Ohio | Department of Medicaid

Testimony to the Finance Committee of the Ohio House of Representatives

Governor DeWine's Executive Budget Proposal SFY 2024-2025
Maureen M. Corcoran, Director, Ohio Department of Medicaid
February 8, 2023

Chairman Edwards, Vice-Chair LaRe, Ranking Member Sweeney, and members of the House Finance Committee: thank you for the opportunity to address you 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 2024-2025 and to be joined by my colleagues.

The Ohio Department of Medicaid (ODM) is the single state agency responsible for the administration of Ohio's Medicaid program. With a network of over 170,000 providers, Ohio's Medicaid program delivers healthcare access and related community support services to more than 3.4 million Ohioans, including children, pregnant women, adults, seniors, and individuals with disabilities, across the life spectrum. The following statistics highlight this important role in serving Ohioans:

- Over half of Ohio births are covered by Medicaid.
- More than 1.3 million children in our state are served by Medicaid.
- More than 16,500 children are enrolled and receiving specialized services through OhioRISE.
- Nearly a third of Ohio Medicaid's adult population suffers from a mental illness and about twenty five percent of children have a behavioral health diagnosis.[1]
- More than 141,000 Ohioans are served on 7 HCBS waivers; ~51,500 are served on waivers for individuals with intellectual and developmental disabilities, and ~90,000 are served on waivers for elderly, physically and developmentally disabled people.
- 46,140 Ohioans served in Nursing Facilities have Medicaid, representing 64% of all NF days.

ODM's budget proposal for state fiscal year (SFY) 2024-2025 addresses five priorities for our state:

1. Ensuring eligible Ohioans have continuous access to high-quality health care as the state resumes routine eligibility operations.
2. Preserving and strengthening access for Ohioans to behavioral health and other community-based services, focusing on those who provide direct care and services to individuals while working to address workforce shortages.
3. Continued implementation of Medicaid's Next Generation of Managed Care, including OhioRISE, the Single Pharmacy Benefit Manager (SPBM), Fiscal Intermediary (FI), and the Provider Network Management (PNM) module.

[1] Prevalence for calendar year 2021. See Ohio Medicaid Assessment Survey (OMAS) dashboard. (n.d.). Retrieved November 19, 2022, from https://grcapps.osu.edu/app/omas

4. Ensuring Ohio's mothers and children have access to the necessary programming for sustainable healthcare they need, connecting pregnant mothers to evidence-based resources that improve birth outcomes, seeking to eliminate disparities that negatively impact the health of Ohioans we serve.
5. Continuing progress on priority policy initiatives approved in HB 110 of the 134th General Assembly.

Budget Overview

Medicaid: A Shared State/Federal Health Care Program

Medicaid is a joint federal-state program financed through a payment arrangement called the Federal Medical Assistance Percentage (FMAP). This means that the federal government will match state spending on healthcare at a certain percentage. In Ohio, that FMAP rate is approximately 64%. Since the majority of program funding comes from federal sources, Ohio is able to alleviate pressure on the state general revenue fund by maximizing non-GRF resources such as franchise fees and local funds from sister agencies like the Department of Developmental Disabilities (DODD). This is represented in Figure 1, where $1 of state share spending is expected to purchase $5.91 worth of services for Ohioans in SFY 2024.

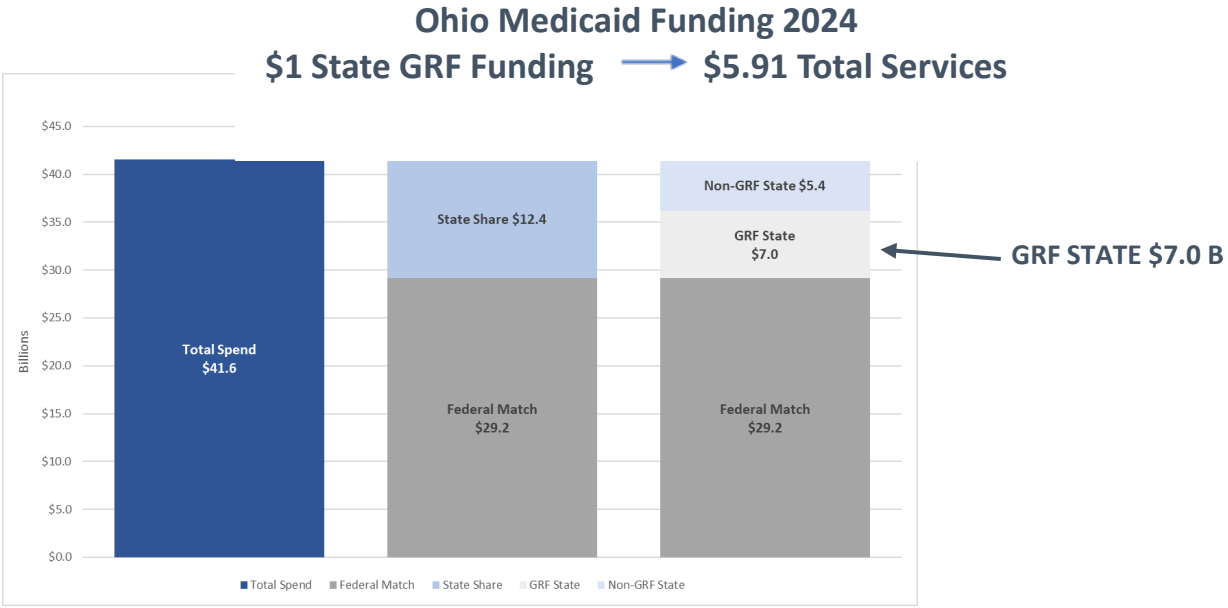


***Figure 1**: In SFY 24, the Medicaid program is 70.2% federally funded*

Overview of Funding

Ohio Medicaid's budget across all agencies is projected to be $41.6 billion (all funds) in SFY 2024 and $43.8 billion in SFY 2025 (all funds).

Medicaid as a Component of Various Systems of Services

Of these totals, ODM-administered components of the Medicaid program make up 89%, while the balance is administered by seven other state agencies – DODD, Job and Family Services (JFS), Mental

Health and Addiction Services (MHAS), Health (ODH), Aging (ODA), Education (ODE), and the Pharmacy Board – as well as several local public entities. The figure below shows the breakdown of the percentage of Medicaid funding by agency.

Figure 2

Medicaid across the life spectrum

Medicaid % by Department	
ODM	81.1%
DODD	10.3
MHAS/ODM	5.66
AGE/ODM	2.14
JFS	0.8%
Health. ODE, Pharm Bd	0.1%

- More than 1.3 million children in our state are served by Medicaid.
- Over half of Ohio births are covered by Medicaid.
- More than 16,500 children are enrolled and receiving specialized services through OhioRISE.
- Nearly a third of Ohio Medicaid's adult population suffers from a mental illness and about twenty five percent of children have a behavioral health diagnosis
- More than 141,000 Ohioans served on 7 HCBS waivers;
  - ~51,500 IDD and
  - ~90,000 elderly, physically and developmentally disabled
- 46,140 Ohioans served in Nursing Facilities (64% of all NF days)

SFY 24-25 Financial Drivers: Inflation, Shifting Workforce Dynamics and Continuous Eligibility Coverage

Throughout the SFY22-23 biennium, Ohio faced increased economic, medical, and workforce pressures. Inflation is impacting individual's and business's cost to operate, at a time consumers are already struggling with high costs associated with food, transportation and household expenses. The last couple of years have highlighted the significant challenges of supporting the healthcare workforce and assuring basic health and safety for those served.

In March 2020 in response to the COVID-19 pandemic, Congress passed the Families First Coronavirus Response Act (FFCRA) which provided states with an additional 6.2 percentage point increase in their federal share of Medicaid funding, also known as enhanced FMAP (eFMAP). This increase amounted to approximately $350 million per quarter, through the end of March 2023. The eFMAP was contingent on a "maintenance of effort" (MOE) provision in the FFCRA. The MOE provision (otherwise known as continuous coverage) required states to maintain eligibility for individuals served by Medicaid throughout the federally declared Public Health Emergency (PHE) effectively prohibiting termination of coverage except in limited circumstances (i.e., moved out of state, death, requested to be removed).

However, in December 2022, Congress enacted the Consolidated Appropriations Act, 2023 (CAA), officially delinking the continuous coverage provision from the PHE and phasing out the eFMAP throughout the remainder of 2023. The table below indicates the increased percentage and total actual and expected funding through the end of this calendar year. The Biden Administration recently notified states that the PHE will end on May 11th.

Figure 3

Post Pandemic: End Maintenance of Eligibility & Convert/End Flexibilities

- In late 2022, Congress enacted the Consolidated Appropriations Act 2023 (CAA), officially delinking the continuous coverage requirement from the PHE
  - » Normal Eligibility Operations resume Feb 1, terminations after April 1st
- Federal requirements in place prior to the CAA and new reporting requirements contained in the CAA must be adhered to.
  - » Procedure for renewing eligibility is federally prescribed.
  - » CAA provides new authority for CMS to intervene with states
- Biden Administration has notified states that the PHE will end on May 11th
- HCBS waiver flexibilities end

