As health care reform is front and center in Ohio and nationally, the role of our agency in delivering high quality health care coverage while maintaining a sustainable Medicaid program is more important than ever. Thanks to Governor John R. Kasich’s leadership, Ohio Medicaid remains a stable health insurer with a program growth of 1 percent in 2017, down from 8.9 percent in 2009 through 2011, making it possible for the state to responsibly extend Medicaid coverage to an additional 1.1 million Ohioans since 2014, covering approximately 700,000 individuals per month.

In collaboration with our sister agencies, stakeholder and advocacy groups, and the legislature, we continue to build on Ohio’s health care transformation.

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

• extending benefits of care coordination to additional populations and strengthening the focus on quality of care by enrolling individuals in managed care;

• prioritizing home and community-based services so that seniors and people with disabilities have the option to live with dignity in the setting they prefer, especially their own home, instead of a higher-cost setting like a nursing home;

• modernizing outdated reimbursement policies by establishing a definitive relationship between what a provider is paid and the effectiveness of the services provided;

• changing the way Ohio Medicaid pays for health care to decrease costs and improve health outcomes by rewarding better care, not just more care; and

• rebuilding Ohio’s community behavioral health system capacity through new services, better care coordination, and alignment with national coding standards.

Through these reforms, and many others, Ohio Medicaid is making Ohio a healthier place to live and work.

Sincerely,

Barbara R. Sears
Director, 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 CORE VALUES

Innovation
Continuously driving positive change to Ohio’s healthcare landscape through creativity, curiosity, and challenging convention.

Collaboration
Working together openly and inclusively to reach mutual goals.

Stewardship
Efficiently and conscientiously managing the public resources entrusted to us.

Accountability
Establishing and using meaningful measurable performance standards for all we do.

Integrity
We are committed to being honest and ethical in all we do.

Passion
We are committed to people and determined to succeed.
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ADMINISTRATION

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. Roughly 89 percent of Ohio’s Medicaid population receive 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 to improve health care across the state and modernize how health care is delivered to the people served by the program. Figures 1.1 - 1.10 below illustrate basic demographics and healthcare utilization for Medicaid’s eligibility groups.

FIGURE 1.1

Group VIII

Number of Members

FIGURE 1.2

Aged, Blind, Disabled, Medicaid Buy In for Workers w/ Disabilities, and Duals

Number of Members

FIGURE 1.3

Covered Families & Children, and Modified Adjusted Gross Income

Number of Members

FIGURE 1.4

All Others

Number of Members

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Group VIII Assessment

The Ohio Medicaid Group VIII Assessment is one of the nation’s most comprehensive reviews of a state’s Medicaid expansion population (called Group VIII for the section of federal code that expanded the program). At the request of the Ohio General Assembly, Ohio Medicaid commissioned the assessment, which was then independently developed and carried out by a partnership of the Ohio Colleges of Medicine Government Resource Center, The Ohio State University College of Public Health, Ohio University, and RTI International. The report found that Medicaid expansion improved enrollees’ health care access and overall health, while also making it easier to work or find work and pay for housing.

Employment/Stability

- Nearly all new enrollees (89.0%) had no health insurance at the time of enrollment
- 75% of new enrollees looking for a job reported that coverage made their job search easier
- 52% of new enrollees with jobs reported that coverage made it easier to work
- 59% of all new enrollees reported that having coverage made it easier for them to buy food
- 48% of all new enrollees reported that having coverage made it easier to pay for housing
- The percentage of enrollees with medical debt fell by nearly half (55.8% to 30.8%)

Physical and Mental Health

- 47% of all new enrollees reported improvement in their overall health
- 32% of all new enrollees were diagnosed with substance abuse or dependence
- 27% of all new enrollees were diagnosed with at least one chronic health condition
- Of those who have gained coverage since January 2014, 500,000 have had behavioral health needs addressed

Access to Care

- 43% of all new enrollees reported a decline in unmet health care needs
- 34% of all new enrollees reported going to the emergency department less
- Nearly half of all new enrollees have shown improvements in the management of their chronic conditions

View the full Group VIII Assessment Report on the ODM website.
Medicaid State Plan

Every state’s Medicaid program is administered through a set of requirements known as the Medicaid State Plan. The State Plan serves as the contract between the state and the federal government and documents each state’s covered groups, services, reimbursement methodologies and program administration.

