OHIO DEPARTMENT OF MEDICAID

SFY 2015 ANNUAL REPORT

HEALTH CARE FOR OHIOANS

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

THE OHIO DEPARTMENT OF MEDICAID

ANNUAL REPORT
STATE FISCAL YEAR 2015
(JULY 1, 2014 TO JUNE 30, 2015)

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

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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 2015.

Over the past twelve months, our staff has worked tirelessly to build on the success that was realized in the previous fiscal year – our department's first as a stand-alone agency. 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:

- balancing Ohio's long-term care spending by investing more than 50 percent of funding to home and community-based options;
- working with the Department of Rehabilitation and Correction (DRC) to reduce recidivism by connecting inmates to managed care and behavioral health services prior to their release;
- conducting on-site provider visits to identify and combat instances of fraud, waste, and abuse;
- updating nurse and aide rates for home and community-based services;
- introducing a new and innovative health delivery strategy with the use of telemedicine; and
- collaborating with provider groups and private insurers to foster payment innovation.

Through these reforms, and many others, the Ohio Department of Medicaid is delivering better care that is person and family-centered, while also refining care coordination to improve the overall health care landscape in our state. Much has been accomplished this past year, and important work lies ahead.

Sincerely,

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.

Ohio Department of Medicaid
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MAKING OHIO BETTER

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 OHIOANS

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

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

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

FOR OUR PARTNERS AND PROVIDERS

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

ACCOUNTABILITY:
Create an environment that promotes accountability for outcomes.

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

FOR OUR ORGANIZATION & STAFF

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

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

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

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

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OHIO MEDICAID AT A GLANCE

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 over 2.9 million Ohioans insured through Medicaid at some point during SFY 15.

Roughly 80 percent of Ohio's Medicaid population received benefits through five private managed care plans under contract with the Department of Medicaid. Today, the program serves low-income individuals of all ages, in addition to older Ohioans and people living with disabilities.

As Ohio's largest health care payer, the Ohio Department of Medicaid 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.

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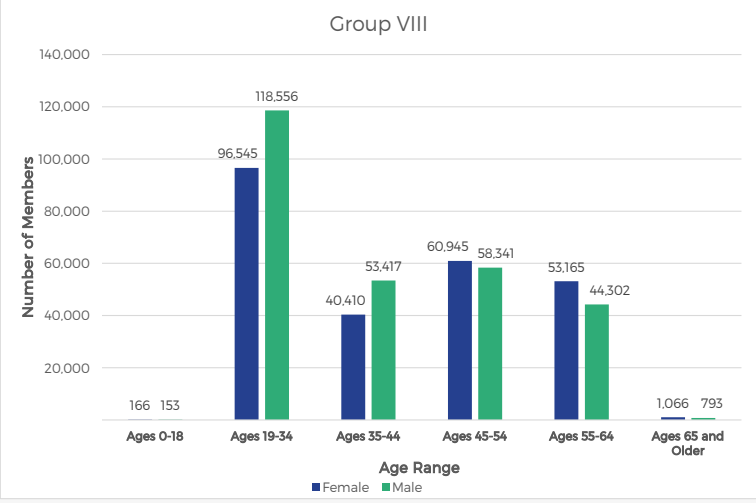

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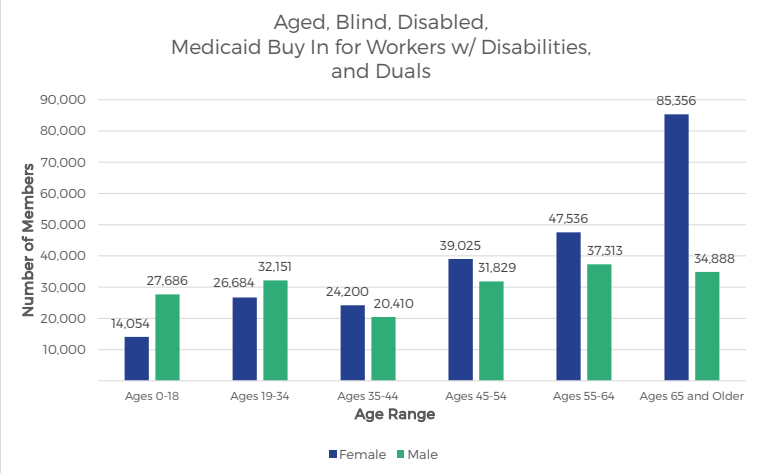

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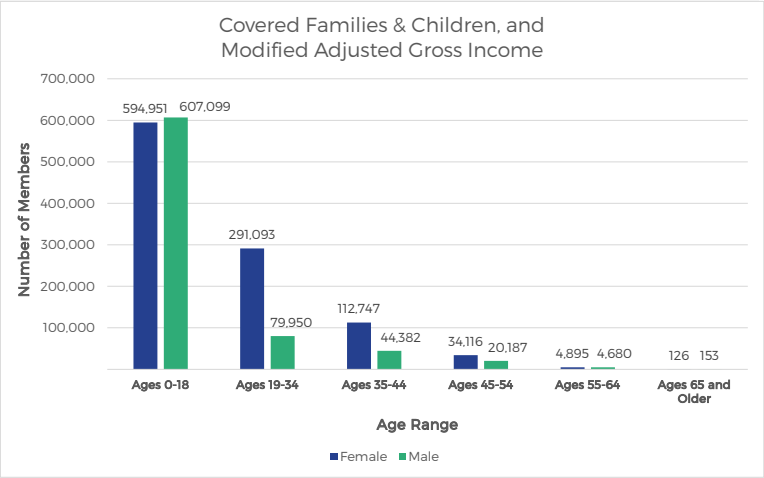

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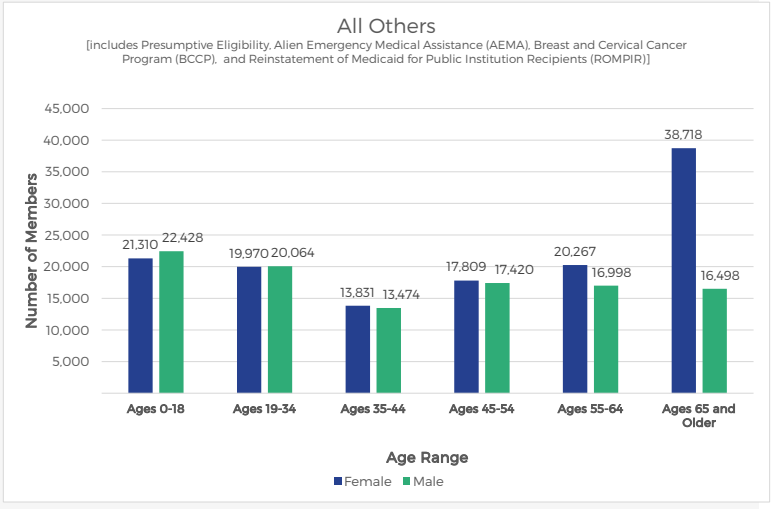

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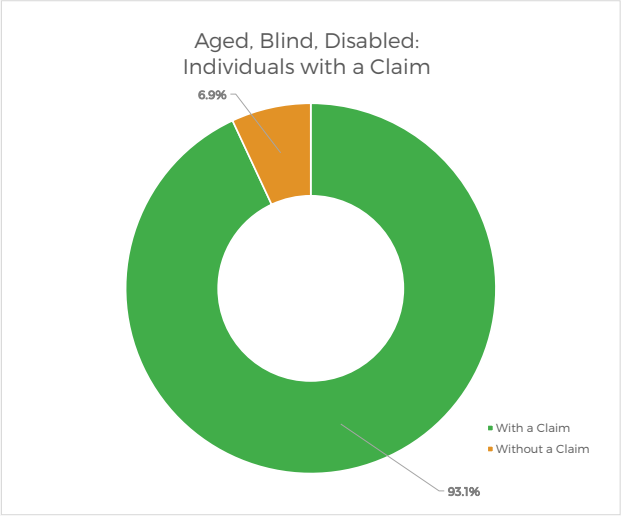

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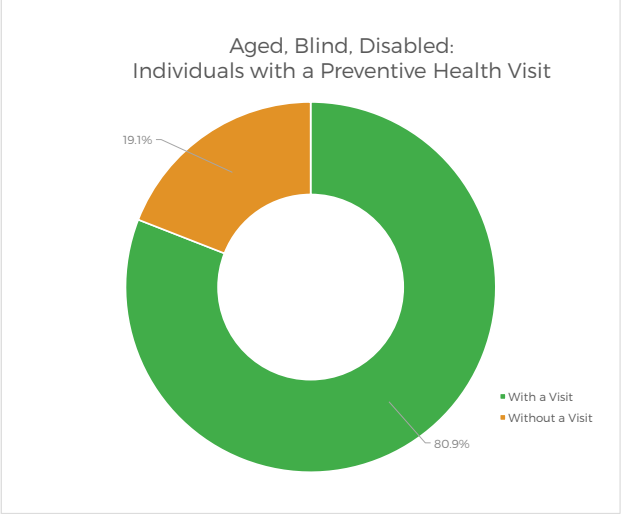

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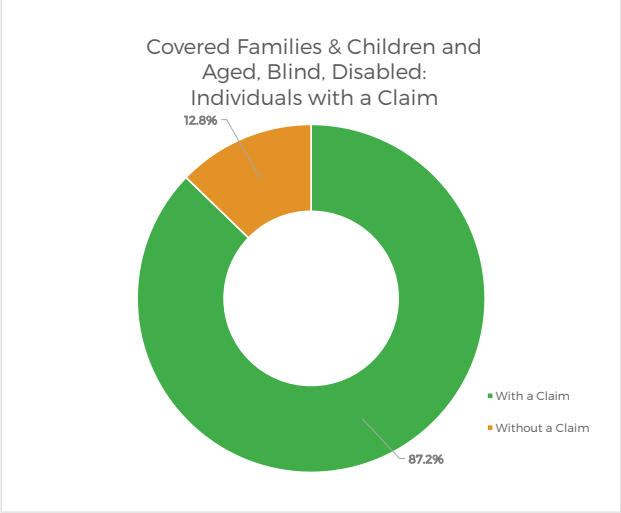

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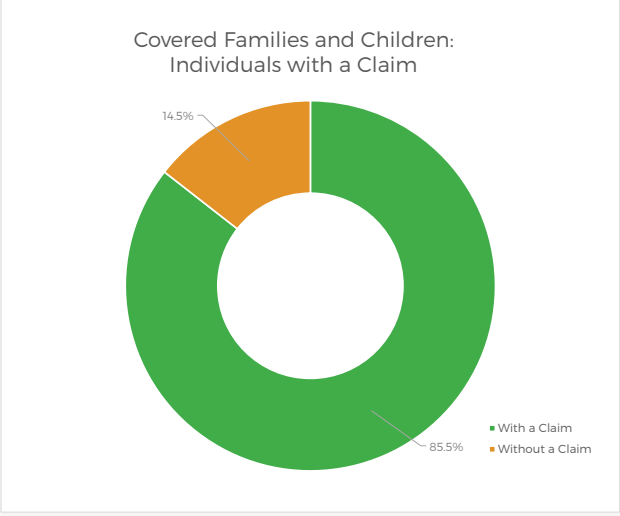

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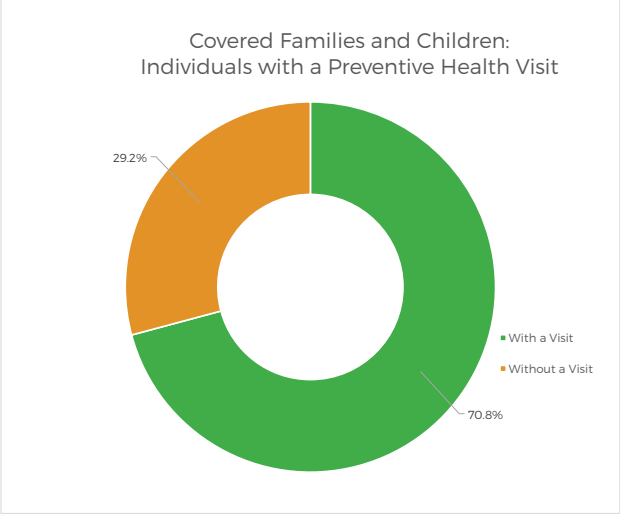

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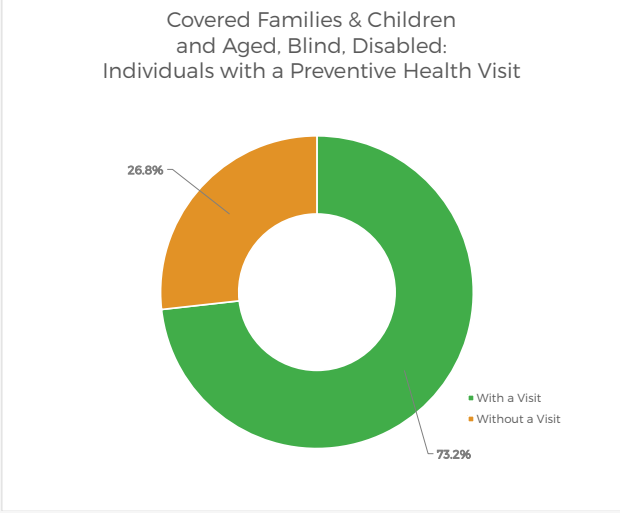


2 POLICY

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.

Areas such as provider payments and hospital policy underwent change in state fiscal year 2015. The following sections reflect some of the ways in which the Ohio Medicaid program has evolved over the past year.

OHIO 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 FMAP in the state's Medicaid program. It documents each state's covered groups, services, reimbursement methodologies and program administration. As times change and factors evolve, changes are often required to a Medicaid program's State Plan. This is done through the submission and approval of State Plan Amendments (SPAs) to the Centers for Medicare and Medicaid Services (CMS).

