



Annual Report

Submitted August 1, 2016

The Ohio Department of Medicaid

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

A LETTER FROM THE DIRECTOR



Dear Governor Kasich:

I am pleased to present to you the Ohio Department of Medicaid's Annual Report for state fiscal year 2016.

In collaboration with its sister state agencies, as well as a variety of private stakeholder and advocacy groups, our agency continues to modernize Medicaid and shape the national conversation around health care.

The following report highlights a number of new and ongoing initiatives, such as:

- » working with sister agencies and various stakeholders to finalize Ohio's statewide home and community-based services transition plan;
- » developing a new care management strategy that will adopt a population health management approach;
- » conducting on-site provider visits to identify and combat instances of fraud, waste, and abuse;
- » engaging local leaders in nine Ohio communities to identify and fund innovative projects aimed at reducing infant mortality;
- » transitioning to a new pharmacy claims processing system; and
- » simplifying health care coverage for Ohioans by establishing a single process for the application and determination of disability benefits.

Additionally, a new and more accurate eligibility system, paired with an improving economy in Ohio, resulted in Ohio Medicaid spending \$1.3 billion below the original budget estimate enacted by the Ohio General Assembly for this state fiscal year. Through the reforms listed above, and many others, the Ohio Department of Medicaid is delivering more choice and better person-and family-centered care, while also refining care coordination to improve the overall health care landscape in our state. Much has been accomplished over the past 12 months, and important work lies ahead.

Sincerely,

A handwritten signature in blue ink that reads "John B. McCarthy". The signature is fluid and cursive.

John B. McCarthy

Director

The Ohio Department of Medicaid

Our Mission

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

Our Vision

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



Our Guiding Principles

For Our Market

VALUE

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

INNOVATION

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

TRANSPARENCY

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

RESPONSIVENESS

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

For Our Organization & Staff

For Ohioans

COORDINATION

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

ACCESS

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

DECISION-MAKING

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

MISSION FOCUS

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

INFORMATION-BASED

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

TEAM-BASED

Maintain ODM as a collaborative partnership with sister state agencies built on staff experience and service.

ADAPTABLE

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

For Partners & Providers

SHARED OUTCOMES

Promote a standard of collaboration among stakeholders in order to achieve desired outcomes.

ACCOUNTABILITY

Create an environment that promotes accountability for outcomes.

INTEGRITY

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

Table of Contents

1 Medicaid Snapshot	5
Medicaid Snapshot	6
Medicaid State Plan	8
Healthy Ohio Waiver Applications	9
2 Policy	10
Disability Determination Redesign	11
Behavioral Health Redesign	11
Ohio Benefits 2.0	12
Payment Innovation	12
Hospital Payments	13
ICD-10	14
Prior Authorization & Durable Medical Equipment Expenditures	14
Ohio Medicaid Consumer Hotline	15
Pharmacy Benefit Manager	15
3 Long-Term Care Services & Supports	16
Electronic Visit Verification	17
Medicaid Waivers	17
Ohio Benefits Long-Term Care	18
HOME Choice	18
Ohio Home Care Operations	19
Nursing Facilities	20
Home and Community-Based Services Regulation	21
Waiver Quality Reviews	21
4 Managed Care	23
New Initiatives	24
Care Management	24
Quality Strategy and Measures	25
Pay for Performance	25
Consumer Satisfaction Survey	26
Infant Mortality	26
MyCare Ohio	27
5 Providers	29
Provider Site Visits and Revalidation	30
Ordering, Referring, Prescribing Providers	30
Medicaid Information Technology System	31
Program Integrity	31
Inpatient Hospital Review Contract	33
Third Party Liability	33
Provider Electronic Records Growth	34
Appendix A: Medicaid Quality Strategy	35
Appendix B: Medicaid Data	37

1

Medicaid Snapshot

Medicaid Snapshot

Medicaid is a joint federal-state health insurance program for individuals with low income and limited resources. The program is nationwide and administered by each individual state under broad federal guidelines.

The Medicaid program was created in 1965 through amendments to the national Social Security Act. The federal government provides matching funds to states to assist in the cost and administration of the program. These matching funds are commonly referred to as FMAP (Federal Medical Assistance Percentage) and are reformulated on an annual basis.

Medicaid serves low income individuals of all ages in addition to residents over the age of 65 or living with a disability. Federal, state, and local funding provided quality care for more than 3 million Ohioans insured through Medicaid at some point during SFY 16. Roughly 80 percent of Ohio’s Medicaid population received benefits through five private managed care plans under contract with the Department of Medicaid (ODM).

As Ohio’s largest health care payer, ODM relies on the innovation, collaboration and partnership of various state and private entities. In doing so, Ohio Medicaid remains committed to improving health care across the state and modernizing ways in which health care is delivered to the people we serve.

Figure 1.1

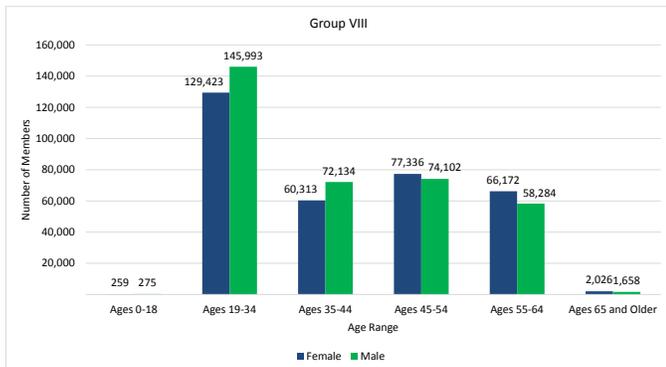


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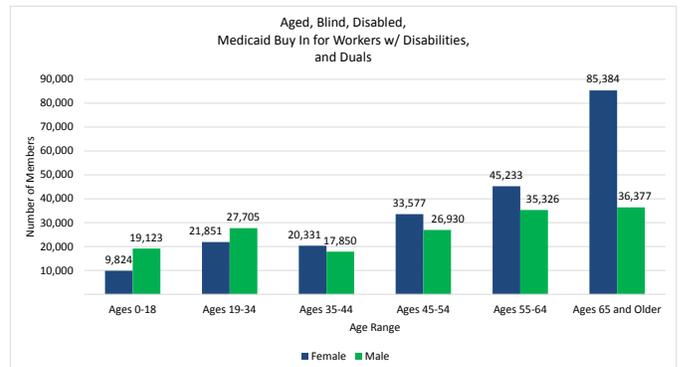


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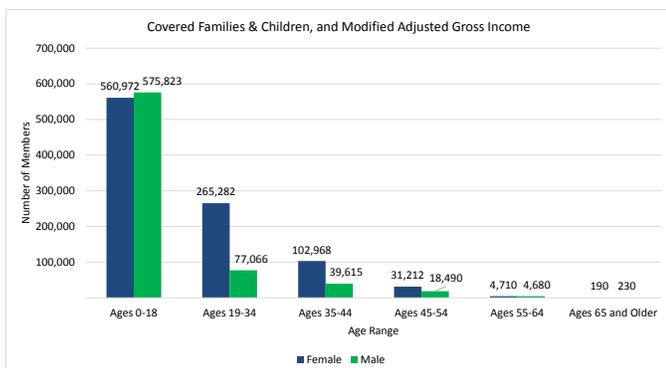


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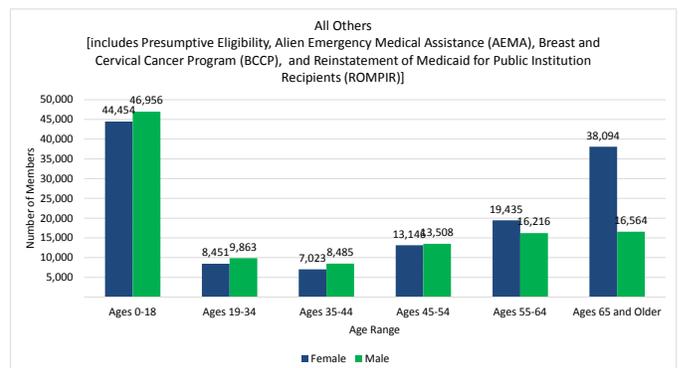


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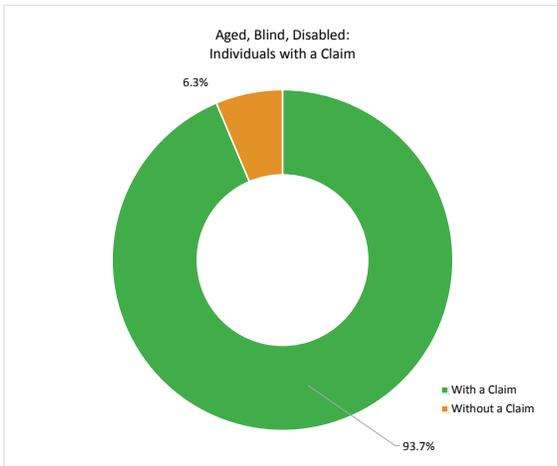


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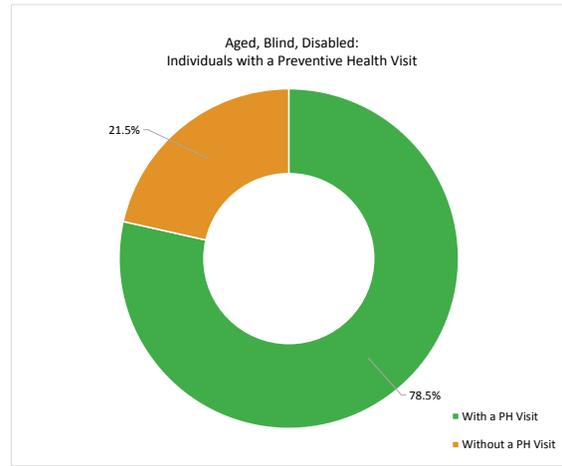


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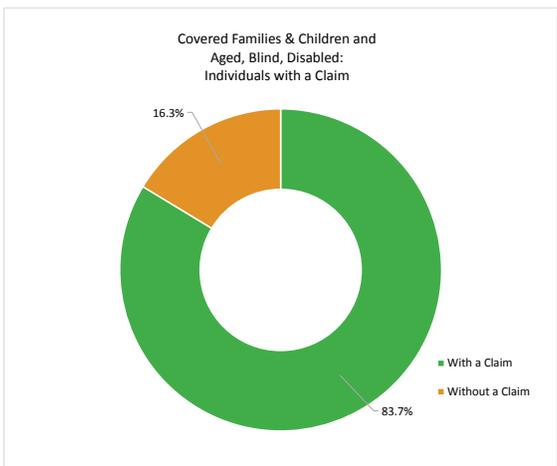


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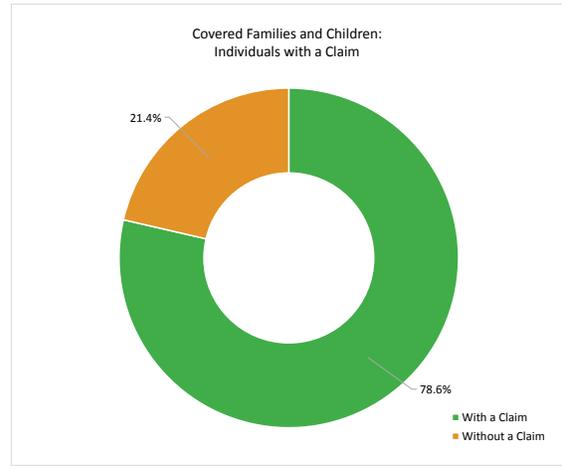


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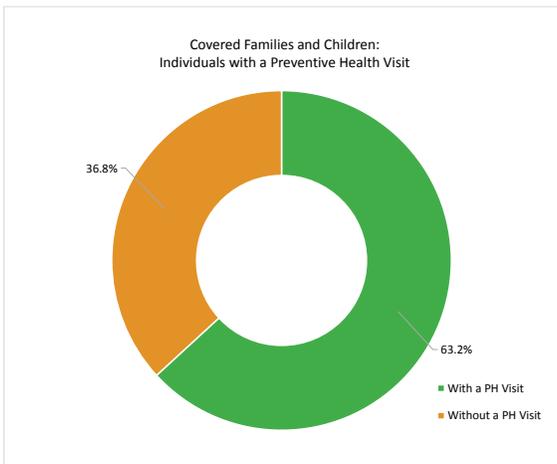
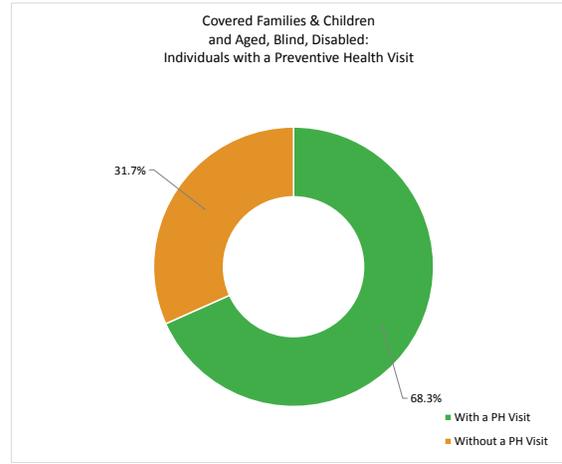


Figure 1.10



Medicaid State Plan

Every state's Medicaid program is administered through a set of guidelines and standards known as the Medicaid State Plan. The State Plan serves as the contract between the state and the federal government and is the basis for Federal Financial Participation in the state's Medicaid program. It documents each state's covered groups, services, reimbursement methodologies and program administration. Over time, changes are often required to a Medicaid program's State Plan. Changes are accomplished by submitting State Plan Amendments (SPAs) to the Centers for Medicare and Medicaid Services (CMS) for approval.

