



30 East Broad Street Columbus, Ohio 43215-3414
jfs.ohio.gov

Testimony of Cristal A. Thomas
Ohio Medicaid Director
Before the Joint Legislative Committee on Medicaid Technology and Reform
October 3, 2007

Madam Chair Jones, Chairman Niehaus and members of the Committee, thank you for inviting me to speak to you today and provide an update on some of the important work being done by the ODJFS Office of Ohio Health Plans. I will focus my remarks on some key topic areas on which you have requested updates. They are:

- Implementation of key initiatives in the 2008-2009 Biennial Budget
- The development of a Medicaid Information Technology System (MITS)
- The development of the Executive Medicaid Management Administration (EMMA)

Each of these initiatives has been under taken by the Strickland Administration to improve the efficiency and effectiveness of the services and supports ODJFS and our sister agencies offer to Ohioans who need them.

Update on The Implementation of Initiatives in Am Sub HB 119

First, I want to thank the members of the Ohio General Assembly for your keen interest and partnership as we debated many important changes and expansions to Ohio's Medicaid and related health care programs. The list of initiatives that emerged from HB 119 was extensive, but also very exciting. Staff within ODJFS have been working non-stop since July 1st to flesh out, plan and implement the new initiatives contained within the budget, many of which have very tight timeframes. In the interest of time, today I will cover a few key items as part of my verbal testimony and then refer you to the written testimony and attached document that provide a more detailed listing of key initiatives enacted in the 2008-2009 Biennial Budget and our status in implementing each.

The four major categories I want to touch on today are: 1) Health care expansion initiatives; 2) Reinstating Medicaid services to adults; 3) Improvements in Medicaid Program Integrity initiatives; and 4) Rate increases for Medicaid providers.

Health Care Expansion Initiatives

The Health Care Expansions contained in HB 119 included several initiatives, aimed at improving the lives of Ohioans. Medicaid expansions were enacted for:

- Children in families with incomes between 200-300% of the federal poverty level;
- Pregnant women with incomes between 150 – 200% FPL;

- Teenagers in foster care or receiving Title IV-E services when they turn 18 and until their 21st birthday;
- A Medicaid “buy-in” program for workers with disabilities; and
- A long term care insurance partnership program, being implemented in conjunction with the Ohio Department of Insurance.

In addition, we will be implementing a buy-in program for children with special needs living in families with incomes > 300% of the federal poverty level. This program will help these families obtain acute and primary care as well as services and supports needed for chronic health conditions. Although we are in the process of seeking a Medicaid waiver to cover these children, we anticipate that, as budgeted, this program will be funded with state dollars.

Once implemented, these expansions mean that over 30,000 Ohioans will have access to coverage and services that are not available to them today. It means that pregnant women will be able to access prenatal care and have healthier babies. It means that Ohioans with disabilities who can and want to work will be able to do so without losing the health care benefits that help them remain independent.

These expansions are the first phase of Governor Strickland’s broader health care reform goal to provide access to quality, affordable health resources for every Ohio child and reduce the number of uninsured Ohioans by 500,000 by 2011. We are working with ODI and a diverse group of stakeholders in pursuing this goal, which will ultimately lead to a Healthy Ohio.

Restoring Medicaid Services for Adults

HB 119 contained funding to restore full coverage of dental services for adults as well as reinstitute coverage for chiropractic and independent psychology services. Access to these services, which are important to maintaining the good health of Medicaid enrolled adults, will become effective January 1, 2008.

Improving Medicaid Program Integrity

HB 119 contained a number of “provider network management” initiatives aimed at improving the program integrity for Ohio Medicaid Providers. We are in the process of implementing:

- Time limited provider agreements for non-institutional providers;
- Expanded ability for ODJFS to suspend or terminate certain types of providers when they have been indicted for certain criminal offenses; and
- A requirement for criminal background checks of Medicaid providers.

ODJFS has formed a number of agency work groups to develop processes, administrative rule changes, and system changes to implement these improvements. We anticipate that all of these changes will be effective no later than December, 2008.

Rate Increases for Medicaid Providers

HB 119 contained funding to increase provider rates as follows:

	2008	2009
Hospitals	3.3%	3.0%
Community Providers	3.0%	3.0%
Nursing Facilities	1.0%	2.75%
ICFs/MR	2.0%	2.0%

So, in summary, this is a brief list of the numerous changes contained in HB 119 we are working to implement. Please see the chart attached to my testimony for more detail.

Update on the Development of a Medicaid Information Technology System (MITS)

For the past several years, ODJFS staff have planned and anticipated the development of a new Medicaid Information Technology System, commonly referred to as MITS. As you may recall, MITS will replace our 20 year old legacy system which was created in 1985 designed to perform claims processing and payment. The new MITS will have state of the art technology and will be aligned with the Federally-defined principles for Medicaid Information Technology Architecture (MITA). Alignment with MITA is important so that Ohio's Medicaid IT system will have the greatest interoperability with other systems, software and hardware throughout the country.