During SFY 15, ODM submitted 21 SPAs to CMS. The vast majority sought approval for implementation of services and adjustments to payment methodologies to providers. Some highlights of recent changes sought through federally approved amendments to the State Plan include:

- allowing the Department of Youth Services to make presumptive eligibility determinations;
- adding payment for telemedicine for certain services;
- increasing the personal needs allowance for residents of nursing facilities;
- modified reimbursements to nursing facilities;
- modifications to inpatient hospital payment methodology;
- modifications to reimbursement for intermediate care facilities for individuals with developmental disabilities;
- adding nursing assessments and consultations to home health and private duty nursing services;
- modernization of payment for home health services;
- reduction in payments for physical therapy, occupational therapy, and speech, hearing and language disorder services when multiple procedures occur during the same visit; and
- modifications to the Disproportionate Share Hospital payment methodology.

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

TRANSITION TO A 1634 STATE

Since 1972, Ohio's Medicaid program has been administered as a '209(b) state,' which means that in the State of Ohio, individuals who receive Supplemental Security Income (SSI) are not automatically eligible for Medicaid benefits. States operating under 209(b) must allow aged, blind, or disabled individuals with income above a certain limit to "spend down" to the income limit by incurring medical expenses.

States that do not operate under 209(b) have two options. One option requires states to cover all individuals who qualify for SSI, albeit with the state determining whether or not a person meets SSI criteria. The second option is known as '1634,' in conjunction with the corresponding section of the Social Security Act. A '1634 state' accepts the Social Security Administration's decision regarding an individual's SSI eligibility and extends Medicaid benefits to him or her based on the person's receipt of SSI. States operating in accordance with 1634 have the option to cover other individuals who are aged or meet SSA standards for blindness or disability.

During FY15, Ohio Medicaid began work to transition from operating as a 209(b) state to become a 1634 state. The transition makes sense in light of recent changes regarding Medicaid and health care at the federal level, including the introduction of the Modified Adjusted Gross Income (MAGI) adult population. The change, when completed, will simplify Medicaid eligibility determinations and bring greater efficiency to the state's Medicaid program.

ODM has engaged a number of stakeholders to assist in this effort, and work is expected to continue throughout the next fiscal year.

GREATER EFFICIENCY

When the change is fully implemented, simplified Medicaid eligibility determinations will bring greater efficiency to Ohio's program.

OHIO BENEFITS

The Ohio Benefits eligibility determination system continues to streamline and transform the way in which residents apply for Medicaid benefits. The state website allows prospective beneficiaries to apply for Medicaid coverage online. Ohio Benefits also maintains connectivity to federal data sources and Healthcare.gov, in case a user is not found to be eligible for Medicaid coverage. Should that occur, the person is then directed to the federal marketplace to purchase subsidized health insurance.

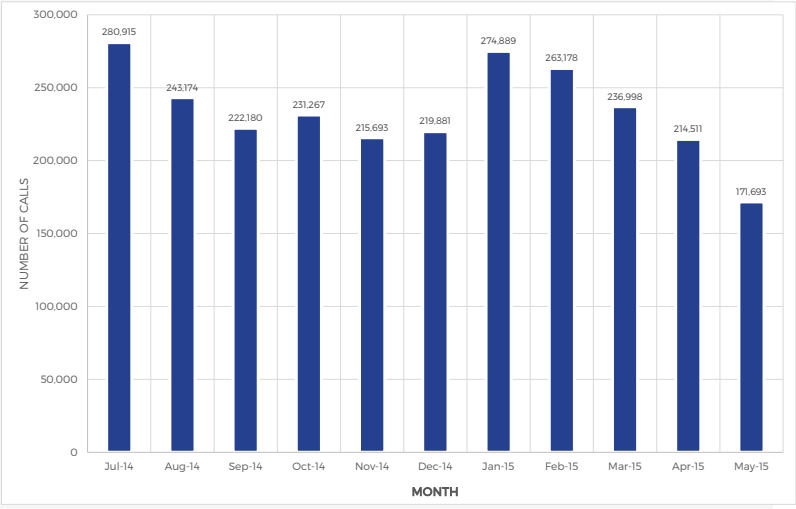
OHIO MEDICAID CONSUMER HOTLINE

Each day, the Ohio Medicaid Consumer Hotline is responsible for helping Ohio residents answer important questions related to the Medicaid program. This may include inquiries regarding eligibility, benefit changes, and provider look up.

The Hotline also serves as ODM's managed care enrollment broker, assisting individuals in the Medicaid managed care enrollment process. During SFY 15, the Hotline played a critical role in assisting newly eligible Ohioans with questions about the MyCare Ohio program and guiding them through the enrollment process.

Ohio Medicaid partnered with Automated Health Systems (AHS) in the administration of the Medicaid Consumer Hotline. Overall call volume decreased by more than 250,000 from SFY 14, when there was a large influx of individuals eligible for Medicaid.

Figure 2.1 Ohio Medicaid Consumer Hotline Call Volume



DATA ACCURATE AS OF MAY 2015

TELEMEDICINE IMPLEMENTATION

The Ohio Department of Medicaid spent more than a year working with various stakeholders and interested parties to develop a strategy for incorporating telehealth services into the Medicaid benefit. In January 2015, ODM began implementing coverage standards for Medicaid services delivered through the use of telehealth, which is also commonly referred to as "telemedicine".

ODM defines telemedicine as a real time video communication between a patient and his or her provider. The telemedicine coverage model follows the "hub and spoke" approach. In such a model, the originating site where the patient is physically located serves as the hub, while the distance site where the consulting health professional operates is the spoke. The distance between the originating and distance sites must be greater than 5 miles.

Implementation and delivery of telemedicine fits into the overall strategy of value-based purchasing and will improve and increase timely access to services. Ohio Medicaid looks forward to continuing its collaboration with the provider community regarding further roll-out of this innovative health delivery strategy.

IMPROVING ACCESS

Real time video communication between a patient and his or her provider improves access to services.

PAYMENT INNOVATION

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

Throughout SFY 15, ODM continued working with Medicaid managed care plans and private insurers to introduce the initial six episode models for episode-based payments. The six episodes are:

- perinatal;
- asthma exacerbation;
- chronic obstructive pulmonary disease exacerbation;
- total joint replacement;
- acute percutaneous coronary intervention; and
- non-acute percutaneous coronary intervention.

Reports for each of the initial six episodes were launched in March 2015. The reports allow providers insights into the patient journey across the entire episode of care, and to compare their costs with those of other health care providers of the same service.

Ohio also determined the next episodes for implementation, including:

- upper respiratory infection;
- urinary tract infection;
- appendectomy;
- cholecystectomy;
- colonoscopy;
- GI hemorrhage; and
- upper GI endoscopy.

Three separate clinical advisory groups convened to define the detailed clinical parameters of the seven additional episodes of care.

In May 2015, the Office of Health Transformation (OHT) convened a PCMH Design Team to develop 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 Design Team includes representatives from ODM, the Ohio Department of Health, and the Ohio Department of Mental Health and Addiction Services, in addition to several key stakeholders representing payers, providers, self-insurers, and advocacy groups across Ohio.

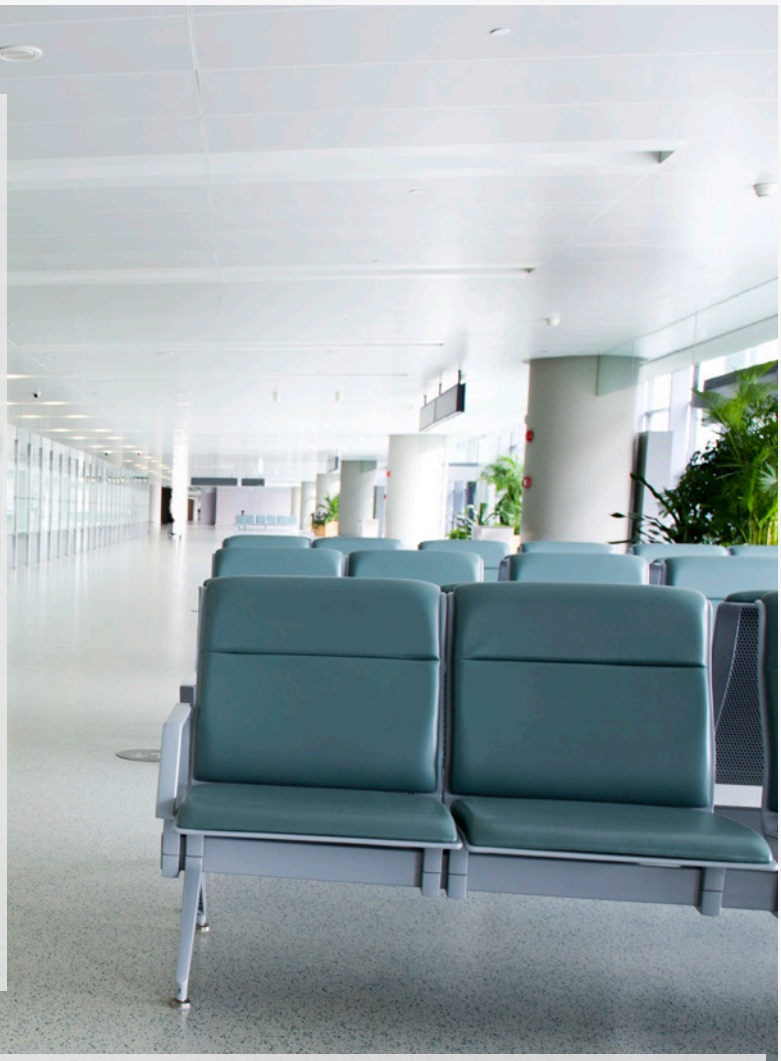
$75M

Total funding Ohio received through a federal SIM grant to continue work around episode based payment strategies.

HOSPITAL PAYMENTS

During SFY 15, ODM monitored the implementation of the 3M Health Information System's All Patient Refined – Diagnosis Related Grouper (APR-DRG). In July 2014, ODM initiated year two of a three year stop loss/stop gain period intended to ease hospitals' transition to the APR-DRG payment system. The APR-DRG Classification System is widely used throughout the United States for adjusting health care claims for severity of illness and risk of mortality. Public and commercial organizations in more than 30 states use the 3M APR-DRGs for payment or public quality reporting.

ODM continues to modernize its hospital payment systems to ensure quality care in Ohio. To further that goal, ODM has implemented 3M Health Information System's Potentially Preventable Readmissions (PPR) grouper. The PPR grouper analyzes inpatient hospital claim data and determines if a readmission within thirty days is clinically related to a previous admission. In February 2015, Ohio Medicaid began publishing PPR reports for all hospitals with more than twenty readmission chains in a twelve month period. The quarterly reports are available at Medicaid.Ohio.gov.



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 a disproportionate share of indigent patients. Each year, Ohio hospitals fund the state share of this program through provider assessments.

Though reporting for calendar year 2014 is not yet complete, ODM anticipates distributing $594 million to hospitals through HCAP. Since the expansion of Medicaid to cover the Group VIII population, ODM estimates that uncompensated care provided by Ohio hospitals has decreased by 66%.

PRIMARY CARE RATE INCREASE

The Affordable Care Act created the Primary Care Rate Increase (PCRI) for calendar years 2013 and 2014. Under the increase, qualified physicians participating in both Medicaid fee-for-service and managed care were paid an enhanced rate for certain primary care services rendered.

Over the two-year period, 10,500 physicians successfully attested and took part in the time-limited federal initiative. The PCRI concluded at the end of CY 14, with a total of $575.7 million paid – 77 percent of which was paid through the managed care plans. Prior to its conclusion, $262.9 million had been paid during SFY 15.

ICD-10

The ICD-10 (International Classification of Diseases, 10th Clinical Modification) coding system will replace the antiquated system of ICD-9 codes, while also aiming to achieve greater precision and transparency in billing. Currently, the ICD-9 coding set features 14,000 codes for the description of treatment. The updated set of ICD-10 will feature 72,000 codes to detail treatment provided.

The conversion from ICD-9 to ICD-10 code sets is federally mandated and all health care providers are required to comply.

Following a postponement from its initial go-live date of October 1, 2014, the ICD-10 coding system conversion implementation date was delayed to October 1, 2015. Ohio Medicaid and its partners remain on track and prepared for the revised launch date.

Despite the delay, Ohio Medicaid successfully completed implementation of its systems on September 9, 2014 and ICD-10 codes will be activated on the federal compliance date.

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

FEDERAL COMPLIANCE

Ohio Medicaid and its partners are on track to meet the federal ICD-10 compliance date of October 1, 2015.

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

DIAGNOSIS [NON-INSTITUTIONAL / INPATIENT / OUTPATIENT]	**ICD-9CM**	**vs. ICD-10CM**
ALPHANUMERIC CHARACTERS	3-5	3-7
CODES	14k	69k
PROCEDURE [INPATIENT ONLY]	**ICD-9PCS**	**vs. ICD-10PCS**
NUMERIC CHARACTERS	3-4	7
CODES	4K	72k

3

LONG-TERM CARE SERVICES & SUPPORTS

In SFY 15, 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.

Highlights include Ohio achieving balance in long-term care spending and the HOME Choice program successfully completing its 6,500th community transition.

MEDICAID HOME & COMMUNITY-BASED WAIVERS

Medicaid home and community-based service waivers provide the services that enable individuals to live at home rather than in an institution. These programs are called waivers because, under current 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 the Centers for Medicare and Medicaid Services (CMS).

TRANSITIONS CARVE-OUT WAIVER (TCOW)

Throughout SFY 15, Medicaid staff worked with their counterparts at the Ohio Department of Aging (ODA) to move individuals off of the Transitions Carve-Out Waiver (TCOW) and onto the more comprehensive Pre-Admission Screening System Providing Options and Resources Today (PASSPORT) program. The work aligns with Ohio's overarching goal to improve access to the home and community-based services delivery system and provide more Ohioans with care options outside of institutional settings. Effective June 30, 2015, TCOW has been phased out and all individuals have been enrolled on PASSPORT.

Prior to the phase-out, TCOW was administered by Ohio Medicaid and served individuals age 60 and older who were receiving a nursing facility level of care and had previously been enrolled on the Ohio Home Care Waiver. The PASSPORT waiver, administered by ODA, was revised in July 2014 to offer all of the same services as TCOW. With this expansion, there was no longer a need to have two separate waivers that would serve the same people and offer the same services.