During SFY16, ODM submitted 32 amendments to CMS. Most sought approval to implement services and adjustments to payment methodologies for providers and most were initiatives that had been approved by the 131st General Assembly. Some highlights of recent changes sought through federally approved amendments to the State Plan include:

- » modifying nursing facility rates and reimbursement;
- » modifying the inpatient and outpatient hospital payment methodology;
- » modifying reimbursement for intermediate care facilities for individuals with intellectual disabilities;
- » modifying the Disproportionate Share Hospital payment methodology;
- » updating language to reflect the merger of two agencies into the Ohio Department of Mental Health and Addiction Services (OhioMHAS);
- » changing the reimbursement methodology for Targeted Case Management services provided to individuals with developmental disabilities;
- » adding the requirement that all physicians are subject to Medicare Part B Cost-Sharing payment methodology;
- » increasing reimbursement rate for Home Health Aides;
- » updating non-institutional professional fee schedules;
- » increasing the personal needs allowance for residents of Intermediate Care Facilities for Individuals with Intellectual Disabilities;
- » updating the Transitional Medical Assistance program;
- » eliminating the limited Family Planning Services-only eligibility group;
- » simplifying the Residential State Supplement Program;
- » reauthorizing the Upper Payment Limit programs for inpatient and outpatient services;
- » extending the Health Homes program;
- » making changes to the pharmaceutical reimbursement methodology;
- » creating the new Specialized Recovery Services Program for individuals with severe and persistent mental illness under the 1915(i) Home and Community-Based Services option;
- » transitioning Medicaid eligibility authority from 209(b) status to 1634 status; and
- » changing reimbursement to align with the State's value-based purchasing strategy.

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

Healthy Ohio Waiver Application

During the 2017-2017 Biennial Budget proceedings, the Ohio House of Representatives included a legislative amendment that requires ODM to request a 1115 waiver from CMS for the implementation of health savings accounts for a portion of Ohio's Medicaid population. The public comment period for Healthy Ohio began on April 15, 2016, and ended on May 16, 2016, and included two public hearings.

ODM finalized and submitted the waiver application in June 2016 and it is currently under review by CMS.

2

Policy

The Ohio Department of Medicaid’s policy bureau closely monitors federal and state activities to identify potential impacts to the state’s health care landscape. As health care policy continues to evolve across the United States, Ohio Medicaid remains committed to shaping the national conversation around coverage by pursuing an innovative, reform-minded approach. The following sections reflect some of the ways in which the Ohio Medicaid program has evolved over the past year.

Disability Determination Redesign

Ohio Medicaid is simplifying coverage for thousands of Ohioans who must “spend down” a portion of their income each month to be eligible for health care benefits. Beginning August 1, 2016, the income limit will be raised for these individuals so that they no longer need to “spend down” to a more restrictive income limit or apply separately for Social Security Income (SSI) and Medicaid benefits.

Section 1634 of the Social Security Act allows states to accept the federal Social Security decision for SSI as a decision to also enroll that individual in Medicaid. Ohio Medicaid submitted a SPA to CMS in December 2015 seeking approval to terminate the 209(b) option and begin processing Medicaid applications based on 1634 eligibility criteria beginning August 1, 2016. Under the new system, the definition of disability will stay the same, but income and asset limits for Medicaid will increase to match SSI.

Most of these individuals will be automatically enrolled in full Medicaid without spend down. Others may have a new pathway to coverage through the Medicaid-funded Medicare Premium Assistance Program, Medicare, federally subsidized private insurance on the federal Marketplace Exchange, or private health insurance. Impacted individuals will retain their Medicaid coverage until their next regularly scheduled eligibility redetermination.

The disability determination redesign is part of a comprehensive strategy to modernize the administration of Ohio’s Medicaid program. As a result of the disability determination redesign, Ohio will join the majority of states in having a single process for the application and determination of disability benefits.

Behavioral Health Redesign

Ohio Medicaid and its sister agencies have had great success in improving and modernizing the Medicaid program in recent years, including vast enhancements to Ohio’s system of mental health and addiction services.

The Behavioral Health Redesign continues this work by rebuilding Ohio’s community behavioral health system capacity. In collaboration with the Governor’s Office of Health Transformation (OHT) and the OhioMHAS, ODM is implementing a series of reforms to enhance the quality of care delivered to the residents we serve. SFY16 highlights include work toward the following changes, which will be implemented at the beginning of the next fiscal year:

- » developing new services for individuals with high intensity service and support needs;
- » coordinating care across physical and behavioral health care services; and
- » recoding of all Medicaid behavioral health services to achieve alignment with national coding standards.

Additional changes will follow through 2020. Details about this initiative can be found at the newly launched bh.medicaid.ohio.gov.

Ohio Benefits 2.0

Through its enhanced eligibility determination and case management systems, Ohio Benefits is streamlining and transforming the way in which Ohioans apply for Medicaid benefits.

ELIGIBILITY DETERMINATION

In the three years since its inception, the Ohio Benefits eligibility system has enabled more than 2.5 million individuals to apply for and manage their Medicaid benefits online through Benefits.Ohio.Gov.

As of August 2016, all Medicaid benefits programs successfully transitioned to Ohio Benefits. In total, this process has converted more than 1.7 million individuals to the new system.

Continued innovation within the system has allowed for more than 615,000 individuals to automatically renew eligibility without human intervention, saving time for Ohioans and creating administrative efficiencies.

CASE MANAGEMENT

The value of a streamlined eligibility system, however, extends beyond just helping Ohioans access benefits. An integrated approach provides new opportunities for state and county workers to provide citizens better service and work more efficiently.

In support, Ohio Benefits is establishing a new statewide Enterprise Document Management System (EDMS) which allows counties to share documents and caseloads across county lines. EDMS will be fully integrated into Ohio Benefits eligibility system and provide standardized taxonomy and workflows across Ohio's 88 counties.

Payment Innovation

In December 2014, the Centers for Medicare and Medicaid Innovation awarded Ohio a State Innovation Model (SIM) test grant. The funding – totaling \$75 million over 48 months – allows Ohio to continue its focused strategies around episode-based payments and Patient-Centered Medical Homes (PCMH).

Throughout SFY16, ODM worked with Medicaid managed care plans and private insurers to set payment and quality thresholds for each of the initial six episode models for Wave 1 episode-based payments. The six Wave 1 episodes are:

1. perinatal;
2. asthma exacerbation;
3. chronic obstructive pulmonary disease exacerbation;
4. total joint replacement;
5. acute percutaneous coronary intervention; and
6. non-acute percutaneous coronary intervention.

The performance period for Wave 1 episodes began January 1, 2016, and will run through December 31, 2016. During this time, providers receive performance reports, which allows them to compare their costs with those of other health care providers of the same service.

ODM, along with OHT, Medicaid managed care plans and private insurers, also introduced Wave 2 episodes during SFY16. The seven Wave 2 episodes are:

1. upper respiratory infection;
2. urinary tract infection;
3. appendectomy;
4. cholecystectomy;
5. colonoscopy;
6. GI hemorrhage; and
7. upper GI endoscopy.

In SFY16, ODM consolidated informational reports for Wave 2 episodes across the Medicaid program so the providers receive one report with information across Medicaid fee-for-service as well as all five Medicaid managed care plans.

Throughout SFY16, ODM and OHT convened the PCMH Design Team, along with provider, advocate and payer focus groups, to develop and implement a payment model aimed at rewarding team-based primary care that holds down the total cost of care by preventing disease and managing chronic conditions. The PCMH model design included input from more than 800 stakeholders across Ohio. Additionally, ODM released a provider survey on PCMH and received more than 650 valid responses from clinicians and office managers across the state, and OHT and ODM used this input to further refine Ohio's PCMH model. ODM plans to implement the model statewide in SFY17.

Hospital Payments

During SFY16, ODM continued to monitor the implementation of the 3M Health Information System's All Patient Refined – Diagnosis Related Grouper (APR-DRG), a system widely used in the United States for adjusting inpatient health care claims for severity of illness and risk of mortality. In July 2015, ODM initiated the final year of a three-year stop loss/stop gain period intended to ease hospitals' transition to the APR-DRG payment system. In September 2015, ODM began policy analysis and stakeholder engagement to recalibrate the APR-DRG payment system.

ODM is in the final stages of reforming payments for outpatient services. ODM has traditionally paid outpatient hospital services based upon prospective payment methods developed in the late 1980s. In January 2017, ODM will begin processing outpatient hospital claims through 3M's Ambulatory Patient Groups (EAPG). The Enhanced Ambulatory Patient Groups used in the EAPG system categorize the amount and type of resources used in outpatient visits, and encourage providers to manage costs and operate more efficiently. Outpatient reimbursement will be determined by multiplying a hospital-specific base rate by an EAPG relative weight.

ODM continues to modernize its hospital payment systems to ensure quality care in Ohio. Beginning July 2015, ODM developed a Potentially Preventable Readmissions (PPR) report, which compares PPR rates across managed care plans. The report also includes hospital-specific data, which identifies each hospital's readmission rate across the entire managed care program, as well as its readmission rate under its contract with each plan.

Hospital Care Assurance Program

The Ohio Hospital Care Assurance Program (HCAP) is Ohio's primary mechanism for administering the federal Disproportionate Share Hospital (DSH) payment program. The DSH program provides additional payments to hospitals that provide care to an uneven share of indigent patients. Each year, Ohio hospitals fund the state share of this program through provider assessments.

Through the 2015 HCAP program year, ODM distributed \$609 million to hospitals. Since the expansion of Medicaid to cover the Group VIII population, ODM estimates that costs of uncompensated care provided by Ohio hospitals has decreased by 69%.

ICD-10

October 1, 2015, was the implementation date for the International Classification of Diseases, 10th Clinical Modification (ICD-10) coding system. It replaced the antiquated system of ICD-9 codes, which were used nationally for three decades. ICD-10 codes provide greater precision and transparency when providers bill for services. The updated set of ICD-10 features 72,000 codes to detail treatment provided compared to the 14,000 codes featured by ICD-9 coding.

The conversion from ICD-9 to ICD-10 code sets was federally mandated and all health care providers are required to comply. Ohio Medicaid successfully completed the implementation of the ICD-10 code sets to meet the federal compliance date of October 1, 2015.

On October 1, 2015, every claim submitted to Ohio Medicaid by health care providers were coded with ICD-10 as well as the invoices submitted to Ohio Medicaid from sister state agencies who deliver services on behalf of Ohio Medicaid.