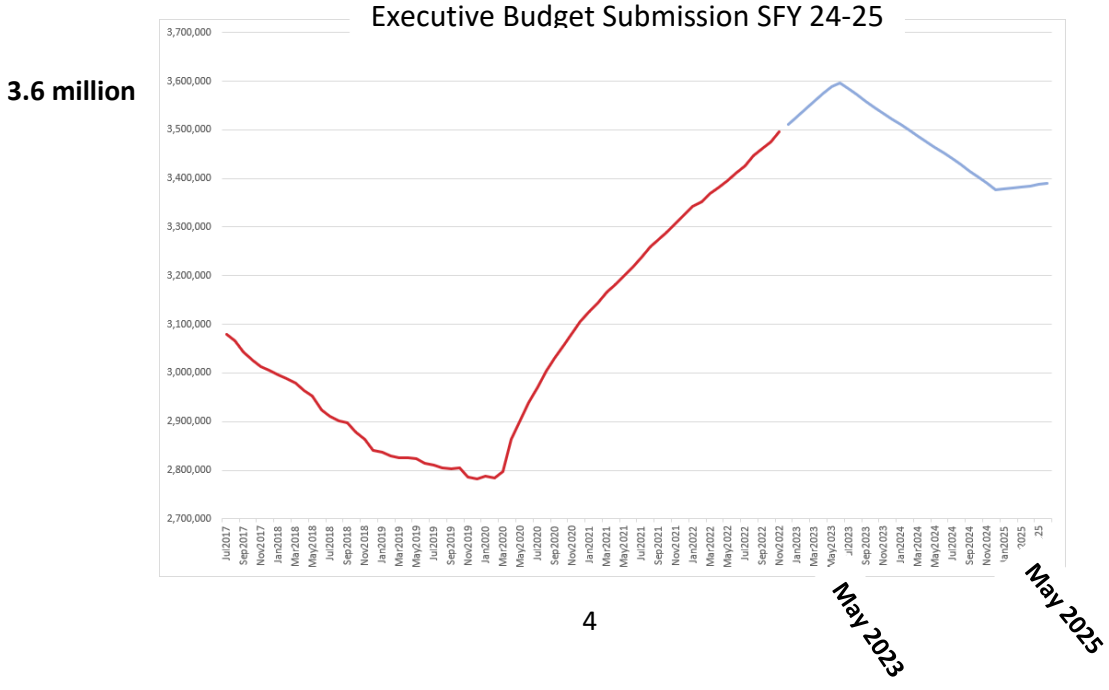
Figure 4
Enhanced Federal Funds

Time Period	No. Calendar Quarters	Enhanced Matching Rate (Percentage Increase)	Enhanced Federal Funds Received
Jan. 1, 2020 – Mar. 31, 2023	**13**	**6.20%**	**$4.54 Billion**
Apr. 1 – Jun. 30, 2023	**1**	**5.00%**	**$310 Million**
Jul. 1 – Sept. 30, 2023	**1**	**2.50%**	**$157 Million**
Oct. 1 – Dec. 31, 2023	**1**	**1.50%**	**$85 Million**
Jan 1,2020 – Dec.31, 2023	**16**	**Total**	**$5.1 Billion**

Medicaid Caseload and Eligibility

After nearly three years of Medicaid caseload increases due to the continuous coverage provision, recent action by Congress allows states to return to routine eligibility operations. As of this writing, a net of 761,000 newly eligible individuals have enrolled in Medicaid, a 27.3% increase since February 2020. The total caseload as of January 2023 is 3.55 million. ODM projects that at its peak, caseload will top out at 3.6 million members.

Figure 5
Medicaid Caseload SFY 2018-2025
Executive Budget Submission SFY 24-25



As disenrollments begin, ODM anticipates the biggest caseload declines to occur within the Group VIII and CFC populations, as these populations are the most sensitive to economic fluctuation. In contrast, we expect the aged, blind, and disabled (ABD) and dual eligible (those eligible for Medicare and Medicaid) populations to remain steady.

Figure 6
Medicaid Caseload by Aid Group
SFY2018-2025
Executive Submission SFY 24-25

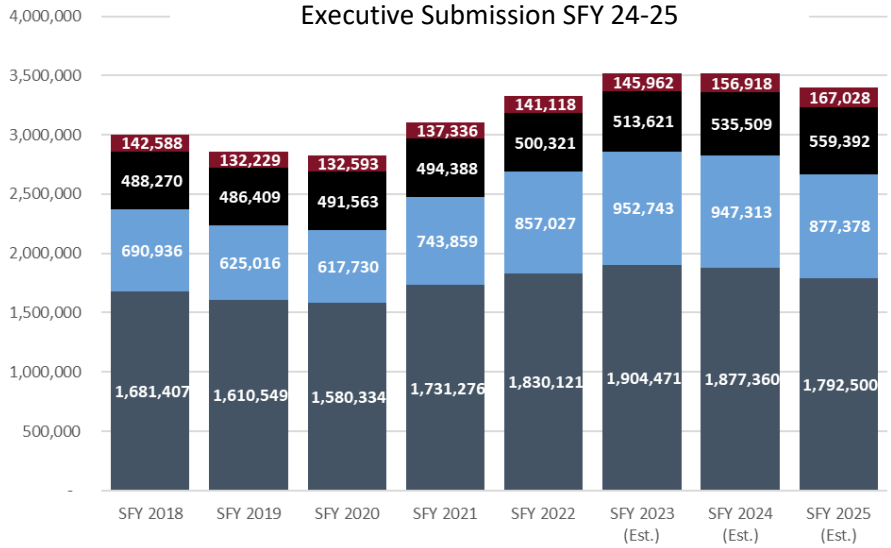


Figure 7
Medicaid Caseload SFY 2023-2025
Executive Budget Submission SFY 24-25

Average Monthly Caseload								
SFY	**CFC Adults**	**CFC Children**	**Expansion**	**ABD Adult**	**ABD Children**	**Dual Eligible**	**Others**	**Total**
2023	604,639	1,299,833	952,743	197,446	52,458	263,716	145,962	3,516,796
2024	588,015	1,289,345	947,313	200,341	53,849	281,318	156,918	3,517,100
2025	541,069	1,251,431	877,378	203,415	55,285	300,692	167,028	3,396,298

Caseload Considerations: Why Medicaid Caseload Will Not Return to 2020 Levels

- Economy
  Right before the pandemic, the economy was coming off a decade of economic growth, with historical levels of employment, improving labor force participation, and low inflation. Medicaid caseloads had been in decline for 35 consecutive months. While the unemployment rate has rebounded, labor force participation has not recovered to February 2020 levels. Additionally, national and state economist are predicting a mild recession to occur at some point in 2023.

Given that, and the fact that Medicaid is countercyclical, we would expect then to see an uptick in enrollment.

- CMS/Federal Requirements re: procedures, repeated notifications, and appeal requirements
  ODM must follow all federal requirements related to all eligibility processes and reporting.
- "Woodwork Effect"
  There is always a portion of the population who is "eligible" for Medicaid but never enrolls. As a result of the pandemic and the continuous coverage provision, new enrollments to Medicaid continued throughout the pandemic.
- Pressures/Reductions in Commercial Insurance
  Continuing trends in the overall commercial and employer-sponsored insurance market added pressure to families. In 2020, nearly 60% of employees with employer-sponsored insurance had a high-deductible plan.
- County Challenges
  Administrative efficiencies and additional funding resources have been invested to assist counties, but workforce challenges and turnover have impacted counties, as with the rest of the economy.
- Aging of Ohio's Population
  Ohio's population is growing increasingly older, putting upward pressure on overall caseload.

Returning to Routine Eligibility Operations

ODM has been preparing for the return to routine eligibility operations for over two years and has worked tirelessly to set our county partners up for success. Additionally, Ohio submitted its required plan and has been in ongoing discussions with CMS. Federal guidance and other requirements are described in Appendix 1. The following is an outline of the enormous work that has gone into preparations:

Ohio Readiness

Data & IT System Improvements

- Continuous IT system improvements since 2020 to streamline Ohio Benefits
- Hired a 3rd party vendor (PCG) to assist in identifying "likely ineligibles"
- Improved *Ex Parte* renewal process
- Developed automations (i.e., BOTs) improve accuracy and reduce county workload

Additional Outreach

- Ongoing effort to improve contact information for members
- MCOs will receive info re member renewals and will reaching out to assist Ongoing effort to update contact information

County Training, Support & Monitoring

- County trainings are scheduled and providing additional support as they return to routine operations
- Ohio General Assembly appropriated $30M to CDJFS specific to Unwinding activities (per HB 45, 134th General Assembly)
- Augmented ODM Central Processing Unit (CPU) to help counties with increased workload

- Creating new dashboards to monitor county and statewide progress.

Communications:

- Continuous updates and linkages to stakeholders and grass roots organizations throughout the PHE
- Disenrollment notices include contact information for navigators.
- Created a dedicated webpage that houses additional information and resources for members, providers, stakeholders, and partners
- Published a partner packet that, among other key messages, encourages members to update their contact information

Ohio's process officially kicked off February 1, the earliest date allowed by CMS. The first disenrollments to occur will be for those members who have an annual renewal date in the month of April.

Regulations Governing Ohio's Return to Routine Operations

- Existing federal requirements governing eligibility determination and renewal process
  - Three CMS State Health Officials (SHO) letters released in December 2020, August 2021, and March 2022 setting out federal expectations and requirements related to case processing timelines and member communications for redetermining Medicaid coverage for those who had their coverage continuously maintained
  - CMS provided guidance related to the Medicaid Continuous Enrollment Condition Provisions in January 2023
- With the reinstatement of routine eligibility operations, individuals can be terminated beginning on **April 1, 2023.**
- Federal requirements in place prior to the CAA and new reporting requirements contained in the CAA must be adhered to
- States will continue to receive the 6.2 percentage enhanced FMAP (eFMAP) during the first quarter of 2023 after which it phases down before the end of CY23
- Two federal corrective action plans (CAPs) put in place to remedy an application backlog and PERM audit finding
- House Bill 110 (134th General Assembly) contains a variety of provisions directing how certain aspects of unwinding should occur

Unwinding Challenges

Ohio's state-supervised, county administered framework relies on county caseworkers for the majority of the work in processing Medicaid applications, renewals, etc. Consequently, when unwinding begins, Ohio's 88 county department of Job and Family Services (CDJFS) will experience an unprecedented set of challenges and competing obligations, with workforce constraints top among them. In addition:

- Enrollee contact information may be out-of-date
- Some eligibility workers have never processed renewals outside of the continuous eligibility requirement
- People enrolled on Medicaid for the first time after March 2020 may not be familiar with the renewal process

- In addition to Medicaid, county JFS offices are responsible for other programs, such as SNAP, TANF, and childcare.
- Ohio is still under a federal corrective action plan (CAP) and must remain in compliance by continuing to timely process applications.

HB 45 of the 134th General Assembly appropriated $30 million in dedicated county funding ***solely to process Medicaid renewals and disenrollments*** as Ohio returns to routine eligibility operations. In order to monitor performance, ODM has developed a series of dashboards that break down progress at the county level giving detailed insight into the state's overall progress. CMS will be collecting such performance data from states, to be shared publicly.

PLEASE SEE APPENDIX 1 FOR MORE INFORMATION REGARDING RETURN TO NORMAL ELIGIBILITY OPERATIONS

- Monthly Operational Flow
- Additional Info re: Federal and State requirements
- Monitoring and Dashboards: State & County Progress
- Overview of Comprehensive Member Outreach and Other Coverage Options

Next Generation of Medicaid Managed Care Status Update

Phase 3 started on February 1st

Ensuring the vision of the Next Generation of managed care is carried out and meets population health, care coordination and person-centric, business transformation objectives will require continued refinement and focus through SFY24-25.

