Ohio | Department of Medicaid

Mike DeWine, Governor
Jon Husted, Lt. Governor

Maureen M. Corcoran, Director

October 14, 2020

Director Kimberly Murnieks
Ohio Office of Budget and Management
30 E. Broad Street, 34th Floor
Columbus, Ohio 43215-3457

RE: Director's Letter SFY 2022-2023 Budget:
Purpose, Partnerships, Priorities, PERM, Procurement…*AND a Pandemic*

Dear Director Murnieks:

MEDICAID: PURPOSE AND PARTNERSHIPS

Medicaid makes it possible for millions of low-income adults and children can get and stay healthy – making sure they can work and take care of their families. It allows them to see a doctor when they are sick, get check-ups, buy medications, and go to the hospital without fear of choosing between their health and groceries or paying for housing.

Through a network of over 150,000 active providers, ODM delivers health care access and related community support services to more than 3 million Ohioans, including low-income adults, children, pregnant women, seniors, and individuals with disabilities. Over a third of those served by Ohio's Medicaid program are children.

The mission of Medicaid includes providing services and supports to Ohioans at any age or stage of their life--providing prenatal care and education to low-income pregnant women, supporting health and behavioral needs from youth through adolescence, into adulthood and supporting aging Ohioans' independence and other needs for care.

ODM collaborates with several other agencies that are also responsible for administering aspects of the program and providing other community services. Additionally, a variety of local entities assist with parts of the program, including 88 county departments of job and family services, public children services agencies, county boards of developmental disabilities, county behavioral health authorities, area agencies on aging and school districts. Working in partnership with these agencies and community leaders across Ohio is a cornerstone of the DeWine administration. ODM maintains oversight and administrative responsibility for the Medicaid program and assures the federal Centers for Medicare and Medicaid Services (CMS) that federally required standards and requirements are maintained and met.

DEWINE ADMINISTRATION PRIORITIES

From the outset of state fiscal year (SFY) 2020, Medicaid faced organizational, operational and policy challenges and opportunities. Governor DeWine charged Medicaid and all state agencies to work together to support his priorities for Ohio:

- Recovery Ohio
- Opportunity for Every Ohio Kid
- Accountability and Transparency

Shortly after taking office, the governor asked that ODM begin the process of procurement, and to do so with a focus on the administration's priorities for children and families. It also meant meeting a legislative mandate to implement a single pharmacy benefits manager, unbundling the pharmacy service from the current managed care structure.

COVID-19 PANDEMIC

The COVID-19 health crisis that surfaced in early 2020 introduced new and unprecedented challenges for the agency. The latter half of SFY2020 required an agency-wide effort that focused on three goals:

- Ensuring continuous access to care for all who are eligible for Medicaid.
- Devising health delivery models to safeguard against the virus' spread without compromising quality of care.
- Leveraging federal dollars and programs to relax regulatory requirements and financially supplement income for providers hardest hit by the crisis.

ODM worked alongside the Ohio Department of Mental Health and Addiction Services (ODMHAS) to relax existing telehealth rules as a means to enable safe distancing while delivering both medical and behavioral health care services as families and individuals coped with the stresses and physical impact of income and health emergencies. Other programmatic and regulatory relief encompassed more than 175 rules and seven federal state plan and waiver changes.

The agency introduced an emergency provider agreement through Medicaid managed care organizations (MCO) that lightened provider administrative responsibilities and expanded access to medications by dissolving in- and out-of-network pharmacy delineations.

The Impact of COVID-19 on the Medicaid Budget

Like many agencies, ODM was impacted by the outbreak of COVID-19 and the declaration of the public health emergency. ODM has continued to closely monitor caseloads and utilization to ensure it was able to operate within the appropriated amounts.

Medicaid Caseload is Counter Cyclical with the Economy

As a safety net program, the trend of the Medicaid caseload typically moves in the inverse direction and slightly lags or follows behind the state's economy. With the unusual nature of this pandemic, projecting Medicaid caseload has been particularly difficult. The federal unemployment stimulus, the temporary furloughing of employees with continuing health care coverage, and other economic and psychological dynamics have contributed to the uncertainty related to projecting caseloads.