Figure 2.2 ICD-9 vs. ICD-10 Change Code Graph

Prior Authorization & Durable Medical Equipment Expenditures

During SFY16, Ohio Medicaid improved its fee-for-service prior authorization process. This process ensures that Medicaid services that require prior authorization are medically necessary and appropriate. It also evaluates and prices, when necessary, prior authorization required for medical, transportation, durable medical equipment, organ transplantation, supplies, and dental and vision services.

Burns & Associates helped Medicaid gather prior authorization data from the Medicaid Information Technology System (MITS) to determine where Medicaid could improve efficiency. Ohio Medicaid also removed many frequently used prior authorization codes to permit providers to bill directly for services rather than request prior authorization. It contracted the remaining fee-for-service prior authorizations to HP Enterprise Services, LLC.

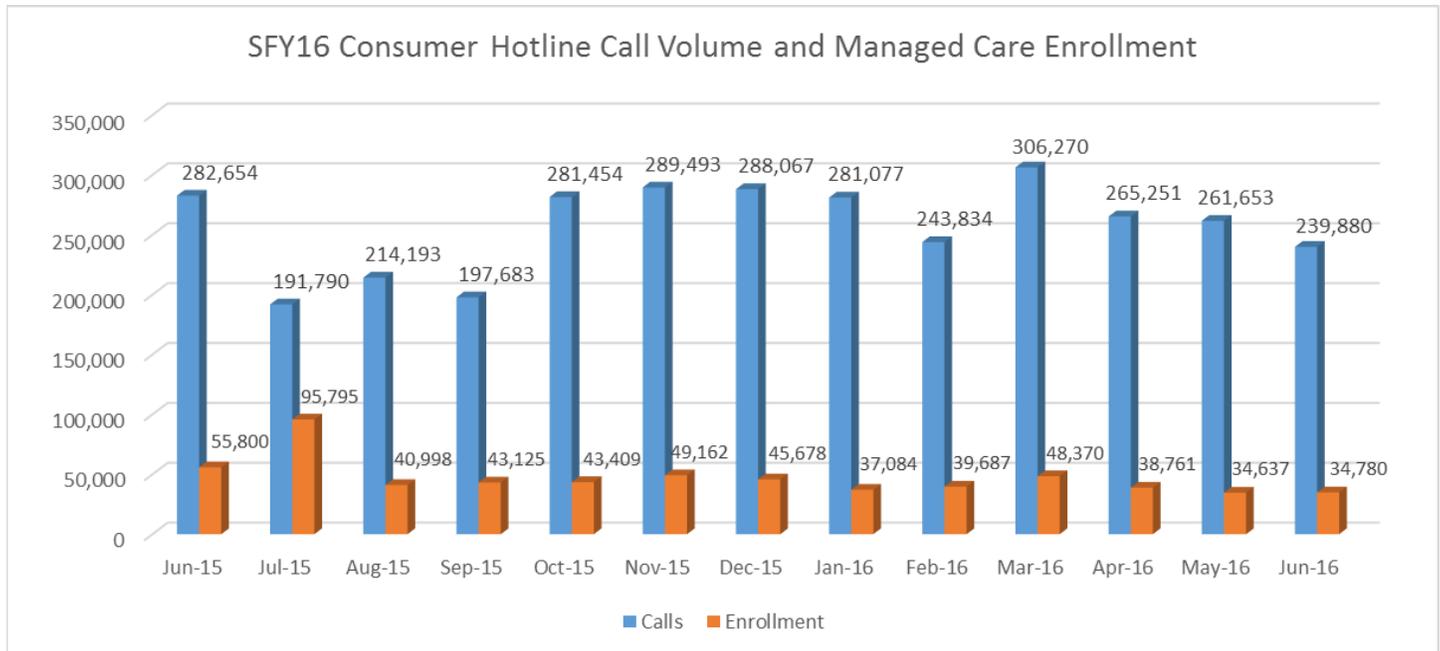
Ohio Medicaid retains the hearing portion of the prior authorization process to ensure quality customer service.

Ohio Medicaid Consumer Hotline

The Ohio Medicaid Consumer Hotline helps to answer important questions from Ohio residents related to the Medicaid program. This may include inquiries regarding eligibility, benefit changes, and providers. The Hotline also assists individuals in the Medicaid managed care enrollment process.

Ohio Medicaid contracts with Automated Health Systems in the administration of the Medicaid Consumer Hotline. In SFY16, the hotline handled more than 3.3 million calls and more than 600,000 managed care enrollment transactions.

Figure 2.1



Pharmacy Benefit Manager

On June 12, 2016, ODM transitioned to a new pharmacy claims processing system, Goold Health Systems (GHS).

This implementation features several improvements for Medicaid providers and recipients. Pharmacies will be paid one week earlier than previously, and additional functionality has been included to allow pharmacies to dispense a three-day supply of a medication requiring prior authorization in an emergency situation. GHS will receive Medicaid recipient eligibility information on a near real-time basis, so newly eligible recipients will be able to pick up prescriptions on the day they are found eligible.

Future enhancements with GHS will include a provider portal where prescribers can send and view prior authorization requests, and enhanced program integrity features including claim review services.

3

Long-Term Care Services & Supports

In SFY16, the Department of Medicaid continued to make significant progress in its work to provide seniors and individuals with disabilities more opportunities to receive health care in home and community-based settings. During the last year, Ohio became one of only three states to achieve initial approval of its statewide home and community-based services (HCBS) transition plan from CMS. Additionally, the HOME Choice program surpassed 8,000 successful community transitions.

Electronic Visit Verification

ODM released a request for proposals in 2015 to select a vendor to provide an Electronic Visit Verification (EVV) service for Ohio Medicaid. An EVV system can validate service delivery to eligible individuals by authorized service providers, significantly reduce the risk of paying improper claims, and reduce the administrative aspects of the “pay-and-chase” model. Relying on various technologies, EVV authenticates service providers and receives verification from the individual receiving the services at the time of delivery.

Ohio is seeking an innovative model that focuses on the individual using services and that relies on GPS technology instead of traditional telephony to improve the accuracy of verifications. The initial implementation will focus on nursing and aide services provided through Medicaid programs operated by ODM and Medicaid managed care plans. The emphasis will be on improving payment accuracy by ensuring that claims submitted to Medicaid Information Technology System “match” visits documented with the EVV service. ODM anticipates implementing the EVV service in early 2018.

Medicaid Waivers

Medicaid home and community-based services (HCBS) waivers allow individuals with intellectual or developmental disabilities, physical disabilities or mental illness to receive care in their homes and communities instead of nursing facilities, hospitals or intermediate care facilities. Waivers enable individuals to have more control of their lives and be active participants in their communities.

The programs are called waivers because, under federal law, individuals living with disabilities and chronic conditions are entitled to facility-based care, but home and community-based care is considered optional. Each new or innovative program must have approval from CMS.

Although ODM has responsibility for all Ohio’s HCBS waivers, it administers only the Ohio Home Care Waiver. The PASSPORT and Assisted Living waivers are administered by the Ohio Department of Aging (ODA). The Ohio Department of Developmental Disabilities (DODD) administers the Transitions DD, Individual Options, Level One and SELF waivers.

Highlights of HCBS waiver activities include:

- » Ohio Medicaid phased out and terminated the **Transitions Carve-Out Waiver (TCOW)** on June 30, 2015. TCOW rules were rescinded effective July 1, 2016, to enable providers of TCOW services to bill for services rendered in the final days of the waiver.

TCOW served individuals age 60 and older receiving a nursing facility level of care and who were previously enrolled on the Ohio Home Care Waiver. Throughout SFY15, ODM worked with ODA to move more than 1,300 individuals to the more comprehensive Pre-Admission Screening System Providing Options and Resources Today (PASSPORT) program. Additionally, individuals who are on the Ohio Home Care Waiver will now also have the opportunity to enroll in PASSPORT at age 60.

- » The **Self-Empowered Life Funding (SELF) Waiver** renewal application continues through June 30, 2020. The renewal permits individuals with intellectual and developmental disabilities to continue to be served through the waiver instead of institutionalization and allows participant-directed services.

- » As part of the **Transitions Developmental Disabilities (TDD) Waiver** renewal, effective July 1, 2015, DODD plans to transition enrolled individuals onto Ohio’s Individual Options, SELF, or Level One waiver. The phase-out of the TDD Waiver, to be completed by June 30, 2017, aligns with the goal of reducing the number of waivers administered in Ohio. It will also provide individuals currently enrolled on the TDD waiver with access to a broader array of services, which will allow for access to the full benefits of community living.
- » Ohio’s 1915(c) home and community-based services **Level One Waiver**, approved July 1, 2011, allows individuals with intellectual and developmental disabilities to be served through the waiver in lieu of institutionalization. The State has submitted a renewal request to CMS for another five-year waiver span with an effective date of July 1, 2016.
- » The **PASSPORT Waiver** serves individuals age 60 and older, and offers 21 distinct services, including participant-directed services. The **Assisted Living Waiver** serves individuals 21 and older who require an environment that offers more immediate access services and supervision than a traditional community residence. In SFY16, both waivers were amended to increase the number of individuals who could be enrolled, which will allow greater access to community living options for more people.

Ohio Benefits Long-Term Care

Ohio Benefits Long-Term Care (OBLTC) is the name for Ohio’s no wrong door, single-entry point (NWD/SEP) system that will fulfill ODM’s commitment to removing barriers and expanding access to long-term care services and supports. The OBLTC system is designed with the local Area Agencies on Aging serving as lead agencies. The initiative will launch in late 2016.

The goals of the NWD/SEP are to:

- » increase awareness of the full range of home and community-based options available to individuals;
- » provide objective information to individuals and families on accessing long-term services and support; and
- » assist individuals and families so they may make informed decisions about the care and services they receive.

HOME Choice

Ohio’s HOME Choice Program continued to be a national leader throughout SFY16 in transitioning individuals out of institutional settings and back into homes in the community. Ohio’s version of the federal Money Follows the Person (MFP) program again received national recognition by ranking first among MFP states in transitioning individuals living with mental illness and second overall in total transitions completed (11 percent of total transitions for the 44 participating states).

New milestones achieved in SFY16 by HOME Choice included reaching 8,000 transitions in May 2016. There were 1,675 transitions recorded in 2015, which is more than 300 above any previous year for Ohio.

Targeted education and outreach to children’s hospitals, residential treatment facilities and other institutions providing services to infants, children and young adults, resulted in significant increases in enrollment for the birth to age 21 population. This population accounts for 27 percent of current HOME Choice enrollees, a 40 percent increase over the previous year. In comparison, 43 percent are in the 22 to 59 age group and 30 percent are in the 60 and over age group.

Ohio’s MFP program has continued to focus on housing challenges. In 2016, hundreds of HOME Choice participants were able to access MFP-sponsored programs to overcome the common housing barriers of affordability and accessibility. Rental subsidies, home modifications, and assistance with obtaining disability benefits were among the housing-focused services available for HOME Choice participants.

Effective July 2015, Ohio started using the Q+ algorithm, which assigns a score to each resident based on different domains of the Minimum Data Set (MDS) assessment, to identify and reach out to additional residents with community living potential. Ohio expanded its scope with MDS data and these outreach efforts have led to a 28 percent increase in the HOME Choice application rate in 2016.

Figure 3.1 HOME Choice Transitions by Calendar Year

	2008	2009	2010	2011	2012	2013	2014	2015	2016*	Total
MI/SUD	0	5	31	201	504	578	564	719	345	3,292
PD	2	136	320	455	425	423	427	507	285	3,265
Elderly 60+	1	82	141	220	203	215	243	296	105	1,611
ID/DD	67	134	31	41	88	136	98	153	100	948
Total Transitions	70	357	523	917	1,220	1,352	1,332	1,675	835	8,281

* Information available at the time of publication (half year)

Ohio Home Care Operations

Since 2012, Ohio Medicaid has been modernizing its nursing facility-based level of care (NF-based LOC) HCBS waivers and continues to offer more choice to individuals who are served through home and community-based programs. SFY16 highlights include:

- » **HCBS Transition Plan Approved.** In SFY16, Ohio received initial approval of its proposed transition plan to meet the CMS new requirements for Medicaid HCBS programs administered by states. The final regulation enhances the quality of HCBS, provides additional protections to individuals who receive HCBS, and establishes the characteristics of the settings in which they can live and/or receive services. The regulation also defines person-centered planning requirements to empower individuals to express their wants, needs and preferences, and to identify and access medically necessary services and supports.

