Ohio | Department of Medicaid

Mike DeWine, Governor
Jon Husted, Lt. Governor

Maureen Corcoran, Director

Testimony to the Finance Committee of the Ohio House of Representatives

Governor DeWine's Executive Budget Proposal SFY 2022-2023

Maureen M. Corcoran, Director, ODM Feb. 10, 2021

Executive Summary

Introduction and Acknowledgments

Acknowledge the incredible work of our stakeholders and other partners in the pandemic; hospitals, MCOs, behavioral health providers, FQHCs, NFs and LTSS community providers

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

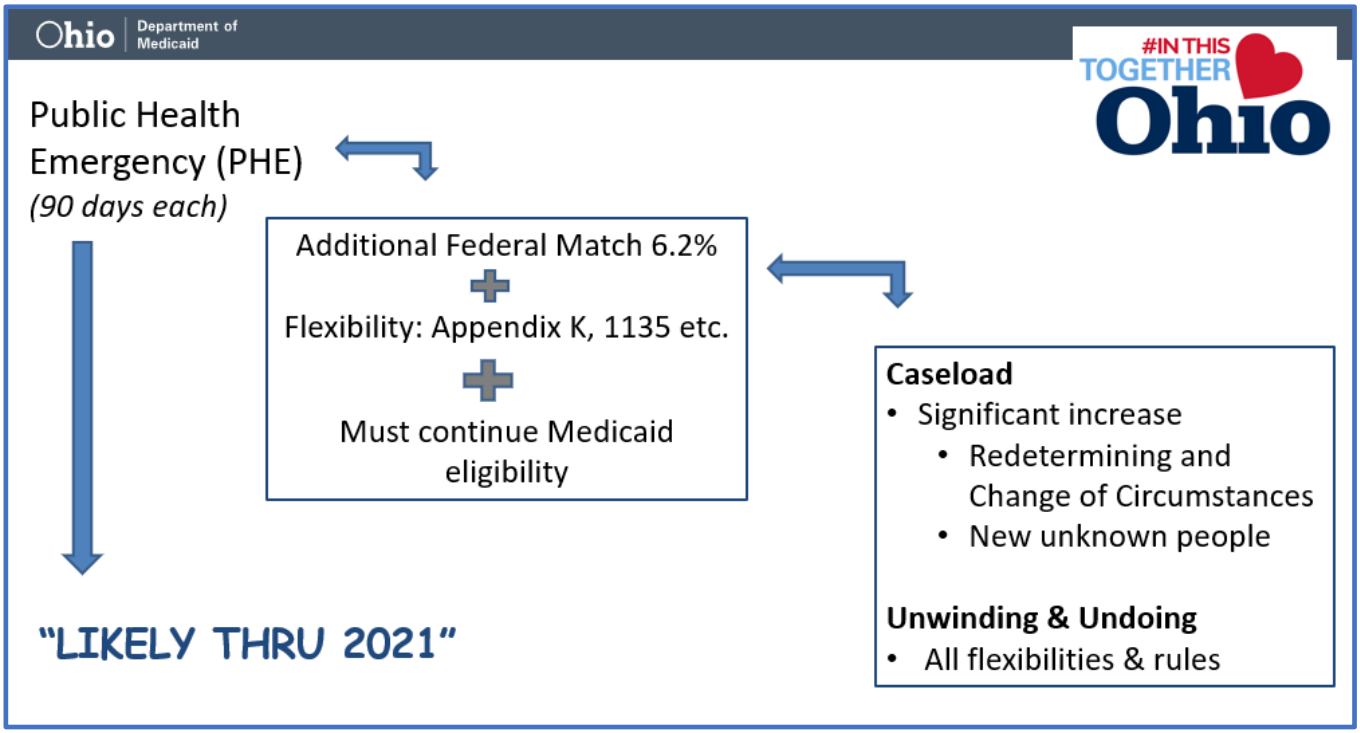
ODM Priorities:

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.

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.
- Despite these dynamics, the Medicaid Executive Budget supports the Governor's priorities while keeping spending at or below national trends.

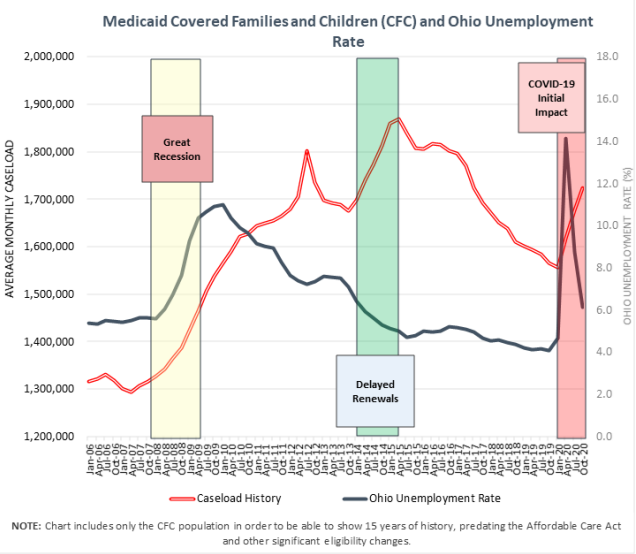
Part 1 SFY 22-23 Financial Drivers: PHE, Enhanced FMAP and Caseload



- 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)