Through Ohio Medicaid's partnership with ODA, more than 1,300 TCOW participants were successfully enrolled on the PASSPORT waiver. Individuals leaving TCOW kept their current service package, gained access to additional services, and now have more choice in the delivery of their care. Individuals aging out of the Ohio Home Care Waiver when they reach age 60 will also now have the opportunity to enroll in PASSPORT.

SELF-EMPOWERED LIFE FUNDING (SELF) HOME & COMMUNITY-BASED SERVICES 1915 (C) WAIVER

n SFY 15, the SELF Waiver renewal application was submitted for CMS approval with an effective date of July 1, 2015. 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. The waiver renewal runs through June 30, 2020, and is administered by the Department of Developmental Disabilities (DODD) and ODM.

TRANSITIONS DEVELOPMENTAL DISABILITIES (TDD) HOME & COMMUNITY-BASED SERVICES 1915(C) WAIVER

As part of the TDD Waiver renewal, effective July 1, 2015, DODD plans to transition enrolled individuals onto the 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.

INDIVIDUAL OPTIONS HOME & COMMUNITY-BASED SERVICES 1915(C) WAIVER

The State of Ohio's 1915(c) home and community-based services Individual Options waiver was renewed in SFY 14 and, effective July 1, 2014, allows individuals with intellectual and developmental disabilities to continue to be served through the waiver in lieu of institutionalization. The waiver, which was approved for a period of five years through June 30, 2019, is administered by DODD, in conjunction with Ohio Medicaid.

WAIVER QUALITY REVIEWS

ODM uses several methods to ensure compliance with CMS standards and ongoing improvement of the waivers, including:

- interviewing randomly selected waiver participants;
- reviewing care plans for randomly selected waiver participants;
- assuring resolution of case-specific problems;
- generating, compiling, and analyzing data;

- producing performance reports;
- holding semi-annual quality briefings with each waiver-operating agency;
- holding a quarterly multi-agency quality steering committee; and
- performing audits and fiscal reviews.

Every year, ODM conducts interviews with approximately 150 Ohioans on each waiver. During SFY 15, the agency completed reviews on the Level One waiver (July 2014) and Ohio Home Care waiver (November 2014). ODM also completed pilot and targeted reviews addressing Home Care Attendant Services for the Ohio Home Care Waiver (October 2014) and Medication Management (November 2014).

At least twice a year, Ohio Medicaid convenes a Quality Assurance meeting with each agency that administers Medicaid waivers. Such meetings provide an opportunity to review performance data, identify trends and patterns, and develop quality improvement plans. During SFY 15, these briefings were held in January 2015 and June 2015 with ODA, and February 2015 and June 2015 with DODD.

ODM also leads an interagency HCBS Waiver Quality Steering Committee (QSC) that meets quarterly. The QSC is a forum in which representatives from ODM, DODD, and the Ohio Department of Aging (ODA) can examine performance data across waiver systems, provide updates on quality assurance activities, and share information about best practices.

IMPROVING ACCESS & PROVIDING ALTERNATIVE CARE OPTIONS TO MORE OHIOANS

Figure 3.1 Ohio Medicaid Waiver Enrollment as of May 2015

MYCARE OHIO	OHIO HOME CARE WAIVER	TRANSITIONS II CARVE-OUT WAIVER	PASSPORT WAIVER	ASSISTED LIVING WAIVER	TRANSITIONS DD WAIVER	INDIVIDUAL OPTIONS WAIVER	LEVEL ONE WAIVER	S.E.L.F.
24,571	5,707	7,55	18,267	2,688	2,851	17,991	14,182	447

NOTE: ENROLLMENT AS OF MAY 2015. AS OF JUNE 30, 2014 CONSUMERS ENROLLED ON THE TRANSITIONS CARVE-OUT WAVIER WERE TRANSITIONED TO PASSPORT.

ELECTRONIC VISIT VERIFICATION SYSTEM

An Electronic Visit Verification (EVV) system validates service delivery to eligible individuals by authorized service providers, significantly reduces the risk of improper claims being paid and reduces 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. The EVV can validate the claims submitted to the Medicaid Information Technology System (MITS) and test the claims to ensure the service and the amount were authorized.

ODM released a Request for Information in 2014 to collect information about various EVV systems and implementation strategies used by vendors throughout the country. ODM has also researched implementation strategies used by other states to analyze options, successes, and lessons learned. ODM is pursuing full implementation for some home and community-based services.

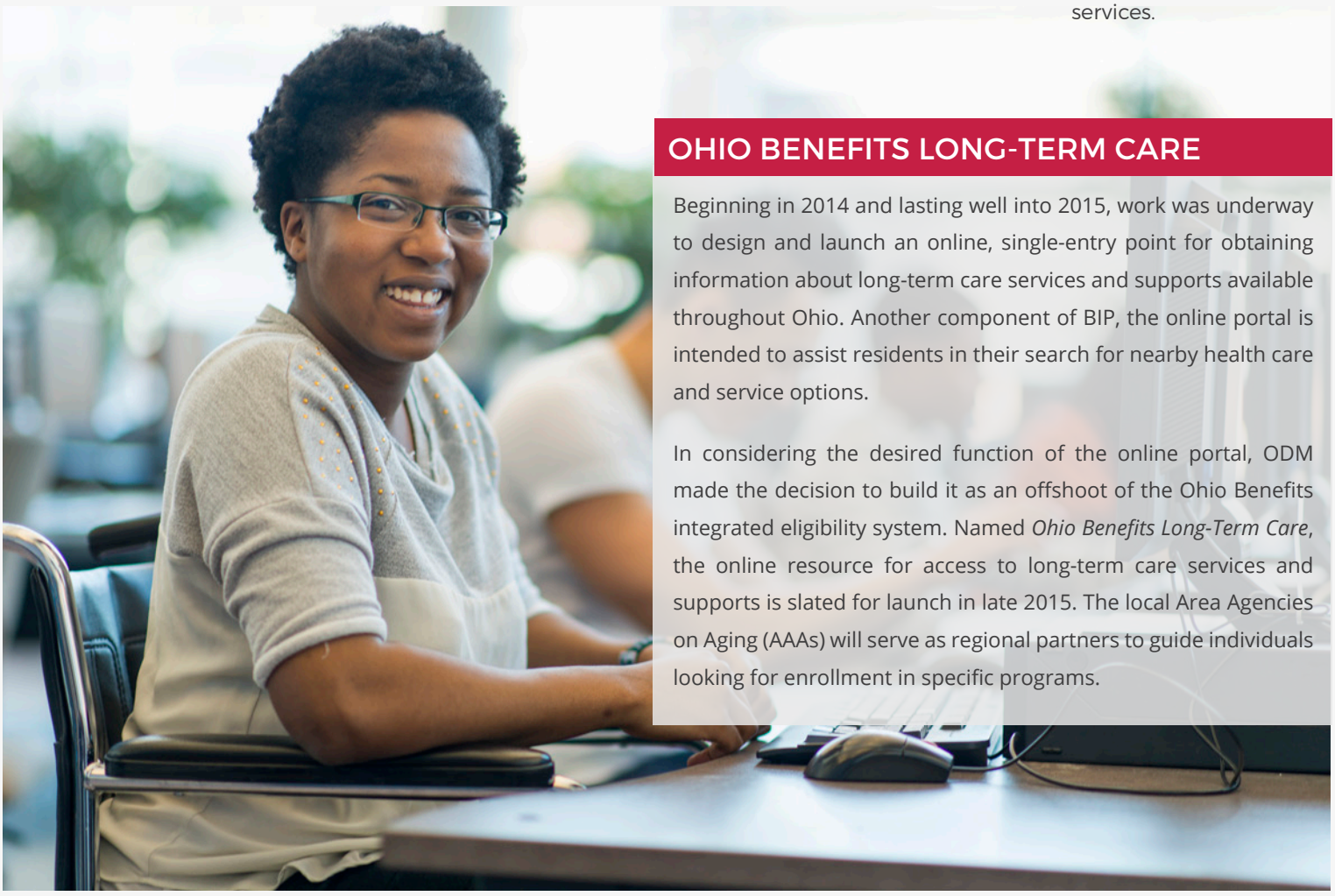
BALANCING INCENTIVE PROGRAM

In June 2013, Ohio was awarded more than $169 million in enhanced federal medical assistance percentage (FMAP) for its participation in the Balancing Incentive Program (BIP).

Ohio's work to achieve balance in long-term care funding became a reality in SFY 15. On September 10, 2014, the Department of Medicaid announced that it had reached the 50-percent spending target to direct half of all Medicaid long-term care funding to home and community-based services.

50%

Ohio Medicaid surpassed the 50-percent spending target for home and community-based services.



OHIO BENEFITS LONG-TERM CARE

Beginning in 2014 and lasting well into 2015, work was underway to design and launch an online, single-entry point for obtaining information about long-term care services and supports available throughout Ohio. Another component of BIP, the online portal is intended to assist residents in their search for nearby health care and service options.

In considering the desired function of the online portal, ODM made the decision to build it as an offshoot of the Ohio Benefits integrated eligibility system. Named *Ohio Benefits Long-Term Care*, the online resource for access to long-term care services and supports is slated for launch in late 2015. The local Area Agencies on Aging (AAAs) will serve as regional partners to guide individuals looking for enrollment in specific programs.

HOME CHOICE PROGRAM

Throughout SFY 15, Ohio's HOME Choice program continued to cement its status as a national leader for transitioning individuals out of institutional settings and back into the community. In years prior, Ohio's iteration of the federal Money Follows the Person (MFP) program received national recognition by ranking first among MFP states in transitioning individuals living with mental illness and second overall in total transitions completed.

HOME Choice hit a new milestone in August 2014 as it successfully completed its 5,000th transition. By the fiscal year's conclusion, the total number of transitions since the program's 2008 inception reached 6,500 – more than tripling its initial goal of 2,000 transitions.

The State of Ohio also received a federal grant totaling $12 million to implement an 811 Project Rental Assistance Demonstration program. The effort was a collaboration between the Ohio Department of Medicaid, the Ohio Housing Finance Agency, the Ohio Department of Developmental Disabilities, and the Ohio Department of Mental Health and Addiction Services. Funding made available through the grant is intended to support a five-year rental assistance program for nearly 500 program units located at selected Low Income Housing Tax Credit properties around the state. The HOME Choice program was identified as a priority for the use of these funds that will enable more individuals to live independently in community settings.

Figure 3.2 HOME Choice Transitions By Calendar Year and Service Population

	HOME CHOICE PROGRAM YEAR								TOTALS TO DATE*
	2008	2009	2010	2011	2012	2013	2014	2015	
NUMBER OF TRANSITIONS	70	360	525	922	1,232	1,363	1,342	727	6,541
TRANSITIONS BY SERVICE POPULATION									
PHYSICAL DISABILITIES	2	138	320	457	429	426	427	261	2,460
MENTAL HEALTH / SUBSTANCE ABUSE	--	6	32	204	510	587	574	308	2,221
ELDERLY	1	82	142	220	205	215	245	120	1,230
DEVELOPMENTAL DISABILITIES	67	134	31	41	88	135	96	38	630

*AS OF MAY 2015

HOME CARE OPERATIONS

Since 2012, Ohio Medicaid has made efforts to modernize its home and community-based waivers by bringing more choice to individuals who are served through home and community-based programs.

In SFY 15, Ohio Medicaid released a Request for Proposals regarding case management operations. Effective July 1, 2015 , the Department of Medicaid entered into contractual agreements with CareStar, CareSource and the Council on Aging to serve individuals on Medicaid waivers. The new contracts will enable individuals on the Ohio Home Care Waiver to choose their case management agency for the first time in the waiver's history.

As of June 2015, the Ohio Home Care Waiver served 8,999 Ohio residents with home and community-based services. ODM expects to serve between 8,000 and 10,000 in SFY 16.

NEW CASE MANAGEMENT SYSTEM

Ohio Medicaid has continued work to implement a streamlined, single-point assessment and case management system. Following a Request for Proposals in SFY 14, ODM secured Harmony, a nationally known case management software development company, to assist with system development.

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

NURSE & AIDE RATE CHANGES

In response to the increasing need for access to home and community-based services, Ohio continues to modernize the way Ohio Medicaid pays for nursing and aide services. Throughout the FY14-15 biennium, ODM engaged an actuary to study factors such as labor market data, education and licensure status, and the length of service visits to assist in the development of a new rate structure.

Effective July 1, 2015, rates were updated to require all providers to be present and providing services for a minimum of 35 minutes in order to bill for the Medicaid base rate. Ohio Medicaid also accounted for the advanced education and skill level of a registered nurse (RN) in modifying its rates, and added two new home and community-based services: RN Assessments and RN Consultations.

Total HCBS expenditures for nurse and aide services will increase by $20 million annually. Initial service time will continue to be paid at a higher level than unit rates, but the new base rate will be less than that of the current base rate.

These updates are the result of a collaborative dialogue that commenced in 2013 between ODM and a broad group of stakeholders, including providers and their associations, beneficiaries, advocates, and sister agencies.

