Ohio | Department of Medicaid

Mike DeWine, Governor
Jon Husted, Lt. Governor

Maureen Corcoran, Director

Testimony to the Finance Committee of the Ohio Senate

Governor DeWine's Executive Budget Proposal SFY 2022-2023

Maureen M. Corcoran, Director, ODM April 15, 2021

Executive Summary

Introduction and Acknowledgments

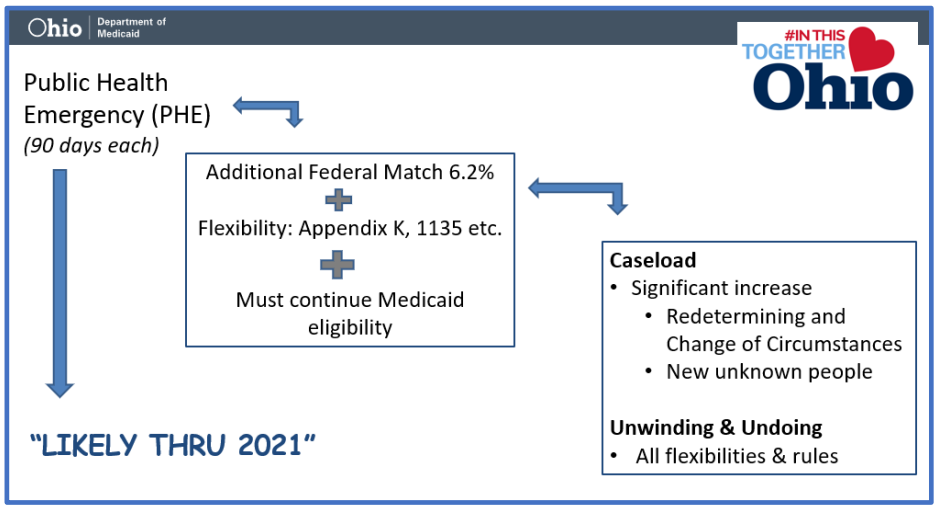
Ohio Medicaid

- ~3 million Ohioans who are serve
- Network of over 178,000 providers
- More than 1.2 million children in our state are served by Medicaid
- Approximately 48,000 children in foster care are served by Medicaid
- More than 900,000 individuals served by Medicaid received behavioral health services last year

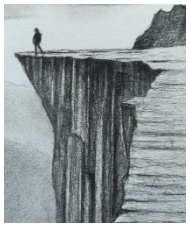
ODM Priorities:

1. Ensuring eligible Ohioans have continuous access to high-quality health care as the nation continues to manage through the recovery from the COVID-19 pandemic.
2. Continuing and completing priority policy initiatives approved in HB 166 of the 133rd General Assembly.
3. Maintaining disciplined fiscal oversight of the Medicaid program and controlling spending growth to levels ***below*** national measures.
4. Continuously working to improve the health while encouraging independence for millions of Ohioans.

Part 1 SFY 22-23 Financial Drivers: PHE, Enhanced FMAP and Caseload



The caseload "pig in the python"
&
The money CLIFF



- Recently, the Secretary of Health and Human Services (HHS) notified Governors that "the PHE will likely remain in place for the entirety of 2021", and states will receive a 60-day notice prior to termination. As submitted, the ODM budget incorporates this updated guidance.
- PHE & Medicaid impact

- Additional federal match of 6.2% per quarter. January-December CY 2020 & 2021, 8 quarters
- CMS Flexibilities for telehealth, home and community-based waivers and other administrative simplification
- Maintenance of Effort (MOE) Must continue Medicaid eligibility throughout the PHE

- Caseload observations: redeterminations and new people

Caseload Forecast

- Ohio Medicaid's average monthly caseload forecast
  - Projected 3.39 million SFY2022 and 3.22 million in SFY 2023
  - Peak caseload of 3.45 million in February 2022
  - Assume PHE ends December 2021
  - Caseload is projected to decline for the remainder of the biennium
  - We do not anticipate the caseload will return to pre-pandemic levels by the end of FYY22-23 biennium
  - Figure 6 and Figure 7 have more detail by aid category (page 9-10)
  - ***See comparison of ODM caseload estimates with LSC caseload estimates in Appendix 1.***

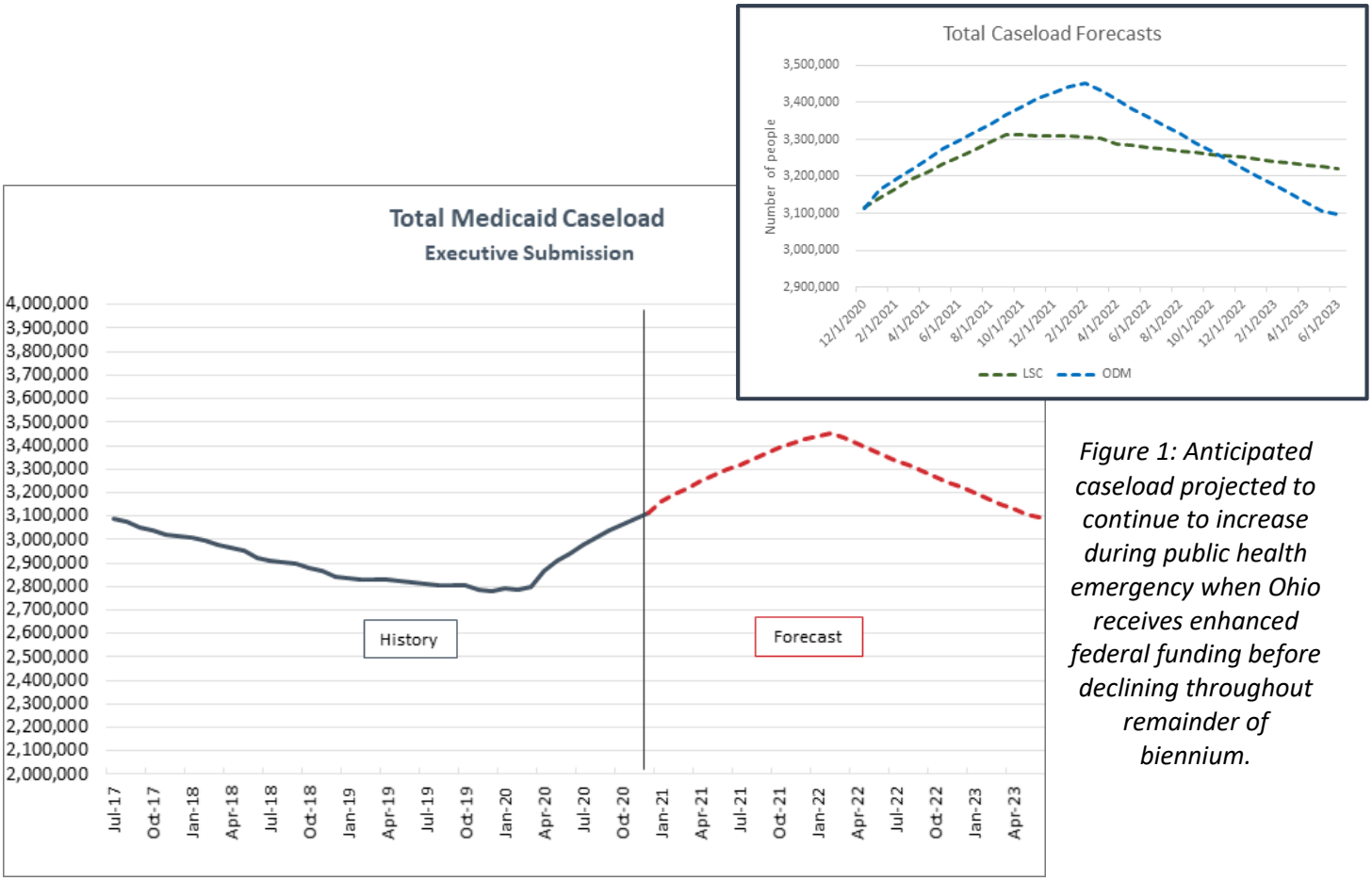


Figure 1: Anticipated caseload projected to continue to increase during public health emergency when Ohio receives enhanced federal funding before declining throughout remainder of biennium.

Medicaid matching-funding dynamic:

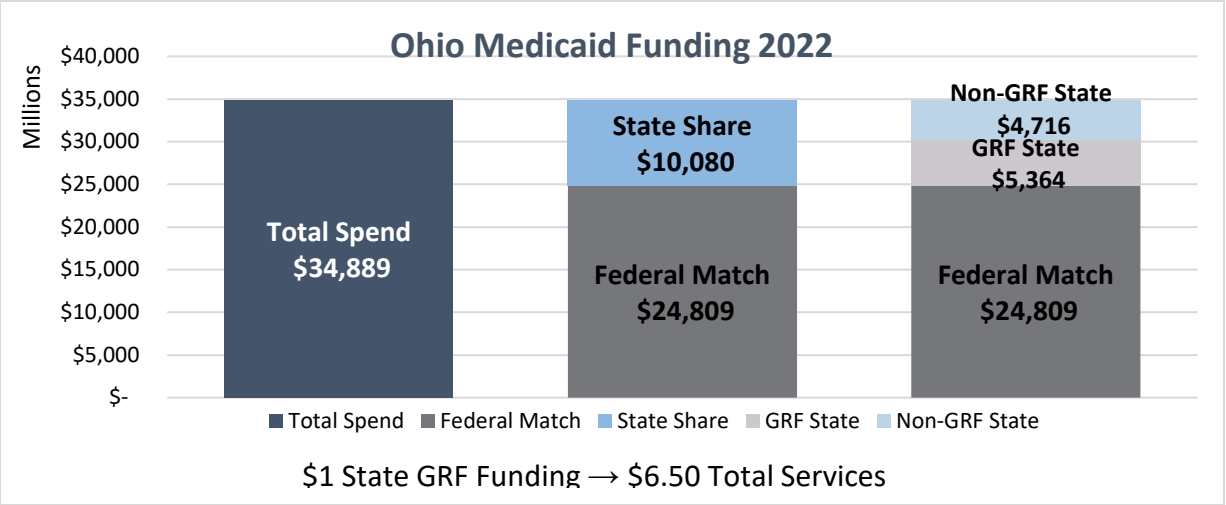


Figure 1: In SFY 22, the Medicaid program is 71% federally funded (pg.2)

Overview of SFY 22-23 Funding

- Total Medicaid budget is projected to be $34.9 billion in SFY22 and $35.7 billion in SFY23 (all funds)
- ODM-administered components of the Medicaid program = 89%. Balance is administered by seven other state agencies – DODD, JFS, ODMHAS, ODA, ODH, ODE, Pharmacy Board & several local public entities.
- **ALL FUNDS** increase of 7.4% and 2.3%
- State share amounts: $3.9 billion and $5.4 billion for SFY 22 and 23 respectively.
- **STATE SHARE** Increases of 4.4% in 2022 and 37.6% in SFY 22 and 23 respectively, 2023 is when we will see the discontinuation of the E-FMAP
- Figure 3 shows adjusting for the enhanced FMAP and the usage of the **Health and Human Services fund**.
- LSC Analysis: See Appendix 1

Table 1: Total all funds Medicaid spending ($ in millions) Pg.3

	SFY 2021	SFY 2022	SFY 2023
Total Appropriated Medicaid	**$ 32,489.50**	**$ 34,889.28**	**$ 35,679.96**
Growth Rate		7.4%	2.3%

Table 2: GRF 651525 state share impact Pg.3

	SFY 2021	SFY 2022	SFY 2023
GRF 651525 State	**$ 3,783.26**	**$ 3,950.52**	**$ 5,433.99**
Growth Rate	7.3%	4.4%	37.6%
Adjustments Affecting 525 State			
Enhanced FMAP	$ 1,131.75	$ 607.63	$ -
Reserve Fund		$ 900.00	$ 300.00
Total Effective 525 State	**$ 4,915.01**	**$ 5,458.15**	**$ 5,733.99**
Growth Rate		11.1%	5.1%

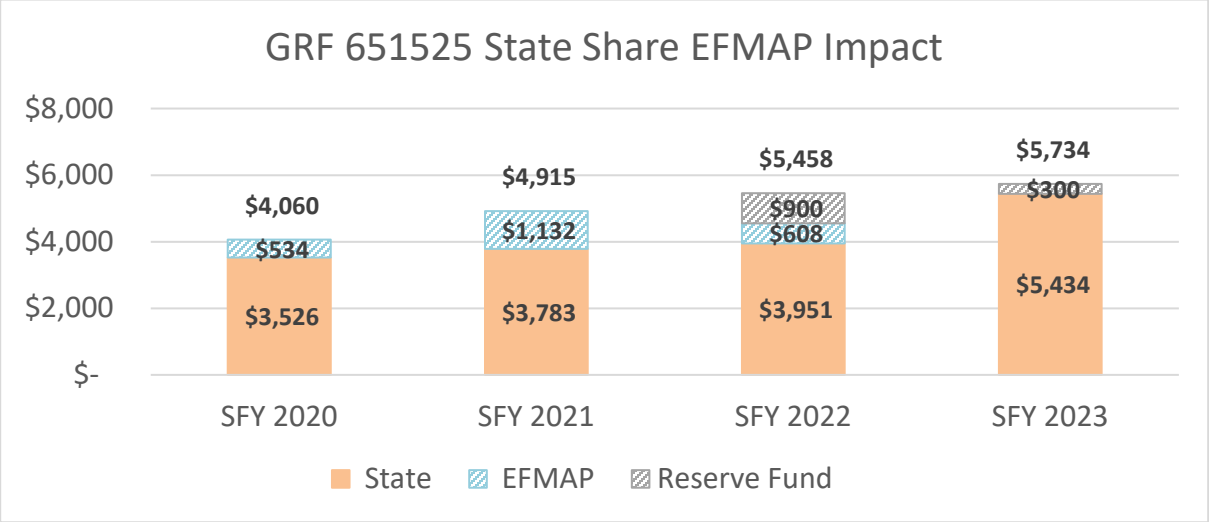


Figure 3: Additional funding realized from EFMAP provided by the CARES Act. *Pg.5*

JMOC Growth Rate and Other Measures of Medicaid and Health Care Growth (pg.6)

- Per Section 5162.70 of the Revised Code, the Medicaid director must limit the per member per month (PMPM) growth across all Medicaid recipients to the lower of the JMOC rate, or comparable to the three-year average Consumer Price Index (CPI) for medical services for the Midwest region.
- Ninety days prior to the submission of the state Executive Budget, Ohio Revised Code 103.44 requires JMOC to select and communicate a growth rate for the coming biennium.
- In the absence of a JMOC rate, the department complied with the spirit of the law and following precedent set by Optumas in prior budgets, replicated the calculation to produce the weighted CPI-medical rate which came out to 3.3%. The Executive version of the Medicaid budget is 3.2% over the biennium, lower than the CPI-based JMOC calculation.

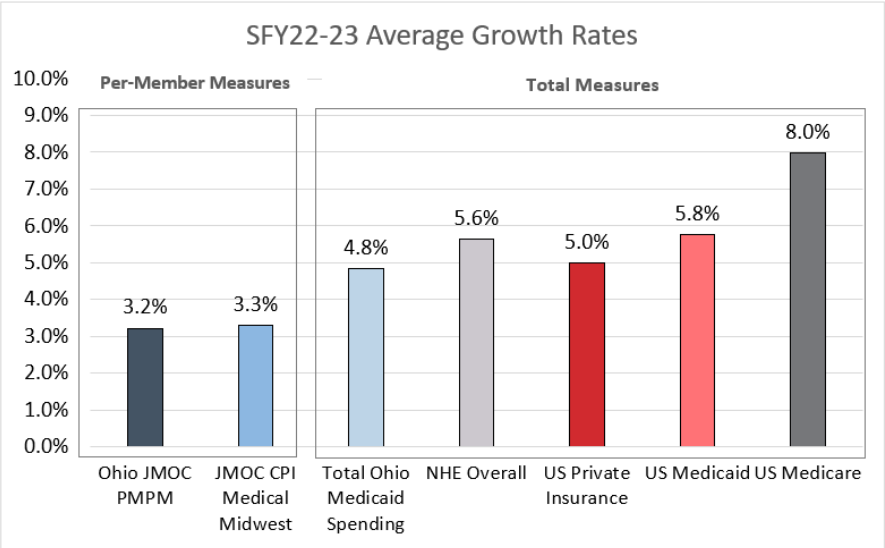


Figure 4: SFY22-23 average growth rates

Cost Containment Strategies

- MCO rate adjustments
- Refer to Appendix 3
- Also "Next Generation" Managed Care Program
- To highlight a few here for you:
    - Unified PDL
    - CPC for Kids
    - Multi-System Youth Relinquishment Program
    - Telehelath in Schools Pilot
    - Electronic Pregnancy Risk Assessment Form

A Preview of Unwinding from the PHE

Flexibility:

To maintain access to care and provide regulatory relief providers during the pandemic, ODM adopted:

- 100 emergency rules
- 74 permanent rules
- 7 CMS State Plan Amendments
- 5 CMS Appendix K submissions
- 2 CMS 1135 waivers

Health Care Isolation Centers:

In SFY 20-21, ODM worked with the General Assembly to designate certain nursing facilities as Health Care Isolation Centers to provide quarantine and isolation levels of care. To date:

- 32 HCICs have been approved, and 2 more provider applications are pending
- 423 people have been served by HCICs
- $1.3M in health care reimbursement has been provided to HCICs

Eligibility, all flexibility and HCICs must be unwound!

New Voluntary Community Engagement Program (pg.11)

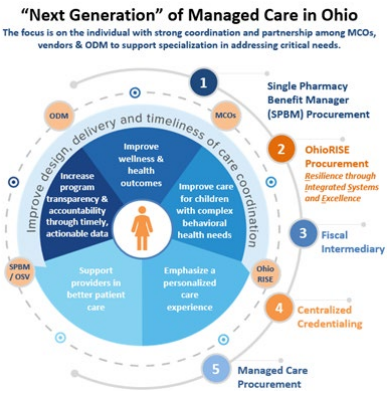
- Scheduled to begin in January 2021, discussions with the Trump Administration in mid-2020 indicated that the program could not proceed, in light of the federal PHE and the prohibitions on eligibility and coverage changes.
- Instead, ODM proceeded with a voluntary work program to serve as a bridge to our mandatory waiver program with the goal of creating opportunities to link individuals to meaningful work and community engagement programs.
- In February we received notice from CMS of their intent to revoke Ohio's waiver
- In response, ODM submitted additional information defending the waiver and requesting a meeting with CMS. Appendix 5 contains a copy of our letter to CMS. CMS has denied our request for a meeting at this time.
- To date, CMS has pulled rescinded the work requirement waivers in four states: Wisconsin, New Hampshire, Arkansas and Michigan.

Part 2 Budget Priorities & Initiatives:

Accountability, Transparency, and Quality Improvement in Managed Care SFY2021

Adjustments in our business relationship with MCOs span three major areas of work: COVID-19 response, pharmacy accountability, and program transparency. My complete testimony has additional information in the following areas.

- *COVID QUALITY INNOVATIONS page 15*
- *COVID-19 PANDEMIC RESPONSE TO SUPPORT INDIVIDUALS & PROVIDERS Pg.16*
- *PHARMACY ACCOUNTABILITY IN MANAGED CARE Pg.16*
- *SAVING MONEY WHILE REDUCING CONSUMER AND PROVIDER BURDEN Pg. 17*
- *PHARMACISTS AS PROVIDERS AND OTHER PHARMACY INNOVATIONS Pg.17*
- *OTHER AREAS OF ENHANCED MANAGED CARE ACCOUNTABILITY Pg.18*



Managed Care Cost Containment and Risk Corridor Strategy (pg.24)

- In accordance with COVID guidance issued from the Centers for Medicare and Medicaid (CMS), ODM added a two-sided risk mitigation strategy (risk corridor) to the provider agreement. The risk corridor was required by CMS in CY20 and continued in CY21 in recognition of claims cost uncertainty attributable to the COVID-19 pandemic and associated state policy changes.
- Rate adjustments were made in late SFY 20 and early SFY 21 to recognize the reduced utilization and population changes attributable to the pandemic. January through June 2020 rates were reduced by 1.5%, saving approximately $150 million. In addition, the original CY 2020 Medicaid Managed Care (MMC) program capitation rates were reduced by approximately 3% in recognition of population changes attributable to the COVID-19 pandemic and the MOE which allowed for Medicaid recipient's eligibility to be extended. This resulted in a decrease to projected CY 2020 capitation payments of approximately $270 million.