Changes to the State Plan are accomplished through the submission and approval of State Plan Amendments (SPAs) to the Centers for Medicare and Medicaid Services (CMS). During SFY17, ODM submitted 29 SPAs to CMS.

More information on Ohio Medicaid State Plan and all recent amendments can be found here.

POLICY

Behavioral Health Redesign

Ohio Medicaid and its partner 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 and the Ohio Department of Mental Health and Addiction Services, ODM is implementing a series of reforms to enhance the quality of care delivered to the residents we serve. Work over the last two and a half years has been accomplished with the assistance of behavioral health stakeholders representing a large number of both community mental health agencies and substance use disorder treatment facilities across the state. SFY17 highlights include work toward the following changes, which are expected to be implemented beginning January 1, 2018.

- the development of new services for individuals, both adult and multi-system youth, with high intensity service and support needs;
- care coordination across physical and behavioral health care services; and
- recoding of all Medicaid behavioral health services to achieve alignment with national correct coding standards.

Additional changes will follow through 2020. Details about the Behavioral Health Redesign initiative can be found at bh.medicaid.ohio.gov.

Payment Innovation

In December 2014, the Centers for Medicare and Medicaid Innovation awarded Ohio a State Innovation Model 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.

In SFY17, ODM enrolled 111 practices into the Ohio Comprehensive Primary Care (CPC) program. ODM and the Governor’s Office of Health Transformation, along with input from provider, advocate and payer focus groups,
developed this payment model aimed at rewarding team-based primary care that holds down the total cost of care, for public and private payers, by preventing disease and managing chronic conditions. The model design included input from more than 800 stakeholders across Ohio. Over 830,000 lives are covered by the 111 practices enrolled in Ohio CPC.

ODM also continued its work with Medicaid managed care plans and private insurers to set payment and quality thresholds for the second wave of episode models for Wave 2 episode-based payments. The 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.

The performance period for Wave 1 episodes began January 1, 2017, and will run through December 31, 2017. 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.

Ohio Medicaid, along with the Governor’s Office of Health Transformation, Medicaid managed care plans and private insurers, also began developing an additional 30+ episodes during SFY17. Wave 3 episodes will be introduced in batches over the next year. Wave 3 includes new episodes, like attention-deficit hyperactivity disorder, oppositional defiant disorder, neonatal episodes, skin and soft tissue, and dental episodes.

**Transportation Brokerage System**

Transportation is an increasingly important component of health care for low-income older adults and people with disabilities. The SFY18/19 Ohio Medicaid budget proposed a transportation brokerage system to help improve the efficiency and effectiveness of non-emergency transportation for Medicaid beneficiaries while meeting federally required core components for the transportation. ODM intends to have regional transportation brokerage contract(s) in place during SFY19.

ODM’s goal is to improve transportation services for Medicaid beneficiaries by addressing challenges in accessing the transportation benefit provided by the 88-county departments of job and family services. Under the current model, each county department of job and family services is responsible for coordinating non-emergency medical transportation for its county’s residents. This arrangement can have limitations based on geographical borders and result in inconsistent service delivery from county to county, and can be unreliable. Being late for, or missing, medical appointments can have serious consequences for individuals enrolled on Medicaid.

Non-emergency transportation funding will transition from the Ohio Department of Job and Family Services to ODM. Brokers operate in the transportation space as managed care plans operate in the health care space.
A state or managed care plan contracts with a transportation broker that is usually paid a capitated fee for a geographic area. Brokers generally contract with local transportation providers and function as a call center and gatekeeper to services. The Medicaid beneficiary goes through the broker to arrange a ride.

Authorized transportation types include wheelchair vans, taxis, personal cars and taxis. Contracts with transportation broker(s) and transportation providers will include standards to ensure consistent response times, scheduling and provision of transportation services for individuals, regardless of where they live in the state.

