



# Department of Medicaid

Mike DeWine, Governor  
Jon Husted, Lt. Governor

Maureen M. Corcoran, Director

TO: Governor Mike DeWine

1/13/20

FROM: Maureen M. Corcoran, Director Ohio Department of Medicaid

RE: 2019 Year End Summary

Early in my tenure, I communicated in budget testimony before the House and Senate Finance committees that, as a nurse, I am accustomed to “cleaning up messes.” It has become clear that the state of Medicaid program, as we inherited it, was a mess.

As one example, very shortly after I began my tenure, I learned that, per the timelines established by the prior administration, we were less than one week away from implementing major changes with an Electronic Visit Verification (EVV) program for authorizing payment for home and community-based services for elderly and disabled Ohioans. Had this occurred, stunningly, *approximately 2/3 of provider payments would have been denied*. The results would have been dramatic for consumers and providers. Our team, with significant stakeholder communication and additional testing, is carefully progressing and satisfying the federal requirements. We are not imposing financial consequences until providers are adequately trained and able to use the EVV system. And when a program is not ready, or isn’t working, ODM will take the time to identify the problem and pursue a solution.

The purpose of this letter is to inform you of our recent communication with the Centers for Medicare and Medicaid Services (CMS) regarding some of the inherited “messes” within the Medicaid Program, including Ohio’s Payment Error Rate Measurement (PERM) audit for state fiscal year 2018 (July 1, 2017 to June 30, 2018). Further, my intent is to provide a summary of the state of the Medicaid program as it was inherited after the administration change and the efforts the Medicaid team has undertaken to stabilize it. While every Medicaid program in the country encounters challenges, Ohio’s Medicaid program needs considerable repair, collaboration, time and resource investment.

## **Payment Error Rate Measurement (PERM) Audit**

On November 26, 2019, we received Ohio’s PERM audit results referenced above. Ohio is actively engaged with CMS and must submit a Corrective Action Plan by February 24, 2020. On December 16, we held an exit conference by phone with CMS related to these results, and since that time have had several more discussions with them about Ohio’s compliance activities. We are expecting additional written communication from CMS shortly.

Of concern, the CMS report indicated that during fiscal year 2018 (FY18) Ohio was above the national average in payment errors, with Overall Payment Error Rates of 44.28% for the Medicaid population and 55.41% for the Children’s Health Insurance Program (CHIP) population. Among the 17 states sampled in this cycle of audits, Ohio ranked last for Medicaid and second to last for CHIP.

Ohio's error rate for eligibility determination for Medicaid is 43.49%, double the national average of 20.6%. This finding indicates that appropriate documentation was not properly maintained or stored to verify eligibility of beneficiaries.

CMS's communication points out that the findings do not necessarily represent improper payments or that those individuals were not eligible to receive benefits; "Please note that improper payments do not necessarily represent expenses that should not have occurred".<sup>1</sup> Instead, it demonstrates that Ohio did not adequately follow timely administrative processes. Many of the audit findings relate to delays in making eligibility determinations. Though Ohio Medicaid does not fully agree with CMS's interpretation that some payments do not meet statutory, regulatory, and administrative requirements, the report itself illustrates the magnitude of problems with Ohio Benefits and administrative controls for Ohio's Medicaid program.

States with PERM audit findings that include higher-than-acceptable error rates can face large financial penalties from CMS when the findings exceed the permissible error rate in two consecutive audits. Since this is Ohio's first audit under this new CMS protocol, CMS will not levy significant financial penalties. Our repayment will be approximately \$88,000. CMS indicates, however, that its extrapolation of the first PERM error rate to establish the fiscal penalty would result in approximately \$5.9 billion dollars owed by the state of Ohio to the federal government.

If Ohio exceeds the accepted error rate in the next audit cycle and does not demonstrate "good faith" to meet the accepted error rate, Medicaid could face significant financial penalties. Because we are already in the sampling time period for the second audit and it will take considerable time to fix the system, our continued collaboration and good faith efforts with CMS will be essential to prevent a future fiscal penalty.