Implementing the Next Generation of Medicaid Managed Care (pg.19)

Two years ago, during the deliberations on HB 166, we discussed at length with members of the General Assembly the procurement of the Medicaid managed care program. Working closely with you in the legislature, we proceeded to engage stakeholders and Medicaid members through in-person listening sessions and multiple requests for information. Throughout months of complex system design and approvals with our federal partners, we kept

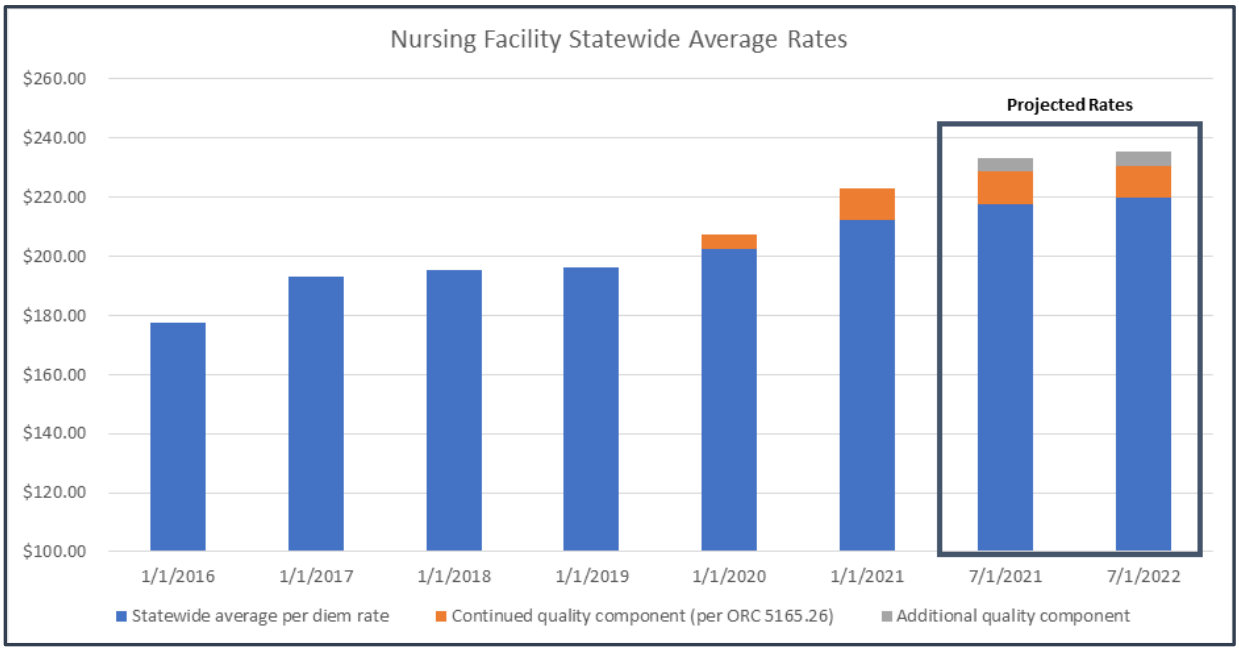
members of JMOC apprised of developments within the legal bounds of the active procurement. Yesterday we announced the Pharmacy Pricing and Audit Consultant. We have announced all five of the major procurement components. ODM is now in the "protest period" and therefore I am limited in what I am permitted to share as we complete the protest periods for several of these procurements.

Our SFY 22-23 proposed budget incorporates the redesigned managed care program, with fiscal projections indicating the change will be roughly budget neutral, with a margin of approximately one half of one percent within the current program expenditures for our current managed care system. Go live with the new partners and new services is scheduled for January 2022.

New Policy Initiative Re: Nursing Facility Quality (pg. 20)

Governor DeWine's budget proposes a package of reforms to regulate and ensure quality in long-term care service delivery. The Governor's Executive Budget includes components from the budgets of the Departments of Medicaid, Health and Aging.

- Voluntary reduction of under-utilized licensed nursing home beds in Ohio, in ODH's budget
- Increase the authority and ability of the Department of Health to protect nursing home patients from dangerous situations
- Launch new training opportunities through the Department of Aging.
- **ODM Quality Driven Reimbursement:** total of $440m into new payment formula, developed collaboratively with stakeholders and ODA, ODM, ODH
- Encourage high quality oversight and ensure key nursing home staff can be on site
- In addition, the budget includes an additional **$50 million** in one-time funding for NFs that have experienced revenue losses due to COVID-19.
- Figure 11 below shows the impact of the continued and expanded quality payment.



Continuation of Priority Policy Initiatives

Governor DeWine's Children's Initiative Pg.21

RecoveryOhio Pg.22

Ohio Long-Term Services & Supports for Elderly or Disabled Individuals Pg.22

- Honoring the choice and preferences of individuals, whenever possible
- ODM budget includes continuation funding for ODM and ODA-administered waivers. Several initiatives to improve access to home delivered meals; aligning services across waivers, such as participated-directed services and vehicle modifications; and sustainable telehealth services will be continued.
- Community nursing and aide services in the ODM and ODA-administered waivers will receive a modest four percent increase in rates, as will the assisted living waiver; at a state share cost of $18.3 million and $25.5 million in SFY 22 and 23 respectively.
- Despite receiving federal CARES Act relief funding, all of these long-term services providers have been impacted harshly by the pandemic

Closing

- Overview of the quirks and irregularities of the PHE, the cliff and the pig in the python
- With a disciplined approach from the outset of the pandemic, we have prudently managed the taxpayers' resources, maintained access to services, and done all we can to prepare for the transition out of the public health emergency without causing unnecessary strain on the state's resources.
- As I discussed our plans with you in the last budget process, we have now completed a series of procurements for our "next generation of managed care plan"
- Our targeted investments proposed in this budget narrowly focus on genuine access issues, needed structural changes, necessary COVID-19 reforms, fiscal discipline, continuing past commitments, and implementing the policies adopted by the General Assembly
- I will make myself and my staff available to answer any questions you may have as we work together in the coming months.

Appendices

Appendix 1: ODM Baseline Medicaid Forecast Comparison To LSC pg.27-28

Appendix 2: Ohio Medicaid Employee Workforce pg.29

Appendix 3: Results of Select SFY 20-21 Initiatives pg.30

& SFY 22-23 New Initiative: Initiative and Expected Results Pg.32

Appendix 4: Ohio Medicaid Dashboards pg. 33

1. Dashboard #1: COVID Medicaid Risk Analysis: During the early days of testing, this dashboard was created to assess whether testing was occurring equitably across the state, using data regarding comorbidity and risk factors, by age cohort.
2. Dashboard #2: Telehealth Impact on Services
    a. Mental health & addiction services utilization: Telehealth enabled behavioral health services to remain near pre-pandemic levels. This is an example of how telehealth helped stabilize

access to behavioral health services, more so than in other services that require face to face care.

   b. See the pattern with Diabetes HbA1c/Cancer Screening, which require in person care.
3. Dashboard #3: Churn of Medically Complex Kids January 2021: Dashboard of medically complex kids with a gap of four or more months in care, over the 24 months prior to January 2021.
4. Dashboard #4: Covid-19 PPE Dashboard. This is an example of a dashboard that was created early in the COVID pandemic to track distribution across the state in nursing facilities; including various metrics of availability of PPE and status of facility (number tested, positive, exposed, etc.).

Appendix 5: Ohio letter to CMS regarding CMS rescission of 1115 Community Engagement and Work pg. 34

Testimony to the Finance Committee of the Ohio Senate

Governor DeWine's Executive Budget Proposal SFY 2022-2023
Maureen M. Corcoran, Director, Ohio Department of Medicaid
April 15, 2021

Chairman Dolan, Vice-Chair Gavarone and Members of the Senate Finance committee: thank you for the opportunity to be here today. I am Maureen Corcoran, Director of the Ohio Department of Medicaid. I am pleased to present the Medicaid portion of Governor DeWine's executive budget proposal for SFY 2022-2023.

The Ohio Department of Medicaid provides health care coverage for more than 3 million Ohioans who are served by a network of over 165,000 providers. Ohio Medicaid ensures access to health care services and supports to individuals with low income, including adults, children, pregnant women, seniors, and individuals with disabilities. The following statistics highlight this important role in serving Ohioans:

- Over half of Ohio births are covered by Medicaid.
- More than 1.2 million children in our state are served by Medicaid.
- Approximately 48,000 children in foster care are served by Medicaid.
- More than 900,000 individuals served by Medicaid received behavioral health services in 2020.

Ohio Department of Medicaid (ODM) budget proposed for state fiscal year (SFY) 2022-2023 addresses four priorities for our state:

1. Ensuring eligible Ohioans have continuous access to high-quality health care as the nation continues to manage through the COVID-19 recovery.
2. Continuing progress completing priority policy initiatives approved in HB 166 of the 133rd General Assembly.
3. Maintaining disciplined fiscal oversight of the Medicaid program and controlling spending growth to levels ***below*** national measures.
4. Continuously working to improve the individual health as a means to foster independence for millions of Ohioans.

Budget Overview

Medicaid: A Shared State/Federal Health Care Program

Medicaid is a joint federal-state program. The majority of the program's dollars comes to the state from federal matching funds. Figure 1 shows the major funding sources used in our program, as well the portion of the Medicaid budget that is derived from each. For SFY 2022 one dollar of state general revenue fund (GRF) will finance a total of $6.50 of services. For the coming biennium, that $6.50 in services becomes relevant in light of the federal public health emergency (PHE) and enhanced federal matching funds.

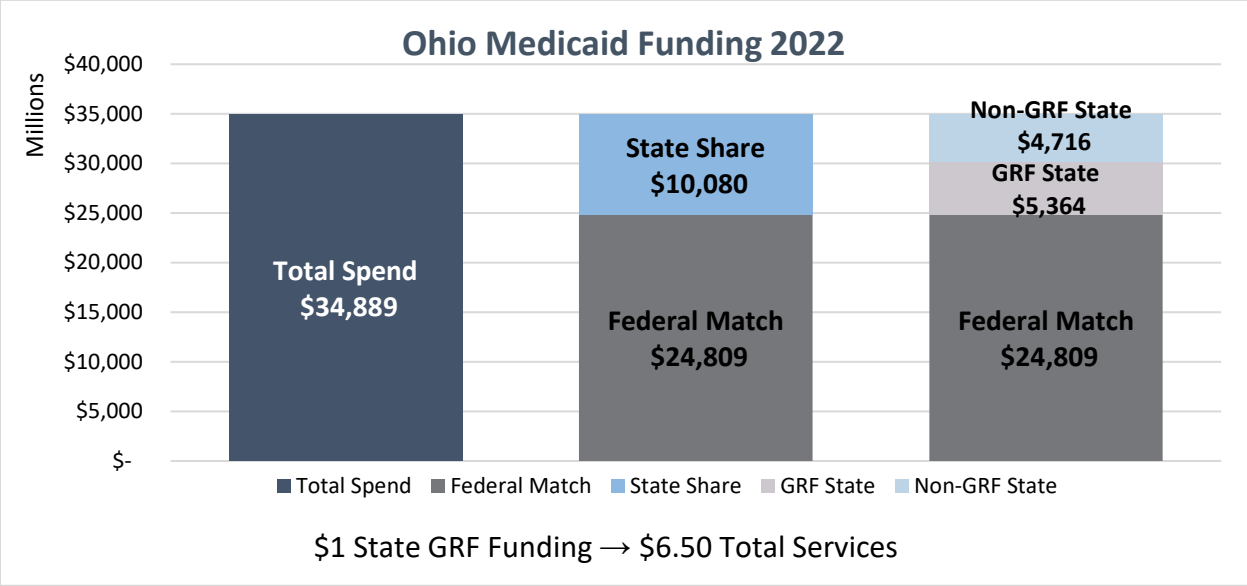


Figure 1: In SFY 22, the Medicaid program is 71% federally funded

SFY 22-23 Financial Drivers: PHE, Enhanced FMAP and Caseload

Throughout 2020, Ohio faced increased economic, medical, and mental health risks associated with the COVID-19 pandemic. The state's Medicaid caseload and associated spending grew significantly, reflecting the effects of the global health crisis. While becoming accustomed to reading about pandemic's impact on children and families struggling with remote learning, the isolation felt by seniors in nursing homes, and changing levels of hospital capacity due to care for patients with COVID, the Medicaid program provided continuous support to our health care system and helped millions of Ohioans maintain access to necessary care. As the pandemic continues into the next biennium, receipt of enhanced federal matching funds distorts the federal/state split of funding and year over year spending patterns.

Federal legislation to address the COVID-19 crisis resulted in a 6.2% increase to the Federal Medical Assistance Percentage (FMAP), or roughly $300 million per quarter in additional federal financial relief. Medicaid started receiving increased FMAP during the first quarter of calendar year (CY) 2020 and is projected to continue receiving this increased FMAP rate for all four quarters of CY2021. In total, Ohio Medicaid projects eight quarters of increased payments totaling $2.4 billion. The 6.2% increase is referred to as enhanced FMAP or E-FMAP. This additional federal funding is conditioned on "maintenance of effort" (MOE) requiring Ohio to continue Medicaid eligibility for individuals served by the program throughout the time of the federally declared PHE. The MOE prohibits terminations of coverage or changes in certain eligibility requirements during this time. Recently, the Secretary of Health and Human Services (HHS) notified Governors that "the PHE will likely remain in place for the entirety of 2021", and states will receive a 60-day notice prior to termination. Despite these dynamics, the Medicaid Executive Budget supports the Governor's priorities while keeping spending at or below national trends. As submitted, the ODM budget incorporates the updated federal guidance.

Overview of Funding

Ohio's Medicaid budget is projected to be $34.9 billion in SFY 2022 and $35.7 billion in SFY 2023 (total of all funds). Of these totals, ODM-administered components of the Medicaid program make up 89%, ($31.1 billion in SFY2022 and $31.7 billion in SFY2023) while the balance is administered by seven other state agencies – Developmental Disabilities, Job and Family Services, Mental Health and Addiction Services, Health, Aging, Education, and the Pharmacy Board – as well as several local public entities.

The amounts indicated represent an all funds increase of 7.4% in 2022 and 2.3% in 2023. In the first year of the biennium (SFY22), growth is largely driven by the continuation of increased caseload due to the COVID-19 pandemic, with gradual recovery in SFY23.

Table 1: Total all funds Medicaid spending ($ in millions)

	SFY 2021	SFY 2022	SFY 2023
Total Appropriated Medicaid	**$ 32,489.50**	**$ 34,889.28**	**$ 35,679.96**
Growth Rate		7.4%	2.3%

GRF State Share

The proposed GRF 651525 state-share of the Medicaid budget is $3,950.5 million for SFY 2022, and $5,434.0 million for SFY 2023. These dollars represent an increase of 4.4% in 2022 and 37.6% in 2023 when the state anticipates discontinuation of the PHE and associated E-FMAP. ODM currently anticipates the PHE and enhanced FMAP will end in December 2021.

Table 2: GRF 651525 state share impact

	SFY 2021	SFY 2022	SFY 2023
GRF 651525 State	**$ 3,783.26**	**$ 3,950.52**	**$ 5,433.99**
Growth Rate	7.3%	4.4%	37.6%
Adjustments Affecting 525 State			
Enhanced FMAP	$ 1,131.75	$ 607.63	$ -
Reserve Fund		$ 900.00	$ 300.00
Total Effective 525 State	**$ 4,915.01**	**$ 5,458.15**	**$ 5,733.99**
Growth Rate		11.1%	5.1%

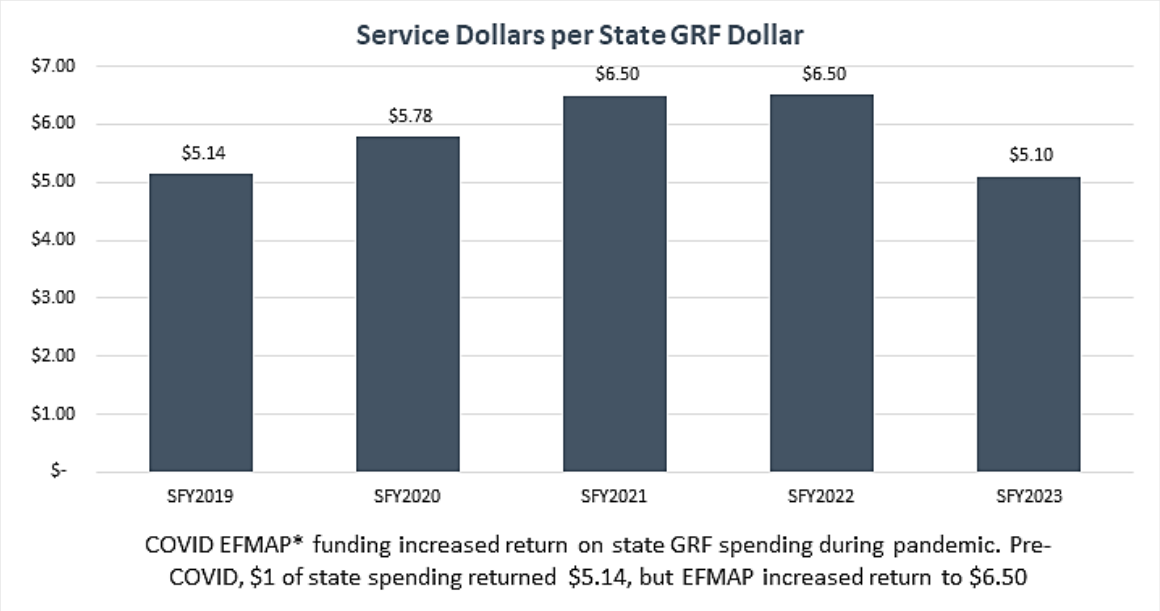
With the December 2021 end in mind, Medicaid will need to take on a greater proportion of state GRF funding for the program beginning in CY 2022, ODM will have an elevated caseload and a return to the normal federal/state split, accompanied by a return to normal program requirements and operations. However, restoring pre-pandemic operations cannot occur immediately; they will take time, unlike flipping a light switch.

Figure 2 demonstrates the effect of the EFMAP – $1 of state share spending is expected to purchase $6.50 worth of services for Ohioans in SFY 2022. This number changes over time with the rate of federal participation, as shown below.

Preview of Unwinding from the PHE

Example: Resume routine terminations when federally allowed to do so.

- Prior to taking any action, ODM must follow federal rules requiring advance notice of any potential negative action and review by a caseworker.
- Typically, these activities take place throughout the year as each person reaches their federally required annual renewal period.
- Consider what would occur if ODM took action to review several hundred thousand cases following the PHE; 12 mos. later case workers would need to review the same "bulge" of several hundred thousand cases
- ODM expects the restart of determinations to stretch over a number of months and will be challenged to prevent such spikes in future years.



***EFMAP**: enhanced Federal Medical Assistance Percentages

Figure 2: Due to federal match, each dollar of GRF state share spending returns several dollars of services

Returning to the state GRF impact, a portion of GRF 651525 state share will be funded in SFYs 2022 and 2023 through the Health and Human Services Reserve fund to facilitate the transition back to normal FMAP. The state's health and human services reserve fund will support a reduction in GRF state share growth in SFY22 but inflate the rate of growth in SFY23. Figure 3 shows the effective GRF 651525 state share spending, adjusting for the enhanced FMAP and the usage of the Health and Human Services fund. While many state Medicaid agencies around the country are proposing provider rate cuts to balance their Medicaid budgets, Ohio has rigorously planned for the transition out of the public health emergency to ensure we are prepared for the simultaneous loss of enhanced federal dollars combined with temporarily inflated caseloads.