Figure 3.3 Rate Changes

HOME HEALTH, PDN, OR WAIVERRN NURSING	AGENCY		NON-AGENCY	
(G0154, T1000, T1002)	CURRENT	FINAL	CURRENT	FINAL
BASE RATE	$52.20	$45.40	$41.76	$38.60
UNIT RATE	$5.69	$8.32	$5.69	$6.96
HOME HEALTH, PDN OR WAIVER LPN NURSING	AGENCY		NON-AGENCY	
(G0154, T1000, T1003)	CURRENT	FINAL	CURRENT	FINAL
BASE RATE	$52.20	$37.90	$41.76	$31.65
UNIT RATE	$5.69	$6.82	$5.69	$5.57
WAIVER HOME CARE ATTENDENT	AGENCY		NON-AGENCY	
(S5125)	CURRENT	FINAL	CURRENT	FINAL
BASE RATE	N/A	N/A	$25.89	$25.95
UNIT RATE - NURSING	N/A	N/A	$4.17	$4.43
UNIT RATE - PERSONAL CARE	N/A	N/A	$3.00	$2.86
HOME HEALTH AIDE OR WAIVER PERSONAL CARE	AGENCY		NON-AGENCY	
(G0156, T1019)	CURRENT	FINAL	CURRENT	FINAL
BASE RATE	$23.26	$22.45	$18.61	$18.10
UNIT RATE	$3.00	$3.73	$3.00	$2.86
RN ASSESSMENT	AGENCY		NON-AGENCY	
(T1001)	CURRENT	FINAL	CURRENT	FINAL
PER ASSESSMENT	N/A	$37.08	N/A	$31.64
RN CONSULTATION	AGENCY		NON-AGENCY	
(T1001-U9)	CURRENT	FINAL	CURRENT	FINAL
PER 15-MINUTE UNIT	N/A	$8.32	N/A	$6.96

NURSING FACILITIES

Ohio Medicaid continued its work with various state partners to ensure that individuals receive quality services in Ohio's nursing facilities. These partners include ODA, DODD, and the Ohio Departments of Health (ODH) and Mental Health and Addiction Services (MHAS), and the Office of the State Long-Term Care Ombudsman.

ODM participates with ODH, ODA and the Ombudsman in a joint review of selected ODH citations issued during the licensure and certification survey process of nursing facilities. This collaboration engages multiple perspectives to 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 based on the facility's performance on 20 measures. Two new quality indicators were introduced in SFY 15: the presence of a full-time social worker in the facility and person-centered medication delivery. These measures have been incorporated into the rate setting for SFY 16.

Effective January 1, 2015, ODM increased the personal needs allowance for individuals in nursing facilities from $45 per month to $50 per month. This increase was part of the SFY14-15 budget package approved by the General Assembly and built on the increase made the prior year. Individuals receiving Medicaid funded nursing facility services use their personal needs allowance for expenses not included in the Medicaid rate.

NEW QUALITY INDICATORS

Two new quality indicators were introduced to nursing facility incentive payments in SFY 15: the presence of a full-time social worker in the facility and person-centered medication delivery.

CMS HOME & COMMUNITY-BASED SERVICE TRANSITION REGULATION

In January 2014, CMS adopted a regulation to increase opportunities for community living and promote choice for individuals receiving Medicaid-reimbursed services.

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 the current home and community-based settings and develop a plan for bringing all settings into compliance no later than March 17, 2019.

ODM collaborated with ODA and DODD to complete the assessment, obtain public input from key stakeholders, including individuals receiving waiver services, and draft the statewide transition plan. ODM submitted the proposal to CMS on March 13, 2015. Upon CMS approval, ODM will partner with all interested parties to implement the final plan.

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 vast majority of individuals served by the program.

Through innovative programs such as MyCare Ohio and the Medicaid Pre-Release Program, ODM and its managed care partners are working to improve care quality and achieve better health outcomes.

OHIO'S MEDICAID MANAGED CARE PLANS

ALL PLANS AVAILABLE STATEWIDE

buckeye health plan. | CareSource Health Care with Heart | MOLINA HEALTHCARE | PARAMOUNT ADVANTAGE | UnitedHealthcare Community Plan

CARE MANAGEMENT

Effective care management is a cornerstone of maintaining a managed care delivery system. Care management provides a person-centered approach to health care by tailoring activities and services to an individual's health-related needs. In addition to being person-centered, components of care management must be culturally-competent, goal-oriented, and outcomes-focused.

Key care management functions include:

- identification of individuals with complex needs;
- assessment of needs;
- assignment of a care manager;
- development of an individualized care plan;
- assistance with accessing needed medical, social, behavioral and other support services;
- implementation of the care plan through coordination of services, information exchange, and conducting follow up;
- evaluation of the effectiveness and appropriateness of the care plan and updating when necessary; and
- coordination between providers and members through all of steps of the care management process.

Ohio Medicaid's care management program places an emphasis on the most vulnerable, high-risk beneficiaries by providing a hands-on approach to coordinated care. ODM's approach highlights the importance of managing clinical and non-clinical needs, the staff-to-consumer ratio, and strives to enhance the consumer-care manager contact with in-person visit contacts each quarter. The intensive approach to care management must be extended to at least one percent of the managed care plan's overall membership.

Results for 2014 were compiled and released in SFY 15.

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

Figure 4.1 Care Management of High Risk Members

MANAGED CARE PLAN	MEMBERS IN HIGH RISK CARE MANAGEMENT*
BUCKEYE COMMUNITY HEALTH PLAN	2,305
CARESOURCE	9,550
MOLINA HEALTHCARE OF OHIO	3,447
PARAMOUNT ADVANTAGE	2,167
UNITEDHEALTHCARE COMMUNITY PLAN OF OHIO	2,584
TOTAL	20,053

*AS OF MARCH 2015

The Department of Medicaid is planning to make additional reforms to its care management approach in the year ahead. ODM is currently working to transform the care management strategy towards a population-level health management approach, align care management with the entity best poised to connect with the beneficiary and influence behavior change, and better support existing community-based care management models.

PRE-RELEASE PROGRAM

As part of the 2014 expansion of Medicaid eligibility, the Ohio Department of Medicaid has collaborated with the Department of Rehabilitation and Correction (DRC) to connect incarcerated individuals to managed care benefits in preparation of their release from prison. Such an endeavor aims to reduce recidivism among offenders with behavioral health needs and chronic conditions by connecting them to care management and health care services, while also bringing savings to the state prison system.

The Medicaid Pre-Release Program project commenced in September 2014 to provide transition of care activities for Medicaid-eligible offenders preparing to re-enter the community. By connecting with care management before their release, these individuals are able to access resources to help rebuild their lives and tend to health care needs.

In addition to working with DRC, Ohio Medicaid and its managed care plans are partnered with the Ohio Departments of Health (ODH) and Mental Health and Addiction Services (ODMHAS) to rolled out services in Ohio's women's prisons during the second half of 2014. Those facilities included the Dayton Correctional Institution, the Northeast Pre-Release Center, and the Ohio Reformatory for Women.

The Medicaid managed care plans perform pre-release transition of care activities by utilizing administrative dollars already included in their capitation rate.

The department and its partners continue to introduce the project to at least one facility per month with the goal of achieving full implementation by 2017.

PAY-FOR-PERFORMANCE

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

The program uses key clinical performance measures to evaluate Medicaid's most critical clinical conditions such as:

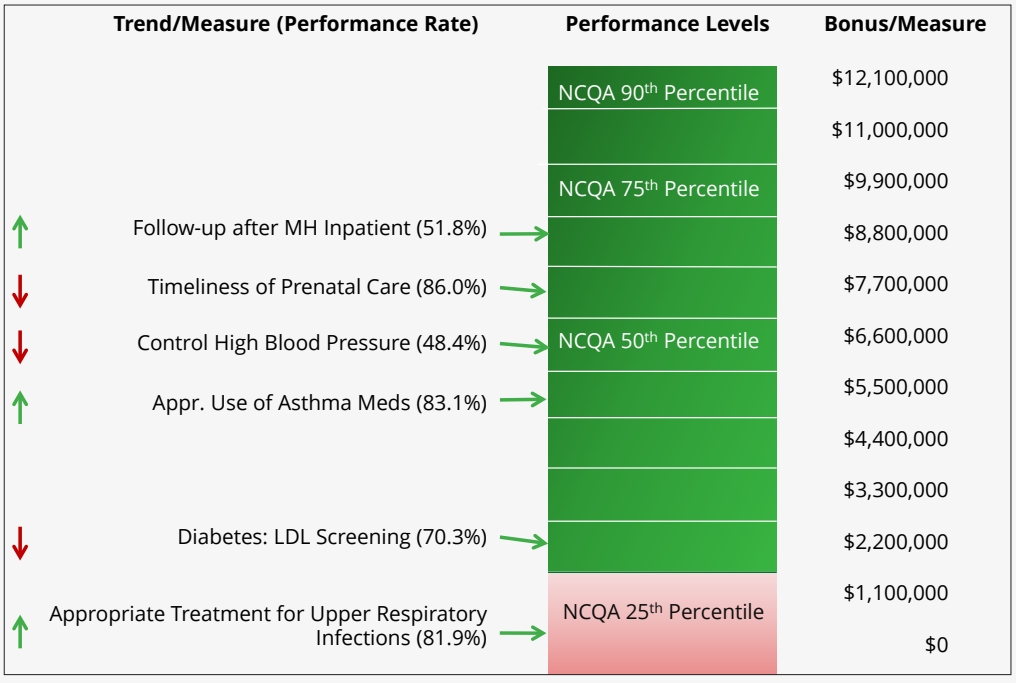
- high-risk pregnancy;
- behavioral health;
- cardiovascular disease;
- diabetes;
- asthma; and
- upper respiratory infections.

The managed care plans' results are compared to standards based on national data. In CY 14, ODM significantly increased these standards, which set a higher bar for plans to reach in order to receive incentive money.

In 2014, the Medicaid plans were awarded just over $15 million (22%) of roughly $70 million in available incentives. While some areas saw improved performance, collectively, the five plans earned less incentive money than in the previous year.

ODM has challenged the plans to commit their organizations to initiatives aimed at viable improvement.

Figure 4.2 Pay-For-Performance Results CY 2014



QUALITY MEASURES

Ohio Medicaid's Quality Strategy measures quality performance to evaluate services and improve healthcare outcomes for targeted priority populations and all Ohioans. Process and outcome measures, which are quantifiable and performance-driven, evaluate program data in a meaningful way to drive quality improvement. Managed care plan quality performance measurement is focused on high impact populations in the following clinical areas:

- 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 MCPs accountable. The expectation was that MCPs should meet or exceed 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 18 of the 24 standards measured by ODM.

Ohio Medicaid is committed to continuing its partnership with Medicaid managed care plans and fostering further improvement over the coming years.

CONSUMER SATISFACTION SURVEY

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 on member experience and satisfaction with health care provide important feedback on managed care plan performance, and also assist in finding new ways to ensure continued program improvement.

Each year, managed care plans must administer Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Surveys to their Ohio Medicaid members. Data is collected using a National Committee for Quality Assurance (NCQA) Certified Survey Vendor, then submitted to the state. Ohio Medicaid averages and NCQA National Medicaid benchmarks are used for comparative purposes, and results for the adult and child populations are reported separately.

From February to May 2014, the Medicaid managed care plans collected data from adult members and the parents or caretakers

of child members using the CAHPS® 5.0H Adult Medicaid Health Plan Survey and the CAHPS® 5.0H Child Medicaid Health Plan Survey (with the children with chronic conditions measurement set), respectively.

That data was then submitted to the Ohio Department of Medicaid. 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.

CONTINUED IMPROVEMENT

Feedback from Ohio Medicaid members provide valuable information on plan performance and assist in continued program improvement.

SURVEY RESULTS

- Compared to national Medicaid percentiles, Ohio's Medicaid managed care program had good to excellent performance (i.e., none of the program's means were below the 50th percentile).
- Compared to national Medicaid data, the program's mean was at or above the 75th percentile for four of five composite measures and three of four global ratings for the child population. For the adult population the program's mean was at or above the 75th percentile for two of five composite measures and one of four global ratings.
- Areas of excellent performance included Rating of All Health Care (general child population), Getting Care Quickly (general child population), and How Well Doctors Communicate (both adult and general child populations). For each of the areas, the program mean was at or above the 90th percentile compared to national Medicaid percentiles.
- Program mean scores for the general child population exceeded the national Medicaid averages for all five composite measures and were the same or higher than the national Medicaid averages for two of four global ratings.
- Program mean scores for the adult population exceeded the national Medic aid averages for two of four global ratings and were the same or higher than the national Medicaid averages for all five composite measures.
- Ratings for the general child population tended to be higher than those for the adult population.

OHIO MEDICAID'S INFANT MORTALITY EFFORTS

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 Sudden Infant Death Syndrome (SIDS).

Ohio's infant mortality rate has been relatively stagnant for more than a decade. According to 2013 data released by the Ohio Department of Health, Ohio's infant mortality rate was 7.4 per 1,000 live births, compared to a national rate of 6 deaths per 1,000. During SFY 15, Governor Kasich announced new efforts to combat infant mortality. Ohio Medicaid was made central to those plans.

INFANT MORTALITY RATE

Ohio's infant mortality rate is 7.4 per 1,000 live births, compared to a national rate of 6 per 1,000 (ODH).

Included in these initiatives are plans to:

- identify 'hot spots' where infant mortality is highest in the state;
- connect pregnant women and babies in these communities with high-risk care management benefits;
- enlist the support and resources of the Medicaid managed care plans to administer help to at-risk moms and babies; and
- fund research based best-practice methods of group care for expectant mothers in targeted urban and rural communities.

Ohio Medicaid and its partners are committed to ensuring that all Ohio babies are born and remain healthy throughout their first year of life. Ongoing initiatives, such as eliminating payments for medically unnecessary scheduled deliveries and improving the administration of progesterone for mothers at risk for pre-term birth, aim to reduce pre-term births. The extension of Medicaid coverage to previously uninsured individuals is also helping to ensure that prospective mothers may tend to their health care needs prior to becoming pregnant.

This aggressive approach to combatting infant mortality will carry into the following fiscal year.

MYCARE OHIO

MyCare Ohio is a three-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, Centers for Medicare and Medicaid Services (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 care that is patient-centered;
- providing a primary contact for beneficiaries;
- focusing on individual choice and control of care delivery;
- coordinating long-term care, behavioral health, 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 seamless transition between settings and programs.

Initial Medicaid enrollment began on May 1, 2014 and continued, by region, through July 1, 2014. The Medicare passive enrollment period began on January 1, 2015, and 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 95,000 individuals in 29 Ohio counties. Approximately 70% 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 weekly calls and facilitated monthly meetings with the MyCare Ohio plans. The department also regularly sought out the assistance and feedback of provider and consumer advocacy groups. The MyCare Ohio plans convened workgroups to resolve early implementation issues concerning managed care contracting and new billing methods. 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. Over the next several years, outcomes of these care coordination processes are expected to produce positive and measureable results.