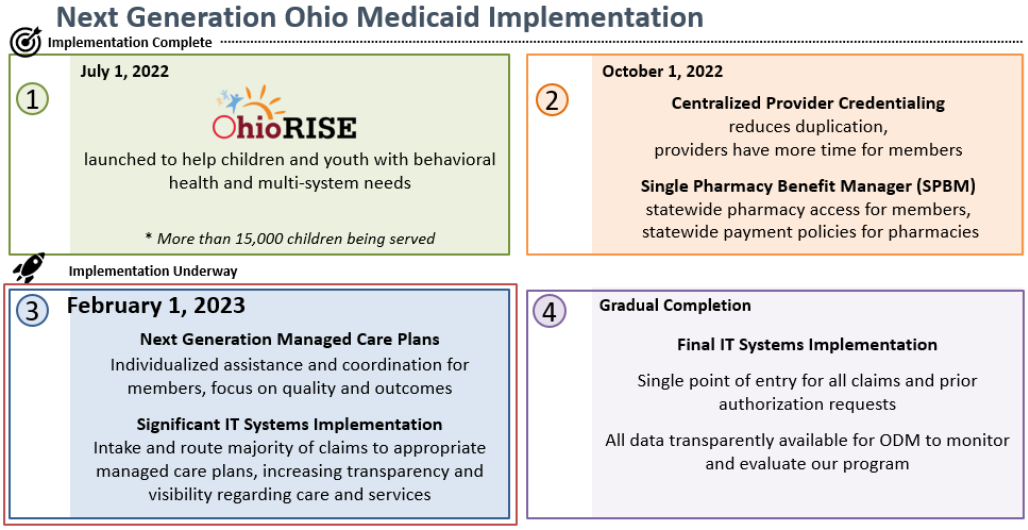
DeWine Administration Priorities: Focus on the Individual and the Next Generation of Managed Care

Shortly after taking office, Governor DeWine asked ODM to redesign the state's healthcare program, bringing high quality affordable care that supports this administration's priorities for children and families. In response, ODM worked with the General Assembly and developed a bold new vision, one that focuses on the individual and not just the business of managed care. The result is the Next Generation of Medicaid Managed Care which represents the first structural change to the program in 15 years. With extensive stakeholder feedback and building on the federally required modular replacement of MITs, this major overhaul is composed of five components:

- OhioRISE (Resilience through Integrated Systems and Excellence)
- Single Pharmacy Benefit Manager (SPBM)
- Centralized Credentialing
- Seven New Medicaid Managed Care Plans
- Fiscal Intermediary (FI)

The roll-out of Next Generation was planned in three stages as shown below:

Figure 8
Stages of Implementation



OhioRISE, stage one of the launch, is a specialized behavioral health managed care program that aligns with the federal Family First Prevention Services Act (FFPSA) by prioritizing youth in the care of public children services agencies emphasizing prevention, early intervention and evidence-based practices for children and families. Although it is new, we expect OhioRISE to play a key role in addressing the needs of youth who could be better served in their homes rather than in out-of-home care (foster home, residential facility) hereby avoiding the heartbreaking stories we have all heard from families across this state regarding custody relinquishment. More than 16,000 multi-system children and high-risk youth can now access necessary behavioral health services and supports through coordinated community care.

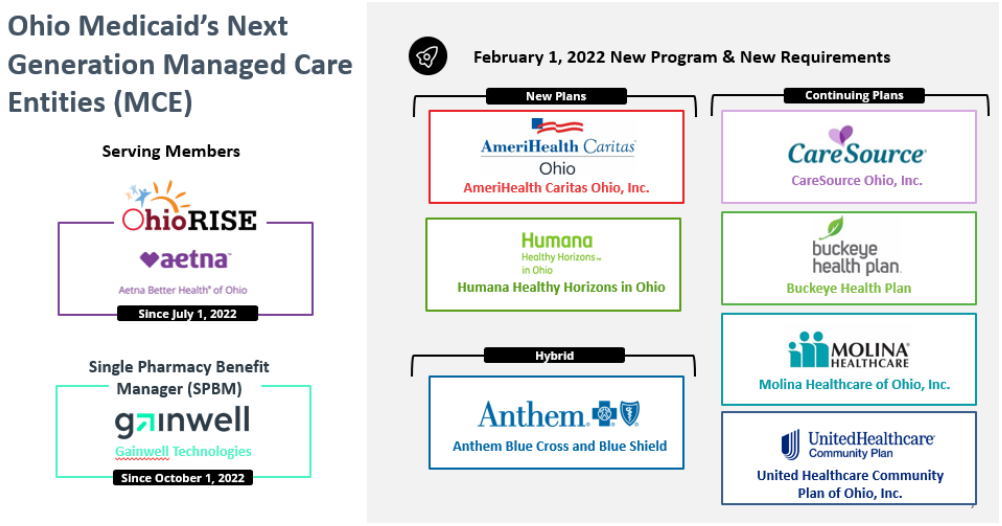
Stage Two of the launch, Ohio's SPBM, fulfills a 2019 Ohio legislative mandate to bring transparency and accountability to the billion-dollar pharmacy benefit. The SPBM, operated by Gainwell Technologies, addresses years of concerns by pharmacies and stakeholders regarding obscure reimbursement methodologies and conflicts of interest that allegedly diverted profits to legacy managed care organization pharmacy programs. With the SPBM, members have access to more than 2,600 pharmacy locations, and for the first-time, consistently have a choice of specialty pharmacies to access medications that require extra care to treat conditions such as cancer, hemophilia, and other rare diseases.

The SPBM's pharmacy pricing method is fair, transparent, and predictable. It is based on evidenced-based costs Ohio pharmacies incur and is audited by the contractor who developed and maintains the National Average Drug Acquisition Cost (NADAC) pricing benchmark for CMS. Moreover, the new structure gives ODM the tools needed to better meet member health and wellness needs.

In our commitment to reduce provider administrative burdens in the new program, the Stage Two implementation also introduced elements of Ohio Medicaid Enterprise System (OMES), including

centralized credentialing through the new Provider Network Management module. By moving the role of credentialing in-house here at the department, providers no longer need to understand or comply with requirements or processes unique to each managed care plan. As a result, centralized credentialing improves provider revenue cycles, and lowers credentialing costs for hospitals, facilities, providers, and practices.

Figure 9



New Next Generation Program

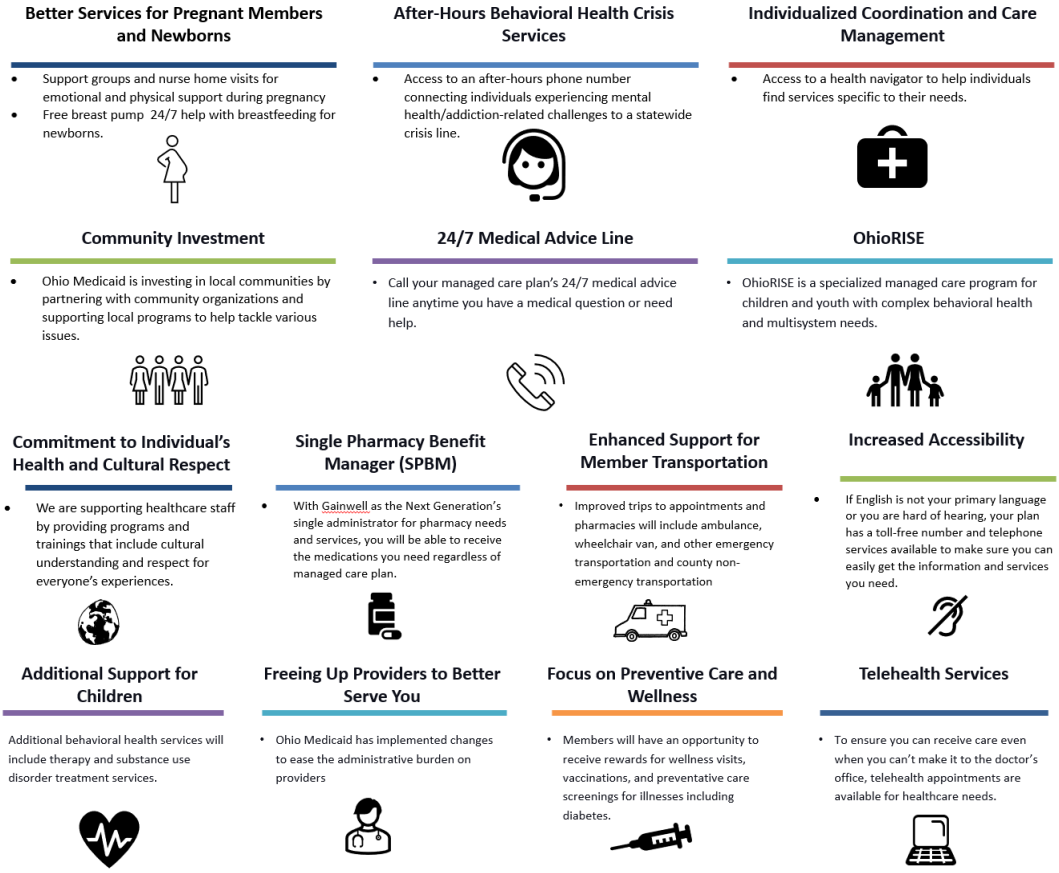
Stage 3 is the initiation of the new Next Generation program requirements, operating under significantly enhanced quality and population health management requirements. ODM is pleased to partner with AmeriHealth Caritas, Anthem, Buckeye Health Plan, CareSource, Humana Healthy Horizons, Molina Healthcare, United Healthcare Community Plan and OhioRISE Aetna Better Health.

Community Investment, Quality Improvement and the Science of Population Health: All the Ohio Medicaid Next Generation managed care entities are committed to improving member wellness through the science of population health and the practice of collective impact. New quality strategies are well underway, an unexpected benefit of the PHE with the incredible efforts of the plans. Using a population health management approach, disparities and opportunities for building health equity are identified when analyzing population data. Community engagement and listening to the "voice of the customer" are cornerstones of this first in the nation, cutting edge approach.