Compounding this is the federally required maintenance of effort (MOE) requirement which is a condition of receiving the federal enhanced Federal Medical Assistance Percentage (FMAP), described in the next section. Section 6008 of the Families First Coronavirus Response Act (FFCRA) requires states to maintain eligibility standards, methodologies and procedures; to not impose new premiums or other cost sharing; and to maintain benefits for those enrolled as of March 2020.

Enhanced FMAP with Associated Maintenance of Effort Requirement

In response to the COVID-19 pandemic, the federal Families First Coronavirus Response Act instituted a temporary 6.2% increase to the FMAP, which will be in place for the entire quarter in which there is a declared federal public health emergency (PHE). The agency budget submission assumes that the enhanced FMAP will remain active through the end of December 2020, however the emergency has just been extended further to January 2021. Future budget updates will include the most current FMAP assumptions available.

For calendar year 2020, enhanced FMAP will have contributed approximately $1.2 billion dollars of financial relief to the state, roughly $300 million per quarter.

Once the enhanced FMAP expires, the financial impact of these caseload increases to state general revenue funds will be felt immediately. Even after the pandemic is over and an economic recovery is underway, the reduction of FMAP and increased caseload will have lingering effects on the budget well into the following biennium.

Uncertainty Regarding Federal Requirements and the "Off Ramp" from COVID

In addition to the host of other uncertainties presented by the pandemic, significant action will be needed to come out of the pandemic. Post-PHE work will entail discontinuing and redetermining eligibility, which is likely to create an immediate backlog situation and risk of audit findings. Nursing facility Health Care Isolation Centers will need to be phased out and final payments made. Also, all Medicaid waiver Appendix K provisions will expire on January 27, 2020, even if the pandemic is extended further. ODM is in very regular contact with federal partners and Medicaid authorities across the country to assess and prepare for the "off ramp". We await needed federal guidance.

Work Requirement and Community Engagement 1115 Demonstration Waiver

Since the approval on March 15, 2019, the Ohio Group VIII Work Requirement and Community Engagement Demonstration has been in the planning and secondary approval stages as mandated by CMS. Prior to COVID, ODM was scheduled to "go live" in January 2021.

However, the enhanced FMAP funding and associated MOE requirements associated with the PHE require the start date of the work and community engagement requirements to be delayed. We are in discussions with CMS and assessing our options.

ODM remains committed to fulfilling the legislative requirement as soon as possible and implementing this waiver in a way that connects people within the Medicaid expansion population with job training programs, job opportunities, and community engagement activities to promote financial independence, economic stability, and meaningful employment.

COST CONTAINMENT AND JMOC GROWTH RATE

A major focus of Medicaid has been to support the delivery of quality healthcare services during a pandemic while remaining responsible stewards of taxpayer funds. During the FY20-21 biennium, ODM implemented a variety of cost containment measures, including a quality withhold initiative for managed care plans, realigning provider fee programs, and implementing a unified preferred drug list (PDL). Administrative reductions combined with a reduction in the managed care rates for the first half of the calendar year enabled ODM to balance the state fiscal year ending June 30, 2020.

The budget submission reflects a baseline for estimated spending based on current policy and law for services provided through ODM. The total ODM budget is expected to grow by 21.4% in SFY2021, 4.8% in SFY2022, and 1.4% in SFY2023. CFC and Group VIII caseload is the major driving force of these increases in SFY2021. Caseload has already increased by more than 270,000 individuals through September due to the pandemic, and further increases are anticipated in SFY2021.

ODM will work with the Governor's office, OBM, and the legislature to contain program costs. Generally, cost containment options include rate changes, provider taxes, cuts to optional services and eliminating some eligibility groups. Under such circumstances, it is commonly debated whether optional service reductions actually save money or increase overall service cost due to shifting to higher-cost settings, such as hospital emergency departments.

Provider taxes are currently set to the maximum allowed by federal law except for the hospital tax, which was restructured last biennium. Due to federal maintenance of effort requirements tied to the enhanced FMAP, ODM's options for cost containment are limited until the declared public health emergency ends.

The Joint Medicaid Oversight Committee (JMOC) sets the projected medical inflation or growth rate that the Governor's budget for ODM should not exceed. JMOC's report on growth rate is

due to the General Assembly and ODM by approximately November 3. Upon receipt of the report, ODM will work with JMOC and their actuaries to resolve any outstanding questions.