Figure 4.4 MyCare Ohio Demonstration Regions

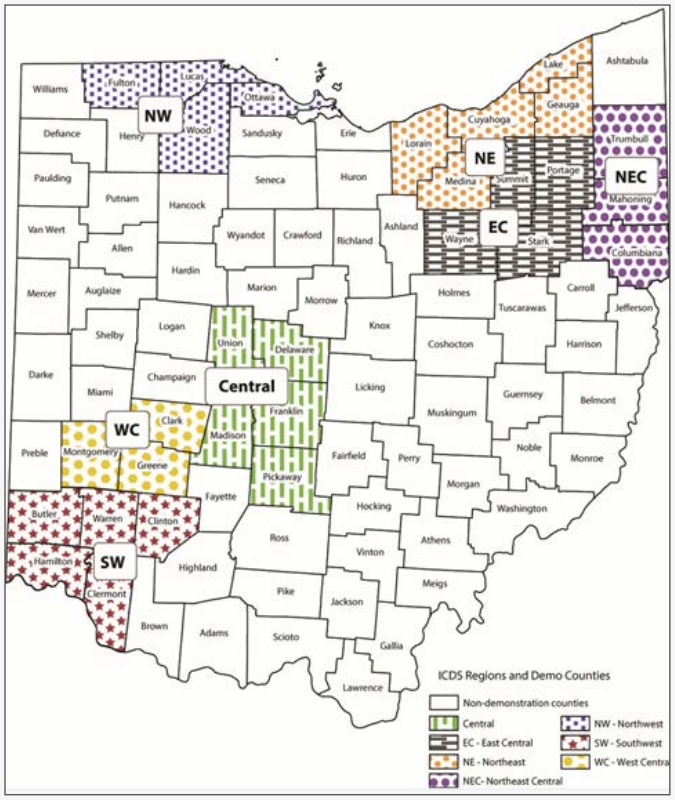
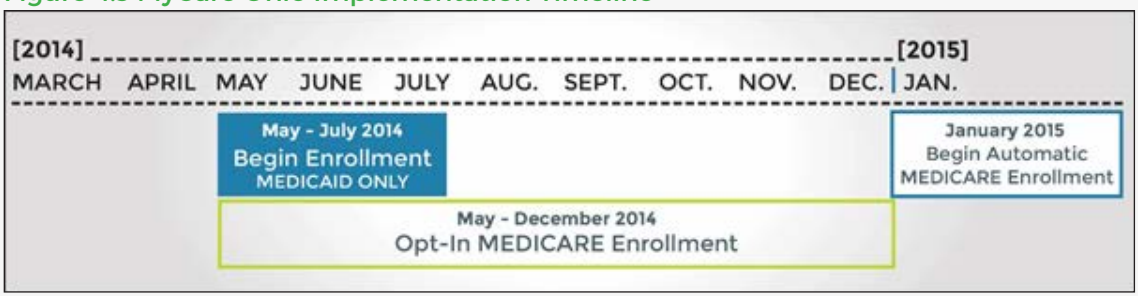


Figure 4.3 MyCare Ohio Implementation Timeline



5 PROVIDERS

Ohio is home to more than 83,000 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.

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. MITS also acts as a secure 'front door' in the administration of new provider enrollment and screening. On a monthly basis, the department receives and screens approximately 1,200 applications from prospective Medicaid providers.

1,200

Applications ODM screens each month from potential providers.

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

PROVIDER ENROLLMENT & NETWORK MANAGEMENT

Over the past year, the Department of Medicaid continued to strengthen the provider enrollment screening process. Recent enhancements include implementing the new federal requirement for the enrollment of providers who order, refer or prescribe services to individuals.

444

Site visits PCG completed in SFY 15, with 19 referred to the Ohio Attorney General.

Ohio Medicaid continues to contract 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 fiscal year 2015, PCG had attempted 536 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 SFY 15, there were 444 completed site visits with 19 cases referred to the Office of the Ohio Attorney General.

ORDERING, REFERRING & PRESCRIBING PROVIDERS

In January 2015, Ohio Medicaid began phasing in 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 (ACA) 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 any claims submitted for payment to the Ohio Department of Medicaid.

On July 1, 2014, ODM initiated a "pay and post" period to educate all impacted providers. Providers were notified of the pay and post period through the MITS provider portal, direct communication from ODM, and departmental transmittals posted on the ODM website. Informational claims edits were also posted on provider remittance advices through MITS and on prior authorization requests. This time served as a trial period in that providers were paid accordingly while being instructed on how to submit claims once ORP regulations take full effect.

ORP regulations were implemented in two phases, with the first phase reaching completion during SFY 15. The second phase will be completed in SFY 16. As of 5,700 individual providers have fully enrolled in accordance with ORP status.

PROGRAM INTEGRITY GROUP

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 craft data mining algorithms aimed at identifying fraudulent Medicaid providers and plan coordinated responses to these findings. This coordinated approach has been nationally recognized as a best practice in program integrity. The PIG continued to refine its efforts in SFY 15 and increased coordination with other program integrity partners. The success of the PIG model led to 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.

Coupling the PIG's work with the findings of additional audit programs within ODM is essential to fostering lasting success. Should the results of any ODM review lead the agency to believe 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 those covered by the Medicaid program.

Conversely, 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 (CMS) to discuss procedures, investigations, and provider areas that are at a heightened risk for fraud or abuse.

In SFY 15, the Medicaid Fraud Control Unit of the Attorney General recorded:

- 154 indictments;
- 157 convictions; and
- $15.8 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 FFY 14 and Ohio was number one in fraud indictments and convictions.

154
INDICTMENTS

157
CONVICTIONS

$15.8M
DOLLARS IN RECOVERY

#1
RANKED NATIONALLY FOR FRAUD INDICTMENTS & CONVICTIONS

SURVEILLANCE & UTILIZATION REVIEW

The Surveillance and Utilization Review Section (SURS) and Audit section are central to Ohio Medicaid's efforts to detect instances of fraud, waste and abuse. Specifically, work conducted by the two directly contribute to the efforts of the Program Integrity Group.

During SFY 15:

- ODM issued 136 final adjudication orders and 970 final resolution reports to nursing homes and intermediate care facilities. These audits identified recoveries of $26.14 million owed to the state.
- SURS staff conducted 226 provider reviews that identified overpayments of $2.9 million.
- SURS staff completed a provider audit with overpayments findings totaling $6.05 million and adopted 19 audit reports issued by the Auditor of State totaling $1.09 million.

Additionally, some Medicaid providers may conduct independent reviews of their billing practices and, at times, discover cases of overpayment by the state Medicaid agency. Should such an instance occur, providers contact the agency with the overpayment information and remit payment. During SFY 15, providers conducted 42 self-reviews, for total overpayments of $2.36 million.

$26.14M

RECOVERIES IDENTIFIED BY AUDITS OF NURSING & INTERMEDIATE CARE FACILITIES

INPATIENT HOSPITAL REVIEW CONTRACT

The Department of Medicaid contracts with Permedion to conduct retrospective reviews primarily focused on inpatient hospital care. These reviews assist the agency in determining whether care rendered to a beneficiary meets medical necessity and quality of care standards. Any hospital that is subject to a review may appeal its findings to Permedion. Should the finding be upheld at that level, the provider may request a Surveillance and Utilization Review.

In SFY 15, Permedion reviewed 16,575 inpatient cases that resulted in denials and/or adjustments to 5,949 claims for a savings of $38.1 million. Permedion also completed 1,372 outpatient reviews resulting in 500 cases being denied for using incorrect coding for a savings of $1.3 million.

Permedion also conducts pre-certifications for certain inpatient medical procedures. Hospitals must obtain pre-certification for all procedures that are performed in an inpatient hospital setting that are normally performed in an outpatient setting. Permedion receives about 143 pre-certification requests per month. In SFY 15, Permedion completed 1,580 reviews for the first 11 months of the state fiscal year that resulted in 38 denials and a cost savings of $333,580.

16,575

INPATIENT CASES REVIEWED

$38.1M

SAVINGS REALIZED AS A RESULT OF CLAIMS REVIEWS

THIRD PARTY LIABILITY

Health care providers are prohibited from billing the State of Ohio for services when other 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 so claims are paid properly. System enhancements during SFY 15 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 billion in billed charges for health care services during SFY 15.

Changes in insurance or other events can impact the payment responsibility after a claim has been paid by the Department of Medicaid. In such cases, when Ohio Medicaid learns that it is not responsible for the claim, a contractor performs collection activities on behalf of the department. This contractor specializes in recovering medical expenses paid by the state when a legally-obligated third party source is later identified. In SFY 15, such activities resulted in over $56 million being returned to Ohio Medicaid.

$1B

In billed charges Ohio avoided in SFY 15.

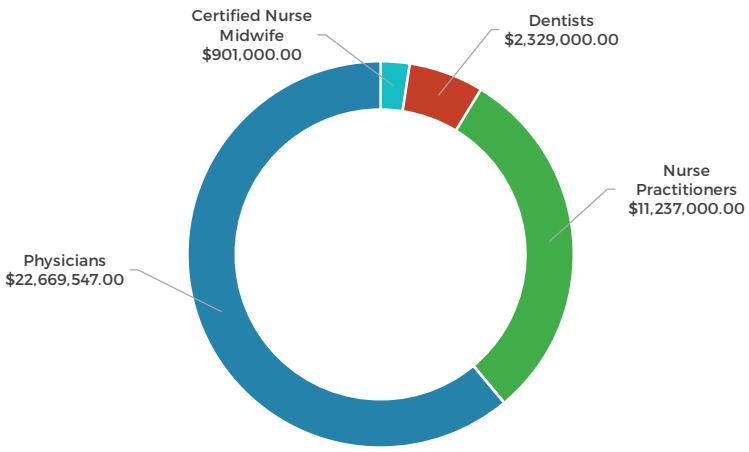
PROVIDER ELECTRONIC RECORD GROWTH

Ohio Medicaid continues to work with doctors, hospitals and other health care providers to convert paper-based medical records to electronic formats. The shift to an electronic standard allows 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.

The need to migrate paper-based records to electronic platforms is growing, but 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 (MPIP) grants 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 (11,931) distributed to providers and sixth in the nation for total amount paid by the program (more than $386 million). In SFY 15, Ohio Medicaid distributed 3,169 payments totaling nearly $72.8 million.

Figure 5.1 MPIP Payments by Provider Type

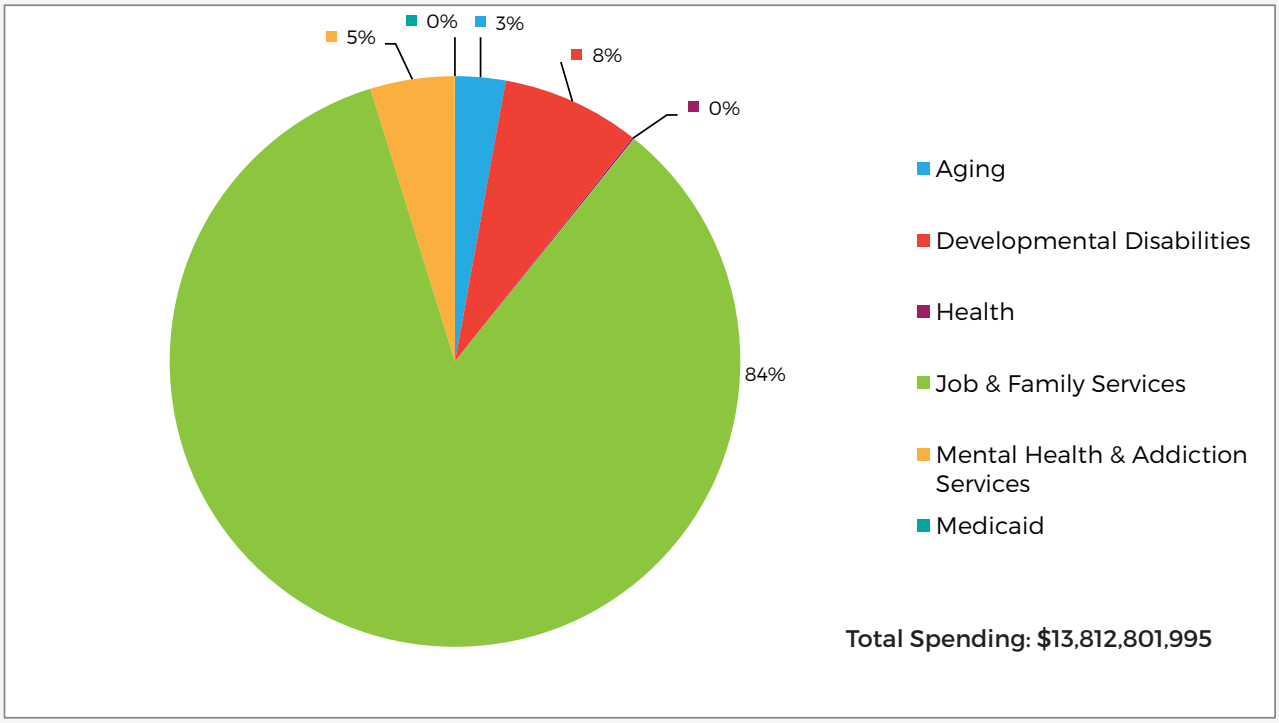


PAYMENTS TO HOSPITALS

In addition to the payments made above, Ohio Medicaid made more than $35 million dollars in incentive payments to qualifying hospitals.