The following are just a few of the other changes in the Next Generation program to help address individual's healthcare needs:

Figure 10

Key Next Gen Program Improvements



Significant IT Systems Implementation: Ohio Medicaid Enterprise System (OMES)

Stage 3 is also the initiation of new functionality as part of a comprehensive effort to modernize ODM's management information systems – OMES. So, what does this all mean? OMES is the modernized replacement of most functionalities in the Medicaid Information Technology System (MITS) and other supporting systems. These information system changes were made in direct response to new CMS requirements for a more "modular" system. OMES is made up of all the systems that are used in the delivery of Medicaid services, and new business capacity including **Provider Network Management (PNM), Single Pharmacy Benefit Manager (SPBM), Fiscal Intermediary (FI) and Electronic Data Interchange (EDI)**.

How do these changes benefit Ohio Medicaid providers? Simply, these initiatives emphasize an improved provider experience by providing transparency and visibility for care and services. Additionally:

- This transition will reduce administrative burden for providers and enable providers to focus on the more meaningful and important work of providing care to members.

- OMES will serves as a single point of entry for all provider credentialing, claims, member eligibility requests and more.
- **Minimizing** missing claims, delays in claims submission, and delayed payments
- Making the claims process more **transparent** and **efficient** by limiting submission and communication of status to one single portal regardless of the MCE involved.
- Enabling **increased ODM oversight** of MCEs and ability to identify and address trends by providing ODM with consistent access to claims and prior authorization request data.

Bold Beginnings, New Children's Cabinet Agency and Other Children's Initiatives

Bold Beginnings

Since taking office, Governor DeWine has committed to ensuring that Ohio is the "best state in the nation to start and raise a family".

On September 30, Governor DeWine announced - Bold Beginnings – a gateway to early childhood resources. The initiative aims to remove barriers to healthcare, ease financial burdens, and support parents and families, and since Ohio Medicaid covers more than half of births in the state each year, we are a key partner in implementing Bold Beginnings.

As part of the Bold Beginnings package, ODM's budget proposes to:

- **Increase eligibility for pregnant women and children up to 300% of the federal poverty level**. For a single, expectant mother, the income limit will be $59,160 per year and for a family of three, that's up to $74,580 a year. This will allow more working families to access prenatal, labor, delivery, post-partum, and preventative care, as well as well-baby visits and other care for the youngest Ohioans, without the financial stress that accompanies major medical care. Earlier this year, at the direction of the General Assembly, Ohio expanded access to postpartum women by allowing new mothers to continue receiving coverage for up to one year after giving birth.
- **Expand healthcare coverage for privately adopted youth who have special healthcare needs**. Governor DeWine will work with the legislature to allow comparable access to Medicaid for privately adopted youth, reducing economic barriers for potential adoptive families. Ohio will seek federal approval to allow children with special health care needs adopted through private agencies to be eligible for Medicaid coverage, even if their adoptive parents have private insurance.
- **Create a pathway to safe, secure housing for more struggling and new mothers**. Innovative pilot programs such as Healthy Beginnings at Home, which connects pregnant women and new mothers with housing and wrap-around supports, holds promise for demonstrably reducing infant mortality and improving birth outcomes. Ohio will pursue federal approval to increase the scale of this program to assist pregnant women and families who are struggling to find stable housing.

Complete implementation of Medicaid's Maternal and Infant Support Program (MISP). MISP was created by listening to and understanding the challenges facing Ohio families, incorporating best practices, and evaluating a wide range of stakeholder strategies. MISP advances innovative and clinically sound policies and payment reforms to improve the lives of moms and babies across Ohio. As adopted in the last biennial budget, MISP has expanded post-partum Medicaid coverage to 12 months for new moms, introduced new coverage for nurse home visiting, expanded access to breastfeeding and location consulting supports, provided new opportunities for women to participate in group pregnancy learning, and launched ODM's new Comprehensive Maternal Care program. MISP is supported by Medicaid's work on the electronic Pregnancy Risk Assessment Form, which helps providers determine if state or community assistance is needed to provide stable housing, home visiting, nutrition, and education, to contribute to a healthy, stable environment, ultimately leading to improved outcomes for mom and baby.

In the coming biennium, ODM will complete implementation of additional MISP services, including coverage for doula care and an innovative approach to co-located care for moms with substance use disorders and infants with neonatal abstinence syndrome.

New Department of Children and Youth

The Governor's budget emphasizes supporting families to ensure that every child has a strong foundation for life. It takes the bold step of creating a new cabinet-level agency, the Department of Children and Youth (DCY), to place a greater focus on improving our communities for children and families. This new department will consolidate programs currently housed across six agencies, including the Departments of Job and Family Services, Education, Health, Developmental Disabilities, Medicaid, and Mental Health and Addiction Services.

Additional Children's Initiatives

In addition to completing the maternal and infant work described above and revisions to the Applied Behavioral Analysis (ABA) service for youth with autism, this budget proposes to expand services in the Medicaid School Program to a broader group of children with disabilities. This policy change would help schools draw down additional federal dollars for services provided, at no cost to the state's GRF.

Long Term Services & Supports Priorities for SFY 24-25

The Ohio Revised Code directs Medicaid to remove barriers that impede Medicaid recipients' ability to transfer to lower cost, and more appropriate, Medicaid services, including home and community-based services (ORC 5162.70).

The first chart below provides an overview of those served in Ohio's home and community-based services waivers. The second chart below shows the progress we have made over the years toward rebalancing our long-term care system. However, as the chart shows, we have begun to plateau, and many individuals on Medicaid have identified several barriers to these lower cost services that often make them unattainable.

Figure 11

Home and Community Based Services

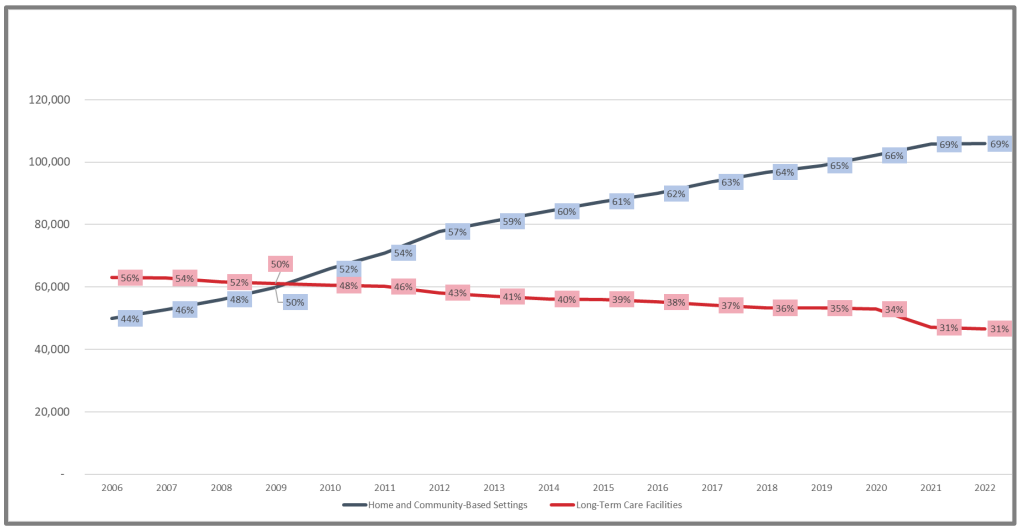
Who Medicaid serves today

	Individuals Who are Intellectually and Developmentally Disabled (DODD waivers)			Individuals Who are Elderly, Physically & Developmentally Disabled (ODM & ODA waivers)			
Names of the Waivers →	**Individual Options**	**Level One**	**Self**	**My Care**	**Ohio Home Care**	**Passport**	**Assisted Living**
Capacity # People	28,300	19,766	3,600	38,262	10,212	37,863	5,583
Total 141,586	Total 51,666			Total 89,920			
Ave. Cost of Waiver	$65,810	$11,400	$14,780	Mgd Care	$17,220	$10,700	$11,587

Figure 12

Rebalancing Ohio's Community & Institutional Service Capacity

Individuals Receiving LTSS in Facilities & HCBS Settings SFY 2006 -2022



In addition to the workforce issues discussed in more detail below, the following policy changes are planned to increase self-direction, enable the greatest degree of independence in community living for each individual, address program inefficiencies and misalignment, and improve care coordination for those with complex needs.

- **Increasing SELF DIRECTION** to the ODM Ohio Home Care waiver
  - » This helps addresses workforce challenge
  - » Consumers and advocacy organizations have been clamoring for this
- **MyCare Conversion**
  - » Must be completed by the end of calendar year 2025

    - » Redesign will improve care coordination and attention to behavioral health needs.
- Adding the **Structured Family Care** waiver service to ODM waiver
    - » Payments to the family caregiver
    - » Specifically targets caregiver support to avoid unnecessary institutionalization.
- Adding **Remote Monitoring** to ODM/ODA waivers
- **Additional waiver reforms** to increase efficiency and effectives of waiver services, including case management alignment.

Economic Realignment of Ohio's Direct Care Workforce

More than 170,000 providers across Ohio serve Medicaid members, from large hospital or nursing home companies to community mental health agencies and independent providers of in-home services. The partnership between Ohio's Medicaid agencies (ODM, DODD, Ohio MHAS, and ODA) and its network of providers is critical to ensuring reliable and timely access to care that improves quality of life, supports recovery and independence for individuals enrolled in the program, strengthens families, and sets Ohio's children and youth on the best possible path so they can grow up to lead healthy and successful lives.

Staffing challenges that existed across the spectrum of health care providers prior to the COVID-19 pandemic were exacerbated by the pandemic. Constriction in the workforce with business closures, earlier-than-planned retirements, changing recruitment pressures and the desire for hybrid work-at-home options added to the turnover and hiring pressures. While telehealth, remote monitoring and other uses of technology have helped, the technology cannot replace care provided directly for individuals.

Medicaid rates for most types of providers are not regularly adjusted for inflationary and environmental factors. From 2020-2022, the DeWine Administration and the Ohio General Assembly provided swift and targeted one-time relief payments to providers using several federal sources and some state GRF. Medicaid providers across the spectrum received provider relief: NFs, Behavioral Health, Hospitals, HCBS, ICF-IID and other groups of Medicaid providers, totaling more than $2.7 billion. While that relief was welcome, it did not make a fundamental change to address wage pressures and the difficulty attracting individuals for essential positions.

