursement rates for Medicaid certified facilities, both nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICF/MRs). Additionally, the Bureau negotiates final settlements and provider agreements; files rules and state plan amendments for NFs and ICF/MRs; compiles annual calendar cost reports; and oversees estate recovery.

Table 4-16: Scripps Nursing Home Utilization in Ohio, 1993-2003

Year	Adjusted Nursing Facility Beds[1]	Average Number of Residents per Day	Nursing Facility Occupancy Rate[2]
1993	93,204	84,536	90.7%
1995	96,579	86,728	89.8%
1997	99,302	84,643	87.7%
1999	95,701	79,216	83.5%
2001	94,231	78,427	83.2%
2003	90,712	76,850	84.7%

Source: Miami University Scripps Gerontology Center Long-Term Care Utilization in Ohio 1993-2003 Research Brief (2005)
[1] Adjusted nursing facility beds include private, Medicaid, and Medicare certified beds that were available for service.
[2] Since 1996, occupancy rates have been based on facilities without ICF-MR certified beds.

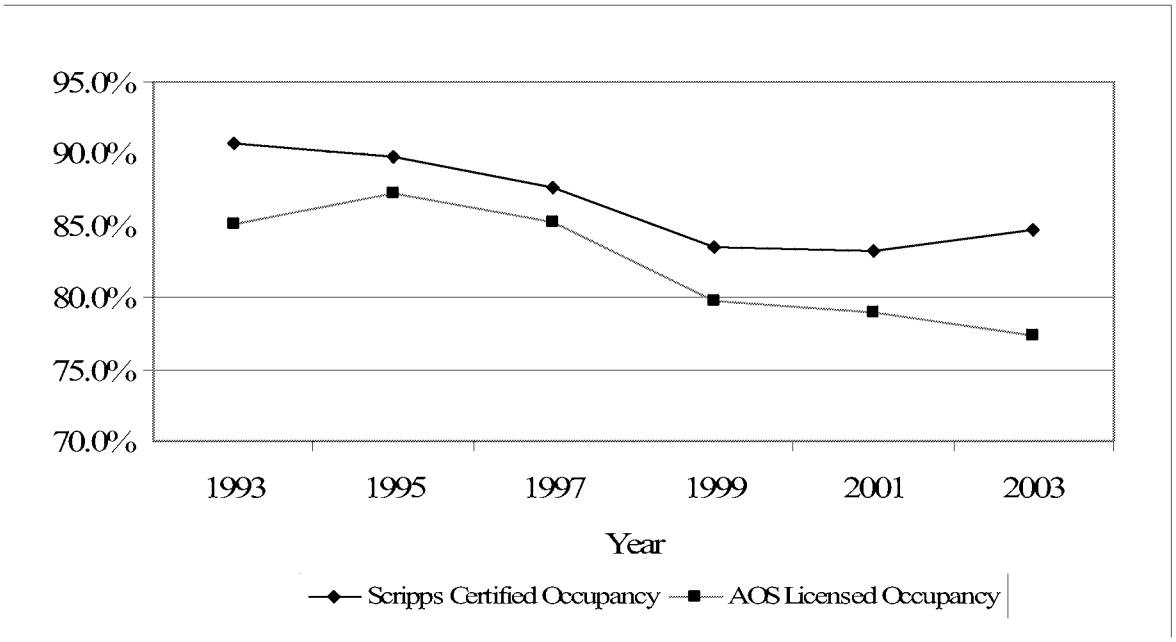
Although the certified number of beds is portrayed in **Table 4-16**, Scripps stated that currently the licensed bed supply in Ohio is approximately 100,000 beds. Of these 100,000 beds, approximately 10,000 are currently decertified. Owners decertify beds for several reasons, one of which is to increase revenue per occupied bed.

Scripps' observations and calculations were confirmed using ODH data which showed that on February 27, 2006, Ohio had 99,852 beds in active, closed, and pending licensure status, and an additional 819 on inactive licensure status, for a total of 100,671 beds. Representatives from ODH stated that although these figures are close, there is no definitive number of beds in inventory that can be referenced since the moratorium did not specify a maximum number of beds. Furthermore, county licensed beds are not licensed by the State and are not included in this figure. HB 66 includes language that requires ODJFS to include any beds that a facility removes from its Medicaid-certified capacity unless the facility also removes the bed from licensed capacity. As a measure of Ohio's occupancy rate based on the estimated licensed nursing home beds in Ohio, AOS used the highest reported year from **Table 4-16** (1997) as a baseline and calculated occupancy based on the average number of residents per day for each year.

A representative of the Ohio County Commissioners Association explained that about 37 counties in Ohio operate county nursing homes which are an optional service provided by the county. She explained that these homes are often older facilities and mostly serve low income individuals who are largely self-sufficient but may need minimal assistance or monitoring—more like an assisted living arrangement. Counties have not taken advantage of licensure, she continued, because the facilities do not meet current ODH requirements. However, many commissioners reportedly feel that maintaining the homes is essential to provide care for county residents who have no other care options.

Chart 4-12 shows the difference in occupancy rates based on certified capacity and occupancy if licensed capacity is considered.

Chart 4-12: Certified and Licensed Occupancy Percentages



Source: Miami University Scripps Gerontology Center Long-Term Care Utilization in Ohio 1993-2003 Research Brief (2005 and auditor's calculations (AOS licensed occupancy is based on Scripps 1997 bed capacity)

As shown in **Chart 4-12**, occupancy based on licensed capacity has been steadily declining. Recent research by Scripps notes that nursing homes have experienced dramatic changes in length of stay patterns over the past 10 years. For many residents, the nursing home has become a place to receive short-term care. Stakeholders acknowledged that they are serving more short-term Medicare residents for rehabilitation due to shorter hospital stays.

Additional observations by Scripps that may help to explain the decline in occupancy are:

- The number of residents paid for by Medicaid dropped from its 10 year high of 56,000 in 1994 to 50,800 (9.3 percent) in 2003;
- The number of Ohioans paying privately for nursing homes dropped from 24,976 in 1993 to 16,852 in 2003 (36 percent); and
- Ohio's PASSPORT program (refer to the ***waiver*** section) has become a major component of the State's approach to delivering long-term care, with 7,161 consumers receiving service during 1994 and 22,560 consumers actively receiving services at the end of June 2004.

According to the Ohio Commission to Reform Medicaid's *Transforming Ohio Medicaid* (2005), the use of certificate of need to limit the number of nursing facility beds in Ohio has created a

monopoly which artificially inflates the value of nursing facility beds and limits competition from any provider who lacks a certificate of need. Additionally, the existence of certificate of need in Ohio removes market incentives for nursing facility owners to compete and adjust their supply of beds and services to meet the changes in market demand. As of July 1, 2005, HB 66 provides that amortization of the cost of acquiring operating rights for relocated beds is not an allowable cost for the purpose of determining the facility's Medicaid reimbursement rate. Prior to July 1, 2005, once a certificate of need was granted, the owner of the beds could transfer and sell beds and the purchaser would be reimbursed for the purchase price as part of the formula.

Use of Bed Banking

ODH works with ODJFS on projections and data validation of utilization statistics. This is particularly important since occupancy rates are reflected differently in cost reporting. In the reimbursement formula prior to HB 66, higher occupancy in the formula meant higher payment per bed. This provided an incentive for owners with historically low occupancies to decertify or "bank" beds and increase their revenues per bed for those remaining.

A review of states with restrictive certificate of need and moratorium policies revealed that exceptions are routinely made, usually to the benefit of existing providers. Alabama has a 95 percent occupancy rate, and if the rate for the county reaches 95 percent, then the facility can add another 10 beds or 10 percent of its bed supply, whichever is greater. Mississippi, New Jersey, and Texas have similar rules. Furthermore, Texas can decertify unused Medicaid beds, especially in facilities with poor quality records, and reallocate them to higher quality facilities. The exception is intended to create a pool of 2,000 to 3,000 beds that will be made available to facilities without any major deficiencies or any quality sanctions against them. In Wisconsin, if a facility banks beds, those beds must remain in the bank for minimum of 18 months. However, Wisconsin penalizes nursing facilities with lower Medicaid reimbursement rates if they fall below the average state occupancy level, currently 91 percent. Such facilities lose 10 percent of their banked beds each year that they are under the average state occupancy level and the state maintains those forfeited beds for its use and possible redistribution. This policy has resulted in a statewide reduction of approximately 800 beds.

Washington maintains a program that allows facilities to bank beds through two mechanisms. One for facilities that are closing and would like to retain or sell the rights to those beds and one for facilities that would like to bank beds for an alternative use (e.g., to convert nursing home beds into assisted living beds). More than 2,100 nursing home beds, 7 percent of the state's total bed complement, are banked in Washington's program, and these beds are counted as available beds in the state's calculation of need.

Missouri restricts the transfer of beds to only higher quality providers and discourages development in areas with low occupancy with the Purchase of Beds Program. This program

requires a buyer expanding through the purchase of new beds to have a 90 percent occupancy level for the previous 18 months and receive no class 1 deficiencies[46] in their surveys. Missouri also requires providers to file occupancy surveys with the certificate of need division every three months to track the capacity and utilization of institutional healthcare services.

Minnesota's bed banking law allows facilities to take beds out of service for up to five years. Similar to other programs, there is an incentive for facilities to decertify beds. When beds are out of service, facilities are not charged the bed surcharge. Bed banking also increases the likelihood of receiving bed hold payments since the state pays for bed holds as long as occupancy is above 93 percent and decreases the property payment because there are fewer beds. Minnesota also offers incentives for planned closure programs and single bed rooms. Although Minnesota reduces liabilities for each bed taken out of the system, the remaining beds receive higher reimbursement.

Control of beds through certificates of need has fostered other legislation that seeks to control capacity such as bed banking and planned closures when nursing home occupancies are declining. Cost-based reimbursements have left the states struggling to reduce capacity since they are statutorily controlling the market with certificate of need and moratorium policies.

National Long-Term Care Market Entry and Control

The Urban Institute's December 1998 report, *Controlling the Supply of Long-Term Care Providers at the State Level* states that the premise of supply constraints as a cost-control strategy is based on Roemer's Law, which holds that utilization increases when supply raises, independent of need. For example, a new nursing home bed has a high probability of being occupied, most likely by a Medicaid beneficiary. The availability of open-ended, third-party reimbursement gives providers substantial control over demand, resulting in a high correlation between bed supply and occupancy. Moreover, given the high cost of long-term care and the low level of insurance coverage for these services, the majority of nursing home residents, nearly 70 percent, rely on Medicaid to help finance their care. As a result, expansion of the long-term care supply guarantees an increase in Medicaid expenditures.

According to the American Health Planning Association's *Permit of Approval Health Services Planning and Regulation in Arkansas* (2002), market entry regulation, such as certificate of need and moratorium, and the benefits and costs of health planning and regulation continue to be debated by health care experts, industry officials, legislators, business leaders, and many others

[46] According to the Missouri Department of Health and Senior Services, a class 1 deficiency is defined as a violation which presents either an imminent danger to the health, safety or welfare of any resident or a substantial probability that death or serious physical harm would result. This is the most severe classification of State deficiencies. If an inspection results in any Class I violations, inspectors will revisit the facility within 20 days.

engaged in the formulation of public policy. This debate has intensified in some states, as providers of health services, insurers, and other interested parties respond to, and seek to gain advantage in, a dynamic health care market. Changes in the marketplace are also being brought on by the states seeking to comply with the spirit and directives of the *Olmstead* decision which requires states to ensure the availability of a wide range of services that permit those requiring long-term care to obtain it in the least restrictive setting appropriate to their needs.

Overall, state nursing home certificate of need regulatory patterns are distinctive in that:

- Every state with a certificate of need program covers nursing homes;
- Fewer states have eliminated or reduced certificate of need regulation of nursing home services than have eliminated or reduced certificate of need regulation of any other service;
- The duration of certificate of need regulation of these services is comparatively long, with many states beginning regulation of the service earlier and retaining it longer than for many other services;
- A number of states have augmented certificate of need regulation of nursing home services with other forms of market entry or capacity management such as moratoria on development; and
- A majority of states that have formally dropped certificate of need regulation have replaced it, at least temporarily, with equally or more stringent market entry and capacity management controls such as development moratoria and reimbursement limits.

According to the Federal Trade Commission and U.S. Department of Justice July 2004 report, *Improving Health Care: A Dose of Competition*, in the overwhelming majority of U.S. markets outside of healthcare, the government does not decide the prices and quality at which sellers offer goods and services. Noting that there are positive effects on price and quality that competition can have, the report also acknowledged that competition in the healthcare setting will not shift resources to those who do not have them. The regulatory framework at both the federal and state levels affects where and how competition takes place in healthcare markets. Restrictions on entry and extensive regulation of other aspects of provider behavior and organizational form can bar new entrants and hinder the development of new forms of competition.[47] The report notes that much of the regulatory framework rose haphazardly and proposals for new regulatory interventions typically focus solely on the claimed benefits and not the costs or how they fit into existing regulatory frameworks, which may frustrate competition unnecessarily.

[47] The healthcare market and delivery of long-term care services has expanded outside of nursing home care. Currently, Ohio's regulations only control nursing home care. There is limited opportunity for consumer's to seek access to lower cost alternatives to nursing home care.

Of primary concern in the long-term care market is the impact of the following factors:

- Aging population;
- Growing consumer awareness;
- Restrictions imposed by certificates of need; and
- Changing consumer preferences for increased care options.

Various long-term care options are available, including nursing homes, assisted living facilities, home care, and adult care.[48] Assisted living facilities are the most rapidly growing form of senior housing. Competition for the long-term care market is limited by the consumer's ability to shop around for nursing home care because they are too sick, lack time, or have insufficient information to compare. Medicare and Medicaid are the dominant purchasers in the nursing home market with two thirds of residents covered by Medicaid. The report urges states to consider whether certificate of need programs involving long-term care facilities are best serving their citizens' health care needs.

The following is a list of pros and cons on certificate of need taken from several reports and stakeholder comments:

Pros:

- Certificates of need seek to control the Roemer Effect ("supply generates demand") by controlling entry into the nursing home market and the supply of beds. The Roemer Effect in health care contributes to an inefficient allocation of health care resources and higher healthcare costs.

- *A Case of Neglect* (Governing, 2004) states that gaining control over the supply of nursing home beds is clearly one key to taming the cost of long-term care. States can use certificate of need programs to restrict the building or purchase of nursing homes and other related healthcare services.

- When done intelligently and with proper planning, certificate of need regulation is one of the few practical planning tools available to policymakers. Certificate of need decision making should include all interested parties, including ordinary citizens.

- Community-based planning, done correctly, highlights and appropriately acknowledges quality, cost, and access concerns. The goal is an improved distribution of services that limits the concentration of services and facilities in affluent areas at the expense of less

[48] Adult care includes services such as adult day-care and hospice.

affluent areas. Planning and certificate of need regulation can be used to proactively improve both geographic and economic access to care.

- The American Health Planning Association sees the certificate of need as a useful market balancing tool due to the imperfections in the healthcare marketplace. Additionally, health care is an essential social need that should not be viewed as an ordinary economic commodity.

- The certificate of need, in practice, is used to counteract excess supply and needless duplication of some services by restricting provider capital expenditures.

- The studies and experience in some states indicate that certificate of need regulation can have a positive effect on the cost, access, and quality of several services. Additionally, certificate of need regulation provides some level of quality assurance when expansion opportunities are limited for providers with poor quality histories.

- States that do not control nursing home development generally have low occupancy rates and significant quality of care problems. Every state that has a certificate of need-style regulatory program covers nursing homes in its program and almost half of the states that have discontinued their programs have placed a moratorium on nursing home development.

Cons:

- State certificate of need programs generally prevent firms from entering certain areas of the health care market unless they can demonstrate to state authorities that there is an unmet need for their services. Upon making such a showing, prospective entrants receive from the state a certificate of need allowing them to proceed. Proving that unmet need to state authorities is sometimes expensive and time consuming.

- Encouraging the purchase and relocation of surplus nursing home beds is likely to prove problematic. However laudable the underlying objectives, this practice is likely to increase aggregate costs, distort the inherent value of nursing home beds, confer on existing owners and operators an unearned economic benefit, and weaken the planning and regulatory process. The key to accommodating the natural pattern of ownership changes lies in shifting from a strict county orientation as the basic planning unit to regional planning areas. Replacement of outdated facilities should be favored over the addition of new services in these more broadly defined service areas. This should accommodate those sales/purchases and the relocation of capacity where there is a sufficient demand to make such purchases economically attractive.

- Certificate of need programs often do not have the technical rationale to find a lack of "need" for more nursing home beds, especially given a rapidly aging population and the lack of control over the funding for home and community-based services, arguably a substitute for nursing home care.

- Certificate of need programs are usually required to judge only need and to ignore state budgetary concerns. A more blunt strategy used by many states is to inhibit construction of new nursing home beds by establishing a moratorium on certification of additional beds for participation in Medicaid.

- *Controlling the Supply of Long Term Care Providers at the State Level* (The Urban Institute, December 1998) highlighted several states that used bed-to-population ratios as a basis for initial planning. However, there is no best practice for what the bed-to-population ratio should be since access to alternative services plays an important role in the need for nursing home capacity.

- The system of cost-based reimbursement may have driven the problem that the original certificate of need legislation sought to solve. Originally, the system was retrospective resulting in consumers demanding the highest quality services without sufficient price sensitivity.

- Wisconsin has had a moratorium on the construction of new beds for so long that certificate of need is not perceived to have any policy relevance. As a result, Wisconsin has gone through a redesign of its long-term care system that has made supply controls less necessary because payment to providers has been changed. In the past, capital was reimbursed based on depreciation, interest, and the expense of construction. Changes in ownership were continually driving costs up. Wisconsin changed its reimbursement base to deemphasize capital reimbursement.

- California eliminated certificate of need for nursing homes in 1987, and no moratorium is in place. While the number of nursing home beds increased from 115,803 in 1986 to 133,127 in 1996, the number of nursing home beds per 1,000 individuals ages 85 and older actually decreased faster than the national average, even as nursing home occupancy rates have declined. Nursing home bed supply has not exploded in California despite the lack of explicit supply controls.

- Indiana eliminated the certificate of need and moratorium in 1999 which resulted in slight increases in the number of beds and then steady decreases. Similar to California, nursing home bed supply did not explode. Indiana did several things when it lifted the certificate of need requirement including eliminating the capital reimbursement incentive in the funding formula. Additionally, there was an incentive payment added to the formula for

occupancy levels greater than 90 percent with quality standards met. Also, quality of care fines increased as the state focused on inspections to maintain the standard of care.

- Missouri uses the certificate of need process to regulate nursing homes in addition to residential care and some outpatient services. Similar to Ohio, Missouri no longer has certificate of need for acute care. The certificate of need for both nursing home and residential care is based first on the demand in a 15 mile radius for services based on demographics projected for the year 2010. Missouri's moratorium on nursing home beds sunset in 2003, but always included loopholes that allowed an owner to increase beds in an existing facility by ten percent. Overall, Missouri has too much capacity, thereby causing nursing homes to have low occupancies and high bankruptcy rates.

The pros for certificate of need use in general, and in the nursing home industry in particular, focus primarily on controlling expansion in an effort to control money flowing toward capital expenditures designed to promote access to services for individuals who have the most limited resources and cannot afford services in either a home or institutional setting. The cons, on the other hand, typically highlight the problems caused by the free market expansion of other services while only controlling and supporting one segment of the market. Although access and quality seem to be controlled, costs escalate under the cost-based reimbursement for nursing homes in most states. Regardless of certificate of need, nursing homes across the country are experiencing lower occupancy levels and restricting the use of Medicaid dollars to promote access to other services.

Open Market Entry Controls

The United States Government Accountability Office's (GAO) *Residential Care Facilities Mortgage Insurance Program: Opportunities to Improve Program and Risk Management (*2006) report highlights the risks associated with Department of Housing and Urban Development offices' monitoring of the 232 mortgage insurance program.[49] This report illustrates controls already built in to the market place for constraining development.

The GAO states that the Federal Housing Administration requires a review of the most recent annual state-administered inspection report for state-licensed facilities applying for program insurance, and recommends, but does not require, continued monitoring of such reports for facilities once it has insured them. The Department of Housing and Urban Development has

[49] Through its Section 232 Mortgage Insurance for Residential Care Facilities program (Section 232 program), the Department of Housing and Urban Development's (HUD) Federal Housing Administration insures mortgages for nursing homes, assisted living facilities, board and care homes, and intermediate care facilities. The program insures HUD-approved private lenders against financial losses from loan defaults; insured loans can be used to finance the purchase, construction, or rehabilitation of a facility, enable borrowers to refinance projects that do not need substantial rehabilitation, or to install fire safety equipment.

proposed revising its standard regulatory agreements to require insured facility owners or operators to submit annual inspection reports and to report notices of violations.

The GAO cites as a potential risk to the Section 232 program, the projected shifts in demand for residential care facilities and type of facilities that the Department of Housing and Urban Development insures. According to the GAO, uncertainty exists about the future demand for residential care facilities and the corresponding effects on occupancy. As the number of Americans aged 65 and older increases at a rapid pace, lenders interviewed by GAO projected an increased need for residential care facilities. Industry officials also noted a rise in alternatives to nursing home care, such as assisted living facilities and home and community-based care options. As patients choose alternative care options, traditional nursing homes may face occupancy challenges. Overall, these changes to the nursing home facilities patient base may lower occupancy and income levels for nursing homes. However, these changes may positively affect the occupancy and income levels of other types of residential care facilities, including those in the Section 232 portfolio.

As an example of factors that control entry into the marketplace when financing a facility, this excerpt from the GAO report highlights several market factors that effectively control supply and constrain development.

> "Federal Housing Administration has numerous underwriting requirements for loans made under the Section 232 program. Some examples include:
>
> - Requiring documentation of a state-issued certificate of need for skilled nursing facilities and intermediate care facilities, and in states without a certificate of need procedure, an alternative study of market needs and feasibility.
>
> - Requiring an appraisal of the facility (prepared by the lender under the MAP [Multifamily Accelerated Processing] program) and a market study with comparable properties.
>
> - Reviewing current or prospective operators of the residential care facility and ensuring that they meet certain standards. For example, the Federal Housing Administration has a requirement that operators of an assisted living facility have a proven track record of at least three years in developing, marketing, and operating either an assisted living facility or a board and care home.
>
> - For new construction facilities specifically, the Federal Housing Administration requires a business plan along with an estimate of occupancy rates and prospective reimbursement rates with the percentage of population for patients whose costs are reimbursed through Medicare and Medicaid.
>
> - For existing facilities applying for a refinance loan, the Federal Housing Administration requires the submission of vacancy and turnover rates and current provider agreements for Medicare and Medicaid, three years of balance sheet and operating statements, as well as the latest inspection report on the project's operation."

Recent Ohio Legislative Actions

HB 66 introduced reimbursement rates based on peer groups, which reduces the incentive to decertify beds.[50] The new rate also changes the way capital costs are reimbursed. The pricing formula is anticipated to be a catalyst in helping Ohio's Medicaid system achieve some balance between institutional care and home and community-based care by moving from cost-based reimbursement toward price paid for services rendered. Appropriation of $10 million during SFY 2005-06 and SFY 2006-07 to nursing facilities and ICF/MR construction projects (HB 530) was an effort by ODJFS and the legislature to meet language in HB 66 that provided capital reimbursements for certain qualified projects approved through certificate of need prior to July 30, 2005. As a result of this appropriation, some providers agreed not to proceed with pending litigation.[51]

Additionally, HB 66 disallows the amortization of the cost of acquiring operating rights for relocated beds from being used to determine a facility's Medicaid reimbursement rate. Prior to July 1, 2005, once a certificate of need was granted, the owner of the beds could transfer and sell beds and the purchaser would be reimbursed for the purchase price as part of the formula. This often resulted in the State paying the cost of capital acquisition on an accelerated depreciation schedule. This, in turn, created an artificial increase in historical bed cost and drove purchase prices. In SFY 2004-05, the price was approximately $18,000 per bed, although ODH reports the purchase of a bed has been as high as $50,000 in SFY 2005-06.

The Chief of Ohio Health Plan's Bureau of Long-Term Care states that the continuing decline in occupancy of Ohio's nursing homes is an indication of a changing market place. According to Scripps, there is no real indication that nursing home bed demand will increase in the future. The baby boomer generation has more money and will be able to live independently longer, so they will not enter nursing homes any sooner. There will always be a need for nursing homes, but not at the current level or with the current budget impact.

In Ohio, there are many other areas of the budget that are driving a change in the Medicaid delivery system. The number of alternatives available for long-term care delivery has grown and there is pressure to provide access to more home and community-based services. The market for long-term home and community-based services has developed markedly in the past three decades, but the Ohio Medicaid program, to date, has limited access due to budgetary constraints and the concentration of resources in institutional facilities. Because this market already exists without the constraints of certificates of need, the entry by Ohio Medicaid into home and

[50] Under the old funding formula, higher occupancy rates contributed to higher reimbursement rates on a per bed basis.

[51] Reimbursement is in constant negotiation and capital funding continues to be a point of discussion along with quality incentives.

community-based services greatly diminishes the effectiveness of certificates of need in the long-term care market within the State.

R4.8 Ohio should consider eliminating certificate of need and lifting the moratorium on beds in Ohio. Certificate of need does not have the same policy relevance in controlling the marketplace and assuring access and quality of long-term care services as it had in the early 1970's. Because Ohio is "over-bedded" and the availability of alternative types of long-term care services has expanded, certificate of need and moratoria no longer exert the control originally intended. Removing certificate of need will allow the long-term care market to adjust itself to a balance point. Likewise, the banking industry and loan approval processes for development include several controls for market entry.

Ohio's move to a pricing system should further reduce its need for supply controls. A key consideration in removing certificate of need is the need to ensure that quality of care does not suffer and that access to services is consistent. Other states have implemented changes to reimbursement while maintaining quality standards. Additionally, the new reimbursement formula (see *nursing facility reimbursement methodology*) should not over-reimburse capital.

R4.9 With the removal of certificate of need, Ohio should take steps to ensure quality standards are met and readily available for comparison by consumers. Additionally, the State Medicaid agency should implement an incentive payment similar to Indiana's for occupancy levels greater than 90 percent with quality standards met. The Medicaid Agency may also want to consider quality of care fines similar to Indiana's which focus on inspections to maintain the standard of care.

R4.10 In the event Ohio continues to use certificate of need to control construction and remodeling of nursing homes, it should update its certificate of need process to include the following:

- **An evaluation of State and county needs;**
- **Use of alternative long-term care services such as home health, assisted living, and hospice; and**
- **Occupancy and use of nursing homes in the area.**

Additionally, Ohio should either develop regions or institute open bed shifting statewide so it can more effectively meet the changing demographics across county lines. The State should have more control over the number of beds in the system.

R4.11 If Ohio continues to use certificate of need, the State Medicaid agency and the Ohio Department of Health, with the assistance of the General Assembly, should work with the industry to implement policies that reduce the number of beds in the system and redistribute them in a manner that provides access to Medicaid and meets the needs of the State. Ohio may also want to consider having facilities with low occupancy forfeit a number of beds so that average occupancy is 90 percent. If Ohio continues to allow bed banking, it should consider policies that take a number of beds out of service for a given number of beds banked, similar to Minnesota or Washington.

R4.12 Regardless of whether or not Ohio maintains the certificate of need program, it should collect and publish quarterly occupancy data by levels and by county, similar to Missouri. If Ohio maintains certificate of need, this will show redistribution efforts, both by county and region. Furthermore, tracking changes in occupancy and availability by county would help future policy reviews of nursing home access.

Nursing Facility Reimbursement Methodology

Ohio's reimbursement for nursing homes has followed national trends. From 1980 to 1991, the reimbursement was based on retrospectively paying the nursing homes for costs associated with providing Medicaid services. From 1991 to 1993, the reimbursement system changed to a semi-prospective payment system whereby some payments began to be predetermined by historical costs for services rendered. From 1993 to 2005, a full prospective payment system was in place. The reimbursement formula in the prospective payment system was based on four cost centers: direct care costs, indirect care costs, other protected costs, and capital costs. In SFY 2005-06 and SFY 2006-07, Ohio is transitioning to a new reimbursement methodology that goes from a cost-based to a priced-based reimbursement system. OHP's Bureau of Long Term Care intends for the new formula to reflect an acuity based system that brings the rates closer to care management and away from capital.

The origin of the new reimbursement method stems from Ohio House Bill 95 of the 125th General Assembly which charged the Nursing Facility Reimbursement Study Council with studying the Medicaid reimbursement system for nursing facilities. The Council published *The Report of the Nursing Facility Reimbursement Study Council* on July 21, 2004. As a result of the Council's work, provisions in HB 66 revised the statutes governing the Medicaid reimbursement methodology and procedures for nursing facilities and ICF/MRs. However, uncodified sections of the act override the new statutory formula for SFY 2005-06 and SFY 2006-07 as the new reimbursement methodology is implemented.

Among the revisions are changes to the categories into which nursing facilities' costs are placed for the purpose of calculating reimbursement rates and the establishment of peer groups used in

determining cost groupings based on geographical differences in nursing homes. According to the *Quarterly Cost Management Report on Ohio's Medicaid Program*, November 21, 2005, ODJFS analysis determined that the use of peer grouping is a statistically valid way of aligning nursing facilities.

The old reimbursement formula included four cost centers, while the new formula in SFY 2005-06 is based on three cost centers with add-ons for taxes, franchise fees, and quality adjustments. Because the new formula is based on a price model, the cost centers may begin to be called price centers. The following are the new price centers:

- **Direct care**-includes medically based direct care services;
- **Ancillary/support services**-includes costs for all reasonable costs other than direct care or capital costs; and
- **Capital**-includes cost of ownership, depreciation on capital, amortization and interest in land, and lease and rent of land, buildings and equipment.

HB 66 also established quality incentive payments. ODJFS is required to annually place each nursing facility in one of four tiers, with those facilities in the first, second, and third tiers receiving the quality incentive payment. The placement of a nursing facility into a particular tier depends on the number of quality points it earns. A nursing facility earns one quality point for each of the following accountability measures it meets:

- Having no health deficiencies on the facility's most recent standard survey;
- Having no health deficiencies with a scope and severity level greater E, as determined under nursing facility certification standards for the Medicaid program, on the facility's most recent standard survey;
- Having resident satisfaction above the statewide average;
- Having family satisfaction above the statewide average;
- Having a number of nurse hours that is above the statewide average;
- Having an employee retention rate that is above the average for the facility's direct care peer group;
- Having an occupancy rate that is above the statewide average;
- Having a Medicaid utilization rate that is above the statewide average; and
- Having a case-mix score for direct care costs that is above the statewide average.

Unique to Ohio is the fact that significant parts of the nursing home reimbursement formula are statutory. Ohio has been slow to change its formula which included guaranteed rate adjustments prior to HB 66. In contrast, other Medicaid reimbursements fall under the rulemaking authority of OHP and sub-recipient agencies in the OAC. By keeping nursing facility rates in statute, OHP has limited ability to effectively budget for the broad range of long-term care services available.

Representatives from AOPHA spoke in support of maintaining the nursing home reimbursement in the ORC explaining that it ensured consistency and predictability in the system. Public hearings on rates was important to the members to prevent decisions being made in the "bureaucratic arena" An AOPHA representative summarized the issue by saying "Predictability is good. Generosity is better. Predictable generosity would be ideal."

While stakeholders voiced concern over OHP having rulemaking authority over the formula, it should be noted that rule changes in Ohio require public notice and hearing pursuant to ORC §119.03 and go through the Joint Committee on Agency Rule Review (JCARR). JCARR consists of five State Representatives and five State Senators and its primary function is to review proposed, amended, and rescinded rules to ensure the following:

- The rules do not exceed the scope of the rule-making agency's statutory authority;
- The rules do not conflict with a rule of that agency or another rule-making agency;
- The rules do not conflict with the intent of the legislature in enacting the stature under which the rule is proposed; and
- The rule-making agency has prepared a complete and accurate rule summary and fiscal analysis of the proposed rule, amendment, or rescission.

JCARR has the statutory authority to make recommendations to the General Assembly, which would also apply to rule changes affecting Medicaid payment for services.

Medicaid Nursing Home Payments: States' Payment Rates Largely Unaffected by Recent Fiscal Pressures (GAO, 2003) reviewed the nursing home payment systems in 19 states (Alabama, Arkansas, California, Colorado, Connecticut, Florida, Illinois, Iowa, Massachusetts, Michigan, New Jersey, New York, North Dakota, Oregon, Pennsylvania, Rhode Island, South Dakota, Texas, and Vermont). The report provides background and the changes that have impacted state nursing home payment systems since 1972. Of the more recent changes, the Balanced Budget Act of 1997 (BBA) repealed the Boren Amendment, providing states with increased flexibility to develop approaches to pay nursing homes that participate in Medicaid. States are no longer required to submit annual rate findings to the federal government, but instead must develop and implement a public process for determining rates. The BBA requires that states publish all proposed and final rates, including their methodologies and justifications, and ensure that providers, beneficiaries, and their representatives are given reasonable opportunity to review and comment on rates. Additionally, states must continue to ensure that payments are consistent with efficiency, economy, and quality of care standards.

Through the design of their payment methods, states generally seek to encourage nursing home spending on direct resident care. They typically divide nursing home costs into categories, or cost centers, with common categories being direct resident care, indirect care, administrative, and

capital. By varying their payment policies for each category, most states seek to target more of their funds to direct resident care.

States have the latitude to use several other strategies in developing their reimbursement formulas, including home specific rates, efficiency incentives, ceilings, flat rates, peer groups, add-on payments for direct resident care, and occupancy standards. Additionally, rate adjustments were included in some states through annual rebasing[52], inflating rates in non-rebase years, and/or case-mix adjustments based on the acuity level of residents. Fiscal pressures have compelled states to confront difficult choices, especially because 49 states and the District of Columbia are required to balance their budgets. The GAO reported that many states implemented or planned new cost-containment measures in order to control Medicaid spending growth in 2003 in recognition that the Medicaid program represents a large component of many states' budgets.

The GAO found that states in the report designed their payment methods to encourage nursing homes to deliver care efficiently and economically. Most states develop their payment rates prospectively, or prior to the time during which the rates apply, using historical cost reports. Under the alternative, retrospective payment systems, the actual costs incurred during the year are paid after the submission and review of a nursing home's cost report at the end of the year. Retrospective systems are recognized as inflationary while prospective rates encourage nursing homes to operate efficiently and incur only necessary costs. Homes that deliver care for less than the prospective payment amount profit; conversely, providers experience losses if costs are higher than the payment rate. Several of the states that GAO reviewed use explicit efficiency incentives to further encourage homes to minimize spending by providing them with additional payment if they keep their spending below a certain amount.

The GAO report confirms that states are always making adjustments to their rates. Despite the various ways states encourage nursing home efficiency, industry representatives and industry-sponsored studies nonetheless raise concerns that Medicaid payments do not cover the full costs of all nursing homes. GAO cited a 2002 industry-sponsored study that reported nursing home costs for Medicaid-covered residents in 2000 exceeded Medicaid payment rates an average of $10 per resident day in the 37 states included in the study. In addition, industry representatives in some of the states included in the report expressed concern that state payment methods do not adequately account for increases in certain costs, such as liability insurance or direct resident care staff wages and benefits. However, by incorporating features such as ceilings into their nursing home payment methods, states have intentionally designed their payment methods so

[52] Rebasing refers to a process that is designed to measure the relative costliness of caring for residents in one group versus another. The result provides "relative resource weights" that are used in the reimbursement formulas as a case mix multiplier. Rebasing is used to recalibrate the relative resource weights that apply to a given case mix.

that not all homes receive their full costs and lower cost homes, which are more likely to be efficient and economical, have payment rates nearer their costs.

A Case of Neglect (Governing, 2004) cites the institutional bias and effective lobbying by nursing homes that limit a state's ability to provide resources for other service options in long-term care. Additionally, Ohio and other states find they are supporting an industry where demand is declining, but reimbursement supports the capital investments made in "bricks and mortar." The nursing home industry has been experiencing pressure to change for many years, but has so far been adept at pressuring legislators to increase rates and maintain the count of nursing home beds. With other options for the delivery of long-term care services opening up, nursing homes are also now in competition with assisted living, residential care, and home and community-based services. By having their reimbursement formula in statute, nursing homes operate outside of the rate setting process applied to other services. In Ohio, the recent expansion of waivers for assisted living and the continued growth of PASSPORT recipients increase the availability of service alternatives to nursing homes. However, the availability of money to fund these service alternatives is restricted because under ORC, nursing homes are guaranteed their rate increases, while other services may or may not see a change in funding depending on the State budget.

With the development of other options in Ohio, stakeholders are changing their business models. One continuing care retirement community provider stated that his organization provided a continuum of care, but was somewhat limited to nursing home care for individuals who had expended their resources because it was the entitlement option. Additionally, he stated "if you ask anyone in one of his nursing homes if they want to be there, the answer will be no. No one is banging down the door to get in a nursing home. Residents are usually in a home because they have no choice for safety reasons and the supervision of their daily living or medical needs." One agency stated that the move to a nursing home pricing system in Ohio could lead to more flexible contracting and efficient delivery of services on a per recipient basis in either institutional or home and community-based settings. Several stakeholders are concerned that the new system will negatively affect quality of care and lead to deteriorating facilities. However, all stakeholders and agencies agreed that nursing homes have a place in the market and appropriately serve a frail population.

R4.13 With the implementation of a new pricing system, the State Medicaid Agency should monitor the nursing home industry for quality and the condition of its facilities. As the pricing system moves toward full implementation, the State Medicaid Agency should consider a move toward contracting services based on appropriate placement in a range of long-term care service options.

R4.14 The nursing home reimbursement formula should be removed from ORC and included in the OAC, which is consistent with other payment methodologies. Any changes to rates in OAC must go though the JACCR sand ORC §1911.03 process

which provide opportunities for stakeholder and public hearings on rule changes. By removing the formula from ORC, nursing home reimbursement can be more readily considered as one component of Medicaid long-term care service delivery.

Estate Recovery

Ohio Medicaid estate recovery programs, which began on January 1, 1995, involve the recovery of certain paid Medicaid benefits after the recipient is deceased, as required by the federal Omnibus Budget Reconciliation Act of 1993 (OBRA 1993), and by ORC §5111.11. Services charged prior to January 1, 1995, are not affected and will not be recovered. Estate recovery applies to all individuals who received services paid for by Medicaid which were rendered after the recipient reached age 55 and to all permanently institutionalized individuals regardless of age. There is no minimum time for receiving services which qualify for estate recovery, either through nursing home or home and community-based services. Recovery from the estate may only be made with the following provisions:

- After the death of the individual's surviving spouse;
- At a time when the (deceased) Medicaid consumer has no surviving child under age 21; and
- At a time when the consumer has no surviving child of any age who is totally blind or totally disabled.

Ohio's Medicaid Estate Recovery Program is administered jointly by ODJFS and the Ohio Attorney General's Office (Attorney General). At the time of application or re-application for Medicaid, recipients are informed of the Medicaid Estate Recovery Program by their local CDJFS. The Medicaid Management Information System (MMIS) maintains a tracking file of all Medicaid recipients subject to the estate recovery program. The tracking file is an ongoing record of all services provided to that recipient for which Medicaid has made payment. At the end of each month, MMIS prepares a computer tape listing data for all recipients in the tracking file for whom the status has been changed to deceased.

Not all of the persons listed on the monthly tape have actually died in that month due to differences in how the information on death is reported. There are two primary ways that ODJFS learns of a Medicaid recipient's death. In the first instance, the caseworker at the CDJFS changes the eligibility of someone receiving Medicaid payments in the CRIS-E system to indicate the deceased status. This is then compared monthly to the MMIS tracking file. The second means is for ODJFS to use the death tapes provided by the Ohio Department of Health's Bureau of Vital Statistics to compare against any previous Medicaid claims. In the latter case, there is generally a period of six months or more between date of death and status change.

The claims tape compiled as a result of comparisons to the tracking file are sent to the Attorney General Collections Enforcement Section on a monthly basis for input into the collection tracking software. The Attorney General investigates the existence of an estate and may, as part of the investigation, call nursing homes and CDJFS for additional information. A letter is generated to the estate invoicing them for past Medicaid services. Additionally, the Attorney General can file claims in local probate courts on behalf of ODJFS to recover what Medicaid has paid for the recipient's care. If an estate has not been filed but assets exist for a deceased recipient, the Attorney General can petition the courts for the right to present claims against the assets that are identified in Medicaid asset recovery statutes.

Table 4-17 displays Ohio's efforts on estate collections for SFY 2000-01 to SFY 2004-05.

Table 4-17: Ohio Attorney General Estate Collections and Ohio Total Medicaid Expenditures SFY 2000-01 to SFY 2004-05 and Ohio Total Medicaid Expenditures

	SFY 1999-2000	SFY 2000-01	SFY 2001-02	SFY 2002-03	SFY 2003-04	SFY 2004-05
Attorney General Estate Collections	$8,505,351	$9,387,321	$11,208,857	$14,628,161	$15,993,854	$17,453,284
Percent Change	N/A[1]	10.4%	19.4%	30.5%	9.3%	9.3%
Medicaid Expenditures[2]	$7,090,279,990	$8,036,337,905	$9,087,705,592	$10,254,163,105	N/A[3]	N/A[3]
Collection percentage per total Medicaid Expenditures[4]	**0.12%**	**0.12%**	**0.12%**	**0.14%**	**N/A[3]**	**N/A[3]**

Source: Ohio Attorney General WEP reports
[1] SFY 1998-99 data unavailable for comparison.
[2] As reported in the Ohio Medicaid reports from the ODJFS website.
[3] As reported in the Ohio Medicaid reports from the ODJFS website (SFY 2003-04, SFY 2004-05 are unpublished).

As shown in **Table 4-17**, Ohio's estate collections for all Medicaid recipients increased in SFY 2002-03 significantly and then showed a consistent increase the next two years. However, the collections as a percent of total Medicaid expenditures remained consistent from SFY 1999-00 to SFY 2002-03. Coinciding with this timeframe, in August 2003, the Attorney General's office began using special counsel to assist in the estate recovery program. The special counsel is hired in cases where local representation for the Attorney General provides a cost effective means to allow more access to file claims and petitions in local courts. It should be noted that the Ohio Attorney General is the collection arm for over 300 State agencies. By agreement, the Attorney General charges ODJFS 10 percent for all collected debts and therefore collection costs remain stable regardless of the amount collected.

Prior to HB 66, Ohio had elected to use the minimum standard set by Congress for assets subject to estate recovery. Only probated assets from the deceased recipient's estate were subject to recovery. An estate is real and personal property, such as a house, land, cars and bank accounts. HB 66 amended the program effective September 29, 2005, to include all real and personal

property and other assets in which the decedent had a legal title or interest at the time of death. This includes assets conveyed to a survivor, heir, or assigned by the decedent through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.

HB 66 made several additional changes that increase the scope and ability of the Attorney General to collect on estates. They include the following:

- Places in the Revised Code the administrative rule that specifies when a home becomes a countable resource for purposes of determining an aged, blind, or disabled individual's eligibility for Medicaid when the individual is institutionalized, but extends from 6 months to 13 months the period of time during which the home is not a countable resource.

- Requires that ODJFS apply for a federal Medicaid waiver to expand to five years the look-back period for determining whether any assets, not just assets in a trust, have been transferred for less than fair market value.

- Creates the offense of Medicaid eligibility fraud, prohibits making false or misleading statements, concealing an interest in property, or failing to disclose certain transfers of property in an application for Medicaid benefits or in a document that requires a disclosure of assets for the purpose of determining eligibility to receive Medicaid benefits.

- Authorizes the Attorney General and the prosecuting attorney to bring a civil action for the recovery of Medicaid benefits improperly paid as a result of Medicaid eligibility fraud.

- Revises state law governing Medicaid estate recovery and liens to make it consistent with federal law.

- Expands the Medicaid Estate Recovery Program to include any real and personal property and other assets in which an individual subject to recovery has any legal title or interest at the time of death, including assets conveyed to a survivor, heir, or assign of the individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.

- Repeals a law that permitted ODJFS to enter into a contract with any person under which the person administered the Medicaid Estate Recovery Program on ODJFS' behalf or performed any of the functions required to carry out the program and instead requires that ODJFS certify amounts due under the Medicaid Estate Recovery Program to the

Attorney General pursuant to continuing law that authorizes the Attorney General to collect debts owed the state.

- Requires that a person responsible for the estate of certain deceased Medicaid recipients submit a properly completed Medicaid estate recovery reporting form to the Administrator of the Medicaid Estate Recovery Program.

- Requires that the Medicaid estate recovery reporting form list all of the decedent's real and personal property and other assets that are part of the decedent's estate subject to the Medicaid Estate Recovery Program.

The changes in HB 66 are important in that they both implement a more full collection on allowable assets per CMS policies and effectively place Ohio into a more aggressive stance on asset recovery than in previous years.

The CMS policy brief *Medicaid Estate Recovery Collections* (2005) reported that over $361.7 million was collected by all states in 2004, which represents an increase of 12.4 percent over 2002. CMS acknowledged that while this figure is substantial, it represents only a small percentage of the total Medicaid spending for nursing home services in 2004. **Table 4-18** shows the national estate recovery collections as a percentage of nursing home spending.

Table 4-18: Summary of National Estate Recovery Collections

	SFY 2001-02	SFY 2002-03	SFY 2003-04	Percent Change (SFY 2001-02 to SFY 2003-04)
Estate Recovery Collections	$321,725,993	$330,337,483	$361,766,396	12.4%
Medicaid Nursing Home Spending	$46,439,880,813	$45,578,649,736	$45,835,646,786	(1.3%)
Collections as % of Nursing Home Spending	**0.69%**	**0.73%**	**0.79%**	**13.9%**

Source: Centers for Medicare and Medicaid Services/ *Medicaid Estate Recovery Collections September 2005*
Note: Data gathered by CMS is self-reported by each state.

As shown in **Table 4-18,** estate recovery collections are less than 1 percent of what is spent on nursing homes from SFY 2001-02 – SFY 2003-04.

Table 4-19 shows the top 10 states in recovery of probate collections in SFY 2003-04 as reported by the Centers for Medicare and Medicaid Services.

Table 4-19: Changes in Medicaid Estate Recovery Collections 2002-2004 (Top Ten in Collections for 2004)

State	Collections: Probate 2002	Collections: Probate 2003	Collections: Probate 2004	Percent Change (2002-2004)
California	$36,335,161	$44,024,077	$44,668,847	13.60%
Massachusetts	$28,837,456	$28,524,313	$32,577,301	13.00%
New York	$26,878,856	$27,244,711	$29,953,334	11.40%
Minnesota	$18,668,919	$12,899,750	$24,999,595	33.90%
Illinois	$17,003,820	$16,993,946	$21,254,742	25.00%
Wisconsin	$15,447,888	$12,812,864	$16,772,729	8.60%
Ohio	$10,814,457	$12,382,674	$13,987,964	29.30%
Oregon	$13,738,730	$13,996,362	$13,843,592	0.80%
Florida	$9,683,087	$11,474,485	$13,478,207	39.20%
Iowa	$9,145,536	$10,977,823	$12,194,616	33.30%

Source: Centers for Medicare and Medicaid Services/ *Medicaid Estate Recovery Collections (*2005)
Note: Data gathered by CMS is all self-reported by each state

As shown in **Table 4-19,** Ohio was seventh in collections for 2004 and reported a 29.3 percent increase in estate recovery collections from 2002 to 2004. According to the Medicaid estate collections data; Arizona (10.4 percent), Oregon (5.8 percent), and Idaho (4.5 percent) recouped the largest share of their respective nursing home expenditures. To put the estate recovery collections in perspective, **Table 4-20** shows the top five states based on what each spends on nursing homes in their respective states versus the national Medicaid expenditures on nursing homes.

Table 4-20: 2004 Collections Sorted by Top Five States Nursing Home Spending as a Percent of National Nursing Home Spending

State	Collections: Probate SFY 2003-04	FY 2003-04 Medicaid Nursing Home Expenditures	Collections as % of Each State's Nursing Home Spending	Each State's Nursing Home Spending as % of National Nursing Home Spending
New York	$29,953,334	$6,486,722,331	0.50%	14.20%
Pennsylvania	$5,888,558	$4,069,955,523	0.10%	8.90%
California	$44,668,847	$3,033,946,724	1.50%	6.60%
Ohio	$13,987,964	$2,722,643,741	0.50%	5.90%
Florida	$13,478,207	$2,250,455,672	0.60%	4.90%

Source: Centers for Medicare and Medicaid Services/ *Medicaid Estate Recovery Collections (*2005)

According to **Table 4-20**, Ohio is fourth in nursing home expenditures related to nursing home care. Additionally, further analysis showed that Ohio is tied with New York, North Carolina and the District of Columbia in collection as a percentage of nursing home spending. All three states collection percentage is 36 percent below the national average of 0.79 percent in **Table 4-18**.

According to the Attorney General's office, Ohio's conservative eligibility criteria are an intrinsic part of being a 209(b) state, and the State's history of meeting minimum federal requirements of estate recovery reduces recoverable assets and impacts the State's efforts on collections.

According to CMS, there are several reasons for variations in reported estate recovery activities which include the following:

- Variations in implementation of federal recovery options;
- Other state policy changes;
- Effect of Federal Medical Assistance Percentage rate;
- Individual state political considerations; and
- Interaction of Medicaid with other state laws.

As an example of federal changes, the Deficit Reduction Omnibus Reconciliation Act of 2005 (DRA) makes provisions for reducing Medicaid spending by increasing penalties on individuals who transfer assets for less than fair market value in order to quality for nursing home care and by making individuals with substantial home equity ineligible for nursing home benefits.

ODJFS identified the following changes to estate recovery requirements as a result of the DRA:

- Expands the assets that are subject to the look back period and penalty, including the purchase of a life estate interest in another individual's home, and funds used to purchase promissory notes, loans or mortgages;

- Lengthens the look back period on asset transfers from three to five years (This is now congruent with State statute enacted in HB 66);

- Discontinues Medicaid eligibility for long-term care services to individuals with an equity interest in their home of greater than $500,000 (States may choose to reset this value up to $750,000);

- Includes certain annuities among the assets that are subject to Medicaid recovery;

- Requires income to be counted first for transfers to the community spouse and requires that assets may only be transferred if the income does not meet the community spouse's needs;

- Mandates states to not round down or disregard any period of ineligibility; and

- Allows states to accumulate multiple transfers into one penalty period.

ODJFS anticipates filing a minimum of seven sets of OAC rule changes for approval by JCARR to comply with asset related provisions of the DRA. For additional information on JCARR refer to the ***background and nursing facility reimbursement methodology***.

During stakeholder discussions, members of the Ohio State Legal Services Association (OSLSA) expressed concern with the process used to conduct estate recovery in the area of its effect on the community spouse. OSLSA members explained that, although the community spouse is not responsible for reimbursing Medicaid, the spouse sometimes receives collection notices from the State. They attribute this to the use of form letters and the absence of a process to ensure that there is not a community spouse provision on each case. However, OSLSA members said that their clients are often greatly concerned when they receive the form letters but, when their cases are examined, they are often not obligated to make repayments to Medicaid. Process changes that would better protect community spouses would, in the opinion of OSLSA members, greatly improve the estate recovery process by ensuring the protection of individuals who fall under the designation of community spouse.

On the other hand, a member of the Ohio Academy of Family Physicians expressed frustration with programs that advertise to protect individual assets from Medicaid recovery. The physician commented that it appeared that individuals receiving Medicaid long-term care were often of the middle or upper middle class and had taken steps to ensure that their assets would not be seized by Medicaid.

The expansion of recoverable assets in HB 66 to include non-probate assets also places a burden on the Attorney General to recover assets that are typically harder to identify than real property. The Attorney General has recommended changes in statute that require the beneficiary of transfer on death deed provide notice to the State if the owner of the property was on Medicaid prior to filling the affidavit to transfer. By requiring notice to the State, the Attorney General anticipates greater compliance by legal counsel that are handling estates, fewer property searches and more efficient collection of assets.

R4.15 Ohio should follow the Attorney General's recommendation and add language in statute requiring that beneficiaries of assets from anyone who has been on Medicaid must give notice upon death of the deceased recipient. Additionally, adding to the notice provision in ORC § 2117.061 that notice be given if the decedent or the predeceased spouse was on Medicaid would assist in recovery in cases where recovery is deferred due to surviving spouse who is not on Medicaid. With additional notice requirements on non-probate assets, Ohio should realize an increase in yearly collections. An estimate of resources available for recovery can not be made since the reluctance of people to enter a nursing home will create the

necessity to spend down assets to avoid placement. Additionally, Ohio has one of the most restrictive income and asset limits for eligibility which in turn reduces any residual assets.

F. Prescription Drug Program

Medicaid prescription drug coverage is an optional service under the Medicaid program. The Ohio Medicaid Drug Program is a federal and State supported program that provides prescription drug coverage to eligible recipients and is administered by ODJFS. A member of the Ohio Association of County Behavioral Health Authorities spoke to the importance of this optional service, "The prescription coverage is really important related to behavioral health, particularly with the psychiatric disorders. …Having that coverage is critical when we think about the people who are only functioning with medication." Ohio Medicaid spending on prescription drugs totaled $1.5 billion in SFY 2002-03 and is the single largest item of new Medicaid spending. Prescription drug total expenditures increased an average of 13.4 percent between SFY 2002-03 to SFY 2004-05 (refer to **Table 3C-2** in **Appendix 3-C** of the **organizational issues** section).

Medication Therapy Management Program

Medication therapy management (MTM) is a distinct service or group of services that optimize therapeutic outcomes for individual patients. MTM services are independent of, but can occur in conjunction with, the provision of a medication product. MTM encompasses a broad range of professional activities and responsibilities within the licensed pharmacist's, or other qualified health care provider's, scope of practice.

Recognition of the impact of MTM programs is evident in the requirements of prescription Drug Plans participating in the Voluntary Medicare Prescription Drug Benefit program. Under 42 CFR Section 423.153, plans are required to establish drug utilization management, quality assurance measures and systems, and medication therapy management programs as part of Medicare's cost control and quality improvement requirements. MTM programs are designed to pay pharmacists to counsel and otherwise assist enrollees with multiple chronic diseases (such as diabetes, asthma, hypertension, hyperlipidemia, and congestive heart failure), multiple medications and high drug costs. MTM programs are required to coordinate with other care management programs being offered to recipients.

In accordance with CFR §423.153(d), a Medicare Part D sponsor must have established an MTM program that includes the following for contract year 2007:

- Ensures optimum therapeutic outcomes for targeted beneficiaries through improved medication use;

- Reduces the risk of adverse events, including adverse drug interactions, for targeted beneficiaries;
- Is developed in cooperation with licensed and practicing pharmacists and physicians;
- Describes the resources and time required to implement the program if using outside personnel and establishes the management and dispensing fees for pharmacists or others;
- May be furnished by pharmacists or other qualified providers;
- May distinguish between services in ambulatory and institutional settings; and
- Is coordinated with any care management plan established for a targeted individual under a chronic care improvement program.

Beneficiaries may qualify for their plan's MTM program based on the following criteria:

- Have multiple chronic diseases;
- Are taking multiple Part D drugs; and
- Are likely to incur annual costs of at least $4,000 for all covered Part D drugs, which is a predetermined level specified by the Secretary of HHS.

MTM programs are new to the Medicare program and CMS acknowledges that it is still developing evidenced-based practices so that MTM activities will be meaningful and practical. CMS has formed a Pharmacy Quality Alliance to collect and share information on ways to promote care coordination and deliver the most appropriate and cost-effective therapy available. In recent testimony, CMS has stressed the importance of involving pharmacists in efforts to both lower pharmaceutical costs and in improving recipient outcomes. The CMS Deputy Director noted in her May 23, 2006 testimony to the House Health Subcommittee of the Committee on Energy and Commerce that pharmacists can:

> "...help people who have multiple illnesses understand how to use their medication, thus improving patient compliance with treatment plans and preventing complications. All of these things can improve quality and reduce overall healthcare costs, to achieve a healthcare system that provides the right care for each patient every time."

During this testimony, the CMS Deputy Director also highlighted the need for states to have the tools and options to promote a value-based approach to the delivery of healthcare and specifically, the delivery of prescription drug benefits. In March 2006, CMS provided states with a *Roadmap to Medicaid Reform*. This roadmap outlines how states may use new tools along with existing options to improve quality and coordination of care. The roadmap includes the option for states to adjust payments to provide more financial support to pharmacists that improve quality and reduce costs of drug coverage and chronic disease management. Several states have implemented MTM programs.

In 2002, West Virginia implemented a pilot program called, the face-to-face initiative or face-to-face diabetes management for their Public Employees Insurance Agency (PEIA). Essentially, the program was planned as a year-long pilot having local pharmacists counsel diabetics to encourage improved control over glucose levels and more stringent glucose monitoring, as well as encouraging greater attention to the patient's disease state. This program was initially piloted in six counties. Local pharmacists were trained in two day sessions with special trainers and participated in intense self-study programs. After only 8 months, the pilot was expanded to all 55 counties in West Virginia. To encourage participation, patients enrolled in the program were rewarded with waived co-payments (after meeting their deductibles) for certain diabetes-related drugs, supplies, and lab tests. The program started with 24 pharmacists trained to counsel the diabetic patients, but now has 120 pharmacists serving 965 patients. According to the Ohio Pharmacists Association, Ohio pharmacies bordering West Virginia are also participating in this program for West Virginia residents.

The Ashville Project, another MTM program, was started by the City of Asheville, North Carolina in 1997. The City paid pharmacies for diabetes self-management services provided by trained pharmacists to municipal employees. After 14 months, 67 percent of all patients in the program had blood sugar readings in the normal range compared to only 33 percent at the beginning of the period. The City saved over $20,000 during the first twelve months of the program in reduced costs of care for these employees. The Asheville Project decreased insurance claims from $6,096 in 1996 to $1,584 in 2001 and decreased annual direct medical costs, which includes insurance claims, diabetes prescriptions, and other prescriptions, from an average of $7,082 per patient in 1996 to $4,651 in 2001. Although pharmacy costs increased due to the appropriate use of medicines and patient compliance, the overall savings from lower insurance claims was more than double the increased prescription spending. Additionally, employee productivity increased because participants used fewer sick leave days between 1997 and 2001. Up to 82 percent of patients increased their level of optimal medication at every follow-up.

Based on the eight-year Asheville Project, GlaxoSmithKline and the American Pharmacists Association Foundation launched the Ten City Challenge project in January 2006, a nationwide project that seeks to improve the health of diabetic patients and reduce employers' health care costs. Under the Ten City Challenge project, participating employers must agree to waive workers' co-payments on medicines to treat diabetes to encourage the drugs' use. All diabetes prescription medications will be included in the program. Patients would be matched with specially trained pharmacists to learn how to manage their diabetes more effectively. A spokesperson for the initiative said that employers would pay between $350 and $450 per patient for coaching by the pharmacists in the first year but added that such costs would decrease over time. According to the spokesperson, employer spending on drugs could double in the first year, as employees with diabetes improve their compliance with treatment regimens. However, participating employers in the North Carolina initiative reportedly saved about $900 per patient

with diabetes in the first year of the initiative. In addition, employees would save $400 to $600 annually on co-pays. Christopher Viehbacher, president of GlaxoSmithKline's U.S. pharmaceuticals unit, said diabetes is among the most costly conditions for employers because of complications such as heart, kidney, eye, and nerve damage.

The Academy of Managed Care Pharmacies notes several diseases that are appropriate for MTM and disease management (see **managed care and care management** section). These include diabetes, congestive heart failure, hypertension, high cholesterol, asthma, and depression. Because Ohio Medicaid has not implemented a MTM program or a disease management program, the State is forgoing improved health outcomes and potential cost savings associated with such programs.

A member of the Ohio Pharmacists Association (OPA) spoke to benefits of increased involvement of pharmacists in service provision saying that 10 to 20 percent of hospital admissions (usually through the emergency department) are related to adverse drug effects. In addition, the pharmacist said that many patients with common diseases, like high blood pressure (hypertension) or high cholesterol (hyperlipidemia) are non-complaint with treatment regimens within two years of the original diagnosis. OPA members felt that pharmacists could increase treatment compliance and success through teaching patients how to appropriately administer medications (in the case of asthma inhalers) or through reinforcing treatment plans. While increasing the involvement of pharmacists in service provision would, according to OPA members, necessitate an increase in reimbursement amounts to allow patient-contact time, an overall cost-savings could be achieved through greater medication counseling and appropriate use.

R4.16 The State Medicaid Agency should work with major stakeholders, including pharmacy providers, recipients, and physicians to develop a Medication Therapy Management pilot program for aged, blind, and disabled Medicaid recipients that will not be enrolled in a managed care plan. The pilot program may want to focus on a specific chronic disease or a group of diseases, depending upon the State's most recent utilization data. In developing the pilot program, an evaluation model should be developed concurrently so that there is a methodology put in place to evaluate program outcomes. The State Medicaid Agency should work with sub-recipient agencies to encourage their participants to join the Medication Therapy Management program. The State Medicaid Agency should request consultation and assistance from CMS to ensure that the results being seen by CMS are factored into the State's program. Additionally, during future contract negotiations with managed care plans, the State Medicaid Agency should include a MTM program requirement.

Financial Implication: **If the State Medicaid Agency implemented a MTM program for individuals diagnosed with diabetes, the State could save approximately $450 per person, or a total of $45 million. This estimate is based on the net savings participants in the Ten Cities Challenge are expected to realize and a conservative estimate of 100,000 Medicaid participants diagnosed with diabetes. However, the State's actual savings could be significantly different given the dissimilar populations.**[53]

Drug Utilization Review

Ohio Medicaid's drug utilization review (DUR) program is a provider-oriented, educational outreach program designed to alert physicians and pharmacists to inappropriate or medically unnecessary pharmacological care. The program has three primary goals: to safeguard the health of Medicaid consumers; assess the appropriateness of drug therapy; and reduce the frequency of fraud, abuse, and gross overuse. State Medicaid programs are required under 42 USC 1396r-8g to have a DUR program.

The Ohio Medicaid DUR program has three phases: prospective, retrospective, and concurrent. Prospective DUR uses a point of sale system connecting all Ohio Medicaid pharmacies, which enables a pharmacist to determine, prior to dispensing, if the drugs requested are over-utilized, under-utilized, contraindicated drug combinations, or contraindicated drug use by diagnosis. The point of sale system operates in conjunction with the counseling services provided by pharmacists to all patients prior to dispensing any drug, as required by OAC 4729-5-20.

Retrospective DUR evaluates patterns of drug therapy either concurrent with therapy or after a patient has completed therapy. Medicaid claims data is used to screen for potential adverse drug reactions, therapeutic appropriateness, incorrect drug dose or duration, drug allergy interaction, and clinical abuse. Patient profiles generated by Medicaid paid claims data are reviewed on a monthly basis according to criteria approved by the DUR Board. After a review, intervention letters and response forms are mailed to selected providers. Guidelines and publications may accompany the consumer's profile and intervention letter sent to providers. To calculate cost savings, re-review is completed 12 months after the initial review.

According to OHP staff, provider notifications were not consistently sent over the past year due to staffing shortages in the pharmacy section. As of August 2006, OHP is in the process of hiring a part-time contract employee to serve as the DUR program director and expects the position to

[53] According to ODJFS, in CY 2005 there were 114,359 Medicaid recipients who experienced a diabetic episode. Furthermore, the American Diabetes Association states that 7 percent of the children and adults in the United States have diabetes. Based on the CY 2005 Ohio Medicaid population of 1,733,405, 7 percent of the population equals 121,338 individuals.

be filled by the end of calendar year 2006. The program director will be responsible for the following activities:

- Working with OHP's Health Services Research Section to identify Medicaid recipients who hit pre-determined quality indicators;
- Drafting letters to providers regarding medication recommendations;
- Chairing the DUR Committee;
- Reporting to the DUR Board; and
- Providing recommendations for the Medicaid pharmacy program design, such as quantity and prior authorization.

Ohio Medicaid's DUR program also includes concurrent DUR, which involves the evaluation of drug therapy and any necessary intervention while the patient is undergoing therapy. The DUR program identifies Medicaid recipients who are at high risk of drug-induced illness requiring hospitalization, communicates risk factors to the physicians and pharmacists involved in the drug therapy, and recommends evaluation of drug therapy, when appropriate.

The DUR Board and DUR Committee help achieve these goals. Four physicians and four pharmacists, each serving a two-year term, serve on the DUR Board. Board member responsibilities include the following:

- An advisory role providing medical and pharmaceutical expertise to the DUR program;
- The development of standards and criteria for retrospective DUR; and
- The development of educational outreach programs for physicians and pharmacists.

The DUR Board meets quarterly. Unlike the Board, the DUR Committee meets monthly. The Committee consists of eight pharmacists and is chaired by OHP's pharmacist consultant. At the monthly meetings, the Committee reviews consumer claims profiles to identify those consumers requiring an intervention and alert their physicians and pharmacists. Furthermore, DUR Committee members may select recipients or providers they feel should be referred for a more detailed review to the recipient lock-in program (PACT) or the Surveillance and Utilization Review Section.

In addition to the DUR activities mentioned above, OHP started a behavioral health medication management program with Comprehensive Neurosciences in July 2005. Funding for the project, which is provided by the pharmaceutical manufacturer Eli Lilly, runs through June 2007. Comprehensive Neurosciences compiles a medication history for each patient, reviews utilization, and sends out letters to physicians when there are multiple physicians and/or multiple prescriptions for a particular medication or class of medications. Specifically, they are monitoring for possible interactions or overuse, such as the prescribing of psychiatric drugs.

OHP staff stated the project will not continue beyond June 2007 without additional external funding.

42 USC 1396r-8g outlines requirements for Medicaid DUR programs. A state's Medicaid DUR program must assure that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical results. DUR programs must educate physicians and pharmacists to identify and reduce the frequency of patterns or fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, or patients. Additionally, the DUR program must provide education on the following areas:

- Therapeutic appropriateness;
- Overutilization and underutilization;
- Appropriate use of generics;
- Therapeutic duplication;
- Drug-disease contraindications;
- Drug-drug interactions;
- Incorrect drug dosage or duration of drug treatment;
- Drug-allergy interactions; and
- Clinical abuse and misuse.

States are permitted to contract with accredited health care educational institutions, state medical societies, state pharmacists associations, or other organizations identified by the state to provide educational outreach programs. According to survey results presented at the March 2006 conference of the American Drug Utilization Review Society, 28 of the 30 states that completed the survey contract the retrospective DUR function. Contracts are with pharmacy benefit managers, state universities, state pharmacists associations, other states agencies, or a combination of the aforementioned. OHP contracted with the University of Cincinnati to analyze the claims data used to identify patients and providers needing intervention, but brought this function back in house because the Decision Support System now allows OHP staff to complete these analyses.

The Director of CMS, in his December 2004 testimony to the House Energy and Commerce Subcommittee on Oversight and Investigation, said, "In addition to promoting patient safety and positive health outcomes, the DUR program serves as a cost saving strategy by avoiding problems such as adverse drug interactions, drug-disease interactions, and therapeutic duplication and over-prescribing by providers."

R4.17 The State Medicaid agency should use an independent party, such as a private vendor, state medical or pharmacy association, or state university, for its retrospective DUR program. In the interim, the State Medicaid agency should proceed with plans to hire a contract employee to serve as the DUR Program

Director. The DUR Program Director should resume sending notifications to providers and ensuring the completion of follow-up activities. Furthermore, the State Medicaid Agency should complete the project with Comprehensive Neurosciences. If the program results in positive health outcomes and cost savings, the State Medicaid Agency should seek funding to continue the program indefinitely or fund the program through cost avoidances.

Multi-State Purchasing Pool

Ohio Medicaid does not participate in bulk purchasing for its pharmaceuticals. HB 66 authorized the Director of ODJFS to enter into an agreement or cooperative arrangement with other states to create or join a multi-state prescription drug purchasing program. The purchasing program would be for the purpose of negotiating with manufacturers of dangerous drugs, as defined in ORC §4729.01, to receive discounts or rebates for dangerous drugs dispensed under Medicaid. According to OHP, the State is able to negotiate lower prices through supplemental rebates than the multi-state purchasing pools. However, OHP plans to monitor the supplemental rebates for any negative impacts due to Medicare Part D and statewide managed care, which combined, account for approximately a 75 percent decrease in pharmacy spending.

Furthermore, managed care plans (MCPs) that provide prescription drug benefits to Medicaid beneficiaries as part of the capitated managed care benefit are not entitled to federal Medicaid rebates. Therefore, their members cannot be pooled with fee-for-service beneficiaries unless the state "carves out" the prescription drug benefit from the managed care plan and removes it from the capitation rate. Thus, states with significant numbers of Medicaid beneficiaries enrolled in managed care plans that could include prescription drug benefits that are not "carved out" by the state could have reduced potential for market power under a pooling scenario.

The State of Ohio has a history of coordinating non-Medicaid prescription drug purchases. ODMH is authorized to procure, store, repackage, distribute, and dispense drugs on behalf of other State and local agencies, and to provide other agreed-upon services as provided for in ORC §5119.16(C). These functions are administered by ODMH's Pharmacy Service Center.[54] In 2005, the Pharmacy Service Center procured and distributed prescription drugs totaling nearly $50 million. It procures prescription drugs for 393 State and local facilities and programs that purchase medications. The Ohio Department of Rehabilitation and Corrections (ODRC), Ohio Department of Youth Services (ODYS), and ODMH account for 95 percent of Pharmacy Service Center sales. The Pharmacy Service Center lists approximately 3,600 items in its formulary, which are determined by the Interdepartmental Pharmaceutical and Therapeutics (P&T) Committee. The Committee includes the following individuals:

[54] ODMH has had the authority to operate the Pharmacy Service Center since 1972. The Pharmacy Service Center is funded entirely by the sales of its products and services to customers.

- Medical directors of ODMH, ODYS, ODRC Medical Services, and ODRC Mental Health Services;
- Medical services administrator from ODYS;
- Pharmacists from ODMH, ODRC, and ODJFS;
- Representative of the alcohol, drug addiction, and mental health service boards; and
- Representative of community mental health provider agencies.

In response to rising pharmaceutical costs, states are implementing or exploring innovative prescription drug cost containment strategies, such as bulk purchasing. The multi-state purchasing pool, wherein states attempt to increase their bargaining power, generally through a common pharmacy benefits manager (PBM), negotiates drug prices with manufacturers. States may pool purchasing for the Medicaid program, state children's health insurance program (SCHIP), and other groups on whose behalf states buy pharmaceuticals.

Several states have opted to join multi-state purchasing pool plans in order to gain deeper discounts. The National Medicaid Buying Pool (NMBP), also referred to as the Michigan Multi-State Pooling Agreement (MMSPA), began in February 2003 when Michigan and Vermont announced they would create a Medicaid pooling initiative. The pool received price proposals from 26 manufacturers. After Alaska, Nevada, and New Hampshire joined in 2004 the pool received price proposals from 40 manufacturers. In 2005, Hawaii, Minnesota, Montana, and Tennessee joined and Kentucky is awaiting CMS approval to join. The program covers approximately 3.5 million participants, with purchase costs of approximately $5 billion annually.

In October 2005, Vermont announced it was leaving NMBP to create a new purchasing pool, the Sovereign States Drug Consortium, with Iowa, Maine, and Utah. The Consortium will work with Med Metrics Health Partners, a non-profit pharmacy benefits manager started by the University of Massachusetts Medical School.

TOP$ is another multi-state Medicaid pharmaceutical purchasing pool administered by Provider Synergies, a pharmacy benefits administrator (PBA). The pool was created by Louisiana, Maryland, and West Virginia, under a proposal submitted to CMS in December 2004 and approved in May 2005. Delaware and Wisconsin joined later in 2005. Louisiana, Maryland, and West Virginia estimate the pool will save their Medicaid programs, $27 million, $19 million, and $16 million, respectively, in 2006. Overall, the pool covers over 1.3 million recipients of Medicaid prescription drug coverage. Although the states are pooling their drug buying efforts, they all retain and maintain their own PDL and exercise clinical oversight of those lists to assure adequate access to needed medicines for their recipients.

Because of the Medicaid Drug Rebate Program's confidentiality rules, only the Comptroller General and the Director of the Congressional Budget Office are permitted to review rebate information. As such, OHP or any other State government office can not compare the actual

price Ohio pays for a given drug to the price paid by other states or multi-state purchasing pools. As a result, AOS could not complete a comparison of actual drug costs. OHP relies on experience and the relationship with its PBM to conclude that joining a multi-state purchasing pool would not result in lower prices for Ohio Medicaid. However, given the confidentiality requirements, it is not possible for AOS or any other State government entity to verify that Ohio Medicaid would not realize a cost savings by joining a multi-state purchasing pool.

R4.18 The State Medicaid Agency should monitor the impact of Medicare Part D and statewide managed care on the Medicaid prescription drug program, specifically its supplemental rebates from manufacturers. If Ohio Medicaid experiences a loss in purchasing power as a result of a high volume of drug purchases being transferred to Medicare Part D, it should explore opportunities to join a purchasing pool for prescription drugs.

Furthermore, the Agency should work with CMS to have the Comptroller General or Director of the Congressional Budget Office review and compare states' drug costs, after supplemental rebates, on a routine basis. Based on the outcomes of the review of drug prices, the Agency should consider increasing the use of generic pharmaceuticals to further reduce Medicaid pharmaceutical costs.

Financial Implication: **If the State Medicaid agency were to experience savings through joining a multi-state purchasing pool at a level similar to Michigan (less the estimated reduction in purchasing volume associated with the implementation of Medicare Part D), the Agency could avoid costs of $2 million annually.**

If the State Medicaid agency were to increase the use of generics to 62 percent[55] and it was able to achieve costs savings of 25 percent of the estimated rate of $19 million for every 1 percent increase in generic substitution (to account for the effects of reduced volume as a result of Medicare Part D), the State could save $57 million annually in prescription drug costs.

[55] Based on the average generic use rate of five states and the VA as included in the Ohio State University Study, *Alternatives for Reform of the Ohio Medicaid Pharmaceutical Program* (Vazquez, 2004).

G. Waivers

Section 1115 Demonstration Projects

Overview of Ohio Waivers

Ohio has seven waiver programs administered by three separate agencies. ODJFS administers the Ohio Home Care and Transitions Waivers; ODA administers the PASSPORT, Choices, and Assisted Living Waivers; and ODRMDD administers the Level 1 and Individual Options (IO) Waivers.

The **Ohio Home Care Waiver** is a limited-enrollment, cost-capped program of home and community services for people with serious disabilities and unstable medical conditions who would be eligible for Medicaid coverage in a nursing home or hospital. The waiver covers the following services:

- Nursing;
- Daily living;
- Skilled therapies;
- Home-delivered meals;
- Emergency response systems;
- Home modifications;
- Supplemental adaptive/assistive devices;
- Adult day health services;
- Out-of-home respite;
- Supplemental transportation; and
- Social work and nutrition counseling.

The **Transitions Waiver** is a limited-enrollment, cost-capped program of home and community services for people who are eligible for Medicaid coverage in an ICF/MR. Only people who were originally enrolled in the Ohio Home Care Waiver and have an ICF/MR level of care are eligible for the Transitions Waiver, which has the same services, providers, and method of operation as the Ohio Home Care Waiver.

ODJFS has redesigned the Ohio Home Care benefit package, which includes the Ohio Home Care and Transitions Waivers, effective July 1, 2006. In order to be eligible for the new Ohio Home Care Waiver, in addition to being eligible for Medicaid, individuals need to have a nursing facility level of care and must be 59 years and under. A new waiver, the Transitions Carve-Out Waiver, is available to existing Ohio Home Care Waiver consumers age 60 or older with services identical to the Ohio Home Care Waiver. The benefit package for the redesigned Ohio Home

Care and Transitions Carve-Out waivers includes all existing services, except for nutritional consultation and social work/counseling. No programmatic changes were made to the Transitions MRDD Waiver.

The **Pre-Admission Screening System Providing Options and Resources Today (PASSPORT) Waiver** is a limited-enrollment, cost-capped program administered by the ODA through the local Area Agencies on Aging (AAAs).[56] To be eligible for PASSPORT, participants must be 60 or older, eligible for Medicaid institutional care, require a nursing home level of care, and able to remain safely at home with the consent of their physician. The waiver covers the following services:

- Adult day care;
- Chore service;
- Emergency response systems;
- Home delivered meals;
- Homemaker services;
- Home medical equipment and supplies;
- Independent living assistance;
- Minor home modifications;
- Nutrition consultation;
- Personal care services;
- Social work and counseling; and
- Medical transportation.

The **Choices Waiver** has the same eligibility criteria, service package and cost-cap as the PASSPORT Waiver. However, the Choices Waiver allows the participant to become the employer of record and hire service providers, including friends, neighbors and relatives to provide community-based care. The Choices Waiver is only available in central and southern Ohio.

The **Assisted Living Waiver** pays for care in an assisted living facility with the individual responsible for the cost of room and board. The waiver is open to individuals residing in a nursing facility or who are enrolled in a home and community-based waiver program. Additionally, participants must be financially eligible for Medicaid and require a nursing facility

[56] Area Agencies on Aging (AAAs) were created by the Older Americans Act of 1965 to respond to the needs of the elderly in the communities they serve. Ohio has 12 AAAs, each serving a multi-county planning and service area. PASSPORT Administrative Agencies are responsible for the day-to-day operations of Ohio's PASSPORT waiver. There are 13 PASSPORT administrative agencies in Ohio, which for the most part are the AAAs. In Champaign, Darke, Logan, Miami, Preble, and Shelby Counties, Catholic Social Services of the Miami Valley administers PASSPORT.

level of care. Participants can select any participating licensed assisted living provider. Enrollment is capped at 200 individuals and costs are capped at 70 percent of nursing facility costs.

The **Level 1 Waiver** was designed for individuals with mental retardation and/or developmental disabilities (MRDD) who live in family homes and receive voluntary family support, including those with aging caregivers. As of June 30, 2006, there were 3,692 people enrolled in this wavier and approximately 2,000 on waiting lists for enrollment.

The **IO Waiver** provides community-based services to MRDD individuals who, without such services, would require care at an ICF/MR. On June 30, 2006, there were 11,849 people enrolled in the IO Waiver. There are about 24,000 people on the waiting list, which is maintained at the county level and monitored by ODMRDD. The waiting list has grown because ODMRDD has added only 6,501 slots to the waiver over the past four years.

Ohio is working on a new waiver, the ICF/MR Conversion Waiver that will be administered by ODMRDD. The ICF/MR Conversion Waiver will allow ICF/MR facilities to convert all of their beds to community-based services. Participation in the waiver is voluntary and limited to 200 beds during the pilot period. ODMRDD will send the waiver application to CMS by the end of CY 2006. According to ODMRDD, one of the program's benefits for the consumer is that it allows individuals to keep more of their income and receive other public assistance.

Members of the Ohio Health Care Association expressed concerns about the new ICF/MR Conversion Waiver. In particular, members were concerned that the waiver would be fully implemented without a trial period to ensure that the waiver is working properly. Because ICF/MR residents a highly dependent on caregivers for basic needs, members are concerned that major changes to the program without a pilot period might endanger residents. A member said, "Let's develop the waiver program first and make sure it's working before we get rid of the ICF/MRs benefit." Another member expressed it as a "Gee, let's just try it and see what happens" attitude at the State level and asked "what happens when you're talking about 5,700 individuals' lives at stake here?"

In terms of Ohio's use of waivers in providing services for those with mental retardation and developmental disabilities, one stakeholder noted that waivers have made Medicaid in the MRDD system more creative and beneficial. The stakeholder noted that the challenge remains in fully adapting the institutional model to community-based care.

A member of the Ohio Job and Family Services Directors' Association discussed one barrier to implementing waiver services in Ohio noting that many states regularly seek waivers but Ohio Health Plans does not seem eager to pursue waivers. The member said,

> "It [seems that it is] some kind of monumental task to change the state plan. …The status quo isn't good here. Let's move forward. …[We] very rarely see a waiver generated from ODJFS. Most of the waivers have been generated from local systems or from the other departments that are in Medicaid, like MRDD and ADAMH…. …There aren't enough people that are looking at the big picture and willing to change things to make them work better."

In terms of the current waivers in place in Ohio, there were concerns expressed about the manner in which they are implemented. (See **organizational issues** section for further discussion of compliance issues related to these programs). A member of Arc of Ohio described, at length, the problems with the Individual Options waiver in Ohio. First and foremost, the member explained that there is no state-wide waiting list saying, "if you are on a MRDD waiver waiting list, you're on 88 different waiting lists." Counties that have limited financial resources may not ask for waiver slots, even though there may be a waiting list in the county. As a result, the process violates CMS' requirement for state-wideness. The member also related instances where appeal processes do not generate waiver slots or the process for being accepted into the Individual Options waiver is subjective and differs from county to county. Overall, the member felt that recipients in metropolitan counties were much more likely to be accepted into the waiver program than those in rural counties. The member concluded by saying, I don't know how you're going to overcome [the lack of state-wideness] unless the State resumes its responsibility for providing the match." A member of the Ohio Provider Resource Association had similar comments noting that waiver slots are not being requested by the counties and that the Individual Options waiver slots are based on county requests rather than the number of individuals waiting for waiver slots. According to the member, several Level 1 waiver slots were "returned" to the federal government. Furthermore, counties are unwilling to participate in the waiver program, the member remarked, which leads to a highly disproportionate distribution of available services.

Finally, a parent of a child in the Individual Options waiver program discussed the documentation requirements for the program and the difficulty in meeting documentation requirements because of the high volume of information required. The stakeholder, participating as a member of the Ohio Developmental Disabilities Council, explained that she had to fill out records – birth records and educational histories – for all of her children as a component of the waiver application process. Similarly, she had to go through the process of having each individual in her family denied for SSI before her child could be considered for the waiver program. Upon re-determination, the member noted that the amount of paperwork had been reduced but still wondered how a person of limited education or who had cognitive impairments could comply with the requirements.

Types of Waivers

Section 1115 Demonstration Waivers provide states with broad flexibility to test policy innovations to further the objectives of the Medicaid program. These waivers are intended to implement and evaluate a policy or approach that has not been demonstrated on a widespread

basis. Section 1115 waivers are generally approved to operate for five years, and states may submit renewal requests to continue the project for additional periods of time. Section 1115 waiver demonstrations must be "budget neutral" over the life of the project, meaning the waiver cannot cost more than the Medicaid program would cost without the waiver.

Under waivers, states can change eligibility, benefits, and cost-sharing in ways that do not meet federal standards and still receive federal matching funds. A state does not need a waiver to expand Medicaid to children, parents of dependent children, pregnant women, or elderly or disabled people; it can do so under regular program options. However, waivers are needed to:

- Cap enrollment in Medicaid;
- Reduce benefits or increase premiums or cost sharing beyond federal standards;
- Provide Medicaid coverage to adults without dependent children who are not elderly, disabled, or pregnant; and
- Cover groups other than uninsured children using SCHIP funds.

In 1982, Arizona became the first state to use an 1115 demonstration waiver for managed care. During the 1990s additional states used the 1115 demonstration waiver to test whether managed care worked well for enrollees and led to cost savings. The CMS website provides a list of 1115 demonstration waivers by state and date originally approved. Many states began the greater use of Medicaid managed care for the delivery of care and expanded coverage to previously uninsured populations including childless adults. Some states, like Oregon and Tennessee (discussed later in the section), used savings from implementing managed care to expand Medicaid coverage, a process that met with mixed results. The 1115 waivers were accompanied by formal evaluations that paved the way for legislative changes that gave states the option to implement certain managed care arrangements without seeking a waiver.

In 2001, the Health Insurance Flexibility and Accountability (HIFA) waiver was introduced. This Section 1115 waiver encouraged states to expand coverage within existing resources and offered states increased waiver flexibility. The goal of the HIFA waiver is to encourage innovation and improvement in how Medicaid and SCHIP funds are used to increase health insurance coverage for low-income individuals by giving states the programmatic flexibility required to support approaches that increase private health insurance coverage options. At the time HIFA was developed, states began facing fiscal problems. The Kaiser Commission on Medicaid and the Uninsured suggests that the combination of flexibility and increasing fiscal pressures led some states to use waivers as tools to reduce program spending rather than to expand coverage.

Section 1915(b) Managed Care/Freedom of Choice Waivers allows states to create a managed care program or create a "carve out" delivery system for specialty care. These waivers are not necessarily statewide waiver programs and cannot be used to expand eligibility to those individuals who are not eligible under the approved Medicaid state plan. Moreover, a Section

1915(b) waiver cannot negatively impact beneficiary access, quality of care services, and cannot cost more than the Medicaid program would have cost without the waiver. A 1915(b) waiver does not have the same evaluation requirements associated with Section 1115 waivers; however, there is an independent assessment for the first two waiver periods. The Balanced Budget Act of 1997 permitted states to require most Medicaid beneficiaries to enroll in managed care plans without obtaining a section 1915(b) waiver.

The Deficit Reduction Act of 2005 (DRA) will also impact state Medicaid programs as it includes additional spending for home and community-based services for the elderly and disabled by allowing states to offer these services as an optional benefit instead of requiring a waiver. However, unlike other optional services, states would be able to cap the number of people eligible for services.

Several states are recognized as having developed innovative alternatives to state plan requirements and have achieved CMS approval to pilot these approaches within their states. Those discussed below include Arizona, Oregon, Tennessee, Vermont, Florida, Iowa, South Carolina, and Kentucky. In many instances, these states, like Ohio, were facing budgetary pressures that required alternative approaches to providing health care to the indigent and medically needy within their states. In other cases, opportunities to expand services to previously uninsured populations were identified and financed through changes in financing structures and reimbursement systems.

Arizona

Arizona's Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS), was created to defray the cost of indigent health care. Arizona's Medicaid program has operated under an 1115 Research and Demonstration Waiver since 1982 when the original waiver was granted by the Centers for Medicare and Medicaid services (CMS). At that time, Arizona became the first statewide Medicaid managed care system in the nation.[57] The 1115 Waiver allows the state to operate a statewide, managed care system and to require all Medicaid eligibles to enroll in a contracted health plan.

Long-term care in Arizona is also provided under a capitated system. Like the acute care program managed through the 1115 waiver, the Arizona Long-Term Care System provides community-based placements and support services in lieu of institutional care for the elderly, physically disabled, and developmentally disabled populations. Long-term care services are coordinated by managed care organizations. The demonstration project provides services to the following waiver populations:

[57] Arizona implemented Medicaid under managed care and has not operated a fee-for-service system for most populations.

- The Arizona Long-Term Care System provides coverage to individuals over the age of 65 who are aged, blind, or disabled and need ongoing services at the nursing facility level of care, but do not have to be in a nursing home. Services can be provided to individuals whose income does not exceed 300 percent of the Supplemental Security Income federal benefit rate.

- The Title XIX Waiver provides coverage to non-categorically linked individuals with adjusted net countable income at or below 100 percent of the federal poverty level ($817 per month for an individual in 2006) who are not otherwise eligible for Medicaid.

- Medical Expense Deduction provides coverage to individuals who do not qualify for other Arizona Medicaid programs because their income is too high. However, if these individuals have medical expenses that reduce their quarterly income to 40 percent of the federal poverty level, they qualify for Medical Expense Deduction.

- Health Insurance Flexibility and Accountability I provides coverage to childless single adults and childless couples over the age of 18 with income between 40 percent and 100 percent of the federal poverty level.

- Health Insurance Flexibility and Accountability II provides coverage to eligible parents of KidsCare and/or Sixth Omnibus Budget Reconciliation Act[58] eligible children with income between 100 percent and 200 percent of the federal poverty level.

Oregon

In 1993, the Oregon 1115 waiver, the Oregon Health Plan, became the first statewide waiver approved by CMS (then HCFA) in over a decade. The waiver sought to achieve more universal coverage through both public and private insurance initiatives while simultaneously restructuring health benefits and health care delivery to enhance efficiency and stretch the available resources to expand coverage. The Medicaid component of the Oregon Health Plan aimed to expand coverage to all Oregonians below the poverty level with savings generated both by instituting managed care for almost all beneficiaries and by designing the benefit package to use a priority list to define conditions and covered treatment pairs. For additional information on the Oregon priority list see the **organizational issues** section.

[58] In 1986, the Consolidated Omnibus Budget Reconciliation Act (COBRA) and Sixth Omnibus Budget Reconciliation Act (SOBRA) included a variety of changes in Medicaid and Medicare. Among the changes were significant expansions in Medicaid eligibility for children and pregnant women.

A study conducted in 1999 by the Kaiser Commission for Medicaid and the Uninsured found that the initial transition to the Oregon Health Plan occurred with relatively little disruption of health care and administrative systems due to the generous time frame for plan implementation, the existing base of managed care plans for both the Medicaid and the commercial populations, the consensual style of decision making, and the initial focus on transitioning only those eligible for Medicaid because of low-income.

Since the Oregon waiver was first implemented, several amendments have been made to the 1115 waiver. In 2002, the Oregon Health Plan was amended to allow the state to reduce costs by reducing coverage and capping enrollment for existing Medicaid beneficiaries. Under the amended waiver, the population served by the Medicaid program changed. The amendment allows Oregon to use SCHIP funds to expand Medicaid eligibility to some children and adults and to refinance and expand a state-funded premium assistance program. The amended program, Oregon Health Plan 2, has the following categories of coverage:

- Oregon Health Plan Plus provides service to most previously eligible beneficiaries and newly eligible children and pregnant women, with incomes between 170 and 185 percent of the federal poverty level. There are no premiums, but some beneficiaries are required to make co-payments.

- Oregon Health Plan Standard provides service to some previously eligible parents and other adults with income below poverty. Under the waiver, the state gained authority to increase eligibility, cap enrollment, increase premiums and cost sharing, and reduce benefits to this group. To date, the state has not expanded eligibility and enrollment is closed; however, benefits for Oregon Health Plan Standard beneficiaries were reduced and the state gained authority to further reduce benefits without CMS approval.

- Federal Health Insurance Assistance Program subsidizes the purchase of employer sponsored insurance and non-group insurance. This program was refinanced with SCHIP and Medicaid funding. Subsidized insurance must meet or exceed a benchmark based on an evaluation of benefits and cost sharing found in the state's small group insurance market. The state may make changes to the benefit and cost sharing benchmarks without CMS approval, so long as the benchmark equals or exceeds a level actuarially equivalent to federally mandated Medicaid benefits.

The Oregon Health Plan has faced several challenges. According to the Kaiser Commission on Medicaid and the Uninsured, both fiscal constraints and a conservative political climate in the state have limited Oregon's ability to meet its broader coverage objectives. Moreover, total enrollment in the Medicaid program has stagnated; for the five years following 1994, total enrollment in the Oregon Health Plan decreased both in the number of new eligibles and in the traditional Medicaid eligibles. In 1995, Oregon implemented premium contribution

requirements. Individuals who miss premium contributions are disenrolled after six months and must repay their accumulated premiums, up to 36 months, before they can re-enroll. The managed care plans expressed concern that individuals are only paying premiums when care is urgently needed, which limits the ability of the health plan to spread the enrollees' risk out over time. Furthermore, it limits the ability to manage care and provide preventive services.

Tennessee

Tennessee essentially replaced its Medicaid program on January 1, 1994 when it created a new health care reform program, TennCare. A managed care model, TennCare extended coverage to uninsured and uninsurable persons who were not eligible for Medicaid, covering 1.3 million people (25 percent of the Tennessee population). The original waiver expanded coverage for children and adults and placed all beneficiaries in a managed care system. All enrollees were given the same benefits, and some with income above the federal poverty level were required to pay premiums and participate in cost sharing. Due to budget constraints, eligibility was scaled back and enrollment was closed to some groups. TennCare was amended on March 24, 2005 to allow the state to disenroll 323,000 individuals in optional and expansion groups, including uninsured adults below 100 percent of the federal poverty level, adults over the age of 19 who have medical conditions that make them uninsurable, and adults who have Medicare and who have met the criteria for Medicaid, but are uninsurable. On June 8, 2005 Tennessee was granted an amendment to limit or eliminate certain optional pharmacy and non-pharmacy benefits for both Medicaid eligible individuals and expansion groups. Subsequently, pharmacy, over-the-counter, methadone clinic, and dental care were eliminated for most adults over the age of 21. Additionally, co-payments were imposed on brand name drugs and the state limited the authority to provide substance abuse services.

Vermont

In September 2005, Vermont implemented a Section 1115 waiver, the Global Commitment Waiver, to restructure its Medicaid program. The waiver places a cap on the amount of federal Medicaid funding Vermont can use to provide acute care services to the Medicaid population.

The Global Commitment Waiver makes Vermont the only state receiving, by mutual agreement, a fixed dollar limit on the amount of federal funding available for its Medicaid program. In limiting the amount of federal funds to a fixed amount, the waiver provides Vermont with substantial flexibility in using the funds. The goals of the Global Commitment Waiver are to provide Vermont with financial and programmatic flexibility in order to maintain broad public health care coverage and provide more effective services; explore new ways to reduce the number of uninsured; and foster innovation by focusing on health care outcomes. The Vermont waiver shares some characteristics of a block grant - capped federal funding, cost sharing, and

entitlement to coverage for many beneficiaries. The key elements of the Global Commitment Waiver are as follows:

- Imposes a global cap that limits the federal Medicaid matching funds the state can draw down for 2006 through 2010 to $4.7 billion. The cap is in contrast to the traditional Medicaid financing structure that provides states with guaranteed federal Medicaid matching funds for all Medicaid services without limit and the budget neutrality requirement.

- Allows Vermont to act as a managed care company. As such, the state will pay itself a premium for each beneficiary served. If Vermont is able to deliver care for less than the premium revenue, it can use the excess revenue for a broad array of purposes.

- Gives Vermont the option of using Medicaid funds for non-Medicaid health programs. Moreover, the state can use its "excess" premium healthcare revenue to replace some of its own spending on other state-funded health care initiatives. As of April 2006, Vermont identified 50 programs for which it could replace some state funds with federal Medicaid matching funds, including tobacco cessation programs and domestic violence initiatives.

- Provides Vermont with flexibility to reduce benefits, increase cost sharing, and limit enrollment for most of the optional and expansion populations in the state (i.e. children and parents in low-income working families and all other adults who are not disabled or elderly covered by the Medicaid program). The waiver gives the state authority to decide if and when it will impose benefit reductions or cost sharing increases.

Before Vermont adopted the Global Commitment Waiver, much of its Medicaid program operated under a Medicaid waiver known as the Vermont Health Access Program (VHAP) that provided coverage to three groups: the mandatory population (individuals for whom the state is required to provide coverage); the optional population (children in low-income working families and parents with income above mandatory coverage); and the expansion population (primarily non-disabled childless adults under the age of 65 with income below 18 percent of the federal poverty level).

The Global Commitment Waiver changes the means by which Vermont finances its health care system. By capping federal funding, financial risk transfers to the state. Initially, the Global Commitment Waiver offers Vermont fiscal relief; it is estimated that without the implementation of the Global Commitment Waiver, Vermont would face a $60 million funding shortfall in SFY 2006-07. In the long run, if the cost of providing Medicaid exceeds the federal cost cap, Vermont would have to choose between cutting back on Medicaid coverage, reducing the use of Medicaid funds for non-Medicaid health initiatives, or using 100 percent state funds to cover additional costs.

The Kaiser Commission notes that widespread use of the Global Commitment waiver is not practical in all states because the same type of funding may not be available to other states under this waiver. Before the implementation of the Global Commitment Waiver, Vermont already provided Medicaid coverage to one in four of its citizens and a third of its children. Compared to other states, Vermont already provided coverage to a substantial share of the population, meaning Vermont is less likely to see a significant increase in enrollment or reach its federal funding cap.

Florida

Florida gained approval of a Section 1115 waiver on October 19, 2005 to make fundamental changes to its Medicaid program. As of December 2005, the Florida Medicaid program was the country's fourth largest program in terms of enrollment and ranked fifth in spending.[59] Prior to the implementation of the waiver, Florida operated as a defined benefit program under which beneficiaries were guaranteed a set of benefits established by the state within federal guidelines where Medicaid eligibles receive care from private providers through fee-for-service or capitated arrangements. Under the waiver, Florida seeks to increase the number of individuals in capitated or premium-based managed care programs and reduce the number of individuals in fee-for-service programs. As such, Florida will create a new Medicaid program that recognizes the individual's role in planning and purchasing health care services, provides transparency in the performance of health care plans and providers, assures access to quality service, provides stability to Florida budgeting, reduces confusion about coverage, and leverages the dollars spent to measurably improve service and invest in prevention. According to the Florida Waiver Request, the new Medicaid system will rely on the measurement of, and transparency in, outcomes.

Under Medicaid reform, the state's role will change from being a centralized decision maker that creates and manages health care services to that of a purchaser of health care services responsible for ensuring the systems of care delivery meet higher standards and follow the rules for ensuring the delivery of services. The state of Florida will contract with an independent choice counselor to ensure that enrollees are provided with full and complete information about managed care plan choices and the ability to opt out of Medicaid. Managed care plans will have the ability to create customized packages to meet the needs of specific Medicaid groups. Individuals with access to employer sponsored insurance will be able to "opt out" of Medicaid at the time of eligibility determination or any time they are offered access to an employee sponsored insurance plan. The authors of the waiver proposal believe this choice will help bridge the gap to independence by providing individuals with a subsidy to move to private health insurance coverage.

[59] The top ten highest states for 2004 Medicaid expenditures are, in order, New York (3), California (1), Texas (2), Pennsylvania (6), Florida (4), Ohio (7), Illinois (5), Georgia (10), Michigan (8), Massachusetts (13). (The number following the state name indicates the state's rank in population based on 2002 estimates)

In order to pay for the Medicaid reform program, Florida will move to a premium-based system. In this model the state will set aside a specific amount of money for each person enrolled in Medicaid. Under Medicaid reform, cost-sharing requirements consistent with the currently approved nominal levels in the State plan may be imposed by managed care plans. Florida will also establish a maximum benefit limit similar to what already exists in private insurance, and enhanced benefit accounts will provide incentives to Medicaid reform enrollees for healthy behaviors. For instance, if a person with diabetes, asthma, or heart disease participates in a disease management program, he or she could earn an incentive and have funds deposited into an enhanced benefits account. These funds may be used to purchase non-covered health-care-related items, such as over-the-counter pharmaceuticals or vitamins.

The waiver was initially implemented on July 1, 2006 as a pilot in Duval and Broward counties and requires participation of non-institutionalized elderly and disabled adults and children receiving Supplemental Security Income, excluding those of Medicare; parents and pregnant women with incomes below 23 percent of the federal poverty level or about $300 per month for a family of three; and children aged 0-1 under 200 percent of the federal poverty level, age 1-6 under 133 percent of the federal poverty level, and age 6-21 under 100 percent of the federal poverty level. Individuals who are excluded from mandatory participation during the initial phase may voluntarily participate in Medicaid reform. The state estimates that by June 2007, 212,189 people in Broward and Duval counties will be enrolled in new plans under the waiver, representing about 9 percent of Florida's Medicaid beneficiaries. By June 2007, three additional counties, Baker, Clay, and Nassau, will be included in the Medicaid reform model.

The state believes the flexibility in benefit design will result in competition-inspired innovation and efficiency that will increase individual access to care. Each plan will face the competitive pressure of offering the richest possible package within the confines of the premium offered by the state. As each plan better manages the higher-cost services and shifts to outpatient options allowed by advances in medicine, it will likely shift its benefit offerings. At all times, the state is to ensure that services like inpatient hospitalization are available at an actuarially appropriate level based upon the utilization patterns of recipients.

Iowa

Effective June 2005, CMS ruled that Iowa would no longer be permitted to use the state's intergovernmental transfers funding source as a Medicaid funding mechanism. As a result, it was projected that Iowa would lose $65 million in federal resources for its Medicaid program and would face significant reductions in services to its most vulnerable population. Coupled with the loss of revenue to fund Medicaid, a report made by a legislative committee to the Iowa Legislature predicted a continued increase in enrollment because of limited job opportunities and declining private insurance within the state. As a result, the state applied for a Section 1115 demonstration project to change several parameters of the state plan.

On June 30, 2005, CMS approved a waiver to allow Iowa to provide health care insurance coverage to uninsured Iowans, eliminate Medicaid financing arrangements whereby providers do not retain 100 percent of claimed expenditures, provide home and community-based services to children with chronic mental illness, and move toward community-based settings for delivering state mental health programs. The waiver will do the following:

- Provide a limited set of Medicaid benefits to adults aged 19 through 64 using a provider network of specified hospitals. Enrollees will pay monthly premiums not to exceed 5 percent of annual family income.

- Incorporate home and community-based services for children diagnosed with chronic illness so they do not have to be institutionalized.

- Cease financing arrangements that improperly utilize intergovernmental transfers.

- Implement the Mental Health Transformation Pilot that will allow the state to move from an institutional-based program model to a managed care and/or community-based care program for individuals with long-term psychiatric stays.

South Carolina

Due to rising healthcare costs, South Carolina submitted an 1115 waiver request to CMS on June 15, 2005.[60] If approved, the waiver would allow South Carolina to implement an innovative health care delivery system. The Medicaid reform plan is consumer centered; South Carolina recognizes that third party payment systems insulate consumers from the full cost of service and can cause beneficiaries to undervalue and over utilize services. As such, the state seeks to shift the balance of economic demand back to the patient by providing Medicaid eligibles with more financial control and more access to pricing and health education.

South Carolina's Medicaid reform plan creates a competitive environment by allowing plans and networks to compete directly for the consumer's business. A competitive environment is expected to foster innovation, thereby creating plans that move from the one-size-fits-all approach to those that better meet the needs of the consumer.

Furthermore, the creation of an integrated delivery system will contribute to providing effective coordination of care. The Medical Homes Network Program is a physician driven service delivery system designed for Medicaid recipients. Beneficiaries who choose to enroll in this program agree to use their primary care physician for medical needs, providing them with

[60] As of July 2006, the CMS website listed South Carolina's Healthy Connections 1115 proposal as pending.

coordinated medical services. Additionally, the program is expected to reduce beneficiaries' trips to the emergency room and hospitalizations due to enhanced primary care.

A fourth tenet of the proposed Medicaid reform plan limits unnecessary administrative costs. The South Carolina waiver proposal notes that nationally, over twenty cents of each healthcare dollar is spent on administrative costs. Excessive administrative costs drain limited resources that could be otherwise used to improve services or productivity. South Carolina proposes leveraging technology and existing administrative capacity in the marketplace to reduce the administrative burden created by the current fee-for-service system and refocus on quality.

In order to implement the above elements, South Carolina will increase consumer and provider participation in the Medicaid program. Currently, Medicaid beneficiaries can take advantage of covered Medicaid services by going to a provider who agrees to serve them. Except for the very limited participation in Managed Care Organizations in South Carolina, providers do not market to beneficiaries. Under the reform program, this would change. The Medicaid reform proposal allows beneficiaries to shop from approved plans and select the plan that best meets their coverage needs. Beneficiary choice will bring competitive pressure to the plans that are allowed to market to beneficiaries through the state. Plan options will range along a continuum of prepaid health plans to primary care case management networks.

The Medicaid reform plan will provide Medicaid eligible consumers with a Personal Health Account (PHA) that will be administered by the state. The PHA is a tool that will vest the beneficiary with buying power and ownership responsibilities. Most enrollees will have their own account funded with amounts sufficient to purchase healthcare coverage from State approved plans and networks and will be funded with an amount sufficient to purchase healthcare coverage from state approved plans and networks. The account will be funded periodically with an actuarially determined amount based on current fee-for-service expenses and will be risk adjusted.

Qualified Medicaid beneficiaries are also given the opportunity to opt-out if they have access to group health insurance through an employer (Medicaid will pay the premium, up to the amount the individual would have received in his or her PHA) or by choosing a self-directed plan (the PHA can be used to pay for a major medical insurance plan). The South Carolina waiver proposal classifies the state agency in the role of an employer by providing a description of the desired plan and contribution of funds for coverage in the typical insurance-based model of healthcare.

Unlike some of the other Medicaid reform plans, the South Carolina plan limits expansion to other uninsured family members that are enrolled in employer group plans as part of family coverage, but are otherwise ineligible for Medicaid on their own. (e.g., a family in which the children, not the parents, qualify for Medicaid. The parents would be considered the expansion

population.) Expansion is also extended to recipients who lose eligibility due to a change in circumstances but have a balance in their PHA. These individuals remain eligible for a period of 12 months or until the PHA funds are exhausted, whichever occurs first.

Kentucky

Kentucky Health Choices, an 1115 waiver demonstration, was approved by CMS in May 2006 and will impact most of Kentucky's 700,000 Medicaid beneficiaries. Kentucky is the first state to receive approval for a statewide plan to move beneficiaries to managed care plans under the new DRA rules. The waiver enables Kentucky to stretch its resources to meet the needs of recipients and encourage individuals eligible for Medicaid to be personally responsible for their own health care. In order to achieve this goal, the Kentucky Medicaid reform plan includes better integration of the provision of care and the use of best practices for the improved coordination of mental health, mental retardation/developmental disabilities, substance abuse, and physical health services.

The Health Choices Proposal indicates the need for Medicaid reform within the state of Kentucky. Statistically, Kentucky has one of the highest percentages of residents living below the poverty line and ranks 47th in the nation in median household income. Considered one of the least healthy states in the nation, Kentucky ranks at or near the top of all states in cancer and cardiovascular deaths (per 100,000 residents) and ranks second in overall mortality. The need for medical support coupled with a $425 million Medicaid budget deficit evidence the necessity for Medicaid reform.

In reforming Medicaid, Kentucky centered its efforts on the following four principles:

- Quality and prevention;
- Consumer empowerment and choice;
- Personal responsibility; and
- Community solutions.

Medicaid reform is centered on tailored benefit packages for specific populations to meet basic medical and rehabilitative needs. Most individuals enrolled in the Medicaid reform program will be required to pay co-payments and premiums. Co-payments will be based on income and will typically range from $1 to $10; the maximum out-of-pocket cost per beneficiary per year is $225 for health care services and $225 for prescriptions. However, preventive services will not require a co-payment because the state wants to encourage wellness and decrease dependency on acute services. Further plans to increase the efficient use of Medicaid dollars include limiting Medicaid eligibles to four prescription drugs per month with a maximum of three of those drugs being brand-name drugs.

The Kentucky reform model will include consumer-directed options for non-medical services to the Medicaid population because research has shown that consumers are more satisfied with their lives and their support services when they control their own personal assistance services. Support brokerage will be required for all persons participating in the consumer-directed option to provide consumers with information necessary to make informed choices regarding care planning and a variety of support services. Get Healthy Accounts will allow individual members who have specific targeted diseases to earn funds by participating in certain healthy practices. Initially, the program will be limited to individuals with pulmonary disease, diabetes, and cardiac conditions; however, more disease conditions may be added in the future. As individuals with Medicaid earn access to incentives, funds will be deposited into their accounts and may be used to offset healthcare related costs.

To ensure that Kentucky Medicaid is the payer of last resort, the Medicaid reform plan establishes a program for members with access to private insurance coverage that requires them to enroll in the Health Insurance Purchasing Program. Medicaid will pay private insurance premiums and wrap around the commercial coverage with Medicaid services.

Opportunities for Ohio to improve its current waivers or to seek additional waivers were discussed by a number of stakeholders. A member of the Ohio Advocates for Mental Health suggested that the carve-out might not be the best option for mental health services in Ohio. The member noted that Florida had a variety of plans (which included behavioral health) – a self-directed care plan, a traditional Medicaid plan, and managed care plans. A member of the Ohio Coalition for Health Communities described the need for waivers in the mental health system to allow recipients access to residential treatment facilities. A Medicaid option for individuals with traumatic brain injuries was suggested by a member of the Ohio Developmental Disabilities Council. The member said, "We don't have a Medicaid waiver that covers that population. …Those people … just fall between the cracks…. They are the largest growing disability population in the United States….. The member went on to explain, "They don't qualify for existing waivers or the existing waivers aren't structured in a way to meet their needs." and concluded by recommending Ohio examine a program for traumatic brain injury patients in Michigan.

A member of the Arc of Ohio recommended condensing the existing MRDD system waivers into a single program that would be capped by a recipient's needs rather than an arbitrarily pre-determined level. The member felt that waiver program treatment plans would be more successful if developed by an interdisciplinary team in conjunction with the individual and their family. Because of the limited number of waiver slots, the member explained that, "Right now we have people on waiting lists for multiple different waivers. I've gotten to the point where I have told folks, "If you can find a waiting list, get on it for anything and everything because who knows, you may need it some day."

According to the former deputy director, Ohio's Medicaid program is not innovative, but manages the system well given the legislative and industry environments in which it operates. However, Ohio lags other states in accessing opportunities to implement programs that stray from the traditional or tried and true medical health services programs. Although several of the examples provided above are too new to have yielded program evaluation results, they demonstrate the wide range of options being implemented in other states and the level of innovation being achieved. Ohio has the knowledge, experience, and resources to develop similarly pioneering programs through OHP, the sub-recipient agencies, its universities, and providers. Through the implementation of groundbreaking programs, the State Medicaid Agency could, in the future, cover additional populations or services, improve the health of poor and disabled Ohioans, create cost savings for the State, or achieve other notable results within the Medicaid program.

R4.19 The State Medicaid Agency should, with the assistance of the subrecipient agencies and stakeholders, identify potential programs, services or populations that would benefit from a 1115 or 1915(b) waiver. The State Medicaid Agency should actively pursue pioneering approaches, similar to those highlighted above, to improve services to existing recipients and expand coverage. Although the aforementioned programs are new and therefore have not been evaluated, they clearly show the level of innovation being considered by other states. As stakeholder organizations expressed familiarity with the range of demonstration projects in other states, the State Medicaid Agency should use their expertise to identify appropriate waivers for trial in Ohio.

The Agency should use limited populations to pilot the projects but should ensure that throughout the duration of the initial waiver, appropriate input, output and outcome data is maintained so that the efficacy and cost effectiveness of the program can be determined. Any future renewals or expansions of current or future waivers should be based on results supported by data collected during the trial period.

Consumer Directed Programs

Traditionally, public assistance programs that finance personal care services follow the vendor payment model where the program purchases services for consumers from an authorized vendor (i.e., service providers or equipment suppliers). Cash allowance programs are not typically used as the medium to deliver personal care services. However, Cash and Counseling is an 1115 Medicaid demonstration aimed at building "a nation where every state will allow and even promote a participant-directed individualized budget option for Medicaid-funded personal assistance services."[61] Cash and Counseling improves the consumer's ability to control personal care services and satisfaction with such services without increasing Medicaid costs.

Cash and Counseling provides a flexible monthly allowance to recipients of Medicaid who are given the authority to make their own choices about their personal care services or home and community-based services. This program is designed to allow beneficiaries to receive services that address their specific needs because the beneficiary, rather than the agency, decides who to hire and what services he or she will receive. Beneficiaries also have the option of using their budget to purchase labor saving devices or to make home modifications to help them live independently. Cash and Counseling programs authorize the beneficiary to hire a family member or friend as his or her personal care worker. States are given the option of allowing beneficiaries to hire a legally liable relative like a spouse or the parent of a minor. New Jersey exercised the option of allowing beneficiaries to hire a legally liable relative, similar to Ohio's Choices waiver administered by ODA.

Cash and Counseling originated in the 1960's independent living movement in which disability rights advocates argued that individuals, if equipped with adequate funding, were better at organizing their own services than agencies contracting with state and local governments to provide care. These advocates wanted beneficiaries to control the personal care services necessary for daily living.

The Independence Plus initiative was created in response to the concern that complex Medicaid laws present barriers to promoting self-directed programs. The initiative is designed as a means of simplifying the process for states to establish or amend home and community-based services. Moreover, the Independence Plus Initiative gives states expanded opportunities within Medicaid for consumer direction of long-term services and supports. Like Cash and Counseling, the Independence Plus Initiative provides beneficiaries with an individual budget (i.e., a voucher) to manage a broad range of services, including a number of professional and home and community-based services. The Initiative may be implemented by using either the section 1115 or 1915(c) waiver and builds on the Cash and Counseling Demonstration program. The Independence Plus Initiative impacts targeted populations needing an institutional level of care, including the

[61] Quote taken from Cash & Counseling National Program Office.

elderly, adults with physical disabilities, and children and adults with mental retardation and developmental disabilities.

The 2005 Deficit Reduction Act creates opportunities for states to re-focus their Medicaid long-term service delivery system toward greater community orientation; Cash and Counseling programs provide cost-effective and desirable services for the aged and disabled populations. The Kaiser Commission for Medicaid and the Uninsured notes that under the Deficit Reduction Act, states are allowed to permit self-direction of personal assistance services without needing to get a waiver. The Deficit Reduction Act requires that safeguards are included to protect the health and welfare of participants and to ensure financial accountability for funds. However, comparability and state-wideness are not required.

Ohio does not have a Cash and Counseling program or an Independence Plus program. However, ODA administers the 1915(c) Choices Waiver, although this waiver is not statewide. To be eligible for Choices, an individual must first be on the PASSPORT Waiver. Participants in Choices are assigned a dollar amount for specific waiver services, up to a $1,800 cap, to hire and supervise their own workers and use case manager and payroll agent services. Additionally, HB 66 authorized ODA to implement a pilot program for individuals already in nursing facilities, the PASSPORT, or Ohio Home Care waivers, but did not define the parameters of the program. The pilot program is limited to 200 individuals and is cost capped at 70 percent of the cost of nursing facility care. As of July 2006, ODA and ODJFS were working jointly on developing this waiver, including the specific services offered, with expected implementation in May or June of 2007.

Cash and Counseling

In July 1995, a research and demonstration initiative was jointly funded in three states by the Robert Wood Johnson Foundation and the federal Department of Health and Human Services (through the office of the Assistant Secretary for Planning and Evaluation) to test the outcomes of the Cash and Counseling model. The preliminary demonstration in Arkansas, Florida, and New Jersey ended in 2003. In October 2004, 11 additional states were awarded funds to implement their own Cash and Counseling programs. They include the following:

- Alabama;
- Iowa;
- Kentucky;
- Michigan;
- Minnesota;
- New Mexico;
- Pennsylvania;
- Rhode Island;
- Vermont;
- Washington; and
- West Virginia

Additionally, Illinois received funding from the Retirement Research Foundation to implement a Cash and Counseling program.

The basic outline of a Cash and Counseling waiver stipulates a cash benefit which covers a variety of goods and services be provided in lieu of traditional personal assistance services either under the current Medicaid state plan or under a Medicaid waiver.

Arkansas, Florida, and New Jersey, the original three states to test the Cash and Counseling model in their state environments, did not expect to save money; instead, the states wanted to increase access to care. In all three states, participants in demonstration Cash and Counseling programs were self-selected. Medicaid recipients who met the criteria and were interested in the demonstration were eligible to enroll in the waiver. No Cash and Counseling programs have adopted a formal screening process to exclude those inappropriate for a cash program (save those who did not expect to remain in the community for six months). A New Jersey program review indicates that the Cash and Counseling program staff believes it would be very difficult to identify in advance consumers who are unable to manage the cash benefit by themselves or with help from a representative and fiscal agent.