Overall growth in non-GRF items is much lower than GRF items, leading to a distorted state share GRF growth rate in comparison to overall Medicaid growth. Additionally, non-GRF revenue sources such as the member month tax and other provider fees, which are held flat, are not growing at the same rate as the total program.

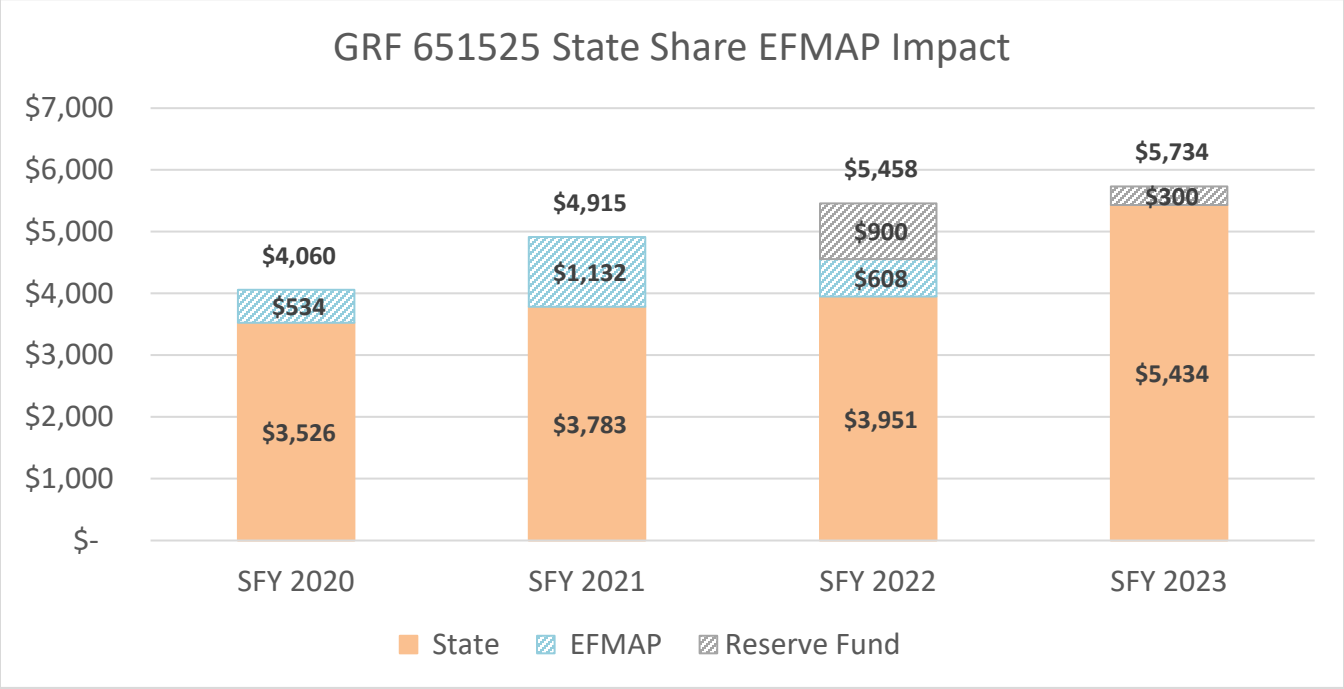


Figure 3: Additional funding realized from EFMAP provided by the CARES Act

ODM Program Administrative Cost

Ohio consistently ranks below the national average of 5% for Medicaid administrative expenses. More than 95% of the agency budget purchases health care services from hospitals, medical practitioners, federally qualified health centers (FQHC), behavioral health providers, pharmacies, and long-term care providers. More than 80% of ODM expenditures are administered by private sector commercial managed care organizations, however the administrative costs of the managed care organizations are included as a component of the service costs in the 651525 line item, rather than separated as a program administrative cost.

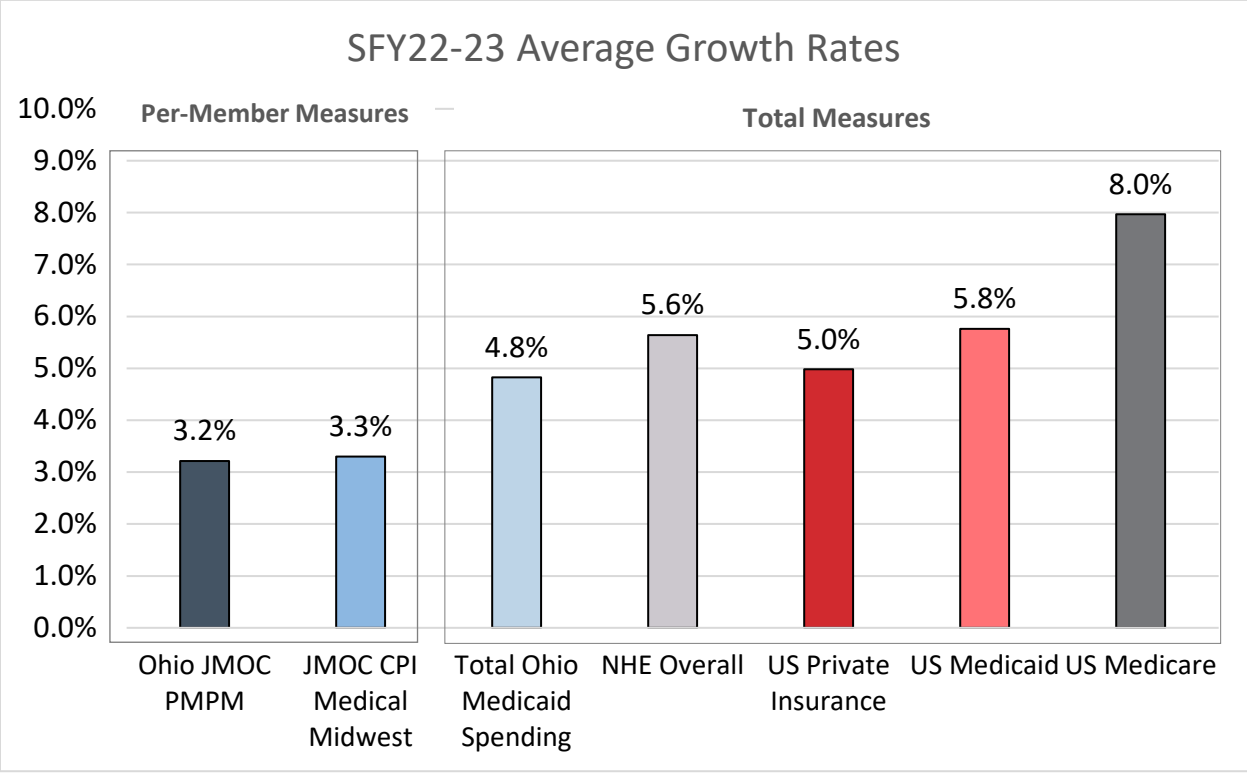
JMOC Growth Rate and Other Measures of Medicaid and Health Care Growth

The Ohio Legislature's Joint Medicaid Oversight Committee (JMOC) sets a target growth rate for the Medicaid budget. Under Section 5162.70 of the Revised Code, the Medicaid director must limit per member per month growth across all Medicaid recipients to the lower of the JMOC rate, or comparable to the three-year average Consumer Price Index (CPI) for medical services for the Midwest region.

Ninety days prior to the submission of the state Executive Budget, Ohio Revised Code 103.44 requires JMOC to select and communicate a growth rate for the coming biennium. However, for SFYs 2022-2023, the committee was unable to provide the rate, and as a result, ODM assumed a rate based on the "Medical Midwest" CPI. **ODM's executive budget proposal is at 3.2% for the biennium, lower than the CPI-based JMOC calculation of 3.3%.**

Calculation of the per member per month (PMPM) growth is not straightforward. Certain costs are removed from the total cost calculation, such as fees and intergovernmental transfers that do not reflect a cost to the GRF. Caseload is forecasted in each of the distinct eligibility categories and a PMPM cost is projected for each category using a combination of historical and outside economic forecast data. The PMPM cost per eligibility category is multiplied by the caseload to produce an overall forecast for Medicaid spending.

Figure 4 provides a comparison of several measures of Medicaid and health care growth.

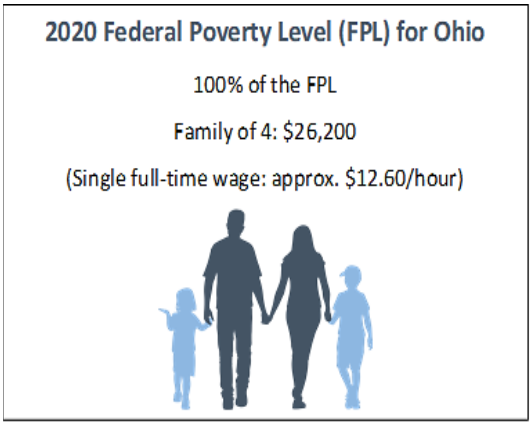


JMOC: Joint Medicaid Oversight Committee | **PMPM:** per member, per month | **CPI:** Consumer Price Index | **NHE:** National Health Expenditure

Figure 4: SFY22-23 average growth rates

Medicaid Caseload and Eligibility

Medicaid eligibility is dependent on several factors established by federal law, including income, disability status, age, and pregnancy status. To enroll in the program, individuals must be a U.S. Citizen or qualified alien residing in Ohio and meet all requirements for an approved eligibility category.



Ohio Medicaid's primary eligibility categories (aka "Medicaid populations") include:

- CFC (formerly the Covered Families and Children Program) including children up to 206% of the Federal Poverty Level (FPL), pregnant women up to 200% FPL, and low-income parents up to 90% FPL.
- ABD (aged, blind, and disabled) including individuals with low-income who have disabilities or are aged 65 and over.
- Group VIII Medicaid Expansion which covers adults under age 65 with income up to 138% FPL

Ohio Medicaid also includes the Medicare Premium Assistance Program (MPAP), coverage for Ohioans who are dually eligible for both Medicare and Medicaid. MPAP pays some or all Medicare expenses for individuals with lower income who are eligible for Medicare.

Historically, Covered Families and Children (CFC) and Group VIII are the two major categories of Medicaid eligibility that are most sensitive to an economic fluctuation and account for most of the forecasted variation in the caseload. Following more than two years of declines in the Medicaid caseloads, primarily in these populations due to a strong economy, the Medicaid's caseload increased by nearly 330,000 in 2020 following the declaration of the federal COVID-19 PHE.

Though many Ohioans enrolled in Medicaid for the first time during the pandemic, the primary driver behind Ohio's caseload growth is the federally required maintenance of effort (MOE) described earlier. During the PHE, MOE requirements dictate that Medicaid may only terminate coverage as a result of death, an out of the state relocation, or an individual request to be disenrolled from the program. In addition to forecasting caseload changes based on MOE requirements and the need to "unwind" the PHE previously described in this testimony, ODM's projects slight increases in ABD, dual Medicare/Medicaid eligible, and MPAP populations during the SFY2022-23 biennium because of the aging of Ohio's population.

Caseload Forecast

See comparison of ODM caseload estimates with LSC caseload estimates in Appendix 1.

As depicted in Figure 5 below, Ohio Medicaid's average monthly caseload forecast is projected to be 3.39 million in SFY 2022 and 3.22 million in SFY 2023. Medicaid's caseload is expected to continue growing for the duration of the PHE, which is currently anticipated to end in December 2021, resulting in peak caseload of 3.45 million in February 2022. As anticipated routine redeterminations resume in CY 2022, the caseload is projected to decline for the remainder of the biennium. Despite projected declining caseloads following the PHE, we do not anticipate the caseload to return to pre-pandemic levels by the end of the SFY 2022-23 biennium, but we expect a downward trajectory at that time.

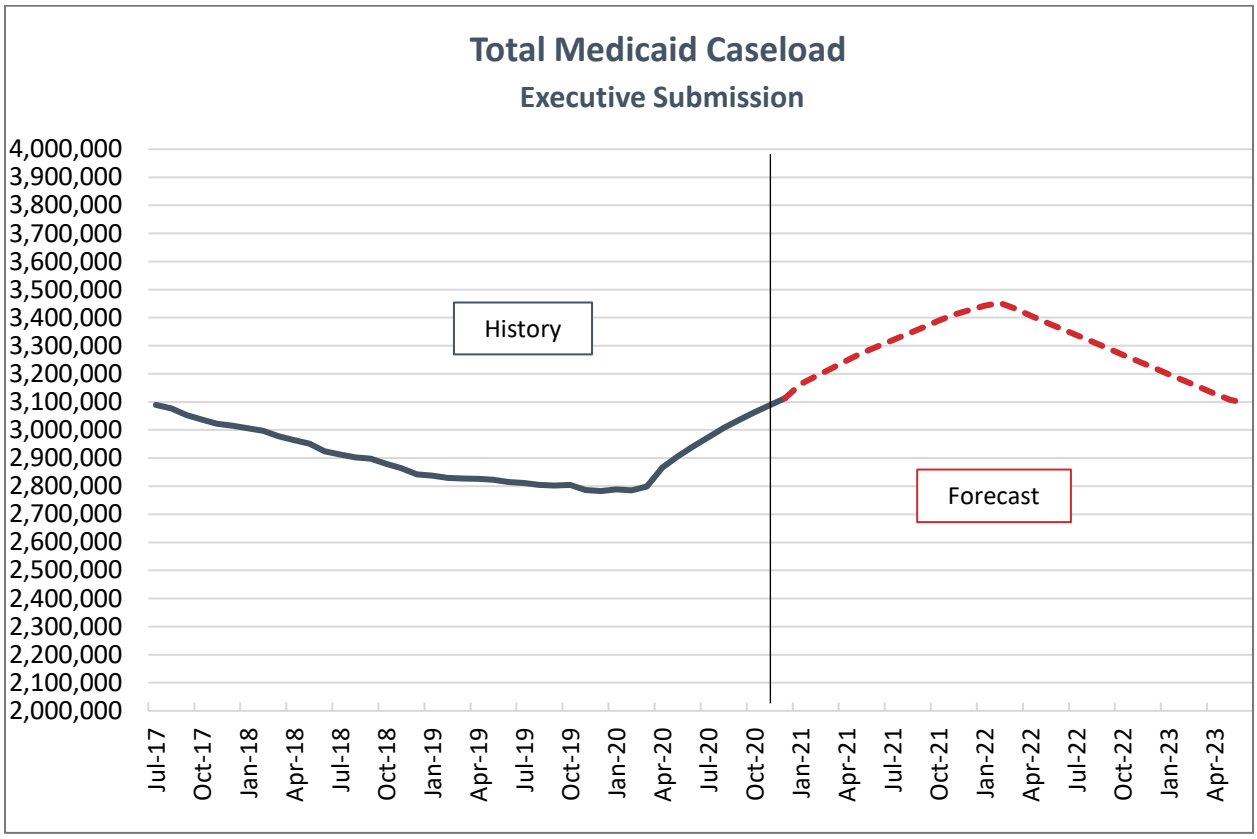


Figure 5: Anticipated caseload projected to continue to increase during the public health emergency when Ohio receives enhanced federal funding before declining throughout remainder of biennium

Figure 6 (below) shows changes in historic and projected caseload by eligibility group. These figures demonstrate the historic and anticipated economic sensitivity for the caseload within the CFC and Group VIII groups. Figure 6 shows that the overall caseload trends pictured in Figure 5 is largely a result from changes within these two groups. It is noteworthy that the projected decline within these groups following the end of the PHE is projected to be partially offset by an anticipated increase in enrollment of individuals within the ABD and dual eligible categories due to Ohio's growing population of residents over age 65.

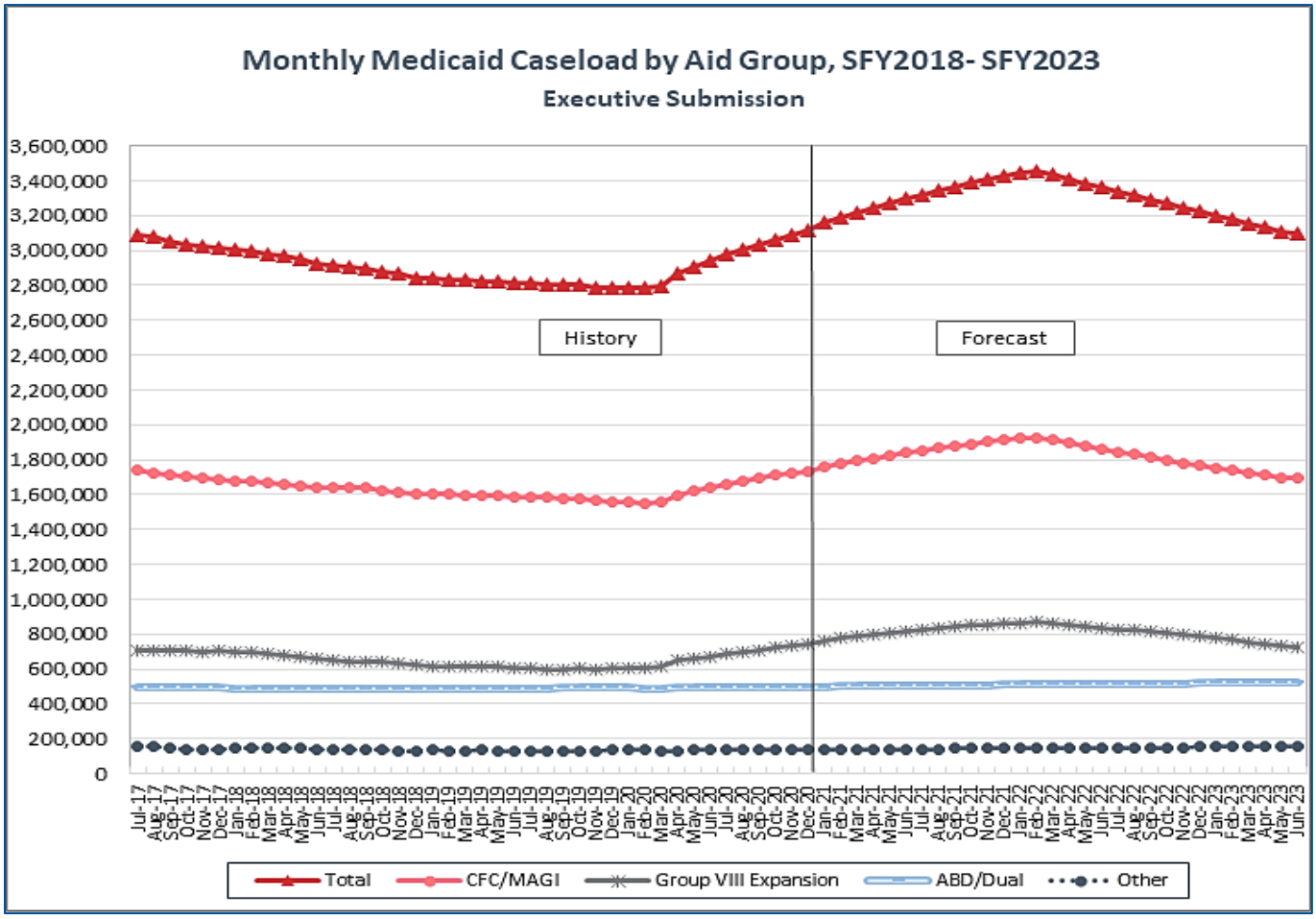


Figure 6: Trendline of historical and projected caseload through SFY23 by eligibility group