In accordance with the transition plan and with the assistance of waiver participants, providers, partnering sister agencies, advocates, case management and provider oversight contractors and other key stakeholders, Ohio Medicaid developed two new Ohio Administrative Code (OAC) rules to outline the new HCBS settings characteristics and person-centered planning requirements (OAC rules 5160-44-01 and 5160-44-02, respectively). Ohio Medicaid also provided training components to assist nursing-facility NF-based LOC waiver providers, case managers and participants with implementation.

- » **Ohio Home Care Waiver Open Enrollment.** Ohio Medicaid instituted its first-ever open enrollment for Ohio Home Care Waiver case management services, enabling individuals to freely select from among the two case management agencies participating in the service region where they live. ODM invited all Ohio Home Care Waiver participants to take part in open enrollment and approximately 150 elected to switch case management agencies.

- » **Ohio Home Care Waiver Amended.** The Ohio Home Care Waiver was also both amended and renewed in SFY16. The waiver was initially amended in April 2016 to reflect the addition of the HCBS settings and person-centered planning requirements, as well as modifications and improvements to the waiver’s case management and provider oversight structure and functions, eligibility requirements and quality improvement strategy. New policy was added, which permitted the enrollment of individuals dis-enrolling from another NF-LOC waiver in certain circumstances. The waiver was renewed for another five years effective July 1, 2016.
- » **Ohio Home Care Waiver Self-Directed Services.** In SFY16, Ohio Medicaid began exploring the feasibility of offering self-directed services in the Ohio Home Care Waiver. This service allows individuals to exercise more choice and control over, and manage more aspects of the care and services they receive, to support them in their homes and community.
- » **People Served.** As of June 2016, the Ohio Home Care Waiver provided HCBS to 6,440 Ohio residents. ODM expects to serve between 6,000 and 8,000 in SFY17.
- » **Provider Oversight.** To help maintain program integrity, ODM contracts with Public Consulting Group (PCG) for provider oversight services, which include initial review of enrollment and revalidation of providers; onsite reviews of high and moderate-risk providers; incident investigations for Ohio Home Care, MyCare Ohio and HOME Choice; annual structural reviews of Ohio Home Care and MyCare Ohio waiver providers; and provider education.

In SFY16 PCG completed 4,738 initial application reviews and revalidations; 572 on-site visits; approximately 1,250 incident investigations; and 2,330 structural reviews and multiple training sessions for waiver providers across the state.

Nursing Facilities

During SFY16, Ohio Medicaid continued to work with state partners to ensure that individuals receive quality services in Ohio’s nursing facilities. The partners include the Ohio Departments of Aging (ODA), Developmental Disabilities (DODD), Health (ODH) and OhioMHAS, and the Office of the State Long-Term Care Ombudsman.

ODM participates with ODH, ODA and the Ombudsman to review selected ODH citations issued during the nursing facilities’ licensure and certification survey process. The multiple perspectives help provide a comprehensive evaluation of the citations and improve the quality of services provided in Ohio’s nursing homes over time.

The payment rate for each nursing facility is a reimbursement formula that includes a quality incentive payment. A new methodology for measuring quality, developed with various state agencies and stakeholders, became effective July 1, 2016. The new reimbursement formula financially incentivizes nursing facilities to deliver high-quality services to Ohioans by setting thresholds for selected measures. Each measure will have a reimbursement value and a nursing facility will receive additional reimbursement for each point earned.

ODM has laid groundwork to offer several new specialty programs for participating nursing facilities. The programs are being developed with stakeholders to serve populations with unique needs in a cost-effective manner with a quality payment component.

Home and Community-Based Services Regulation

In March 2014, the CMS implemented new regulations for Medicaid HCBS waiver programs. The intent is to ensure that individuals receiving services and supports through Medicaid HCBS waiver programs have full access to community living and are able to receive services in the most integrated settings.

The regulation established the person-centered plan, described the characteristics of home and community-based settings and adopted additional requirements for provider-owned or -controlled home and community-based residential settings. CMS required Ohio Medicaid to perform an assessment of current home and community-based settings and develop a plan for bringing all settings into compliance no later than March 17, 2019.

The new federal regulations require all states to submit a transition plan describing the actions they will take to ensure compliance with the regulations. Ohio Medicaid worked extensively with ODA and DODD to develop and finalize a Statewide Transition Plan. Ohio was granted initial approval of its plan by CMS on June 2, 2016.

Final federal approval will follow the completion of several activities required in the plan, including an assessment of all HCBS settings and a remediation strategy to resolve any site-specific issues.

Ohio is one of only three states to achieve initial approval of its statewide HCBS transition plan from CMS.

Waiver Quality Reviews

Ohio Medicaid takes various steps to ensure compliance with the CMS standards and ongoing improvement of Ohio's HCBS waivers, including:

- » interviewing randomly selected waiver participants;
- » reviewing care plans for randomly selected waiver participants;
- » resolving case-specific problems;
- » generating, compiling, and analyzing data;
- » producing performance reports;
- » holding semi-annual quality briefings with each waiver operating agency;
- » holding quarterly multi-agency quality steering committee meetings; and
- » performing audits and fiscal reviews.

Every year, ODM interviews approximately 300 Ohioans on each HCBS waiver. During SFY 16, the agency completed reviews on the Individual Options Waiver (July 2015), Ohio Home Care Waiver (October 2015), Assisted Living Waiver (March 2016), and PASSPORT Waiver (May 2016).

At least twice a year, Ohio Medicaid convenes a quality assurance meeting with each agency that administers Medicaid HCBS waivers. Such meetings provide an opportunity to review performance data, identify trends and patterns, and develop quality improvement plans. During SFY 16, ODM held these briefings in September 2015 and May 2016 with ODA, and August 2015 and February 2016 with DODD.

ODM also leads an interagency HCBS Waiver Quality Steering Committee (QSC), which meets quarterly. The QSC is a forum in which representatives from ODM, DODD, ODA, and case management vendors examine performance data across HCBS waiver systems, provide updates on quality assurance activities, and share best practices. During the past year, QSC meetings have focused on Quality Improvement Science methods, the National Quality Forum’s effort to improve HCBS performance measurement, a special analysis to identify at-risk candidates for Naloxone, and a Medicaid project to reduce potentially preventable hospital readmissions.

Figure 3.1 SFY16 Ohio Medicaid Waiver Enrollment

MyCare Ohio	Ohio Home Care Waiver	PASSPORT Waiver	Assisted Living Waiver	Transition DD Waiver	Individuals Options Waiver	Level One Waiver	S.E.L.F.
27,902	6,440	27,227	4,203	2,157	20,068	15,161	706

4

Managed Care

Today, nearly 80 percent of Medicaid beneficiaries are insured through private managed care plans. The Ohio Department of Medicaid contracts with five health plans to deliver person-centered, coordinated care to the majority of individuals served by the program.

Through innovative programs such as MyCare Ohio, which in SFY16 was the first dual demonstration in the nation to be extended two additional years, Ohio Medicaid is working with its managed care partners to improve care quality and achieve better health outcomes.

New Initiatives

Most individuals who have Ohio Medicaid must join a managed care plan to receive their health care. Managed care plans work with hospitals, doctors and other health care providers to coordinate care and to provide the health care services that are available with an Ohio Medicaid card.

ODM achieved the following in SFY16:

- » Initiated efforts to enroll new populations into managed care next year, including children in custody, individuals participating in the Bureau of Children with Medical Handicaps program, and Breast and Cervical Cancer program members.
- » Approved optional managed care enrollment for individuals enrolled in home and community-based waivers administered by DODD. Efforts included changing language in contracts, reconfiguring systems, and reaching out to stakeholders.
- » Worked with CMS to become the first state in the nation to extend the duals demonstration, My Care Ohio, two additional years until December 31, 2019. MyCare Ohio coordinates health care delivery for individuals served by both Medicare and Medicaid.
- » Developed a new care management strategy, which will adopt a population health management approach. Responsibility for population health will shift from the managed care plans to capable providers to increase access to patient-centered medical homes.
- » Collaborated with CMS to adopt the first new federal managed care rule updates in more than a decade.
- » Developed new actuarially sound capitation rates for managed care organizations during calendar year 2016 that included a 1.6% reduction from the prior year rates. This represents an anticipated savings to Ohio.

Care Management

In 2015, ODM took initial steps to improve Medicaid's care management strategy. The transformation began in 2016 and will continue to roll out over the next two years. The new care management strategy will adopt a population health management approach, which focuses on five established populations: women of reproductive age, those with chronic conditions, behavioral health conditions, healthy adults and children. Responsibility for population health will shift from the managed care plans to capable providers through access to patient-centered medical homes. The shift aligns with the Office of Health Transformation's value-based purchasing efforts.

The new framework will position the Medicaid managed care program for service and population expansions (e.g., behavioral health carve-in and children in custody). By 2018, each Medicaid managed care member will be in a member-chosen care management arrangement with a plan or provider that is positioned to connect with the member and address consumer- and provider-determined health goals.

Quality Strategy and Measures

Ohio Medicaid's Quality Strategy provides a blueprint to improve health care outcomes for Medicaid populations. Process and outcome measures, which are quantifiable and performance driven, are used to evaluate Medicaid programs and services in a meaningful way to drive quality improvement. Performance measurement is focused on high impact populations, guiding the appropriate care for:

- » high risk pregnancy/premature births;
- » behavioral health;
- » cardiovascular disease;
- » diabetes;
- » asthma; and
- » upper respiratory infections.

One of ODM's quality initiatives is to measure the five managed care plans' performance levels and hold the managed care plans accountable.

The expectation was that managed care plans should meet or exceed established minimum standards on specific performance measures for the high impact populations listed above, as well as measures related to prenatal and postpartum care and access to primary care. The managed care plans met 17 of the 21 standards measured by ODM.

Ohio Medicaid is committed to implementing its Quality Strategy in new ways with Medicaid managed care plans to further improve health outcomes. In the upcoming year, ODM is shifting to a value-based strategy by taking a population health management approach. This strategy will proactively manage clinical and financial opportunities to improve health outcomes and patient engagement, while also reducing costs.

Pay for Performance

Under its Pay-for-Performance program, ODM utilizes financial incentives to reward managed care plans for high levels of performance and to encourage improvement in program priority areas.

The program uses key clinical performance measures to evaluate Medicaid's most critical clinical conditions as outlined in the department's Quality Strategy.

The managed care plans' results are compared to standards based on national data. A plan with better results will receive more incentive money, while ODM requires a plan with low results to develop and implement quality improvement initiatives.

For CY14, the Medicaid plans were awarded just over \$30 million (26 percent) of roughly \$116 million in available incentives. Collectively, the five managed care plans earned a higher percent of available incentive money than in the previous year.

ODM has challenged the plans to commit to continuous quality improvement in the clinical areas of focus highlighted by the Pay-for-Performance program.

Consumer Satisfaction Survey

Medicaid Managed Care

Ohio Medicaid relies on a series of quality assessment and improvement activities to ensure that high-quality health care services are available to individuals insured through Medicaid managed care plans. Annual surveys of member experience and satisfaction with health care provide important feedback on managed care plan performance, and identify potential opportunities for program improvement.

Each year, state managed care plans must administer Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Surveys to their Medicaid members. A National Committee for Quality Assurance (NCQA) Certified Survey Vendor collects the data and submits it to ODM. Ohio Medicaid averages the results for comparison with NCQA National Medicaid benchmarks. Results for the adult and child populations are reported separately.

From February to May 2015, the Medicaid managed care plans' survey vendors collected data using the CAHPS® 5.0H Adult Medicaid Health Plan Survey and the CAHPS® 5.0H Child Medicaid Health Plan Survey (for children with chronic conditions measurement set), respectively.