Our vision is that MITS will move Ohio Medicaid toward excellence in health care operation and reform. The system will truly change the way Ohio Medicaid does business, and the way our stakeholders do business with us. MITS will have powerful data collection and analysis capabilities, allowing us to better utilize data in our policy development. Interactive web-based portals will allow our providers to submit, revise and check the status of claims electronically. It will be possible to check Medicaid eligibility and benefits online. MITS will provide an environment of collaboration for ODJFS staff, our sister state agencies, and other key stakeholders while maximizing efficiencies and reducing program costs.

Electronic Data Systems (EDS) has been selected, via a competitive bid process, as the Ohio MITS vendor. EDS staff are now on site and meeting with OHP staff to begin the Design, Development, and Implementation Phase of the project. We have started reviewing the EDS deliverables and are learning the full scope of the EDS proposed solution, called "interchange," a proven and scalable system already certified in three states. Although we are off to a good start, there is a lot more to be done before MITS is actually in operation. In broad terms, the timeline from MITS design and development is as follows.

MITS Timeline

- Phase one of the design, development and implementation process will continue through January, 2008. During this period, EDS and ODJFS staff will participate

in intensive sessions to review and align the capabilities of the EDS product “interchange” with our unique business needs. We will identify gaps and then develop solutions to fill them.

- Early in 2008, we will begin establishing the foundational architecture of the software and hardware that will be the new MITS. Subsequently, the system will be customized to meet Ohio’s business needs. Each of the business processes will be tested, retested, and validated.
- We are in discussion with EDS about developing and implementing some critical functions as early as mid-2008. Functions under discussion for this early implementation include a clinical claims editor, care management tool, a provider locator, and a web portal for providers to submit claims electronically.
- We expect the core MITS system to become operational by late 2009. Core functionality will include replacements of all current Medicaid IT functions including some advanced features such as improved claims adjudication and payment and providing internet “web” portal access to more advanced information for providers and other stakeholders.
- Once the core system is up and running, we will design and test some additional “Phase Two” capabilities that will ultimately be operational by early 2010. These will include some advancements in workflow and business processes. After completion of the Phase Two improvements, the development and implementation work of the vendor will be complete and the support and maintenance phase of MITS will begin.

We have some aggressive timelines and challenging tasks ahead of us. But the work is also exciting because it offers the opportunity to completely transform our business – not just software and hardware, but people and business processes as well. As was determined in our 2004 study of the return on investment for MITS development, a new Medicaid Information Technology System is definitely worth the investment. It will bring tremendous improvements in Ohio’s Medicaid program, demonstrated by improved efficiency for our business partners and better outcomes for Medicaid consumers.

Update on Developing An Executive Medicaid Management Administration (EMMA)

Several extensive reviews of the Ohio Medicaid program have occurred over the past few years, all of which recommended improved efficiency and changes in the administration of Medicaid in our state. Recommendations were made by the Ohio Commission to Reform Medicaid, the Auditor of State’s Medicaid Performance Audit and the Medicaid Administrative Study Council, which studied the question of separating Ohio Medicaid into its own state agency.

During budget deliberations this spring, the Administration worked with the General Assembly to craft language to establish an Executive Medicaid Administration. House

Bill 119 authorized the creation of an Executive Medicaid Administration to “manage all Medicaid policies and functions and promote the efficient and effective delivery of health care.” This “virtual” agency replaces the concept of a stand alone Department of Medicaid. One of the primary responsibilities of this Administration is to implement the spirit and intent of the recommendations of the Medicaid Administration Study Council without creating a separate state Medicaid agency.

The Administration has already made strides toward the goals of collaboration and improved transparency in the administration of Ohio’s Medicaid program. Cabinet directors of the state agencies that administer parts of Medicaid began meeting in July with staff from Governor Strickland’s Office to discuss the new “Executive Medicaid Management Administration” or “EMMA”. These meetings resulted in consensus on ways to improve coordination as well as initial design of EMMA’s structure, functions and responsibilities. The ultimate goal is to tear down the silos of Ohio’s Medicaid program and replace them with services, supports and administrative activities that are efficient and coordinated. Work completed to date includes:

- A common vision for a Healthy Ohio and EMMA/Medicaid;
- Drafted goals and measures to achieve the health care vision. These are in the process of being finalized;
- A status review and report of the recommendations from the Auditor of State performance Audit and the Commission to Reform Medicaid. Substantial progress has been made on these recommendations, and this work is ongoing. (A summary status report is attached to my written testimony.); and
- Completion of the structural design and decision making process for EMMA.