The Cash and Counseling programs in Arkansas and New Jersey cashed out Medicaid state-plan personal care to elderly adults and non-elderly adults with physical disabilities while the Florida Cash and Counseling program cashed out home-and-community-based waiver services for elderly adults, non-elderly adults with physical disabilities, and children and adults with developmental disabilities. In Arkansas and New Jersey, the amount of the allowance is based on cashing out a consumer's care plan or based upon one's claims history. In Arkansas, beneficiaries receive an average of $350 per month, while in New Jersey the average cash allowance is $1,400 per month. In Florida, elderly adults and adults with physical disabilities are cashed out an average of $975 per month, while children and adults with developmental disabilities receive an average cash allowance of $1,825 per month.

In all states, counselors and fiscal agents are available to assist clients with the decision making and bookkeeping aspects of the Cash and Counseling program. Fees and functions of the counselors and agents are determined on a state-by-state basis. Furthermore, Cash and Counseling programs recommend consumers name a representative to help manage their allowance. A 2003 review of the New Jersey Cash and Counseling program found that approximately two-thirds of participants named a representative. The report also states that sometimes the representative was named per the request of the family, rather than the beneficiary.

Since their initial implementation, the Cash and Counseling waivers in Arkansas, Florida, and New Jersey have expanded. No longer is the randomization of enrollees mandated; at the time of expansion, CMS amended this waiver requirement. **Table 4-21** shows the implementation and expansion dates for the three demonstration programs.

Table 4-21: Original Cash and Counseling Demonstration Programs

State	Cash and Counseling Program	Date Implemented	Date Expanded
Arkansas	Independent Choices	December 1998	2002
Florida	Consumer Directed Care Plus	March 2000	2003
New Jersey	Personal Preference	November 1999	2004

Source: Kaiser Commission on Medicaid and the Uninsured

Individuals and research institutions have expressed some caution as states choose to implement Cash and Counseling programs. A 2003 report released by the Kaiser Commission on Medicaid and the Uninsured cautions that consumer direction and individual budgets may not be appropriate for certain services. The report suggests that federal policy makers consider placing reasonable constraints on services and supports that are appropriate for consumer direction. Defined parameters will also ensure that consumer direction is not used to shift financial risk for the cost of medical care and supportive services to beneficiaries. For instance, the report suggests consumer direction may not work effectively for other services for which the need is unpredictable (i.e., replacing a major piece of medical equipment would cause the costs for an individual's services to be significantly higher than usual).

Representatives of individuals with disabilities, while supportive of the Cash and Counseling program, question the appropriateness of consumer satisfaction as the primary evaluation criteria. They argue that satisfaction could reflect the fact that individuals are able to stretch limited resources further than an agency or reflect satisfaction with the person providing a service, without providing adequate information to assess the level of the individual budget or the quality of services provided. Nevertheless, a majority of the individuals who participate in Cash and Counseling programs are the non-elderly – children and adults with developmental disabilities. In each of the three demonstration states, just 8 to 10 percent of elderly Medicaid recipients took advantage of Cash and Counseling programs. In New Jersey, more than 20 percent of the non-elderly personal care assistance beneficiaries participate in the Cash and Counseling program while the elderly participants represent just over 10 percent of the number of elderly personal care assistance recipients.

Members of the Ohio Chapter of the National Multiple Sclerosis Society explained the current parameters for consumer choice in Ohio. One member remarked how the case manager develops a plan and the consumer then can "react to it" or appeal decisions they do not support. Another member noted that consumer-directed care was permitted except for Medicaid services. In Ohio, they explained, consumer-directed care for disabled individuals is set up on the PASSPORT model and is not a true consumer-directed or Cash and Counseling program.

Policymakers are interested in the long-term implications of Cash and Counseling, particularly in reference to the labor shortage in the home healthcare industry. A 2005 report suggests that relatives receiving compensation for providing personal care services for a family member are apprehensive about caring for a stranger. While there are some concerns surrounding consumer-

directed Cash and Counseling programs, reviews of the three original demonstration states suggest consumers are satisfied with the programs.

Arkansas's Cash and Counseling Program, Independent Choices found that self-directing beneficiaries were more satisfied with their supportive services and reported fewer unmet needs than beneficiaries relying on agency services. Moreover, the individuals receiving care were typically elderly, female beneficiaries with functional impairments, of poor or fair health who relied heavily on informal care from adult daughters. Florida's Cash and Counseling program includes a cash benefit for children with disabilities; this program is attractive to parents of children with developmental disabilities. A greater percentage of children with developmental disabilities enrolled in a Cash and Counseling program than any other population. At the end of the initial waiver period, 25 percent of all enrollees were children with developmental disabilities.

A 2002 review of Arkansas's Independent Choices program cites the ability to hire a family member as the single most attractive feature of the Cash and Counseling program. Hiring a family member as a worker provided consumers with security and peace of mind; they disliked having strangers come into their homes. Under the traditional personal assistance services, some consumers found it demeaning to have intimate personal assistance provided by a stranger or were unable to rely on the aide. On the other hand, beneficiaries of the Cash and Counseling program who lacked family members or friends to serve as workers were not pleased with the program. The Florida Cash and Counseling review recognizes that paying a legally liable individual is a sensitive issue; however, the report suggests parents will rarely even appear to take advantage of the opportunity to be paid. Safeguards, including monitoring when the representative of the beneficiary also serves as the health care worker, act as a check and balance on the system.

A reoccurring concern surrounds the issue of wages being potentially insufficient to attract workers who did not personally know the consumer. The Arkansas program review recognizes the benefit is rather small, but notes that it has the potential to provide a balance between the demands of care giving and work responsibilities.

Participants and caregivers of the Independent Choices program voiced their opinions about the program in a 2005 review. While there was initial concern over the formal training of personal caregivers, 97 percent of beneficiaries surveyed believed their caregiver possessed sufficient knowledge to care for their condition. Likewise, over 95 percent of surveyed paid caregivers believe they were provided with sufficient feedback and were satisfied with their working conditions. The 2003 New Jersey review cited language diversity as an important aspect of its program; non-English speaking consumers have the potential to benefit greatly from hiring workers who speak their languages and who are familiar with their cultures. The Personal Preference program translated program materials into the state's most common languages and

provided information in multiple media to accommodate individuals with vision or hearing impairments.

A 2003 Health Affairs article reports Arkansas' experience is evidence that state can design a Cash and Counseling program that better meets the needs of recipients at no greater cost per month of service than historically incurred under the traditional agency approach. Moreover, if personal care service costs are higher than they would have been as a result of improved access to care or induced demand, they appear to be offset by reduced need for other long-term care services. The Congressional Budget Office estimates that over the next ten years, 60,000 Medicaid beneficiaries will take advantage of self-directed services, 25 percent of whom would not otherwise access Medicaid long-term care services.

Despite concerns about implementing consumer choice, a member of the Ohio Chapter of the National Multiple Sclerosis Society voiced support for a Cash and Counseling program saying, "…I would highly encourage Ohio to apply for one of the "money follows the person" demonstration projects…."

R4.20 The State Medicaid Agency should work with the sub-recipient agencies, specifically ODA and ODMRDD, to develop and implement a Cash and Counseling or Independence Plus program in Ohio. These programs would grant Ohio Medicaid participants greater flexibility and direction over their care. When developing a Cash and Counseling or Independence Plus program, the State Medicaid Agency should review the evaluations of existing programs to ensure successful implementation and utilization. Furthermore, the new waiver currently under development by ODJFS and ODA could serve as a method to pilot these programs before implementing them statewide.

H. Rate Setting Methodology

Rate Methodology

The provision of health care services takes place in a manner unlike the selection and purchase of any other goods or services. Often there are few providers of a particular service at hand and it is very difficult, if not impossible, for the service user to judge the quality of competing goods or services. The decision about which good or service to purchase is usually not made by the consumer of those goods or services, but rather by a physician or clinician. Also, payment to the provider is not normally made by the user of the goods or services, but by a third-party payer.

Regardless of the payer for a particular health care service, only a limited number of payment methods are used to reimburse providers. According to the Association of University Programs of Health Administration, payment methods fall into two broad classifications, fee-for-service

and capitation. In fee-for-service payment methods, of which many variations exist, the greater the amount of service provided, the higher the amount of reimbursement. The three primary fee-for-service methods of reimbursement are: cost-based, charge-based, and prospective payment. [62] Under capitation, a fixed payment is made to providers for each covered life, regardless of the amount of service provided.

ODJFS, through the Office of Ohio Health Plans (OHP), conducts the majority of rate setting activities and administers 85 percent of Ohio's total Medicaid spending. OHP also sets rates for ODA and ODMRDD. Only ODMH and ODADAS have separate rate setting responsibilities. [63] According to the Ohio Commission to Reform Medicaid, ODJFS usually has been successful in managing Medicaid spending within appropriations approved by the Ohio General Assembly. However, the method of determining appropriation levels in the first place, from the executive budget through the deliberations of the General Assembly, to enactment has lacked the discipline of consistency. Additionally, the Ohio Commission to Reform Medicaid indicated that the collective impact of external pressures, combined with decisions of Ohio policy makers over time, have increased Medicaid spending at a rate that exceeds growth in spending for other important State services; and, more importantly, exceeds growth in general revenues produced through taxation. Many of the Commission's recommendations are specifically designed to reduce the rate of growth in Medicaid spending and will require several years to achieve their full impact.

ODJFS does not have a regular process in place for the periodic evaluation of the adequacy of Medicaid service rates or for periodically adjusting them. Thus, the rate adjustments approved in prior years in the budget process have generally been adopted on an ad-hoc basis, usually in response to complaints about limited access to specific services and to provider requests for rate increases. ODJFS has not quantified the cost to the State for its rate setting activities nor has the total cost of litigation over rates been determined.

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[62] Under cost-based reimbursement, the payer agrees to reimburse the provider for the costs incurred in providing services to the insured population. Reimbursement is limited to allowable costs, usually defined as those costs directly related to the provision of healthcare services. When payers pay billed charges, they pay according to the schedule of charge rates established by the provider. In a prospective payment system, the rates paid by payers are determined before the services are provided. Payments are not directly related to either reimbursable costs or billed charges.

[63] ODH does not conduct Medicaid rate setting activities for services. ODH has a relatively minor role in terms of funding within the Medicaid program. ODJFS contracts with ODH to certify skilled nursing facilities, nursing facilities, and ICF/MR facilities. See ***nursing facility reimbursement methodology*** for additional rate setting information.

ODE does not conduct Medicaid rate setting activities for services. ODE's current involvement in Medicaid is related to the Medicaid Administrative Claim (MAC) process. The development of the MAC was through a plan amendment to the state Medicaid plan. ODE oversees and monitors the cost reports to ensure appropriate activities are captured and correctly reported.

According to ODJFS, the current payment structures for most services were formulated and based on the Medicare reimbursement system. **Table 4-22**, illustrates the institutional care rate methodologies for Medicaid services offered in Ohio.

Table 4-22: Ohio Institutional Care Reimbursement Methodologies

Services	Reimbursement Methodology
Inpatient Hospital, Nursing Facility and Intermediate Care Facility Services in Institutions for Mental Diseases, age 65 and older	Prospective payment/discharge using diagnosis related group system
Inpatient Psychiatric Service, under age 21	Prospective payment/discharge using diagnosis related group
Intermediate Care Facility Services for the Mentally Retarded	Prospective cost based per diem with limits
Nursing Facility Services, other than in an Institution for Mental Diseases	Prospective per diem based on cost using peer groups and limits, acuity adjusted
Religious Non-Medical Health Care Institution and Practitioner Services	Prospective cost based on a per diem amount using peer groups and acuity adjustment

Source: Kaiser Commission, 2004
Note: Institutional care services do not require co-payments or prior approval.

As illustrated in **Table 4-22**, Ohio's hospital inpatient services are reimbursed on a prospective basis using the diagnosis related group (DRG) system. A small portion of hospital services provided in freestanding rehabilitation or long-term hospitals, in hospitals which are licensed as health maintenance organizations, and in cancer hospitals are paid on a reasonable cost basis. Under the DRG system, hospitals are reimbursed based on the principal diagnosis or condition requiring the hospital admission. The DRG system is designed to classify patients into groups that are clinically coherent with respect to the amount of resources required to treat a patient with a specific diagnosis. Applicable additional payments are added for capital, medical education, and outliers.

According to ODJFS, Ohio chose this system in an effort to contain costs, permit providers to operate in a less regulated environment, and allow sharing of savings for those providers who identify ways to provide quality services more efficiently and economically. Just as hospitals do not get more than their fixed payment if the DRG amount is less than charges, their DRG payment rate is not lowered to match the billed charge amount.

Table 4-23 illustrates the long-term care rate methodologies for Ohio Medicaid services.

Table 4-23: Ohio Long-term Care Reimbursement Methodologies

Services	Reimbursement Methodology
Community-Based Care	Dependent upon the services provided
Home Health Services	Fee-for-service for nursing, home health aide and therapies; medical supplies are paid at 75% of the average list price if no payment limit is available
Hospice Care	Prospective rates based on Medicare methodology
Private Duty Nursing Services[1]	Fee-for-service
Program of All-Inclusive Care for the Elderly	Capitated payment

Source: Kaiser Commission, 2004
Note: Long-term care services do not require co-payments.
[1] Private Duty Nursing Services require prior approval.

As illustrated in **Table 4-23**, Ohio offers multiple reimbursement methodologies for long-term care services. By their nature, home and community-based services may be delivered by a number of different providers and vary in scope and intensity depending on the needs of the beneficiary. The reimbursement methodology can be fee-for-service for some waiver populations, a negotiated rate for others, or cost basis for yet others. As such, there is no specific reimbursement methodology identified for this service.

Table 4-24 illustrates the institutional and clinical rate methodologies for Ohio Medicaid services.

Table 4-24: Ohio Institutional and Clinic Reimbursement Methodologies

Services	Reimbursement Methodology
Clinic Services, by an organized facility or clinic not part of a hospital: Freestanding Ambulatory Surgery Center	Fee-for-service using surgical group rates, ancillaries paid separately
Clinic Services, by an organized facility or clinic not part of a hospital: Public Health and Mental Health Clinics	Fee-for-service for Public Health Clinics, cost based payment for Mental Health Clinics
Federally Qualified Health Center Services	Prospective cost based rate/visit
Inpatient Hospital Services, other than in an Institutional for Mental Diseases	Prospective payment/discharge using DRG and peer groups, facility specific rates for children's hospitals, cost based payment for LTC and rehab hospitals/unit
Outpatient Hospital Services	Fee-for-service or prospective payment based on percentage of charge
Rehabilitation Services: Mental Health and Substance Abuse	Cost based payment
Rural Health Clinic Services	Provider based: prospective cost based rate/visit with ancillaries paid fee-for-service, Independent: prospective cost based rate/visit using Medicare rates with ancillaries paid fee-for-service.

Source: Kaiser Commission, 2004
Note: Institutional and clinical services do not require co-payments or prior approval.

As shown in **Table 4-24,** Ohio uses multiple rate setting methodologies for its institutional and clinic services. Ohio uses a fee-for-service payment methodology for freestanding ambulatory surgery center, public health, mental health, and various outpatient services. However, a prospective cost based rate setting methodology is used for its federally qualified health center, rural health clinic, and other inpatient and outpatient services. Additionally, cost based payments are made for mental health and rehabilitation services.

Table 4-25 lists the practitioner, physical therapy, other, and transportation rate methodologies for Ohio Medicaid services.

Table 4-25: Ohio Practitioner, Physical Therapy, Other, and Transportation Reimbursement Methodologies

Services	Reimbursement Methodology
Certified Registered Nurse Anesthetist Services	Fee-for-service
Dental Services[1]	Fee-for-service
Medical/Surgical Services of a Dentist	Fee-for-service
Nurse Midwife Services	Fee-for-service
Nurse Practitioner Services	Fee-for-service
Optometrist Services	Fee-for-service
Physician Services	Fee-for-service
Podiatrist Services	Fee-for-service
Occupational Therapy Services[2]	Fee-for-service
Physical Therapy Services[2]	Fee-for-service
Services for Speech, Hearing, and Language Disorders[2]	Fee-for-service
Ambulance Services[2]	Fee-for-service
Non-Emergency Medical Transportation Services[2]	Service specific
Diagnostic, Screening and Preventive Services[2]	Dependent upon service and billing provider
Early and Periodic Screening, Diagnosis, and Treatment[2]	Not specified
Extended Services for Pregnant Women[2]	Not specified
Family Planning Services[2]	Not specified
Laboratory and X-Ray Services, outside Hospital or Clinic[2]	Fee-for-service
Targeted Case Management[2]	Fee-for-service

Source: Kaiser Commission, 2004
Note: Practitioner services do not require co-payments.
[1]Dental services require prior approval for specified services.
[2] Kaiser Report categorized these services as "other services".

As shown in **Table 4-25**, Ohio uses fee-for-service reimbursement methodologies for practitioner, physical therapy, other, and transportation services. However, non-emergency medical transportation service rates are service specific. Additionally, diagnostic, screening and preventative services, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), extended services for pregnant women, and family planning service rates are not based on a specific rate methodology, but rather, are based on services rendered.

Table 4C-1, in **Appendix 4C,** illustrates other state reimbursement methodologies for Medicaid services. For clinic services provided at a freestanding ambulatory surgery center, five states reimburse based on fee-for-service, similar to Ohio. Another three states use prospective cost based, and another uses the Medicare rate adjusted to the county wage index. For clinic services provided by public health or mental health clinics, eight states, including Ohio, reimburse based on fee-for-service. One state reimburses using a cost based methodology or the service is included in the capitated rates, and another state does not cover these services. Ohio, similar to each of the other nine states, reimburses dental services and physician services using fee-for-service. For inpatient hospital, nursing facility and intermediate care facility services in institutions for mental diseases for individuals age 65 and older, Ohio reimburses based on prospective payment, as do six other states. One state reimburses on a per diem basis, and two states do not cover the service. Overall, Ohio's reimbursement methodologies for the above listed services are in line with those used by a majority of the other nine states with the highest total Medicaid expenditures in FFY 2003-04.

Ohio's reimbursement for prescriptions is the weighted average cost (WAC) plus 7 percent, or the Average Wholesale Price (AWP) minus 12.8 percent if the WAC is unknown. In accordance with OAC 5101:3-1-60(F), ODJFS reimburses pharmacies for the lesser of the billed charge or the maximum allowed for the cost of the drug, plus a dispensing fee for those drugs. Providers must bill their usual and customary charge (the amount charged to the general public). A $3.70 dispensing fee is provided to pharmacies to aid in covering the costs of dispensing prescriptions for Medicaid recipients. Additionally, there is a $3.00 co-payment allocated to prescriptions that are not listed on the preferred drug list which must be paid by the recipient.

Specific rate methodologies and payment systems to providers and provider types vary from state to state. Many states have implemented rate setting cost control mechanisms in order to reduce Medicaid expenditures. According to the National Conference of State Legislatures (NCSL), Kentucky enacted a rate freeze for acute hospitals, home health providers, and local health departments, with expected savings of $20 million. Colorado implemented a risk-adjustment system for Medicaid managed care that assesses risk based on health status and then adjusts accordingly. Maryland uses a diagnosis-based adjustment system with its health plans, like Ohio does for multiple services. In addition, NCSL found that of 39 responding states, 19 (48 percent) administer their own Medicaid rates, 13 (33 percent) use a competitive bidding process to establish rates, and 7 (18 percent) use a negotiated rate process.

If a state's Medicaid rates are lower than the private market or Medicare for particular services, a state may have limited ability to cut or freeze reimbursement rates enough to achieve significant savings without compromising access and quality. Growing provider resistance to lower rates negotiated through managed care and a desire to make up for several years of flat payment have led to difficult price negotiations for public and private payers alike. In fact, at least 10 states, despite looming budget crises, actually raised reimbursement rates for certain services in 2001 to ensure an adequate supply of providers.

Table 4-26 shows a comparison of fee-for-service rates as a percentage of Medicare payments for 13 states, including Ohio.

Table 4-26 Comparison of Fee-For-Service Rates as Percentage of Medicare Payment

State	Medicaid FFS Payments as a Percent of Medicare FFS Payments (weighted)[1]
Ohio	**64%**
Massachusetts	89%
Arkansas	71%
Florida	71%
Texas	71%
Nevada	66%
Illinois	61%
Washington	60%
Colorado	57%
Louisiana	57%
New York	54%
California	48%
Pennsylvania	32%

Source: *Medicaid and SCHIP: States Use Varying Approaches to Monitor Children's Access to Care* (U.S. General Accounting Office, 2003).

[1] Methodology reported by GAO included compiling fees for 12 medical services using codes from the *Physicians Current Procedural Terminology, 4th edition (CPT 4)*. For each state, the Medicaid and corresponding lowest Medicare fees for that state were weighted by the relative utilization of the service among pediatricians. The sum of the weighted Medicaid fees was then expressed as a percentage of the sum of the Medicare payments to develop a single, weighted payment rate. Codes used for the analysis include office or other outpatient visit and preventive medical services for children.

Table 4-26 shows that Ohio in the midrange of the 13 states reviewed in terms of its fee-for-service rates as a percentage of Medicare fee-for-service rates.

Hospitals and many other service providers recently have been very vocal in their claims that Medicaid reimbursement does not cover the costs of service, and some have even sued their state governments for increased payments on the grounds that Medicaid laws call for "fair market" rate reimbursement. Physicians historically have also fared badly under Medicaid because states have tried to cut Medicaid costs by freezing physicians' fees.

In addition to cost shifting, which is not sustainable in the long-run, providers have been using case-mix management to try to control costs and enhance profitability. Case-mix management can be exercised at two levels. First, at the lower level, it is used to lower the costs associated with a particular diagnosis by changing the mix of procedures applied to the diagnosis. The second type of case-mix management involves changing the provider's overall patient mix by lowering the number of patients with diagnoses that typically result in losses and increasing the number with diagnoses that are highly profitable.

Providers, like individuals and other businesses, react to the incentives created by the financial environment. Under cost-based reimbursement, providers are given a "blank check" to be used in acquiring assets and incurring operating costs. If payers reimburse providers for all costs, the incentive is to incur costs. Furthermore, as in billed-charge reimbursement, services that may not truly be required will be provided because more services lead to higher costs, which mean higher revenues.

Under charge-based reimbursement, providers have the incentive to set high charge rates, which lead to high revenues. Providers can increase utilization, and hence revenues, by churning, or creating more visits, tests, and inpatient stays. Although charge-based reimbursement encourages providers to contain costs, the incentive is weak because charges can be more easily increased than costs can be reduced.

With prospective payment reimbursement, provider incentives are altered. First, under per procedure reimbursement, the profitability of individual procedures will vary depending on the relationship between the actual costs incurred and the payment for that procedure. The incentives under per diagnosis reimbursement are similar. Providers, usually hospitals, seek patients with diagnoses that have the greatest profit potential and discourage services that have the least profit potential. In all prospective payment methods, providers have the incentive to reduce costs because the amount of reimbursement is fixed and independent of the costs actually incurred. When per diem reimbursement is used, particularly with hospitals, providers have an incentive to increase the length of stay. Because the early days of hospitalization are typically more costly to the provider than the later days, the later days are more profitable.

Under global pricing, providers do not have the opportunity to be reimbursed for a series of separate services, which is called unbundling. Capitation reimbursement totally changes the playing field by completely reversing the actions that providers must take to ensure financial success. As with prospective payment, capitated providers have the incentive to reduce costs, but now they also have the incentive to reduce utilization.

According to the National Conference of State Legislatures, there are pros and cons to activities that change reimbursement strategies. Some effects of changing reimbursement methodologies include:

- States can slow growth in spending by freezing rates. Reducing rates by a small percentage can produce significant savings.

    - However, lower rates may lead to decreased participation rates among providers and consequently compromise both quality and access to care. Decreased participation rates in certain service areas may further increase the strain on providers, such as disproportionate share hospitals that have significant numbers of Medicaid patients.

- Rate adjustments (usually upward) can produce rates that more accurately reflect the cost of care. This can make expenditures more predictable and reduce risk to providers, thereby increasing participation.

    - The methodologies are complex, not perfected, and may be costly to administer. Accurately predicting a person's health needs can be difficult. More complicated payment methods, such as case-mix reimbursement or risk-adjusted managed care payments, may increase administrative costs.

- Flat capitated rates may give providers an incentive to engage in risk-selection by selecting the healthiest patients; risk adjustments may reduce or eliminate that incentive. Case-mix systems reduce the incentive for nursing homes or health plans to select the healthiest patients by reimbursing them for the actual cost of delivering care – thereby reimbursing at a higher level for caring for more critically ill patients.

    - Changes in incentives under different payment systems may not operate as planned. In long-term care facilities, case-mix reimbursement may provide a disincentive to rehabilitate some patients and/or lead facilities to misreport a patient's condition. Increasing payments for higher cost patients does not guarantee that patient will receive better quality care.

In February 2001, the California Legislative Analyst's Office completed a review of the California Medicaid program's (Medi-Cal) physician rates. The study indicated that the program's physician service fees were relatively low compared to the rates paid by Medicare and other health care purchasers. The report recommended the Legislature establish a more rational process for periodically reviewing and adjusting California's Medicaid rates.

The report recommends that Medicare rates be used as a benchmark and directs the California Department of Health Services, which administers the Medicaid program, to perform a comprehensive analysis of access to physician services and of the quality of care provided to California Medicaid beneficiaries, and to offer proposals for periodic future adjustments to rates

based on the analysis. The annual review of physician rates must take into account the following factors:

- Annual cost increases for physicians as reflected in the Consumer Price Index;
- Physician reimbursement levels of Medicare, Blue Shield, and other third-party payers;
- Prevailing customary physician charges within the state and in various geographical areas;
- Changes in the list of approved medical procedures; and
- Characteristics of the current population of California Medicaid beneficiaries and the medical services needed.

A recent national analysis of Medicaid physician rates by the Urban Institute concluded that physician fee levels affect both access and outcomes for Medicaid patients. One study cited by the Urban Institute report found that higher rates were associated with a small, but significant, decline in the infant mortality rate. While state policy requires that California Medicaid pay adequate physician rates, there is no simple formula that relates rate levels to health care access and quality.

The California report indicated that Medicare provides the state with a useful benchmark for rate-setting, for several reasons. Because the relative values and conversion factor the Medicare rate system assigns to medical procedures are updated regularly, Medicare rates fairly and accurately reflect the current costs of providing physician services. According to the report, using Medicare rates as the basis for California Medicaid rate setting would allow the Department of Health Services to avoid the expensive and unnecessary process of developing its own separate rate structure. Although the report did not estimate the potential cost to the state in moving to the Medicare rates or the cost savings through reduced labor costs in rate setting and avoided litigation, some positive and negative cost effects would result from such a change.

The report's recommendation that Medicaid physician rates generally not be increased beyond 80 percent of the allowable Medicare rates[64] is intended to ensure that the California Medicaid program does not incur a disproportionate increase in state costs. The report recommends the enactment of legislation directing the Department of Health Services to perform a comprehensive analysis of the access to physician services and quality of care provided to California Medicaid beneficiaries. The Department of Health Services would recommend periodic adjustments to physician rates based upon the results of that analysis. The Legislature would then determine whether to appropriate funding for such rate adjustments. This analysis would involve regular measurement and evaluation of both patient access to health care and the quality of that care.

[64] In most cases, the Ohio Medicaid Program reimburses providers at about 85 percent of the allowable Medicare rate.

While the department now contracts for such reviews for California Medicaid managed care plans, it does not comprehensively or regularly do so for fee-for-service.

The report indicated the following:

> "The adoption of the proposed rate setting approach is likely in the long-term to foster reasonable access to health care for Medi-Cal beneficiaries and a better quality of care. This is because the recommended proposal would ensure that rates are reviewed and adjusted with these factors in mind. The proposal ensures that Medi-Cal rates keep pace with changes in medical practices and technology. Such medical innovations have the potential either to significantly reduce or to increase the cost of patient care, as well as to significantly change the effectiveness of patient treatment. Because the revised rate setting procedures we propose are based upon extensive and ongoing collection of medical cost data, they would ensure that Medi-Cal rates are kept more in line with the actual costs of innovative medical practices."

The Modernization of the Texas Medicaid Program, the final report issued by the Texas Medicaid Reform Workgroup in March 2005, identifies how Medicaid in the state needs to evolve and improve its operations, suggests new mechanisms for the improvement of care, and guides the future development of the program. Included in the report is a proposal for a comprehensive review and re-evaluation of all the financing mechanisms and funding formulas in Medicaid to determine if they are cost effective for the state and if they promote positive health outcomes.

The proposals supported by the report recommend various changes to funding formulas and purchasing methods used in Medicaid. The re-evaluations are recommended because all of the formulas and mechanisms in the state Medicaid program are intertwined in an effort to avoid unintended and negative consequences. Further, the Texas Health and Human Services Commission recommended the state consider hospital financing, physician and other provider financing, as well as new and innovative funding mechanisms to help the state benefit from additional federal funds.

The general themes reflected in these proposals are the efficient use of state funds and optimization of federal Medicaid dollars. The Texas workgroup noted that the goals of the finance system should be the following:

- Optimize federal funds to the state;
- Create incentives for providers to use preventive care;
- Increase and encourage the use of less expensive and appropriate treatments to keep providers in the system and maintain an adequate provider network;
- More accurately reflect the costs borne by providers; and
- Encourage best practices and quality care.

The Modernization of the Texas Medicaid Program report provided a general work plan to make reimbursement rates more effective and efficient and to more accurately reflect the Medicaid program's funding priorities, which include the following:

- Analyze rate setting best practices in other states and determine their applicability to Texas providers while considering the goals above.
- Work with the legislature to determine the most effective rate methodologies for the state.
- Plan data system improvements that are necessary for the new system and increase automation of financial information received from providers and processed by the state. Stakeholder input would be important to this aspect of rate setting evaluation design.
- Implement updated rate methodologies for physicians, hospitals, and HMOs.
- Seek stakeholder input to design the new rate methodology system and improve the automation of the financial information system that providers will be required to use.

Additionally, the report recommends the establishment of a review process through which the Health and Human Services Commission will examine and re-evaluate financing formulas and mechanisms currently used in the Medicaid program, and determine whether those formulas are in the best interest of the Medicaid program. The goal is to ensure that these funding formulas provide the state with the best opportunity to promote appropriate utilization within the Medicaid program and maximize the impact of each dollar spent.

Because Medicaid covers a wide range of services, a comparison of overall rates for Medicaid services between states is difficult. Also, each state may use a slightly different reimbursement methodology or calculation, adding to the complexity of the rate structure (see **Tables 4-22** through **4-25**). **Table 4-27** provides a comparison of select Medicaid rates in Ohio and surrounding states to highlight the variations in rates between states and among procedures.

Table 4-27: Comparison of Physician/Practitioner Medicaid Fees

Service	CPT Code	Ohio	Michigan	Indiana	Kentucky	Peer Average	Ohio as % of Peer Avg.	Medicare
Dental Services								
Periodic Oral Exam	D0120	**$16.74**	$14.89	$20.25	N/C	**$17.57**	**(5%)**	N/A
Comprehensive Oral Exam	D0150	**$25.82**	$18.90	$35.50	$26.00	**$26.80**	**(4%)**	N/A
Office/Other Outpatient Visit or Preventive Medical Services								
Office/outpatient Visit New	99201	**$21.81**	$20.88	$20.82	$22.05	**$21.25**	**3%**	$35.49
Office/outpatient Visit New (Comprehensive Exam)	99205	**$87.97**	$99.04	$88.36	$91.89	**$93.10**	**(6%)**	$169.67
Office/outpatient Visit Established (Minimal does not Require Physician)	99211	**$13.43**	$12.27	$9.98	$10.57	**$10.94**	**23%**	$20.60
Office/outpatient Visit Established (Comprehensive)	99215	**$81.04**	$68.25	$63.87	$66.39	**$66.17**	**22%**	$116.71
Preventive Visit, New, Infant	99381	**$50.70**	$58.99	$39.85	$69.85	**$56.23**	**(10%)**	$99.98
Preventive Visit, New, 1-4 yrs	99382	**$57.61**	$63.51	$34.52	$79.91	**$59.31**	**(3%)**	$107.84
Preventive Visit, Established, 1-4 yrs	99392	**$51.12**	$50.16	$24.36	$69.85	**$48.12**	**6%**	$85.49

Source: Fees schedules taken from state web sites on October 16, 2006, Center for Medicare and Medicaid Services
Note: West Virginia and Pennsylvania are not included as these states did not have fee schedules available on websites.
[1] Michigan pays a lower rate of $14.89 for comprehensive oral exams for adults over age 19.

Table 4-27 shows that, overall, Ohio is comparable to neighboring states rates. However, Ohio is more than 22 percent higher in two of the selected services. In another service, Ohio's reimbursement rate is 10 percent lower than the average of neighboring states. However, the services shown in **Table 4-27** represent only a minute portion of the services covered under the Medicaid program and should not be used to draw conclusions about Ohio's reimbursement rate schedule. In order to develop overall conclusions about the reimbursement rate schedule, a more comprehensive review of fees on a procedure-by-procedure basis would be required.

Changing payment rates saves money in the simplest way by paying less for the same care. However, such changes inevitably affect what providers will do, even if the response is as simple as deciding not to serve Medicaid recipients. Complex rate adjustments, such as case-mix strategies or risk adjustment, are often needed to make providers equally willing to care for people with a range of health care needs and induce providers to treat efficiently for a given condition. However, systems that are adjusted based on health characteristics and needs must be carefully designed so as not to create financial incentives to withhold care or provide anything

that can be construed as a kickback to providers. New federal regulations will require states to demonstrate that adjusted capitation rates are actuarially sound.

During stakeholder meeting, providers expressed concerns with Medicaid rate setting. A member of the Ohio Pharmacists Association stated that, because Ohio Medicaid only updates pharmaceutical reimbursement rates on a monthly basis (when supplier costs usually change each day), pharmacists must struggle to compensate for the rate changes. A member of the Ohio Developmental Disabilities Council described the shortage of dentists who will serve Medicaid clients and said, "We need to find a way to provide incentives to dentists to accept Medicaid; otherwise, it's not going to work." A member of the Ohio Council of Behavioral Healthcare Providers explained that the low reimbursement rates have caused the behavioral health system to intervene at later times which results in higher costs to the program. The member said, "Every provider will tell you that we're becoming increasingly fragile economically, and pretty much hand to mouth…. There really is nobody available to step up to the plate… because the same economic pressures exist for everyone....and a lot of us are teetering on the edge of whether [we] are going to make payroll."

A member of the Ohio Council for Home Care said that providers in the home care industry have been concerned about rates for a long time. In the home care industry, rising gas prices and other economic pressures are beginning to have a great effect on the viability of home care agencies. During the stakeholder meeting, members revealed that they had just received an email notification from ODJFS that their rates were going to be reduced because of State budgetary concerns. Despite continued requests, a member said, ODJFS has not been able to adequately explain how rates for the home care industry are determined.

Although Ohio used an actuary to determine its capitated rates as required by the federal government, the State's practice of adjusting fee-for-service rates when physician complaints become overwhelming does not address the characteristics of an effective rate setting system for the fee-for-service side. During stakeholder interviews with providers, rates were the primary issue discussed in every instance. Not only did providers indicate that financial considerations affected their decisions to treat Medicaid recipients, but several indicated that they would reduce the caseload of Medicaid recipients because of the financial impact the reimbursement rates were having on their practices. Under the fee-for-service model, Ohio Medicaid has substantial room for improvement in its rate setting and processes.

R4.21 The State Medicaid Agency should implement a regular process for the periodic evaluation of all Medicaid service rates and should examine each of its rate setting methodologies separately as it undertakes new rate adjustment strategies. The State Medicaid Agency should also set rates to achieve specific public policy objectives, such as access to primary care, well-child care, or prenatal care. See the

organizational issues section for a discussion of the prioritization of goals. The rates should reflect the priorities of the program.

The overall goal of the State Medicaid Agency's rate reimbursement cost reduction activities should be to ensure that all Medicaid recipients are provided access to necessary care, as well as high quality services. When determining rate setting cost reductions, the State Medicaid Agency should use the recommendations provided by the California Legislative Analyst's Office, which include the following:

- **Establish a more rational process for periodically reviewing and adjusting payment rates;**
- **Use Medicare rates as a benchmark;**
- **Perform a comprehensive analysis of access to physician services and the quality of care provided to California Medicaid beneficiaries; and**
- **Offer proposals for periodic future adjustments to rates based on analysis.**

Additionally, the Texas report on re-evaluating its Medicaid financing formulas and mechanisms should be used as a guideline to make reimbursement rates more effective and efficient and to more accurately reflect the Ohio Medicaid program's funding priorities. Although modifying the design of a state health care payment system presents risks, ignoring inequities and inefficiencies in Ohio's Medicaid payment approach also endangers the well-being of the overall healthcare system.

Transparency

Although several agencies participate in the Medicaid Program in Ohio, ODJFS serves the largest number of consumers and has the greatest impact on rate setting and service levels. OHP, the office within ODJFS that is responsible for the Medicaid program, has four sections in the Bureau of Health Plan Policy that conduct rate setting activities. These sections include the following:

- **Hospital Section:** Conducts hospital program design and reimbursement activities. Additionally, rate setting activities are conducted by the section for in-patient and out-patient services.

- **Non-Institutional Benefit Section:** Conducts rule and policy making for non-institutional care services. Additional areas of responsibility include rate setting for non-institutional services and pharmacy benefits. Hospice is also included under this section.

- **Research Section:** Develops the Decision Support System.[65] The Section develops and implements the OHP research agenda, which includes funding extramural research through Ohio's colleges and universities, and performing research projects related to the quality, cost and access to health care for the Medicaid eligible population. This includes leading primary data collection efforts and performing secondary analysis of Medicaid enrollment and claims data. The Research Section supports analysis and evaluation of Medicaid delivery and payment systems. It also provides budget support by running models and cross checking budget models. Additionally, the section manages the actuary contract and works with the Bureau of Managed Care.

- **Strategic Development Section:** Conducts activities related to special program waivers, CMS codes and regulations, Health Insurance Portability and Accountability Act requirements, and the Medicaid Management Information System. Provider agreements, co-pays, and State plan administration and compilation are also handled through this section. This section provides administrative and technical support for the other rate setting sections.

Ohio has a mixed array of Medicaid reimbursement rate strategies. **Table 4-28** illustrates the OAC sections relating to Medicaid reimbursement rates.

[65] The Decision Support System is discussed in detail in the **technology and program management** section.

Table 4-28: Ohio Administrative Code for Rate Setting and Reimbursement

Legal Code	Policy
OAC 5101:3-1-60(A)	The **Medicaid payment for a covered service constitutes payment-in-full** and may not be construed as a partial payment when the reimbursement amount is less than the provider's charge. The provider may not bill the recipients for any difference between the Medicaid payment and the provider's charge or request the recipient to share in the cost through a co-payment or other similar charge, other than Medicaid co-payments as defined in rule OAC 5101:3-9-09.
OAC 5101-3-2-07.3 (A)	**Hospitals**: For hospitals subject to prospective payment for inpatient services, ODJFS will reimburse for inpatient hospital services an amount per discharge in each diagnostic category. The payment is reflective of the relative hospital resources used by each diagnostic category in comparison to the statewide average resource use for an admission. The method for determining the weight of a diagnostic category is based on its average charge compared to an average charge for all discharges.
OAC 5101:3-2-07.4 (A)	**Prospective Payment:** Computing the payment rate- the average cost per discharge is determined and adjusted as described in paragraphs (D) to (G)(3)(b) of this rule is multiplied by the relative weight for the DRG as described in rule 5101:3-2-07.3 of the Administrative Code. Applicable allowances for capital and medical education, as described in this rule, are added after the average cost per discharge component is multiplied by the relative weight.
OAC 5101-3-27-05(E)(1)	**Community Mental Health**: A prospective unit rate for each covered service will be calculated in accordance with the uniform cost report as established in rule 5122-26-19 of the Administrative Code and thus may vary from agency to agency.
OAC 5101-3-29-05(A)	**Out-patient health facility service payments** for authorized services in an outpatient health facility (OHF) are calculated on a prospective reasonable cost-related basis from cost reports filed by each participating clinic.
OAC 5101-3-30-04(E)(1)	**Community Alcohol and Drug**: A prospective unit rate for each community Medicaid alcohol and other drug treatment service will be calculated in accordance with the uniform cost report as established in rule 3793:2-1-09 of the Administrative Code and thus may vary from agency to agency.
OAC 5101-3-31-07(E)(4)	**Passport HCBS Waiver**: A regional rate shall be determined by ODA as a weighted average rate paid in the region using cost and unit data either from the most recently completed state fiscal year or the most recent twelve calendar months for which complete data is available, whichever is later.
OAC 5101-3-32-08	**Choices HCBS Waiver**: Subject to the limits set forth in rule 5101:3-1-06.4 of the Administrative Code, consumers negotiate rates with providers whereby expenditures may not exceed the authorized amounts identified in the service plan. The consumer shall contract for the services specified in paragraph (B) of this rule with providers who have a signed Medicaid provider agreement with ODJFS to provide choices services, and who meet the requirements set forth in rules 5101:3-32-02 and 5101:3-32-04 of the Administrative Code to provide the specified service in the region for which the rate will be negotiated. The consumer shall base rates on the units of service as set forth in rule 5101:3-32-05 of the Administrative Code.
OAC 5101-3-56-06	**Hospice**: Medicaid payment for hospice services is made at one of four predetermined rates. Medicaid hospice program rates are established by CMS and set forth in the state Medicaid manual and shall be adjusted in accordance with CMS's determined area wage adjustments. Each rate is based on the level of care which is appropriate for the client for each day while under the care of the hospice. Each rate covers all services rendered by the hospice (either directly or under contractual arrangement), the administrative and general supervisory activities performed by physicians, and travel expenses and supervision provided by other hospice staff. The hospice shall bill ODJFS the appropriate code and unit(s) for the appropriate level of care. The rate paid for any particular day depends on the level of care furnished to the individual on that day.
OAC 5123-2-9-06	ODJFS retains final authority, based on the recommendation of the department, to establish payment rates for all waiver services included in Home and Community Based Service waivers administered by the department. The services and payment rates for all waiver services other than day habilitation and transportation to access day habilitation are included in appendix A of this rule. The payment rates for day habilitation and transportation to access day habilitation are contained in OAC 5123-2-9-12.

Source: OAC

As illustrated in **Table 4-28**, Ohio has numerous Medicaid reimbursement rate methodologies listed within the OAC.

Ohio's Medicaid DRG payment structure for hospitals was implemented in 1984 based on Medicare formulas for hospital service payment. Medicare provides annual inflationary updates, which are also mirrored in its DRG payment system. However, the General Assembly denied Ohio's annual inflation update for the last two biennia. The OAC and State plan documents have to be amended each time the legislature denies requests for annual inflationary increases. The

methodology for inflationary rate increases, which includes local wage indexes, (hospital market basket) are provided in the OAC 5101:3-3-99.

OHP's Hospital Section staff indicated general hospital services did not receive a full market basket rate[66] increase during SFY 2003-04. General hospital services received a 3 percent inflationary rate increase during SFY 2004-05; however, rates were frozen for SFY 2006-07. The children's hospital rate received a full market basket increase of 3.3 percent in SFY 2004-05, which is in accordance with the budget bill. A full market basket increase was also received by the children's hospital during SFY 2002-03 and SFY 2003-04.

In the Ohio Medicaid reimbursement methodology, many services have multiple reimbursement rates. For example, Appendix DD of OAC § 5101-3-1-60 illustrates that there are approximately ten different rates for outpatient surgical services, which is only one of several listed in Appendix DD and one of several hundred services provided under Ohio Medicaid. ODJFS staff indicated that requests for rate increases typically arise from provider groups many times each year. Additionally, rate alterations are considered during a budgetary review, due to current year Medicaid funds already allocated to specific services. When the Bureau of Health Plan Policy receives a rate review request from a provider, an internal staff team researches pertinent information related to the specific rate under review. Furthermore, populations are reviewed to assist with the determination to implement a waiver for a specific number of enrollments (i.e., number of recipients using medical breathing equipment). According to the Bureau Chief, research is conducted internally to determine what the market will bear. Ohio Medicaid uses the same methodology as Medicare which looks at historical use of equipment or services. OAC must be amended when legislation is passed approving a rate change.

After OHP researches a given rate, an internal team develops a new rate and discusses it with provider groups. OHP, with assistance from ODJFS' executive staff, negotiates the new rate with the provider groups. According to the Chief of the Bureau of Health Plan Policy, provider group associations and agencies are involved during the entire negotiation process. Although OHP does not disclose the exact process used in determining a rate because this process is used to leverage rates that are more advantageous to the State, the providers are informed as to what Medicare reimburses and the market value for a specific service or piece of equipment. After a rate is negotiated between the provider group and OHP staff, a public comment process is conducted where any and all involved participants may object to the rates being proposed for a specific service or piece of equipment. After the public hearing and comment period, rule making with CMS begins. The new rate is ultimately placed in OAC and the State plan is updated.

[66] The CMS market baskets are used to update payments and cost limits in the various CMS payment systems. The CMS market baskets reflect input price inflation facing providers in the provision of medical services. ODJFS contracts with Global Insight for market basket information collection. The market basket information that is collected by Global Insight is fed into the hospital formula and rate update annually. Global Insight also develops the market basket for Medicare.

OHP staff indicated that informal prioritization occurs during the budgetary process when deciding what rates should be adjusted. Although not a documented policy, children and pregnant mother service and equipment rates are reviewed first to ensure that rates are appropriate to ensure continued access. The chief of the Bureau of Health Plan Policy indicated that, in accordance with federal law, ODJFS is required to either provide fee schedules or reimbursement methodologies within the OAC. According to the Bureau Chief, the fee schedules are placed in OAC because, "If methodologies were placed in code, the Bureau would no longer have a bargaining chip or negotiation process which is used to ensure the best rate is being provided."

ODJFS uses multiple rate reimbursement strategies when setting Medicaid service rates (see **Tables 4-22, 4-23, 4-24, and 4-25**), which are provided in its State plan and OAC. However, a majority of these rate setting methodologies are developed and communicated within OHP, without the assistance of external stakeholders and providers.

In the case of sub-recipient agencies, ODMRDD does not directly complete rate setting activities. OHP sets the rates used in the ODMRDD system on behalf of ODMRDD and with input and recommendations from ODMRDD. OHP establishes payment rates for all waiver services including those administered by ODMRDD. The services and payment rates for all waiver services other than day habilitation and transportation are included in appendix A of OAC 5123:2-9-06. Recent changes to the rate setting methodology within the MRDD system have been made to address issues of state-wideness in service access. Uniform rates have been set for certain services, reducing or eliminating the CBMRDDs' ability to negotiate rates.

In comparison, both ODMH and ODADAS set the rates for services in their respective systems. ODMH provides mental health services on a fee-for-service basis. There are no caps or limits on services for individuals. There is a rate limit/ceiling cap that will be paid per service. ODMH uses the Uniform Cost Report to obtain all costs associated with providing Medicaid services. The ODADAS rate setting activities are also conducted under the Uniform Cost Report rules for cost reporting. ODADAS indicated its respective Medicaid rates have not been raised in over eight years. The rates were originally based on the 95th percentile, but were lowered to the 90th percentile. The current rate system for ODADAS consists of the following:

- Cost-based for each provider;
- Providers use an estimated cost for the current year rate or use last year's rate;
- Cost reporting rules are used to detail rates; and
- Providers can change rates throughout the year.

ODADAS indicated that its respective reimbursement rules are listed in the State Medicaid plan. Additionally, OAC 5101-3-30.04 illustrates that ODADAS provides a prospective unit rate for

Medicaid services. ODADAS indicated that the mean, median, and mode rates from providers are reviewed and used to determine the current rate reimbursement percentiles.

ODA indicated that all of its service rates are set by ODJFS (OHP) with input from the Agency. ODA indicated that the PASSPORT waiver has a regional average rate for each Medicaid service which is intended to account for different costs of personnel and mileage reimbursement for rural areas. Historical providers were grandfathered in above the regional rate, yet lower than the maximum ceilings, when applicable. New providers are eligible to receive reimbursement up to the regional average rate maximums.

ODA indicated that the rate calculations were developed approximately ten years ago based on geographical location. Additionally, market place economic items drove the ceilings. The regional average rate is calculated based on the number of units delivered at each rate, weighted to adjust for increased delivery costs. ODA indicated that it reviews the ceiling rates every two years to see if changes should be requested. Some services, such as installing a ramp or purchasing durable medical equipment, are bid by ODA rather than using reimbursement rates.

According to multiple Medicaid stakeholders and providers, the Ohio Medicaid Program does not have a transparent Medicaid rate setting process for many of its recipient services. The Ohio Hospital Association indicated that $1 million was cut from its most recent State budget for hospital Medicaid payments. The cut came from a recalibration of the inpatient reimbursement rates. A representative of the Ohio Hospital Association stated that he was unaware of why the hospital reimbursements were targeted or how reimbursement rates were recalibrated.

The Ohio Council of Behavioral Healthcare Providers indicated that the Uniform Cost Reporting rule 5122-26-19 for ODADAS and ODMH was the first documented OAC process for Medicaid cost reimbursement for behavioral health care. A member of the Ohio Council of Behavioral Healthcare Providers indicated the reimbursement structure was all over the place in terms of how it was recalibrated by ODJFS. There are some recent rules that ODJFS has put in place on behavioral health care reimbursement rates and reconciliations that again, according to the Ohio Council of Behavioral Healthcare Providers, need to be in rule because they have never been codified or transparent.

A provider representative stated that it would be nice to know how Medicaid reimbursement rates are calculated without having to file a lawsuit. The representative indicated that the rules and the mechanism ought to be open and an association shouldn't have to fight in order to get that information. A representative of AOPHA indicated that providers shouldn't have to go through litigation on every reimbursement rate issue.

Representatives of Ohio speech and hearing providers indicated that when reimbursement rate changes occur, communication with ODJFS is very minimal. When rates are changed for speech

and hearing services, the providers indicated that they are not notified and that a more transparent process for rate reimbursement would be beneficial. Some of the represented speech and hearing providers indicated that they were involved in limited rate discussions on reimbursements, but when it came to setting rates, they were not consulted.

Stakeholders consistently voices frustration with Ohio Medicaid's rates and the ODJFS rate setting process. A member of the Ohio Association of Area Agencies on Aging said, "Rates for home care remain stagnant. …There is little control of who the providers are. " A member of the Ohio Hospital Association stated that, during the most recent State budgeting process, funds were cut from hospital reimbursements. The member said that $100 million had been reduced from the reimbursement pool for hospital services. A member of the Ohio American College of Emergency Physicians said that rates have, "basically not kept pace with …inflation …." As a result, the physician noted that treating Medicaid recipients resulted in a loss for the practice. A member of the Ohio Health Care Association said that, to cut costs in an ICF/MR facility, staff reductions were required. The member felt that rate setting was applied to the geriatric nursing homes and institution facilities for the mentally retarded and developmentally disabled were treated as an afterthought.

The inability to access rate information was a prime concern for members of the Ohio Council of Speech and Hearing Administrators. One member said that, in other states, updated rate and billing code manuals are readily available; however, in Ohio, it is almost impossible to get up-to-date, correct rate and code information. A member also said that speech and hearing practitioners were not involved in discussions on the rate setting process and that the choices made to reduce costs were, in some cases, poorly planned.

A member of the Ohio Children's Hospital Association said, "I think they comply with Chapter 119 [of the Ohio revised Code]. I mean, they follow the rules of the promulgation process." Although ODJFS shared the data upon which the rates were determined, the member questioned the validity of the data and the soundness of the rate structure. The member concluded saying, "The whole reimbursement system is set up on the idea that you have costs and that the system should recognize the costs will increase and inflationary adjustments will be awarded. That's built into the rule. But every year they go in and they change the inflationary adjustment to zero."

A member of the Ohio Association of Medical Equipment Suppliers (OAMES) was more critical in his assessment of the process. He said OAMES asked, throughout the last rate setting process, for information and explanations on changes to services and rates. The member also remarked that efforts to develop a single state Medicaid agency might create cleaner lines of accountability and, at that point, members might be able to obtain information on the rate setting process. "I would suggest to you that reimbursement is set by policy people and program people and that may or may not be a good thing." the member said. One member stated, "I think they just grab

numbers out of the air. They start with Medicare and do something less … there is not an established fee schedule for an item…. There is no theory [methodology] for the fee schedule. …The only … rule is that they cannot pay more than Medicare."

R4.22 The State Medicaid Agency should make its rate setting process more transparent by consistently keeping stakeholders and providers informed of pending reimbursement rate changes and seeking their input to arrive at rates that ensure the State is maximizing public funds while providing access to quality care. Stakeholder input is important to the rate setting evaluation and design for recalibrating existing Medicaid rates, in addition to the development of new rates.

OHP should formally document its rate setting prioritization and goals. Although OHP staff indicated the rates for specific service populations, such as children and pregnant women, are reviewed prior to other services, a documented policy would assist stakeholders and providers in knowing why certain service population's rates are continually reviewed and updated. To ease stakeholder concerns about the nature and timing of rate changes, the State Medicaid Agency and the sub-recipient agencies should establish a more formal schedule of rate reviews and include ample opportunity for stakeholder comment.

Cost Reductions

Ohio uses multiple reimbursement strategies for Medicaid services. Staff from the Bureau of Health Plan Policy in OHP indicated there is no documented policy or detailed goals for setting reimbursement strategies or rate reductions. OHP staff indicated that with the repeal of the Boren Amendment, ODJFS is now required to report and publicize, in legislative code, either the rates for all services or the methodologies for setting rates.

Rate setting actions that have been taken by OHP consist of the following:

- Contracting with a third party (Permedion) to review utilization, DRG reimbursement, billing errors, and coding errors;
- Using the processes that Medicare utilizes, to assist with trending activities; and
- Developing cost containment peer groups (hospitals paid on a peer group basis).

According to the Lewin Group, a national health and human services consulting firm, reducing provider fees is another technique to reduce overall Medicaid spending. States can reduce provider payments quickly by cutting the direct fee-for-service payments to providers, or through long-term strategies such as eliminating annual fee adjustments, capitation, selective contracting, and bulk purchasing. While fee reductions can help states solve immediate budget shortfalls, rate cuts are very unpopular among providers, who typically receive low reimbursement from

Medicaid. If rates are too low, it can be difficult for states to attract and retain providers in the Medicaid program, which in turn creates access problems for beneficiaries. (See also the **managed care and care management** section for a discussion on access issues.)

Traditionally, states have treated reduced fees, and the immediate savings generated, as the end in itself. States are now recognizing that fee structures can be designed to encourage or discourage certain provider behaviors, which can lead to changes in utilization, the effective driver of Medicaid costs. Additionally, some states have implemented a pay for performance model, which may increase negative provider behavior in some cases (see the **managed care and care management** section). States have implemented the following fee reduction strategies:

- **Cutting provider fees:** Payments to certain types of providers (i.e., dentists) or for certain services (i.e., pharmacy dispensing) can be reduced by fixed dollar amounts or percentages. Payments to providers that are reimbursed based on costs rather than fees can be rebased at a lower amount. Additionally, states can delay or eliminate periodic increases based on inflation or cost-of-living adjustments instead of actually cutting provider fees.

- **Consolidating and leveraging buying power:** States have implemented or are considering leveraging the state's marker power to obtain concessions on provider fees. Some states have implemented selective contracting models to negotiate preferred provider pricing with certain providers in exchange for a greater share of the Medicaid patient population. Furthermore, states have considered combining the purchasing power of various state-funded health programs or creating purchasing pools with other states.

- **Encouraging new utilization patterns:** States may intentionally manipulate provider rates to encourage certain types of utilization and discourage others. For example, Illinois and New York changed from a single dispensing fee to a tiered approach with lower dispensing fees to pharmacists who dispense brand name drugs.

The National Conference of State Legislatures reported in early 2002 that 38 states have made the review of Medicaid reimbursement rates a high priority in their legislative sessions. However, reducing provider fees can be politically challenging because most providers are organized into associations that petition legislators at the state level to protect the interests of their members.

Reducing provider payment rates can generate immediate savings to state Medicaid programs. Low provider rates can also create longer-term savings. If fewer providers are willing to accept the lower payments, beneficiaries will have difficulty accessing care and will consequently use fewer services, which will lead to lower costs. However, reducing access, which is a potential consequence of reducing provider payments, can have negative consequences for personal and

public health and potentially shift utilization towards more expensive inpatient and emergency services. Thus, states must carefully consider the impact of this cost-containment approach on health status as well as coverage costs.

Several of the Medicaid cost-containment strategies available to states involve cuts to services, beneficiaries, utilization, and provider payments. None of these choices is politically appealing, and while they may appear to solve short-term Medicaid budget problems, these choices have consequences in other parts of the state's healthcare and economic systems.

Faced with difficult budget decisions, Oregon revisited specific objectives of its Medicaid program (also discussed in **organizational issues**). In response, The Oregon Association of Hospitals and Health Systems asked the Lewin Group to focus on four areas related to the Oregon Medicaid program and provider reimbursement, which are as follows:

- An analysis of Medicaid provider payments compared to actual provider costs;
- Comparisons to other states' Medicaid programs and to Medicare;
- The impact of proposed budget reductions; and
- The effect of Medicaid payment rates on access to care.

The Lewin Group issued a report, *Analysis of Medicaid Reimbursement in Oregon*, in February 2003. The report measured Oregon's Medicaid payment system against broad principles that national policy makers and researchers believe should govern health care provider payment systems. According to the Lewin Group, the overall goal of health care payment policies is to ensure that Medicaid enrollees, who are either low-income or disabled, have access to medically necessary, high-quality health services.

The following criteria can be used to evaluate the equity and performance of payment systems:

- Payment rates are high enough to encourage program participation by efficient providers, ensure access to beneficiaries/enrollees in all markets and to the general population in local markets, and contribute to a financially viable provider marketplace for medical services.

- Payment rates are low enough to minimize taxpayer burden and enable the provision of program services and enrollee coverage, discourage inefficient or excessive service provision, and minimize the clinical risk associated with overuse of services.

- Payments rates are appropriate to the overall market and individual submarkets to sustain program viability across and within a state's market areas and to avoid under and over provision of care, recognizing practice variation from one market to the next.

Additionally, the payment system is easy to explain and understand, simple to administer, and provides predictability for providers and the state.

According to the Lewin Group, many states have recognized that after a period of operation, a careful assessment of Medicaid's payment approach is necessary. As time passes, payment systems may become increasingly inequitable, outdated, and in certain cases, under-funded. Attempts to revamp payment systems are difficult because modifications, after lengthy periods of operation without updating, would be likely to redistribute payments across individual providers and create administrative and political challenges. Although modifying the design of a state healthcare payment system presents risks, ignoring inequities and inefficiencies in Medicaid's payment approach also endangers the well-being of the overall health care system.

The Health Policy Institute of Ohio, in *Ohio Medicaid Reform: Key Issues to Consider* (April 2005), recommends acting with caution when considering cost containment policies. The potential for unintended consequences from any cost-saving strategy should be carefully evaluated. It is possible that a proposal that generates one-time cost savings could cost more in the long-run. Actions to produce intense short-term savings may work in conflict with preferred approaches to pursue long-term cost management initiatives.

The federal match for Medicaid intensifies the financial consequences resulting from cost containment measures. It is impossible for policymakers to simply set a target for reducing the commitment of state dollars without having to reduce total spending by a much greater amount. This distinction between state and federal funds makes assists in understanding the extent of savings that are attributable to certain policy actions.

Stakeholder concerns with cost reduction efforts were discussed during interviews. A member of the Ohio Academy of Family Physicians noted that Ohio Medicaid reimbursed about 60 percent of the Medicare rate for a particular procedure – an amount that was well below the physician's private pay and actual operating costs. He said, "It's ludicrous, I mean, you know … we … take care of these patients despite the fact that it comes out of our wallets, and that's a really tough thing to sell to somebody.." A member of the Ohio Children's Hospital Association said, "…for children's hospitals, Medicaid is a very, very challenging payer. …Other states have rate setting commissions, single payer operations. …California hospitals go through a selective contracting and rate negotiation process." The member said that Ohio Medicaid publishes the rate they will reimbursement the hospitals which covers only about 88 percent costs. In each case, the stakeholder indicated that additional reductions for particular services would have a detrimental affect.

R4.23 The single State Medicaid Agency should develop a documented policy containing detailed goals for setting reimbursement strategies and rates. The Agency should routinely determine if access to Medicaid services and quality of care are compromised when rate setting cost reduction strategies are proposed and implemented. Additionally, the State Medicaid Agency should document service prioritization goals when determining rate setting cost reduction strategies to ensure the most appropriate service rates are reviewed (see the organizational issues section).

The State Medicaid Agency should use the recommended rate reimbursement criteria provided by the Lewin Group to the state of Oregon regarding the equity and performance of its payment systems.

Appendix 4-A: Eligibility

Adult Coverage

Table 4A-1: Federal, Ohio, and Other States' 2003 Adult Medicaid Eligibility Coverage

	Pregnant Women	Parents/Caretaker Relatives	Breast and Cervical Cancer Medicaid	Immigrants
Federal	133% FPL	42% FPL	N/A	N/A
Ohio	**150 % of FPL**	**100 % of FPL**	**200 % of FPL**	**Arrived before 8/22/96 and is documented: he/she may qualify in any eligibility category for which they meet eligibility requirements Arrived on or after 8/22/96: ineligible for Medicaid for five years, with certain exceptions (such as refugees) for which they meet eligibility requirements**
Arizona	133% FPL. No resource Limit	100% FPL. No resource limit.	250% FPL. No income/resource limit.	Must meet the requirements of any eligibility category.
Arkansas	200% FPL.	N/R	200% FPL. No resource limit.	Must qualify through any category.
California	200% FPL. No asset limit.	100% FPL. Asset limit: $3,000-$4,200, depending on family size.	N/R	Must qualify through any category.
Colorado	133% FPL. No asset limit.	N/R	N/R	Must meet eligibility requirements of any eligibility category.
Connecticut	185% FPL. No asset limit.	100% FPL. No resource limit.	Cannot have other medical insurance or be eligible under a mandatory Medicaid eligibility category.	N/R
Delaware	200% FPL.	N/R	Income and resources are not counted.	Must meet qualifications of any category.
Florida	185% FPL. No asset limit.	N/R	200% FPL.	Non-citizens who are eligible on all factors save citizenship status may be eligible for Medicaid to cover medical emergencies.
Georgia	235% FPL. No resource limit.	N/R	Must be uninsured or otherwise ineligible for Medicaid.	N/R
Hawaii	185% FPL. No asset limit.	100% FPL	250% FPL. Asset limits: $2,000 for one person or $3,000 for two,	Must qualify through any eligible category.

	Pregnant Women	Parents/Caretaker Relatives	Breast and Cervical Cancer Medicaid	Immigrants
Illinois	200% FPL. No asset limit.	90% FPL. No asset limit.	200% FPL. No resource limit	Must meet the eligibility requirements of any category.
Indiana	150% FPL. No resource limit.	N/R	250% FPL. Not eligible for other Medicaid programs or have other medical insurance that covers breast/cervical cancer.	Must meet the eligibility requirements of any category.
Iowa	200% FPL. Resource limit: $10,000.	N/R	Available for individuals who do not already have credible coverage.	Must meet income and resource requirements of any eligibility category.
Louisiana	133% FPL. No asset limit. (Expanded to include income 133 to 185% of FPL by disregarding the first 15 %.)	N/R	May not be eligible under any other mandatory eligibility program or have other medical insurance.	Must qualify through any eligibility category
Maine	200% FPL. No asset limit.	N/R	250% FPL. Asset limit: $2,000.	Must meet eligibility requirements of any category.
Massachusetts	200% FPL.	133% FPL.	N/R	Must meet the financial and categorical requirements of Medicaid.
Michigan	185% FPL. No asset test.	Income test. No asset test.	N/R	N/R
Minnesota	275% FPL. No asset limit.	Income cannot exceed 100% FPL. Asset limits: $15,000 for one person and $30,000 for two people.	N/R	Must meet Medical Assistance (MA) eligibility requirements not related to immigration status
Nebraska	185% FPL. No resource limit.	N/R	225% FPL.	Must meet eligibility requirements of any category.
Nevada	133% FPL. Resource limit: $2,000.	N/R	Must be uninsured or underinsured and not eligible in any other Medicaid group.	Must meet eligibility requirements of any category.
New Hampshire	185% FPL. No resource limit.	N/R	Must be uninsured.	Must meet eligibility requirements of any category.
New Jersey	185% FPL. No asset limit.	133% FPL. No asset limit.	N/R	Must meet the same financial requirements as citizens for either Medicaid or S-CHIP eligibility.
New Mexico	185% FPL. No resource limit.	N/R	Must be uninsured.	Must meet all eligibility requirements of existing categories save alien status.
New York	200% FPL. No resource limit.	100% FPL. Resource limit: $3,000.	250% FPL. Must be uninsured.	Must meet eligibility requirements of any category.
North Carolina	185% FPL. No resource limit.	48% FPL. Resource limit: $3,000.	No credible medical insurance coverage. Must meet other general eligibility requirements.	Must meet categorical and financial eligibility requirements, including state residency to be eligible.
Oklahoma	185% FPL. No asset test.	N/R	N/R	Must meet eligibility requirements of any category.
Oregon	170% FPL. No asset limits.	N/R	N/R	Must meet eligibility requirements of any category.
Pennsylvania	185% FPL. No resource limit.	N/R	250% FPL. No resource limit.	Must meet eligibility requirements of any category.
Rhode Island	350% FPL. No asset limit.	N/R	N/R	N/R
Vermont	200% FPL. No resource limit.	185% FPL. Resource limits: $2,000 for one and $3,000 for two.	N/R	N/R

	Pregnant Women	Parents/Caretaker Relatives	Breast and Cervical Cancer Medicaid	Immigrants
Wisconsin	185% FPL. No asset limit.	N/R	250% FPL.	Must meet eligibility requirements of any category.

Source: HHS (2003)
N/R: not reported to HHS.
Note 1: To qualify for Medicaid, a person must meet income and resource requirements. Income is money that one gets from any source. Resources are things like cash, savings, stocks, bonds, and real property. Low income is only one test for Medicaid eligibility; assets and resources are also tested against established thresholds.
Note 2: HHS did not have information for Alabama, Alaska, District of Columbia, Idaho, Kansas, Kentucky, Maryland, Mississippi, Missouri, Montana, North Dakota, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, and Wyoming.
Note 3: Arkansas resource limits for its medically needy, adult, children, and family income and resource levels are $2,000 to $3,800 depending upon family size.

Families/Children

Table 4A-2 illustrates Ohio and other states' (for which data was available) 2003 families/children qualifications for Medicaid eligibility categories.

Table 4A-2: Ohio and Other States' 2003 Families/Children Medicaid Eligibility Coverage

	Children up to age 19 (Healthy Start)	Temporary Assistance for Needy Families (TANF)
Ohio	**0-18: 200% FPL.**	**Families that participate in the Ohio Works First cash assistance program are automatically covered by Medicaid.**
Arizona	Sixth Omnibus Reconciliation Act (SOBRA)<1: 133% FPL. SOBRA 1-5: 133% FPL. SOBRA 6-18: 100% FPL. No resource limit.	100% FPL
Arkansas	0-5: 133% FPL. 6-18: 100% FPL. No resource limit	Total countable resources cannot exceed $1,000 for the assistance unit. No income test for the first six months; thereafter, 185% FPL.
California	<1= 200% FPL. 1-5: 133% FPL. 6-18: 100% FPL. No resource limit.	100% FPL
Colorado	<1: 133% FPL. No asset limit. 1-6: 133% FPL. Resource limit: $1,000.	Income below AFDC Need Standard. Resource limit: $2,000.
Connecticut	0-18: 185% FPL. 9-20: 100% FPL. No asset limit.	Must meet income and asset eligibility requirements established by AFDC.
Delaware	<1: 200% FPL. 1-6: 133% FPL. 6-19: 100% FPL.	75% FPL.
Florida	<1: 200% FPL. 1-5: 133% FPL. 6-20= 100% FPL.	25% FPL. Asset limit: $2,000 Homestead and cars up to $4,500 do not count as assets.
Georgia	<1: 185% FPL. 1-5: 133% FPL. 6-18: 100% FPL. No resource limits for any category.	Income Limits: $235 to $500 per month, dependent upon size of family.
Hawaii	< 1:185% FPL. 1-6: 133% FPL. 6-19: 100% FPL. No asset tests for any category.	100% FPL
Illinois	0-18: 133% FPL. No asset limits.	Income limits are dependent upon county groupings and range between $435 and $408. Asset limits: $2,000 for one person, $3,000 for two people, and $50 for each additional person.
Indiana	0-18: 150% FPL. No resource limit.	100% FPL. Resources cannot exceed $1,000.
Iowa	<1: 200% FPL. 1-18: 133% FPL. No resource limit.	Income limits: $183-$670, depending on family size. Resource limits: $2,000 per applicant household, $5,000 per recipient household.
Louisiana	0-5: 133% FPL. 6-19: 100% FPL. No asset limit.	Income cannot exceed 15% of FPL. No asset limit.
Maine	0-18: 200% FPL. No asset limit.	Automatically eligible for Medicaid based on eligibility for TANF.

	Children up to age 19 (Healthy Start)	Temporary Assistance for Needy Families (TANF)
Massachusetts	<1: 200% FPL. 1-18: 150% FPL.	Eligible for MassHealth based on their eligibility for Transitional Aide to Families with Dependent Children cash assistance, but may choose to receive MassHealth.[l]
Michigan	<1: 185% FPL. 1-18: 150% FPL. No asset limit.	Earned income disregard is $200 plus 20% of remainder. Asset limit: $3,000.
Minnesota	<2: 275% FPL. 2-18: 170% FPL. 19-20: 100% FPL. No asset limit for any category.	<2: 275% FPL. 2-18: 170% FPL. 19-20: 100% FPL. No asset limit for any category.
Nebraska	<1: 150% FPL. 1-5: 133% FPL. 6-18: 100% FPL. No resource test for any category.	Income limits depend upon the number of individuals in the family, but is around 40% of FPL. Resource limits: $4,000 for one person and $6,000 for two or more people.
Nevada	1-5: 133% FPL. 6-18: 100% FPL. Resource limits: $2,000 to $4,200, depending on family size.	Resources cannot exceed $2,000 per case.
New Hampshire	<1: 300% FPL. 1-19: 185% FPL. No resource limit for either category.	Income limits depend on the number of family members and ranges from $489 to $688. Resource limits: $1,000 for applicants and $2,000 for recipients.
New Jersey	<1: 185% FPL. 1-18: 133% FPL. No asset test.	There are gross income limits dependent on the size of the family that range from $243 to $732. There is an asset limit of $2,000.
New Mexico	0-18: 185% FPL.	New Mexico Works program which uses TANF criteria with certain exceptions. No resource limit.
New York	<1: 200% FPL. 1-18: 133% FPL. No resource limit.	Income limit: $642 for one to $1,417 for eight, plus $142 for each additional person. Asset limit: $3,850 for one to $8,500 for eight, plus $850 for each additional person.
North Carolina	<1: 185% FPL. 1-5: 133% FPL. 6-18: 100% FPL. No resource limit.	Automatically eligible for Medicaid if currently eligible for and receiving Work First cash assistance payments.
Oklahoma	0-18: 185% FPL. No asset test.	Income limits are determined by family size. No asset test.
Oregon	<1: 170% FPL. 1-5: 133% FPL. 6-18: 100% FPL. No resource limit for any category.	50% FPL. Resource limit: $2,500.
Pennsylvania	<1: 185% FPL. 1-5: 133% FPL. 6-18: 100% FPL. There is no resource limit.	Automatically eligible if receiving TANF cash assistance.
Rhode Island	0-18: 250% FPL. No asset test	Automatically eligible if receiving TANF cash assistance.
Vermont	0-18: 300% FPL. No resource limit.	Automatically eligible if receiving TANF cash assistance.
Wisconsin	<6: 185% FPL. 6-18: 100% FPL. No asset limit for either category.	Automatically eligible if receiving TANF cash assistance.

Source: HHS (2003)

Note 1: HHS did not have information for Alabama, Alaska, District of Columbia, Idaho, Kansas, Kentucky, Maryland, Mississippi, Missouri, Montana, North Dakota, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, and Wyoming.

[l] Massachusetts Medicaid and S-CHIP are combined into one program called MassHealth.

Medically Needy and Spend-down Medicaid

Table 4A-3: Ohio and Other States' 2003 Medically Needy Medicaid Eligibility Coverage

States	Spend-down Medicaid
Ohio	**If an individual's countable income exceeds the Medicaid need standard, but is otherwise eligible by meeting all other eligibility requirements such as citizen, residence, resources, etc**
Arizona	40% FPL. Resources cannot exceed $100,000.
Arkansas	Income limit: $108-$675. Resource limit: $2,000-$3,800, depending upon family size.
California	Must meet SSI disability of AFDC requirements. Income limits: $600-$1959. Asset limit: $2,000-$4,200, depending on family size.
Colorado	N/R
Connecticut	Asset limits: $1,600 for an individual, $2,400 for a couple.
Delaware	No medically need category.
Florida	Gross income after medical expenses must be below limits for regular Medicaid. Asset limits: $5,000-$16,500.
Georgia	Income limits: $208-$442, dependent upon family size and category. Resource limits: $2,000 to $4,200, dependent upon size of family.
Hawaii	No income limits. QUEST [1] families cannot have income exceeding 300% FPL.
Illinois	Income limit: $283-$558, depending on family size. No asset limit.
Indiana	As long as meets all other qualifications, needs to spend-down excess income each month before being Medicaid eligible.
Iowa	Resource limit: $10,000 for all eligibles except children. No resource limit for children.
Louisiana	Income limit: $100 for individuals, $192 for a couple. Resource limit: $2,000 per individual, $3,000 per couple.
Maine	Asset limits: $2,000 for one, $3,000 for two people, and $100 for each additional person.
Massachusetts	As long as the individual meets the program requirements, but exceeds the income requirements, he or she can spend-down the income.
Michigan	Income limit: $341-$1,126, depending on family size and county. Asset limits: $2,000 for one person, $3,000 for two people or a family group.
Minnesota	Applicants can spend-down their income to qualify for Medicaid.
Nebraska	Three categories can spend-down: Ribcoff Children, Aid to the Aged Blind, and Disabled Medically Needy, and Medically Needy Caretaker Relatives.
Nevada	No medically needy category.
New Hampshire	Eligible if income is above limits, but all other requirements are met. Resource limits: $2,500 for one, $4,000 for two or more.
New Jersey	Asset limit: $4,000 for one person, $6,000 for two people, and $100 for each additional person.
New Mexico	Only refugees are eligible under this category.
New York	Income limit: $642 for one to $1,417 for eight, plus $142 for each additional person. Resource limits: $3,850 for one to $8,500 for eight, plus $850 for each additional person.
North Carolina	Income limit: $400 per month for a family of four. Resource limit: $3,000.
Oklahoma	If income and resources are not sufficient to net costs associated with medical care, eligible people can spend-down.
Oregon	Resource limits: $2,000 for one person, $3,000 for two people, and $50 for each additional person.
Pennsylvania	Income limits based on family size. There are some resource limits determined by the intended use of funds.
Rhode Island	Individuals who are not considered "medically needy" can spend-down their income.
Vermont	Must meet Aid to Needy Families with Children or SSI related criteria and must be eligible for Medicaid per all other requirements.
Wisconsin	There are specific groups eligible for the spend-down program including pregnant women, children under age 19, and disabled individuals.

Source: HHS (2003)
N/R: not reported to HHS.
Note 1: HHS did not have information for Alabama, Alaska, District of Columbia, Idaho, Kansas, Kentucky, Maryland, Mississippi, Missouri, Montana, North Dakota, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, and Wyoming.
[1] QUEST is Hawaii's free or low-cost Medicaid for children.

Elderly and Disabled

Table 4A-4: Ohio and Other States' 2003 Elderly and Disabled Medicaid Eligibility Coverage

	Aged, Blind, and Disabled (ABD) receiving SSI [1]	Institutional Level of Care [2]	Qualified Medicaid Beneficiaries (QMB's), Specified Low-income Medicare Beneficiaries (SLIMB), Qualified Individual (QI) [3]
Ohio	**Automatically eligible for Medicaid based on eligibility definition for SSI**	**Income must be less than cost of care**	**QMB: 100 % FPL. SLMB: 120 % FPL. QI: 135 % FPL.**
Arizona	Income limit: $552 for single, $829 for a couple, approximately 76% of FPL. Resource limit: $2,000 for single, $3,000 for a couple.	300% of SSI. Resource limit: $2,000 for an individual.	QMB: 100% FPL. SLMB: 120% FPL. QI-1: 135% FPL. No resource limit.
Arkansas	Automatically eligible for Medicaid on the basis of their eligibility for SSI. Income limit: $545 for single, $817 for a couple. Resource limit: $2,000 single, $3,000 for a couple.	Income cannot exceed $1,635 per month unless an income trust is established. Resource limit: $2,000 for single, $3,000 for a couple.	QMB: $738 for single, $995 for a couple. SLMB: $738-$886 for single, $995-$1,194 for a couple. QI-1: $886-$996 for single, $1,194-$1,343 for a couple. Resource limit: $4,000 for one, $6,000 for two for all categories.
California	Automatically eligible for Medicaid. Resource limit: $2,000 for single, $3,000 for a couple.	Income limit: $600-$1,959, dependent upon family size. Resource limit: $2,000.	QMB: 100% FPL. SLMB: 120% FPL. QI-1: 135% FPL. Asset limit: Two times SSI, about $4,000 for one.
Colorado	Income limit: $512 per month. Asset limit: $2,000 for single, $3,000 for a couple.	Income limit: $1,635 per month. Asset limit: $2,000 for single, $3,000 for a couple.	QMB: 100% FPL. Income limit: $759 for individual, $1,015 for a couple.
Connecticut	Income limit: $1,656 for an individual. Asset limits: $1,600 for an individual, $3,200 for a couple, and $19,732 if one is receiving services.	Income cannot exceed monthly cost of nursing home care. Asset limits vary depending on marital status.	QMB: 100% FPL. SLMB: 120% FPL. QI: 135% FPL. Asset limits: $4,000 for an individual, $6,000 for a couple for all categories.
Delaware	Categorically eligible for Medicaid based on eligibility for SSI.	250% of SSI payment rate. Resource limits: $2,000 for one, $3,000 for two.	QMB: 100% FPL. SLMB: 120% FPL. Resource limit: $4,000 for an individual, $6,000 for a couple for both categories. QI-1: 135% FPL. QI-2: 175% FPL.
Florida	Automatically eligible for Medicaid. Income limit: $552 per month for an individual. Resource/asset limit: $2,000.	Income limit: $1,656 for an individual, $3,312 for a couple in the same facility. Asset limit: $2,000 for an individual, $3,000 for a couple if both are institutionalized.	QMB: Income <$749 per month. SLMB: Income between $749-898. Asset limits: $5,000 for an individual, $6,000 for a couple for both categories.
Georgia	Income limits: $545 per month for an individual, $817 for a couple. Resource limits: $2,000 for an individual, $3,000 for a couple	Income limit: $1,635 per month. Resource limit: $2,000.	QMB: 100% FPL. SLMB: 120% FPL. QI: 135% FPL. Resource limit: $4,000 for an individual, $6,000 for a couple for all categories.
Hawaii	100% FPL. Asset limits: $2,000 for one, $3,000 for two.	Income does not exceed monthly medical expenses. Resource limit: $2,000 for one, $3,000 for two.	QMB: 100% FPL. SLMB: 120% FPL. QI-1: 135% FPL. QI-2: 175% FPL. Asset limits: $4,000 for one, $6,000 for two for all categories.
Illinois	Must apply for Medicaid.	N/R	QMB: 100% FPL. SLMB: 120% FPL. QI-1: 135% FPL. Asset limits: $4,000 for one, $6,000 for two for all categories.
Indiana	Income limits: $552 per month for an individual, $829 per month for a couple. Resources limit: $1,500 for	N/R	QMB: 100% FPL. SLMB: 120% FPL. QI-1: 135% FPL. Resource limit: $4,000 for an individual, $6,000 for a couple for all categories.

	Aged, Blind, and Disabled (ABD) receiving SSI [1]	Institutional Level of Care [2]	Qualified Medicaid Beneficiaries (QMB's), Specified Low-income Medicare Beneficiaries (SLIMB), Qualified Individual (QI) [3]
	an individual, $2,250 for a couple.		
Iowa	Income limit: $552 for an individual, $829 per couple. Resource limit: $2,000 per individual, $3,000 for a couple.	Income cannot exceed 300% of the basic SSI benefit. Resource limit: $2,000 for an individual, $3,000 for a couple.	QMB: 100% FPL. SLMB: 120% FPL. Resource limits: $4,000 for an individual, $6,000 for a couple for both categories.
Louisiana	Income and asset limits are the same as SSI.	Income < 3 times the SSI amount that applies to the applicant. Resources limit: $2,000 for one, $3,000 for two.	QMB: 100% FPL. SLMB: 20% FPL. QI-1: 135% FPL. Asset limit: $4,000 for one person, $6,000 for two people for all categories.
Maine	Individuals receiving SSI are automatically eligible for Medicaid	N/R	QMB: 100% FPL. SLMB: 120% FPL. Asset limit: $4,000 for one person, $6,000 for two people for both categories.
Massachusetts	N/R	N/R	N/R
Michigan	SSI recipients are automatically eligible for Medicaid.	N/R	QMB: 100% FPL. SLMB: 120% FPL. Asset limit: twice the SSI level for both categories.
Minnesota	Income limit: $739 per month for one person, $995 per month for two. Asset limits: $3,000 for one person, $6,000 for a household of two, and $200 for each additional household member.	N/R	QMB: 100% FPL. SLMB: 120% FPL. QI: 135% FPL. Asset limits: $10,000 for one person, $18,000 for a couple for all categories.
Nebraska	Income limits: $563 per month for an individual, $835 per month for a couple. Resource limits: $2,000 for an individual, $3,000 for a couple.	N/R	QMB: 100% FPL. SLMB: 120 % FPL. QI-1: 135% FPL. Resource limits: $4,000 for one, $6,000 for two for all categories.
Nevada	Income cannot exceed 300% the SSI payment level.	N/R	QMB: 100% FPL. SLMB: 100%-120% FPL. QI-1: 120%-135% FPL.
New Hampshire	Income limits: $566 for one person, $830 for two people. Resource limit: $1.500.	N/R	QMB: 100% FPL. SLMB: 120% FPL. Resource limits: $4,000 for one person, $6,000 for a couple for both categories.
New Jersey	Automatically eligible for Medicaid.	Income limit: $1,635 per month. Asset limit: $2,000 for one, $3,000 for two.	QMB: 100% FPL. SLMB: 135% FPL. Asset limit: $4,000 for an individual, $6,000 for a couple for both categories.
New Mexico	Income limits: $552 per month for an individual, $829 per month for a couple. Resources limits: $2,000 for an individual, $3,000 for a couple.	Income limit: $1,636. Resource limit: $2,000.	QMB: 100% FPL. SLMB: 120% FPL. OI-1: 135% FPL. Resource limit: $4,000 for one person, $6,000 for a couple for all categories.
New York	74% FPL. Resource limits: $2,000 for one, $3,000 for two.	N/R	QMB: 100% FPL. SLMB: 120% FPL. OI-1: 135% FPL. Resource limit: $4,000 for one person, $6,000 for a couple for all categories.
North Carolina	Automatically eligible for Medicaid on the basis of their eligibility for SSI.	Income must be less than the cost of long-term care. Resource limit: $2,000 per individual.	QMB: 100% FPL. SLMB: 120% FPL. QI: 135% FPL. Resource limit: $4,000 for one, $6,000 for two for all categories.
Oklahoma	Automatically eligible for Medicaid on the basis of their eligibility for SSI.	N/R	QMB: 100% FPL. SLMB: 120% FPL. QI-1: 135% FPL. QI-2: 175% FPL. Resource limits: $4,000 for an individual, $6,000 for a couple for all categories.
Oregon	Resource limit: $2,000 for one, $3,000 for two.	N/R	QMB: 100% FPL. SLMB: 135% FPL.
Pennsylvania	Automatically eligible for Medicaid. Resource limit: $2,000 for one, $3,000 for two.	Income limits: 300% FBR for Categorically Needy individuals, $2,550 for Medically Needy Only individuals. Resource limits: $2,000-$2,400	QMB: 100% FPL. SLMB: 120% FPL. QI-1: 135% FPL. Resource limits: $4,000 for one person, $6,000 for two people for all categories.

	Aged, Blind, and Disabled (ABD) receiving SSI [1]	Institutional Level of Care [2]	Qualified Medicaid Beneficiaries (QMB's), Specified Low-income Medicare Beneficiaries (SLIMB), Qualified Individual (QI) [3]
		depending on qualification status.	
Rhode Island	Income limit: $700 per month. Asset limits: $4,000 for an individual, $6,000 per couple.	Income cannot exceed the cost of care.	QMB: 100% FPL. SLMB: 120% FPL. QI-1: 135% FPL. Resource limits: $4,000 for one person, $6,000 for a couple for all categories.
Vermont	Must be eligible for SSI and/or AABD, or meet other categorically needy requirement..	N/R	QMB: 100% FPL. SLMB: 120% FPL. QI-1: 135% FPL. Resource limit: $4,000 for one person, $6,000 for a couple for all categories.
Wisconsin	Must be receiving SSI or meet income and asset requirements.	N/R	QMB: 100% FPL. SLMB: 120% FPL. Asset limits and resource limit: $4,000 for one person, $6,000 for a couple for both categories.

Source: HHS (2003)

Note 1: HHS did not have information for Alabama, Alaska, District of Columbia, Idaho, Kansas, Kentucky, Maryland, Mississippi, Missouri, Montana, North Dakota, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, and Wyoming.

[1] To qualify for ABD Medicaid, applicants must be age 65 or over or considered legally blind or an individual with a disability (as classified by the Social Security Administration) and be a U.S. citizen or meet Medicaid citizenship requirement. When applying for ABD Medicaid, proof of income, resources, age or disability, citizenship (if not a U.S. citizen) and other health insurance is required. A face to face interview with the local county department of job and family services is also necessary.

[2] ABD Medicaid provides long-term care services in Nursing Facilities (NFs) and Intermediate Care Facilities for the mentally retarded (ICF/MRs). Home and Community Based Services Waivers provide home health care to individuals who wish to stay in their home but otherwise need institutional care. The number of consumers that can be enrolled in a waiver program at any one time is limited. There are several types of waivers.

[3] QMB individuals are entitled to Medicare Part A, have income of 100% FPL or less and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for full Medicaid. SLMB individuals are entitled to Medicare Part A, have income of greater than 100 percent FPL, but less than 120 percent FPL and resources that do not in exceed twice the limit for SSI eligibility, and are eligible for full Medicaid benefits. QI individuals are entitled to Medicare Part A, have income of at least 120 percent FPL, but less than 135 percent FPL, resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only. FFP equals FMAP at 100 percent.

State Children's Health Insurance Program

Table 4A-5: Ohio and Other States' 2003 SCHIP Medicaid Eligibility Coverage

State	SCHIP Children up to age 19
Federal	Preschool Children: 133% FPL, School Age Children: 100% FPL
Ohio	**200% FPL. No resource limit**
Arizona	200% of FPL. No resource limit.
Arkansas	200% of FPL. No resource limit.
California	250% FPL. No resource test.
Colorado	185% FPL. No asset limit.
Connecticut	300% FPL.
Delaware	200% FPL. No resource limit.
Florida	200% FPL. No asset limit.
Georgia	235% FPL. No resource limit.
Hawaii	200% FPL.
Illinois	200% FPL.
Indiana	200% FPL. No resource limit.
Iowa	1-18= < 133% FPL. No resource limit. Children under 1 at 200% FPL are already covered under Medicaid.
Louisiana	200% FPL. No asset limit.
Maine	200% FPL. No asset limit.
Massachusetts	200% FPL. No asset limit.
Michigan	200% FPL. No asset limit.
Minnesota	<2: 280% FPL. No asset limit.
Nebraska	185% FPL. No resource test.
Nevada	200% FPL.
New Hampshire	300% FPL. No resource limit.
New Jersey	350% FPL. No asset limit.
New Mexico	235% FPL. No resource limit.
New York	250% FPL.
North Carolina	200% FPL. No resource limit.
Oklahoma	185% FPL. No asset test.
Oregon	< 170% FPL. Resource limit: $5,000.
Pennsylvania	200% FPL.
Rhode Island	185% FPL. There is no asset test.
Vermont	300% FPL. No resource limit.
Wisconsin	185% FPL. No asset limit.

Source: HHS (2003)

Note: HHS did not have information for Alabama, Alaska, District of Columbia, Idaho, Kansas, Kentucky, Maryland, Mississippi, Missouri, Montana, North Dakota, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, and Wyoming.

Appendix 4-B: Long-term Care Spending

Table 4B-1: Distribution of Medicaid Spending on Nursing Facilities, Home Health, and Mental Health and ICF/MR, FFY 2003-04

	Nursing Facility	Home Health and Personal Care	Mental Health & ICF/MR
Ohio	**53.8%**	**21.9%**	**24.3%**
Alabama	63.6%	29.9%	6.5%
Alaska	35.9%	58.9%	5.2%
Arizona	46.7%	36.9%	16.4%
Arkansas	56.0%	24.6%	19.4%
California	30.4%	42.6%	27.0%
Colorado	44.3%	50.6%	5.1%
Connecticut	49.0%	38.3%	12.7%
Delaware	55.6%	28.3%	16.1%
Florida	59.0%	32.6%	8.4%
Georgia	56.6%	36.6%	6.8%
Hawaii	61.1%	36.4%	2.5%
Idaho	38.5%	40.8%	20.7%
Illinois	47.7%	26.9%	25.4%
Indiana	46.7%	24.7%	28.6%
Iowa	42.5%	32.4%	25.1%
Kansas	37.3%	53.0%	9.7%
Kentucky	54.3%	31.7%	14.0%
Louisiana	44.1%	23.9%	32.0%
Maine	32.4%	54.5%	13.1%
Maryland	51.3%	34.1%	14.6%
Massachusetts	48.2%	43.4%	8.4%
Michigan	77.7%	20.5%	1.8%
Minnesota	33.9%	57.7%	8.4%
Mississippi	61.5%	14.8%	23.7%
Missouri	46.2%	37.3%	16.5%
Montana	55.4%	38.1%	6.5%
Nebraska	52.9%	33.5%	13.6%
Nevada	47.5%	32.0%	20.5%
New Hampshire	60.3%	38.5%	1.2%
New Jersey	47.6%	30.7%	21.7%
New Mexico	29.5%	66.7%	3.8%
New York	37.6%	43.8%	18.6%

	Nursing Facility	Home Health and Personal Care	Mental Health & ICF/MR
North Carolina	41.0%	41.6%	17.4%
North Dakota	56.2%	23.9%	19.9%
Oklahoma	45.0%	37.2%	17.8%
Oregon	25.0%	71.2%	3.8%
Pennsylvania	65.2%	24.4%	10.4%
Rhode Island	53.4%	42.5%	4.1%
South Carolina	44.3%	35.0%	20.7%
South Dakota	53.6%	36.8%	9.6%
Tennessee	61.9%	23.7%	14.4%
Texas	36.3%	45.1%	18.6%
Utah	33.4%	46.3%	20.3%
Vermont	39.6%	60.0%	0.4%
Virginia	42.1%	27.4%	30.5%
Washington	34.7%	55.1%	10.2%
West Virginia	50.0%	38.0%	12.0%
Wisconsin	46.9%	40.1%	13.0%
Wyoming	34.2%	50.8%	15.0%
Average percentage	**47.4%**	**38.3%**	**14.3%**

Source: Pew Center on the States Special Report on Medicaid 2006

Note: The nursing facility and home health costs were compiled from estimates by Urban Institute and Kaiser based on uninsured estimates from the CMS data. The mental health and ICF/MR percentages were estimated based on what was left to make of 100 percent of the spending and the Kaiser Commission on Medicaid Facts for FFY 2003-04.

Appendix 4-C: Reimbursement Methodologies

Table 4C-1: Other States' Medicaid Service Reimbursement Methodologies

Service	Ohio	California	Florida	Georgia	Illinois
Institutional & Clinic Services					
Clinic Services, by an organized facility or clinic not part of a hospital: Freestanding Ambulatory Surgery Center	Fee for service using surgical group rates, ancillaries paid separately	Fee for service	Medicare payment rates adjusted by county wage index	Prospective cost based rate per episode of care using Medicare payment rates as ceiling	Fee for service at 75% of rate paid in outpatient hospital setting
Clinic Services, by an organized facility or clinic not part of a hospital: Public Health and Mental Health Clinics	Fee for service for Public Health Clinics, cost based payment for Mental Health Clinics	Fee for service	Fee for service or prospective cost based rate for primary care	Fee for service	Fee for service, $75/encounter for specified clinics
Practitioner Services					
Dental Services	Fee for service	Fee for service	Not covered	Fee for service	Fee for service through contracted intermediary
Physician Services	Fee for service	Fee for service, some services performed in outpatient hospital setting paid 80% of fee	Fee for service or prospective cost based rate	Fee for service	Fee for service, certified cost for certain government-employed practitioners
Institutional Care					
Inpatient Hospital, Nursing Facility and Intermediate Care Facility Services in Institutions for Mental Diseases, age 65 and older	Prospective payment/discharge using DRG	Prospective cost based per diem	Prospective cost based per diem	Not covered	Prospective cost based per diem for private facilities, per diem based on certified cost for state-operated facilities, nursing facilities paid for leave days at 75% of facility's rate

Source: Kaiser Family Foundation, State Health Facts

Table 4C-1: Other States' Medicaid Service Reimbursement Methodologies (Cont.)

Service	Ohio	Massachusetts	Michigan	New York	Pennsylvania	Texas
Institutional & Clinic Services						
Clinic Services, by an organized facility or clinic not part of a hospital: Freestanding Ambulatory Surgery Center	Fee for service using surgical group rates, ancillaries paid separately	Fee for service	Fee for service using physician reimbursement rates	Prospective cost based rate	Fee for service	Prospective cost based rate per episode of care using Medicare payment rates as ceiling
Clinic Services, by an organized facility or clinic not part of a hospital: Public Health and Mental Health Clinics	Fee for service for Public Health Clinics, cost based payment for Mental Health Clinics	Fee for service	Cost based payment for public health clinics, mental health clinics paid at capitation rate	Fee for service or prospective cost based rate	Fee for service	Not covered
Practitioner Services						
Dental Services	Fee for service	Fee for service	Fee for service	Fee for service	Fee for service	Fee for service
Physician Services	Fee for service	Fee for service	Fee for service	Fee for service	Fee for service with maximums/day dependent on setting, second and subsequent surgeries performed at same time paid a reduced fee	Fee for service
Institutional Care						
Inpatient Hospital, Nursing Facility and Intermediate Care Facility Services in Institutions for Mental Diseases, age 65 and older	Prospective payment/discharge using DRG	Prospective cost based per diem	Prospective cost based per diem with limits, reduced per diem paid for hospital leave days	Prospective cost based per diem	Per diem using case-mix payment system, hospital leave days paid at 1/3 of nursing facility's rate and therapeutic leave days paid at full rate	Not covered

Source: Kaiser Family Foundation, State Health Facts

Managed Care and Care Management

Managed Care and Care Management Table of Contents

Background

This section of the performance audit examines the use of managed care and care management in Ohio. The primary objective is to evaluate the use of managed care and care management practices to improve health outcomes for Ohio recipients of Medicaid, and reduce program costs through improved care management.

Managed care is a system of medical management that links patients, purchasers, administrators, and providers together with the common goals of improving health care quality and reducing costs. This review of managed care for Medicaid recipients examines the history of managed care in Ohio, Ohio's decision to expand managed care, national trends, alternative healthcare models, and how access to care can be improved.

In addition to managed care, this report will review care management activities. Care management is a process designed to organize and coordinate medical services. In this report, the review of care management will focus on three distinct areas: case management, disease management, and utilization review/utilization management.

The Development and Growth of Managed Care

The early roots of managed care started with companies that offered health services as a way to recruit and retain workers. The Kaiser Corporation was the first to suggest using capitated payments[1] to pay for health services for the workers on the Grand Coulee Dam project in the 1930's. Using capitation was so successful that the Kaiser Corporation founded the Kaiser Foundation Health Plan during WWII to provide health services to large numbers of ship builders joining the company. In 1945, the Group Health Cooperative of Puget Sound was founded in Seattle, Washington. This was the first Health Maintenance Organization (HMO) in which physicians were directly salaried by the plan. In 1954, the San Joaquin Foundation for Medical Care, the first association of independently practicing physicians, was formed. This group allowed local physicians to provide comprehensive health care for a fixed capitated rate without having to join a group practice. In 1973, the federal HMO Act allowed managed care plans to expand and increase their membership through government loans, grants, and contracts. After the passage of the HMO Act, support for managed care from the business and public sector began to increase. In the early 1970's, the United States Department of Health, Education and Welfare (now Health and Human Services) became alarmed by projections of the rising cost of Medicare and Medicaid and began to look at managed care as a way to control expenses. Like

[1] A capitated rate refers to a method of payment for health services in which an individual or institutional provider is paid a fixed, per capita amount for each person without regard to the actual number or nature of services provided. Capitation is characteristic of managed care practices. Capitation differs from fee-for-service (the traditional payment methodology) in that fee-for-service results in payment for each service where capitation results in payment for each person, irrespective of services provided.

managed care in the private-sector health insurance industry, Medicaid managed care has steadily grown since the 1970's as a service delivery model.

Except for small-scale, voluntary managed care enrollment in a few areas, Medicaid operated almost exclusively on a fee-for-service[2] basis from its inception in the 1960's until 1982. Certain states, including Ohio, limited the use of managed care to small portions of the Medicaid population, such as pregnant women. Arizona[3], which until 1982 had not participated in the Medicaid program, requested a waiver to operate Medicaid as a prepaid, capitated managed care demonstration project. The Health Care Financing Administration (HCFA), now known as the Centers for Medicare and Medicaid Services (CMS), granted Arizona's request and permitted the state to operate its Medicaid program using managed care arrangements. This was the first instance of using managed care for Medicaid on a statewide basis. Other states expressed interest in using managed care to provide Medicaid benefits to a large percentage of their eligible populations, and HCFA approved mandatory managed care organization enrollment in certain metropolitan areas of Minnesota, Missouri, and Wisconsin during the 1980's. HCFA developed a managed care waiver[4] process for states during the 1980's, with the provision that the cost of the program under managed care could not exceed the cost (known as the Upper Payment Limit) of providing the same services on a fee-for-service basis to an actuarially equivalent non-enrolled population group. Interest in waivers for Medicaid managed care plans increased throughout the 1990s.[5] Between 1991 and 2000, the number of Medicaid recipients in managed care grew from 2.7 million to 18.8 million. As of June 30, 2005, the Kaiser Foundation reported that 28.6 million, or 63 percent of the total eligible Medicaid population in the U.S., were enrolled in managed care. In comparison purposes, approximately 40 percent of individuals with private insurance in the U.S. were enrolled in a managed care plan.

In commercial insurance and governmental healthcare, managed care has steadily increased in use and has become the predominate healthcare delivery model. While 63 percent of Medicaid recipients receive service under managed care, the percentage enrolled by state (penetration rate) varies. Tennessee, Nevada and Puerto Rico had the highest managed care penetration rates at 100 percent; Ohio had a rate of 31 percent; Alaska and Wyoming had implemented no managed care

[2] Fee-for-service means a physician or other practitioner bills for each treatment or service rendered and then receives reimbursement for that treatment or service based on a fee schedule.

[3] Prior to 1982, Arizona was the only state in the U.S. that had declined federal Medicaid funds for low-income women, children, aged, blind, and the disabled. Rather than accepting federal funds for health care, the state had a disjointed system of indigent health care provided by individual counties as it saw fit and could afford. In 1980, the counties turned to the Arizona legislature for funding assistance. The legislature responded and passed legislation in 1981 that created the Arizona Health Care Cost Containment System (AHCCCS). On October 1, 1982, AHCCCS became the first statewide Medicaid managed care system in the nation.

[4] The term "waiver" refers to a process whereby states can obtain CMS approval to modify how they administer Medicaid programs. Under waivers, states can modify eligibility, benefits, and cost sharing to models that diverge from the federal standards and remain eligible to receive federal matching funds.

[5] CMS no longer requires states to request waivers to operate their Medicaid programs under managed care plans. Instead, states are only required to identify the use of managed care within their state Medicaid plans.

models of service delivery for their Medicaid populations. **Table 5-1** illustrates the growth of managed care enrollment from 1996 to 2004.

Table 5-1: National Medicaid Managed Care Enrollment

Year	Total Medicaid Population	Managed Care Population	Percent Enrolled in Managed Care
1996	33,241,147	13,330,119	40.10%
1997	32,092,380	15,345,502	47.82%
1998	30,896,635	16,573,996	53.64%
1999	31,940,188	17,756,603	55.59%
2000	33,690,364	18,786,137	55.76%
2001	36,562,567	20,773,813	56.82%
2002	40,147,539	23,117,668	57.58%
2003	42,740,719	25,262,873	59.11%
2004	44,355,955	26,913,570	60.68%

Source: CMS 2004 Medicaid Managed Care Enrollment Report.
Note: This data was not tested due to time constraints and the availability of source data.

As shown in **Table 5-1**, over eight years, the population enrolled in managed care nationwide has increased by 51 percent. However, the effects of managed care as a service delivery model for Medicaid populations are not widely known and the reported cost savings achieved through managed care may not be sustainable over the long-term, as discussed below. Therefore, while managed care has supplanted fee-for-service in a majority of Medicaid markets, the long-term efficacy of managed care as a single delivery model for Medicaid recipients has not been demonstrated.

Impact of Managed Care on Health Care Costs

Proponents of the managed care systems believed they would be able to control costs through managerial oversight of the medical system. Private sector management involvement in strategic planning, resource acquisition, and allocation, as well as all aspects of financing, was deemed essential to coordinating and combining the insurance and delivery components of healthcare. Managed care proponents anticipated that increased administrative efficiency and improved physician decision-making would lead to meaningful cost reductions. By placing an emphasis on outcomes research and utilization review,[6] managed care plans have sought to reduce the use of expensive inpatient and specialist care, common in American medicine, without compromising quality. By requiring all providers to accept some financial risk for providing care, and thereby aligning the financial incentives of payers, physicians, and hospitals, more immediate cost

[6] Utilization review involves post-payment review of services to monitor provider performance and trends in service use.

reductions were anticipated. However, reviews of managed care have yielded mixed results in terms of the effectiveness of managed care in attaining cost containment while maintaining quality. For instance, *Managed Care and Preventable Hospitalization among Medicaid Adults* (Basu, Friedman, and Burstin, 2004) found that, while private HMOs were successful in decreasing preventable hospitalizations, there was no significant difference between Medicaid managed care and fee-for-service rates of preventable hospitalization.

According to *Medicaid in North Carolina, Annual Report State Fiscal Year 2005* (North Carolina Department of Health and Human Services Division of Medical Assistance, May 2006), the Community Care of North Carolina program made significant progress during SFY 2004-05. Eligibility to participate in a managed care plan is mandatory for the majority of Medicaid recipients in North Carolina and 71 percent of the Medicaid eligible population is covered under managed care. Through this managed care plan, Mercer Management Consulting determined that the program saved the state $124 million during SFY 2003-04 by controlling costs and more closely managing specific diseases such as sickle cell anemia, diabetes, and asthma.

While states report cost savings from implementing Medicaid managed care, some recent research notes that these savings may be short-term. In *Second Generation of Medicaid Managed Care: Can It Deliver* (Gold, and Mittler, 2000), researchers reported that the first states that implemented Medicaid managed care experienced initial cost savings because the programs resulted in reduced payments to providers. However, the cost savings decreased as the program matured; providers started demanding payments more in line with Medicare and private insurance payments in order to cover the cost of care to Medicaid recipients. A member of the Ohio Association of Nursing Homes raised the issue of administrative costs and projected savings during a stakeholder interview.

> "I would suggest to the powers that be here to look long and hard at [administrative costs]... because from what I've seen of the managed care industry, all you're doing basically is paying for somebody's yacht because you've got a whole other overlay of administration and a lot of that money gets siphoned off. It doesn't go into the care package."

A member of the County Departments of Job and Family Services Leadership Committee echoed similar sentiments saying that managed care will ultimately cost more than fee-for-service care because of increased administrative costs. The member attributed these cost increases to transportation, scheduling, and attracting sufficient providers in limited access areas.

Alternatively, cost savings may be achieved through the reduction of administrative costs. By lowering administrative costs, managed care plans can increase their profits without affecting enrollees' benefits (*Managed Care Week,* August 15, 2005). Managed care plans control administrative costs by reducing incentive-based compensation, controlling staffing numbers, and other expense-reduction initiatives. However, a number of plans reported increases due to merger and acquisition costs, new Medicaid contract implementation costs, lawsuit settlements,

and increased marketing activities. Plans expected administrative costs to stabilize as transitional and acquisition expenses diminish.

History of Managed Care in Ohio

Ohio first implemented Medicaid managed care in 1978 with voluntary enrollment in Cuyahoga County for pregnant Medicaid-eligible women. The Ohio Department of Job and Family Services (then called the Ohio Department of Welfare and later the Ohio Department of Human Services) petitioned the federal government for permission to waive federal requirements for provider participation and recipient choice in order to implement managed care on a county-by-county basis. In 1989, Montgomery County became the first county to implement mandatory enrollment for pregnant Medicaid-eligible women. Throughout the 1990's, managed care enrollment was encouraged through the Ohio Department of Job and Family Services (ODJFS) and metropolitan county departments of job and family services where there was a sufficiently large population to attract a number of health plans. In 1996, under the OhioCare waiver program, six additional counties (Butler, Cuyahoga, Franklin, Hamilton, Lucas, and Summit) began mandatory enrollment bringing the total to seven counties with mandatory enrollment for the Covered Families and Children[7] population. The remainder of the State remained under fee-for-service payment.

As ODJFS permitted any managed care plan that accepted the State's terms and conditions (including the capitated per member, per month rate) to serve Medicaid recipients in a given county, there were numerous turnovers and financial failures during the period of initial mandatory managed care enrollment. Beginning in the late 1990's, the effect of insufficient market opportunities caused several managed care plans to rescind their contracts to serve Medicaid recipients in the mandatory counties.[8] In some cases, contracts were terminated because the plans were unable to remain financially solvent.

Several stakeholder groups recalled the difficulties experienced in Ohio with the growth of managed care. Comments from a member of the Ohio Dental Association reflect the concerns shared by many providers. The member recounted how, in the Cleveland area, several managed care plans were not financially viable and the plans went bankrupt leaving a large number of claims unpaid. As a Medicaid provider of more than 30 years, the member explained, "with the low fees, at least I had the full faith and credit of the State of Ohio guaranteeing the payment" but, under managed care plans, providers have no access to financial information about the plans and their long-term stability.

[7] Covered Families and Children include Healthy Start/State Children's Health Insurance Program and Healthy Families populations: children up to the age of 19 with an income of 200 percent of the federal poverty level and pregnant women with incomes of 150 percent of the federal poverty level. Healthy Families must have at least one child under 18 and the total family income must be under 100 percent of the federal poverty level.

[8] In 1996, there were 15 managed care plans serving the Ohio Medicaid population and in 2002, there were only 6.

Table 5-2 highlights some of the key developments in Ohio's use of Medicaid managed care.

Table 5-2: Developments in Ohio Medicaid Managed Care

Year	Change
1978	Voluntary managed care began on a limited basis in Cuyahoga County
1989	Mandatory enrollment begins in Montgomery County
1990-1995	State continues to use managed care on a limited basis
1995-1997	Expansion of mandatory enrollment in urban counties[9]
1997-2000	Commercial plans exit, • Under-capitalized plans go out of business, and • Enrollment in managed care becomes voluntary in counties that had managed care including mandatory counties)
2001-2003	Added Preferred option to the existing voluntary and mandatory options; • Enrollment grows state-wide
2003-2005	Mandatory enrollment reinstated in nine counties • Hospital based plans exit, • New plans enter Ohio
2006	Statewide managed care implementation begins

Source: CareSource, January 18, 2005

As shown in **Table 5-2**, Ohio Medicaid managed care has a 30-year history in the State, focused largely in urban counties. Throughout the period, there has been expansion and decline, although the trend has been toward expanding managed care as a service delivery model for Ohio Medicaid recipients. Most recently, managed care has been expanded through use of the preferred option during the past three to five years, culminating with the move to statewide managed care in SFY 2005-06.

During a stakeholder interview, a representative of the Universal Healthcare Action Network described the efforts to move to managed care as "trying to shave pennies instead of trying to save dollars." The member recommended Ohio examine ways to save "the big dollars" and said the State should continue efforts to improve cost containment.

Table 5-2 shows that, in Ohio, enrollment by Medicaid recipients in managed care plans has been on a voluntary, mandatory, or preferred option basis. Under voluntary enrollment, recipients have a choice between enrolling in a managed care plan and using the traditional fee-for-service program. Under mandatory enrollment, select Medicaid recipients are required to enroll in a managed care plan or are assigned to one. In preferred option enrollment, eligible recipients have the option of receiving health care services through fee-for-service or the participating managed care plan. However, preferred option-eligible recipients who do not contact the enrollment services center (a third-party vendor) upon receiving eligibility notification are enrolled in a managed care plan.[10]

[9] The counties include Butler, Cuyahoga, Franklin, Hamilton, Lucas, Montgomery, and Summit.

[10] Recipients are initially enrolled in a managed care plan by their county department of job and family services. A third party vendor, Automated Health Systems, works with recipients to change plans or select a primary provider.

State-wide Managed Care Expansion in Ohio

Amended Substitute House Bill 66 (HB 66), effective June 30, 2005, requires ODJFS to implement statewide managed care and enroll all Covered Families and Children (CFC) and portions of the Aged, Blind, and Disabled (ABD) population into managed care throughout the State by December 31, 2006. According to ODJFS, as of August 2004, 45 percent of the eligible CFC Medicaid population was enrolled in a managed care plan. Medicaid recipients who are exempt from mandatory enrollment under HB 66 include the following:

- Children in foster care and adoptive homes;
- Recipients in nursing homes;
- ABD recipients receiving services through a waiver program;[11]
- Dual eligible ABD recipients;
- ABD children;
- Recipients that are on spend down; [12] and
- Persons who receive institutional level care, (e.g. nursing home care).

Once the statewide expansion is complete, ODJFS estimates that over 90 percent of the CFC and 20 percent of the ABD population will be enrolled in managed care.

However, several stakeholders expressed concerns about the statewide expansion and the member enrollment process. A member of the Ohio Children's Hospital Association said the State Medicaid agency must make sure that all eligible persons are enrolled in managed care. Likewise, those persons who are exempt from enrollment in managed care must be identified and the State Medicaid agency needs to ensure that they remain under fee-for-service. The member stated that several instances of "Children under the Covered Families and Children category who are supposed to be exempt from managed care … still being swept up into the managed care program" had been noted by member hospitals.

In March 2005, ODJFS announced the decision to implement the managed care expansion on a regionally-based, as opposed to a county-based, approach. Through a competitive process,

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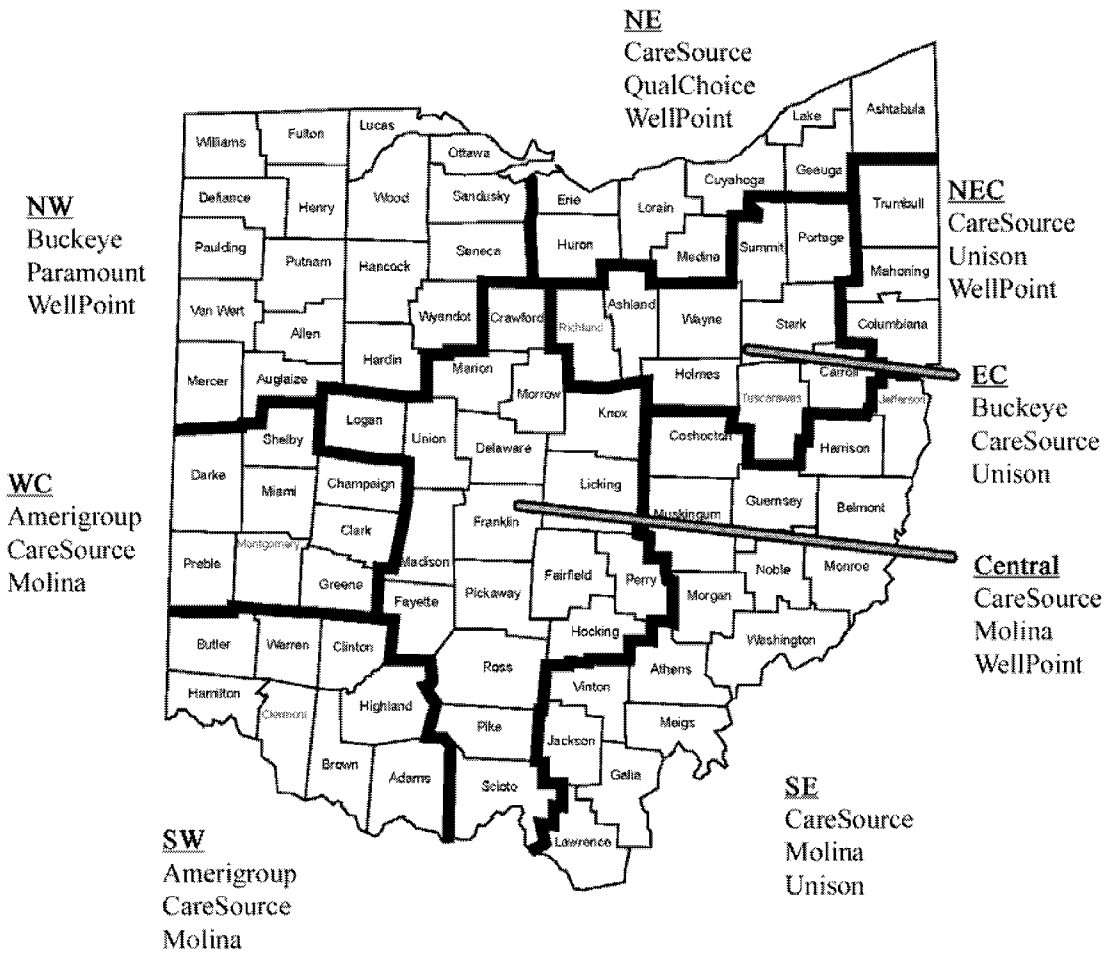
In addition, Automated Health Systems automatically assigns a primary provider if one was not selected by the recipient.

[11] Ohio has seven waiver programs administered by three separate agencies. ODJFS administers the Ohio Home Care and Transitions waiver, Ohio Department of Aging administers the PASSPORT, Choices, and Assisted Living waivers. The Ohio Department of MRDD administers the Level 1 and Individual Options waivers. See the **service provision** section for additional details on Ohio Medicaid waivers.