CAHPS® satisfaction measures are derived from individual questions that ask for a general (or global) rating, as well as groups of questions that form composite measures.

Survey Results

- » Compared to national Medicaid percentiles, Ohio's Medicaid managed care program had good to excellent performance (i.e., the program's means were at or above the 50th percentile for all eight core measures for the child population, and seven of the eight core measures for the adult population).
- » Compared to national Medicaid data, the program's mean was at or above the 75th percentile for all four composite measures and two of four global ratings for the child population. For the adult population the program's mean was at or above the 75th percentile for one of four composite measures and one of four global ratings.
- » Areas of excellent performance included How Well Doctors Communicate (both adult and general child populations), Rating of All Health Care (general child population), Getting Care Quickly (general child population), and Customer Service (general child population). For each of the areas, the program mean was at or above the 90th percentile compared to national Medicaid percentiles.
- » Ratings for the general child population tended to be higher than those for the adult population.

Infant Mortality

Infant mortality is the death of a baby within the first year of life. Most infant deaths are attributable to preterm births, poor maternal health, serious birth defects, and sleep-related deaths.

The 2014 Infant Mortality Data Report from the Ohio Department of Health showed slight improvement in Ohio's overall infant mortality rate, down from 7.4 infant deaths per 1,000 live births in 2013 to 6.8 in 2014. However, Ohio's rate – especially the black infant mortality rate – remains too high and exceeds the national average. The infant mortality rate for black infants

(14.3/1,000) is more than twice that of white infants (5.3/1,000). During SFY 15, Governor Kasich announced new efforts to combat infant mortality. Ohio Medicaid is central to those plans as Medicaid covers 52 percent of Ohio's births. The department has taken clear action to address the problem.

Key initiatives have included:

- » identifying priority regions in which infant mortality and disparities in infant health outcomes are highest;
- » connecting pregnant women and babies in these communities with enhanced high-risk care management benefits;
- » enlisting the support and resources of the Medicaid managed care plans to provide additional resources at the local level to remove barriers that may limit attaining better birth outcomes;
- » organizing a formal improvement effort to streamline the provision of Progesterone to prevent pre-term births; and
- » funding research in a partnership to better understand best-practice methods of group care for expectant mothers in targeted Ohio communities to inform future improvement efforts.

Ohio Medicaid and its partners are committed to ensuring that all Ohio babies are born and remain healthy. The extension of Medicaid coverage to previously uninsured individuals is helping to ensure that prospective parents are able to tend to their ongoing health care needs prior to becoming pregnant. These aggressive approaches to combatting infant mortality will carry into the following fiscal year with statewide multi-payer, value-based purchasing efforts including newborn deliveries driving the transparency in performance and outcomes.

MyCare Ohio

MyCare Ohio is a five-year demonstration project aimed at coordinating health care delivery for individuals served by both Medicare and Medicaid. The demonstration is a collaborative effort between Ohio Medicaid, CMS, and five private managed care plans. MyCare Ohio is a fully capitated program that provides comprehensive services to Medicare-Medicaid enrollees. The demonstration integrates and coordinates health care delivery by:

- » utilizing managed care to improve continuity and coordination of patient-centered care;
- » providing a primary contact for beneficiaries;
- » focusing on individual choice and control of care delivery;
- » coordinating long-term care, behavioral health services, and physical health services;
- » encouraging and supporting an individual's right to live independently;
- » reducing the overall cost of care for the individual, Medicare, and Medicaid; and
- » providing a seamless transition between settings and programs.

Ohio Medicaid recently completed the first full year of Medicare passive enrollment, which began on January 1, 2015. Beneficiaries maintain the freedom to 'opt-out' of the Medicare benefits if they choose. Since its implementation, the average monthly enrollment for MyCare Ohio is approximately 94,000 individuals in 29 Ohio counties. Approximately 68

percent of MyCare Ohio enrollees are enrolled for both Medicare and Medicaid benefits, optimizing the benefits of care coordination.

Throughout the fiscal year, Ohio Medicaid coordinated with CMS through bi-weekly calls and facilitated monthly meetings with the MyCare Ohio plans. The department also regularly sought the assistance and feedback of provider and consumer advocacy groups. In this past year, Ohio Medicaid made policy changes to improve the experiences of individuals needing transportation to and from medical appointments, as well as the care management component of the demonstration. Ohio Medicaid continues to work closely with all entities to inform policy and monitor progress.

The effectiveness of MyCare Ohio and its care coordination requires further evaluation. In SFY16, Ohio Medicaid, CMS and the managed care plans extended the three-year demonstration to five years to allow more time for evaluation. Over the next several years, outcomes of these care coordination processes are expected to produce positive and measureable results.

5

Providers

Ohio is home to more than 90,400 active Medicaid providers. The relationship between Ohio Medicaid and its provider network is critical to ensure reliable and timely care for beneficiaries across the state. Expanded use of the Medicaid Information Technology System continues to improve provider management and aids in communicating new initiatives to existing providers.

Additionally, Ohio Medicaid remains committed to protecting taxpayer dollars and enhancing program integrity efforts. The agency continues to work with various state entities to ensure the timely and accurate payment of provider claims, while finding new ways to curb instances of fraud, waste, and abuse.

Provider Site Visits & Revalidation

Throughout SFY16, ODM continued to strengthen program integrity efforts during the provider enrollment process and the five-year provider agreement revalidation process. In addition to automated screenings of applicants through various federal exclusion databases, ODM collects and screens information about owners and managing employees of those provider organizations.

Since the beginning of Ohio's revalidation process of all provider agreements in 2013, ODM has revalidated more than 41,000 providers and is working to complete its first full cycle of revalidation by the end of 2016.

Ohio Medicaid contracts with Public Consulting Group (PCG) to execute unannounced provider site visits as part of its focus on provider types that have been deemed high risk for fraud. Wheelchair van providers, durable medical equipment providers and non-Medicare certified home health agencies have all been cited as provider types that are at a heightened risk for potential fraud and abuse.

In SFY16, PCG completed 578 of 698 attempted unannounced inspections on behalf of Ohio Medicaid. Based on the results of the site visits, further action may include provider sanctioning, corrective action, or referral to the Ohio Attorney General's Office in cases of suspected fraud. In SFY16, ODM referred three cases to the Office of the Ohio Attorney General. Ohio Medicaid expects the number of site visits to increase during the first quarter of 2017 as many provider types are in the process of revalidating their Medicaid provider agreement.

Ordering, Referring, Prescribing Providers

Throughout SFY16, Ohio Medicaid continued its efforts to comply with federal program integrity regulations concerning practitioners who order, refer, or prescribe (ORP) services for individuals on Medicaid.

In accordance with Section 6401 of the Patient Protection and Affordable Care Act and 42 CFR 455.410(b), all physician and non-physician practitioners who "ORP" or certify a Medicaid-covered service are required to be actively enrolled in the Medicaid program. This regulation also requires that the practitioner's National Provider Identifier and name be on claims submitted for payment to the Ohio Department of Medicaid. ODM screens providers who apply for an ORP status in the same manner that it screens all active billing providers.

Ohio Medicaid implemented ORP regulations in two phases with the first phase completed in SFY15 and 5,700 individual providers fully enrolled. As of June 2016, a total of 8,455 individual providers have fully enrolled as ORP providers. This enrollment number is expected to rise significantly during the summer of 2016 as this year's medical students graduate, enter residency programs and begin to enroll as ORP providers with ODM.

Medicaid Information Technology System

Since its launch in 2011, the Medicaid Information Technology System (MITS) has proven to be a vital resource in completing timely and accurate payment of provider claims. During SFY16, MITS implemented overtime payments for independent providers as directed by the U.S. Department of Labor, as well as a process to check the State of Ohio Medical Board File. Additionally, HP Enterprise Services now completes the Medicaid fee-for-service prior authorizations using MITS.

MITS undergoes regular maintenance and upgrades to ensure that all operations are conducted efficiently. Such system improvements to the provider enrollment and claims payment functions preserve the integrity of the Ohio Medicaid program.

Program Integrity

The Ohio Medicaid Program Integrity Group (PIG) is a collaborative initiative that brings together Ohio Medicaid, the Ohio Auditor of State, and the Ohio Attorney General – all of whom operate complementary Medicaid integrity sections.

Together, the respective entities create data mining algorithms to identify fraudulent Medicaid providers and coordinate responses to these findings. Their coordinated approach has been nationally recognized as a best program integrity practice. The PIG continued to refine its efforts in SFY16 and increased coordination with other program integrity partners. The success of the PIG model led to the development of similar groups aimed at ensuring program integrity in managed care organizations and exploring creative ways to find patterns of abuse in prescription drugs.

Pairing the PIG's work with the findings of additional audit programs within ODM is essential to fostering lasting success. When the results of an ODM review indicate that an incident of fraud has occurred in the Medicaid program, ODM refers the case to the Attorney General's Medicaid Fraud Control Unit (MFCU). ODM assists the Attorney General by providing supporting documentation and resources as needed, while also protecting the privacy rights of individuals covered by the Medicaid program.

Additionally, Ohio Medicaid accepts referrals from the Attorney General that may lead to the recovery of improper payments made to providers. The PIG also engages representatives from the Centers for Medicare and Medicaid Services to discuss procedures, investigations, and provider areas that are at a heightened risk for fraud or abuse.

In SFY 16, the MFCU of the Attorney General recorded:

- » 137 indictments;
- » 127 convictions; and
- » \$63.4 million in recovery.

The U.S. Department of Health and Human Services Office of Inspector General issues an annual report that highlights statistical achievements from the investigations and prosecutions conducted by 50 MFCUs nationwide. The latest issuance covers Federal Fiscal Year 15 and Ohio was number one in fraud convictions and number two for indictments.

Bureau of Program Integrity

The Bureau of Program Integrity's (BPI) comprehensive approach for preventing and detecting fraud, waste, and abuse focuses on collaboration and partnership with key stakeholders.

In an effort to build upon Medicaid's nationally recognized efforts to detect fraud, waste, and abuse, the agency reorganized its BPI. This included merging the Bureau of Audit into BPI, expanding the Surveillance Utilization Review Section (SURS) function, and realigning staff to provide enhanced focus in Long-Term Care and Post-Payment Review (LTC-PPR), Managed Care Audit, County Program Integrity, and State Agency and Sub-recipient Monitoring.

In addition, the BPI increased its coordination efforts with Ohio Attorney General Mike DeWine's MFCU. This included key processes for identifying and referring potential Medicaid fraud cases, determinations of credible allegations of fraud and related internal processes, expanding upon program integrity coordination efforts already identified as national best practices, increasing communication and fraud awareness with ODM partner state agencies, and identifying opportunities to coordinate more closely with Ohio's managed care plans in the fight against fraud, waste, and abuse. BPI-SURS continued its long-time coordination efforts with Ohio Auditor of State Dave Yost on provider audits.

BPI supports provider enrollment and provider suspension efforts by partnering with the ODM Network Compliance team. It is increasing collaboration with the ODM pharmacy team on fighting drug addiction and abuse through coordination with the Ohio Medical Board and Ohio Pharmacy Board.

BPI continues to promote efficiency and effectiveness by updating processes related to home health care fraud referral, credible allegation of fraud, county fraud referrals, monitoring Electronic Health Record incentive payments, and tracking and reporting key metrics.

During SFY16:

- » LTC-PPR issued 187 final adjudication orders and 789 final resolution reports to nursing homes and intermediate care facilities. These audits identified recoveries of \$17.75 million owed to the state.
- » SURS staff conducted 735 provider reviews that identified overpayments of \$2.8 million.
- » SURS adopted 17 audit reports issued by the Auditor of State totaling \$3.2 million.
- » ODM referred 664 cases to the Attorney General's MFCU, including those from managed care plans. According to MFCU, Ohio is a national leader in managed care plan fraud referrals. Coordinated efforts in home health care fraud referrals accounted for 154 of the 664 referrals made.