Once created, EMMA will be Ohio’s Medicaid program. It will be comprised of an Executive Director, the “EMMA partners” comprised of Cabinet Directors of sister agencies administering portions of Ohio Medicaid and OBM, EMMA staff, and the Medicaid staff of sister agencies. The member Departments are: Job and Family Services, which will remain the single state Medicaid agency, Aging, Education, Health, Mental Health, Alcohol and Drug Addiction Services, and Mental Retardation and Developmental Disabilities.

EMMA staff will report to the Executive Director. The make up of EMMA’s staff is being finalized, but we envision that it will consist of a small, professional staff with the skill set needed to research and set strategic direction for Ohio’s Medicaid program, facilitate and inform the EMMA subcommittees, and build consensus among subcommittee members.

EMMA Responsibilities

As I previously stated, EMMA will efficiently and cost effectively manage, coordinate and be accountable for Ohio’s Medicaid program across all Medicaid systems. It will also be responsible for implementing many recommendations of the Medicaid Administrative Study Council, Auditor of State and Commission to Reform Medicaid. EMMA will:

- Establish and facilitate subcommittees with responsibility to coordinate policy in the following functional categories (information technology, strategy and planning, clinical decisions, program integrity, legal, resources and budgeting, local government relations, and unified budgeting);
- Establish a governance structure for decision-making across agencies;
- Prioritize work across state agencies to maximize effectiveness of staff and other resources toward meeting the Administration's health care vision and goals;
- Align spending and policy authority with budget responsibility; and
- Eliminate overlap and duplication between departments.

Next Steps

The Strickland Administration will continue its work over the next few months to finalize the structure and create EMMA. Our next steps are to:

- Develop an inventory of the type of activities and decisions agencies engage in regarding Medicaid and which should fall under the purview of EMMA;
- Develop and enter into Service Level Agreements with member agencies;
- Hire EMMA staff;
- Designate Subcommittee Chairs and complete the work plan for each;
- Complete the plan for implementation of the Ohio Medicaid Administrative Study Council recommendations; and
- GOAL: EMMA will be established and operational by January, 2008.

Conclusion

Changing our Medicaid program has been likened to turning an ocean liner. Change isn't simple or quick. It must be well planned and executed by "all hands" working together. So rather than waiting for EMMA, we have convened "all hands" to begin working together in the spirit of EMMA to chart a new direction for Ohio Medicaid. This direction will include:

- Increasing the number of Ohioans with access to health care;
- Making it easier for consumers to get the health care they need;
- Updating and improving Ohio's Medicaid information technology system;
- Reducing the administrative burden for Medicaid providers; and
- Creating the "spirit of EMMA" by improving the communication and coordination among state agencies and their county counterparts that administer parts of the Ohio Medicaid program.

With the support of the Ohio General Assembly, staff within the Strickland Administration have charted the course and begun executing these changes. We look forward your ongoing support as we continue our journey in the coming months.

Thank you for the opportunity to talk with you today. I am happy to respond to questions.

Key Budget Initiatives and Status Report

ODJFS Office of Ohio Health Plans

Revised or Temp
Code Section #

State Fiscal Years 2008 and 2009 Budget Initiative

Status report

109.572, 5111.028, 5111.03, 5111.031 to 5111.034, and 5111.06	<p>Improve program integrity of Medicaid provider agreements: The budget bill makes the following changes relative to Medicaid provider agreements:</p> <ul style="list-style-type: none"> (1) Requires the use of time-limited provider agreements; (2) Eliminates the five-year limit for termination of a provider agreement based on an action brought by the Attorney General; (3) Authorizes the denial or termination of a provider agreement for any reason permitted or required by federal law; (4) Requires the suspension of a provider agreement held by a noninstitutional health care provider based on an indictment of the provider or its owner, officer, authorized agent, associate, manager, or employee; (5) Authorizes the exclusion of an individual, provider, or entity from participation in Medicaid for any reason permitted or required by federal law; and (6) Modifies the circumstances under which ODJFS is not required to conduct an adjudication when imposing sanctions relative to a provider agreement, including sanctions imposed against a provider for failing to obtain or maintain a required certification. 	<p>Rules that require all new providers to have time-limited agreements become effective 1/1/08. ODJFS/Ohio Health Plans will send each existing provider a notice that its provider agreement will be converted to a time-limited agreement over the next three years as part of the phased implementation of these requirements.</p>
309.30.13	<p>Requires the ODJFS Director to pay the full cost (100%) of Medicaid cost outlier claims for inpatient admissions at children's hospitals that are less than \$443,463 (adjusted annually for inflation).</p>	Completed
309.30.40	<p>Increase the intermediate care facility for the mentally retarded (ICF/MR) provider rates 2% each year (7/1/2007 and 7/1/2008)</p>	Completed
309.30.60	<p>Requirement to cover chiropractic services for adult Medicaid recipients in an amount, duration, and scope specified in rules adopted by the Director.</p>	Rules are being developed.