[12] Spend-down applies to individuals who have too much income to qualify under a state's income limits and takes into account incurred medical expenses during a budget period of from one to six months. In some cases, the state can also look at anticipated expenses, such as the cost of health insurance. The state then deducts incurred costs for medical services covered under the state's Medicaid plan during the budget period from the countable income until the individual meets the state's income limit.

ODJFS would select a maximum of three plans for each region. On March 17, 2006, ODJFS announced its selection of the managed care plans for the statewide Medicaid managed care expansion of the CFC population. **Figure 5-1** lists the regions and the selected managed care plans.

Figure 5-1: Ohio's Regions for Implementation of Statewide Managed Care



Source: ODJFS, March 17, 2006.
Note 1: For the Central region, only two managed care plans were selected causing the Request for Application process to reopen for that region only. On June 28, 2006, ODJFS announced that the WellPoint (Anthem Blue Cross Blue Shield Partnership Plan) was selected as the third managed care plan to serve CFC Medicaid recipients in the Central Ohio Region.
Note 2: In April 2006, Amerigroup, WellPoint and Unison submitted applications for the Central region to serve the CFC population.

The managed care plans selected by ODJFS to serve Ohio Medicaid recipients are primarily Medicaid focused plans, most of which have served Medicaid populations in other states or have been serving populations in Ohio. For example, CareSource also serves Medicaid populations in Indiana and manages a health plan in Michigan. Molina operates in California, Indiana, Michigan, Utah, and Washington. Amerigroup operates in Texas, Florida, Virginia, Washington DC, Maryland, New Jersey, New York, Illinois and Georgia. Buckeye operates in Indiana, Kansas, Missouri, New Jersey, Texas, Wisconsin, and Georgia. Only QualChoice, which was owned by University Hospital Health System in Cleveland,[13] was unique to Ohio. Of these health plans, Amerigroup, Buckeye, Molina and WellPoint are publicly traded corporations while CareSource, Paramount and Unison are non-profit organizations.

On July 1, 2006, the East Central region began mandatory managed care enrollment for the Covered Families and Children. Enrollment began in August and ended in September for the Covered Families and Children in the Southwest and West Central regions. The final regions to be included in the expansion, the Northwest region and Southeast region, began enrollment September 15 and October 1 respectively. As of September 1, 2006, eight managed care plans had applied to serve the Aged, Blind and Disabled population.

Advocates for Ohio's disabled citizens expressed concern about the ADB managed care expansion. A member of the Ohio Developmental Disabilities Council cautioned, "people think that this is really a homogenous population and it's really not...." adding that ODJFS appeared far better prepared for the Covered Families and Children expansion which comprises the easier group to serve.

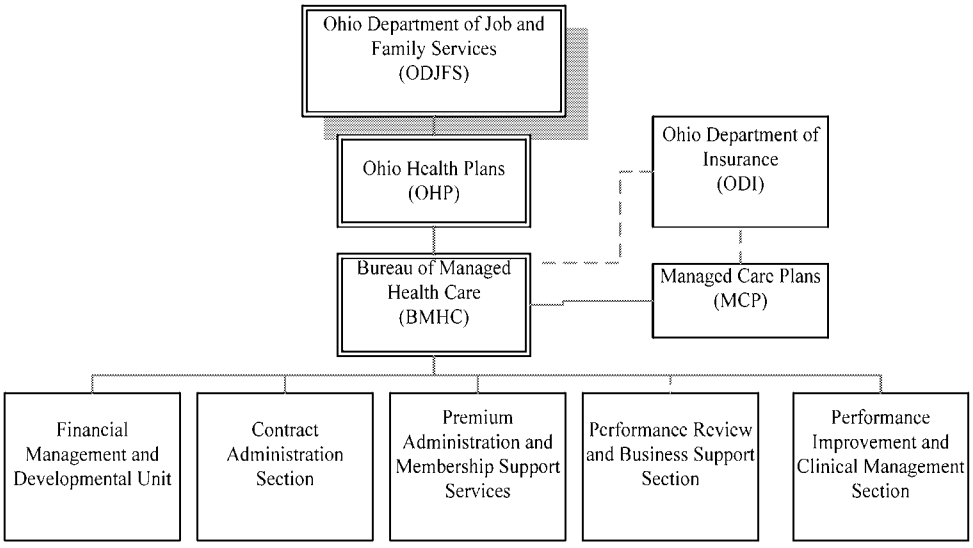
Ohio Managed Care Licensure Process and Oversight Activities

Under Ohio Revised Code, the Ohio Department of Insurance (ODI) reviews all health care plans, including Medicaid managed care plans, for the purpose of granting licensure to conduct business as a health-insuring corporation. ODI ensures that all managed care plans are financially sound and obtains a surety bond from each company to cover potential unpaid expenses in the event that the plan is insolvent and ceases to do business in Ohio. The managed care plans that contract with ODJFS for Medicaid are also monitored by the Bureau of Managed Health Care (BMHC), one of eight bureaus within Ohio Health Plans (OHP) at ODJFS. (For additional information on OHP and BMHC, see **Medicaid overview, history, and status** and **organizational issues** sections.)

Chart 5-1 illustrates the structure for oversight of managed care plans that contract with ODJFS to serve Medicaid recipients.

[13]In April 2006, ODJFS was notified that the Anthem Blue Cross and Blue Shield Partnership Plan, Inc. agreed to purchase QualChoice Health Plan. QualChoice's acquisition reduced the number of Medicaid health plans selected for the northeast region from three to two. As a result, ODJFS selected WellCare of Ohio, Inc. to enter into the readiness review process as the third health plan in the northeast region.

Chart 5-1: Structure for Oversight of Managed Care Plans



Source: ODJFS (March 8, 2006)

The Bureau of Managed Health Care (BMHC) monitors the development, administration, and assessment of Ohio Medicaid Managed Health Care plans. Within BMHC, there are four sections and one unit; each section or unit reports to the bureau chief. Their responsibilities include:

- **Financial Management and Development Unit:** sets rates, analyzes managed care plan financial reports, and reviews managed care plan financial data;
- **Contract Administration Section:** oversees the contracting, procurement, and monitoring of managed care plans;
- **Premium Administration and Membership Services Section**: processes and develops premiums and monitors membership transactions;
- **Performance Review and Business Support Section**: reviews managed care plan performance through data collection and implements managed care plan incentives; and
- **Performance Improvement and Clinical Management Section**: monitors clinical and quality performance measurements.

These sections and unit work together to oversee the managed care plans and each has specific responsibilities ranging from clinical performance measurement to rate setting. With the State's increasing use of managed care, this Bureau's oversight role will become more critical. During stakeholder meetings, several expressed concern that the Bureau would not adequately monitor the plans and the experiences of the 1990's would be repeated.

A representative of the Ohio Association of Health Plans also expressed concern about the level of contact with the county departments of Job and Family Services and the ability of the plans to build relationships within individual counties. The member remarked that the plans had limited contact with county departments and that the plans had little success getting information like enrollment data, to help identify plan members, or redetermination dates, which would help decrease churning.

Care Management

Care Management is a process designed to organize and coordinate medical services to enhance patient health. This process is considered a preventive form of care and, in a broader sense, is an approach that may encompass a holistic view of patient care. Three distinct areas of care management exist:

- Case management,
- Disease management, and
- Utilization review/utilization management.

These programs include a variety of activities such as treatment plan development and monitoring, follow-up visits, education, communication, service authorization, and assistance in accessing services.

The Case Management Society of America defines case management as a collaborative process designed to assess, plan, implement, coordinate, monitor, and evaluate options to meet each individual's health needs and to promote successful and cost-effective outcomes Case management has been around for more than 80 years. It originated in the 1920's out of the fields of psychiatry and social work and focused on long-term, chronic illnesses that were managed in outpatient, community-based settings. Case management processes were also used by visiting nurses beginning in the 1930's to assist in coordinating services for patients with complicated health needs. In the 1970's, case management evolved into a formalized and distinct profession. By the late 1980's, insurance companies, health care facilities, managed care organizations, and pharmacy management companies implemented case management as a way to improve the quality of care, and started to incorporate it into their disease management programs. As a care delivery system, case management is a relatively new concept in the acute care setting.

Disease management is a system of coordinated health care interventions and patient communications for populations with conditions in which patient self-care efforts are significant. For example, it is important for individuals with diabetes to follow a specialized diet and monitor their glucose levels. Heart-diseased patients should also follow a proper diet and follow all directions regarding their medication. Disease management performs the following functions:

- Supports the physician or practitioner/patient relationship and plan of care;
- Emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies; and
- Evaluates clinical, humanistic, and economic outcomes on an on-going basis with the goal of improving overall health.

Many disease management programs entail regular physician visits and letters or calls from a plan-employed nurse to encourage positive disease management practices. For example, in the case of diabetes, patients have quarterly blood glucose (A1c) tests, receive information on healthy diets and methods to better manage blood glucose levels, and receive free testing supplies. Better blood-glucose management delays or prevents the onset of severe diabetic complications such as blindness, neuropathy, or amputation. Disease management components, regardless of diagnosis, include the following:

- Population identification processes;
- Evidence-based practice guidelines;
- Collaborative practice models to include physician and support-service providers;
- Patient self-management education (may include primary prevention, behavior modification programs, and compliance/surveillance);
- Process and outcomes measurement, evaluation, and management; and
- Routine reporting/feedback loop (may include communication with patient, physician, health plan and ancillary providers, and practice profiling).

Finally, utilization management is the evaluation of the medical necessity, appropriateness and efficiency of the use of healthcare services, procedures and facilities under the provisions of the applicable health benefits plan. Utilization management describes proactive procedures such as discharge, planning, concurrent planning, pre-certification[14] and clinical case appeals, while utilization review encompasses the review of cases after healthcare services have been provided. Utilization review is often used to educate providers through the monitoring of provider performance. Utilization management allows healthcare coordinators to direct patients to cost-effective resources before treatment and helps ensure, particularly in the commercial insurance market, appropriate utilization of costly resources such as emergency room care.

[14] Pre-certification is determined by a contractor to ensure "that covered medical and psychiatric services, and covered surgical procedures are medically necessary and are provided in the most appropriate and cost effective setting" (OAC 5101:3-2-40(A)).

Care Management in Ohio Medicaid

Care management for Ohio's Medicaid program is provided by different entities depending on the population served. These entities include county agencies, area agencies, managed care plans, and direct service providers. In Ohio, some Medicaid recipients receive no care management while others can only access services under a highly coordinated plan of care. The case management programs available in Ohio for Medicaid recipients include the following:

- PASSPORT, a case management program that is administered by the Area Agency on Aging;
- Ohio Home Care, administered by ODJFS, where case management services are provided by a third-party vendor, CareStar; and
- Targeted case management services provided to disabled individuals served by County Board's of Mental Retardation and Developmental Disability (CBMRDD).

Care management services are also provided in the behavioral health systems through ODMH, ODADAS, and their local boards. While case management exists, at some level, program-wide, this process is inconsistent and may be provided at the State, regional, local, or provider level.

Ohio implemented an enhanced care management program in 2005. The program provided care coordination to recipients with chronic health conditions and placed particular emphasis on the ABD population. The enhanced care management program was discontinued after the decision to expand to statewide managed care because BMHC did not feel it had the necessary internal resources to administer both programs.

Utilization management and utilization review functions are also used throughout the Ohio Medicaid Program. Utilization management is used in each of the systems, excluding behavioral health, which is seeking the authority to conduct this activity. In some cases, utilization management and utilization review functions are contracted to a third-party vendor.

A related issue that affects care management is the emphasis on prevention services. Several stakeholders identified the reluctance to cover prevention services and recent reductions in preventive care as a shortsighted policy by the State. A member of the Ohio Family Services Council noted that prevention services are usually the first item cut when there is a budget shortfall. The member elaborated that recipients who participate in preventive care, particularly in the behavioral health setting, are able to remain in and be productive members of their communities. However, if the support and focus on prevention is withdrawn, the member said, "They're institutionalized. They lose their jobs. They stop paying taxes. It seems so simple." A member of the Ohio Association of Community Health Centers noted that, after age 18, recipients are not covered for preventive care. The member felt that this was "a very short-sighted policy". Finally, a representative of the Medical University of Ohio remarked that prevention services were much less expensive than medical care but that

Medicaid recipients often do not access preventive care. The representative suggested, "Maybe there should be a requirement that you have an annual physical on Medicaid" and recommended efforts be made to better educate recipients on the preventive and primary care services provided by managed care plans.

The Uninsured Population

By 2004, over 45 million Americans under the age of 65 lacked health insurance coverage. The number of uninsured Americans has increased over the last decade, driven by alternating periods of declining employer-sponsored insurance and declining public coverage. Medicare covers nearly all individuals 65 and older, while Medicaid and State Children's Health Insurance Program (SCHIP)[15] provide coverage for millions of low-income people who qualify under the means-tested[16] guidelines. Medicaid coverage for adults is limited, covering only some low-income uninsured and disabled individuals, leaving immigrants and most childless adults ineligible. Limits to public healthcare programs and gaps in employer coverage leave millions of non-elderly Americans uninsured.

In 2001, the Kaiser Family Foundation estimated that uninsured health care coverage results in uncompensated care amounting to approximately $35 billion. The primary source of funding for uncompensated care is the government, which spent an estimated $30.6 billion for care of the uninsured. Costs aside, individuals without health insurance tend to have higher mortality rates and shorter life spans than those with health care coverage. In addition, poor health is attributed to lower educational attainment and 10 to 30 percent lower annual earnings.

Immigrants are more likely to work in low-wage jobs that do not offer health coverage. Federal law prohibits legal immigrants from enrolling in Medicaid and SCHIP for the first five years they reside in the United States. Undocumented immigrants generally are ineligible for Medicaid or SCHIP regardless of their length of residency in the United States. However, children born in the United States to immigrants could be eligible for Medicaid. Citizens and non-citizens are eligible for emergency Medicaid, which covers treatment for a medical emergency, regardless of their status.

Families USA, a nonprofit organization, conducted a study that identified four barriers to employers offering insurance coverage:

- Smaller employers cannot afford the expensive premiums;
- Service and labor jobs are less likely to provide workers with health insurance;

[15] The State Children's Health Insurance Program is administered through Medicaid and has a higher federal match rate than standard Medicaid.

[16] Means-tested means that resources are tested against threshold levels as determined by each state within federal guidelines.

- Part-time workers are often not eligible for insurance; and
- Employers with low-wage workers have a harder time affording the premiums and are their employees are more likely to remain uninsured.

Health insurance determines the kind of healthcare people are able to afford and where they can obtain care. The lack of insurance often compromises a person's health. Individuals without insurance are less likely to receive preventive care, more likely to be hospitalized, and more likely to be diagnosed in the late stages of a disease. Preventive care encompasses measures taken in advance of symptoms to prevent illness or injury. This type of care is best exemplified by routine physical examinations and immunizations. The emphasis for this type of care is on preventing illnesses before they occur. According to *The Uninsured: A Primer* (Kaiser Family Foundation, 2006), having insurance improves health overall and could reduce mortality rates for the uninsured by 10 to 15 percent.

Ohio's Uninsured

Ohio's overall population ranks the sixth highest in the nation. Accordingly, in 2003, Ohio also ranked sixth in the number of uninsured.[17] Ohio had 2.6 million uninsured individuals, or 23 percent of the total population, and 66 percent had been uninsured for more than six months. One in every three children born in Ohio's hospitals receive care through Medicaid funding, and the program protects many of the State's Aged, Blind, and Disabled citizens. Cuts to Medicaid and government assistance programs at both the State and federal level sends low-income working Ohioans into the growing uninsured population. Serving Ohio's uninsured population often means hospitals are inundated with bad debt (because the income level of the uninsured prevents them from repaying large hospital bills) and lost reimbursement. Over the years, hospitals have provided donated care for Ohioans at or below the federal poverty level. The Ohio Hospital Association reported that, in 2004, $343 million in care was provided to individuals at or below the poverty level[18] and the total cost of uncompensated care exceeded $1 billion.

[17] The 10 states with the highest uninsured population are, in order, California, Texas, New York, Florida, Illinois, Ohio, Pennsylvania, Georgia, North Carolina, and Michigan.

[18] The 2006 Federal Poverty Level is $13,200 for family of two, and $20,000 for a family of four. The Social Security Administration developed the poverty thresholds that are used today in 1964. At that time, poverty was based on calculations underpinned by survey data indicating that families generally spent about one-third of their income on food. The U.S. Department of Agriculture used its data about nutritional needs of children and adults to construct food plans for families. The dollar amounts for each food plan varied according to the number of people in the family, with the least expensive being the economy food plan. The economy food plan became the basis for poverty thresholds and, since economy food plan budgets varied by family size, the poverty thresholds also vary. The economy food plan was designed to address the dietary needs of families on strict budgets. In 1975, the thrifty food plan was established to replace the economy food plan at the same general cost level. The thrifty food plan has never been used to revise or update the poverty thresholds. Forty years later, housing, health care, child care and transportation consume a much bigger proportion of household budgets than the cost of food, although the food-based federal poverty guidelines have not been changed.

A member of the Ohio Children's Hospital Association noted the importance of this issue saying, "The General Assembly has to make some … huge decisions about the role of public insurance in the health insurance system. ….[but] regardless of the decision, the administration has an obligation to deliver the best health care at the lowest cost, [as well as]… ensure the highest quality and good access."

State and federal governments are looking to control the large percentage of revenue represented by Medicaid, but cuts to eligibility may bring a higher price. Recent federal budget acts (Deficit Reduction Act of 2005) have made reductions to state funding and placed other caps on federal money distributed to the states for Medicaid. In February 2005, Ohio planned cuts to Medicaid eligibility that affected an estimated 25,000 working adults and eliminated adult dental and vision coverage,[19] which would have impacted an estimated 800,000 recipients who received these services in SFY 2004-05 but would no longer be eligible under the reduced income guidelines. Under the implemented reduced income guidelines, more low-income Ohioans are likely to find themselves uninsured and, in many cases, forced to choose between basic expenses and necessary health care services.

A member of the Universal Healthcare Action Network explained the effects of being uninsured or having limited access to healthcare saying, "from a public health perspective … you can't get help to stay healthy." The member said that this results in much more expensive care for individuals who end up disabled, instead of averting costs through disease management and primary care coverage early in an individual's life.

States can set Medicaid income eligibility at almost any level within the federal guidelines and with federal approval for low-income parents. Some states have expanded Medicaid eligibility for low-income parents, but most states continue to tie income eligibility for parents to former welfare assistance levels. **Table 5-3** shows Ohio Medicaid income eligibility levels for the Healthy Start, Healthy Families, Aged Blind and Disabled, SCHIP, and Traditional Medicaid programs. (See the **service provision** section for further discussion and comparison of Ohio guidelines with those of other states.)

[19] The elimination of adult dental and vision coverage was not implemented. Dental, podiatry, and vision were funded and specifically required to be maintained at current levels in temporary law. The Governor vetoed this as a statutory mandate because the requirement, as previously written, would have limited ODJFS's ability to make routine changes in the management of these benefits in the future. However, the Governor instructed ODJFS to continue offering these services as part of the Medicaid benefit package.

Table 5-3: Ohio Medicaid Income Guidelines

Program	Population	Income Eligibility Guidelines	Monthly Income Requirements			
			Family Size (Persons)			
			1	2	3	4
State Children's Health Insurance Program (SCHIP)	Children up to age 19	200% FPL	$1,634	$2,200	$2,767	$3,334
Healthy Start	Pregnant women	150% FPL	$1,225	$1,650	$2,075	$2,500
Healthy Families	Parents with children < age 18	90% FPL	$735	$990	$1,245	$1,500
	Individuals age 65 or older, legally blind or have a disability classified by Social Security Administration		**Individual Income**	**Couple Income**	**Individual Resources**	**Couple Resources**
Aged, Blind & Disabled		64% FPL	$525	$904	$1,500	$2,250
Transitional	Families that no longer meet the criteria for Healthy Families	185% FPL				

Source: ODJFS effective January 1, 2006

As illustrated in **Table 5-3**, income eligibility guidelines for each covered population vary. Income is just one requirement for Medicaid eligibility (see **service provision** section for a discussion of additional requirements). Medicaid does not provide healthcare, even for very poor persons, unless they fall into one of the income guidelines and single adults are typically not eligible. In some cases, Ohio's income guidelines are based on federal Social Security Insurance (SSI) amounts, which are just over $500 per month for an individual. Stakeholders noted that the income guidelines, particularly for the ABD population, cause difficulty for individuals in finding housing and affording newly implemented co-payments within the income amounts. The income guideline for Healthy Families has decreased from 100 percent of federal poverty level to 90 percent of federal poverty level, effective January 1, 2006. The full impact of the change in the income guideline could not be quantified because current enrollees were not affected until their redetermination date, and many of those impacted will likely qualify for Transitional Medical Assistance.

Findings and Recommendations

A. Medicaid Managed Care and Alternative Service Models

In Ohio, HB 66 requires ODJFS to expand to mandatory managed care statewide for the CFC and a portion of the ABD populations by the end of December 2006. With the expansion, 125,000 members of the ABD population and 1.2 million CFC participants will be enrolled in managed care. HB 66 also requires the establishment of the Care Management Working Group whose charge is to examine best practice standards in managed care and related systems and develop guidelines for ODJFS to consider.

While Ohio has used managed care plans to administer Medicaid services since 1978, these plans have worked primarily in larger urban counties and only with the CFC population. In addition, many of the counties offered managed care only as an option, thereby allowing recipients to elect to participate in managed care or to remain under the fee-for-service program. Since the passage of HB 66, ODJFS has focused on implementing the statewide expansion for the CFC and ABD populations separately. In preparing for statewide expansion, ODJFS has adopted a regional approach rather than the county approach used in the past. ODJFS grouped the counties into eight regions, limiting managed care plan participation in each of the regions to no more than three plans. Part of the General Assembly's impetus for implementing managed care statewide was drawn from the Ohio Commission to Reform Medicaid, which issued a report in January 2005 recommending adoption of managed care to reduce costs.

Discontinuing the Enhanced Care Management (ECM) model was another step that ODJFS took to prepare for the statewide expansion. Although less than a year old, and with no data to ascertain its success, ODJFS decided that the statewide expansion and the continuation of ECM would be too great a strain on its internal staff resources. (See the ***care management*** section for further details on this service delivery model). The ECM program focused more heavily on the ABD population that comprises 75 percent of Medicaid costs in Ohio. Stakeholders who were instrumental in its design asserted that the model retains viability in Ohio and should have been used in conjunction with managed care.

Managed Care and Fee-for-Service Comparison

Managed care and fee-for-service delivery each have distinct advantages and disadvantages, which, over the history of managed care, have been widely debated. The Ohio Commission to Reform Medicaid identified several of these advantages and disadvantages during its 2004-2005 study of Ohio Medicaid. The Commission's perspective on the advantages and disadvantages of managed care in comparison to fee-for-service are outlined in **Table 5-4**. The items contained in the table are the perspective of the Commission, however, and may not fully capture the viewpoints of all stakeholders.

Table 5-4: Comparison of Managed Care to Fee-for-service

Managed Care	Fee-for-service
Advantages	
• Lower cost • Budget predictability • Opportunity to improve quality • Shift financial risk to care plans • Focus on prevention and wellness • Care plans manage provider networks • Customer focused	• Providers prefer this model • Already in place, so no changes needed • Direct relationship between State and providers
Disadvantages	
• Change from retrospective to prospective payments • Provider resistance to participation • Lower payments to providers • History of managed care plan insolvency • Provider groups can block coverage via non-participation (like hospitals)	• 6-8 % higher costs • Less control of quality and costs • State bears full financial risk • State does not selectively contract with providers • No financial incentive for providers to improve quality

Source: Ohio Commission to Reform Medicaid

As shown in **Table 5-4**, managed care shifts the risk of financial responsibility for the program and its participants from the State to the managed care plans, thereby allowing better budgetary planning. In contrast, though, the model often lowers payments to providers, a concern expressed in several stakeholder meetings held by audit staff. A representative of the Ohio Family Service Council stated, "Different streams of funding [silos] are a problem. Capped service rates result in low salaries…The fee-for-service creates a culture of billing – [a] focus on billable hours and medical necessity. [It] also fragments service provision." Managed care also can result in improved performance measurement whereas, historically, fee-for-service performance has not been subject to scrutiny. Although fee-for-service has been the traditional method for delivering Medicaid services, the ability to fully compare fee-for-service to other models is hampered by the fact that no formal evaluation or measurement of its effectiveness or impact exists. Therefore, although the effectiveness of managed care over fee-for service in Ohio is stated as a reason for the transition, this cannot be demonstrated through the information currently available to decision-makers.

Another advantage to managed care over fee-for-service not discussed in **Table 5-4** is the inherent opportunity to measure, evaluate, and make decisions regarding the managed care system by requiring managed care plans to provide encounter data[20] to ODJFS. Although this data is collected, ODJFS has not yet used it for decision-making purposes (see also the **technology** section). The potential for system evaluation exists in the managed care system, but, currently, no mechanism for measuring or evaluating the fee-for-service system exists in Ohio.

[20] Encounter data refers to claims that have been paid by the managed care plans and are then submitted to ODJFS on a monthly basis.

In many respects, the limitations of information are a result of the State's antiquated information systems. Yet, on several occasions during this audit, auditors noted that ODJFS missed opportunities to use readily available data to guide decisions within the agency and inform external stakeholders, such as the General Assembly. (See ***C. Monitoring Managed Care Plan Service Delivery and Health Outcomes*** for more information on performance monitoring).

In comparison to fee-for-service, managed care plans assert a higher degree of customer focus. A member of the Ohio Association of Medical Equipment Services stated that managed care plans "run more like a business" and use technology to their advantage, which makes them more efficient.

As noted in **Table 5-4,** managed care plans often offer additional services to Medicaid members above the State and federal Medicaid requirements. These include:

- Coverage for some over the counter medications, such as prenatal vitamins;
- Incentives for getting preventive services, such as gift certificates for completing a immunization series;
- Additional health care service benefits that are not covered under the State Medicaid plan;
- Member education through written materials, a 24-hour nurse line, and one-on-one interaction;
- Outreach for high risk individuals, including high risk pregnancies;
- Personalized case management; and
- Enrollment in disease management programs.

In contrast, primary care providers noted in stakeholder meetings that they could provide many of the same services to recipients in a fee-for-service environment if Medicaid would consider compensating them for the time involved in such measures. A member of the Ohio State Medical Association commented that the Medicaid population had traditionally not received good primary care. Recipients receive episodic "sick care" but do not have a continuity of care. The member felt that using the primary care model and regular check-ups would allow the State to collect data points and, eventually, measure the quality of care. A member of the Ohio Academy of Primary Care Physicians further emphasized the value of a medical home explaining that recipients who develop long-term relationships with their physicians would see the value in primary care because "they physically feel better. They're not treated differently. They're not treated as a second-class person. They're not pushed off to an emergency setting where … no one is going to look at the other aspects of their health care, let alone their emotional needs…." The member concluded saying, "I think a lot of patients… [would adopt a medical home] when they see a person sitting across from them who cares."

The concept of a "medical home" with a primary care provider is widely acknowledged to be an important health management tool under both service-delivery models. A member of the Ohio

Dental Association described the importance of the primary care physician and "medical home" as follows, "I have always maintained that they should pick a primary care physician, a pharmacy, and a primary care dentist. …There has to be some mechanism that …[recipients] can change providers, but you would get less cost, less duplication of services, less shopping [for services and prescriptions]...." Because of the reported advantages, including initial cost savings, most states have adopted a managed care model for certain populations in place of the fee-for-service model.

Historical Costs of Ohio Managed Care and Fee-for-Service

> "It's … been my understanding that about 80 percent of the Medicaid dollars get spent on about 20 percent of the population. …we are talking about carving up pennies because the CFC population… [is] not …. the population where all the dollars in Medicaid are going. It seems like they … have it backwards. They should have targeted the population [where] they were spending the most dollars. …. Sometimes you have to tackle the problems first and -- the things that are not so messed up -- you … leave those alone."
>
> *Member of the Ohio Association of Community Health Centers*

Table 5-5 illustrates a three-year history of payments made to managed care plans compared to State fee-for-service costs and average monthly membership. Managed care plans are paid a capitation rate each month for each member[21] served. They are paid a separate amount for each newborn delivery. The fee-for-service figures are the claim costs for Medicaid recipients not enrolled in managed care. Data in **Table 5-5** is provided to show historical costs, and is not necessarily indicative of cost effectiveness. The Managed Care Costs for 12 Months and the Average Amount of Monthly Members columns in the table are based total annual costs and a single month's membership, respectively. Managed care and fee-for-service membership fluctuates each month and thus, the average membership per year cannot be calculated from the data provided by ODJFS because of potential double counting. The membership data may count recipients more than once if they have enrolled in a managed care plan during the month. Members who have not enrolled in managed care are covered by fee-for-service until they either choose a plan or are assigned to one.

[21] Members and recipients are synonymous. However, the term "member" is used to designate Medicaid recipients enrolled in a managed care plan.

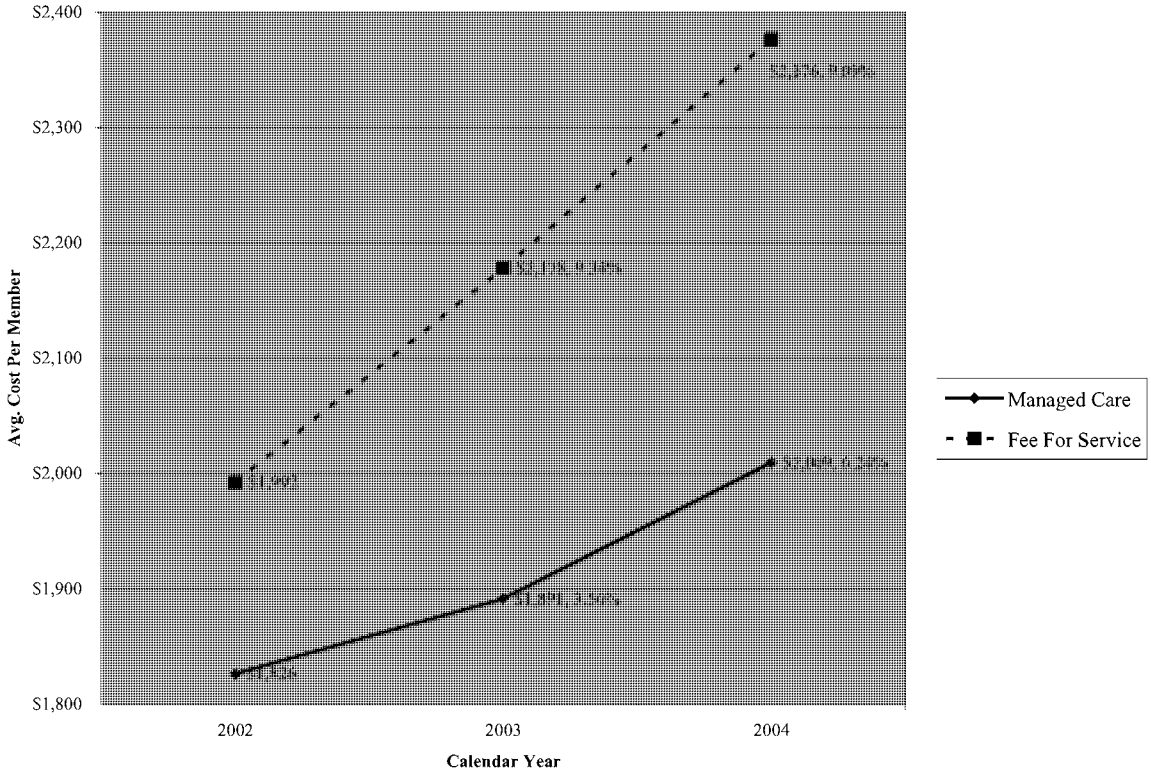
Table 5-5: Historical Cost for Managed Care and Fee-for-Service for the CFC Population

	Managed Care Costs for 12 Months	Managed Care Avg. Monthly Members	Managed Care Costs per Avg. Monthly Member	Fee-for-Service Costs for 12 Months	Fee-for-Service Avg. Monthly Members	Fee-for-Service Costs per Avg. Monthly Member	Difference in Fee-for-Service and Managed Care Costs per Avg. Member per Month
CY 2002	$678,470,053	371,613	$1,826	$1,451,876,278	728,927	$1,992	8.33%
CY 2003	$844,185,697	446,429	$1,891	$1,623,033,459	745,264	$2,178	13.18%
CY 2004	$1,023,839,533	509,642	$2,009	$1,782,811,612	750,314	$2,376	15.45%

Source: ODJFS, Office of Fiscal Services, Bureau of Budget Management and Analysis
Note: Data provided by ODJFS was qualified and marked by the Department as "not for statistical purposes".

Table 5-5 shows that managed care costs per average monthly member have consistently been lower than comparable fee-for-service costs for the CFC population. However, during the three years reflected, managed care was not statewide and was more prevalent in counties with larger urban populations. The costs reflected in **Table 5-5** have not been adjusted to reflect any regional differences. **Chart 5-2** shows the growth rates for managed care costs per average monthly member as compared to the fee-for-service costs.

Chart 5-2: Growth Comparison of Average Cost per Member in Managed Care versus Fee-for-Service for 2002 to 2004



Source: ODJFS, Office of Fiscal Services, Bureau of Budget Management and Analysis
Note: Data provided by ODJFS was qualified and marked by the Department as "not for statistical purposes"

As shown in **Chart 5-2**, the growth of the average cost per member from 2003 to 2004 for managed care was 6.24 percent while fee-for-service grew at about 9 percent during the same period. Over the two-year period (2002 to 2004), managed care costs per average monthly member grew by 10 percent while fee-for-service grew by 19 percent. However, the annual growth rate for fee-for-service was stable, growing at approximately 9 percent each year. In contrast, health insurance premiums in Ohio grew by 12.8 percent in 2003 and 14.7 percent in 2004, as reported by the State Employment Relations Board. Managed care costs grew more sharply, from a 3.6 percent growth in 2003 to 6.2 percent in 2004, which may support research that has found that savings from managed care models decrease over time. In comparison, national health expenditures grew by 8.2 percent in 2003 and 7.9 percent in 2004, which was slightly lower than the increase in fee-for-service Medicaid expenditures and slightly higher than the increase in managed care expenditures in Ohio Medicaid.

According to an independent assessment completed by Mercer Government Human Services Consulting Group (Mercer), Ohio has seen a 4.2 percent and a 7.0 percent savings in Medicaid expenditures due to the use of Managed Care in SFY 2001-02 and SFY 2002-03, respectively. The process used by Mercer to calculate the savings entailed a comparison of expected costs for the managed care population (forecasted costs if they remained in a fee-for-service environment) to actual program costs. This comparison included both those members who were required to enroll in managed care and participants who remained under fee-for-service. Although Mercer attributes these savings to the impact of the managed care plans, other factors could have been responsible for portions of the cost savings. These factors include a "spill over" effect on the fee-for-service rates noted by Mercer but discounted in their analysis, and reduced enrollment and provider rates noted by the auditors.

Financial analysts expressed concern regarding Ohio's managed care expansion and the health plans' ability to implement its contracts with ODJFS successfully (*Ohio Picks Medicaid Health Plans,* Managed Care Week, March 27, 2006). Analysts estimated that Molina would likely experience the largest per share earnings with a 5 percent pretax profit margin because Molina will add 47 counties to its market with the Ohio expansion of managed care. However, experts warned that Molina and Amerigroup both have had trouble in the past when expanding their Medicaid markets.

Managed Care Week describes 2005 third quarter losses for Amerigroup, Buckeye and Molina (*Managed Care Week October 15, 2005*). Amerigroup had higher than expected medical costs, higher numbers of infant deliveries, and higher outpatient utilization rates, thus driving down its profits for Medicaid markets. The initial implementation costs associated with expanding Medicaid managed care caused the managed care company to show a loss. The managed care company takes on the full risk and must absorb costs beyond its Per Member Per Month (PMPM) payments. Analysts suggested quick acquisitions and a smaller pool for risk sharing as the reason for the losses. Experts speculate that fewer investors will be interested in Medicaid due to increased investing in Medicare. Amerigroup and Molina are expected to recover from any losses they experienced late in 2005 because, once the expansion is completed, the financial conditions and resource outlays of the plans are expected to stabilize.

National Managed Care Trends

According to the Kaiser Foundation, 48 states had implemented managed care for some portion of their Medicaid populations in 2004. During the same period, a few states discontinued managed care because of service delivery problems. Like Ohio, states that are increasing the use of managed care through mandatory enrollment for Medicaid include Illinois, Georgia, Maryland South Carolina, Texas, and Wisconsin. Examples from two of these states, Wisconsin and Maryland, show the range of applications of managed care. Wisconsin uses managed care for the major categories of Medicaid recipients (ABD, SCHIP, and CFC) while Maryland uses managed care for select Medicaid populations.

Wisconsin has selected three distinct managed care programs to serve ABD, State Children's Health Insurance Program (SCHIP), low-income (CFC), Social Security Insurance (SSI), and long- term care populations. Fourteen managed care plans operate in Wisconsin to provide these programs. The long-term care and SSI populations are each served by a unique managed care plan; while the third managed care plan covers the ABD and CFC populations. While Wisconsin was seeking to implement statewide managed care, the model is only available in 65 of 72 counties. Managed care was not implemented statewide because Wisconsin did not have any managed care plans that were interested in serving all counties or that could secure contracts with a sufficient number of providers. If there are two or more managed care plans in a county for a specific program, then it is mandatory that the Medicaid recipients enrolled in that program also enroll in a managed care plan. Under a new provision not yet implemented as of June 1, 2006, if there is one managed care plan in a rural area serving a particular program, the Medicaid recipients covered under that program will be required to enroll with the managed care plan. However, the SSI population participates under voluntary enrollment throughout the state.

Maryland has seven managed care plans that cover approximately 75 percent of the Medicaid population. After going through a competitive selection process and being certified for financial solvency, the managed care plans may select the counties in which they will operate. Enrollment in a managed care plan is mandatory for those Medicaid recipients who are not exempt from managed care membership. Maryland's exemptions include individuals who receive Medicare, are 65 and older, are eligible for Medicaid under spend down, are institutionalized for mental diseases, are in an Intermediate Care Facility for Mentally Retarded, or are enrolled in the Model Waiver.[22] The Maryland Department of Mental Health and Hygiene assigns enrollees to a geographic/demographic category that reflects their age, gender, residence, and eligibility group.

Some states have reduced their reliance on managed care for Medicaid recipients because of increased costs and plan failures within their states. According to *Medicaid Capitation Expansion's Potential Cost Savings* (the Lewin Group, April, 2006), researchers cited Illinois and Oklahoma as states that have significantly reduced or eliminated the use of Medicaid managed care. Oklahoma had to move to a partially capitated system because, as a result of low reimbursement rates, managed care plans started pulling out of the state leaving only one plan in 2005. In 2005, the Illinois Legislature required $70 million in Medicaid cost reductions. In order to enact the legislation, the state Medicaid agency carved out pharmacy from managed care and reduced the contractual reimbursement rates to health plans. This caused two plans to withdraw from the Medicaid program and the remaining plans to reduce marketing efforts and staff. In reaction to the cost reductions, some managed care plans ceased serving Illinois Medicaid recipients and enrollment has decreased by 16 percent. Illinois is now working to reverse the decrease by phasing in mandatory managed care for the CFC population by March 2007. The state is also implementing a statewide Primary Care Case Management (PCCM) program, which

[22] Started in 1985, this program allows medically fragile children (enrolled before age 22) who would otherwise be hospitalized to receive community-based care.

is a variation on the fee-for-service model and described in more detail in the ***alternative service delivery models*** sub-section of this report.

During stakeholder interviews with various groups, several expressed concern with the State's decision to move to statewide, full-risk managed care. A member of the Ohio Podiatric Association commented that Medicaid recipients typically have used the emergency room as a primary care facility. The member was concerned that co-pays and other new efforts in the program would not address problem areas but might create new problems within the program.

Also, managed care is being implemented in rural regions of the State where providers are already at a premium and access to care is limited. According to a federal Health and Human Services representative responsible for monitoring federal program in Ohio, managed care implementation is most difficult in states with diverse populations (e.g. very rural and very urban) like Ohio. A representative of the County Commissioners' Association commented on the problems in implementing statewide managed care in rural areas. The representative was concerned about access and the distance recipients might have to travel to see a physician. The representative recounted, "for years we have been discussing … the possibly of provider-based networks as opposed to a traditional HMO. I think many of us who have worked with rural areas still believe that that's a better model for those areas.'

Finally, inclusion of the ABD population presents financial risks for managed care companies and may result in unforeseen complications in statewide implementation. During the audit, stakeholders remarked that the BMHC typically monitored procedural compliance and did not focus on health outcomes or the effectiveness of managed care in serving recipients. As a result, stakeholders speculated that the potential benefits of managed care would remain unrealized because the plans were unable to focus on service and instead were required to focus time and attention on paper-driven, laborious reporting processes. Advocacy groups interviewed during the audit also expressed concern about the managed care plans' ability to meet the needs of ABD recipients, particularly in already underserved areas.

A member of the Ohio Association of Health Plans remarked on the monitoring typically required by BMHC saying that monitoring is focused on technical details like "street versus road" and not sufficiently focused on access and service quality. Another member went on to say that BMHC has not examined best practices from other states. An intense focus on Ohio and the managed care plans serving Ohio recipients has detracted from BMHC's ability to "either take a breath or look back and think about, is there a better way that this could be done." The member attributed this to limited resources as well as the technical aspects that the Bureau chooses as a focus. The member elaborated saying, "they spend all of their resources… chasing meaningless things instead of trying to figure out what is best way to do things and using the resources on something that is more productive ." Finally, one member explained that Ohio micromanages how the health care for Medicaid recipients is handled instead of using the expertise of the plans like West Virginia does. The member said that in West Virginia, the state

says, "these are your parameters, you are the expert, you do what needs to be done, and we'll check with you on the outcomes." Similarly, Wisconsin was cited as having a very successful 20-year program. The member concluded saying, I think we're ending up with such rigidity that, ultimately, it doesn't really benefit the program long-term."

Although ODJFS and BMHC annually measure plan performance, they have not made significant performance gains from year to year. This may indicate that they have not fully implemented strong performance monitoring. Furthermore, the repertoire of data used of decision-making is limited and, as a result, the Department and Bureau may not be aware of problems arising in statewide managed care implementation. Coupled with the termination of programs for alternative service delivery methods and the reticence to pilot or study options, Ohio Medicaid administrators may be faced with the difficult decision of implementing service models with untried populations or in untried regions of the State without alternatives for ensuring the safety and welfare of recipients.

R5.1 Ohio's single State Medicaid agency should develop and use a robust and meaningful evaluation system to monitor the implementation and operation of statewide managed care (see R5.7 and R5.8). Similarly, the State Medicaid agency should track and monitor fee-for-service delivery, as well as other managed care exempt populations, through an effective evaluation system. These evaluation systems should be helpful in making fact-based decisions and determining the populations, including those currently carved out, that are best suited for either the managed care or alternative service delivery models.

To assist the single State Medicaid agency in developing and collecting this information, State universities have expressed an interest in and capability of forming a joint venture with the State to promote health services research. (See the Care Management section for more information on Academic Medical Center Research). Also, the Care Management Working Group, developed as a result of HB 66, could assist the Agency by taking an active role in determining specific measures and criteria for defining positive health outcomes.

Additional Service Delivery Models

Several additional service delivery models, beyond traditional managed care, are used to enhance coordination of services for clients. These include fee-for-service, primary care case management (PCCM), Program of All-Inclusive Care for the Elderly (PACE), and pay-for-performance. These models are discussed below.

Primary Care Case Management

Primary Care Case Management (PCCM) is a variation on the fee-for-service model. Through this program model, enrollees select a "medical home" through a primary care provider who is responsible for providing and coordinating care. PCCM provides continuity of care, preventive services, and case management for those patients who have complex medical conditions. It also is designed to improve the provision of primary and preventive care services for Medicaid recipients and ensure the efficient use of limited Medicaid resources.

In 1981, the Omnibus Budget Reconciliation Act allowed state Medicaid programs to implement both Primary Care Case Management (PCCM) and full-risk managed care programs. The Health Care Financing Administration (now CMS) defined PCCM as a program in which a provider "contracts to locate, coordinate, and monitor covered primary care" for Medicaid patients who are enrolled with a primary care physician. PCCM programs are forms of managed care that are unique to Medicaid. Medicaid agencies developed PCCM programs to improve access to care for the Medicaid population, to provide structures to assess and improve quality, and to reduce costs. The primary care physician manages each patient's care and the patient understands that the primary care physician is responsible for ensuring access to all medical care. PCCM programs usually pay the primary care physician a monthly case management fee.[23] PCCMs share the following characteristics with managed care plans:

- Operate through a network of providers;
- Incorporate strategies for utilization management;
- Develop specific payment strategies;
- Focus on patient education; and
- Ensure access to care.

PCCM programs differ from managed care plans in two fundamental aspects. First, PCCM typically pays for all services on a fee-for-service basis and does not transfer financial risk to primary or specialty care providers. Secondly, PCCM is a program unique to the single state Medicaid agency – there is not a commercial equivalent. The Medicaid agency provides the structure, skills, and resources to run the program.

The Center for Health Care Strategies conducted a study of PCCM programs. State officials and stakeholders in the states surveyed, like Texas and Louisiana, identified the following key functions:

- Management administration;
- Reimbursement;

[23] A fee of $3 per member per month is the most common rate (*Emerging Practices in Medicaid Primary Care Case Management*, National Academy for State Health Policy, June 2001).

- Enrollment with primary care physicians;
- Member education and services;
- Provider recruitment and retention;
- Quality improvement and utilization; and
- Management information systems, claims processing, eligibility verification and other systems.

When compared to the commercial managed care plan functions, PCCM shares several attributes and processes. Ohio had implemented a primary care case management program called Enhanced Care Management (ECM), which provided case management services to the ABD population with certain chronic diseases through comprehensive treatment plans and coordination of care. Patients also received access to a 24-hour nurse line, care management services, and other relevant health information. The program ended in the fall of 2005 before its effectiveness could be determined. (See also **E. Care Management**.)

Primary Care Case Management (PCCM), including ECM, is very similar and a viable alternative to the managed care model. However, data to judge the effectiveness of the ECM program was not collected by ODJFS. Any future pilot programs for PCCM should incorporate an evaluation component.

Program of All-Inclusive Care for the Elderly (PACE)

The Program of All-Inclusive Care for the Elderly (PACE) is a variation of the managed care model that focuses on older Ohioans who meet State standards for nursing home care. The program brings together all medical and social services needed for someone who otherwise might be in a nursing home.

PACE is a component of the Medicare program that enables states to provide services to Medicaid beneficiaries as an optional service in the state plan. To be eligible for PACE in Ohio, a person must be 55 or older, live in the service area of a PACE organization, and need intermediate or skilled levels of care. Services may be provided in an adult day health center, a member's home, a hospital, or a long-term care facility. Program enrollment is voluntary and it allows elderly people to live at home and receive the care that they need.

Once an enrollee is certified as eligible, the PACE program serves as the sole source of services. A team of professionals and paraprofessionals within the PACE organization develops a care plan for the recipient. The core program provides social and medical services, primarily in an adult day health care center, which are supplemented by in-home and referral services as determined by the participant's needs.

In October 2000, CMS evaluated the PACE program and compared capitation rates to projected costs during the first year of enrollment. The projected fee-for-service costs were nearly equal to

the capitated PACE costs. CMS determined that PACE had a positive impact on Medicare costs and, in the case of Medicare, capitation saved 42 percent over the fee-for-service costs. However, PACE capitation costs were higher than expected for fee-for-service Medicaid. CMS did not measure the cost effectiveness of PACE because it compares the capitation rates to the projected cost of care if the member had not enrolled in PACE. The review did not compare PACE capitation rates to the estimate of actual costs incurred by each site to provide the care. CMS stated that the projected costs are a "best guess" of what the costs would have been in the absence of PACE. The study found improved health outcomes at all PACE sites, including fewer inpatient hospitalizations, fewer nursing home stays, and better overall health status.

There are two PACE sites in Ohio: TriHealth Senior Link in Cincinnati (serving Hamilton County and areas of Warren, Butler, and Clermont counties) and Concordia Care in Cleveland Heights (serving Cuyahoga County). ODJFS evaluated the PACE program in 2001 and was able to draw some conclusions about the differences between the PACE sites and other models of long term care delivery. However, the study made no direct conclusions about the cost effectiveness of the implementation of PACE in Ohio and ODJFS recognized that it does not fully use the data available from PACE sites. In the study, ODJFS noted that there are large differences between the PACE sites in terms of case-mix and cognitive status, factors that are important in predictive modeling of PACE expenditures which caused the Department to question the reason for the differences and how these differences impacted costs. Also, ODJFS could calculate the percent of patients that would have used nursing home care in the absence of PACE but was unable to quantify the extent of care that would have been used in the absence of the program and thereby, the cost effectiveness. Lastly, ODJFS determined that, in the future, several pertinent data sets should be included the study. This data included simplistic information that was readily available to ODJFS but was not used, such as the length of time that PACE participants have been enrolled in the program and the nature and types of services enrollees use over their tenure in PACE. Auditors noted that no further evaluations have been performed on the PACE program. Furthermore, the report completed in 2001 by ODJFS disclosed severe data limitations in the report, particularly in member demographics and the payment source for member medical care, used only limited data in the report discussion, and reached no conclusions about the program.

ODJFS is considering a further, budget neutral, expansion of the program and has already obtained CMS approval to add 50 participants to the program. HB 66 transferred administration of the PACE program from ODJFS to the Ohio Department of Aging (ODA). In January 2006, the Ohio Department of Aging temporarily froze enrollment in the PACE program during the transition from ODJFS to ODA. ODA is also analyzing expenditures to ensure that the program stays within the appropriated budget.

Texas and Louisiana have both implemented PCCM programs and both states report seeing an overall reduction in the cost of the Medicaid Program since their inception. However, neither state has yet quantified savings achieved by the PCCM programs. Louisiana has reported that its

PCCM program, Community Care Program, has contributed to an overall improvement in the health outcomes of Medicaid recipients.

Although there are several alternative Medicaid service delivery models, Ohio has not extensively explored their use. Pilot programs have not been implemented for common alternatives and ODJFS did not respond to inquiries about its efforts to collect outcome data from pilot programs in other states. Furthermore, when alternative programs have been implemented in Ohio, little or no data has been collected and evaluated to determine their efficacy. Without a combined emphasis on exploration and study of alternative programs, Ohio Medicaid may miss substantial opportunities to improve the cost effectiveness of Medicaid services.

R5.2 The single State Medicaid agency should pilot and evaluate alternative care models. At a minimum, the Agency should begin with the abovementioned models and pilot each (excluding PACE which is already in use) on a limited basis to determine which would be most effective in Ohio, both under fee-for-service and managed care plans. The results of each pilot and the PACE program should be evaluated in a manner consistent with recognized outcome evaluation methods. In addition, the Agency will need to expend substantial resources to re-establish relationships with stakeholder groups and providers who have supported prior projects and been negatively affected by the Agency's commitment to programs like ECM. The State Medicaid agency also must be committed to implementing pilot programs for a sufficient length of time to allow for a thorough evaluation of their effectiveness.

Those Medicaid recipients having multiple, chronic healthcare needs should be targeted as they may benefit most from an enhanced care management plan or a primary care case management program. Furthermore, the State Medicaid agency should independently identify cutting-edge service delivery models used in other public and private sector venues and apply the lessons learned through evaluations of these models to Ohio Medicaid. Finally, as the cost of medical care increases and becomes a larger portion of the State's budget, the State Medicaid agency should be prepared to support decisions to continue or eliminate programs through data-driven, empirical evaluations.

Pay-for-Performance Programs

Pay-for-performance incentive programs are not alternative service delivery models, but are used in conjunction with any service delivery model to enhance patient care through evidence-based treatment. Although relatively new, and implemented only on a small scale in selected areas, pay-for-performance may serve as a positive force in healthcare by improving the quality of care and patient safety. These patient-centered programs link evidence-based performance measures

to financial incentives. The American Medical Association (AMA) and Ohio State Medical Association have developed the following pay-for-performance principles:

- **Ensure Quality of Care** – Programs use evidence-based quality of care measures, created by physicians across appropriate specialties. Variations in individual patient care regimens are permitted based on a physician's judgment. Disagreements or judgments should be based on appropriate evaluation by peers.

- **Foster the Patient/Physician Relationship** – Programs support the patient/physician relationship and overcome obstacles to physicians treating patients, regardless of patients' health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.

- **Offer Voluntary Physician Participation** – Programs offer voluntary physician participation and do not undermine the economic viability of non-participating physician practices. These programs support participation by minimizing potential financial and technological barriers, including start-up costs.

- **Use Accurate Data and Fair Reporting** – Programs use accurate data, scientifically valid analytical methods, and transparent processes. Physicians may review, comment on, and appeal results prior to their use for programmatic changes or any type of reporting.

- **Provide Fair and Equitable Program Incentives** – Progressive programs provide financial incentives to physicians for their participation, progressive quality improvement, and attainment of goals within the program. The program supports the goal of quality improvement across all participating physicians; physician performance is compared to benchmarks instead of the performance of other participating physicians.

The Ohio Medicaid program has not implemented pay-for-performance programs. However, at the time of reporting, ODJFS and the Medicaid Care Management Working Group had explored or proposed several possible avenues to implement a pay-for-performance program. In September, Ohio was one of seven states chosen to participate in a Center for Health Care Strategies initiative created to develop and implement provider incentive programs aimed at improving care for Medicaid beneficiaries.

Performance incentive programs for Medicaid managed care plans have been implemented in California, Maryland, Michigan, New Mexico, New York, and Rhode Island. Service model incentive programs have also been implemented on a more limited scale in Pennsylvania, which has incentive programs for both Medicaid managed care and fee-for-service; North Carolina, which has incentives for physicians enrolled in Primary Care Case Management; and Iowa, which offers incentives to participating behavioral health organizations. The most common types of performance rewards were financial incentives, financial penalties, and automatic preferred

assignment of new members to the physician. All of the managed care programs using pay-for-performance models based physician performance on the Health Plan and Employer Data Information Set (HEDIS) and the Consumer Assessment of Health Plans Survey (CAHPS) measures. The measures for fee-for-service performance in Pennsylvania were based on claims data and infrastructure improvements.

The Center for Health Care Strategies[24] identified eight lessons learned in using pay-for-performance programs for Medicaid. These lessons included emphasizing the promotion of access and use of preventive care; ensuring that providers are engaged in the program; and making certain that performance measures are clear. Likewise, the Center recommended paying attention to the structure of incentive programs, being mindful of data challenges, considering member incentives, and coordinating care with other payers.

Other providers noted the need to focus on quality and outcomes. A representative of one of the children's hospitals in the State discussed the benefits of a focus on quality improvement and how basing improvements on quality is "better for the child, better for the patient, better for the family, and better as a cost savings." The member said that there is, "really a business case to be made around quality improvement," and then related an example of using quality measures and outcomes to improve service:

> "A year ago [our Children's Hospital] was having ventilator acquire pneumonia in our intensive care unit about once or twice a week at a cost of about $40,000. ... It's a big problem, and a big cost intensifier. We put together some procedures and a package to do some improvements around that, and it's now been 215 days since there has been any ventilator acquired pneumonia in our intensive care unit."

Since the Ohio Medicaid program has not implemented pay-for-performance, it has not been structured in a manner that emphasizes the use of evidence-based care for Medicaid recipients. Similarly, the Program has missed opportunities to enhance care for Medicaid recipients, potentially reducing long-term costs, by creating incentives for physician contact time. Stakeholder physician groups appeared eager to implement a pay-for-performance program in Ohio Medicaid, and the Single State Medicaid agency should take advantage of that support.

R5.3 The single State Medicaid agency should implement pay-for-performance programs within the Ohio Medicaid Program and encourage the adoption of pay-for-performance within the sub-recipient agency programs. The Agency should pursue work in developing performance measurements that could be used to implement a future pay-for-performance program.

[24] The Center for Health Care Strategies is a national non-profit organization devoted to improving the quality of health services for beneficiaries served by publicly financed care.

The State Medicaid agency should also examine program implementation and effectiveness in other states and use the lessons learned from other programs to focus Ohio Medicaid on quality outcomes. The State Medicaid agency has an opportunity to implement additional outcome-focused programs, particularly to address the needs of the ABD population transitioning to managed care, as well as those remaining under fee-for-service. Using pay-for-performance for the managed care and fee-for-service populations would help the State Medicaid agency better focus its financial incentives on quality evidence-based care for Medicaid recipients.

B. Managed Care Expansion in Ohio

Serving the Expanded Population

Under HB 66, the General Assembly directed ODJFS to implement full-risk managed care for the Covered Families and Children (CFC) population, and the Aged, Blind and Disabled (ABD) populations. However, the needs of the ABD population differ greatly from the needs of the CFC population. The ABD population usually experiences chronic conditions and as a result, requires much higher levels of care. Further, ABD recipients are commonly older and experience longer enrollment in Medicaid than the CFC population due to their health conditions. On an expenditure basis, the ABD population comprises about 25 percent of recipients but accounts for about 75 percent of Medicaid resources.

Ohio Health Plans (OHP) is in the process of developing ABD specific performance measurements, reimbursement mechanisms, and care coordination efforts. The RFP to serve the ABD population under managed care was issued with a preliminary reimbursement rate on May 28, 2006. As of June 2006, OHP officials were still working with their actuarial company to develop ABD rates. In addition, OHP is holding limited stakeholder discussions with ABD Medicaid recipients and their advocates. The ABD RFP uses the same regions as Covered Families and Children expansion and the plans that wish to serve the ABD population must apply for enough regions that the membership is at least 45,000. However, if the plan was also selected for the CFC expansion, it may apply to serve any of the regions. No more than three plans will be selected for any region.

During the audit, certain stakeholder groups voiced concern over the move to managed care in general and for the ABD population in specific areas. Overall, the concerns included the following themes:

- Managed care plans may not save the State money due to higher administrative costs associated with providing additional services, such as transportation of consumers;
- Managed care plans pay much slower than fee-for-service Medicaid for some providers;
- Managed care plans have their own medical definitions of what is "medically necessary";

- Managed care plan rules restrict physicians from providing the care they believe is necessary for their patients;
- Managed care plans do not reduce emergency room usage;
- Managed care plans decrease necessary care in order to reduce costs;
- Managed care plans bundle services so that providers are reimbursed for a package of services typically associated with a particular diagnosis instead of each line item associated with those services;
- Providers perceive they have no recourse outside the managed care plan if there is a problem with a plan; and
- Medicaid recipients often have changes in eligibility and this causes them to change plans often.

Although many of the provider concerns about their interactions with managed care plans stem from early conflicts in implementing the program, providers reportedly had not had an opportunity to discuss these concerns with OHP. In many cases, providers and recipients had conflicting information and an unclear understanding of how the transition to managed care would be completed. A member of the Ohio Coalition for Healthy Communities shared some of the concerns saying, "In states like Texas and Arizona …they found because everybody is so high end, you don't have that more general population to offset the balance, and there have been some legal issues around access." The member remarked that, "access becomes one of the big issues" and recommended ensuring that program strengths, like community-based case management, are protected. A representative from the Ohio Advocates for Mental Health explained that, "The principal of managed care is that you have got to have a big pool and you let the people in the deep end of the pool who are costing money be balanced out by the people in the shallow end of the pool…." The member also expressed concern that, in concentrating the high-cost recipients in a single pool, Ohio Medicaid managed care would begin to experience rationing. The member concluded saying that managing care on the health care side would result in confusion for behavioral health recipients who accessed care through both systems.

According to *Case Studies of Managed Care Arrangements for Dually Eligible Beneficiaries* (Walsh, Greene, Hoover, Khatutsky, Layton, and Richter for CMS, 2003), states must ensure the following three practices are in place when implementing a managed care program for the ABD population:

- Increase information to the beneficiaries about the health plans and benefits available to them;
- Improve the accuracy and timeliness of information available to the health plans about the enrollees; and
- Improve the coordination of benefits for enrollees.

A California study, *Medi-Cal Beneficiaries with Disabilities: Comparing Managed Care with Fee-for-Service Systems* (Chimento, et. al., 2005) found that there was limited data available to determine how people with disabilities fare in Medicaid managed care or fee-for-service. The California study determined that beneficiaries enrolled in managed care experience fewer preventable hospitalizations than those in fee-for-service. However, recipients in fee-for-service and managed care both reported difficulty in finding physicians, communicating with their providers, and gaining physical access to their providers. The study recommended the following to improve the efficiency and effectiveness of Medi-Cal for disabled recipients:

- Strengthen state oversight by developing performance standards for providers and health plans that reflect the characteristics and needs of the ABD population, including access, chronic care, and coordination of care among programs and services.
- Measure and publicly report fee-for-service and managed care performance.
- Develop reimbursement mechanisms for providers and health plans that foster efforts to improve efficiency, quality, and coordination of care to recipients (similar to the pay-for-performance programs).
- Facilitate efforts to improve coordination across many state programs that serve the ABD population, including medical care services, mental health, rehabilitation, development services, and alcohol/drug addiction services. These efforts may involve technology advances that would allow better coordination among state programs.

The study also concluded that California focused little attention on the quality of care for the ABD population and collecting consumer satisfaction and other data from this population difficult and expensive. In addition, the Health Plan Employer Data and Information Set (HEDIS) and Consumer Assessment of Health Plans (CAHPS) measurement tools used by Medi-Cal did not reflect the varying needs of this population.[25] Furthermore, like many states and commercial health plans, Medi-Cal had difficulty distinguishing disabled beneficiaries from the Medicaid population. However, the study noted that California Health plans are trying innovative techniques to improve service to the ABD population. The plans are tailoring outreach and education programs to the needs of the ABD population, and providing directories that rate providers on access and care coordination.

In 2005, the Center for Disabilities Issues and the Health Professions, the Center for Health Care Strategies, and the Lewin Group recommended steps to California and its Medicaid health plans (Medi-Cal) to better serve the ABD population. **Table 5-6** details the recommendations and state actions needed to improve Medicaid managed care under Medi-Cal for serving the ABD population.

[25] HEDIS and CAHPS were developed by employers to measure commercial health plan performance; however, the ABD population has much more complex health problems than those reflected in these measurements.

Table 5-6: Medi-Cal Managed Care Recommendations for ABD Populations

Managed Care Plan	Recommended Medi-Cal Action
Consumer Access	
Measure and disclose accessibility of provider sites	Review accessibility policies and procedures as part of periodic MCO compliance audit
Conduct early identification of health and accommodation needs	Develop initial screen for new members
Engage in meaningful consumer participation	Provide MCOs with member specific, historical fee-for-service data (aggregate and member level)
File annual ADA Accessibility plan with California Department of Human Services	Use community standards of care to assess exemptions from time and distance standards
Conduct quality improvement programs on issues related to members with disabilities and chronic conditions	Facilitate quality improvement programs to improve care coordination among MCOs and "carve out" services
Combine case management and care coordination into negative care management plan	Establish work group to evaluate innovative practices in care management
Facilitate member advocacy for members with disabilities	N/A
Provide member services guide and other materials in alternative formats within seven days of receipt of request.	N/A
Expand definition of accessibility	N/A
Enhance definition of medical home (Specialists as primary care physicians)	N/A
Ensure smooth transition from fee-for-service to MCO (e.g. ongoing treatment not interrupted, medical files transferred)	N/A
Identify members who need care management	N/A
Develop individual care plans	N/A
Assist members in coordinating out of plan services	N/A
Arrange for specialty services provided out of network when medically necessary	N/A
Physician/Plan Relationships	
Clarify criteria used to make review decisions for new technology and investigational treatment revised	Review medical necessity definition to reflect maintenance of function
Conduct MCO disability and competency training for providers	Develop state-wide provider education plan
Use qualified physicians with appropriate expertise review all service denials	N/A
Data and Evaluation	
Identify and stratify members with disabilities and chronic conditions	Provide MCO with member data that is stratified for its population
Collect and stratify utilization indicators	Select quality improvement programs on issues related to members with disabilities and chronic conditions
Stratify populations through existing measures	Identify non HEDIS measures to pilot test
Collect additional HEDIS measures	Enhance state-wide consumer satisfaction survey

Source: Center for Disabilities Issues and the Health Professions, the Center for Health Care Strategies, and the Lewin Group Medi-Cal presentation, November 21 and 22, 2005.

Table 5-6, emphasizes actions required of both the state and the health plans to ensure successful implementation of managed care for the Medi-Cal ABD population. As Ohio has only recently included stakeholder input in the ABD managed care expansion, it has not used the recommended steps above in preparing for the expansion. In many areas, the recommended actions for the Medi-Cal program would equally suit stakeholder concerns related to the Ohio Medicaid transition to managed care. While state policies must support the managed care plans' requirements of physicians and recipients as a condition of participation, state collaboration with

the health plans increases the probability of program success. As shown in **Table 5-6,** California recognizes the need for care management and coordination of services, and plans to emphasize performance measures tailored to the needs of Medi-Cal consumers. For the ABD population, the coordination of care efforts across the different programs is central to improving the quality of care. The Medi-Cal recommendations are applicable to Ohio Medicaid, particularly during the expansion of managed care to the ABD population.

R5.4 The single State Medicaid agency should implement actions similar to those identified in California when enrolling ABD recipients in managed care. In addition, the State Medicaid agency should apply recommended actions from the Medi-Cal study to Ohio Medicaid as the identified problems closely mirror those identified in Ohio. Specifically, the Agency should:

- **Strengthen State oversight by developing performance standards for providers and health plans that reflect the characteristics and needs of the ABD population, including access, chronic care, and coordination of care among programs and services;**
- **Collect, measure, and publicly report fee-for-service and managed care performance for the ABD and other populations; and**
- **Facilitate efforts to improve coordination across State programs that serve the ABD population, including medical care, mental health, rehabilitation, development, and alcohol and drug addiction services.**

New Initiatives for Serving the Aged, Blind, and Disabled

Ohio has not implemented innovative programs for serving its ABD population. Through the State Medicaid agency, only ECM, and other minor programs have been briefly used to improve coordination and access to care for the ABD population. Although the State sub-recipient agencies[26] are more actively involved in improving care coordination for their Medicaid populations, the nature and extent of care coordination and quality improvement programs is limited.

Several pilot programs across the country have demonstrated means to improve Medicaid managed care for beneficiaries with disabilities. Likewise, these programs have developed innovative measurement methods to determine the effectiveness of managed care plans for the ABD population. In *Measuring the Effectiveness of Managed Care for Adults with Disabilities,* (Mastal and Palsbo, Center of Health Care Strategies, 2005) seven pilot programs were evaluated

[26] The Ohio Department of Aging, Ohio Department of Health, Ohio Department of Mental Health, Ohio Department of Alcohol and Drug Addiction Services, Ohio Department of Mental Retardation and Developmental Disabilities, and the Ohio Department of Education.

which represent the use of coordinated care organizations[27] in Medicaid. The organizations are described below:

- *Access II Care of Western North Carolina (Ashville, North Carolina)* offers a Primary Care Case Management (PCCM) program in rural North Carolina serving 25,000 recipients. The program uses non-profit networks of primary care physicians who contract with the state's Medicaid managed care program. Reimbursement is under fee-for-service.

- *AXIS Health Plan (Minneapolis, Minnesota)* is a non-profit company subcontracted to a state Medicaid health management organization to provide care coordination services. The program operates under fee-for-service billing to the health management organization for all encounters.

- *Commonwealth Care Alliance (Boston, Massachusetts)* is a non-profit organization that provides care coordination through a cost reimbursement arrangement to all persons who are Medicaid and Medicare eligible in Massachusetts.

- *Independence Care System (New York, New York)* is a non-profit organization that coordinates health and social services for 600 Medicaid adults with physical disabilities.

- *Vermont Medical Home Project (Montpelier and Burlington, Vermont)* is a Primary Care Case Management program for severely and persistently mentally ill patients who have a secondary diagnosis of diabetes. The Project provides services and care coordination under a fee-for-service arrangement.

- *Community Health Partnership (Eau Claire, Wisconsin)* is a capitated program administered through Medicare and Medicaid. The Partnership provides comprehensive medical and long-term support services, behavioral health benefits, and care coordination for elderly and working-age disabled adults.

- *Community Living Alliance (Madison, Wisconsin)* is also a capitated program administered through Medicare and Medicaid, which includes elderly and working-age disabled adults. About 60 percent of the members served are dual eligible recipients.[28] The Alliance provides care coordination for 300 members.

[27] Coordinated care organizations are an emerging type of comprehensive managed care for Medicaid adults with disabilities and complex chronic disease.

[28] "Dual eligible" refers to an individual who receives both Medicare and Medicaid because he or she meets income and chronic health condition requirements. In this instance, Medicare would pay for a portion of the costs of care and Medicaid would pay for any additional amounts or for additional services.

Although a range of techniques and service-delivery methods are used in the programs mentioned above, each provides care management services in addition to the typical Health Maintenance Organization type health coverage. In most plans, there is a social service component to assist patients with non-medical issues affecting their underlying chronic health conditions. In all of these programs, the coordinated care organizations address patient needs in a holistic manner by coordinating health and other support services in order to ensure recipients remain independent and productive.

The state programs described above highlight different approaches to serving the ABD population. A member of the Ohio Family Services Council spoke to the issue of using a strict medical model versus a more rehabilitative model saying that Medicaid "is a health insurance policy in essence. However, it can be much, much more broadly defined.... We get confused [about] where our priorities should be, and we end up doing things that aren't necessarily quality, that aren't necessarily the best thing … for the community or for the eligible recipients of this program." The member explained that Medicaid could deviate from the medical model to include mental health and rehabilitation services.

Although the patients express high levels of satisfaction, the coordinated care organizations have not established methods to measure program outcomes or effects on patients. Mastal and Palsbo identified a framework to measure coordinated care organizations' performance, which included the following elements:

- Community resources and policies;
- Health system organization of care;
- Self management support;
- Delivery system design;
- Decision support;
- Clinical information systems;
- Informed, active patients; and
- Prepared proactive practice team.

Overall, expanding managed care to the ABD population is highly feasible but requires a greater level of planning to implement. The programs that appear to work well require a commitment by both the state and the health plans to tailor care to the needs of the population. Furthermore, innovative programs typically include an individualized case management component, regardless of condition– a feature included in ECM but not necessarily emphasized in full-risk managed care. A member of the Ohio Hospital Association commented on managed care plans and their ability to implement strong case management for Medicaid recipients saying, "Care management, education, training of primary care delivery... one hopes that Medicaid will do this as we go to managed care products." However, the member cautioned that this depends on how managed care plans approach their role and noted that Medicaid managed care in urban counties

(which has been in practice for several years) has not reduced emergency room use or shown other improvements that could be achieved through care management.

The Ohio Medicaid Program has not prepared for the more intensive case management needs of ABD recipients and may, without modifications to the managed care implementation process, subject recipients to unnecessary hardships in accessing needed care. However, if Ohio were able to implement lessons learned through the Medi-Cal study (see **Table 5-6)** and incorporate strategies outlined in the innovative programs illustrated above, it could realize anticipated cost containment and improve the quality of care to Ohio ABD recipients.

R5.5 The single State Medicaid agency should, in its expansion of managed care to the ABD population, incorporate greater use of case management services as a condition of service for the managed care plans. Furthermore, it should seek to implement non-medical (social services) case management on a pilot basis and consider additional case management services based on the outcome of the pilot. When developing additional case management services, the State Medicaid agency should contact each of the identified pilot programs to request program evaluation information and input from the program originators concerning the pros and cons of following a similar service template. Finally, the State Medicaid agency should enhance management of the complex medical needs of the ABD population by evaluating pilot and traditional service delivery systems.

Intra-Program Coordination

Ohio uses separate systems to deliver mental health, and substance abuse services (behavioral health services). The Ohio Department of Mental Health (ODMH) funds and administers mental health services through local mental health boards and community mental health agencies. ODMH often works in conjunction with Ohio Department of Alcohol and Drug Addiction Services (ODADAS) who funds and administers substance abuse services. In the majority counties, the local boards of ODMH and ODADAS function as a combined Alcohol, Drug Addiction and Mental Health Services (ADAMH)[29] board. ADAMH boards have also regionalized services and several boards serve more than one county. In each of these cases, the agencies pool state and local funds to provide services to Medicaid recipients, as well as persons not eligible for Medicaid. Within the last decade, though, Medicaid has become the largest single payer for these services at the county level.

According to stakeholder groups, there is limited coordination of care for Medicaid recipients who receive behavioral health services in addition to general health services.[30] When a Medicaid

[29] In this section, both combined boards and stand-alone Mental Health boards and Alcohol and Drug Addiction Services boards are collectively referred to as ADAMH boards.

[30] Medicaid recipients can access limited mental health as well as alcohol and drug addiction services through primary care physicians and medical specialists.

recipient receives behavioral health services through a local ADAMH board, the board works with its providers to ensure that the recipient receives services. However, once the recipient has located a provider, the provider, not the board, is responsible for case management. Also, behavioral health services have been excluded from mandatory managed care. Service recipients who are not covered under Medicaid may be directed to specific providers by the local board.

Managed care plan members are permitted to self-refer to ODMH and ODADAS-certified Medicaid providers. However, managed care plans must ensure access to behavioral health services for members who are unable to access community behavioral health services in a timely manner (because of a waiting list or other barriers) or are unwilling to access services through community providers. Managed care plans in Ohio are also financially responsible for all medications prescribed to Medicaid recipients, including those for mental illness and drug and alcohol treatment.

In most instances, Medicaid recipients served through the behavioral health system see a primary care physician for their physical health problems and a separate physician or psychiatrist for specific behavioral health needs.[31] If a patient does not provide information about services received from other health professionals through Medicaid, the physician has no knowledge of the treatment received or the pharmaceuticals prescribed through other sources. Ultimately, no single agency or provider has a full picture of the health needs of the Medicaid recipient or the services they have used.

A member of the Ohio State Medical Association described shortfalls in the system as "silos within the Department" that result in uncoordinated care for recipients. The member said that this was probably true for all age groups and in both Medicaid and traditional payer programs. "If the left hand doesn't know what the right hand is doing, and doesn't have anyway of communicating … it can be really, really wasteful and very inefficient," the member concluded.

A member of the Ohio Association of Health Plans likewise described the structural problems within Ohio Medicaid that create silos of care and discussed instances where managed care plans will bridge those care gaps. The member explained that, "Because there are certain services that may be cut out of the benefit design … waiting lists, shortages of community resources [etc.], [managed care plans] end up providing that care…." The member said that the plans try to integrate medical management with community providers but may not receive cooperation from the provider. The member concluded, "When you've got little parts and pieces that [are] carved out, it's less effective."

Uncoordinated care can result in duplication of services and negative drug interactions. Several other states have implemented innovative programs to address the integration of behavioral health and medical services under a managed care service model. Programs in use in

[31] This process is also common for individuals under private pay or commercial health insurance plans.

Massachusetts, Colorado, Utah, Minnesota, Tennessee, Wisconsin, and Florida are described below.

Massachusetts

In 1992, Massachusetts was the first state to introduce a statewide mental health managed care plan for Medicaid, which resulted in cost savings resulting from reduced inpatient stays. Mental health and substance abuse benefits were carved out from the health maintenance organization and allocated to a for-profit managed care company through a shared risk contract with the state. Medicaid recipients have the option of selecting a separate behavioral health managed care plan instead of receiving those services under fee-for-service.

In Massachusetts, behavioral health expenditures are estimated to account for between 9 and 15 percent of total Medicaid spending, with 20 percent of Medicaid recipients using mental health services. Medicaid managed care has generally had a positive impact on behavioral health services as it has allowed for a more flexible service mix and, at least initially, saved between 15 and 40 percent over fee-for-service arrangements. The savings result from reduced inpatient hospitalizations, provider reimbursements, and outpatient visits. Managed care has also improved access to mental health services by expanding the network of providers.

Stakeholder Perspectives on Public Managed Care in Massachusetts (Beinecke, 2005) emphasizes the need for integrated services within Medicaid.[32] The need for integration becomes important when a primary care physician prescribes medication that may adversely interact with already prescribed behavioral health medications. Another article, *Crossing the Divide: Primary Care and Mental Health Integration* (Upshur, 2005), describes problems in the program resulting from its use of a care manager at the primary care level to help coordinate mental health services. The majority of patients in the pilot program diagnosed with depression also suffered from one or more chronic medical conditions such as asthma, hypertension, and diabetes. The high rate of illness detected in this population pointed to the necessity of primary care intervention in treating mental illness. However, the author found that none of the physicians at the pilot program sites reported being contacted by any of the managed care plans or behavioral health "carve out" providers. The author suggested that creating separate administrative and financial arrangements for behavioral health exacerbates the existing communication problems between the two delivery systems. Patients with chronic mental illness often suffer from inadequate primary care while patients in the primary care system suffer from inadequate behavioral health care. The use of a care manager at the primary care site can potentially bridge these gaps.

In a related article, *Case Study: A Medicaid Health Maintenance Organization Quality Initiative for Behavioral Health* (Chang and Wilcox, 2005), the authors study how effective Massachusetts Medicaid managed care plans have been in identifying new members who need behavioral health

[32] Integration refers to coordination of behavioral and physical health in order to improve continuity of care.

services during an initial screening interview. Massachusetts required the managed care plans to screen new members through a questionnaire to identify health needs and then notify the behavioral health plan of members in need of services.

Colorado, Utah, and Minnesota

In *Two Year Outcomes for Fee-for-service and Capitated Medicaid Programs for People with Severe Mental Illness* (Cuffel, Bloom, Hausman, and Hu, 2002), two models of capitation were examined for effects on clinical outcomes for Medicaid patients in Colorado, Minnesota, and Utah. In Colorado, behavioral health services contracts were awarded in one of three methods: to local community health agencies through direct capitation; to a joint venture between local community health agencies and privately managed behavioral health organizations; or to providers under fee-for-service arrangements. In Utah, the state contracted directly with mental health providers, which resulted in a reduction of inpatient admissions and expenditures. In Hennepin County, Minnesota, severely mentally ill patients were randomly assigned to either managed care plans or fee-for-service Medicaid for treatment. The study found that there were no differences in the health outcomes for the patients in each state. Although capitation reduced costs for the severely mentally ill, outcomes remained steady for patients under both fee-for-service and capitated arrangements.

Wisconsin

A representative of the Wisconsin Department of Health and Human Services described how it "carves in" Medicaid behavioral health services for CFC and SCHIP Medicaid recipients to provide a more comprehensive benefit package and increase care coordination with the physical health component. In Wisconsin, the counties provide locally funded services such as community support programs, targeted case management, and mental health crisis intervention. The community mental health and substance abuse boards have contracts with the managed care plans, which allow for better information sharing and care coordination.

Florida

Florida has implemented a model program under an 1115 waiver for comprehensive managed health care, including behavioral health services. The waiver program emphasizes the individual's role in planning and purchasing health care services, and is expected to provide transparency in the performance of health care plans and providers, assure access to quality service, provide stability to Florida's budget, reduce confusion about coverage, and leverage the dollars spent to measurably improve service and invest in prevention. The new system will rely heavily on measurement of outcomes. Although relatively new, the program may hold promise for improved coordination of services. This program was noted by Ohio advocates for persons suffering from behavioral health disorders as an attractive option for service in Ohio.

According to stakeholder testimony, several mental health advocacy groups are interested in "carve in" programs that other states have tried. The concern is that the "carve out" practice is not working well for recipients who need behavioral health services. Stakeholders indicated an interest in trying new programs that would allow for greater flexibility for patients. A representative of Ohio Advocates for Mental Health said, "I'm not so sure the carve-out is a good idea anymore…. I have always been a firm believer that a …waiver is the way to go." The member recommended examining the Florida model and the plan types used in that state—self-directed care, managed care, and traditional fee-for-service care. A member of the Ohio Association of Health Plans noted that, while opinions might differ between groups on continuity of care, "Our perspective is carving in is better then carving out because of being able to manage the whole continuum and benefits." The member mentioned Indianan and Wisconsin as examples of "carve in" programs and attributed the differences between states (carve in versus carve out) to funding streams, political environments, and the strength of mental health advocacy within the state.

Ohio's Medicaid patients reportedly receive poorly coordinated care compared to other service delivery systems. Under current conditions in Ohio, there is a convoluted channel of communication. The managed care plans report directly to the State Medicaid agency, while the community behavioral health agencies report to their respective State agency, who then shares information with the State Medicaid agency. Information is not shared directly between community mental health agencies and managed care plans, which results in disjointed care for patients.[33] Both the managed care plan and the community health agency would benefit from sharing information so they could better coordinate care for the Medicaid recipients they serve.

R5.6 The State Medicaid agency, with support from the General Assembly, ODMH, ODADAS, and the ADAMH boards, should closely examine other states' practices of managing behavioral health and pilot different types of behavioral health case management and "carve in" managed care programs. The pilot programs should be used to determine the efficacy of these programs for Ohio behavioral health services recipients. Whether Ohio should continue to "carve out" these services from managed care, adopt the Community Behavioral Health Medicaid Business Plan to allow the ADAMH boards to conduct case management,[34] or adopt a "carve in"

[33] Recipients served in the behavioral health system are entitled to use their Medicaid card for standard medical services offered by the Medicaid managed care plans. In some cases, these managed care services also include access to behavioral health services or treatments that the managed care plans are required to offer to recipients. Furthermore, the efficacy of both physical and behavioral health services may be diminished by uncoordinated care. For example, pharmaceuticals used to treat diabetes and high blood pressure may have an impact on the effectiveness of pharmaceuticals used to treat psychological illnesses.

[34] The proposed Business Plan would allow the county-level Behavioral Health Authorities to implement oversight of clinical treatment levels, among other changes. The Plan outlines the components needed at the State and local levels within the Medicaid community behavioral health system for efficient and consistent administration. The goals of the Plan include ensuring local flexibility and federal compliance; establishing a statewide clinical improvement process; developing uniform cost reporting, rate setting, compliance, and auditing processes; and

program (akin to Wisconsin) is a particularly controversial issue within the Medicaid program. Any decisions regarding the inclusion of this program in managed care should be based on empirical data.

The State Medicaid agency, in conjunction with ODMH, ODADAS, and the ADAMH boards should also investigate alternative solutions, such as those using a specific managed care organization exclusively for behavioral health services. Under any scenario, program recipients would likely experience benefits from coordination of care but also experience potential restrictions on services. (See also the technology and program management section for a discussion on the potential attributes of electronic health records and their effect on care management.)

Several options exist for the State to explore. Models used in other states that should be considered include the following: permitting the local behavioral health boards to provide care management (as outlined in the Community Behavioral Health Medicaid Business Plan, 2004); carving behavioral health into managed care but contracting with a specific managed care plan for these services; carving behavioral health into managed care using existing plans; or carving in behavioral health but dividing services and contracts between managed care plans and local boards.

C. Monitoring Managed Care Plan Service Delivery and Health Outcomes

Managed Care Plan Performance

ODJFS monitors the effectiveness of managed care plan activities in providing access to quality care through the following elements:

- The use of continuing quality improvement approaches to encourage ongoing managed care plan performance above basic program requirements;
- The use of independent enrollee satisfaction surveys;
- A review of enrollee complaints and grievances, state hearings, and voluntary disenrollments;
- Ongoing monitoring of reports identifying provider turnover;
- A review of cost reports and annual reviews of audited financial reports and disclosure statements;

establishing consumer protection standards. The Plan applies to Medicaid services many of the same initiatives and processes already in use in the behavioral health system for locally funded services. The most important aspects of the Plan include the application of utilization review and management, and care management to Medicaid services, a function prohibited to the boards under current rules.

- The review and prior approval for managed care plan-developed marketing and member materials; and
- The development and monitoring of corrective action plans for certain program problems or deficiencies.

ODJFS' descriptions of MCP Performance Requirements indicate that the Department will conduct, whenever possible, comparable surveys and data collection among Medicaid consumers served by the fee-for-service delivery system (i.e., satisfaction surveys and utilization reviews). However, as recently as April 2006, the Department indicated that it does not collect or evaluate fee-for-service performance data. Information obtained on both fee-for-service and managed care plan-enrolled groups is provided to the public in the form of an annual report but this includes only the most basic data on numbers served, costs and expenditures, geographic distribution of enrollees and expenditures, and other minor demographic statistics. The most recently released annual report is for SFY 2002-03.

ODJFS requires managed care plans to collect encounter data (paid claims) for each member at each visit to any provider. Encounter data is claims that have been paid and submitted by the managed care plan to ODJFS on a monthly basis. The data is compiled and analyzed by the performance review section in the Bureau of Managed Health Care (BMHC). BMHC publishes an annual report (*clinical performance measure report*) detailing how well each managed care plan performed according to national and ODJFS-specific clinical performance requirements. The *clinical performance measure* report lists the benchmarks for each performance measure, which include care management measures and Health Plan and Employer Data Information Set (HEDIS) indicators. (See **Table 5-8**).

Clinical performance measures used for Ohio Medicaid managed care are often used by ODJFS for comparison with national measures, even though the Department has modified its measures to be inconsistent with data contents of the national benchmarks. ODJFS uses national measures but adds local adjustments to include additional services or providers in the measures that nullify the Department's ability to compare its service levels to other states. BMHC representatives explained that local adjustments were necessary because of the different way Ohio codes payments to providers. However, Health Insurance Portability and Accountability Act (1996) requirements have dramatically decreased the number of special codes used by ODJFS and these will be eliminated with the implementation of the Medicaid Information Technology System (MITS) (see **technology and program management** section). OHP also reported that it modified the national measures since the measures did not meet its data needs.

Further, BMHC does not use all of the national HEDIS measures available because, as stated by the Bureau, the managed care plans could not improve their performance in all areas at once. The Bureau explained that by using only a portion of the measures at a time, the plans could focus on certain measures selected by the Bureau for improvement. BMHC has purchased additional software that is capable of measuring all Medicaid services against national indicators.

ODJFS conducts an annual Consumer Assessment of Health Plans Survey (CAHPS) to capture recipients' satisfaction with managed care plans, clinical care, access to care, and their personal health status. The sample used for the consumer survey included adults, age 18 and older, who were enrolled in a managed care plan for five of the last six months, and parents/caretakers of children who were enrolled in managed care plans during five of the last six months. The most recent survey was conducted from February through May 2005. The sample size included 3,697 adults and 3,590 caretakers/parents of children, and the Department received a 36.2 percent response rate (or 0.5 percent of Ohio Medicaid recipients enrolled in a managed care plan). ODJFS stated that, given the data limitations, which include case mix adjustments, non-response bias, and causal inferences,[35] generalizations must be made cautiously. The results from the 2005 CAHPS survey are shown in **Table 5-7**.

Table 5-7: 2005 CAHPS Survey Results for Ohio Managed Care Plans

Areas Above National Averages	Areas Consistent with National Averages	Areas Below National Averages
General Child Rating of All Health Care	General Child Rating of Personal Doctor	General Child and Adult Rating of Health Plan
General Child and Adult composite of Getting Needed Care	General Child Rating of Personal Specialist	Adult Rating of All Health Care
General Child Composite of Getting Care Quickly	Adult Composite of How Well Doctors Communicate	Adult Rating of Personal Doctor
General Child Composite of How Well Doctors Communicate	Adult Composite of Courteous and Helpful Office Staff	Adult Rating of Specialist
General Child Composite of Courteous and Helpful Office Staff		Adult Composite of Getting Care Quickly
General Child and Adult Composite for Customer Service		

Source: ODJFS 2005 CAHPS.

As shown in **Table 5-7**, recipients rated child services above the national average. On the other hand, ratings for adult services were below the national average, except in the case of the general child and adult composite of getting needed care. For both child and adult services, personal doctor and personal specialists were consistent with or below the national average.

The Basics of Social Research (Babbie, 2002) indicates that although mass mailings are a very popular method of administering surveys, relying on respondents to return the survey is an unreliable method of obtaining feedback from consumers. Response rates can be increased if the researcher readily monitors return of the survey, does follow-up mailings and designs the survey to be more user-friendly. A response rate of 50 percent is considered adequate for analysis; 60 percent is good; and anything above is very good. The 2005 CAHPS response rate was less than 40 percent and included only 1.4 percent of participants, which limits the usefulness of results

[35] Based on the number of surveys distributed, ODJFS would have received responses from only a 1.4 percent of Ohio Medicaid recipients enrolled in managed care plans if all surveys had been returned. At the end of 2004, there were approximately 518,000 recipients enrolled in managed care plans.

for drawing valid conclusions. Furthermore, the use of a mass mailing survey may be less appropriate for Medicaid recipients because of the transient nature of the populations and potential communication barriers.

The National Committee for Quality Assurance (NCQA), a national health plan accrediting organization,[36] uses a nationally recognized performance monitoring tool. The NCQA measures evaluate health plan activities that help people maintain good health and avoid illness. To evaluate how the health plan helps its members stay healthy, NCQA reviews health plan records, interviews health plan staff and grades independently verified clinical data and results from consumer surveys conducted by independent survey organizations. NCQA looks for the following:

- The presence of guidelines for physicians about the need to provide immunizations and screening tests to plan members;
- Effective communications that make physicians in the plan aware of the guidelines;
- Effective communications that make plan members aware of what they can do to reduce illness, disease and accidents;
- The percentage of children under the age of two who have received recommended immunizations to prevent childhood diseases;
- The percentage of children who, by the age of 13, have received recommended immunizations for the continued protection against childhood diseases;
- The percentage of Medicare members over the age of 65 who received an influenza vaccination to prevent the flu (only for health plans serving Medicare beneficiaries);
- The percentage of women ages 52-69 who received a mammogram with the past two years to detect breast cancer early;
- The percentage of adult women who received a pap smear within the past three years to detect cervical cancer early;
- The percentage of pregnant women who received their first prenatal care visit during the first three months of pregnancy;
- The percentage of new mothers who received a check-up within eight weeks after delivery;
- A well-defined program for improving the quality of clinical care and service provided to plan members;
- The number of individuals in the health plan responsible for overseeing quality improvement programs; and
- Actual improvements that the plan has made in care and service.

[36] These services are restricted to NCQA accredited plans. Ohio Medicaid does not require NCQA accreditation of its plans, although some Ohio plans are accredited through other organizations.

Collectively, these measures are termed HEDIS measures and are in use nationally by most managed care plans and government health care programs under a fee-for-service delivery system. Using a national measurement system allows the comparison of performance among similar programs.

ODJFS monitors the locally modified HEDIS measures for each of its managed care plans and establishes target levels of performance. **Table 5-8** shows performance data for the ODJFS plans in 2004.

Table 5-8: 2004 Clinical Performance Measures

2004 Clinical Performance Measures Table	Overall		Managed Care Plan	Managed Care Plan Individual Results for 2004							
	CY 2003	CY 2004	Targets	Plan A	% Change from 2003	Plan B	% Change from 2003	Plan C	% Change from 2003	Plan D	% Change from 2003
Perinatal Care											
Initiation of Prenatal Care	84.4%	85.4%	90.0%	85.7%	1.1%	87.6%	(1.5%)	85.6%	3.8%	79.2%	(0.8%)
Frequency of Ongoing Prenatal Care	58.6%	58.9%	80.0%	56.9%	(0.2%)	72.3%	0.5%	58.2%	3.6%	63.8%	(2.1%)
Cesarean Section Rate	21.5%	23.5%	N/A	23.1%	1.4%	23.2%	2.9%	23.1%	3.1%	28.3%	5.0%
Low Birthrate Weight	7.6%	9.6%	N/A	9.5%	1.0%	10.1%	7.8%	11.1%	4.2%	8.1%	0.9%
Very Low Birth Rate Weight	1.6%	2.4%	N/A	1.7%	(0.2%)	1.0%	0.8%	8.5%	7.8%	1.0%	1.0%
Postpartum Care	49.4%	52.8%	80.0%	52.6%	(4.2%)	54.9%	(2.1%)	52.4%	0.7%	53.6%	7.2%
Child Health Care											
Well Child Visits 15 Months of Life	41.9%	43.5%	80.0%	40.1%	1.7%	61.6%	3.0%	42.6%	0.5%	52.8%	6.8%
Well Child Visits 3-6 Years	62.0%	62.2%	80.0%	60.6%	0.6%	65.4%	(2.1%)	69.5%	1.9%	59.4%	(2.4%)
Adolescent Well Child Visit 12-21 Years	35.8%	36.6%	80.0%	34.6%	1.1%	36.8%	(1.4%)	46.3%	2.4%	35.6%	(0.7%)
Childhood Immunization Status	17.7%	23.6%	N/A	21.3%	6.4%	29.4%	10.2%	26.6%	5.1%	31.8%	4.8%
Annual Dental Visit	41.0%	44.3%	60.0%	45.4%	3.4%	52.3%	3.1%	37.9%	3.7%	39.6%	(1.3%)
Lead Testing for 1 Year Olds	40.3%	43.0%	80.0%	43.7%	2.7%	31.4%	4.7%	47.0%	2.0%	40.6%	1.1%
Lead Testing for 2 year Olds	23.3%	24.2%	80.0%	24.6%	0.7%	16.2%	0.5%	28.2%	(0.4%)	21.9%	5.2%
Chronic Care											
Use of Appropriate Asthma Medication	56.0%	55.9%	80.0%	55.3%	(0.3%)	57.5%	(7.0%)	56.2%	2.7%	57.4%	0.3%
Comprehensive Diabetes Care (Those Who Receive the HBA1c Test)	59.4%	59.8%	N/A	60.4%	0.3%	57.7%	(2.3%)	62.4%	6.1%	54.1%	(5.1%)

Source: ODJFS Clinical Performance Measures report for 2004.
Note: Data was not tested because source data was unavailable.

As shown in **Table 5-8**, none of the managed care plans achieved the ODJFS performance target. The overall State average also fell below the ODJFS targets. However, there was improvement between 2003 and 2004 for most of the managed care plans and in many of the measures.

In the HCFA article, *Combining HEDIS Indicators: A New Approach to Measuring Plan Performance* (Lied, Marlsbary and Ranck, 2002), the authors evaluated if HEDIS indicators provide the most complete or accurate reflection of care. HEDIS indicators are aggregate measurements designed for comparing the managed care organization's performance on particular measures against the performance of other managed care plans. Because aggregate measures focus on a limited set of indicators, they do not allow for exploration of program related issues and/or program management. Since most aggregate data is reported annually, the reports are not considered timely enough for evaluation of program management. In addition, most aggregate measures focus on continuously enrolled populations thereby excluding a large percentage of Medicaid recipients that roll on and off Medicaid on a monthly basis. Another limitation deals with how HEDIS and other aggregate measurement tools combine certain services, such as immunizations, which can miss a problem with one particular service. Aggregate measures do not provide enough detail to support causal and correlation analyses. For example, the HEDIS childhood immunization measure combines information on 14 individual immunizations per child. The data aggregation makes it impossible to detect problems with a particular service or specific immunization, and the measures do not recognize utilization and outcome differences among subpopulations of Medicaid recipients. To counteract these limitations with HEDIS and other aggregate measures, encounter level data must be used to supply the differences in utilization and outcomes.

The use of HEDIS indicators to measure fee-for-service and Primary Care Case Management delivery system performance is described in *Medicaid HMO and Fee-for-service Comparison Strategy: Methodological Issues* (NCQA, 1998). The report suggests that HEDIS can be used for fee-for-service and PCCM if the accountable entity can be identified; the benefits which must be delivered are specified; and the population has been identified. In **Table 5-9**, the actual and theoretical uses of these measurements for fee-for-service and Primary Care Case Management are described.

Table 5-9: Actual and Theoretical Uses of HEDIS

Type	Accountable Entity	Accountable For:	Delivered To:
Managed Care Plan	Managed Care Plan	Delivery of contracted services	Enrolled population meeting measurement criteria
Primary Care Case Management (theoretical)	Primary Care Case Manager	Delivery of primary care and case management services	Eligible persons with a defined period of assignment
Fee-for-service (theoretical)	Delivery System payer (Medicaid)	Delivery of all Medicaid covered services	All eligible members with a defined length of Medicaid eligibility

Source: National Committee for Quality Assurance.

Although Ohio has not applied performance measurement methods to fee-for-service or Primary Care Case Management, and has only used HEDIS indicators in a limited fashion, other performance measurement frameworks are available for use. Since there is little, if any, performance monitoring done for fee-for-service in Ohio, it is important to develop a method to

measure health outcomes in conjunction with monitoring costs. In discussing measurement, a member of the Ohio Psychological Association remarked that, "Performance-based outcomes for mental illness are different than for other areas, such as health. Mental illness requires different measurement." These comments are an indication that an expansion in measures is critical for understanding the complexities of Ohio Medicaid.

A member of the Ohio Association of Health Plans also expressed frustration at the limited use of measures and outcome focuses in Ohio saying that the plans often have interventions or a toolkit" for addressing certain conditions. However, the State requires certain interventions in its contract with the plans. The member said, "If I were the State, I'd want to move to outcomes. In fact, I wouldn't want us all doing it the same way because if we all do it the same way … then how do you know which is the best practice? …We ought to be learning from each other. But if we all do it the same way, what do we end up with?" The member went on to highlight practices in Michigan explaining that, "Michigan [rewards] plans for being accredited by a national accrediting body and thereby really has streamlined down the more prescriptive kinds of requirements. Then they are very focused on HEDIS and CAPS outcomes and use full Medicaid HEDIS." The member concluded saying, "Michigan is a best practice and has really shown significant improvements."

Since Medicaid expenditures represent approximately 40 percent of the State budget and the program provides critical services to vulnerable populations, the State Medicaid agency must be able to show the efficacy of each service delivery method to ensure that the target populations are being appropriately served. Finally, without appropriate performance measurement data, the State Medicaid agency may adopt service delivery methods that prove less appropriate for the intended population.

R5.7 The single State Medicaid agency should immediately begin collecting data for all HEDIS indicators to monitor managed care plan clinical performance. Using unmodified national measures instead of altered versions is critical to ensuring that Ohio's results can be compared to national averages. The State Medicaid agency should also collect clinical performance data for the populations who will remain in fee-for-service. The Agency should also seek additional measures for use within the sub-recipient State agency services or compile existing measures used by these agencies into a comprehensive annual report.

R5.8 The single State Medicaid agency should improve the use of the CAHPS (consumer survey) to monitor recipients' access to care, customer service concerns, and perceptions of unmet medical needs. The Agency should expand the CAHPS survey methodology to ensure greater penetration and response rates. The response rate could be improved through a variety of methods including conducting the survey in conjunction with redetermination and using a third-party vendor to conduct the survey and analyze results.

Managed Care Plan Contract Management

The competitive process for managed care plan selection by ODJFS to provide service to the Medicaid population begins with a Request for Proposal (RFP). The RFP details the terms of the contract and the plan scoring criteria. Each prospective managed care plan had to submit the documentation outlined in the RFP. Addendum C of the RFP comprised the point scoring system with a total of 1,000 points possible. Point categories included the following:

- C1: Mandatory Application Requirements (Pass/Fail);
- C2: Applicant Experience/Compliance History (Maximum of 280 points possible);
- C3: Delegation (Maximum of 100 points possible);
- C4: Performance Improvement and Clinical Management (Maximum of 70 points possible);
- C5: Information Technology (Maximum of 100 points possible);
- C6: HIPAA Experience and Compliance (Maximum of 50 points possible); and
- C7: Regional Provider Panel Specifications (Maximum of 400 points possible).

In the RFP scoring, the greatest emphasis was placed on the regional provider panel (or provider network) with 400 possible points. Essentially, managed care plans were required to meet the provider panel requirements to compete for the contract. **Table 5-10** shows the scores for each managed care plan in each region:

Table 5-10: Managed Care Plan RFP Scores by Region 2006

Managed Care Plans	Central	EC	NE	NEC	NW	SE	SW	WC	Avg. Managed Care Plan Score
Amerigroup							823	814	818.5
Buckeye	551	854	735		831	591	558		686.6
CareSource	810	851	821	910		771	886	846	842.1
Gateway		499		814		515			609.3
HomeTown		615				513			564.0
Molina	837					758	786	879	815.0
Paramount					840				840.0
QualChoice			902						902.0
Unison		827		878		797			834.0
WellCare			809			574			691.5
WellPoint	656	615	821	834	753	624		603	700.8
Avg. Score	713.5	710.1	817.6	859.0	808.0	624.8	763.2	785.5	
Avg. Score of Selected MANAGED CARE PLAN	823.5	844.0	848.0	874.0	808.0	775.3	831.6	846.3	

Source: ODJFS Scoring Criteria and Managed Care Plan Results, March 2006.

As shown in **Table 5-10**, scores ranged from 564 to 902 for the RFP data submitted by the managed care plans. Average scores for selected managed care plans in each region were above 800 for all regions except the Southeast Region. Managed care plans responding to the RFP to serve Ohio Medicaid recipients undergo a competitive process to win approval for a contract with ODJFS for each service region that they would like to serve. The selected plans must also undergo a readiness review prior to beginning to operate in the contracted regions. Some plans may only receive contracts for a portion of regions for which RFPs were submitted, while others plans may not receive any contracts. ODJFS outlines managed care plan required services in the contract. In addition to medical services requirements, ODJFS requires the managed care plans to meet a number of other criteria, several of which are listed below:

- Have a valid license to do business in the State of Ohio;
- Offer a toll-free number for customer service to their members;
- Pay claims within guidelines of the Code of Federal Regulations;
- Provide a provider directory of contracted providers;
- Submit paid claims data;
- Submit performance measures;
- Provide members with an insurance card; and
- Provide disease management.

Based on industry standards for Medicaid managed care plan contracting, ODJFS' competitive selection process and the requirements for managed care plans seeking to do business in Ohio Medicaid meet industry standards. Once a managed care plan is selected by ODJFS, a provider agreement, consisting of the following elements, is signed to formally initiate the contract:

- Managed care plan responsibilities;
- ODJFS responsibilities;
- Rate methodology;
- Coverage and services;
- Program integrity;
- Data quality;
- Performance improvement; and
- Provider panel.

Managed care plans are responsible for ensuring that their members have the resources needed to receive services. The plans are required to obtain a license to manage care from the Ohio Department of Insurance (ODI) as a Health Insuring Corporation before ODJFS finalizes the contract to service Medicaid recipients. The plans are also required to have an office located in Ohio, be represented at all meetings and events designated by ODJFS as requiring mandatory attendance, assure that all employees are trained on program requirements, and provide a call center for providers and members.

Under previous managed care implementation processes, Ohio had several managed care plan failures. Failed managed care plans were unable to pay providers for services and several urban providers had large, outstanding balances that they were unable to collect. Consequently, providers were initially reluctant to contract with the managed care plans competing for the ODJFS contracts. A member of the Ohio Children's Hospital Association spoke about this past experience and its impact on providers' level of concerns for the system: "In the mid 90's, [Medicaid managed care] stumbled badly -- claims we're not being paid. Care wasn't being provided. It wasn't being authorized. It was extremely difficult and it's taken nearly a decade to try to rebuild from these missteps. We had five bankruptcies in Cleveland. We lost tens of millions." The member explained that new processes and standards implemented by ODJFS have improved confidence in Medicaid managed care plans."

In order to ensure the integrity of the plans, the State has taken steps to reduce the risk of managed care plan failure. The contract management of managed care plans is a joint effort between ODJFS and ODI. The Bureau of Managed Health Care monitors the managed care plans' responsibilities and compliance with the contract while ODI oversees the financial stability of the plans by reviewing their capital adequacy, asset quality, reserves, reinsurance, management, earnings, and liquidity (called the CARRMEL process). ODI uses an internal rating system, based on the plan's performance, to determine the frequency of future ODI reviews.

Each managed care plan submits to BMHC hard copies of annual audited financial statements, ODJFS Cost Report, auditor's certification of the cost report, reinsurance agreement, prompt pay reports, a copy of National Association of Insurance Commissioners (NAIC) quarterly and annual health statements. Any managed care plan notified by ODI of proposed or implemented regulatory actions must report notification and the nature of the action to ODJFS no later than one working day after receipt from ODI.

Claims are submitted to the managed care plans by medical providers and, under the ODJFS contract prompt payment clause, the managed care plan must pay 90 percent of all submitted clean claims within 30 days of the date of receipt. Of that 90 percent, 99 percent must be paid within 90 days of the date of receipt. However, while ODI monitors the amount of unpaid claims, ODJFS does not enforce prompt payment requirements.[37]

Table 5-11, shows the amount of unpaid claims by each managed care plan that served Medicaid recipients in CY 2005, as available from ODI financial reports. Unpaid claims refers to the amount of claims submitted by providers to the managed care company that have not been paid, including pending claims and recently submitted claims. The level of unpaid claims is an important indicator of the managed care plan's ability to financially sustain operations and, during stakeholder meetings, was a prime source of concern for providers.

[37] ODJFS only receives paid claims information through encounter data but does not collect information on denied or pending claims. The Ohio Department of Insurance collects information on denied and pending claims.

Table 5-11: 2005 Managed Care Plans Unpaid Claim Amounts

Managed Care Plan	2005 Unpaid Claims Amount	Total Claims Paid 2005	Unpaid Claims as a % of Total Paid Claims
Amerigroup	$857,688	$4,947,197	17%
Buckeye	$1,440,262	$64,250,752	2%
CareSource	$11,279,916	$683,393,409	2%
Gateway	$313,829	$2,283,643	14%
MediPlan	$1,552,502	$646,216	240%
Molina	$4,283	$0	0%[1]
Paramount	$1,428,027	$0	0%[1]
QualChoice	$49,120,105	$198,679,404	25%
Unison	$439,556	$1,393,710	32%
Total Amount of Unpaid Claims	**$66,436,168**	**$955,594,331**	7%

Source: ODI 2005 financial statements for each managed care company. Information not tested for reliability by AOS due to time constraints and the availability of source data.
Note: Unpaid claims include claims that had not yet been paid but that were approved, as well as pending and denied claims.
[1]Molina and Paramount started enrollment December 1, 2005 and did not have any paid claims for 2005.

As shown in **Table 5-11**, the total unpaid claims amount was over $66 million. QualChoice had the most unpaid claims at $49.1 million; however, as a percentage of claims, MediPlan had the largest balance of unpaid claims at 240 percent of paid claims. Unison had the second largest percentage of unpaid claims at 32 percent, and QualChoice was third with 25 percent unpaid claims. Certain stakeholder provider groups stated that managed care plans have not been timely in paying claims. Yet, the aggregate amount of unpaid claims is only about 7 percent of total paid claims. Overall, there was a mix of provider experiences when dealing with managed care plans and the timeliness of payments, with the most common issues being slower payment than under fee-for-service (two-week turn around under fee-for-service compared to 30-90 days under managed care), and different criteria for clean claims under managed care than under fee-for-service.

Representatives of the Ohio American College of Emergency Room Physicians said, "the managed care organizations cut the time that you can file a claim in half. The State gives 365 [days], they give 180 days." The member also said, "they don't always pay for the same coverage services that the State policy pays for. They decide if they're going to pay us for all of the services we perform or some of the services we perform." The member also elaborated on the payment time frames saying, "If you bill electronically to the State, you can typically expect payment or a denial … within a week. You will either have your payment or you're explanation as to what's wrong with it and why you're not paid. With managed care, it's … four to six weeks…. And that's to get either [a] payment or a denial."

Table 5-12 shows the criteria that the Ohio Department of Insurance uses to assess all health insuring corporations, including Medicaid managed care plans. In 1999, ODI implemented more rigorous reviews of all health insuring corporations.

Table 5-12: ODI Quantitative Guidelines for Health Insuring Corporations

Strong	• Risk Based Capital is greater than 400%. • Positive net income last two years. • No reserve deficiency. • Health Care and Affiliated Receivables are less than 30% of net worth. • Analysis and examination processes indicate only minor issues regarding risks.
Satisfactory	• Risk Based Capital is between 300% and 399%. • Net loss is ≤5% than net worth & surplus decline of ≤5%. • Reserve deficiency is <5% of net worth. • Analysis and examination processes indicate few issues regarding emerging risks. • Health Care and Affiliate Receivables are less than 30% of net worth.
Fair	• Risk Based Capital is between 210% and 299%. • Net loss during the year is <10% of net worth. • Above minimum net worth requirement. • Analysis and examination processes may indicate emerging risks regarding assets, earnings, premium growth, reserve adequacy, management, corporate governance, etc.
Marginal	• Risk Based Capital of 150% to 209%. • Evidence that company is moving toward being in hazardous financial condition under Rule 3901-3-04 of the OAC. • Within 15% of statutory minimum net worth requirements. • Net loss during the year is >10% of net worth. • OFRS has material concerns regarding the quality and expertise of the company's management and board of directors, given the company's risk profile.
Weak	• Risk Based Capital of less than 150%. • Evidence that the company is in hazardous financial condition under Rule 3901-3-04 of the OAC. • Below statutory minimum net worth requirements.

Source: ODI manual.

Although ODI had a documented process for evaluating managed care plans prior to 1999, it did not use this method and did not have sufficient staff to effectively monitor the managed care plans. Furthermore, ODI had not yet codified the principles that would be used to judge soundness of the plans or the risk associated with certain plans. Under the statewide expansion, ODI has addressed these issues and now requires plans to score in the strong or satisfactory categories to qualify for licensure. Plans that are licensed but fall below satisfactory in a future review are then subject to more frequent ODI reviews. In the worst cases, monthly reviews may be conducted.

A member of Columbus Speech and Hearing Center expressed concern about the providers' ability to reach ODJFS and request them to intercede with managed care plans. The member described missed payments and retroactive denials – imposed after a service has been authorized

– and estimated that it cost providers in their center "tens of thousands" of dollars. When the member approached ODJFS to resolve the problem, the Department reportedly referred the member back to the managed care plan. Likewise, appeals to the Ohio Department of Insurance reportedly had no impact. A different experience was shared by a member of the Ohio Hospital Association who discussed the positive response from the Bureau of Managed Health Care saying the Bureau "[has] good customer service. They have good follow-up." The member said that he hopes the Bureau's "philosophy is… maintain[ed]." ."

Managed care plans are also required to meet minimum performance standards for quality of care, access, customer satisfaction, and administrative capacity. ODJFS may impose disciplinary actions when managed care plans do not meet the performance standards. Disciplinary actions include implementing a corrective action plan or a performance improvement project (PIP), imposing financial sanctions, freezing membership, or adding penalty points to the managed care plan rating.

According to the *Contract Management Manual: A Guide To Bidding, Selecting, Contracting and Monitoring Service* (Appalachian Partnership for Welfare Reform, 2001), a contract must clearly state the responsibilities as they relate to the scope of work to be performed; the deliverables; the results to be obtained; any reporting requirements; all performance monitoring activities; and, of course, the price and payment methodology. In managing a contract, the managing party should clearly define the product, the bidding or RFP instructions, the methods of contract construction, the means of vendor performance, and compliance reporting. Similarly, the managing organization must implement a contract monitoring and management system, and develop a procedure for contract closeout.

Representatives of the Ohio Association of Health Plans stressed the need for a focus on outcomes: "I think that theme of process versus outcome permeates the entire way they run the business." The member provided several examples of frustrations with the process orientation superseding recipient services.

Although ODJFS and ODI have radically improved the oversight of managed care plans under statewide expansion, additional steps could be implemented by the State Medicaid agency to ensure the long-term soundness of managed care plans. Bidding and RFP instructions meet industry standards, but monitoring and enforcement of contract provisions could be improved. Furthermore, according to managed care plan stakeholders, the State Medicaid agency could improve the focus of contract compliance and shift from procedural issues to quality measures. This would allow the managed care plans to concentrate staff expertise on providing services and away from paper-driven, non-value adding technical oversight. However, without strong financial requirements, Ohio Medicaid managed care plans may again experience financial failure. ODJFS and ODI must ensure the financial stability of managed care plans through the reviews conducted by ODI and enforcement of prompt payment requirements. Additional emphasis on and consistency in defining clean claims would also improve this process.

R5.9 The single State Medicaid agency should enforce the requirements surrounding the prompt payment of individual claims by each managed care plan to encourage provider confidence and ensure access to care for recipients. The Agency should enforce its standards for pending and denied claims and require managed care plans to submit aging accounts data on a monthly basis to better monitor pending claims. In particular, the Agency could monitor the volume of claims in pending status.

The single State Medicaid agency should also review denied or pending claims. As a high number of denials or pending claims could result in providers canceling contracts causing a decrease in access to care, the State Medicaid agency should work with the managed care plans to improve the claims payment process.

D. Access to Services and Providers

Medicaid Recipient Access to Care in Ohio

> "I think there are some advantages of being in managed care, because a managed care company may… give you access to a better provider then you would get if you were just in a fee-for-service. I think we saw that … when we went to managed care years ago. More providers started participating in Medicaid. …Pediatricians got involved …. I think it may increase access to specialists. and it … has the ability to provide some kind of care management."
>
> *Representative from the Universal Healthcare Action Network*

Under both fee-for-service and managed care, recipient access to providers has been an area of concern for ODJFS, providers, and recipient advocates. During stakeholder interviews conducted by the Auditor of State, participants introduced many issues surrounding Medicaid recipients' ability to access needed care. National studies conducted by Health Services Research in 2004 and 2005 found that Medicaid recipients were far more vulnerable, experienced more substantial access problems, and had a lower capacity to exercise choice than insured Americans. Furthermore, low levels of provider participation by both physicians and dentists have plagued the Medicaid program since its inception. Finally, *Specialists' and Primary Care Physicians' Participation in Medicaid Managed Care* (Journal of General Internal Medicine, December 2001) found that many physicians do not participate in Medicaid, thus limiting the effectiveness of Medicaid in improving access to care. Under the right conditions, managed care can improve access to care. However, if its implementation and progress is not carefully monitored and adjustments made when necessary, it can exacerbate access issues and increase direct medical care costs.

Stakeholder interviews highlighted many of the issues around low levels of provider participation in Ohio. A member of the Ohio Dental Association remarked that many dentists would not participate because of concerns over the contractual arrangements. In addition, he mentioned that the managed care credentialing process was a disincentive for dental care

providers. A member of the Ohio Hospital Association noted that there is a shortage of primary care physicians and that many primary care physicians are closing their practices to Medicaid patients. This results in the Medicaid recipient using the emergency room for their general medical needs. The member said, "We opened up a free clinic, and have physicians, the medical director of the ER, and nurses, and people like ourselves that donate an evening a week just to try to take care of them to keep them out of the emergency department." While this appeared to help provide some primary care, the member noted, "They'll use the clinic, but if they want something the next night, they'll be right back in the ER." A member of the Ohio State Legal Services Association described access issues as based on geography and payment source, as well as specialty needs and relationships with providers. The member said,

> ".People routinely travel very long distances … to get to providers who will accept Medicaid. In urban areas, Medicaid recipients are … funneled into certain providers…In some service areas … access is completely inadequate. The last I heard, it takes six months to get an emergency dental visit in Franklin County. …We need to have a better approach to making access uniform -- to making access equitable, to making access appropriate. Again, I would say that if any of us were told that we had to wait six months for an emergency dental visit, we'd find another dentist. We'd find another insurance plan. We'd do something and that's not acceptable in the standards that we have but we're invoking those standards and requiring low-income people who have Medicaid to accept that as the norm, which is unacceptable..."

Access to care issues are highlighted in high cost services like emergency room care. The National Association of Community Health Centers 2006 Summary of Findings reported that $18 billion a year is spent on avoidable emergency room visits each year. One third of all emergency room visits are non-urgent or could be treated in a primary care setting, such as a community health center. However, 36 million people reportedly do not have a regular source of care.