Pg.10 Fig. 7 Demonstrates the inverse relationship w CFC enrollment & Ohio

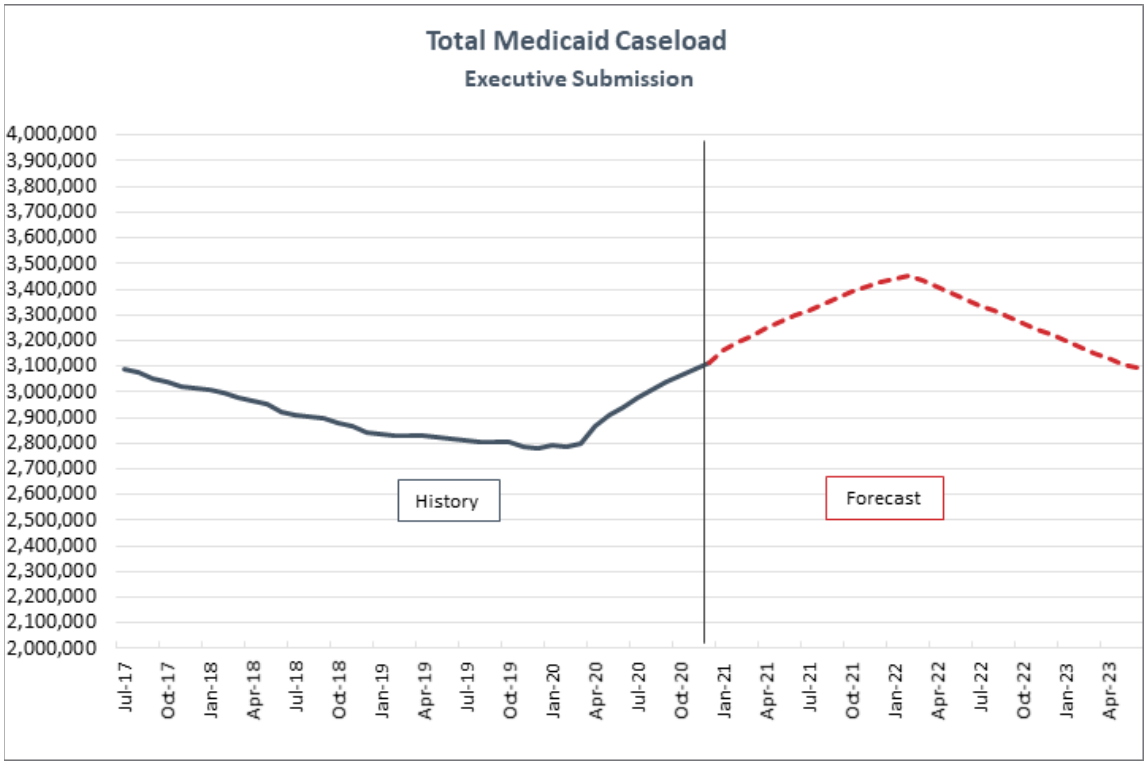


Figure 1: Anticipated caseload projected to continue to increase during public health emergency when Ohio receives enhanced federal funding before declining throughout remainder of biennium.

Overview of 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 when 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 here in Executive summary and on last page of complete testimony

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

	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.2

	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%

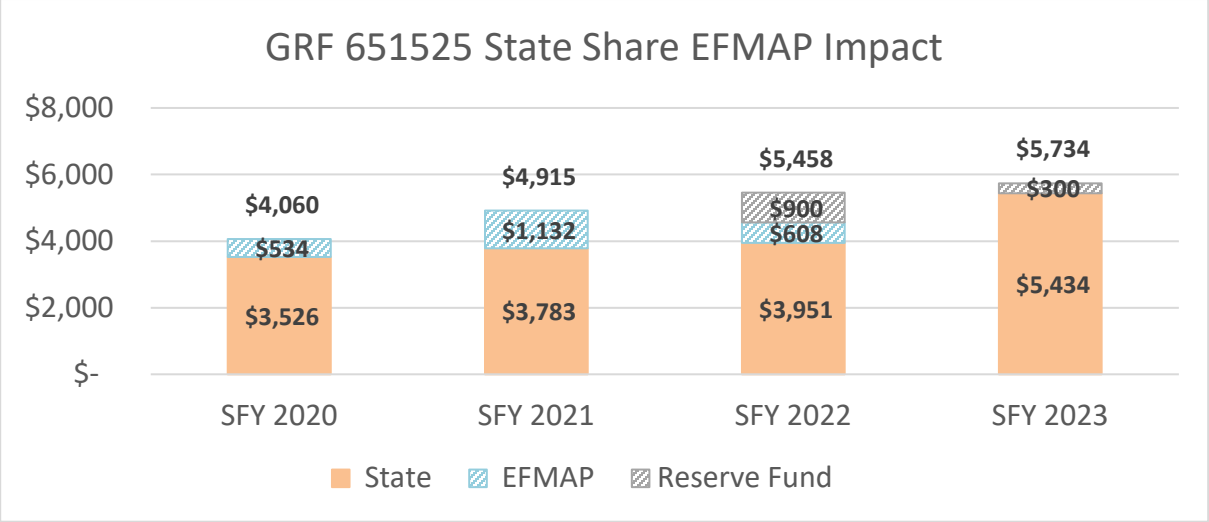


Figure 3: Additional funding realized from EFMAP provided by the CARES Act. Pg.5

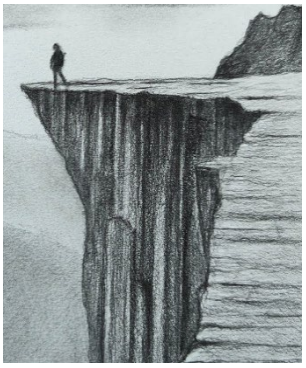
A Preview of Unwinding from the PHE

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

- Prior to taking any action to terminate an individual from the program, ODM must follow federal rules requiring advance notice to each individual of any potential negative action and a personal 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 individuals in "Month 1" following the PHE: one year later, case workers would need to review the same "bulge" of several hundred thousand cases at once.
  ODM expects the review of routine terminations following the pandemic to stretch over a number of months, and it could take years to smooth out the bulges.
  Many months ago, ODM started working intensively with CMS to anticipate requirements and timelines so we can be as prepared as possible to "unwind" when the time comes.

Summary of the PHE

The money CLIFF



The caseload "pig in the python"

New Voluntary Community Engagement Program

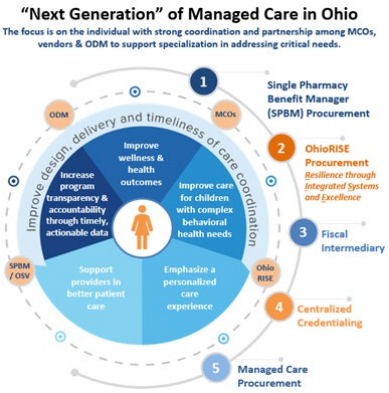
- Discussions with the Trump Administration in mid-2020 indicated that the program could not proceed, in light of the federal PHE and the prohibitions on eligibility and coverage changes.
- ODM will proceed with a voluntary work program, to serve as a bridge to our mandatory waiver program.
- Ohio joined as amicus in Gresham vs Azar. ODM agreed to modification of terms/conditions of waiver to enable discussion, if CMS changes their position.
- Our goal is to create opportunities for individuals to link with meaningful work and community engagement programs prior to the conclusion of the PHE. ODM's critical preparation for this time goes beyond the strict parameters of traditional Medicaid; our actions to implement the voluntary program prior to the end of the PHE will help build the necessary infrastructure to connect Ohioans with meaningful employment. Funding for the program is included in the baseline budget for ODM.

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.15*
- *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.17*



Managed Care Cost Containment and Risk Corridor Strategy

- 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 CY21in recognition of claims cost uncertainty attributable to the COVID-19 pandemic and associated state policy changes.
- Discussions are ongoing with the MCOs and CMS regarding the implementation of the risk corridors for the opt-in population of MyCare.
- 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 $150million. 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