Revised or Temp
Code Section #

State Fiscal Years 2008 and 2009 Budget Initiative

Status report

309.31.13(B) and
309.31.16(B)

ODJFS Director to analyze the fiscal impact that the federal upper limits (FULS) established under federal law, as amended by the Deficit Reduction Act (DRA), will have on pharmacists in fiscal years 2008 and 2009. The budget bill requires the fiscal impact analysis for 2008 to be completed not later than 30 days after the effective date of the regulation the Secretary of Health and Human Services must promulgate, as discussed above, under Section 6001(c)(3) of the DRA. The fiscal impact analysis for 2009 must be completed not later than March 15, 2008. Each fiscal impact analysis must include a projection of the revenue a pharmacist is expected to lose during fiscal year 2008 or 2009 from each unit of multiple source drug dispensed to a Medicaid recipient. The budget requires the Director to increase the dispensing fee to be paid to pharmacists with a valid Medicaid provider agreement for dispensing a multiple source drug to a Medicaid recipient in fiscal year 2008 or 2009. For each fiscal year, the budget bill requires that the increase be made not later than ten days after the Director completes the fiscal impact analyses described above. The amount of the increase for each fiscal year must be determined in a manner that compensates pharmacists for the loss of revenue the Director projects pharmacists will, on average, incur during fiscal year 2008 or 2009.

ODJFS/Ohio Health Plans cannot analyze the impact of the federal upper payment limits until the Secretary of Health and Human Services promulgates them as required under Section 6001(c)(3) of the DRA; the Secretary has yet to do so.

309.32.50

In progress; work group ongoing

Based on the recommendations made by the Disability Determination Consolidation Study Council, the Rehabilitation Services Commission and ODJFS are required to work together to reduce the duplication of activities performed by each agency and develop a systems interface so that medical information for mutual clients may be transferred between the agencies.

309.32.60

Report preparation is in progress.

Requirement that ODJFS Director submit a report on the Primary Alternative Care and Treatment (PACT) program to the General Assembly no later than January 1, 2008. The report is to compare the average monthly medical costs of participants in the program with the average monthly costs of those individuals prior to program participation. The budget bill further requires the Director, no later than January 1, 2009, to submit a report on the total cost savings achieved through the program.

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State Fiscal Years 2008 and 2009 Budget Initiative

Status report

309.32.70	By July 1, 2008, ODJFS Director to submit a report to the General Assembly on the effect of Medicare Part D and the care management system on the Supplemental Drug Rebate Program. The report is to evaluate the changing cost of pharmaceuticals for which supplemental rebates are made under the program as a result of the high volume of drug purchases being transferred to Medicare Part D. The report is to include a review of the use of generic drugs by Medicaid recipients and cost savings to be achieved by increasing the use of generic drugs.	Report preparation is in progress.
3119.022, 3119.023, 3119.05, 3119.29, 3119.30, 3119.302, 3119.32, and 803.03	Cash medical support changes to increase medical child support collections (in cooperation with the Office of Child Support) For children receiving Medicaid, the cash medical support must be paid by the obligor to the Office of Child Support to defray the cost of Medicaid expenditures. ODJFS Director creates and annually updates a table to be used to determine the amount of cash medical support to be paid.	The Policy Requirements document is complete; forms and rules are in the draft stage. The work group (comprised of Office of Child Support staff, Management Information System staff, and Child Support Enforcement Agency administrators and attorneys) is currently reviewing the Business Function Requirements document.
5101.52, 5101.521 to 5101.526, 5101.528, and 5101.529	Expansion of the Children's Health Insurance Program (CHIP) Part III for children in families with incomes 200% to 300% of the federal poverty level	Rules are in clearance.
5101.5211, 5101.5215, 5101.5212, 5101.5213, 5101.5214, and 5101.5216	Health care for uninsured children in families with income above 300% of federal poverty level. The Director shall submit to the United States Secretary of Health and Human Services an amendment to the state Medicaid plan, an amendment to the state child health plan, one or more requests for a federal waiver, or such an amendment and waiver requests as necessary to seek federal matching funds for this program. The Director may not begin implementing the program until after submitting the amendment, waiver request, or both. However, the Director may begin implementation of the program before receiving approval of the amendment, waiver request, or both using state funds only. The Director is to implement the program regardless of whether the amendment, waiver request, or both are denied.	In progress
5111.011	Medicaid coverage for former foster children	Rules are in clearance.
5111.014 and 309.30.90	Expanded Medicaid eligibility for pregnant women with family incomes between 150%-200% of the federal poverty level.	Rules are in clearance.