Since last summer as we were beginning preparations for this budget, I have been visited by a constant stream of literally every type of Medicaid provider, professional groups, associations, consumer and family organizations providing feedback about their needs. Rarely did anyone ask for less than a 30% rate increase, and requests equal to or greater than 50% were not uncommon. This is the same thing that I am hearing from Medicaid directors across the country.

Our responsibility to provide access to services is clear and the pressure to adapt to the changing workforce dynamics is real. To address this need in a structurally sound, fiscally responsible and

sustainable way, the Administration is proposing a variety of targeted rate adjustments, using a combination of state GRF and one-time funds.

The budget proposes several rate increases in the following areas:

- Home and community based and community behavioral health services,
- Pharmacy providers and other Medicaid non-institutional services,
- Intermediate Care Facilities for Individuals with Intellectual or Other Developmental Disabilities (ICF-IID) and Nursing facility services.

With any rate adjustment it is important to considering the unique differences across the service delivery sectors and the differences in how services are reimbursed. Our goal is to establish some comparability across similar services or face the continuing challenge that waiver providers will move from one waiver to the other for higher pay, doing nothing to retain or cultivate the needed workforce. We experienced this during the pandemic. While the ODM budget only addresses Medicaid funding, the various types of services and types of providers rely on Medicaid to varying degrees; with only some services allowable for payment under Medicare, commercial or employer sponsored insurance.

Home and community based and community behavioral health services. The budget proposes targeted increases in services that provide direct hands-on care to individuals.

- For HCBS services this includes nursing, personal care aide or homemaker personal care, adult day services and home delivered meals.
- While still not comparable to neighboring states, assisted living rates are increased and includes an add-on payment for the extra services required by someone with dementia or memory care.
- Community behavioral health services rates will be increased and a new mental health peer support service is being created. Both will be important to build out the system of care and contribute to the development of crisis response capacity.

Select Medicaid Non-Institutional Service and Pharmacy providers. In addition to a modest increase generally, dental and transportation services are targeted for significant rate increases. Forty percent of children between the ages of 3 and 17 on Medicaid had a dental appointment within the past year, compared to approximately 74% nationally. Feedback and concerns about access have been particularly significant with both dental and transportation services.

Intermediate Care Facilities for Individuals with Intellectual or Other Developmental Disabilities (ICF-IID) and Nursing Facility services. A modest increase is proposed to ensure individuals with intellectual and developmental disabilities (I/DD) have access to facility-based care by increasing the direct care component of the ICF reimbursement rate and increasing the daily rate for ICFs supporting people on ventilators. With regard to the rebasing and quality of nursing home services, this was addressed in the Governor's state of the state address.

Removing Barriers to Meaningful Employment

Access to healthcare coverage is only one aspect of employment. Individuals who receive Medicaid healthcare coverage face a variety of challenges entering the workforce, employees who have access to employer sponsored insurance (ESI) cannot always afford the coverage, especially with the prevalence of high deductible plans, opting for Medicaid coverage; health care and other benefits may not be offered to lower wage occupations or part time employment.

Over the last few years, we have been conducting a thorough analysis of our populations and the barriers they face in obtaining meaningful employment. We anticipate talking about this in greater detail throughout the budget, but some of the highlights include:

- Among the working age, expansion group, those who were not working had twice the amount of annual BH spending and three times the likelihood of having a mental health impairment than those who were working.
- From 2015 to 2021 the percentage of individuals with access to employer-sponsored health insurance in Appalachia dropped significantly by 5.8% (from 54.9% to 49.1%). This is an estimated increase of 110,187 adults without ESI.
- Increasing use of high-deductible health plans has made employer-sponsored health insurance unaffordable for many low and modest income workers
- People on Medicaid are likely to be sicker, use more behavioral health services, and struggle with basic necessities like food security and paying the rent
- People on Medicaid who are not working have higher instances of chronic health conditions than those who are working
- Those who were previously incarcerated have a lower rate of working than any other Medicaid group, including those with disabilities.
- Comparing the working age individuals who have been continuously enrolled on Medicaid with those who enrolled after the pandemic, each group was ***just as likely as the other*** to be working.

Helping Individuals Transition Off of Medicaid

In this upcoming biennium, ODM will take additional next steps in working with the managed care plans on comprehensive plans that address social determinants of health, such as transportation, housing, and food security. Some examples include:

- Identifying successful MCO housing pilot programs and scale them appropriately
- Provide supports for family caregivers to prevent burnout and prevent individuals from transitioning to higher cost settings prematurely
- Implement new non-emergency medical transportation guardrails
- Complete a dedicated portal for Medicaid individuals to OhioMeansJobs to help provide strained healthcare provider needs like personal care aides

- Implement mental health peer support to treatment plan availability to provide more individuals with mental health diagnoses with additional support, helping them become and remain more workforce ready.

Closing

Medicaid plays a unique and necessary role for our state. We have the opportunity to positively change the trajectory of many young Ohioans' lives. We also have opportunities to lower barriers to employment for working age adults, and to ensure the full range of home and community-based options for Ohioans who are elderly or have a disability and wish to remain at home.

As Medicaid Director, I take very seriously the responsibility that the Governor and you have given me; for more than 3.5 million Ohioan's healthcare and the financial stewardship of this large program. The achievements of the last few years could not have been accomplished without the partnership with the General Assembly, the Governor's leadership and amazing hard work by ODM staff, our new Next Generation managed care plan partners and all the vendors who have assisted us.

When we talk about truly making Ohio the best place to have and raise a family ***and*** helping every Ohioan achieve their God Given Potential, I believe that Medicaid is a cornerstone in making this a reality for many.

We will be providing additional details and white papers in the coming weeks. Thank you for the opportunity to provide an overview of our budget, Mr. Chairman. I'll be happy to answer any questions after my colleagues have testified.

Next Generation of Ohio Medicaid Managed Care

Next Generation of Ohio Medicaid Managed Care | Ohio Medicaid Managed Care

- **Provider**
  - Feb. 1 Launch Provider Placemat
  - Feb. 1 Launch Provider Help Desk One Pager
- **Member**
  - Feb. 1 Launch Member Placemat
  - Feb. 1 Launch Member Help Desk One Pager
- **Trading Partner**
  - Feb. 1 Launch Trading Partner Placemat
  - Feb. 1 Launch Trading Partner Help Desk Support Guide

Ohio | Department of Medicaid

Testimony to the Finance Committee of the Ohio House of Representatives
Governor DeWine's Executive Budget Proposal SFY 2024-2025
Maureen M. Corcoran, Director, Ohio Department of Medicaid
February 8, 2023

Appendix 1

Resuming Routine Eligibility Operations and Convert/End Flexibilities

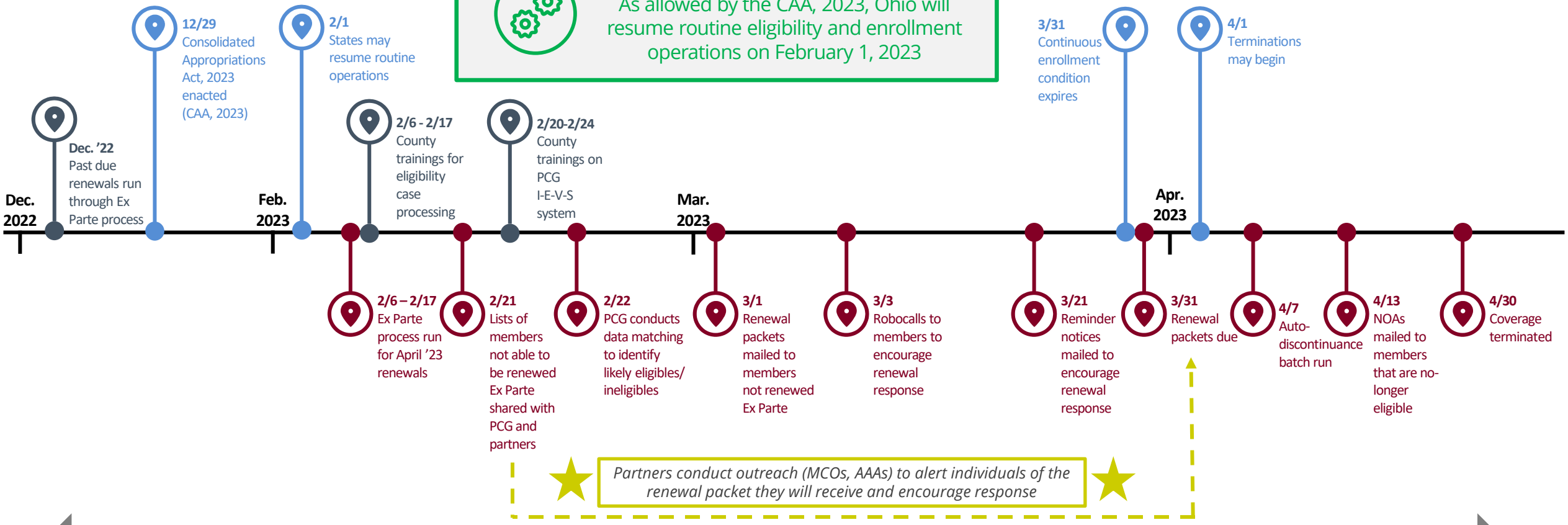
Ohio's Return to Routine Renewal Operations

Legend
- Ohio Department of Medicaid activity
- Key Federal dates
- Monthly Medicaid renewal process*

**Note: illustrative example for renewals due in April 2023. This process will repeat monthly throughout the Unwinding period.*

RETURN TO ROUTINE OPERATIONS

As allowed by the CAA, 2023, Ohio will resume routine eligibility and enrollment operations on February 1, 2023



Efforts to ensure member contact information is up to date

ODM has received authority from CMS via a 1902(e)(14)(A) waiver to partner with MCOs to update beneficiary contact information and establish linkages with the United States Postal Service and National Change of Address database. In the coming months, robocalls will be deployed to confirm accuracy of member addresses before the renewal process begins.