Managed Care Risk Corridors

As of this date, ODM is in the process of finalizing agreements with the MCOs to implement risk corridors for both the Medicaid Managed Care Program (MMC) and MyCare, for the time period January through December 2020. Based on preliminary information through the end of June 2020, the net underwriting gain for the MMC and MyCare is 3.7% and 3.6% respectively. Risk corridors are being required of managed care states by CMS associated with COVID related changes and are intended to serve as protection for the state, federal government, and the health plans. During this period of extraordinary uncertainty, a risk corridor will reduce the state risk of over or under funding the capitation rates. The 2020 settlement will occur during the 3rd quarter of CY 2021.

PROCUREMENT FOR THE NEXT GENERATION OF MANAGED CARE

Nearly 90 percent of Ohio Medicaid members receive their care through one of six MCOs: United Health, CareSource, Molina, Buckeye Health Plan, Paramount Advantage and Aetna. For 15 years, the basic structure of the managed care model has remained unchanged, performing at adequate levels to meet federal and state regulatory requirements but leaving opportunity for improvement in scaling patient-centric services, innovative pricing and expanding value-added purchasing arrangements.

To support the administration's priorities Medicaid initiated a managed care procurement process that enables the agency to identify critical gaps, inefficiencies, obstacles and opportunities to strengthen the program statewide. To begin the process, the agency conducted a statewide outreach and listening campaign meeting with providers, members, advocates, policymakers and others to understand the impact of the current structure on those we serve. More than 1,100 individuals or organizations responded.

In February 2020, ODM introduced its vision for the future based on five overarching principles.

ODM's vision is to focus on the individual rather than the business of managed care by:

- Personalizing the experience of care.
- Improving wellness and health outcomes.
- Enhancing care for children and adults with complex needs.
- Strengthening patient care by reducing provider's administrative burden.
- Increasing program transparency and accountability.

The complete procurement is comprised of the following components:

- Managed care

- Single pharmacy benefit manager, and consultation of a separate operational support vendor
- Centralized provider credentialing
- Fiscal intermediary, for claims and prior authorizations
- OhioRISE, a specialized managed care plan for multi-system youth

Managed Care

ODM is developing the "next generation" managed care program that can reach beyond the status quo and respond to the constantly changing healthcare needs of Ohioans. The focus is on the individual with strong coordination and partnership among MCOs, vendors and ODM, and incorporates specialization by unbundling certain responsibilities from the current model to address critical needs. New contracts will focus on coordinated care, health outcomes, transparency and accountability, personalized care, and services for children and adults with complex needs. The transparency and enhanced data capacities will provide better tools and leverage for needed cost containment efforts.

Single Pharmacy Benefit Manager

HB 166 required that ODM procure a single PBM to address concerns with PBMs in Ohio and across the nation. A myriad of problems resulted in the call for this structural change;

- Pricing issues: conflicts of interest and lack of transparency with rebates, fees, clawbacks and delays in updating MAC lists;
- Pharmacy issues: inadequate reimbursement to cover acquisition costs; access to independent, rural pharmacies; and inadequate dispensing fees;
- Formulary and specialty pharmacy issues, including steering; and
- Inadequate data and lack of transparency: difficulty getting timely, accurate, complete data; general lack of transparency and inability to assess appropriate reimbursement for drugs and pharmacy services, as well as for PBM services and profit.

The single pharmacy benefit manager will be a specialized managed care organization contracted with ODM to administer the Medicaid prescription drug program. The design will support wholistic clinical care and care coordination. On July 24, 2020 ODM published an RFP for the SPBM. Responses have been submitted and the agency expects to announce its selection in November. Once implemented, Medicaid's pharmacy benefits strategy will ease provider administrative burdens, reduce operational costs and strengthen the state's fiscal oversight of this vital health care benefit, in support of ORC 5167.24.

ODM was required by CMS to "certify" the PBM program, thereby securing enhanced federal matching funds that will save Ohio taxpayers millions as the program evolves. Certification allows Ohio Medicaid to receive a 90% federal match for costs incurred to build the program, and a 75% federal match for operational sustainment costs. The time needed to gain certification will be offset during transition and does not affect the Department's overall timelines.

Additionally, ODM is securing a consulting contract with a Pharmacy Operational Support Vendor (POSV) to remove potential conflicts of interest with the PBM. The POSV will advise ODM on reimbursement issues as well as audit the SPBM to ensure it carries out its functions appropriately.