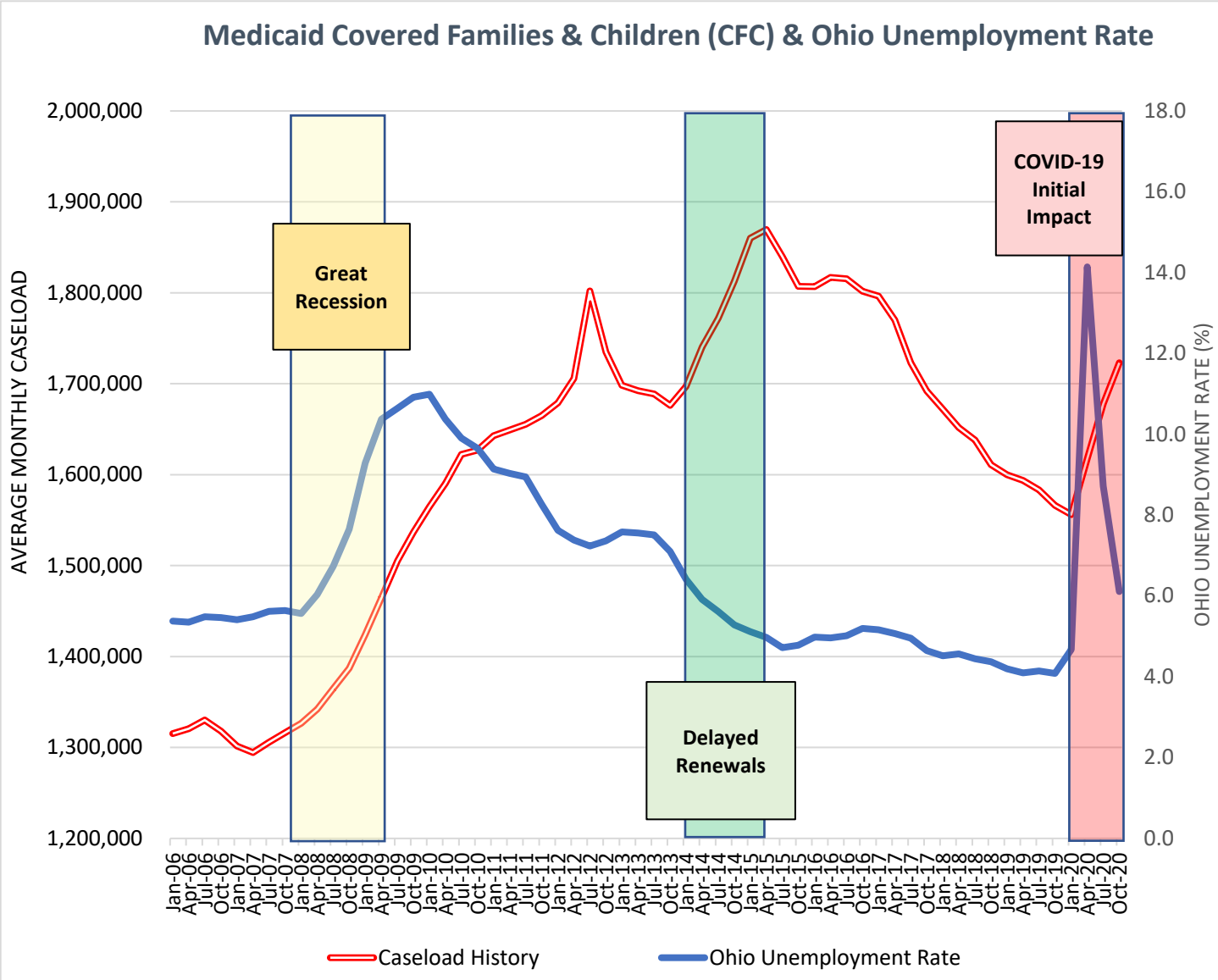
Table 3 provides greater specificity for Medicaid's current and projected caseload within a number of adult and child eligibility groups.

Table 3: Average monthly enrollment broken out by state fiscal year and population category

Average Monthly Enrollment								
SFY	**CFC Adults**	**CFC Children**	**Expansion**	**ABD Adult**	**ABD Children**	**Dual Eligible**	**Others**	**Total**
2021	527,505	1,223,123	752,321	193,205	50,431	254,664	138,209	3,139,458
2022 *(estimated)*	591,579	1,299,274	849,069	195,303	49,975	263,872	145,187	3,394,259
2023 *(estimated)*	528,064	1,233,972	779,286	197,558	49,856	271,463	151,580	3,211,779

Historically, Medicaid caseload and Ohio's unemployment rates have been directly and inversely correlated, with Medicaid's caseload lagging a few months behind the economy. Below, Figure 7 illustrates historical changes in the CFC group caseload charted with changes in Ohio's unemployment rate.

Figure 7: Demonstrates the inverse relationship with CFC enrollment and Ohio unemployment rate.



NOTE: Chart includes only the CFC population in order to be able to show 15 years of history, predating the Affordable Care Act and other significant eligibility changes.

As Figure 7 shows, ODM's CFC caseloads increased substantially during the Great Recession (2007-08) as the state's unemployment rate climbed, and growth in the CFC group continued even after the recession ended. The CFC group experienced similar growth during the COVID-19 pandemic, influenced largely by the economy and continuous eligibility as a condition of enhanced federal funding.

New or first-time Medicaid applications, though higher during the pandemic, have not reached levels reflected in previous economic downturns due to a variety of factors, including:

- Employers continue to provide health care insurance for workers laid-off during the pandemic. About 42% of the establishments that laid off staff as a result of the pandemic continued to pay a portion of health insurance premiums for those workers, at least for a period of time.
- Many who lost jobs expect their layoffs to be temporary, so they may not seek alternative health care coverage.
- People may delay applying for Medicaid due to lack of awareness of enrollment resources and online options, or they may be reluctant to seek in-person or telephonic support through local county offices.
- With an economic downturn, an individual or family's primary concerns likely focus on food and other basic living essentials. Despite being eligible for Medicaid, many individual and families may not apply for coverage until they need medications or medical care.
- Since many low wage workers are already covered by Medicaid, some individuals would have received ongoing health care coverage, but lost their lower paying jobs during the PHE.

Looking back over the past 15 years, periods of increased unemployment and the suspension of routine terminations led to increased enrollment in Ohio's Medicaid program. The COVID-19 PHE features both of these conditions; the federal requirement for continuous eligibility and elevated but declining unemployment rates likely to persist throughout the SFY 2022-23 biennium even after the PHE ends. ODM forecasts CFC and the Group VIII caseloads will decline but remain above pre-pandemic caseloads during the biennium.

New Voluntary Community Engagement Program

In 2017, the General Assembly passed HB 49 which required the Medicaid Director to submit an 1115 demonstration waiver implementing a work and community engagement requirement for Ohio's Group VIII population unless they met certain conditions. The Work and Community Engagement Requirement was approved by the Center for Medicare & Medicaid Services (CMS) with the effort and support of Governor DeWine early in calendar year 2019. The mandatory program was scheduled to begin in January 2021. Discussions with the Trump Administration in mid-2020 indicated that the program could not proceed, in light of the federal PHE and the prohibitions on eligibility and coverage changes. ODM then began working on a voluntary work program, to serve as a bridge to our mandatory waiver program.

Other states have approved work requirement initiatives across the nation which had been paused until a challenge was decided by the U.S. Supreme Court in a case called Gresham versus Azar. In that case, the State of Ohio joined a multi-state amicus brief that supports the decision of the federal government to allow state experimentation with work requirement efforts. The Biden Administration requested that the case be withdrawn, which it was. On February 12th the Ohio Department of Medicaid received notice from CMS that the approval for the 1115 waiver was being withdrawn. We submitted additional information defending the waiver and requested a meeting with CMS. The meeting was denied. Appendix 5 contains a copy of our letter to CMS. CMS has denied our request for a meeting at this time.

Given this, with the Executive Budget, we felt it was important to continue to pursue our goal to create opportunities for individuals to link with meaningful work and community engagement programs. Using the requirements of the 1115 waiver as a proxy, Table 4 below quantifies the number of individuals who would require an assessment, under various scenarios. ODM's critical preparation for this time goes beyond the strict parameters of traditional Medicaid. Funding for this voluntary program is included in the baseline budget for ODM.

Table 4: Number of Individuals Subject to the 1115 Community Engagement Assessment

ODM Waiver: Work & Other Criteria	All Counties	With 12 counties exempted	With 42 counties exempted
Total # Individuals Expansion Group 8	741,836		
Individuals working ≥ 20 hours	307,545		
Exempt-SNAP, Other Exemptions	191,303	202,618	315,265
# Individuals who would require ASSESSMENT	242,988	231,673	119,026

As was noted in ODM's initial waiver application to CMS, "there is a strong connection between improved health and being employed." ODM and many of its sister agencies have, in recent years, focused on ways to address social determinants of health such as food insecurity, poverty, housing, and employment status to improve the quality of life for Ohio's citizens even if doing so requires actions beyond the traditional parameters of our programs. In that spirit, just as we endeavor to connect the people we serve with WIC, SNAP, and, TANF when they qualify, we sought to also lower barriers to meaningful employment when given the opportunity. In doing so, we plan to continue to evolve the program with the aim of enabling those who can, to achieve and maintain independence.

Since the beginning of the federal PHE, Ohio's unemployment system received more unemployment claims (over 2,000,000) than in the previous five years combined. As Figure 8 shows, while there are more than 150,000 jobs posted on OhioMeansJobs.com, many of these positions require training or additional upskilling for job seekers to meet minimum qualifications for employment. The state of Ohio has invested in a variety of workforce strategies to connect job seekers with available jobs, but many Medicaid beneficiaries are not familiar with the training opportunities available to them.

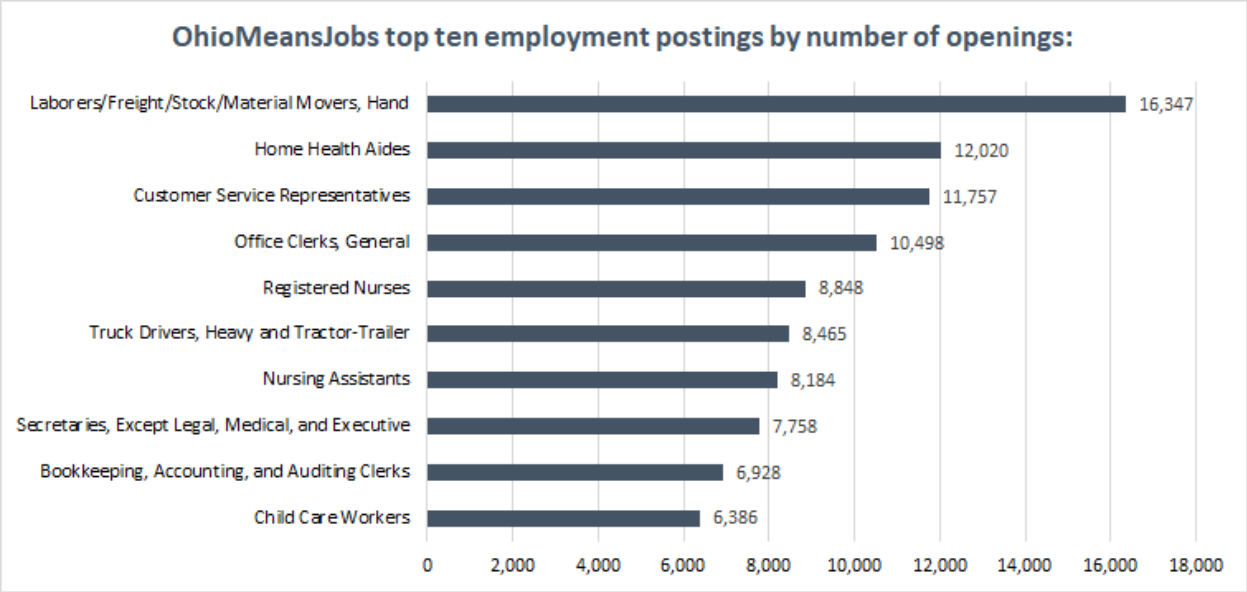


Figure 8: The number and type of available jobs

Until Ohio is able to proceed with the approved Group VIII Work Requirement and Community Engagement Demonstration, the voluntary community engagement program will encourage work among the able-bodied working age population. This program will connect beneficiaries with training opportunities that will lead to increased earning potential, promote economic stability and financial independence, and provide participants with the opportunity to improve their quality of life through work. The program will include communications to Medicaid beneficiaries explaining the services available under the Voluntary Community Engagement Program, as well as an explanation regarding the importance of work to overall physical and mental health. Any individual who is in receipt of Medicaid is eligible to volunteer to participate in the program.

Under the Voluntary Community Engagement Program, ODM will provide communication to Medicaid beneficiaries regarding:

- OhioMeansJobs.com, which offers job-searching, upskilling, and career-pathing activities.
- Workforce Innovation and Opportunity Act (WIOA) one-stop centers, where job seekers can find information regarding job openings, training, and career opportunities.
- Ohio's Aspire Adult Education and Literacy Program, which provides free services for individuals who need assistance with acquiring the skills to be successful in post-secondary education and training, and employment.
- Online employability training programs such as LinkedIn Learning/Lynda.com, Saylor Academy, Alison, Skills to Succeed Academy, and Career Campus that offer interactive training modules, video tutorials, learning paths, and virtual vocational courses for participants to learn at their own pace.

Due to health concerns, complications posed by distance learning, and other limitations faced by beneficiaries during the public health emergency, the initial focus of the program will be on activities

that can be accessed remotely via virtual training platforms; however, the focus will expand to encompass in-person activities.

With the goal of making meaningful, sustaining employment accessible for Medicaid beneficiaries, ODM also will explore new partnerships with education and training providers to increase the number of available training opportunities.

Ohio's Managed Care Platform & the Next Generation of Managed Care

Two years ago, during testimony on the DeWine Administration's first budget, I spoke about the need to change the business relationship with our private managed care partners. Today, in addition to describing the benefits of managed care for Medicaid members and Ohio taxpayers, I will highlight ODM's work to make improvements during SFY20 and SFY21 to address issues raised by consumers as well as members of the general assembly with our managed care program.

History of Managed Care in Ohio

Fifteen years ago, in a deliberate effort to move away from paying for ***volume*** of health care services to paying for health care ***value***, Ohio implemented a managed care program. Since then, Ohio transitioned new populations and services into the mandatory managed care program, and today approximately 90% of Ohio's Medicaid population is enrolled in managed care. Approximately 80% of ODM-administered services spending occurs through the managed care delivery system, including almost half of the total spending on nursing facilities. Ohio's move away from Fee-For-Service (FFS) payment toward managed care is part of a national trend, as demonstrated in Figure 9 below.

In most states with comprehensive MCOs, at least 75% of beneficiaries are enrolled in an MCO[1]

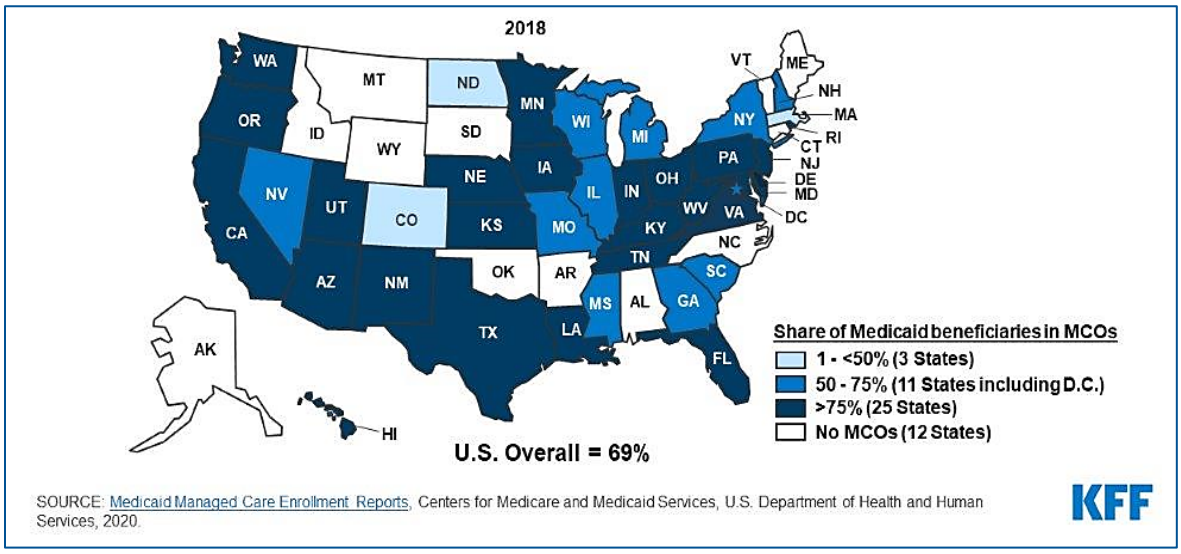


Figure 9: States' share of Medicaid population covered by MCOs as of July 1, 2018

[1] Kaiser Family Foundation. States Focus on Quality and Outcomes Amid Waiver Changes: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2018 and 2019. October 2018. Available at: http://files.kff.org/attachment/Report-States-Focus-on-Quality-and-Outcomes-Amid-Waiver-Changes-Results-from-a-50-State-Medicaid-Budget-Survey-for-State-Fiscal-Years-2018-and-2019

Of the individuals enrolled in Medicaid managed care, 2.63 million are fully covered by regular managed care organizations and 132,000 individuals receive their coverage through Medicare and Medicaid plans, known in Ohio as MyCare plans. Managed care provides Ohio Medicaid and enrollees with the following benefits:

- Budget predictability for the state.
- Increased free-market competition.
- Individual choice between competing managed care organizations.
- Opportunities to pay for value while moving away from a volume-based model.
- Flexibilities to invest in health and wellness programs and unique support services.
- Coordination of care and supports for members.

The budget proposal before you today builds on and continues the work started in SFY 20 and 21. The changes we have implemented to date and those we plan to implement over the next biennium clearly demonstrate that the Department of Medicaid is dedicated to disciplined management of the program within budgetary constraints with increasing accountability and transparency so we can help Ohioans improve their health and achieve in school, at work and with family responsibilities.

Accountability, Transparency, and Quality Improvement in Managed Care

Throughout the first two years of the DeWine administration, the Department of Medicaid leveraged new business relationship with our private partners to make the following improvements in the program. Those adjustments, accomplished through changes to the managed care contract (known as the provider agreement), span three major areas of work: COVID-19 response, pharmacy accountability, and program transparency.

COVID-19 PANDEMIC: QUALITY IMPROVEMENT CHANGES

In early 2020, as the pandemic began to grip Ohio's health care system, ODM worked with the MCOs to pivot quickly. Together, we developed five rapid cycle improvement efforts for targeted populations. This collaborative 'boots on the ground' program focused on improving health outcomes during the pandemic. The department asked the MCOs to work in unison and with a singular purpose to develop and implement interventions to maximize the impact for each of population. Those interventions include:

- **Nursing Facilities and Assisted Living Facilities**: a friendly caller program to reduce loneliness, collecting metrics regarding behavioral health for individuals living in these facilities, and a COVID-19 testing intervention in nursing homes.
- **Children:** multiple interventions intended to help kids catch up on childhood vaccinations missed because of the pandemic.
- **Transportation**: improve safe transportation to in-person health care and health-related social needs services with a focus on special populations, e.g., those individuals who were pregnant or had diabetes.
- **Provider support**: interventions and support to increase access to telehealth for individuals with Medicaid, with focus on primary care and behavioral health providers in rural counties.
- **Restored Citizens:** Individuals being released from corrections facilities received a "care kit" intervention pack aimed at preventing COVID-19 infections in the first 30 days following release.

Supplies included a backpack with face masks, hand sanitizer, and a cell phone to enable follow-up and rapid connection to health care.

Ohio Medicaid required the MCOs to use the Institute for Healthcare Improvement's quality improvement framework as they MCOs developed their approach to improve key population health outcomes. Each team included all MCOs that collectively proposed aims, drivers, interventions, and measures for ODM's approval through an executive governance committee. The metrics of improvement were tied to the MCOs' quality withhold payments for 2020. This approach is continuing for CY2021.

COVID-19 PANDEMIC RESPONSE

In addition to adjusting quality improvement strategies to account for the COVID-19 pandemic, ODM worked closely with the MCOs to quickly streamline the administration of the program and adjust for distanced health care through telehealth. Together our work helped ensure access to health care could be maintained throughout the pandemic while relieving in-person pressure on our health care system. Notable changes executed by the plans include:

- Extended prescription refills, waived all copayments, and allowed non-network pharmacies to bill.
- Significantly expanded telehealth services.
- Enhanced payments for nursing homes serving as Health Care Isolation Centers (HCIC).
- Expanded transportation services.
- Accelerated claims payments to providers and extended timeframes for submitting claims.
- Extended existing prior authorizations and suspended most new prior authorization requirements.
- Lifted pre-certifications and prior authorizations for long-term care facility services.
- Donated funds to community providers to purchase PPE and other needed supplies.
- Streamlined provider credentialing.
- Eliminated possible administrative and financial barriers for COVID testing and vaccination.
- Aligned efforts with Medicare emergency provisions.