Additionally, Medicaid providers may independently discover cases of overpayment by ODM. When this occurs, providers contact the agency with the overpayment information and arrange for repayment. During SFY16, providers conducted 39 self-reviews, totaling overpayments of \$532,000.

Inpatient Hospital Review Contract

The Ohio Department of Medicaid contracts with Permedion to conduct retrospective reviews primarily focused on inpatient hospital care. The reviews assist ODM in determining whether care rendered to an individual meets medical necessity and quality of care standards.

Any hospital with findings from a review may appeal them to Permedion. If Permedion upholds the findings, the provider may then request a Surveillance and Utilization Review.

In SFY16, Permedion reviewed 13,399 inpatient cases that resulted in denials and/or adjustments to 4,874 claims, which saved \$35 million. Permedion also completed 3,099 outpatient reviews resulting in 1,960 cases being denied for using incorrect coding, which saved \$3.9 million.

From July 1, 2015 through September 30, 2015, Permedion also conducted pre-certification reviews for certain inpatient medical procedures. During that time, hospitals were required to obtain pre-certification for all procedures that were performed in an inpatient hospital setting that can usually be performed in an outpatient setting. In SFY 16, Permedion completed 180 reviews for the first three months of the state fiscal year, which resulted in five denials and a savings of \$66,005. Effective October 1, 2015, ODM stopped requiring pre-certification for inpatient medical procedures, but continues to require prior authorization on certain medical procedures.

Prior authorization is required on all medical procedures that Medicaid typically does not cover as described in Ohio Administrative Code. This includes inpatient and outpatient services that may be considered experimental in nature or may be routinely performed for cosmetic purposes. Permedion conducts prior authorization reviews on these types of services in order to determine if the requested service is medically necessary, and if the desired setting of the service is medically appropriate.

In SFY 16, Permedion completed 1,046 reviews, which resulted in 59 denials and a savings of \$430,526.

Third Party Liability

Health care providers are prohibited from billing the State of Ohio for services when third-party resources are responsible for payment. Those other sources may include private insurance companies, Medicare, or court-ordered coverage. Under federal and state law, Medicaid is the payer of last resort.

Ohio Medicaid staff aggressively monitors payment and updates its systems to ensure that claims pay properly. System enhancements during SFY16 have improved the tracking of dollars paid to providers, while also assisting larger program integrity efforts.

Through the work of ODM's Cost Avoidance staff, the State of Ohio avoided more than \$864 million in billed charges for health care services during SFY16.

Changes in insurance or other events can affect the payment responsibility after ODM has paid a claim. Ohio Medicaid contracts with the company HMS to collect payment on behalf of the department. HMS specializes in recovering medical expenses paid by the state when a legally obligated third-party source is later identified.

In SFY16, HMS's activities resulted in more than \$62 million being returned to Ohio Medicaid.

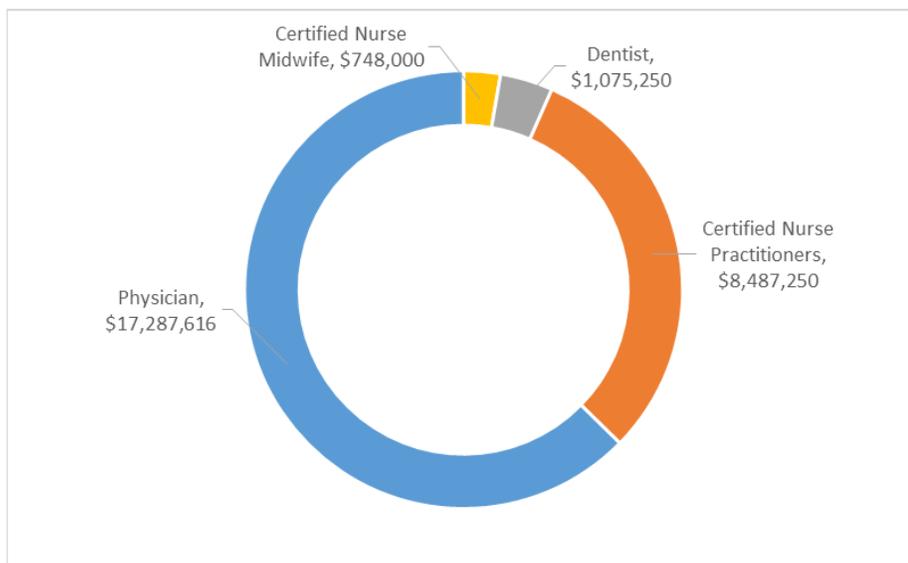
Provider Electronic Records Growth

Ohio Medicaid continues to work with doctors, hospitals and other health care providers to convert paper medical records to electronic formats. Electronic medical records allow for more efficient sharing of information among patients, insurers and providers. Ohio Medicaid has become a national leader in its assistance to medical professionals and hospitals making the transition to electronic health records.

Although the need to migrate paper records to electronic platforms is growing, the process is expensive and time-consuming for providers. In order to meet the demand for modernization, Ohio Medicaid has been aggressive in securing Ohio's share of federal Medicaid Provider Incentive Program funding to help health care providers make a successful transition.

Since work began in 2011, Ohio Medicaid ranks fourth in the nation for the total number of Medicaid incentive payments (15,273) distributed to providers and sixth in the nation for total amount paid by the program (more than \$441 million). In SFY16, Ohio Medicaid distributed 2,815 payments totaling nearly \$41.8 million. Additionally, Ohio Medicaid made more than \$14 million dollars in incentive payments to qualifying hospitals.

Figure 5.1 Medicaid Provider Incentive Program - Payments by Provider Type



Appendix A

Medicaid Quality Strategy

Ohio Medicaid's Transformational Quality Strategy

**Making Ohio Better
by improving the health of Ohioans.**

Focus Populations

Design & Implement "Pay for Value"

Desired Health Improvements:
Health Equity

Healthy Children & Adults

Women of Reproductive Age (14 to 45)

Behavioral Health

Chronic Conditions

Preventative Screenings

Improved pre-term birth & infant mortality rates

Integrated Behavioral & Physical Health Care
Appropriate Prescribing

Well Managed Asthma, Diabetes & Hypertension



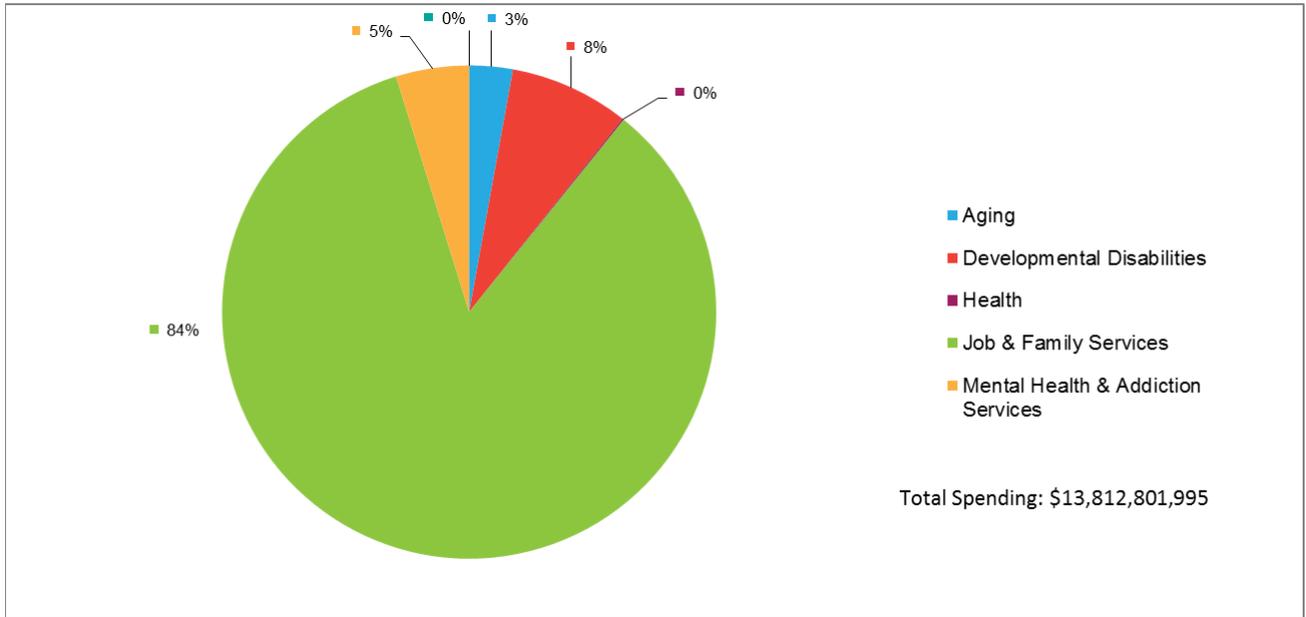
SPECIAL INITIATIVES

Behavioral Health Redesign & Infant Mortality Reduction

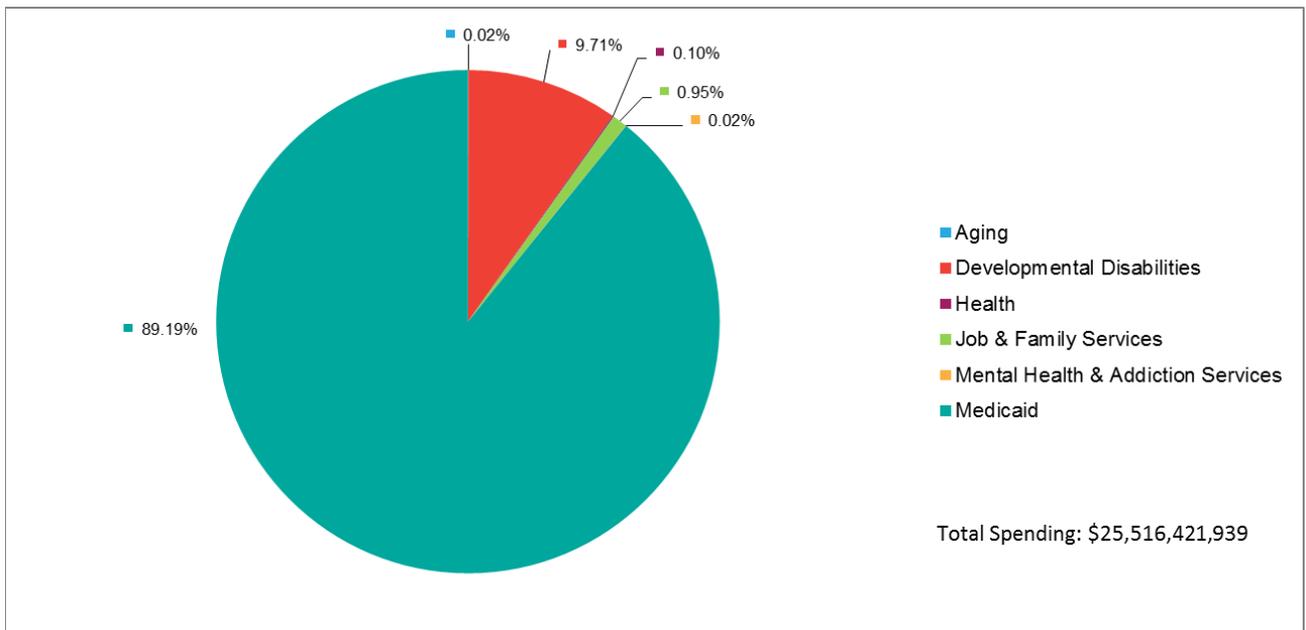
Appendix B

Medicaid Data

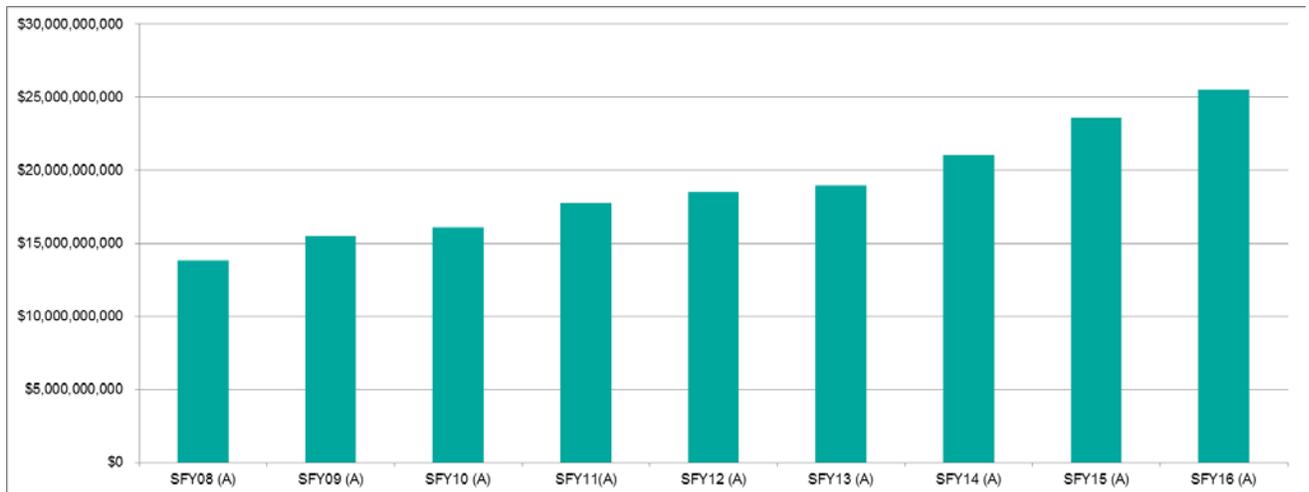
1. Medicaid Expenditures By Agency SFY 08