### **State of Medicaid Program**

As I also noted earlier, my intent with this letter is to summarize the state of the Medicaid program. Ohio Medicaid has encountered numerous challenges requiring my team to dedicate considerable resources—both human capital and financial resources—to repairing issues inherited by the DeWine Administration. The issues include structural issues that could have a significant fiscal impact, policy issues that have required corrective action, and changes in priorities.

### ***Structural Issues with Fiscal Impact***

#### **1. Audits and internal controls: Gaps in oversight and potential for significant financial penalties**

While shocking, the PERM audit discussed above is not the only illustration of what we inherited. Other recent audits of Medicaid have demonstrated that Medicaid previously lacked the management focus and critical infrastructure to effectively monitor the program. Instead of further kicking the can down the road, since January 2019, we have diligently made improvements and progress on numerous issues. We have reorganized the relevant divisions of Medicaid, made changes in key staff positions, improved internal processes and communication, and improved

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<sup>1</sup> Chrissy Fowler, Director Payment Accuracy and Reporting Group, Centers for Medicare and Medicaid Services. *Ohio PERM Medicaid and CHIP RY19 Error Rate Notification*. November 26, 2019. page 2.

cross-agency collaboration. We have proactively engaged the Office of Budget and Management to conduct several targeted program reviews, with particular emphasis on management oversight. In September 2019, I reviewed this generally with the Joint Medicaid Oversight Committee (JMOC).

As a large state agency, Medicaid is routinely audited. With many audits focusing on past years under the leadership of the prior administration—years when the defects in Ohio Benefits and other issues described above were compounding—we can expect that these audits will uncover more challenges for our agency. The list below provides a small sample of ongoing and recent audits.

- Capitation Payments that were Duplicative or Improper, HHS Office of Inspector General (OIG) (audit period July 1, 2014 to June 30, 2015). Final report released. The audit determined that Ohio made duplicative capitation payments, made payments that did not correspond with the beneficiary's eligibility status or category, made capitation payments that did not correspond with the beneficiary's age or gender; because eligibility system controls did not prevent them, payment system controls did not adjust them, or users entered incorrect data in the eligibility system. Duplicative capitation payments made to the managed care plans must be recouped.
- Group VIII Eligibility, HHS OIG (audit period October 1, 2014 to March 31, 2015). Final report pending. This audit is reviewing Medicaid's determinations of eligibility for newly eligible members.
- Managed Care Deceased Beneficiaries, HHS OIG (audit period July 1, 2014 to June 30, 2016). Final report released. The audit determined that Ohio should have recovered capitation payments made for deceased beneficiaries from managed care plans in the amount of approximately \$50 million dollars.
- MCO Concurrent Eligibility, HHS OIG (audit period July 1, 2018 to September 30, 2018). Final report pending. This audit is reviewing whether Medicaid made capitation payments on behalf of members with concurrent eligibility in another state.
- Public Interest Audit on Eligibility, Auditor of State (audit period July 1, 2018 to June 30, 2019). Final report pending. This ongoing audit is evaluating whether eligibility is being determined in compliance with select requirements.

## **2. Unaddressed Medicaid caseload backlog and Ohio Benefits**

As you may recall, Ohio Benefits is an information technology application that supports the Departments of Medicaid (ODM) and Job and Family Services (JFS). It is a proprietary system, owned by Accenture, and customized by it and other contractors to meet Ohio's specific integrated benefits needs. It is not owned by the State of Ohio; rather it is licensed by the State. The original request for proposal was issued by the Department of Administrative Services (DAS) in 2012, with the first phase of Ohio Benefits going live in 2013. Because the underlying system is proprietary to Accenture, future use will require continued license and maintenance agreements with, or the outright purchase of the system from, Accenture.