Federal and State Requirements for Restoring Normal Eligibility Operations

Requirements Governing Ohio's Unwinding

- Existing federal requirements governing the eligibility determination and renewal process
  - Three CMS State Health Official (SHO) letters released in December 2020, August 2021, and March 2022 A out federal expectations and requirements related to case processing timelines and member communications for redetermining Medicaid coverage for those who had their coverage continuously maintained
  - CMS provided guidance related to the Medicaid Continuous Enrollment Condition Provisions in January 2023
  - CMS provided written guidance on January 27 re: conditions for receiving temporary FMAP

  EOP Showstoppers State Health Official Letter (medicaid.gov)
- Two federal corrective action plans (CAPs) put in place to remedy an application backlog and PERM audit findings
- House Bill 110 (134th General Assembly) contains a variety of provisions directing how certain aspects of Unwinding should take place

Congressional Action on Unwinding

Decoupling the Public Health Emergency (PHE) and Continuous Coverage Requirement

- In late 2022, Congress enacted the Consolidated Appropriations Act 2023 (CAA), officially delinked the continuous coverage requirement from the PHE
- With the reinstatement of routine eligibility operations, individuals can be terminated beginning on **April 1, 2023.**
- Federal requirements in place prior to the CAA and new reporting requirements contained in the CAA must be adhered to.
- States will continue to receive the 6.2 percentage enhanced FMAP (eFMAP) during the first quarter of 2023 after which it phases down before the end of 2023—subject to additional federal requirements

2023 Quarter	Medicaid Matching Rate Increase (Percentage Points)
January 1 – March 31	6.2 %
April 1 – June 30	5.0%
July 1 – September 30	2.5%
October 1 – December 31	1.5%

- **NEW requirements for states and CMS enforcement**
  - States must be in compliance with all eligibility rules and regs.
  - Make good faith efforts to maintain up to date contact information.
  - States wouldn't be allowed to disenroll on basis of returned mail unless the state also attempts to contact with another modality, like email or phone.
  - Institutes new public reporting requirements. The monthly reports to HHS will be made public.
  - Legislation lists out required metrics.
  - There are FMAP penalties for states that are not compliant with reporting requirements.
  - New CMS enforcement and oversight authority includes:
    - CMS can require state corrective action plans. The legislation stipulates how quickly states need to respond and make progress
    - HHS could require states to suspend procedural terminations if not compliant with the corrective action plan.
    - CMS can also apply a civil monetary fine up to $100,000 per day when state is not in compliance
    - The additional CMS enforcement authority is limited to 12-month period in which public reporting is required.

Home and Community Based Services (HCBS) Waiver Flexibilities and Timeline

Flexibilities implemented during the PHE for Ohio's HCBS waivers are **not** impacted by the CAA

- As part of the COVID-19 public health emergency (PHE), ODM made a series of operational changes to its Medicaid program, including changes to Ohio's Home and Community Based Services (HCBS) 1915c waivers through flexibilities implemented via Appendix K
- The CAA does **not** impact the timeline for expiration of Appendix K flexibilities, which is still tied to the end of the PHE
- As it becomes available, information regarding the Appendix K flexibilities will be posted on the ODM Resuming Routine Medicaid Eligibility Operations webpage

HB 110 Implementation Efforts: Section 333.255

Seek Controlling Board approval for a 3rd party vendor by November 1st, 2021 (A)	Completed on time. Received CB approval on 10/25/21.
Vendor must have access to 8 different types of records to assist in verifying eligibility (B)	The contracted vendor will have access to these data sources.
Vendor must assist ODM in identifying those enrolled in Medicaid who are deemed to be “likely ineligible” to prioritize those case when PHE ends and complete them within 90 days (C)	•Data analytics vendor is in place; will assist in identifying individuals who are "likely ineligible". •ODM and the counties will prioritize the processing of those deemed to be “likely ineligible” while complying with federal requirements. •States cannot make an eligibility determination if the data being used is more than 3 months old.
ODM must conduct an expedited eligibility of newly enrolled for 3 or more months during PHE but not in the last 6 months. This must be done within **six months** after the PHE ends (D)	•Data analytics vendor will help identify those "most likely to be ineligible" •As required, ODM made this request to CMS. However, per 42 CFR 435.916 and reiterated in CMS’ unwinding guidance, states are not permitted to do eligibility renewals on an individual more than once every 12 months. •Per CMS guidance, states may not redetermine more than 1/9 of their total Medicaid caseload each month. •States cannot make an eligibility determination if the data being used is more than 3 months old. •Ohio's plan will prioritize those likely ineligible while balancing other important priorities, including new applications, changes of circumstance and Ohio's two federal Corrective Action Plans.
ODM must write a report of its findings from working with the 3rd party vendor and submit it to certain public officials no later than 120 days after the PHE ends. (E)	ODM will complete the required report.
The 3rd party vendor must be reimbursed entirely based on validated cost savings realized by the department. (F)	Reimbursement/vendor contract with ODM is compliant with the statutory requirement.

HB 110 Implementation Efforts: Section 5163.52

ODM must continue to conduct eligibility redeterminations to the fullest extent permitted under the law. (A)	The counties have continued to perform redeterminations and renewals throughout the PHE. However, because of the requirement to maintain eligibility, states are unable to disenroll, except in limited circumstances.
Within 60 days of the end of the PHE, ODM must complete an audit (B)	ODM has or will comply with the requirements for the audit.
Completes and acts on redeterminations within 60 days of all individuals who haven't had a redetermination in 12 months (B)(1)	•This conflicts with the 6-month timeline in 333.255(D). •Per CMS guidance, states may not redetermine more than 1/9 of their membership every month. •States cannot make an eligibility determination if the data being used is more than 3 months old •PCG data analytics will help identify those who are "most likely to be ineligible". Prioritization of these cases by the county will enable us to right-size the Medicaid caseload. •Ohio's plan will prioritize those likely ineligible while balancing other important priorities, including new applications, changes of circumstance and Ohio's two federal Corrective Action Plans.
Requests approval from CMS to conduct redeterminations on recipients enrolled for more than 3 months and act on those redeterminations within 90 days. Individual counties can request an additional 30 days (B)(2)	•As required, ODM made this request to CMS. However, per 42 CFR 435.916 and reiterated in CMS' unwinding guidance, states are not permitted to do eligibility renewals on an individual more than once every 12 months. •Per CMS guidance, states may not redetermine more than 1/9 of their total Medicaid caseload each month. •States cannot make an eligibility determination if the data being used is more than 3 months old •Data analytics vendor will help identify those "most likely to be ineligible" •Ohio's plan will prioritize those likely ineligible while balancing other important priorities, including new applications, changes of circumstance and Ohio's two Corrective Action Plans.
Submit a report summarizing the results of the audit to certain public officials (B)(3)	ODM will submit the required report.

Sample Dashboards to Measure State and County Progress

Illustration Only

Screenshots of New Dashboards

Comparison of Rates Between Counties and State

Home

Back

Select a county

Cuyahoga

Note: Ross County manages applications and redeterminations for Vinton and Hocking County. To view combined results for these three counties, refer to Ross County.

Metric	County	Statewide
Passive Renewals Attempted	80,935	668,334
Passive Renewals Approved	58,657	465,925
Auto Discontinuances (non-response closures)	0	0
Manual Renewals Completed in Reporting Month	4,945	62,596
Manual Renewals Completed and Due in Reporting Month	102,108	42,538
Pending Renewals Due in Reporting Month	2,773	94,878
All Pending Renewals	185,706	1,582,192

Illustration Only

County Complete Due Benchmark Map and List

Reporting Month Year: September 2022

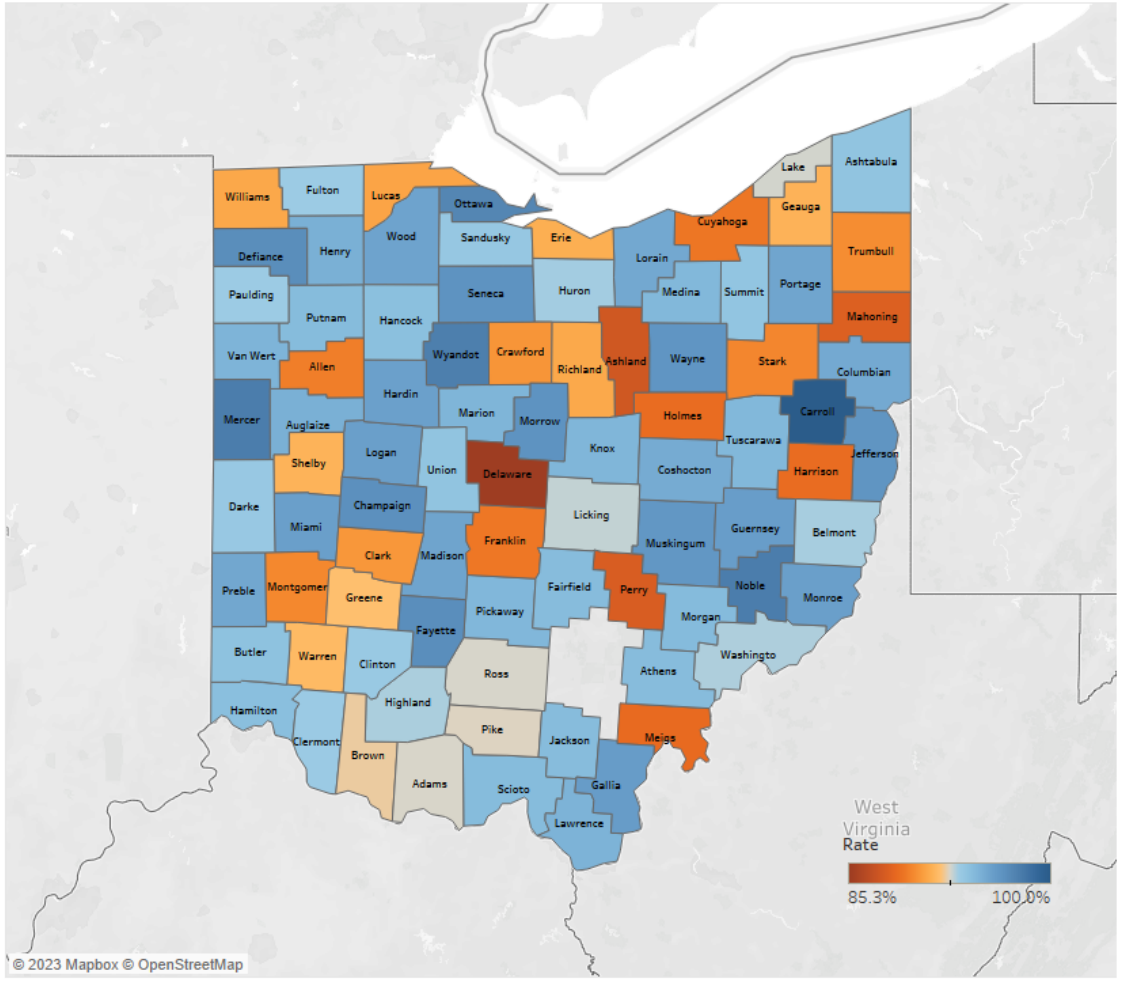
Staff County Name: (All)