Ohio's plan to contract with third-party transportation broker(s) to manage Medicaid non-emergency medical transportation on a regional basis will provide better transportation options for Medicaid beneficiaries. It will also allow Ohio to draw down an enhanced federal match saving an estimated $6.8 million annually.

LONG-TERM SERVICES AND SUPPORTS

Electronic Visit Verification

ODM is implementing an Electronic Visit Verification system to validate service delivery to eligible individuals by authorized service providers, significantly reduce the risk of paying improper claims, and reduce the administrative burdens related to the “pay-and-chase” model. Ohio's innovative model will rely on GPS technology instead of traditional telephony to improve the accuracy of service verifications, as well as devices provided to individuals using services so that they can confirm services have been provided. More information about the system can be found here.

Medicaid Home and Community-Based Services Waivers

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. The Federal Centers for Medicare and Medicaid Services (CMS) must approve each new or innovative program with a waiver. 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.

ODM is responsible for all of Ohio's HCBS waivers even if other agencies operate them. The PASSPORT and Assisted Living waivers are operated by the Ohio Department of Aging. The Ohio Department of Developmental Disabilities operates the Individual Options, Level One, Transitions DD (closed 6/30/17) and Self-Empowered Life Funding (SELF) waivers. ODM administers the Ohio Home Care Waiver.

Waiver Quality Review

Ohio Medicaid takes various steps to ensure compliance with the CMS standards as well as ongoing improvement of Ohio's HCBS waivers.
Every year, ODM interviews approximately 300 Ohioans enrolled on HCBS waivers. During SFY17, ODM completed a review of the Ohio Home Care Waiver (November 2016), conducted a special review of HCBS (July 2016) and an initial and baseline review of the Specialized Recovery Services Program (March 2017).

### FIGURE 2.1 - WAIVER ENROLLMENT

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<thead>
<tr>
<th></th>
<th>Assisted Living</th>
<th>PASSPORT</th>
<th>ODA Waivers Total</th>
<th>Individual Options</th>
<th>Level One</th>
<th>SELF</th>
<th>Transitions</th>
<th>ODD Waivers Total</th>
<th>Ohio Home Care</th>
<th>MyCare Ohio</th>
<th>ODM Waivers Total</th>
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<td>26,571</td>
<td>20,068</td>
<td>15,161</td>
<td>706</td>
<td>2,157</td>
<td>37,138</td>
<td>6,440</td>
<td>27,902</td>
<td>34,086</td>
<td>95,824</td>
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### Ohio Benefits Long-Term Services and Supports

Ohio Benefits Long-Term Services and Supports (OBLTSS) is the name for Ohio’s “no wrong door, single-entry point” system, which will fulfill the Ohio Department of Medicaid’s commitment to remove barriers and expand access to long-term services and supports. The goals of the initiative include:

- increasing awareness of the full range of home and community-based options available to individuals;
- providing objective information to individuals and families on accessing long-term services and supports; and
- assisting individuals and families so they can make informed decisions about the care and services they receive.

The OBLTSS system is designed with the local Area Agencies on Aging serving as lead agencies and will launch in late 2017.

### HOME Choice

Ohio’s [HOME Choice](#) Program continued to be a national leader throughout SFY17 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). HOME Choice reached a milestone of 10,000 transitions in May 2017 and as of July 2017 has transitioned 10,280 individuals.

In 2015, Ohio committed to continuing transitions through HOME Choice after the end of the federal grant funding on December 31, 2019. Sustainability planning, called MFP 2.0, began immediately and continues today. The focus of this planning is to incorporate existing HOME Choice services effectively into Medicaid’s future for Ohio.

Team members continue to have collaborative discussions within ODM and with partner state agencies and stakeholders. These discussions have helped identify critical outcomes necessary for success. The MFP 2.0 planning team will continue to ensure qualified individuals have the opportunity to live and thrive in the community of their choice.
Home Care Operations

Modernization of Ohio’s nursing facility-based level of care (NF-based LOC) Home and Community Based-Services (HCBS) waivers continued in SFY17.

HCBS Settings Regulation

In March 2014, 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.