Within the first week of taking office, I was notified by CMS that the backlog of Medicaid eligibility cases in Ohio was longstanding and unacceptable. CMS noted its

appreciation of the seriousness with which we immediately approached this problem, but indicated that repeated, inadequate responses by the prior administration required it to take further action.

Since February, Medicaid has worked aggressively and collaboratively with county partners to address human errors following administrative processes and with DAS and JFS to address Ohio Benefits issues. We hold weekly meetings with CMS to discuss progress on our corrective action plan. We've added twenty-five staff for trouble shooting and technical assistance. Medicaid's efforts to address the backlog over the course of the year are documented in budget testimony and in the September JMOC presentation, as well as in interviews with the media. Today, Medicaid's team has re-established constructive working relationships with county partners and reduced the backlog by approximately 70%. Additionally, ODM has completed on-site visits to over 25 counties, helping some counties to reduce their backlog to near zero.

### **3. Ohio Benefits: Process and information technology systems defects**

Implemented in 2013 in order to comply with the Affordable Care Act (ACA), the Ohio Benefits system has cost \$1.2 billion dollars to date. Replacing a thirty-year old eligibility system, it was intended as a simplified, online application process for various benefits, including Medicaid eligibility. Highlighted as a priority for the last administration, numerous components and functionality were added. Unfortunately, it appears that the messaging may have been more important than the basic functioning of the system, which calls into question our ability to trust the data output from the system to make multi-billion-dollar decisions. Additionally, with the implementation of the ACA, CMS did not keep to its regular schedule of auditing state Medicaid programs. The delayed audits of state eligibility programs allowed technology issues like those with Ohio Benefits to go undetected for years.

Multiple audits and performance reviews conducted by federal and state accountability agencies have implicated defects with Ohio Benefits. However, Ohio's PERM error rate described above demonstrates the *degree* to which basic system functioning was ignored and the *magnitude* of potential fiscal penalties for the state of Ohio for years to come.

While I question why significant issues and defects with the Ohio Benefits system were left unaddressed by the leadership of the prior administration, we have been working diligently with CMS to ensure that the Ohio Benefits system is repaired and to avoid future financial penalties. To put in context the gravity of our task ahead, in early 2015, Ohio had identified about 300 defects associated with Ohio Benefits. These 300 defects were categorized as "requiring immediate attention and repair". The prior administration allowed the defects to continue to grow at an alarming rate through the close of 2018. An April 2019 report from our independent verification vendor indicated that "during calendar year 2018, the system generated 18-20 critical/high defects per week". *Today, we are faced with nearly 1100 system defects.*

Each defect creates the risk of an eligibility-documentation error or another type of error. Each defect adds substantial time to day-to-day program operations for case workers. By way of example, the defects have necessitated 1765 "work arounds." These work-arounds require staff to go through multiple time-consuming manual steps to complete routine tasks. This additional work would not be necessary if the system were properly functioning.

The defects are also compromising the integrity of member privacy. In 2019, twenty-two separate privacy incidents have occurred, stemming from network defects such as improperly-linked member portals. The privacy incidents have affected over 700 Medicaid members and Medicaid staff have spent hundreds of hours addressing these issues and preparing federal reports and notices to affected members. For each incident, we properly adhered to federal and state policy regarding notice and additional protections for the individual.

Here are a few examples of the numerous defects within Ohio Benefits:

- The Ohio Benefits system allows overwriting of eligibility data and documentation. This is eliminating the historical documentation needed to prove that member eligibility was properly established for audit purposes.
- Many eligibility documents are hidden in tables accessible only by Medicaid's vendor and are not accessible by caseworkers, auditors, or Medicaid IT staff.
- The system is ascribing incorrect dates for renewals causing late renewals or in some cases failing to trigger a renewal at all.
- The system is allowing duplicate member identifications, potentially resulting in paying a managed care plan more than once for the same person.
- The system is not tracking whether it is properly submitting all required IRS forms.
- System errors have caused hundreds of privacy incidents where members received mail for other members and members have been able to access the portals of other members.
- For years, stakeholders have complained that the system is not providing appropriate access for individuals who have visual challenges or speak English as a second language.
- The system auto-populates new browser windows when a case worker does not close a prior case file. This results in the wrong data uploaded into a case file.
- The system sometimes incorrectly links newborns to individuals who are not their actual parents. For example, we discovered an instance where the system linked a newborn to an eleven-year-old child.
- The system allows multiple ways of inputting data such as "male," "m," "ma," or "2." This configuration defect creates numerous problems when assessing and aggregating data.
- The system does not automatically prompt the caseworker to "ping the federal hub," which is a procedure to confirm citizenship and verify income.
- County workers are reporting that the Ohio Benefits system is causing some individuals' applications for benefits to disappear.