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State Fiscal Years 2008 and 2009 Budget Initiative

Status report

5111.029	Requirement that the Medicaid program cover occupational therapy services provided by a licensed occupational therapist	Rules are being developed.
5111.032	Increase program integrity for providers by expanding requirements for criminal records checks	In progress
5111.084	Psychiatrist appointed as member of the Pharmacy and Therapeutics Committee	In progress
5111.101	Deficit Reduction Act required the education of employees of all entity's receiving \$5 million or more annually from Medicaid.	Completed
5111.11, 2113.041, 2117.061, 2117.25, 5111.112, 5111.113, 5302.221, and 5309.082	Requirement that the administrator of the Medicaid Estate Recovery Program prescribe a form regarding transfer of death deeds and a form regarding survivorship tenancies	In progress
5111.70 and 5111.707	Establish a program for Medicaid buy-in for workers with disabilities	In progress
5111.709, 5111.7010, and 309.30.95	Medicaid Buy-In Advisory Council: ODJFS is required to provide the Council with accommodations for it to hold its meetings. ODJFS must also provide the Council with other administrative assistance it needs to perform its duties. The ODJFS Director was required to call the Council to meet for the first time by August 31, 2007.	The Medicaid Buy-In Advisory Council has met twice.
N/A	Increase Medicare enrollment	In progress
N/A	Expedite managed care enrollment	In progress
N/A	Conduct the annual inpatient hospital recalibration	ODJFS is on track with the recalibration project and hopes to have the rule ready for clearance/filing signatures in the near future.

Revised or Temp
Code Section #

State Fiscal Years 2008 and 2009 Budget Initiative

Status report

N/A

Implement a system to ungroup claims and to identify questionable claims prior to payment (clinical claims editing)

ODJFS/Medicaid Information Technology System (MITS) executive steering committee has met to discuss time lines and priority of MITS change orders including clinical claims editing. The MITS team will meet with Electronic Data Services (EDS) senior leadership to set expectations for delivery and scheduling. ODJFS/Ohio Health Plans is setting up the meeting.