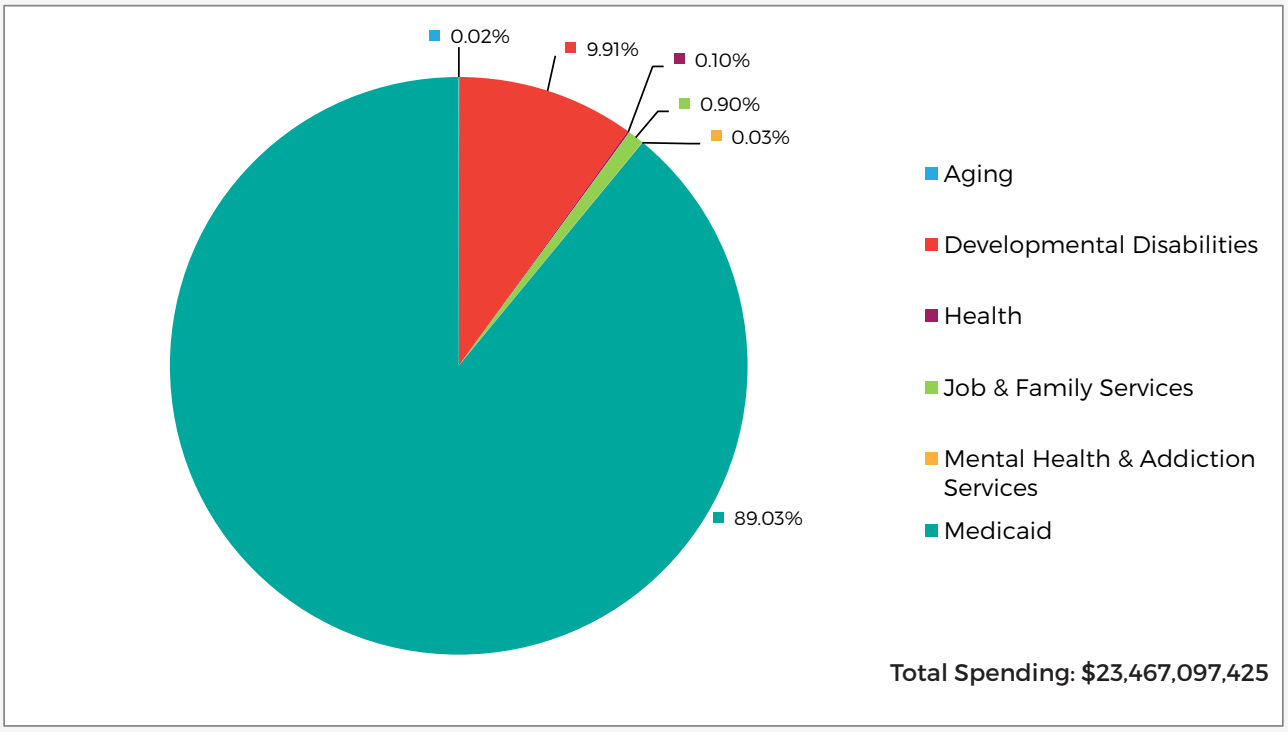
APPENDIX A
DATA

1. MEDICAID EXPENDITURES BY AGENCY SFY 08



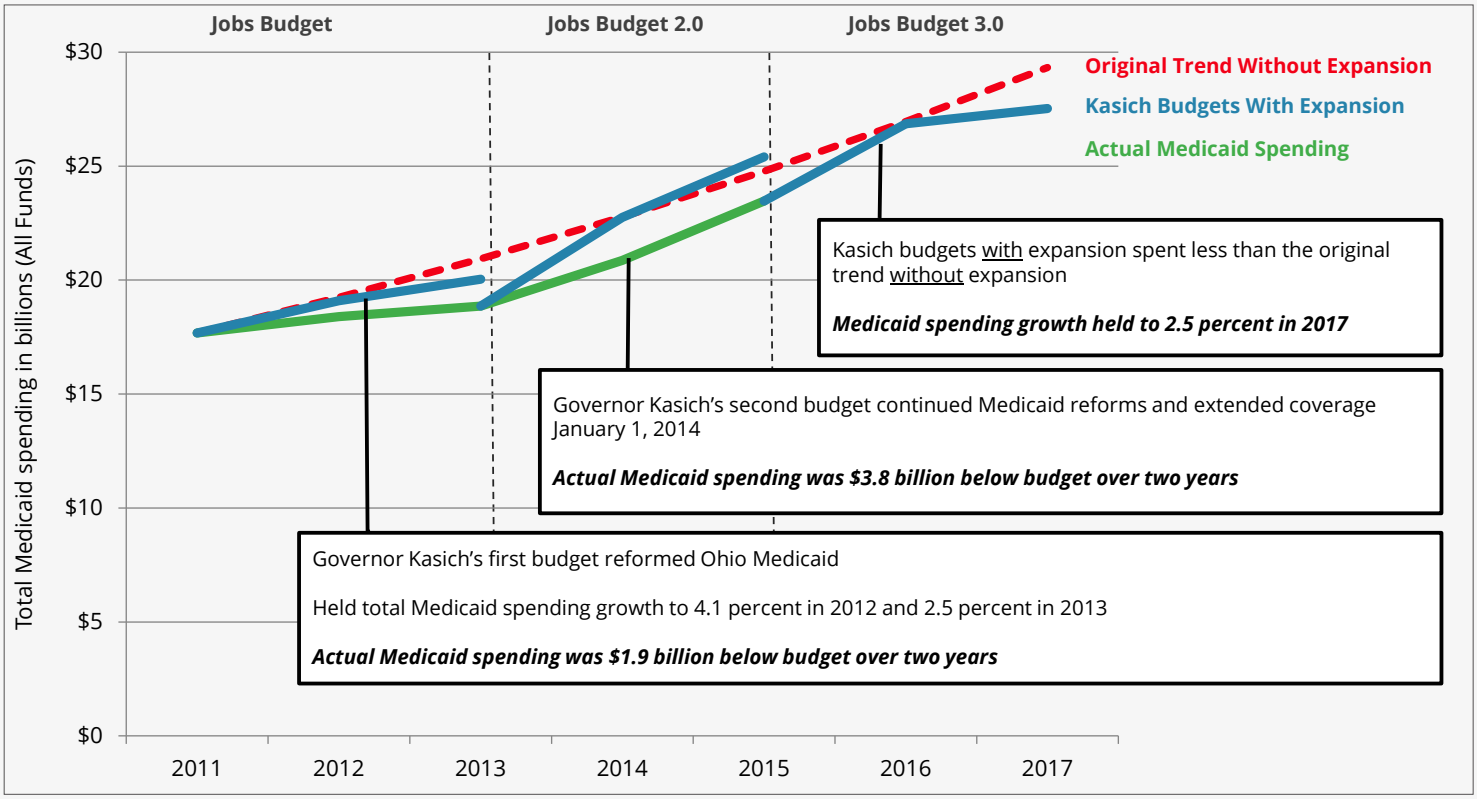
A historic capsule of Medicaid expenditures when organized under the Ohio Department of Job and Family Services. Note that Medicaid spending was spread accross four agencies.

2. MEDICAID EXPENDITURES BY AGENCY SFY 15

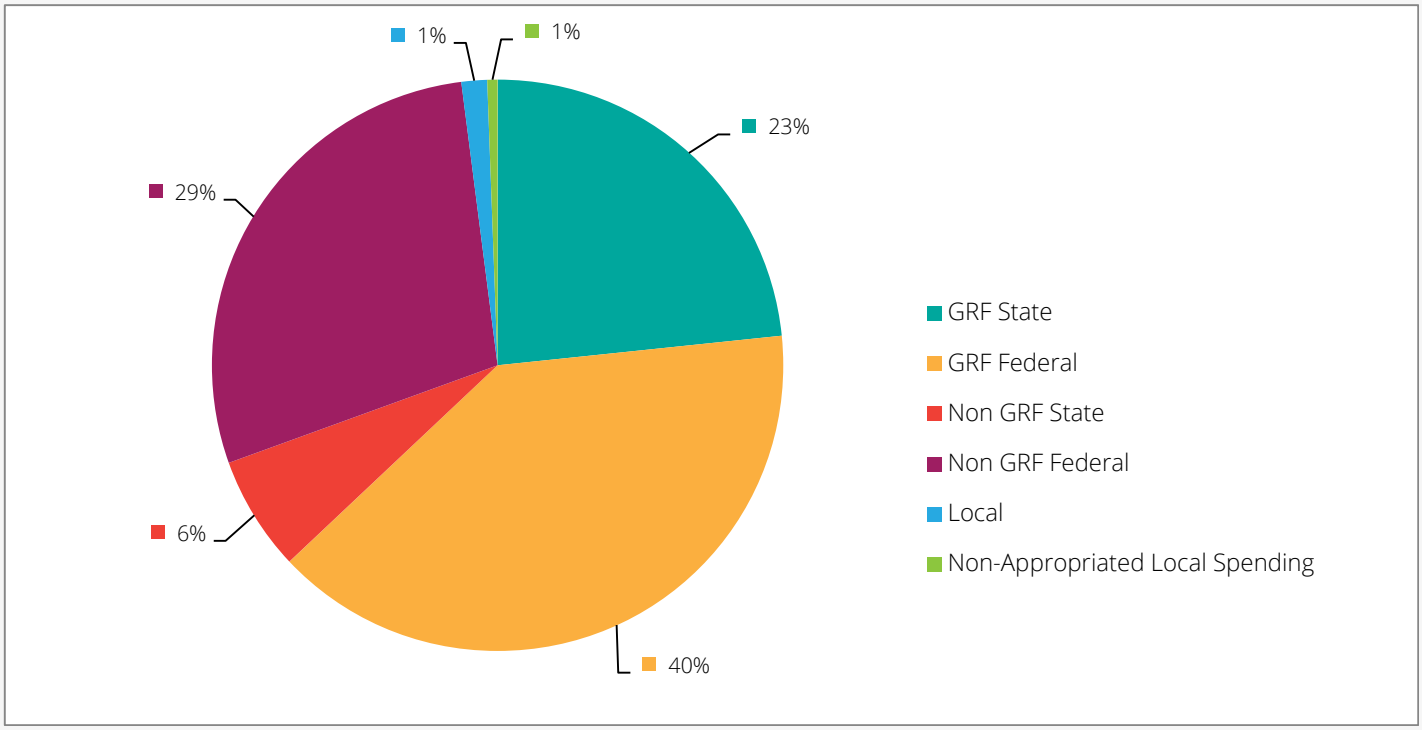


Current Medicaid expenditures as organized under the Ohio Department of Medicaid. Now, 99% of the program is housed within the Ohio Departments of Medicaid and Developmental Disabilities.