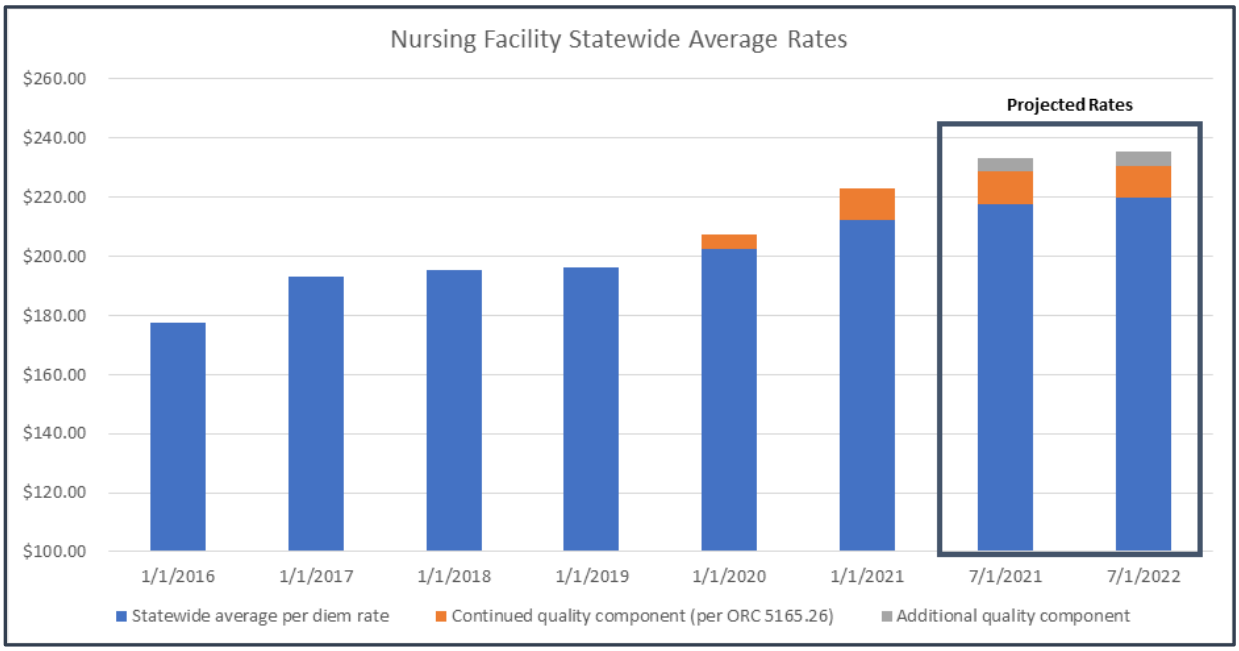
Two years ago, during the deliberations on HB 166, we discussed at length with members of the General Assembly the procurement of the Medicaid managed care program. Working closely with you in the legislature, we proceeded to engage stakeholders and Medicaid members through in-person listening sessions and multiple requests for information. Throughout months of complex system design and approvals with our federal partners at CMS, we kept members of the Joint Medicaid Oversight Committee apprised of developments within the legal bounds of the active procurement. The design and related posting of competitive procurements are now complete; three of the five vendors for our major procurements have been announced. We remain in the "quiet period" as we prepare to announce the final awards. The five interlocking components, are reflected in Figure 10 above.

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

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.21

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

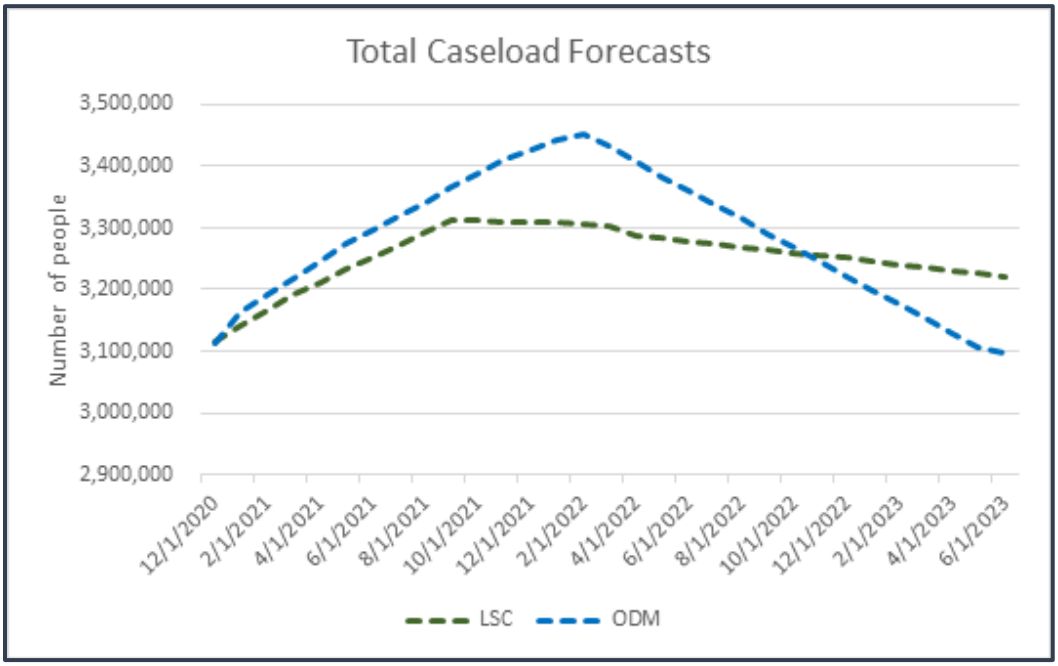
- Overview of the quirks and irregularities of the PHE, the cliff and the pig in the python
- With a disciplined approach from the outset of the pandemic, we have prudently managed the taxpayers' resources, maintained access to services, and done all we can to prepare for the transition out of the public health emergency without causing unnecessary strain on the state's resources.
- 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.

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%

Testimony to the Finance Committee of the Ohio House of Representatives

Governor DeWine's Executive Budget Proposal SFY 2022-2023

Maureen M. Corcoran, Director, Ohio Department of Medicaid

February 10, 2021

Chairman Oelslager, Vice-Chair Plummer, Ranking Member Crawley, and members of the House 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.