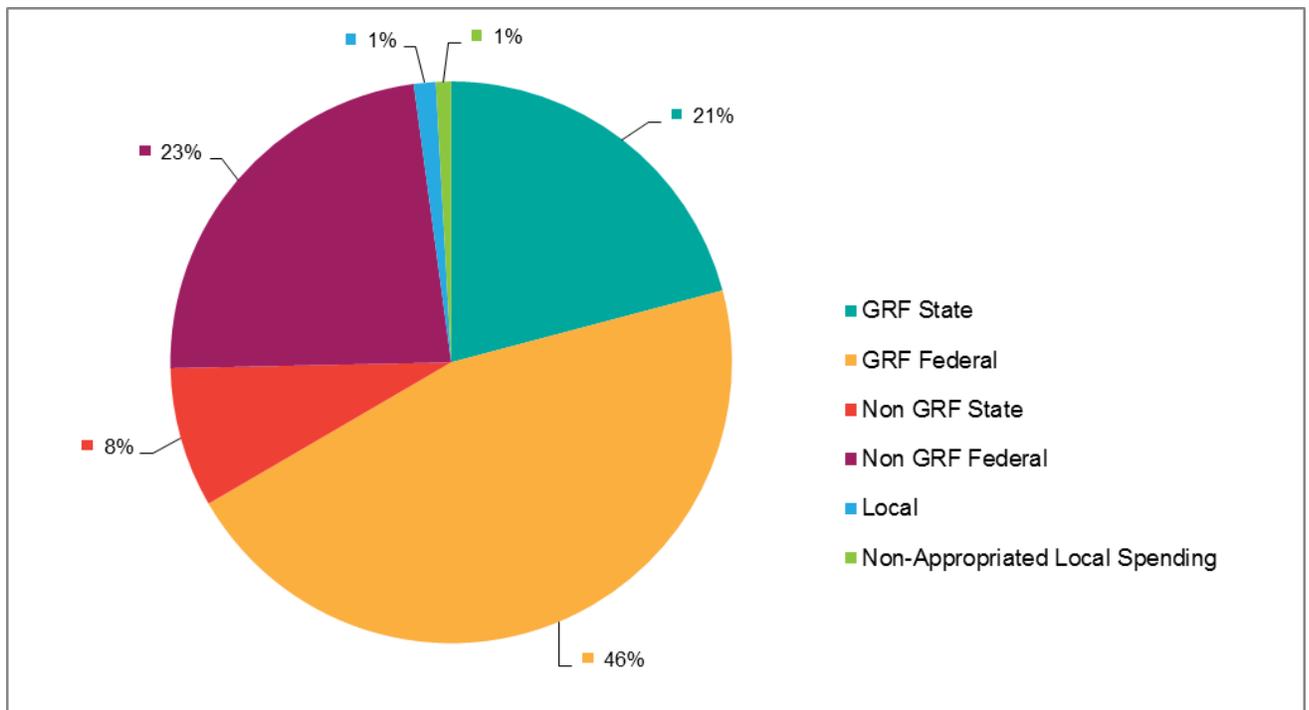
2. Medicaid Expenditures By Agency SFY 16



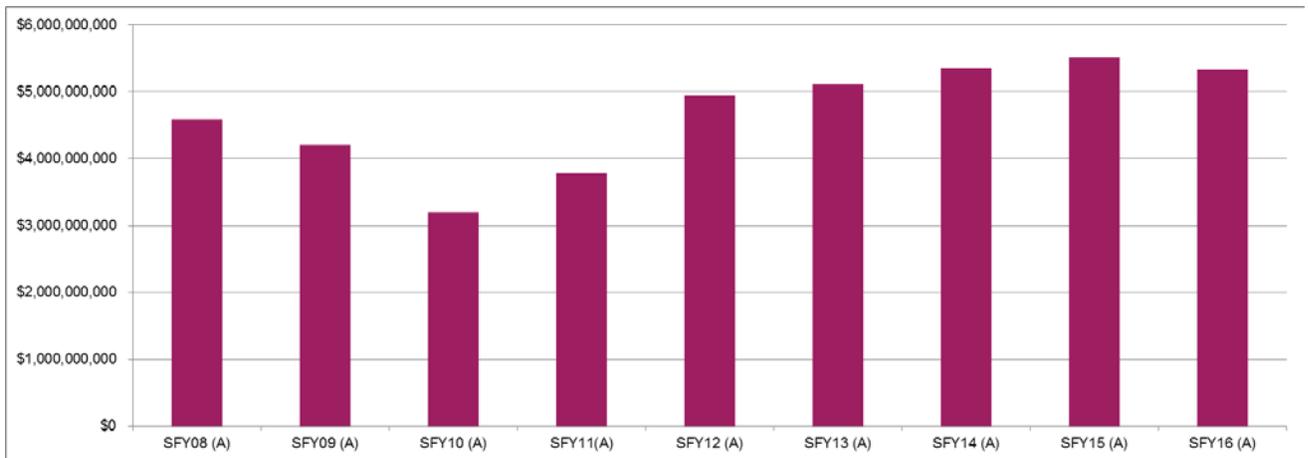
3. All Agency Medicaid Expenditures Actual/Budget SFY08 - SFY16



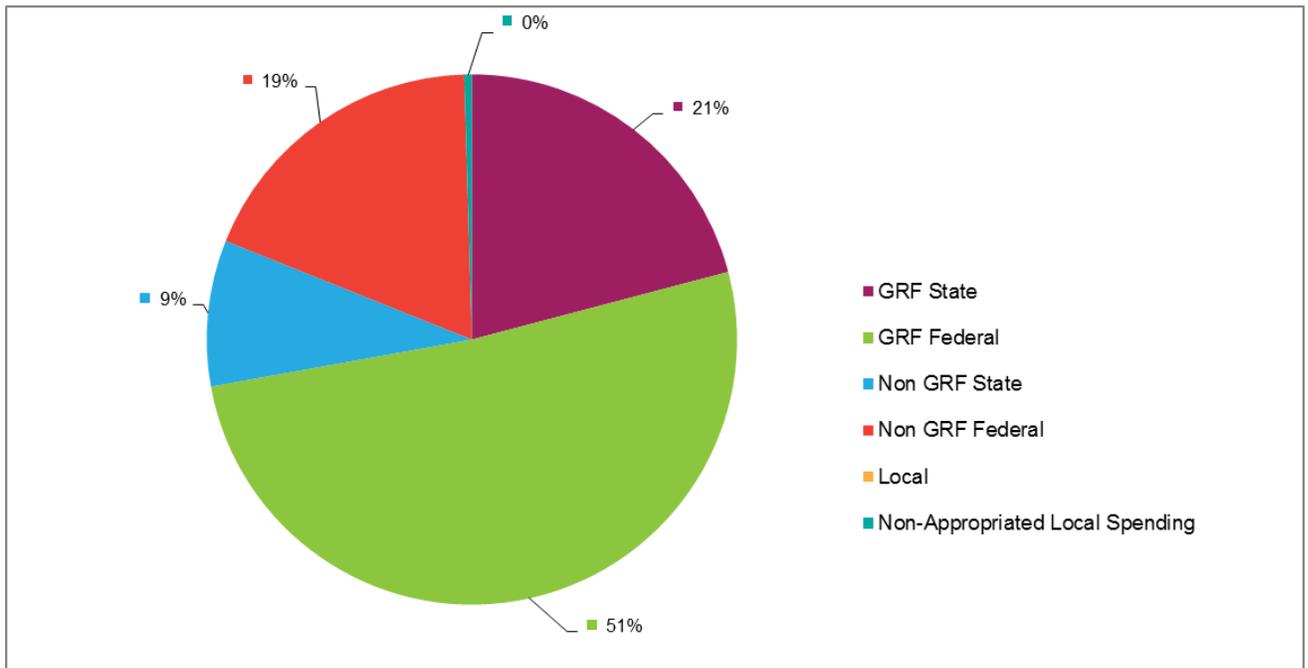
4. All Agency Medicaid Spending by Funding Source SFY16