The Ohio Benefits defects have made it even more difficult and time consuming to respond to audit findings. On average, audits with 100 cases that include error findings require in excess of 300 total review hours from Medicaid, DAS and the Ohio Benefits vendor to find eligibility-

related documents and research the findings. Thus, an audit that involves 500 cases with findings requires about 1500 hours of work, including about 1000 hours of Medicaid staff time.

Fortunately, JFS programs, such as SNAP and TANF, do not appear to be experiencing the difficulties encountered by Medicaid. But it is likely that every Medicaid staff member and every county eligibility worker has been affected by the Medicaid-related defects in Ohio Benefits. Processing applications requires more time that affects individuals and providers. Day to day work processes take much longer. Audit responses and coordination require more time. Privacy officers dedicate significant time responding to each new privacy incident caused by the system. Technical assistance and eligibility are more time-consuming and more complex than they should be.

Medicaid, JFS, and DAS have been working closely to manage this situation, with regular meetings of the Directors and Senior IT staff every other week. Teams of people are working every day and additional staff have been added. Led by the state Chief Information Officer of DAS, cross-agency teams, including the Ohio Benefits vendor's staff, are recreating audit findings and additional assessments are being conducted to get to the root cause of the system deficiencies. With this information, we will be contracting for an external review of the system. Finally, continued collaborative work with CMS is essential to our ability to mitigate future financial penalties.

We are committed to repairing the flawed system that we inherited and to tackle these issues head on. This could have been prevented, or at least mitigated, had the past administration acknowledged and addressed it, rather than kicking the can down the road. We will continue to openly communicate with you and the members of the General Assembly about our progress, but this will take years to fix.

#### **4. Managed Care: Capitation rate corrections**

Calendar year 2019 continued an overall decline in the Medicaid caseload that began in March 2017. The declines overall in the caseload and specifically for kids have been the subject of much interest from the stakeholders and the media. We have gone to great lengths to analyze and provide explanation, publishing two white papers with our findings—one specific to kids and the other the overall caseload reduction. While the continuing economic recovery has been a significant factor, the explanation for the decline is more complex than this.

As the caseload declines, the remaining individuals have, on average, greater healthcare needs. Yet, Ohio's calendar year 2019 experience was unusual and unexpectedly pronounced. The remaining individuals had even greater healthcare needs than expected (*i.e.*, increased morbidity), in particular with the Covered Families and Children and Group 8 populations. During my discussions with other Medicaid directors, I have learned that—while many states saw a declining caseload and increasing needs of individuals—only a few states witnessed a *significant degree* of increased morbidity, as in Ohio. While Ohio's trend was most concentrated with the Group 8 expansion, this increased morbidity is also evident in the Covered Families and Children population.

CMS has strict requirements for how states establish payment rates for managed care plans; rates must be actuarially determined and certified. To accommodate these requirements, managed care contract and rate adjustments are scheduled to occur twice each year. As you are aware,



managed care rates were adjusted in the conference committee to stabilize MCO rates. The first rate increase was conservative, as small as possible. As the year progressed, we determined that an additional rate adjustment retrospectively in the amount of \$232.7 million dollars (all funds) for 2019 was also necessary.