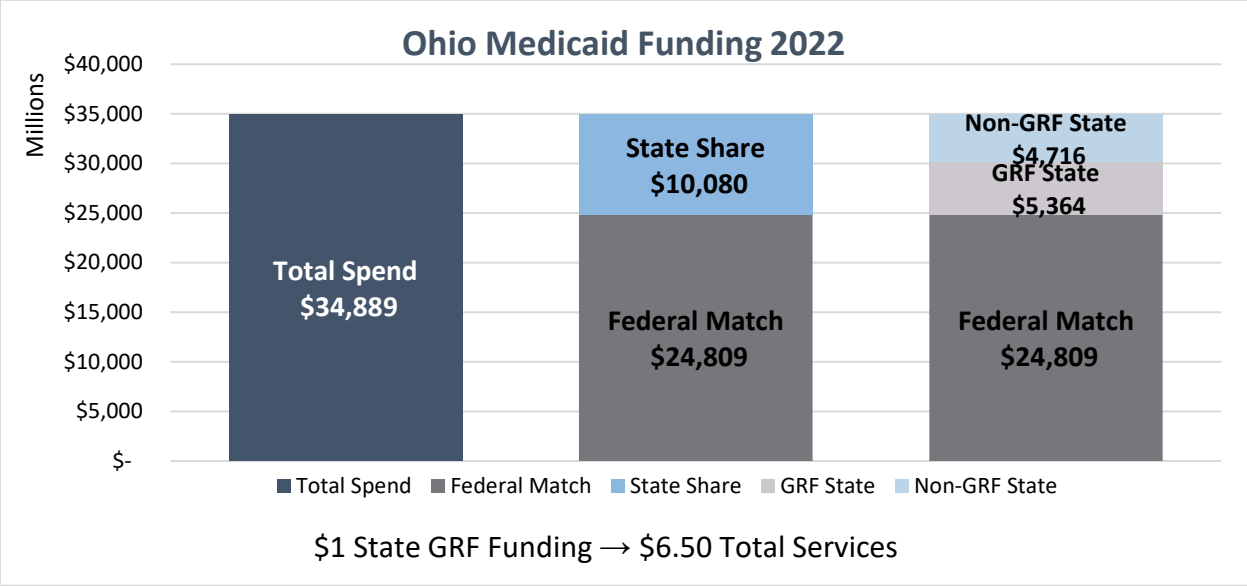


Figure 1: In SFY 22, the Medicaid program is 71% federally funded

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%

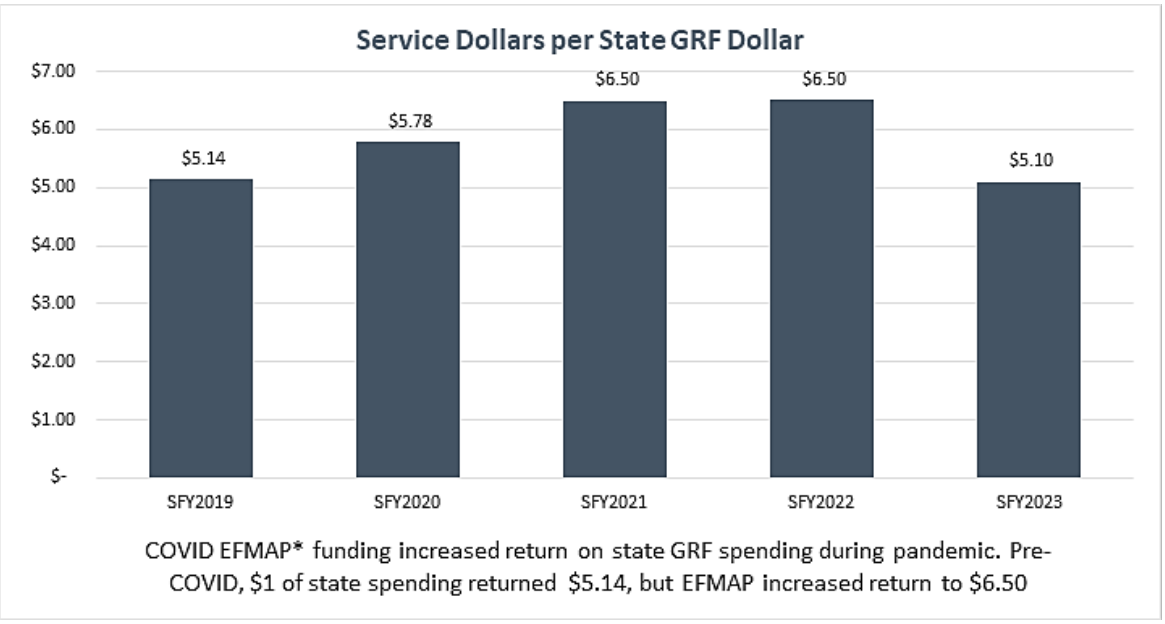
With the December 2021 end in mind, Medicaid will need to take on a greater proportion of state GRF funding for the program beginning in CY 2022, ODM will have an elevated caseload and a return to the normal federal/state split, accompanied by a return to normal program requirements and operations. However, 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