OCRM Section	Description	Status per HB 66, HB 119 or other	Description of Implementation Progress
LTC	Remove NF formula from statute Phase out CON	Partially Not included	SFY 06 Rates frozen. New pricing system implemented SFY 07. Rate increase enacted per HB 119 via "stop-loss-stop gain". Not implemented, although continues to be discussed in various venues
LTC	Pre-admission screening	In process	ODA and ODJFS have made some improvements and complete reform is under discussion with all affected agencies in the Money/Follows the Person Project
LTC	AAA's LTC resource centers	In process	ODA and ODM/RDD have obtained a grant to develop LTC resource centers
LTC	Assisted living waiver	Done	Asst Living program began July, 2006; consumers are being enrolled
LTC	Increase clinical capacity and flexibility of PASSPORT home care options	In discussion	Waiver consumers can receive all state plan Medicaid services. Changes have been made to state plan private duty nursing and home health services. Array of waiver services is being reviewed in the Money Follows the Person initiative. Increase look-back to 5 years, extend to 13 months homestead exclusion & expand estate beyond probate. Changes required by Federal Deficit Reduction Act have been implemented.
LTC	Estate recovery	Done	ODA Choices waiver being expanded in Toledo area; other Medicaid waivers are expanding self direction practices
LTC	LTC voucher pilot for self direction	In Process	Not implemented - cost prohibitive
LTC	Increase waiver asset limit	Not included	Also recommended MASC. Implemented in HB 119 and meetings have begun with ODA in the lead
LTC	Consolidate LTC budgets	In Process	Also recommended MASC. Under discussion in Unified LTC budget migs and via the Executive Medicaid Mgmt Agency
LTC	Create LTC policy body	In discussion	
Care Management	Expand CFC managed care	Done	Statewide expansion is complete for CFC population. As of August, 2007, about 1.2 million CFC Medicaid consumers are receiving their health care via managed care arrangements.
Care Management	Implement Care management for ABD population	Done	Enrollment complete with 128,000 ABD consumers receiving their care via managed care plans.
Care Management	Monitor effectiveness of outcome based care management - CHAP	Done	Part of ongoing review of statewide managed care expansion
Care Management	Improve HMO management, quality review & financial strength	Done	HB 66 authorized ODI to increase standards for HMO actuarial soundness
Care Management	Establish Care Management Working Group (CMWG)	Done	JFS has formed group/group issued its first progress report in 12/05 and has begun work planning for 2007. Meetings ongoing.
Care Management	The GME to managed care participation	Done	HB 66 tied direct GME to hospital managed care participation.
Pharmacy	Consolidate all state Rx spending and institute multi-state purchasing	In discussion	Rx consolidation recommended by a committee including DRG, MH, M/RDD and others. Medicaid reviewing the changes resulting from managed care and Medicare Part D. Will report to Gen Assembly per HB 119. Will consider state purchasing pool if beneficial to OH Medicaid.
Pharmacy	Increase Medicaid revenue from Rx rebates	Done	Medicaid rebate revenue (Federal and Supplemental) is approximately 36% for SFY 2006. ODJFS will study the impact post managed care and Medicare Part D and report to the Gen Assembly per HB 119.
Pharmacy	Replace rebates with transparent system	Not included	Prohibited by Federal and state law. See item 22 for more info.
Pharmacy	Limit drugs to effective and low cost through a closed formulary	Not included	Preferred Drug List is similar, but ODJFS is federally prohibited from closing the formulary.
Pharmacy	Use evidence based research, drug therapies -adopt Oregon Model	Ongoing	Behavioral Health Quality Initiative assessed prescriber compliance with clinical quality guidelines; other quality oversight in process via Managed Care Plans
Pharmacy	Increase % of generics included in preferred drug list	Ongoing	Ohio Medicaid already maximizes the cost and clinically effective use of generics. MCPs manage in similar fashion.
Pharmacy	Bring pharmacy reimbursement into parity with commercial insurers	Done	HB 66 reduced retail pricing to WAC + 7% rather than WAC + 5%, pricing change has been implemented
Pharmacy	Consumer co-pay for all drugs	Done	\$2 co-pay for trade-name PDL drugs & \$3 per script for Rx requiring PA
Pharmacy	Implement mail order for chronic care maintenance drugs	Not included	ODJFS is studying this option in view of changes from Medicare Part D and increased managed care enrollment.
Pharmacy	Implement medication therapy management	Ongoing	PACT program & Behavioral Health Quality Initiative
Pharmacy	Provide incentives for electronic prescribing	In discussion	ODJFS awaiting decision re: submitted Medicaid Transformation Grant to fund e-prescribing and electronic hlth record
Pharmacy	Limit optional Medicaid drugs for Dual Eligibles (Medicare Part D)	Done	Policy implemented to continue limited Medicaid coverage for Part D enrollees
Eligibility	Maintain current eligibility for CFC population	Not included	
Eligibility	Move to single state agency performing disability determination	In discussion	HB 66 reduced eligibility for working parents from 100% FPL to 90% FPL. Policy maintained by Gen Assembly in HB 119.
Eligibility	Study a switch to 209(b) to 1634	Done	Disability Determination Study Council report issued. ODJFS pursuing changes and improved coordination with RSC
Eligibility	Collect premiums for transitional benefits	Not included	Disability Determination Study Council report studied and recommended not making this change
Eligibility	Require enrollment in private insurance where applicable	Ongoing	ODJFS performed comprehensive study of consumer cost sharing and chose to focus on other populations
Eligibility	Medicaid "Ticket to Work" Buy-in	Done	Federal Deficit Reduction Act provides some opportunities; part of Gov. Strockland's platform
Finance	Establish firm Medicaid spending targets	Included	Part of Gov. Strockland's TAO initiative; under implementation eff 1/1/08
Finance	Freeze Hosp rates. Reduce NF, ICF/MR by 3%, then flat	Done	Accomplished within existing Medicaid spending projection and budgeting process
Finance	"Optimize" payment schedule (delay payment cycle)	Not included	NF rates frozen (with Franchise Fee increase), ICF/MR rates frozen, Hospital rates frozen 1/1/06; Rate increases for all three prov grps in HB 119
Finance	Medicare/Medicaid benefits coordination	Done & In Process	Considered and rejected by Administration
Finance	Switch to prospective payment for LTC & rehab hospital payments	Under study	ODJFS implemented limits on Medicaid payment of "crossover" claims for dual eligibles; Medicare/Medicaid ("Medi-Med") project underway; third party liability improvements enacted in HB 119
Structure & Management	Provide Auditor of State with full audit authority and funding	Done	ODJFS is monitoring significant Medicare payment changes and evaluating alternatives in the context of increased Medicaid managed care.
Structure & Management	Make Program Integrity Improvements	In process	AoS finalized performance audit of Ohio Medicaid; ODJFS working to implement recommendations; AoS granted independent audit auth in HB 119
Structure & Management	Update Ohio's Medicaid Information System	In process	Addressed in the JFS corrective action plan to the OIG report and as part of AoS Part Review
Structure & Management	Medical Transition Council	Done	Data warehouse study completed; RFP in development to make changes. MITS vendor selected and on site developing system
Structure & Management	Create Ohio Department of Medicaid	Ongoing	Medical Admin Study Council completed work 12/06. Recommendations being implemented or considered
Structure & Management	Selective contracting and Pay for Performance	In process	HB 119 created Executive Medicaid Management Agency (EMMA) to coordinate Medicaid business and policy across agencies
Structure & Management	Collaborate with state's academic medical centers	In discussion	Pay for performance pilot in process; selective contracting part of managed care expansion and part of HB 119 assumptions for some services