A member of the Ohio State Medical Association, in describing emergency room care and its use over the physician's office, remarked:

> "…When a child has to go to the hospital, it costs usually up to twice as much as it would have cost had he provided the same care in his office. There are certain procedures or episodes of care that can take place at the physician office level as opposed to the hospital. You should make it more enticing. Perhaps increase the reimbursement to the physician so that they would take more patients and those patients wouldn't have to go the hospital, or make it somehow easier or more enticing for the patient to be driven to the physician office as opposed to going to the emergency room. ….There … [are] barriers imbedded in the Medicaid system in term of how they reimburse, so it drives the patient to the hospital instead of the physician's office where they could actually receive the same care at a [lower] cost."

Similarly, a member of the Ohio Association of Primary Care Physicians said, "I think it's going to be hard to manage a population that is very much used to going to the emergency department for their care as opposed to going to [a medical home]…." The member elaborated saying, "We have to get that through to the patient population, that [primary care is] a good idea … I don't

think they will see the benefit unless they actually experience it, and that's going to be tough." The physician suggested that perhaps emergency rooms would have to triage patients and, in some cases, redirect patients to more appropriate care. However, the physician recognized that "When ERs are forced by things like EMTALA[38] and regulatory bodies [to provide care] … [they] can't turn … people away …."

However, a member of the Ohio American College of Emergency Physicians noted that, "the emergency department and the emergency department physicians have been… those who have basically seen or provided medical care [to Medicaid recipients], sometimes a lot of primary care because they can't get primary care anywhere else." The physician explained that access issues drive patients to the emergency room and that the issue is often complicated by "well-meaning people saying, "Stop them from going to the emergency department in some way. Don't pay for it."" The physician concluded that the issue of emergency room use becomes a health policy issue but often legislators do not recognize the impact of federal regulations like EMTALA

Positive attributes associated with enrolling Medicaid recipients in managed care have been identified in several studies. In "*Medicaid Managed Care: Effects on Children's Medicaid Coverage and Utilization"* (Currie and Fahr, 2005), the authors determined that the growth of Medicaid managed care has changed the nature of the Medicaid population as increased use of managed care to serve Medicaid recipients shifted the Medicaid caseload away from African American children and children 2 to 5 years of age. In addition, managed care growth increased the probability that African American children with chronic conditions, Hispanic children and low-income teenagers had seen a physician in the previous year. Baker and Afendulis (*Medicaid Managed Care and Health Care for Children*, 2005) studied how Medicaid managed care affected enrollment, access, utilization, and satisfaction rates for enrolled children. They found that although Medicaid managed care decreased emergency room use, hospitalization, and overall member satisfaction with health care; it increased outpatient visits and decreased instances of patients delaying needed care, indicating an increase in appropriate utilization of care. The authors also determined that Primary Care Case Management also increased outpatient visits, but decreased reports of unmet care needs, reports of putting off needed care, and having no usual source of care.

A member of the Ohio Developmental Disabilities Council remarked on access to care issues saying:

> "… If you want to save money in Medicaid, you get people the health care they need when they need it, and … everything about this program works against that, and therefore in the end you have higher costs. I mean, if you want one simple way to make this program work better, you task

[38] EMTALA refers to a federal law protecting an individual's right to receive care, within the capabilities of a hospital's staff and facilities, if the person has a medical emergency or is in labor. This also includes an appropriate Medical screening examination, necessary stabilizing treatment (including treatment for an unborn child) and, if necessary, an appropriate transfer to another facility even if the individual cannot pay or does not have medical insurance and is not entitled to Medicare or Medicaid.

> that agency with having the providers that people need and making access possible when that health care is needed, and you're going to have healthier people who need less health care, and that's how you save money."

During SFY 2003-04, there were 1,967,991 Medicaid-eligible recipients in Ohio and 17,792 Primary Care Providers who had submitted a Medicaid claim. During the same period, there were 1,664 dentists practicing in Ohio who submitted Medicaid claims. This enrollment figure includes people who have rolled on and off Medicaid during SFY 2003-04. To illustrate access to primary care providers, **Table 5-13** shows the number of primary care and dental service providers in Ohio compared to Medicaid eligible populations by region.

Table 5-13: Providers and Eligible Populations for SFY 2003-04

Region	CFC Eligibles	ABD Eligibles	Dual Eligibles	% Rural Eligibles	PCP	Dental
NW[1]	233,553	26,897	24,223	32.53	1,746	171
SE	151,155	25,193	20,294	61.76	657	89
WC	218,129	23,693	21,696	9.47	1,478	133
EC	300,750	30,171	28,838	14.92	3,459	204
SW	310,932	35,776	31,337	9.15	2,465	225
Central	450,706	50,667	41,781	26.70	3,064	334
NE	450,377	56,156	48,778	7.58	4,185	426
NEC	110,676	15,825	12,700	20.57	738	82
Totals	**2,226,278**	**264,378**	**229,647**	**25**	**17,792**	**1,664**

Source: Ohio Health Plans, 02-23-06

[1]Northwest includes the following counties: Allen, Auglaize, Defiance, Fulton, Hancock, Hardin, Henry, Lucas, Mercer, Ottawa, Paulding, Putnam, Sandusky, Seneca, Van Wert, Williams, Wood, and Wyandot.

[2]Southeast includes the following counties: Athens, Belmont, Coshocton, Gallia, Guernsey, Harrison, Jackson, Jefferson, Lawrence, Meigs, Monroe, Morgan, Muskingum, Noble, Vinton, and Washington.

[3]West Central includes the following counties: Champaign, Clark, Darke, Greene, Miami, Montgomery, Preble, and Shelby.

[4]East Central includes the following counties: Ashland, Carroll, Holmes, Portage, Richland, Stark, Summit, Tuscarawas, and Wayne.

[5]Southwest includes the following counties: Adams, Brown, Butler, Clermont, Clinton, Hamilton, Highland, and Warren.

[6]Central includes the following counties: Crawford, Delaware, Fairfield, Fayette, Franklin, Hocking, Knox, Licking, Logan, Madison, Marion, Morrow, Perry, Pickaway, Pike, Ross, Scioto, and Union.

[7]Northeast includes the following counties: Ashtabula, Cuyahoga, Erie, Geauga, Huron, Lake, Lorain, and Medina.

[8]Neast Central includes the following counties: Columbiana, Mahoning, and Trumbull.

According to **Table 5-13**, the majority of regions have more than 10 percent of the Medicaid population classified as rural. Only two regions, West Central and Northeast, have less than 10 percent classified as rural. The rural nature of many Ohio counties compounds access issues as the number of providers is limited and transportation to a provider location may not be available. In Vinton County, for example, there is only one primary care physician and two dental providers who submitted claims during SFY 2003-04. During the same period, there were 5,430 Medicaid-eligible recipients in the county.

A representative of the Ohio Association of Community Health Centers spoke on the issue of finding providers willing to participate in the Medicaid program explaining, "there is only one doctor's office in all of Vinton County. In Jackson County, there are plenty of providers, but

there are very few in the area where we are located." The representative noted that some rural physicians only see Medicaid recipients on a certain day or the week or at a certain time of the day. At the time the representative was interviewed, managed care was just being introduced in Columbiana County and many physicians were reportedly opting out of serving Medicaid recipients. The representative concluded, "we are having a very difficult time…finding anybody to take our patients, and it's going to become a clinical nightmare very quickly."

Although ODJFS collects data on providers by region and county, the data has several limitations. These limitations include providers coded as "missing" which are usually out of state providers who are located in the bordering states (2,631 total, of which 2,571 are primary care physicians and 60 are dentists). The number of primary care physicians is also based on those who submitted claims during SFY 2003-04, the number that are licensed Medicaid providers (the number of total providers is over twice the number that submitted a claim, but this number also includes those who have retired and those who have stopped seeing Medicaid recipients). In some cases, provider practices are *closed* and do not accept new Medicaid patients, so the practice may continue to submit claims for existing Medicaid patients but is not accessible for new Medicaid patients.

As the managed care plans were developing provider networks in preparation for the RFP selection process, Ohio physicians were asked to contract with the plans. However, during stakeholder interviews, some physicians remarked that there was hesitation on the part of physicians to sign contracts. A member of the Ohio Academy of Primary Care Physicians said that the contracts with the plans offered the Medicaid fee schedule or, in some cases, maybe 10 percent above the standard rate. However, the physician was expected to manage the care of the recipient. The physician said, "If we are going to a true managed care model…, then we have to be in the front line where they're coming in... And somehow [there needs to be] a paper trail, whether electronic paper or true paper, [which will require] a human body in our office to help us manage." However, the member noted, there will not be an additional reimbursement for the care management aspect of services. Furthermore, the member remarked that the contracts were not user friendly and some included stipulations that were not advantageous to physicians. A member of the Ohio Podiatric Association, when discussing access, expressed strong concern about the impact of managed care plans.

> "They are going about this totally the wrong way. …You're reducing access. That's all it is about. You reduce access; you reduce amounts you spend; you reduce care to the patient, plain and simple. It's very basic. This has been tried 100 times, failed 100 times. I don't even know why they thought it would work. For me it isn't American. It doesn't even seem constitutional that taxpayers shouldn't be able to be providers for American-run health care plans…. It's something about it that just doesn't seem right to me."

Figure 5-2 illustrates the Medicaid recipient population density by county in SFY 2003-04. The counties shaded light gray are areas with a lower proportion of residents receiving Medicaid compared to the total Medicaid population. The counties shaded dark gray are counties with more than 6 percent of residents receiving Medicaid compared to the total Medicaid population.

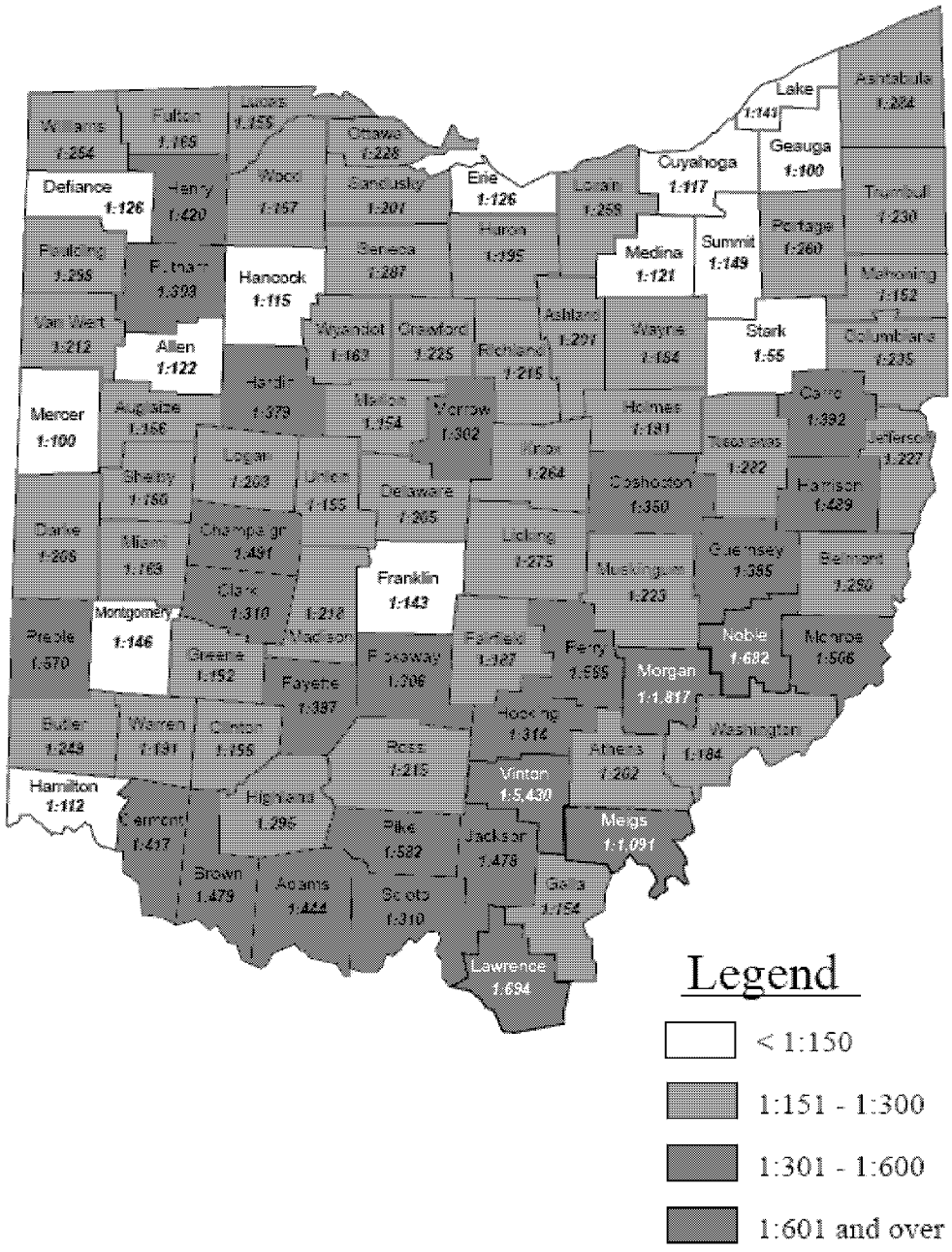
Figure 5-2: 2004 Medicaid Recipient Population Density

Source: Ohio Health Plans, February 23, 2006

Most Ohio counties had between 10 and 30 percent of the total county population enrolled in Medicaid during SFY 2003-04. Approximately 25 percent of the Medicaid recipients reside in counties designated as rural. The Southeastern region of Ohio, at 30 percent rural, has consistently high percentages of Medicaid recipients. Pike County in the Central region has the highest percentage of recipients at 45 percent. Delaware, Geauga, Holmes, and Warren Counties have the lowest percentage of recipients in comparison to county population. The Northwest region has the lowest regional percentage of recipients compared to total population at 15 percent.

Figure 5-3 shows the ratio of primary care physicians to Medicaid recipients by county in 2004. A higher ratio of primary care physicians to number of recipients indicates a possible access issue for Medicaid recipients. A lower number of Medicaid recipients per primary care physicians indicate that Medicaid recipients are able to access care easier. As shown in **Figure 5-3**, there are more Medicaid recipients per primary care physician in the Southeastern part of the State. Stakeholders reported inadequate transportation to be an access barrier, especially in the rural counties where public transportation is more limited. A representative from the Ohio Association of Community Action Agencies discussed the issue of transportation and its impact on service access saying, "a lot of times too, families that have transportation problems try to schedule everyone who need a service, like three family members, at one time. Well, if three family members don't show up, boy, you're in trouble." The member explained, "if they only have a car once in a while that works and they're going to be able to use that car this day, and … the car doesn't work or they've got a child sick and there is nobody else to watch the child," then the recipient will not be able to access needed services.

Figure 5-3: 2004 Ratio of Medicaid Primary Care Physician to Medicaid Eligible Population by County



Source: Ohio Health Plans, February 23, 2006
Note: CFC recipients can obtain care in neighboring counties or in any of the neighboring states (particularly for those residing in border counties).

Examined on a statewide basis, the Southeastern region has the highest number of recipients per primary care provider. Vinton County only has one Primary Care Physician reported for a ratio of 5,430 recipients per provider. The Northeast Central region, which consists of three counties, has the lowest ratio of recipients per primary care provider, with the lowest being Stark County which has a ratio of 55 recipients per primary care physician.

In interviews with the County departments of Job and Family Services (CDJFS), the majority of counties report a shortage of providers, especially dentists, pediatricians, and specialists. A member of the County departments of Job and Family Services Leadership Committee said, "There are several aspects that fail to meet the needs of the recipients. Physicians and obstetricians are not available in some counties (Butler County). There is a vision and dental provider shortage in Hamilton County." County officials identified low reimbursement rates and slow payments to providers, high rates of "no shows," and claim submission problems as the main causes for the shortage of providers. Several rural counties also noted that it was very difficult to recruit providers in their areas. Some counties reported that providers who would accept Medicaid were not accepting any new Medicaid recipients, which also contributes to the shortage. In addition, several counties identified clientele issues, such as the stigma associated with low-income populations, as the reason providers would not accept Medicaid patients. Most counties had some sort of provider recruitment policies and education on billing claims to help alleviate some of the problems experienced. In the majority of areas, local charities were very involved in providing safety net services. In only eight counties (Athens, Auglaize, Gallia, Jackson, Lake, Lawrence, Lucas, and Ross), the county officials stated they did not experience any provider shortages.

During stakeholder interviews, a member of the Ohio State Legal Association described the problems with access and the limited efforts made by Ohio Medicaid to minimize provider shortages. The member stated that ODJFS had not tried to "create, promote, maintain, or enhance access" and that while "the Medicaid card may be theoretically the Gold Card… the theory is spoiled by the fact that in some places you can't get to a dentist."

For providers, there are few incentives to accept Medicaid patients. As a result, a limited number of providers may serve a large population of Medicaid recipients. An Ohio State Legal Association member described it as "a struggle somewhat for providers within the population base to have practices for dental services and vision services and that type of service. So there's a limit- -- a very limited number of providers who then are absorbing the Medicaid population. In our area, the majority of folks are eligible for Medicaid because it's a very low income part of Ohio."

According to provider stakeholder groups and CDJFS officials, Medicaid reimbursement rates are a fraction of the cost of care. There is a high "no show" rate, referring to the number of patients who schedule appointments but do not show up at the scheduled time. Patient no shows are often attributed to transportation issues, but providers still lose revenue because those

appointments cannot necessarily be filled with paying patients, and they cannot recoup the costs of "no show" appointments from Medicaid recipients. As a result, many Medicaid providers limit the number of Medicaid recipients they will accept as patients. While contracts between the managed care plans and providers could include requirements to serve a specific threshold of Medicaid recipients, this provision often deters provider participation.

Counties with the highest and lowest ratios of primary care physicians per eligible recipient are shown in shown in **Figure 5-4**. The counties with the lowest ratios are all in northern Ohio while the counties with the highest ratios are all in southeastern Ohio. A member of the Ohio State Legal Services Association discussed the access issue in areas with the highest ratios saying:

> "Unless you live in rural Southeast Ohio, you may never experience what it means to have a medical problem and try to find a provider, no matter what your income is. …There are a limited number of services …. We have two counties where there's no hospital, so it doesn't matter whether you're a woman on Medicaid, you have to travel somewhere to have your baby in a hospital, and there is not one intensive neonatal unit in the whole southeastern part of Ohio. So if you have a child born with a serious medical problem, that child will be flown to Columbus, you will not be with your infant. …There are access issues … inherent to the area being rural….

Since high patient to physician ratios would indicate the possibility of access issues, **Figure 5-4** also identifies the 10 highest and lowest ratio counties in the State.

Figure 5-4: 2004 Counties with Lowest and Highest Ratios of Patients per Primary Care Physician

Source: Ohio Health Plans, February 23, 2006

As shown in **Figure 5-4**, the counties with the highest number of eligible recipients per primary care provider were in the rural areas of southeastern Ohio. The highest number of eligible recipients to primary care providers was in Vinton County where a single primary care provider was available for over 5,430 Medicaid recipients. In contrast, the lowest ratios, and areas where access to care is likely to be a less critical issue, are found in the northeast and northwest areas of Ohio. The greatest level of primary care provider access on a physician to recipient ratio basis was in Stark County where only 55 recipients were identified for each primary care provider listed as accepting Medicaid.

Access to dental services was also identified as a barrier for Medicaid recipients during stakeholder and county interviews. A member of the Ohio Dental Association explained the reasons dentists are hesitant to participate in Medicaid stems from three basic reasons, "Number one [is] fees. Number two [is] red tape or administrative burdens. And the third … is patient behavior and particularly missed appointments. …There is never one silver bullet [like] if you simply increase fees that fixes everything. It's got to be a mix of all three of those components."

Figure 5-5 depicts the ratios of dentists accepting Medicaid compared to Medicaid eligible residents by county in 2004. Ohio has few dentists that accept Medicaid patients.

Figure 5-5: Ohio 2004 Dental Service Provider Ratio by County

Source: Ohio Health Plans, February 23, 2006
Note: CFC recipients can obtain care in neighboring counties or in any of the neighboring states (particularly for those residing in border counties).

Table 5-5 shows that a number of rural counties throughout Ohio have limited access to dental services. Several counties (Logan, Putnam, and Preble) do not have dentists listed as serving Medicaid recipients. As in the case of primary care physicians, the ratio of dental service providers to eligible recipients can create barriers to access. Several counties have only one or two dentists who serve Medicaid recipients.

A member of the Ohio Association of Community Action Agencies described the effect of dental provider shortages saying, "We're the only dentist office in Noble County. There are no other dentists. So I think we're successful because not only do we have about 60 percent Medicaid, we have private pay patients, [and] we have insurance patients. …We have people calling from Mt. Vernon, Columbus, West Virginia just because of the lack of dental providers." The member explained that reduced dental services was resulting in a greater number of extractions and stressed that, "Oral health affects your entire body. …But people don't come in unless they are in agony. We've had to walk people up to the emergency room because they've got life-threatening infections. …It costs more to treat them after their mouths are trashed. We've got 19-year-olds with dentures in our county."

The counties with the highest and lowest ratios of dentists per eligible recipient are depicted in **Figure 5-6**. The counties with zero are those counties in which no dentists submitted Medicaid claims in 2004.

Figure 5-6: 2004 Counties with Lowest and Highest Ratios of Patients per Dental Care Provider

Source: Ohio Health Plans, February 23, 2006

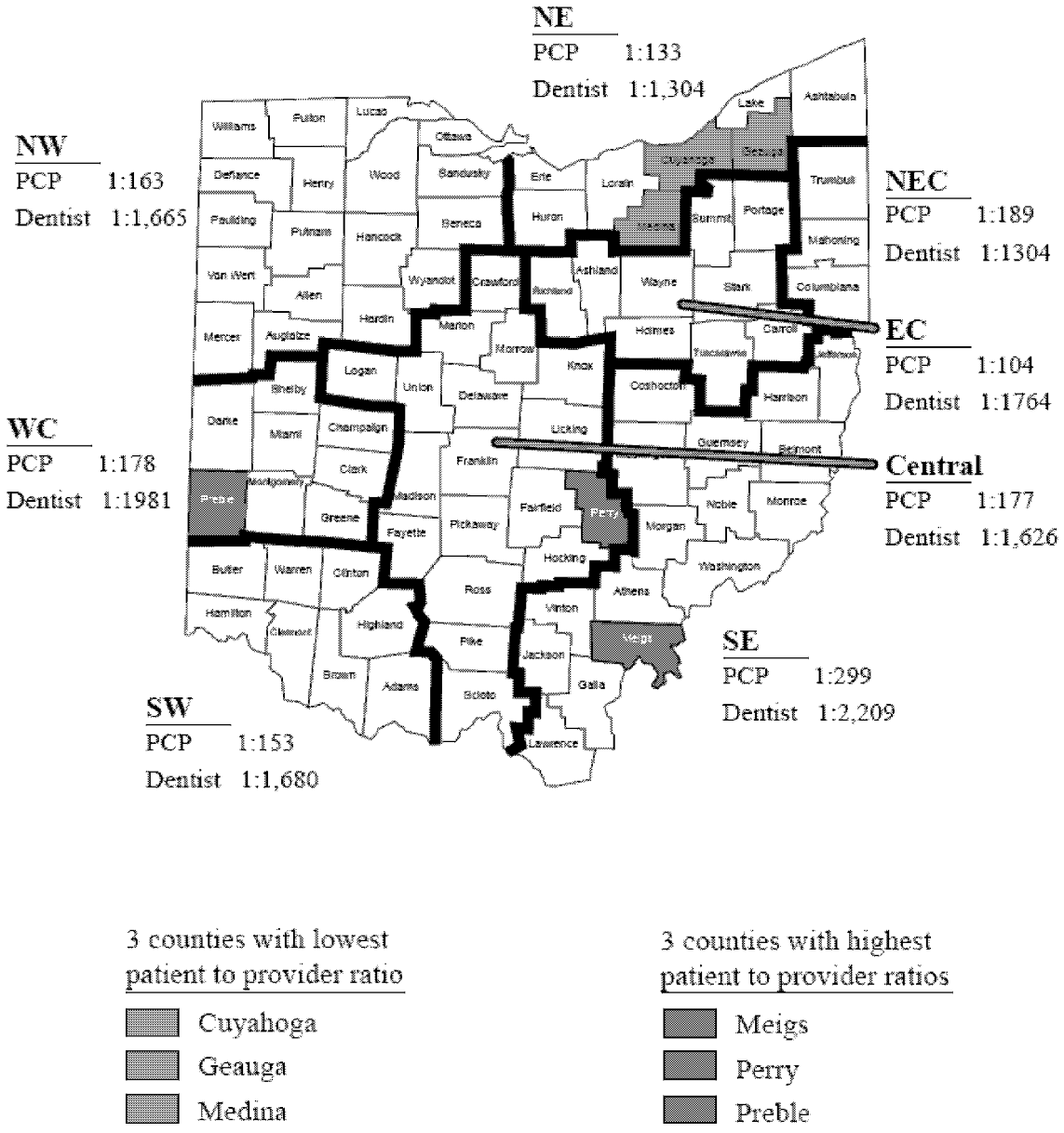
Among the highest ratio counties are Darke, Logan, Perry, Fulton, Hardin, Williams counties where Medicaid recipients have the most limited access to dentists. The counties with the greatest opportunity for access include Holmes, Medina, Seneca, and Lucas. To ensure access to care, there must be a sufficient number of Medicaid providers who are accepting new patients. According to OHP, there is no expectation that the managed care plans will attract new providers. The focus is to attract providers already serving Medicaid recipients in a region to become contractors of the managed care plan. Interviews with CDJFSs revealed that some counties have attempted to mitigate the shortage of dental providers by developing and staffing local dental clinics. Brown, Guernsey, Henry, Licking, Muskingum, Scioto, and Union have opened dental clinics using grant funding. However, Meigs and Wayne counties have tried unsuccessfully to open a dental clinic for their Medicaid recipients.

A member of the Association of Community Action Agencies describes some of the efforts and barriers to providing dental services within the Medicaid program: The member explained that it was difficult to get dentists to participate because "Reimbursement rates are so low … and trying to get anybody to answer questions was terrible." The member also noted that, "We still have a problem with when we put a new provider on -- it seems to take forever for that person's license to be approved….." Members of the Ohio Dental Association remarked on the limited scope of Medicaid dental care and stated that Ohio Medicaid adds new, proven medical procedures but does not make additions to the dental program. One member said, "The dental program has been stagnant for 30 plus years. All they seem to be interested in is if it's either revenue negative or revenue neutral, if there is any kind of change taking place. If it involves spending any additional money, it's gotten the kibosh." The member elaborated saying, "…None of the HMO's would even consider [adding periodontal coverage even though] …It's the most common form of adult dental disease, more common than tooth decay."

Another Ohio Dental Association member noted that, "Medicaid managed care does not work, particularly in the rural areas… because you don't have enough dentists to begin with." Another member said of the managed care organizations, "It just seems like another level of bureaucracy has been added and patient care has either been eliminated or reduced or dental fees reduced." The member predicted that dentists would drop out of the Medicaid program because of the additional paperwork required to be credentialed by the managed care organizations. A member pointed out that, "Not only are there potentially multiple contracts to sign, but …there had to be dividing lines and different regions. And, in my region… my biggest areas of Lawrence and Scioto counties are split into different regions. So that …could mean more applications for me to fill out to treat the same patient based on our region. It could be dreadful….."

Figure 5-7 shows the regional ratios for primary care physicians and dentists to Medicaid recipients based on 2004 data. The regions represented are those used in the managed care expansion initiative.

Figure 5-7: 2004 Regional Averages of Primary Care Physicians and Dentists to Medicaid Recipients



Source: Ohio Health Plans, February 23, 2006
Note: CFC recipients can obtain care in neighboring counties or in any of the neighboring states (particularly for those residing in border counties).

The Southeast region has the highest recipient to provider ratio, underscoring the overall access issues. This is followed by the Central region. In contrast, the regions with the lowest ratios and the greatest access to care are in the East Central region for primary care physicians and the Northeast and North Central for dentists. These represent averages and actual access may vary within counties that comprise the region.

Access to care in the Southeastern part of the State was also identified as a significant problem for home health care services by a member of the Ohio Association of Area Agencies on Aging: "The Southeast has been particularly hit hard. Turnover of providers is high and in some cases providers are scarce. Marietta has lost all hospital-based providers. This problem is compounded by the high cost of training."

To address access to care issues, OHP requires managed care plans to contract with a certain number of providers to serve their region. The minimum provider requirements state that a managed care plan must have enough primary care providers to serve 55 percent of the region's Medicaid recipients. The minimum ratio for each region is one primary care physician for 2,000 Medicaid recipients. OHP also stipulates the geographical location of the providers to the recipients. In urban counties, 40 percent of the eligible population must be located within 10 miles of a primary care physician with available capacity. In rural counties, 40 percent of the population must be within 30 miles of a primary care physician with available capacity. In addition, managed care plans must be able to provide transportation to all members who travel 30 miles or more to medically necessary Medicaid covered services.

However, managed care plan representatives with the Ohio Association of Health Plans expressed concern with ODJFS procedures for enrolling physicians and developing the physicians' guide, and the impact that these procedures would have on accessibility. They stated, "….The earliest a consumer is ever going see a provider directory under the current system …is at least six-month old data, may be nine-month old data, and it's not going to be updated again for an entire year. So by the end of that cycle people are getting information that is a year and a half old." Members attributed this to the prescriptive nature of ODJFS' review of provider information. A member said, "The whole provider submission process is just so cumbersome" and noted that other states have better processes in place to ensure up-to-date information is available for recipients. The member recommended West Virginia as a potential model to examine to improve provider enrollment in the State Medicaid program. Members elaborated on some of the problems in Ohio stating: "….In Ohio they have to be registered with Ohio Medicaid, and they have to be only located within the State of Ohio. There is a whole network in West Virginia that Ohio managed care plans can't publish because they're not in the State of Ohio, but they are on the border… just across the river." The member concluded, "…You can't list those providers in your provider network or provider directory because they're not located [in Ohio]. You can contract with them, and patients go to them, but you can't put them in the directory."

The credentialing process was noted by a number of providers as a deterrent to participating in the Medicaid program, particularly under the statewide expansion of managed care. Members of the Ohio Dental Association said that filling out credentialing information for each agency in Ohio was a deterrent to participating in the program as a provider. One dentist said, "I can see where the dentists are going to be quite dismayed if they have to fill it out for the different managed care entities and the other insurance companies in the state as well as for their hospitals." The member stated, "…Then I was told that it would take four to six weeks to get the credentials. We basically have a choice of holding off on patient care or trying to find a way to bill." Another member of the Association said, "Being a licensed dentist would not be enough [to contract with a managed care plan]. In fee-for-service, the traditional Medicaid, it is. …But ODJFS requires the HMO's to have this credentialing process. It's not the HMO's idea."

A member of the Ohio Academy of Primary Care Physicians described the difficulties in getting a Medicaid number saying, "…it's tough to get a Medicaid number, and it takes months to get it, and you know when you consider the reimbursement rates and everything … I'd think you would want to get that guy a number pretty quick. It can take several months, and applications tend to get lost… And it's very frustrating for those who credential physicians that it takes Medicaid [so long]." Even advocacy groups, like the Ohio Developmental Disabilities Council, are sensitive to the multiple credentialing processes in use in Ohio Medicaid. A member of the council said, "It just seems like some set of universal certification standard with maybe some add-ons for specialty care, would make much more sense here, instead of just going through these machinations of getting certified for each waiver. I'm convinced that a lot of these providers could serve across populations if we find a way to try to address the certification process."

Several states' managed care plan agreements were summarized and compared to Ohio based on contractual efforts for increasing managed care access to providers. **Table 5-14** compares Ohio's managed care plan agreement for SFY 2004-05 with several states that are similar in size to Ohio or are recognized innovators in Medicaid services. The table lists the details from the other states' contracts, including maximum number of patients per physician and any geographical requirements.

Table 5-14: States' Parameters for Ensuring Provider Access in Managed Care

Provider Type	Ohio	Arizona	Georgia	Illinois	New York	North Carolina	Tennessee	Wisconsin
Physician	1:2,000 members	Dependent on service area	N/R[1]	1:1,200 members	1:1,500 members	1:2,000 members	Within 30 miles of members	1 within 20 miles of any member
Physician Team	N/R[1]	Dependent on service area	N/R[1]	N/R[1]	1:2,400 members	N/R[1]	N/R[1]	N/R[1]
Primary Care Providers	N/R[1]	No more than 1,800 members	2 w/in 8 miles (urban) or 2 w/in 15 miles (rural)	1:2,000 members	1:1,000 members	N/R[1]	N/R[1]	1 within 20 miles of any member
Dentist	Adequate	Dependent on service area	1 w/in 30 miles (urban) or 1 w/in 45 miles (rural)	Service not covered	1:2,000 members	out of plan benefit	N/R[1]	1 within 35 miles of any member

Sources: Ohio's statewide Expansion for Covered Family and Children (CFC) Medicaid Consumers Regional Provider Panel Specifications; Contract between HMO and Wisconsin Dept. of Health and Family Services; Contract between the State of Illinois Dept. of Public Aid and MCO; New York's Medicaid Managed Care and Family Health Plus Model Contract; Medicaid Managed Care Risk Contract between the State of North Carolina and Wellpath Select, Inc.; Model Contract between the State of Tennessee (TennCare) and MCO; the Georgia Cares Program; the Arizona Healthcare Cost Containment System Administration Intergovernmental Agreement Amendment

[1]Not Required

Table 5-14 shows that when compared to other states' minimum provider guidelines, Ohio's physician and dental guidelines either require fewer providers per Medicaid recipient (for physicians) or are not stated empirically (for dentists). Ohio has fewer empirical requirements for the managed care plans than several of the other states examined, increasing the possibility of access problems for recipients. ODJFS requires at least one primary care physician for every 2,000 eligible residents, which is the same as North Carolina. In Illinois and New York, the requirement is one physician per 1,200 eligible recipients and one per 1,500 eligible recipients, respectively. In Tennessee, Wisconsin, and Georgia, the requirement is one physician or primary care physician within a specified number of miles from any eligible recipient.

Wisconsin defines service areas based on zip code. Managed care companies must agree to serve all the members in the zip code and have providers within 20 miles of members for every service area. In Arizona, the requirements are dependent on the service area, and are defined by zip codes. In the metropolitan areas of Tucson and Phoenix, there are different minimum standards than for the rural areas of the state. In Arizona, there is also a maximum of 1,800 eligible recipients per primary care physician, although the particular guidelines for each managed care plan are outlined in the individual contract.

Ohio also differs from the other states in how it defines primary care providers. ODJFS defines primary care providers in its contract with managed care plans to include an individual or a

group practice. Generally, in the U.S., accepted specialty types for primary care physicians include family or general practice, internal medicine, pediatrics, and obstetrics/gynecology.

Several other states have defined primary care physician to include other types of providers who can provide primary care services. Arizona, New York, North Carolina, and Tennessee have expanded their definitions of primary care physicians to include physician assistants and/or advanced nurse practitioners.

With the expansion of managed care to the ABD population, ODJFS must more closely monitor managed care plans and access to care issues. A practical guide for state Medicaid agencies to use when examining access to care, *Ensuring Special Needs Populations' Access to Providers in Managed Care Networks* (Center for Health Care Strategies, Inc, 2001) includes a self-assessment tool designed to determine access to care for special needs populations. The guide identifies specific times when a state Medicaid agency must pay attention to the adequacy of the managed care network, including the following:

- When access problems are evident;
- When shifting special needs populations into managed care;
- When capitation rates have been decreasing or not keeping up with inflation;
- When commercial or other health plans have withdrawn; and
- When supportive program features, such as care coordination, are weak and inconsistent.

The guide also explains the real costs of having an inadequate provider network. Legal and regulatory issues can become costly when managed care programs collapse in certain areas of the state. The collapse of managed care plans may lead to actual physical harm to medically needy consumers. All of these costs lead to negative press and perceptions by the legislature, advocates, CMS, and the public. Ohio has experienced many of the abovementioned problems when implementing managed care in the past. However, the success of a managed care program can be increased by employing ratios that are more useful, better time/distance standards, and more effective monitoring. These are described below:

Usefulness of ratios: Using ratios that are more specific for the maximum number of enrollees per provider is recommended. The Medicaid agency would apply the ratio to each individual provider who is accepting new Medicaid patients and would take into account the entire patient load the provider sees, not just Medicaid patients. The ratio should also apply to full-time-equivalent providers with a smaller ratio for part-time clinicians, nurse practitioner, and physician assistants.

Time/Distance Standards: The time/distance standards should preferably apply to providers who are accepting new Medicaid patients and address geographic issues (rural and remote areas. The standards should not include vague language but should include a threshold of enrollees that

must be covered under the standards since it may be difficult for health plans to meet the requirements for all members.

Effective Monitoring: Monitoring should occur on a regular cycle and the state agency must be notified immediately of any major changes in the network. Major changes include physicians entering or leaving the plan, provider address or phone number changes, or changes in the status of a provider accepting new Medicaid members. The state should occasionally check the reliability of the data reported by the managed care plans to ensure access data is accurately reported. The monitoring of access should not be burdensome to the health plan, but rather, integrated into overall plan monitoring. Access monitoring should include certain targets for basic and specialty care. Monitoring should not rely on a single method, but should employ a mix of methods while adjusting the timing and intensity of the activities.

In describing the problems associated with county and regional approaches in Ohio, a member of the Ohio Community Health Centers remarked:

> "In Ohio it's not just one state. It's county levels and the differences between county levels that have to be dealt with.... I don't know how you do that in a home rule state like Ohio. Don't you want county control rather than state control of a "one size fits all"? I think one of the issues you run into with that, other states can actually ... [provide comprehensive care] for a population that is equally diversified. I don't think New York quite does the regional stuff, and that's an incredibly different state with a lot more people. We have three metropolitan areas, Cleveland, Cincinnati and Columbus. New York has New York City. Well, there's Albany and Buffalo, cities of significant size, that roll into that.... I think a kid who needs services in Cleveland is the same as a kid who needs services in Pike County -- but can they get the same services? They can't get the same services, and one of the reasons they can't get the same services there is no consistent overall state policy on what kind of services should be offered or paid for, for that matter. A diagnosis in Cleveland is the same as a diagnosis anywhere else in the state, and if you look at clusters of needs, the clusters of needs may be slightly different but not all that different. I think expectations are different, depending on where in the state you are."

Ohio appears to have more rural than urban areas in each region, and certain rural counties have few providers available. As a result, Medicaid recipients under managed care must travel greater distances to receive care. However, by increasing the types of providers classified as primary care providers and enhancing monitoring, ratios, and time and distance standards, ODJFS can increase the likelihood of successful managed care implementation statewide. Yet, without additional emphasis on access and availability of providers, the Department is likely to face increased quality of care issues and emergency room utilization. In the direst of cases, limited access to care could have serious health implications, particularly for the ABD population.

R5.10 To increase access to care, the single State Medicaid agency should seek approval from the General Assembly to include services provided by additional specialty types, such as physician assistants and advanced nurse practitioners, as primary care services covered by Medicaid. As there are a finite number of physicians in

Ohio, by increasing the number of specialty types that can serve as primary care providers, the State Medicaid agency can increase access to care. Implementing this recommendation may require changes to statutes governing the services provided by physician assistants and advanced nurse practitioners.

R5.11 The single State Medicaid agency should examine the time and distance standards, as well as the usefulness of its ratios, in comparison to the Center for Health Care Strategies recommendations and the standards and ratios used in the other states examined. Improving these standards, and the effectiveness of monitoring, will help the State Medicaid agency better ensure access to care under statewide managed care. Furthermore, areas where access to care issues are identified could be addressed more rapidly, thereby improving Medicaid recipients access to medical services.

Options to Increasing Access to Care

ODJSF has not explored options or piloted initiatives to increase access to care, particularly in conjunction with the statewide expansion of managed care. Similarly, the Department has not fully identified the potential negative effects statewide managed care may have on Medicaid recipients' access to care. *Second Generation Medicaid Managed Care: Can it Deliver?* (Gold and Mittler, *Health Care Financing Review,* Winter 2000) describes lessons certain states have learned about using managed care to deliver Medicaid services and the effect of managed care on safety net providers, such as Federally Qualified Health Centers. Medicaid managed care appears to have had the greatest adverse effect on the safety net providers who have shouldered the burden of providing services to the uninsured and Medicaid recipients. When these types of centers lose revenue, they sometimes go out of business, leaving their patients without access to care. These smaller non-hospital based safety net providers are vulnerable to reductions in revenue that result from Medicaid managed care because they typically have few other revenue sources.

Gold and Mittler also describe policies that state Medicaid agencies can implement to mitigate the adverse effects of managed care. The policies include:

- Using an appropriate risk adjustment technique to equitably pay plans and providers who may treat more severely ill patients;
- Enacting limited rate adjustments (e.g., maternity "kick" payments at the time of newborn delivery);
- Making discretionary provider payments on the basis of adverse selection,[39] and

[39] In this case, the authors recommend using incentive payments to physicians for choosing higher risk patients, particularly in the ABD population.

- Encouraging continuity of care for those Medicaid recipients who gain and lose eligibility often.[40]

The authors assert that states usually must decide on certain tradeoffs when implementing managed care to ensure access for recipients through safety net providers (e.g., focusing on containing costs through limiting access to care versus ensuring access to care with less focus on cost containment).

In *Health Care Delivery Systems in Oregon* (Office for Oregon Health Policy and Research, August 2000) the Office evaluated how well managed care and other arrangements increased access to care for Medicaid recipients. Oregon found that access was uneven and fragmented for those with Medicaid and those who are uninsured. The state has had some success in resolving these issues by using more than one managed care model. The Oregon Health Plan designed a variance in payment levels for fully capitated health plans (FCHP) and fee-for-service payments. FCHP payments reflect the cost of care while the fee-for-service payments remain at their previous levels. The strategy worked to motivate providers and FCHPs to expand managed care to more geographical areas. Oregon also passed legislation that requires rural and semi-rural hospitals to receive facility specific cost-based Medicaid payments. It also detailed a set of elements that a subcommittee, charged by the legislature with studying access to care, decided must be present for any type of care delivery system to be successful. These included:

- Long-term commitment to meeting the community's health care needs stated in the Mission;
- Effective physician and hospital leadership;
- Diverse partners in the delivery system, including "mainstream" providers, safety net clinics, nurse practitioners, and other specialties;
- Collaborative partnerships between physicians, clinics, and hospitals;
- Alignment of incentives through "win-win" risk sharing models based on collaborative distribution of savings and losses;
- Control and predictability of savings and losses and adjustments in distribution methodology to reflect experience over time;
- Clear and agreed upon relationships between payment levels and risk sharing;
- Timely distribution of accurate physician and hospital performance data in a useful format;
- Discrete "product lines" with managed care services kept within budget without subsidies from other accounts;
- Explicit arrangements for balancing and meeting the needs of various populations (Medicare, Medicaid managed care, privately insured, and uninsured);
- Recognition and accounting for uncompensated care;

[40] Continuity of care can be improved through simplified recertification and redetermination, and the use of transitional care.

- Administrative simplicity regarding management of care, submittal and payment of claims and information management; and
- Constructive connections between the health care delivery system and the economic development of the community.

However, according to *Analysis of Medicaid Reimbursement in Oregon* (The Lewin Group, 2003), access to primary care practitioners has diminished and Oregon's capitation payments were below hospital costs. Physician practices appear to be filling up and some are closing to new Medicaid fee-for-service and managed care members. In one Medicaid managed care plan, 20 percent of the physicians were seeing 80 percent of the members.

In a study conducted on behalf of the Texas Health and Human Services Commission, *Actuarial Assessment of Medicaid Managed Care Expansion Options* (The Lewin Group, December 2003), rural access issues due to the large number of rural Medicaid recipients were examined. Three access barriers to the expansion of managed care in rural areas were identified as limited pools of providers, reluctance of health plans to serve rural areas, and decreased cost savings achieved through managed care (because of reduced access when compared to urban areas). The six markers of managed care sustainability identified in the study were as follows:

- Total population greater than 30,000;
- County rural designation code[41] no greater than six;
- Population to land area ratio of at least 10 persons per square mile;
- Minimum of 0.4 physicians per 1,000 population;
- Minimum of 0.02 hospitals per 1,000 population; and
- No fewer than five commercial HMOs.

Specialists' and Primary Care Physicians' Participation in Medicaid Managed Care (Backus, Osmond, Grumbach, Vranizan, Phuong, and Bindman, 2001) examined how California Medicaid (Medi-Cal) managed care affects physician participation and found that specialists were less likely to participate in Medicaid managed care and more likely to accept recipients under fee-for-service than primary care physicians. This resulted in decreased access to specialist care for Medicaid managed care members. Minority physicians were also more likely to accept new Medicaid fee-for-service or managed care patients than Caucasian physicians. Lower reimbursement rates, negative perceptions of managed care, and the density of physicians in the area examined were the primary reasons physicians rejected participation in Medi-Cal.

In order to offset access issues for dental services created by managed care, South Carolina implemented a number of Medicaid program reforms in 2000.[42] It increased reimbursement

[41] An indicator developed by the Department of Agriculture to classify counties on a scale as urban (0) to rural (9).
[42] *The Impact of an Innovative Reform to the South Carolina Dental Medicaid System* (Nietert, Bradford and Kaste, 2005).

rates to dental providers for many of their services, including most common procedures. It also developed a children's oral health coalition, started recruiting through the state dental association, streamlined the Medicaid billing process, and added a dental component to Family Support Services to address patient compliance with appointment and treatment issues. All of these factors increased the number of dental providers participating in Medicaid, thereby increasing access to dental care for Medicaid recipients.

The Community Health Access Project (CHAP) is a local initiative used to increase access to care. First developed and used in Alaska, the program improved health outcomes for isolated and impoverished Inuit people. The program focused on using the cultural connections to implement care management strategies, such as prenatal care, immunizations, and other basic medical necessities. The care managers are local people who receive training with college credit. CHAP has implemented programs in Mansfield and Columbus to address low birth weight babies with a focus on prenatal care. By increasing the number and frequency of prenatal care visits, the program improved the low birth rate to less than 5 percent of births in the target areas. According to CHAPS program information, the average cost of a low birth rate baby is $17,500 for the first year of life and there were 4,300 low birth weight babies born under fee-for-service Medicaid in 2004.

Stakeholder groups identified additional means for increasing access to care. These approaches involved improved transportation, delegated credentialing, implementing a Healthy Kid's Dental Program, varied recruitment approaches, improved customer service, and outreach services. A member of the Ohio State Medical Association noted that public transportation does not run to his office so "my Medicaid panel has trouble getting to me, and they will use the emergency room as their primary care provider because of access barrier. It's not that they have any problem with seeing me. It's not that they don't like me or like coming to my office. Quite the contrary, sometimes they just can't get here." The member said that using primary care physicians more extensively would save money within the program but transportation issues would need to be addressed. A member of the Ohio Academy of Primary Care Physicians recommended Ohio Medicaid encouraging physician participation by adopting a practice in use by a traditional HMO at Ohio State University Hospitals called delegated credentialing. The member explained,

> "…As soon as we have our hospital privileges, we have privileges for United Health Care. I wonder, if, in fact, Medicaid, CareSource, Molina, whoever, could do some of those same kind of things so that as soon as the hospital has taken you through the whole credentialing process and has authorized you… that you could have your privileges instead of having to wait nine months to get them."

A member of the Ohio Dental Association made a similar comment saying, "Single credentialing would get the dentists…if you're looking at it from a provider's standpoint, provider enrollment, reenrolling all of the providers is going to be difficult at best. Asking them to jump through extra hoops is going to be much more cumbersome and probably cause a diminishment in the enrollment." The member noted that, while providers are willing to treat Medicaid patients,

"giving them something else to make it more cumbersome will make it more difficult to get them to enroll." Another Association member recommended Ohio Medicaid examine a program in Michigan, the Healthy Kid's Dental Program. The member explained that, while would be more costly, it would reduce the "red tape issue" associated with Medicaid. In his description "Essentially, if you're a child in rural counties, Delta Dental is your dental insurance…. The patients have to travel less distance to get care. They can go to a local dentist…. But you have to pay for that to happen." The member also recommended a case management, care management model in use in Athens County as a means to improve patient compliance with appointments and, by extension, entice additional dentists into the program by reducing the problems associated with missed appointments.

A member of the Ohio Association of Community Action Agencies described a program developed through a rural health outreach grant. The member uses a portion of the grant to fund equipment for a rural dental clinic and works with the University of West Virginia to recruit new dentists to the program. Another member described an outreach program that was successful with improving the clinic's relationship with its patients. The member said,

> "I think week one, there were 20 no-shows and two people [who] showed up for appointments. So we just gradually started to change our way of thinking. We started calling the patients, "Are you going to be here? We were worried about you because you were about 15 minutes late and we just wanted to double-check," …We [also] tried situations where if we have a no-show, then they can't schedule another appointment for four weeks. …Gradually, it's gotten much better. I think, now we may have one no-show a day at the most. But we've developed a working relationship with our clients."

The Ohio Children's Hospital Association described a program developed in Cuyahoga County where the hospital "applied for county funding and had indigenous workers that were out there in the community, folks at the hospitals -- because you want to get kids when they're healthy not when they are sick." An Association member also noted, "Notwithstanding some report cards that suggest that access is pretty good in Ohio, we have too much evidence to the contrary to trust that report card. But I think the administration of the program needs to attend to some of those fundamentals, access and quality being one of them."

The need for increased emphasis on preventive care was underscored by a member of Ohio Family Services Council who said, "We really need to start looking at the bigger picture of what we're going for and we would certainly encourage you to push for long-term effectiveness and cost efficiency rather than the short-term. Prevention and early intervention do in fact pay. Quality pays, and we need to figure how to make sure that this program gets what it's supposed to be getting and the providers provide what they're supposed to be providing."

To increase access to care, ODJFS could use methods developed in Oregon, or offer options to the managed care plans for particularly hard to find specialists (e.g., fee-for-service reimbursement). Similarly, ODJFS might consider increasing rates for hard-to-find specialists

like dentists. However, without additional effort to increase the participation of primary care physicians, specialists, and dentists, Medicaid recipients will continue to experience access to care issues, particularly in the Southeastern portion of the State.

R5.12 The State Medicaid agency should implement processes to improve access as identified by Oregon. Many of the steps identified by Oregon are also addressed in this report because of issues raised by stakeholders and Ohio agencies. First, the State Medicaid agency must make a commitment to meeting the community's health care needs in its mission (see organizational issues). Next, it must help cultivate effective physician and hospital leadership. The State Medicaid agency should include diverse partners who participate in the Medicaid delivery system, including "mainstream" providers, safety net clinics, nurse practitioners, and other specialties, by developing collaborative partnerships between physicians, clinics, and hospitals. Finally, communication by the State Medicaid agency with providers should be improved and administrative processes streamlined as discussed in this and other portions of the report. Implementing these recommended steps would help the State Medicaid agency ensure improved access through the availability of providers.

R5.13 The single State Medicaid agency should consider offering alternatives to joining a managed care plan to hard-to-find specialists and dentists. Similarly, where access issues become critical in a certain field, the State Medicaid agency should consider increasing rates or offering incentives, like credentialing options or case management services, for practitioners to treat rural recipients.

R5.14 The State Medicaid agency should seek to implement programs like CHAP throughout the State. Based on the data provided by the low birth weight program, Ohio could save approximately $19 million annually by reducing the low birth weight rate by 25 percent. Although the State Medicaid agency may initially need to focus the community-based program on pre-natal care, it should seek to expand it to immunizations and other areas of preventive care, as was the case in Alaska. If the program cannot be implemented statewide, the State Medicaid agency should ensure its implementation in rural Ohio counties where access to care issues have been observed.

Financial Implication: **By reducing the incidence of low birth weight by 25 percent in the Medicaid population by implementing community-based programs like CHAP, the State Medicaid agency could save about $19 million annually. This does not include the cost of State assistance in implementing these programs.**

The Effects of Churning

During stakeholder interviews, Ohio recipients and their advocates expressed concern about the redetermination process in use by ODJFS (see **issues for further** study). Similarly, practitioners and managed care plans indicated the redetermination process creates churning - members who are often losing coverage and are then re-enrolled in Medicaid managed care. Churning creates continuity of care issues and limits managed care plans' ability to improve the health outcomes of members. Furthermore, once a member is placed with a primary care physician, churning effects the member's ability to maintain a relationship with the selected health professional.

A member of the Ohio State Legal Services Association explained impact of churning, the term used to describe when "people fall in and out of eligibility" which often disrupts continuity of care in the Medicaid program -- "As people's circumstances change with respect to employment, their benefits change, and they're on and off benefits." The member said this not only has implications for managed care, but for the health of the family as well. When the recipient is reinstated into the program, "Theoretically, people get a fee for services card in the interim but there's many a slip up being off the managed care plan-- maybe not getting their fee for services card after all-- and then taking a while to get back into managed care. [It] creates these tremendous inefficiencies for everyone and for all parties."

Churning and its effects were discussed at the January 2006 Medical Care Advisory Committee meeting. Members of the Committee indicated that if managed care plans knew the redetermination date for their members, they could send reminders and possibly provide transportation to those appointments. A member of the Ohio Association of Health Plans reiterated the concerns over churning in a subsequent stakeholder meeting:

> "…back to the churning issue that we discussed at Medical Care Advisory -- there has not been a good process in place so that, on our enrollment information, we get information about the redetermination date.... We could do some proactive outreach to members in terms of really addressing the churning that we're all experiencing … [but] the Bureau {of Managed Care} really hasn't … take[en an]… active role in terms of dealing with the counties. So we're dealing [with it] county by county…"

Medicaid and SCHIP Retention in Challenging Times: Strategies from Managed Care Organizations (Redmond, 2005) found that the main problem for managed care plans is retention of Medicaid members due to redetermination complications. Since some states have increased the amount of documentation required for redetermination and the frequency of redetermination, managed care plans are seeing an increase in "churning." Interrupted periods of eligibility make it difficult for health plans to manage the member's health care and deliver effective preventive services. In addition, it is difficult to maintain the solvency and financial stability of a health plan (which is dependent on membership) when churning limits the plan's ability to maintain continuity in its membership. For state agencies, reducing churning decreases the administrative expenses incurred when eligible recipients must be reprocessed through the system. States can

reduce churning through less frequent and less complicated recertification for Medicaid coverage (see also **issues for further study**). Health plans can also reduce churning by reminding members of their redetermination date and assisting members with the application process. Difficult renewal processes impede continuity of care efforts; although some states have used these methods to reduce the number of Medicaid recipients.

Periods of Unmanaged Care in Medicaid Managed Care (Fairbrother, Park, Haidery, and Gray, 2005) explains that churning erodes a health plan's ability to affect the health care of its members because members are not enrolled long enough for the plan to identify health problems. In addition, a short enrollment period does not give the plan enough time to manage any chronic health problems for the member. Churning may also discourage health plans from implementing programs whose returns will not be evident in the short term. Lastly, churning allows health plans to report on only a fraction of their Medicaid members because HEDIS requires reporting only on members who have been enrolled continuously for the reporting year.

A member of the Ohio Podiatric Association noted the impact on disruptions in care from a service provider's perspective. The physician explained that continuity of care is important for patients with serious illnesses but, as Medicaid recipients change plans, they may not be able to access their doctor. The physician noted that this happens with employer-paid insurance plans as well. However, he felt that it may be more common with the Medicaid population and asked, "Are there provisions in the plan to get the patient the care…?"

Policies and Practices that Lead to Short Tenures in Medicaid Managed Care (Fairbrother, Park, and Haivderv, 2004) recommends improving the outcomes of Medicaid managed care recipients by lengthening enrollment tenures and reducing discontinuous care through the following:

- Minimizing the time between eligibility determination and managed care enrollment.
- Lengthening the enrollment in a health plan by increasing the time between initial enrollment and redetermination.
- Developing systems to help plans manage continuity of care through information transfer improvements and by monitoring performance across plans as people move on and off Medicaid.

During stakeholder interviews, a member of the Universal Healthcare Action Network suggested ODJFS provide managed care plans with "peoples' redetermination dates so [the plans] can help remind people and they can have their care manager say, "Hey, you know, it's coming up, do you need any help?" The member said that ODJFS could provide this data to the plans, but the managed care plans had no success in obtaining the information. Another member noted that it was difficult to narrow down redetermination dates because it is based on the application approval date, not the submission date. The member said, "I have been trying to track

[redetermination dates] too so that I can keep [recipients] in the system because, sometimes once they get out, it's harder to get it back in." The member concluded saying, "it makes no sense for [the managed care plans] not to be able to track their own patients to at least send them reminders, because it would reduce work load."

Improving practices around performance measurement and quality monitoring is also recommended. This can be accomplished by monitoring enrollment data in health plans using existing data sources and collecting additional enrollment data. Tracking members who are not enrolled long enough to be captured by HEDIS reporting gives a better picture of the population the health plan serves and can be captured by using modified performance measures that account for short enrollment and do not rely on continuous enrollment. Monitoring performance of Medicaid enrollees across all plans to account for members who change health plans frequently is also recommended. This can be done by using statewide encounter data to measure performance and track individual members and by using registries to measure performance in services not provided through the health plans.

R5.15 The State Medicaid agency should examine the redetermination schedule (see also technology and program management) and strongly consider lengthening the time between redeterminations, particularly for the ABD population. Furthermore, the State Medicaid agency should enhance performance measurement by soliciting the feedback of managed care plan members who may not have been enrolled for a full year in the HEDIS data collection process.

E. Care Management

Care management encompasses a broad array of activities including case management, disease management, utilization review, and utilization management. A good care management system establishes target changes in clinical outcomes, access standards, satisfaction scores, and the use of best practices. While small portions of these practices have been implemented in Ohio, care management is fragmented and inconsistent between the State's separate systems of care. In terms of case management, utilization review, and utilization management, practices vary within the Ohio Medicaid program overseen by ODJFS and the sub-recipient agencies. As these systems are designed to treat populations with particular clinical conditions (e.g., mental heath, mental retardation, drug addition, etc.), the case management activities used in these systems are structured to meet the unique needs of the populations served.

During the course of the audit, various stakeholder groups expressed concern that the Ohio Medicaid program lacks preventive care, coordination of care, and case management. A member of the Ohio Association of Health Plans said, "I believe there is a need for ODJFS to step back and look at some of the best practices of the industry. They are so prescriptive …. They have taken away the ability to manage the care and have made it so restricted and prescriptive as to what you can prior authorize, what you can cover, what you can't cover…. You're taking away

the expertise that … [managed care plans are] able to bring to that process..." Medicaid care management programs have been shown to be effective in improved prevention and care of people with chronic conditions.

Case Management

Case management is the key service for developing plans of care and coordinating treatment. Case managers facilitate communication between various providers serving a particular recipient. Case management services provided by each State system are described in Ohio Administrative Code. In several instances, the extent of case management permitted is determined under Ohio statute. The entities responsible for providing case management activities in Ohio Medicaid vary by system and include county agencies, area agencies, managed care plans, and direct service providers. Some Medicaid recipients receive no case management while others can only access services under a highly coordinated plan of case management by the agency through which they accessed the program. Case management activities vary between physical health care, long-term care, behavioral health care, and enrollees in managed care plans.

Some of the difficulties associated with providing case management to the Medicaid population were expressed by a member of the Ohio American College of Emergency Physicians who said, "One of the things that makes managing a program like this so difficult is that it's the mind set and the behavior of the enrollees. A lot of times people who are in Medicaid programs who don't have to pay a premium, who don't have any accountability, are not of the prevention mind set. They are more of the treatment mind set." The member explained that teaching healthy habits and preventive care is more difficult because of the mind-set of recipients. The physician said, "I think that care management programs are a great concept, but they're not necessarily going to be real, real easy to implement…."

The case management activities within Ohio Medicaid are described by agency or system below.

ODJFS

ODJFS does not have uniform case management or disease management programs for the fee-for-service population. The Ohio Department of Job and Family Services administers the Ohio Home Care Program through the Bureau of Home and Community Services. ODJFS contracts with CareStar to provide home-care case management and improve access to health care in all 88 counties. Home care case management incorporates case management, overall care coordination and data collection, and is provided to recipients enrolled in the Ohio Home Care Waiver, the Core Plus Waiver, and the Transitions Waiver. CareStar representatives complete assessments in the homes of recipients and the information gathered assists ODJFS in determining recipient eligibility for home care services. CareStar also coordinates with all involved providers and community agencies serving these waiver recipients.

In 2005, Ohio briefly implemented an enhanced care management program to address a subset of recipients with a chronic health conditions. Ohio's Enhanced Care Management (ECM) Program provided care coordination and case management services to the ABD Medicaid population with specified chronic diseases. These diseases, which were identified and targeted by the Bureau of Managed Health Care (BMHC), included asthma, diabetes, congestive heart failure, coronary artery disease, non-mild hypertension, and chronic obstructive pulmonary disease. Asthma was the only condition covered for children. The ABD population was selected for this program because of the high costs of care associated with this population. The program was discontinued in July 2005.

ODJFS contracted with four plans, including health maintenance organizations and disease management companies. The plans formed a collaborative with local providers to establish supportive and meaningful relationships between providers and patients; develop comprehensive treatment plans, and coordinate specialist care. Participation in the plan was voluntary and could be discontinued at any time. ODJFS believed that this program would increase access to care and be a cost savings. ECM was projected to increase access to care through the following:

- Helping members establish an ongoing relationship with a primary care provider;
- Providing a 24-hour toll free health advice line staffed by member services and health care professionals;
- Contacting each member within 30 days of membership in order to educate them about the program and services, and to review existing sources of care;
- Conducting an assessment within 60 days of enrollment; and
- Developing a treatment plan within 90 days.

The ECM Program was provided at no cost to participants and was very similar to disease management programs in Pennsylvania and Florida. Enhanced Care Management did not replace the care of a doctor. Instead, ECM was designed to augment physician care by providing information on health conditions, guidance on how to improve overall health, and help on how to follow doctors' orders. ECM was intended to decrease cost by improving care coordination, increasing consumer compliance with health care treatment guidelines, and preventing inappropriate hospitalizations and emergency room use.

While ODJFS planned to offer ECM in six rural counties (Muskingum, Coshocton, Guernsey, Morgan, Noble, and Perry) and seven urban counties (Cuyahoga, Franklin, Lucas, Montgomery, Stark, Hamilton, and Summit) it was never fully implemented. Enrollment in ECM only occurred in Cuyahoga, Franklin, Lucas, and Hamilton Counties and the highest number of recipients served at any one time was 4,000. The ECM program was discontinued by ODJFS after the passage of HB 66 because the agency chose to redirect internal resources to statewide managed care implementation. Due to the short life span of the program, no outcomes were measured to determine the program's success. Stakeholder groups felt as though this was a good program headed in the right direction for cost effective case management.

A member of the Ohio Developmental Disabilities Council commented on the disappointment resulting from ODJFS' decision to terminate the ECM program.

> "...[ECM was] starting to show results when it was eliminated ... and what we have seen around the country is that managed care can work in urban areas, but in rural areas it is very difficult to make it work. ...There are not enough providers. ...So, I have grave reservations about just jumping in with both feet for full risk managed care, including this group of people [the ABD population]. I'm not convinced that the insurers are going to understand enough about their medical needs to be able to make sure they're getting good health care."

A member of the Universal health Care Action Network also commented on the ECM program saying, "people in the disabled population [often have] diseases that are particularly susceptible to good care management, ... you can do interventions based on protocols for treatment of diabetes, lung disease, heart disease, and asthma. It seems to make such perfect sense that you provide very cost effective care management targeting at keeping those folks healthier to save Medicaid money." The member expressed concern that managed care does not engage in health acre management and stated "They really don't do healthcare management well, so you just can't think that the one substitutes for the other." The member cautioned, "the Medicaid program really needs to take a step back and figure out how they are going to do to care management." A program in Massachusetts was cited as a model that could potentially be replicated in Ohio. In the Massachusetts program, providers are compensated for providing preventive care and active care management, in order to maintain patients' health.

Medicaid recipients enrolled in managed care are now offered disease management and/or case management through managed care plans. In accordance with OAC § 5101:3-26-03.1(A)(8), managed care plans must offer and provide case management services which coordinate and monitor the care of members with specific diagnoses, or who require high-cost and/or extensive services. Members who have asthma, diabetes, Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS), pregnancy, or high blood pressure can receive case management through a managed care plan. Managed care plans use medical claims, pharmacy claims, welcome calls to new members, and referrals from providers to identify members who would be eligible for case management. Once a Medicaid recipient is determined eligible for case management, they are notified by a case manager who then introduces them to the program. These case management services will be offered to all managed care plan members as they are enrolled into the managed care plans, Covered Families and Children, and Aged, Blind and Disabled Medicaid recipients alike. However, ABD Medicaid recipients who are exempt from managed care will not have access to these services.

A representative of the Ohio Children's Hospital Association stressed the importance of case management saying, "Children's Hospitals certainly have a great deal of faith in care management as a principal, particularly when you recognize the number of children that have very complex needs with multiple number of specialists involved in their care." The member explained that the hospital often serves as the case manager but said, "We need responsible

entities to keep an eye on the whole range of care that a child needs." The member concluded that children's hospitals were embracing the State's move to managed care "tenderly and carefully but supportively."

However, some stakeholders have reservations about a managed care plans' ability to manage care and benchmark performance. A member of the Universal Healthcare Action Network commented that the State might not be ensuring that the managed care companies perform good case management. Standard measurements are not widely reported by the State Medicaid agency and, as a result, providers are left wondering how effective case management efforts are for Medicaid recipients. – The member said, "I'm certainly not aware of how well the managed care companies are doing at even those basic indicators, let alone managing chronic conditions."

A member of the Ohio Association of Primary Care Physicians also remarked on the importance of using disease management and the "medical home" to improve health outcomes saying, "Family medicine can't cure all ills, but I think if we got this … patient population at an earlier state in their disease process and did the preventive care that they're probably not getting in an emergency care setting, we could prevent a lot and not even need to use some of these specialists." The physician said that many Medicaid recipients do not receive regular treatment for chronic conditions like hypertension, COPD, diabetes, and heart disease. The member commented that, "You used to catch a lot of this stuff at other visits, and you have to build the trust up. The fact that they have someplace to go and that they realize that somebody cares about their needs, you can tell them, "Besides this illness, you need to do these things," it's a constant reinforcement that doesn't happen when you have episodic care."

In some cases, recipients would appreciate a greater level of case management. A member of the Traumatic Brain Injury Association said, "that's been a primary goal of ours for many, many years … to establish a comprehensive, we call it service coordination…. What we have now is funded through the Rehab Services Commission Brain Injury program. But it's not just enough … for folks that really have intensive needs, what we envision is individual service coordinators or case managers."

A different perspective was shared by members of the Ohio Association of Health Plans who voiced concerns over the State's requirements for the case management programs provided by managed care plans. A member said, "We've got a lot of very prescriptive requirements around case management-- who we should be case managing, how we should be reaching out to the them, versus, using the expertise of the plans to really look at who is the most high-risk and high-cost population and managing those." The member said, "we are managing to a prescriptive number that may not have any impact on high risk and high cost." Association members remarked that Ohio Medicaid's case management process was very different from the case management process in use in other states' Medicaid programs.

Behavioral Health

Ohio County Alcohol, Drug Addiction and Mental Health Boards; Alcohol and Drug Addition Boards; and Community Mental Health Boards (ADAMH will be used to refer to all of the behavioral health county boards) contract with agencies to provide case management services as prescribed through treatment plans for service recipients. In accordance with OAC § 3793:2-1-08, ODADAS case management services include interactions with families, other individuals or entities. Case management activities consist of coordinating client assessments, treatment planning and crisis intervention services, monitoring service delivery, providing financial assistance and housing assistance, and assisting individuals in becoming involved in self-help support groups. Within these systems, case management is performed at the provider level as the Boards are prohibited from providing direct clinical services. For Medicaid, the board contracts with any provider who meets certification standards and the board's monitoring of service provision is limited to compliance with service and billing standards. All providers are entitled to offer services without any limitations on the amount or scope of those services, and to receive Medicaid funding for those services.

The ADAMH boards along with the Ohio Department of Mental Health and the Ohio Department of Alcohol and Drug Addiction Services developed a business plan in 2004, which would give them increased authority over care management activities. The goal of the business plan is to present a unified vision for how the Ohio Department of Alcohol and Drug Addiction Services, the Ohio Department of Mental Health, and local boards can improve the administration and management of the community Medicaid behavioral health program. In order to improve clinical services, several components of a clinical monitoring system must exist simultaneously to ensure that the system is focused on providing the best clinical care while at the same time monitoring the quality and quantity of care delivered to individual clients. These components include utilization review, utilization management and care management. HB 66 called for a working group to explore the recommendations in this business plan. This group is currently meeting, but no report has been issued.

Stakeholders had numerous comments about the role of case management in the behavioral health system. Members of the Ohio County Behavioral Health Authorities expressed concerns about the following:

- Limited service environments in rural areas;
- Oversight of residential treatment for children;
- Clinical oversight of providers ;
- The financial drain on county behavioral health authorities because of their inability to monitor service provision;
- The absence of management in Medicaid behavioral health as a health benefit;
- Inconsistencies within the system because of the county-based administration;

- Adversarial relationships between the providers and the county boards; and
- The inability of the system to adapt fully to the newest clinical methods.

A member summarized their concerns by saying, "It's not Medicaid that's the problem for us, it's the way we manage Medicaid" The member explained that it was important for the behavioral health system to develop safeguards for patients shifting between the private and public systems. The member stated, "We don't want to further separate our behavioral health system. We want to get control [over it] and then work constructively with the primary health care side."

A member of the National Alliance for the Mentally Ill described the inability of clients to select the most appropriate services for their needs and the reliance of some providers on service packages. He said, "It's a system that's broke. …The wrong services are being delivered, not because of the client need but because of system need. And Medicaid is a major instrument in that happening. We know what we need; we know what recovery is." A member of the Ohio Association for Mental Health remarked that, "Part of the problem is that in 88 separate counties there are 88 different opinions. -- 88 different understandings…." The member continued by explaining that, "In all of the rules, I think it's very difficult for a consumer who moves from one part of Ohio to another to be sure that they are getting -- well, the services are titled the same but they're not necessarily delivered in the same way."

Medicaid recipients and advocates noted some limitations of the service delivery system: One advocate said, "I know that if you're a non-Medicaid client, [county agencies] can do a lot more with case management at the county level. They can, but do they? All of their money is going for Medicaid match." Another advocate mentioned that transportation is a substantial problem for the mentally ill in Ohio. A recipient commented, "You ought to be where I came from. One cab company, no buses, you walked, road your bike, or you owned a car. …You can't get anywhere. You can't get to the services. And our system has not accepted the concept; go to where the client is." An advocate mentioned that some programs perform extensive client outreach (Project Mainstream was cited), but this is not the norm.

Finally, a parent of a child served in the behavioral heath system commented on the impact of provider turnover on services. The parent stated, "You're more likely to have continuity with a private provider because that's their livelihood and they're in it for the long haul." The parent said that her child was served by three different psychiatrists in a six month period, and four counselors over an eight month period. She related, "Finally my kid said, "I'm not telling my story again." …We know the [patient/provider] relationship is critical but if you spend all your time trying to create a new relationship every three or four months, you lose the effectiveness of the counseling."

Mental Retardation and Developmental Disabilities

The County Boards of Mental Retardation and Developmental Disabilities (CBMRDDs) provide case management through Service and Support Administrators that complete the intake process for the Board's service recipients. The Board continuously works on the individual care plans by adjusting them and making certain that the service recipients' care needs are being met. When the recipient needs a service that is not covered under the waiver,[43] a pre-authorization claim is processed allowing the recipient to receive the care that would not normally be authorized by the plan. In the MRDD system, the County boards provide case management services -- they do not provide waiver services.

All MRDD clients require a specific care plan. Needed services are identified and linked to the appropriate resource provider. Targeted case management,[44] the case management service provided by the County boards of MRDD to Medicaid recipients, is defined as managing the services that will assist individuals in gaining access to needed medical, social, educational and other services. This process uses referrals to link the agencies that can meet the customers' needs (e.g., rent subsidies, housing authority, Heat and Energy Assistance Program (HEAP), and mental health services.) Targeted case management enables states to reach beyond the boundaries of the Medicaid program to coordinate a broad range of activities and services necessary to maximize the functioning of select categories of Medicaid beneficiaries. Targeted case management is also used to monitor high-risk Medicaid patients. (See **technology and program management** for a discussion on ODMRDD's Payment Authorization for Waiver Services (PAWS) system and its use in targeted case management.)

Although the CBMRDDs provide case management to their customers, care coordination remains an issue. Gaps exist because every agency has its own intake process. In addition, the MRDD boards have no role in managing health care. Once recipients are placed in a health facility, the Board no longer manages their care. The boards are only involved in targeted case management and bill payment processes for individuals in MRDD waiver programs and community-based care. Monitoring is difficult because in a number of counties, there are a large number of service providers.

[43] The MRDD system operates two waiver programs, the Level 1 waiver provides home and community services for people who live in family homes and receive voluntary family support, including those with aging caregivers. The Individual Options waiver provides home and community services for individuals who, without such services, would require care at an ICF/MR. There are 14,000 people (out of 80,000 MRDD recipients on Medicaid) in the MRDD waiver programs.

[44] During stakeholder interviews, some advocates for MRDD clients expressed concern about the cost of targeted case management as it is provided at the board level. Until recently, clients could receive targeted case management services from any licensed Medicaid provider but changes to these regulations have restricted this service to the county Board of MRDD. Although county boards can subcontract for the services, only the boards are allowed to bill Medicaid. Advocates also mentioned that they had concerns about the tendency of certain county boards to "self-refer" clients to other board services during the targeted case management process.

A member of the Ohio Developmental Disabilities Council expressed the following concerns about the case management process:

> "We are increasingly hearing stories out of to MRDD system, that the care managers are told explicitly they cannot advocate for a person. They can't make a recommendation on how to select a provider, even though they know things about providers in their area. People are increasingly left out there alone to figure out this morass of regulations and services, and it's hard enough for those of us who work with it every day and know what's going on."

Pre-Assessment Screening System Providing Options and Resources Today

The Area Agencies on Aging (AAA) provide case management through the Pre-assessment Screening System Providing Options and Resources Today (PASSPORT) waiver program that provides senior citizens age 60 and older with home health care and community-based services in lieu of institutionalized care. A recipient enrolled in the PASSPORT program is assigned a case manager to ensure they are safe in the community and that their health care plans are adjusted according to their needs.

Directors of the Area Agencies on Aging described their system a continuum of care options including nursing homes, PACE (Program for All Inclusive Care for the Elderly), Assisted Living, RSS (Residential State Supplement), and PASSPORT. The directors indicated that the strength of the system is based on the provider network, which has been cultivated over several years. Furthermore, the directors referred to the AAA system as a "unified and collaborative system" designed to provide services to the family and recipient. They described the staff in the aging industry as "highly trained" and "compassionate"

A PASSPORT Director added, "We have a good relationship with our customers. Standards for care management are high, the intake process is reasonable, and our caseloads are relatively small" (60 – 65 per case manager). The director continued, "…Our responsiveness to the consumer, the family, and the providers is a strength." The PASSPORT director noted that they would like to be able to provide complete case management for their clients because the PASSPORT program has the capacity to perform such services and it could capitalize on preventive services to achieve greater cost savings.

Although the goal of the AAAs is to provide adequate care, the system is also fragmented. Communication between AAAs and providers is not strong and in some cases, is not a priority. In addition, a significant gap in the system is the lack of communication between community agencies, which may lead to duplications of service. Likewise, once a Medicaid recipient receives his or her Medicaid card, care can be accessed through other physicians under fee-for-service or managed care arrangements that are outside the coordination limits of the AAAs. Although the Passport Information Management System (PIMS) system is used by the AAAs and the Ohio Department of Aging to track and pay services as authorized under the plan of care, recipients can access services that are direct-billed to ODJFS outside the plan of care. (See also

technology and program management for a discussion on ODA's PASSPORT Information Management System (PIMS) and its use in case management.)

Case Management Programs in Other States

Wisconsin's Family Care program serves people in a managed care plan with physical disabilities, developmental disabilities, as well as frail elders. Participants receive interdisciplinary case management and each member has support from a team of professionals. The team includes a social worker, case manager, and registered nurse. The team conducts a comprehensive assessment of the participant's needs, abilities, preferences, and values. The assessment includes a review of daily living activity, physical health, nutrition, self-determination, communication, and mental health. An independent assessment by APS Healthcare, Inc. found that Family Care produced substantial savings for Wisconsin's Medicaid program. It appeared that more frequent primary care physician visits provide opportunities to increase prevention and early intervention health care services. This reduces the need for more acute and costly services. As of September 2005, the savings achieved by Family Care were estimated at $1.9 million, with an enrollment of 9,396.

In June 2003, Health and Human Services approved Indiana's Coordinated Care Management program. The program is designed to offer special, targeted care management services to Indiana's Medicaid recipients who are enrolled in Hoosier Healthwise. Hoosier Healthwise is Indiana's Medicaid insurance that offers medical care to children, pregnant women, and low-income families. The program focuses on diabetes, chronic heart failure, and asthma. Enrollment into the program is voluntary. Once recipients are enrolled in the coordinated care management program, they work with a nurse case manager to develop a treatment plan. High-risk enrollees receive intensive one-on-one nurse case management while low-risk enrollees receive telephonic nurse management. All enrollees receive regular medical assessments, education about their disease, dietary information and instructions on how to manage their care.

Colorado has incorporated an advanced care management program into its high-risk health insurance program. The advanced care management program is a combination of specific disease management and more generalized care management. The goals are to reduce the costs and improve the quality of life for enrollees. The care management portion consists of nurse counseling, pharmacy review, utilization management, case management, and depression management. Colorado contracted with Health Integrated for care management and utilization management. Colorado estimates that its care management interventions generated $2.3 million in direct savings[45] from May 2002 to September 2003.

During stakeholder interviews, a member of the Ohio State Medical Association commented that using primary care physicians as gatekeepers has fallen "out of fashion" because it did not work

[45] Colorado direct savings are from reductions in utilization, redirection of care toward lower cost services, clinical decision support, timely management, and direct negotiations with providers.

as well as expected. The member noted that some managed care plans are using a disease management model that has resulted in greater successes.

A member of the County departments of Job and Family Services Leadership Committee noted "…changes are needed with regard to the coordination of benefits. Often the use of waiver programs is not coordinated. A better match of one's needs with the program is desirable. This can occur through the implementation of case management, better worker training, and designated places for recipients to go to see the appropriate program." This indicates that case management efforts used by the Ohio Medicaid program may not be meeting the expectations of the Program designers and could benefit from closer scrutiny.

Medicaid recipients also expressed frustration over current coordination efforts. A member of the Ohio Federation of the Blind said,

> "…The agencies really ought to be working in partnership when it comes to helping people find jobs and get the services they need. … One shouldn't be exclusive of the other. I mean obviously if we could get people meaningful jobs … we would cut down on the need for Medicaid a little bit at a time and certainly among blind people. That really isn't happening. …There should be some way [county agencies] can … work together even if they have to share records somehow to show what they're each doing for me. I don't care … I could have benefited a little bit from [better case management]…."

Another area in which improved care coordination could positively affect health outcomes is that of immunizations. A member of the Ohio American College of Emergency Physicians noted that the vaccination rate in Ohio, one measure of the effectiveness of public health services, was below more than half of the other states. The physician attributed the low rate to access issues, record keeping, and limited use of primary care physicians by lower income State residents or Medicaid recipients. He said that emergency departments would welcome the opportunity to participate in improving the rate of vaccinations because "sometimes that's only time kids are ever seen…. They don't go to their primary care doctor or they don't have a primary care doctor and that's where they should get their immunizations." The physician noted that the low rate of immunizations impacts emergency room services as children contract illnesses that could be prevented through vaccinations, and then their parents seek care for the child through the emergency department.

Because Ohio's case management activities are fragmented across systems and technology is not used to bridge communication gaps, the Ohio Medicaid program may be paying for duplicative or unnecessary services. For example, a recipient may be enrolled in a waiver and may be served under a plan of care, but is also entitled to use their Medicaid card to obtain fee-for-service care (card services), which could result in duplication of care efforts. Similarly, case management services, particularly for the ABD population who may not be served through a sub-recipient system, could have positive health outcomes and result in reduced usage of Medicaid services. If the Ohio Medicaid program implements additional case management activities, particularly for

high cost populations, and improves intra-system coordination, it could realize additional savings, by reducing unneeded, high-cost, or duplicative services, and have a substantial positive impact on Medicaid recipients' long-term health outcomes.

One option for the State is to build on the county systems that are in already in place. A member of the Ohio Job and Family Services Directors' Association noted that case management is already performed within the county agencies for multiple programs (e.g., children's services, welfare, etc.). The member said that there were strengths within each CDJFS and other county agencies that could be expended to develop an intensive case management system concluding, "It would be a logical avenue for that concept." However, another member of that organization disagreed, noting that caseworkers at a CDJFS did not have the appropriate education and skills at this time to perform a more clinical case management role.

R5.16 The single State Medicaid agency should implement a case management program for all Medicaid recipients remaining in fee-for-service and not enrolled in a waiver program in which case management is already a component. To accomplish this, the State Agency should initially review current case management services to determine who is not receiving services and who is getting case management from multiple systems or providers. This population should serve as the initial target population for the expanded case management services. As an enormous amount of research was completed to implement the former Enhanced Care Management program, the ECM research and model should be used as a starting base for the new case management program. However, adjustments to the ECM model will be needed and the new case management program should consist of CFC and ABD populations who are not covered under managed care. As many individuals in these populations suffer from multiple diseases, the program should include high risk pregnancy, diabetes, asthma, lung disease, congestive heart failure, coronary artery disease, hypertension, hyperlipidemia, HIV/AIDS and chronic obstructive pulmonary disease.

R5.17 The single State Medicaid agency should require the managed care plans to expand their case management programs to include the same diseases as the fee-for-service case management model (see R5.5). Medicaid recipients often move from managed care to fee-for-service. If both managed care and fee-for-service focused on the same diseases, then the recipients would have minimal interruption in their case management services.

R5.18 The Single State Medicaid agency should work with sub-recipient agencies to develop a program-wide case management system (see also technology and program integrity). At a minimum, the Agency should seek to ensure that new information systems and data warehouse structures are able to communicate plans of care from among the participating agencies. While a program-wide case management system

would require additional funding and would represent implementation challenges, the adoption of electronic health records, as described in the technology and program management section, would expedite this process and may make it unnecessary for the State to invest in additional information systems.

Disease Management

Ohio does not have a disease management program for fee-for-service recipients. However, managed care plans offer disease management to their members through a variety of practices. Disease Management seeks to improve the quality of care and slow the growth of health care costs through enhanced screening, monitoring, education, and coordination of care among providers. Disease Management has several care components, which include the following:

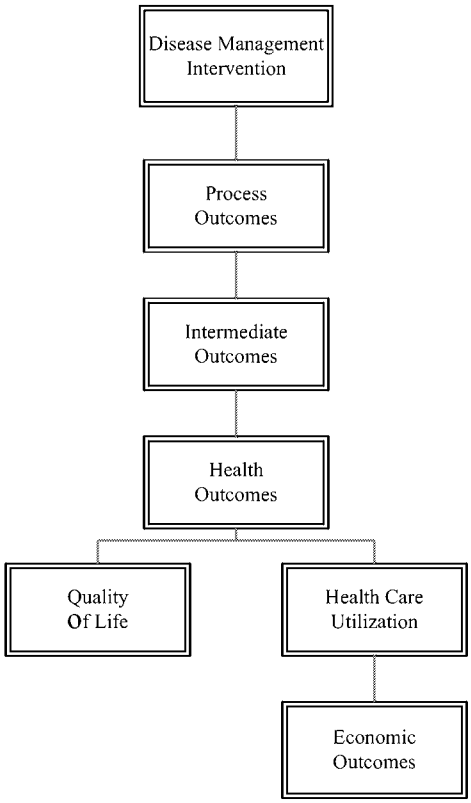
- Selection of patients;
- Education;
- Communication;
- Monitoring;
- Feedback;
- Coordination of care; and
- Adherence to evidence-based guidelines.

Educating patients about chronic diseases and disease management enhances their understanding of the importance of taking medication properly and monitoring symptoms, and explains the advantages of changing certain behaviors. The Government Finance Officers Association encourages governments to adopt an approach to health care that includes health care education. Education programs have proven successful in modifying behaviors that drive health care costs. Because patients often receive care from a range of providers, coordination of disease management or treatment plans is often difficult. However, according to *Medical Management* (Continuing Care News, December 2004), when each person involved in the patient's coordination of care knows what the other is doing, quality improves, errors are decreased, and costs are controlled.

Disease Management Programs in Other States

Disease management practices for the diabetic population, for example, include annual foot and eye exams, annual tests for kidney function and cholesterol, and biannual tests for hemoglobin A1C, or control of blood sugar. Changes in intermediate measures that are monitored by the physician include hemoglobin A1C, blood pressure, and cholesterol. The Congressional Budget Office developed a diabetes disease management program model that could lead to better health outcomes and lower health costs. The model is illustrated in **Chart 5-3.**

Chart 5-3: Disease Management Program for Diabetes



Source: Congressional Budget Office, *An Analysis of the Literature on Disease Management Programs (2004)*

In 2000, Kentucky established disease management programs for Diabetes and Asthma. The diabetes program was designed to reduce complications among adult Medicaid recipients and improve their overall health. The diabetes program coordinator contacted Medicaid recipients who had an emergency room visit or hospital admission for diabetes and who were not receiving ongoing diabetes care. The program sent health care providers quarterly reports on the extent to which their Medicaid patients with diabetes were using services critical to their health, such as eye exams, prescription drugs, and regular health screening. The report also indicated those patients who had other medical conditions that can cause complications of diabetes. In 2003, the National Committee for Quality Assurance (NCQA) chose Kentucky's diabetes disease management program for a best practices award.

Kentucky also offers disease management to Medicaid recipients ages 2 through 56 with asthma. The program is designed to improve members' health and quality of life, and reduce unnecessary asthma related hospitalization and emergency room use. Based on claims data, prescription drug usage, and the severity of their illness, the program divides Medicaid recipients into five groups

based. Members receive materials and services tailored to their needs. Emergency department visits for asthma related services has decreased 1.5 percent for participants. This disease management program was recognized for its improvements by the Robert Wood Johnson Foundation's Center for Health Care Strategies. In 2002, the program was awarded the Best Clinical and Administrative Practices Award. According to *Innovations in Medicaid Managed Care* (American Health Insurance Plans, March 2005), the U.S. Environmental Protection Agency estimated that implementation of asthma management plans can save an average of $1,200 per year in health care costs for individuals with moderate to severe asthma.

In 2002, Oregon also implemented disease management programs for both diabetes and asthma. The program targeted 11,000 of the 85,000 members in medical management programs for diabetes, asthma, and congestive heart failure. The savings came from reduced hospital admissions. Increased knowledge of the disease resulted in better management of blood glucose levels and lower lipid counts among diabetes patients with high cholesterol.

Medicaid recipients who were enrolled in the program were identified through claims data. Once enrolled, the recipients underwent a disease-specific health risk assessment that was then used to develop a care plan. Recipients received regular health education materials and nurse assistance via phone or through a personal visit and the use of a 24-hour nurse line was available to recipients enrolled in the program. In January 2005, the Department of Human Services estimated that the disease management program assisted Oregon in avoiding $6 million in medical costs.

In December 2005, Colorado reported that its diabetes disease management program for Medicaid recipients showed a definitive return on investment. A 12-month analysis of participants showed:

- A 69 percent increase in the number of patients who had an action plan for dealing with their disease;
- A 43 percent increase in the number of patients taking aspirin or a certain drug to help prevent heart disease. Diabetes is a major risk factor for heart disease;
- A 33 percent increase in the number of patients who know their cholesterol level;
- Ninety-five percent of responding patients reported satisfaction with the program; and
- Ninety-four percent would recommend the program to a friend or family member with diabetes.

Florida contracts with disease management organizations to implement strategies for each high-cost chronic disease. It has disease management contracts in place for HIV/AIDS, hemophilia, diabetes, asthma, cancer, congestive heart failure, chronic kidney disease, and hypertension. The state has worked with disease management vendors to implement program solutions. **Table 5-15** outlines creative solutions to disease management program barriers as identified in Florida.

Table 5-15: Potential Problems and Solutions Associated with Disease Management Programs

Potential Problems	Possible Solutions
Data limitations: • Medicaid data systems are often inadequate to identify appropriate disease management participants. • Faulty coding in data records leads to false positives and negatives (falsely identifying recipients as needing treatments and failing to identify those who do.) • States also have great difficulty getting Medicaid data into a disease registry or decision support system.	States can: • Work with physicians, social services, public health facilities, and hospitals to screen and refer patients directly into appropriate programs. • Use nurse care managers to make follow up calls to validate computer generated assessments. • Adopt existing disease registry and decision support systems and input their data.
Medicaid recipients as a challenging population to serve: Medicaid recipients: • Are often transient; • Lack telephones or internet access; • May lack transportation; • Move in and out of eligibility; • May have mental health problems, substance abuse issues, or cognitive barriers; and • Have trouble with reading proficiency, making it difficult for them to follow disease management protocols.	Health plans and vendors have: • Hired locators to find people; • Given recipients direct-connect mobile phones, or have used videos to convey information; • Coordinated transportation or offered house calls; • Provided appointment reminder systems; • Extended services temporarily after Medicaid eligibility lapses and reminded recipients to renew coverage; and • Written materials at the third-grade to fourth-grade level.
Difficult to measure effectiveness of disease management programs: • Demonstrating program outcomes is complicated by difficulties in establishing appropriate baseline comparison data due to fluctuations in Medicaid enrollment and costs each year. • Demonstrating the effectiveness of a disease management intervention due to patient turnover, general medical inflation, regression to the mean (the statistical tendency of last year's most expensive members to move toward the group average the following year, and the need to indicate what outcomes would have occurred absent the intervention.	Solutions to measurement include: • Setting measurable goals, designing effective evaluation strategies, and spelling out evaluation methodology in contracts. • Using control groups instead of comparisons to prior data to measure impact, or managing the entire effected population to avoid cherry-picking. • Controlling for patient turnover, general medical inflation, and regression to the mean in measurement systems. • Working with consultants to establish unbiased measurement terms in contract negotiations.
Physician and Patient Participation: • Physicians may resist vendor intrusion in their practices, as well as physician education programs. • Medicaid recipients may not elect to participate in disease management programs, preventing programs, from having a large impact.	States can improve participation by: • Partnering with physicians in designing disease management strategies and provide incentives, such as Continuing Medical Education credits, for training programs. • Automatically enrolling patients in disease management programs and provide a time period in which they can opt out.
Medicaid Regulations: • Disease management often requires a plan amendment or waiver; waiver process can delay implementation.	States can: • Initiate early conversations with CMS to share program plans and determine which route to pursue.
Co-morbidities: • Patients with chronic diseases often suffer multiple illnesses that must be managed concurrently.	States can: • Account for co-morbidities in program design or use a limited number of vendors that manage multiple diseases and life issues.
Risk-based contracting: • Placing vendor fees at risk creates an adversarial relationship between purchasers and vendors and can lead to disputes about whether expected outcomes were actually achieved.	Purchasers and vendors can: • Specify program design, expected outcomes, and evaluation methods in the contract; • Use third parties to reconcile data; or • Eliminate risk-based contracting.

Source: NGA, *Disease Management: The New Tool for Cost Containment and Quality Care (2003)*

Table 5-15 illustrates the barriers that Florida experienced as it was establishing its disease management programs and the possible solutions to have an effective disease management model.

During stakeholder interviews, a member of the Ohio Pharmacists Association described the effectiveness of disease management programs in place in West Virginia:

> "Medication Therapy Management does work. I'm down on the Ohio River, rural southeast Ohio, and most of my clients are customers that come from across the river. [The] Public Employees Insurance Association of West Virginia [has] a program called *face-to-face diabetes management*, and my store is one of three stores in the Parkersburg/Marietta area that's involved. [The program] is actually based on the Ashville study [completed] years ago, and we [perform] face-to-face counseling with diabetics, trying to get them … to pay more attention to their disease state. We've been involved in it for just 11 months in our store, and so far none of the people that we have counseled have had to go to the hospital…. [The program] started off [as a pilot] in six counties… and after eight months they expanded it to all 55 counties. The program does work. I have one client whose A1C level went from 7.8 to 6.2 in four months-- totally unbelievable."

Representatives of Ohio Hospice and Palliative Care also noted benefits of an interdisciplinary approach to care coordination and disease management saying that Medicaid could benefit by using the case management process in use in hospice. The representative illustrated this point through a description of the hospice pain management program. It uses behavior modification, addresses the non-physical component of pain, and relies on an interdisciplinary approach to patient care.

Medicaid managed care plans have used disease management programs for years and many states are beginning to implement disease management programs for the fee-for-service side of Medicaid. States either purchase or outsource disease management programs by contracting with disease management organizations. States typically pursue disease management programs in hopes of curbing current Medicaid spending, improving health outcomes, and getting greater savings in the future.

Although the Medicaid managed care plans offer disease management services, ODJFS could potentially lower long-term costs and improve health outcomes for specific, high-risk populations through the increased use of disease management programs for fee-for-service clients. Similarly, coordinating with the sub-recipient agencies to enroll recipients in disease management programs would help offset medical care costs for recipients served in those systems. Finally, increasing the use of disease management programs in contracted managed care plans would help the Ohio Medicaid program slow the growth in medical care costs for the majority of Covered Families and Children and Aged, Blind and Disabled recipients.

R5.19 The single State Medicaid agency should implement a disease management program for its fee-for-service recipients. In addition, the Agency should work with sub-recipient agencies to ensure that their clients are enrolled in appropriate disease management programs.

A disease management program should raise awareness about disease management by providing educational materials. These might contain information on warning signs, the effectiveness of taking medication, and quick tips on self-monitoring assessments. Disease management programs should offer a 24-hour nurse line and incentives to recipients to help encourage participation. Research shows that the following diseases have the greatest potential for savings and should be included in a disease management program:

- **Asthma;**
- **Diabetes;**
- **Congestive heart failure:**
- **Lung disease;**
- **Chronic kidney disease;**
- **Hypertension;**
- **Hyperlipidemia;**
- **Cancer;**
- **HIV/AIDS;**
- **Chronic obstructive pulmonary disease; and**
- **Sickle cell anemia.**

Through implementing disease management for only three of the abovementioned conditions for 11,000 recipients, the State of Oregon was able to reduce emergency room visits and hospital admissions. Oregon estimated the savings through implementing the program at $6 million per year. An external review of the program estimated savings at $23 million, but the state indicated that the amount included savings from other plan changes.

Financial Implication: **Assuming Ohio implemented a similar program on a limited basis for a small population and achieved savings of a magnitude similar to Oregon (based on the 2003 eligible population for Ohio and Oregon),[46] Ohio could achieve savings of about $15 million annually. However, program-wide implementation of disease management for all recipients would likely result in much greater savings. Assuming 20 percent of recipients would benefit from disease management and assuming an average cost savings of about $550 (based on the per-participant savings achieved in Oregon), Ohio could save up to $59 million annually. Although**

[46] In 2003, Ohio reported 1.9 million eligible recipients and Oregon reported about 626,000.

there will be an initial cost to provide the disease management programs, the savings produced from the reduction of emergency room visits and hospital admissions will offset these costs.

R5.20 Managed care plans have disease management and case management programs for asthma, diabetes, HIV/AID, hypertension, and pregnancy. With mandatory managed care, managed care plans will be serving a larger part of the Covered Families and Children population as well as the Aged, Blind, and Disabled. The State Medicaid agency should insist that the managed care plans expand the focus of disease management and case management to include congestive heart failure, chronic kidney disease, hypertension, hyperlipidemia, cancer, HIV/AIDS, chronic obstructive pulmonary disease, and sickle cell. The Agency should also ensure that all appropriate managed care plan recipients are included in and use these programs.

R5.21 The State Medicaid agency should develop benchmarks that would measure the additional diseases in the expanded disease management program and the improvements in health outcomes. These benchmarks would help the Agency better communicate the utility and potential cost savings of the programs to stakeholders and the General Assembly. Similarly, an expansion of the use of disease management benchmarks would help the Agency better track the effectiveness of programs, allowing it to enlarge successful programs and alter those with more marginal performance.

R5.22 Since Medicaid recipients frequently lose and gain eligibility, the State Medicaid agency should investigate means to assist recipients in continuing their disease management programs. When recipients lose Medicaid eligibility, the State Medicaid agency should consider extending disease management programs through transitional care, through the fee-for-service model, or through the recipient's selected primary care physician.

Utilization Review/Utilization Management

Utilization review describes the process, technique, or method by which a healthcare organization reviews, monitors, and evaluates its use and allocation of resources and services. In a hospital, this includes review of the appropriateness of admissions, services ordered and provided, length of a stay, and discharge practices, both on a concurrent and retrospective basis. The results of utilization review are contingent on such factors as the medical care process, patient variables, inaccuracies in the medical record, and differences in practice patterns of physicians in various regions. Utilization review is generally conducted by professional nurses using one or more sets of criteria. It is one of the primary tools used by integrated delivery

systems, managed care organizations and health plans to control over-utilization, reduce costs and manage care.

Utilization management describes programs that focus on planning, organizing, directing, and controlling healthcare resources and services in an effort to ensure the provision of cost-effective, appropriate, and high quality care. Utilization management involves coordinating how much or how long care is given for each patient, as well as the level of care. The goal is to ensure care is delivered cost-effectively, at the right level, and does not use unnecessary resources.

Although utilization management and utilization review are often used interchangeably, they are not the same. **Table 5-16** summarizes the differences.

Table 5-16: Differences between Utilization Review and Utilization Management

Category	Utilization Review	Utilization Management
Medical Record Review	Yes, Retrospective	Yes, Prospective/Concurrent
Use of Criteria	Yes	Yes
Patient Contact	No	Yes
Monitoring of Resources	Allocation	Necessity/Appropriateness
Authorization of Services	No	Yes
Scope of Responsibility/Service	Limited	Wide
Providers Contact	Indirect	Direct
Cost	Containment	Effectiveness
Setting	Acute Care	Across the Continuum of Care
Focus on Transitional Planning or Level of Care	Minimal	Maximal
Interaction of Managed Care Plans	No	Yes
Contribution to the Plan of Care	No	Yes
Case Conferencing with Providers	No	Yes
Case Conferencing with Patient/Family	No	Yes
Reimbursement Appeals Function	Minor	Major

Source: *The Case Manager's Survival Guide (2003)*

As illustrated in **Table 5-16**, patient contact is not included in utilization review. The lack of direct patient contact limits the utilization review analysis to only what is documented in the medical record. The level of service being provided must be supported by the medical records not the interaction with patients.

Since 1985, Permedion has contracted with the ODJFS to review, improve, and assure the quality of care and appropriateness of services delivered to Ohio's Medicaid recipients. Permedion is continuously monitoring and improving the quality and appropriateness of hospital services. The contracted services include pre-certification of inpatient and outpatient elective procedures; retrospective medical necessity review of hospital services; and focused quality and utilization improvement studies. These studies incorporate data collection and analysis, feedback sessions with providers, and development of strategies to improve care. Within ODJFS, the Office of Research, Assessment, and Accountability (ORAA) performs quality assessments of

Medicaid services and manages program integrity by identifying improper payments through Surveillance Utilization and Review System (SURS) audits/reviews. (See also **program integrity** section.)

Some healthcare providers who have participated in Permedion utilization reviews expressed concerns that they use InterQual criteria to guide utilization management and Permedion is using Milliman criteria. InterQual's guidelines are designed to determine whether the level of care is appropriate by evaluating the intensity of the services provided and the severity of the illness while Milliman Care Guidelines focus on the appropriate services for specific days of a hospital stay as defined by diagnosis and/or procedures.

Under ORC § 340.03(A)(8)(a), local boards establish utilization reviews as part of the contract for services entered into between a board and a community mental health agency. The board may establish this process in a way that is most effective and efficient in meeting local needs. ODMH also conducts utilization reviews of inpatient psychiatric care. ODMH outsources this process to a company that provides a monitoring program staffed by professionals who have detailed knowledge and understanding of federal and state guidelines. The utilization review processes monitor medical necessity for inpatient care, premature discharge, appropriateness of readmission, appropriateness of treatment and discharge planning, and lengths of stay.

Behavioral healthcare agencies are not permitted to conduct utilization management activities. However, the Community Behavioral Health Businesses Plan proposes authorizing utilization management activities so that behavioral health agencies may conduct targeted reviews to identify areas for clinical improvement, or unusually high or low services. ODMRDD and ODA both conduct utilization management through their respective waiver programs. Finally, ODADAS has limited utilization management authority using clinical protocols governing administration, continuing stays, and discharge criteria.

Several stakeholders interviewed during the audit highlighted the need for improved utilization management and utilization review. A member of the Ohio Council for Home Care described how managers occasionally note that recipients receive unneeded services. The member attributed State reluctance to reduce services to pressure exerted by the recipient's family. However, the member remarked, "By the same token there are fragile people out there who need services who cannot get them because the resources are going to that type of consumer." Another member of the Council expressed concern about the use of home health aides to perform housekeeping. The member explained that, under Medicare, some light housekeeping is permitted. However, some recipients use their home health aide to perform yard work or window washing. The member concluded that, in some cases, Medicaid was providing funding and services beyond the needs of the recipient.

A member of the Ohio Academy of Primary Care Physicians explained that, under Medicaid, there are no penalties for over-utilization or improper utilization of resources. The physician

explained that insurance co-pays for emergency room use discourage individuals from using the emergency room as a primary care setting. The physician said, "I'm not looking to penalize this population, but there's nothing to modify behavior. …There is no punishment. I mean, what are you going to take away? …Maybe set up a reward system. …Send them 20 bucks December 31 if they haven't used the ER all year." The physician went on to say, "It's got to be some incentive program, something in the program that incentivizes them to buy in. That's how you get everyone else to buy in. It's not one sided. We all have to do that as a partnership."

R5.23 The single State Medicaid agency should begin evaluating Medicaid health care expenditures through enhanced utilization review and/or utilization management. Although hospital inpatient claims are currently reviewed, the State Medicaid agency would benefit from utilization reviews on all health care services. The data should be used to identify high use services and compare provider capacity to use and need. Similarly, the data could be used to identify areas that would benefit from alternative treatments or innovative programs to reduce costs. The State Medicaid agency should coordinate with the sub-recipient agencies to ensure that utilization review and utilization management data is used in agency decision-making.

Primary Alternative Care Treatment (PACT)

Over-utilization and underutilization represent costly and inappropriate uses of services that should be monitored and evaluated. ODJFS established the Primary Alternative Care and Treatment (PACT) program in 1983 to target Medicaid recipients who have a history of over-utilizing services.

A pattern of inappropriate utilization of services is determined by reviewing the Medicaid recipient's claims for medically necessary services. PACT places Medicaid recipients with identified patterns of inappropriate utilization of medical and/or pharmaceutical services with a single primary care physician and pharmacy. The primary care provider receives $8 per member per month reimbursement to coordinate the recipient's care. The Medicaid recipient is enrolled by ODJFS into the PACT program for a minimum of 18 months. ODJFS notifies Medicaid recipients of their enrollment into PACT and, if they disagree with the placement, they can request a State hearing.

PACT participants receive a new Medicaid insurance card that lists the single provider and pharmacy from which the recipient is allowed to receive services. Recipients can be released from the program if a review of services deems them medically necessary; they enroll in a Medicaid managed care plan, or are admitted to a long-term care facility. When the member is released from the program, the primary care physician no longer receives the monthly case management fee. PACT is also used as a program integrity function (see **program integrity section** for more information).

During the audit, comparison data on utilization management cost savings under the PACT program was requested from ODJFS. Initially, the Department stated that it did not track this information. Later, when the information was requested again, the Department indicated that it would not track these costs because the program was intended to improve quality of care, not create cost savings. While quality of care is an essential issue in utilization management, the PACT program was designed to minimize over-utilization of services by controlling access and educating recipients. By extension, this program results in immediate cost savings and, if recipient education efforts are successful, may also result in long-term cost avoidances. Without an understanding of the cost effectiveness of the PACT program, ODJFS is unable to gauge the efficacy of its utilization management effort or compare potential costs savings to other types of utilization management programs that may be in use in other states.

R5.24 The single State Medicaid agency should track and, at least annually, report participation in PACT and the potential cost avoidance generated by member participation in the program. Better coordinated care and a decrease in service over-utilization will not only improve the cost effectiveness of the program, but also enhance recipients' care and potentially produce long-term health benefits for members. (See the program integrity section for further discussion and recommendation regarding the PACT program.)

Academic Medical Center Research

In September of 1995, ODJFS and the Ohio Board of Regents (OBOR) entered into an interagency agreement to promote health services research related to the Ohio Medicaid Program at Ohio's institutions of higher education. Because of this agreement, a Medicaid Technical Assistance and Policy Program (MEDTAPP) committee was formed with representatives from OBOR, the Health Services Research Task Force (HSRTF) of the Ohio Medical School Council of Deans, and ODJFS with overall authority for administering the policy relevant services residing with ODJFS. Since 1996, ODJFS has funded 21 MEDTAPP projects that were completed by one of the following universities: Case Western Reserve University, Miami University, Ohio State University, Ohio University, University of Cincinnati, and Wright State University.

In initiating MEDTAPP, ODJFS sent invitations to Ohio universities to participate in Medicaid-related research projects. The invitations generated substantial interest among the researchers in all universities and, as a result, ODJFS received several strong proposals. The proposals went through a rigorous review process that included the MEDTAPP Advisory Committee, external reviewers, and ODJFS staff. Each proposal was evaluated based on its relevance to the Medicaid Program, the validity of the research design and methods, applicant qualifications and experience, the timeline for completion, and the reasonableness of the proposed budget. Areas of proposed investigation included prenatal care and childbirth, emergency room utilization for infants, behavioral health services, managed care for the disabled population, hospital care,

nursing home care, pharmacy services, risk-adjusted patient outcomes and quality measures. Some of the selected studies are complete and have already provided ODJFS with valuable and much needed information to guide its Medicaid strategies.

MEDTAPP serves as a crucial information source for ODJFS and the Department is committed to making the best use of this joint venture. As ODJFS moves into statewide managed care, the Department must remain very knowledgeable about the health care market place and the needs of its Medicaid recipients. In establishing MEDTAPP, ODJFS and OBOR sought to draw upon the special knowledge and skills of Ohio's scholars to better prepare ODJFS and the sub-recipient agencies for the challenges and opportunities in Ohio Medicaid. Likewise, MEDTAPP can provide valuable insight and alternatives into methods for financing and delivering health services to the State's vulnerable populations.

Most recently, the University of Cincinnati has submitted a proposal to develop technical specifications for measuring physician performance, designing and implementing a pilot program for monitoring the effectiveness of indicators in supporting a physician pay-for-performance system, and conducting fact-finding reviews on quality monitoring. If accepted, this study will provide design information to assist ODJFS in implementing a performance management system to monitor and manage quality of care for managed care Medicaid recipients.

The Center for MassHealth Evaluation Research, a component of the University of Massachusetts Medical School's Center for Health Policy and Research, has collaborated with the Division of Medical Assistance's MassHealth program to complete a number of projects aimed at improving the quality of medical care and related services offered to MassHealth[47] enrollees. The Center for Health Policy and Research's mission is to undertake and promote health policy and health services research as well as related clinical, educational and public service activities aimed at improving the health status of the residents of Massachusetts. These projects not only evaluate and document the status of quality in managed care plans, but also have led to concrete changes in the approach that MassHealth takes to oversee and purchase quality medical care. The collaboration between the Division of Medical Assistance and the Center for MassHealth Evaluation Research has contributed to recognition of the Massachusetts Medicaid program as one of the most progressive in the country, winning national recognition as a model for collaboration between a state agency and a state university.

R5.25 The single State Medicaid agency should expand its use of State universities to research and administer Medicaid-related projects. By using these resources, the Agency will be able to access data and evaluations to help improve the quality of Ohio's Medicaid program. Furthermore, MEDTAPP and similar programs will assist the Agency in collecting critical decision-making information regarding the

[47] MassHealth is the Medicaid program in the state of Massachusetts.

program. As this has been noted as an area of continued weakness, the State Medicaid agency should use all appropriate external resources to increase its capacity to identify, collect, interpret, and report decision-making information.

F. Extended Programs to Assist the Uninsured

Nationally, nearly 46 million Americans, including more than 8 million children, do not have health insurance. Recent studies of the conditions caused by being uninsured found that uninsured Americans are typically sicker during their life span and die younger than those with health insurance. Just one serious illness or injury can wipe out an uninsured family's bank account, causing them to delay seeking care and magnifying the problem as health care costs increase. Eighty percent of the individuals classified as uninsured are working citizens. Individuals without insurance tend to put off preventive[48] and even necessary care, until they require emergency attention. As lower income Americans avoid preventive measures because of the costs, their long-term health costs to the state can skyrocket, eventually placing a larger burden on the Medicaid and Medicare programs. For lower to middle-income individuals and families, the lack of insurance often causes them to choose between seeking medical attention and paying basic expenses such as rent and groceries. Waiting to seek medical attention may worsen medical conditions or cause longer and more acute suffering.

According to *Uninsured in America, Life and Death in the Land of Opportunity,* (Sered and Fernandopulle, 2005), a growing number of Americans have become trapped in what they call the "death spiral." The book describes the strong link between employment and health insurance and states that a "death spiral" occurs when an individual loses health care coverage because of a life event like corporate restructuring, outsourcing, divorce, family crises, chronic illness, and serious accidents. The loss can lead to health concerns going untreated, which can then make the individual less able to work (and obtain health care coverage again) because of the untreated health problems. Alternatively, health problems can lead to problems with employment, making it less likely that an individual will have health insurance that could be used to solve original health issues. Whatever the starting point, once a person enters the "death spiral" and the associated financial hardships of high medical care bills and low income, it is difficult to escape.

Most employers do not offer health insurance to part-time employees and the cost of health insurance is often too expensive for employees that are paid minimum wage to afford. Individuals that do not have, or cannot afford health insurance and are not eligible for Medicaid rely on donated or discounted care. However, the number of health care providers that offer discounted or donated care is declining. As a result, the uninsured usually incur high medical bills and could face insurmountable financial burdens to access needed care. Testimonial evidence presented during stakeholder interviews and several recent studies of working

[48] Preventive care is a set of measures taken in advance of symptoms to prevent illness or injury. This type of care is best exemplified by routine physical examinations and immunizations. The emphasis is on preventing illnesses before they occur.

uninsured persons noted that persons not eligible for Medicaid due to the income requirement are often only a paycheck away from eligibility.

Care Without Coverage: Too Little, Too Late (The Institute of Medicine, 2003) states that uninsured adults are less likely than insured adults to receive recommended health screening services. Health insurance enhances access to appropriate care for a range of preventive, chronic, and acute care services. According to an October 2000 CNN report, 32 percent of women without health insurance for over a year report not getting a mammogram in the past two years. Twenty-six percent of the long-term uninsured with hypertension or diabetes has not had a checkup with a doctor in two years. Among those with access to employment-based insurance, only 89 percent are actually covered by a health-care plan.

A member of the Ohio Association of County Behavioral Healthcare Providers explained the problems faced by the uninsured, particularly when transitioning to work, as follows:

> "If you want to take a look at it long-term or clinically, it doesn't pay to be [part of the] working poor. What we have now is a system that creates tremendous incentive for disabilities. It creates disincentives to abandon that disability. When you have a client in your office who could step up to some improvement, but it will cost them their Medicaid, and they could join the class of the working poor who I can no longer serve, it puts us at a conflict of interest as to what direction we want to take. Do I want to create a situation for them where they become an uninsured person, particularly if they have children or something like that, and they can no longer receive the services that have kept them stable and enabled them to move to the point where they become employable? Congratulations, your improvement just earned you abandonment by this agency. That's not only bad for them, but that puts us in a bad situation. … What do I …recommend here?"

The Government Finance Officers Association (GFOA) approved a health care reform policy in May 2006. The policy urges the federal administration and Congress to work together with state and local governments on initiatives to reform the nation's health care delivery system in order to contain the growth of health care costs and expand access to health care. The cost of uncompensated and under-compensated health care shifts to employers who provide health insurance coverage as well as to individual purchasers of health insurance.

Donated Care

A number of states have implemented programs to provide the uninsured population with healthcare services. These programs are creative solutions to a growing public health issue. They include donated care, discounted care, Medicaid buy-in programs, premium assistance programs, high-risk pools, and group purchasing agreements.

Donated care is a model that can be used to assist uninsured individuals. Under donated care, participating physicians and other providers, such as dentists, agree to see a certain number of patients or provide a certain number of visits each year at no cost. This model was created to coordinate and formalize the provision of charity care. The goal of this model is to provide some

structure to the charity care that physicians provide, encourage more physicians to participate in charitable activities, and provide a central point of contact for medically uninsured patients.

Federal law requires hospitals to provide, without charge, basic medically necessary hospital-level services to all individuals who arrive through the emergency department under the federal Hospital Care Assurance Program. If the individual is not able to pay for the service, the hospital donates the care. A large portion of the uninsured population uses the emergency department as their primary provider for medical and dental services, although hospitals are not equipped to conduct disease management, like a primary care physician or dentist. With the recent decrease[49] in the Ohio Healthy Families income requirement, more people will be using emergency department services as their regular method of health care.

According to *Proportion of Doctors Giving Charity Care Declines* (The Washington Post, March 23, 2006), the proportion of U.S. physicians providing charity or donated care has steadily declined over the past decade. Less charity care in the doctor's office means more demands on hospital emergency departments. Service rendered in hospital emergency departments, where many uninsured people receive care, is among the most expensive care and adds to the high cost of operating trauma units, burn units and other critical services that communities need. As the uninsured problem grows larger, many of the uninsured fall outside the qualifications for charity care because of income guidelines. At the same time, the price of health care in the nation is rising because providers deliver high-quality care that uses cutting-edge technology. Medicare and Medicaid, hospitals' largest insurers, pay less than the cost of care, while health maintenance organizations, managed care plans, and other insurers use their market power to negotiate deep discounts. One in three hospitals are losing money and many more are struggling, at the expense of self-pay patients who do not receive discounts.

The American Hospital Association asked for and received permission from the federal government to offer discounts for people with limited means, without the fear of violating federal anti-kickback statutes. In February 2004, a letter to the American Hospital Association from the U.S. Department of Health and Human Services stated unequivocally that hospitals are permitted to provide discounts to uninsured and underinsured patients who cannot afford their hospital bills. The federal Office of Inspector General believes that hospitals have the ability to provide relief to uninsured and underinsured patients.