***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.

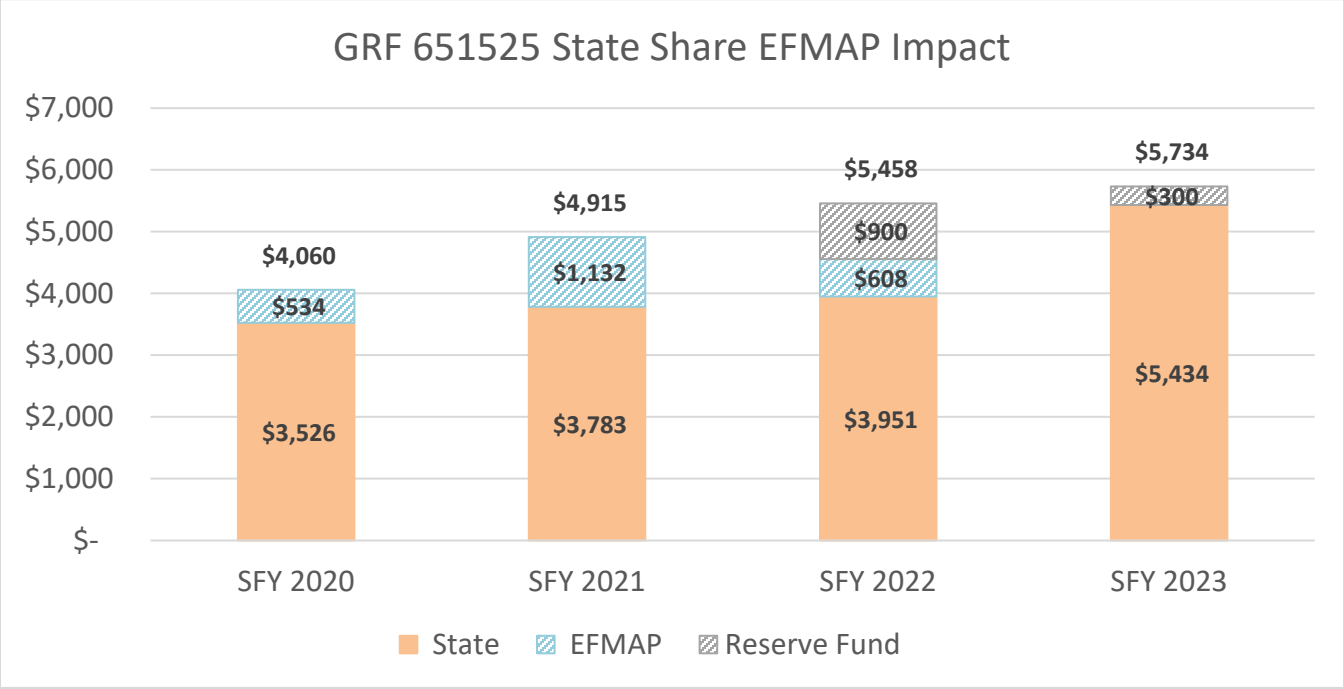


Figure 3: Additional funding realized from EFMAP provided by the CARES Act

ODM Program Administrative Cost

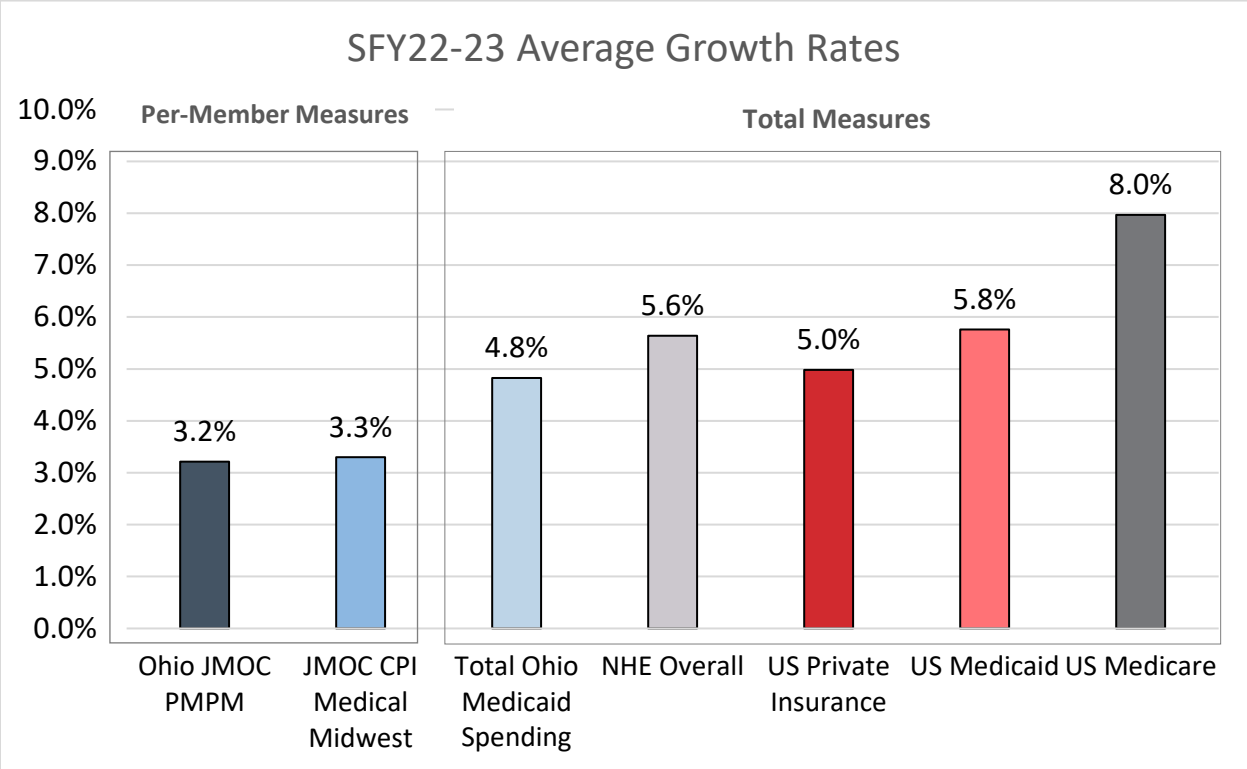
Ohio consistently ranks below the national average of 5% for Medicaid administrative expenses. More than 95% of the agency budget purchases health care services from hospitals, medical practitioners, federally qualified health centers (FQHC), behavioral health providers, pharmacies, and long-term care 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 (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. 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%.**

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

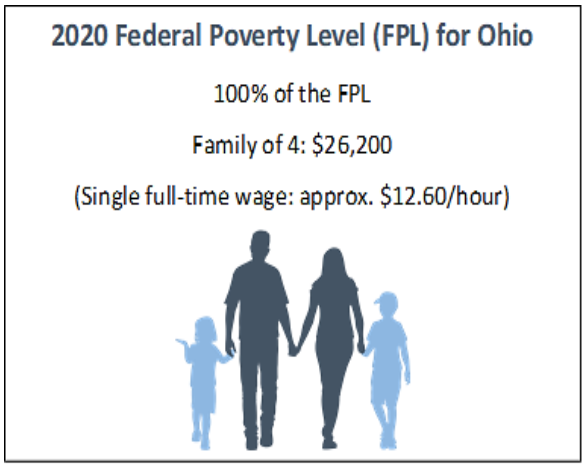
Figure 4: SFY22-23 average growth rates

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

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.

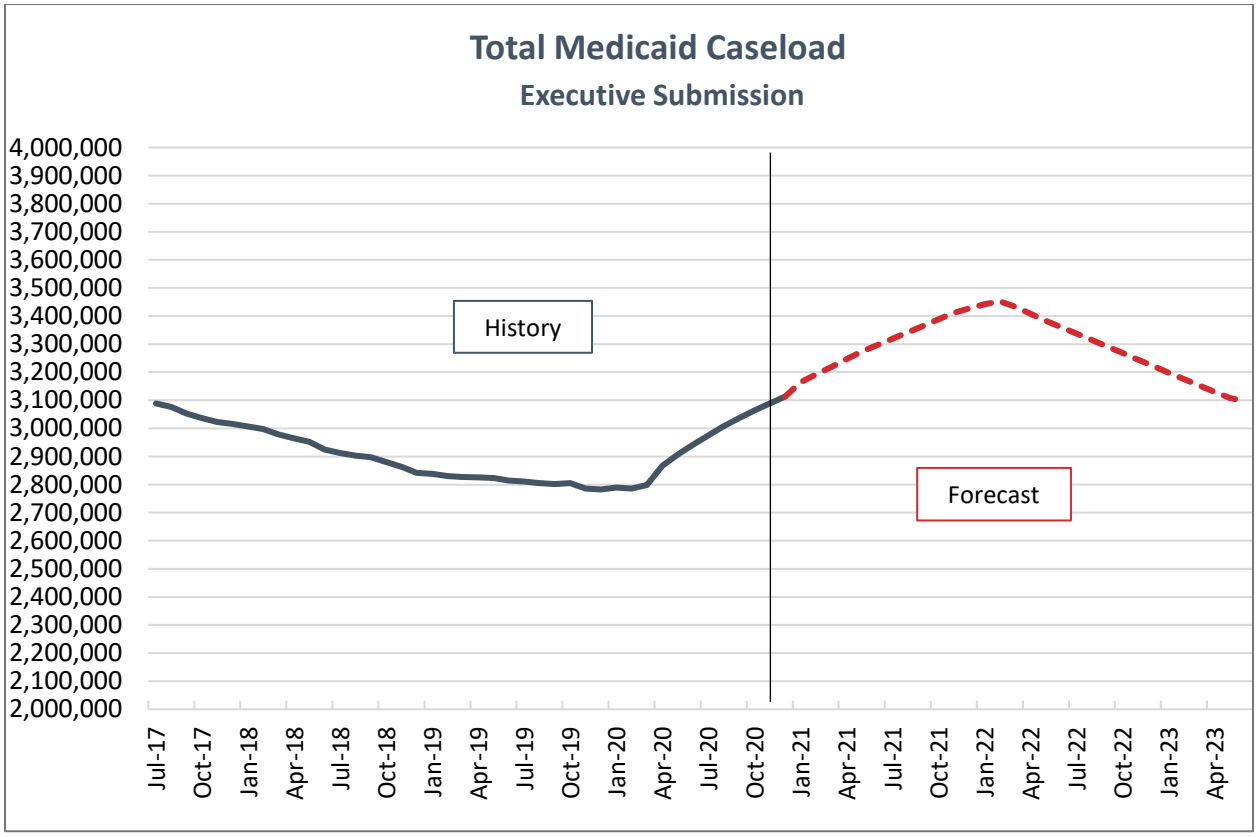


Figure 5: Anticipated caseload projected to continue to increase during the public health emergency when Ohio receives enhanced federal funding before declining throughout remainder of biennium

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.