3. OHIO MEDICAID BUDGET VS. ACTUAL SPENDING (ALL FUNDS)

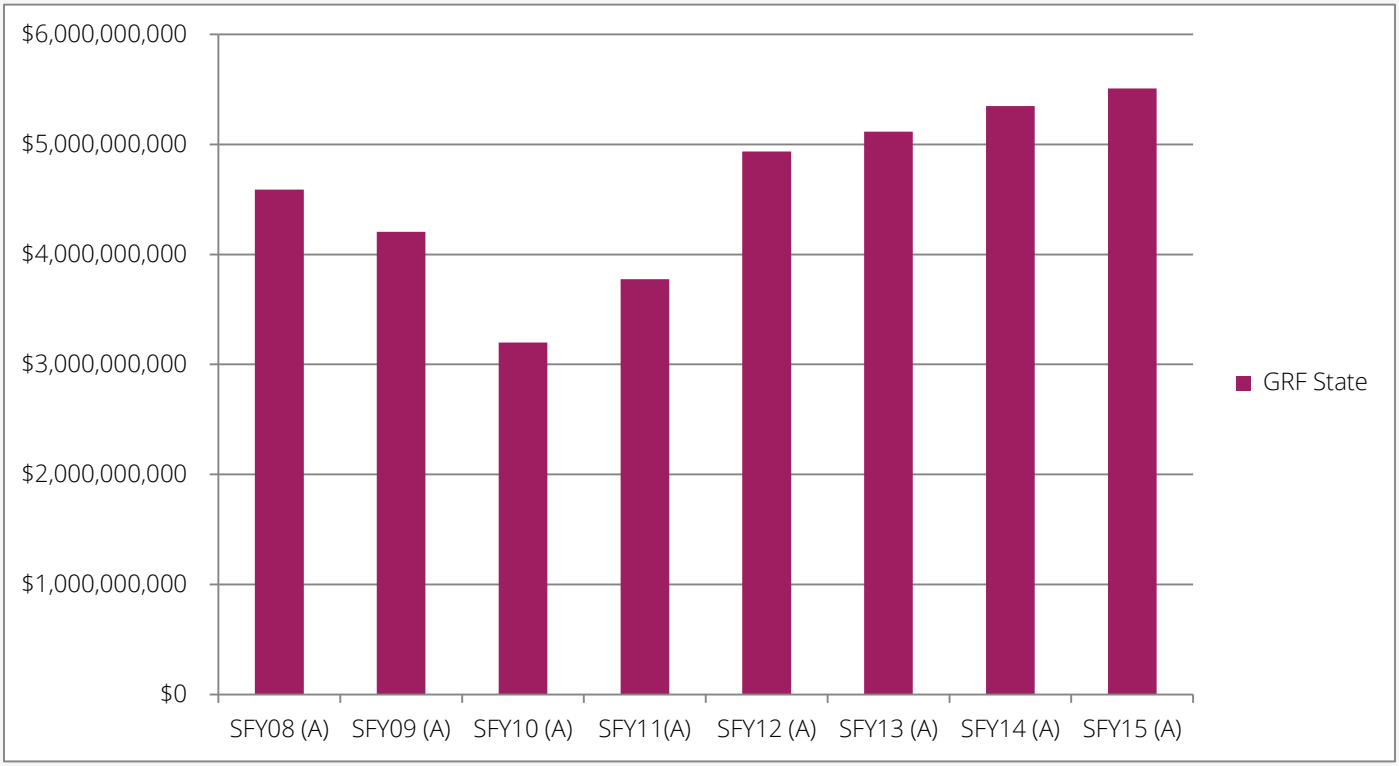


4. ALL AGENCY MEDICAID SPENDING BY FUNDING SOURCE SFY 15



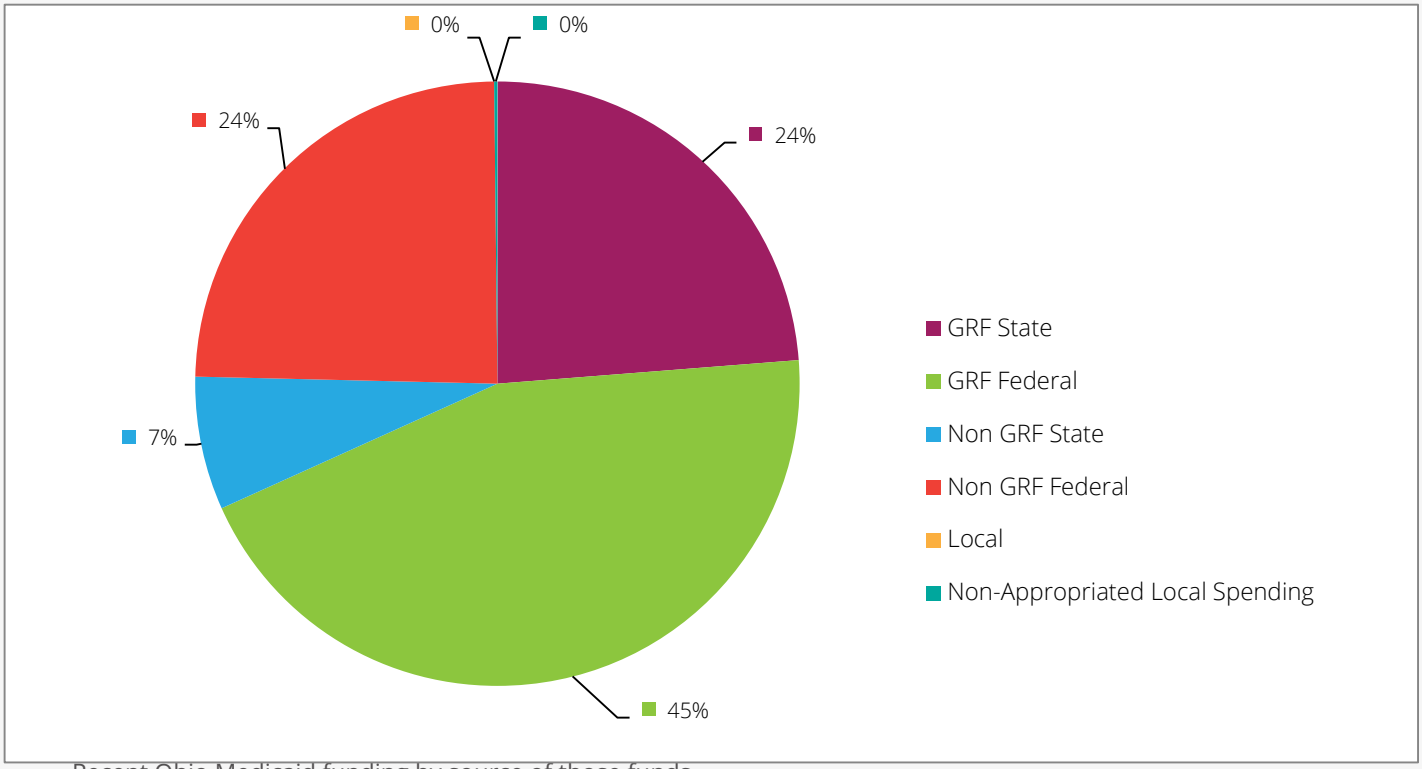
Sources include the state and federal General Revenue Funds, special dedicated state and federal revenues and local contributions including health and human service levies.

5. ALL AGENCY MEDICAID GRF STATE SHARE



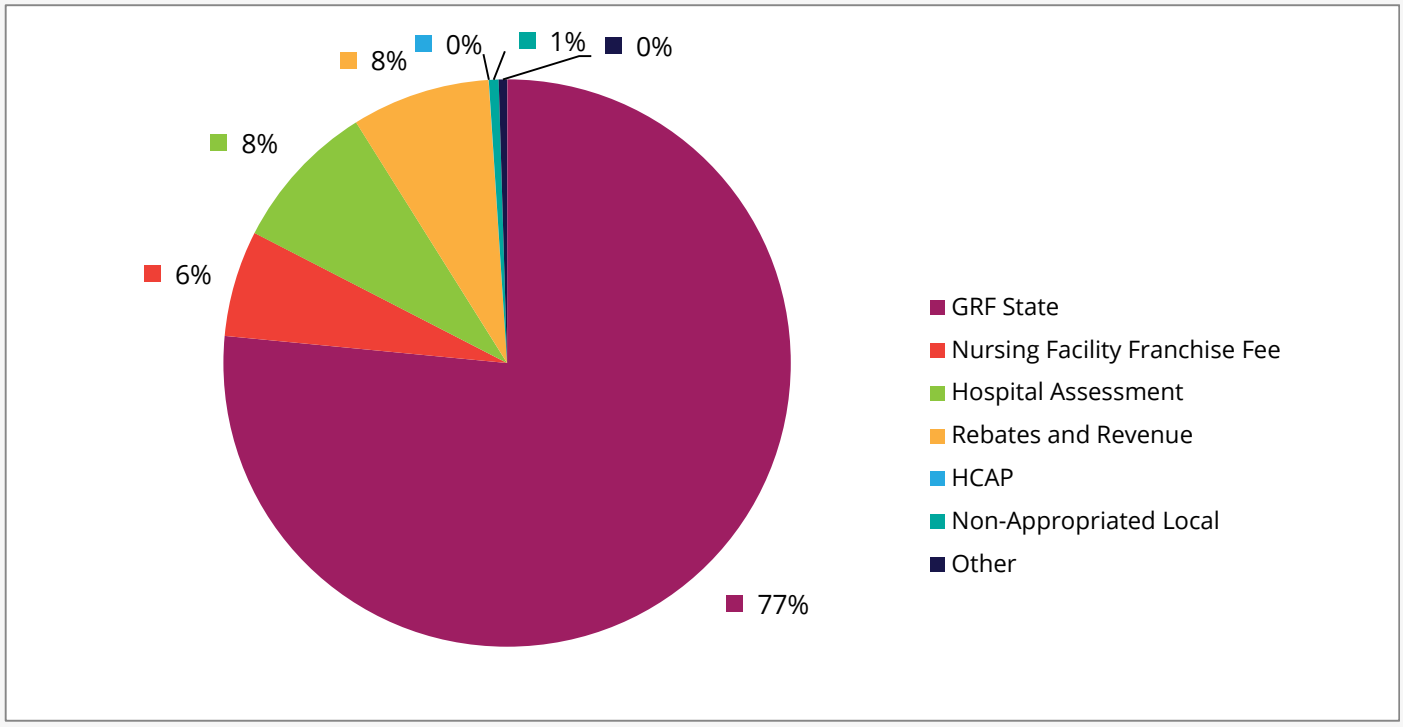
A historic view of Ohio general revenue fund spending from SFY 08 - SFY 15

6. ODM MEDICAID SPENDING BY FUNDING SOURCE SFY 15



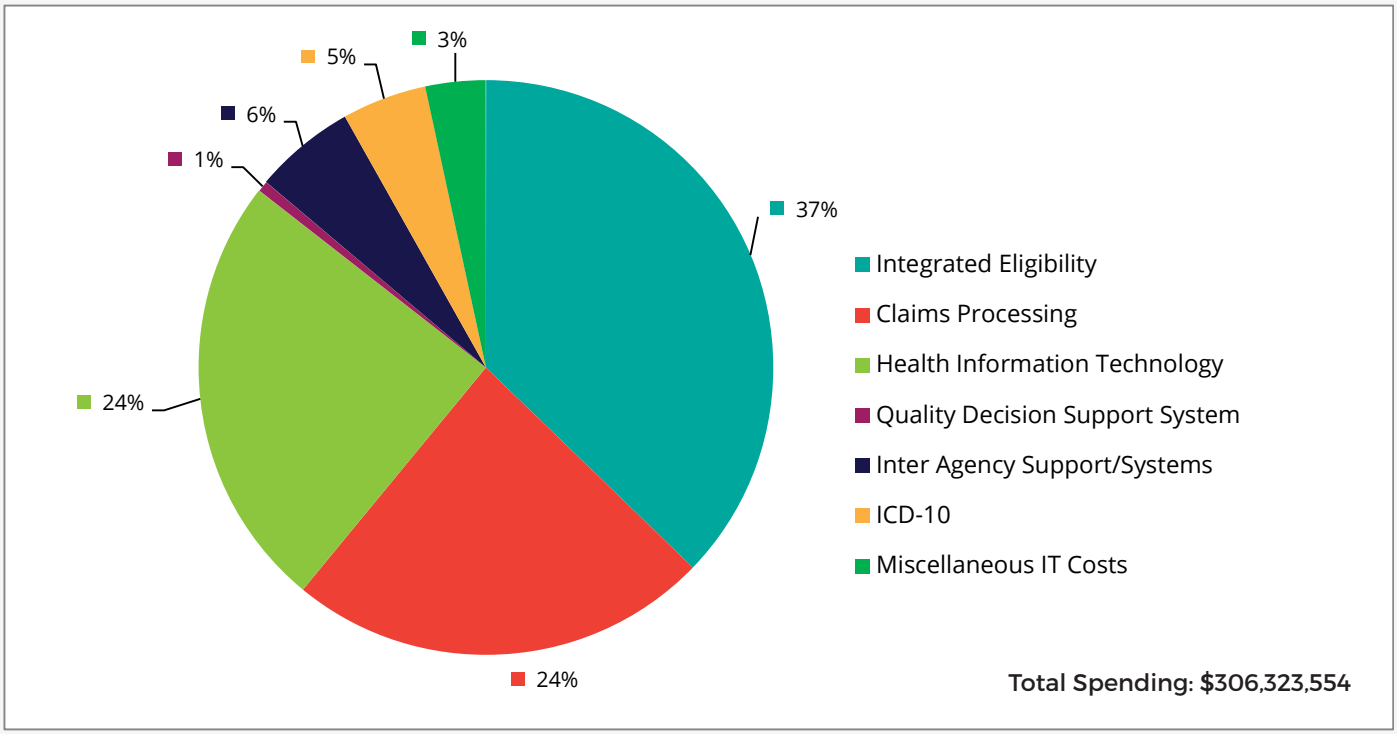
Recent Ohio Medicaid funding by source of those funds.

7. ODM MEDICAID STATE MATCH FUNDS BY FUNDING SOURCE SFY 15



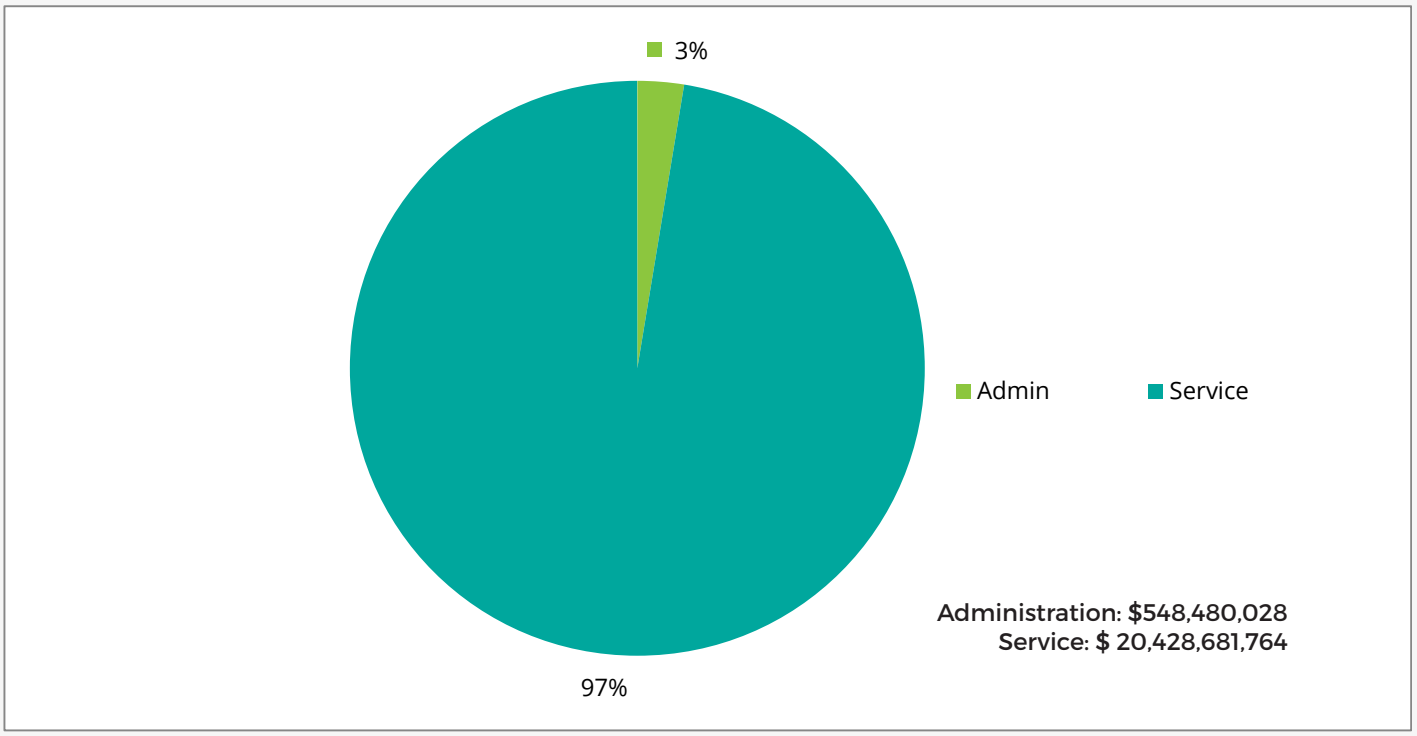
Sources of state contribution for Medicaid payments based on origination.