Unbundling the current responsibility for the pharmacy benefit from the managed care structure results in:

- Elimination of confusion and conflict for individuals and providers created by variability between existing MCOs
- Elimination of PBM conflicts of interest and increases transparency
- Greater ability to be ensure accurate and optimal levels of rebates
- Direct access to data, to support quality, program integrity and value-based purchasing initiatives
- Elimination of associated administrative costs for plans, but an increased administrative cost for ODM

Centralizing Provider Credentialing

As of June 2020, there are approximately 152,790 active Ohio Medicaid providers. ODM receives on average 3,500 – 4,000 new applications and revalidation (re-enrollment) applications per month.

Medicaid will implement a single, centralized provider credentialing process beginning in March 2021, to replace the current process which is duplicated by each managed care plan.

During calendar year 2020 the Ohio Department of Medicaid prepared the new Provider Network Management module to replace the existing provider enrollment and screening system and support the centralized credentialing process. In addition to reducing the administrative burden for providers and MCOs, it will improve ODM's ability to monitor payments and timely recoup those made to debarred providers.

Fiscal Intermediary

Currently there are multiple systems for claims submissions and a significant lag in normal reporting that hinders timely, data informed decision making. Each managed care plan has its own requirements, with different rules for prior authorization and coding billing invoices. Implementing a fiscal intermediary will create a single system for intake of claims and prior authorization requests. Also, by reducing the normal six-month lag to secure complete, accurate data, the usefulness of data for decision making and transparency will be improved.

OhioRISE (Resilience through Integrated Systems and Excellence)

The following are a few facts to illustrate the difficulty for Ohio's children and youth with multi-system needs in receiving care, including circumstances when their families are forced to relinquish custody to get needed treatment.

- *140 kids per day* are receiving care out of state - a *200% increase* in kids per year compared to 2016.
- *Over 40% of kids* over age 15 in the child welfare system are in congregate care
- *38% of youth with multi-system needs* have individuals in their families with a history of opiate or other substance use disorder, and/or primary diagnosis of serious mental illness.

OhioRISE is a specialty managed care plan that will provide services to a subset of children and youth who are at risk of custody relinquishment and who require intensive behavioral health services. The type of services these youth require is not available in Ohio in the amount and intensity required. This is resulting in kids being sent out of state at a cost of up to $1,100 per day, youth being held in a hospital inpatient stay for weeks or months at a time, or other options that are not appropriate or effective to meet their needs and cost more than the alternative services. Features of the new program include:

- Multi-agency governance to drive toward improving cross-system outcomes
- Provide intensive high fidelity wrap around care coordination
- Provide specialized intensive services specific to the needs of these youth and their families, including coordination with DODD's intensive behavioral support ICF/IDD residential services
- Utilize a new 1915c waiver to target the most in need and vulnerable families and children to prevent custody relinquishment
- Relieve some pressure on local child welfare dollars and investing Medicaid funds in more *effective evidence-based services*
- Align with state and federal requirements and priorities for the Family First Prevention Services Act.

QUALITY STRATEGY & PROGRAM INTEGRITY

ODM adheres to a quality strategy that ensures continuous quality improvement through improvement methods that adhere to the Institute for Healthcare Innovation's (IHI) "science of improvement". ODM has an overall Quality Strategy and also is required to have quality improvement components and structured evaluation for each Medicaid waiver, with formal research plans required for 1115 waivers.

In recent years ODM has implemented several delivery systems reforms with the goal of closing equity gaps and providing better care through family- and person-centered models. A few examples follow:

- ODM is a few years into the MyCare expanded coordinated care program for individuals in both Medicare and Medicaid. This demonstration creates a single point of accountability for long-term services and supports (LTSS), behavioral health services, and physical health services with additional value-added supports such as transportation.

- Targeted community efforts with managed care partners to reduce infant mortality in geographic areas of greater risk for African American women has continued.
- ODM also has reformed payment structures to focus on value. The most notable example is comprehensive primary care (CPC), in which practices receive monthly payments for specific functions -- 24/7 access, or ensuring patient referrals are followed through -- with additional bonuses for overall improvements in key quality measures that focus on the management of chronic physical and behavioral health conditions. CPC for kids was implemented in 2019.

Programs such as these acknowledge the importance of longitudinal care within the context of community, addressing social determinants of health as part of the holistic care required for improved outcomes.