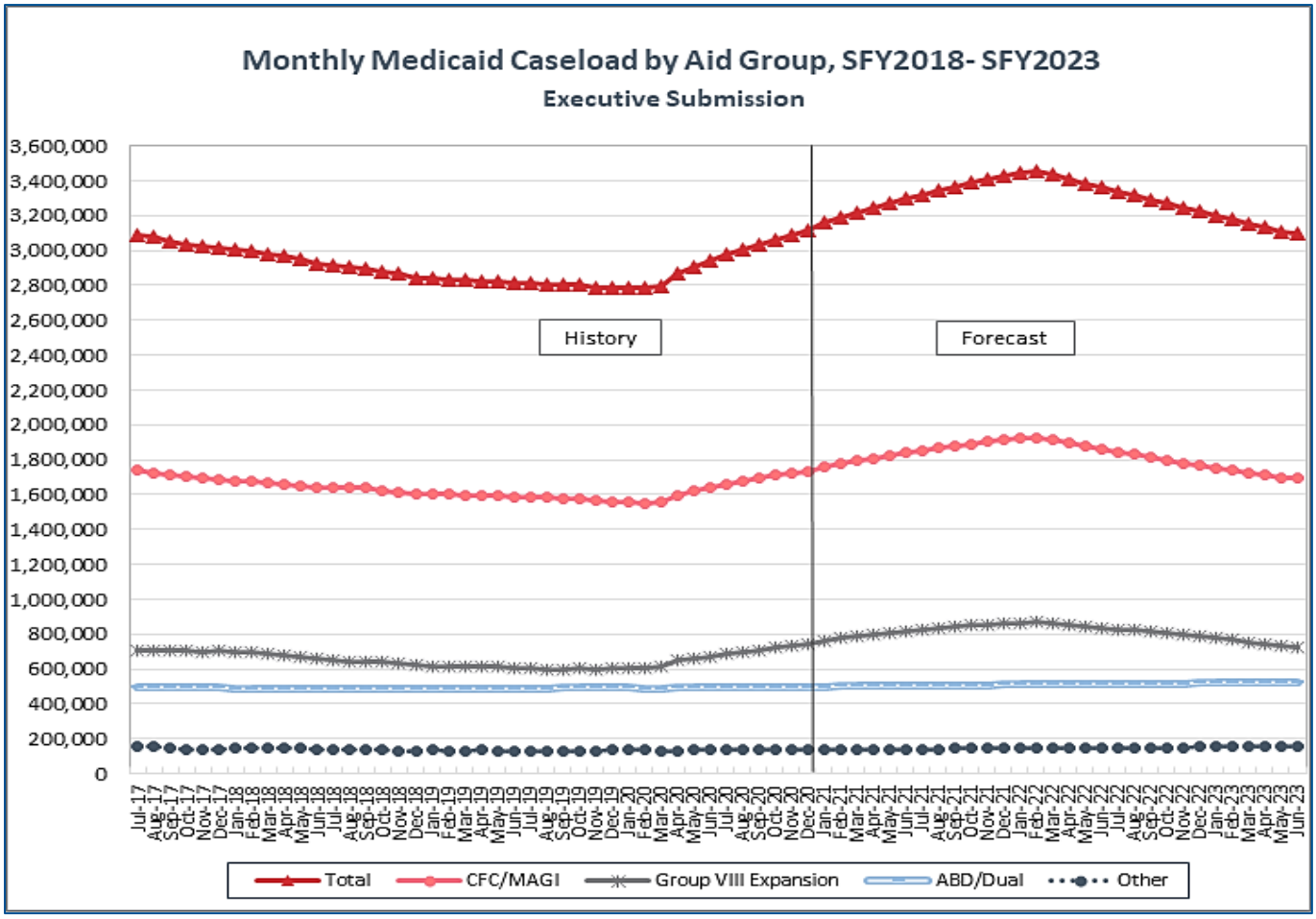


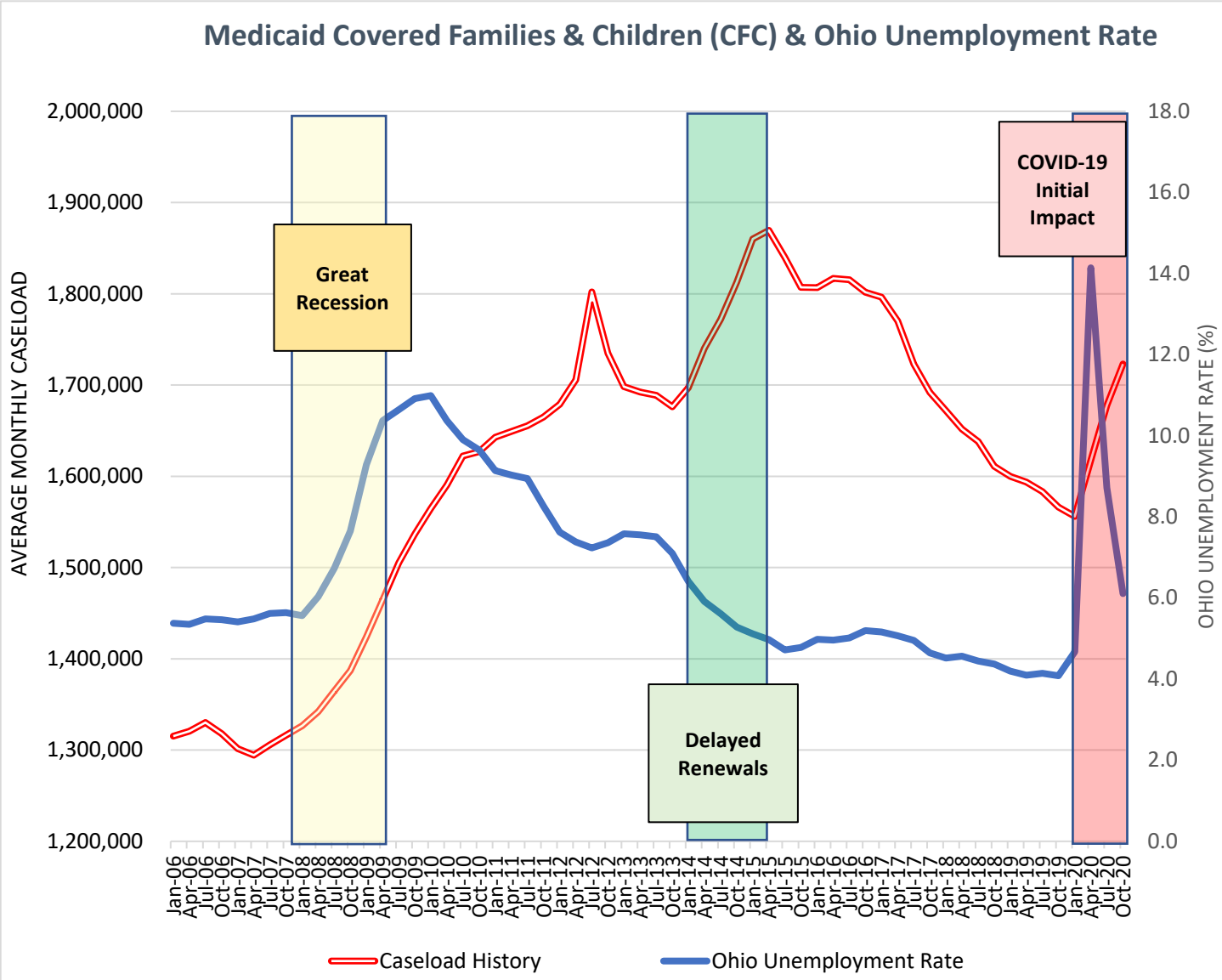
Figure 6: Trendline of historical and projected caseload through SFY23 by eligibility group

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.