For January 2020, there is an increase in managed care rates over the original budget estimates by \$163 million, combined with a reduction of rates for MyCare, results in a net increase of \$107.5 million dollars (all funds) over the original budget estimates for managed care. The composite increase in the per member per month rate, over the August 2019 rates, is 17.2%. Of this 17.2% increase, the vast majority is due to structural and policy changes approved in the budget; hospital franchise fee, single preferred drug list and standard trend accounting. The unanticipated morbidity accounts for 15% of the increase or 3% of the overall growth.

In retrospect, as we began to evaluate the financial concerns of the managed care plans in 2019, it became evident that rates set prior to our administration had not anticipated the trends in the acuity of individuals' needs described above. As we worked to analyze the situation and assess the adequacy of the managed care capitation payments, we became aware of three critical issues—Ohio Benefits, behavioral health, and delays obtaining actionable data.

First, the myriad Ohio Benefit problems noted above confounded the analysis. Our inability to trust the data necessitated thousands of hours of analytic and actuarial work to understand the problems, as well as additional analysis and discussions with the managed care plans. As one example, Ohio Benefits miscategorized Medicaid members, which led to inaccurate or inadequate Per Member Per Month (PMPM) payments to plans. As another example, we initially had difficulty seeing the problems with the automatic assignment of certain managed care members because increasing morbidity and other issues masked the problem.

Second, throughout the year, managed care plans most often attributed their financial difficulties to the behavioral health changes. We worked throughout the year to understand and try to untangle the operational problems with behavioral health described above from the financial performance being reported by the plans. Ultimately, we concluded that behavioral health services were *not* the cause of the financial concerns raised by the plans, although Medicaid members did experience increasing need for behavioral health services, along with other services such as hospitalization, emergency room utilization, and medications.

Finally, the prior administration's rapid implementation of sweeping behavioral health system changes created a paucity of timely, actionable data, which greatly complicated our work. Ohio Medicaid worked with managed care plans to conduct special analyses and collect data at additional intervals in order to overcome the normal lag of 3 to 6 months to gather sufficient data to be able to rely on its completeness and accuracy. When the Medicaid program is operating in a fairly stable environment, this lag time for the data is workable. With massive program changes—such as the integration of behavioral health services and trying to understand unusual data patterns—delays in data create difficulties in assessing data and adjusting to the findings.

## ***Corrective Policy Adjustments***

### **5. Behavioral Health Redesign: Stabilization and correction**

As indicated in numerous discussions with you and your office, numerous presentations to the legislature and the Joint Medicaid Oversight Committee (JMOC), many discussions with individual legislators and leadership, and numerous interviews with the media, the Behavioral Health redesign and folding behavioral health services into managed care during the last administration significantly disrupted Ohio's system of behavioral health providers and services. Behavioral health services are used by more than 25% of Ohio's Medicaid population, roughly 700,000 children and adults and last year accounted for roughly a billion dollars in services. As reported in the Columbus Dispatch, in a hearing before JMOC on June 28, 2018, addressing BH and other topics, legislators questioned the competence of Medicaid officials who were present, asking "are you incompetent?", and describing their attitude as "callous and insensitive"<sup>2</sup>. The implementation was the worst I have seen in my professional career of more than 30 years. The scope of the changes and the vulnerable nature of the individuals affected made it all the more tragic, particularly while Ohio led the nation with opiate addiction and related deaths.

Behavioral Health (BH) redesign service coding changes were poorly implemented and the transition to managed care was hasty, with woefully inadequate guidance to providers and managed care plans. In July 2018, the first month of managed care implementation, *less than 1/3 of the normal amount of funds was paid out to community providers*. The first six months of billing implementation resulted in *providers being paid 43% of the dollars they were owed for services rendered during that time period*.