Notes:

OCRM stands for Ohio Commission to Reform Medicaid

Status Report of Recommendations Made by Auditor of State (AoS) Performance Audit

AoS recommendation #	Description of AoS Recommendation	Authorized in HB 119 or other	Complete	In progress	EMMA	Under Discussion
ODJFS Organizational Issues						
R3.1	Develop a long term Medicaid Perspective	x		x	x	
R3.2	Use value purchasing service strategies	x		x		
R3.3	Improve state-level relationships	x		x	x	
R3.4	Use an intermediary reporting agency	x		x		
R3.5	Establish an intermediary oversight body	x		x	x	
R3.6	Prioritize program goals for Medicaid	x		x	x	
R3.7	Centralize claims	x		x	x	
R3.8	Revise interagency agreements			x	x	
R3.9	Improve relationships with sub-recipients	x		x		
R3.11	Grant information access to independent bodies		x			
R3.12	Reorganize based on a clear purpose for the program			x	x	
R3.13	Permit the program to stabilize w/out near-term changes	x			x	
R3.14	Centralize contract management w/in the Medicaid agency	x				x
R3.15	Decentralize authority w/in State Med agency	x				x
R3.16, 17, 18	Involve program participants stakeholders, and internal staff in strategic planning			x		
R3.19	Implement appropriate information technology to measure program outcomes			x		
R3.20, 3.21	Manage employee skills within participating agencies & Improve human resources support			x		
Medicaid Service Provision						
R4.1	Align Medicaid eligibility with program goals	x		x		
R4.2	Reshape coverage using DRA flexibility (OH Dept of Insurance is leading this.)					x
R4.3	Implement the Disability Determination Consolidation Study Council recommendations			x		
R4.4, 4.5	Implement an employer-sponsored premium assistance and Medicaid buy-in programs (Buy In for workers with disabilities is in progress; broader premium assistance is under discussion)	x		x		x
R4.6	Improve consistency and process among counties in calculating Medicaid spend-down			x		
R4.7	Rebalance and divert consumers from inst to community settings & provide more community options	x		x		
R4.8, 4.10	Eliminate CON, lift Nursing Facility bed moratorium, & revise reimbursement to rebalance Long Term Care			x		x
R4.9, 4.11	Implement consumer comparison & use incentives or penalties to insure higher occupancy and quality			x		
R4.12	Publish quarterly occupancy levels by county (not possible given current technology)					x
R4.13	Monitor nursing home facility quality and condition		x			
R4.14	Remove NF reimbursement from ORC & Place in OAC					x
R4.15	Require heirs to notify state upon death of M'caid recipient	x	x			
R4.16	Implement a medication therapy management program for fee-for-service recipients		x			
R4.17	Contract out the retrospective drug utilization review program.		x			
R4.18	Monitor the effect of Medicare Part D on supplemental prescription rebates and increase generic substitution	x		x		
R4.19	Use waiver programs to implement pioneering approaches to services and coverage.				x	x

Status Report of Recommendations Made by Auditor of State (AoS) Performance Audit

AoS recommendation #	Description of AoS Recommendation	Authorized in HB 119 or other	Complete	In progress	EMMA	Under Discussion
R4.20	Implement a Cash and Counseling or Independence Plus program	x		x		
R4.21	Implement a regular process to evaluate rates and rate setting methodologies, and set rates to achieve program purposes				x	x
R4.22	Improve the transparency of the rate-setting process			x		
R4.23	Document the rate setting process and prioritization goals	x		x		
Managed Care/Care Management						
R5.1	Develop and use a meaningful system to monitor managed care and FFS delivery systems			x		
R5.2	Pilot alternative care models and implement effective models in Ohio				x	x
R5.3	Implement pay-for-performance			x		
R5.4	Develop performance standards for the ABD managed care plans			x		
R5.5	Incorporate greater case management components for ABD managed care plans and implement non-medical case management			x		
R5.6	Pilot forms of behavioral health "carve in" managed care programs				x	x
R5.7	Collect data for all HEDIS indicators of managed care clinical performance and collect FFS performance measures		x			
R5.8	Improve the use of consumer surveys (Managed care consumers are surveyed currently; ODJFS lacks resources to survey the FFS pop)					x
R5.9	Enforce prompt payment of provider claims by managed care plans and review pending and denied claims.			x		
R5.10	Include services provided by additional specialty types under Medicaid			x		
R5.11	Ensure physician access standards are appropriate for Ohio Medicaid managed care plans		x			
R5.12	Improve access to providers through diversifying delivery system partners, using risk-sharing models, and improving administrative processes			x		
R5.13	Offer alternatives, incentives, or increased rates to ensure access to hard to find specialists			x		
R5.14	Implement community-based low birth weight programs and seek to expand community-based programs into other areas.			x		
R5.15	Lengthen redetermination periods to reduce churning			x		
R5.16	Implement case management for FFS programs			x		
R5.17	Ensure consistent case management services between managed care and FFS.					x
R5.18	Develop program wide case management			x		
R5.19	Implement disease management for FFS recipients					x
R5.20	Require managed care plans to expand the focus of disease management programs.			x		
R5.21	Develop and use benchmarks to measure improvements in health outcomes due to disease management programs			x		
R5.22	Develop means to provide disease management continuity as Medicaid recipients transition off Medicaid (have applied for a grant)			x		
R5.23	Enhance utilization review and utilization management			x	x	