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.

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

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

Ohio Medicaid's 1115 Work and Community Engagement Requirement was approved by 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. Alternatively, ODM will proceed with a voluntary work program, to serve as a bridge to our mandatory waiver program.

Other states have similarly proposed mandatory work requirement programs. These initiatives across the nation are on pause until a challenge is 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. Ohio also agreed to a request by the federal government to adjust Ohio's work requirement waiver to allow Ohio to better engage in discussions about the merits of the Ohio program if the federal government changes its position on this topic.

Our goal is to create opportunities for individuals to link with meaningful work and community engagement programs prior to the conclusion of the PHE. ODM's critical preparation for this time goes

beyond the strict parameters of traditional Medicaid; our actions to implement the voluntary program prior to the end of the PHE will help build the necessary infrastructure to connect Ohioans with meaningful employment. Funding for the program is included in the baseline budget for ODM. Profile of Jobs and Individuals

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.

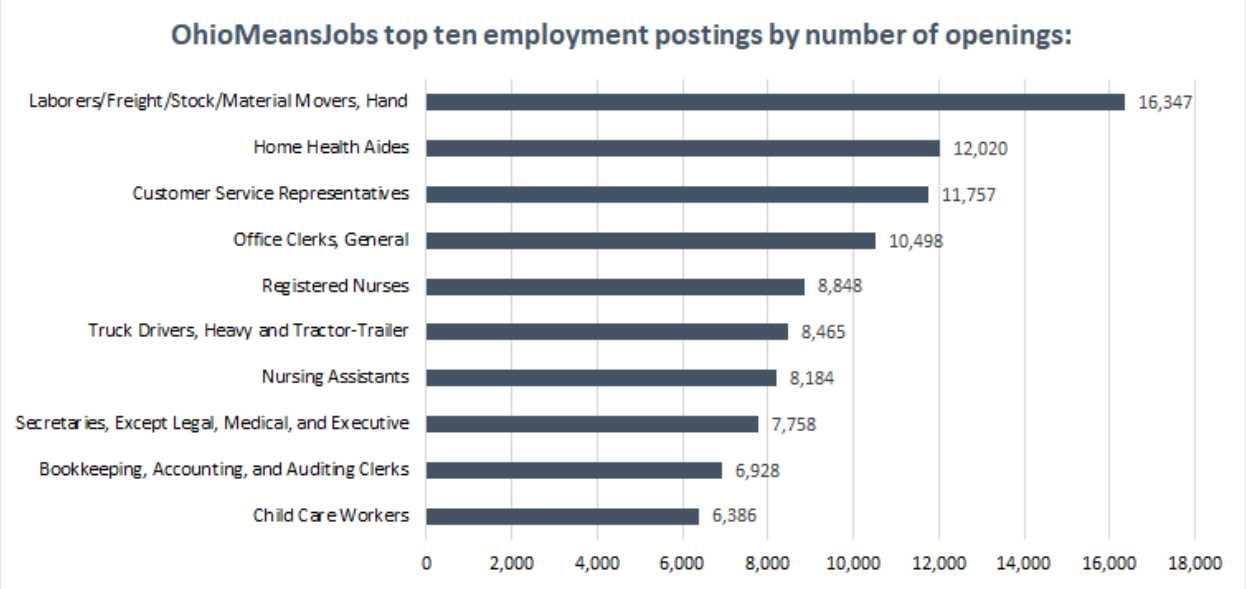


Figure 8: The number and type of available jobs

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 and 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 one

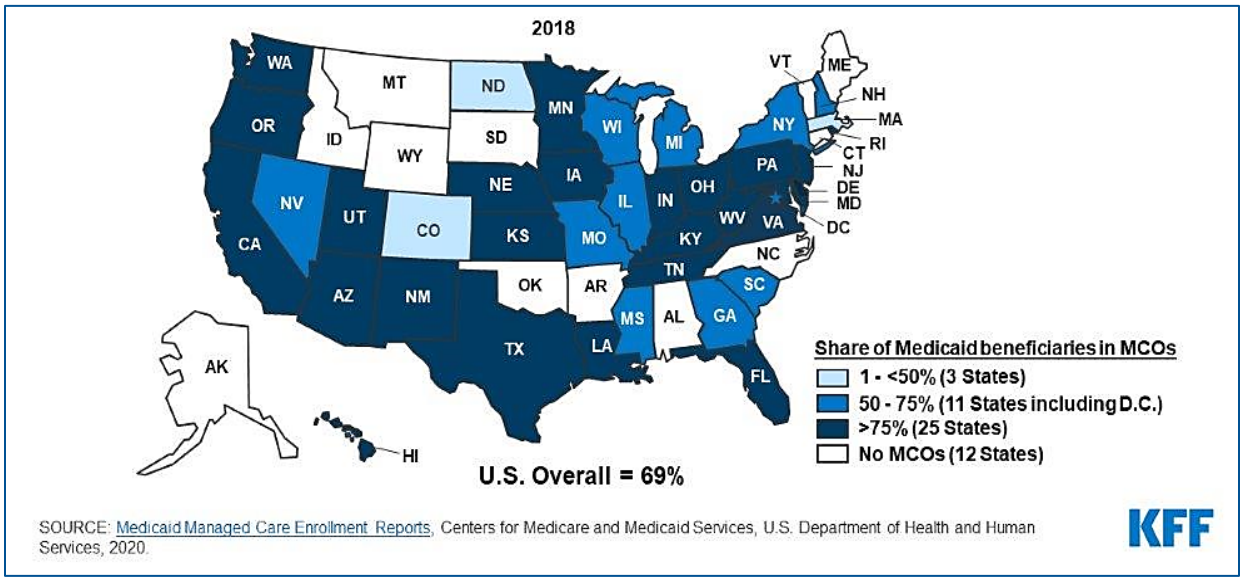


Figure 9: States' share of Medicaid population covered by managed care organizations, as of July 1, 2018[1]

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.

[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

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 have to 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 at CMS, we kept members of the Joint Medicaid Oversight Committee apprised of developments within the legal bounds of the active procurement. The design and related posting of competitive procurements are now complete; three of the five vendors for our major procurements have been announced. ODM remains in the "quiet period" as we prepare to announce the final awards. The five interlocking components are reflected in Figure 10 below and include: 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. Go-live with the new partners and services is scheduled for January 2022.