Immediately upon taking office, to help avoid additional potential provider agency closures and reduced access to services for Ohioans with addictions and mental illness, Medicaid worked closely with the Department of Mental Health and Addiction Services (MHAS) to repair policy and operational issues, including:

- Behavioral Health (BH) redesign service coding changes created significant operational problems for providers and managed care plans and inadequate reimbursement for certain key services.
- Plans and resources intended for provider training and technical assistance were abandoned without explanation.
- Inadequate preparation for carving BH services into managed care resulted in delayed claims payment, administrative and payment confusion (including confusion regarding third party liability), and inability to consistently and timely enroll providers with each managed care plan. Provider enrollment reportedly took as long as eight months. There was a lack of adequate guidance about information system requirements to managed care plans.
- Community provider agencies went out of business.
- To address serious provider agency insolvency and cash flow problems, payments were advanced to BH providers during 2018. This had to be repeated in early 2019, with difficulty now in collecting these advanced payments and creating a bad debt expense

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<sup>2</sup> Columbus Dispatch. June 28, 2018.



for the state. Advanced payments were made to a total of 173 providers for a total of \$179 million dollars.

The questionable decisions, the considerable number and magnitude of structural and system flaws, and overall mistrust and poor communication, necessitated immediate action by this administration. Those actions are summarized as follows:

- Medicaid and MHAS formed a large workgroup to meet every two weeks for six months with managed care plans and all behavioral health stakeholders to reestablish communication, stability, and trust in our delivery system for behavioral health.
- Coding changes and reimbursement was evaluated in depth. Months of analysis and discussion with managed care plans and providers occurred to understand and remedy the problems.
- An open door for communication from consumers and providers to both Director Criss and myself, with follow up on individual problems or concerns was established.
- Intensive, *individualized* outreach to behavioral health providers and the respective MCOs to address claims payment and cash flow issues was implemented. More than 25 Medicaid staff were deployed to provide months of individualized assistance to more than 150 provider agencies and associations.
- Transition of care requirements and rates were frozen, to prevent further instability and confusion.
- Funds were advanced to lessen the cash flow problems of providers and thoughtful recoupment is underway.
- Rate increases were approved by the legislature and implemented by Executive Order (effective August 1, 2019), to address insufficient rate reimbursements for certain key mental health services.
- Implementation of centralized credentialing for behavioral health and all other Medicaid providers to ease administrative burden on providers, enabling more time to deliver care to those in need of services. ODM expects to complete the centralized credentialing work by the end of next year. This administration has made a commitment to ongoing detailed technical assistance for providers and managed care plans, as well as a commitment to ongoing, inclusive policy dialogue involving all stakeholders.

## **6. Behavioral Health – Institutions for Mental Diseases Compliance and Financing**

The federal government notified the prior administration of its very serious noncompliance with federal regulations, known as institutions for mental diseases (IMD), which can result in the loss of all Medicaid funding for individuals receiving residential treatment for substance abuse disorders. And the federal government communicated its intent to act. According to information prepared by the prior administration, this loss of funding would impact approximately 4,000 beds that are essential to helping Ohio recover from the opiate use crisis that has ravaged Ohio communities. Given the pattern of interaction with stakeholders, the prior administration's hasty and inadequate communication regarding this noncompliance was met with complete distrust by external constituents and stakeholders.

We discussed during the biennial budget process and received legislative support with key budget resources to begin addressing the IMD noncompliance. This administration has now successfully negotiated a Medicaid 1115 demonstration waiver that gives Ohio five years to

address this issue, while also enhancing the continuum of SUD services across Ohio.<sup>3</sup> In furtherance of this effort, we have held two webinars regarding this implementation, reaching more than 1500 participants. An inclusive, stakeholder advisory group began meeting on December 20, 2019. Ohio has also been selected by the Arnold Ventures foundation as a partner to implement best practices in medication assisted treatment. Ohio Medicaid's work, combined with unprecedented work by Director Criss and the MHAS team, illustrates the seriousness of your Recovery Ohio commitment and the partnership of our agencies.