CMS required Ohio Medicaid to develop a statewide transition plan for bringing all settings into compliance by March 17, 2019. CMS issued initial approval of Ohio’s statewide transition plan, developed in collaboration with DODD and ODA, on June 2, 2016.

Ohio Home Care Waiver Enrollment

Ohio Medicaid instituted its second open enrollment for Ohio Home Care Waiver case management services, enabling individuals to 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 50 of the nearly 6,000 individuals served on the waiver elected to switch case management agencies.

As of May 2017, the Ohio Home Care Waiver provided HCBS to more than 6,700 Ohioans. ODM expects to serve between 6,000 and 8,000 in SFY18.

Nursing Facilities

During SFY17, 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, Developmental Disabilities, Health and Mental Health and Addiction Services, and the Office of the State Long-Term Care Ombudsman. ODM participates with the Ohio Departments of Health and Aging and the Ombudsman to review selected Ohio Department of Health citations issued during the nursing facilities’ licensure and certification survey process.

ODM has laid groundwork to offer two new specialty programs for participating nursing facilities. The programs were developed with stakeholders to serve populations with unique needs in a cost-effective manner with a quality payment component. The programs include both a specialized rehabilitation program and a program for ventilator dependent individuals.
MANAGED CARE

MyCare Ohio

Ohio Medicaid, in partnership with the Centers for Medicare and Medicaid Services, launched the MyCare Ohio duals demonstration in May 2014 to bring better health outcomes to dual-eligible individuals who have both Medicare and Medicaid benefits. MyCare Ohio managed care plans coordinate Medicare and Medicaid services across physical, behavioral, and long-term services and supports for 107,000 individuals in 29 counties. Ohio was the third state in the nation to earn federal approval for its dual demonstration program, which is authorized through December 31, 2019.

In April 2017, Ohio Medicaid released a three-year evaluation of the MyCare Ohio demonstration program that reported significant benefits for Ohioans enrolled in the program and taxpayers. See MyCare Ohio Three-Year Progress Report for more information.

Quality Strategy

Ohio Medicaid’s new transformational quality strategy provides a blueprint to improve health care outcomes for the three million individuals enrolled on Medicaid. The quality strategy takes a population health management approach, which customizes outcome improvement strategies depending on risk level and population stream.

Each Medicaid managed care plan divided its members into the following population streams: women of reproductive age, those with chronic conditions, behavioral health conditions, healthy adults and children. The plans developed a model of care for each population, which takes into account its unique characteristics and began implementation with their highest risk members.

Measuring processes and outcomes are key to evaluating the success of the managed care plans’ quality improvement initiatives. Results of these measures, which are quantifiable and performance driven, are provided in the next section.
to the plans to hold them accountable and to drive quality improvement. ODM expects the plans to meet or exceed established minimum standards on specific performance measures for each population stream.

In SFY17, the managed care plans met 15 of the 20 standards established by ODM. The 2016 Managed Care Plans Report Card can be seen [here](#).

**Care Management**

In 2017, ODM improved its care management program by aligning with Medicaid’s new transformational quality strategy. The new care management strategy adopts a population health management approach, which uses data to risk stratify members and group them into defined populations.

Strategies specific to risk levels and population streams are developed to improve quality of care, patient experience, and reduce costs of care. Responsibility for population health will shift from the managed care plans to capable providers through access to a comprehensive primary care practice. The shift also aligns with the Office of Health Transformation’s value-based initiatives.

The new framework will position the Medicaid managed care program for service and population expansions. By 2019, more high-risk Medicaid managed care members will be in a care management arrangement with a plan or provider that is positioned to connect with the individual and address their health goals.

**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 populations as outlined in the department’s transformational 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 2016, the Medicaid plans were awarded more than $48 million (34%) of roughly $142 million in available incentives. Collectively, the five managed care plans earned a higher percent of available incentive money than the previous year because of higher performance in program priority areas.

**Customer Satisfaction Survey**

Ohio Medicaid relies on 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 individuals’ experiences and satisfaction with health care provide important feedback on managed care plan performance, and identify opportunities for program improvement.

Each year, state-managed care plans must administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey to their Medicaid members. The plans contract with a National Committee
for Quality Assurance (NCQA) certified survey vendor to collect the data and submit 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 2016, 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.