Blocks Completed/Due Benchmark: (All)

State Wide Blocks Completed	State wide Estimated Blocks Due Benchmark	State Wide Block Completed Rate
48,294	52,376	92.2%

Home

Back



Staff County N..	Blocks Complete	Estimated Blocks Due Benchmark	Blocks Completed/Due Benchmark
Carroll	126	126	100.0%
Noble	45	46	97.8%
Mercer	135	138	97.8%
Wyandot	86	88	97.7%
Ottawa	145	149	97.3%
Defiance	155	160	96.9%
Fayette	92	95	96.8%
Champaign	207	214	96.7%
Seneca	197	204	96.6%
Morrow	112	116	96.6%
Jefferson	327	339	96.5%
Wayne	377	391	96.4%
Muskingum	723	751	96.3%
Gallia	166	173	96.0%
Guernsey	212	221	95.9%
Monroe	46	48	95.8%
Miami	276	288	95.8%
Logan	183	191	95.8%
Hardin	136	142	95.8%

Comprehensive Member Outreach and Other Coverage Options

Website Updates

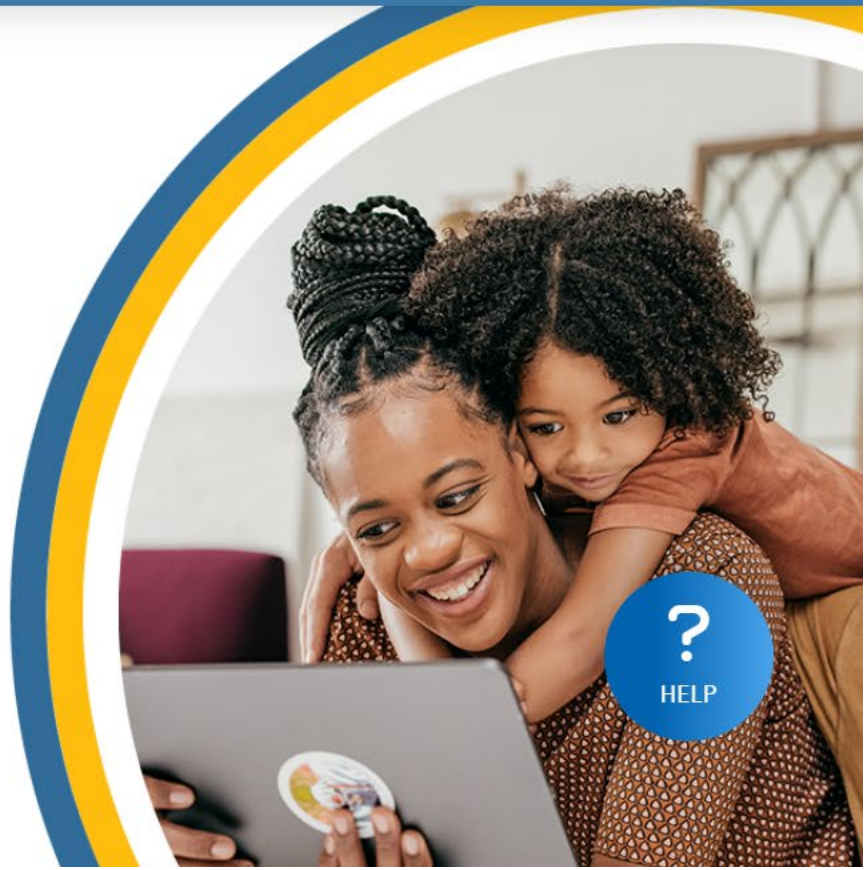
Ohio | Department of Medicaid

FAMILIES & INDIVIDUALS | RESOURCES FOR PROVIDERS | STAKEHOLDERS & PARTNERS | OUR STRUCTURE ABOUT US | Help | Search

Medicaid / Stakeholders & Partners / COVID-19 Unwinding / Resuming routine Medicaid eligibility ope…

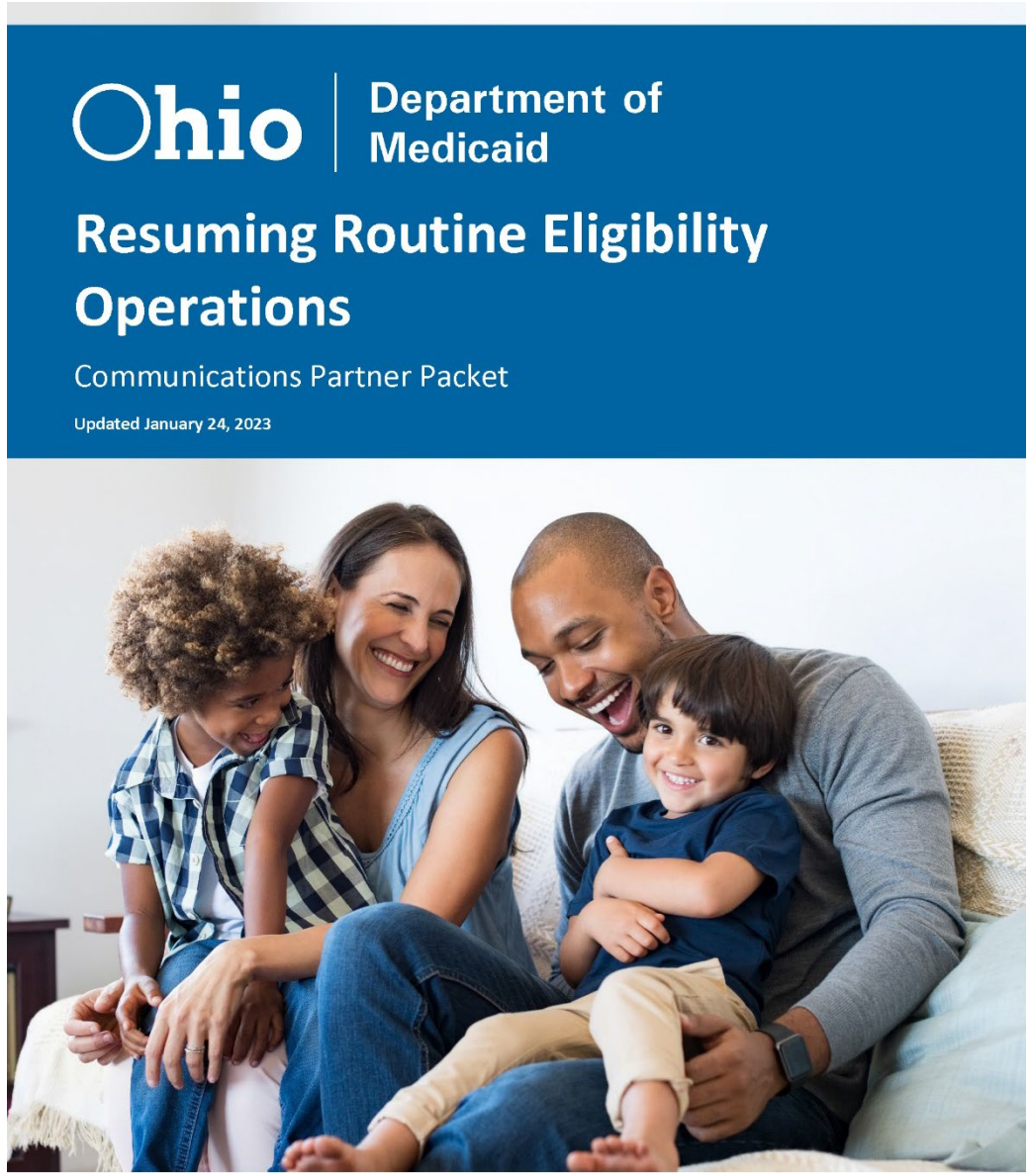
Resuming routine Medicaid eligibility operations

Updated January 13, 2023.

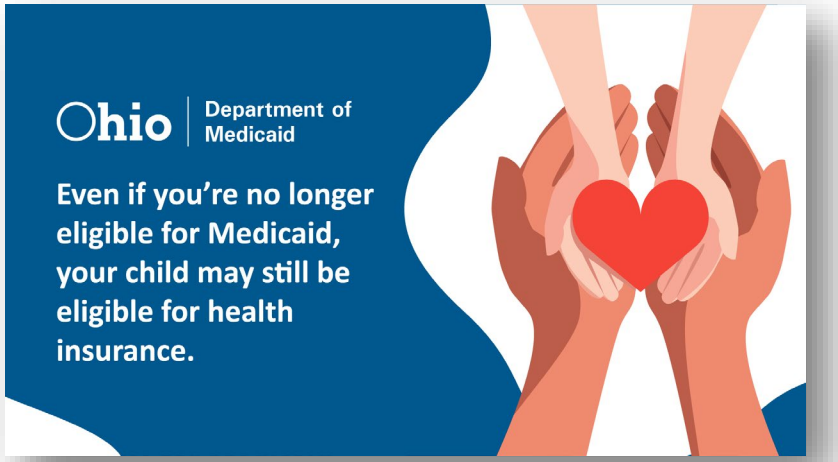


Partner Packet 2.0

- As the state gets ready for a return to routine eligibility operations, ODM has updated its partner packet to reflect recent federal actions as well as updates to its key messages for Medicaid members. Key messages in 2.0 include:
  - Update Your Contact Information
  - Watch Your Mail
  - Respond to Requests for Information
  - Complete and Mail Back Your Renewal Packet
  - Transition to Other Coverage
  - Children May Still be Eligible