Ohio Administrative Code § 5101:3-2-07.17, reiterates the federal Hospital Care Assurance Program and states that hospitals are required to provide, without charge to the individual, basic, medically necessary hospital-level services to all Ohioans with incomes at or below the federal poverty level. The federal Hospital Care Assurance Program offers some financial relief to hospitals that provide donated care but many people above the federal poverty level still lack the financial ability to pay for needed health care. In 2003, Ohio hospitals actually provided more

[49] The decrease is a result of a change in the Ohio income guidelines from 100 percent of federal poverty level to 90 percent of federal poverty level.

donated care to individuals above the poverty level than those below the poverty level. Without health insurance, individuals often put off needed health care services until their conditions worsen and they require emergency room care, putting their health at a greater risk and making the cost of care much higher.

Within Ohio, several county-specific programs provide health care services to a portion of the uninsured population that are not affiliated with Medicaid or the State of Ohio. Access Health Columbus is a non-profit organization that works with providers to supply health care services to uninsured residents of Franklin County under the Voluntary Care Network Program. Access Health has received funding from various sources. To be eligible for the program, participants must have an annual income of less than $19,140 for an individual or $25,660 for a couple, and be a resident of Franklin County living in one of several zip codes (43204, 43206, 43207, 43215, 43222, and 43223). The program provides healthcare from doctors and hospitals, transportation to doctor visits, a medical interpreter, and affordable prescriptions.

The Hospital Council of Northwest Ohio, in January 2003, implemented a program called CareNet.[50] This program was designed to provide healthcare to uninsured Lucas County residents. CareNet is a collaborative, community-based model that uses the strengths of existing community resources to tackle the access issues of awareness, coordination, cost, and transportation. CareNet members receive a membership identification card that is renewable every six months. Persons may apply for the program at one of CareNet's eight enrollment sites where enrollment workers first determine if an individual is eligible for public healthcare programs such as Medicaid. If no other source of coverage is available, and the applicant meets income guidelines, they are enrolled into CareNet.

To be eligible for CareNet members must be residents of Lucas County for more than six months, earn no more than 200 percent of the federal poverty level, and be ineligible for private insurance. CareNet providers donate healthcare services or provide services on a sliding fee schedule. The sliding-scale fee is used for hospital-based radiologists, pathologists, emergency medicine physicians, and anesthesiologists. Participating hospitals provide care at no cost to CareNet members. CareNet success is measured by the number of applicants identified as eligible for public healthcare coverage, the number of CareNet members enrolled, service utilization, and member satisfaction.

[50] The American Hospital Association presented CareNet with the 2005 NOVA award. The NOVA award recognizes hospitals and health systems for collaborative efforts to improve community health. CareNet also received the 2005 Ohio Hospital Association Meritorious Service Award for supporting healthcare that reflects the public interest.

Discounted Care Programs

Another way to offer healthcare to the uninsured is through discounted care programs. Private providers agree to provide health care services at discounted rates to those willing to pay for a discount card. Discounted care programs are usually privately sponsored and administered by a nonprofit organization that is affiliated with community health clinics. Discounted care differs from charity care and typically attracts the working uninsured. Community-based groups in Ohio have implemented limited discount programs, as described above under donated care. In addition, federally qualified health centers and rural health centers (FQHCs and RHCs) provide discounted care on a sliding scale as required under federal regulations.

Healthcare Connect, a medical discount program in Phoenix, Arizona, is a nonprofit organization that assists low-income uninsured residents of Maricopa County in obtaining coordinated health care at affordable rates. Members pay an enrollment fee and receive discounted office visits, hospitalization, laboratory services, radiology services, dental services, prescription services, and vision services. Members of the Healthcare Connect program are charged 50 percent of the Medicare rate. In general, physicians in these programs are members of a hospital or physicians association and donate or discount care as a component of charitable activities conducted by the membership. In other cases, physicians are affiliated with hospitals that provide discounted care.

Health Choice Network in Miami, Florida is a discount medical plan that provides individuals who are uninsured or underinsured with discounts for certain providers for medical services. This program was created to address the health care needs of the working uninsured and underinsured in Miami, Florida. Individuals that cannot afford regular health insurance for various reasons including income, age, migratory and residency status can benefit from this program. Members pay a monthly membership fee to Health Choice Network.

Buy-in Programs

A Buy-in program for the uninsured provides Medicaid or Medicaid-like coverage to the uninsured. A buy-in program is similar to private health insurance plans in which an individual purchases health insurance coverage. Recipients pay monthly premiums and/or co-pays for a standard set of benefits. Buy-in programs[51] must be federally approved through either a regular Medicaid 1115 waiver or a Health Insurance Flexibility and Accountability (HIFA) waiver. Most states are funding their buy-in programs with unspent SCHIP dollars or a combination of Medicaid and SCHIP funds. States also have the option of using unspent or diverted Disproportionate Share Hospital (DSH) dollars. DSH funds are used to provide supplemental support to safety net hospitals.

[51] Under the Balanced Budget Act of 1997 or the Ticket to Work and Work Incentives Improvement Act of 1999, some states have established Medicaid Buy-in programs for persons with disabilities. These programs provide incentives for people with disabilities to continue to work without the fear of losing Medicaid coverage if they earn too much income.

According to the Florida Office of Program Policy Analysis and Government Accountability, 19 states and the District of Columbia have designed new Medicaid options to increase health care access for uninsured individuals who do not usually qualify for Medicaid. The programs typically offer healthcare to uninsured parents or caregivers of children who are enrolled in the state's SCHIP program or other low-income working age adults. States have implemented a variety of strategies to address their uninsured populations. Each state determines its program's structure, including eligibility, service delivery, cost-sharing, and benefit provisions. **Table 5-17** lists the states that have implemented Medicaid buy-in programs for non-eligible individuals.

Table 5-17: States with Buy-In Programs to Expand Insurance Coverage

State	Waiver Authority	Funding Source(s)	Population Covered	Cost-Sharing	Benefits Package
Arizona	HIFA	Reallocated SCHIP and DSH funds	Childless adults with incomes up to 100% FPL and SCHIP/Medicaid parents with incomes from 100% – 200% FPL	Premiums and co-payments based on income	Same as SCHIP
California	HIFA	Reallocated SCHIP funds/tobacco settlement funds	SCHIP and Medicaid parents with income under 200% FPL	Premiums and co-payments based on income, premium assistance option	Similar to SCHIP
Colorado	HIFA	Reallocated SCHIP funds	Uninsured pregnant women with income at or below 185% FPL	Premiums and co-payments similar to SCHIP requirements	Prenatal benefit package
District of Columbia	1115	Medicaid	Childless adults age 50-64 with incomes at or below 50% FPL	None	Same as Medicaid
Hawaii	1115	Reallocated SHIP, Medicaid	Non-categorical adults with incomes at or below 100% FPL and adults with incomes below 300% FPL who lose Medicaid eligibility	Premiums, co-payments, and deductibles based on income	Limited Medicaid
Illinois	HIFA	Medicaid and reallocated SCHIP funds	SCHIP parents with incomes up to 185% FPL	Same as Medicaid/SCHIP, depending on income, premium assistance option	Same as Medicaid
Maine	HIFA	Redirected DSH payments	Childless adults with incomes at or below 125% FPL	Co-payments as required by Medicaid	Same as Medicaid
Massachusetts	1115	Medicaid and redirected DSH payments	Eight different eligibility groups including parents and childless adults with incomes at or below 133% FPL (those under 200% FPL are eligible for premium assistance), long-term unemployed at or below 100% FPL, and emergency services to undocumented immigrants	Premiums and co-payments based on income, premium assistance option	Similar to Medicaid
Michigan	HIFA	Reallocated SCHIP funds	Childless adults with incomes at or below 35% FPL	Co-payments are required only for some services and prescription drugs.	Same as SCHIP
Minnesota	1115	Reallocated SCHIP funds	Medicaid and SCHIP parents with incomes up to 275% FPL, childless adults up to 175% FPL	Premiums and co-payments based on income	Same as Medicaid
Montana	1115	Reallocated SCHIP funds	Parents/Caregivers of dependent children, aged 21-64 and not pregnant/disables with incomes at or below 185% FPL	Same as Medicaid depending on income	Limited Medicaid package

New Jersey	HIFA	Reallocated SCHIP funds (Medicaid funds used if allotment insufficient)	SCHIP parents with incomes at or below200% FPL	Premiums and co-payments required for those above 150% FPL, premium assistance option	Same as SCHIP
New Mexico	HIFA	Reallocated SCHIP funds	SCHIP and Medicaid parents and childless adults with incomes up to 200% FPL	Premiums required only for those over 100% FPL, co-pays required for all enrolled	Similar/Limited Medicaid
New York	1115	Medicaid and redirected DSH payments	Childless adults at or below 100% FPL and parents at or below 150% FPL	None	Same as Medicaid fee-for-service plan
Oregon	HIFA	Reallocated SCHIP funds	SCHIP and Medicaid parents and childless adults with incomes up to 185% FPL	Premiums and co-payments based on income, premium assistance option.	Two beneficiary levels: (1) full Medicaid/SCHIP and (2) reduced benefits.
Rhode Island	1115	Medicaid	Parents with incomes up to 185% FPL	Premiums based on income, premium assistance option	Same as Medicaid
Tennessee	1115	Medicaid	The state established different benefit levels for Medicaid eligibility and the expansion population. A Tennessee advocacy group brought suit against the state. The state agreed in federal court not to implement different benefit packages and to keep benefits intact. More people became eligible for the program than the state projected and as a result, Tennessee was given federal approval to disenroll 323,000 individuals in the optional and expansion groups.		
Utah	1115	Medicaid	Adults with incomes up to 150% of the FPL	Enrollment fees, co-payments, and/or co-insurance based on income, premium assistance option	Similar/Limited Medicaid
Vermont	1115	Medicaid and redirected DSH payments	Medicaid parents with incomes up to 185% FPL. Adults with incomes up to 150% of the FPL.	Enrollment fees, premiums, and co-payments based on income	Same as Medicaid
Wisconsin	1115	Medicaid and reallocated SCHP funds	Custodial parents and spouses with incomes at or below 200% of the FPL.	Families with incomes over 150% FPL must pay 5% premium, no co-pays or deductibles, premium assistance option	Same as Medicaid

Source: Office of Program Policy Analysis and Government Accountability Report 05-62 (December 2005)
Note: The 2006 federal poverty level for an individual is an annual income of $9,800.

As illustrated in **Table 5-17**, many states have used waivers to expand health insurance coverage (see **service provision** for more information on types of waivers). In general, most states provide buy-in coverage that is the same as Medicaid. In addition, just over half of the states (60 percent), reallocated SCHIP funds, 25 percent have reallocated disproportionate share payment,

and two states (10 percent) are using tobacco settlement funds. Nine states (45 percent) created their buy-in programs under HIFA authority while 11 (55 percent) used 1115 waiver authority.

Ohio has a program referred to as a buy-in program. However, this program is restricted to individuals who are income-guideline eligible but cannot afford their Medicare premiums. In these cases, ODJFS will pick up a portion of the entire amount of the Medicare premium, as well as co-payments and/or deductibles. Participants in this program are referred to as qualified Medicare beneficiaries. However, the ODJFS program does not constitute a true buy-in program (see **service provision**).

A member of ARC of Ohio spoke about the importance of Medicaid buy-in programs in other states saying, "Minnesota, Illinois, Indiana and I think Pennsylvania.... They all have very good programs." The member highlighted the strengths of programs in several other states as well. A member of the Ohio Association of County Behavioral Healthcare Providers also remarked on the importance of buy-in programs.

> "While we talk a good talk about consumers going back to work and many of us have programs to encourage that, this State still does not have Medicaid buy in. Until we have Medicaid buy in, in good faith I cannot say to consumers, "Gee, it's a good thing for you to do. Never mind you are going to lose your benefits and getting either no benefit or a [lousy] benefit." States that have Medicaid buy in can, in good faith, encourage people to go back into the job market, be successful and eventually leave Medicaid."

Other stakeholders remarked on the potential importance of a buy-in program, including members of the Universal Healthcare Action Network, the Ohio Developmental Disabilities Council, and the Ohio Coalition for Health Communities. A member of the Ohio Coalition for Healthy Communities said, "Without the buy-in, it is a disincentive to work, and a disincentive in the recovery process...." The Coalition member elaborated saying, "Being a mental health consumer shouldn't have to be a lifetime designation ... but because the treatment for many of this disorders require long-term medication regimens and the medications are expensive, [a buy in is] the only way to maintain the benefits until they ... obtain a job that may offer them some sort of health care...." The member concluded, "having [an] option would certainly create an incentive for folks."

Premium Assistance

Premium Assistance is a health insurance purchasing strategy in which a state uses public funds to pay for a portion of the premium costs of employer-sponsored insurance. Premium assistance programs can be implemented under a Medicaid waiver, the Health Insurance Premium Payment program, or some other mechanism. (See the **service provision** section for detailed waiver

information.) Sixteen states[52] have implemented premium assistance programs; however, Ohio is not among them. Individuals that would benefit from this type of program are people that are not eligible for Medicaid and have employer-sponsored health care available, but cannot afford it due to the cost.

In 2002, Utah received approval from CMS to make changes to its Medicaid program. Utah implemented two new programs: Primary Care Network and Covered at Work, a premium assistance program. These programs gave options to the low-income population that did not have insurance or could not afford the insurance offered by their employer. Primary Care Network expanded coverage to low-income parents and other adults who were not eligible for Medicaid. Adults must have income below 150 percent of poverty, be uninsured, and have no access to employer-sponsored insurance. Primary Care Network enrollees received primary care services, specialty care, mental health services, and limited drug coverage. Enrollment for this program was capped at 19,000 and was full within the first 18 months of operation.

Covered at Work assists adults who would be eligible for the Primary Care Network but have employer-sponsored insurance available. Participants receive subsidies for premium costs for up to five years. The subsidy is paid directly to the employer or insurer. The enrollment for this program has a maximum enrollment of 6,000 but enrollment has been very limited and less than 100 individuals had taken advantage of the program in its first year of operation. **Table 5-18** outlines the programs administered through Utah's Medicaid system.

[52] The states that have implemented premium assistance are California, Georgia, Illinois, Iowa, Maryland, Massachusetts, Missouri, New Jersey, New York, Oregon, Pennsylvania, Rhode Island, Texas, Utah, Virginia, and Wisconsin.

Table 5-18: Expanded Medicaid Program Options, Utah

	Traditional Medicaid	Non-Traditional Medicaid	Primary Care Network	Covered at Work
Eligibility	Elderly, blind, and disabled <100% FPL Children 0 – 6 <133% FPL Pregnant women <133% FPL Children 6 – 18 <100% FPL Women with breast and cervical cancer	Parents with incomes below TANF eligibility levels (0-54% FPL) Parents eligible for TMA Parents with high medical expenses who "spend down" to qualify	Parents 50 – 150% FPL Other adults 0 – 150% FPL (Age 19-65, uninsured for ≥ 6 months, no access to employer-sponsored insurance.)	Parents 50-150% FPL Other adults 0-150% FPL (Age 19-65, uninsured for ≥ 6 months, no access to employer-sponsored insurance.)
State Can Cap Enrollment	No	No	Yes	Yes
Enrollment Fees/ Premiums	None	None	$50 annual fee (lower for some eligible adults)	Premium costs that exceed subsidy
Benefits	Full State Medicaid Benefit Package	Some limits not found in Traditional Medicaid, for example: • No coverage of non-emergency transportation • 30 inpatient and 30 outpatient days per year for mental health services • 16 visits per year for physical therapy and occupational therapy, combined • $30 vision benefit limit, no coverage of eyeglasses • Dental care limited to relief of pain and infection	Primary care services only; no coverage for hospital (other than emergency) or specialty care. Limits on covered services: • 4 drugs per month • Durable medical equipment only covered for recovery needs • $30 vision benefit limit, no coverage of eyeglasses • Dental care limited to preventive care	$50 a month subsidy for an individual or $100 a month subsidy for a family for up to two years. Decreasing subsidy amounts for an additional three years.
Co-payments	For non-pregnant adults: $2 - $6 for some services and $220 per hospital admission. Services can be denied based on inability to pay.	$2 - $6 for some services and $220 per hospital admission. Services can be denied based on inability to pay. $500 out of pocket maximum per year.	$5 - $30 co-pays and 5% - 10% coinsurance for some services Services can be denied based on inability to pay. $1,000 out of pocket maximum per year.	Vary based on subsidized private plan.

Source: Kaiser Commission on Medicaid and the Uninsured (March 2006)

As illustrated in **Table 5-18**, Utah has expanded its Medicaid system to offer healthcare to the non-eligible Medicaid population. The expanded options cover adults and children with income up to 150 percent of the federal poverty level. Although the programs offer only limited services and pharmaceuticals, they provide health care coverage options to adults who may not meet

income guidelines for Medicaid. In addition, some of the programs require annual fees or co-payments. However, as discussed above, the Primary Care Network has enjoyed far greater popularity than the Covered at Work Program.

Reinsurance Programs

State government-provided *reinsurance*—essentially, insurance for insurance companies—can relieve health insurers of the risk of "adverse selection" (disproportionate enrollments of individuals with extraordinarily high medical costs), particularly in the small group and individual markets. With such programs in place, insurers may significantly lower premiums, thereby making health coverage affordable for more people. These programs stabilize health insurance markets and maintain or increase health insurance coverage. A reinsurance program can be used to reduce premiums by shifting some of the expenses for high-cost enrollees to a third party. Reinsurance programs are sometimes linked to other strategies, such as those discussed above, to make health care coverage more affordable. Six states offer reinsurance programs: Arizona, Connecticut, Idaho, Massachusetts, New Hampshire, and New York. Ohio does not have a reinsurance program.

High Risk Pools

High-risk Pools are typically state-created, nonprofit associations that offer health insurance benefits to individuals who are uninsurable in the private market due to chronic or catastrophic pre-existing health problems. Even though most Americans obtain their health insurance through their employer or the employer of a family member (group health insurance), some people do not have access to this type of coverage and must buy their own insurance independently. Unlike the group health insurance market, in most states an insurer can turn you down for individual coverage if you have a serious pre-existing medical condition (e.g., cancer or HIV) that would make you uninsurable. States are not required to have an alternative option for medically uninsurable individuals to access coverage, although most do. Thirty-three[53] states provide coverage to medically uninsurable people through high-risk health insurance pools. These pools serve a small but very critical portion of a state's population. Pools provide an important safety net for people with catastrophic medical conditions who do not have access to employer-based group health insurance, such as early retirees, self-employed individuals, and employees of businesses that do not offer health insurance coverage. High-risk pools are one approach used by states to address the issue of uninsurable individuals.

A High-Risk Pool bill was introduced in the Ohio Senate in the fall of 2003 and was referred to committee. The Ohio Department of Insurance contracted with Leif Associates, Inc to conduct a

[53] The states that have high risk pools are: Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Florida, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Mexico, North Dakota, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Washington, Wisconsin, and Wyoming.

High Risk Pool Feasibility Study to determine whether a qualified high-risk pool would be an appropriate model for providing health care coverage to federally eligible individuals and uninsured Ohioans. According to Leif Associates Inc, implementing a high-risk pool option in Ohio could have the following population and market impacts:

- A high risk pool could reduce the number of uninsured individuals in Ohio;
- Estimated enrollment would be 17,250;
- Approximately 1,800 individuals would move to the high-risk pool from open enrollment plans. These individuals would have little or no rate impact on the individual insurance market;
- There would be no movement from Medicare or Medicaid to the high-risk pool;
- There would be no movement from the group insurance market to the high-risk pool due to the fact that individuals eligible for employer provided coverage would not be eligible for high-risk pools; and
- A reduction in the number of uninsured individuals would be beneficial to the provider community since there would be less uncompensated care.

According to the Ohio Association of Health Underwriters, the study emphasizes what the Association asserted about the feasibility of a high-risk pool for Ohio. The high-risk pool would be a tremendous asset to its targeted population. It would help those who, through no fault of their own, find themselves uninsured or uninsurable. The Association indicated that the high-risk pool would be a substantial step in reducing the number of uninsured by helping those Ohioans who are uninsured and uninsurable acquire health care. The Association estimated the cost to operate this program at about $19 million.

Senate Bill 272, introduced to the Ohio General Assembly in February 2006, would establish a Health Insurance Risk Pool. This program would serve as a means of providing health care coverage to individuals who are unable to obtain affordable health care coverage due to high-risk medical conditions. It would have the authority to enroll Ohioans in the plan and to charge premiums for coverage within certain limits. However, this bill was assigned to committee and has not been brought to the floor.

The U.S. Senate Health, Education, Labor, and Pensions Committee approved U.S. Senate Bill 288 in February 2005. The legislation authorized $15 million for FFY 2004-05 and 2005-06 for states establishing new high-risk pools. Ohio has not accessed these funds.

Group Purchasing Arrangements

Group purchasing arrangements are public or private efforts to allow more than one employer and/or individuals to pool together to collectively purchase health insurance. Nine states[54] have implemented group purchasing arrangements; however, Ohio is not among them. As recently as May 2006, Senate Bill 5 was proposed in the Ohio General Assembly that would make changes to the statutes governing small employer health care alliances and establish the regulation of discount medical plans by Ohio Department of Insurance. This would increase the number of small employers eligible to join a small business employer health care alliance and make health insurance more broadly available. This bill was reported out of committee in May but was not brought to the floor for a vote as of August 15, 2006. **Table 5-19** shows the different types of group purchasing arrangements that may be public or private organizations. The differences in goals and functions of these organizations leads to varying arrangements which provide differing opportunities.

[54] States that have Group Purchasing Arrangements include: Arkansas, California, Kansas, Montana, New Mexico, New York, Texas, West Virginia, and Wisconsin.

Table 5-19: Types of Group Purchasing Arrangements

Group Purchasing Arrangements (GPA)	Health Insurance Purchasing Coalitions (HIPCs)/Employer Alliances	Association Health Plans (AHPs)	Multiple Employer Welfare Arrangements (MEWAs)
Primary Purpose	To buy or provide health insurance to small businesses and/or self-employed people.	To meet various business goals; these health plans are offered by professional and trade associations as one of many benefits to their members.	To provide health coverage to employees of two or more employers or self-employed individuals, according to federal law. HIPCs, alliances, AHPs, and any other group purchasing arrangement may also be considered MEWAs for purposes of federal law.
Eligibility Requirements	Any employer may enroll as long as the employer meets size qualifications	One must be a member of the association. Associations may restrict membership to a particular trade or industry, or may permit any employer or individual to join.	Varies depending on whether the arrangement is a HIPC, an AHP, or another type of GPA.
State Legislation Needed	Authorizing statue is needed	Specific legislation is not required.	Authorizing statue is not needed because MEWAs are defined by the federal Employee Retirement Income Security Act of 1974.
Private/Public Arrangements	These could be private or quasi-government pools managed by a state agency.	Private	Public or Private
Examples	Healthcare Group of Arizona	California Society of Certified Public Accountants Group Insurance Trust	Healthcare Group of Arizona and the California Society of Certified Public Accountants Group Insurance Trust.

Source: AcademyHealth, *Group Purchasing Arrangements: Issues for States* (April 2003)

As illustrated in **Table 5-19**, of the three types of group purchasing arrangements, only one of the arrangements is private. The Multiple Employer Welfare Arrangements (MEWA) could be a public or private arrangement, while the Health Insurance Purchasing Coalitions (HIPC) could be public or quasi-governmental. Regardless of the type of arrangement, each allows small business employers to offer health coverage to their employees.

Although the General Assembly, stakeholder advocacy groups, and ODJFS are aware of the variety of programs for the uninsured, only limited headway has been made toward implementing additional programs. Since the State has recently struggled through lean financial times, the limited promotion of these programs is not surprising. However, State leaders frequently cite the need to increase economic development within the State and recent studies have linked the available of medical care and the corresponding health of the population to desirability in business development. If uninsured or underinsured individuals have access to health care, they would have the ability to receive preventive services and improve their long-term health outcomes. This would reduce both immediate emergency room costs and perhaps defray the high costs of severe long-term illness later in life – costs that are often born by the

State. The Ohio Senate has made tentative forays into examining expanded programs for the uninsured but additional attention in this area may be required to raise community and political awareness of the benefits of these programs.

R5.26 The General Assembly and the Governor, with the assistance from appropriate State agencies, should consider implementing a High-Risk Pool program for uninsured Ohioans. Ohio should also seek funding available under U.S. Senate Bill 288. The High-Risk Pool program should use the research completed by Leif Associates as a basis. The program would help Ohioans who suffer from chronic or catastrophic illnesses and are uninsurable obtain medical coverage and experience some financial relief from high medical costs. By implementing this program, Ohio would be joining 33 other states that have covered uninsurable individuals with catastrophic conditions who would financially affect the Medicaid system. Also, providing viable insurance options to Ohio's high-risk uninsured would help reduce the impact of high claims costs on the Medicaid system.

R5.27 The Medicaid agency should apply for an 1115 demonstration waiver to implement a Premium Assistance/Covered at Work program for uninsured Ohioans. The Premium Assistance/Covered at Work program would be for individuals (parents and childless adults) who are not eligible for Medicaid and cannot afford employer-sponsored health insurance. The State Medicaid agency should design the program with the goal of making preventive and primary care services available to a portion of the uninsured population.

R5.28 Upon reorganization of the Ohio Medicaid Program (as discussed in the organizational issues section), the single State Medicaid agency should use MEDTAPP to examine current programs for the uninsured in Ohio and determine their financial impact, and the impact of the uninsured on Medicaid. Using this data, the State Medicaid agency should develop pilot programs to test the viability of alternatives for the uninsured and study the costs and benefits of these programs. Based on evaluations of the pilot programs, the State Medicaid agency should take a proactive approach by making recommendations, supported by data-driven evidence, to the General Assembly concerning the addition of programs for the uninsured in Ohio. See also the organizational issues section for a discussion of the option of placing the Medicaid program within a health agency and its potential impact on the care of the uninsured.

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Technology and Program Management

Technology and Program Management Section Table of Contents

Background

This section focuses on the technology functions within the Ohio Medicaid program. The scope includes assessments of claims pre-processing activities; interfaces between systems maintained within the Ohio Department of Job and Family Services (ODJFS); interfaces with systems maintained by other State agencies; data warehousing and decision support functions; user support and problem reconciliation; and long-term technology planning and coordination. The objective is to analyze the current architecture of Medicaid information technology and to develop recommendations which will improve coordination and allocation of information technology (IT) resources. The recommendations will provide a framework for building an infrastructure for the Medicaid program which can easily adapt to fluctuations in federal requirements, program objectives, and industry trends. Where viable, recommendations include basic analysis of the political, environmental, and social factors which may impact the implementation of the recommended changes. Comparisons were made between existing conditions and recognized best practices from both inside and outside the public healthcare industry.

The Office of Management Information Services (MIS) is responsible for the management and support of ODJFS' information technology resources. These resources include the primary Medicaid information systems, the Client Registry Information System-Enhanced (CRIS-E), and the Medicaid Management Information System (MMIS). CRIS-E is the statewide system which assists County Departments of Job and Family Services (CDJFS) caseworkers in determining eligibility and calculating benefits for a number of State public assistance programs. CRIS-E supports the following offices and their respective programs within ODFJS:

- Office of Health Plans (OHP) – Medicaid and Disability Medical Assistance;
- Office of Family Stability (OFS) - Food Stamps and Temporary Assistance for Needy Families;
- Office of Children & Families (OCF) – Title XIX;[1] and
- Office of Research, Assessment, and Accountability (ORAA).[2]

MMIS is the central Medicaid information system. The primary function of this system is to process and adjudicate fee-for-service claims. MMIS also serves as a channel for transferring information between 14 ODJFS-maintained systems and databases as well as 7 systems and databases operated by other State agencies.[3]

[1] The Title XIX program permits Medicaid funds for several health related child welfare services.
[2] ORAA does not support a public assistance program, but rather the audit and program integrity functions of the programs.
[3] Ohio Department of Alcohol and Drug Addiction Services (ODADAS), Ohio Department of Mental Health (ODMH), Ohio Department of Mental Retardation and Developmental Disabilities (ODMRDD), Ohio Department of Aging , The Ohio Attorney General (AG), The Ohio Auditor of State (AOS), and the Ohio Department of Administrative Services (DAS).

The CRIS-E and MMIS systems are the two most critical systems to the operations of Ohio Health Plans (OHP), the ODJFS office that administers the Medicaid program. Therefore, these systems and their roles are the primary focus of this section of the report. However, the following State agencies also manage claims processing and case management systems that were examined in the context of their relationship with MMIS.

- Ohio Department of Aging (ODA);
- Ohio Department of Mental Health (ODMH);[4] and
- Ohio Department of Mental Retardation and Developmental Disabilities (ODMRDD).

MMIS History and MITS Implementation

MMIS is a legacy[5] mainframe system that has been in use since the late 1980's. In June 2004, ODJFS, the State Medicaid agency, and the Centers for Medicare and Medicaid Services (CMS) signed an agreement that Ohio would be an early adopter and pilot the Medicaid Information Technology Architecture (MITA) initiative developed by CMS. This project will result in the design, development, and implementation of a new Medicaid Information Technology System (MITS) which will replace MMIS with a solution which meets the following MITA requirements:

- Industry based, open architectural standards;
- Modular components;
- Relational database;
- Rules engine management;
- Data privacy, security and integrity, with access limited by staff role; and
- Interoperable systems that support e-communication and processing between systems.

The MITS project is being conducted in five stages:

- **Phase I, Business Case:** In 2003, ODJFS contracted with Deloitte Consulting to assess the current state of systems operations and make recommendations regarding the future state of the system. Deliverables included documentation of "as-is" current processes and documentation of the "to-be" future operations. This phase was completed in June 2004.

- **Phase II, Business Requirements:** Concurrent with Phase I, ODJFS contracted with Deloitte Consulting to develop the business requirements and identify options for implementing the new system. During this phase, an MMIS system demonstration was

[4] ODMH operates a shared system with the Ohio Department of Alcohol and Drug Addiction Service.
[5] A legacy system is an existing system or application which continues to be used after an organization has implemented more modern technology.

conducted, procurement planning was coordinated, and requirements analysis involving approximately 230 staff from Ohio Health Plans (OHP) was conducted.

- **Phase III, Procurement:** In conjunction with the Ohio Department of Administrative Services (DAS), ODJFS created a request for proposal which was approved by CMS in May 2005.

- **Phase IV, Design Develop Implement:** The focus of this phase is to adopt a transfer system to support the specific needs of the Ohio Medicaid program. During this phase the "to-be" system designed in Phase I will be implemented. The target completion dates will be determined once a vendor is selected.

- **Phase V, Ongoing Operations:** The new system will support outside vendor or in-house models for ongoing operations. The current plan is for in-house program operation, facilities management, and system operation as well as vendor maintenance and support.

The MITS project is currently in Phase III. ODJFS is reviewing the submitted bids with the intention of selecting a vendor by January 2007. Formal timelines for the implementation of the system will be established once a vendor has been selected.

MMIS Claims Processing and Adjudication (Current Process)

In 2005, ODJFS processed approximately 63.5 million claims through the MMIS system. All submitted claims were entered by one of two processes: direct entry or hard copy paper form. Direct entry is an electronic process which allows claims to be submitted in one of three formats:

- Electronic Data Interchange (EDI);
- Cartridge Tapes (C-Tape); and
- Point-of-Sale (POS).[6]

Prior to being entered into MMIS, all claims except POS must be converted to a legacy format which is acceptable to the MMIS system. This is called pre-processing. Claims pre-processing for each type of claim (except POS) are shown in **Chart 6-1**.

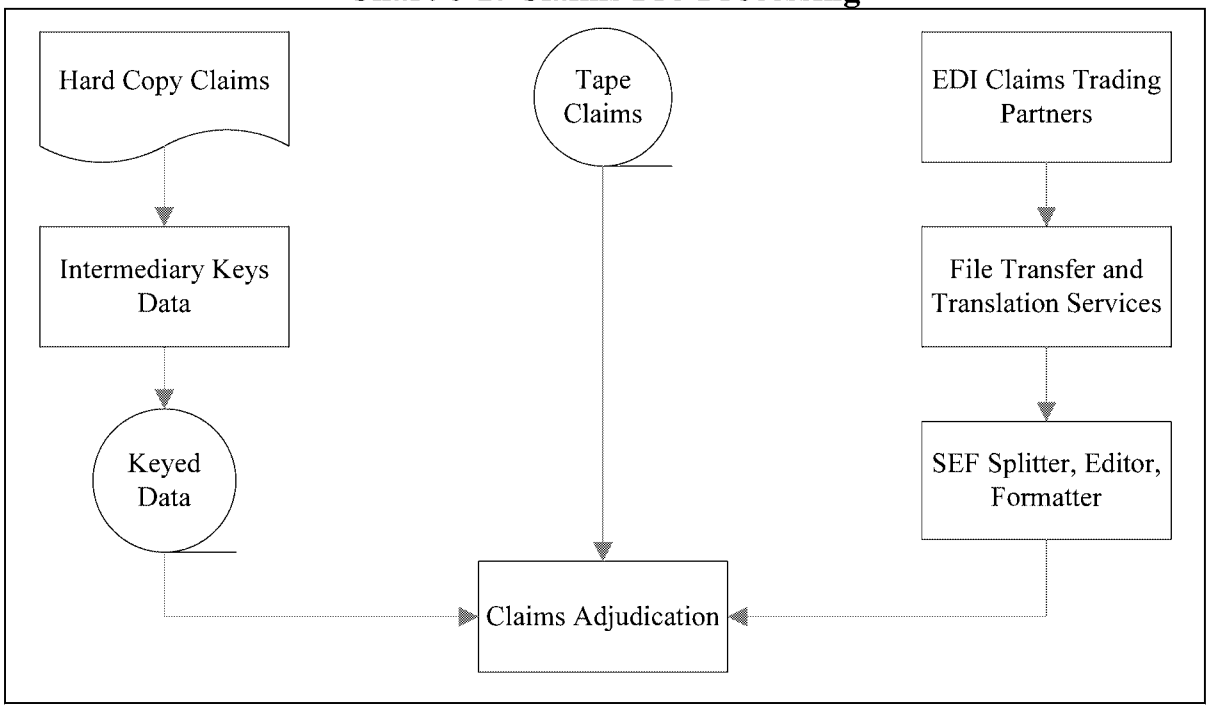
Hard copy (paper) claims are converted into an electronic format by manual data entry or optical character recognition (OCR), where a machine reads the claim into the computer. Claims are then converted to the legacy format and placed on a cartridge tape or transmitted electronically. Currently, these processes are performed by third-party intermediaries. Tapes are then loaded into MMIS for adjudication.

[6] Pharmacy claims only.

Some providers have systems which can generate claims in the required format directly on C-Tape. These tapes are then delivered to ODJFS via courier. Once received by ODJFS, tapes are loaded directly into MMIS for adjudication. However, these C-Tape conversion systems are very costly to maintain and are generally based on outdated technologies. Therefore, few providers maintain systems with this capability and submit claims in this format (as evidenced by **Table 6-3**).

For EDI claims submissions, providers submit claims to an approved third-party agent called a trading partner. The trading partner then combines claims from other providers to create batches of similar claims which are converted to the Standard Exchange Format (SEF). These SEF files are then submitted to the Ohio Medicaid Claims Clearinghouse, operated by Healthcare Transaction Processors, Incorporated. Healthcare Transaction Processors performs file transfer and translation services on behalf of ODJFS. Transfer services include accepting the claims from providers and billing agents and then relaying the remittance from ODJFS once the claim has been adjudicated. Between these file transfers, Healthcare Transaction Processors performs a translation service in which the fields in the SEF formatted claims are split-up, edited, and reformatted. This serves to "map" the original claims data format to the legacy format required by the MMIS system. Translation also includes a review for compliance with the Health Insurance Portability and Accountability Act (HIPAA). Once claims are converted and reviewed, they are submitted to MMIS for adjudication.

Chart 6-1: Claims Pre-Processing



Source: Ohio Department of Job and Family Services

As claims are processed through MMIS, they are reviewed by a series of complex systems edits designed to ensure that payments are accurate and allowable under the Medicaid program, based on the type of claim, service, and the service provider. The edits identify claims as they are processed to be paid, denied, or suspended (put on hold for review). This process is known as adjudication. **Chart 6-2** shows the adjudication process, and the major system edits are explained in greater detail below:

- **Data Validity:** This edit is a high level check to ensure that every data field is completed and has a legitimate data definition.

- **Recipient Eligibility:** At this stage, the MMIS system reviews the claim to ensure that the recipient of the service was Medicaid eligible at the time the service was rendered. This check is performed through an interface with the CRIS-E system, the primary eligibility database for State public assistance programs. MMIS is updated with CRIS-E information on a nightly basis.

- **Provider Validation:** During this edit, the claim is referenced against the internal file of Medicaid eligible providers. The information is provided to MMIS from several different sources. These sources include the State Medical and Dental Boards (through the Department of Administrative Services) and the previously noted sub-recipient agencies.

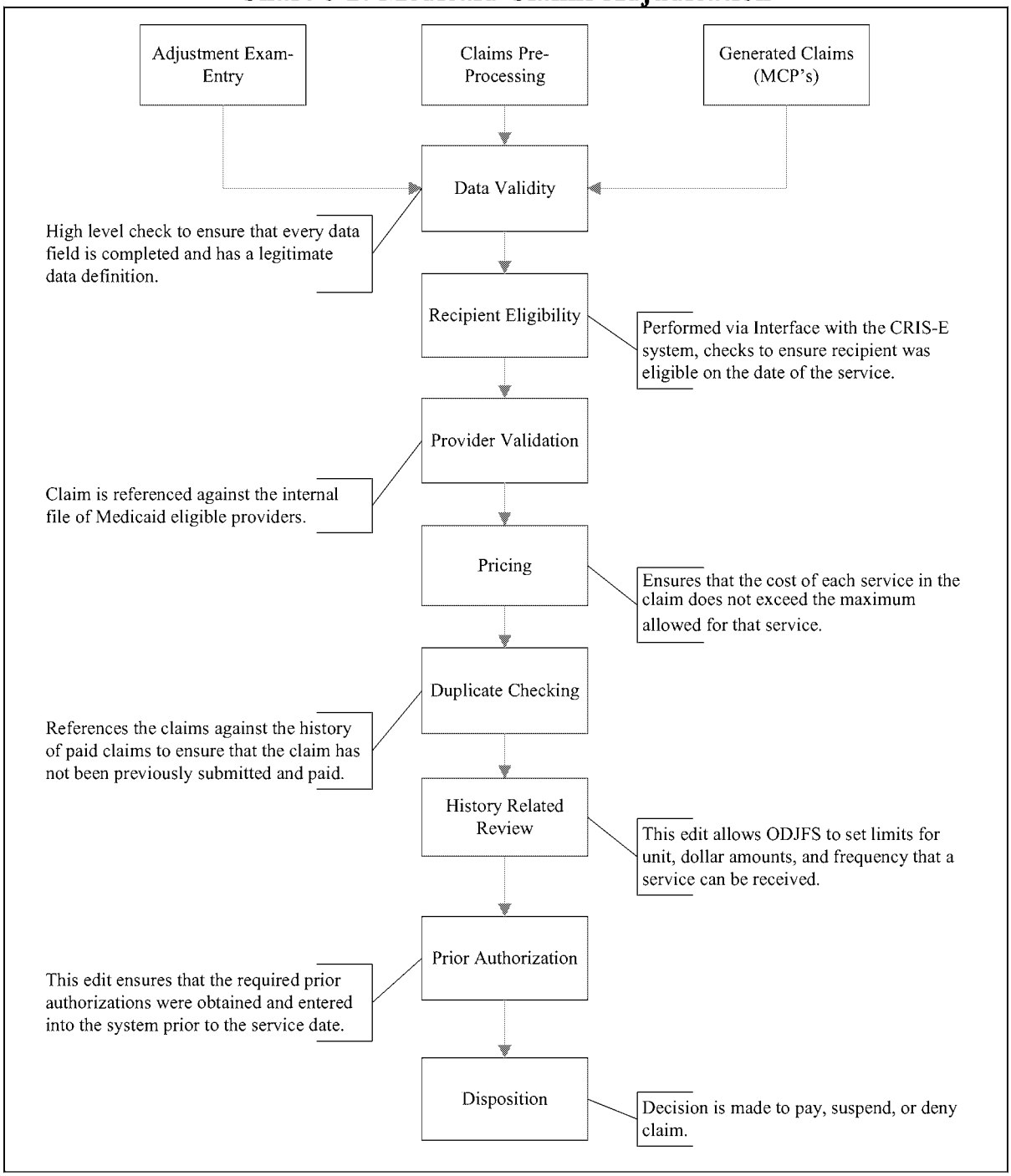
- **Pricing:** This edit ensures that the cost of each service in the claim does not exceed the maximum allowed for that particular service. The maximum allowed cost for each service is determined by the appropriate bureau within OHP.

- **Duplicate Checking:** This edit references the claims against the history of paid claims in an attempt to ensure that the claim has not been previously submitted and paid.

- **History Related Review:** This edit allows ODJFS to set limits for number of units, dollar amounts, and frequency for any service.

- **Prior Authorization:** Certain services paid for by the Medicaid program must be authorized prior to the service being rendered. Driven by the service code, this edit ensures that the required prior authorizations were obtained and entered into the system before the service date.

Chart 6-2: Medicaid Claims Adjudication



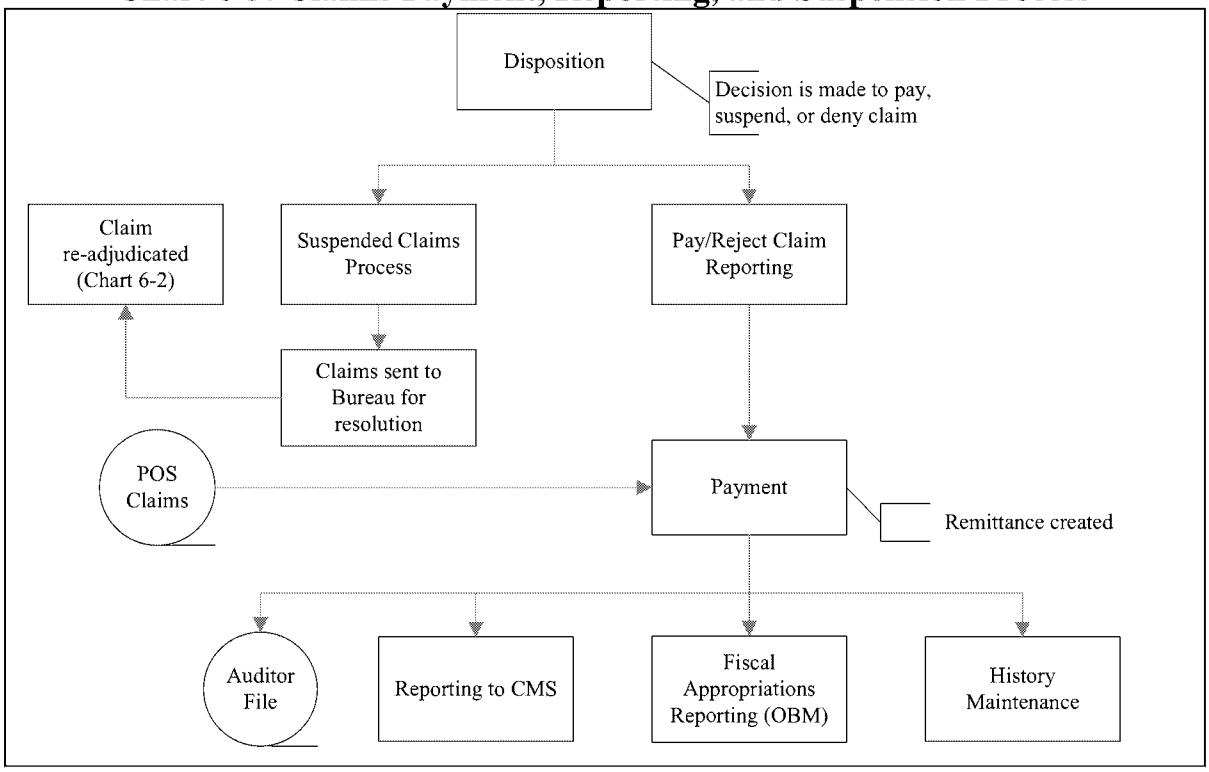
Source: ODJFS

Once claims have been through all of the edits, the final decision is made whether to pay, deny, or suspend the claim. This is referred to as disposition. If a claim is to be paid, the appropriate information is reported to the Central Accounting System and CMS. If suspended, the claim is placed in a suspended claims file and resolved by ODJFS staff. Finally, if denied the claim is marked as such with codes indicating the failed edit. For all claims paid or denied, status is communicated back to the provider through a remittance advice statement.

Suspended claims are those which cannot pass all of the MMIS edits and therefore must be reviewed and resolved manually by OHP staff. Once a claim is suspended an exception code[7] determines the appropriate bureau to resolve the claim. The Bureau then researches and resolves the claim based on the specific on-line instructions provided by MMIS. Once suspended claims are resolved, the claim is placed back into the processing queue to repeat the adjudication process. According to ODJFS, suspended claims are to be resolved in 30 days or less or it is liable to pay interest on the claim. **Chart 6-3** shows the claims payment, reporting, and suspension process.

[7] An exception code is a numerical code indicating why the claim was placed in a suspended category. The suspension may be related to a code that was keyed in incorrectly or a claim that a bureau wants to examine before payment, for example.

Chart 6-3: Claims Payment, Reporting, and Suspension Process



Source: ODJFS

In addition to standard claims, MMIS annually processes approximately 345,000 – 400,000 adjustment exam entries. These are similar claims which are input in-house through an online process by the Adjustments Unit within the Bureau of Plan Operations. These are typically problem claims. Reasons for exam entry adjustments include: billing error, system error, policy decision requiring adjustment, age conflict claims,[8] results of audit, IRS offsets, or re-issue of provider warrant. Typically, for a claim specific adjustment, a provider will send an adjustment form to the claims adjustment unit and if an adjustment is needed, the claims adjustment unit will batch process the claims into MMIS.

Once adjudicated, claims are ready for payment. Provider payment records, based on claims approved for payment, are uploaded from MMIS into the State's Central Accounting System on a weekly basis. Payments are issued to providers by warrants or electronic fund transfers. According to OHP, a correctly submitted claim requiring no adjustments takes a minimum of 8 and a maximum of 30 days to process.

[8] Claims must be submitted within 365 days of the date of service. An "age conflict claim" is a claim that can still be paid if it is more than 365 days old. These cases are rare and usually involve a time lag on ODJFS' part (determining eligibility, bad system edit, etc.).

Sub-Recipient Agency Claims Processing (Current Processes)

In addition to the adjudication process executed by MMIS, some sub-recipient State agencies also maintain their own claims processing and service management systems. In large part, these separate systems were developed to maintain case management information, archive federally required data for specific programs, and manage the local share of Medicaid payments. Once claims are passed through these systems, each respective sub-recipient agency bundles the claims and submits them to ODJFS so that the sub-recipient agency may receive Federal Medical Assistance Percentage (FMAP) funds. As the State's Medicaid administrator, ODJFS is the only State agency which receives FMAP funds directly from the federal government. Once these funds are received, ODJFS distributes them to the sub-recipient agencies. Therefore, the bundles of claims submitted by the sub-recipient agencies identify the sub-recipient agencies as the payee for the claim, not the provider. For each agency except ODMRDD, the provider has already been paid by the sub-recipient agency by the time the claim is submitted to ODJFS. Subsequently, ODJFS reimburses the sub-recipient agencies. In this section, the systems used by ODMH and ODADAS, ODMRDD, and ODA are detailed because of their interactions with MMIS. These systems are detailed in **Charts 6-4** through **6-7**.

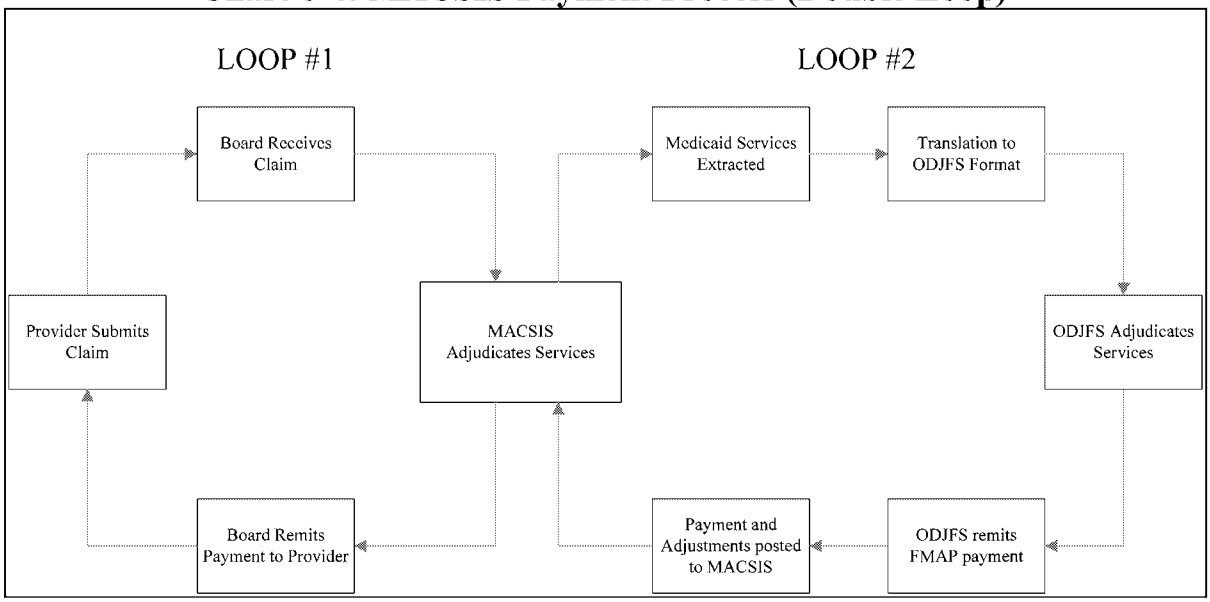
MACSIS

The Multi Agency Community Service Information System (MACSIS) is a single system shared by the Ohio Department of Mental Health (ODMH) and the Ohio Department of Alcohol and Drug Addiction (ODADAS). Implemented in 2000, this system contains information about both Medicaid and non-Medicaid services provided by both agencies. The system was developed in an effort to streamline and standardize operations between local/regional boards,[9] the two departments, and MMIS. Through an interagency agreement, ODMH is responsible for the management and support of MACSIS.

The claims payment process facilitated by MACSIS is a two part process, referred to as the "double loop." The first loop is the process in which the provider is paid by the local board. This cycle begins when the provider submits its claim to a local ADAMH board. The local ADAMH board then submits the claim to the MACSIS system. MACSIS then adjudicates the claims and indicates to the local board if the provider should be paid through Medicaid or non-Medicaid funds. The second loop outlines how the local board then is reimbursed for the federal match portion of the claim. Once a claim is adjudicated by MACSIS, the Medicaid claims are then extracted and submitted to ODJFS for adjudication through MMIS. If ODJFS determines the claim to be Medicaid payable, then the payment is submitted to ODMH (or ODADAS). ODMH or ODADAS then distributes these funds to the appropriate local ADAMH board. The "double loop" process is outlined in **Chart 6-4**.

[9] Throughout this section, local and regional ADAMH, ADAS and MH boards are collectively referred to as local ADAMH boards.

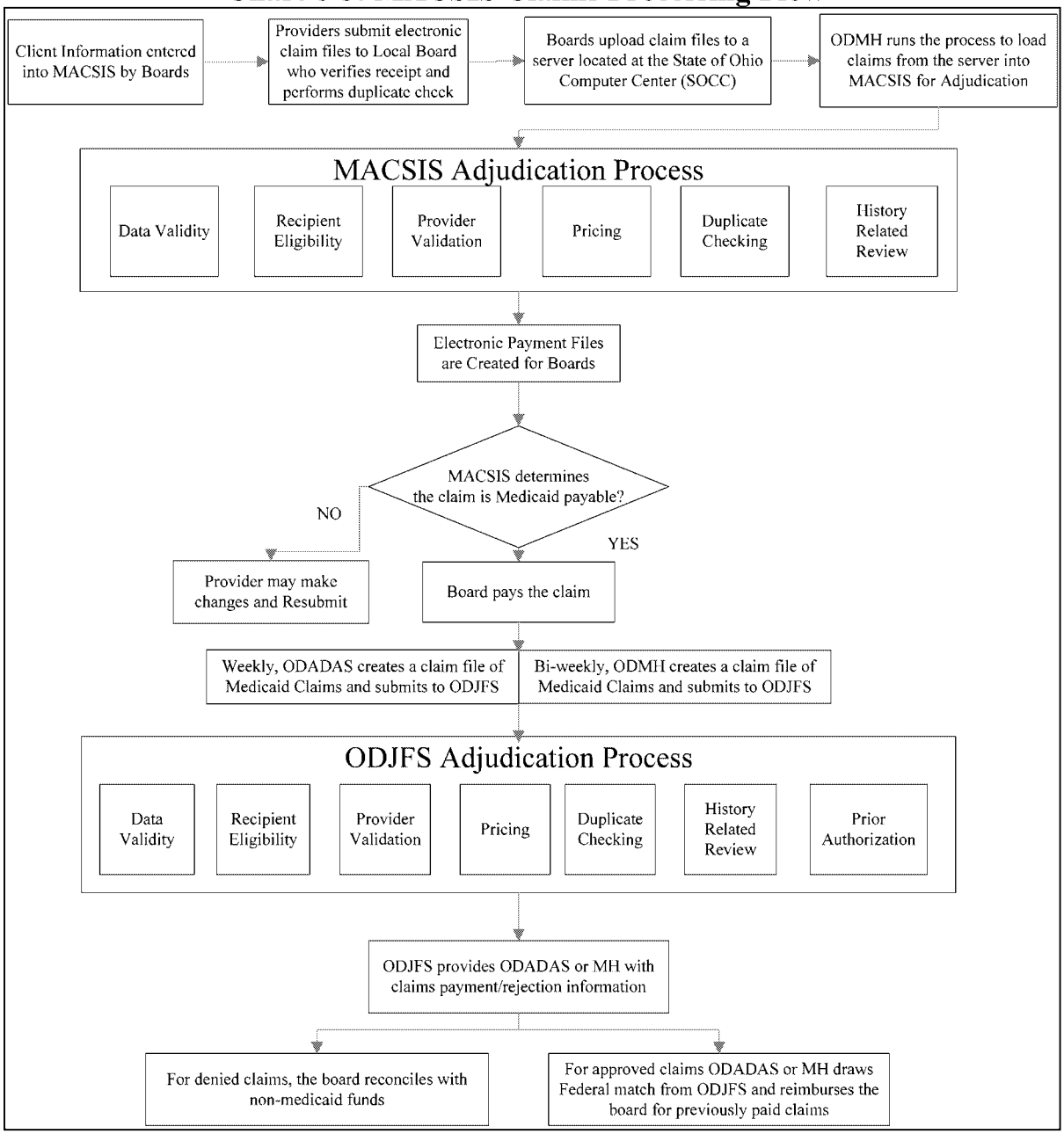
Chart 6-4: MACSIS Payment Process (Double Loop)



Source: ODMH

As shown in **Chart 6-4,** the flow of claims represents payment of direct services and is only partially related to the funding flow from the local ADAMH boards, the respective State agencies, and ODJFS. **Chart 6-5** outlines the claims adjudication process in greater detail.

Chart 6-5: MACSIS Claims Processing Flow[1]



Source: ODADAS and ODMH

[1] Non-Medicaid claims are subjected to all parts of this process which are not performed by ODJFS.

As shown in **Chart 6-5**, mental health or alcohol and drug addiction services providers submit their Medicaid and non-Medicaid fee-for-service claims to the local ADAMH board with whom they have contracted.[10] Along with the claims, providers submit a notification form which includes the following information:

- Provider name and universal provider identifier;
- Submission date;
- Name of the file;
- Number of claim lines and total dollar amount;
- Period the claims are for; and
- Person submitting the file.

Using the information in this notification, the local ADAMH board then verifies the file was received, verifies the file is not a duplicate, and uploads the claim files to a central server[11] located at the State of Ohio Computer Center (SOCC).[12] ODMH then uploads claims from the SOCC server to MACSIS once a week. MACSIS subjects the claims to a number of edits in order to prepare the claims for submission to ODJFS and determination of which claims should be paid by the county board. Similar to the adjudication process implemented by MMIS, MACSIS performs the following edits:

- Data Validity;
- Recipient Eligibility (obtained from ODJFS);
- Provider Validation;
- Pricing;
- Duplicate Checking; and
- History Related Review.

After the claim is subjected to each of these edits, a remittance advice is created by MACSIS for the local ADAMH boards. This remittance details whether a claim should be paid or denied by the board. There is no process for suspending claims. If a claim is denied, the provider may make corrections or changes and then must resubmit it to the board as a new claim. If a claim is approved, then the local ADAMH board pays the provider.

[10] There are 56 combined mental health and alcohol and drug addiction services (ADAMH) boards, 7 stand-alone mental health boards, and 7 stand-alone alcohol and drug addiction services boards. While these boards are organized on a county level, several boards have pooled services and resources to serve a larger, more regional area.
[11] This function is not paid through Medicaid administrative dollars but instead, is compensated under the board's annual allocation from the State.
[12] SOCC is a mainframe computing center operated by the Ohio Department of Administrative Services.

At this point in the process, both ODMH and ODADAS create batches of Medicaid claims for submission to ODJFS. ODADAS prepares batches weekly, while ODMH prepares batches bi-weekly. Once submitted, MMIS adjudicates the claims through its standard process (see **Chart 6-2**). ODJFS then provides each respective State department with a remittance advice showing claims paid or rejected, and reasons for rejection. Claims information is then sent to a shared data mart for storage and decision support.[13]

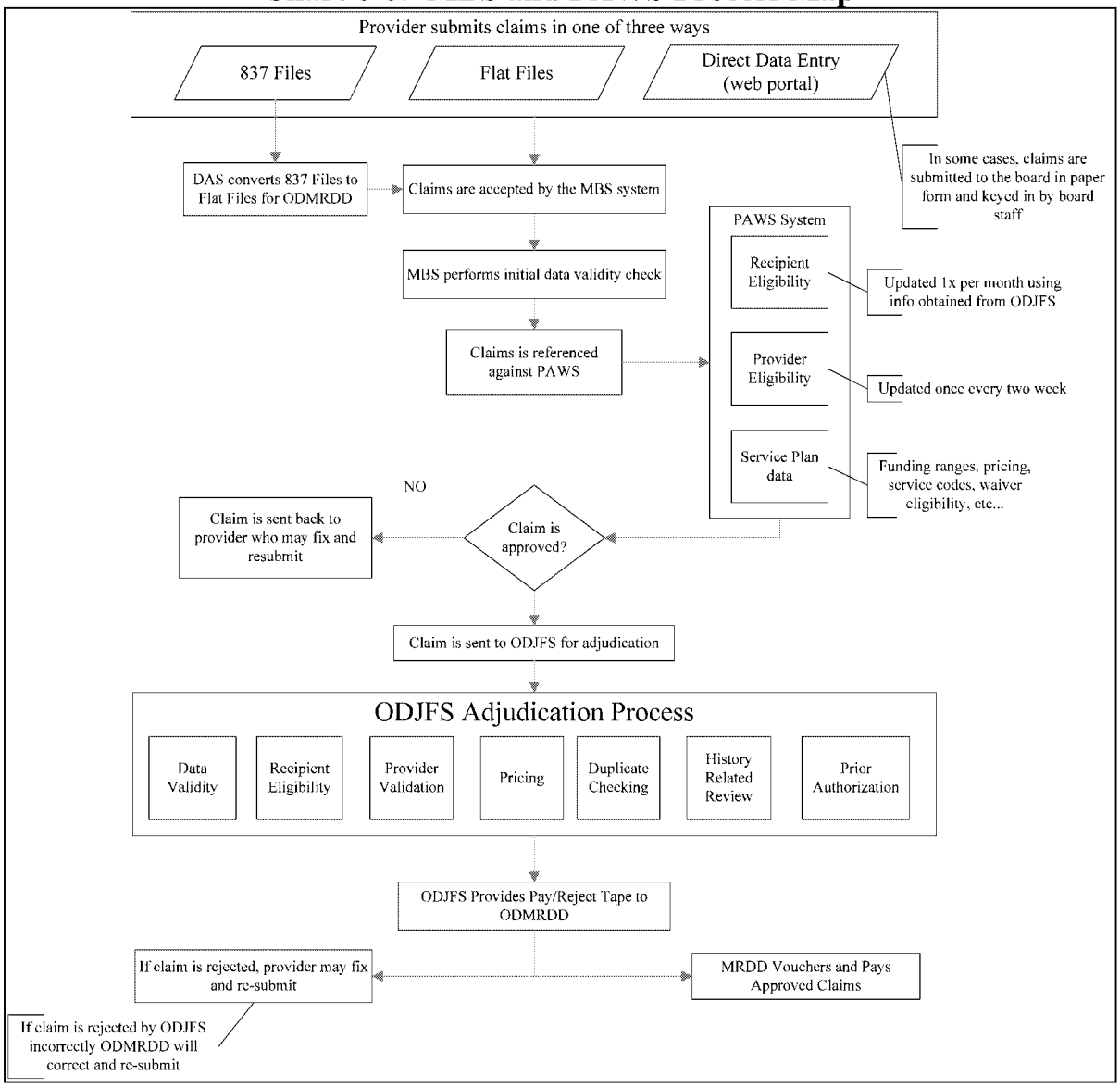
After remittance is received from ODJFS, another remittance is created for each board showing the status of claims they submitted, approved rates, and any denials with reasons for rejection. The State Department, either ODMH or ODADAS, then reimburses the local ADAMH board for Medicaid claims which were approved. For claims which were not approved, the board must request repayment from the provider or use local funds to pay for the service.

MBS and PAWS

The Medicaid Billing System (MBS) and the Payment Authorization for Waiver Services (PAWS) systems are the claims processing and case management systems used by the ODMRDD. MBS is the primary source of billing data for MRDD services funded through a Medicaid waiver (see the **Medicaid service provision** section). The system provides utilization report capabilities, and performs a series of automated edits on waiver claims reimbursements requested by providers. PAWS is the payment authorization system which contains service history files such as pricing, funding ranges, service codes, and waiver eligibility.

[13] Claim information is retained in the ODJFS data warehouse and ODMH or ODADAS is listed as the payee and the services are included in the ODJFS data warehouse. However, the provider information is not retained on the claim. As claims information is returned to ODMH or ODADAS, the respective departments confirm paid claims information in their shared data mart. This information also contains service, provider, and recipient information not available to ODJFS.

Chart 6-6: MBS and PAWS Process Map



Source: ODMRDD
Note: 837 files are a HIPPA required file.

As shown in **Chart 6-6**, the claims process begins when a provider or a county MRDD board[14] submits a claim to the MBS system via a front-end web portal. Claims can be submitted in one of three formats:

[14] In the MRDD system, county boards are also providers of Medicaid services.

- 837;[15]
- Flat files;[16] or
- Direct data entry (web portal).

The MBS system then references the claim against the history files in PAWS. These references include checks of the following:

- Price;
- Funding Ranges;
- Service Codes; and
- Waiver Eligibility.

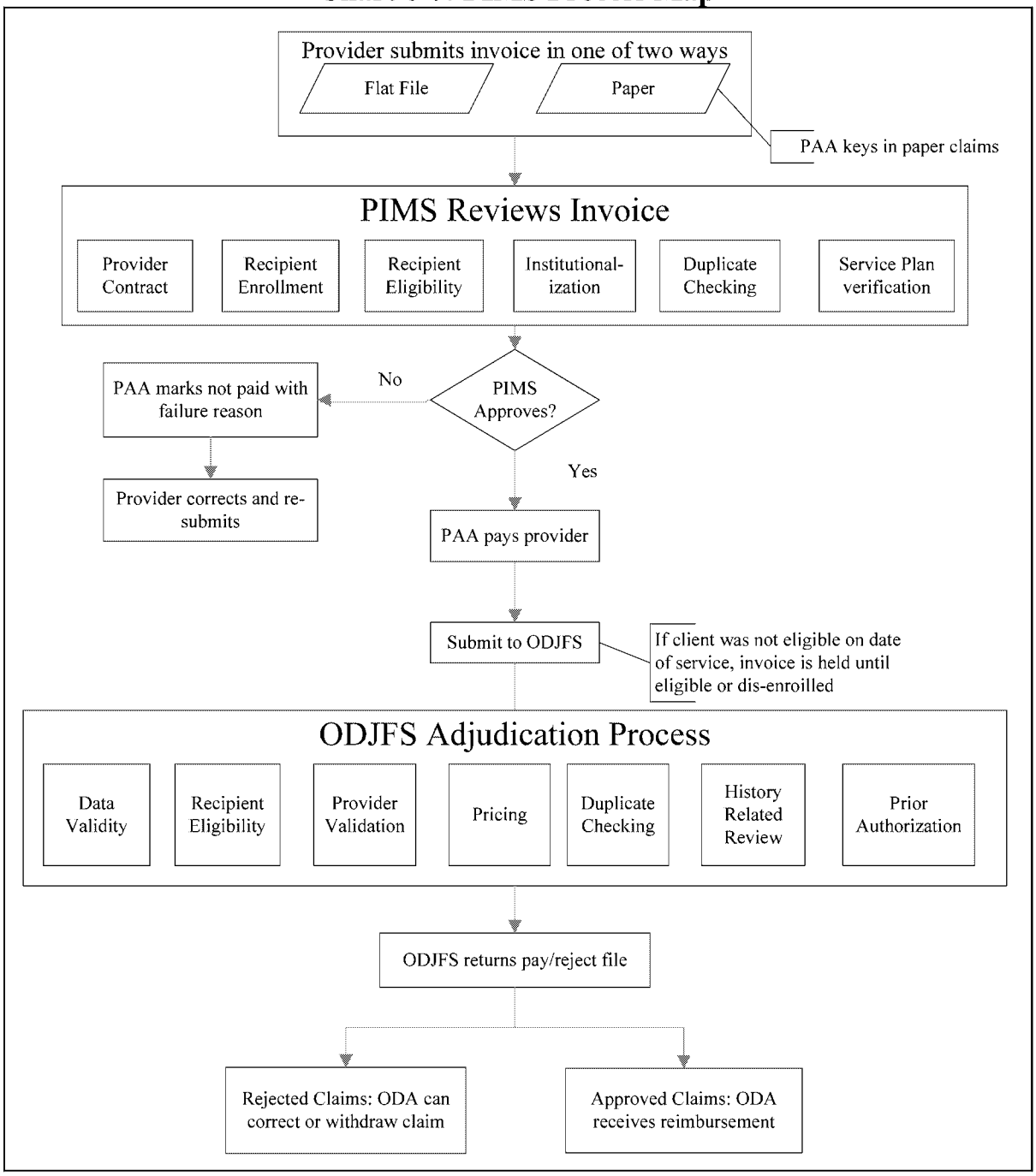
Once these checks are performed, claims are denied or sent to ODJFS for adjudication. Providers can check claim information on-line and, if a claim is denied, the provider may correct and resubmit it. Claims sent to ODJFS are then adjudicated through the MMIS system and either approved or denied by ODJFS. When the claims have been adjudicated, a remittance is provided to ODMRDD from ODJFS in the form of a pay/reject tape. If a claim is denied, it can be corrected and re-submitted either by the providers or ODMRDD. If the claim is approved, ODMRDD creates a voucher for the claim and submits it to the county MRDD board which approves payment.[17] Finally, ODMRDD creates a history file of paid claims and transfers that information to its data warehouse weekly.

PIMS

The Ohio Department of Aging (ODA) maintains the PASSPORT Information Management System (PIMS) to manage the PASSPORT waiver program, which is funded through Medicaid. PIMS collects data regarding consumer screening, assessment activity, and service plans that have been developed with the assistance of PASSPORT Agency Administrators (PAAs), and individual claims records submitted by service providers. **Chart 6-7** below details the PIMS process.

[15] The 837 is the standard HIPAA compliant claim format.
[16] Flat files are data files which contain no structured relationship.
[17] Within the MRDD system, ODMRDD withholds a portion of the county boards' annual allocation and pays the total amount of the claim. If the amount withheld is insufficient, the county board reimburses ODMRDD for the additional amount paid.

Chart 6-7: PIMS Process Map



Source: ODA

As shown in **Chart 6-7**, the claims process begins with a provider submitting an invoice to 1 of 13 PASSPORT Agencies. Once received by the PASSPORT agency, a PASSPORT Agency Administrator (PAA) reviews the claims to ensure that the services are contained in the original plan of care or, if it is not in the original plan, an adjustment to the plan was made and approved by the case manager. Claims are then either approved or rejected by the PAA. If the claim is not approved, the PAA marks the claim not paid with a failure reason and the claim is returned to the provider for correction and resubmission. If the claim is approved, the PASSPORT Agency pays the provider and the invoice detail is marked as paid. Once paid, ODA checks the following in the PIMS system:

- Valid Medicaid number (obtained from ODJFS);
- Passport program enrollment record;
- Date of service; and
- Provider eligibility.

If the claim meets all of the eligibility requirements, the claim is submitted to ODJFS. ODJFS then processes the claim through MMIS and returns remittance in the form of a pay/reject file. If the claim is rejected by MMIS, ODA tries to determine the reason and amend the claim. If the claim can be amended, it is sent back for correction. If the claim can not be amended, ODA must absorb the cost. If the claim is approved by MMIS, ODA receives reimbursement.

Third Party Liability (TPL) and Coordination of Benefits (COB)

The Medicaid program, by law, is intended to be the payer of last resort; meaning that all other available third parties must meet their legal obligation to pay claims before the Medicaid program pays for the care of an eligible individual. This obligation of third parties to pay all or part of the expenditures for medical assistance furnished under any state Medicaid plan is referred to as Third Party Liability or TPL. Examples of third parties responsible for payment prior to the billing of Medicaid include:

- Private health insurance;
- Medicare;
- Employment-related health insurance;
- Court-ordered health insurance derived by non-custodial parents;
- Court judgments or settlements from a liability insurer;
- Workers' compensation;
- First party probate-estate recoveries;
- Long-term care insurance; or
- Other State and federal programs (unless specifically excluded by federal statute).

ODJFS is responsible for the coordination of benefits (COB) for Medicaid consumers in order to assure that Medicaid is the payer of last resort. The goal of benefits coordination is to identify third-party liability and minimize Medicaid's financial liability when enrollees have other sources of health insurance. Benefits Coordination includes the following three functions:

- **Cost Avoidance:** Preventing Medicaid payment when other health insurance coverage exists. The provider of services bills and collects from liable third parties before sending the claim to Medicaid.
- **Payment Coordination:** Processing a claim with Medicaid as the secondary payer.
- **Recoveries:** Recovery of Medicaid payments when commercial or public health insurance coverage should have been billed for, and paid for, the service (i.e., Third Party Liability).

ODJFS identifies other insurance benefits through the County departments of Job and Family Services (CDJFS). During the initial eligibility determination, caseworkers are required to ask applicants if they are covered by any potential source of third party liability. The caseworker primarily relies on the response from the applicant. However, caseworkers in smaller counties indicated that, in some cases, they have identified third-party liability through familiarity with the local businesses in which potential recipients or non-custodial parents who have court-ordered medical responsibility work. Once insurance information is identified, the CDJFS staff then enters the information provided into the CRIS-E eligibility system. This system interfaces with MMIS and automatically updates the master third party liability file. See also **issues for further study**.

Once the information is entered in MMIS, the cost avoidance process begins. During the adjudication process, MMIS references claims against the third party liability file and rejects those claims which attempt to identify Medicaid as the primary payer when the TPL shows that there is other coverage. The remittance notice to the provider will list the other insurance information obtained from the third party liability file so that the provider may request payment from the other insurer.

Claims which are properly coordinated and list Medicaid as the secondary payer are processed through the remaining edits in the MMIS system. ODJFS attempts to recover monies paid for claims in which no third party liability was indicated by the recipient but for which third party liability was present. This type of recovery is known as "pay and chase." ODJFS contracts this function to Public Consulting Group (PCG). This is a $7 million contract which pays PCG a commission of 3.95 percent of actual recoveries. For the period November through December, 2005, PCG has identified over $61 million in potential accounts receivable and sent out first billing notices to insurance carriers. During the same period, PCG work has led to nearly $150,000 in recoveries.

Eligibility Determination

CRIS-E captures demographic and financial information about potential recipients of public assistance. It also serves as the source system for recipients' eligibility information for claims processing purposes. CRIS-E supplies the following information to MMIS:

- Recipient Demographic Information;
- Individual Medicaid Eligibility;
- Third Party Liability;
- Managed Care Plan (MCP) Enrollment; and
- Long Term Care Facility Enrollment.

Similar to MMIS, the CRIS-E system is slated for replacement. A budget proposal for this project was completed in August 2006. According to the ODJFS, the next phase of this project is to complete business requirements and a current competency assessment by the end of State fiscal year (SFY) 2007-08. ODJFS expects the system to be developed and fully implemented by the end of SFY 2008-09.

Data Warehouse and Decision Support System

The ODJFS Medicaid Data Warehouse (Data Warehouse) and Decision Support System provide a comprehensive view of the Medicaid program that integrates eligibility/enrollment, service utilization, payment, and provider data. It also provides flexible reporting capabilities that aggregates and moves information to program managers and decision makers within ODJFS. The Data Warehouse and Decision Support System project was initiated in 2001 and has been operational since 2003. The system has been loaded with seven years of historical data on Medicaid eligibility, health care claims, and managed care encounter data (paid claims). However, it should be noted that not all of this data has been available since 2003. Since its inception, ODJFS has worked to expand the data available in the Data Warehouse, making significant enhancements as recently as February 2006.

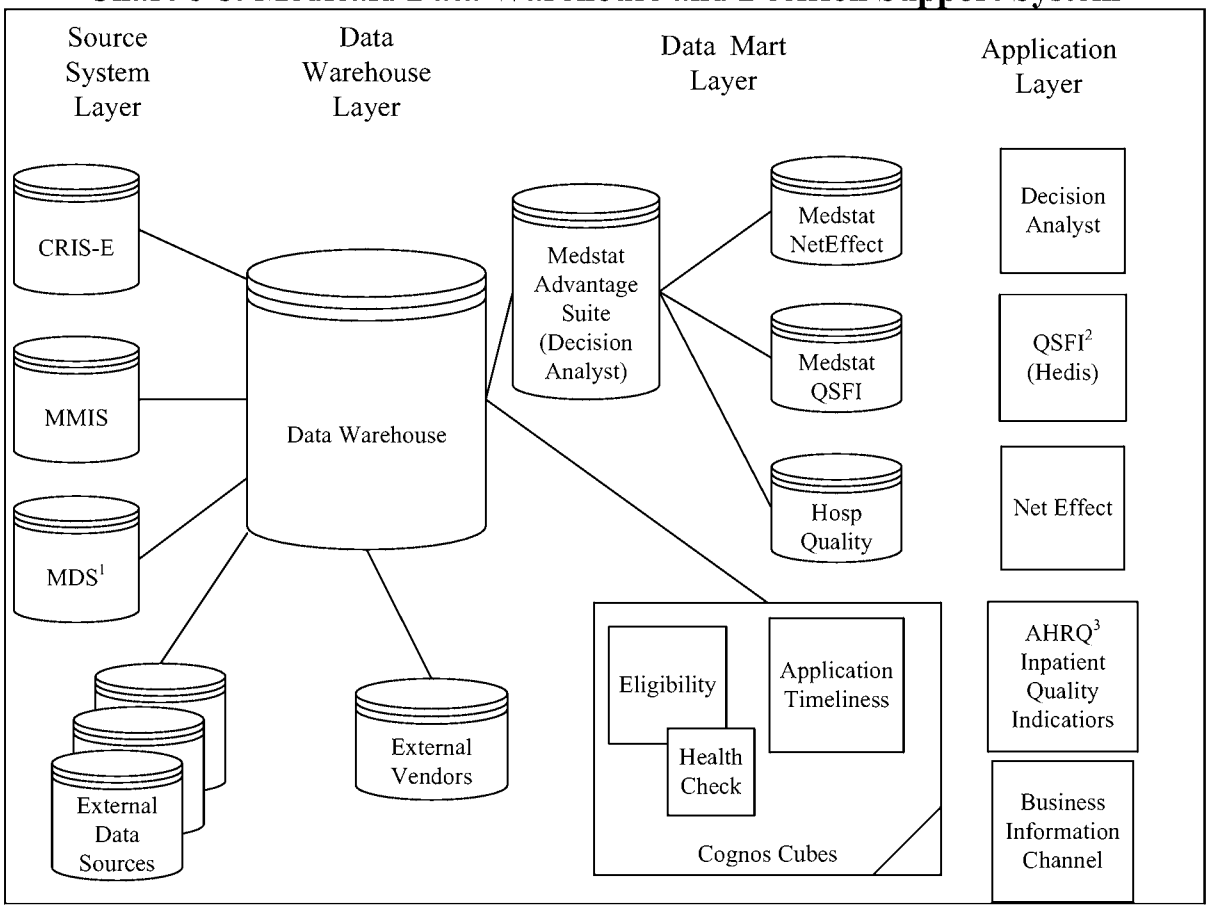
The Data Warehouse Environment architecture consists of four layers:

- **The Source Layer**: Data from the MMIS, MDS,[18] and CRIS-E systems.
- **The Data Warehouse Layer:** A central warehouse containing the data from source systems.
- **The Data Mart Layer:** Sub-sets of data which are populated with information pertaining to a particular business need.
- **The Application Layer:** The means by which users may access data from their desktop.

[18] The Minimum Data Set (MDS) is a uniform set of elements required to be reported by Long-Term Care Facilities.

Chart 6-8 shows the Medicaid Data Warehouse Environment:

Chart 6-8: Medicaid Data Warehouse and Decision Support System



Source: ODJFS
[1] The Minimum Data Set (MDS)
[2] Quality Spectrum Focused Insight (QSFI)
[3] The Agency for Health Care Research and Quality (AHRQ)

The Data Warehouse is updated with information from source systems once per month. Once updated, the Data Warehouse standardizes the data to better facilitate decision support. For example, gender may be noted with a particular code in MMIS and a different code in CRIS-E. The Data Warehouse is designed to merge this data into a single normalized code.

After data is standardized, information from the Data Warehouse is delivered to the various data marts, primarily Medstat, the decision support system. The Medstat Decision Support System provides ODJFS with over 2,000 health care measures that are based on national standards for analyzing Medicaid claims and providers. The current Data Warehouse is able to generate

reports using eligibility and claims data based upon combinations of any of the following elements:

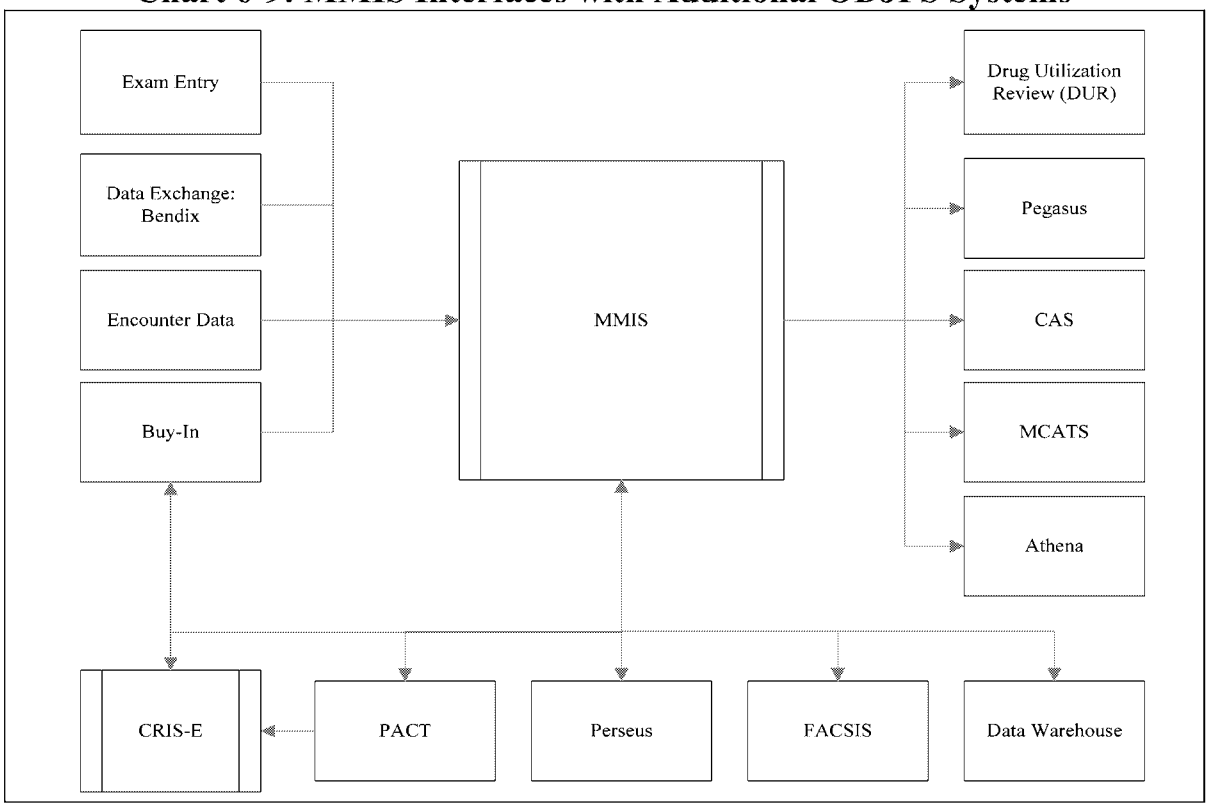
- Demographics;
- Eligibility;
- Diagnosis;
- Procedure; or
- Any other service related characteristics.

It should be noted that the 2,000 measures mentioned above are pre-loaded into a Measures Library which can then be generated without having to run a query. There is also a variety of both Medicaid and commercial benchmarks which are adjusted to ODJFS populations to better show ODJFS performance in the context of relevant comparisons. Data is extracted by Bureau-specific decision support specialists to facilitate data-driven decision making. An example of this was the use of the Data Warehouse/Decision Support System to study the potential cost savings related to establishing cost caps for the Ohio Home Care Waiver Program. It was projected that caps would save $16 million over the biennium. Once the Home Care Waiver Program is implemented, the Decision Support System will be used to monitor monthly cost savings.

Additional ODJFS Medicaid-Related Information Systems

MMIS interfaces with 13 internal information systems which perform Medicaid functions in addition to the core systems of CRIS-E and MMIS. These systems are shown in **Chart 6-9**.

Chart 6-9: MMIS Interfaces with Additional ODJFS Systems



Source: ODJFS Bureau of Services to Families Support (BSFS)

As show in **Chart 6-9**, MMIS serves as the primary information system for the Medicaid Program. Non-core systems use MMIS as an intermediary to communicate share information with one another. Each of the non-core systems detailed in **Chart 6-9** are described below in alphabetical order.

- **Athena:** This system is used to monitor the quality of care provided to recipients enrolled in a managed care plan. MMIS transfers managed care plan eligibility data to Athena which then collects treatment data from the managed care plans through required secure file transfer processes (SFTP).

- **Buy-In:** The Buy-In system pays the Medicare premium for qualified beneficiaries. The Buy-In system, which links to CRIS-E, determines buy-in eligibility by comparing income and asset information obtained from CRIS-E to the requirements of the buy-in program. The system sends monthly add/change/delete information to CMS by automated file transfer.

- **Central Accounting System (CAS):**[19] After claims have been adjudicated through MMIS, the payment appropriation is entered into the Central Accounting System. This information is subject to weekly reconciliation with payment appropriations and biennial budget information.

- **Data Exchange: Bendex/Medicare SSA:** Bendex (the Beneficiary and Earnings Data Exchange) is an automated data exchange received from the Social Security Administration. This exchange matches client name, sex, date of birth, Social Security number, and Social Security claim number, and reports the total amount of Social Security benefits received. The Data Exchange provides support for electronic verification of identity and income information.

- **Drug Utilization Review (DUR):** The DUR program uses paid Medicaid claims data to screen for potential adverse drug reactions, therapeutic appropriateness, incorrect drug dose or duration, drug allergy interaction, and clinical abuse.

- **Encounter Data:** Managed care plans submit encounter data, which are claims that have been paid by a managed care plan, (by tape) on a monthly basis, in one of three formats. This data is submitted to fulfill various reporting requirements. The Encounter Data System creates a "dummy file" from the managed care plan information which is then adjudicated through MMIS so that the claims data is logged in the same manner as fee-for-service data.

- **Exam Entry:** The Exam Entry System is the on-line system used by the Adjustments Unit within the Bureau of Plan Operations to enter, adjust, and resolve problem claims which have been suspended by the MMIS system. If deemed appropriate, the claims data entered into the MMIS system can be adjusted to ensure correct payment.

- **Family and Children's Service Information System (FACSIS):** This system coordinates information to support the protection of children and families vulnerable to abuse, neglect, dependency, and exploitation. FACSIS submits eligibility data for child welfare and family and children's services into MMIS. MMIS also provides FACSIS with the master eligibility rejection file. It should be noted that FACSIS is also slated for replacement. The new system, Statewide Automated Child Welfare Information System (SACWIS) began its pilot phase in the fall of 2006 and should be operational by the end of SFY 2006-07.

- **Medicaid Consumer Activity Tracking System (MCATS):** This stand-alone system was developed to support the Ohio Home Care Program. Vendor employed home healthcare professionals interview Medicaid recipients to determine the home services for

[19] The Central Accounting System is operated by the Office of Budget and Management.

which they are eligible. Based on the interviews, vendors submit home services plans to the Home and Community Services Bureau through the MCATS internet form. MMIS sends program enrollment information to MCATS. However, there is no direct interface between MCATS and MMIS. MCATS information is manually entered into MMIS.[20]

- **Primary Alternative Care and Treatment Program (PACT):** This program matches Medicaid consumers with identified patterns of inappropriate utilization of medical and/or pharmaceutical services. The system transfers program enrollment data to MMIS and CRIS-E, while receiving claims data from MMIS.[21]

- **Perseus:** Annual rates for long term care facilities are set through this system using the acuity-based reimbursement system.[22] The acuity-based reimbursement system is used by the Bureau of Long Term Care, as well as Medicare, in the rate setting process.

- **Pegasus:** Pegasus is a stand-alone application which details rates by component. Pegasus is updated with rate and payment information, as well as the final rate calculation with audit adjustment from Perseus. Pegasus is used for statistical purposes to analyze rates. It pulls information from MMIS and Perseus for this purpose.

MMIS Interfaces with Other State Agencies

MMIS also shares data with the State sub-recipient agencies,[23] the Attorney General's Office (AG); and Auditor of State's Office (AOS). Relatively extensive interfaces exist with ODA, ODADAS, ODMH, and ODMRDD. Each of these agencies submits fee-for-service claims to MMIS and receives payment reports and payment reject files from MMIS after claims are adjudicated. However, prior to submitting claims, each agency (and, in some cases, the county or regional agencies) uses its respective system to perform its own form of adjudication, attempting to identify incorrect or problem claims before they are submitted to ODJFS for payment.

AG, AOS, and DAS obtain information from MMIS on a more limited basis. AG extracts data from MMIS to facilitate oversight through programs such as the Medicaid Estate Recovery Program used in the recovery of paid Medicaid benefits after a recipient is deceased. MMIS provides AOS with approved claim information in order to conduct audits, issue warrants, and disburse electronic payments for approved claims. However, this will be changing in 2006 and this responsibility will shift to the Office of Management and Budget. Finally, DAS does not

[20] This manual data entry is scheduled to be resolved with the implementation of the MITS system.
[21] ODJFS recently began tracking the cost savings achieved through the use of this system after auditors had requested the data for this report.
[22] A system which adjusts reimbursements according to the level of patient care required by individual residents.
[23] This data sharing is limited. The sub-recipient agencies do not have access to all MMIS or Data Warehouse information or features.

extract data from MMIS, but rather, imports updates from a number of State boards to ensure that providers are properly identified.

Assessments Not Yielding Recommendations

In addition to the analyses presented in this report, assessments were conducted on several areas which did not warrant changes and did not yield any recommendations. These areas include the following:

- **Performance Measurement of Manual Claims Processes:** ODJFS does not manually process claims in-house and therefore does not apply performance measurement directly to those activities. However, ODJFS applies timeliness and accuracy performance measures to the contractors who perform these activities, thereby meeting minimum requirements.

  Some manual claims resolution is performed by ODJFS staff and there are no existing performance measures to minimize these activities. However, an independent assessment conducted by Deloitte Consulting concluded that measuring performance would not be possible at this time given the current MMIS limitations.

- **Provider Database:** All submitted claims are validated against the Provider Master File during the claims adjudication process. In 2004, ODJFS implemented an automated process that updates the status and recertification date of providers within the MMIS Provider Master File. This is based on a file, obtained from the Ohio State Medical Board on a monthly basis, listing all physicians, osteopaths, and podiatrists. The file contains license information, demographics, and the current status of providers of the State Medical Board.

  If there is a provider match, the Provider Master File will update the recertification date. Also, if the State Medical Board file indicates the provider is deceased or retired; the status on the Provider Master File is updated accordingly. The automated process also produces a monthly report of inactive providers. If the provider has been inactive for over 120 days, provider enrollment management will manually change the status of the provider to inactive in the provider master file. However, it should be noted that issues still exist regarding the purging of inactive providers from the system. These issues are addressed in the **program integrity** section.

- **Communication of Billing Errors to Trading Partners:** ODJFS offers providers remittance advices that show adjustments to paid claims in detail. ODJFS also communicates the payment process to providers and trading partners (ODJFS approved third-party agents) through quarterly provider group meetings, provider billing training, having access to a customer care desk, providing online handbooks and manuals, and providing medical assistance letters. Although trading partners initially expressed concerns about the information

they receive on billing errors, this problem will be rectified as ODJFS moves to HIPAA standards. The ODJFS payment communication process, including information sent to providers and available to trading partners in the remittance advice and online, is comparable to best practices and in line with industry standards. However, providers are not always aware of the communication processes in place and this is addressed in **R6.19**.

Issues Requiring Further Study

Auditing standards require the disclosure of significant issues identified during an audit that were not reviewed in depth. Those issues may not be directly related to the audit objectives or may be issues that the auditor does not review within the scope of the audit. AOS has identified the following as issues requiring further study.

- **Upon implementation of recommendations R6.1 through R6.3, and in conjunction with the implementation of the MITS system, the State Medicaid agency should evaluate the use of outside vendors to process paper claims. The Agency should perform a break-even analysis to determine at what volume of claims outsourcing is more efficient than performing optical character recognition (OCR) and Data Entry activities in-house.**

  ODJFS expects dramatic reductions in paper claims to occur naturally with the increase in managed care and the implementation of the MITS system. If these expectations do not materialize, recommendations **R6.15** through **R6.17** should serve as sufficient steps to minimize paper claims submissions. Once reductions are achieved and the expected annual claims volume is identified, the cost-benefit of bringing paper claims processing activities in-house can be adequately examined. Until that time any cost-benefit analysis would be fundamentally flawed, as it would include an inflated number of claims to be processed. As this issue could not be adequately examined at this time, ODJFS or the new State Medicaid agency should conduct this assessment after the implementation of MITS.

- **While developing the new CRIS-E system, ODJFS should examine the interface between CRIS-E and MMIS. ODJFS should explore the possibility of an eligibility system that allows service providers real-time access to information through MMIS.**

  During stakeholder interviews, provider groups indicated that eligibility verification is a confusing and difficult process. In addition, they reported that eligibility information is not always up to date or correct because MMIS updates information from CRIS-E on a nightly basis in batch form, rather than in real-time. Stakeholders suggested that an eligibility system that allows real-time access to eligibility information through the internet would be beneficial. According to the MITS request for proposal, the new system

will contain the ability to check eligibility on-line. However, MITS will still update from CRIS-E nightly and the information will not be presented in real-time.

During the course of the performance audit, several states' eligibility verification systems were examined in an effort to explore the possibility of a real-time system. No state could be identified which operates a real time system. Some states give the appearance of real-time but the information provided is based on nightly batch processing, similar to that currently offered by ODJFS through MMIS. In South Dakota, the provider is responsible for verifying eligibility through the Department of Social Services, Office of Medical Services. The verification process can take one of two forms; point of sale devices and/or PC software products, or an automated voice response system. The point of sale device and/or PC software products allows electronic eligibility verification with Department of Social Services Office of Medical Services on a real-time basis. Through the Medicaid Eligibility Verification System, the provider receives a "receipt ticket" in their office immediately upon eligibility verification (in about 10 seconds).

- **After the MITS system is implemented, Ohio should explore the possibility of implementing a single system to process all human services-related claims. As part of this effort, Ohio should strongly consider hiring an impartial third party vendor to operate and maintain the system.**

  While claims processing in Ohio will improve substantially with the implementation of MITS, the system is being designed only to process Medicaid claims. However, a review of the MACSIS system indicated that it also processes non-Medicaid claims for ODMH and ODADS. Ideally, all Medicaid claims should be subjected to a single, easily communicated adjudication process. However, implementing this change would result in providers who submit Mental Health and Alcohol and Drug Addiction Service claims having to use two separate claims processes to receive reimbursement.

  The Pennsylvania Department of Public Welfare has implemented a claims processing system which eliminates this problem. The Provider Reimbursement and Operations Management Information System (PA Promise) is a single system which handles claims processing activities for the following program areas within the Department of Public Welfare:

  - Office of Medical Assistance Programs (OMAP)
  - Office of Mental Retardation (OMR)
  - Office of Mental Health and Substance Abuse Services (OMHSAS)
  - Office of Social Programs (OSP)
  - Special Pharmaceutical Benefits Program (SPBP)
  - Healthy Beginnings Plus (HBP)

In addition, PA PROMISE processes claims for the Departments of Aging, Education, and Health. The primary benefit of this system is that it gives providers of all services a single point of contact for health care claims regardless of the department for which they are providing the service. Therefore, providers who may perform multiple services are not subjected to multiple processes.

According to ODJFS, MITS cannot be expanded to include non-Medicaid services due to funding restrictions put in place by CMS which require the MITS funding to be used strictly for Medicaid purposes. However, recommendations **R6.9** through **R6.11** demonstrate that the State could achieve substantial gains in efficiency and significant cost savings by implementing a system in which there was a single point of contact. Pennsylvania appears to manage the restrictions put forth by CMS by allowing a third-party vendor to administer the system. The third party vendor can use as many different methods or systems as necessary to adjudicate claims, but to the providers, there is only one method of submission and one point of contact to resolve issues. Due to coordination and communication issues that exist between ODJFS, ODMH, ODADAS, and ODA, having an impartial third party administrator operate the system could serve as an optimal solution.

During stakeholder discussion, though, a representative of the Ohio Job and Family Services Directors' Association commented that:

> "…this … brings up a much larger problem of the MIS systems that they run at ODJFS and the [systems] they're looking at for the future…. I think somebody has to look at this on a larger basis and make some decisions about what kinds of MIS needs there are. ….Should we be going in the direction where eligibility and payments are linked? Should we be going in a direction where Medicaid information is linked to the Bureau of Worker Compensation information, to State employee health care? How are they handling this problem of which system is "the" system and who is going to connect to who?"

Findings and Recommendations

A. Technology Planning and Coordination

Ohio has not engaged in a formal, comprehensive, multi-agency planning process for Medicaid technology. Specifically, ODJFS has not worked with its internal (other State and local agencies) and external (provider and recipient advocacy groups) stakeholders to develop technology related goals and objectives. This can be attributed, in part, to the fact that Ohio Medicaid technology responsibilities are dispersed throughout a number of different State agencies and contracted third-party vendors with no central leadership presence. Similarly, the limited functional capabilities of MMIS and CRIS-E have restricted the possibility of substantially changing business processes to meet users' expectations.

Stakeholders who regularly use the systems commented planning and coordination at the State level. A member of the Ohio Hospital Association remarked that the Association had "gone on the record a number of times" concerning the need to a make changes in the Medicaid information system. The member added "at this point it is really held together week to week to week." A member of the Ohio Association of Community Health Centers stated that "the State has historically had a lot of … stops and starts with regard to technology. Knowing that the State is coming out with a new system in 2008, we can expect that it might be 2010 before it actually comes out." The member said that, given the size of the Medicaid budget, a greater focus on the implementation process for information systems is needed. A representative of the Ohio Health Plans Executive Leadership Committee acknowledged that "with regard to IT, the State has used a band-aid approach to the old system rather than [developing] a long-term solution."

Stakeholders also noted differences in use of technology in other states' Medicaid programs. A member of the Ohio Health Plans Executive Leadership Committee reported that "In Ohio, corrections to input data must be made at the State level, rather than at the local level. In Minnesota, corrections can be made at the local level." A member of AOPHA commented on the difference between Ohio and Kentucky:

> "The marked contrast between Ohio and Kentucky is extraordinary. Their system works. They press a button and you know the answer. The Kentucky Cabinet for Health, which is a single State agency that's a combination of our Department of Aging, our JFS, and our Department of Health. They know what's going on. We were able to find out in three weeks the entire potential universal claims would be …. Why can't we do that?"

Each State agency involved in the Medicaid program develops its own two-year strategic information technology plan as part of the biennium budget process. This plan is subject to review by the Chief Information Officer of the State (the CIO) and the Office of Budget and Management (OBM), both of which have approval authority over the IT budgets of State agencies. Each agency's technology plan includes the following:

- Strategic Plan;
- Mission and Vision;
- Business Drivers;
- Organizational Assessment;
- Business Program Areas;
- Agency Business Goals and Objectives; and
- Tactical Plan.

While each IT budget is subject to approval of the CIO and OBM, each agency is responsible for setting its strategic direction with regards to health IT initiatives. The CIO and OBM do not suggest projects to pursue, coordinate between agencies that provide services under the same program, or determine State priorities for health IT initiatives. Long-term planning beyond the required two year perspective is conducted at the will of the agency. While agencies are undergoing projects which will last longer than two years, no agency has created an IT strategic plan longer than two years. In addition, there are no long-term planning efforts which include all Ohio agencies involved in the Medicaid process.

An example of this isolated planning process is the MITS system being implemented by ODJFS. According to interviews conducted with the ODMH, ODA, and ODMRDD, ODJFS spent minimal time consulting with the sub-recipient agencies before submitting the business plan for MITS to CMS. Each Agency stated that they had meetings with ODJFS about the MITS project, but were not consulted or asked about their individual agency needs or input. The agencies were also not represented in the various assessments conducted by Deloitte as part of the planning process.

The MITS project was designed to meet the requirements of the framework put forth by CMS and to address the needs of ODJFS business processes without formal consideration of all aspects of Medicaid or health care technology. Due to budgetary limitations, the system was designed on the premise that all processes that originate outside ODJFS would be kept as-is. As a result, the current duplication between other systems and MMIS will continue to exist once MITS is implemented.

The United States Department of Health and Human Services is an organizational model for establishing a central leadership presence for wide-ranging health IT issues. In 2004, the federal government established the Office of the National Coordinator for Health Information Technology (the Coordinator). The Coordinator serves as the Secretary of Health and Human Services' primary advisor on issues relating to the development, application, and use of health information technology. The Coordinator also coordinates the Department of Health and Human Services' health information technology programs; ensures that health information technology policy and programs are coordinated with those of other relevant executive branch agencies. Finally, the coordinator develops, maintains, and directs the implementation of a strategic plan to guide the nationwide implementation of interoperable health information technology in both the

public and private health care sectors and provides advice to the Office of Management and Budget regarding federal health information technology programs.

The State of Texas has also implemented a strategic management model which could be applied to Ohio. The Texas Health and Human Services Commission has oversight responsibilities for designated Health and Human Services agencies, and administers certain health and human services programs including the Texas Medicaid Program, Children's Health Insurance Program (CHIP), and Medicaid waste, fraud, and abuse investigations. The commission states its mission as follows: "To provide the leadership and direction and foster the spirit of innovation needed to achieve an efficient and effective health and human services system for Texans."

Under the direction of the Texas Health and Human Services Commission, the State of Texas has developed a five-year strategic plan to coordinate services across 12 different health and human services agencies. This plan included the following key components:

- State and Organizational Level definition of Mission, Vision, and Philosophy;
- Identification of Strategic Directions;
- Internal Assessment of participating organizations and their roles;
- External Assessment of Social, Economic, Legislative, and *Technological* Environment;
- Defined Enterprise Strategies; and
- Agency Strategic Planning and Budgeting Structure (Including performance measures).

Another key component of the plan is that the agencies solicited consumer feedback at various stages of the process. Most notably, each agency held community planning forums to solicit feedback directly related to its consumer activities. The agencies then used this input to develop specific goals, objectives, and strategies for all human services activities, including support activities such as technology. With respect to technology, these forums were used to identify opportunities for agencies to consolidate similar activities and share information in a more efficient manner. Once developed the strategic plan was also made available for public comment. This feedback was used to identify issues which reached across multiple agencies and served as the link between each agency's individual strategic plan and the coordinated strategic plan. Since its 2003 implementation, the plan was reviewed and updated in 2005 and is currently undergoing a review for another update in 2007.

Unlike Texas, ODJFS and the sub-recipient agencies have not developed a health information technology infrastructure which meets the needs of its stakeholders. This is largely due to the fragmented nature of Medicaid in Ohio. Ohio Medicaid, under the current structure, does not have central leadership. ODJFS and sub-recipient agencies are permitted and required by Ohio law to maintain individual budgets and authority. There is no single, unifying force which encourages cohesion and a long-term IT plan. During several stakeholder meetings, providers, local agency representatives, and recipients commented on the poor state of IT in Medicaid. Some stakeholders identified the absence of central leadership on many progressive issues and

much needed health IT initiatives as the cause of the current state of Ohio Medicaid information technology systems. This lack of leadership is a result of fragmented agencies with no unifying accountability.

In some cases, stakeholder groups inquired whether they also would be included in MITS planning. For instance, Members of the Ohio Hospital Association (OHA) asked, "What will be the process when they start looking at this new system? What feedback -- will they come back to us again … and ask us about what current problems we're having with the old system and see what the plans they have for the new system are because that has to be reintroduced?"

OHA members went on to say,

> "I think in terms of the general message that we would want you to take to the General Assembly from the statements here especially about the MIS is that the system is costing us a lot of money, and it has a lot to do with other parts of the program that get money cut from them. We have a budget and the budget doesn't continue to grow as quickly as the costs do, so we're wasting money. They need to do a better job so we can serve the Department and Medicaid recipients better, if we get our automated systems up and running, compliant, working like Medicare."

Likewise, a representative of the Ohio County Commissioners Association commented on interoperability and coordination concerns saying,

> "… [There is a] growing concern about the new computer system that's going to be replacing CRIS-E …and this new Medicaid computer system. …I think we've had enough experience with the system in the past that we know that you really have to keep people focused on interaction because otherwise the people that are working on this system have tunnel vision … We're not convinced that that's happening, that there is any kind of talk between the two."

> "I'm not aware of any organized effort to involve counties in MITS….I guess we're very concerned and very skeptical about whether or not this is going to be different, and it's always better if we get involved at the beginning rather than at the end since we're the major users on some of these things."

Other stakeholders remarked that it seemed like ODJFS waited until the last moment to implement new technology, particularly when federal funding was available. A stakeholder with the Ohio Association of Health Plans said, "Ohio is a state that has not kept up within some of the technology in terms of information sharing back and forth with plans." A member of the Ohio Pharmacists Association put it succinctly: "It's like somebody that never, ever worked in a place designed this stuff to make it as difficult as possible…."

ODJFS needs to seek out and obtain sufficient and consistent feedback in regards to its Medicaid technology, both from sub-recipient agencies and provider groups. The receipt of regular feedback allows for better communication and planning between agencies and others involved in the Medicaid process. The single State Medicaid agency and the sub-recipient agencies should work together to make sure that system technology is efficient and meets all of the different

needs of its users. In the future, users affected by technology changes within the Medicaid system should be involved in the planning and implementation process.

As there is currently no Ohio collective strategic plan for IT which addresses the individual plans, goals and needs of the Medicaid system or Medicaid technology, the MITS project is unlikely to meet the expectations of the General Assembly, State Medicaid agency, or sub-recipient and oversight agencies. A collective strategic plan should be created and each agency which participates in Medicaid should have some involvement in the development of the plan to ensure that the project results in a cohesive and comprehensive system.

R6.1 The State Chief Information Office, with support and assistance from the Governor's Office and General Assembly, should create the position of State Coordinator for Health Information Technology to guide health information technology policy. This position should report to the State Chief Information Officer within the Office of Information Technology. The primary focus of this position should be to provide leadership in creating a single statewide consumer-centric health information technology infrastructure. The State Coordinator for Health Information Technology should serve to ensure that health information technology policy and programs are coordinated with all relevant agencies as well as private industry.

R6.2 The State Coordinator for Health Information Technology (as established in R6.1) should facilitate the development, maintenance, and implementation of a long-term strategic plan which identifies the State's technology needs beyond the two-year plan required by the Office of Information Technology. This plan may serve as the basis for the two year plan, but should maintain a planning horizon of at least five-years.

R6.3 The State Medicaid agency should solicit input from all types of stakeholders when implementing changes to Medicaid technology. The Agency should facilitate an on-going, multi-agency, multi-functional workgroup which represents the needs of all provider groups and agencies that submit claims or have a role in the claims process. This group should meet on a regular basis to discuss the different needs and changes in Medicaid technology.

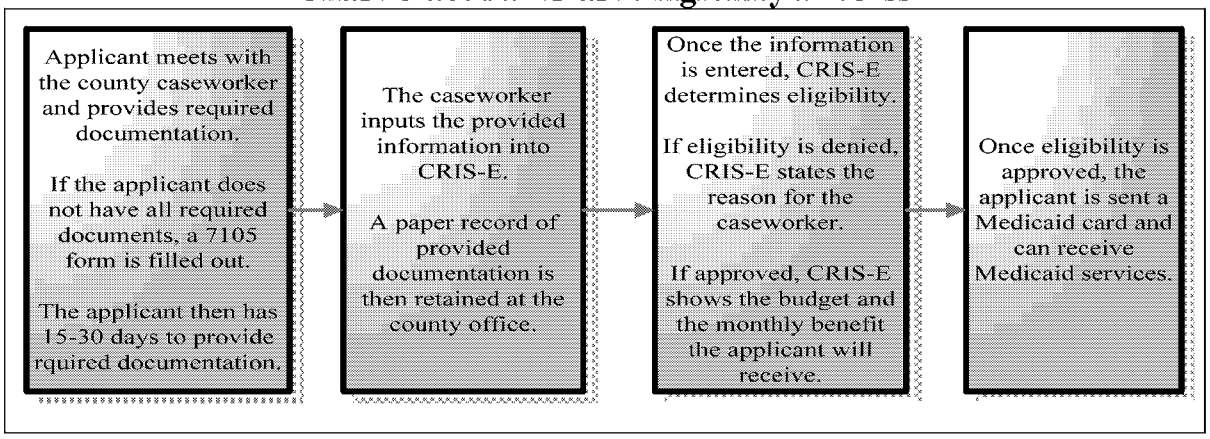
B. Internal Systems Interfaces, Coordination of Benefits, and Third Party Liability

Eligibility Systems

The CDJFS are responsible for determining eligibility for the Medicaid program.[24] The CDJFS are responsible for documenting and recording the determination of eligibility, and subsequently informing the applicant of the eligibility decision. Re-determination of eligibility is also conducted by the CDJFS. Re-determination of Medicaid eligibility is required every 12 months for the aged, blind, and disabled population and Healthy Start program, and every 6 months for covered families and children. (See **Medicaid service provision** section for description of populations and eligibility categories.)

The process of eligibility determination is supported by the CRIS-E system. **Chart 6-10** shows how CRIS-E is used in the eligibility determination process.

Chart 6-10: Medicaid Eligibility Process



Source: OAC 5101:1-38 (Medicaid Eligibility) and Franklin County DJFS

As shown in **Chart 6-10**, the eligibility process begins when a potential recipient meets with a county caseworker and provides the caseworker with the documentation required to verify eligibility. If the potential recipient does not have any of the required documentation, they are given 15 to 30 days to provide it. Once all documentation is received, the caseworker then enters required information into CRIS-E and maintains copies of the documentation for a permanent hard copy file. The CRIS-E system then displays the various programs for which the applicant is eligible, as well as the budget and the monthly benefit level. If the application is denied, CRIS-E displays why, thereby allowing the caseworker to provide an explanation to the applicant.

[24] Except the Ohio Breast and Cervical Project. For this program, eligibility is determined by the Ohio Department of Health.

Information entered into the CRIS-E system is also referenced against the federal Income and Eligibility Verification System (IEVS). IEVS matches data in the CRIS-E system against bank statements, IRS filings, wages, and other financial information collected by the Internal Revenue Service and the Social Security Administration. When the match indicates that the information submitted to the CDJFS is incorrect, the applicant may not be eligible for Medicaid, and the CDJFS is signaled by an automated alert. The CDJFS then has 45 to 120 days to clear the alert by receiving the matched data, comparing the matched information to the information in the eligibility record, obtaining verification when applicable, re-determining eligibility, and initiating appropriate corrective action. All IEVS functions are provided through CRIS-E. Once the CDJFS completes the IEVS match process, the results are recorded in CRIS-E history.

According to CDJFS staff, there are no standard requirements for maintaining the verification documentation supplied to caseworkers. Most counties keep paper copies of these documents in the county office. However, several counties, including Cuyahoga, Butler, and Montgomery, have implemented electronic processes for maintaining documents through document imaging.

During interviews, a number of stakeholder groups and organizations provided feedback on the CRIS-E system and the eligibility process. The recurring themes of these discussions were as follows:

- **The Eligibility Process:** The entire process of eligibility in relation to managed care is very confusing to stakeholders and enrollees. Determination of who is eligible, how they get enrolled in a program, how they become un-enrolled, how they can change plans, and dual coverage is difficult for the lay-person to understand.

- **Eligibility for Children:** Determining eligibility for children whose parents are not both covered by Medicaid is confusing to enrollees. Stakeholders felt that technology was not being effectively used to communicate between the CDJFS and ODJFS regarding eligibility.

- **Eligibility Search:** Stakeholders, particularly providers, felt the CRIS-E system could be enhanced with a search function. If a name is not spelled exactly as it is in the system, it will be difficult to find. This can create confusion when names are spelled with punctuation, like hyphens. Stakeholders would like to see a more flexible system with a search function so that it is easier to identify eligible clients.

- **On-line Eligibility and Health Records:** Being able to obtain eligibility and treatment history information from a web-based system would be helpful, particularly for providers. On-line eligibility information would be preferred to the current voice response system in use for eligibility verification. On-line health records would help providers coordinate care and allow providers to determine if the recipient had already had the type of service or treatment that is planned.

- **Real-time Eligibility and Service History Data:** Real-time data which shows current eligibility and the last date the recipient received certain services would be beneficial to providers. With real time data, providers could ensure patients are eligible (and perhaps even verify the managed care plan in which the recipient is enrolled). Likewise, providers could view statistics about how many services are being rendered on a timelier basis. Currently, available data may be a year old.

Ohio Association of Area Agencies on Aging expressed specific concerns about the eligibility process for elderly Ohioans explaining that CDJFS were focused on medically fragile children and many times an aged client applying for services is intimidated by the environment in the County offices. Additionally, they indicated that aged clients may be treated as a lower priority. The Ohio Association of Community Health Centers noted that transportation to apply for assistance is a barrier for many people in rural communities and that on-line application processes would be very beneficial. Inconsistent documentation requirements were also a noted problem.

A recipient advocate from the Universal Health Care Action Network described her experience in assisting applicants: "Sometimes if you mail in your application, you might never hear from Medicaid again. The problem with that is that when you go to Job and Family Services it takes half of your day, if not all day, just to turn in one application." The advocate also described instances of going to a CDJFS office and finding the line for an appointment running "out the door wrapping around the [outside building] wall." She added that, as an advocate, she has heard many complaints from applicants about eligibility paperwork being lost by CDJFS employees during the application process.

The volume of paperwork was noted on several occasions as well. A member of the Ohio Coalition for Healthy Communities estimated that "each case manager handles [over 100,000] pieces of paper each year." Parents serving as legal guardians for disabled children expressed concerns about the amount of paperwork required to recertify their children for Medicaid coverage. A parent described the re-determination process as follows, "I can't imagine him being able to handle that on his own… there was a lot of paperwork. … It is a complicated process for someone with a disability, a cognitive disability especially, that I'm not sure that he would be able to provide that in order to continue his determination."

The Minnesota Department of Human Services is working with health care stakeholders to develop HealthMatch, a web-based, health care eligibility system. The program is intended to streamline the application and eligibility process by standardizing the rules and processes used by caseworkers. This web-based eligibility system will also serve to improve program access for first-time applicants and current enrollees.

Once completed, Minnesota applicants will have the option to submit their applications online, either on their own or with assistance. Existing program enrollees will be able to manage their

cases directly, with their advocate or a caseworker, using the web or by phone. The information they provide on the automated application process will go directly into the HealthMatch system, reducing the data entry burden on caseworkers and allowing them to focus on matching the needs of the individual with the services available. The system will prompt applicants with a set of rule-based questions, and applicants will be able to find out which programs they may be eligible for based on the information they provide. HealthMatch will also guide applicants (or their representatives) through the eligibility process by retaining their case information and clarifying what information they still need to submit to complete the application. Once completed, verification documents are then mailed or dropped off to the county offices where caseworkers review the documents. Eligibility determination is not complete until documents have been submitted and reviewed by the caseworker. First-time and re-enrollees do not have to meet with a caseworker face-to-face unless they so desire.

Some additional features of HealthMatch aimed at assisting the caseworker are as follows:

- Incorporate changes in eligibility rules quickly, providing a system that contains up-to-date policy information;
- Transfer secure data as needed between counties and with the state, allowing staff to share information;
- Offer accounts receivable features such as calculation and collection of premiums, and generation of billings;[25] and
- Reduced need for paper forms by managing documents electronically.

Some additional features of HealthMatch aimed at assisting the applicant or recipient are as follows:

- Provide anonymity to applicants who would otherwise not be comfortable applying in-person;
- Increase public access points to enable health care providers, schools, and other community organizations with Internet access to help people apply and manage their cases online;
- Create a self-service online site for enrollees which allows them to select health plans, look up premium amounts, manage payments online (via electronic funds transfer or credit card), complete renewals, and check on eligibility status, benefits and other information at their leisure;
- Include online communication links to workers to answer questions (through the self-service site); and
- Offer online information in multiple languages. Upon selection of a language, most benefits, services and consumer-related health care topics will be provided in that

[25] The Minnesota Health Care Program has a mandatory co-pay administered by the county.

language. Notices and premium statements generated by HealthMatch will also be in the enrollee's chosen language.

In addition to HealthMatch, Hennepin County (Minnesota) has implemented county-wide electronic imaging and documentation processing. Hennepin County is the largest county in Minnesota, serving approximately 70,000 clients, and is piloting an initiative to retain all documentation electronically. The Hennepin County system combines Filenet document imaging tools, Microsoft Word, a database of client and worker information, and a collection of business components into a client/server application that provides caseworkers with online access to all of the documentation which would historically have been maintained in hard copy. All incoming correspondence is scanned upon receipt and distributed electronically to caseworkers. Simultaneously, the document is filed in an online case file. Outgoing forms are also generated electronically and stored in the file.