PHARMACY ACCOUNTABILITY IN MANAGED CARE

In early 2019, the department began implementing a series of changes to increase accountability in the managed care pharmacy program. A variety of issues were highlighted at the end of the prior administration and throughout the budget debate on HB 166, as well as by extensive reporting by the Columbus Dispatch and other media organizations. Pharmacies also expressed concerns associated with the Medicaid pharmacy program and the pharmacy benefit managers (PBMs) hired by the Medicaid managed care organizations (MCO). For example, pharmacies expressed concern that payments for acquisition and dispensing fees were inadequate. They also raised concerns over claw backs and other fees charged by the PBMs.

Pharmacies, the media, consumers and consumer groups stated concerns with inadequate access to pharmacies in some rural areas, problems with existing formularies, and the potential for PBMs to steer contracts to higher margin specialty pharmacies, thus hindering consumer access. Consumers, pharmacies, and legislators expressed concerns over transparency, voicing that the State had little

insight and access to pricing and rebate information. In short, financial information related to the pharmacy benefit was hidden from state regulators and the public.

A 2018 report by Health Data Solutions and further validated by additional analyses conducted by the state auditor indicated the PBMs were being paid hundreds of millions of dollars in taxpayer dollars and engaging in practices known as "spread pricing," whereby PBMs were not passing public money through to pharmacies but instead creating a "price spread" that allowed them to pocket significant profits. Referring to PBMs as a "black box," neither the state auditor nor ODM could verify or refute the appropriate use of PBM funds.

In response to these concerns, the 133rd General Assembly directed Medicaid to implement a single pharmacy benefit manager that would replace the multiple PBM structures connected to each of the managed care organizations. Pending the selection of the new single PBM, ODM undertook significant changes to begin the process of reform. Benefits of a single PBM and changes to the provider agreement to address conflicts of interest and visibility gaps in the program include:

- Eliminating the potential for conflicts of interest.
- Improved ability to audit PBMs and ensure compliance with regulations.
- Transparency of PBM contracts and increased public awareness of PBM contracts, operations, and financials.
- Financial transparency related to public monies used for drug costs and payments to pharmacies.
- Transparency and accountability of PBM administrative costs.
- Improved oversight of medication practices to help ensure safety and effectiveness of prescribing practices.
- Enhanced data analytics and metrics related to the Medicaid pharmacy space.
- Oversight, transparency, and safeguards to prevent future "spread pricing" and other financial structures that reduce public confidence and increase public expense.

SAVING MONEY WHILE REDUCING CONSUMER AND PROVIDER BURDEN

Two years ago, I talked about ODM's plans to control costs in the pharmacy program by implementing a unified preferred drug list (UPDL). Ohio Medicaid's UPDL went live in January 2020 and is saving taxpayers $70 million annually. The initiative also significantly reduces administrative burdens for pharmacists and prescribers who no longer must learn up to five different preferred drug lists across managed care organizations. The UPDL also increases predictability for individuals we serve by reducing prior authorizations and discrepancies in policies between the MCOs. Additionally, ODM fulfilled its commitment to redefine its business relationship by increasing oversight in the pharmacy program by using the managed care contract amendments described above.

PHARMACISTS AS PROVIDERS AND OTHER PHARMACY INNOVATIONS

ODM and the Administration's COVID team have been aggressive throughout the COVID pandemic in expanding the partnership with pharmacies for testing and vaccination. In addition, consistent with the permissive authority granted by ORC 5164.14, ODM began enrolling pharmacists as direct providers. Medicaid engaged provider stakeholders to create a framework to allow pharmacists to enroll as individual Medicaid providers who can render clinical services and integrate more seamlessly into the health care team as drug-therapy experts. Following implementation in January 2021, ODM has more than 100 pharmacists enrolled to render clinical services in the Medicaid program. With the leadership

of the General Assembly, and pilot programs initiated by the MCOs, Ohio has become a national leader in utilizing pharmacists to manage drug therapies and disease states to help people achieve better health outcomes.

OTHER AREAS OF ENHANCED ACCOUNTABILTIY

During the current biennium, ODM made extensive revisions to the business relationship with managed care organizations, adding provisions to improve provider efficiencies, remove barriers to improve access to care, increase program transparency and enhanced managed care accountability.

Transparency and Accountability

- Increased transparency and ODM access to data for MCOs, subcontractors, and other entities doing business with the MCOs.
- Strengthened language regarding accountability for, and the importance of quality improvement projects.
- Added provisions that require MCOs to obtain approval from ODM for all downstream subcontracts associated with MCO duties and responsibilities. The new provisions create transparency into these downstream relationships and require subcontractors to mirror the protections and requirements set forth in the MCO provider agreements with ODM.
- Clarified ODM role to ensure compliance with federal and state requirements.
- Added single unified preferred drug list requirement beginning January 1, 2020.

Access to Care

- Established requirement for MCOs to use only American Society Addiction Medicine (ASAM) level of care for substance use disorder (SUD) treatment.
- Extended behavior health redesign transition of care patient protection requirements until further notice by ODM.
- Added urine drug screening guidelines developed by Ohio Department of Mental Health and Addiction Services (ODMHAS).

Care Management/Care Coordination

- Updated Health Risk Assessment requirement for all members and required for all new members within 90 calendar days of enrollment.
- Strengthened requirements to collaborate with care coordination for children in custody, per ODM's Guidance for Children in Custody.
- Updated quality improvement program language to emphasize disparity reduction and health equity efforts, with emphasis on health equity as the utmost goal of the quality strategy.
- Added coordination language for Medication Assisted Treatment and Pre-Release Enrollment program participants, through collaboration and communication with Ohio Department of Rehabilitation and Corrections (ODRC), OMHAS, community providers.
- Added responsibilities related to Addiction Treatment Program drug courts.
- Added requirement to use new level of care (LOC) and prior authorization form for nursing facility stays. MCOs are required to accept the form if properly submitted by a nursing facility.
- Clarified and strengthened language regarding inpatient hospital readmissions.
- Revised TPP (third party payer) requirements.

Claims Adjudication

- Revised notification requirements for denied, pended and/or suspended claims.
- Updated Claims Payment Systemic Errors (CPSE) requirements to clarify MCO reporting expectations.
- Claims adjudication (continued improvement) and communication with providers**:** Upon request of the provider, the MCO or MCOP shall utilize a HIPAA-compliant electronic data interchange transaction (e.g. the 276/277) to provide information to the provider regarding all denied, paid, or pended claims status.
- Updated time frame for MCOs to load rates into systems; if necessary, backdate and re-process claims.
- Provider notification requirement changes to ensure providers receive timely and accurate notification from MCOs when claims are being adjusted.
- Clarifications re: billing inpatient hospital services.
- Easing administrative burden on nursing facilities and change of provider/CHOPs regarding prior authorizations.
- Added payment methodology for federally qualified health centers (FQHC).
- Added requirements for HealthTrack complaint acknowledgement and follow-up.
- Added a 30-day notification requirement for providers and provider associations regarding pending policy changes.
- Added sole-source language requirements to provider directories to inform members of any services that must be obtained from a specific provider and recourse.
- Clarified online provider directory requirements, including required capability to do internet searches by specialty.

Implementing the Next Generation of Medicaid Managed Care

Two years ago, during the deliberations on HB 166, we discussed at length with members of the General Assembly the procurement of the Medicaid managed care program. Working closely with you in the legislature, we proceeded to engage stakeholders and Medicaid members through in-person listening sessions and multiple requests for information. Throughout months of complex system design and approvals with our federal partners, we kept members of JMOC apprised of developments within the legal bounds of the active procurement. Yesterday we announced the Pharmacy Pricing and Audit Consultant. We have announced all five of the major procurement components. ODM is now in the "protest period" and therefore I am limited in what I am permitted to share as we complete the protest periods for several of these procurements. The five interlocking components are reflected in Figure 10 and include:

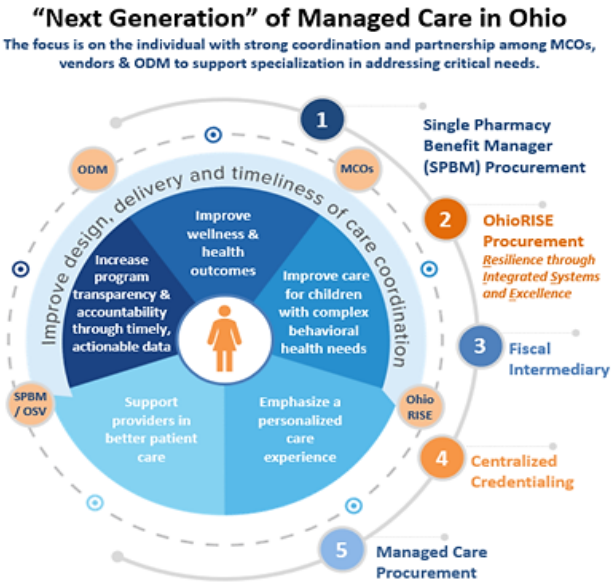


Figure 10: Ohio's next generation managed care framework

managed care organizations, single pharmacy benefit manager, OhioRISE specialty managed care program for multi-system youth, the fiscal intermediary and centralized credentialling.

Our SFY 22-23 proposed budget incorporates the redesigned managed care program, with fiscal projections indicating the change will be roughly budget neutral, with a margin of approximately one half of one percent within the program expenditures of ODM's current managed care system.

New: Nursing Facility Quality Initiative

Given the conditions presented by the COVID pandemic, ODM has taken a disciplined approach to the SFY 22-23 budget. To that end, ODM proposes only two new initiatives for the coming biennium: nursing facility quality initiatives and the Voluntary Community Engagement Program (described above). Continuation initiatives include implementation of each next generation of managed care component, and continuation of other initiatives adopted in the SFY 20-21 budget.

Nursing Facility Quality

Governor DeWine's budget proposes needed reform to further the State of Ohio's ability to regulate and ensure quality in long-term care service delivery. The budget makes additional investment into high-quality nursing homes, while at the same time providing an option for low quality providers to exit the business or invest and improve their care models. The Governor's Executive Budget includes components from the budgets of the Departments of Medicaid, Health and Aging.

- **Invest $50 million** for a nursing home reform initiative in response to the under- utilization of licensed nursing home beds in Ohio. The Department of Health, in collaboration with the Department of Aging and Medicaid, will launch a reform initiative to encourage facilities to voluntarily downsize, move to single patient rooms, and remove costly excess beds from the system. According to current Department of Health records, approximately 18% of eligible nursing home beds are vacant. As Ohioans demand more community-based care options, this initiative will help rebalance the services available and improve the quality of care for all Ohioans, regardless of setting.
- **Increase the authority and ability of the Department of Health to protect nursing home patients from dangerous situations.** The *Patient Protection* proposal would give the Department of Health the authority to swiftly intervene to protect patients in nursing facilities when they determine the health and safety of patients is in jeopardy. If needed, the department will have the authority to immediately remove patients and relocate them into a safe facility. Protecting patients from dangerous, low-quality providers is essential to Governor DeWine's commitment to protect the lives of all vulnerable Ohioans.
- **Launch new training opportunities** through the Department of Aging. The *Training and Improving Ohio Nursing Facilities* proposal will launch a series of new quality improvement initiatives and a technical assistance program to improve the quality of care for Ohio nursing homes. Programming will target infection control, elder abuse, and other areas flagged as prominent concerns during the Department of Health's inspection process.

ODM Budget and Nursing Facility Reimbursement:

Invest $440 million into quality outcome incentives for Medicaid nursing home services. The *Quality Driven Reimbursement* proposal seeks an increase of $100 million into a new payment formula that moves to reward nursing homes for providing high-quality care, based on meaningful outcome-driven industry leading metrics. The Department of Medicaid will work in collaboration with a joint committee and seek input from experts across multiple agencies, providers, and senior advocates to ensure a robust and effective incentive-based payment structure. Figure 11 below shows the impact of the continued and expanded quality payment. Additional quality improvements will be required that key nursing home staff such as an administrator, medical director, nursing director, and quality improvement director reside near their work in the state of Ohio.

The SFY 22-23 budget also includes **$50 million** in one-time funding that can be allocated to support rates for nursing homes that have experienced revenue losses and reduced Medicaid occupancy due to COVID-19. Additional discussion is necessary regarding these issues, as well as continuing to monitor whether additional federal funding is dedicated to nursing facilities.

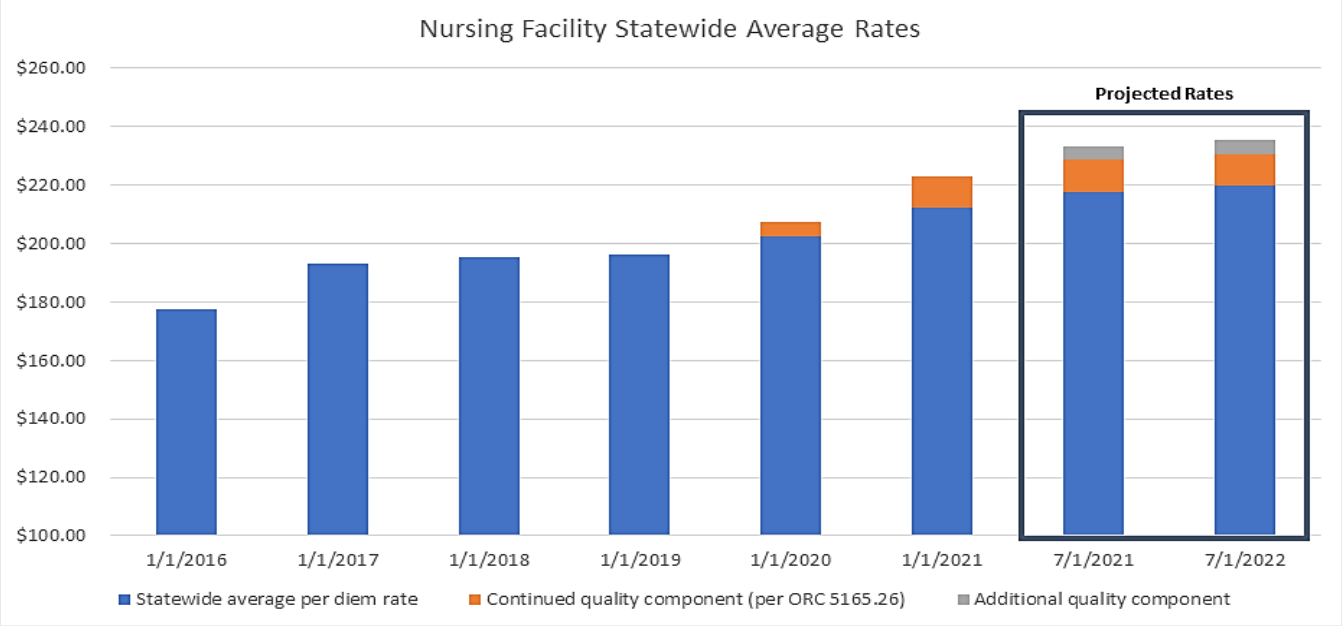


Figure 11: Nursing facility statewide average rates

Continuation of Priority Policy Initiatives

Governor DeWine's Children's Initiative

The ODM budget proposes to continue its policy initiatives related to improving outcomes for children that were thoroughly vetted and approved in the last budget. These initiatives include Comprehensive Primary Care (CPC) for Kids, lead testing and abatement, the multi-system youth custody relinquishment prevention program, and several initiatives to improve health and outcomes for pregnant women and their babies.

RecoveryOhio

The last budget included several initiatives related to promoting recovery for individuals experiencing mental health and substance use challenges; each were thoroughly vetted and approved by the General Assembly. While some of these initiatives experienced a delay in implementation due to the pandemic, design is underway, and they will be implemented over the next biennium. These initiatives include behavioral health care coordination, continuous eligibility for postpartum women with substance use disorder, and implementation of our approved 1115 Substance Use Disorder demonstration waiver.

Long-Term Services & Supports for Elderly or Disabled Individuals

Our policy and operational goals for the biennium related to long term services and supports in the community for elderly or disabled Ohioans include:

- Honoring the choice and preferences of individuals, whenever possible.
- Provide high quality care coordination and clinical services through partnership with AAAs, MCOs and other care management entities.
- Increasing consumer input to policy development in the Ohio Home Care and MyCare waivers.
- Aligning home and community services across the various waivers to prevent disruption in services when individuals transition from one waiver to another.
- Continue the managed care innovations of the MyCare waiver for those who are dually eligible for Medicaid and Medicare in certain Ohio counties.
- Assess the waiver flexibilities provided under the authority of the COVID pandemic and consider what permanent changes should be made, and plan for careful “unwinding” when the pandemic is over.
- Maintaining comparability of wages of similar services across waivers.

To this last point, the COVID-19 pandemic has highlighted the significant challenges of supporting the community workforce and assuring basic health and safety for those served in our community programs. Essential to this is maintaining comparability in wages across all the waivers administered by ODM, ODA and DODD, to prevent transitioning of workers simply to secure greater wages. We need to increase the pool of community workers, not steal from each other.

Both the Ohio Department of Medicaid (ODM) and the Ohio Department of Aging (ODA) administer home and community-based services (HCBS) waivers that offer an alternative to care in a nursing facility. ODM-administered HCBS waivers include the MyCare Ohio and Ohio Home Care waivers. ODA-administered HCBS waivers include the preadmission screening system providing options and resources today (PASSPORT) and Assisted Living waivers. Enrollment in one of these waivers enables individuals who might otherwise live in nursing facilities to remain in their homes with extra services and supports, at lower cost to the program.

Table 5 includes information about these waivers and services. The budget for the Department of Developmental Disabilities will address the developmental disability waivers.

Table 5: Community services and institutional care

Community Waivers & Institutional Care	SFY 2020	Expenditures	Average Monthly Enrollment
Individuals with IDD	DODD Waivers: I/O, Level 1 and SELF	$2,080,000,000	40,990
	ICF-IDD Institutional	$730,000,000	5,182
Older Ohioans & Individuals with Disabilities	ODM Waivers: Ohio Home Care and MyCare Waiver	$710,000,000	36,986
	ODM Home Care Services*	$440,000,000	28,572
	Nursing Facilities	$3,040,000,000	47,311
Older Ohioans	ODA administered: Passport and Assisted Living waivers	$330,000,000	24,363
Totals		$7,330,000,000	

** People receiving these services may also be on a waiver.*

As Figure 12 shows below, the percentage of individuals in the Medicaid program receiving long-term services and supports (LTSS) in home and community-based setting has increased in recent years, while the percentage of individuals receiving services in facility-based settings has decreased. This is consistent with supporting individuals' choice and federal requirements for "rebalancing" Medicaid services and supports.