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AoS recommendation #	Description of AoS Recommendation	Authorized in HB 119 or other	Complete	In progress	EMMA	Under Discussion
R5.24	Track and report participation in the Primary Alternative Care and Treatment program	x		x		
R5.25	Expand the use of State universities to research and administer related programs				x	x
R5.26	Implement a High Risk Pool program for uninsured Ohioans (Development of an Ohio Health Care Exchange being led by ODI)					x
R5.27	Implement a Premium Assistance/Covered at Work program for uninsured Ohioans					x
R5.28	Pilot and test programs for the uninsured in Ohio					x
	Information Technology					
R6.1	Create state coordinator for health information technology		x			
R6.2	Develop a long-term health information technology plan				x	x
R6.3	Solicit feedback from stakeholders when implementing Medicaid technology changes			x		
R6.4	Require electronic storage of recipient eligibility information at county offices	x		x		
R6.5	Allow Medicaid applicants to complete eligibility determination forms on-line					x
R6.6	Install kiosks at high volume county offices to allow applicants to apply for services without meeting with a caseworker					x
R6.7	Implement e-prescribing for the Medicaid program in Ohio (Have applied for a grant)			x		
R6.8	Pilot pre-emptive benefits coordination			x		
R6.9	Centralize claims acceptance with the state Medicaid agency				x	x
R6.10	Use electronic file transfer to reduce manual entry of eligibility data by ODA					x
R6.11	Consolidate and centralize data warehousing activities				x	x
R6.12	Develop regional health information organizations (RHIO) to collect clinical outcome data and create a statewide health information network (Have applied for a grant)			x		
R6.13	Encourage the adoption of electronic health records (Applied for grant)			x		
R6.14	Reduce paper claims submissions			x		
R6.15	Require electronic claims submission	x		x		
R6.16	Change State statute to allow the state Medicaid agency to regulate claims submission processes	x				x
R6.17	Create an Office of Information Security to centralize participating agencies response to information security					x
R6.18	Organize a privacy review committee					x
R6.19	Develop a coordinated strategy for communicating with providers			x	x	
	Program Integrity					
R7.1	Develop and implement a comprehensive risk assessment planning process				x	x
R7.2	Track and monitor the results of provider background and fingerprint checks.	x		x		
R7.3	Link surety bonds to provider risk levels					x
R7.4	Require providers to reenroll in Medicaid at least once every three years.	x		x		
R7.5	Purge inactive providers from the Medicaid information system	x		x		

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AoS recommendation #	Description of AoS Recommendation	Authorized in HB 119 or other	Complete	In progress	EMMA	Under Discussion
R7.6	Become an active participant in the PARIS project	x		x		
R7.7	Centralize Medicaid program integrity related training, education and monitoring activities				x	x
R7.8	Provide explanation of benefit statements to all Medicaid recipients					x
R7.9	Publish State-disciplined and federally-excluded providers on a central, public web site		x			
R7.10	Centralize coordination and monitoring of the recovery audit/review process			x	x	
R7.11	Ensure that provider recovery audits/reviews are conducted consistently, in accordance with auditing standards			x		
R7.12	Centralize post-payment and cost reconciliation auditing					x
R7.13	Consider using neural networking to identify fraudulent providers					x
R7.14	Update managed care contracts to allow the SURS and Auditor of State to audit/review encounter data					x
R7.15	Establish a Medicaid Chief Inspector position wholly responsible for Medicaid program integrity functions				x	x
R7.16	Develop and publish a comprehensive program integrity annual report			x		
R7.17	Establish and monitor program integrity related goals and measures, and adjust program integrity efforts based on outcomes			x	x	
R7.18	Develop universal and comprehensive performance measures for Medicaid program integrity.			x	x	