## **7. Nursing Home policy that creates significant financial burdens for future state budgets**

Language included in the FY2018-FY2019 previous operating budget established a “market basket” rate adjustment for nursing facilities. This automatic rate adjustment tied future Ohio budgets to significantly higher spending in the Medicaid program, regardless of economic conditions or state revenues. Between now and the end of your administration's first term (November 2022), this automatic “market basket” adjustment would have resulted in *additional Medicaid spending of more than \$800 million, surpassing \$1.2 billion dollars in FY24*—presenting challenges to remaining below the JMOC growth rate and ensuring financial discipline and structural balance of future budgets. Throughout this year, this administration has made it a priority to establish cooperative and constructive discussion with stakeholders and has established a path forward on this issue.

## ***Priority Policy Implementation***

## **8. Medicaid Pharmacy Benefit Managers: lack of transparency, accountability and oversight**

Reporting by the Columbus Dispatch prior to this administration exposed inadequate monitoring and oversight of Medicaid pharmacy benefit managers (PBM). Since taking office in January, the Medicaid program has been working to address the concerns we share with the General Assembly related to managing the pharmacy benefit: stronger oversight, increased transparency, and greater control of the cost of PBMs and drugs across the pharmaceutical supply chain. Robust work with the General Assembly throughout the budget process further enhanced our plan of action.

Legislative changes and other policy initiatives have included:

- Successful implementation of pass-through reimbursement (January 2019). [Exec Summary Pass-Through Pricing](#)
- Inclusion of more stringent oversight and transparency provisions in the managed care contract, including specialty pharmacy (July 2019). [Oversight Transparency 2019](#)
- Enhanced data analytics and reporting (2019). [Pharmacy Dashboard](#)
- Implementation of the Unified Preferred Drug List (UPDL) (January 2020). [UPDL White Paper 2019](#)
- Implementation of the supplemental dispensing fee for pharmacies (early 2020).

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<sup>3</sup> Medicaid CHIP Payment and Access Commission (MACPAC). *Report to Congress on Oversight of Institutions for Mental Diseases*. December 2019.

- Procurement of a Single Pharmacy Benefit Manager (ongoing in 2020).
- Participation in National Governor’s Association Pharmacy Collaborative (ongoing in 2020).
- Ohio Prescription Drug Transparency and Affordability Committee (early 2020).
- Managed Care procurement (ongoing in 2020).

Of particular note, our work to implement the UPDL and procurement of a single PBM is on track and promises significant structural change, transparency, increased efficiency and improved customer experience. After several false starts by the prior administration, the UPDL implementation began on January 1, 2020.

In addition to these efforts, early in 2019, Medicaid revised its requirements for downstream agreements, including greater transparency of agreements between PBMs and MCOs. Because of the changes, PBMs and MCOs are now allowed to restrict visibility only to the portions of their contracts that are truly proprietary. Medicaid also mandated that MCOs and PBMs cooperate with auditing entities. Medicaid instituted other important controls including prohibiting PBMs from steering members and providers to pharmacies in which the PBM has a financial interest. Further, Medicaid hired an external consultant to assess the impact of “pass through pricing” reforms and concluded that the pass-through model had been successfully implemented. [Exec Summary Pass-Through Pricing](#)

## **9. Community Engagement and Work Requirements Waiver: Need for transparency and genuine effort to achieve meaningful employment**

Just over a month after I began serving as Medicaid Director, Ohio’s 1115 waiver application was approved by CMS. By way of background, in June 2017, the budget adopted by the General Assembly required the development of this waiver. The approval of the waiver did not occur until March 2019, after the DeWine Administration picked up the negotiations with CMS. While recognizing that the federal waiver process takes time, this extended period of time of 21 months does not suggest that this was a priority.

In contrast, this administration worked to implement your priority and to carry out the intent of the legislature and quickly secure final approval, with the assistance and support of CMS and the federal administration. As you requested, we negotiated several important changes to the waiver application to improve our ability to *successfully* implement the waiver and *connect Ohioans to meaningful employment*. Since then, we have secured approval for required implementation and evaluation plans and are on track with timelines for implementation. We have openly communicated with stakeholders all along the way, going beyond the regular processes for public input.