CAHPS® measures include individual questions that ask for a general (or global) rating, as well as groups of questions that form composite measures. Together, these form a core set of survey items.

**Pre-Release Enrollment Program**

There are currently about 50,000 inmates in 27 institutions located across Ohio. This population has a high prevalence of chronic conditions, mental health issues, and a history of drug and/or alcohol addiction. The Medicaid Pre-Release Enrollment program began in 2014 to provide access to health services, improve health outcomes, and reduce recidivism for former Ohio inmates. Over 12,000 individuals transitioning from prison to the community have been enrolled in a Medicaid managed care plan and are able to access health care services immediately upon release because of the program.

Ohio Medicaid and the Ohio Department of Rehabilitation and Correction has trained over 150 peer educators over the course of the program to promote the importance of health care and coverage to the inmate population. These peer educators are inmates themselves, and serve a vital role in program outreach, efficiency and sustainability. Individuals with the highest needs are connected with a managed care plan care manager prior to release to help develop a health care transition plan and help see the plan through once the individual is back in the community. Approximately 1,900 individuals have received transition assistance from a care manager through the Medicaid Pre-Release Enrollment program.

Strong cross-agency partnerships with the Ohio Departments of Rehabilitation and Correction, Mental Health and Addiction Services, and Health have been key to this initiative since its inception, as well as close collaboration with the Medicaid managed care plans.

**Infant Mortality**

*Infant mortality*, defined as the death of a baby within the first year of life, are attributable mostly to pre-term births, poor maternal health, serious birth defects, and sleep-related deaths.

The Ohio Department of Health *2015 Infant Mortality Data Report* showed that since 1990, Ohio’s overall infant mortality rate has improved from 9.8 deaths per 1,000 live births in 1990 to 7.2 deaths per 1,000 live births in 2015.

However, Ohio’s rate, especially the African American infant mortality rate, remains too high and exceeds the national average. The infant mortality rate for African American infants (15.1/1,000) is more than twice that of white infants (5.5/1,000).
Ohio Medicaid covers 52 percent of Ohio’s births and aggressively addresses infant mortality by engaging with partners in key initiatives, including:

- Identifying priority regions in which infant mortality and disparities in infant health outcomes are highest so that targeted efforts achieve the greatest impact;
- Providing enhanced maternal care to women at risk of poor birth outcomes and to women who live in these priority regions;
- Enlisting the Medicaid managed care plans to provide additional resources to the high-priority communities to remove better birth outcome barriers, such as non-traditional health care workers;
- Improving data tracking and analysis capabilities so that disparities and areas of improvement, can be readily identified through dashboards;
- Collaborating with the Ohio Perinatal Quality Collaborative, Government Resource Center, managed care plans and their contracted partners to streamline the provision of Progesterone to pregnant women in order to prevent pre-term births; and
- Funding a research partnership to understand best-practice methods using predictive modeling tools to inform future improvement efforts.

Ohio Medicaid and its managed care plans are committed to ensuring that all babies born in Ohio are healthy. These aggressive approaches to combatting infant mortality will carry into the next fiscal year, with statewide, multi-payer, value-based purchasing efforts, including newborn deliveries driving transparency in performance and outcomes and paving the way for nontraditional health care entities to participate in improved outcomes.

**PROVIDERS**

**Provider Enrollment, Management, and Site Visits**

Throughout SFY17, 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.

In SFY17, ODM revalidated 7,671 providers on top of enrolling 17,085 new individual providers, group practices and organizations. In addition, ODM terminated provider agreements with 1,305 providers for failure to revalidate and suspended 32 due to credible allegations of fraud.

Ohio Medicaid contracts with an outside vendor to execute unannounced provider site visits as part of its focus on provider types that have been deemed to be at high and moderate risk for fraud. Wheelchair van providers, durable medical equipment providers and non-Medicare certified home health agencies have been identified as provider types that are at a heightened risk for fraud and abuse.
Last fiscal year, the outside vendor completed 719 site visits and referred 13 providers to the Ohio Attorney General’s Office as a result of irregularities uncovered during these visits.