PERM Audit and Program Integrity

In early 2019 the Center for Medicare and Medicaid Services (CMS) put ODM on notice, following longstanding concerns in managing the backlog of Medicaid eligibility cases in Ohio.

In November 2019, Medicaid received Ohio's Payment Error Rate Measurement (PERM) audit results that estimated $6 billion of improper payment made during the SFY18. ODM's rate was the highest among all states participating in the FY 2019 review, and nearly double the national average. The agency's eligibility error rates were 43.49% for Medicaid, and 55.16% for Children's Health Insurance Program (CHIP).

Working with our federal partners, corrective action plans (CAP) were quickly developed that were praised by CMS: "We [CMS] believe the strategies that Ohio has included in its plan will introduce sustainable improvements to state systems and operations" wrote Deputy Director of Children and Adults Health Programs Group Anne Marie Costello in a letter approving ODM's backlog CAP.

Other program integrity efforts include:

- Continued progress in the implementation of Electronic Visit Verification (EVV), which helps ensure individuals are receiving necessary services and that ODM is not paying fraudulent claims,
- Expansion of ODM's incident reporting system for health and safety of individuals served on waivers and
- Monitoring by managed care plans has continued to build collaborative relationships with the plans to fight fraud, waste, and abuse.

GREATER TRANSPARENCY AND TECHNOLOGICAL INNOVATION

On April 14, 2011, Centers for Medicare and Medicaid Services (CMS) issued seven conditions and standards for state Medicaid technology investments to be eligible for enhanced federal match funding. These conditions and standards include a requirement that state Medicaid

agencies continually evaluate Medicaid business, information and technical architectures to determine the state's level of compliance with CMS Medicaid Information Technology Architecture (MITA) requirements.

ODM adopted the CMS "modularity" by implementing a core infrastructure module referred to as an Enterprise Service Bus (ESB) which is being accomplished through the creation of the Ohio Medicaid Enterprise System (OMES). Phase one went live in June 2019 and subsequent phases are timed to coincide with modular deployments that will replace the current MITS system. Today, MITS adjudicates over 52 million fee-for-service claims and over 127 million managed care encounters annually; 99.9% are electronic, including approximately 1.5 million fee-for-service claims submitted through the portal.

OMES will include the Provider Network Management (PNM) and a Financial Intermediary (FI). These modules are being implemented with the support and assistance of existing vendors, state agency service providers such as DAS, and State Sister Agencies. The PNM module will be implemented in SFY21 and support provider management functions, provider credentialing, and the provider portal.

ODM will deploy a fiscal intermediary model in SFY22/23 which will provide prior authorization functions, claims adjudication, encounter management, claims payments, and support rate setting. The FI will greatly enhance transparency provide more timely, actionable data than exists today.

Additional core infrastructure components will be introduced in the ESB to further increase data transparency and system integration which will include Electronic Data Interchange (EDI), Master Data Management (MDM), and Reference Data Management (RDM). EDI will support standardized transfer of data between trading partners and MDM/RDM will ensure consistent use of data elements between modules and system partners and reliable data integrity between systems.

OMES will also host greater connectivity for Managed Care, OhioRISE, Single Pharmacy Benefit Manager (SPBM), close integration with Medicaid HHS Enterprise Data Warehouse (EDW) and provide the potential to support future initiatives such as Customer Relationship Management (CRM) and Case Management.

CONCLUSION

In closing, the following three primary goals will guide ODM's actions in the months ahead:

1. Ensuring every eligible Ohioans receives quality health care through the Medicaid program,
2. Supporting and advancing Governor DeWine's priorities for Ohio and Ohioans and

3. Implementing a new structure for Medicaid's managed care program that will increase accountability, provide unprecedented transparency and enable the agency to serve as responsible financial stewards for taxpayer resources.

The coming biennium will prove to be one of Ohio's most challenging, as the state faces revenue shortfalls and increased demands for support from our citizens. By the time the General Assembly adopts the budget on June 30, 2021, the nation will be more than 16 months into the COVID-19 pandemic. More will be known, Ohio will continue on the road to recovery and, hopefully, widespread vaccine availability will enable Ohioans to engage in robust economic and social relationships. Thank you for your consideration of the ODM SFY22-23 budget.

Sincerely,

Maureen M. Corcoran, Director