Implementing a web-based enrollment system and electronic documentation standards will increase the efficiency and reliability of the eligibility determination process in several ways. The primary benefit will be the reduction in required face-to-face meetings between recipients and caseworkers. This could reduce caseworker workload and would provide caseworkers with access to documentation obtained in any county office throughout the State. This will improve the caseworkers' ability to serve populations who may relocate from one county to another during their eligibility periods. Furthermore, a reduction in caseworker time dedicated to processing documentation would allow them to focus more time and attention on assisting recipients in gaining independence and becoming self-sufficient.

A web-based enrollment system would also provide several benefits to the applicant. For instance, the system will increase access for applicants. Applicants who might find it difficult to attend a face-to-face meeting would now be able to apply for assistance at their residence or another location.[26] In addition, the web-based system could be especially beneficial for recipients enrolled in managed care plans. A web-based resource similar to Minnesota's would provide all enrollees a single location to obtain information about their plan and evaluate options.

R6.4 The State Medicaid agency should adopt a policy requiring the electronic storage of recipient eligibility verification information in county-level offices. This recommendation applies to programs beyond Medicaid and could be implemented for all programs simultaneously. Storing information electronically will reduce the reliance on paper storage, allow for better document management, and make information more easily accessible for caseworkers. If the State Medicaid agency is separated from ODJFS, the State Medicaid agency and ODJFS should work together to implement this recommendation.

[26] For example, persons in rural areas without access to transportation or recipients who may have mobility issues and find it difficult to travel to the county office.

Financial Implication: **This recommendation would result in a cost savings for each Ohio county. Counties would no longer need to pay for document storage and retention and would also benefit from increased caseworker productivity. However, the cost savings generated by this recommendation could not be quantified because the document storage costs for each county are not available. Similarly, the cost-benefit of redirected caseworker efforts could not be quantified.**

R6.5 The State Medicaid agency should develop an application which allows potential Medicaid recipients to complete eligibility determination forms on-line, either on their own or with the assistance of an advocate or caseworker. This recommendation applies to programs beyond Medicaid but could be implemented for all programs simultaneously. By allowing potential Medicaid recipients to complete eligibility determination forms on-line, the State Medicaid agency would reduce caseworker workload and streamline the eligibility determination process. The on-line process should also be supplemented with the stipulation that applicants are not eligible for benefits until the appropriate documentation has been submitted to their county office by mail, fax, e-mail or by hand-delivery. If the Medicaid function is removed from ODJFS, the State Medicaid agency and ODJFS should work together to implement this recommendation. This recommendation would result in a labor allocation off-set, allowing caseworkers to focus on client assistance and dedicate less time to eligibility determination.

R6.6 In conjunction with R6.4 and R6.5, the State Medicaid agency should pilot an initiative to streamline the eligibility process by installing eligibility kiosks at county offices with high caseloads. This recommendation applies to programs beyond Medicaid but could be implemented for all programs simultaneously. Kiosks would allow capable applicants to apply for services without meeting with a caseworker. Information could be entered into the web application and appropriate documentation could then be submitted and reviewed at a later time. Although the State or county would incur costs for the kiosks, it would increase caseworker efficiency thereby creating opportunities to reduce the number of caseworkers necessary while improving the quality of one-on-one assistance.

Drug Utilization Review (DUR) Systems

The Ohio Medicaid pharmacy program processes pharmacy claims through a point of sale (POS) system operated by Affiliated Computer Services, Incorporated (ACS). The system functions by connecting all Ohio Medicaid pharmacies together and enables a pharmacist to determine, prior to dispensation, whether the drugs requested are over-utilized, under-utilized, contraindicated drug combinations, or not recommended drugs based on the diagnosis. These activities are referred to as Prospective DUR (ProDUR) activities. Before the POS system, this task was performed manually by the pharmacist. This system is available on-line and in real-time for use by pharmacies. In the event a particular drug is not approved, the dispensing pharmacist can notify the prescribing physician of possible alternatives. The prescribing physician may then choose an alternative product or may request prior authorization for the original prescription.

The ProDUR program is one phase of ODJFS' three-phase, comprehensive Drug Utilization and Review (DUR) program. The remaining two phases of the program, Retrospective DUR and Concurrent DUR, are supported by both the POS system and the Ohio Drug Utilization Review (DUR) system maintained by ODJFS.

The RetroDUR program uses data from paid Medicaid claims to generate patient profiles which are then reviewed by the State DUR Board. The review involves evaluating patterns of drug therapy either during or after a patient has completed therapy to identify those who are at risk of drug-induced illness or potential drug over-utilization. The program monitors physicians' prescribing activities to screen for potential adverse drug reactions, therapeutic appropriateness, incorrect drug dose or duration, drug allergy interaction and clinical abuse. When problems are identified, the DUR Board notifies physicians and pharmacies of the finding in an effort to remedy the current situation and prevent future occurrences. RetroDRU is used exclusively to ensure patient safety and is not currently employed to manage care or guide more cost effective treatments. Concurrent DUR performs reviews similar to RetroDUR, with the exception that the evaluation of drug therapy and intervention is conducted while the patient is undergoing therapy.

Electronic prescribing, or "e-prescribing," enables a physician to transmit a prescription electronically to the patient's pharmacy of choice. It also enables physicians and pharmacies to obtain information about the patient's eligibility and medication history from pharmacy benefit managers. Having better access to patient information at the point of care makes writing, filling and receiving prescriptions quicker and easier. E-prescribing can also help reduce prescription errors due to hard-to-read physician handwriting and by transferring the process of checking for drug interactions and allergies from the pharmacy to the point of care. E-prescribing puts DUR information into the hands of physicians before they make the initial prescription.

The California HealthCare Foundation[27] has extensively researched e-prescribing and concluded that health insurers and pharmacy benefit managers can benefit greatly from an e-prescribing program. Potential benefits for insurers and benefit managers include the following:

- Increased formulary adherence;
- Reduced therapeutic duplication;
- Reduction in costs associated with adverse drug events; and
- Improved access to data on physician prescribing patterns.

The Florida Medicaid Program is currently piloting an e-prescribing program for physicians. Now in its second year, Florida Medicaid's Gold Standard e-prescribing program reports having incorporated 3,000 physicians who account for nearly 80 percent of the prescriptions covered by the Medicaid program. The system administrator estimates that during the first full year of the program, it saved the state $700 per doctor per month.

The Florida program provides physicians with 200 days of prescribing information for each Medicaid patient through a handheld device provided by Florida Medicaid. In addition, the handheld device provides decision-support functionality to help physicians avoid over-prescribing, under-prescribing, and identifying adverse drug interactions. The device is also loaded with the Gold Standard drug database and the Medicaid preferred drug list to assist the provider in his or her prescribing activity at the point of patient contact.

ORC §5111.083[28] grants the Director of ODJFS the authority to establish an e-prescribing system for the Medicaid program. According to the statute, the e-prescribing system shall eliminate the need for Medicaid providers to make handwritten or telephone prescriptions for Medicaid recipients. The e-prescribing system also should provide such Medicaid providers with an up-to-date, clinically relevant drug information database and a system of electronically monitoring Medicaid recipients' medical history, drug regimen compliance, and fraud and abuse. The FY 2006-07 ODJFS IT plan does not include an e-prescribing initiative. According to ODJFS, the Department will be evaluating this option in conjunction with the implementation of the pharmacy service contract which took effect in July 2006.

When asked about e-prescribing, providers were generally supportive of the idea. A physician commented during a stakeholder meeting:

[27] The California HealthCare Foundation is an independent philanthropy committed to improving the way health care is delivered and financed in California, and helping consumers make informed health care and coverage decisions. Formed in 1996, its goal is to ensure that all Californians have access to affordable, quality health care. CHCF commissions research and analysis, publishes and disseminates information, convenes stakeholders, and funds development of programs and models aimed at improving the health care delivery and financing systems.

[28] Originally ORC § 5111.084, this was renumbered on July 1, 2006.

> "Electronic prescribing would be a wonderful idea because that is one of the major sticking points in terms of formulary coverage. I use a software package to write my prescriptions and the Medicaid formulary in Ohio is not part of it…so it really kind of leaves me in the dark because I am used to buzzing through with [commercial insurers]… and have them linked to the formulary so I know what I can write and what I can't write. That would be really nice to have an online capability where I could go online and look to see what the preferred [drug] … would be. …[Sometimes] I just get a phone call from the pharmacist, "This isn't covered." I don't get the answer to the next question which is, "What is covered?" So then we have to try to call someone and figure what it is and it bogs down my staff rather significantly....
>
> *Member, Ohio State Medical Association*

According to a representative of ZixCorp, the vendor who initiated the Massachusetts e-prescribing program, a typical payer initiated pilot program lasts two years and involves the following activities:

- In year one, approximately 500 to 1,000 providers are recruited to participate. This recruitment is typically performed by the vendor selected by the payer to initiate the e-prescribing program.

- The payer funds the first year of implementation for the recruited providers. This includes the purchase of handheld equipment, maintenance services, licensing and software, wireless infrastructure, and point of care training. These costs vary based on the needs of each provider.

- In year two, the provider starts paying a fee of approximately $600 per program participant to continue software licensing, maintenance, and training services. At this point payers incur no costs for the program but in order to encourage participation, payers frequently subsidize a portion of this cost. For example, a payer may offer a small monthly incentive for providers with low error rates or for meeting other performance targets.

- While not mandatory, after three years, providers may upgrade handheld equipment at a cost of about $200-$300 per device.

As the healthcare industry continues to develop electronic health records, many private providers are electing to implement e-prescribing programs. However, this may create a challenge for health plans as the private providers select systems which meet their own needs and do not consider factors such as interoperability with state IT systems. By initiating a pilot e-prescribing program, Ohio can encourage providers to adopt systems which will meet set standards for interoperability with State systems.

R6.7 The State Medicaid agency should pilot an e-prescribing program for Medicaid providers and develop a plan to implement e-prescribing statewide. The Agency should consider subsidizing providers who participate in the pilot program and who participate in rural areas. Likewise, it should offer financial incentives to ensure

rapid statewide adoption by all active providers. In addition, to achieving cost-savings through improved prescribing methods, implementation of e-prescribing would have an additional benefit to patients through reduced adverse reactions.

Financial Implication: **If the State Medicaid agency implemented e-prescribing for primary care physicians alone (about 7,400 physicians out of the 42,000 active Medicaid providers) and achieved savings comparable to Florida (about $700 per physician per month), the State could achieve savings of up to $5 million per month or $62.2 million annually. A portion of this savings would be reduced by the implementation cost which would be borne, at least in part, by the State Medicaid agency.**

Coordination of Benefits and Third-Party Liability

ODJFS is responsible for the coordination of benefits for Medicaid consumers in order to assure that Medicaid is the payer of last resort. The goal of benefits coordination is to minimize Medicaid's financial liability when enrollees have other sources of health insurance. States are generally required to utilize cost avoidance for claims[29] unless they have a waiver approved by CMS which allows them to use the "pay and chase" method. Ohio has been granted a waiver. However, the cost avoidance method has traditionally been more effective and less costly than pay and chase. In SFY 2004-05, Ohio Medicaid reported avoiding $474 million in up front costs while collecting $180 million by pay and chase.[30] Strictly in terms of the State contribution, Ohio Medicaid avoided $191 million in costs and collected $73 million through pay and chase.[31] It should be noted that the money saved by cost avoidance is simply that which would have been billed to Medicaid had the applicant not disclosed third-party liability to the caseworker. This requires no specific dedicated resources beyond a small portion of the caseworker's time. ODJFS has not dedicated specific resources to enhance cost-avoidance.

Technology used to support third party liability identification is limited. Currently, CDJFS staff obtains information from Medicaid applicants concerning other health insurance coverage and inputs that information on the Medical Insurance Coverage screen in the CRIS-E eligibility system. This system interfaces with MMIS and automatically updates a master file of third party liability.

Once a claim is entered into MMIS, it is referenced against this master third party liability file. If the file indicates that the recipient on the claims does have other insurance coverage, the claim is denied. The remittance notice to the provider who submitted the claim will then list the

[29] Preventing Medicaid payment when other health insurance coverage exists. The provider of services bills and collects from liable third parties before sending the claim to Medicaid.
[30] These amounts represent both State & federal shares; the federal share is returned to the federal government.
[31] These amounts are prior to commissions paid to Ohio's contracted vendors who perform these services.

information pertaining to the recipient's other insurance so that the provider may request payment from the recipient's other insurer before billing Medicaid.[32]

In 1999, the Ohio Medicaid program's Third Party Liability Report reported that resources have not been able to keep up with the verification of third party liability source documents and a backlog existed. This was because CRIS-E and MMIS did not exchange third party liability information. At the time, all third party liability information had to be manually transferred into MMIS. However, during the last year (2005) this problem was corrected and information now transfers automatically. Because of the complexities and problems receiving third party liability information prior to payments, ODJFS has contracted with an outside vendor since at least 1994 to obtain third party liability information and recover payments that should have been made by other insurers. This is done by linking ODJFS data with that of other insurance carriers. The vendor is also responsible for recovering other Medicaid expenditures associated with workers' compensation, accidents or injuries through casualty settlements, or malpractice settlements.

Stakeholders reported numerous problems with the coordination of benefits process in Ohio. A stakeholder with the National Multiple Sclerosis Society in Ohio remarked that, as a provider, he is reliant on the recipient to identify other payer sources as the Medicaid card is not an accurate indicator of this information. He felt this was an area where the State could improve and it could result in savings if the State is serving only as the payer of last resort. A member of the Ohio Pharmacists Association noted that pharmacists struggle with coordination of benefits as, in his pharmacy, the Medicaid process is manual. He went on to explain that this process is automated for commercial insurance companies.

A member of the Ohio Children's Hospital Association said:

> "I used to work in Medicaid in another state, and when I arrived in Ohio and discovered that the third party recovery efforts were anemic at best, I was shocked. I think the State has an obligation because it has the resources to make sure that it enforces its own requirements to be the payer of last resort."

Also, a member of the Ohio American College of Emergency Physicians explained that coordination of benefits for children of divorced parents is a problem because the custodial parent often does not have information about the non-custodial parent's insurance in instances where medical coverage is mandated by court decree. In these cases, physicians are often unable to fully bill for their services because Medicaid rejects the claim but the physician has no information on the commercial insurance or the period for claims submission has passed.

Stakeholders with Arc of Ohio noted that Medicaid in Ohio could improve its record for recouping costs from commercial insurance. The stakeholder noted that Ohio Medicaid is

[32] This information was taken from a report published prior to ODHS becoming ODJFS. Information regarding the county third party liability process as well as CRIS-E and MMIS third party information was verified in an interview with Summit CDJFS. The department names have been updated to reflect current information.

insufficiently aggressive in its pursuit of third party payers. Finally, a representative from the Ohio County Commissioners Association recommended better data sharing across agencies as persons working on Medicaid and child support should be able to share third-party liability information.

According to Healthcare Industry Pulse (BDO Siedman, LLP,[33] January 2005), Digital Healthcare Inc. has developed a technology which will automate the preemptive identification of third party liability using the electronic transactions established under HIPPA. This patented technology acts as a massive switchboard that routes medical claims to the proper payer. According to Digital Healthcare, Inc. other benefits of this technology include:

- Reduction in the number of claims actually received by the payer (resulting in potential staffing savings);
- Compliance with HIPAA mandates for the effective handling of electronic eligibility inquiries;
- Reserve requirements adjusted downward to reflect reduced claims expenses (due to an organization paying less in claims, the associated reserve requirement to cover claims expenses would be reduced as well); and
- Administrative simplification resulting in reduced costs of audit and recovery.

According to Digital Healthcare, it maintains a database of approximately 4,000 payers and identifies the proper primary payer of each medical claim, returning sufficient detail to commence recovery operations. The business process touches on every class of medical provider that submits a claim for medical services in the most common coding formats -- the International Classification of Diseases/Current Procedural Terminology or Diagnosis Related Group -- but does not include regular nursing home care.

Rather than pay and chase, an automated coordination of benefits process could look at an expanded database of payers in real-time before a claim is filed and re-route it to the proper primary payer. Remaining costs, such as co-pays associated with the commercial insurance, would be billed to Medicaid. This could result in a higher volume of cost avoidance and reduce the amount the State pays to contractors who chase claims after they have been paid, thereby increasing the State's return, improving the billing process for medical providers, and avoiding the inappropriate payment of claims.

R6.8 The State Medicaid agency should pilot an automated pre-emptive coordination of benefits process. The State Medicaid agency should review the results in conjunction with the recoveries collected by the pay and chase contractor during the same time

[33] BDO Siedman, LLP is a national professional services firm which provides assurance, tax, financial, risk advisory, and consulting services. Digital Healthcare is highlighted in the report only as an example of the types of technology being developed that could be used for pre-emptive coordination of benefits and is not an endorsement of any specific vendor.

period to determine if an automated system would have identified those same recoveries and if the pre-emptive process would produce greater savings for the State.

If the State Medicaid agency elects to contract with a vendor to implement a pilot program, it should ensure that the service contract is structured so that confidential information is fully protected and that the State is protected from liability related to the project. Additional attention to these matters would be required as the technology has not been implemented in other states.

Financial Implication: **A vendor has proposed a pilot program which would examine claims from October 2003 through January 2006. The proposal was based on a set charge per claim, with a ceiling for the total charges incurred. Assuming on-going services could be obtained for all EDI claims at the rate per claim identified in this proposal, with no cost ceiling, this process would have cost the State approximately $942,400 in calendar year 2005. Ohio's current contract for "pay and chase" third party liability recovery requires a commission of 3.95 percent of actual recoveries. Ohio Medicaid reported collections of approximately $180 million in SFY 2004-05. Based on this amount, Ohio's current contract would have resulted in cost per claim more than twice that proposed by the vendor. Based on the estimates of the pilot program proposal, and assuming the technology could be carried over to ongoing operations, the automated coordination of benefits could serve to eliminate the need for pay and chase collections and could have saved the State up to $6.2 million (based on CY 2005 claims). This estimate does not include the cost to develop or implement this technology.**

C. Interfaces with Other State Agencies

MBS, PIMS, and PAWS Interface with MMIS

As shown in **Chart 6-6**, MBS is the system ODMRDD uses to reimburse providers for services. MBS serves as the gateway through which all claims are submitted to ODMRDD. Once submitted, MBS references the claim against the authorization information contained in the PAWS system. PAWS contains service plan information which must be verified before a claim is paid. **Table 6-1** compares the data checks performed by MBS and PAWS to those which are performed by MMIS.

Table 6-1: Comparison of Claim Review Activities

ODJFS: MMIS	ODMRDD: MBS and PAWS
• Data Validity • Recipient Eligibility • Provider Validation • Pricing • Prior Authorization. • Duplicate Checking • History Related Review	• Data Validity (MBS) • Recipient Eligibility (PAWS) • Provider Validation (PAWS) • Pricing (PAWS) • Prior Authorization (PAWS) • Service Plan Data (PAWS)

Source: ODJFS and ODMRDD

As shown in **Table 6-1**, MBS and PAWS perform edit checks very similar to those performed by MMIS. The difference between the systems is that, for all edits, MMIS checks against the parameters of the Medicaid program while MBS and PAWS check against the service plan parameters defined by ODMRDD. ODJFS does not collect service plan information from sub-recipient agencies and, therefore, MMIS is not capable of adjudicating claims against that information.

MBS and PAWS perform edit checks against different types of information with one exception -- recipient Medicaid eligibility. For this particular edit, the information referenced by MBS through PAWS is obtained directly from MMIS. MMIS updates a master recipient eligibility file every night based on information obtained from CRIS-E. Each month, this file is uploaded into PAWS.

Prior to the implementation of PAWS, ODMRDD adjudicated claims through edits in the MBS system. PAWS was implemented to allow better management of individual cases. As a result, the only edit performed by MBS now is a high-level check of data validity. The remaining edits are performed through a link to PAWS.

ODMRDD provided several explanations for maintaining their own processes rather than attempting to consolidate operations with ODJFS. These explanations are provided below:

- **Privacy Concerns:** Recipient information is considered sensitive material and ODMRDD is concerned that proper access limitations are not in place at ODJFS. Therefore, ODMRDD is not sure that privacy can be maintained if service plan information is shared across agencies.

- **Oversight Ability:** According to several sub-recipient agencies (not just ODMRDD) MMIS does not adequately recognize differences in programs. In some cases, claims from one program are denied due to a business rule which was created for another, unrelated program. Through the years, they have found ways to work around these

problems. Sub-recipient agencies are concerned that a consolidation of systems would make old issues resurface.

- **Accuracy of Data:** Sub-recipient agencies indicated that they were closer to, and had better knowledge of, their recipients and providers than ODJFS. One concern was that the eligibility update process is very slow, resulting in inaccurate eligibility information in the claim processing system.[34]

- **Data Acceptance Capabilities:** MMIS does not have the ability to accept claims through a web portal or the downloading of flat files. These are two of the three formats used by MRDD providers.

- **Provider Identification:** Claims are bundled under a single provider number before being submitted to ODJFS. The single provider number identifies ODMRDD as the payee of the claim.

Similar to the claims processing and case management systems used by the ODMRDD, the PASSPORT Information Management System (PIMS) is used by the PASSPORT Agency Administrators to reimburse providers for services. PIMS also maintains service authorization information for enrollees and serves as the adjudication system for claims that ODA submits to ODJFS. **Table 6-2** compares the data checks performed by PIMS to those which are performed by MMIS.

Table 6-2: Comparison of Claim Review Activities

ODJFS: MMIS	ODA: PIMS
• Data Validity • Recipient Eligibility • Provider Validation • Pricing • Prior Authorization • Duplicate Checking • History Related Review	• Data Validity • Recipient Eligibility • Provider Validation • Pricing • Prior Authorization • Duplicate Checking

Source: ODJFS and ODA

ODA does not describe PIMS as an adjudication system, but rather a flagging system which identifies potentially erroneous claims before they are submitted to ODJFS. However, as shown in **Table 6-2**, PAAs pay claims based on the results of checks against information contained in

[34] ODMRDD updates recipient information through the service plan. If the person is no longer active, the service plan will show the inactive status and cause the system to reject the claim. Updates to CRIS-E, on the other hand, may take several weeks and, if CRIS-E were the only eligibility check, some inappropriate claims would potentially be processed.

PIMS and then send the claims to ODA for submission to ODJFS. Therefore, the true use of the system is to adjudicate claims. The difference between the systems is that MMIS checks against the parameters of the Medicaid Program while PIMS primarily checks against the service plan parameters defined by the Passport Area Administrators (PAA's). ODJFS does not collect detailed service plan information for sub-recipient agencies and therefore, MMIS is not capable of adjudicating claims against that information. However, in two cases, PIMS and MMIS adjudicate against the same information. For recipient Medicaid eligibility, the information referenced by PIMS is obtained from CRIS-E. Similarly, ODJFS obtains provider eligibility information from ODA. ODA submits provider eligibility information to ODJFS through electronic file transfer.

During interviews, ODA highlighted several problems and inefficiencies in the ODA claims process, some of which exist due to technology related issues. These inefficiencies were as follows:

- **Eligibility Delays:** According to ODA, it currently takes several months to verify PASSPORT eligibility. ODA identified several causes for this delay. First, enrollees do not always submit required documentation to the CDJFS in a timely manner, or if they do, it may not be processed in a timely manner. Second, PASSPORT eligibility is more restrictive than Medicaid eligibility, resulting in additional information which must be submitted and verified. Finally, there is no direct link between PIMS and MMIS or CRIS-E to download eligibility information into PIMS. Medicaid eligibility information is manually entered into PIMS by PAA's. No formal impact analyses have been completed to determine how each of these issues impacts the system as a whole.

- **Adjusting Payments from ODJFS to ODA:** ODA can only return money from incorrectly paid or overpaid claims manually. There is no way to process adjustments electronically so ODA must send a paper check to ODJFS for overpayments. It should be noted that this does not include payments from ODA to providers. According to ODA, if claims were processed upon receipt, this would result in ODA sending several hundred paper checks to ODJFS every month. In order to avoid this, ODA holds claims for two months prior to submission to ODJFS. ODA estimates that most adjustments take place within 30 days after the original claim, so ODA accepts, reviews, and pays the claims then waits until the next month's claims are submitted and deducts the negative adjustments from the prior month's total. This creates a net total, which is then reported to ODJFS.

- **Adjusting Payments from ODA to PAAs:** Under the current system, ODA must absorb the cost of claims it has paid but which are rejected by ODJFS. According to ODA, many of these instances result from lags in both the recipient and provider eligibility process. Therefore, both PAAs and ODA pay claims based on their presumption of whether or not the provider or enrollee will meet eligibility standards. Once a final

determination of eligibility is complete, ODA recoups the payment from ODJFS. For those cases rejected by ODJFS, ODA is unable to obtain reimbursement for the federal share.

- **Duplicate Recognition:** According to ODA, ODJFS has removed the duplicate check for date, provider, and service to stop MMIS from incorrectly rejecting ODA claims. To stop these claims from being rejected, ODJFS set up service codes with a unit "ceiling" (maximum amount to be paid per unit). Providers then have to send in multiple entries to get the correct amount if the ceiling is too low. For example, if a vendor installs a wheelchair ramp at a cost of $5,000 but the claim ceiling is set at $10 per service, the provider has to submit 500 $10 claims. According to ODA, this is because MMIS does not apply a different set of edits for each program. This method of submitting multiple claims was created to work around edits designed to adjudicate claims from other programs.

ODA provided several explanations for maintaining its own processes rather than attempting to consolidate operations with ODJFS. These explanations are discussed below:

- **Oversight Ability:** According to several sub-recipient agencies (not just ODA) MMIS does not adequately recognize differences in programs. In some cases, claims from one program get denied due to a business rule which was created for another, unrelated program. Through the years, they have found ways to work around these problems. Sub-recipient agencies are concerned that a consolidation of systems would make old issues resurface.

- **Accuracy of Data:** Sub-recipient agencies indicated that they were closer to, and had better knowledge of, their recipients and providers than ODJFS. One concern was that the eligibility update process is very slow, resulting in inaccurate eligibility information in the claim processing system.

- **Payment Delays:** According to ODA, due to problems with the determination of eligibility, it would likely take a minimum of 6 months to pay most claims. This would be a significant deterrent for providers and likely result in significantly fewer providers willing to participate in the Program.

- **Legality:** By law, providers must be paid by the Area Agencies on Aging. If the claims were to be sent directly to the Medicaid agency, it would then be the payer. A change in the process would require a change in Ohio law.

However, the Area Agencies on Aging directors also indicated that there is a fragmentation of eligibility and silos of care. Agency representatives expressed concern over coordination of

providers and benefits from other agencies. Consolidating systems could help ODA improve this aspect of care provision.

Furthermore, during stakeholder discussions with PASSPORT Agency directors, a representative recommended moving to a one payor/case management system to ensure coordinated quality care is reimbursed appropriately. Under the current process, ODA pays PASSPORT providers and other services are paid through ODJFS. AAA directors cited the need for seamless information sharing, particularly for dual need individuals who may be served by ODA but receive Medicaid services through other systems (e.g., behavioral health).

Ideally, the claims process should be able to pass claims through a single adjudication process and ensure that all payees are reimbursed in a timely manner. As previously mentioned, the claims processing flow between ODJFS and the sub-recipient agencies (ODMRDD and ODA) does not meet this criterion. However, during the course of the performance audit, the states of New York and Pennsylvania were identified as having single adjudication processes which process claims through multiple state departments. These systems are discussed below.

With the implementation of PAWS, MBS has become primarily a gateway system which facilitates the receipt of claims. The New York Medicaid program has implemented a claims processing system for MRDD claims which does not require a gateway system like MBS. Similar to Ohio, the system allows providers of MRDD services to submit claims to a single system. However, New York's system does not require the sub-recipient agency to adjudicate the claims and then submit the claims to the New York State Medicaid agency for a second adjudication. New York's system allows for a single adjudication while providing management information to both the sub-recipient agency and the New York State Medicaid agency. This system is managed by the New York State Department of Health (the single State administrator of the Medicaid program) with assistance from the New York State Office of Mental Retardation and Developmental Disabilities.

Medicaid Service Coordination is a New York Medicaid State Plan service provided by The New York State Office of Mental Retardation and Developmental Disabilities (NYMRDD). The Office requires that service providers register with its Tracking and Billing System. The Tracking and Billing System is used extensively in administering the Medicaid Service Coordination system, allowing the Office to better manage services in its area by determining the number of people a vendor serves at any point in time. By contract, the providers may only bill the New York MMIS for the people assigned to it. This process is similar to Ohio. The key difference being that in New York, the contracts grant the provider a Medicaid Service Coordination ID which is then used to identify the provider in the New York MMIS system. Once these parameters have been established, the providers submit claims directly through MMIS. NYMRDD does not accept claims directly but does provide vendor assistance. The result is a system in which NYMRDD does not perform the second adjudication which is currently performed by ODMRDD.

The Pennsylvania Department of Aging (PDA) provides another example of a more efficient claims process. The PDA has cooperated with the Pennsylvania Office of Medical Assistance Programs (the State's Medicaid Administrator) to implement a claims processing system for waiver claims which would address most of the inefficiencies in Ohio's program.

Pennsylvania providers who perform Department of Aging waiver services submit claims to the Office of Medical Assistance Programs where they are processed through MMIS for a single adjudication. Based on the results of the adjudication, the Office of Medical Assistance Programs then requests payment from the Pennsylvania Treasury Department. Payments are disbursed through check or electronic funds transfer. Under this system, the PDA's primary responsibility is to reconcile paid claims against the original service order. This reconciliation is facilitated through a system which is the equivalent of Ohio's PIMS.

Based on the business requirements established for the MITS project, MITS could provide an opportunity to consolidate systems resulting in the elimination of MBS and a reduced reliance on PIMS. Some key features of MITS should provide ODJFS with the ability to address some of the consolidation concerns identified by ODMRDD and ODA. These factors are detailed below:

- **Privacy Concerns:** MITS will have enhanced role-based security providing ODJFS increased control over what information employees may access. Access to information in MITS will be limited to only that which is required for a specific job duty. This new security feature would allow ODMRDD and ODJFS to specify who gets access to what data in the Inter-Agency Agreement.

- **Oversight Ability:** MITS will be enhanced with rules-based technology which should allow the system to adjudicate claims differently based on which sub-recipient agency originates the claim. Therefore, if a direct connection existed between MITS and PAWS or PIMS, the system could be designed so that once a claim is identified as being from an ODMRDD or ODA provider, the system will call on a set of rules specifically designed to adjudicate claims for those services. The system could then transfer paid claims information to ODMRDD or ODA for reconciliation.

- **Data Acceptance:** Currently, MMIS will accept standard EDI transactions but does not support the web-portal and flat file submission options offered to providers by ODMRDD. MITS will still not be able to accept flat file submissions, but will provide a web-based portal entry system.

- **Provider Identification:** HIPAA mandates that healthcare providers, whether they are individuals or organizations, obtain a National Provider Identifier (NPI) to identify themselves in HIPAA standard transactions. Once established, the NPI stays with the provider regardless of job or location changes. MITS will be designed to support the National Provider Identifier. Using this number, ODJFS should be able to identify and

track MRDD providers and submit payment back to ODMRDD. The NPI will also eliminate any inconsistencies in provider identification between the two agencies.

- **Adjustment Processing:** Currently, MMIS has the ability to process negative adjustments for most fee-for-service providers. These adjustments are facilitated by the EDI claims submission and remittance process. This service is not available for ODA claims because MMIS is not able to recognize the differences in programs and each sub-recipient agency maintains different case management software which creates unique requirements. With the previously detailed rules-based technology and the transition to EDI claims, this problem should diminish in the future.

In addition to MITS, the Business Intelligence Unit of ODJFS has implemented new procedures to assist in resolving the issues associated with eligibility determination. Using the Data Warehouse, the Business Intelligence Unit has developed a standard report which shows eligibility applications which have been pending for 30, 60, and greater than 90 days. This tool will be in use by the end of 2006 and should provide CDJFS with the necessary tools to resolve longstanding applications.

Another key benefit of a consolidated system should be a decrease in the amount of time it takes providers to receive reimbursements. ODMRDD reported that it currently takes a minimum of 21 days for a claim to be paid. If there is a problem with the claim and it does not clear the adjudication process the first time, then the claim must start the process over, resulting in a minimum of 21 additional days of processing. In comparison, ODJFS processes claims in a minimum of 8 days. Therefore, if claims were entered directly into a central system which then adjudicated claims against ODMRDD program information, the minimum time it would take to pay clean claims would decrease by 13 days or approximately 62 percent.

R6.9 The State Medicaid agency should coordinate with ODMRDD and ODA to consolidate claims processing systems activities. This effort should be aimed at designing a workflow model which centralizes claims acceptance with the State Medicaid agency but pulls information from PAWS and PIMS for adjudication. This redesigned process should eliminate the need to maintain MBS.

The State Medicaid agency should also consider a workflow model similar to Pennsylvania where the role of ODA (or any other applicable sub-recipient agency) should be to reconcile claims with service plans and report discrepancies to the State Medicaid agency. A central component of this would be the revision of the ODA payment process so that claims are not paid until ODA is assured that it will receive reimbursement for the federal share from ODJFS.

This process should be designed prior to, and implemented in conjunction with, the roll-out of MITS. As part of this effort, ODA and ODMRDD should also monitor

the timeliness of payments to providers to ensure that existing levels of service are maintained or improved. This consolidation should also be designed with considerations for any unique requirements related to securing and sharing ODMRDD and ODA data.

Financial Implication: **Moving to a centralized system within the single State Medicaid agency and eliminating MBS would result in about $800,000 in annual cost savings in staff, maintenance, and operating costs. Also, according to ODA, the Department submits approximately $6 million in claims per month, 0.7 percent of which are rejected by ODJFS. Therefore, ODA pays approximately $42,000 in claims per month that it would not pay if the claim were to go through the State Medicaid agency first, and the Agency was the source of the payment. If the State Medicaid agency were the source of payment, ODA could avoid about $500,000 annually in un-reimbursed federal match that has been inappropriately paid on rejected claims.**

R6.10 ODA and the State Medicaid agency should review the processes which results in the manual entry of Medicaid eligibility data into PIMS. ODA and the State Medicaid agency should seek to transfer this information through electronic file transfer.

Financial Implication: **ODA does not have staff whose primary responsibility is to input Medicaid eligibility data into PIMS. However, ODA makes this a secondary function of several staff. By streamlining this processing, ODA will be able to re-distribute staff to other activities, eventually resulting in cost savings through the elimination of unnecessary positions. This potential savings could not be determined from available data.**

D. Data Warehousing, Decision Support and Electronic Health Records

An analysis of the information technology used by ODJFS and sub-recipient agencies shows that Medicaid information is stored in three separate data repositories. ODJFS and ODMRDD operate their own data warehouses while ODMH and ODADAS share a data mart. In 2005, ODJFS, in conjunction with the Office of Information Technology, issued an RFP to explore the possibility of consolidating these data repositories into a single data warehouse. ODJFS has contracted with Fox Systems to evaluate the Data Warehouse and MedStat, the ODJFS decision support system. Fox Systems has recently released the results of these assessments.

Fox Systems used interviews with nine[35] agencies and bureaus and held Joint Application Requirement (JAR) sessions to review and validate the current understanding of the information

[35] ODA, ODMRDD, ODH, ODJFS, the Governor's Office, AOS, AG, ODADAS, and ODMH

collected. The sessions also identified any inter-agency data sharing and data warehousing functions, and developed a vision for future Data Warehouse needs. The project included an evaluation of the current system state, an outline of the desired functionality (a future state), and a technical review of system needs and the availability of technology to meet this desired future state. The draft report outlines the following desired outcomes for the future system:

- Information should empower decision making at all levels of the health care system.
- State agencies should have access to information that improves the continuity and quality of health care for the consumers they serve, and which measures the performance of the delivery systems they operate and the providers they manage.
- Information should be made available to State agencies within the context of federal and State privacy, security, and confidentiality statutes.
- State agencies should share access to the same data for the purposes of policy analysis, program oversight and budget development, and program integrity.
- State agencies that use or provide data to the Medicaid Data Warehouse should have a role in its governance.
- State agencies should have access to a comprehensive data mart (Decision Support System) or be able to build their own data marts from their agency's data and the main Data Warehouse.

The Fox Systems report also presents a future state in which Data Warehouse information is accessible through three separate portals; a State portal, a county and regional board portal, and a public portal. Each portal would provide access to different levels of information. However, it should be noted that while this report acknowledges the role of county users, it was largely developed from the level perspective and does not extensively identify or address the needs of county level users.

The Michigan Department of Community Health (MDCH) and the Michigan Department of Human Services have developed an enterprise data warehouse which integrates 11 separate data sources into a single, integrated environment. These include:

- Medicaid providers and recipients,
- Medicaid claims,
- Medicaid encounters
- Women, Infants & Children (WIC),
- Vital Records,

- Michigan Child Immunization Registry (MCIR),
- Pregnancy Risk Assessment Monitoring System (PRAMS),
- Maternal and Child Health Advocacy Services,
- Newborn Metabolic and Hearing Screening,
- Childhood Lead Poisoning Prevention, and
- Epidemiology.

Its enterprise data warehouse has become the critical tool to help MDCH improve its delivery of health-care services, determine which programs are most effective, detect fraud and abuse, reduce overall cost to taxpayers, and predict the State's health-care needs and priorities for years to come.

This integration of data across the MDCH enterprise, coupled with the Unique Client Identifier,[36] has provided the Department with broader health care analysis capabilities, better information sharing, more efficient access for staff personnel to data contained in the warehouse, and more rapid decision making capability. The Unique Client Identifier identifies and organizes data on all services that an individual receives across all programs. It enhances the ability to do pattern analysis, identifies gaps and duplication of services, and provides a common source for data rather than multiple programs. This promotes consistent, more efficient reporting across programs. However, it should be noted that the Michigan Data Warehouse does not include data from Mental Health related services. Data for these services are subjected to stringent rules concerning privacy. Therefore, integrating them into a Unique Client Identifier environment may be challenging. However, the Fox Systems report expresses the opinion that these requirements could be preserved in an enterprise data warehouse environment.

The advanced health-care analysis capabilities of the system enables geographic analysis, cost/benefit analyses of specific health-care services, and patterns of services and expenditures by provider, specialty, county, age, and many other categories. MDCH can make decisions about programs, providers, fees, and levels of care in a timelier manner based on a "total view" of services provided to a recipient and an overall pattern in a particular category (age, geography, etc.)

ODJFS does not have a timetable for implementation of a new data warehouse. As of the time of reporting, the Department was reviewing the Fox Systems report and indicated that it might issue an RFP for a new data warehouse within a year.

[36] The unique client identifier is a single number which identifies patients across multiple health systems.

R6.11 The State Medicaid agency should coordinate an effort to consolidate the data warehousing activities of various State agencies. This effort should be aimed at centralizing the data warehouse environment within the State Medicaid agency to reduce the duplication that exists between ODJFS and sub-recipient agencies. This effort should be conducted with input from the central IT security authority (as established in R6.18). Although a consolidation of data warehousing would result in cost savings by reducing the resources needed to maintain separate systems, the amount could not be quantified.

Electronic Health Records

As noted in the **organizational issues** section, OHP does not collect a substantial amount of clinical outcome information. This is due to the fact that the Ohio Medicaid program is not supported by the technological infrastructure necessary to retain and analyze this type of data. The Data Warehouse is a repository which collects data from each system and relational database which is then used to managed the Medicaid program. However, the information in Data Warehouse is limited to that information which can be derived from claims and standard Health Employer Data and Information Set[37] (HEDIS) indicators. There is no established link between the Data Warehouse and the clinical data collected by private healthcare providers who support electronic health record (EHR) technology.

Quality measures are mechanisms that enable users to quantify the quality of a selected aspect of care by comparing it to an industry standard or other criteria. In the case of Medicaid, quality indicators would permit the State Medicaid agency to determine the types of treatment sought and the efficacy of that treatment. Several different types of information can be captured to measure health care quality, including the following:

- **Access** – Measures the patient's receipt of timely and appropriate health care. These measures may identify barriers to access which could include inability to pay for health care; difficulty traveling to health care facilities; unavailability of health care facilities; lack of a "medical home;" cultural and health beliefs that prevent recognition of the need for, and benefits of, health care; and disparities in responding to persons seeking health care.

- **Outcome** - Outcome-based measures of quality reflect the impact of multiple processes of care. Outcome measures may suggest specific areas of care that require quality improvement.

[37] HEDIS is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care plans.

- **Patient Experience** - A patient experience measure aggregates reports of patients about their observations of, and participation in, health care. These measures provide the patient perspective on quality of care.

- **Process** - A process measure assesses a health care service provided to, or on behalf of, a patient. Process measures are often used to assess adherence to recommendations for clinical practice based on evidence or consensus. To a greater extent than outcome measures, process measures can identify specific areas of care that require improvement.

- **Structure** - A structure measure is a feature of a health care organization or clinician relevant to its capacity to provide health care. Structure data describe the capability of organizations or professionals rather than care provided to, or results achieved for, specific patients or groups of patients. For example, nurse/patient ratio is a structure-based measure because it does not describe care given to specific patients or specific groups of patients.

To regularly collect quality measure data, there must be an established link between the databases maintained by providers and approved users of the information. This requires health care providers to maintain some form of electronic medical records. According to the United States Department of Health and Human Services, no reliable study has been conducted to determine how many providers are currently using electronic medical records. However, Executive Order 13335, issued by the President of the United States in 2004, calls for the widespread use of electronic health records (EHRs) by 2014. The Office of the National Coordinator for Health IT is currently working on several key EHR related initiatives including EHR certification, interoperability standards, and elimination of variations in privacy and security practices throughout the industry. Executive Order 13335 ensures that while EHRs might not be fully available now, they will be in the near future.

A member of the Ohio State Medical Association reinforced the issue of poor measures by explaining:

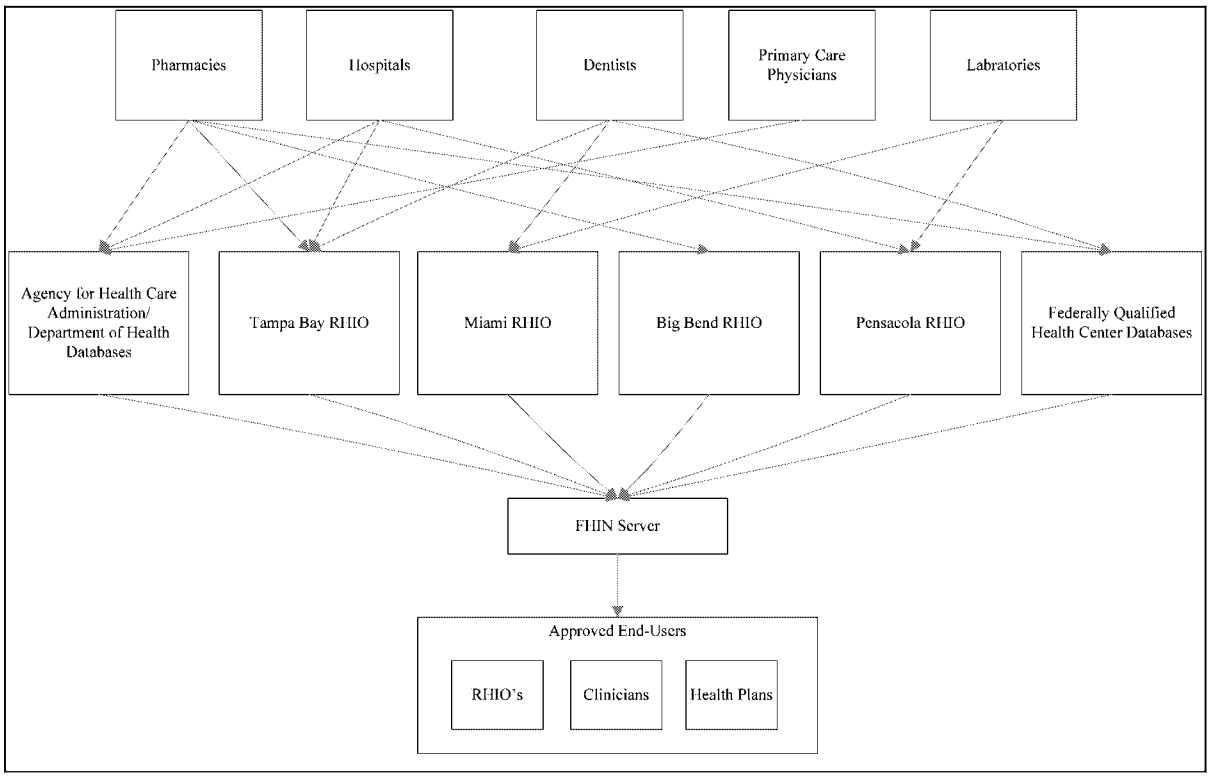
> "Claims data is a very poor way to approach [health management]. But up until now, it's been just about the only way that a managed care company or really any payer can approach that and even get their arms around any of that type of issue because claims data is really about the only measurement that we have that is easily retrievable without an electronic health record....quality indicators under current claims data systems just simply can't be tracked with any ease at all. ...Those data points would then be searchable and easily retrievable. So as that sort of thing catches on and more and more physicians go to that, I think that we'll move from the claims data for pay for performance to something that is truly meaningful and that is what are the actual numbers and is this patient being properly managed based on what those numbers are."

Florida has been proactive in developing a strategy to capitalize on the availability of EHR information. In 2004, the Florida Governor's Health Information Infrastructure Advisory Board was formed to guide the Florida Agency for Health Care Administration (Florida's Medicaid administrator) in developing a strategy for implementing the use of EHRs. Since that time, the Board has defined the framework for the Florida Health Information Network (FHIN).

FHIN links clinical information obtained from physicians, pharmacies, hospitals, and laboratories to databases maintained by State and federal programs using Regional Health Information Organizations (RHIOs). RHIOs are organizations composed of multiple stakeholders who have integrated systems that share information with one another through a central source. RHIOs facilitate the transfer of information among different users to improve the safety, quality, and efficiency of healthcare services.

Typically, RHIOs are initiated by stakeholders with similar business goals. This was the case in Florida as several small, private industry RHIOs already existed when FHIN was initiated. However, the Florida Agency for Health Care Administration has expanded these RHIOs to create larger regional data pools within specific geographic areas and is attempting to link these data pools to a larger statewide network. FHIN is configured so that service providers can continue to operate as-is, submitting data to their original RHIO. The RHIOs, State databases, and Federally Qualified Health Centers are all then linked to a central server. This allows approved users to submit queries to the central server through their RHIO. The central server obtains patient information from the other RHIOs throughout the state. **Chart 6-11** illustrates this process.

Chart 6-11: Florida Health Information Network



Source: Florida Agency for Health Care Administration

It is important to note that the FHIN is currently in the development stages. Florida estimates that only 20 percent of the State's providers use EHR systems. RHIOs have been established to provide the State with the necessary foundation to expand the program as more providers move to fulfill the requirements of Executive Order 13335.

In addition to the continued development of the FHIN, the State is considering several efforts to promote the adoption of effective EHRs by State providers. These options include the following:

- Reducing providers' financial and business risk of purchasing an EHR system through testing and certification of EHR products as meeting certain recommended standards, and through consumer ratings of competing systems conducted by providers themselves, negotiating price concessions on EHR systems through group purchasing arrangements, and promoting the availability of competent technical support;

- Promoting continuing medical (and professional) education to familiarize providers with EHRs and their use in a healthcare practice;

- Training providers on the use of electronic health information systems beginning in medical and nursing schools and internship and residency programs;

- Encouraging EHR adoption through workshops sponsored by professional societies. The Florida Academy of Family Physicians sponsored a successful EHR adoption workshop in May 2004, and is planning another one in April 2005 in conjunction with other physician specialty associations;

- Structuring financial incentives for EHR adoption through methods such as increased reimbursement to providers if they employ EHR systems in their practice; and

- Establishing the use of an EHR system as a billable procedure, just as the use of an MRI or X-ray is billable.

OHP has not considered any strategies to encourage the adoption of EHRs, nor has it formally addressed the health IT infrastructure needs of the State as a whole. This has occurred for two reasons. First, from an IT perspective, the Ohio Medicaid program lacks centralized formal leadership which considers all stakeholders. ODJFS and the sub-recipient agencies are only accountable for their individual performance, not for addressing the needs of the State and its citizens. The other contributing factor is Ohio's persistent lag in addressing IT needs. For example, Ohio's MMIS is the third oldest in the country. Replacing systems such as MITS and establishing a long term Data Warehouse and Decision Support System is necessary before the State can consider taking advantage of recent technologies such as electronic health records.

During stakeholder interviews, many providers and local agency representatives expressed an interest in greater use of EHRs. Members of the Ohio Association of Health Plans noted that having historical information would help them better serve recipients by providing context for why certain pharmaceuticals had been prescribed and what prior treatments may have been sought. Similarly, consolidated records would assist pharmacists in ensuring that recipients receive the appropriate medications, that the medications won't interact with other prescribed pharmaceuticals, and that recipients are not pharmacy hopping. The Ohio Association of Community Action Agencies' members felt that EHRs would help them by identifying when the last dental treatment was obtained, as there are strict restrictions on when certain procedures can be performed.

A member of the Ohio Council of Behavioral Healthcare Providers said,

> "I need to be able to give technology to my folks that are out in the field so that they can do treatment planning and do progress notes and electronic signatures … versus needing to work with people and then coming back and do it. There are just a lot of lost efficiencies that I could really maximize if I could afford utilizing that kind of technology."

Another member noted that there is a "major national effort" to move toward integrated electronic records systems.

A member of AOPHA said:

> "The State has the ability to drag the industry kicking and screaming into the 21st century. Now, they've taken the first step to do that with regard to electronic billing. We haven't done it with regard to electric medical records, and we in fact do not permit electronic signatures in an effective way yet. One of the biggest problems we have is that we have to have physician certification actually signed by the physicians. We really need to bring the nurses' notes and the patients' charts into the 21st century."

He went on to explain that in the nursing home industry, patients are often sent to facilities without background information. Homes must make immediate decisions whether to accept a patient but have no medical information to use for decision-making. Often they do not receive information on the prescription drugs the patient has been using in the hospital or the services they received. EHRs could remedy many of these communication issues.

In the area of services to disabled Ohioans, a member of Arc of Ohio noted:

> "... in the primary care setting, an electronic record system set up ... is going to be paramount to any success so we don't duplicate things. A lot of the cost is things get repeated in a system, and just because you don't know what another person's done or because there isn't the necessary mandated medical home that works for everybody at the moment, they're in and out of the system and multiple tests get done that probably are really not necessary many times. I think that's a huge savings."

This member also expressed the opinion that using EHRs would likely help service providers lower costs or expand services within existing financial constraints. The stakeholder recommended that the State consider providing an incentive to physicians and hospitals to encourage the adoption of EHRs, such as through tax deductions.

However, some providers expressed concerns about the transmission of data and the use of such systems. A member of Ohio Hospice & Palliative Care noted that, in rural areas, only dial-up connections are available and rural providers are hindered by the cost of additional technology. A member of the Ohio American College of Emergency Physicians also expressed concern that electronic records slow the physician's ability to see patients and drive up operating costs. The stakeholder noted the effect of slowing patient services coupled with diminished reimbursement rates for Medicaid services and how these had a detrimental financial effect on the industry. In this case, the stakeholder recommended voluntary adoption of EHRs rather than a State mandate to implement them. Lastly, many providers mentioned concerns about interoperability and the technology needed to interface between systems. A member of Arc of Ohio noted that there may be a standard in the future, but interoperability between hospital systems was an immediate problem for providers in Ohio.

For health care managers and purchasers, such as OHP, outcome measures can identify effective strategies that can be implemented to improve the quality and cost-effectiveness of care. For example, the Florida Agency for Healthcare Administration has begun to incorporate outcome measurement into the State Medicaid program. Currently, Florida issues an annual performance report publishing the results of 58 outcome based performance measures.

R6.12 The State Medicaid agency should seek to establish a leadership role in developing Regional Health Information Organizations which will collect clinical outcome data as it becomes available. The State should then seek to link RHIOs thereby creating a statewide health information network in a manner similar to Florida. In order to begin implementation of this recommendation, the State Medicaid agency, along with sub-recipient Medicaid agencies and other State and local agencies concerned with the health of Ohioans, should work with OIT to develop a reasonable, sound implementation strategy. Ultimately, OIT should oversee the coordination and implementation of a statewide health information network.

The State Medicaid agency could serve as the catalyst for adoption of EHRs by promoting their use in the Medicaid program. Although this would require up-front investment on the part of the agency, long-term cost savings could be achieved through the use of quality outcome data and its application to preferred treatment programs.

R6.13 The State Medicaid agency should develop a strategy for encouraging the adoption of electronic health records. The State, through the agencies responsible for healthcare-related activities and the Chief Health Information Officer, should attempt to minimize the risk to providers by defining its long term needs and promoting EHR systems which fit those needs and its long term goals.

E. Claims Input Mechanisms, Regulations, and Security

ODJFS Claims Pre-Processing

In 2005, ODJFS processed over 63 million claims.[38] The number of claims processed is shown by processing method in **Table 6-3**.

[38] There is no way to determine the number and types of claims processed by the sub-recipient agencies and their local/regional counterparts. However, many of the sub-recipient agencies are moving to 100 percent electronic claims submission.

Table 6-3: Claims by Type (ODJFS 2005 Only)

Type of Claim	Number of Claims Submitted	Percent of Total Claims
EDI	18,849,017	29.7%
C-Tape	1,132,236	1.8%
POS (Pharmacy)	37,270,212	58.7%
Hard Copy (Paper)	6,192,007	9.8%
TOTAL	**63,443,472**	**100.0%**

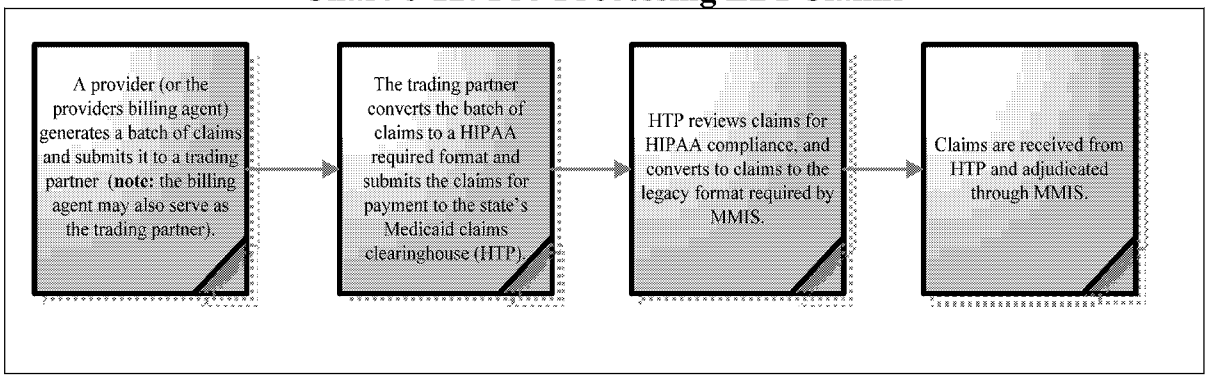
Source: Ohio Department of Job and Family Services

Once entered into MMIS, all claims are subjected to the same adjudication process (see **Chart 6-2**) by ODJFS. Therefore, once claims reach the adjudication point in the process, all types of claims incur equal costs and are processed in equal time. As a result, any discrepancies in efficiency or cost will only exist in the pre-processing phase of the claims process (see **Chart 6-1**). In comparing EDI, cartridge tape, and paper claims submission methods, paper claims are the most costly and inefficient from the perspective of ODJFS. In calendar year 2005, ODJFS processed approximately 6.2 million paper claims. These claims accounted for approximately 24 percent of the non-pharmacy, fee-for-service claims processed by ODJFS.

Claims received in cartridge tape format require no pre-processing, as they are created in the legacy format. However, creating claims in this format is only cost effective for those providers, trading partners, or billing agents who submit large volumes of claims such as large hospitals or third-party vendors who consolidate claims and submit in batches. These submitters already have significant technology infrastructures in place. This is reflected in the relatively low number of claims submitted in C-Tape form as shown in **Table 6-3**. For low volume claim submitters (i.e., small providers), obtaining the necessary technology to create cartridge tapes would require an unrealistic technology investment. In comparison, all providers currently have the ability to create both EDI and paper claims without a significant investment in technology. Pre-processing for these types of claims is shown in **Chart 6-12** and **Chart 6-13**.

Pre-processing of EDI claims begins when a provider or the provider's designated billing agent submits their claims to an approved trading partner. The trading partner is an agent who is approved by ODJFS to transmit claims electronically. The trading partner then transmits claims to the ODJFS claims clearinghouse. Clearinghouse services are currently provided by HealthCare Transaction Processor, Inc. (HTP). HTP reviews the claims for compliance with Health Insurance Portability and Accountability Act (HIPAA) coding standards and forwards validated claims on to ODJFS for adjudication. These steps are illustrated in **Chart 6-12**.

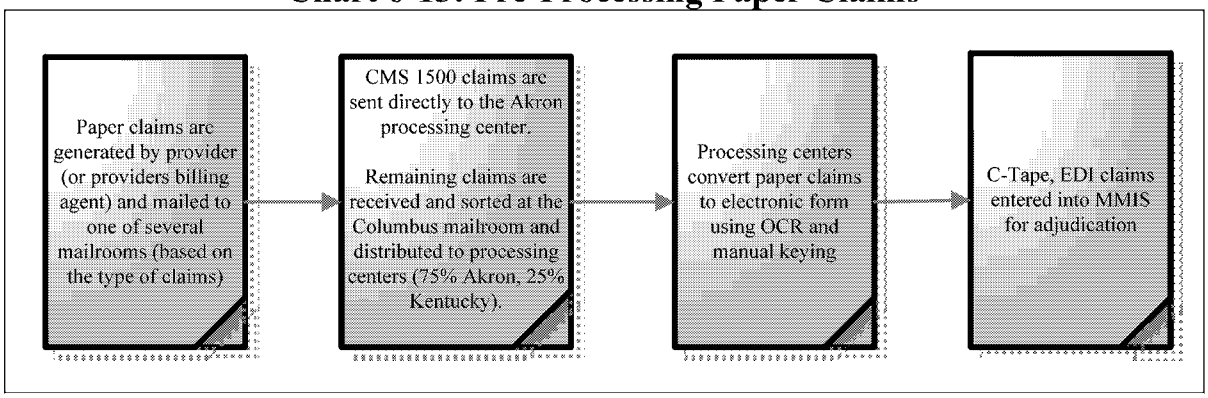
Chart 6-12: Pre-Processing EDI Claims



Source: ODJFS

Pre-processing of paper claims begins when a provider or the provider's designated billing agent submits its claims (by U.S. mail service) to one of two primary mailrooms. The particular mailroom to which the claim is sent depends on the type of claim submitted. CMS 1500[39] claims are sent directly to the Akron mailroom, operated by Ohio Industries for the Handicapped. Claims not sent directly to the Akron mailroom are sent to an ODJFS mailroom in Columbus. In this mailroom CMS 1500 claims received by mistake are sorted and delivered to the Akron processing center. By contract, 75 percent of all claims must go to the Akron center. Therefore, the remaining claims are sorted and a portion is sent to Akron to ensure this requirement is met. The remaining claims go to the Image Entry processing center in Kentucky. Through manual keying of data and OCR, both processing centers convert claims from paper form to the legacy format required by MMIS. These steps are illustrated in **Chart 6-13**.

Chart 6-13: Pre-Processing Paper Claims



Source: ODJFS

[39] The CMS 1500 is the standard claim form used by a non-institutional provider or supplier to bill Medicare carriers and durable medical equipment regional carriers (DMERCs). This form is also used by Ohio Medicaid.

The processes shown in **Charts 6-12** and **6-13** also require substantially different financial commitments. These costs are shown in **Table 6-4**.

Table 6-4: Calendar Year 2005 Costs of Pre-Processing Claims

EDI Claims		Paper Claims	
Claims Submitted	18,849,017	Claims Submitted	6,192,007
Translation & Communication (HTP)	$1,360,882	Mail & Processing (Akron)	$3,671,317
		Mail & Processing (Kentucky)	$594,283
Cost per Claim	**$0.07**	**Cost per Claim**	**$0.69**

Source: ODJFS

As shown in **Table 6-4**, the pre-processing cost per hard copy claim was $0.69 per claim in 2005. This was $0.62 more per claim than the pre-processing cost of EDI claims. In addition to the actual difference in cost, the contractual terms for these services also make EDI claims more cost effective. The contract with HTP is structured so that costs are capped at a maximum of $120,000 per month. Therefore, additional paper claims could be absorbed into the EDI structure within a fixed cost structure. In comparison, contracts with Ohio Industries for the Handicapped and Image Entry, Inc. for the processing of paper claims base fees on the number of transactions with no cap. Based on the cap of $120,000 per month, ODJFS could have incurred a maximum cost of $1,440,000 in 2005. Actual costs of EDI claims were $1,360,882. Therefore, paper claims could have been absorbed into the EDI processing structure for an additional $79,118. As shown in **Table 6-4**, paper claims processing cost the State $4,265,600 in 2005, a difference of $4,186,182.

The Ohio Administrative Code (OAC) presents several significant challenges to the reduction of paper claims. Compared to other states, the OAC is restrictive in regards to the claims process. A coordinated effort to reduce the cost of claims processing through reduction in paper claims would require a change in the following codes:

- **OAC § 5101:3-1-19-1**: This code lists specifications for Medicaid claim formats and coding requirements for paper claim submission. All claims submitted on paper media for Medicaid reimbursement must be made on the appropriate claim form.

- **OAC § 5101:3-1-19-3**: This section of code requires that all claims must be submitted in one of the following methods: cartridge tape [C-tape], electronic data interchange (EDI), paper claim form, or pharmacy point-of-sale [POS]. Most importantly, this code specifies that when submitting claims for payment, if the claims do not meet optical character recognition (OCR) specifications, the department [ODJFS] will continue to enter the claim into the system through the manual entry process. The following are the specification requirements to meet OCR – acceptable print character sizes are pica, ten characters per inch, and elite, twelve characters per inch, letter quality dot matrix print impressions, upper case printing, type or print in designated areas with black ink, and dates using the six-digit format (mmddyy).

It should be noted that OAC § 5101:3-1-19-3 is interpreted by ODJFS to mean that they are required to accept handwritten claims. ODJFS currently accepts a low volume of hand-written paper claims from providers. In the billing instructions sent to the providers each month, it specifically states that they do not want providers to send in hand-written paper claims, but if a provider elects to send in a hand-written paper claim, ODJFS must accept it.

While no states requiring 100 percent electronic submission could be identified, several states have implemented practices aimed at attaining full electronic submission of claims. Two of these states are discussed below.

Effective July 1, 1994, Colorado State Medicaid regulations[40] require providers to transmit claims to the fiscal agent in an approved electronic format unless the Department specifically authorizes submission of paper claims. In practice, Colorado allows the following claims to be submitted in paper:

- Claims from Providers who routinely submit fewer than 5 claims per month;
- Claims that, by policy, require attachments; and
- Reconsideration claims.

It should also be noted that electronically mandated claims which are submitted on paper are processed, denied, and marked with the message "Electronic Filing Required."

Missouri has also transitioned to mandatory electronic claiming. Effective July 1, 2005, all claims must be submitted electronically either through a clearinghouse, billing agent or the Medicaid website at www.emomed.com for billing and to maintain the business relationship with the Missouri Division of Medical Services. In addition, Medicaid providers are asked to submit claims, adjustments and attachments electronically. Notice was given to providers that beginning July 1, 2005 all claims, adjustments and attachments must be submitted electronically.

HIPAA regulations do not mandate that payers accept paper billing from providers. HIPAA requires that electronic billing must comply with the HIPAA format and content requirements. Payers can decide to accept only electronic transactions. Once Medicaid has implemented all-electronic billing, providers must be prepared to use a clearinghouse, billing agent or use an available web-portal for billing and to maintain the business relationship with their state Medicaid agency.

Provider groups interviewed during the audit had substantial commentary about claims processing. A member of the Ohio Health Plans Executive Leadership Committee stated, "Electronic claims are fast, but the cost to submit to a clearing house cause some problems for smaller providers." A member of the Ohio Hospital Association said, "There is a lot … hard

[40] Rule 8.040.2

copy paperwork that is required in some … cases for adjustments and so forth. If we had like an online system similar to what Medicare had it would be a huge advantage."[41] Another provider representative from the Ohio Psychological Association (OPA) commented, "Medicaid billing would be easier if it was all electronic and web-based. Nearly all OPA providers have computer access and are familiar with the Internet."

Paper claims were retained, a member of the Ohio Association of Health Plans explained, because ODJFS required codes that are not HIPPA complaint – a phenomena that causes problems for smaller providers.[42] Also, a representative of the Ohio County Commissioners Association remarked:

> "…County homes that are Medicare/Medicaid certified… complain … about billing and the lack of electronic capabilities to handle the paperwork and how long it takes them to get paid from the State. …They have issues with [whether] they receive the right amount or not and they never feel comfortable with that. …If it's not, it's this long process that's almost all paper to correct it. So they asked me to beseech to you the importance of simplifying the billing process."

Although electronic claims processing was noted as a desirable future process, many stakeholder groups were complementary about ODJFS' claims processing and the rapidity of payment. Members of the Ohio Provider Resource Association, Arc of Ohio, and Ohio Hospice & Palliative Care all remarked on the timelines of claims reimbursement.

ODJFS has required nursing homes to submit claims in EDI format but have not placed the same priority on transitioning the remaining fee-for-service services into a mandatory EDI process. ODJFS representatives expressed the opinion that paper claim submissions did not represent a significant inefficiency in the claims submission process. ODJFS representatives indicated that some providers only submit paper claims because the current processing system has limited functionality. ODJFS anticipates that the new features of MITS will make claim submission easier and encourage electronic submission. These new features are as follows:

- A web portal function allowing direct entry;
- On-line customer support capabilities;
- The ability to process attachments with EDI claims; and
- On-line claim tracking.

[41] The OHA member went on to explain," the Medicare system will tell you when you have done something that it won't accept. If it's denied for a central revenue code or it could be a specific Medicare code, they can go online and it will allow you to go in and change that real time. And this is a real time online adjudication process. We don't have all of that productivity lost -- the man hours on both sides doing a manual process. It would be a worthwhile system to take a look at because you can even look at reason codes online for why it's rejecting or what they don't want or what they don't like about it, and you can correct a claim, you can cancel a claim online, you can do eligibility. It's all in one area, so it's really easy."

[42] MITS will use HIPPA complaint codes. However, MMIS requires a crosswalk to translate HIPPA complaint codes to Ohio Medicaid codes.

ODJFS estimated that only 2 percent of claims submitted will be in paper form once MITS is fully implemented and providers become more familiar with HIPAA regulations for electronic transactions and code sets. However, the Agency did not use a formal methodology to arrive at this projected number. To date, ODJFS has not emphasized reduction of paper claims as a strategic priority.

It should also be noted that the paper claim totals shown in **Table 6-3** do not account for claims which come to ODJFS from the sub-recipient agencies. While these claims are submitted to ODJFS electronically, State-level IT staff from the sub-recipient agencies indicated that some counties still accept some claims in paper form and local agency staff manually key the information into electronic form. Sub-recipient agencies were unable to calculate how many claims are received in paper form at the local level but each agency indicated that they were phasing out paper submissions. However, due to this uncertainty, one must assume that the 10 percent of claims in paper form reported by ODJFS alone is understated. This could create delays in reaching the 2 percent estimate put forth by ODJFS.

ODJFS also expressed the concern that the elimination of paper claims may reduce provider participation in the program. The Department would be opposed to the complete elimination of paper claims because it feels that many independent care and smaller providers in rural areas rely on paper to submit their claims. While a reduction in participating providers in rural areas would be undesirable, the short and long-term legitimacy of this concern cannot be measured. On the other hand, eliminating paper claims will have an immediate and measurable impact on both cost and efficiency. Under the current cost structure if all claims submitted in paper during 2005 were submitted electronically, ODJFS would have saved approximately $4.2 million. This standardization could also serve as the foundation for consolidating the various claims processing systems as recommended in **R6.9** through **R6.11**.

R6.14 The single State Medicaid agency should identify the reduction of paper claims submissions as a formal strategic objective. The Agency should monitor paper claims submissions, and implement formal performance goals which target reduction.

R6.15 The single State Medicaid agency should adopt a formal policy requiring all providers to submit claims electronically unless explicitly permitted to submit paper claims by the State Medicaid agency. The Agency should also define the criteria under which providers will be granted paper claim permission (e.g., low volume of claims per month, lack of information technology infrastructure, etc.) This policy should be supported with timelines for compliance based on the type of service. This will limit the number of providers making the transition simultaneously and allow the State Medicaid agency to focus on group-specific issues which may arise. Ideally, all services should be submitting electronic claims by the time MITS is implemented.

Financial Implication: **If hard copy claims were submitted as EDI claims, the total savings would be approximately $4.2 million based on the number submitted in 2005 (6,192,007 claims).**

R6.16 The State Medicaid agency should pursue Administrative Rule changes to allow for more efficient receipt of claims. Specifically, the Ohio Administrative Code should emphasize the change to electronic processes and allow the single State Medicaid agency to regulate claims submissions as most appropriate to ensure efficient business practices.

Security

Security for the core Medicaid information systems (MMIS and CRIS-E) is the responsibility of the ODJFS Office of Management Information Services (MIS). Within MIS, security functions are handled by the Bureau of Network Support and the Bureau of Information Systems Support. The Bureau of Network Support is responsible for maintaining ODJFS' wide area network. This Bureau handles day-to-day security issues such as requests for system access, username administration, and support of CDJFS offices. In contrast, the Bureau of Information Systems Support is responsible for larger scale IT security issues such as the following:

- Identifying and documenting system security plans;
- Conducting needs assessments for future IT projects;
- Defining the IT security requirements to be included in interagency agreements; and
- Disaster recovery planning

ODJFS coordinates security issues with County Departments of Job and Family Services (CDJFS) through service level agreements. Service level agreements define the IT expectations between ODJFS and the CDJFS and specify the level of service the State will provide to the county. The ODJFS Administrative Procedures Manual requires each CDJFS to enter into a service level agreement with ODJFS. As a means to allow counties to maintain additional control over their IT environment, ODJFS offers several different service level agreements, the SLA 1, SLA 2, SLA 3, and the SLA N. Each successive agreement allows for greater local control over IT activities. Essentially, the service level agreements are intended to define ODJFS as the central authority responsible for maintaining the security of the network and preserving the integrity of the core systems while providing the CDJFS with flexibility in day-to-day operations. For example, all service level agreements require that counties be responsible for completing applications for new user ID's while ODJFS MIS provides the final approval of these requests.

In contrast, the relationships between ODJFS and sub-recipient agencies are transaction based. Sub-recipient agencies maintain their own information technology security environment and do not coordinate with ODJFS on large scale issues. The transfer of data between ODJFS and sub-

recipient agencies is largely limited to the submission of claims. These transactions are conducted through secure file transfer protocol and, due to their routine nature, do not require extensive planning. However, sub-recipient agencies reported that for larger issues such as HIPAA compliance or the MITS project, ODJFS has historically made security decisions unilaterally without input from the sub-recipient agencies.

According to the National Institute of Standards and Technology (NIST), each organization has two primary levels of computer security management. The central security program and the systems level security program. The central security program addresses the overall management of computer security within an organization. Within government this could consist of a department, agency, or other major operating unit. For a central security program to be effective, it should be an established part of organization management which requires consistent interaction with system managers. In contrast, the system security program ensures appropriate and cost effective security for each unique system. This includes determining what controls to implement, purchasing and installing security enhancements, day-to-day computer security administration, evaluating system vulnerabilities, and responding to security problems.

NIST identifies the following as characteristics of a successful central security program:

- **Stable Program Management Function:** An effective program will have a program manager who is recognized as the central computer security program manager. Links will also be established between program management and security personnel in other parts of the organization.

- **Stable Resource Base:** A program should have a stable resource base in terms of personnel, funds, and other support. Without a stable resource base, it is impossible to plan and execute programs and projects effectively.

- **Existence of Policy:** Policy provides the foundation for the central computer security program. Policy is the means for documenting and communicating important decisions about computer security. A program should also publish standards, regulations, and guidelines that implement and expand on policy.

- **Published Mission and Functions Statement:** The statement clearly establishes the function of the computer security program and defines responsibilities for both the computer security program and other related programs and entities.

- **Long-Term Computer Security Strategy:** A well-established program develops long term strategies to incorporate computer security into the next generation of information technology. It is essential to plan for future operating environments.

- **Compliance Program:** A central security program needs to address compliance with national and State policies and requirements, as well as organization-specific requirements.

- **Intra-organizational Liaison**: Computer security often overlaps with other offices within an organization, an effective program should have established relationships with these groups in order to integrate computer security into the organization's management.

- **Liaison with External Groups:** There are many sources of computer security information. An established program will be knowledgeable of and will take advantage of external sources of information. It will also be a provider of information.

Similarly, NIST identifies the following as characteristics of a successful system -level security program:

- **Security Plans:** Sensitive systems should have computer security and privacy plans. These plans should ensure that each system has appropriate and cost-effective security. System-level security personnel should develop and implement security plans.

- **System-Specific Security Policy:** Computer security policy issues need to be addressed on a system-specific basis. The issues can vary for each system, although access control and the designation of personnel with security responsibility are likely to be needed for all systems.

- **Life Cycle Management**: Security must be managed throughout a system's life cycle. This specifically includes ensuring that changes to the system are made with attention to security.

- **Integration with System Operations:** The system-level computer security program should consist of people who understand the system, its mission, its technology, and its operating environment. Effective integration will ensure that system managers and application owners consider security in the planning and operation of the system. The system security manager/officer should be able to participate in the selection and implementation of appropriate technical controls and security procedures and should understand system vulnerabilities.

- **Separation From Operations:** A natural tension often exists between computer security and operational elements. This can lead to the de-emphasis of security activities. The computer security program should maintain a degree of independence, have direct access to upper management, and have dedicated resources.

The current information technology infrastructure of the Ohio Medicaid program exists in a decentralized environment. As a result, the Medicaid program does not have an adequate central IT security program. The level of coordination that exists between State agencies and their county-level complements is inconsistent. Furthermore, there is no central coordination of IT security issues between agencies which could result in a plan for the Medicaid information systems as a whole. This has resulted in an inconsistent security environment which will not meet the needs of the State Medicaid agency.

The State of Oregon has implemented a comprehensive central-level security program which incorporates many of the NIST's recommended practices. By administering the program through an independent Information Security Office within the Oregon Department of Human Services, Oregon has been able to implement a program which reaches across divisions with different functional responsibilities. The Information Security Office is charged with oversight and responsibility for guiding the entire Department of Health and Human Services' information security and privacy needs for everything from e-mail to HIPAA compliance. However, it should be noted that the Oregon Human Services Department is structured in the umbrella agency format shown in the **organizational issues** section. It should be further noted that Oregon's Department of Human Services oversees Medicaid as well as mental health and addiction services. Therefore, the Oregon Department of Human Services is the operational equivalent of ODJFS, ODMH, and ODADAS in Ohio's organizational structure. The Information Security Office is charged with the following functions:

- **Security and Privacy Consulting and Guidance**: The Information Security Office provides guidance and direction on "what" and "how" the Oregon Department of Human Services should support a secure environment. The Information Security Office also participates in the implementation and issue resolution of information security and privacy initiatives.

- **Periodic Reviews and Audits:** The Information Security Office provides periodic review and audit of information security and privacy processes and practices.

- **Security and Privacy Incident Response:** The Information Security Office provides responses and tracks resolutions to privacy and information security incidents. The Information Security Office also chairs a Security Incident Response Team and a Privacy Review Committee. The incident response teams will include staff from the various operating units of the Oregon Department of Human Services.

- **Coordination of Security and Privacy Business Processes and Information Systems Improvements:** The Information Security Office provides project management and coordination for improvements to information security and privacy business processes and information systems.

Another important aspect of the Oregon security operation is that the Information Security Office provides judgment on issues which reach across functional lines. For example, the Office was used to clarify if and how information from Mental Health and Alcohol and Drug Addiction services could be used for other Oregon Department of Human Services programs. Considering the multi-agency configuration of Ohio's Medicaid program, an information security office within the State Medicaid agency would not have the authority to make a similar judgment. However, an information security office could provide valuable interpretations such as the one mentioned above, as the State Medicaid agency negotiates interagency agreements with sub-recipient agencies.

There are currently no committees or workgroups responsible for the coordination of IT security issues between ODJFS, the CDJFS, and sub-recipient State agencies and their local entities. According to ODJFS, there are several significant barriers that prevent the formal and uniform application of IT security through all aspects of the Medicaid program. For instance, the ODJFS MIS Department does not have the resources to monitor CDJFS compliance with all of the service level agreements. Under its current staffing, ODJFS MIS has only 11 FTEs who provide day-to-day support to 88 county offices. Therefore, to a large extent, MIS relies on the counties to resolve issues independently. The result is often the inconsistent application of procedures and policy. Another key issue is the relationship between ODJFS and sub-recipient State agencies. Through interagency agreements ODJFS can define the minimum security requirements for transmitting information to ODJFS, but MIS does not have the authority to impact other aspects of IT security. ODJFS cannot require sub-recipient agencies to implement changes in their own day-to-day IT security programs. Therefore, while information obtained through the immediate connection is secure, MIS has no impact at the point of data entry.

This environment has resulted in a lack of coordination between State-managed IT security and county-managed operations. This lack of coordination has repeatedly manifested itself during the Department's annual financial audit. The Department has been repeatedly cited for inadequate security controls and no actions have been taken to remedy the conditions referenced in the citations. Regardless of the future organizational structure, this lack of coordination and insufficient oversight will continue to create an inadequate IT security program which does not meet the basic NIST standards. Creating an information security office within the single State Medicaid agency with well-defined authority, will provide the necessary central coordination to effectively address the needs of a complex program that relies on information from a number of different systems managed by a number of different agencies.

R6.17 The State Medicaid agency should include an Office of Information Security. This Office should be charged with oversight and responsibility for developing a centralized response to the Agency's information security and privacy needs. In addition, this Office should develop a business plan which identifies the Office's mission, vision, key objectives, programs, services, and initiatives.

R6.18 The Office of Information Security (as established in R6.17) should also be charged with organizing and chairing a privacy review committee. This committee should be composed of a cross-section of representatives from all State agencies who deal with medical information. The focus of this committee should be to provide direct support and policy recommendations for the Medicaid program on issues such as HIPAA compliance and Electronic Health Records (see recommendation R6.13 and RF6.14).

F. Provider Technical Support and Relationship Management

Help Desk and Technical Assistance

On the ODJFS provider web-site, ODJFS offers several methods of customer support for providers.[43] The provider call center is accessed through the Interactive Voice Response System. Representatives answer questions on billing, payment, claim status, and consumer eligibility. The various customer service phone options provided on the ODJFS provider website are shown in **Table 6-5**.

[43] Each sub-recipient agency also provides customer support functions to its providers.

Table 6-5: Provider Customer Service Options[1]

Option	Responsibilities	Contact (s)
Ohio Health Plans Medicaid Interactive Voice Response (IVR) System	Billing Payment Status Claim Status Consumer Eligibility Problem Claim Review It provides 24-hour, 7-day a week access to information regarding client eligibility, claim status, payment status, prior authorization, drug and procedure code, and provider information.	1-800-686-1516
HTP, Inc.	Claims Clearing House	Medicaid@htp-inc.com 614-396-4543
ODJFS MMIS-EDI Support	EDI Support for Trading Partner and Trading Partner Enrollment	MMIS-EDI-SUPPORT@odjfs.state.oh.us 614-387-1212
First Health	Pharmacy Claims	1-877-518-1545
Ombudsman/Technical Assistance	Conducts training sessions One on one technical assistance	1-614-752-9551
ODJFS Claims Adjustment Unit	Claims Adjustments	1-614-466-5080
ODJFS Bureau of Plan Operations	Medical Operations Claims Processing Claims Services Provider Network Management Benefit Coordination and Recovery	1-800-686-1516; PACT (614)466-9689 (614)466-0662 (614)728-3308 1-800-686-1516 (614)752-5768

Source: ODJFS Website

[1] The information presented in this table was obtained in November 2005. This information may have changed due to a subsequent re-organization within ODJFS.

The Provider Call Center (through the Interactive Voice Response System) seeks to address claim billing, payment status, claim status, and consumer eligibility problems. However, providers and trading partners noted that they often do not receive adequate assistance. Some recurring issues included the following:

- Help Desk will not give definitive answers regarding claim coding;
- Help Desk will not address questions concerning HTP or First Health;[44]
- HTP and First Health will not address questions concerning ODJFS;

[44] First Health was replaced as the vendor of the POS pharmacy system on July 1, 2006

- Difficult to identify correct contact; and
- Website is difficult to navigate.

According to the Federal Benchmarking Consortium Study Report on Best Practices in One-Stop Customer Service, improvements can be achieved in an organization's operations by moving to one-stop customer service. Having a customer focus means that business is handled so that the customer does not have to make multiple calls or explain the problem to more than one person. One-stop service practitioners are achieving impressive results in terms of:

- Higher customer satisfaction;
- Higher employee satisfaction;
- Improved efficiency and operation; and
- Increased profits.

During various stakeholder meetings a recurring issue of concern was that of inconsistent or poor customer service to providers at various levels of the Medicaid program. Specifically, providers voiced frustration with the mechanisms available to assist in resolving rejected claims. In one instance, a provider recalled that he was informed that a billing code had changed and he tried to contact ODJFS for the correct code. ODJFS would not provide the correct billing code, but told the provider to review the memos on the Department's webpage and to find the correct code somewhere in the documentation.

During interviews, stakeholders voiced frustration with accessing information on the ODJFS website. A member of the Ohio State Medical Association described the website as "not user friendly". The member went on to explain that "You have to commit some time to finding things. Hours just to go through the thing…even just a simple thing, [like] trying to obtain fee schedules, can be complicated." As a result, many providers become frustrated and contact their professional association for assistance. Similarly, a member of the Ohio Hospital Association remarked on difficulties experiences in using the website saying "It's very difficult to negotiate." The member when on to say that, while information is available on the website, it is difficult to find and the search function is terrible. The member noted that when inquires are made to ODJFS, the response is often that it will take "24 hours" as ODJFS staff are not always certain where the requested information is located.

Several trading partners also noted significant issues in managing relationships between ODJFS and Third-Party vendors. It was noted that there were times when a provider would call ODJFS for customer support and ODJFS would respond by saying that the issue was a technical problem with the clearinghouse processor, HTP, Inc. However, ODJFS did not provide continued support, but rather referred the trading partner directly to HTP. Then the provider called HTP where they were informed that the problem was with ODJFS, and redirected to call ODJFS back. Overall, ODJFS should recognize that they are responsible for customer service even when it involves

third party vendors. Interactions such as the one noted above reflect poorly upon ODJFS and frequently result in short-term fixes or work-arounds which do not adequately address claims processing problems.

R6.19 The single State Medicaid agency should develop a coordinated strategy for communicating with providers. This strategy should involve the re-organization and consolidation of the Help Desk operation to limit the number of contact numbers which providers are able to call. The Help Desk should serve as a gatekeeper, providing one number that providers can call to ensure that inquiries are routed to the appropriate operating units based on the information the provider gives or the problem the provider is trying to solve. In addition, the Help Desk operation should not refer callers to third-party vendors for technical assistance. The State Medicaid agency should take responsibility for resolving technical issues which result from the activities of its contracted third-party vendors.[45]

[45] Recommendations regarding Help Desk customer service procedures and best practices were also provided to ODJFS in a report entitled *Ohio Department of Job and Family Services, Child Support Enforcement Program Performance Audit* (June 28, 2002).

PROGRAM INTEGRITY

Program Integrity

Program Integrity Section Table of Contents

Background

> "If I may offer a modest challenge, it would be to find those states that are both excellent in program integrity and excellent in customer access. At times what we've seen in the food stamp program over the years is that we make it more onerous for people to apply, and that drives down error rates, but it makes program access and participation more difficult."
>
> *Member, Ohio Job and Family Services Directors' Association*

This section examines Ohio's Medicaid program integrity and its ability to minimize fraud, waste, and abuse. The section evaluates Medicaid's internal control environment, identifies obstacles/weaknesses, and recommends structural, operational, or procedural changes that will minimize Ohio's risk of legal liability and financial loss associated with the Medicaid program. Analyses contained within this report include comparisons of program integrity operations in the following peer state Medicaid agencies: Florida (Agency for Health Care Administration), Illinois (Department of Healthcare and Family Services), Maryland (Department of Health and Mental Hygiene), New York (State Department of Health), Oklahoma (Oklahoma Health Care Authority), Pennsylvania (Department of Public Welfare), and Texas (Health and Human Services Commission). Florida, New York, and Pennsylvania were selected because of their similarity to Ohio in terms of the economic and demographic make-up of their respective Medicaid programs. Maryland and Oklahoma are used to illustrate how technology can be used to communicate the Medicaid program integrity-related mission and accompanying goals.

Additional comparisons are made to national best practices and State recommendations, including those from the American Institute of Certified Public Accountants (AICPA), U.S. Department of Health and Human Services (HHS) Office of the Inspector General (HHS-OIG) and Centers for Medicare and Medicaid Services (CMS), the U.S. Government Accountability Office (GAO), the Government Finance Officers Association (GFOA), as well as the Ohio Commission to Reform Medicaid (the Ohio Medicaid Commission), and the Office of Ohio Inspector General (Ohio Inspector General). This report contains a descriptive background on Medicaid program integrity in Ohio and the following sections which address key internal control components: A.) Risk Assessment; B.) Preventive and Detective Controls and Enforcement Strategies; C.) Reporting and Communicating Information; and D.) Monitoring.

During the audit process, it was noted that the State and local agencies conduct many program integrity related activities that focus on clinical and service level issues. Because this audit section focused on financial-related activities of program integrity, the clinical and service program integrity functions are included in the issues for further study section under the *program integrity* heading. The reader should be aware that State and county agencies conduct reviews of facilities, services, treatment plans, and other clinical and service related items. These reviews create an assurance of appropriate treatment and recipient safety. However, they experience the same disjointed approach and limited information sharing that hampers financial program integrity within the Medicaid program. (See **R7.7**)

Internal Controls & Medicaid

According to GFOA, public officials must exercise prudence and integrity in the management of funds in their custody and in all financial transactions. Logically, it follows that the same standard of accountability should also apply to private contractors (providers) and consumers (recipients) who deliver and receive taxpayer-funded services – in this case, Medicaid. Therefore, adequate and formalized procedures are required to protect those funds and ensure that a sound framework of internal control exists. An effective internal control environment is comprised of a variety of components designed to provide reasonable assurance regarding the achievement of objectives in the following categories: reliability of financial reporting; effectiveness and efficiency of operations; and compliance with applicable laws and regulations.

GAO has issued a number of reports on the issue of Medicaid, including studies of several state programs, as well as the federal government's role in overseeing and administering Medicaid. GAO recognizes that improper payments associated with Medicaid fraud, waste, and abuse are a widespread and significant problem receiving increased attention in state and federal governments, as well as private sector companies. *Improper payments* include inadvertent errors, such as duplicate payments and miscalculations; payments for unsupported or inadequately supported claims; payments for services not rendered; payments to ineligible beneficiaries; and payments resulting from outright fraud and abuse by program participants and/or program-related employees. In the private sector (e.g., managed care organizations) improper payments most often present an internal problem that threatens profitability. In the public sector, however, improper payments negatively impact service levels to recipients and create wasteful spending patterns which impact taxpayers. Despite a climate of increased scrutiny, GAO reports that most improper payments go unidentified and drain taxpayer resources away from the missions and goals of the program. They occur for many reasons including insufficient oversight or monitoring, inadequate eligibility controls, and deficiencies in automated systems.

GAO also indicates that the root cause of improper payments can typically be traced to the absence of effective internal controls. Collectively, internal controls are an integral component of Medicaid program integrity because they provide reasonable assurance of effective and efficient operations, reliable financial reporting, and compliance with laws and regulations. Internal controls are not one event, but a series of actions and activities that occur throughout an entity's operations and on an ongoing basis. Program employees make internal controls work, and responsibility for good internal controls rests with all managers. The risk of improper payments increases in programs with complex criteria for computing payments, a significant volume of transactions (see **technology and program management**), or emphasis on expediting payments[1] (i.e., Medicaid).

[1] The Ohio Department of Job and Family Services received management letter comments, non-compliance citations, and questioned costs in its SFY 2002-03 and 2003-04 financial audits because of automated system controls that were not functioning properly within the Medicaid Management Information System (MMIS). As the

It should be noted that a review of internal controls does not necessarily mean that the organization or program lacks controls completely, but that the existing controls and accompanying policies and procedures should be updated and strengthened to improve the overall environment. The AICPA indicates that effective internal controls set the tone of an organization (or program) and directly impact integrity and ethical values, while fostering commitment to competence, management philosophy, and operating style. The internal control environment also helps to shape organizational (or programmatic) structure, facilitates the segregation of duties, and ensures adequate training and education for all stakeholders.

Fraud, Waste, and Abuse

> "Medicaid fraud [efforts] lacks teeth. [The] response to turning in Medicaid fraud is very slow."
> *Member, PASSPORT Agency Directors Association*

Medicaid represents a large and growing share of Ohio's budget and funds lost to fraud, waste, and abuse can negatively impact the State's ability to serve its constituents. Regardless of whether fraud, waste, and abuse occur inadvertently or by intent, losses are not apparent until detected and, at the time of reporting, cannot be quantified. GAO estimates that fraud, waste, and abuse account for approximately 10 percent of Medicaid expenditures. In its recent report to the Governor, the Ohio Medicaid Commission indicated that while the nature and magnitude of fraud, waste, and abuse in Ohio Medicaid is not sufficiently known, it estimated the risk of loss at about $1.2 billion for State fiscal year (SFY) 2005. Of this, the Ohio Medicaid Commission suggests that between $105 and $525 million was recoverable.

As stipulated in Ohio Administrative Code (OAC) 5101:3-1-29, *fraud* is an intentional deception, false statement or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to oneself or another person. It includes any act that constitutes fraud under applicable federal or State law. *Waste* and *abuse*, on the other hand, are practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business, or medical practices; and that constitute an over-utilization of fee-for-service care, resulting in unnecessary costs.

Improper payments attributable to Medicaid fraud, waste, and abuse typically fall into the following groups: improper billing practices, misrepresentations of professional qualifications, inadvertent errors, and improper business practices. Examples of *provider* fraud, waste, and abuse include, but are not limited to, the following, as stipulated by OAC 5101:3-1-29(C):

- Billing for services not rendered or duplicative billing patterns to obtain reimbursement for which a provider is not entitled;

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automated edits were inconsistent in their efficacy, the risk of improper payments was increased. See the **technology and program management** section for additional information on MMIS and the planned MITS system.

- Misrepresenting cost or service provision data, including the quantity provided, date of service, or to whom provided in order to maximize reimbursement;
- Billing, certifying, prescribing or ordering services that are medically unnecessary or non-reimbursable, not clinically proven and effective, or are inconsistent with Medicaid rules and billing instructions;
- Billing for services that are outside current license limitations or specific practice parameters of the provider;
- Purchasing excessive quantities of medical supplies, drugs, or other services;
- Differing charges for the same services to Medicaid and non-Medicaid recipients (for in-patient hospital services billed by hospitals reimbursed on a prospective payment basis, the Ohio Department of Job and Family Services (ODJFS) will not pay, in the aggregate), more than the provider's customary and prevailing charges for comparable services;
- Requesting or obtaining additional payment for covered Medicaid services from either the recipient or recipient's family;
- Colluding with any person or business entity which would involve Medicaid; and
- Misrepresenting by commission or omission any information on provider enrollment forms or included in provider packets.

Examples of *recipient* fraud, waste, and abuse may include, but are not limited to, the following, as stipulated by OAC 5101:3-1-29(E):

- Altering, selling, or lending a Medicaid card to others for securing medical services;
- Receiving excessive medical visits and services; and
- Obtaining services in excess of specified requirements.

For managed care plans, fraud, waste, and abuse is commonly attributed to the under-utilization of Medicaid services: avoiding expensive treatments, under-financing plan operations, providing poor quality care, as well as employing deceptive marketing practices and claiming false enrollments (OAC 5101:3-26).

Medicaid Program Integrity – Ohio's Reporting Structure

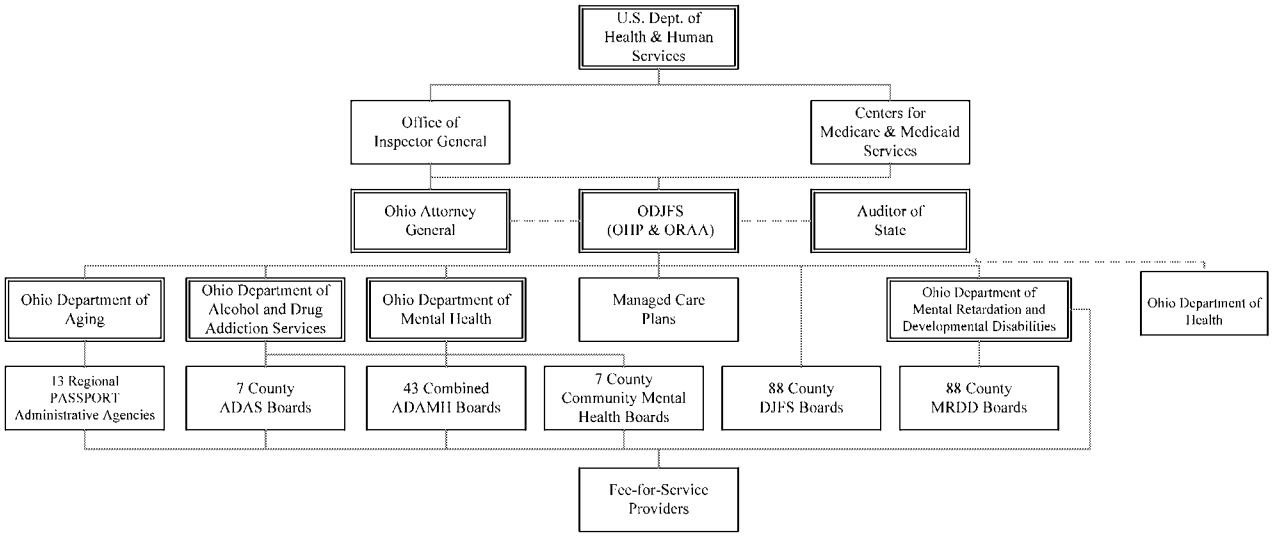
> "…not only is there not a number to call, but have you heard from other providers what happens when you try to send an over payment check back? They don't take it. There is nowhere to send it to. It's assumed that you just kept it and that you are fraudulent."
>
> *Member, Ohio Association of Medical Equipment Services*

Medicaid program integrity entails a complex mix of actors and entities. As the State agency responsible for administering Medicaid, ODJFS – through Ohio Health Plans (OHP) and the Office of Research Assessment and Accountability (ORAA) – is ultimately responsible for coordinating and monitoring program integrity internally (see **Chart 7-2**) and externally, among

the Attorney General, Auditor of State, as well as State sub-recipient and regional/county-level agencies, managed care plans, and fee-for-service providers.

Chart 7-1 illustrates the Medicaid program integrity reporting structure in Ohio.

Chart 7-1: Ohio Medicaid Program Integrity Reporting Structure



Source: Compiled by the Auditor of State of Ohio
Note: See also **Medicaid program overview, history and status** section

At the federal level, the U.S. Department of Health and Human Services (through CMS and HHS-OIG) oversees and audits state processes, and provides training and investigative assistance when necessary. At the state level, Medicaid agencies (e.g., ODJFS and sub-recipient agencies) provide front line oversight and protection against Medicaid fraud, waste, and abuse. Per CMS, Ohio is required to perform the following:

- Collect and verify basic information on potential providers, including whether they meet State licensure requirements and are not otherwise prohibited from participating in federal health care programs;
- Maintain an automated claims payment and information retrieval system to verify the accuracy of paid claims, the correct use of payment codes, as well as recipient eligibility;
- Monitor managed care fraud, waste, and abuse plans;
- Develop statistical profiles on services, providers, and recipients to identify potential improper payments; and
- Refer suspected improper payment and utilization cases to State and local law enforcement authorities, if necessary.

While the Attorney General works with ODJFS, the Auditor of State, and sub-recipient agencies to enforce Medicaid program integrity, investigate cases, and recover improper payments, its federally-mandated[2] Medicaid Fraud Control Unit (MFCU) reports independently to HHS-OIG. The Auditor of State, which does not report to HHS, employs a Fraud and Investigative Audit Group (FIAG) that works with OHP and ORAA to monitor Medicaid providers. State Medicaid sub-recipients and their respective county/regional-level agencies include the following:

- ODJFS – 88 county departments of Job and Family Services (county JFS);
- Ohio Department of Aging (ODA) – 13 regional PASSPORT Administrative Agencies (PAAs),[3]
- Ohio Department of Alcohol and Drug Addiction Services (ODADAS) – 7 county alcohol and drug addiction service boards and 43 combined alcohol, drug, and mental health boards;
- Ohio Department of Mental Health (ODMH) – 7 county community mental health boards and 43 combined alcohol, drug, and mental health boards; and
- Ohio Department of Mental Retardation and Developmental Disabilities (ODMRDD), including 88 county mental retardation and developmental disabilities boards.

The Ohio Department of Education (ODE) and Ohio Department of Health (ODH) are also sub-recipients whose duties do not generally include the submission and processing of Medicaid claims. ODE reviews time studies which serve as the basis for allocating Medicaid funds to school district staff time applied to specific services. It also ensures that participants attend the minimum required training sessions. As ODE performs minimal program integrity functions, it has been excluded from **Chart 7-1**. ODH performs all nursing home inspections for licensure and certification requirements.[4] Ohio was chosen for a new waiver program allowing ODH to focus on outcomes when inspecting nursing homes. The waiver will allow all ODH inspectors to use national benchmarks and similar nursing homes in the evaluation process. The waiver will focus inspectors' attention on quality of care. ODH is included in **Chart 7-1** but does not feature prominently in the section discussions. However, issues raised by stakeholders regarding the inspection and certification process are included in the **issues for further study**.

[2] Omnibus Reconciliation Act of 1980, Public Law 96-499.

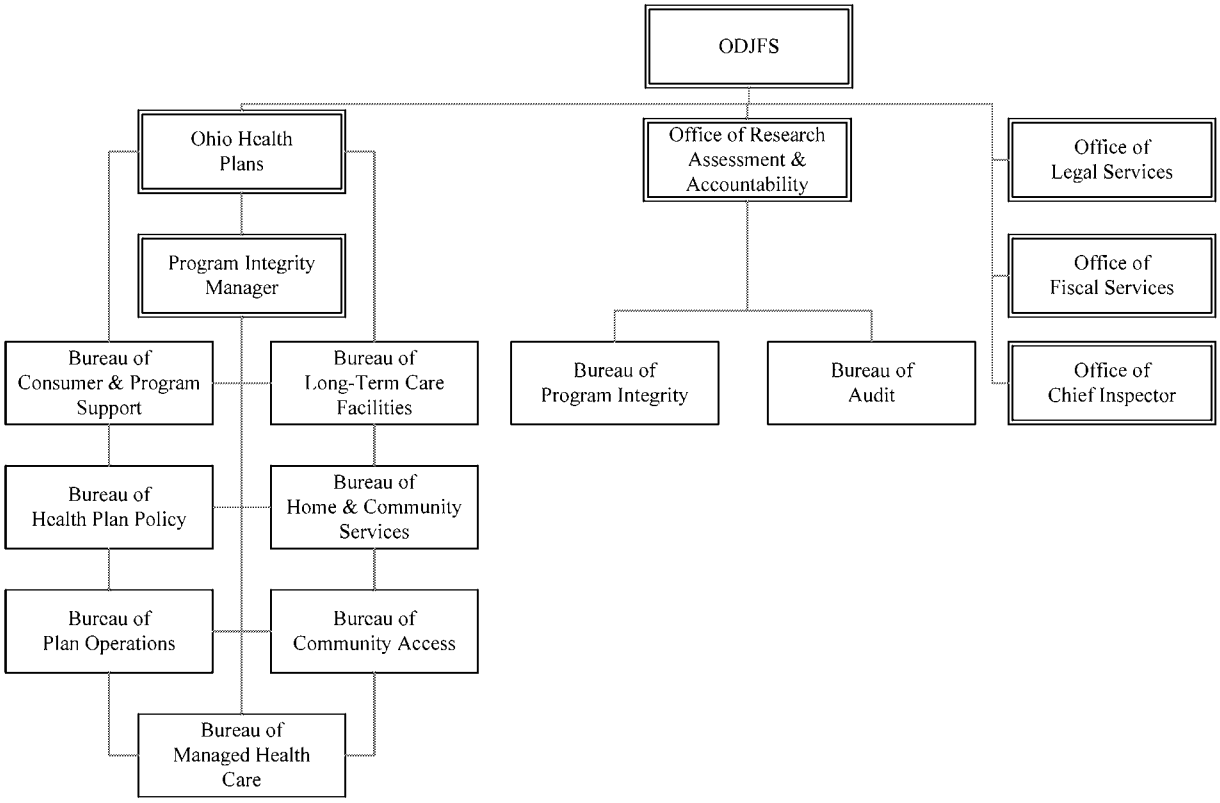
[3] PAAs are responsible for the day-to-day operations of Ohio's PASSPORT home and community-based Medicaid waiver program (see **managed care and care management**). There are 13 administrative agencies designated by ODA throughout the State. For the most part, these agencies are the Area Agencies on Aging, except in Champaign, Darke, Logan, Miami, Preble, and Shelby counties, where Catholic Social Services of the Miami Valley administers PASSPORT.

[4] Excluding some county operated nursing homes. County operated homes are inspected by ODH for compliance with Medicaid facility and bed requirements and subsequent Medicaid certification. Inspections are performed annually.

Medicaid Program Integrity – ODJFS

Internal to ODJFS, Medicaid program integrity is divided among OHP [7 bureaus and 1 program integrity manager (see **R7.15**)] and ORAA [2 bureaus], as well as the Offices of Legal Services, Fiscal Services, and Chief Inspector. **Chart 7-2** illustrates the organizational structure of Medicaid program integrity within ODJFS. Only those offices and bureaus with Medicaid program integrity-related responsibilities are included.

Chart 7-2: Medicaid Program Integrity Structure within ODJFS



Source: ODJFS Table of Organization

Ohio Health Plans

In SFY 2004-05, ODJFS spent just over $11.2 billion for Medicaid-related services. OHP's Medicaid program integrity-related responsibilities include provider education,[5] pre-payment prevention, quality control and quality assessment, as well as the promulgation of rules and coordination of non-monetary corrective action plans for any audit-identified weaknesses. These duties are coordinated through a newly-created program integrity manager position and performed by the following bureaus:

- Consumer and Program Support;
- Health Plan Policy;
- Plan Operations;
- Long-Term Care Facilities;
- Home and Community Services;
- Community Access; and
- Managed Health Care.

Specifically, OHP oversees recipient outreach and eligibility (e.g., Ohio Medicaid Consumer Hotline) and coordinates recipient satisfaction surveys. In addition, OHP manages a drug utilization review program,[6] reviews cost reports, and calculates interim and final settlements for hospitals, clinics, and State-owned developmental centers. Through an outsourced private contractor, OHP issues a quarterly newsletter entitled *Ohio Medicaid Quality Monitor* to help communicate trends and issues (e.g., outpatient utilization, provider access, and claims reviews, etc.) that impact doctors, hospitals, and health plans serving Ohio Medicaid. Furthermore, OHP is responsible for ensuring that all Medicaid services are medically necessary and appropriate. In this capacity, OHP provides clinical/technical assistance to counties and administers the recipient lock-in program, called Primary Alternative Care and Treatment (PACT).[7]

OHP duties also include provider enrollment and claims processing: reviewing and adjusting previously paid claims, processing provider liens and garnishments, resolving suspended claims that may arise from billing errors and problems, coordinating recipient benefits (see **technology and program management**), avoiding and recovering any third party liability payments, conducting risk analyses to determine audit needs, issuing nursing facility surety bonds,

[5] During stakeholder interviews, the positive role of OHP's educational programs was noted by several providers.

[6] Created by the Omnibus Budget Reconciliation Act of 1990, drug utilization review is a provider-oriented, educational outreach program designed to safeguard the health of Medicaid recipients and minimize drug-related fraud, waste, and abuse by assessing the appropriateness of drug therapies.

[7] In accordance with federal regulations, when a recipient is identified for misuse of physician and/or pharmacy services, those individuals are proposed for enrollment into the PACT program and are limited to a primary care physician and/or pharmacy. ODJFS indicates that PACT enrollment is approximately 900, down from about 1,600 in SFY 1998-99. Notwithstanding, ODJFS did not monitor the financial impact of PACT on Medicaid program integrity prior to this audit (see **R7.18**).

managing estate recovery projects,[8] and monitoring *Ohio Home Care* and *Transitions* waivers. Finally, OHP monitors the provider agreements and accompanying fraud, waste, and abuse programs (OAC 5101:3-26-06) of managed care plans. Specifically, the Bureau of Managed Health Care determines whether a managed care plan meets program standards necessary to contract with ODJFS, then works to monitor ongoing compliance, providing training and technical assistance when necessary. This bureau reviews utilization reports and encounter data[9] to assess performance and identify possible deficiencies. Managed care plans are required to report their progress in addressing these deficiencies through corrective action plans (see **R7.14**).

Under its responsibilities as State Medicaid agency, OHP also administers the Children's Health Insurance Program (Title XXI), the Medicare Premium Assistance Program, the Disability Medical Assistance Program, and the Hospital Care Assurance Program.

Office of Research Assessment and Accountability (ORAA)

Independent of OHP as of 2005, ORAA's Bureau of Program Integrity and Bureau of Audit are responsible for monitoring, detecting/preventing, and reporting Medicaid fraud, waste, and abuse. Specifically, ORAA performs quality assessments of Medicaid services and manages program integrity by identifying improper payments through the Surveillance Utilization and Review System (SURS) audits/reviews. ORAA also operates the Ohio Welfare Fraud Hotline, refers potential provider investigations/audits to MFCU or FIAG, and conducts explanation of benefits surveys of recipients. ORAA conducted approximately 77,000 explanation of benefits surveys[10] each year, or about 4.5 percent of eligible Medicaid recipients.

ORAA is responsible for conducting federally-mandated SURS audits/reviews. Specifically, ORAA employs the Data Warehouse to apply post-payment reviews to Medicaid claims and, with the assistance of FIAG and private contractors, reviews provider and recipient billing patterns to assess the risk that fraudulent, improper, or otherwise wasteful payments were made (see **R7.10**, **R7.11**, and **R7.12**). ORAA is also responsible for addressing county-level Job and

[8] Pursuant to the Omnibus Budget Reconciliation Act of 1993, the State must, at a minimum, seek recovery for Medicaid services provided to recipients within nursing facilities and ICFs/MR (see **Medicaid service provision**). Ohio may recover amounts up to the total amount spent on the recipient's behalf. For recipients aged 55 or older, states are required to seek recovery of payments from the individual's estate for services rendered by nursing facilities, home and community-based services, and any related hospital and prescription drug services.

[9] ODJFS relies on *encounter data* for monitoring the performance of managed care plans (see **managed care and care management**), measuring clinical performance, conducting access and utilization reviews, reimbursing managed care plans for newborn deliveries, and helping set capitation rates. Encounter data is detailed data about individual services provided by a capitated managed care plan. The level of detail about each service reported is similar to that of a standard claim form under fee-for-service. Encounter data are also sometimes referred to as "shadow claims".

[10] Explanation of benefits surveys are notices sent to Medicaid recipients concerning services that have been billed and paid on their behalf. These notices let recipients know what was billed on their behalf. If a service was billed that the recipient did not receive, the recipient notifies the State Medicaid agency and the agency can conduct a fraud investigation.

Family Services-related errors (e.g., services provided to ineligible recipients) and conducting cost report audits of nursing facilities, intermediate care facilities for the mentally retarded (ICFs/MR), and ODMRDD developmental centers. In federal fiscal year (FFY) 2003-04, ORAA identified about $301,700 in misspent funds attributable to nursing facilities – an increase of approximately $30,500 (11.2 percent) from FFY 2002-03.

It should be noted that in addition to its Medicaid-related duties, ORAA conducts program eligibility reviews for Temporary Assistance for Needy Families (TANF), Food Stamps, and Title IV-E Foster Care Maintenance programs. Competing, non-Medicaid-related priorities may contribute to recent decreases in improper payments identified per audit/review (see **Table 7-2**). Finally, ODJFS is in the process of establishing a Data Warehouse and Decision Support System within ORAA that allows for more efficient sharing of raw data necessary to conduct audits/reviews. Notwithstanding, a number of technology-related gaps have been identified which inhibit data sharing among ODJFS and other agencies (see **technology and program management**).

Office of Legal Services

The Office of Legal Services is responsible for enforcing and reporting issues pertaining to Medicaid program integrity. Once a SURS audit/review is completed and an improper payment is identified, the Office of Legal Services sends a certified letter to the provider, which initiates the collections process. Upon receipt of this letter, a provider has a maximum of 90 days to remit payment to ODJFS. If, after 90 days, the provider has not remitted payment, ODJFS refers the case to the Attorney General for collection and possible litigation.

Providers that disagree with findings identified in full-scope audits may request a formal hearing in accordance with ORC § 119.07 through 119.10. These rights, however, do not extend to disagreements over limited reviews; explaining, at least in part, why ORAA (or SURS) conducts significantly more limited reviews than full-scope recovery audits (see **Table 7-2**).

Office of Fiscal Services

The Office of Fiscal Services is responsible for monitoring and tracking the recovery of improper Medicaid payments. If the Office of Fiscal Services cannot effectively recover an improper payment within established timeframes, it is certified to the Attorney General. According to the Office of Fiscal Services, audit recoveries totaled approximately $2 million in SFY 2004-05, a decrease of nearly 40 percent, compared to SFY 2003-04. ODJFS attributes this to an estimated six month decrease in SURS productivity, caused by ODJFS restructuring in response to a recent Ohio Inspector General investigation. As a result of this investigation (see **Table 7-1**), ORAA reprioritized its efforts to focus on process mapping, changing statistical methodologies, and re-training staff, in addition to conducting SURS recovery audits/reviews.

Office of Chief Inspector

The overall responsibility of the Office of Chief Inspector is to ensure that all programs administered or supervised by ODJFS comply with State and federal laws, rules and regulations, particularly as they relate to internal controls, safety practices, and ethical or legal considerations. In regards to program integrity, the Office of Chief Inspector interacts with HHS-OIG, CMS, and the Auditor of State during federal and State audits of Medicaid. For example, HHS-OIG recently issued an audit of Ohio's outlier Medicaid payments to hospitals[11] and found that instead of using recent "cost-to-charge ratios," Ohio uses outdated "fixed ratios" to convert allowable billed charges to outlier payments.[12] As a result, Ohio overpaid hospitals by an estimated $24.7 million – $14.5 million (58.8 percent) of which comprises the federal share – during SFYs 1999-2000 through 2002-03. HHS-OIG did not issue a finding for recovery and OIC indicates that ODJFS has taken action to incorporate the use of hospital-specific cost-to-charge ratios into Ohio Medicaid's hospital outlier reimbursement policy, effective January 1, 2006. See **organizational issues** for additional information on federal requirements.

Medicaid Program Integrity – State Sub-Recipients and County/Regional Agencies

OHP coordinates with and monitors State sub-recipient agencies (see **Chart 7-1**) by means of interagency agreements and memoranda of understanding. With the exception of county JFSs, which report directly to ODJFS, State sub-recipients are each responsible for monitoring their respective county/regional agencies. The following discussion of each sub-recipient and its local boards focuses on Medicaid services only. The authority of the sub-recipients and their local boards for non-Medicaid services is, in many cases, much broader than in the case of Medicaid services.

[11] ODJFS compensates hospitals for care based on a diagnosis related group (DRG). However, for extraordinary cases that require substantial additional care, there is a provision for payment for patients whose cost of care exceeds the set DRG amount. Outlier payments are used to compensate hospitals for these excessive costs.

[12] Cost-to-charge ratio is the costs divided by charges while fixed ratios are ratio set by the State. Hospital-specific cost-to-charge ratios are applied to the covered charges for a case to determine whether the costs of the case exceed the fixed-loss outlier threshold. In Ohio, a hospital inpatient admission qualifies as an outlier if it exceeds certain cost or charge thresholds. The State pays each cost outlier under one of three methods. Two methods use cost- to-charge ratios from recent cost reports to convert the billed outlier charges to outlier payments. The third method uses fixed cost-to-charge ratios of 0.60 or 0.80, depending on the diagnosis (or DRG), to convert the billed charges. The fixed ratios were enacted through State legislation. Because a hospital cannot calculate the exact cost for each admission, the State must use the cost-to-charge ratio to convert billed charges to estimated costs. The fixed ratios method applies fixed ratios of either 0.60 or 0.80, depending on the DRG, to convert a portion of the charges to the outlier payment.

Ohio Departments of Mental Health (ODMH) and Alcohol and Drug Addiction Services (ODADAS)

In SFY 2004-05, ODMH and ODADAS combined Medicaid expenditures totaled approximately $479.9 million. ODMH and ODADAS, while representing separate populations, often serve similar recipients and perform many similar functions that pertain to Medicaid program integrity. Specifically, both ODADAS and ODMH certify Medicaid providers (under three-year accreditation) who contract with county/regional Alcohol, Drug, and Mental Health boards (ADAMH boards)[13] to deliver services to recipients. ODMH, ODADAS and their local/regional boards enter provider contract and rate information into the Multi-Agency Community Services Information System (MACSIS), which is a claims processing system for all services provided within the behavioral health system.[14] MACSIS adjudicates claims,[15] through electronic edits, reviewing the type and amount of services each provider is contracted to provide and approving for payment those claims only for services allowed under the provider contract. Submitted claims are uploaded from county/local boards to MACSIS on a scheduled basis where the data can be viewed by all parties (State and local) in real time.[16] County/regional boards pay providers for approved claims. Remittance advices are posted electronically at the time of payment explaining reasons for any denials – these are available to providers and county/local boards. ODMH and ODADAS submit claims data to ODJFS, which performs additional edit checks through MMIS and includes the claims data with its submissions to CMS to receive the federal medical assistance percentage (federal match). ODJFS reimburses the State sub-recipients the federal medical assistance percentage (federal match).

All counties in Ohio and Medicaid providers are subject to A-133 audits[17] which are typically performed by the Auditor of State. Local boards review provider audits and forward them to ODMH and ODADAS for further review. When necessary, corrective action plans may be issued to ensure future provider compliance with federal reporting standards.

Medicaid providers are required to submit their audited financial statements (or cost reports) to the county/regional boards for use in reconciling the cost-based reimbursement rates (based on

[13] In addition to combined ADAMH boards, there are seven counties that have separate boards of Alcohol and Drug Addition Services and boards of Mental Health. In this report, the county-level boards of Mental Health and Alcohol and Drug Addiction Services and the combined boards are collectively referred to as ADAMH boards.