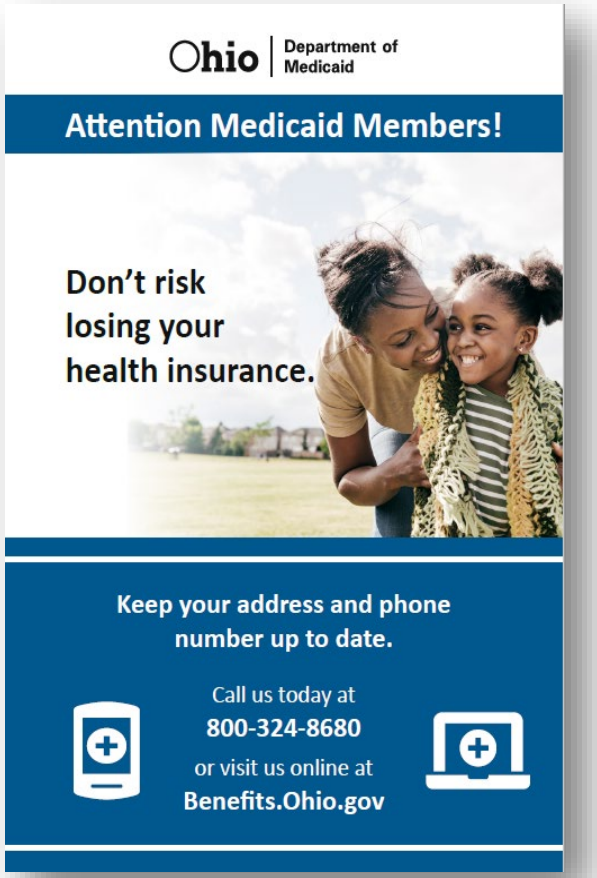


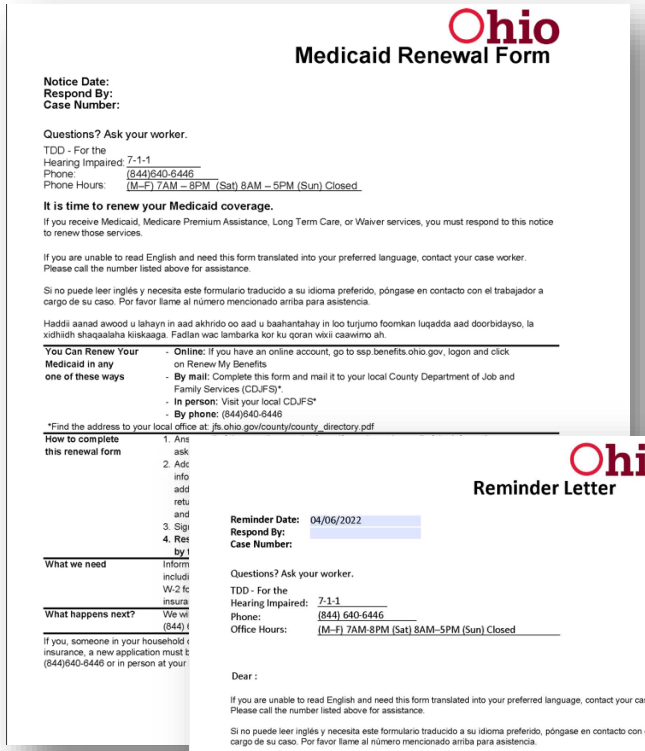
Sample Messages



TWITTER 7m ago

Ohio Medicaid needs your contact information. Otherwise, you may miss important updates about your health insurance and risk losing coverage. Visit Benefits.ohio.gov or call 1-800-324-8680 to update your contact information today.




Ohio
Medicaid Renewal Form

Notice Date:
Respond By:
Case Number:

Questions? Ask your worker.
TDD - For the Hearing Impaired: 7-1-1
Phone: (844)640-6446
Phone Hours: (M–F) 7AM – 8PM (Sat) 8AM – 5PM (Sun) Closed

It is time to renew your Medicaid coverage.
If you receive Medicaid, Medicare Premium Assistance, Long Term Care, or Waiver services, you must respond to this notice to renew those services.

If you are unable to read English and need this form translated into your preferred language, contact your case worker. Please call the number listed above for assistance.

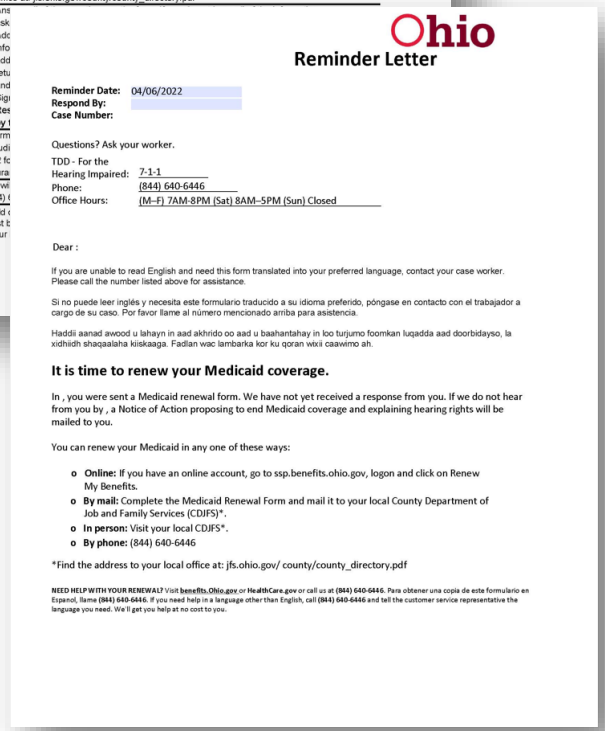
Si no puede leer inglés y necesita este formulario traducido a su idioma preferido, póngase en contacto con el trabajador a cargo de su caso. Por favor llame al número mencionado arriba para asistencia.

Haddii aanad awood u lahayn in aad akhrido oo aad u baahantahay in loo turjumo foomkan luqadda aad doorbidayso, la xidhiidh shaqaalaha kiiskaaga. Fadlan wac lambarka kor ku qoran wixii caawimo ah.

You Can Renew Your Medicaid in any one of these ways	- **Online:** If you have an online account, go to ssp.benefits.ohio.gov, logon and click on Renew My Benefits - **By mail:** Complete this form and mail it to your local County Department of Job and Family Services (CDJFS)*. - **In person:** Visit your local CDJFS* - **By phone:** (844)640-6446
How to complete this renewal form	1. Ans ask 2. Add info add retu and 3. Sig 4. **Res by**
What we need	Inform includi W-2 fo insura
What happens next?	We wi (844) (

*Find the address to your local office at: jfs.ohio.gov/county/county_directory.pdf

If you, someone in your household c insurance, a new application must b (844)640-6446 or in person at your


Ohio
Reminder Letter

Reminder Date: 04/06/2022
Respond By:
Case Number:

Questions? Ask your worker.
TDD - For the Hearing Impaired: 7-1-1
Phone: (844) 640-6446
Office Hours: (M–F) 7AM-8PM (Sat) 8AM–5PM (Sun) Closed

Dear :

If you are unable to read English and need this form translated into your preferred language, contact your case worker. Please call the number listed above for assistance.

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Haddii aanad awood u lahayn in aad akhrido oo aad u baahantahay in loo turjumo foomkan luqadda aad doorbidayso, la xidhiidh shaqaalaha kiiskaaga. Fadlan wac lambarka kor ku qoran wixii caawimo ah.

It is time to renew your Medicaid coverage.

In , you were sent a Medicaid renewal form. We have not yet received a response from you. If we do not hear from you by , a Notice of Action proposing to end Medicaid coverage and explaining hearing rights will be mailed to you.

You can renew your Medicaid in any one of these ways:

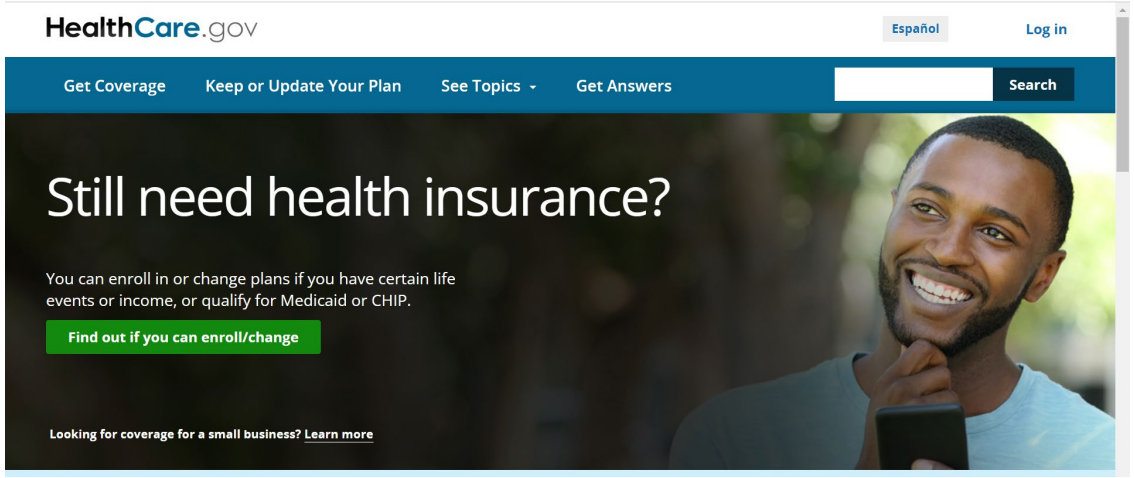
- **Online:** If you have an online account, go to ssp.benefits.ohio.gov, logon and click on Renew My Benefits.
- **By mail:** Complete the Medicaid Renewal Form and mail it to your local County Department of Job and Family Services (CDJFS)*.
- **In person:** Visit your local CDJFS*.
- **By phone:** (844) 640-6446

*Find the address to your local office at: jfs.ohio.gov/ county/county_directory.pdf

NEED HELP WITH YOUR RENEWAL? Visit benefits.Ohio.gov or HealthCare.gov or call us at **(844) 640-6446**. Para obtener una copia de este formulario en Español, llame **(844) 640-6446**. If you need help in a language other than English, call **(844) 640-6446** and tell the customer service representative the language you need. We'll get you help at no cost to you.

Other Coverage Options When Individuals are No Longer Eligible

- If a Medicaid member has been notified they no longer qualify for Medicaid, they may be eligible for other coverage options either through their employer or on the federally facilitated marketplace (i.e. exchange).
  - OB makes automatic file transfers through the exchange for individuals found ineligible (does not apply to individuals disenrolled for procedural reasons)
- ODM partnered with the Ohio Association of Foodbanks to include information on every notice of disenrollment (otherwise known as a Notice of Action) for those individuals who need assistance with other coverage options. They can visit getcoveredohio.org or call 1-888-628-4467 for help in person, online or over the phone.



OHIO ASSOCIATION OF FOODBANKS

get covered