8. ODM IT EXPENDITURES SFY 15



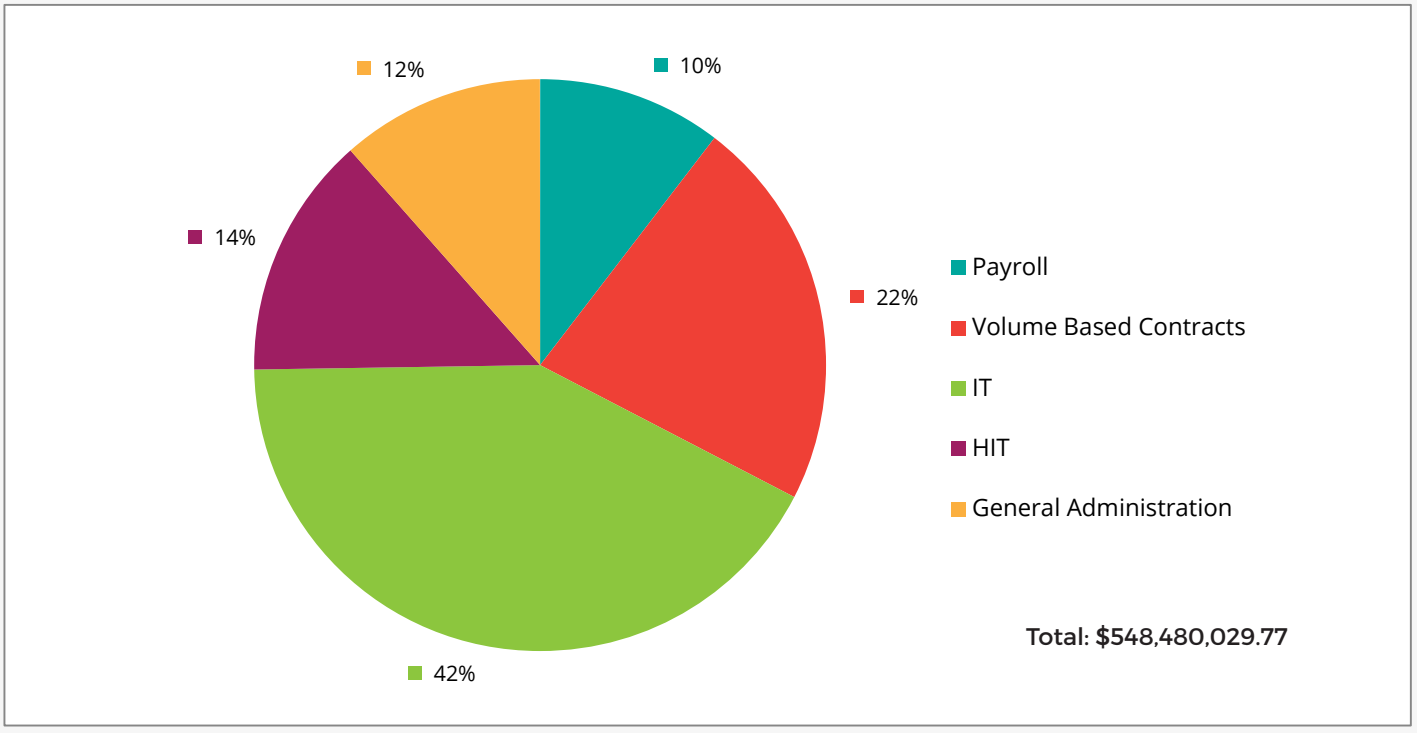
Ohio initiatied several technology programs to make Medicaid operations more efficient, accessible, and accountable while meeting new levels of federal requirements.

9. ODM ADMINISTRATION VS. SERVICES SFY 15



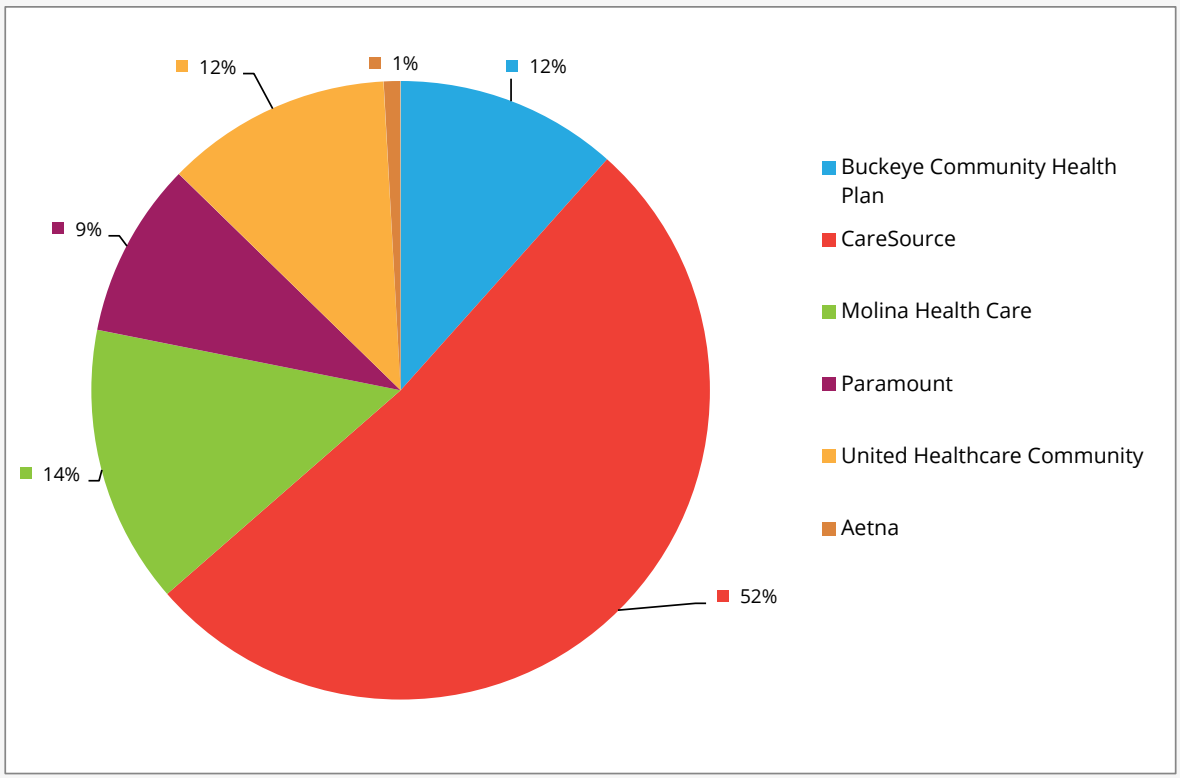
The vast majority of Medicaid funds are spent on services rather than administrative needs.

10. ODM ADMINISTRATION BY TYPE SFY 15



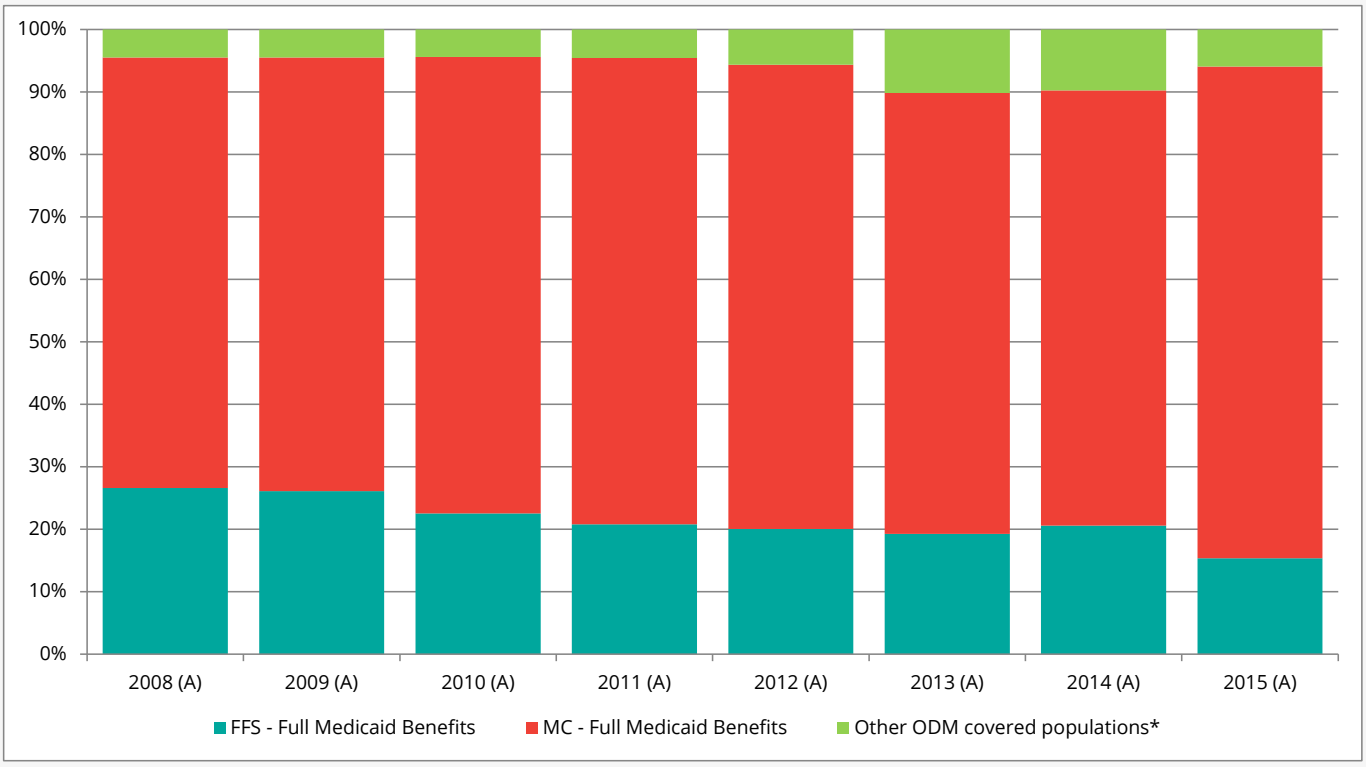
This illustrates how the administrative budget was spent in SFY 15.

11. MEDICAID MANAGED CARE ENROLLMENT BY PLAN SFY 15



Eighty (80) percent of all Ohio Medicaid beneficiaries are enrolled in managed care plans under contract with ODM.

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



*includes Medicare Premium Assistance Program

Historical Managed Care versus FFS enrollment since 2008.

APPENDIX B
QUALITY STRATEGY

Ohio
Department of Medicaid

QUALITY STRATEGY

BETTER CARE: Improve overall quality by making health care more patient-centered, reliable, accessible, and safe.

HEALTHY PEOPLE & HEALTHY COMMUNITIES: Improve the health of the Ohioans by supporting proven interventions to address behavioral, social and, environmental determinants of health.

PRACTICE BEST EVIDENCE MEDICINE: Facilitate the implementation of best clinical practices to Medicaid providers through collaboration and improvement science approaches.

PRIORITIES:

MAKE CARE SAFER	IMPROVE CARE COORDINATION	PROMOTE EVIDENCE-BASED PREVENTION & TREATMENT PRACTICES	SUPPORT PERSON & FAMILY-CENTERED CARE	ENSURE EFFECTIVE & EFFICIENT ADMINISTRATION

GOALS:

Eliminate preventable, health-care acquired conditions and errors.	**Clear communication, accessible care & optimized care.**	**Improve priority populations including the following Clinical Focus Areas*:** HIGH RISK PREGNANCY / PREMATURE BIRTHS BEHAVIORAL HEALTH CARDIOVASCULAR DISEASE DIABETES ASTHMA UPPER RESPIRATORY INFECTIONS MUSCULOSKELETAL HEALTH	**Listen to patient/family & integrate their preferences into care.**	**Sustain a quality-focused, data-informed & continuous learning organization.**

CURRENT INITIATIVES SUPPORTING GOALS*:

Implement hospital payment policy for never events & hospital-acquired infections **Eliminate blood stream catheter infections in neonatal intensive care units** **Human milk feeding to premature infants** **Neonatal Abstinence Syndrome** **Prescription Quality Improvement:** - Atypical Anti-psychotics - Opiates - Dementia Partnership **Medicaid Provider Incentive Program [MPIP]** **Coordinated Services Program [CSP]** **Opiate taskforce**	**MyCare Ohio - Integrating care for individuals served by both Medicare and Medicaid:** - Promote person-centeredness & independent community living **Managed Care Plan [MCP] Delivery System:** - In-person care management for high risk members - Access to services in a timely manner **Integration of Care** - **Health Homes:** intense care management for consumers with severe and persistent mental illness. - Patient-centered medical home - Maternal opiate medical support **Waiver quality & measurement reporting** **HUB model for children and pregnant women** **Minds Matter** **Transitions of Care Performance Improvement Project**	**Prematurity prevention:** - Eliminating scheduled deliveries prior to 39 weeks - Antenatal steroids & progesterone for high-risk mothers - Enhanced maternal care packages for high-risk mothers - Postpartum Quality Improvement Project - Vital Statistics Link **NICU Collaborative: discharge planning** **Strong Start** **Optimizing pediatric psychiatric network** **Diabetes Performance Improvement Project** **MCP Quality Performance Measurement:** - Process & outcome measures for each of the six Clinical Focus Areas above - Pay-for-Performance - Report Cards **Health Equity Work Group** **Health system changes:** - SIM Grant: episode-based payment - Catalyst for Payment Reform - Comprehensive Primary Care Initiative	**NCQA CAHPS Consumer Satisfaction Survey** **Review MCP grievance / appeals / complaints / state hearings** **MCP Consumer quality of life surveys** **MCP Consumer Care Management Survey** **Ohio Medicaid Assessment Survey** **Patient Engagement Study** **ICDS Rebalance Long Term Care Performance Improvement Project**	**Quality Assessment and Performance Improvement [QAPI] Program:** - Performance improvement projects - Performance measure reporting - Over/under utilization of health care services assessment - Quality and appropriateness of care assessment for individuals with special health care needs **Performance transparency & reporting across all Medicaid programs** **MCP compliance monitoring** **Eligibility system replacement** **ICD-10 conversion** **Adult Medicaid Quality Grant** **QI Infrastructure Investment:** - Healthcare workforce development - Quality improvement coordinators

* The Clinical Focus Areas and Current Initiatives were developed for the CFC & ABD consumers who are not on a waiver or in an institution. A separate evaluation will be completed to determine the Clinical Focus Areas and Current Initiatives for these populations.

January 2014

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