[14] Behavioral Health System is an umbrella term used to describe the services covered by ODMH and ODADAS, as well as the local boards and provider networks.

[15] In this context, adjudication means to decide about a claim based on a set of rules or polices.

[16] For additional information on MACSIS and its interface with MMIS and CRIS-E, see the **technology and program management** section.

[17] Federal Office of Management and Budget Circular No. A-133, re-titled *Audits of States, Local Governments, and Non-Profit Organizations*, establishes uniform audit requirements for non-federal entities that administer federal awards. One of the more significant recent revisions to A-133 requirements is that the threshold for when an entity is required to have an audit was raised from $25,000 to $300,000. This will significantly reduce audit costs for many small entities. Other significant changes include: a report submission due date which is shortened from 13 to 9 months and a report submission process that includes a data collection form and streamlined filing requirements.

provider budgeted costs) with actual expenditures.[18] Both ODMH and ODADAS receive these reports from the county/local board and the State departments then reconcile the budgeted and estimated costs with the audited provider records to finalize reimbursement rates. If providers' actual costs are less than the budgeted costs (what was paid prospectively), the provider is subject to a reconciliation process. This process is led by the State departments but involves the local boards and can result in a repayment being made or an adjustment being levied against future payments. If provider costs exceed budgeted costs, the provider must absorb the excess amounts. According to provider stakeholders, ODMH and ODADAS are experiencing a significant backlog (5 to 7 years) in the completion of provider audit reconciliations.[19]

With the exception of in-patient psychiatric care providers which are reviewed by a third-party on behalf of ODMH, providers within the ODMH and ODADAS systems are not normally a focus of SURS audits/reviews. However, administrative rules (OAC 5101:3-27-06) authorizes ODMH, through their local boards, to complete audits of community mental health centers, including medical necessity reviews. ODADAS and their local boards are not covered under this OAC rule but ODADAS representatives have expressed an interest in moving to a fixed-fee pricing system (similar to the diagnostic related groups (DRG) system used on the fee-for-service side) and conducting audits in a manner similar to SURS.

During stakeholder interviews, members of the Ohio Association of County Behavioral Health Authorities (OCBHA) expressed concern about the application of clinical controls to ensure program integrity. One member said,

> "As consumers are more aware and communities are more aware and more concerned about their dollars, they're smarter about asking questions. So take, for example …a provider who is abusive of the system, because there is no limit [on the units of care], they might send you a bill for say 10, 15, 20 hours of treatment in one day. We sign the check for that. So if a newspaper would call us and say, "Do you know that they got 20 hours of treatment?" We have to say yes. "Did you pay for that?" "Yes." Well, who's awake for 20 hours in a row… but we can't legally not pay it, and we can't legally control the clinical aspect of that and yet we're raising the funds to pay for it."

[18] These may be amended during the fiscal year by the provider to ensure that budgeted costs are projected accurately.

[19] ODADAS reported a backlog of five to seven years. ODADAS is in the process of collecting overpayments based on the 1997 reconciliation and was, at the time of the audit, calculating 1998 reconciliations. There is a delay of almost 2 years before reconciliation can occur.
ODMH is in process of doing 1999 cost reconciliations. The agency does not agree that they have a five year backlog as reported by ODJFS. An ODMH representative explained that reconciliations can not begin until two years after the close of a state fiscal year and there are no timelines in State of federal regulations for when reconciliations must be conducted.

OCBHA members also mentioned that they have reported fraud to ODMH, ODADAS, and ODJFS, but because a rule for clinical oversight is not in place, claims are paid even if the level of service is questionable. Finally, members expressed frustration at the process of negotiating settlements with providers who have submitted fraudulent claims. Substantial reductions in the payback amount in comparison to the claims that were paid caused OCBHA members to question the long-term utility of conducting audits, particularly if the State's efforts to collect inappropriately paid claims were so paltry.

However, recent legislation (Amended Substitute House Bill 66) authorizes the State sub-recipients to convene a meeting to begin implementation of the State of Ohio Community Behavioral Health Medicaid Business Plan which will allow the county-level Behavioral Health Authorities to implement oversight on clinical treatment levels, among other changes.[20] HB 66 also gave ODMH, ODADAS, and the local boards specific authority to recoup overpayments or errors identified during audits on behalf of ODJFS. ODMH and ODADAS provider identifiers are not included in claims within the ODJFS Data Warehouse and Decision Support System (see the **technology and program management** section), but this information is available to oversight agencies through MACSIS. OCBHA members mentioned, during a stakeholder meeting, that this information could be easily accessed and used to identify over billing and questionable clinical practices (e.g. billing for units of service beyond reasonable parameters). Overall, instances of inconsistent application of oversight are being remedied within the behavioral health system through recent legislative initiatives, although enhancements to this process may be possible through greater centralization of fraud reporting and investigation results (see **R7.10**, **R7.11**, and **R7.12**).

Ohio Department Mental Retardation and Developmental Disabilities (ODMRDD)

In SFY 2004-05, ODMRDD spent over $1.2 billion for Medicaid services. ODMRDD provides services to developmentally disabled and mentally retarded recipients on a fee-for-service basis through its County boards of Mental Retardation and Developmental Disabilities (CBMRDD) and private providers. ODMRDD also monitors *Individual Options* and *Level One* waivers through its County boards. The CBMRDDs perform annual recipient eligibility assessments and on-site reviews, investigate major unusual incidents involving recipient abuse and neglect, and conduct regular and special provider compliance reviews (OAC 5123:2-9-08). Specifically, ODMRDD issues provider licenses and administers provider certification. See the **service provision** section for additional information on waivers.

[20] The Plan outlines the components needed at the State and local levels within the Medicaid community behavioral health system for efficient and consistent administration. The goals of the Plan include ensuring local flexibility and federal compliance; establishing a state-wide clinical improvement process; developing uniform cost reporting, rate setting, compliance, and auditing processes; and establishing consumer protection standards. The Plan applies to Medicaid services many of the same initiatives and processes already in use in the behavioral health system for locally-funded services. The most important aspects include the application of utilization review and management and care management to Medicaid services, a function prohibited to the boards under current rules.

CBMRDDs are audited as a component unit of their respective county A-133 audits. The CBMRDDs are responsible for determining eligibility for MRDD system services and developing individual service plans for recipients. ODMRDD enters individual service plan information into the Payment Authorization for Waiver Services (PAWS) system (see the **technology and program management** section). Claims are sent from the provider (which may be the CBMRDD) directly to ODMRDD. PAWS provides the individual service plan information to ODMRDD's claims adjudication system (MBS) which pays only claims for authorized services. ODMRDD pays the provider from funds that were reserve from each CBMRDD allocation from the State. Claims data is submitted to ODJFS for inclusion with other claims to CMS for the draw down of the federal match which, for ODMRDD claims, is returned to ODMRDD. Notwithstanding, Medicaid providers within the ODMRDD system do not receive medical necessity reviews and the system's community-based services are not normally a focus of SURS recovery audits/reviews. However, ICF/MRs, which are categorized under long-term care facilities and paid by ODJFS, are regularly included in SURS reviews. (See **R7.10**, **R7.11**, and **R7.12**). ODMRDD does not perform the same post-payment reviews as are used in the behavioral health system because, operating in a waiver environment, it controls services on the front-end through the individual service plan. However, if ODMRDD or the CBMRDD suspects fraud on the part of a provider, they refer the matter to the Ohio Attorney General.

Ohio Department of Aging (ODA)

In SFY 2004-05, ODA spent about $310.3 million for Medicaid services. As it pertains to Medicaid program integrity, ODA:

- Monitors the *PASSPORT* and *Choices* waivers (see **managed care and care management**);
- Ensures the initial and ongoing certification of providers (OAC 5101:3-31-10), including professional licensure and background checks (see **R7.2**);
- Performs on-site provider inspections and conducts annual structural compliance reviews (OAC 5101:3-31-13);
- Verifies samples of paid claims; and
- Works with PAAs to develop and implement corrective action plans.

More specifically, regional PAAs contract with Medicaid providers whose services are guided by recipients' individual service plans. PAAs enter provider contract information into the Payment Information Management System (PIMS) which reconciles Medicaid claims data with recipient individual service plans to ensure claims are for authorized services prior to payment and that planned services are being provided. PAAs pay claims to providers or, in the case of denied claims, give the provider a reason for the denial. ODA sends aggregated claims information to ODJFS for its federal match portion in the manner described for the other sub-recipient agencies above (see also the **technology and program management** section).

ODJFS indicated that PAAs submit cost reports to both ODA and ODJFS, respectively, for review and audit.[21] While OHP is responsible for interim rate setting, ORAA is responsible for auditing administrative costs, proposing adjustments, and reviewing the support documentation that accompanies claims.

ODA performs medical necessity reviews[22] on a sample of paid claims. Although ODA provider information is not included on claims within the ODJFS Data Warehouse and Decision Support System, all service data is available through PIMS (see **technology and program management**). ODA reports instances of over-billing and suspected fraud to AOS, the AG, and SURS.

Medicaid Program Integrity – National Reform Initiatives

In 2003, GAO added Medicaid to its list of high-risk programs because of its size, structure, target population, and coverage, as well as fiscal management weaknesses. Certain characteristics of Medicaid make it an attractive target for exploitation, including the fact that as a third party payer, Medicaid pays for services provided by others and cannot, as a practical matter, police each claim for reimbursement. In 2005, for example, ODJFS processed approximately 63.4 million claims for nearly 2 million recipients. Additionally, the relative impermanence of the recipient population exposes Medicaid to the risk that providers may receive improper payments for services rendered to ineligible or deceased individuals.

Deficit Reduction Omnibus Reconciliation Act of 2005 (DRA)

GAO recently reported that CMS oversight of program integrity has been disproportionately small relative to the risk of serious financial loss. Specifically, there has been a wide disparity between available CMS staff and financial resources and the amount of federal dollars at risk in Medicaid payments. In FFY 2005, CMS spent nearly $200 billion for Medicaid, yet it allocated only 8.1 full-time equivalent employees to support states' program integrity efforts. In addition, CMS lacked a strategic plan to direct its anti-fraud and waste activities.

In response to GAO, Congress enacted the Deficit Reduction Omnibus Reconciliation Act of 2005 (DRA), which requires CMS to add 100 program integrity support staff. Certain provisions also strengthen Medicaid's status as "payer of last resort." For instance, the DRA classifies pharmacy benefit managers and self-insured plans as third party liability payers and requires them to pay for recipient claims before Medicaid does. Examples of other third party liability payers include: private health insurance; Medicare; employment-related health insurance; court-ordered health insurance derived by non-custodial parents, court judgments, or settlements from

[21] PAAs also undergo A-133 audits.

[22] According to HHS-OIG, medical necessity reviews include attestations by physicians stating that they have ordered services or supplies and that the services and supplies ordered are medically necessary for the care and treatment of a Medicaid recipient.

a liability insurer; workers' compensation; first party probate-estate recoveries; and long-term care insurance.

The DRA also prohibits states from double-billing Medicaid for prescription drugs, requires recipients to submit documentation of U.S. citizenship, increases penalties on recipients who transfer assets for less than fair market value in order to qualify for nursing home care, and disqualifies recipients with substantial home equity from receiving nursing home benefits. According to ODJFS, provider and recipient stakeholders are concerned that by requiring documentation of U.S. citizenship, some individuals will be unable to obtain necessary health care.

Finally, the DRA creates a Medicaid Integrity Program within CMS for the purpose of:

- Reviewing the actions of Medicaid providers and educating them about program integrity and quality assurance;
- Auditing Medicaid claims;
- Identifying any instances of overpayments and initiating recovery;
- Developing and implementing a comprehensive, five-year plan for program integrity; and
- Collecting statistical data from designated state Medicaid agencies to include within a national annual report.

According to GAO, the DRA offers CMS a unique opportunity to strengthen its leadership of state and federal efforts to minimize fraud, waste, and abuse. The Congressional Budget Office estimates that Medicaid program integrity-related provisions within the DRA will reduce federal expenditures by approximately $7.9 billion over 10 years.

Medicaid Program Integrity – Ohio Reform Initiatives

GAO suggests that fraud, waste, and abuse arise because Medicaid has traditionally been a fee-for-service system, with nominal co-payments, if any; offering no financial disincentives to excessive use by honest recipients, much less those who perpetrate dubious schemes. Furthermore, because many states pay considerably less under Medicaid than providers customarily charge, providers are often in short supply, especially in rural areas. Thus, Medicaid administrators are reluctant to impose controls that are perceived as unduly burdensome (e.g., mandatory electronic or online billing). Echoing these themes, the Ohio Commission to Reform Medicaid (the Ohio Medicaid Commission) specifically recommended that Ohio move increasingly towards managed care, enforce co-payment requirements, and improve technology.

Ohio Inspector General

In January 2005, the Ohio Inspector General released the results of an investigation into ODJFS, which was initiated because of allegations about a lack of cooperation with various State and federal entities in administering the Medicaid program. The Ohio Inspector General found that ODJFS failed to identify and recover millions of dollars in improper Medicaid payments and issued recommendations in four major areas, including: ODJFS management philosophy; administration of SURS; revenue recovery; and leveraging available resources.

Table 7-1 summarizes key Ohio Inspector General recommendations in these four areas and action steps to be taken by ODJFS, as indicated within its *One Year Progress Report.*

Table 7-1: Ohio Inspector General Recommendations and ODJFS Response

Ohio Inspector General Recommendation	ODJFS Action Steps
ODJFS Management Philosophy	
• **Improve Medicaid program integrity through increased emphasis on fraud detection and revenue recovery** • **Re-evaluate the existing strategy of pursuing settlements over administrative hearings**	• Sustained the allocation of State funds to administer SURS independent of OHP • Enforced OAC 5101:3-1-25, which applies interest to improper payments identified by SURS • Converted older "full-scope audits" into limited reviews, pursuant to OAC 5101:3-1-27 to speed the audit process, allow SURS to conduct more audits, and enhance the validity of audits • Established "arms-length" independence between the auditing and education/prevention functions • Increased ODJFS budget for Medicaid hearing officers • Hired Medicaid attorney responsible for resolving SURS-related issues • Granted the Office of Legal Services independent authority to redesign and issue SURS-related audit notices [1], enforce applicable interest, and grant repayment plans
Administration of SURS	
• **Make audit (SURS) and audit resolution (Office of Legal Services) functions independent of OHP** • **Implement auditing standards into SURS audits/reviews** • **Work with Auditor of State and Attorney General to determine the agency that is best suited to investigate providers**	• Removed SURS from OHP and reorganized within ORAA • Made the Office of Legal Services solely responsible for audit resolution • Established audit methodologies consistent with auditing standards and trained staff • Allocated administrative dollars to cover the full cost of Auditor of State audits, including a recommended performance audit of Medicaid
Revenue Recovery	
• **Advocate a change in federal rules that would permit Ohio to remit federal overpayments to HHS upon collection, not upon identification** • **Deduct settlement dollars from future payments to providers**	• Working with Governor and Attorney General to lobby HHS • Made the Office of Fiscal Services solely responsible for monitoring and tracking overpayments • Obtained approval from Attorney General's Collections Enforcement Section to extend recovery time from 45 to 90 days [2]
Leveraging Available Resources	
• **Improve working relationships with the Attorney General, Auditor of State, Bureau of Workers' Compensation, State licensing boards, and Medicaid sub-recipient agencies** • **Update memoranda of understanding and interagency agreements** • **Increase reliance on in-house and external expertise**	• Developing memoranda of understanding with the Attorney General, BWC, and licensing boards (in process) • Developing website of sanctioned/excluded providers (see **R7.9**) • Meeting regularly with CMS, Attorney General, and Auditor of State to discuss provider compliance and auditing practices, ensure audit consistency, compare information on potential fraud referrals or litigation, improve data sharing, and identify best practices • Created a Medicaid program integrity manager position within OHP [3] (see **Chart 7-2**)

Source: Ohio Inspector General and ODJFS

[1] Includes notices of overpayment, proposed/final adjudication orders, and settlement agreements.

[2] Up to a maximum of 6 months if provider enrolls in a payment offset plan.

[3] Serves as liaison between OHP, Office of Legal Services, and ORAA; coordinating non-monetary response to SURS findings.

Both the Attorney General and the Auditor of State indicate that the working relationship they share with ODJFS has improved over the past year, attributable partly to Ohio Medicaid Commission and Ohio Inspector General recommendations. MFCU and FIAG personnel now meet regularly with ODJFS staff to exchange information and streamline efforts to identify waste, investigate fraud and abuse, collect overpayments, and prosecute offenders. Since FFY 1999-00, for example, MFCU has increased fraud-related convictions and recoveries per conviction by nearly 165 and 17 percent, respectively.

During discussions with Medicaid stakeholders, a member of the Ohio Association of Medical Equipment Services observed the following:

> "...Every year...the State Auditor came and audited our books and they would do a pre-audit conference...and they would sit down at the end [post audit conference]....So we knew exactly what was going to end up in that management letter before it was ever submitted to the Board or at that point made public.... And if there was anything that we needed to correct ahead of time, we took care of it. To me that seemed like a process that works and it has worked very well for your agency and local government units and schools.... So why can't other departments and other units use that type of model and also that business philosophy about coming in and just developing partnerships?"

Likewise, a member of the Ohio Hospital Association stated, "We want to be held accountable. We want to do a good job. All of us do." In the interview the member reiterated the importance of the audit process in ensuring program integrity.

The importance of partnership was emphasized several times in relation to the audit/investigative processes of the Auditor of State and Attorney General.

Ohio Commission to Reform Medicaid

The Ohio Commission to Reform Medicaid, which first convened in 2003, was created by the Governor and Ohio General Assembly for the purpose of reviewing the Medicaid system and making recommendations for comprehensive reform and cost containment. The Commission's scope included conducting an assessment of existing problems, developing principles for resolving identified problems, establishing goals and outcome measures, and collaborating with State agencies and other stakeholders to obtain technical information, research, and analysis. A final report was issued to the public in 2005.

The Ohio Medicaid Commission indicated that there is a relative lack of coordination among State and local agencies, disjointed funding and expenditure tracking, antiquated and fragmented technology systems, and bureaucratic obstacles that cause inefficiencies and waste. As it pertains to Medicaid program integrity, the Ohio Medicaid Commission reported that ODJFS does not have a comprehensive system to identify internal problem areas, test program compliance, and correct weaknesses.

The Ohio Medicaid Commission recommended the following, as a means of correcting these deficiencies:

- Design an all-inclusive Medicaid program integrity system that meets State and federal standards and uses state-of-the-art technology;
- Require that the Auditor of State conduct a performance audit of the Medicaid system to assess overall efficiency and effectiveness;
- Create an Audit Integrity Fund in the Auditor of State budget to minimize the negative impact of federal rules requiring states to remit identified overpayments to CMS before the State has recovered them from providers;
- Grant the Auditor of State the authority to independently initiate audits of Medicaid providers;
- Create a multi-agency Medicaid program integrity task force responsible for identifying risks and developing a strategic plan to combat fraud, waste, and abuse;
- Tighten enrollment controls by purging inactive provider files, periodically re-enrolling active providers, and establishing a probationary/provisional period; and
- Comply with recommendations issued by the Ohio Inspector General in January 2005.

Finally, the Ohio Medicaid Commission suggested that in order to effectively transform Medicaid, Ohio should modernize its data systems and maximize its buying power through selective, performance-based contracting. State and local agencies corroborated Ohio Medicaid Commission findings in interviews conducted by the Auditor of State, as did provider and recipient advocacy groups.

Legislative Action

GAO remains optimistic that states are addressing the problem of Medicaid fraud and meeting with some success, especially in the areas of prevention and early detection, as well as improving utilization monitoring procedures and imposing harsher sanctions for offenders. The 126th Ohio General Assembly has impacted Medicaid program integrity by incorporating the following provisions within Amended Substitute House Bill 66 (HB 66) and subsequent corrective legislation (Sub. HB 530):

- Create the offense of Medicaid eligibility fraud, which prohibits recipients from making false or misleading statements and failing to conceal property interests or transfers in an application for Medicaid eligibility;
- Grant the Attorney General and local prosecuting attorneys authority to file civil actions for recovery of improper Medicaid payments paid as a result of eligibility fraud;
- Permit ODJFS to recover improper payments made to Medicaid providers and extend recovery timelines;

- Permit State-level sub-recipient agencies to recover improper payments on behalf of ODJFS (see **R7.10**, **R7.11**, and **R7.12**);
- Permit ODJFS to withhold a Medicaid payment or terminate provider agreements with nursing facilities and ICFs/MR if these providers fail to pay franchise permit fees in a timely manner;
- Require Medicaid health insuring corporations to make prompt payments and provide a recipient grievance process that complies with federal regulations;
- Permit ODJFS to take disciplinary action against Medicaid health insuring corporations that fail to remit franchise permit fees or cooperate in audits;
- Require that ODJFS adopt rules and procedures for enforcing Medicaid compliance, including procedures for establishing corrective action plans and imposing sanctions;
- Permit ODJFS to terminate a Medicaid provider agreement without an administrative hearing if the provider has not billed or otherwise submitted claims for payment for two or more years and does not have an active address; and
- Require persons and government entities that receive or make annual Medicaid payments of at least $5 million to provide their employees, contractors, and agents with information about federal and State laws on fraud, waste, and abuse prevention and detection, as well as whistleblower protection.

Finally, the Ohio General Assembly introduced legislation that creates financial incentives for potential whistleblowers to report Medicaid fraud, waste, and abuse committed by their employers (Senate Bill 39) and requires documentation of U.S. citizenship to become a Medicaid recipient (House Bill 358) – pursuant to the recent federal deficit reduction act. It is expected that the State will be in a better position to identify and audit high-risk providers[23] and detect and prevent fraud, waste, and abuse more effectively.

[23] Providers that comprise the largest percentage of Medicaid expenditures, and are therefore considered higher risk, include: nursing homes (26.9 percent), hospitals (20.8 percent), and pharmacies (19.5 percent).

Findings and Recommendations

A. Risk Assessment: Determining the Nature and Extent of the Problem

> "…Medicaid needs to look at where most of their money's going and then audit them first and most extensively, and then where the money is going the least. I mean, you're not going to get as much bang for your buck out of auditing where the smallest amount of money goes. Be strategic with audits…Don't pick on the little guy."
>
> *Member, Ohio Academy of Family Physicians*

A primary step in the process of strengthening internal controls is conducting a risk assessment; an activity that entails a comprehensive review and analysis of program operations, including feedback from key stakeholders, to determine where risks exist, what those risks are, and then measuring the potential or actual impact of those risks on program operations. The information developed during a risk assessment forms the foundation or basis upon which a state Medicaid agency can determine the nature and type of corrective actions needed, and it provides baseline information for measuring progress in reducing improper payments. Risk analysis methodologies can vary because of differences in missions and the difficulty in qualitatively and quantitatively assigning risk levels. In addition, GAO recommends that because governmental, economic, regulatory, and operating conditions continually change, risk assessments should be periodically updated to identify and deal with any special risks prompted by such changes.

According to the American Institute of Certified Public Accountants (AICPA), a risk assessment should contain formal goals and objectives that stipulate what the organization hopes to achieve, as stipulated within a strategic plan, and linked to a specific mission. In addition, the risk assessment should include a process for identifying risks and measuring their significance. One of the biggest hurdles that state Medicaid agencies face when managing program integrity is overcoming the propensity toward denial of the problem. It is easy to rationalize, avoid, or defer action if an agency does not know how big the problem is. GAO recommends that states determine the nature and magnitude of the problem, through a systematic risk assessment process that is openly communicated to all relevant stakeholders. When this occurs, especially in a strong control environment, denial is no longer an option, and government can more effectively recover improper payments.

This section focuses on ODJFS as the single State Medicaid agency because it is the authority ultimately responsible for ensuring the integrity of Ohio's Medicaid program. While the program integrity activities discussed in this report are important for all sub-recipient agencies to implement, it focuses overall responsibility for program integrity on the State Medicaid agency.

Strategic Goals & Objectives

> "We have no management [in the behavioral health system]. You talk about waste and abuse… North Carolina had a $600 million …pay back when … [federal auditors] did their behavioral health care.…It's scary to me, and I'm telling you there are no controls, none. Nobody goes and looks."
>
> *Member, National Alliance for the Mentally Ill*

ODJFS and the sub-recipient agencies do not have a comprehensive, risk assessment planning process to identify and measure risks and establish Medicaid program integrity-related goals and objectives for the program on a state-wide basis.[24] Moreover, ODJFS' current strategic plan does not contain a Medicaid program integrity-related mission statement, nor does ODJFS include formal feedback from State sub-recipient and county/regional agencies and provider/recipient advocacy groups. According to CMS, a formal planning process (encompassing both fee-for-service and managed care plans) helps state Medicaid agencies to outline all prevention and detection activities, key partners and stakeholders, as well as roles and responsibilities. Moreover, effective plans outline all program integrity-related goals and objectives, performance measures, areas of vulnerability (i.e., comprehensive risk assessment), and milestones for completion of key activities.

The Oklahoma Health Care Authority's strategic plan begins by providing a brief overview of the mission, vision, and goals of the agency; followed by specific action plans the agency has developed to meet strategic goals. Furthermore, Oklahoma's plan includes a summary delineating key external factors and assumptions that might affect goal achievement. In terms of Medicaid program integrity, Oklahoma's goals and objectives include the following:

- Increase the payment accuracy rate to an agreed-upon benchmark of 97 percent;
- Increase program and payment integrity efforts which may result in recoveries;
- Actively pursue all third party liability and drug utilization review recoveries; and
- Train and educate Medicaid providers, both on an "as-needed" and pro-active basis, through group and/or individual training and other communication.

Maryland's Program Integrity Administration publishes the following goals online:

- Identify ways to reduce the cost of the Medicaid program without reducing services;
- Review program compliance with policies, regulations, and systems;
- Communicate within the program and with other agencies to correct compliance issues;
- Propose enhancements to improve compliance and consistency;

[24] State sub-recipient agencies are very knowledgeable about the risk within their own systems. Application of this knowledge varies as does the risk assessment and planning process at the local level. This information and knowledge, however, has not been transferred to SURS, FIAG, or the Attorney General or applied in a uniform, state-wide manner.

- Provide training to staff to eliminate or reduce Medicaid errors;
- Increase referrals to the Maryland Medicaid Fraud Control Unit;
- Coordinate cases with other State agencies; and
- Provide follow-up reviews of legislative and federal governmental audits.

The absence of stated goals and objectives in Ohio is evident in the large time lag between dates of service and audit functions or cost report reconciliations being conducted.[25] Members of the Area Agencies on Aging Directors' Association remarked that, there was poor turnaround in communications, and timely monitoring is necessary. Similarly, members of the Ohio Council of Behavioral Healthcare Providers stated the following:

> "...from the State side, [reconciliation is] a responsibility that was delegated to ODADAS and ODMH .... They are supposed to reconcile what was billed with what was paid. ...The State has failed to do that. I think ODADAS right now is doing 1997. ODMH I think is current through [1998]...[In order to catch up], they were planning to do a year every six months. Now, if you're eight, nine years behind where the provider system is today...following that kind of schedule is going to kill the system. And I am not sure that people at the top fully understand the business that providers are doing, where providers are at, and the impact on that operation."

During a meeting with AOPHA, a member said, "There are settlements with the Medicaid program in Ohio that probably go back to 1997, 1998. Now, if you'd say to a provider "Here is an audit finding. Find me an invoice. Could anybody find an invoice any place in their lives that they did back in 1997?"

Finally, members of the Ohio Association of Community Health Centers also remarked on the tardiness of audits. One member noted that "we currently have their auditors coming in to audit us for 1998. ...That should be done in a 2-to-3 year span at best. We can't keep these records forever." Another member said, "...we've been very surprised at how far behind the ODJFS audits are, and I'm sure from your perspective trying to find those records is a little bit of a challenge."

The absence of stated goals and objectives, coupled with the sluggish approach to initiating audits, suggests a limited institutional commitment to Medicaid fraud and abuse prevention and detection activities. The State Medicaid agency cannot effectively identify and assess risks across all State sub-recipients, coordinate prevention and detection controls and enforcement strategies, nor can it communicate results that are linked to goals, objectives, and performance measures. This may negatively impact Ohio's ability to meet the program integrity-related expectations of the federal government, especially CMS, which is assuming a stronger role in collecting overpayments and requiring that state Medicaid agencies submit increasingly comprehensive reports on recovery efforts.

[25] Different approaches are used depending on the manner in which the provider is paid for services.

Stakeholder Feedback & Mission Statement

ODJFS and the sub-recipient agencies do not effectively include input and feedback from provider and recipient advocacy groups in planning and evaluating program integrity activities. For example, ODJFS has not established a program integrity-specific mission statement that has been developed with input from key stakeholders. Likewise, the State sub-recipient agencies have not developed program integrity mission statements or involved their specific stakeholders in the program integrity development process. Local/regional agency stakeholders indicate that Medicaid program integrity lacks "teeth" and that it takes too long to remove offending providers from the system. Regarding program integrity in Ohio, provider and recipient stakeholder groups identified the following deficiencies which could negatively impact Medicaid program integrity:

- Lack of communication/collaboration;
- Inconsistent information and untimely responses to questions;
- Need for increased education/training opportunities;
- Need for more consistent rules and definitions;
- Unresolved coding issues that are problematic for providers; and
- Need for improved internal controls.

A member of the Ohio Coalition for Healthy Communities expressed the poor level of collaboration as follows:

> "The assumption is that everybody out there, at least a significant portion of people out there, are committing fraud, waste and abuse. ... Instead of saying how does the system work? How can we enhance it so people can get the services they need, it's an underlying assumption everybody is out to cheat us out of our money, which I think is really damaging to the system...."

Members of the Ohio Council for Home Care expressed a similar sentiment. One member said,

> "...As a provider I feel like I'm just being looked as ...just perpetrating fraud. ...There are no honest mistakes. There is no misunderstanding. ...We are all out there just thieving and stealing, and that offends me. I'm automatically under suspicion. I have worked for Medicare for six years .... By the same token, the majority of us will be the first to admit when we have made a mistake and try to rectify that mistake. We are in the business of caring for people."

When performing a risk assessment, GAO recommends that management include feedback from key internal and external stakeholders. To frame the control environment and risk assessment process (identifying goals and objectives to control risk), many states use mission and strategic planning frameworks. Published online, the mission of Maryland's Program Integrity Administration is to "produce cost savings without reducing eligibility and benefits by identifying and eliminating Medicaid fraud, waste, and abuse." Another example is Florida's Office of Medicaid program Oversight, whose mission is to "optimize the use of Medicaid resources through analysis and evaluation of costs, delivery, outcomes of services and agency

functions." GFOA suggests that the main purpose of a mission statement is to help prioritize strategies and to develop meaningful goals and objectives.[26]

During meetings with Medicaid stakeholder agencies, several expressed frustration with their inability to participate in the audit process or be actively involved in oversight within their systems. For example, members of the Ohio Association of County Behavioral Health Authorities stated that,

> "It was part of our contract with ODADAS that we had to do a Medicaid audit. We've been doing them for years .... We sent it up to the State, nothing. It didn't matter. It wasn't even read and now this past year of course we were told not do them anymore. ... So we're not even doing those minimal reviews. We've set up incentives for them to abuse the system."

Absent formal, mutually agreed-upon aims of program integrity, a state Medicaid agency may have difficulty conveying its program integrity-related direction and goals to federal, State, and local agencies, as well as to providers, recipients, and the public. This increases the risk of financial loss and legal liability, as Medicaid stakeholders may have differing interpretations of their roles and priorities; inhibiting collaborative efforts to minimize fraud, waste, and abuse. Defining expected outcomes of the program and the agency's vision and expectations clarifies the "tone at the top" and enhances the control environment.

Risk Identification: ODJFS Medicaid Program Integrity Model

> "What efforts are you folks using at this time to handle...[program integrity regarding fraud, waste, and abuse] because I know there are lots of billing errors and people double billing and unbundling their coding...."
>
> *Member, National Multiple Sclerosis Society*

In recent testimony before the General Assembly, ODJFS signified a willingness to implement State and federal recommendations to improve Medicaid program integrity. Specifically, following the Ohio Inspector General's investigation, ODJFS announced the adoption of a comprehensive, multi-phase Medicaid program integrity model that creates an "arm's length" relationship between program and monitoring functions, as recommended by the Ohio Inspector General.[27] Specifically, in Phase I, this model segregates the prospective (financial approvals, quality control, and quality assurance) activities performed by OHP and the Office of Fiscal Services from the retrospective (audits and quality assessment reviews) activities performed by

[26] State Medicaid risk assessments generally are not contained in a single document but are reflected in the states' use of Medi-Medi, PERM, mission statements, goals and objectives, and stakeholder input, as well as other elements as discussed in this section. Viewed in total, these comprise the system of risk assessment.

[27] ODJFS did not provide this plan in a formal written format until late in the audit process. Auditors requested documented implementation plans which were later developed to satisfy the audit request. Much of the information surrounding this plan was not in writing until Phase I was largely complete and the performance audit had requested the information.

ORAA, as well as from the settlement/resolution (ORC Chapter 119 hearings and external audits) activities performed and monitored by the Offices of Legal Services and Chief Inspector. In latter phases, the model addresses institutional providers, State sub-recipient agencies, and managed care plans.

The following describes each phase of the ODJFS program integrity model[28] and its implementation status:

Phase I: Addressing Ohio Inspector General Recommendations (Complete)

This phase focused primarily on addressing issues identified by the Ohio Inspector General (see **Table 7-1**): segregating ORAA from OHP, implementing audit standards, as well as improving and formalizing relationships with other State agencies to minimize fraud, waste, and abuse and enhance the recovery of improper payments.

Phase II: Institutional Providers (On-going)

In this phase, ODJFS established two workgroups assigned to evaluate Medicaid program integrity weaknesses of institutional providers, including long-term care (nursing facilities and ICFs/MR) and hospitals. Specifically, these workgroups were responsible for the following:

- Documenting current Medicaid program integrity activities of nursing facilities, ICFs/MR, and hospitals;
- Interviewing personnel to determine ideal conditions, assuming no resource limitations;
- Identifying "material gaps" between current activities and ideal conditions; and
- Determining which area of ODJFS (either OHP or ORAA) is best-suited to address identified gaps.

Phase II workgroups identified a number of material gaps impacting institutional providers. Regarding long-term care facilities, ODJFS noted inconsistencies in the OHP's audit selection process and recommended that ORAA perform utilization review functions, rather than OHP, to more effectively ensure independence. Regarding hospitals, ODJFS identified oversight gaps pertaining to field audits and post-payment utilization reviews of billing adjustments. For example, ODJFS indicates that it has historically relied on Medicare's fiscal intermediaries to complete field audits of hospital cost reports. Medicare has changed its payment policies and modified its oversight functions, however, creating a need for ODJFS to allocate its own resources to conduct field audits. ODJFS also noted that it does not effectively review hospital billings for erratic adjustments that are indicative of fraud, waste, and abuse.

[28] Ohio sub-recipient agencies do not have individual program integrity models. In other states that have sub-recipient agencies, like New York (see **R7.15**), the program integrity model is usually coordinated through a single body (e.g., Medicaid Chief Inspector).

As of September 2006, Phase II workgroups recommended that ORAA, rather than OHP, direct and manage ODJFS's contract with its outsourced hospital utilization vendor.

Phase III: State Sub-Recipients (On-going)

This phase focuses on State-level sub-recipient agencies, including ODA, ODADAS, and ODMH, and ODMRDD. An ODJFS workgroup interviewed State agency representatives and developed gap analyses to assess the following:

- **Funding Streams**: how claims payment systems work and interface with the Medical Management Information System (MMIS); how payment and reimbursement occurs at the local level, what edits are applied in claims processing, and how and from what sources the Medicaid non-federal match is paid (see **Organizational Issues**);
- **Cost Reports**: including how interim cost-based rates are set, how final cost-based rates are reconciled, and on what schedule this occurs;
- **A-133 Audits**: how State-level sub-recipient agencies monitor provider agencies, identify weaknesses, and monitor corrective action plans;
- **Utilization Reviews**: what retrospective processes are in place to assure that Medicaid services were medically necessary and that claims are paid in the correct amounts;
- **Provider Certification**: how State agencies assure that providers are qualified to deliver particular services, with what frequency do certification reviews occur, how are providers de-certified or debarred;
- **Fraud Detection**: how State agencies detect and report fraud;
- **Improper Payment Recovery**: how improper payments are discovered, by whom, and how it is reported; and
- **Sub-Recipient Monitoring**: how provider-specific audits are conducted, by whom, and how information is reported.

American Institute of Certified Public Accountants (AICPA) suggests that risks can arise due to changes in operating (or political) environment, employee turnover, new or revamped technology/information systems, as well as organizational or programmatic restructuring – all of which are applicable to Ohio Medicaid. Many of the gaps identified in Phase III reflect structural issues associated with Medicaid's evolution in Ohio. For example, Medicaid relies on multiple claims payment systems (see **technology and program management**). Another issue relates to SURS and the fact that State agencies also have the legal authority (ORC § 5111.914) to recover claims for improper payments, but that capacity to do this varies. As of April 2006, ODJFS indicates that no SURS recovery audits are performed of ODADAS, ODMH, and ODMRDD Medicaid claims (see **R7.10**, **R7.11**, and **R7.12**).

In July 2006, Phase II and III workgroups began the process of soliciting feedback and estimating financial resources necessary to address material gaps for consideration within the ODJFS biennial budget for SFY 2008-09. For example, ODJFS began to develop a proposal for

how best to manage utilization reviews of providers who are overseen by State-level sub-recipient agencies. ODJFS has been meeting with ODADAS regarding its intent to pilot a SURS-type program for its Disability Medical Assistance providers.

As of September 2006, the Phase III workgroup recommended that ODJFS work with State sub-recipient agencies to centralize SURS; directly impacting work performed by ODA, ODADAS, ODMH, and ODMRDD (see **R7.10**). ODJFS indicates that it has initiated conversations to communicate this decision to these agencies.

Phase IV: Pharmacies, Managed Care Plans, and Home Care Providers (On-hold)

This phase, which is on-hold until phases II and III are complete, will assess Medicaid program integrity activities that surround pharmacies, managed care plans, and home care providers. ODJFS identified one area of risk during its participation in the recent *Data Warehouse Assessment*, pertaining to managed care plans. Specifically, technological barriers currently prevent ODJFS from using encounter data to conduct fraud research.[29] According to CMS, this increases the risk that managed care plans may falsify encounter data in order to inflate service levels and increase capitation[30] payments.

Although there are efforts underway to improve program integrity coordination, ODJFS and the sub-recipient agencies are required to work under different ORC and OAC parameters pertaining to their authority to conduct audits. Members of the Ohio Association of County Behavioral Health Authorities expressed concern that Ohio law is inconsistent (see **organizational issues**) in the audit and oversight powers granted to the sub-recipient agencies. One member stated that: "When Medicaid and state law are inconsistent, which are you supposed to follow? …How do you decide when a law really is a law and when Medicaid trumps it?" Members of this association also commented on inconsistent guidance, particularly in the area of claims processing:

> "Up until very, very, recently there has been a complete lack of rules-- the payment structure, payment processing-- not a rule in place. MACSIS operates by State guidelines. It is changed based upon updates to a web page. That's not notice…"

Inconsistencies in State law and the ability of each agency to monitor providers and recipients creates a greater level of risk in the Ohio Medicaid system.

[29] The primary barrier is the current claims processing system scheduled to be replaced in SFY 2008-09 and the Data Warehouse which is also scheduled to be updated.

[30] Capitation pays the provider a fixed amount for each of the patients for whom he agrees to provide care, regardless of whether those patients seek care or not. Payment is typically based on a set number of dollars "per member-per month."

Risk Measurement

According to GAO, a thorough risk assessment allows entities to target high-risk areas and, therefore, to focus often limited resources where the greatest exposure exists. Ohio has only recently begun to identify and measure Medicaid program integrity risks. In addition to its Medicaid program integrity model, ODJFS is participating in CMS's Payment Error Rate Measurement (PERM) and Medicare-Medicaid Match (Medi-Medi) programs as a means of identifying and eliminating fraud, waste, and abuse.

CMS developed PERM as a result of Medicaid payment accuracy studies conducted in Illinois and Texas. Specifically, in 1998, the Illinois Department of Healthcare and Family Services conducted a comparison of Medicaid payments with claims information and documentation to determine payment accuracy. From this information, Illinois calculated that the state's payment accuracy rate was about 95 percent. The review identified errors and associated causes, allowing the state to focus its attention on the remaining 5 percent of inaccurate payments and target improvement strategies. To illustrate, of about $37.2 million in payments for non-emergency transportation services, nearly $11.6 million (31 percent) was estimated to be in error. This finding led to a series of improvements, including checks to ensure that providers who bill Medicaid actually exist, and education to ensure that they bill correctly and are aware of the state's expectations regarding program integrity.

Similarly, in 2001, the Texas Comptroller scrutinized Medicaid services for payment errors using three analytical review techniques. First, it examined the electronic payment history of a sample of recipients to determine if select services complied with published Medicaid payment procedures and policies. Second, it conducted recipient telephone interviews to confirm that paid medical services had been delivered. Finally, it reviewed recipient medical records to determine if the service was properly documented. According to the Texas Comptroller, a lack of documentation or inappropriate documentation of billed medical services was the most significant finding in its Medicaid study. Specifically, documentation-related errors comprised nearly 84 percent of all identified errors. Texas also assessed the risk of fraud and abuse in managed care plans and found that, similar to Ohio, a lack of complete and accurate encounter data[31] is a significant obstacle to effective monitoring (see **R7.14**). Texas and Illinois incurred direct costs of about $250,000 and $400,000, respectively for their payment accuracy reviews. However, both states indicate that costs decreased after the baseline measurement had been determined and found the reviews to be cost-beneficial in light of the ability to focus on high-risk areas. Resources are maximized when strategically aimed at the areas that need the most improvement. Thus, they regarded the payment accuracy review as an effective and cost-beneficial way to combat improper payments.

[31] The problems with encounter data are related to the antiquated functions of the current Data Warehouse (see **technology and program management**).

Under PERM, Ohio is required to establish baseline Medicaid program integrity measures and identify current fraud and abuse control activities to target high-risk areas in need of improvement. These include in-patient hospital services, long-term care services, independent physicians and clinics, prescription drugs, home and community-based services, primary care case management, and other services and supplies. Using private contractors (e.g., a statistical contractor, a documentation/database contractor, and a medical review contractor), CMS helps states examine the accuracy of their claims processing systems and reviews the medical necessity of services rendered. As suggested by Florida's Office of Program Policy Analysis and Government Accountability (OPPAGA), PERM participation helps to facilitate a clearer understanding of the level of investment required for Medicaid fraud and abuse detection and control activities.

In 2004, Ohio became the ninth state to participate in Medi-Medi. Originating in California in 2001, Medi-Medi is designed to identify improper billing and utilization patterns by matching Medicare and Medicaid claims information on providers and recipients (dually-eligible) to minimize fraudulent schemes that cross program boundaries and might not be evident when either program is viewed individually. It should be noted that after two years in Medi-Medi, California secured $75 million (about $77 per dually-eligible recipient) in total cost avoidances, savings, and recoveries. Assuming Ohio achieved similar results on a per dually-eligible recipient basis, of which there were 221,000 in 2003, it could reduce improper payments by just over $17 million.

Once all risk areas are identified, their potential impact on programs and activities should be measured and additional controls should be considered. Specifically, AICPA suggests that once a risk is identified, management should consider its significance – the likelihood that it will occur and all attributing costs. If the potential cost (or negative impact) of a risk outweighs the cost to mitigate it, corrective action should be taken; otherwise, management may decide to accept the risk as a reasonable cost of doing business. PERM and Medi-Medi notwithstanding, the State Medicaid agency emphasized the difficulty in measuring risks.

County DJFS offices focus on recipient fraud using, among other resources, the Income Eligibility Verification System (IEVS). ODJFS indicates that county prosecutors vary in the manner by which recipient fraud cases are prioritized and pursued. As such, ODJFS indicated that densely populated, metropolitan counties with increased financial resources are usually more aggressive, while smaller, rural counties are more likely to focus on prevention efforts – through recipient education – rather than prosecution. During interviews with County DJFS officials, 12 noted that the decision to prosecute is made on a case-by-case basis and 17 stated that there is a dollar amount threshold used to determine whether to pursue prosecution. In some cases, small counties had much lower dollar thresholds when compared to larger counties. Van Wert County has a fraud plan in place and Marion County has purchased specific software to track fraud within the county. Based on this information, the manner in which cases are pursued at the

county level has no correlation to county size. County DJFS officials also indicated that, when a fraud case is opened, it is logged in CRIS-E and, therefore, ODJFS is made aware of the case.

In the area of sub-recipient agencies, only ODMH has statutory authority to pursue provider fraud through provider audits conducted by the local boards. The other sub-recipients rely on the State oversight agencies to pursue provider fraud. ODJFS indicated that, on State sub-recipient claims, provider identifiers[32] are not included and, therefore, not accessible in the Data Warehouse and Decision Support System. As a result, neither ORAA nor FIAG can independently data-mine claims from these agencies for the purpose of conducting recovery audits/reviews (see **R7.10**, **R7.11**, and **R7.12**). However, FIAG and MFCU can access claim data with full provider identifiers through MACSIS and the other sub-recipient agency system, and have used MACSIS for data-mining purposes.

Overall, though, there is not strong communication between ODJFS and the sub-recipient agencies on program integrity, and federal confidentiality requirements are often cited as a reason to exclude ODJFS from portions of available Medicaid claims data.[33] However, recently, ODADAS approached ODJFS and asked to implement SURS audit procedures within the agency. Also, Phase III of ODJFS' program integrity model states that ODJFS will work with the sub-recipient agencies to institute consistent audit procedures program-wide. However, to date, consistent procedures have not been implemented program-wide which leads to the program integrity fragmentation identified by the Ohio Commission to Reform Medicaid as an internal control weakness.

Providers remarked on the limitations of the information system, the inconsistent application of procedures within ODJFS, and the delayed audit processes. A member of the Ohio Dental Association explained the following:

[32] Because of the antiquated nature of the MMIS system, ODJFS uses special codes to indicate claims that come from the sub-recipient agencies and follow a different set of decision-making rules in the adjudication process. These codes reside where the provider code would normally be maintained. The sub-recipients maintain the provider codes on claims within their separate information systems.

[33] Based on the practices of other states, auditors indicate that ODJFS has the authority, as the single State Medicaid agency, to access Medicaid information that may currently be withheld based on cited confidentiality issues (e.g. personal information about recipients). However, provider information should be readily available and the inability of ODJFS to access this data is related to a technology issue. This is addressed more fully in the **technology and program management** section.

> "If you look at the Medicaid handbook …. It's black and white in the handbook. You might do something that wasn't covered, bill it, and they pay for it. Well, you do this for several years and you keep getting paid for it. Then when the audit gets done, it's just, 'Well, we should not have paid for that. We want this money back.' That was strictly a review of those records that were paid. Then the dentists say, 'Well, why didn't you deny it to begin with? If I would have known this, we wouldn't have kept billing for it because we didn't know any better.'…the response is, 'Well, the handbook is clear. You should have known.' But it still begs a question,'…why did you pay for the last five years?' [ODJFS says], 'Our auditing system, the computer, we can't have that many screens to adjudicate every record claim coming in.' Okay, but then, how was your audit system able to figure it out five years down the line?"

Using PERM and Medi-Medi, as well as examining current processes for inconsistencies, would help Ohio and the State Medicaid agency to improve its understanding of Medicaid risks and create more effective controls to mitigate financial risks to the State.

R7.1 The State Medicaid agency should work with internal and external stakeholders to develop a comprehensive, risk assessment planning process to identify and measure risks, using PERM and Medi-Medi results as component of this process. It should also establish Medicaid program integrity-related goals and objectives, and performance measures (see R7.18). If ODJFS maintains its Medicaid responsibilities after SFY 2007-08, these duties should reside with a program integrity manager (or Medicaid Chief Inspector) who is independent of OHP (see R7.15). This will help to clarify the roles of State sub-recipient and county/regional agencies in minimizing fraud, waste, and abuse; thereby reducing the risk of financial loss and litigation. Likewise, the program integrity manager can oversee audit schedules and ensure that all provider audits are conducted on a timely basis. At minimum, ODJFS and the sub-recipient agencies should work with the General Assembly to ensure consistent application of oversight processes through Ohio law and rules (see Organizational Issues).

If a newly created State Medicaid agency (or other organizational structure) is responsible for these functions after SFY 2007-08, the designated State Medicaid agency should continue efforts to develop a Medicaid program integrity-related mission statement, based on feedback from State sub-recipient and county/regional agencies and provider/recipient advocacy groups. As SURS will likely be moved with the State Medicaid agency, the new agency will need to take additional steps to maintain the independence of this function that the conditions stated in the Ohio Inspector General's report do not reoccur. Using an external Medicaid Chief Inspector or similar position could assist in this process. A formal risk assessment planning process will help to ensure compliance with new federal Medicaid guidelines (i.e., the recent federal deficit reduction act) and may also help to ensure that all Medicaid providers undergo prioritized, risk-based audits/reviews in compliance with audit standards and with minimal duplication of effort (see R7.10, R7.11, and R7.12).

***Financial Implication*: Assuming Ohio can achieve financial results similar to the Medi-Medi Program in California ($77 per dually eligible recipient) and the PERM Program in Illinois (approximately $12 million), through PERM and Medi-Medi, it could reduce improper payments to providers by up to $29 million. Direct implementation costs appear to be insignificant, especially when compared to the potential for savings, avoidances, and recoveries to Ohio Medicaid.**

B. Control Activities: Minimizing Risks through Prevention, Detection, and Enforcement

ODJFS, as the State Medicaid agency, does not effectively coordinate those prevention and detection controls that are necessary to ensure Medicaid program integrity. In addition, ODJFS does not employ all control activities that are available. These factors, combined with the lack of a formal risk assessment plan that is linked to program integrity-related goals, objectives, and performance measures, limit ODJFS's ability to implement sufficient, targeted enforcement strategies (e.g., SURS and FIAG recovery audits/reviews, managed care plan monitoring, etc.) to minimize fraud, waste, and abuse.

The relative absence of coordinated preventive controls used in Ohio Medicaid was surprising considering the statements by stakeholders about oversight bodies and the manner in which provider auditing is approached in some cases. A member of the Ohio Association of Medical Equipment Services described his audit experience as follows:

> "…We had been to a meeting about auditing and the auditors were there… and they said, 'I would just like you to know that when we're called in to audit, the assumption will be that there is fraud.'… They are going into these audits with that assumption instead of, 'Let's see what we have,' and asking the questions."

Once an organization has identified areas of its operations that are at risk and quantified the possible extent of the risk, and its management and other key officials are committed to and have set a goal for reducing the risk, the organization must take action to achieve that goal. Preventive and detective control activities include policies, procedures, techniques, and mechanisms that are designed to help ensure that management's decisions and plans are carried out. Furthermore, highly effective preventive controls reduce the need to rely on detective controls (audits) and post-payment collections enforcement. According to GAO, control activities include both pre-payment and post-payment mechanisms to manage improper payments.

According to HHS, a state Medicaid agency is responsible for ensuring that potentially fraudulent or wasteful recipients and providers do not enter the Medicaid system. Effective pre-payment strategies include, but are not limited to, the following:

- Conduct state and federal background/fingerprint checks of all providers;
- Require that high-risk providers post surety bonds of significant value (see **R7.3**);
- Periodically re-enroll all providers (see **R7.4**); and
- Purge all inactive provider numbers from the Medicaid system (see **R7.5**).

Given the large volume and complexity of federal payments and historically low recovery rates for certain programs like Medicaid, it is considered most efficient to pay bills and provide benefits properly in the first place. In Ohio, the care management and prior authorization of services indicated in the treatment plans and used by ODMRDD and the local boards, and PAAs, in their waiver programs are representative of this front end control environment. HHS and GAO recommend the following post-payment controls to help minimize fraud, waste, and abuse on the part of providers and recipients who are already in the system:

- Issue explanation of benefits surveys;
- Participate in the federal Public Assistance Reporting Information System (PARIS) (see ***minimizing recipient fraud: PARIS)***;
- Provide comprehensive education/training programs;
- Coordinate benefits effectively to avoid third party liability-related payments (see **technology and program management**);
- Notify all providers and recipients of any state or federal disciplinary actions resulting in termination/exclusion from the Medicaid program;
- Conduct effective recovery audits; and
- Monitor managed care plans though effective encounter data mining and contracting techniques.

Preventive and detective controls are an integral part of an organization's actions in planning, implementing, reviewing, and achieving effective results. The control activities used by an organization to address improper payments vary according to the specific threats faced and risks incurred; differences in objectives; managerial judgment; size and complexity of the organization; operational environment; sensitivity and value of data; and requirements for system reliability, availability, and performance. Additionally, they must comply with all relevant laws and help strike a balance between the sometimes competing goals of privacy and program integrity. Effective controls enable states to establish a "sentinel effect"[34] that discourages high-risk and potentially fraudulent providers/recipients from entering the Medicaid program. They also put states in a better position to implement effective enforcement strategies.

[34] The "sentinel effect" is defined as having a strong audit and investigative presence which serves as a substantial deterrent for fraud, waste, abuse, and mismanagement.

Provider Background and Fingerprint Checks

The overall process for conducting and verifying Medicaid provider background/fingerprint checks is inconsistent and open to varying levels of scrutiny, which may inadvertently result in the admittance of potentially fraudulent providers into Ohio Medicaid. Moreover, ODJFS does not track and monitor the results of provider background/fingerprint checks. This can be attributed to significant fragmentation of Medicaid functions in Ohio. To illustrate, ODJFS relies on State sub-recipient and county/regional agencies to obtain provider background/fingerprint information and verify professional licensure/certification. As stipulated within its interagency agreement with ODJFS, ODA relies on its regional PAAs to ensure provider files contain information related to background checks. Similarly, ODADAS, ODMH, and ODMRDD delegate this function to county and regional boards. OHP, on the other hand, relies entirely on State licensing/certification boards (e.g., Ohio State Board of Pharmacy, Ohio State Board of Optometry, State of Ohio Board of Nursing, State of Ohio Medical Board, etc.) to ensure this function is performed. Nonetheless, ODJFS does not specifically stipulate within its interagency agreements that providers be required to submit to both State and federal-level background/fingerprint checks, as preferred by CMS.

Florida's Agency for Health Care Administration works with the Florida Department of Law Enforcement to conduct risk-based background/fingerprint checks on new and re-enrolling providers. Specifically, all providers with 5 or more percent ownership in a business applying for a Medicaid provider number are required to be fingerprinted. Florida's state Medicaid agency uses this information, in part, to identify high-risk counties. In select counties, all re-enrolling and newly enrolling providers must be fingerprinted. Of 60,000 providers in the Florida Medicaid program, 52,000 have undergone a background investigation and been fingerprinted. Of these, nearly 1,600 providers (3.1 percent) were found to have a criminal record.

As a result of system fragmentation and the absence of monitoring, ODJFS cannot effectively assess which providers are most likely to fail background/fingerprint checks, which would help in developing a formal risk assessment and targeting enforcement strategies. In addition, because ODJFS does not specifically stipulate that both State and federal-level background/fingerprint checks be conducted, providers may receive inconsistent levels of scrutiny. This increases the risk that potentially fraudulent providers from other states may be admitted into the system.

R7.2 The State Medicaid agency should track and monitor the results of background and fingerprint checks on providers who apply for Medicaid certification. Moreover, the State Medicaid agency should formally require within its interagency agreements with State sub-recipients that all Medicaid providers must submit to State and federal-level checks. By tracking and monitoring the results of these checks, the State Medicaid agency will be in a better position to assess the risk of certain provider types. In addition, by mandating both State and federal-level checks of all

providers, the State Medicaid agency can better deter potentially fraudulent providers from entering the Medicaid system, while ensuring uniform and consistent scrutiny among State sub-recipient agencies.

Surety Bonds

While ODJFS requires surety bonds for institutional providers with high Medicaid expenditures and providers who work closely with recipients, it does not link surety bond-related requirements to a formal risk assessment plan or accompanying risk measures. Moreover, ODJFS does not specifically require that providers who have been investigated for fraud obtain surety bonds. In Ohio, nursing facilities, durable medical equipment providers, and managed care plans are required to obtain surety bonds. As stipulated with OAC 5101: 3-3-60, a surety (or performance) bond is an agreement between the principal (e.g., the provider), the surety (e.g., the insurance company), and the oblige (e.g., recipient and/or ODJFS acting on behalf of the recipient), wherein the principal and the surety agree to compensate the oblige for any loss of funds that the principal holds, safeguards, manages, and accounts for. The purpose of the surety bond is to guarantee that the facility will pay the recipient or ODJFS for losses occurring from any failure by the facility to hold, safeguard, manage, and account for the residents' funds (i.e., losses occurring as a result of acts or errors of negligence, incompetence or dishonesty). The principal assumes the responsibility to compensate the oblige for the amount of the loss up to the entire amount of the surety bond, which, at minimum, must protect the full amount of recipient funds deposited with the provider, including interest earned, at all times. Unlike other types of insurance, surety bonds protect recipients and not providers from financial loss. Surety bonds differ from fidelity bonds, which cover no acts or errors of negligence, incompetence, or dishonesty.

According to HHS-OIG, surety bonds are a financial incentive designed to discourage potentially fraudulent providers from enrolling in a state's Medicaid program. They help to ensure that a provider has the capacity to provide services and that they provide financial protection against provider fraud. Pursuant to Am. Sub. HB 66, Ohio requires that managed care plans obtain $3 million performance bonds in order to bill Medicaid. Similar to Ohio, Florida requires that select providers obtain a surety bond. Specifically, a $50,000 surety bond is required of all new durable medical equipment providers, private transportation companies, non-physician owned clinics, independent laboratories, and home health agencies. Unlike Ohio, however, Florida also requires one-year surety bonds for providers who have been investigated for fraud, whether substantiated or not, and providers within counties designated as high risk.

Florida officials indicate that their primary reason for the surety bond requirement is that in underwriting a bond, surety companies check the capacity and financial ability of providers to operate their business. They consider such review to be an effective and administratively efficient screening tool to keep unqualified providers from participating in the Medicaid program. The required surety bond is a guarantee that the bondholder's principals, agents, and

employees will comply with Florida's Medicaid statutes, regulations, and bulletins and will perform all obligations faithfully and honestly. By not linking surety bond-related requirements to a formal risk assessment planning and measurement process, ODJFS cannot effectively ensure that all high-risk providers are obtaining surety bonds. Moreover, by not requiring that providers who have been investigated for fraud obtain a surety bond, should fraud occur, Ohio may not be in the best position to mitigate the risk of financial loss.

R7.3 The State Medicaid agency should link surety bond-related requirements to a formal risk assessment plan and accompanying risk measures (see R7.1) so that the bond reflects the level of risk associated with different provider types. Moreover, the State Medicaid agency should specifically require that any provider who has ever been investigated for fraud obtain a surety bond. Combined with State and federal-level background and fingerprint checks (see R7.2), stringent surety bond requirements will discourage potentially fraudulent providers from doing business in Ohio. Moreover, should fraud occur, Ohio will be in a better position to offset its financial liability.

Provider Re-Enrollment

The State Medicaid agency does not require that all Medicaid providers periodically re-enroll. Rather, this requirement is fragmented and has been delegated to the State sub-recipient agencies and managed care plans. See the **managed care and care management** section for additional information on managed care plans. ODADAS, ODMH, and ODMRDD require that providers within their systems re-certify at least every three years. If they do not, then they are no longer permitted to bill for Medicaid services through those departments. Neither ODA nor ODJFS, however, have such standards. Furthermore, the ODADAS, ODMH and ODMRDD certification process is centered on State and national accreditation standards, and is not directly related to Medicaid provider re-enrollment. The sub-recipient agencies require different levels of documentation and collect this information to support accreditation – it is not used for reenrollment purposes.

GAO suggests that periodic re-enrollment allows state officials to verify provider information such as medical specialty credentials, ownership, and licensure/certification status. According to CMS, re-enrollment helps states to remind providers of their obligations and alert them to any policy changes. Also, re-enrolling providers every two to three years reduces billing address information errors and eliminates time spent tracking down lost providers and de-activating them due to billing inactivity. Florida has re-enrolled all of its Medicaid providers and re-enrolls about 33 percent of its providers every 3 years. When Florida requested (via mail) that all providers update their applications, numerous letters were returned as undeliverable. As a result of this project, Florida reduced the number of durable medical equipment providers from 4,385 to 1,500 (nearly 66 percent) and home health agencies and transportation providers were reduced by about 50 percent after re-enrollment. Between 1995 and 1999, Florida reduced Medicaid

providers by approximately 28 percent – from nearly 83,000 to 60,000. Unlike Florida, Illinois re-enrolls providers by specialty, of which, dentists were the first. Re-enrollment in Illinois reduced dentist-related providers by 77 percent. By eliminating providers through periodic re-enrollment, Florida and Illinois reduce the risk that improper Medicaid billing may occur.

By not requiring that all providers periodically re-enroll in Ohio Medicaid, ODJFS sustains Ohio's fragmented system and facilitates inconsistent provider scrutiny. Furthermore, because Ohio lacks a formal risk assessment planning process for Medicaid program integrity, existing re-enrollment requirements may not be targeted to high-risk providers. Therefore, staffing and financial resources may be allocated ineffectively, increasing the likelihood of administrative waste in the Medicaid system.

R7.4 The State Medicaid agency should require that all providers, regardless of the State sub-recipient agency to which they report, periodically re-enroll in Medicaid at least once every three years, similar to Florida. This will help to discourage would-be fraudulent providers from applying to Medicaid. In addition, by requiring that all providers periodically re-enroll, the State Medicaid agency can ensure program-wide uniformity and consistent provider scrutiny across all systems and sub-recipient agencies. More importantly, it would further limit opportunities for Medicaid fraud and abuse.

Inactive Provider Numbers

The Ohio Commission to Reform Medicaid indicates that ODJFS has not historically purged MMIS of inactive provider numbers. According to ODJFS, there are approximately 90,000 Medicaid providers in the system, but only about 42,900 (47.7 percent) of these actively bill Medicaid. ODJFS indicates that Am. Sub. HB 66 authorized the termination of providers who had not billed Medicaid in 24 months. This practice, which has also been recommended by CMS, resulted in the termination of about 14,000 inactive provider numbers. Nonetheless, terminated provider numbers still exist within MMIS, which can be attributed to technology-related gaps and inefficiencies recently identified by private contractors hired by the Department (see **technology and program management**).

The Ohio Medicaid Commission warns that by keeping inactive provider numbers in Medicaid data files, ODJFS increases the risk that fraudulent individuals may steal these numbers and submit fraudulent claims. GAO concurs, adding that many states allow providers, once enrolled, to bill the program indefinitely without updating information about their status. Poor control over provider billing numbers can make Medicaid programs more vulnerable to improper payment as questionable providers have been known to keep multiple billing numbers "in reserve" in case their primary billing number is suspended. By canceling these numbers and purging them from the system, as the Ohio Medicaid Commission recommends, ODJFS can mitigate these risks more effectively.

R7.5 As Ohio moves to implement national provider identifiers, as required by the Health Insurance Portability and Accountability Act (HIPAA), the State Medicaid agency should purge all inactive provider numbers from MMIS, as recommended by the Ohio Medicaid Commission and GAO.[35] Specifically, the independent program integrity manager or Medicaid Chief Inspector (see R7.15) should collaborate with technical staff to correct technology-related deficiencies and monitor and report progress in this area by means of comprehensive performance measures and annual reports (see R7.16 and R7.18). This will help to prevent fraudulent individuals from obtaining inactive numbers and billing improperly, as well as improve Medicaid program integrity-related reporting, communication, and monitoring activities. See Technology and Program Management for additional information on HIPAA.

Minimizing Recipient Fraud: PARIS

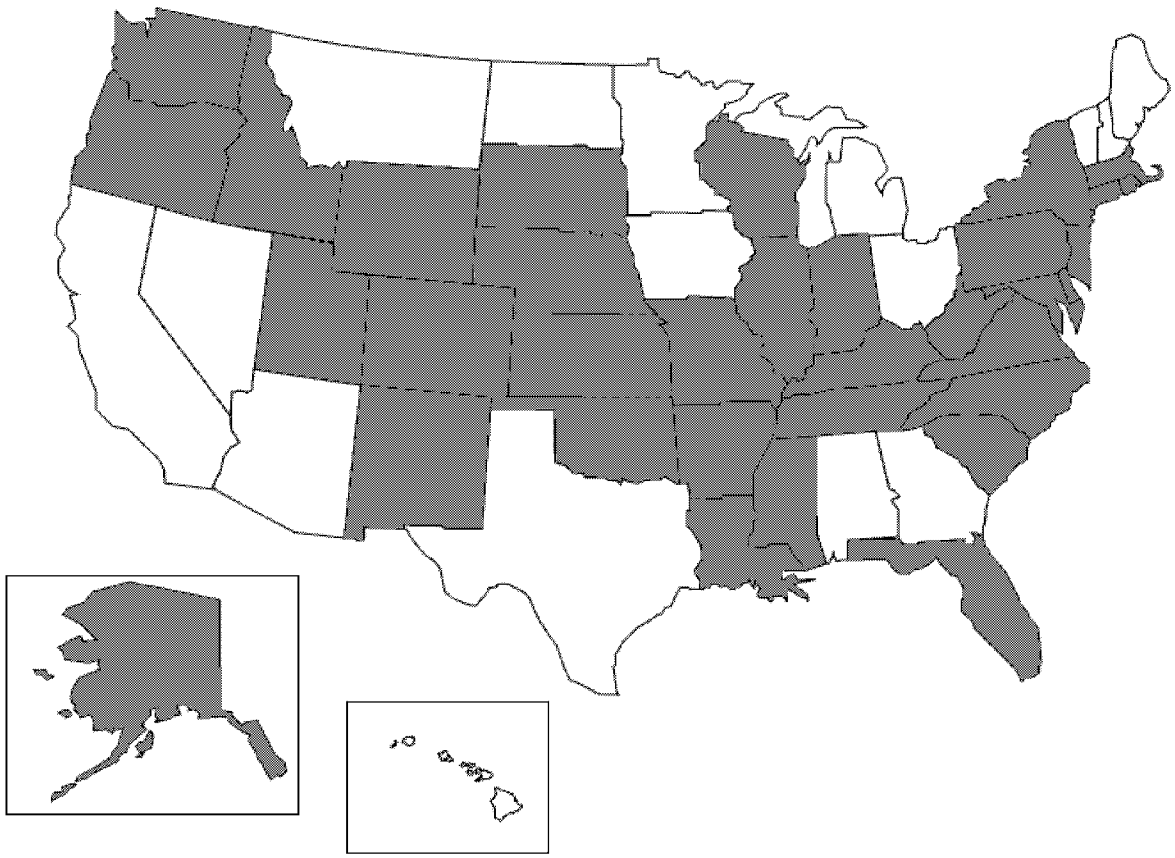
According to GAO, fraud schemes often cross state lines and enforcement jurisdictions; entailing a number of federal, state, and local agencies that may have different and competing priorities in their efforts to investigate, prosecute, and enforce compliance. Nonetheless, Ohio does not participate in PARIS – a voluntary, federally-administered project for states to share public assistance data to maintain Medicaid program integrity and detect and deter improper payments to recipients. Specifically, PARIS is an information exchange system designed by HHS to provide state Medicaid agencies with recipient data that has been mined and matched against information provided by all member states. The resulting matches are used by participating agencies to validate recipient payments and identify potentially fraudulent activity (e.g., receiving services in multiple states). In addition to Medicaid, PARIS also performs matches for other federal programs, including TANF and Food Stamps. According to GAO, PARIS is especially important for states that are transitioning recipients to managed care. Specifically, GAO reports that in a Medicaid capitated managed care environment, states make prospective monthly payments to managed care plans for each enrolled recipient to provide or arrange for all needed health services. Thus, if a Medicaid recipient moved out of state and the state did not register the change, it would continue to make the monthly payment to the managed care plan until the discrepancy was discovered.

In a June 2006 audit, HHS-OIG found that Ohio Medicaid inappropriately paid $333,716 for 471 Medicaid recipients who had established eligibility in both Ohio and Michigan but should only have been eligible for Medicaid in Michigan. HHS-OIG recommended that ODJFS consider additional procedures for identifying recipients who move out of Ohio, including participation in PARIS.

[35] During a June 16, 2006 meeting with ODJFS representatives, ODJFS stated that it was beginning this process in anticipation of migrating information to its new system.

A majority of states participate in PARIS, including most of Ohio's neighbors, as illustrated by the shaded states in **Exhibit 7-1**:

Exhibit 7-1: States Participating in PARIS



Source: U.S. Department of Health & Human Services

HHS recently made $100,000 available in grants for prospective states interested in participating in PARIS and partnering with a neighboring state. Pennsylvania, one of the first states to join PARIS, has expressed an interest in assisting Ohio with this process. In fact, HHS indicates that Ohio would likely achieve results similar to Pennsylvania, due, in part, to demographics and the relative size of each state's Medicaid program. According to HHS, Pennsylvania saved approximately $4,300 for every 1,000 Medicaid recipients in SFY 2003-04. This figure excludes additional, non-Medicaid savings that could be realized by linking PARIS to other federal programs. Pennsylvania and New York, for example, have each saved or avoided costs totaling over $40 million by linking PARIS to Medicaid, TANF, Food Stamps, Social Security, and Veterans' Affairs benefits.

HHS further reports that PARIS is not cost prohibitive, with implementation costs ranging from $10,000 to $20,000. ODJFS indicates that it is aware of PARIS and the benefits of participation, yet its efforts are currently focused on addressing Ohio Inspector General recommendations, implementing PERM and Medi-Medi, as well as updating and installing a new information technology system (see **technology and program management**). Without PARIS, however, ODJFS is not making use of all available tools and financial opportunities to effectively minimize recipient fraud and recover improper payments.

In implementing PARIS and methods to minimize recipient fraud, the State Medicaid agency and the sub-recipient agencies should be sensitive to the complexity of the program, particularly to populations who may struggle with literacy. In meetings with the Auditor of State, Medicaid stakeholders remarked on the level of uncertainty surrounding eligibility (see **Medicaid service provision**). A member of the Ohio Chapter, American College of Emergency Physicians said, "I will tell you that eligibility is very confusing to us and to the enrollees. Who truly is eligible, how they get enrolled, how they become dis-enrolled, how they can change plans…" The high degree of complexity in the program, coupled with the frequency with which recipients may vacillate between eligible and ineligible status requires the State Medicaid agency to implement all available resources to ensure program integrity, such as PARIS, while applying consideration of intentional versus accidental recipient misuse.

R7.6 The State Medicaid agency should work with HHS and neighboring states (e.g., Pennsylvania) to join and participate as an active member of PARIS. This will help to minimize the risk of recipient fraud through effective State and federal cooperation. This will also help to increase Ohio Medicaid savings achieved through improper payment recoveries.

***Financial Implication*: Assuming ODJFS participates in PARIS and achieves results similar to Pennsylvania ($4,300 for every 1,000 Medicaid recipients), it can expect to recover about $7.3 million per year in improper Medicaid payments. This figure excludes, however, additional potential savings and avoidances that could be achieved by linking PARIS to other federal programs, similar to New York and Pennsylvania.**

Education and Training

> "There seems to be an assumption that we steal. When I look at all of these rules, I feel as though I'm getting an indirect accusation that I'm stealing or, better yet, I'm making money."
> *Member, Ohio Council of Behavioral Healthcare Providers*

Auditor of State interviews with provider advocacy groups indicate that training/education is a major concern. Specifically, a number of stakeholder groups indicate that they receive inconsistent information from ODJFS personnel on numerous issues and that there is a general lack of training opportunities pertaining to the numerous State and county-level audits that are conducted. This can be attributed to the fact that ODJFS and the sub-recipient agencies do not work well with internal and external stakeholders to assess Medicaid training needs, nor does it link Medicaid education and training activities to a risk assessment planning process with measurable, program integrity-related goals and objectives. Finally, it does not work closely with the sub-recipient agencies to ensure consistent information is communicated to county/regional boards, providers, and recipients in the other systems.[36]

OHP indicates that it meets regularly with providers who are experiencing claims billing-related problems which typically arise due to provider staffing turnover. Specifically, ombudsmen/technical assistance and regional medical assistance coordinators assist providers by:

- Conducting on-site Medicaid provider billing assistance (e.g., new provider basic training and nursing facility direct bill);
- Conducting provider-oriented seminars;
- Resolving provider-specific Medicaid claims issues, consumer complaints, and hotline referrals;
- Identifying Medicaid system and policy issues; and
- Training county JFS staff on MMIS and Client Registry Information System – Enhanced (CRIS-E) systems.

In 2005, OHP reports that it conducted 57 individual Medicaid provider meetings, as well as 44 county training sessions on such topics as MMIS eligibility and Medicaid Buy-In systems, long-term care billing, and fraud workshops. OHP also oversees a provider assistance hotline and distributes handbooks, manuals, and newsletters for providers and recipients to reference as Medicaid-related questions arise. While these activities are generally in line with federal best practices, OHP has not linked them to Medicaid program integrity-related goals, objectives, and

[36] ODJFS and the sub-recipient agencies all conduct training for county/local level agencies and providers. ODJFS, as the Single State Medicaid agency, often delegates communication of its policies, procedures and rules to the sub-recipient agencies. Because these activities are delegated and the State Medicaid agency does not participate in or monitor training conducted by the sub-recipient agencies, providers and county/local agencies noted that they often receive incomplete or conflicting information.

performance measures in order to track the effectiveness of these efforts. Moreover, ODJFS has not worked with State sub-recipient agencies to establish measurable goals and objectives and measure their progress in addressing Medicaid-related training needs.

The challenges in ensuring appropriate processes are communicated to providers and advocacy groups were apparent during stakeholder interviews. Of the subjects discussed, inconsistent communication was one of the most widely talked-about topics (see also **organizational issues** and **service provision**). Below are several representative examples of the problems encountered by stakeholders:

> "See, we have a manual in Ohio…. It had what is to be accomplished in a session of therapy. And then we started to do that and then we got nailed, 'You can't do that.' But nobody ever updated that book … We can't get good written instructions - Hardly ever."
>
> *Member, Ohio Council of Speech and Hearing Administrators*

> "That's why we started collecting [information]…because policy said this and obviously SURS [37]does the audit later. We want to make sure that they are on the same page... Because one's the enforcer of what the other determines.... Where if you have an update and it's not actually written down…miscommunication, misinterpretation of what they were actually saying, and that sometimes does have a fallout to it."

> "And in one instance…it took almost a year before we got something in writing back from them [ODJFS]. So we went an entire year under the premise of what you needed to do as a provider and not really sure if that's indeed factual. We tried that model where you actually write down the question…it was nine to ten months before we had the answer. That's not…timely and so clearly there are some internal problems."
>
> *Member, Ohio Association of Medical Equipment Services*

A member of the Ohio Hospital Association described the Medicare system as model to follow:

> "Clear instructions, appropriate systems, working on issues and solutions that work for everyone. I would like to say that Medicare has accomplished many of those tasks.… So I think that as a model, that the Medicare system stepped up to that. The approach there is more educational than punitive. …. I'm telling you up-front education, what you're supposed to do, is the primary goal.

HHS considers training and education to be one of the first lines of defense against Medicaid fraud and abuse (i.e., preventive control). With that in mind, HHS recommends that state Medicaid agencies centralize responsibility for, and improve, employee fraud and abuse awareness training. HHS also recommends that SURS personnel (i.e., ORAA) collaborate with state Medicaid agency policy personnel (i.e., OHP), as well as other stakeholders (e.g., MFCU and advocacy groups) to train and educate providers. Stakeholder concerns notwithstanding,

[37] The representative went on to say that, when calling ODJFS, the customer service representative would only provide his or her first name which made it very difficult to later justify the instructions that one had been given over the phone.

OHP and ORAA indicate that they collaborate with county JFS personnel, as well as several provider associations (e.g., Ohio State Medical Association) to conduct training.

As part of its Medicaid Reform Implementation Plan, Florida partners with community stakeholders, including local officials, small businesses, providers, and advocacy groups to ensure the workshops, public meetings, and written materials it produces are effective in educating all interested parties about Medicaid. By not working with all stakeholders to formally assess training needs and linking these activities to Medicaid program integrity-related goals, objectives, and performance measures, ODJFS cannot ensure that its efforts are sufficiently targeted to minimize fraud, waste, and abuse. (See also **R7.15**).

R7.7 The State Medicaid agency should better coordinate Medicaid program integrity-related training, education and monitoring activities with a program integrity manager or Medicaid Chief Inspector who is independent of OHP (see R7.15). Specifically, this position should work with OHP and State sub-recipient agencies to assess stakeholder training needs, develop accompanying goals and objectives, and monitor progress through performance measures that can be reported in online annual reports (see R7.16 and R7.18). Whenever training is provided to sub-recipient agencies, OHP should attend in conjunction with the sub-recipient agency presenters to ensure consistent guidance is provided. This will help to ensure sufficient and adequate communication of training and education-related expectations and needs, as well as independent monitoring of progress in this area.

Explanation of Benefits Surveys

ODJFS issues explanation of benefits surveys in accordance with federal best practices which helps to minimize the potential for fraud, waste, and abuse. Explanation of benefits surveys, as described by HHS-OIG, are detective, post-payment safeguards used by state Medicaid agencies as a means of offering recipients information about providers who billed Medicaid for services ostensibly provided to them. Medicaid recipients are typically asked to verify that they have used the services of the provider and received the services which have been billed to Medicaid.

ORAA issues explanation of Medicaid benefits surveys to approximately 6,400 recipients per month (nearly 77,000 annually). Of these, 6,000 are targeted to recipients of providers who have been referred to ORAA by auditors or investigators. Another 400 random letters are sent to recipients of providers who are not on the target listing. This is recognized by CMS as a best practice.

During stakeholder meetings, participants suggested providing Medicaid recipients with an explanation of benefits – in a manner similar to those sent by commercial insurance companies to their members. Included this information with the Medicaid recipient's monthly Medicaid

card would help to better educate recipients about the benefits they are receiving and the costs of those services to the State. Increasing the understanding of the costs of medical care by Medicaid recipients could potentially help ODJFS and the sub-recipient agencies reduce costs by enhancing consumer responsibility. If ODJFS informed the sub-recipient agencies and providers of plans to send explanations of benefits to all Medicaid recipients, these agencies and organizations would be better prepared to answer recipient questions.

R7.8 Although ODJFS's EOB survey process has been recognized as a best practice, the State Medicaid agency may wish to consider providing explanation of benefits to all Medicaid recipients when it issues monthly Medicaid cards.[38] Providing recipients with an explanation of benefits enhances consumer responsibility as the recipient has a better understanding of the types and associated cost of care billed to the State on their behalf.

Provider Exclusion

ODJFS does not work with State sub-recipient agencies and licensing boards to publish State and federally-excluded providers online. When providers defraud federal or state health care programs or give poor quality care, HHS-OIG has the authority to exclude them nationwide from participation in these programs. It is the states' responsibility to provide HHS-OIG with information pertaining to provider debarment, termination, and any disciplinary actions. According to GAO, the process for excluding providers has operated successfully, with approximately 35,600 providers excluded from Medicare, Medicaid, and other federal health care programs over the years, including about 1,200 from Ohio. Twice annually, HHS-OIG prepares a Cumulative Sanction Report, which is an alphabetical list of all individuals and organizations that have been excluded nationwide from federal health programs. For each name listed, the report shows date of birth and Social Security number (for individuals), health care specialty or type of business, and address. HHS-OIG provides a copy of this report to CMS, which then distributes the information to state Medicaid agencies.

ODJFS is notified each month of providers who have been excluded, as well as those who have been reinstated by HHS-OIG. This information is shared with SURS personnel, who match files to determine if any active providers within Ohio are on the federal list. ODJFS does not, however, maintain a centralized list of the providers Ohio excludes from Medicaid or other federal programs. State sub-recipient agencies and licensing boards report their own terminations, debarments, and disciplinary actions to HHS individually.

[38] If ODJFS implemented EOB for all Medicaid recipients, it might consider also providing the information on-line in a manner similar to Blue Cross and Blue Shield of Michigan. This could be done in conjunction with information on eligibility and recipient redetermination.

In contrast, New York's State Department of Health and the Texas Health and Human Services Commission publish an online, searchable list of all excluded providers. CMS considers this a best practice as it helps to better educate and inform all stakeholders and the public of the importance of not doing business with, or inadvertently hiring, excluded providers. By not publishing excluded providers online, ODJFS is not making use of all available tools to detect potentially fraudulent providers and prevent them from entering the system. In addition, by not centralizing this list and making it public, the State Medicaid agency cannot effectively ensure that State sub-recipient or other agencies are reporting this information to HHS.

R7.9 The State Medicaid agency should work with State sub-recipient agencies and licensing boards to publish State-disciplined and federally-excluded providers on a centralized, public website. This is in line with best practices identified by CMS, New York, and Texas and serves as an additional deterrent against those providers who would seek to join Medicaid and act inappropriately. During the course of the performance audit, ODJFS updated its website to include information on excluded providers.

Recovery Auditing: SURS & FIAG

> "Post-payment audits are very effective. I've been through about three of them and they are not fun. And, you know, they're there. That hammer is over your head all of the time. And you're going to be compliant."
>
> *Member, Ohio Association of Medical Equipment Services*

Recovery auditing refers to the practice of data mining paid claims information to identify and potentially recover improper, duplicative, or erroneous payments to Medicaid providers. This function is typically performed by a state Medicaid agency's SURS personnel. Despite combined Medicaid-related expenditures of nearly $2 billion, the State Medicaid agency does not conduct independent SURS recovery audits/reviews of providers within State sub-recipient systems, although ODMH also conducts post-payment reviews. More specifically, Ohio's recovery auditing process is fragmented and inconsistent among State sub-recipient agencies, particularly among ODJFS, ODA, ODADAS, ODMH, and ODMRDD.[39] In accordance with federal regulations [42 CFR 456.3], state Medicaid agencies are responsible for implementing a state-wide SURS function that safeguards against unnecessary or inappropriate use of Medicaid services and excess payments and assesses service quality.

As required by HHS, state Medicaid agencies must maintain a MMIS automated claims payment and information retrieval system, which the state SURS uses to process information on medical and health care services that guide Medicaid program managers and to identify those providers

[39] This section does not include information on local-level, non-Medicaid, quality related audits, such as facility reviews, examinations of policies and procedures, or credential reviews, only on federally-mandated utilization review audits.

(and recipients) most likely to commit fraud against the Medicaid program. At the state level, SURS recovery audits serve as a post-payment safeguard to examine the accuracy of claims that have already been processed, facilitating a "sentinel effect" which deters provider fraud, waste, and abuse. Recovery audits do not always prevent recipients from receiving excessive or medically unnecessary services and they do not prevent erroneous payments from being made to providers. Often referred to as the "pay and chase" method, HHS required SURS to conduct post-payment recovery audits to detect improper payments that may have already been made to providers. Providers who have been paid incorrectly are notified and asked to refund the identified overpayment(s). Providers whose claims activity is deemed fraudulent are referred to the Medicaid Fraud Control Unit (MFCU) for further investigation.

Ohio's SURS function is performed within ODJFS by ORAA personnel who conduct either full-scope audits or limited reviews. However, a substantial amount of audit-related work is contracted out by ODJFS to third-parties and is monitored by ORAA or OHP. ODMH audits are conducted by ODMH personnel or their third-party contractor. Full-scope audits are lengthy, formal examinations, conducted in accordance with audit standards. Limited reviews, by contrast, are less formal and consist more of a "desktop review" of provider records, claims, and supporting documentation of medical necessity. The Auditor of State, through FIAG, also conducts recovery audits, yet prior to Am. Sub. HB 66, it could only audit providers based on ODJFS referrals and was not permitted the authority to independently conduct post-payment reviews.[40]

Table 7-2 compares improper Medicaid payments identified in provider recovery audits/reviews conducted by in-house ORAA (SURS) and Auditor of State (FIAG) personnel in SFYs 2003-04 and 2004-05. It should be noted, however, that these figures are for audits/reviews conducted prior to the Ohio Inspector General's investigation; prior to ORAA implementation of government auditing standards and the increased focus on cost recovery.

[40] The State Auditor's Office requested the General Assembly grant AOS this authority because of the limited number of referrals and the poor collections levels within ODJFS.

Table 7-2: Medicaid Recovery Audit Findings – SFYs 2003-04 and 2004-05

	Improper Payments Identified	Audits/Reviews Conducted	Improper Payments Identified per Audit/Review
ODJFS (ORAA)			
Total ORAA	**$3,222,180**	**1,018** [1]	**$3,165**
• SFY 2004	$2,060,752	460	$4,480
• SFY 2005	$1,161,428	558	$2,081
Annual Percentage Change	**(43.6%)**	**21.3%**	**(53.5%)**
Auditor of State (FIAG)			
Total FIAG	**$1,593,187**	**59**	**$27,003**
• SFY 2004	$499,329	29	$17,218
• SFY 2005	$1,093,858	30	$36,462
Annual Percentage Change	**119.1%**	**3.4%**	**111.8%**
TOTAL ORAA and FIAG	**$4,815,367**	**1,077**	**$4,471**
• SFY 2004	$2,560,081	489	$5,235
• SFY 2005	$2,255,286	588	$3,836
Annual Percentage Change	**(11.9%)**	**20.2%**	**(26.7%)**

Source: ODJFS Office of Research Assessment and Accountability - Bureau of Audit
[1] Includes full-scope audits and limited reviews.

In SFY 2004-05, SURS conducted 11 full-scope audits[41] and identified approximately $280,600 in improper payments (an average of about $25,500 per audit). On a per audit basis, this represents a decrease of about $18,400 (41.9 percent), compared to SFY 2003-04. In SFY 2004-05, SURS also conducted 547 limited reviews; identifying an average of $1,600 in improper payments per review. This represents a decrease of $1,500 per review (48.4 percent), compared to SFY 2003-04. Prior to Am. Sub. HB 66, ORAA and FIAG identified improper payments totaling $2,255,286, a decrease of over $304,700 (11.9 percent) from SFY 2003-04. As **Table 7-2** illustrates, however, FIAG identified significantly more on a per audit/review basis in both fiscal years. This can be attributed to the fact that prior to the Ohio Inspector General's investigation of ODJFS, the Auditor of State employed stronger, more reliable statistical sampling methods than ODJFS.

However, a member of the Ohio Association of County Behavioral Health Authorities remarked on the limited enforcement of judgments stemming from audit findings[42] and the problems with the sampling techniques used until only recently; "[in] one case…there were findings for a recovery, about seven figures. By the time it got done, [the provider] wrote a $24,000 check. And because there is avoidance of really having to go to court and then really the 119 process [the ORC hearing process]…it rang so hollow to us." They went on to say, "The notion of using

[41] According to ODJFS, it costs approximately $14,400 to conduct a full-scope SURS audit, which equates to a net identification of $11,100 in recoverable payments per audit.
[42] The Ohio Inspector General likewise criticized SURS for low recovery amounts on its audits of Medicaid providers.

the local oversight infrastructure that's already there - we're heading in the opposite direction in many ways."

In consideration of the relative decline in SURS performance, and in accordance with Ohio Medicaid Commission recommendations, the Auditor of State requested and the Ohio General Assembly granted FIAG the authority – through Am. Sub. HB 66 – to initiate audits of all Medicaid providers, independent of ODJFS referral. The Auditor of State recently issued a request for qualifications and quotes and has engaged a private contractor to expedite compliance with Am. Sub. HB 66. It is expected that this will put Ohio in a better position to prevent and detect fraud, waste, and abuse and recover improper payments from nursing facilities, hospitals, and pharmacies. Nonetheless, in Phase III of its Medicaid program integrity model memo, ODJFS reports that SURS conducts no recovery audits (including medical necessity reviews) of providers who work exclusively within the ODA, ODADAS, ODMH, or ODMRDD systems. Provider stakeholder groups report that State sub-recipient audit processes, including limited medical necessity reviews are inconsistent and laborious. Providers, in these cases, expressed concern about the ability to demonstrate their adherence to regulations on cost reporting as ODADAS and ODMH are currently reconciling SFY 1998-99 cost reports. A ODMH representative indicated that the agency is striving to be more current, but acknowledged that there are no stipulated timelines and that the agency waits for providers to repay amounts before beginning examination of the next year's cost report (in order to minimize the impact of repayment on provider solvency).

Because of the limitations of the MMIS system, and the inability of the Single State Medicaid agency to conduct post-payment audits in these systems, the Ohio General Assembly has granted State sub-recipient agencies the authority to recover improper payments on behalf of ODJFS, as stipulated within Am. Sub. HB 66. Also in response to stated concerns about program-integrity across Medicaid, ODJFS is developing a proposal for how best to manage post-payment and utilization reviews of providers who are overseen by State-level sub-recipient agencies. For example, ODJFS has been meeting with ODADAS regarding its intent to pilot a SURS-type program for its Disability Medical Assistance providers.

By working with State sub-recipients to develop agency-specific recovery audit functions, ODJFS appears to be encouraging decentralization related to its efforts to implement HHS's recommendation for greater involvement of SURS personnel in all provider audits.[43] These evaluations, according to HHS, are in order to:

- Measure claims payment accuracy (PERM and Medi-Medi);
- Identify improperly paid claims;
- Identify problematic policies and procedures;

[43] HHS recommended that SURS personnel within state Medicaid agencies oversee independent evaluate all provider types and services within Medicaid.

- Identify providers who defraud or abuse the system;
- Respond to problem areas and formulate timely policies; and
- Provide feedback on the effectiveness of safeguards in the claims processing system to those stakeholders responsible for implementing proactive safeguards.

New York – one of the nation's largest Medicaid programs in terms of state and federal share of expenditures – centralizes its Medicaid provider recovery audit function (e.g. collection processes) within the state Medicaid agency: the New York State Department of Health – Office of Medicaid Management.[44] In contrast with Ohio, New York formally stipulates that provider recovery efforts cannot be delegated by the state Medicaid agency to any other political subdivision. Any improper payments recovered by New York's Medicaid agency are distributed to sub-recipient agencies based on their respective share of program expenditures. According to the New York State Department of Health – Office of Medicaid Management, a centralized recovery audit function, combined with percentage-based recovery distribution, helps to minimize audit duplication and ensure consistency in the application of Medicaid program monitoring and control activities.

Of the program integrity-related functions, providers who were interviewed as a component of this audit reacted most strongly to the subject of cost reporting and recovery audits. In many cases, the process in use was of great concern. Members of the Ohio Council of Behavioral Healthcare Providers expressed concerns with process for the cost reconciliation process as services they provide are reimbursed differently for each provider based on that provider's unique costs:

> "…the problem with reconciliation [of payments to actual costs] is that there has been this idea always that there has to be a pay back, but never until just within a few months has there ever been any legal standard that defines what it is a provider has to pay back. … I would argue that the provider for years and years and years had this cloud hanging over their head. They never had sufficient legal notice to really know what, if any, obligations that they would have to repay as part of the system.

Representatives from AOPHA expressed concern over the time to complete reviews as it creates uncertainty for providers as to when their historical financial statements can be views as "final and binding". The representatives noted that accountants are putting disclaimers on financial statements that the information can not be fully certified as accurate because the historical information has not been finalized. One AOPHA member noted "We need to almost have, if you will, the Medicaid equivalent of tax amenity, that says, 'It's over ...you can close your books once and for all." A member of the Ohio Hospice Association noted that when recovery audits

[44] HHS recently criticized New York for shifting Medicaid program integrity efforts away from recovery and enforcement and towards provider education. Notwithstanding, HHS commended New York for announced plans to strip the State Department of Health of its anti-fraud enforcement responsibilities and to consolidate those powers in a separate Medicaid inspector general's office.

are not conducted in a timely manner, providers do not have adequate time to resubmit corrected claims for services provided. The member explained that "the problem was that they did the audit in the arrears so when they took away the money from the nursing home, then we couldn't bill because the time limitations had run out."

Members of the Ohio Dental Association voiced concerns over the difference in auditing methodologies used in Medicaid audits:

> "Very few audits take place in the dental world. ...when the State Auditor many years ago audited dentists, they would take a set number of claims and they would look at them and say, 'The State should not have paid these claims, we want that amount of the money back, dollar for dollar.'"

> "When SURS and Medicaid does an audit that's typically done by [ODJFS]...Then they will extrapolate those findings into the dentist's entire Medicaid patient population. So now the dollars go from $1,000 to $15,000. And then when word of that gets out, a lot of dentist get real leery about [it]...'Am I now going to have to pay back an exponentially greater amount of money that I don't think I even got paid to begin with?'"

Members of the Ohio Home Care Association questioned the manner in which providers are selected for an audit and the use of independent audit firms, some of which are located outside of the State.

> "...I have clients that have never been audited since 1993. And I have clients that get audited every year and the adjustment is $200, $500 or whatever, and they pick them seven out of eight years. ... Why wouldn't you set up a program for integrity purposes to capture everybody at least once in five years or something like that."

> "I have a situation where one provider was audited three straight years, and they used a different audit firm every one of those three years. Some of those things in that particular cost report that we did are very complex, and truthfully they don't have a chance of finding anything in there when they're using different people every year. Why not use the same contract audit firm on that same provider every year because they can dig a little deeper every year?...Sometimes I wonder because even the use of the audit doesn't seem like it's being used in the most efficient way."

> "One of the firms is from Colorado, so how can they audit from Colorado? You know, especially when you are dealing with a company...that maybe has a big home office...It's a desk audit in our case. I'm not complaining about it, but if you're talking about program integrity, I think it makes you wonder. I think you would be better off doing less audits and doing them a little bit better."

During stakeholder interviews, members of the Ohio Health Care Association and the Ohio Council for Home Care had several suggestions for the audit process. First, they recommended the State develop a schedule of audits so each provider has a review on a regular basis. Members mentioned that some members were audited every year and some had never had audits. Second,

in the case of cost-report auditing[45], they recommended using a firm consistently so that the auditors could learn the business process and have a greater chance of identifying irregularities. One member reported that a provider in their Association was reviewed by a different auditing firm three years in a row and the complexity of the cost report was such that new auditors had little chance of finding any errors. Last, an association member recommended that the audit focus be on quality. The member expressed concern about the State's practice of using out-of-state firms to perform desk reviews and the contracted auditors' ability to understand the materials they were sent.

Compared to other state and federal practices, Ohio perpetuates a fragmented audit recovery function using out-dated technology and duplicative legal and audit authority. This has the potential to weaken Medicaid program integrity by facilitating inefficiency and waste, as well as foster discord among State-level sub-recipient agencies and providers as a result of inconsistent auditing methodologies. In addition, until technology-related issues are resolved, claims paid by the sub-recipient agencies can not easily be included in PERM and Medi-Medi studies. This may negatively impact the State Medicaid agency's ability to identify and measure program-wide risks (see **R7.1**).

R7.10 The State Medicaid agency should centralize coordination and monitoring of the recovery audit/review process with a program integrity manager (or Medicaid Chief Inspector) who is independent of OHP (see R7.15). Specifically, this position should collaborate with ORAA (SURS), FIAG, as well as with State sub-recipient agencies to minimize duplication of effort and target recovery audits and utilization reviews to high-risk providers, based on the results of a joint risk assessment planning process (see R7.1).

R7.11 The program integrity manager (or Medicaid Chief Inspector) should work with ORAA, FIAG, and State sub-recipient agencies to ensure that provider recovery audits/reviews are conducted under consistent procedures and in accordance with standard auditing practices. As indicated by HHS, and using New York as an example, the State Medicaid agency can better ensure consistent oversight by consolidating the recovery audit/review procedure development process rather than delegating and fragmenting these responsibilities to sub-recipient and other State agencies.

[45] A cost-report audit is an examination of the entity's financial records of actual costs incurred in providing services. Costs are identified as reimbursable and non-reimbursable and are used to determine the Medicaid reimbursable costs per encounter or recipient day. If the cost report audit determines that the reimbursable amount is less than the entity has received, the entity must repay the funds and the reimbursable amount is used to recalibrate the rate of payment. Costs reports are often very complex and entail several schedules and asset depreciation, as well as potentially several service locations.

R7.12 If centralization and improved oversight are ineffective at resolving the identified issues, or, if all Medicaid-related claims processing is encompassed under a single agency, the State Medicaid agency should consider encompassing all post-payment and cost report reconciliation auditing under its auspices.

Neural Networking

Ohio is not currently capable of implementing neural networking technology as a means of strengthening Medicaid program integrity. ODJFS is only in the beginning stages of measuring Medicaid payment accuracy (PERM and Medi-Medi), identifying and purging inactive provider numbers (see **R7.5**), and updating its information technology systems (e.g., Data Warehouse and Decision Support System). As described by GAO, a *neural network* is intended to simulate the way in which a brain processes information, learns, and remembers. A neural network is initially trained or "fed" large amounts of data and rules about data relationships. Neural networks "learn" by comparing new data with historical data and can be used to detect patterns that are difficult and sometimes impossible to detect without computer intervention in large volumes of data (e.g., Medicaid eligibility, billing, and claims data). The more data a neural network processes the better it performs (i.e., the better it identifies the characteristics of potentially fraudulent payments). Based upon this knowledge, neural networks automatically alter their analytical processes to produce more accurate detection results.

In 1997, the Texas Legislature mandated the use of neural networks in the Medicaid program. After examining the results of a pilot test of neural networks conducted by the Texas Comptroller's Office, the Texas Health and Human Services Commission implemented the Medicaid Fraud and Abuse Detection System in 1998. This system combines both data mining (e.g., Data Warehouse and Decision Support System) and neural network capabilities to identify fraudulent patterns from large volumes of medical claims and historical provider/recipient data. Specifically, the Medicaid Fraud and Abuse Detection System monitors provider compliance and fraud referrals, SURS recoveries, as well as statistics used in tracking the progress of individual cases: case hours, investigative costs, and travel expenses related to the Medicaid program. According to Texas, this system has supplemented SURS recoveries by an additional 124 percent (or $2.1 million) per year, on average.

R7.13 Upon implementation of all Medicaid program integrity and technology-related recommendations (see Technology and Program Management), the State Medicaid agency should consider using neural networking as a means of identifying fraudulent patterns from large volumes of medical claims and historical provider/recipient data if cost-benefit studies indicate that this is an appropriate option. The State Medicaid agency should also consider collaborating with the Texas Health and Human Services Commission, which was one of the first Medicaid agencies to implement neural technology and has been recognized by GAO as an innovator in program integrity.

Program Integrity and Managed Care

Although managed care plans are contractually-required to report instances of fraud and abuse, technology-related limitations within the Decision Support System prohibit ORAA and FIAG from mining and evaluating encounter data for the purposes of independently detecting such instances. Specifically, a recent ODJFS survey of technology use by an outside contractor found that the Decision Support System does not permit sufficient access to quality encounter data, preventing both SURS and FIAG from independently detecting potentially fraudulent activity.

As in Ohio, HHS indicates that more and more states are shifting to managed care as a means of administering Medicaid, rather than relying on traditional fee-for-service (see **managed care and care management**). This presents new challenges to authorities responsible for preventing and detecting fraud, waste, and abuse. One common misperception is that managed care automatically eliminates fraud and abuse since medical services are not reimbursed individually. In fact, fraud and abuse attributable to over-utilization is still found in cases where managed care plans reimburse member providers on a fee-for-service basis.

For fully-capitated managed care plans, there is a fixed amount of money paid to the plan for the care of recipients and no fee-for-service claims are submitted to the State Medicaid agency for reimbursement. As a result, there are no independent claims review at the State level processes through which billable services are filtered before payment is remitted.[46] As is the case in Ohio, state Medicaid agencies must re-evaluate and potentially add to the role of SURS, as it pertains to program integrity. Managed care plans incur a financial risk that capitated rates will not cover all recipient services. Consequently, there are incentives to provide fewer services than are necessary in order to minimize expenditures and preserve profits. This results in the following forms of fraud, waste, and abuse, which are less common in the traditional fee-for-service system:

- Underutilization and denial of necessary services;
- Recipient exclusion from necessary services;
- Illegal marketing tactics;
- Unreasonable times and distances that prevent recipients from making appointments;
- Enrolling fictitious or ineligible recipients;
- Submitting falsified encounter data to justify higher capitation rates; and
- Establishing fraudulent sub-contracts.

State Medicaid agencies differ in how they assign responsibility for detecting and referring managed care-related fraud, waste, and abuse. Traditionally, as part of the fee-for-service system, state Medicaid agencies rely on SURS to detect deviations through post-payment review

[46] The managed care plans use their own claims adjudication process and use their own pre-payment review processes.

of claims. Potential fee-for-service fraud cases detected through these reviews are typically referred to MFCUs for investigation, as is the case in Ohio. In Medicaid managed care, however, no additional guidance has been provided. Specifically, some states suggest that ensuring program integrity is the responsibility of managed care plans themselves and any detection and referral activities performed by the state Medicaid agency are duplicative. HHS suggests that state Medicaid agencies can promote Medicaid program integrity in managed care plans by:

- Developing and maintaining a strong relationship between managed care plans and state program integrity staff;
- Ensuring that any entity or provider excluded by HHS-OIG is prevented from entering into the managed care plan when they initially apply for participation, or is removed from active status if already participating;
- Incorporating language with explicit fraud and abuse measures into contracts, programs, and waivers; and
- Requiring that managed care plans refer instances of fraud and abuse to the program integrity unit, as well as periodic reports on related activities and accurate encounter data so that SURS may conduct independent reviews.

Ohio managed care plans, in accordance with HHS recommendations, are contractually-required to have a program that includes administrative and management arrangements or procedures, including a mandatory compliance plan, to guard against fraud and abuse. Managed care plans must designate staff responsibilities for administering the compliance plan, including clear goals, milestones or objectives, measurements, key dates for achieving identified outcomes, and explain how the managed care plan will determine the compliance plan's effectiveness. In addition to requirements outlined in OAC 5101:3-26-06, managed care plan fraud and abuse programs must specifically address prevention, detection, investigation, and reporting strategies in the following areas:

- **Embezzlement and theft**: Managed care plans must monitor activities on an ongoing basis to prevent and detect activities involving embezzlement and theft (e.g., by staff, providers, contractors, etc.) and respond promptly to such violations.

- **Underutilization of services**: Managed care plans must monitor for the potential underutilization of services by their members in order to assure that all Medicaid-covered services are being provided, as required. If any underutilized services are identified, the managed care plan must immediately investigate and, if indicated, correct the problem(s) which resulted in such underutilization of services. Managed care plan monitoring efforts must, at a minimum, include the following activities:

    - Review their prior authorization procedures to ensure they do not unreasonably limit recipient access to Medicaid-covered services;

- Review the procedures that member providers are to follow in appealing managed care plan denials of prior authorization requests to ensure the process does not unreasonably limit recipient access to Medicaid-covered services; and

- Monitor service denials and utilization on an ongoing basis in order to identify services which may be underutilized.

- **Claims submission and billing**: Managed care plans must regularly identify and correct claims submission and billing activities which are potentially fraudulent, including, at a minimum, double-billing and improper coding, such as up-coding and bundling.[47]

- **Reporting managed care plan fraud and abuse activities**: Pursuant to OAC 5101:3-26-06, managed care plans are required to submit annual reports to OHP which summarize the fraud and abuse activities of the previous year in each of the areas specified above, and identify any proposed changes to the managed care plan compliance plan for the coming year. Finally, managed care plans are required to promptly report all instances of provider fraud and abuse to OHP and recipient fraud to county JFS boards.

- **Encounter Data**: Managed care plans must also submit accurate encounter data to OHP (Bureau of Managed Health Care) for validation through a private contractor, who measures the rate of agreement between encounters and corresponding medical records. The primary purpose is to verify that managed care plans submit encounter data accurately and ensure that only one payment is made per service delivery.

As stipulated in OAC 5101:3-26-10(F), managed care plans are required to initiate corrective action for any managed care plan program violations or deficiencies as soon as they are identified by the managed care plan or OHP. Specifically, managed care plans that fail to comply with contract provisions are required to submit a corrective action plan to OHP for approval. Failure to do so can result in monetary fines, surety bond forfeiture, or termination from Ohio Medicaid.

While Ohio's contract for managed care plans appears to materially comply with federal suggestions, it does not appear that State program integrity personnel are actively involved with managed care plans. For example, managed care plan contracts do not formally stipulate that SURS (or FIAG) staff may conduct periodic audits/reviews of encounter data. This can be somewhat attributed to technology-related limitations which prevent both SURS and FIAG from independently detecting potentially fraudulent activity. During the course of the performance audit, ODJFS indicated that it was enhancing its Decision Support System to improve the quality of encounter data. Until these deficiencies are addressed, however, the State Medicaid agency

[47] Up-coding occurs when standard codes are misused to obtain more money than is allowed by law. Bundling indicates a process of offering two or more services together which are billed under a single code.

must continue to rely solely on managed care plans to report instances of fraud, waste, and abuse on their own. Absent independent review, either by SURS or FIAG, the State Medicaid agency cannot effectively ensure the Medicaid program integrity of managed care plans.

In addition to guarding Ohio Medicaid against potentially fraudulent providers and recipients, effective prevention/detection controls increase public confidence in the administration of benefit programs and help to optimize "pay and chase" and "cost-avoidance" methods of minimizing improper payments. Recognizing that some overpayments are inevitable, however, GAO suggests that state Medicaid agencies also need to adopt effective detection techniques to quickly identify and recover them. Prevention/detection controls play a significant role not only in identifying improper payments, but also in providing data on why these payments were made and, in turn, highlighting those enforcement strategies that need to be strengthened.

R7.14 The State Medicaid agency should update its contracts with managed care plans to formally stipulate that SURS and FIAG personnel may periodically audit/review all data related to a claim. By formally requiring that Medicaid program integrity personnel be actively involved in managed care plan monitoring, the State Medicaid agency will bring its contracts more in line with HHS guidelines, while facilitating improved oversight.

C. Reporting and Communicating Information: Coordinating Knowledge

> "...It's a little bit difficult, because...the Attorney General's Office has been involved in collecting Medicaid overpayments and the counties [are] involved, and sometimes it crosses. There probably needs to be better coordination there."
>
> *Representative, County Commissioners' Association of Ohio*

Coordination of Medicaid program integrity has improved among ODJFS, the Attorney General, and Auditor of State, as a result of the Ohio Inspector General's recent investigation, yet several issues remain. For example, ODJFS has not worked with key internal and external stakeholders to develop a Medicaid program integrity-related mission, goals and objectives, nor does it publish an annual report that uses performance measurement to monitor progress on minimizing fraud, waste, and abuse. This can be attributed to the fact that the State Medicaid agency has not centralized its program integrity functions under the auspices of an independent authority, or manager, who is wholly accountable for minimizing fraud, waste, and abuse and reporting the results of efforts to do so. Rather, the State Medicaid agency has spread accountability for these functions among numerous bureaus and offices, both internal and external to OHP (see **Chart 7-2**). ODJFS indicated that fraud reports may be made to any agency employee but that there was no centralized tracking or resolution process. Furthermore, despite available hotlines, a wide variety of entities take Medicaid fraud complaints, including county, regional, and State agencies and bureaus and departments within the State agencies, creating a perception among provider/recipient stakeholders that complaints may be easily lost or simply ignored.

Members of the Ohio Association of County Behavioral Health Authorities remarked that, "We can report fraud to our State Departments. We have some Boards who have reported directly to ODJFS…" And, as it pertains to using technology in identifying fraud:

> "…You can develop the technologies that allow you to instantly know where those cost drivers are…it takes us, literally out of 16,000, 17,000 Medicaid clients, it would take us about 3 minutes to identify, based on utilization…For instance, I can show you where there is a 14-year-old kid that's generated over $75,000 worth of Medicaid at a residential provider…but I can't do anything about it."

GAO recommends that the following strategies should be considered to effectively report and communicate information:

- Determine what information is needed by managers to meet and support initiatives aimed at reducing improper payments;
- Ensure that needed information is provided to managers in an accurate and timely manner;
- Provide managers with timely feedback on applicable performance measures so they can use the information to effectively manage their programs;
- Develop educational programs to assist program participants in understanding program requirements;
- Ensure that there are adequate means of communicating with, and obtaining information from, stakeholders that may have a significant impact on improper payment initiatives, such as periodic meetings with oversight bodies; and
- Develop working relationships with other organizations to share information and pursue potential instances of fraud or other wrongdoing.

Both CMS and GAO indicate that effective program coordination of the internal control environment provides for a timely and consistent exchange of information regarding potential instances of fraud, waste, and abuse. As such, effective coordination includes regular meetings with key internal and external stakeholders – such as MFCUs – to identify Medicaid program risks, plan investigations, and report results.

Program Integrity Manager

In December, 2005, ODJFS created and filled a program integrity manager position (see **Chart 7-2**) that is responsible for interpreting and coordinating Medicaid recovery audits performed by SURS and FIAG and overseeing the development of corrective action plans that may result from audit findings. This position also has duties similar to the Office of Chief Inspector. Specifically; the program integrity manager coordinates with internal ODJFS personnel, as well as external State (e.g., Auditor of State, Attorney General, and Ohio Inspector General) and federal agencies (e.g., HHS-OIG and CMS) on audit findings and Medicaid program integrity-related activities,

such as PERM. Finally, the program integrity manager responds to inquiries from providers, recipients, and the public and assists in the development of administrative rules.

In its recommendation to remove SURS from OHP, the Ohio Inspector General found that because the former SURS chief reported to OHP, which is responsible for maintaining positive relationships with providers, the State Medicaid agency could not ensure the independence necessary for Medicaid program integrity. This logic also applies to the current program integrity manager position, which as of March 2006, reported directly to the chief of staff of OHP. More recently, OHP has been reorganized and the position now reports to a subordinate of the OHP Assistant Deputy for Operations (Chief of Staff).

The Ohio Inspector General has suggested that Medicaid program integrity-related functions could be overseen by the ODJFS Office of Chief Inspector to better ensure independence. Currently, the Office of Chief Inspector operates independently of OHP and is responsible for ensuring that all programs administered or supervised by ODJFS comply with State and federal laws, rules and regulations, particularly as they relate to internal controls, safety practices, and ethical or legal considerations.

As part of New York Governor George Pataki's *Five-Point Plan to Fight Medicaid Fraud* initiative, New York State Department of Health established the Office of Medicaid Inspector General.[48] This independent office is responsible for integrating and efficiently coordinating the Medicaid anti-fraud resources of several state agencies, including the following:

- Office of Mental Health;
- Office of Mental Retardation and Developmental Disabilities;
- Office of Alcohol and Substance Abuse Services;
- Office of Children and Family Services; and
- State Education Department.

The New York Office of Medicaid Inspector General has also been granted broad authority to subpoena witnesses, administer oaths and examine witnesses under oath, and require the production of records deemed relevant or material to fraud investigations. Finally, the Office of Medicaid Inspector General collaborates with federal and local government officials, including New York's MFCU, the State Office of Welfare Inspector General, and local prosecuting attorneys. Similarly, both Florida and Texas centralize their respective state Medicaid agencies' program integrity activities (e.g., SURS recovery audits/reviews, internal and quality control audits, fraud investigations, MFCU relations, etc.) under the auspices of an independent inspector general. By requiring that the newly created program integrity manager report directly

[48] In the most recent New York State budget presented by the Governor, the plan has been expanded to encompass seven points. This initiative has not yet resulted in a written plan.

to the deputy director of OHP, the State Medicaid agency compromises its independence, in direct contrast to Ohio Inspector General's recommendations.

R7.15 The General Assembly should consider establishing a Medicaid Chief Inspector position, to replace the program integrity manager. The Medicaid Chief Inspector would be wholly responsible and accountable for all program integrity functions. Because Ohio already has several oversight agencies involved in the Medicaid program, the Chief Inspector positions should focus on resolution of issues involving fraud, waste, and abuse but would not require the same type of subpoena powers as other states have granted to their Medicaid inspector generals. Ohio agencies, such as the Attorney General or the Ohio Inspector General, can already provide these functions. Realigning Medicaid program integrity functions under a Chief Inspector position will increase coordination among State agencies and ensure effective oversight. This process has been used by other states, including Florida, Texas, and New York and has been recognized by HHS as a "significant step" in correcting the course of anti-fraud responsibilities in these states.

If the Medicaid program remains with ODJFS, the State Medicaid agency should, at a minimum, make the current program integrity manager independent of internal program and policy functions, in line with Ohio Inspector General's recommendations regarding SURS. Specifically, the State Medicaid agency should reorganize the program integrity manager's responsibilities under the Office of Chief Inspector, rather than within the bureaus of OHP. The Office of Chief Inspector and program integrity manager share similar responsibilities and this reporting structure will help to further ODJFS commitment to developing an "arm's length" relationship between Medicaid providers and those responsible for monitoring them.

If the General Assembly elects to establish a stand-alone Medicaid agency, the staff position responsible for program integrity functions within the new organizational structure should be placed in a position where it directly reports to the agency executive or its governing authority, as is common in internal audit functions.

Collaboration and Annual Reporting

> "If you look at the amount of money that is spent in administrative overhead to have someone to check the checkers, to check the checker's checkers, there might be more funds available for services to be provided…We're not going to say that there are never any agencies that do anything wrong because that's not true. But if they're doing stuff wrong, we want them prosecuted…"
>
> *Member, Ohio Council for Home Care*

When providers with aberrant patterns or practices are identified by SURS, that information is typically referred to the state MFCU. In the U.S., most state MFCUs rely on SURS referrals to generate their case investigations. This process is aided immensely when an effective memorandum of understanding is in place between the state Medicaid agency and MFCU. In most states, the cooperation between SURS and MFCU usually leads to a more efficient process of identifying and prosecuting Medicaid fraud. HHS encourages all state MFCU and SURS personnel to maintain an open dialogue and hold regular meetings to discuss case progress, as well as the number and quality of SURS referrals offered to MFCU.

Although the State Medicaid agency is in the process of formalizing its memoranda of understanding with MFCU and FIAG, it has not yet collaborated with these agencies to develop a joint interagency report on efforts to minimize fraud, waste, and abuse. In accordance with federal and State recommendations, ORAA/SURS personnel now meet regularly with MFCU and FIAG to discuss provider compliance and auditing practices, ensure audit consistency, compare information on potential fraud referrals or litigation, improve data sharing, and identify best practices. However, SURS does not meet with the State sub-recipients to discuss these topics. The Attorney General's Health Care Fraud Section, which includes MFCU, publishes its own annual report, yet these agencies have not worked to assess program-wide risks and establish a shared vision of Medicaid program integrity that is linked to goals and objectives (see **R7.1**) and monitored through the use of performance measures (see **R7.18**).

According to the AICPA, open and timely communication helps to facilitate an understanding of expectations among all participants in a given program. An example of effective information and communication controls includes the prompt (i.e. online) publication of comprehensive strategic plans and annual reports. Florida's state Medicaid agency and MFCU have strengthened their working relationship and enhanced cooperation by submitting a joint report to the Florida Legislature that documents the effectiveness of the state's efforts to control Medicaid fraud and abuse and to recover Medicaid overpayments during the previous fiscal year. Similarly, in Texas, the state Health and Human Services Commission and MFCU recognize the importance of partnership and regular communication in the coordinated effort to fight fraud and abuse in the Medicaid program. As such, these agencies collaborate to publish a joint, semi-annual interagency coordination report. This report highlights statistical data pertaining to referral sources, as well as fraud convictions and improper payment recoveries.