**Provider Oversight**

To help maintain program integrity, ODM contracts with the same outside vendor for provider oversight services. During the first three quarters of SFY17, the outside vendor completed 2,800 initial application reviews; 513 revalidations; 490 on-site visits; more than 9,600 incident investigations across the Ohio Home Care, MyCare Ohio, HOME Choice and Specialized Recovery Services programs; 2,283 structural reviews and multiple training sessions for waiver providers across the state.

**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 which 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.

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.

In SFY 17, the MFCU of the Attorney General recorded:

- 148 indictments;
- 138 convictions; and
- $47.74 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. For the fourth year in a row, the Ohio Medicaid Fraud Control Unit (“MFCU”) ranked in the top two for indictments and convictions among all 50 MFCUs, and for FFY 2016, ranked #1 for Medicaid provider fraud convictions.
The Bureau of Program Integrity’s comprehensive approach for preventing and detecting fraud, waste, and abuse focuses on collaboration and partnership with key stakeholders.

During SFY17:

- LTC-PPR redesigned its audit approach for nursing homes and intermediate care facilities to make them more efficient and effective, promote the use of data and technology, and limit the burden on providers. These audits identified potential recoveries of about $18.8 million owed to the state by nursing facilities and about $1.5 million for intermediate care facilities.
- SURS staff conducted 463 provider reviews that identified overpayments of $1.6 million.
- SURS adopted 17 audit reports issued by the Auditor of State totaling $3.2 million.
- ODM referred 773 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 107 of the 773 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 SFY17, providers conducted 77 self-reviews, totaling overpayments of $1.3 million.

**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 SFY17 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 $1.4 billion in billed charges for health care services during SFY17. Additionally, in SFY17, the activities of an outside vendor resulted in more than $58 million being returned to Ohio Medicaid.
APPENDIX A
Quality Strategy Map

Ohio Medicaid’s Transformational Quality Strategy

Making Ohio Better by improving the health of Ohioans.

Focus Populations

Healthy Children & Adults
Women of Reproductive Age (14 to 45)
Behavioral Health
Chronic Conditions

Design & Implement “Pay for Value”

Social Determinants of Health
Patient-Centered Medical Homes
Value-Based Purchasing
Community Engagement
Actionable Data

Desired Health Improvements: Health Equity

Preventative Screenings

Integrated Behavioral & Physical Health Care
Appropriate Prescribing

Well Managed Asthma, Diabetes & Hypertension

Behavioral Health Redesign & Infant Mortality Reduction

Ohio Department of Medicaid
John R. Kasich, Governor
Barbara B. Sears, Director
March 2017
APPENDIX B

1. All Agency Medicaid Expenditures Actual/Budget SFY08-SFY17

[Bar chart showing expenditures by year from SFY08 to SFY17]

2. All Agency Medicaid Spending by Funding Source SFY17

[Pie chart showing percentage distribution of funding sources]
3. All Agency Medicaid GRF State Share SFY08-SFY17

![Bar chart showing Medicaid expenditures by year from SFY08 to SFY17.]

4. ODM Medicaid Spending by Funding Source SFY17

![Pie chart showing Medicaid spending by funding source for SFY17.]

- GRF State: 52%
- GRF Federal: 22%
- Non GRF State: 18%
- Non GRF Federal: 8%
- Local: 0%
- Non-Appropriated Local Spending: 0%
5. ODM Medicaid State Match by Funding Source SFY17

6. ODM IT Expenditures SFY17
7. ODM Administration vs Services SFY17

8. ODM Administration by Type FY17
9. Medicaid Managed Care Enrollment by MCP - SFY16

![Chart showing Medicaid Managed Care Enrollment by MCP - SFY16]

- United Healthcare Community: 12%
- Buckeye Community Health Plan: 12%
- Aetna: 1%
- Paramount: 9%
- Molina: 13%
- CareSource: 53%

10. Average Monthly Medicaid Enrollment Actual/Estimated SFY08-SFY16

![Chart showing Average Monthly Medicaid Enrollment SFY08-SFY16]

- FFS - Full Benefits
- MC - Full Benefits
- Other