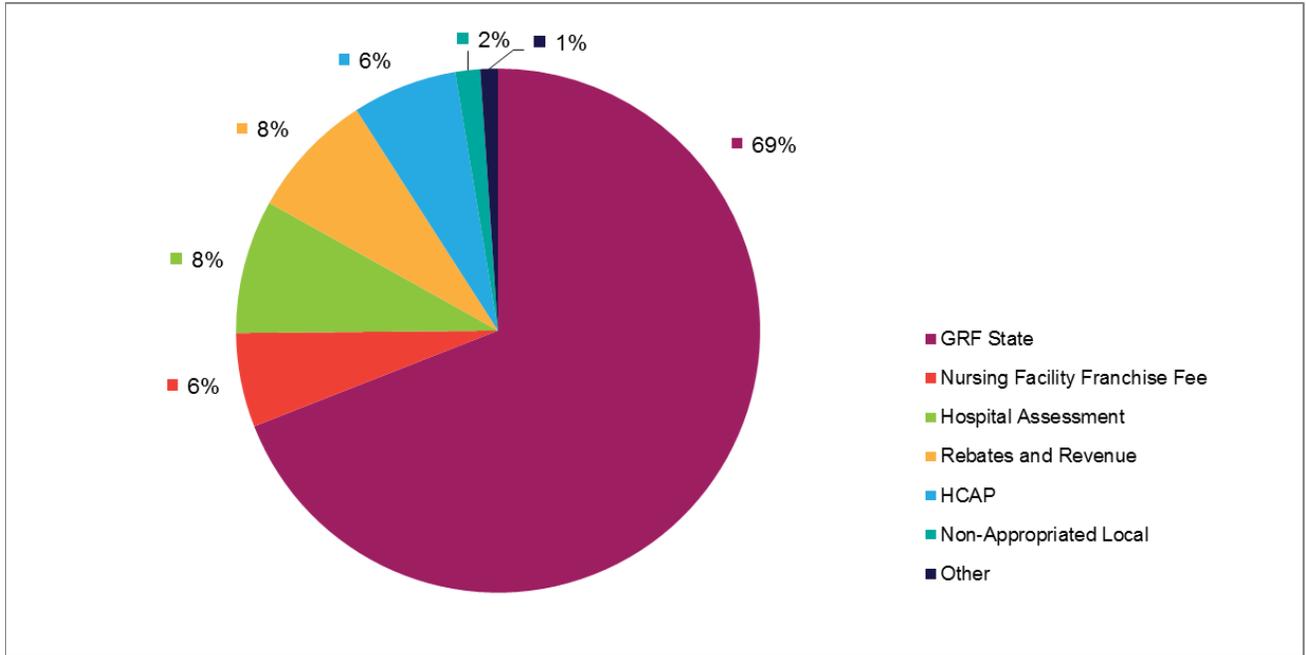
5. All Agency Medicaid GRF State Share



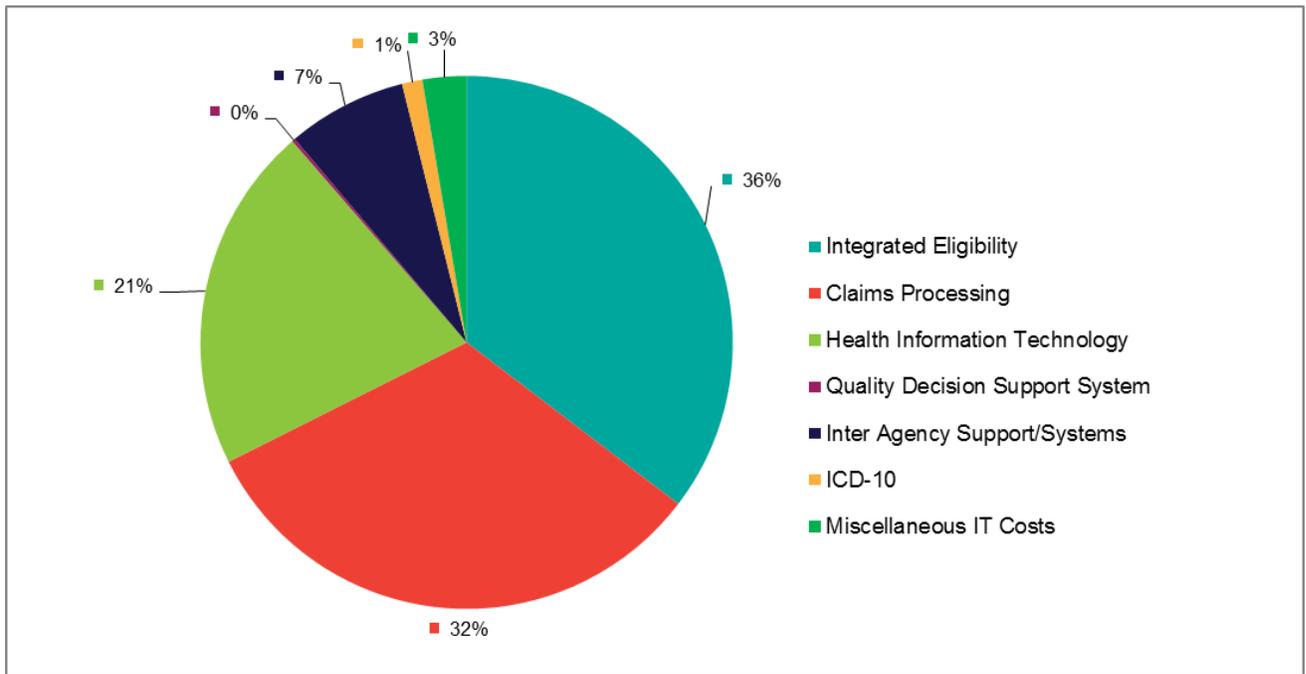
6. ODM Medicaid Spending by Funding Source SFY16



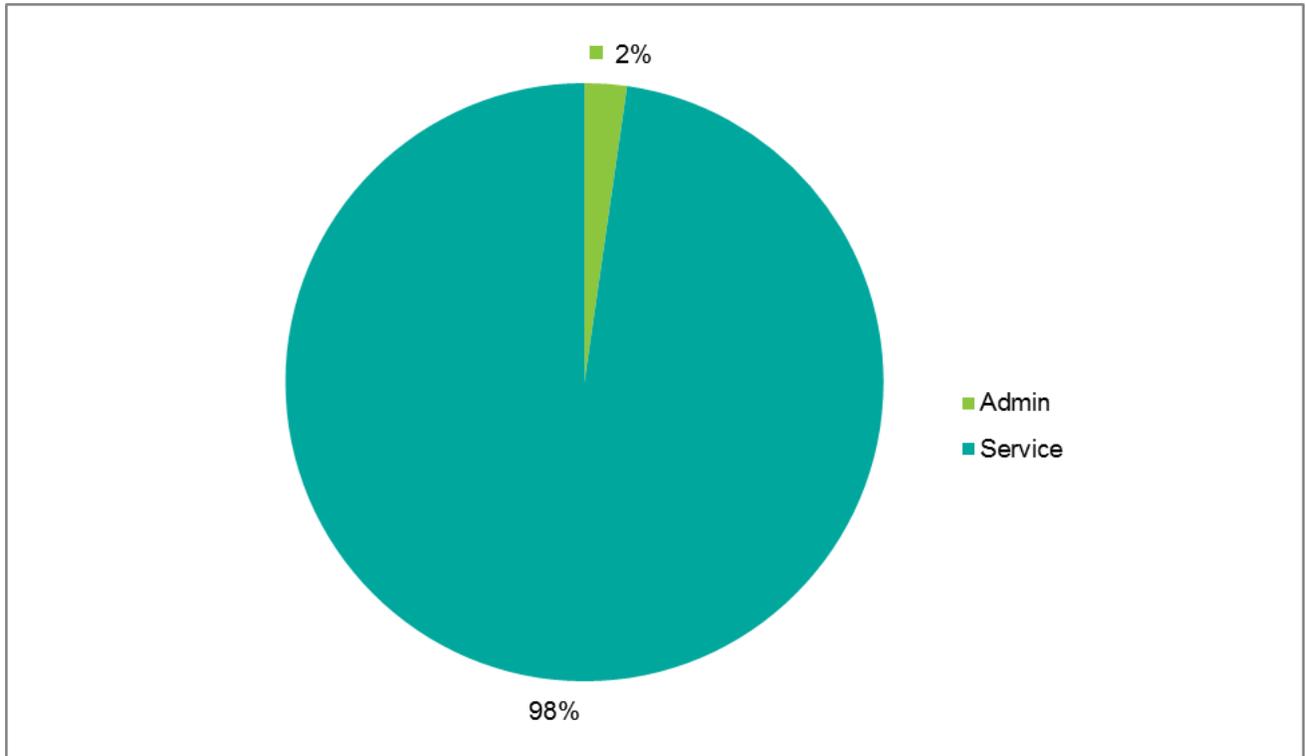
7. ODM Medicaid State Match by Funding Source SFY16



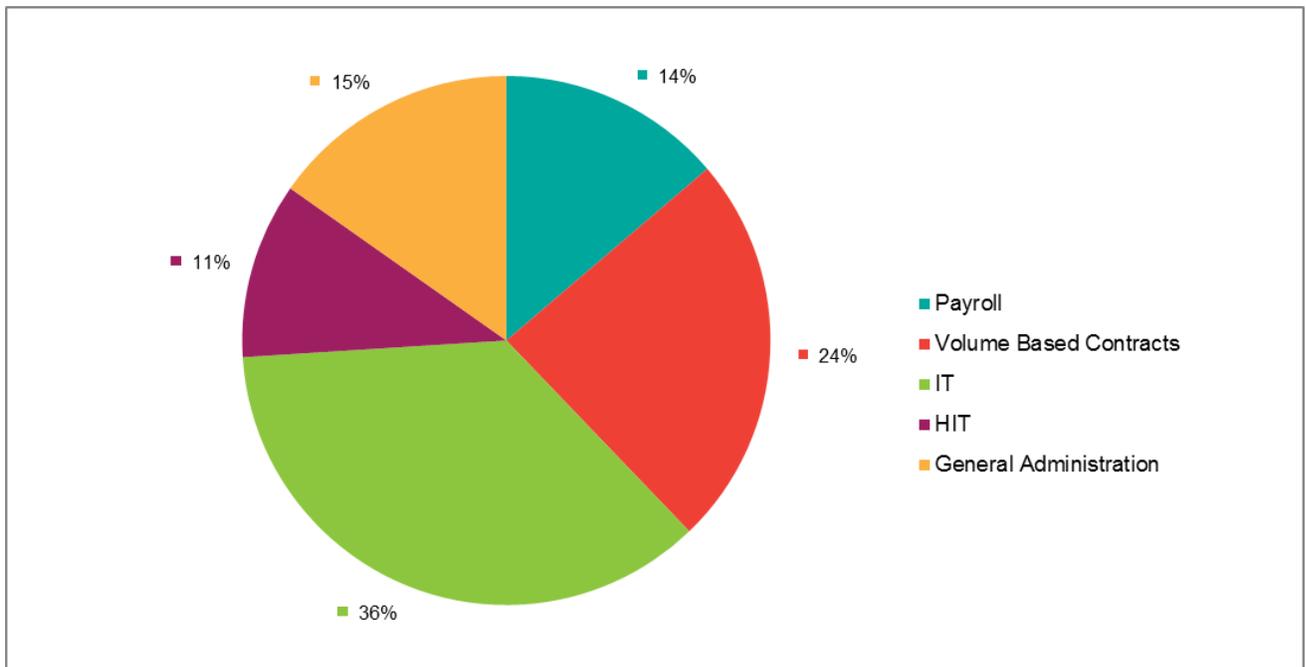
8. ODM IT Expenditures SFY16



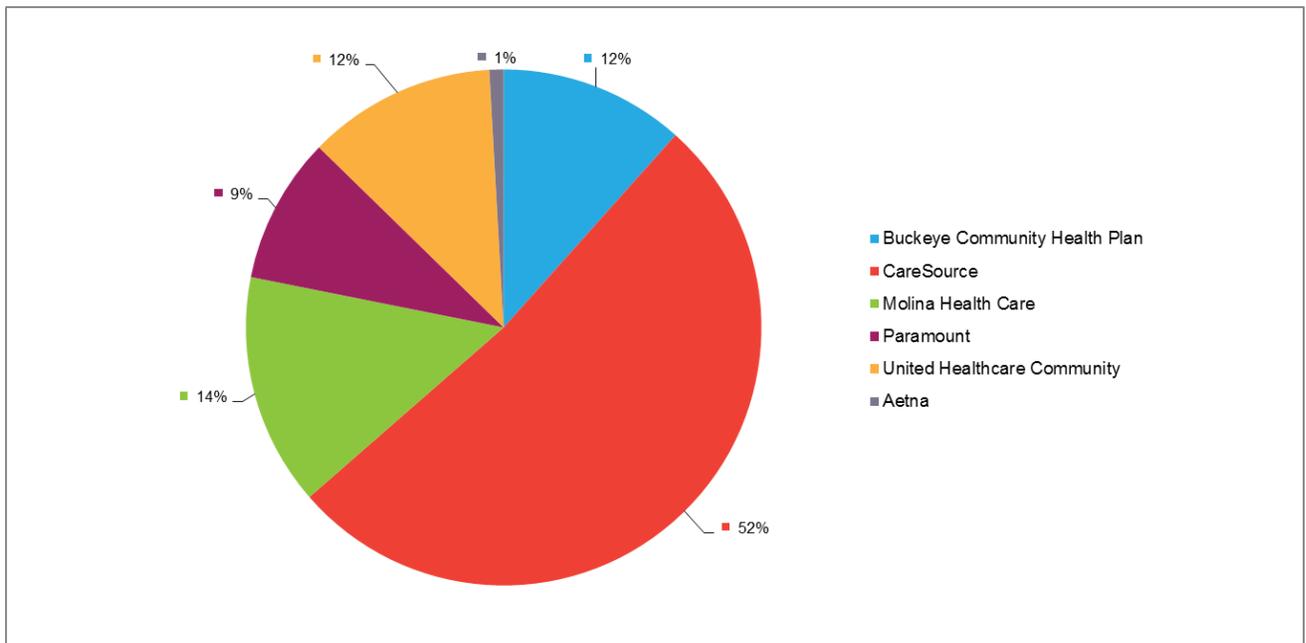
9. ODM Administration vs Services SFY16



10. ODM Administration By Type FY16



11. Medicaid Managed Care Enrollment by MCP – SFY16



12. Average Monthly Medicaid Enrollment Actual/Estimated SFY08 – SFY16