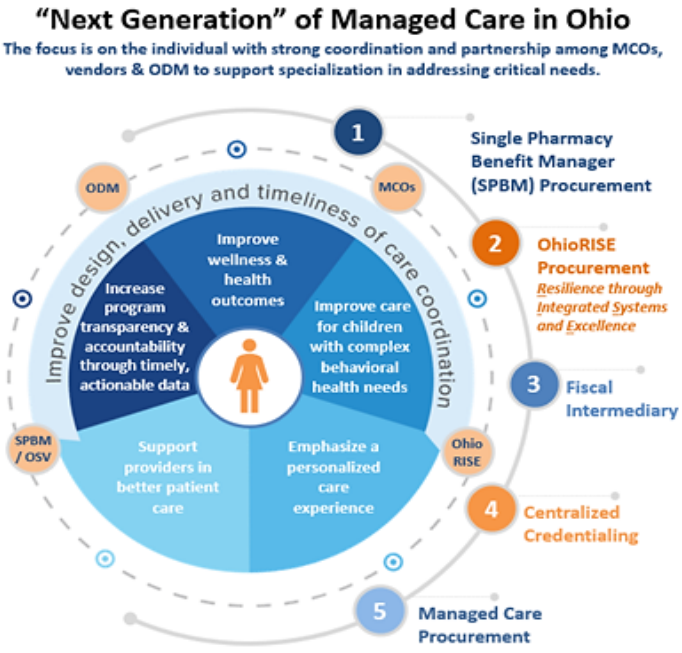


Figure 10: Ohio Medicaid's next generation managed care framework

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 in and 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 due to COVID-19.

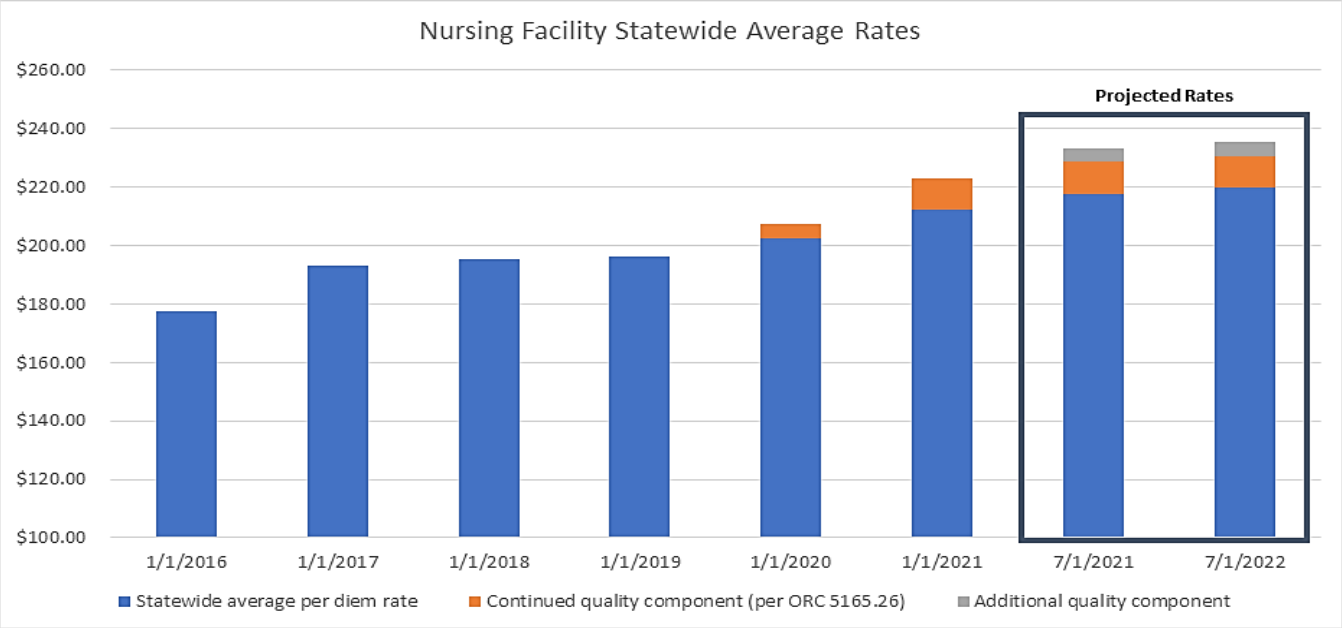


Figure 11: Nursing facility statewide average rates

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

Table 4: 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.

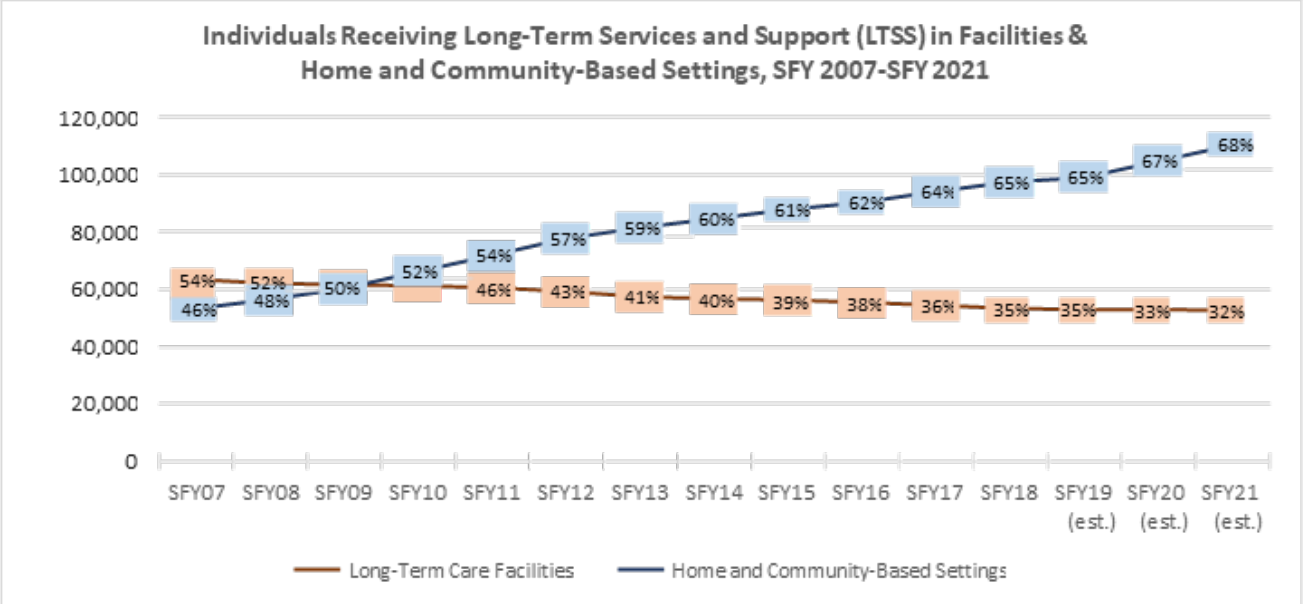


Figure 12: Rebalancing of Ohio's Services with an increase in home and community services

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.

Discussions are ongoing with the MCOs regarding the implementation of the risk corridors for the opt-in population of MyCare.

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.

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.

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%