Annual reports help to provide benchmark comparisons, past performance trends, and established performance targets. GFOA suggests that objectives can only be fully realized if they are readily available to all interested parties and that presentation on a government website offers an unparalleled means of providing easy access to such information. Without an annual report that uses performance measurement to monitor progress on strategic goals and objectives, the State Medicaid agency, MFCU, and FIAG cannot effectively communicate shared accomplishments, needs, goals, and initiatives to sub-recipient agencies and other stakeholders.

Moreover, this may negatively impact compliance with new federal reporting standards (i.e., DRORA) pertaining to Medicaid program integrity.

R7.16 The State Medicaid agency, through an independent program manager or Medicaid Chief Inspector (see R7.15), should collaborate with FIAG and MFCU, as well as with State sub-recipient and county/regional agencies to develop one, formal annual report that can be used to provide operational and financial statistics on efforts to minimize fraud, waste, and abuse. This report should also reflect the mission and vision of Ohio Medicaid program integrity efforts, incorporate mutually agreed-upon goals and objectives, and include performance measures for monitoring all State and local activities. Finally, the State Medicaid agency should collaborate with Medicaid stakeholders to publish the annual report online and make copies available to federal, State, and local officials and the general public. This will help to facilitate and communicate shared expectations and monitor progress on state-wide efforts.

D. Monitoring: Ensuring Success

As indicated above, the State Medicaid agency does not currently employ universal and comprehensive performance measures to monitor the efficiency and effectiveness of State and local Medicaid program integrity efforts. To illustrate, ODJFS does not monitor the financial impact (cost/benefits) of its recipient lock-in program, PACT, because it is considered a clinical quality program. By contrast, Florida's state Medicaid agency reports that its Pharmacy Lock-in program resulted in savings of over $10 million, attributable not only to a reduction in the number of prescriptions for drugs with the potential for misuse or abuse, but also to significant reductions in the number of office visits and associated medical claims. During the course of the performance audit, however, OHP indicated that it intends to use ORAA's Decision Support System to establish PACT-related benchmarks and high-level financial data. While pertinent data is available (e.g., provider audits performed, overpayments identified and recovered, etc.), it is spread out among various State and county agencies, and ODJFS has not collaborated with key internal and external stakeholders to compile the information into a report that can be used to manage and prioritize activities (see **R7.16**).

Performance Measures

Monitoring performance, over time, is critical to program management and oversight. GAO suggests that the evaluation of program successes in meeting established goals is an integral element of performance measurement and continued improvement. Monitoring focuses on the assessment of the quality of performance over time and on the prompt resolution of problems identified either through separate program evaluations or audits. Once an organization has identified its risks related to improper payments and undertaken activities to reduce such risks by

upgrading its control activities, monitoring performance allows the organization to gauge how well its efforts are working.

GFOA indicates that a key responsibility of government is to develop and manage programs, services, and their related resources as efficiently and effectively as possible, and to communicate the results of these efforts to internal and external stakeholders. When linked to an organization's budget and strategic planning process, performance measures can be used to assess accomplishments on a system-wide basis and should:

- Be based on program goals and objectives that tie to a mission statement or vision;
- Measure program outcomes;
- Provide for resource allocation comparisons over time;
- Measure efficiency and effectiveness for continuous improvement;
- Be verifiable, understandable, and timely;
- Be consistent throughout the life of the strategic plan;
- Be reported internally and externally (e.g., websites, annual reports);
- Be monitored and used in managerial decision-making processes; and
- Be designed in such a way to motivate staff at all levels to contribute toward improvement.

Florida's state Medicaid agency and MFCU are statutorily required to submit a joint report to the legislature documenting the following statistics:

- Number of cases opened and investigated each year;
- Sources of the cases opened;
- Disposition of the cases closed each year;
- Amount of overpayments alleged in preliminary and final audit letters;
- Number and amount of fines or penalties imposed; any reductions in overpayment Amounts negotiated in settlement agreements or by other means;
- Amount of final agency determinations of overpayments;
- Amount deducted from federal claiming as a result of overpayments;
- Average length of time to collect from the time the case was opened until the overpayment is paid in full;
- Amount of overpayments recovered each year;
- Number of providers, by type, that are terminated from participation in the Medicaid program as a result of fraud and abuse; and
- All costs associated with discovering and prosecuting cases of Medicaid overpayments and making recoveries in such cases.

To assist in reporting this information, Florida's state Medicaid agency has developed a new provider case tracking and management database, called the Fraud and Abuse Case Tracking System. This system links monies repaid by providers and information related to the status of appeals and administrative hearings to cases in the database. In addition, the Fraud and Abuse Case Tracking System incorporates monthly and annual benchmarks which help monitor Program integrity operations by generating reports that detail the extent to which providers actually repay misspent Medicaid funds, how long it takes providers to repay these funds, which providers have a history of over-billing Medicaid or have previously violated program policies, as well as the type and extent to which the agency imposes sanctions on providers.

When used in the long-term planning and goal-setting process and linked to the Medicaid mission, goals, and objectives, meaningful performance measures can assist the State Medicaid agency and all stakeholders in identifying financial and programmatic results, evaluating past resource decisions, and facilitating qualitative improvements in future decisions regarding resource allocation and service delivery. The lack of a universal and comprehensive system of performance measurement, combined with fragmented authority (see **R7.10**, **R7.11**, and **R7.12**) and inadequate technology, limits the State Medicaid agency's ability to effectively monitor all efforts to minimize fraud, waste, and abuse. Moreover, it cannot adequately communicate its expectations in this regard to other agencies (federal, State, and local), or to employees and the public.

R7.17 The State Medicaid agency should consider implementing the following strategies, as recommended by GAO:

- **Establish specific goals and measures for reducing improper payments (see R7.1);**
- **Periodically monitor the progress in achieving the established performance measures, using baseline information for comparison (see R7.18);**
- **Make the results of performance reviews widely available to permit independent evaluations of the success of efforts to reduce improper payments (see R7.16);**
- **Ensure timely resolution of problems identified by audits and other reviews (see R7.10, R7.11, and R7.12); and**
- **Adjust prevention/detection control activities (see R7.2 through R7.9), as necessary, based on the results of monitoring activities.**

R7.18 The State Medicaid agency should cooperate with key stakeholders to develop universal and comprehensive performance measures for Medicaid program integrity, similar to Florida. Examples include, but should not be limited to, the following:

Provider Enrollment/Termination Measures (fee-for-service and managed care plans)

- **Providers certified/enrolled/re-enrolled per year;**
- **Background checks performed per year (including fingerprinting);**
- **Provider applications approved/denied/terminated per year as a result of background checks or other investigations;**
- **Providers added/removed from State and federal exclusion list; and**
- **Inactive provider numbers added/removed from system per year.**

Provider Monitoring (Pre- and Post-Payment) Measures

- **Provider-related fraud, waste, and abuse incident referrals received by means of telephone, Internet, and/or word-of-mouth;**
- **Pre-paid claims reviews/rejected claims per provider type per year;**
- **Incident referrals per provider type and per county/region per year;**
- **Fraud referrals to MFCU;**
- **MFCU convictions and amount recovered per conviction;**
- **Recovery audits/reviews conducted/appealed/overturned per provider type per year by SURS, FIAG, managed care plan, and/or private contractor;**
- **Average length of time/cost to complete SURS/FIAG audit/review;**
- **Overpayment amount identified/percentage collected/referred to the Attorney General;**
- **Average time to collect overpayments;**
- **Percentage of recipients per county/region receiving explanation of benefits surveys;**
- **Investigations/recoveries/convictions resulting from explanation of benefits surveys per county/region per year; and**
- **Onsite provider reviews conducted per county/region per year.**

Recipient Monitoring and Third Party Liability Measures

- **Recipient-related fraud, waste, and abuse incident referrals received through telephone, Internet, and/or word of mouth;**
- **Recipient fraud-related referrals/prosecutions/collections per county/region per year;**
- **Recipients enrolled in/removed from PACT per year; and**
- **Third party liability dollars recovered and avoided per year.**

Program Integrity Training/Education Measures

- **Provider training/education hours per county/region per year;**
- **Recipient training/education hours per county/region per year;**
- **State and county/region employee training hours per year; and**
- **Cost per training hour.**

By developing these measures in conjunction with the PERM and Medi-Medi projects and recommended strategic planning processes, the State Medicaid agency – through an independent program integrity manager or Medicaid Chief Inspector – can more effectively monitor goal achievement, prioritize, and communicate the results of State and local efforts to minimize fraud, waste, and abuse.

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ISSUES FOR FURTHER STUDY

Issues for Further Study

Issues for Further Study Table of Contents

Auditing standards require the disclosure of significant issues identified during an audit that were not reviewed in depth. Those issues may not be directly related to the audit objectives or may be issues that the auditor does not review within the scope of the audit. Several of these issues were raised during stakeholder meetings and many expand on issues included within the report. The issues for further study are organized in the same manner as the five sections of the report.

Organizational Issues

Local levy funding, its impact on the behavioral health system, and recoupment of "State share": The General Assembly should examine the scale of local funding and its appropriateness within the program. Ohio uses local levy dollars to match federal funding in some of the systems participating in Medicaid. A member of the County Behavioral Health Authorities indicated that using local dollars for Medicaid match impacted the behavioral health boards' ability to intervene with their clients on the non-Medicaid side or provide housing and employment assistance. They described Medicaid as driving the system and requiring behavioral health authorities to put Medicaid recipients at the "front of the line" while the people to whom the boards are responsible and who may be more clinically and financially needy are not getting served. A member stated that it is becoming more difficult to pass local levies because the funds will not go to local priorities. Association members indicated that about $60 million in local levy funds were used for match in 2004 and that state legislators do not consider the local match when increasing funding to ODJFS for Medicaid. Furthermore, members stated that, while there is a state-wide entitlement for a select group, there are increasingly uneven, unequal, and separate levels of service for other Ohioans who have not qualified for Medicaid. Members of the Ohio Council of Behavioral Healthcare Providers expressed concerns over the repayment process (for overpayment of Medicaid claims) and said that, while they are not concerned about paying back overpayments during reconciliation, the local match may not be appropriately returned to the county that initially paid the "State share" of the claim.

Administrative costs at the local level in the behavioral health system: The State Medicaid agency should consider examining methods to allow the behavioral health boards to engage in administrative claiming to recoup costs for Medicaid administration. The behavioral health system does not have the ability to recoup federal funds to offset the costs of administering the program. Some of the sub-recipient systems have been approved for Medicaid Administrative Claiming (ODE and ODH) and representatives from the behavioral health systems have inquired into obtaining approval for this process. Because the behavioral health system does not have a statutory case management role in Medicaid (boards are prohibited from case management for Medicaid recipients), conceptually there should be no additional administrative costs. However, members of the Ohio Association of County Behavioral Health Authorities indicated that they were unable to charge administrative costs because of the claims processing system in use at ODJFS and that there are additional costs associated with the Medicaid side of operations beyond case management. These items included bookkeeping, claims processing, enrollment, auditing, information technology, and the Medicaid/non-Medicaid interface. The Association estimates that administrative claims for 2003 were $24 million in real costs.[1]

Opportunities for rebalancing managing and providing services within County Boards of Mental Retardation and Developmental Disabilities (CBMRDD): The General Assembly, ODMRDD, and the State Medicaid agency should study the roles of the county boards of MRDD to determine if changes should be made to the local relationships with providers. There is a perceived opportunity for a rebalancing of roles in the area of CBMRDDs providing direct services. Members of the Ohio Provider Resource Association expressed concerns over county boards being a funder, a contractor, the service planner, the quality manager, the major unusual incident monitor, investigative agent, and doing service provision at the same time. Anecdotal evidence provided by recipient advocates also indicated that this area may warrant closer examination. However, in some areas, CBMRDDs are the only providers for certain services.

Administrative burdens and barriers impacting recipients and providers: The State Medicaid agency, ODMH, and ODADAS should examine the audit processes in use at the local level and the efficacy of current processes to determine if changes should be made to better regulate the process. Similarly, the State Medicaid agency and ODMRDD should examine the new reimbursement methodology to determine if the additional administrative costs are outweighed by improved record keeping and reduced care costs. Behavioral health providers spoke to added cost and burden with the multiple layers of administration that exists in Ohio. A member of the Ohio Council of Behavioral Health Care Providers indicated that the multiple layers in the system creates a large expense for the boards and providers, particularly in the manner in which local boards conduct Medicaid audits. The audit process is particularly cumbersome for providers who serve multiple counties as each county uses its own methodology and has its own expectations. A member of the Ohio Provider Resource Association also spoke

[1] A recent plan developed by the behavioral health authorities addresses case management. The behavioral health authorities are reportedly awaiting submission of the plan to CMS for its approval.

about the administrative burden in the MRDD system. An example was the method of measuring contact time required of the MRDD providers. At the time of reporting, MRDD providers are required to document staff to client ratios in 15 minute increments. The member explained, "You've got ratios so that you could have 15 minutes intervals with 15 people, and you have five staff. So [as people move in and out of the activity] it's to a 1:3 [ratio] and all of a sudden it can be a 1:6 and 1:8 [ratio]."

Inconsistent Medicaid administration between counties: The General Assembly and State Medicaid agency should study the enrollment process to determine if there are ways to make the process more uniform and user-friendly at the county level. Stakeholders raised concerns about the lack of consistency in administering the Medicaid program across Ohio's 88 counties. Although enrollment into Medicaid is the responsibility of the county departments of job and family services, a member of the National Alliance for the Mentally Ill of Ohio stated that CDJFS caseworkers do not know what services are available in some cases and are quick to discourage an applicant. A member of the Ohio Association of Area Agencies on Aging said that there is inconsistent interpretation in eligibility. Similarly, a member of the Ohio Hospital Association stated that eligibility process timelines vary widely from county to county. A member of the Universal Health Care Action Network also detailed problems that recipients have with the reenrollment process, such as a caseworker allowing a reenrollment period to expire and Medicaid coverage to lapse. [This example was conveyed to us by several stakeholder groups].

Members of the Universal Health Care Action Network shared several positive practices in streamlining eligibility. These practices were not standard but were adopted by certain counties. In one case, when a caseworker does not hear back from an employer on employment verification within 10 days, the application is processed without additional delays. In another case, a county allowed applicants to self-verify income. The county that piloted this program reportedly found that applicants had a 2 – 3 percent error rate – a rate lower than the error rate of caseworkers. Another member of the network expressed an interest in reviving the immigrant unit in urban counties. In one county, the member said, "There used to be a unit that handled immigrants, who understood refugee Medicaid, who understood what immigrants were eligible and which weren't, who understood alien emergency medical assistance. When … [the county] went to the five opportunity centers, they dismantled that one unit. So every caseworker is supposed to be an expert."

The authority and oversight of Medicaid vendors: The State Medicaid agency should examine the level of authority it permits to its vendors and the oversight used to ensure that the vendors do not inappropriately apply their authority to Medicaid recipients. A member of the Ohio State Legal Services Association brought up CareStar and expressed concerns that the vendor was "pretty heavy-handed with the clients."

Instilling personal responsibility in Medicaid recipients: The State Medicaid agency and sub-recipients should study opportunities to increase the level of personal responsibility of Medicaid clients. A member of the American College of Emergency Physicians discussed ideas to encourage a greater level of personal responsibility on the part of recipients. In the example given, the member said that recipients often do not bring in their Medicaid cards when seeking treatment at the emergency room. The member suggested waiving the co-pay to incentivize recipients to bring in their cards and reduce the administrative burden on the ER personnel in processing claims.

Collecting payment for care: The State Medicaid agency should study methods to better communicate to providers and recipients the recipient's liability for charges when they were not eligible for Medicaid. During the interview process, numerous physician groups expressed concerns over their ability to collect payments from recipients who may not have been Medicaid eligible at the time of service. While the Medicaid program has implemented a co-pay for some services, in the majority of cases, the Medicaid payment is considered the full payment and service recipients are not required to pay towards the cost of the care. In the area of payment for services, a member of the American College of Emergency Physicians described the enrollee handbook which reportedly states, "If you get a bill from someone and you're enrolled, you need to call them and tell them you're enrolled" but then does not clarify that the recipient may not have been eligible at that time or describe any other circumstances that might lead to a billable service. On the other hand, a member of the Ohio State Legal Services Association explained that there are "providers who are very aggressive debt collectors.... the Department started taking a hands-off approach." A balanced approach to this issue would be required.

Regulatory relief: The State Medicaid agency and sub-recipients should examine the regulatory processes currently in use to determine ways to reduce potentially burdensome documentation and data requirements. The onerous burden on providers from Medicaid regulations and data collection activities was noted by stakeholders. Members of the Ohio Family Services Council gave several examples of regulatory burdens that, in their opinion, had grown out of control. In particular, the paperwork associated with clients in the behavioral health system was considered overly burdensome. A member described the following: "You know, instead of doing good therapy, we're looking for people who know how to document medical necessity. ...These kids that are coming out of school all they think about is documentation.... I'm teaching medical necessity, which has nothing to do with social work and social work core values, but because you're going to be employed by an agency that's going to use these forms, this is what I have to teach you." A member of the Ohio Association of Community Health Centers also described data collection and noted that, "we're collecting data, our QY teams are collecting data, so if the audit is going to ask for data, we'd like to see that the audit can ask for data that we're already collecting, rather than coming in and say, "Here, collect a whole new set of data." I think Medicaid should be looking at what data is being collected and try to build on that."

A member of AOPHA also commented on over-regulation saying:

> "Most of the governing regulation is regulatory and not in statute for long-term care. And the only industry that has more regulations than the long-term care is the nuclear regulatory. We have more inspections, more often, by more different jurisdictions than any other industry. There's the feds. There's the State. There's the local [inspectors]. There's the city. There's building codes. There's a life safety—There's the fire marshal. Our facilities are inspected an average of at least one a month. Now, not by the same people. So that's a challenge of the field and that's okay. Look, we're charged with providing everything to people who can't take care of themselves, by and large. So we should be held to a high standard."

Seek additional program opportunities and stakeholder involvement: The State Medicaid agency and sub-recipients should examine opportunities to explore new programs, engage stakeholders in discussions on how to improve the program, and move forward on suggestions and recommendations. A member of the Ohio Association of County Behavioral Health Authorities said, "Since 1990 there has never been a period of time when I haven't served on some kind of Medicaid reform committee with these same issues, so it's like, okay, this is going to be time limited, every single one. And here we are 15 years later still talking about the same thing." A member of the Ohio Academy of Primary Care Physicians said, "It would be nice to be able to continue a dialogue as either your issues come up or we have access to continue to provide, hopefully, positive feedback to -- this is small think tank, but it would be nice to continue this type of a dialogue." A member of the Ohio Association of Area Agencies on Aging also described a program being investigated by ODA which would establish Age and Disability Resource Centers through a CMS/ADA grant (Systems Change Grant).[2]

Medicaid Service Provision

Eligibility standards: The General Assembly and State Medicaid agency should study the impact that current eligibility standards have on Ohioans and determine if the standards are appropriate for Ohio in relation to the program goal (as described in **organizational issues**). Ohio's current eligibility standards for who can obtain Medicaid coverage, and conversely who can not obtain coverage, were areas of concern for many stakeholders. Related to the eligibility issue is how those standards impact recipients' ability to access care, work, obtain housing, and other aspects of their lives. A member of the National Alliance for the Mentally Ill of Ohio suggested that "every legislator who votes on the Medicaid budget should have to live below the poverty level for a month so that they would… get to evaluate their sort of philosophy that

[2] Aging and Disability Resource Center (ADRC) grants offer states the opportunity to create 'one stop' entry points to long-term support services. These centers can serve as visible and trusted places for information on long-term care options, to help seniors and people with disabilities get long-term care where they want it. CMS' goal is to make ADRCs the foundation for community-based care. States and territories receiving the grants are Alabama, Arizona, Colorado, District of Columbia, Guam, Hawaii, Idaho, Kansas, Kentucky, Michigan, Mississippi, Nevada, Ohio, Tennessee, Texas, Vermont, Virginia, Washington and Wyoming. All together, 43 states have received the three-year grants with awards of up to $800,000.

everybody should pay something versus the reality of living below poverty. Let's have them adopt a family and let them see how that family lives." Another NAMI member stated that, "There should be ways to get on Medicaid rather than being so totally poor." A member of the Ohio Developmental Disabilities Council indicated that "…the system needs to be changed to make parents and family members and trusts of parents and family members be partners in the process, and what I'm suggesting is there ought to be a way that a family member can contribute to the well-being of this individual with the disability without being penalized." A member of Ohio State Legal Services Association stated that "… [Medicaid eligibility] applies for a very narrow population… … Poverty, of course, is a very unrealistic, low number. So there are lots of kids and families… and individuals who simply do not qualify under the rules for that Medicaid care."

Stakeholders also discussed the problems with transitional Medicaid, a benefit intended to support a recipient's reentry into the workforce. Members of the Ohio Legal Services Association noted that some of the guidelines were unrealistic and should be reexamined. Some recipients also noted that they had not received transitional Medicaid when they returned to work.

Access to services: The State Medicaid agency should study the impact of service access for persons with limited English-proficiency and immigrant status. A member of the Universal Health Care Action Network said that, "There are a lot of challenges and barriers for undocumented pregnant women who don't speak the language. …In many other states (Illinois, Indiana, New York, Texas, California) …they are able to get emergency Medicaid if they're pregnant…they get prenatal care." A member went on to say, "Ohio is one of only four states that doesn't confer eligibility to legally-present people after that 5-year [federal] bar, and there was no public comment process on it. They just amended their Medicaid plan to condition the bar indefinitely for legally-present women." The member concluded, "Our goal should be that every baby born in Ohio should born healthy." A member of the Ohio State Legal Services Association recommended allowing pregnant women in these circumstances to pre-certify for Medicaid and Alien Emergency Medical Assistance.

Enforcing medical support orders for disabled children past age 19: The State Medicaid agency should study whether opportunities exist to keep disabled children on the responsible parent's insurance past age 19 when health insurance coverage is dictated by a medical support order.

Medicaid or health insurance coverage as a barrier to employment: The General Assembly and State Medicaid agency should study opportunities to allow Medicaid recipients to work and retain Medicaid coverage, particularly in the area of permanently disabled individuals. Throughout numerous discussions, recipients expressed a strong desire to better their lives and contribute to the economic well-being of the State. A member of the Ohio Association of County Behavioral Health Authorities explained:

> "One of our fellows who is articulate enough to advocate says, "I feel like I'm penalized for having worked." Because he gets Social Security disability, he gets a little more income, the amount he has to pay [in spend-down] more than offsets the difference, so it's a disincentive. ...when they bump up to that level of having a spend-down, I think it becomes a disincentive. "Why am I going through all of this? Why do I want to work? Why do things and give up this benefit?"

A member of the Arc of Ohio put it more succinctly:

> "If there is a desire to do cost control in Medicaid, it's to find a way to permit people who have disabilities to become employed and not have to become medically indigent because we have lot of folks who have a choice between staying alive -- if they get a job and they loose their Medicaid they are going to die. So they decide, "I think I'll stay on Medicaid." It does not have to be that way and it's only because the State continues to construct a system that requires that choice."

A member of the National Alliance for the Mentally Ill of Ohio said, "Everybody wants to work. To get employment, even if people work part time, they are paying taxes....and if they're making money, they're paying taxes you're giving them less money...and if they're making more money they can pay the co-pay, then there is less money being paid ...[by] Medicaid. A member of United Cerebral Palsy of Central Ohio said, "I went to work one time. They took my money away.... If I [work], they take my money away. I'm not lazy. ...Why did they do that?" Two members of the Brain Injury Association described personal experiences. One said, "...My sister here, her son had a stroke at 42, and the only thing he cries [is]... "Auntie, when I am able to work again, I am going to work, work, work, work, work. That's all he wants... They don't want to be helpless." And, "This guy wants to work. You know, does the government have anything that would help these people, you know, even if it's a short-term thing to feel good about what they're doing? Like any person, if you feel good about what you're doing, you will try harder."

Members of the Ohio Federation of the Blind offered these comments on the barriers to employment:

> "You go to work you lose everything, even if you don't make that much. If I was making thousands of dollars it would be different, but I'm not, I'm still way within the poverty guidelines."

> "I think with Medicaid and all of these programs the phrase is very applicable that it's basically a handout and never a hand up . . . Nothing in any of these systems is designed for people to really be upwardly mobile from moving from the lower end of the stratosphere, as far as financial things go, to trying to move up because there is [no] bridge [for] that gap in between layers."

> "My goal is to be able to pay taxes again and [become] self-supporting and get off of Social Security and Medicaid and Medicare and all that. That's my ultimate goal, not just to get off Medicaid and stay ... I don't want to live like this for the rest of my life."

> "There's a person here [who]... got a job with the V.A. and he's been working there for about three years now.... It took him three years to get back up to the level of making what he was making with Social Security and Medicare. So no, it's definitely not encouraging to get a decent job."

Federal poverty level as the basis for eligibility: The State Medicaid agency should examine the current calculations on the federal poverty level to determine if this calculation is still appropriate as a means of determining eligibility. As shown in the report, other states no longer base eligibility on the federal poverty level and instead have adopted income guidelines. A member of the Ohio State Legal Services Association explained,

> "Back in the 50s they came up … [with] the concept the thrifty food basket, which is the food that a family needs to eat for a month. …They figured out what that cost. They attributed that food is about one-third of a family's expenses. Of course, food costs have increased at lower rates than housing, transportation, clothing, … So the food is now much less than one-third of the average cost of the household expenses but we're stuck with the thrifty food basket and attribute the thrifty food basket for the poverty level so the poverty level continues to … lag behind inflation.
>
> "…it's really a made-up number. It really is pernicious though because people who aren't familiar with the number who hear us talking about the poverty level, they think that's an all meaningful number... It's just an intolerably low number. Which is why when we talk about the needs, SSI standard, pegging it to SSI standard is more appropriate because that -- it should be double the SSI number. They've come up with that number in the [19]50s and now they use that number and every year it gets increased by a cost of living increase, but the underlying number has never changed. The food basket is 64 percent of that…"

The frequency and process for reenrollment and redetermination: The State Medicaid agency should examine the process and frequency for redetermination and reenrollment, particularly in the case of permanently disabled individuals. A member of the Federation of the Blind expressed frustration over going for recertification because of the lengthy waits and the potential to get "lost in the shuffle" saying, "its just too complicated to go down there and sit for 6 hours waiting to get shuffled from person to person …. If you just show up down there you just spend the whole day down there. Unless you show up at 7 in the morning. And I have to go to work; I don't have time for all that." A member of the Ohio State Legal Services Association described an instance where a client was wrongfully terminated because of delays in the caseworker contacting the recipient and then not understanding the information provided. The member described the caseworker as having "an attitude of I've got to have exactly this." The termination resulted in the client requesting a State hearing.

A member of the Ohio Job and Family Services Directors' Association said that it seemed like all the programs are on different time lines for re-determinations and, for people in multiple programs, it is very complicated. Furthermore, the member said that the application process can be different program to program but the inconsistent timelines and applications cause clients and caseworkers many problems. The member recommended consolidating application processes and redeterminations periods to improve efficiency. A member of the Ohio Children's Hospital Association recommended implementing a 12 month continuous enrollment period for children. The member said, "I think 12 month continuous would be a very, very good thing for Ohio to do for all of its Medicaid kids."

A member of the Ohio State Legal Services Association recommended creating a recertification by mail for QMB [Qualified Medicare Beneficiary] that seniors can do specifically for Medicaid. Other types of programs can accept Medicaid recertification by mail but the QMB program is not included because recipients have to show proof of income and bank statements. "Generally, recipients can mail those in to the caseworker and get recertified just for the buy-ins but if they want to keep their medical card, they've got to go down for a visit once a year." The member asked "Why can't they do those by mail? It would certainly help caseworkers administer it. Remember what this population is, that these are seniors, disabled people … People in the nursing homes. ... Why do they have to go down and meet with the caseworkers on a one-to-one basis just to sign a form? They can sign it by mail and they can send proof in by mail." A member of the Association also attributed churning (rolling on and off Medicaid) to redetermination saying, "Every six months or every year, people fall off for procedural reasons, not substantive reasons. They're still eligible. Everybody knows it. …but they've fallen off for procedural reasons….People get confused about all that. …things get lost."

Many recipients had personal stories and examples about being terminated because of complications during the redetermination process. A member of the Federation of the Blind described talking with her caseworker and dropping off the documentation required for redetermination. The caseworker terminated eligibility because she forgot that the documentation had been dropped off and did not "get around" to processing the redetermination. Another member of the Federation recommended, particularly for recipients who are blind, using an automated call system to remind recipients about redetermination appointments. The member conveyed that the county caseworkers would not tell him of the date ahead of time because "it's all automated and they have to go through the State office and the State makes the appointments for the local offices and… there was no way they could do it." In describing an option, the member said, "I get these stupid telemarketing calls now all the time where they just call and leave a message. If … [the State] could set up a system like that where they just call and say you need to call us or you need to come in for an appointment then we would know what to do and it could be programmed so that they could just have certain messages that they would leave."

Last, a member of the Universal Health Care Action Network recommended better methods for tracking the redetermination date so that advocates and recipients could tell when their redetermination was coming up and could be prepared for it. The member said it was hard to determine because "they put it in their computer a certain way, and maybe it's on the application date, maybe it's on the approval date or just whatever date that somebody puts in there…."

Management of ODMRDD waivers: The State Medicaid agency and ODMRDD should study consumer concerns about the two waivers under ODMRDD's administration and the impact that complaints and CMS studies may have on the programs. A member of the Ohio Developmental Disabilities Council expressed concerns that when individuals roll off of a waiver program, those places are not filled until the next year saying, "you have people languishing in need that could use that, but they're not available because of this [time lag]." The method by which ODMRDD

counts the use of wavier slots was also of concern because reportedly, under the current system, a reused slot causes the count of total places to increase (as opposed to hold neutral) and thereby hit the cap imposed by the waiver. A member of the Ohio Provider Resource Association commented that there is notable disparity in the way waiver programs have been set up. Under the Individual Options waiver, providers are required to bill in 15 minute increments (see ***administrative burdens*** above). The member indicated that Indiana had been under the same timekeeping system but discontinued it. Another member of the Ohio Provider Resource Association expressed concern with delays in receiving a plan of care. The member said, "Every provider in this room will tell you how many months go by that they provide services to someone because it's been mandated that they serve the person with no plan of the care… So trying to document based upon a plan of care that doesn't exist presents a tremendous problem. …The provider had no control over the authorizing document and its existence."

Options for using waivers for selected populations and services: The State Medicaid agency should study whether using additional waivers to cover selected populations would be appropriate for the State Medicaid program. A member of the Brain Injury Association said, "There are other states that have done more to help people with brain injury through Medicaid. And I know that there are some states that have TBI [traumatic brain injury] waivers and serve more people." Another member said, "You know, brain injury is one of the big three, [in terms of prevalence rates] but it's not recognized. It's up there with mental health and mental retardation…." A member of the Ohio State Legal Services Association mentioned that "One of the groups that could be covered by Medicaid is the group who is now on the disability of medical assistance, DMA program, where these are… not quite disabled because they're taking medications that keep them from being disabled…. Ohio is paying for all of this with State dollars… rather than using the waivers that might be available to try to cover those people with Medicaid dollars…"

Reimbursement Process for Federally Qualified Health Centers: The State Medicaid agency should review reimbursement rules applied to the federally qualified health centers to ensure that they are appropriate and consistently applied. This may require the Agency to modify its claims processing system. A member of the Ohio Association of Community Health Centers said that they have difficulty with wrap-around billing and being able to get the federally qualified health center rates (which are sometimes different from standard provider rates). The member said, "[To force] FQHCs to bill twice, it involves everyone having to go back to their computer systems and try to get them programmed correctly, and then try to interface that with the nightmare of dealing with Medicaid billing. …this double billing for wrap-around is just a nightmare." Another member said "I've spoken with FQHC out of West Virginia, and what they do with their managed care is that … the managed care actually pays the clinic rate. And then they get reimbursed from the State for the clinic rate rather than the fee for service rate. [W]e tried to negotiate that and we were unsuccessful with every plan we tried it with."

Services included and excluded from the program – dental, vision, and others: The State Medicaid agency should study the services included and excluded from Medicaid to ensure that they make sense and are sufficiently comprehensive to meet the expectations of the State for the program (see **organizational issues**). Stakeholders noted issues around the services that Ohio has decided to include within the Medicaid program and expressed concerns with limitations to vision and dental services. Members of the Ohio Dental Association described some of the pitfalls current dental care coverage saying, "Diabetes, heart disease, there are all kinds of links with periodontal disease now. The [program] rules were written back in the '60's before periodontal disease was even defined. It's not a covered service." Another member said, "[I]t was great that Medicaid was able to keep the partial and denture services, but …a lot of the oral surgery procedures were cut….if a patient has had their teeth removed, in order to put a denture in they would have to have the ridges smooth…. If they're not smooth, you can't build a denture…. And that smoothing …is now not a covered service…"

Use of co-payments: The State Medicaid agency should study the economic impacts of co-pays on recipients. A member of the Ohio State Legal Services Association explained that their members agree it is less inappropriate to have these costs sharing for middle income people because they can afford to pay them, whereas low income people have more difficult making co-payments. The member said, "A family of three, $400 a month. They get some food stamps but they're supposed to pay for their health care. You do the math... It just doesn't add up. People cannot live on $400 a month and then still pay a lot for health care… Comprehensive services are essential for the Medicaid program to remain meaningful…."

Reducing long-term care costs: The State Medicaid agency should work with stakeholders to identify additional ways to reduce long-term care costs. A member of the Ohio Developmental Disabilities Council remarked, "I think the time has come when you need to look at requiring a contribution from family members who want to place their individuals in expensive developmental centers [if] the family member doesn't need that intensive level of service. If they want to buy the Cadillac program, then they should make a contribution for it..." A representative of AOPHA commented on individuals paying for long-term care saying, "We're taxing a system that was built as a safety net for those people that were the poorest of the poor, to provide the services that are needed. But 76 percent of the people who are in nursing homes are on Medicaid. Why? Because we let them be. The long-term care insurance—it's a disincentive. Why would I pay a premium if I know I can get it for free at the end of the road?"

A member of the Ohio Academy of Primary Care Physicians also commented on the costs and high use of Medicaid long-term care saying, "ODJFS needs to pay for an ad campaign that you need to talk to your agent about long-term care insurance. …[Right now ODJFS is] the long-term care insurance … for a lot of these folks, and even if you had a lot of money in life, that money could quickly go, and then you would be eligible, even if you didn't purposefully divert the money." The member went on to explain, "Why would you even buy long-term care insurance when you know you can go on Medicaid? …The question is -- is the nursing home the

environment most of these individuals need to be in … many of them really need assisted living…."

Customer service to limited English proficiency recipients: The State Medicaid agency should seek out stakeholder input on customer service to non-English speakers and study methods to improve it within the Agency and sub-recipients. Several stakeholders noted gaps in the Medicaid program's communication to service recipients. Members of the Universal Health Care Action Network spoke of difficulties in getting interpreter services so that information could be understood by the recipients. The member said, "Communications with the clients don't always happen in the client's language. That's a huge problem." A member of the Universal Health Care Action Network described instances where a client and interpreter had been scheduled for different appointment times and a relative had to translate on behalf of the recipient. Lastly, a member of the Ohio State Legal Services Association said, "Translator services, interpreter services are spotty around the state. Some counties are better than others, and with today's demographics, that's unacceptable. We have to have consistent access to interpreters and translators..." The State Medicaid agency should also study the feasibility of providing interpreters through managed care companies or requiring interpreter services as part of the contract. Likewise, it should study methods to provide the same types of services under the fee-for-service model.

Updated Medicaid cards: The State Medicaid agency should study methods to provide Medicaid cards without having to print and mail new cards each month. ODJFS already distributes reusable cards for food stamps. In a number of instances, stakeholders commented on the cost to mail cards out each month. A member of the Arc of Ohio said, "I don't know how much the State spends mailing everybody this card every month. There's got to be a better way to do that. The month-to-month eligibility seems very wasteful, particularly if you're in a waiver." A member of the Ohio Podiatrists Association said, "I think we would save a lot of money by not having to send participants cards every month and give someone three months eligibility at a time." Another member of the Association recommended, "You go ahead and just swipe the thing [proposed card] on the Visa machine... Theoretically, if they were issued a card like a credit card …. If they could do eligibility that way… and electronically process eligibility, that could … be a positive."

Members of the Federation of the Blind had several comments on updating the card to work more effectively. One member said, "I get a card each month … and I want to put in a suggestion to use some sort of a card like you now do … with the food stamps. Because getting a new card and having to wait for that and figure out which envelope it is and find it and make sure I have the new one each time I go to a doctor, that's a pain…." The member remarked, "I'd like to know why it needs to change each month? What changes so often that you need to send a new one out each month and not just send one per year like the plastic food stamp card, that kind of thing." Another member said, "Well it would seem too that they could set up a system like the direction card where you could go in and download it or something and if you're eligible you're

eligible, and if you're not then it wouldn't download." In addition, a member said, "...My finances don't change. Why can't there be one situation maybe where some people could get, even for a 3 month period or something, every quarter even, or something that was updated when you recertified." A member commented on how the food stamp card had decreased the embarrassment associated with using food stamps. Lastly, a member commented on the format of the current card noting that certain typefaces are easier to read for partially blind individuals and, "The other thing that I'm wondering is on the health care card if it could be bolder and in larger point...Well normal for blind, partially blind people is 14 point. [So just a little bit larger typeface would be helpful.]"

Managed Care and Care Management

Care coordination across systems and innovative care coordination programs: The State Medicaid agency and sub-recipients should study methods to better coordinate care across systems to ensure appropriate case management for recipients. Likewise, they should study and pilot methods for care coordination that extend beyond traditional methods. Care coordination activities are conducted differently in different systems within the Medicaid program. A member of the National Alliance for the Mentally Ill of Ohio described a care coordination program for behavioral health that was piloted in Hamilton County. She explained,

> "There was, for a very brief time in Cincinnati, a program that I worked, and there were only a small number families. We called it Parents as Case Managers. It was under the FCF [Families and Children First], so it was with flexible dollars. [F]amilies having the deepest-end kids ...with multiple issues and needs... Those families came in and said, "You know, if you let us have the pot of money that you're using on behalf of our kids, we guarantee we can get what our families need and we can bring it in for a lot less." Right off the top there was $800 a month that was saved automatically because they didn't use case management services. And in every one of those cases, they were undercut by half, and the kids did better. ...And they saved the system -- I think it was almost a half a million dollars in a year's time. That was just a small number of families."

Stakeholders also commented on the impact of Medicare Part D and the absence of case managers to help people navigate the new system. A member of the Ohio Council for Home Care described instances where they had been, "...working with providers and consumers trying to help them through the Medicare D issues...."

A member of Arc of Ohio commented on the limited choices for service coordination for persons in the MRDD system. The individual said, "In Ohio ... we have one exclusive entity that can provide service coordination and service brokerage. It's the county boards of MRDD... [o]r Care Star if you're on the home waiver. ...folks don't have any need to be accountable to their client. I think it would be a huge improvement in the system, in service coordination and service brokerage [if there was competition]. .... [Recipients] should have the alternative to choose, and I think that's a premise of the federal Medicaid system." Another member said that service coordination is a problem because the boards do not communicate or process information in a

timely manner. The member went on to say, "The service coordinators are not knowledgeable. …They are not trained properly. …The State and the counties put on a training about what service coordinators should do to prepare for due processes … they came out with a training session on how … to defend yourself in case a family would appeal their denial … It wasn't anything to try to help the consumer."

Educating and encouraging recipients to adopt a medical home in a primary care setting: The State Medicaid agency should study methods to better encourage recipients to adopt a medical home (a primary care physician) and then seek means to support this through reduced churning. Members of the Ohio Academy of Primary Care Physicians spoke to the importance of having medical care being in a primary care setting: "…Our ER has come up with… a fast track so that those folks who are trying to come in and … use the emergency room as a primary care center were triaged a little differently." Another member encouraged recipients to use the Urgent Care rather than the emergency room. In some cases, referral systems were used as described by an Academy member:

> "We have a backup list, and if a patient comes in … and does not have a physician, when they leave there, they are given the name of a physician to call to become a patient, and then if it's something that needs to be followed up within 24, 48 hours, the emergency room docs will call up and say, "We have a patient here who doesn't have a doctor. Will you take them in?" …I think that's where it's going to have to start, at a grass roots level where we take responsibility for our patients in the community."

Another member went on to say, "Unless there is some mechanism that transfers a shift economically to the primary care office, whether it is an internist, family doctor, pediatrician …we still have the same thing. So unless we … fix the economic model, the shift … may or may not happen based on human behavior." Last, an Academy member shared a strategy being used in a community setting where several practices owned by the hospital system accept Medicaid patients and are paid [a salary] by the hospital rather than on a per patient basis.

Acute care environment to chronic disease management: The State Medicaid agency should continually study and seek out opportunities to improve disease management, thereby diverting recipients from acute care into a disease management environment. Members of the Ohio Hospice and Palliative Care Organization noted the importance of disease management in care delivery saying, "No one explains [chronic conditions] to the patient or the family, so it's crisis to crisis."

Immunizations: The State Medicaid agency should work with the Department of Health to study the reasons for low immunization rates within the Medicaid population, as well as barriers to physicians and pharmacists providing immunization services.

Behavioral health care service provision: The State Medicaid agency and ODMH should study utilization patterns for behavioral health care recipients and the impact of provider-centered case

management. A member of the Ohio Association of County Behavioral Health Authorities said, "In terms of any kind of reasonable appropriate oversight, I'm not sure even what we're required to do, let alone kind of push the envelope through waivers or care management or some ways. There are essentially no controls on Medicaid right now." A member of the National Alliance for the Mentally Ill gave an example of potentially wasteful utilization patterns saying, "I had a memo out of the mental health center from a director instructing every one of his therapists to see every SMD [severely mentally disabled] client at least three times a week. It had nothing to do with whether they needed it or not. [it] has to be recovery focused and it has to be focused on … what the patient needs, not what the system needs." Another NAMI member recounted the following: "When you have a case management agency, it comes with a package of services, and it's bundled. So if you don't use their psychiatrist, if you don't agree to use their therapist, if you don't use the case manager …you don't get the service. My son because of his cognitive issues will never benefit from psychotherapy…. The system paid for a really nice man to be his friend for an hour a week, a hundred dollars a week for five years….."

A member of Ohio Advocates for Mental Health explained that "…under regular Medicaid, I've got my card and I can go to any provider that will take my card and if I don't like that provider I can vote with my feet and go some place else. That's not an option [in the behavioral health setting]... A member of NAMI shared the following idea: "You give a client a mental health card that says, 'I'm going to buy my mental health care. And I've got $20,000 a year to do it.' …That's what we want here, a credit-card system that the client comes in and says, 'Guys, I need this for the family. I need this.' And let people decide. You would have a system where people would recover."

Provider credentialing process with managed care plans: The State Medicaid agency should study the various means used by managed care plans in Ohio and nationally to credential providers and identify methods that encourage provider participation. Members of the Ohio Association of Community Health Centers and the Ohio American College of Emergency Physicians discussed their concerns regarding the credentialing process being used by the managed care plans and its impact on their organizations. One member of the Ohio Association of Community health centers described it as a paper nightmare saying, "Each managed care plan is requiring each provider you have to get credentialed through them … for bigger health centers… that could really definitely be a nightmare in sending in copies of licenses, DEA cards…." Another Association member questioned why credentialing was required with the plans since they are already credentialed as Medicaid providers and "as FQHC's, we have to do very stringent credentialing of our physicians anyway, which the Medicaid managed care plans don't understand." Other members described on-line credentialing processes but also explained that there were problems in scanning documents. The on-line system also has reportedly had trouble linking providers who work in more than one practice with the appropriate practice (a particular concern for the FQHCs). Furthermore, some members were concerned about the short timeframes for recredentialing – in some cases every three months – and the fact that they were spending a large amount of time recredentialing provider group members. Members of the Ohio

American College of Emergency Physicians also had concerns about the credentialing process including reciprocity between states. Finally, members of the Ohio Dental Association and the Ohio Academy of Primary Care Physicians expressed concern with the laborious credentialing process and, especially for physicians and dentists who serve multiple counties, the necessity to credential with many (sometimes a half-dozen) plans. The State Medicaid agency should take this into account and monitor whether the process has a potential impact on access by diminishing the number of physicians and dentists accepting Medicaid recipients.

Prompt provider payment under managed care: The State Medicaid agency should periodically study the payment timeframes for providers under managed care and ensure that late or denied payments are not affecting access by reducing the number of providers willing to participate in the program. Representatives of provider groups also expressed frustrations related to Medicaid as a payer for services. Their concerns were both with managed care plans and with the State Medicaid agency's processes for paying claims. A member of the Ohio Association of Community Health Centers said, "You'd want to have that consistency. Take that back to them to say that you don't want your managed care plans to have the different statute of limitation timeframe then the actual state does. That becomes a big problem." Members described being denied then having claims rejected because they were over the managed care plan's 180 day time limit for submission. Other members described denials of up to 50 percent of claims because of claims processing systems issues.

Prior Authorization requirements: The State Medicaid agency should study the effects of prior authorizations in terms of cost savings versus potential impacts on access because of physician frustration with the process. A parent of a recipient asked, "Any way to get technology to speed that [pre-authorizations] up? You can put it through the computer and you still wait on the phone for an hour. I've waited at my pharmacist's for an hour to get my son's okay for medication. It doesn't make sense. There's a whole lot of us being tied up, not just the person on one end of the phone." A member of the Ohio Pharmacy Association described frustrations with the process as follows:

> "The problem I have or concern that I have is in the process of prior authorization. …To me it's not saving dollars. In my perspective, it's cost shifting... The pharmacist is going to have to spend more time calling the physician up, telling them this product is not covered … …His nurse has to type up a letter, fax it in and get an authorization. [Are] the physician and his support personnel getting paid for this? Are we getting any paid extra for this? What type of savings is involved? What was the total savings to the State? …The physician, his nurse or staff, their time involved, the pharmacy and their time involved, and then nothing's coming through. …. And it's great that there is a system and process, but time is definitely money."

Members of the Ohio Association of Medical Equipment Services had the following to say about prior authorizations, "The only items they are looking at in any kind of prior authorization is a high-ticket item which are usually customized items and stuff like that." And, "Across the system, what percentage of our resources are spent on prior authorizations? How many dollars

across the state are tied up? It's an amazing number." Also, "That would be nice if there was an emergency rush-through process." One association member said, "We need more of the electronics, and I think the prior authorization process should be adjudicated online... ...And technology is there where we could do it through the pharmacy." As well as "we all have had managed care plans drop their PAs [prior authorizations] because they realized they were spending more money administering it than they were saving." Finally, members commented:

> "How many claims are they actually denying for lack of medical necessity? I've always argued that for an oxygen recertification -- nobody gets on oxygen and gets better. You still need it or you die. If they're not recertified and we didn't submit it, it's because they're not here anymore. So all of that time and money spent on recertifying oxygen patients, they don't get better and go off of oxygen. It's just a huge waste of time and money."

Access, outreach, and contact in rural areas: The State Medicaid agency should study the concerns and suggestions of providers and local boards on access, outreach, and serving rural recipients. A member of the Ohio Association of Area Agencies on Aging stated that there is a lack of sufficient ability to do outreach." Another member said that the turnover rate for home health aides is very high, in both rural and urban counties, and they are expensive to train. Turnover was attributed to low wages, no benefits, and the demanding work. A member of the Ohio Family Services Council spoke to a shortage of social workers saying, "I think we're seeing a shortage of people going into the counseling and social work profession because of the productivity and because of documentation. They're going to private practice... where the documentation, may I add is nothing. ...They're not going to take the Medicaid client."

A provider serving members of the Brain Injury Association commented that "If you're not getting services through a community mental health center, you have no access to services from a psychologist. ...The big problem is, our patients, our clients, do not fit that model, and we are constantly struggling to write goals, to write objectives, to try to document the need. ... People with Medicaid are [not getting] psychological services in an appropriate setting..." A member of the National Alliance for the Mentally Ill said, "The availability of psychiatric coverage is going down ... [there is a] lack of psychiatric coverage and one of the things that we are asking for right now in a rule change is, telemedicine. We really believe that ... talking to somebody ... with a psychiatric nurse or therapist ... would be a good thing to do."

A member of the Ohio Academy of Primary Care Physicians also brought up the benefits of telemedicine for providing services in rural areas:

> "You might want to consider for rural areas paying for telemedicine services. Some services lend themselves to telemedicine. ...I mean, it costs a lot to put a patient in an ambulance to take them to a doctor's office and then put them back in the ambulance and take them back. If you could do that by telemedicine, it would save an awful lot of money. Some of these nursing homes are across the street from the hospital, and they have to take an ambulance to go across the street. It cost a fortune."

Technology

Prompt and accurate eligibility information for providers: As several stakeholders discussed difficulties in obtaining accurate and timely information on Medicaid eligibility, the State Medicaid agency should examine methods to improve eligibility information in conjunction with the CRIS-E update to occur in the next four years. Out of date eligibility information results in payment problems and added administrative costs to the system. Provider groups also noted the benefits in obtaining limited service history information to better assist recipients. A member of the Ohio Association of Community Health Centers said, "It seems to me that you can get online anywhere and find out who is eligible or not eligible with insurance companies…but with Medicaid eligibility it's awfully difficult to do that … it just seems to me there ought to be a T-1 line that you can tie into and very quickly determine if people are eligible at any particular time…Or even a web portal." Another member said,

> "We do patient eligibility … at the front window at their appointment time when they are checking in and it has helped us dramatically. I have a 1-800 number and they let you know if they are eligible just for Medicaid or for the managed care plan…. The only problem is if you don't have a number and you are trying to verify by social [security number] and date of birth and the patient has more then one billing number…then you actually have to speak to someone. I also have occasions where the system is down and it says that they are too busy or something is going on, but other than those two problems it works pretty well."

A member of the Ohio Children's Hospital Association noted, "It would be great if we could get a CRIS-E terminal at the hospital … [Y]ou know, we have these little terminals that can get just their Medicaid number, but you can't see all that stuff behind it that the third party recovery folks [who] signed [the person] up for Medicaid would know, if there was a third-party payer…." A member of the Ohio Dental Association suggested, "Getting eligibility …off the internet would be helpful, so they could determine if you have had this service, and you only get it so often and that they can determine that without having to call the voice response system … [a]nd all of the information isn't always there…. [Some] HMO's, have that capability." Another Association member said, "…You would think with a service if it should be denied, it's denied at the front end…Almost all of the insurance carriers will give [that information] to you now through a website. Some of the newer software you can go directly to a clearinghouse and grab eligibility information, last x-ray date, last prosthesis date, that sort of thing right off of their database -- all HIPAA compliant …" Finally, a member of the Ohio State Medical Association commented,

> "…Many of the recipients either don't know whether they are covered or actually think they're covered when they're really not. …Then the doctor sees them and bills them and finds out that they are ineligible. It's a tremendous waste of time and money for the whole billing process. There needs to be a very easy process whether it's traditional Medicaid or the Medicaid HMO's to check eligibility and not just find out eligibility but if there are any kinds of co-pays or deductibles ….There are a lot of practice management systems out there that have all of the patient information. So Ohio Medicaid needs to have an open architecture so that the practice management systems can actually go and check eligibility -- just have an automated process instead of having to double key."

Current third-party eligibility information: The State Medicaid agency should study methods to improve third party liability (TPL) coordination and ensure that providers can obtain timely and accurate information on third party liability. This helps inform the provider if there are other sources of coverage that should be billed before Medicaid. Without current TPL information, providers may serve recipients and bill for charges that should be covered by a commercial insurance carrier. The State Medicaid agency should study ways to improve the interface between the Support Enforcement Tracking System (SETS) and MMIS, as well as ways to improve the timeliness of medical support order information in the system.

Streamline communications with recipients to make the process easier to understand: As stakeholders discussed opportunities for using technology to improve communications to Medicaid recipients, the State Medicaid agency should examine its current range of communication products and study alternative methods of communicating eligibility, redetermination, and other information to recipients. Opportunities may exist to streamline communications to recipients who might be enrolled in more than one public assistance program. Likewise, the State Medicaid agency may be able to better gear its communications to certain reading levels. A member of the Ohio State Legal Services Association commented, "All the notices, approval[s], denial[s] are sent out separately, so, in our improving on technology, if there could be one list saying you're approved for this, you're denied for this…. If those notifications consolidated, just like the application is, that would save [dollars] administratively and the consumers would [better understand the letters]." Another Association member said, "If you're being denied, you need to know that you've been considered for all eligibility criteria for all categories. So if the smart computer system could say you're approved for Medicaid or you've been denied under these headings…" Finally, a member of the Ohio Federation of the Blind remarked, "Sometimes I get two and three letters of the same thing. …They're wasting a lot of paper and time generating letters … [and] some of them aren't even necessary or applicable."

Opportunities to increase the use of technology in Medicaid direct care: Growing the use of technology in providing direct services was highlighted as a need by many stakeholders. Areas discussed included implementation of electronic health records (see **technology** section), gathering data for monitoring quality of care provided, providing patient education, and using Smart cards to capture treatment information. The State Medicaid agency should examine these and other items in future planning on technology relevant to the Medicaid program. A member of the Ohio Council of Behavioral Healthcare Providers suggested the need to "…get good information to support decision making even within the provider agency. The ability to integrate your financial [records] with your demographics [records] and your clinical records. …If you can get computers into people's hands to help support the clinical decision making, there are all kinds of resources available to help physicians make drug decisions." A member of the Ohio State Medical Association said, "Claims data is a very poor way to approach this [pay for performance]. But up until now, it's been just about the only way that a managed care company or really any payer can approach that…because claims data is really about the only measurement

that we have that is easily retrievable without an electronic health record." The member continued, "If you want to measure true quality outcomes … [t]hose quality indicators under current claims data systems just simply can't be tracked with any ease at all … Those data points [in electronic health records] would then be searchable and easily retrievable." The member concluded that electronic health records would help physicians move to meaningful care management. A member of the Ohio Council of Home Care discussed assessment tools for home health nurses and new technology in use in some agencies. The member said that some agencies were using palm pilots for on-site work and downloading the data when the nurse returned to the office. According to the member "monthly, [its] uploaded to the federal government …that data has been used to identify outcomes of home care and which agencies are doing a better job than others.

A member of the Ohio Council of Behavioral Healthcare Providers recommended giving nurses laptop computers to improve patient education saying, "Give them a computer and a printer and connect them up to WebMD and they can get the current medical information in layman language that they can have printed out and handed to the patient." However, the member said that these technologies require an investment. Finally, a member of the Ohio American College of Emergency Physicians commented,

> "The smart card[3] concept makes sense, because a lot of people don't know what's wrong with them, what medications they're on. …An electronic medical record …You can … go through and scan … a problem list or a medication list. But there are difficulties inherent with a lot of these… electronic processes…. I mean we find patients that come in, that use their brother's card, that use their neighbor's card, and so forth… This is a true medical care problem.

Availability of data on the Medicaid program: Stakeholders spoke to difficulties obtaining information from ODJFS regarding the Medicaid program. The information could be used for service provision or to examine the nature of the program to identify potential improvements. As this concern was raised by many stakeholders, the State Medicaid agency should study the data needs of stakeholders and sub-recipients and apply this information to updates and upgrades to its information systems and data warehouse. A member of the Universal Health Care Action Network said, "A lot of our proposed policy initiatives get blocked by the inability to get the data necessary to cost it out. …I don't know that it's personnel or understaffing as much as it may be an antiquated system. It's very hard to query the system to find out, for instance, how many limited-English-proficiency people on Medicaid are there..." A member of the Ohio Dental Association made a similar comment saying, "The House brought up that the State's computer

[3] A smart card is a plastic card embedded with a computer chip that stores and transacts data between users. This data is associated with either value or information or both and is stored and processed within the card's chip, either a memory or microprocessor. The card data is transacted via a reader that is part of a computing system. Smart card-enhanced systems are in use today throughout several key applications, including healthcare, banking, entertainment and transportation. There are a number of potential uses for smart cards in the health-care industry, including secure transactions that verify insurance coverage and benefit eligibility for individuals, as well as their identity.

system is antiquated. You cannot get real-time data out of it. …They need real-[time] information..." A member of the OHP Executive Leadership Committee commented on the system's inability to identify which bills meet spend-down requirements.

Limitations in sharing data among program administrators: There are multiple levels of entities responsible for administering different programs within the Ohio Medicaid program. The use of State, county and regional entities to administer the program, along with the need to communicate data to the federal government, raises concerns about the fragmentation of the data, the ability to share information between parties. The State Medicaid agency should examine the data needs of the sub-recipients and local administrators and seek to factor this information in to design requirements for its Medicaid-related information systems. Some of the comments made by stakeholders are as follows:

> "We have no way of reporting address changes to anybody to fix them so you continue to send mail and get 20 percent of it back. We've just got to tell the member, "Go to the county and tell the county…Then when we get the new file, if we changed it in your system, it gets overridden. So now we have the same incorrect information yet again. It is a nightmare system…."
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> *Member, Ohio Association of Health Plans*

> "…The federal rule that came down said that the information that they're collecting on wage data [in SETS] cannot be shared with any other part of the county, for example, Job and Family Services wage data. So we are collecting [wage data] for two, separate computer systems and we can't share. If the County Department of Job and Family Services knows that a dad who owes child support [and] just got a job, we can't automatically share that information…. It's called Federal simplification. It's not always at the State level where we are encountering these problems…. And there have been situations where we have been told there were federal restrictions and when we looked more closely, they weren't that clear. It was more of a very … [s]trict interpretation … or very biased in one direction [of] interpretation."
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> *Representative, County Commissioners Association of Ohio*

> "[W]hen it comes down to the report driver at the local level, it allows you to go in and enter specific characteristics or statistics on search populations. Oftentimes if we want to deal with a group of individuals, whatever the program, we have to inform the State. They have to go in and see if that reporting tool is available; if not, create that report. It could literally take months…."
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> *Member, Ohio Job and Family Services Directors' Association*

Standardized provider numbers: Members of the Ohio Pharmacists Association spoke of difficulties getting provider numbers of prescribing physicians. The move to national provider numbers, which is underway, may help alleviate this problem. A member of the Ohio Pharmacists Association remarked, "[Provider numbers are] still sitting on microfiche …by the time you get it out and you set it up, turn it on, plug it in,…and you go through trying to figure out from that microfiche which one it is and put the number in there, you may as well not bill the prescription. They could easily put it on CD ROM, send it to the pharmacies, even twice a year, you would have 90 percent, maybe 99 percent. ....But they won't send it and they won't actually put it on the website where you can access it."

County boards of MRDD entering Individual Service Plan (ISP) and claims information in PAWS: During stakeholder interviews, concerns were raised about ODMRDD's payment authorization system PAWS (See also **technology and program management** section). The PAWS system contains the authorized services which are used to adjudicate provider claims. Members of the Ohio Provider Resource Association expressed concerns over the increased length of the individual service plan and its link to the payment authorization form. Some providers noted that the two were not always consistent. A member said, "Now, [the ISP] doesn't authorize services, and sometimes they don't match. But you don't find out until after the fact …" Finally, a member said, "[OD]MRDD did their own review of PAWS… and they found disparities all over the board. Some counties are very good once the ISP is done, which could take a long time … the average was …317 [days]…[we] have 330 to bill…"

Program Integrity

Relationships between Medicaid agencies and providers: During the course of the audit, many providers spoke of wanting a sense of partnership with the Medicaid program and greater sense of involvement. The participating Medicaid agencies should study the manner in which agency representatives interact with providers and examine opportunities to increase agency/provider collaboration. A member of AOPHA noted, "There are rotten apples everywhere, but we ought not have a system that treats everybody as if they all were a rotten apple." A member of the Ohio Coalition for Healthy Communities echoed this sentiment saying,

> "The assumption is that everybody out there, at least a significant portion of people out there, are committing fraud, waste and abuse. And that's the mentality, the approach …It's very damaging in terms of perception of the public and the perception of the people that receive the funds. I don't know if there's a way of turning it around, but I think that is one of the crucial things that is problematic in this whole relationship."

A member of the Ohio Association of Medical Equipment Services asked, "How do we get them to understand that we want to be business partners? I know all of the legitimate businesses, not just in our industry but in any industry, always want to have a business relationship that works for both ends…." Another member of the Association said "Isn't SURS and the Department …and everybody else all supposed to be working together as opposed to working against [each other]? …When you go to SURS or another auditing agency, you are guilty until you can prove yourself innocent." Another member remarked,

> "What came out of it [OIG report] was the media had articles all over Ohio in newspapers saying that providers were crooks. The whole message was completely lost ... it was like, you're putting people out of business and you're saying, "Oops, I might have made a mistake in one of the investigations."

A member of the Ohio Council for Home Care remarked, "if [agencies are] doing stuff wrong, we want them prosecuted, too, because we try to make sure that our members are doing what

they are supposed to do and following the rules as they are set up, and I think for the most they do a good job of that." Another member summed up the concerns saying, "[A]s a professional person and as a provider I feel like I'm just being looked as … just perpetrating fraud… [T]here are no honest mistakes. There is no misunderstanding. That we are all out there just thieving and stealing, and that offends me…."

Communicating ODJFS program integrity activities and following up on stakeholder-reported incidents: As described in the report, the State Medicaid agency can implement several recommendations to improve its program integrity-related activities. In conjunction with improving activities, it should study methods to improve communication of its efforts and the changes to stakeholders and ensure that stakeholder reports of fraud are acted upon. During interviews, stakeholders expressed concerns about certain program integrity-related functions. A member of the Ohio Association of Area Agencies on Aging commented that ODJFS poorly monitors programs and providers. A member of the Ohio Dental Association commented that the definition of medical necessity was occasionally abused and asked that ODJFS "put it in writing for everybody. …It's medically necessary if we deem it necessary, and it should stand up to peer review not to some selective arbitrary criteria that a person on [an audit] looks at." A member of the Ohio State Medical Association said that, while OSMA and the AMA agrees physicians who commit fraud should be punished, the State Medicaid agency must ensure that its audit and appeal process are fair. The member related the following story:

> "Apparently, the physician had previously written to ODJFS asking about the review of their practice and didn't get a response so they asked for reconsideration and they had some very specific questions about the review and the manner in which it was handled.
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> The practice asked for … [the] review sheet that the reviewer used, which they were not provided or they were denied because they wanted to know what was the basis for saying that they didn't meet the requirements. They felt that they were in compliance with CMS guidelines and they wanted to see [if there] was there some other standard being used. And apparently [they] had not been able to get that as of yet…
>
> There was no communication for over a year, and then when they did hear from them, they had only 30 days to respond with either an appeal or refund… They want to have a fair process so they know specifically what the charges are against them or where they deviated or who is reviewing it and can they have an opportunity to challenge it."

Program integrity activities conducted by the State sub-recipient agencies: Concerns about program integrity activities on the part of the Medicaid sub-recipient State agencies and their local administrative entities were numerous. Stakeholder comments about these functions included the following:

> "...You have someone that comes in and ... reviews your records, who has not done therapy forever...and is judging people who are senior clinicians... and they're kicking out [claims] because it's not medical necessity. There is something wrong with that...when the county comes in and looks at it, and the review [is not conducted by professionals]...."
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> *Member, Ohio Family Services Council*

> "It's in a State rule... [in] which [authority] is delegated to boards. But there is no consistency across the State in how that's carried out, and that's particularly troubling from a business perspective, efficiency point of view for providers who ... [provide services] in different counties, and they run into very different systems...it should be very consistent"
>
> *Member, Ohio Council of Behavioral Healthcare Providers*

> "...There are no rules [on audits] anywhere, so as a business I have no idea what the ground rules are that I'm operating under."
>
> *Member, Ohio Council of Behavioral Healthcare Providers*

> "...I have four different ADAMH boards that I go to, they come and audit me four different times, in four different ways. ...it seems like there has got to be a savings there if you didn't have to come and do it four different times. Do it one time.... ...Maybe that should be a State function. That could be a savings in money because I'm not the only one. I'm sure there are others in the same boat that I'm in. [Another participant indicated that he works with several boards]."
>
> *Member, Ohio Family Services Council*

> "We have [to say] ..., "I'm in X county today so this is the way I have to write medical necessity for X. Now, I'm in Y county and this is the way I have to write medical necessity ...." There [is] a lot of subjectivity to those audits..."
>
> *Member, Ohio Family Services Council*

The role of local agencies in program integrity: Once the General Assembly determines the most appropriate program structure, the State Medicaid agency should study opportunities for the local agencies to participate more fully in program integrity activities in a consistent manner. A member of the Ohio Association of County Behavioral Health Authorities commented that there was a concern that the county agency was legally required to pay Medicaid claims, even when the claims appeared fraudulent. Another member recommended using the Medicaid claims processing system to identify high cost recipients and allowing county agencies to apply case management principles to those recipients, thereby reducing costs. In addition, a member commented, "Community Behavioral Health Authorities can put no limits [on services] and we have no real clinical oversight and that's balanced with really no utilization review in our system to even look at the extreme outliers, so we're kind of stuck with, if they're at the door, they get seen. We pay irrespective of the level of clinical need." Finally, an Association member concluded,

> "What's our liability as the ones writing the check, when we're not the one that signs the contract with the single state agency? [But b]ecause of litigation and weird politics that the Boards have raised ... the response has been to pull even the little bit of authority we have away from us."

A member of the National Alliance for the Mentally Ill of Ohio stressed that, "There is no oversight … which I think is crucial, absolutely crucial. [The county behavioral health boards'] planning, their funding, and their evaluation are watered down to where they have become basically … pass [through agencies]..." Another member referred to the conflict between federal Medicaid law and Ohio Revised Code saying, "The boards cannot evaluate because the minute they start evaluating or they want to talk about something like, "Why are you seeing Joe Smith four times this week?" The agent says, "Get off my back. This is a Medicaid claim." The member concluded his remarks saying, "You have absolutely no say into duration, scope of services, or anything because the law doesn't provide that. It provides that to Job and Family Services through federal mandate and they really have washed their hands of the Department of Mental Health."

A representative of the Ohio County Commissioners Association stated, "The worst part of dealing with provider fraud is that sometimes you can't get rid of them. They have the fraudulent claims and it takes you two years to get them off of the program."

Impact of any willing provider on program integrity: During the course of the audit, stakeholders expressed concerns with the any willing provider requirements and its impact on agencies' ability to perform effective program integrity. A member of the Ohio Council of Area Agencies on Aging remarked that the "any willing provider" language leads to a bureaucratic hassle requiring agencies to register those unlikely to be good providers and those with past problems. This leads to an increased potential for fraud. Ultimately, the rules protect the provider, not the consumer. A member of the Ohio Association of County Behavioral Health Authorities remarked, "[The] notion of selectivity, who you do business with can also have a lot to do with it. [We] need to incentivize good, low cost providers -- incentivize them to take entrepreneurial risk to build for greater capacity. You could push a value agenda and try to create some value if you had the ability to pick and choose.

Known problems within the MRDD waiver services: The State Medicaid agency and ODMRDD should collect information on known problems within the MRDD waiver programs and act to rectify them. Members of the Ohio Provider Resource Association commented on the dual licensure procedures and requirements to provide care without a plan of care from the CBMRDD. Member concerns were also highlighted regarding consistent answers to provider questions. "It's not just that, it's also because of the lack of clarity around service definitions and what happens when there are various combinations of services occurring at the same time. The Department has actually given us documentation … they've given us answers to questions in writing on their website that conflict with the federal waiver document…." A member stated:

> "[W]e have been operating these types of waivers in Ohio for 15 years and these have been a problem since the beginning. And regardless of… the efforts from JFS or from ODMRDD or whatever attempts have been made, these are still not in compliance. They are being watered down. The feds are being provided documentation by the State Department saying here's what we're going to do. But… [providers are] experiencing nothing different than they have all along.

> The conflict of interest, the State-wideness issues, all of those things … creates significant barriers to Ohio being able to meet the federal requirements for waiver services…."

Cost report reconciliation process: In addition to audits, ODMH and ODADAS are cost-based reimbursement systems so there is a reconciliation process that occurs to ensure that the rate paid was reflective of the actual cost. The State Medicaid agency, in conjunction with ODMH and ODADAS should study the process in place and its impact on providers. A member of the Ohio Coalition for Healthy Communities raised the issue that "[I]t is a cost-based system and you are required to pay back any overpayment, [but] you are not made whole for services that are provided where you were underpaid, and that's an issue…." The State Medicaid agency should examine this process to determine if it meets the expectations of the State.

Gaps and overlaps in program integrity system throughout the program: During the course of the audit, stakeholders identified what they perceived as overlapping and contradictory program integrity-related activities. Gaps in the program integrity systems were also identified. Some stakeholders questioned the efficiency and effectiveness of the program integrity efforts in place in Ohio's Medicaid program. Once the recommendations for improved program integrity have been implemented and the General Assembly has selected the program organization, the State Medicaid agency should examine stakeholder feedback to ensure that any remaining gaps or overlaps are resolved. A member of the Ohio Academy of Nursing Homes explained, "…The more departments, the more people, the more organizations, the more bureaucracy you have and the less efficiency [it is]..."

Members of the Ohio Association of Area Agencies on Aging and PASSPORT directors said that the provider certification process for their system was too loose. They also mentioned that the fragmented eligibility process and siloed care process allows redundancy and gaps in the system. Finally, they mentioned that adult protective services are given little attention in relation to other county-level DJFS functions. Other stakeholder comments included the following:

> "I think the departments all have fraud units…. But it's a little bit difficult because … the Attorney General's office has been involved in collecting Medicaid overpayments, and the counties have been involved in it, and sometimes it crosses. And there probably needs to be better coordination there."
>
> *Member, Ohio County Commissioners Association of Ohio*

> It seems so redundant to have to continuously adhere to all of these other groups [agencies within the state] and their surveys [in addition to federal requirements]. And then on top of that if you happen to be …accredited …you're dealing with that too and that's something you're paying for especially with a hospital-based agency. …I don't think anybody expects not to be surveyed. We are in a regulation-imbedded business. It's just the overlap, the redundancy…."
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> *Members, Ohio Council for Home Care*

> "The documentation requirements are different, depending on which system you are in …that certainly becomes an issue in redundancy of some of the documentation. You can't use the same information for one system that you use in the other system, so it is not even something you can duplicate. You have to get entirely different data."
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> *Member, Ohio Coalition for Healthy Communities*

> "You get the conflict where the two agencies [ODJFS and ODH] will take a different opinion or interpretation and the [nursing home] facility is left in middle. …If I do that to make you happy, I'm now not consistent with the MDS manual and not consistent with the Department of Health… [We] would like to see them together when they are talking about regulations."
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> *Member, Ohio Health Care Association*

Lack of timeliness in completing audits: A significant concern raised by providers was the delays in getting audits completed, regardless of the type of audit. The State Medicaid agency should study the current timelines and examine their effectiveness. A member of AOPHA commented, "It's three years beyond adjudication if I'm not mistaken. [And] once the audit is done you can request an exit conference and that can go on for years and years and years, that request." A member of the Ohio Association of Community Health Centers also remarked, "If you look at the timing of their financial audit, we currently have their auditors coming in to audit us for 1998. That's a little ridiculous when you start talking these lengths of times to get out and do financial audits. So …that should be done in a two to three year span at best. We can't keep these records forever..."

Suggestions from stakeholders to improve Medicaid program integrity: During the audit, stakeholders had several suggestions for improvement in program integrity and program performance. These included adopting a process similar to that used between Medicare and the Joint Commission where providers can choose to have a separate Medicare survey or have the Joint Commission perform the Medicare survey. In the area of reconciliation, the Medicare program process of annual reconciliation was mentioned and the stakeholder said that overpayments and underpayments are reconciled. A member of the Ohio Association of Medical Equipment Services recalled a process used by his Association saying that the regional representative meets with the Medicare administrator to field Association questions. "We really have a quality set of questions that go in. And then the providers have the [answers] in writing, in an official capacity versus something someone told them." Other ideas proposed included the following:

> "…Years ago we went through a short period of time where there was feedback to the customer as to what was expended on their behalf. That was a kind of a program integrity [process]: Well, did the dentist bill you twice? Did you actually receive this service? Was there something going on? And that melted away.... …It would be a significant step in the direction of connecting people with the program, and …my sense is that many customers would do a heck of a lot of cost containment on their own if they realized what the costs were….."
>
> *Member, Ohio Job and Family Services Directors' Association*

> "[M]aybe institute a secret shopper system type of service where they actually have credible information that they can study better and they will actually believe the individuals themselves. In other words, have a secret shopper program to give them more information that they don't think they're collecting right now."
>
> *Member, Ohio Developmental Disabilities Council*

Unclear and conflicting standards: During the course of the audit, stakeholders frequently voiced confusion and frustration regarding the standards for which they are held accountable. The State Medicaid agency should examine the feedback from providers on the standards in place, and educational and information materials provided by the agency. A member of the Ohio Association of Medical Equipment Services commented that the Association had asked ODJFS to write down answers to their questions and "in all fairness to them [ODJFS] sometimes they need to go back and sometimes it takes research, sometimes it takes legal counsel; sometimes it takes actually accepting claim information or whatever. But …it was nine to ten months before we had the answer." A member of the Ohio Academy of Nursing Homes voiced the preference that the "State would say, "Here is what everyone is going to do," and survey us on whether we're doing it or not rather than surveying us on whether we're doing what we think is best for our residents and telling us we're wrong when it's working." Another Academy member elaborated on the required plan of care and how, on occasion, a State survey team will determine that the plan of care does not meet the intent of the regulation. In cases where a facility has hired a consultant to develop a template, the problem then extends to all of the facility's patients. In some cases this results in a fine, in others, the citation is publicly reported. The member continued,

> "So then we'll come up with a format that they suggest that has been proven out in other states, other cities, your neighboring nursing home or whatever. You redo everybody's plan of care… it's a huge expense; redo everybody's plan of care. The survey team will come in a couple of months later and say, "Perfect. Now you are on track." A year will go by and another survey team will come in, maybe from the same district office, and they'll say, "You know, this plan of care, it does not meet the intent of regulations, doesn't really specify the needs of these residents. This whole format is flawed. So you might go through that same process again. And this has happened to me several cycles, until finally one survey member said to us, "You really can't listen to us. You really have to just put your foot down and say, 'No, this works' …"

Other stakeholder comments included the following:

> "I think a troubling trend that we are starting to see as it relates to ODMRDD and ICF is they're suddenly starting to write rules for us. We have federal regulations about this thick for an ICF/MR program. They are now starting to write rules that we would see as in conflict with our federal regulation."
>
> *Member, Ohio Provider Resource Association*

"...A medically necessary procedure...it's not defined in the rules. That's what needs to be put into writing, things like that. ...It's up to the Medicaid officials. That should be defined. It should be in the manual. ... For the kind money they spend, the [parameters] should be spelled out much better. Here's what is covered. Here's what is not covered. If you cross the line, then you're subject to audit and you're subject to penalties and so forth. ...We don't have a well-defined dental program and well-defined dental criteria. The rules were set down in the late '60's, early '70's, and nothing has ever been updated or changed or clarified."

Member, Ohio Dental Association

"... [The] doctrine of medical necessity comes up and it's not well defined.... It depends on which examiner looks at it on any given day and what mood they are in when they look at it."

Member, Ohio Dental Association

"There are many times that the program doesn't provide enough information, doesn't give you a response to your questions, or penalizes you when you make your best judgment as to what is appropriate or they simply don't agree with what basic clinical guidelines say is appropriate medical care. [Program integrity] money is better spent in education and communicating with the physicians and giving them accessible information so that they can know what to expect or what the standards are, and having someone that they can reach for technical assistances if they have a question."

Member, Ohio State Medical Association

"[T]ell me for sure this [waiver service] will pass audit on how we documented this, because I really don't know how to document this nor do we know how to train our staff to do it." We're providing these services, we don't know if we're going to get paid for them. ...we have no protocol ...we've had no training, no template.... Because waiver services are a fee-for-services program under the federal regulations, the audit is on the claim basis, and the claim basis is based on did the service occur or not, which documentation, and the documentation has to match the authorizing document."

Member, Ohio Provider Resource Association

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A-1 RESOURCES

Appendix 1: Selected Resources

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- University of Cincinnati Institute for the Study of Health and the College of Pharmacy
- Ohio Attorney General's Office
- Ohio Department of Aging
- Ohio Department of Alcohol and Drug Addiction Services
- Ohio Department of Education
- Ohio Department of Health
- Ohio Department of Insurance
- Ohio Department of Job and Family Services
- Ohio Department of Mental Health
- Ohio Department of Mental Retardation and Developmental Disabilities
- Ohio Office of Budget and Management

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Appendix 2: Summary of Objectives

Summary of Objectives Table of Contents

Organizational Issues

The following questions were used to evaluate the Ohio Medicaid program organization and selected functional areas:

- **High Performing States and Organizational Arrays:** Which state Medicaid agencies demonstrate high levels of efficiency and high levels of performance as it relates to efficiency, quality of care, access to care, and compliance with federal requirements? How does this compare to the current structure and performance of Ohio Medicaid?

- **Legal Barriers and Challenges**: What legal barriers at the federal level may impede efficiency in Ohio's Medicaid Program? What legal barriers in Ohio Revised Code and Ohio Administrative Code may impede efficiency and program design changes?

- **Funding Structure and its Impact on Costs:** How do Ohio's historical expenditures for Medicaid compare to trends nationally and in other states? Is the Ohio Medicaid Program funding structure conducive to long, moderate, and short-term organizational planning? Does this structure represent a material barrier to reorganization initiatives?

- **Culture and Leadership of Oversight Bodies and Medicaid Administrating Agencies:** What is the relationship between political oversight bodies and Medicaid agencies? Is there a clearly stated "role' for Medicaid as defined by political oversight bodies or state agencies? How divergent are the definitions of the role of Medicaid? How does the leadership and culture of participating Medicaid agencies promote responsibility, accountability, and transparency? How well do the current reporting structures meet operating environment challenges?

- **Short-term and Long-term Planning and its Impact on Medicaid**: How effective is Ohio's short and long-term planning in the area of Medicaid? What process does Ohio's State Medicaid agency use to establish Medicaid policy and practices? How well do Medicaid strategic plan(s) address the external and internal environment facing the administrating state agencies? How well does the Medicaid plan address stakeholder (sub recipient agencies) and population needs and expectations? Are Ohio Health Plan's programmatic changes guided by clearly prioritized goals?

- **Organizational Effectiveness:** Does the current organizational structure promote an effective and efficient Medicaid program? Does the current structure facilitate quality services based on federal reviews? Does the current organizational structure provide sufficient control and authority for coordination? How should the organizational structure components be organized to best administer the Program?

- **Supporting Functions:** How effective are Ohio Health Plans' supporting functions, such as human resources management, budgeting and management reporting? Are OHP's operations monitoring and feedback mechanisms sufficient to make good public policy? Does OHP appropriately manage the technical and analytical skills of the workforce responsible for Medicaid Program implementation and monitoring to ensure appropriate oversight and responsiveness? Is management information used for decision-making within Ohio Health Plans and the sub-recipient agencies? Does the performance measurement system have mechanisms that allow the General Assembly, the Governor, and State agencies to comprehensively review operating results and costs?

Medicaid Service Provision

The following questions were used to evaluate aspects of Ohio Medicaid program services:

- **Services Provided Under the State Medicaid Program:** How do the services covered by Ohio compare to the minimum required by federal rules and those offered in other states? What cost does Ohio's Medicaid program incur for additional/optional programs offered above the federal government floor?

- **Eligibility and Cost Sharing:** How does Ohio's eligibility process compare to federal requirements and practices in other states? How is this affected by Ohio's status as a 209(b) state, and how does this affect Medicaid buy-in programs, and premium assistance programs? Would cost sharing, such as implementing co-pays for pharmacy benefits and some selected health care expenditures, improve cost effectiveness without negatively impacting the health of poor and disabled Ohioans?

- **Long-term Care Eligibility and Estate Recovery:** How do Ohio's eligibility process for long-term care and its estate recovery policies compare to federal guidelines and other

states? How should Ohio consider addressing long term care admission of people diagnosed with mental illness other than dementia? Are there barriers to recovering assets that Ohio can overcome? Is there an effective model for Ohio to follow in estate recovery?

- **Long-term Care Utilization, Funding, and Costs:** How does Ohio's service provision for long-term care compare in efficiency and effectiveness to other states? How does access compare to other states? How do utilization rates compare to other states. How do costs compare to other states and national averages? How does Ohio's reimbursement of long term care services compare to other states?

- **Certificates of Need:** How does Ohio's use of certificates of need compare in efficiency and effectiveness to other states? Does Ohio effectively use certificates of need to apportion long term care services throughout the state? Could expansion and better control of certificates of need improve cost effectiveness and service delivery? Is certificate of need effective in controlling expenses and reducing costs to Medicaid?

- **Medicaid Prescription Drug Program:** How will Ohio's Medicaid prescription drug program be affected by Medicare Part D and how does its program compare to best practices? How does Ohio's prescription drug program design (co-pays, use of generics) compare to other states? Does the use of a preferred drug list and rebates improve the cost effectiveness of the prescription drug program? How does Ohio's use of mail-order programs for maintenance drugs compare to other states? How does Ohio's medication therapy management program compare to other states? How does Ohio's bulk purchasing compare to other states?

- **State Plan Waivers and Waiver Expansion:** Does Ohio effectively use waivers and could expansion of waiver programs enhance service delivery and cost effectiveness?

- **Rate Setting Processes and Alternative Reimbursement Methodologies:** How should Ohio approach rate setting to ensure that the system is cost effective while maintaining client access to medical services? How does current ORC language impact rate setting, particularly for long-term care facilities? Could Ohio use alternative reimbursement methodologies to enhance the cost-effectiveness of the Medicaid program?

Managed Care and Care Management

The following questions were used to assess key components of managed care and care management within the Ohio Medicaid program:

- **Medicaid Managed Care Implementation and Effectiveness:** Is managed care an effective model for delivering health services to Medicaid recipients? Are there

advantages and disadvantages or national trends that Ohio should consider when implementing full-risk managed care for Medicaid? How does Ohio's managed care compare to other states? Are there other alternatives to using managed care arrangements to serve the Medicaid population? Are there other program types being used to provide services to Medicaid recipients in other states? If so, what are these programs and what is known about their effectiveness?

- **Managed Care for High Risk Populations in Medicaid:** Is Ohio's plan to enroll all covered families and children and some portion of the aged, blind and disabled population in managed care consistent with recommended practices? What populations are served in managed care arrangements in Ohio and how is this changing under Amended Substitute House Bill 66? What are the historical costs for this approach compared to fee-for service? What are the benefits covered by managed care plans and how to they compare to the state plan services under fee-for-service arrangements? What, if any, changes are needed to serve entire state and subset of aged, blind and disabled population under Medicaid managed care plans?

- **Medicaid Managed Care Use under Ohio's Separated Systems:** Is Ohio's current practice of using separate systems for other services such as mental health, drug and alcohol, mental retardation consistent with national trends and recommended practices? How would expanding the use of managed care plans impact services provided through the other state agencies that administer Medicaid services (ODMRDD, ODMH, ODA, ODH, and ODADAS)? How does Ohio monitor service delivery across the separate state systems? If it does not monitor services across systems, is there a model to provide a comprehensive view of all services being provided? What practices are used in states for providing these services to the Medicaid population?

- **Impact of Managed Care on Health Outcomes:** How do health outcomes under managed care compare to fee for service for Medicaid recipients? What does the historical data show in terms of health outcomes in managed care plans? Does Ohio's practice of collecting HEDIS indicators give adequate information to monitor health outcomes? Are there benchmarks set for quality of care management, such as health checks, immunizations, and prenatal visits? Does the use of managed care plans improve access in rural areas? What practices are used in other states to address access to services in rural counties? How do the health outcomes in managed care compare to other service delivery systems?

- **Contract Management and Best Practices for Monitoring Managed Care Contracts for Medicaid Recipients:** Does Ohio use the best practices for managing contracts with managed care plans? What are the guidelines for a managed care plan contracting with ODJFS in Ohio? How does Ohio/ODJFS manage its contracts with managed care plans? Are there disciplinary actions for managed care plans that fall below benchmarks? If so

what are they? If not, then should there be? Is there a policy for timely payment of claims? How does the state ensure the financial stability of managed care plans?

- **Access to Services:** Do Medicaid eligible Ohioans, particularly in rural counties, have sufficient access to services and providers? What steps is the State taking to encourage providers in critical areas? What are counties doing to increase access to care? Are there barriers to access created by how the system is administered?

- **Care Management for Medicaid Populations:** What care management activities are recommended in delivering effective health care services? What are other states doing in providing care management/case management for Medicaid populations? How can care management plans be used to monitor the continuity and coordination of care that members receive across practice and providers? Should care management activities differ for low-income consumers that have chronic health problems? What health care service areas should be included under a care management program? How should recipients be recruited into a care management program?

- **Care and Case Management and its Role in Improving Medicaid Efficiency and Effectiveness:** How could Ohio improve its Medicaid program through utilization and care management? What were the outcomes for Ohio's Enhanced Care Management program? Does the data show that this model was beneficial to both providers and patients in terms of coordinating care? How can Ohio employ this disease management model further? What care or case management programs are currently in use in Ohio Medicaid? What approaches could Ohio Medicaid use to implement care management activities for Medicaid recipients under fee-for-service? Are there best practices for utilization review and utilization management, perhaps in other states or industry wide, which could be used to improve these practices in Ohio? Is there an opportunity for academic medical centers to play a role in this area?

- **Care Management and Coverage of the Uninsured:** How could better prevention and care management for uninsured Ohioans impact the Medicaid program? Could improved health care for the uninsured decrease the influx of new high cost consumers into the Medicaid program? Are there health programs in other states or countries that incorporate prevention and care management for low-income consumers? What is the effectiveness of these programs? What programs exist in Ohio to assist uninsured Ohioans?

Technology

The following questions were used to evaluate the use of technology in program management within Ohio Medicaid:

- **Claims, Cycle Time, and Security:** Does the primary Medicaid information system receive a sufficient amount of data and is data submitted in an efficient manner, and if not how could data collection be expanded with reduced cycle time reduced? Are existing methods of submitting claims efficient and necessary? What are the existing requirements for submitting claims and how would mandated entry standards impact the program? Can outsourced data entry functions be performed in-house or eliminated? Does ODJFS effectively minimize the number of claims which require manual processing? Are system security needs identified and address in an effective manner?

- **System Effectiveness, Manual and Duplicative Processes, Eligibility, and Verification:** Are the central agencies recipient eligibility, provider validation, and program enrollment systems designed for maximum efficiency and effectiveness? If not, what changes can be made to expedite these processes while increasing reliability? Is technology effectively utilized at the county level in the determination of recipient eligibility? Can manual processes be automated without limiting user access? Are updates to the internal recipient database reliable and timely?

- **Third Party Liability and Coordination of Benefits:** What are recommended coordination of benefits (COB) activities and how does Ohio's activities compare to these recommended practices? Could e-prescribing technology be used to improve the performance prescription drug benefit? Could electronic medical records be implemented to enhance third party liability recoveries and COB? How can Ohio improve on its current technology to better identify those recipients which may also be eligible for Medicare or have additional insurance coverage?

- **Existing interfaces and Consolidation Opportunities:** Are the interfaces between MMIS systems and external agency systems necessary, reliable, and performed at an optimal point in the process? How could efficiency be gained by changing the way these processes are performed? Does overlap exist between the MMIS system and the primary processing systems of the other agencies? Are communications between MMIS and other external systems efficient? Could a re-organization of systems or cooperative agreements provide greater information sharing across agencies? What is the optimal solution for handling the future needs of the Medicaid program?

- **Decision-making Data and Performance Measurement:** Is the information collected by the MMIS (MITS) system sufficient to guide program decision makers? If not, how can data warehousing and decision support activities be improved and barriers to

information be eliminated? Is the data received by the Medicaid central information system sufficient to support outcome-based decision making? Are federal reporting requirements met? Is the data collected to fulfill federal reporting requirements reasonably accurate?

- **Provider Interaction and Support:** Is the payment process clearly communicated to providers and are payments processed accurately and timely? Is the payment process clearly communicated to providers? Do mechanisms exist to assist providers in resolving suspended claims?

- **Technology Required to Meet Business Needs:** Overall, is the current technology used for Medicaid sufficient to meet the programs business needs? Are future changes to the system addressed in a systematic manner which considers feedback from all levels of stakeholders? Based on the results of stakeholder meetings, will the MITS systems sufficiently address the needs of system users? Are the future needs of the system adequately identified and long-term strategic planning efforts conducted in accordance with best practices?

Program Integrity

The following questions were used to assess key components of the Ohio Medicaid program internal control environment and program integrity efforts:

- **Risk Assessment**: Has Ohio developed a formal and comprehensive risk assessment planning process for Medicaid program integrity to evaluate the environment and associated risks? Has ODJFS – in its capacity as the designated state Medicaid agency – worked effectively with key internal (State sub-recipient and county/regional agencies) and external (provider and recipient advocacy groups) stakeholders to develop program integrity-related goals, and objectives?

- **Prevention and Detection Controls and Enforcement Strategies**: What preventive and detective controls and enforcement strategies does Ohio employ to effectively minimize the risk of fraud, waste, and abuse in Medicaid? Are these in comparable to federal and peer best practices? What obstacles and/or weaknesses (either internal or external to ODJFS) exist that may inhibit the implementation of sufficient and adequate controls? Are these controls and strategies sufficient and adequate to meet the changing demands of a Medicaid system that is transitioning increasingly to managed care?

- **Reporting and Communicating Information**: Are internal and external stakeholders coordinating program integrity efforts in an effective and efficient manner? Are key stakeholders working together to identify program risks, plan audits, reviews, investigations, and report results?

- **Monitoring**: What strategies does Ohio employ (e.g., performance measures) to monitor Medicaid program integrity? Are these in comparable with federal and peer best practices? What obstacles and/or weaknesses (either internal or external to ODJFS) exist that may inhibit Ohio's ability to effectively monitor compliance?

Appendix 3: Glossary

Term	Definition
A	
A-133 Audits	Non-Federal entities that expend more than $500,000 or more in a year in Federal awards are required to have a single or program-specific audit conducted for that year in accordance with the federal Office of Management and Budget Circular No. A-133. It sets forth standards for obtaining consistency and uniformity among federal agencies for the audit of States, local governments, and non-profit organizations expending federal awards.
AAAs	Area Agencies on Aging
Affiliated Computer Service (ACS)	The Ohio Medicaid pharmacy program processes pharmacy claims through a point of sale system operated by Affiliated Computer Services, Incorporated
ADAMH boards	Alcohol, Drug Addiction and Mental Health Services boards
ADAS	Alcohol and Drug Addiction Services
AFDC	Aid to Families with Dependent Children
AG	Attorney General's Office
Aged, Blind and Disabled (ABD)	To qualify for ABD Medicaid, applicants must be: age 65 or over, considered legally blind or an individual with a disability (as classified by the Social Security Administration) and meet certain financial requirements.
AICPA	American Institute of Certified Public Accountants
AMA	American Medical Association
AOPHA	A nonprofit trade association representing nearly 300 not-for-profit providers of senior housing, both subsidized and market rate, adult day care, home- and community-based services, assisted living and skilled nursing.
AOS	Auditor of State's Office
APB	Accounting Principals Board
ASTD	American Society for Training and Development
Athena	The system used to monitor the quality of care provided to recipients enrolled in a managed care plan.
Average Wholesale Price (AWP)	Average Wholesale Price of brand-name pharmaceuticals, as stated by the manufacturer, is used as a basis for determining discounts and rebates.
B	
BBA	1997 Balanced Budget Act
Balanced Scorecard (BSC)	The BSC provides a more holistic view of organizational performance that includes cultural aspects of the organization such as employee learning and growth, internal business processes, and aspects of customer satisfaction to balance the traditional focus on financial measures. It uses this basic tenant and seeks to make strong formalized links between high level mission, vision, and values; strategies, and a measurement feedback loop.
Breast and Cervical Cancer Prevention and Treatment Act of 2000	On October 24, 2000, the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Public Law 106-354) was signed into law. This Act, which has an effective date of October 1, 2000, gives states the option to provide medical assistance through Medicaid to eligible women who were screened through the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) (see Related Links

Term	Definition
	Outside CMS below) and found to have breast or cervical cancer, including pre-cancerous conditions.
BWC	Bureau of Workers Compensation
C	
CAHPS	Consumer Assessment of Health Plans Survey
Capitation	Capitation pays the provider a fixed amount for each of the patients for whom he agrees to provide care, regardless of whether those patients seek care or not. Payment is typically based on a set number of dollars "per member-per month".
Cartridge Tapes (C-Tape)	A removable storage medium (tape)
CAS system	Central Accounting System
CBMRDD	County Boards of Mental Retardation and Developmental Disabilities
CBO	Congressional Budget Office
CDJFS	County Departments of Job and Family Services
Centers for Medicare and Medicaid Services (CMS)	CMS is the federal agency charged with administrative oversight of al Medicaid programs. In this capacity, CMS promulgates regulations, develops policy, and guides states in the operation of their Medicaid programs. CMS also must approve each state plan, all state applications for Medicaid waivers, and any amendments to either the plan or waiver programs. The Ohio is in CMS' region five (under the Chicago regional office) which includes the states of Indiana, Illinois, Michigan, Minnesota, and Wisconsin.
Certificate of Need (CON)	A certificate issued by a governmental body to an individual or organization proposing to construct or modify a health facility, or to offer a new or different service.
CFR	Code of Federal Regulations
CIO	Chief Information Officer
Community Alternative Funding System (CAFS)	The Ohio Department of Mental Retardation and Developmental Disabilities operated the CAFS under a federally approved Medicaid state plan. The CAFS program began in the early 1990's. It was designed as a financing mechanism to draw down federal money into Ohio to help pay for services which were already being provided by County Boards of MRDD. Eventually it was expanded to include services being provided to some children in special education classes. The program ended June 30, 2005.
Community Health Access Project (CHAP)	The Community Health Access Project began as a community based outreach program in Richland County in 1999. The CHAP program expanded to rural Knox County in February 2000 and to the City of Columbus in 2001. CHAP employs, trains, and supports Community Health Workers to help at risk individuals overcome barriers to health and social services.
Coordination of Benefits (COB)	Activities that support the collection, management, and reporting of other insurance coverage for Medicaid beneficiaries.
Cost-to-charge ratio	Equals costs divided by charges
County rural designation code	An indicator developed by the Department of Agriculture to classify counties on a scale as urban (0) to rural (9).
Covered Families and Children (CFC)	Covered Families and Children Medicaid is a federal and state financed grant-in-aid program intended to provide medical coverage for low-income families and pregnant women. Individuals who are receiving Ohio Works First are automatically covered under this program. Families or individuals who become ineligible for OWF may continue to be eligible if they meet certain eligibility criteria. In Ohio, this category includes Healthy Start/Healthy Families.
CRIS-E	Client Registry Information System-Enhanced

Term	Definition
D	
DAS	Department of Administrative Services
Disability Medical Assistance (DMA)	Ohio's Disability Financial Assistance Program is a safety net for needy individuals who do not meet all of the eligibility requirements necessary to receive help from other federal and state benefit programs.
Disease management	A system of coordinated health care interventions and patient communications for populations with conditions in which patient self-care efforts are significant.
Deficit Reduction Omnibus Reconciliation Act (DRA)	Deficit Reduction Omnibus Reconciliation Act of 2005 made several revisions to Medicaid, allowing states to reduce benefits, increase cost sharing; limit payments for certain drugs, and tighten rules related to asset transfers.
Diagnosis Related Group (DRG)	A DRG is a cluster of diagnoses that are expected to require comparable hospital resources and lengths of stay.
Disproportionate Share Hospital (DSH)	Congress established the Medicaid disproportionate share hospital (DSH) program in 1981 to help ensure that states provide adequate financial support to hospitals that serve a significant number of low-income patients with special needs. The Omnibus Budget Reconciliation Act of 1993 limits these payments to a hospital's uncompensated care costs, which are the annual costs incurred to provide services to Medicaid and uninsured patients less payments received for those patients. This limit is known as the hospital-specific DSW limit.
DSS	Decision Support System
DUR	Drug Utilization Review
Durable medical equipment (DME)	Devices which are very resistant to wear and may be used over a long period of time. DME includes items such as wheelchairs, hospital beds, artificial limbs, etc.
E	
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	EPSDT service is the Medicaid-based comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 and includes periodic screening, vision, dental, and hearing services. In addition, Section 1905(r)(5) of the Social Security Act requires that any medically necessary health care service listed at Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan.
Electronic Data Interchange (EDI)	The transfer of data between different agencies using private networks or the Internet.
EHR	Electronic Health Record
Electronic medical records (EMR)	The set of databases (or repositories) that contains the health information for patients within a given institution or organization.
Encounter Data	Claims that have been paid by the managed care plans and submitted to ODJFS on a monthly basis. An encounter represents all services (including medical supplies and medications) provided to the recipient of a managed care plan.
Enhanced Care Management (ECM)	The ECM program targeted aged, blind, and disabled Medicaid recipients identified as having specific chronic conditions. Care management organizations and medical provides were paid a per-member per-month care management fee. The program was in operation for less than one year.
Explanation of Benefits (EOB) Surveys	A notice sent to all Medicaid recipients concerning services that have been billed and paid on their behalf.
F	
FACSIS	Family and Children's Service Information System

Term	Definition
FASB	Financial Accounting Standards Board
Federal Medical Assistance Percentage (FMAP)	The federal government pays a share of the medical assistance expenditures under each State's Medicaid program. That share, known as the Federal Medical Assistance Percentage, is determined annually by a formula that compares the State's average per capita income level with the national income average. States with a higher per capita income level are reimbursed a smaller share of their costs.
Federal Poverty Level (FPL)	The U.S. Department of Health and Human Services (HHS) issues new federal poverty guidelines every year, usually in February or March. These guidelines are commonly referred to as the Federal Poverty Level (FPL), and serve as one of the criteria for determining eligibility in a wide variety of federal and State programs.
Federally Qualified Health Centers (FQHC)	FQHCs are entities that receive federal grants as community health centers under section 330 of the Public Health Service Act and typically provide a variety of services, including physicians' services and services provided by physician assistants and nurse practitioners (Codified in 42 U.S.C. § 254b (2000)). FQHCs are nonprofit, consumer-directed corporations that provide care and treatment to the underserved and the uninsured. FQHCs include Community Health Centers, Migrant Health Centers, Health Care for the Homeless programs, Public Housing Primary Care programs, and Urban Indian and Tribal Health Centers.
Fee-for-Service (FFS)	Under FFS, a provider is paid based on the number and type of services that are performed.
FFY	Federal Fiscal Year
FIAG	Fraud and Investigative Audit Group (Auditor of State's Office)
Fixed Ratios	In Ohio, a hospital inpatient admission qualifies as an outlier if it exceeds certain cost-to-charge thresholds. The State pays each cost outlier under one of three methods. Two methods use cost- to-charge ratios from recent cost reports to convert the billed outlier charges to outlier payments. The third method uses fixed cost-to-charge ratios of 0.60 or 0.80, depending on the DRG, to convert the billed charges. The fixed ratios were enacted through State legislation. Because a hospital cannot calculate the exact cost for each admission, the State must use the cost-to-charge ratio to convert billed charges to estimated costs. The fixed ratios method applies fixed ratios of either 0.60 or 0.80, depending on the DRG, to convert a portion of the charges to the outlier payment.
Formulary	A list of approved drugs for treating various diseases and conditions.
G	
GAO	U.S. Government Accountability Office
GFOA	Government Finance Officers Association
H	
Health Care Common Procedural Coding System (HCPCS)	The Health Care Common Procedural Coding System was developed to ensure that Medicare and other health insurance program claims are processed in an orderly and consistent manner.
Health Care Financing Administration (HCFA)	Now known as the Centers for Medicare and Medicaid Services (CMS).
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996 required CMS to adopt standards for coding systems that are used for reporting health care transactions. The act contains several other provisions, as well.
Health Opportunity Account	These accounts would require low-income Medicaid beneficiaries to meet a

Term	Definition
(HOA)	substantial deductible before they could access their standard Medicaid benefits. States would make contributions to the accounts to help beneficiaries pay for the costs they would incur before Medicaid coverage kicked in, but states would *not* be required to fully offset those costs.
Health Plan Employer Data and Information Set (HEDIS)	A set of standardized performance measures designed to ensure that purchasers and consumers have reliable information with which to compare the performance of managed care organizations.
Healthy Families (HF)	The Medicaid program that offers quality health coverage to families who meet certain income guidelines.
Healthy Start (HS)	The Medicaid program covering children (up to age 19) and pregnant women.
HHS	U.S. Department of Health and Human Services
HHS-OIG	U.S. Department of Health and Human Services- Office of the Inspector General
HIC	Health Insurance Corporation
HIFA waiver	Health Insurance Flexibility and Accountability waiver
HIPC	Health Insurance Purchasing Coalitions
Home and community-based services waivers (HCBS waivers)	Home and community-based services waivers. Under Section 1915(c) of the Social Security Act, the federal government waives certain Medicaid rules to allow a limited number of eligible people with severe disabilities and medically unstable conditions to live in their homes and in the community instead of in nursing homes, hospitals, or facilities for people with mental retardation/ developmental disabilities (ICF-MR).
Hospital Care Assurance Program (HCAP)	HCAP is the mechanism Ohio uses to fulfill its federal obligation to provide disproportionate share funding to general/acute care hospitals which provide indigent care. As part of the program, all general/acute care hospitals in the State are required to provide basic, medically necessary hospital- level services without charge to patients whose income is at or below the federal poverty level and to patients enrolled in the Disability Assistance program. Funding for HCAP is derived from an assessment on Ohio hospitals and federal matching funds.
Hospital-specific cost-to-charge ratios	These are applied to the covered charges for a case to determine whether the costs of the case exceed the fixed-loss outlier threshold.
HSRTF	Health Services Research Task Force
I	
ICF/MR	Intermediate Care Facility for the Mentally Retarded
IEVS	Income and Eligibility Verification System
International Classification of Diseases (ICD-9)	ICD-9 classifies morbidity and mortality information for statistical purposes and for the indexing of hospital records by disease and operations for data storage and retrieval. ICD-9 codes are used for coding and reporting the diagnosis and procedures for an encounter.
IO Waiver	Individual Options Waiver
IT	Information Technology
J	
JAR	Joint Application Requirement
Joint Committee on Agency Rule Review (JCARR)	JCARR consists of five State Representatives and five State Senators and its primary function is to review proposed new, amended, and rescinded rules.
L	
LIF	Low Income Families
LOC	Level of Care

Term	Definition
LSC	Legislative Service Commission
M	
MACSIS	Multi-Agency Community Services Information System
MBS	Medicaid Billing System
MCATS	Medicaid Consumer Activity Tracking System
MCO	Managed Care Organization
MCP	Managed Care Plan
MDS	Minimum Data Set
Medicaid Buy-in programs (MBI)	Under the Balanced Budget Act of 1997 or the Ticket to Work and Work Incentives Improvement Act of 1999, some states have established Medicaid buy-in programs for persons with disabilities. These programs provide incentives for people with disabilities to continue to work without the fear of losing Medicaid coverage if they earn too much income.
Medicaid/Medicare Dual Eligibles	Dual eligibles are individuals who are entitled to Medicare Part A and/or Part B and are eligible for some form of Medicaid benefit. Dual eligibles include all of the Qualified Medicare Beneficiaries, Specified Low Income Medicare Beneficiaries, Qualifying Individuals, Qualified Disabled and Working Individuals, and Medicaid only groups.
Medicaid Only Dual Eligibles (Non QMB, SLMB, QDWI, QI-1, or QI-2)	These individuals are entitled to Medicare Part A and/or Part B and are eligible for full Medicaid benefits. They are not eligible for Medicaid as a QMB, SLMB, QDWI, QI-1, or QI-2. Typically, these individuals need to spend down to qualify for Medicaid or fall into a Medicaid eligibility poverty group that exceeds income/asset limits. Medicaid provides full Medicaid benefits and pays for Medicaid services provided by Medicaid providers, but Medicaid will only pay for services also covered by Medicare if the Medicaid payment rate is higher than the amount paid by Medicare, and, within this limit, will only pay to the extent necessary to pay the beneficiary's Medicare cost-sharing liability. Payment by Medicaid of Medicare Part B premiums is a State option; however, States may not receive FFP for Medicaid services also covered by Medicare Part B for certain individuals who could have been covered under Medicare Part B had they been enrolled.
Medically Needy	The option to have a medically needy program allows states to extend Medicaid eligibility to additional qualified persons who may have too much income to qualify under the mandatory or optional categorically needy groups. This option allows them to spend down their resources to Medicaid eligibility by incurring medical and/or remedial care expenses to offset their excess income, thereby reducing it to a level below the maximum allowed by that state's Medicaid plan. States may also allow families to establish eligibility as medically needy by paying monthly premiums to the state in an amount equal to the difference between family income (reduced by unpaid expenses, if any, incurred for medical care in previous months) and the income eligibility standard.
Medication Therapy Management (MTM)	Medication Therapy Management programs are designed to pay pharmacists to counsel and otherwise assist enrollees with multiple chronic diseases, multiple medications and high drug costs.
Medstat	Medstat is a healthcare information company that provides market intelligence and benchmark databases, decision support solutions, and research services for managing the cost and quality of healthcare.
MEDTAPP	Medicaid Technical Assistance and Policy Program
MFCU	Medicaid Fraud Control Unit (Attorney General's Office)

Term	Definition
MITA	Medicaid Information Technology Architecture
MITS	Medicaid Information Technology System
MMIS	Medicaid Management Information System
MRDD	Mental Retardation and Developmental Disabilities
N	
NAMI	National Alliance for the Mentally Ill
NASHP	National Academy for State Health Policy
NCQA	National Committee for Quality Assurance
NCSL	National Council of State Legislatures
NF	Nursing facility
NGA	National Governor's Association
NIST	National Institute of Standards and Technology
NMBP	National Medicaid Buying Pool
NPI	National Provider Identifier
NSAF	National Survey of American Families
O	
OAAAA	Ohio Association of Area Agencies on Aging
OAC	Ohio Administrative Code
OBM	Office of Budget and Management
OBRA 1990	Omnibus Reconciliation Act of 1990
OCR	Optical Character Recognition
OCRM	Ohio Commission to Reform Medicaid
ODA	Ohio Department of Aging
ODADAS	Ohio Department of Alcohol and Drug Addiction Services
ODE	Ohio Department of Education
ODH	Ohio Department of Health
ODI	Ohio Department of Insurance
ODJFS	Ohio Department of Job and Family Services
ODMH	Ohio Department of Mental Health
ODMRDD	Ohio Department of Mental Retardation and Developmental Disabilities
ODRC	Ohio Department of Rehabilitation and Corrections
OHA	Ohio Hospital Association
Ohio Works First (OWF)	OWF is a state-supervised, county-administered program that serves every political subdivision in the State. OWF provides time-limited cash assistance to needy families with (or expecting) children, by furnishing parents or specified relatives with work, training, and other support services they need in order to attain permanent self-sufficiency while meeting the family's ongoing basic needs. Non-time-limited OWF cash assistance is also provided to child-only cases
OHP	Ohio Health Plans
OIG	Office of Inspector General
OIT	Office of Information Technology
OMAP	Office of Medical Assistance Programs
OMASC	Ohio Medicaid Administrative Study Council
OPA	Ohio Psychological Association
OPRA	Ohio Provider Resource Association
ORAA	Office of Research, Assessment and Accountability (within the Ohio Department of Job and Family Services)

Term	Definition
ORC	Ohio Revised Code
P	
PAA	PASSPORT Administrative Agency
PACE	Program of All-inclusive Care of the Elderly
PACT	Primary Alternative Care and Treatment
PASSPORT	Pre-Admission Screening System Providing Options and Resources Today
PAWS	Payment Authorization for Waiver Services
Pay For Performance (P4P)	Payment for Performance pays providers based on their success in meeting specific performance measures.
Payment Error Rate Measurement (PERM)	A program to measure improper payments in the Medicaid program and the State Children's Health Insurance Program.
PCP	Primary care provider
PDL	Preferred Drug List
Pharmacy Benefit Manager (PBM)	A company under contract with managed care organizations, self-insured companies, and government programs to manage pharmacy network management, drug utilization review, outcomes management, and disease management.
Pharmacy and Therapeutics Committee (P&T Committee)	The P&T committee evaluates the clinical use of drugs, develops policies for managing drug use and drug administration, and manages the formulary system.
PIMS	PASSPORT Information Management System
PMPM	Per-Member Per-Month
POS	Point-of-Sale
Pre-Admission Screening and Resident Review (PASRR)	The PASRR is used by ODA to determine level of care needs for an individual. To be medically eligible for Medicaid long-term care services, an individual must meet the intermediate or skilled level of care need required for nursing home placement. Pre-admission screening and level of care determination is required for individuals seeking admission to nursing facilities and/or waiver services.
Prevention, Retention and Contingency (PRC)	PRC is a county-administered, State-supervised program that serves every political subdivision in the State. PRC provides ongoing services and nonrecurring short-term benefits designed to accomplish one of the four purposes of TANF by addressing supports needed by working families and by addressing the needs of families with barriers to self-sufficiency.
Primary Care Case Management (PCCM)	A Medicaid health care delivery system that lies between traditional fee-for-service and risk-based HMO managed care. Under PCCM, consumers are linked to a Primary Care Provider (PCP) who coordinates their health care. Providers are paid on a fee-for-service basis, and receive additional dollars to compensate for care management responsibilities. Providers are not at financial risk for the services they provide or authorize.
Pro-DUR	Prospective Drug Utilization Review activities
Public Assistance Reporting Information System (PARIS)	The PARIS interstate match helps states share information on public assistance programs, such as TANF and Food Stamps, to identify individuals or families who may be receiving benefit payments in more than one state simultaneously.
PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act
Q	
Qualified Disabled and Working Individuals (QDWI)	These individuals lost their Medicare Part A benefits due to their return to work. They are eligible to purchase Medicare Part A benefits, have income of 200 percent FPL or less, have resources that do not exceed twice the limit for SSI

Term	Definition
	eligibility, and are not otherwise eligible for Medicaid. Medicaid pays the Medicare Part A premiums only.
Qualified Medicare Beneficiaries with full Medicaid (QMB Plus)	These individuals are entitled to Medicare Part A, have income of 100 percent FPL or less, have resources that do not exceed twice the limit for SSI eligibility, and are eligible for full Medicaid benefits. Medicaid pays their Medicare Part A premiums, Medicare Part B premiums, and, to the extent consistent with the Medicaid State plan, Medicare deductibles and coinsurance, and provides full Medicaid benefits.
Qualified Medicare Beneficiaries without other Medicaid (QMB Only)	These individuals are entitled to Medicare Part A, have income of 100 percent FPL or less, have resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for full Medicaid. Medicaid pays their Medicare Part A premiums, Medicare Part B premiums, and, to the extent consistent with the Medicaid State plan, Medicare deductibles and coinsurance for Medicare services provided by Medicare providers.
Qualifying Individual (QI)	QIs are a Medicare/Medicaid dual eligible category
Qualifying Individuals (QI-1s)	This group was effective from January 1, 1998 through December 31, 2002. There is an annual cap on the amount of money available, which may limit the number of individuals in the group. These individuals are entitled to Medicare Part A, have income of at least 120 percent FPL, but less than 135 percent FPL, have resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only.
Qualifying Individuals (QI-2s)	This group is effective from January 1, 1998 through December 31, 2002. There is an annual cap on the amount of money available, which may limit the number of individuals in the group. These individuals are entitled to Medicare Part A, have income of at least 135 percent FPL, but less than 175 percent FPL, have resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays only a portion of their part B premiums.
R	
Regional Health Information Organization (RHIO)	RHIOs are organizations composed of multiple stakeholders who have integrated systems which share information with one another through a central source.
Residential State Supplement (RSS)	RSS is a cash supplement to low-income adults with disabilities who do not require nursing home care. Participants use the supplement along with their income to pay for approved living arrangements.
RFP	Request for proposals
RSC	Rehabilitative Services Commission
Rural Health Centers (RHC)	An RHC is a facility located in a rural area designated as a shortage area and is neither a rehabilitation agency nor a facility primarily for the care and treatment of mental diseases.
S	
SACWIS	Statewide Automated Child Welfare Information System
Secure File Transfer Process (SFTP)	Any method used to transfer data between two locations securely.
SFY	State Fiscal Year
SLA	Service Level Agreements
SLMB	Specified Low-Income Medicare Beneficiary
SLMB with full Medicaid	These individuals are entitled to Medicare Part A, have income of greater than

Term	Definition
(SLMB Plus)	100 percent FPL, but less than 120 percent FPL, have resources that do not in exceed twice the limit for SSI eligibility, and are eligible for full Medicaid benefits. Medicaid pays their Medicare Part B premiums and provides full Medicaid benefits.
SLMB without other Medicaid (SLMB Only)	These individuals are entitled to Medicare Part A, have income of greater than 100 percent FPL, but less than 120 percent FPL, have resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only.
SNF	Skilled Nursing Facility
SOCC	State of Ohio Computer Center
SPBP	Special Pharmaceutical Benefits Program
SSA	Social Security Administration
SSDI	Social Security Disability Income
SSI	Social Security Income
Standard Exchange Format (SEF)	An open-standard, computer readable, text format that contains the schematic information of an EDI document. SEF files are used to convey the EDI implementation guidelines of trading partners.
State Children's Health Insurance Plan (SCHIP)	Also referred to as Children's Health Insurance Program (CHIP). A program created by the federal government to encourage states to provide insurance coverage for children. SCHIP is funded through a combination of federal and state funds, and administered by the states in conformity with federal requirements.
SURS	Surveillance and Utilization Review System
T	
TANF	Temporary Assistance for Needy Families
Telemedicine	Telemedicine involves the use of electronic communication and information technologies to provide or support clinical care at a distance.
Third-Party Administrator (TPA)	A firm that performs administrative functions (e.g., claims processing, membership) for a self-funded plan or a start-up managed care organization.
Third party liability (TPL)	Third Party Liability (TPL) refers to the legal obligation of third parties (i.e., certain individuals, entities, or programs) to pay all or part of the expenditures for medical assistance furnished under a State plan. The Medicaid program by law is intended to be the payer of last resort; that is, all other available third party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid.
TWWIIA	Ticket to Work and Work Incentives Improvement Act
U	
Utilization management	The evaluation of the medical necessity, appropriateness and efficiency of the use of healthcare services, procedures and facilities under the provisions of the applicable health benefits plan.
W	
Weighted Average Cost (WAC)	Ohio's reimbursement for prescriptions is the WAC plus 7 percent, or the Average Wholesale Price (AWP) minus 12.8 percent if the WAC is unknown.

Sources: The National Library of Medicine's (NLM) controlled vocabulary database, Medical Subject Headings, Glossary of Terms and Acronyms in *Essentials of Managed Health Care* (Peter R. Kongstvedt ed., 4th ed. 2003), the Centers for Medicare and Medicaid Services, and Ohio Department of Job and Family Services

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