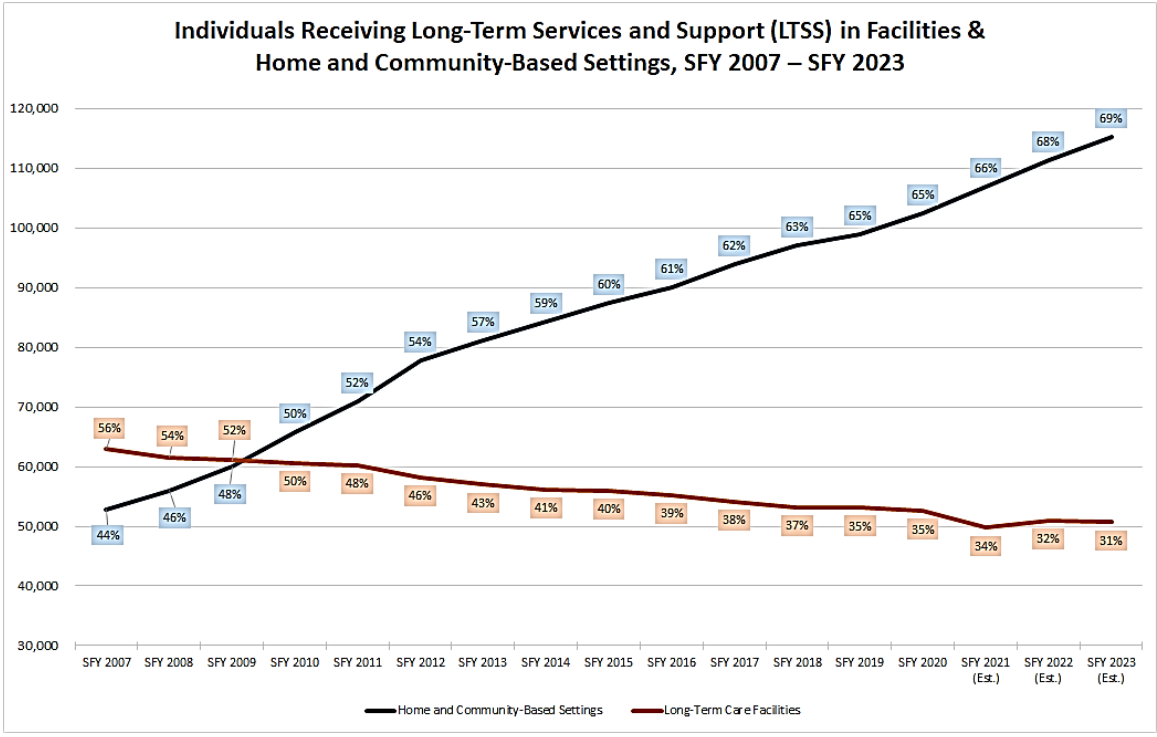


Figure 12: Rebalancing of Ohio's Services with an increase in home and community services

One of Ohio Medicaid's greatest success stories long-term care is the Ohio HOME Choice Program. HOME Choice was established in 2008 as Ohio's approach to the federal Money Follows the Person (MFP) program. As of December 2020, HOME Choice has helped more than 14,400 people move from long-term care facilities to community settings. The program is a national leader and currently ranks first in the country for effective transitions, and first for transitioning individuals with mental illness into home-based settings. HOME Choice program delivery was revised in 2019 anticipating the end of the federal MFP grant, however funding was extended by Congress through 2023.

In addition to the new nursing facility quality initiatives described above, ODM's budget includes continuation funding for ODM and ODA-administered waivers. These efforts include improving access to home delivered meals; aligning services across waivers, such as participated-directed services and vehicle modifications; and continuing sustainable telehealth services.

Community nursing and aide services in the ODM and ODA-administered waivers will receive a modest 4% increase in rates, as will the assisted living waiver, at a state share cost of $18.3 million and $25.5 million in SFY 22 and 23 respectively.

Despite receiving federal CARES Act relief funding, long-term services providers have been impacted harshly by the pandemic, and at a time when they were called upon to respond and care for one of Ohio's hardest hit populations during the public health emergency.

Cost Containment

The following highlights several areas of targeted cost containment efforts with significant change or additional focus since the adoption of HB 166.

MANAGED CARE COST CONTAINMENT AND RISK CORRIDOR STRATEGY

In accordance with COVID guidance issued from CMS, ODM added a two-sided risk mitigation strategy (risk corridor) to its managed care provider agreement. The risk corridor was required by CMS in CY20 and continued in CY21 in recognition of claims cost uncertainty attributable to the COVID-19 pandemic and associated state policy changes. A risk corridor serves as a risk mitigation mechanism where ODM retains gains and losses outside of defined levels, while also constraining the gains and losses for the MCOs. This has the potential to result in capitation recoupments from the MCOs, yet the magnitude of such recoupments is unknown at this time.

Rate adjustments were made in late SFY 20 and early SFY 21 to recognize the reduced utilization and population changes attributable to the pandemic. January through June 2020 rates were reduced by 1.5%, saving approximately $150 million. In addition, the original CY 2020 Medicaid Managed Care (MMC) program capitation rates were reduced by approximately 3% in recognition of population changes attributable to the COVID-19 pandemic and the MOE which allowed for Medicaid recipient's eligibility to be extended. This resulted in a decrease to projected CY 2020 capitation payments of approximately $270 million.

OHIO UNIFIED PREFERRED DRUG LIST

ODM implemented a Unified Preferred Drug List (UPDL) on January 1st, 2020 for the whole Medicaid program. ODM pharmacy staff and leaders from the Managed Care Plans collaborated together in clinical, technical, and communications-based workgroups to help ensure a smooth transition. The goals of the UPDL include:

- Reducing the administrative burden for providers by streamlining the prior authorization (PA) process across FFS and managed care
- Consolidating six PDLs into one
- Facilitating coordination of care for approximately three million covered Medicaid lives
- Minimizing member movement between the Ohio Medicaid Managed Care Plans

ELECTRONIC VISIT VERIFICATION

Federal law mandates that states implement Electronic Visit Verification for all Medicaid personal care services and home health services that require an in-home visit by the provider. EVV requires caregivers to record the visit date and time, visit location, individual receiving services, the caregiver who is providing services, and the service provided, and ODM has contracted with Sandata Technologies to provide an EVV system to all providers at no cost. During calendar year 2020, Ohio Medicaid completed implementation of EVV, and will now work to increase provider compliance and decrease provider administrative burden with the EVV system and use Ohio EVV data to reduce fraud and abuse within the system.

MINIMUM DATA SET AUDITS

Ohio Medicaid contracts with a vendor to conduct Minimum Data Set (MDS) exception reviews, which examine the accuracy of the MDS data that skilled nursing facilities (SNFs) provide to ODM, for use in calculating the direct care rates paid to SNFs. The MDS is part of the federally mandated process for a comprehensive, standardized assessment of each nursing facility resident's functional capabilities and health needs. Due to the public health emergency, ODM's vendor conducts these reviews virtually to maintain oversight while minimizing disruption to patient care. In the most recent round of reviews conducted in FY2021, ODM's vendor reviewed 27 providers and found 11 of 27 (37%) LTC facilities did not meet the documentation requirements. This will result in ~$1,000,000 in savings to ODM. In just over three full years, ODM audits have saved more than $4,000,000.

Closing Remarks

In closing, I appreciate the opportunity to present our executive budget proposal to you today. It was incredibly important to me that I share with you some of the quirks and irregular funding components of this particular Medicaid budget that are being caused by the pandemic. Medicaid is not a simple topic, and when you layer on top of that additional concepts such as enhanced FMAP and "unwinding" after the PHE, it becomes even more daunting of a topic to comprehend. Having co-taught a state budget class at Ohio University, I'm also sensitive to the fact that this is not the only area of our state government you have on your plate, and I know you have limited time review everything before you for consideration.

As you know, the Ohio Department of Medicaid has an enormous responsibility to provide health care for Ohio's most vulnerable individuals, maintain the highest levels of accountability to taxpayers, and ultimately make a positive difference in our state. With a disciplined approach from the outset of the pandemic, we have prudently managed the taxpayers' resources, maintained access to services, and done all we can to prepare for the transition out of the public health emergency without causing unnecessary strain on the state's resources. Our targeted investments proposed in this budget narrowly focus on genuine access issues, needed structural changes, necessary COVID-19 reforms, continuing past commitments, and implementing the policies adopted by the General Assembly. I will make myself and my staff available to answer any questions you may have as we work together in the coming months.

Thank you for the opportunity to present to you today.

Appendices

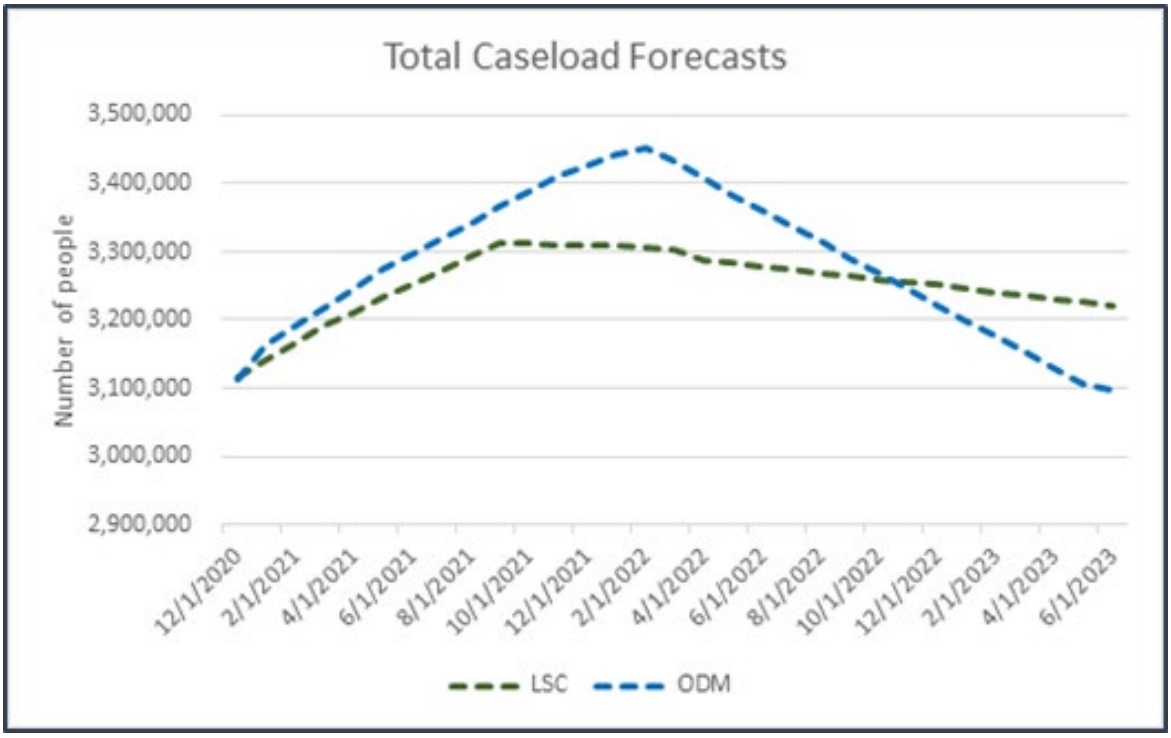
1. Dashboard #1: COVID Medicaid Risk Analysis: During the early days of testing, this dashboard was created to assess whether testing was occurring equitably across the state, using data regarding comorbidity and risk factors, by age cohort.
2. Dashboard #2: Telehealth Impact on Services
    a. Mental health & addiction services utilization: Telehealth enabled behavioral health services to remain near pre-pandemic levels. This is an example of how telehealth helped stabilize access to behavioral health services, more so than in other services that require face to face care.
    b. See the pattern with Diabetes HbA1c/Cancer Screening, which require in person care.
3. Dashboard #3: Churn of Medically Complex Kids January 2021: Dashboard of medically complex kids with a gap of four or more months in care, over the 24 months prior to January 2021.
4. Dashboard #4: Covid-19 PPE Dashboard. This is an example of a dashboard that was created early in the COVID pandemic to track distribution across the state in nursing facilities; including various metrics of availability of PPE and status of facility (number tested, positive, exposed, etc.).

Appendix 1: ODM Baseline Medicaid Forecast Comparison To LSC

Process and Findings

- ODM and LSC both independently forecast Medicaid services expenditures provided by the Ohio Department of Medicaid prior to introduction of the budget bill.
    - Overall, LSC spending forecast is lower than ODM by $290,000,000 (≈0.5%) over the SFY22-23 biennium. Caseload differences are the primary contributor to expenditure differences.
- LSC caseload forecast is lower than ODM by an average of 29,855 people (≈0.9%).
    - ODM assumes higher caseload burden during the continuing public health emergency in SFY22, but a quicker caseload decline in SFY23.

LSC comparison with ODM Projection



Expenditure Variance – ODM Medicaid Services

	ODM Baseline	LSC	Difference (ODM-LSC)	% Variance
SFY22				
All Funds	$26,840,790,475	$26,394,710,793	$446,079,682	1.7%
State Share	$8,320,645,047	$8,182,360,346	$138,284,701	1.7%
SFY23				
All Funds	$27,198,941,675	$27,354,586,675	($155,645,001)	-0.6%
State Share	$8,431,671,919	$8,479,921,869	($48,249,950)	-0.6%
Biennium				
All Funds	$54,039,732,150	$53,749,297,469	$290,434,681	0.5%
State Share	$16,752,316,966	$16,662,282,215	$90,034,751	0.5%

Note: Dollars are baseline only and include only ODM claims and capitation payments. The amounts exclude programs such Hospital Care Assurance Program, Medicare premium assistance payments and program administration.

Caseload Variance – Average Monthly Caseload

	ODM Baseline	LSC	Difference (ODM-LSC)	% Variance
SFY22				
Total	3,394,259	3,298,531	95,728	2.8%
SFY23				
Total	3,211,778	3,247,795	(36,017)	-1.1%
Biennium				
Avg	3,303,018	3,273,163	29,855	0.9%

Appendix 2: Ohio Medicaid Employee Workforce

Ohio Medicaid is made up of approximately 568 professionals dedicated to providing health care coverage and services that improve the quality of life for our enrollees. ODM is committed to fostering a diverse workforce. In 2018 the department was awarded the state's Diversity and Inclusion Award for a diverse, equitable and inclusive work environment. We value our employees and realize our differences make us better equipped to serve Ohioans.

ODM employee breakdown by gender and ethnicity (568 total employees)

All Employees	
Gender	
Female	381
Male	187
Ethnicity	
Asian/Pacific Islander	31
Black or African American	156
Hispanic	4
Two or More Races	3
White	374

All Employees		
Ethnicity	Gender	
Asian/Pacific Islander	F	19
Asian/Pacific Islander	M	12
Black or African American	F	120
Black or African American	M	36
Hispanic	F	2
Hispanic	M	2
Two or More Races	F	2
Two or More Races	M	1
White	F	238
White	M	136

ODM supervisor breakdown by gender and ethnicity (134 total supervisors)

Supervisors	
Gender	
Female	86
Male	48
Ethnicity	
Asian/Pacific Islander	9
Black or African American	22
Hispanic	1
Two or More Races	1
White	101

Supervisors		
Ethnicity	Gender	
Asian/Pacific Islander	Female	6
Asian/Pacific Islander	Male	3
Black or African American	Female	16
Black or African American	Male	6
Hispanic	Male	1
Two or More Races	Male	1
White	Female	64
White	Male	37

Ohio | Department of Medicaid

Appendix 3: Results of Select SFY 20-21 Initiatives

Initiative	SFY 20-21 Results
Comprehensive Primary Care for Kids (CPC for Kids) In 2020, ODM implemented a pediatric-focused primary care medical home model to enhance prevention efforts, pediatric-focused activities, and outcomes for kids with Ohio Medicaid.	Research demonstrates investments in childhood primary care result in fewer costly hospitalizations through immunization, screening, and prevention efforts. After launching the program in this biennium, ODM's CPC for Kids program: • Served 708,339 kids in 2020 in 130 enrolled primary care practices • Paid $8,248,131 in monthly payments to participating providers
Infant Mortality Grants As discussed at length in Ohio's Infant Mortality Report, African American infants in Ohio are almost three times as likely to die before their first birthday than white babies. In response to this challenge, Ohio Medicaid and the managed care plans granted two years of funding to target improving Black infant outcomes in communities with the highest racial disparities in infant deaths.	ODM's infant mortality grants to Butler, Cuyahoga, Franklin, Hamilton, Lucas, Mahoning, Montgomery, Stark, and Summit Counties aim to reduce the racial disparity in infant outcomes using community led, person-centered, evidence-based practices including group pregnancy counseling, home visiting, parenting assistance, care connections to community resources, and fatherhood initiatives. The 2020-2021 grants aim to: • Serve 34,510 women who are or may become pregnant • Leverage 104 unique community outreach organizations • Provide a total of $25,866,916 in funding over two years
Multi-System Youth Custody Relinquishment Program With leadership from the Governor's Office of Children's Initiatives and the Family and Children First Cabinet Council, ODM administers a state-level program to provide financial and technical support to youth and families with complex needs who may be at risk of custody relinquishment or have already been relinquished to the foster care system.	As of February 2021, the program has: • Provided funding to 411 youth across 78 counties. To date, a total of $13.1M has been provided to families to preserve custody. • Custody relinquishment was prevented in more than 98% of funded cases. • Provided technical assistance to an additional 74 children and families (funding not requested).
Lead Poisoning Prevention and Hazard Control Childhood lead poisoning affects thousands of Ohio children each year. In 2019, Ohio Medicaid received federal approval to conduct a Children's Health Insurance Program (CHIP) Health Services Initiative (HSI) to prevent lead poisoning among children with Medicaid. The CHIP program is implemented through the Ohio Department of health.	Research on childhood lead poisoning has estimated that each dollar invested in lead paint hazard control results in a return of $17–$221. The ODM/ODH program is statewide and available in every Ohio county. • In SFY 2020-21 (to date), 111 applications for lead hazard control have been received. • $10M funding was allocated to the program for the biennium.
Telehealth in Schools Pilot On March 9, 2020, the state announced the launch of a telehealth pilot project to connect students with behavioral health providers in the Switzerland of Ohio School District in Monroe County. The objective was to test methods to connect the school district with behavioral health services while also	As a result of the Switzerland Telehealth project, more families have access to broadband and telehealth opportunities. With these connections in place, academic success can be improved by assisting students to achieve and maintain physical and mental health. Specifically: • Access to telehealth services can be provided to the district's 2,000 students and families.

providing high-speed internet connections to Ohioans who have been left behind the "digital divide".	• Telehealth access now spans 8 buildings across 536 square miles.
Electronic Pregnancy Risk Assessment Form (PRAF) The electronic PRAF 2.0 was developed to standardize pregnancy notification and decrease the risk of preterm birth by facilitating the provision of progesterone. Submission of an electronic PRAF automatically notifies: county JFS agencies to maintain Medicaid coverage, ODH's home visiting central intake program, and managed care and home health providers to facilitate clinically appropriate progesterone use.	Linking to home visiting intake and maintaining Medicaid coverage can improve pregnancy and infant outcomes. For example, research shows uninsured newborns are more likely to have adverse outcomes, including low birth weight and death, than are insured newborns, and uninsured women are more likely to have poorer outcomes during pregnancy and delivery than women with insurance. In SFY 20-21 (to date): • 19,793 electronic PRAF forms were submitted to link women to services • 228 providers used electronic PRAFs for women they serve
Telehealth Flexibilities On March 9th 2020, ODM adopted emergency telehealth rules to preserve access to vital healthcare services during the temporary delay of elective procedures. Many of these changes were made permanent in November including: • Relaxed patient and provider site restrictions • Increased provider types utilizing telehealth • Allowing telephone and secure portal communications to be reimbursed	While utilization of health care services decreased overall during the pandemic, access was largely maintained for individuals in the Medicaid program, particularly for crucial preventive services such as behavioral health as shown in Appendix 4, Dashboard #2
Behavioral Health System Stabilization Significant collaborative work among Ohio Medicaid, providers, and the managed care plans was needed to systemwide challenges resulting from Behavioral Health Redesign implementation of 2018. Investments in BH System Stabilization in August 2019 and ongoing technical assistance efforts to address system and process issues have helped to stabilize payments to community BH providers.	Following investments and systemwide work, the most recent BH provider payment data indicates vast improvements in the system: • Average monthly payments to providers (by submission date) rose 29% from SFY 2019 to SFY 2020. Payments remained stable in SFY 2021, which is noteworthy given the ongoing pandemic conditions. • As of January 2021, BH Advanced Repayment data indicates 71% of the original funds advanced have been collected - this represents a 67% increase in the total amount collected since July 2019. The MCOs have agreements in place to recoup another 21% of advanced payments.
Unified Preferred Drug List (UPDL) On January 1, 2020, ODM implemented a unified preferred drug list to replace the process of having each managed care plan adopt a different preferred drug list.	Implementing the UPDL has: • Eased administrative burden for prescribers by decreasing unnecessary prior authorization requirements and requiring all MCPs to use one consistent set of requirements. • Maximized the collection of federal and supplemental rebates, ensuring that all supplemental rebates are sent directly to ODM and are not retained by the Medicaid MCPs or their PBM. This resulting in net savings to the state of $61M.

Home CHOICE Ohio's HOME Choice program transitions eligible Ohioans from institutional settings to home and community-based settings, where they receive services and supports at home and in their communities	In 2021, the SCAN Foundation awarded Ohio Medicaid with its **Pacesetter award** in recognition of the Department's continued efforts to improve the lives of older adults, people with disabilities, and their family caregivers across the state. ODM was specifically recognized for its leadership in transitioning people who need long-term services and supports (LTSS) out of institutions and back into the community. • In SFY 2020-21 (to date), the Home CHOICE program transitioned 891 individuals into community settings. • The CY 2020 budget for Home Choice was $13,607,646 (85% federal funds, 15% GRF). The budget for CY 2021 is being approved by our federal partners.
COVID-19 Regulatory Relief At the onset of the public health emergency, ODM worked closely with legislative leaders and Controlling Board members to strategically allocate available CARES Act dollars for provider relief funding. Additionally, ODM quickly moved to ease regulatory requirements in light of COVID-19 that might otherwise have resulted in increased proliferation of the virus.	To maintain access to care and provide regulatory relief providers during the pandemic, ODM adopted: • 100 emergency rules • 74 permanent rules • 7 CMS State Plan Amendments • 5 CMS Appendix K submissions • 2 CMS 1135 waivers
Health Care Isolation Centers As COVID-19 spread across the state, individuals within nursing homes were at particularly high risk for poor COVID outcomes. ODM, in partnership with ODH, created a Health Care Isolation Centers (HCIC) regulatory and payment framework. HCICs were established to specialize in the care of patients with COVID-19 infections while preventing the spread of disease to non-infected individuals. ensuring clinically appropriate isolation and/or quarantine protocols.	In SFY 20-21, ODM worked with the General Assembly to designate certain nursing facilities as Health Care Isolation Centers to provide quarantine and isolation levels of care. To date: • 32 HCICs have been approved, and 2 more provider applications are pending • 423 people have been served by HCICs • $1.3M in health care reimbursement has been provided to HCICs

SFY 22-23 Initiatives and Expected Results

Initiative	Expected SFY 22-23 Results
Nursing Home Quality Payments Ohio Medicaid's proposed SFY 22-23 budget invests $440 million into nursing facilities based on quality measures such as reducing and preventing pressure ulcers and urinary tract infections. This adds on to a quality payment created legislatively in HB 166.	By tying additional reimbursement to measurable outcomes, this initiative is expected to improve quality of care while providing additional reimbursement providers among the hardest hit by the pandemic.

Appendix 4: Ohio Medicaid Dashboards

1. COVID Medicaid Risk Analysis: During the early days of testing, this dashboard was created to assess whether testing was occurring equitably across the state, using data regarding comorbidity and risk factors, by age cohort.

2. Telehealth Impact on Services
    a. Mental health & addiction services utilization: Telehealth enabled behavioral health services to remain near pre-pandemic levels. This is an example of how telehealth helped stabilize access to behavioral health services, more so than in other services that require face to face care.
    b. See the pattern with Diabetes HbA1c/Cancer Screening, which require in person care.

3. Churn of Medically Complex Kids January 2021: Dashboard of medically complex kids with a gap of four or more months in care, over the 24 months prior to January 2021.

4. Covid-19 PPE Dashboard. This is an example of a dashboard that was created early in the COVID pandemic to track distribution across the state in nursing facilities; including various metrics of availability of PPE and status of facility (number tested, positive, exposed, etc.).

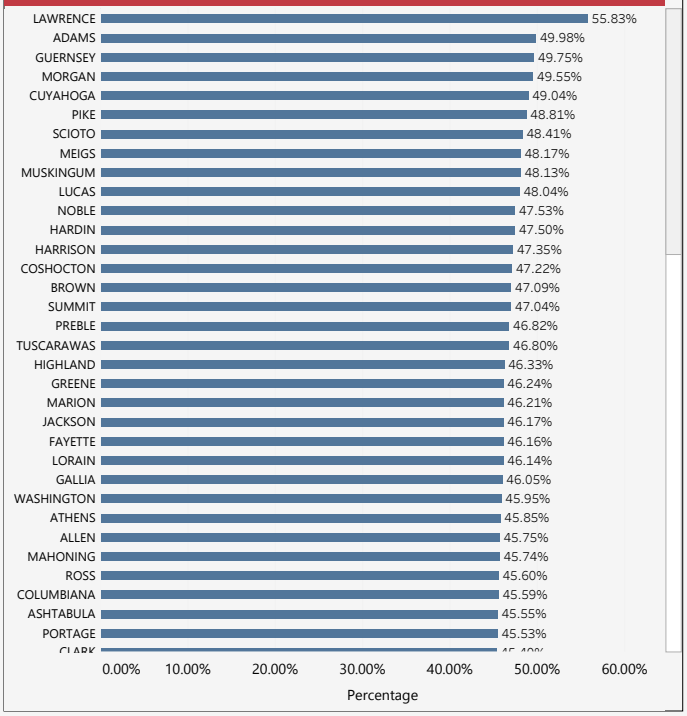
Dashboard #1

Ohio | Department of Medicaid

Medicaid COVID-19 Risk Analysis

Risk Factor	COVID19 Region	County	Age Group	Race	Sex
Multiple values	All	All	All	All	All

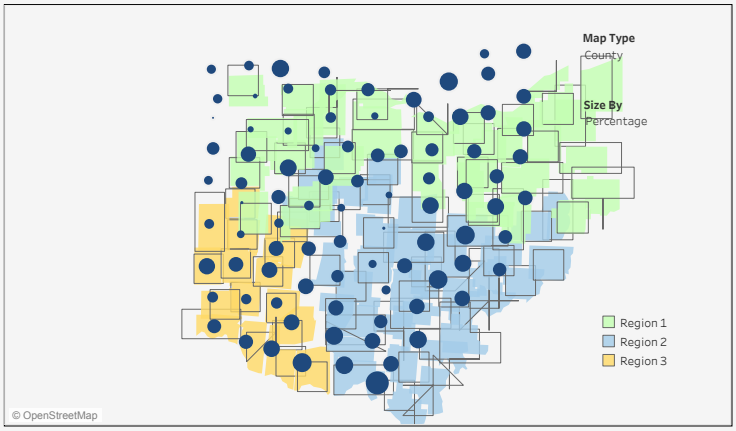
Risk Percentage by County



Risk Analysis by Age Group

Age Group	# of Recipients	Total Recipients	Percentage
Under 10	122,358	634,677	19.28%
10-19	162,853	543,942	29.94%
20-29	140,013	337,289	41.51%
30-39	173,507	339,275	51.14%
40-49	163,761	254,155	64.43%
50-59	194,689	256,692	75.85%
60-69	157,174	201,896	77.85%
70-79	58,863	77,138	76.31%
80 or Older	44,197	53,459	82.67%

Statewide Medicaid County Map by Percentage

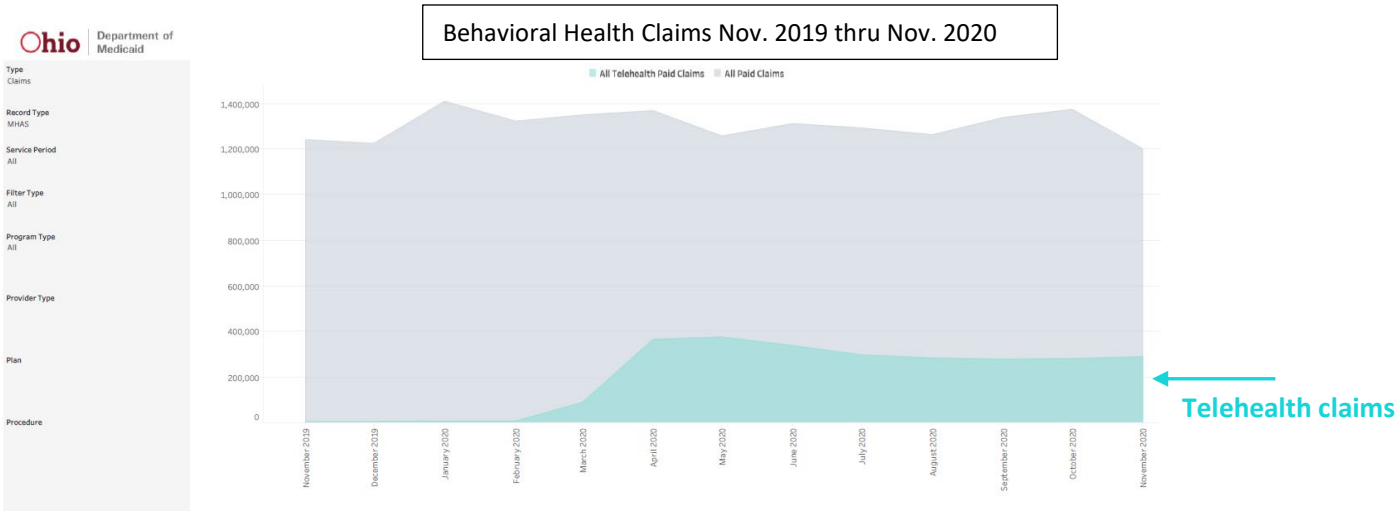


Dashboard #2

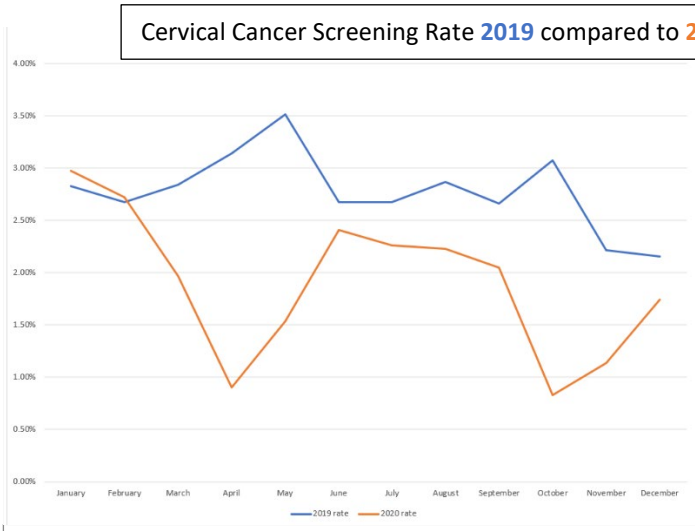
Telehealth Impact on Services

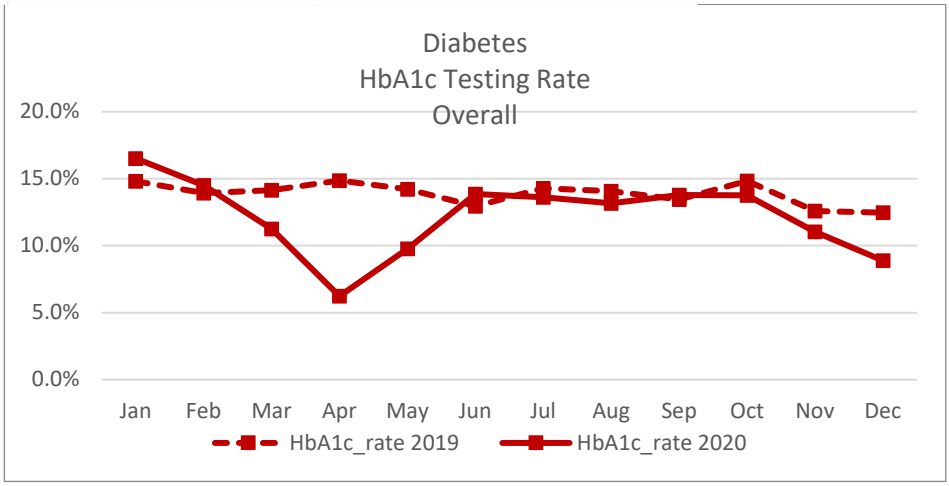
Example Mental Health & Addiction Services Utilization: Telehealth enabled behavioral health services to remain near pre-pandemic levels; stabilizing access to behavioral health services, more so than in other services that require face to face care. See the pattern with Diabetes HbA1c/Cancer Screening, which require in person care.

Behavioral Health Claims Nov. 2019 thru Nov. 2020



Cervical Cancer Screening Rate **2019** compared to **2020**

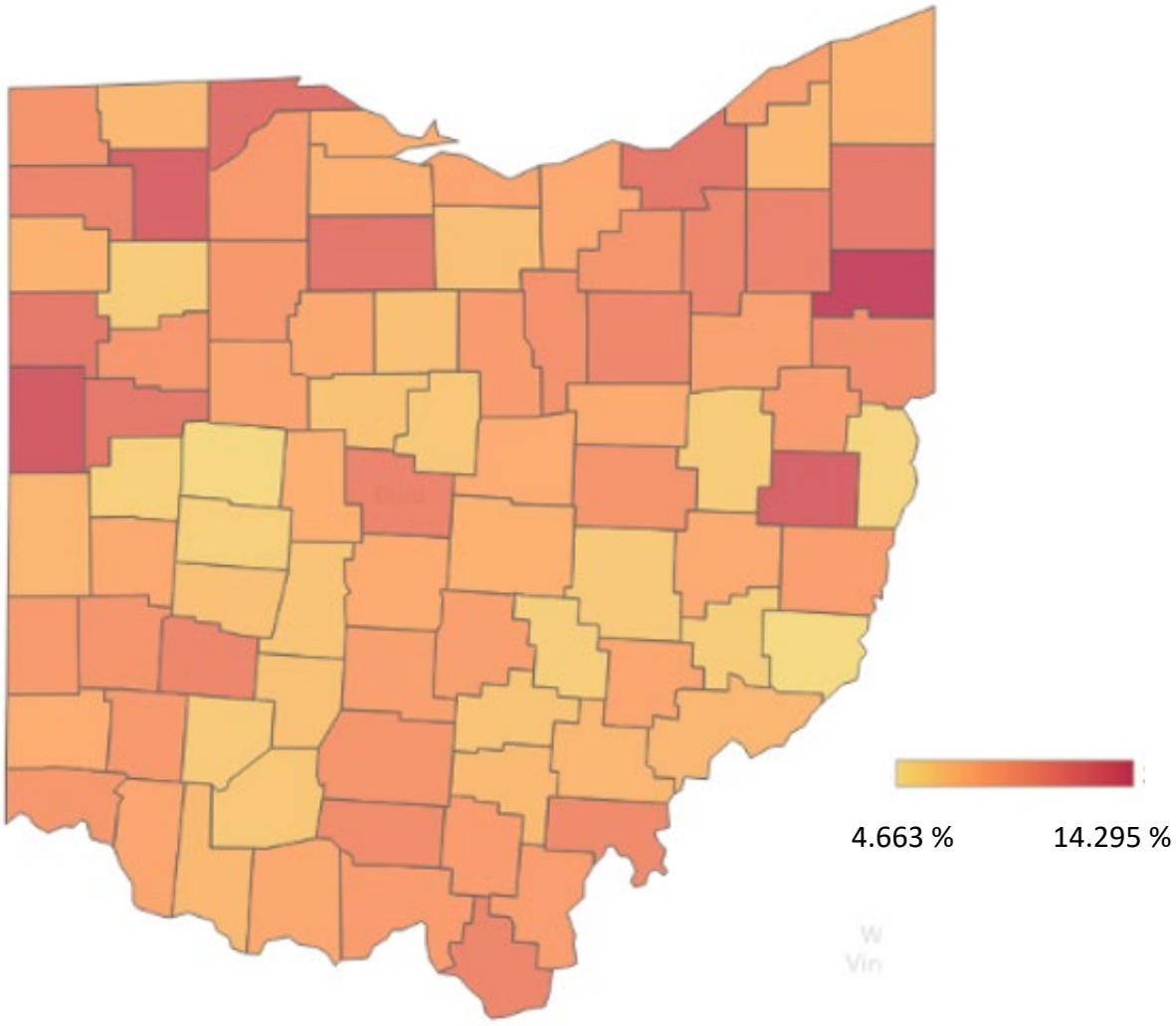




Dashboard #3

Jan. 2021 Medicaid Eligibility Churn for Medically Complex Kids

Gap of ≥ 4 mos. over prior 24 months



Count gives the no. of recipients that have churn based on their being flagged as having a special health care need, with missing continuous months looking back 24 months from Jan. 2021. Percentage is calculated by dividing the count by the total Jan. 2021 Medicaid kids with special health care needs.

Dashboard #4

Ohio | Department of Health

COVID-19 Staffing PPE survey Dashboard

Reset

Data as of: 6/25/2020 10:08:00 PM

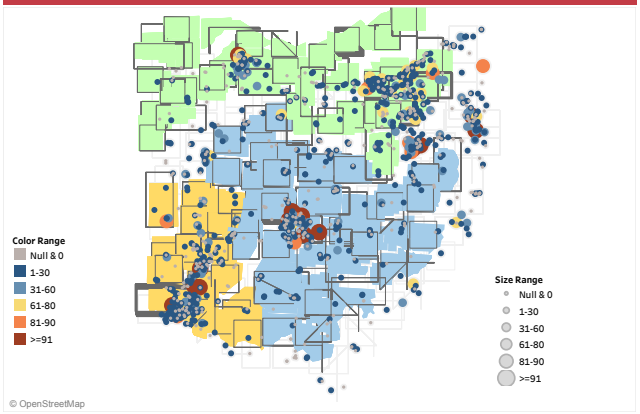
Covid Catgories	Facility type	Provider Name	COVID19 Region	County	Provider Zip Code	Updated Date	Positive cases%
Cases Tested	All	All	All	All	All	All	0

Physician Level	Nursing Level	Admin Level	Gowns	N 95	Crafted PPE masks	Surgical mask
All	All	All	All	All	All	All

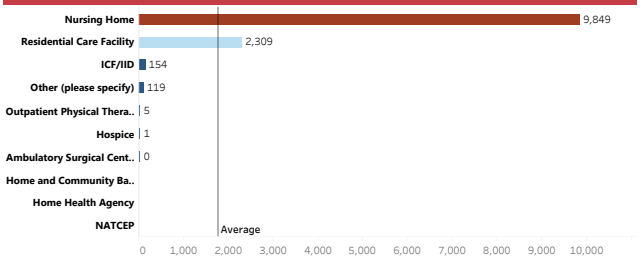
0 663

Gloves	Manu PPE Masks	Face Shields	Non PPE Gloves	Non PPE Gowns	Non PPE Goggles	value selector
All	All	All	All	All	All	All

COVID-19 Cases Tested Statewide Map



Cases Tested by Facility Type



Provider Facilities COVID-19 case status

Provider Name	Asymptomatic Test	Symptomatic Test	Tested	Positive	Pending	Exposed	All
Grand Total	3,486	525	12,437	1,990	1,124	1,014	4,128
OTTERBEIN SENIORLIFE	232	0	663	8	0	11	19
OTTERBEIN LEBANON	0	0	210	0	0	0	0
DANBURY SENIOR LIVING	178	7	187	23	2	27	52
HANOVER HEALTHCARE	0	0	148	1	0	0	1
PARKSIDE VILLAGE	0	6	140	4	0	0	4
KINGSTON RESIDENCE OF SYLVANIA	132	0	132	1	0	0	1
THE ASSUMPTION VILLAGE	1	0	123	0	0	9	9
BETHANY NURSING HOME	10	2	104	3	2	2	7
ROLLING HILLS CARE CENTER	104	0	104	0	0	0	0
TUSCANY GARDENS	102	0	102	0	102	0	102
SABER HEALTHCARE	96	1	100	2	28	12	42
O'NEILL HEALTHCARE	0	5	97	83	0	0	83
BURLINGTON HOUSE	0	0	96	84	0	0	84
ECLIPSE SENIOR LIVING	0	0	96	0	0	0	0
MAJESTIC CARE OF WHITEHALL	40	1	95	55	41	2	98
INN AT BEAR TRAIL	4	3	93	1	2	12	15
OMNI MANOR HCC	0	1	93	1	0	0	1
THE INN AT OLENTANGY TRAIL	55	1	93	1	0	34	35
BRETHREN RETIREMENT COMMUN..	90	0	90	1	90	0	91
ASTORIA PLACE OF CINCINNATI	15	0	83	21	15	46	82
ROSE LANE NURSING AND REHABI..	5	7	83	12	0	0	12
ANDOVER VILLAGE SKILLED NURSI..	83	0	82	2	41	79	122
MAPLEWOOD AT CHARDON	0	0	82	0	0	0	0
SCIOTO COMMUNITY	0	0	82	65	0	0	65
PARAMOUNT OF WESTERVILLE	1	1	81	81	0	2	83
CHARDON HEALTHCARE CENTER	0	0	80	4	0	0	4
PARK HEALTH CENTER	80	0	80	0	80	0	80
WESLEYAN VILLAGE	0	3	79	3	0	0	3
WOODED GLEN	1	1	78	0	0	0	0
CROWN POINTE CARE CENTER	75	2	77	1	0	0	1
DIVERSICARE OF ST THERESA	4	0	77	0	1	0	1
NORMANDY CARE CENTER	25	3	77	37	0	0	37
DAVIS	0	0	75	49	0	0	49
PARK VISTA	9	1	75	30	9	0	39
ALTERCARE NOBLES POND	1	0	74	13	0	0	13
COURTYARD AT SEASONS	0	0	74	0	37	7	44
HEARTLAND AT PROMEDICA	0	2	74	0	1	0	1

Ohio | Department of Medicaid

Mike DeWine, Governor
Jon Husted, Lt. Governor

Maureen M. Corcoran, Director

March 11, 2021

Ms. Elizabeth Richter, Acting Administrator
Department of Health and Human Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

EMAIL SUBMISSION ONLY

Dear Ms. Richter,

The Ohio Department of Medicaid (ODM) respectfully submits this response to CMS's correspondence dated February 12, 2021, which invited ODM to provide information relevant to CMS's deliberation about whether to revoke ODM's approved 1115 demonstration community engagement waiver.

Ohio believes that individuals' active engagement in their own economic wellbeing is consistent with the Medicaid program and furthers Medicaid's objectives. As discussed in this response, the Ohio community engagement program is supported by academic research that shows individual engagement is associated with improved health outcomes. The program encourages individuals onto a path of self-sufficiency, free of government assistance. And separate from Medicaid, the program is consistent with our economic and workforce goals; helping to satisfy Ohio's unmet need for more entry-level workers, and encouraging skills development, training and education on a path to higher paid positions.

In 2017, the Ohio General Assembly established the statutory requirement for the Ohio community engagement program. *See* O.R.C. 5166.37. Subsequent to passage of the legislation, ODM invested hundreds of hours of thoughtful and detail-oriented research, planning, and design into preparing the program and presenting the program to CMS for approval. The approved program is narrowly tailored. It applies to only a modest subset of individuals who are within the Group VIII expansion category of Medicaid. This expansion occurred in 2014, when Ohio chose to expand the Medicaid program to individuals in a higher income bracket from what the federal program otherwise requires. Within this expansion category, the Ohio program identifies individuals who can and are positioned to transition into more meaningful work experience and community engagement opportunities. Importantly, Ohio is also pursuing programs and policies designed to connect prospective workers to jobs and job training opportunities. Qualifying activities go beyond paid employment and include the pursuit of education, job training, and community volunteer activities, among other options.

To address a threshold comment in CMS's letter, Ohio is not pursuing this program during the COVID pandemic—nor is Ohio permitted to do so under its Maintenance of Eligibility obligations that apply during the pandemic. Instead, the program would be implemented following the pandemic, after a return to more normal economic times. Also, the Ohio community

engagement program is starkly different from the work requirement programs in most other States, and it differs from the programs that are currently being examined by the United States Supreme Court.

ODM respectfully requests that CMS not rescind the waiver permitting Ohio's community engagement program.

This response is divided into three sections. The first section explains that the design of the Ohio community engagement program addresses and eliminates the concerns raised by CMS in its letter. The second section further explains the benefits associated with Ohio's program. And the final section briefly discusses the history of federal Medicaid legislation and the place of Ohio's program within this legislative framework.

1. **Ohio's program includes flexibilities that eliminate the stated concerns in CMS's letter**

CMS's letter raised several valid concerns associated with the COVID pandemic and state work requirement programs generally. In the letter, CMS expressed concerns associated with activity reporting by individuals, lack of economic opportunities caused by the pandemic, transportation, childcare, and health consequences of COVID-19. Ohio's community engagement program differs from the description in CMS's letter, which appears to be more directed to the programs designed by States other than Ohio. CMS's concerns do not exist in the Ohio community engagement program or are otherwise resolved by the program's design.

- **The Ohio program resolves CMS's concern over activity reporting by individuals**

CMS stated that the Ohio demonstration "authorizes the state to require all demonstration beneficiaries" to "timely report 80 hours per month of community engagement activities . . . as a condition of continued Medicaid eligibility." This statement is incorrect. The approved Ohio waiver does not include any weekly, monthly, quarterly, or other periodic reporting requirement regarding community engagement. The only reporting requirement consists of reporting a change in circumstances that may affect eligibility. This, as CMS is aware, is a requirement for all Medicaid members, regardless of the demonstration program. Thus, if any Medicaid member receives a raise or relocates to a different State, the member must report the change. *See* Ohio's approved demonstration waiver, p. 4.[1]

- **The Ohio program resolves CMS's concern about lack of economic opportunities due to the pandemic**

[1] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/oh/oh-work-requirement-community-engagement-pa.pdf

CMS referred to "[u]ncertainty regarding the current crisis and the pandemic's aftermath, and the potential impact on economic opportunities." First, Ohio recognizes that it is unable to implement the program during its Maintenance of Eligibility obligations that apply during the pandemic. Second, Ohio's program closely mirrors the program requirements of the federal Supplemental Nutrition and Assistance (SNAP) program. Like SNAP requirements, the Ohio program accounts for lack of job opportunities when those exist. Medicaid members in counties that have SNAP work requirement waivers due to high unemployment will be exempt from the work requirement as well.

In addition, the expansion group individuals who qualify for the program can meet the requirement in ways other than through paid work. *See* Ohio's approved demonstration waiver, pp. 3, 7, 10. The requirement can be met through community engagement activities which include: self-employment, work in exchange for goods and services ("in kind" work), unpaid formal and informal volunteer, community service and public service activities, education and training activities, formal and informal job search or job readiness programs, and participation in and compliance with SNAP and/or Temporary Assistance for Needy Families (TANF) work registration or employment and training (E&T) requirements. The program requires 20 hours of qualifying activities per week, or 80 hours per month.

- **The Ohio program resolves CMS's concern about lack of transportation**

CMS expressed concern that "[u]ncertainty regarding . . . access to transportation" has "greatly increased the risk that implementation of the community engagement requirement approved in this demonstration will result in unintended coverage loss." Under the Ohio waiver, lack of transportation is a good cause exception for not meeting the work requirement and will not result in loss of Medicaid coverage. *See* Ohio's approved demonstration waiver, p. 13.

- **The Ohio program resolves CMS's concern about lack of access to childcare**

CMS also expressed concern about "access . . . to affordable childcare." Under the Ohio waiver, parents and caretakers are exempt from participating in the community engagement program. *See* Ohio's approved demonstration waiver, p. 7.

- **The Ohio program resolves CMS's concern about health consequences of COVID-19**

CMS lastly noted that "the uncertainty regarding the lingering health consequences of COVID-19 infections further exacerbates the harms of coverage loss for Medicaid beneficiaries." Again, Ohio's waiver accounts for health concerns. Under the Ohio program, any person who cannot work due to self-attested medical conditions, including lingering health consequences of COVID-19 infections, are exempt from community engagement requirements under Ohio's program. *See* Ohio's approved demonstration waiver, pp. 10-11.

In sum, the concerns raised by CMS are not present in the Ohio community engagement program. Indeed, the Ohio program is starkly different from the programs of many other States. It is narrowly tailored to encourage a return to the work force for those individuals who are positioned to make that change. The Ohio program allows for paid and unpaid qualifying activities. The Ohio program's design also incorporates flexibility and responds to changes in individual circumstances and overall economic conditions. It identifies a modest subset of individuals within the expansion group and encourages actions that will help lead to improved individual circumstances and better health outcomes.

2. The benefits of the Ohio waiver program

In its approval of the Ohio program, CMS determined that the Ohio program "promotes beneficiary health and financial independence" and is "designed to lead to higher quality care at a sustainable cost." *See* CMS letter approving Ohio community engagement program.[2]

Ohio's program builds on the expanded and established policy that economic well-being and health status are directly associated. Ohio's program implements policies that drive improvements in economic status to address a host of social needs that directly impact a person's health. Specifically, Ohio's programmatic engagement of individuals at the time of eligibility application or renewal is optimal for presenting job training or community engagement activities in concert with the process of engagement for signing up for health coverage.

- **Increased personal engagement is linked to improved health**

A growing body of academic policy research demonstrates that patient and family engagement in health care is associated with improved health outcomes. Having the skills, knowledge, and confidence to effectively manage care is associated with improved self-rated health,[3, 4] increases in preventive health behaviors and decreases in health risk behaviors,[5] and reductions in cost of care.[6]

---

[2] Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/oh/work-requirement-and-community-engagement/oh-work-requirement-community-engagement-demo-appvl-20190315.pdf

[3] Simmons, L. A., Wolever, R. Q., Bechard, E. M., & Snyderman, R. (2014). *Patient engagement as a risk factor in personalized health care: A systematic review of the literature on chronic disease.* Genome Medicine, 6(2), 16.

[4] Harvey L, Fowles JB, Xi M, Terry P. *When activation changes, what else changes? the relationship between change in patient activation measure (PAM) and employees' health status and health behaviors*. Patient Educ Couns. 2012 Aug;88(2):338-43. doi: 10.1016/j.pec.2012.02.005. Epub 2012 Mar 27. PMID: 22459636.

[5] Hibbard, J. H., and J. Greene. *What the Evidence Shows About Patient Activation: Better Health Outcomes and Care Experiences; Fewer Data on Costs.* Health Affairs, vol. 32, no. 2, 2013, pp. 207–214. doi:10.1377/hlthaff.2012.1061

[6] Hibbard, J. H., J. Greene, and V. Overton. *Patients with Lower Activation Associated with Higher Costs; Delivery Systems Should Know Their Patients' 'Scores.'* Health Affairs, vol. 32, no. 2, 2013, pp. 216–222. doi:10.1377/hlthaff.2012.1064.

CMS has recognized that economic well-being goes hand in hand with health status and CMS officially and actively encourages States to develop programs that support and encourage employment. This was the officially stated position of CMS in 2011 under the administration of President Obama:

> Work is a fundamental part of adult life for people with and without disabilities. It provides a sense of purpose, shaping who we are and how we fit into our community. Meaningful work has also been associated with positive physical and mental health benefits and is a part of building a healthy lifestyle as a contributing member of society. Because it is so essential to people's economic self-sufficiency, as well as self-esteem and well-being, people with disabilities and older adults with chronic conditions who want to work should be provided the opportunity and support to work competitively within the general workforce in their pursuit of health, wealth and happiness. All individuals, regardless of disability and age, can work – and work optimally with opportunity, training, and support that build on each person's strengths and interests. Individually tailored and preference-based job development, training, and support should recognize each person's employability and potential contributions to the labor market.[7]

In 1996, under the administration of President Clinton, CMS developed the Person and Family Engagement (PFE) Strategy. The goals of the PFE strategy include enhancing person and family engagement, serving as a guide to support meaningful, intentional application of person and family engagement principles to all policies and programs addressing health and well-being, and creating a foundation for expanding awareness and enhancing person and family engagement.[8] This broader trend towards engagement has taken a variety of programmatic forms at the state level.

A further mechanism more directly focused on engagement in care is 1915(j) waivers for "Self-Directed Personal Assistant Services," which empower individuals who already receive section 1915(c) waiver services to engage in a person-centered and directed planning process regarding care. Provisions within this framework allow for the involvement of friends and family in the care planning process, if the participant so chooses.[9]

Many Medicaid managed care plans today already provide incentives and education, incentivize healthy behavior, and/or improve financial involvement and health literacy related to

[7] https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-09-16-2011.pdf
[8] Center for Medicare and Medicaid Services. Person and Family Engagement Strategy: Sharing with Our Partners. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/Person-and-Family-Engagement-Strategy-Summary.pdf Accessed 2-22-2021.
[9] Center for Medicare and Medicaid Services. https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/self-directed-personal-assistant-services-1915-j/index.html

the cost of care. Such operations include completing an annual Health Risk Assessment (HRA) and attending an annual wellness exam or routine dental exams.[10] Some have taken the next step—along with the state of Ohio—to add employment related services which includes job training and employment connections.[11, 12, 13]

Ohio has developed and continues to refine and improve robust programs to support job training and employment opportunities for the Medicaid expansion group and others. One example is the Ohio Means Jobs program, which offers job-searching, upskilling, and career-pathing activities. Below is only a partial list of the aggressive programs that Ohio is undertaking by itself or in connection with the federal government to promote and foster work and job training opportunities:

- Eligible training providers use the Ohio Workforce Inventory of Education and Training system to list their training services to individuals who can also search for approved training programs.
- Employment Services, through the Wagner-Peyser Act, provides labor exchange services, such as job search assistance, job referral, and placement assistance for job seekers and recruitment services for employers with job openings.
- The Ohio Labor Market Information site has tools and information on wages, expected openings, and training options for occupations in Ohio.
- The Ohio Migrant and Seasonal Farm Worker services initiative has information for those working or interested in agricultural jobs
- OhioMeansAccessibility.com offers links to resources for individuals with disabilities.OhioMeansJobs.com is a free site where individuals can post their resume for employers to review, and where individuals can search for job openings, internships, and apprenticeships, view job fairs, and register for workshops.
- The Reemployment Services and Eligibility Assessment Program provides intensive reemployment assistant to individuals receiving unemployment and likely to exhaust their benefits before becoming reemployed.
- The Ohio trade program helps workers who have lost or may lose their jobs as a result of foreign trade, with opportunities to obtain the skills, credentials, resources, and support to become reemployed.

[10] https://www.ohiomh.com/Documents/OhioMedicaidComparisonChart.pdf
[11] https://www.caresource.com/oh/members/tools-resources/life-services/medicaid/
[12] https://www.caresource.com/oh/members/tools-resources/life-services/members/medicaid/
[13] https://www.buckeyehealthplan.com/community-outreach/grant-program.html

- Veterans' workforce services alleviate unemployment and underemployment for veterans and other eligible persons.

There are many more examples. Ohio's Aspire Adult Education and Literacy Program provides free services for individuals who need assistance with acquiring the skills to be successful in post-secondary education, training, and employment. The Ohio Office of Workforce Development offers a variety of services, provided by county, state, and various partners to people seeking employment. And, Ohio Means Jobs centers offer access to computers, office equipment, job-related workshops, supportive services, individual training accounts, and other activities to assist with work force development. In addition to Ohio, the federal government recognizes the need for improved training and education through such programs as Pell Grants and the Workforce and Innovation Opportunity Act, which authorizes federal funds to be invested in skill development, employment, and training services for adults, dislocated workers, and youth.

- **Ohio's waiver program is narrowly tailored and designed to foster personal engagement**

Ohio's demonstration waiver is narrowly tailored to identify the individuals, through data available to the state, who are positioned to transfer back into the work force. Importantly, the Ohio program is limited to the Group VIII expansion Medicaid population—individuals whom Ohio (and some other States) have voluntarily chosen to include in the Medicaid program. The Group VIII expansion broadened Medicaid eligibility to most Ohioans age 19 through 64 with incomes at or below 138% of the federal poverty level. Prior to January 1, 2014, Medicaid eligibility for adults was limited to those with certain qualifying characteristics such as parenthood or disability, and the income limitation for most Medicaid eligibility groups was at or below 90% of the federal poverty level.

Within this already limited subset of Medicaid members, the Ohio program further excludes any individual who:

- is already working,
- is already in job training,
- is receiving treatment for a substance use disorder
- cannot work due to underlying medical conditions,
- are in counties exempt from work requirements under SNAP due to high unemployment rates in a county, or
- are a parent or caretaker of a minor child

The Ohio community engagement program does not require any of the above groups to report activities, fill out forms, or take any action beyond the standard reporting of changes required of any Medicaid member. In addition, any individual who is not in one of these exempt categories can complete a simple self-appraisal form, which by attestation alone can exempt the

individual based on a medical condition, employment status, job training status, education status, childcare status, or county residence status not already noted in state records. No medical or other verification is required for this, and these individuals would also be exempt and not reviewed until their next eligibility renewal.

After these reductions, county caseworkers will appraise the remaining individuals who appear to be qualified for the program. If the caseworker observes any circumstance that would exempt the individual, the person would likewise be excluded. Finally, the remaining individuals who can benefit from economic and job opportunities, in concert with a county caseworker, will have the opportunity to choose a work or other qualifying activity. That activity would be in place until their next eligibility renewal. No periodic reporting of work activity or other activity is required except changes in circumstances. They would be re-evaluated at their next annual renewal.

Ohio's community engagement program differs from other States, particularly States that have had their programs challenged in courts. For example, the Arkansas program requires monthly reporting, includes eligibility lock out periods for noncompliance, and requires medical certifications. In contrast, the Ohio program requires only annual reporting unless there is a change in circumstance, does not have lock out periods, and does not require medical validations.

Ohio's 1115 waiver is closely aligned to the SNAP and TANF work and community engagement requirements and targeted to identify individuals who can most benefit from employment activities and support. It seeks to engage and empower the identified individuals, rather than to penalize them.

3. The Ohio waiver fits within the legislative history and framework of Medicaid

The Medicaid program was created as a support system and a means to self-sufficiency. The Medicaid program was one part of The War on Poverty. The War on Poverty was social welfare legislation introduced in the 1960s by the administration of President Lyndon B. Johnson to end poverty in the United States. The legislation included education, job training, medical care, and housing.[14] President Johnson offered Medicaid as a support for people who were seeking to improve their economic situation:

> The war on poverty is not a struggle simply to support people, to make them dependent on the generosity of others. It is a struggle to give people a chance. It is an effort to allow them to develop and use their capacities, as we have been allowed

[14] President Lyndon B. Johnson, Annual Message to the Congress *on the State of the Union*, Jan. 8, 1964. Available online by Gerhard Peters and John T. Woolley, The American Presidency Project: https://www.presidency.ucsb.edu/documents/annual-message-the-congress-the-state-the-union-25.

to develop and use ours, so that they can share, as others share, in the promise of this nation.[15]

Medicaid both at the federal level and the state level has evolved over the past 50 years to provide more flexibility for states to create a supportive structure for individuals and families. Employment supports the Medicaid Buy-In for working disabled individuals and continuous eligibility (CE) for youth who are enrolled in Medicaid, which enables parents and households with modest incomes from having to immediately find replacement health care coverage for their children. It includes home and community based "waiver" programs to cover the cost of health care for family members with challenging medical conditions so that working parents' income is not counted as part of a physically or mentally challenged child's eligibility for Medicaid.

ODM continues to evolve in a supportive role with the aim of enabling those who can, to achieve and maintain independence, and for those who cannot, to maintain a quality of life through comprehensive health care coverage. That is the central pillar of Ohio's community engagement 1115 demonstration waiver.

The Ohio community engagement program was carefully designed and is intended to promote and foster independence—and the associated health outcomes—with increased community engagement. The Ohio program falls squarely within the purpose of Medicaid and it does not include the areas that CMS has identified as problematic in its February letter.

For all the foregoing reasons, ODM respectfully asks CMS to uphold its approved waiver. In addition, ODM requests a meeting on this matter, to further dialogue with CMS about the structure and benefits of the Ohio program.

Sincerely,

[redacted]

Maureen M. Corcoran
Director

CC: Judith Cash, Acting Deputy Director, Center for Medicaid and CHIP Services

Christine Davidson, State Monitoring Lead, Medicaid and CHIP Operations Group

[15] President Lyndon B. Johnson, *Special Message to the Congress Proposing a Nationwide War on the Sources of Poverty*, March 16, 1964. Available at https://www.presidency.ucsb.edu/documents/special-message-the-congress-proposing-nationwide-war-the-sources-poverty.