## **10. Inaction on Multi-System Youth, custody relinquishment and other children’s behavioral health issues**

In June 2016, the Joint Legislative Committee on Multi-System Youth (MSY) made a series of policy recommendations addressing issues affecting multi-system youth and families who were faced with the heart-wrenching possibility of relinquishing child custody in order to simply

obtain needed services. The prior administration took *no action* in the years that followed the joint legislative committee's report. The prior administration also appeared to ignore obligations that were as simple as legislatively required reporting of data and paid no noticeable attention to healthcare policy decisions for children (as required of the state Medicaid departments comprising the Family and Children First Cabinet Council).

As only one indication of the disregard for Ohio's most vulnerable children, in 2018 and before, more than 100 children and youth received intensive behavioral support services every day outside of Ohio because Medicaid services did not exist in-state to meet their unique and intensive needs. For the first time, in 2019 Medicaid began supporting 94 Ohio youth in out-of-state placements for intensive residential treatment, easing the financial burden for local children's services agencies. Notably, the cost to local children's services agencies to care for these youth has reached as much as \$2,000 per day.

With leadership from your Governor's Office of Children's Initiatives and a rejuvenated Family and Children First Cabinet, Medicaid is working to better support children with complex needs who are often served by multiple state and local systems. In early 2019, Medicaid established an internal interagency team to support local county children services agencies in accessing care for the children in their custody and for the families who are in danger of giving up custody to the county. With funding established in the current budget and additional support of the legislature, Medicaid partnered with other child-serving agencies to establish state-level technical assistance and funding for children at-risk for custody relinquishment. To date, the Family and Children First Cabinet has granted funds for 29 youth across 19 counties. Technical assistance and modest funding have enabled families to stay together, rather than giving up custody of their children. In addition to addressing the immediate need, the assistance we provide to each individual case is being used to help us understand and develop system-wide changes that will help many more children in the future.

Many Medicaid staff are working diligently with these and other cross-agency priorities to support your vision for children. We are active and fully engaged in the deep and expansive work to implement the Family First Prevention Services Act and Children Services Transformation work of Director Hall and her team, as well as supporting their efforts to prevent custody relinquishment. We are pleased to be partnering on a variety of other initiatives to reach all children and youth with behavioral health and other needs—with MHAS, the schools, the Departments of Developmental Disabilities, Department of Youth Services, the Department of Health, Innovate Ohio and the H.B.12 Ohio Children's Behavioral Health Prevention Group. Your commitment and our collective work for children stands in stark contrast to the prior administration's approach.

## **Conclusion and Moving Forward**

Since assuming leadership of this agency, I have reorganized Medicaid's leadership team and organizational structure to concentrate on the areas identified above. We are also engaged in a long-term strategic planning process with the assistance of the Center for Health Care Strategies and Robert Wood Johnson Foundations, at no cost to us. The staff of Ohio Medicaid is hard-working and dedicated to the administration's priorities and the needs of the Ohioans we serve. I am proud to work with everyone on this team.

In addition to improving internal processes, my senior staff and I are committed to open doors. We have met with scores of stakeholder and advocacy groups, consumers, physicians, and providers, addressing the full spectrum of Medicaid's human and sometimes arcane technical issues.

I also committed to open communications and engagement with our partners in the legislature as we work together to accomplish our shared goals for Ohio's Medicaid program. I promised them an open-door policy and increased responsiveness to their questions, concerns, and the needs of their constituents. To date, my office has fielded just over 650 constituent case requests from legislative offices.

Considerable time and resources have been dedicated to repairing Ohio's Medicaid program over the course of the last year. Though we have significant work ahead, our team is committed to restoring accountability to the Medicaid program and successfully implementing the priorities of this administration. Ohio has the unique opportunity to implement some of the most innovative health care reforms in the country, and to do it in a way that is, as you said recently, forward-looking, futuristic and focused on people. Thank you for the privilege of serving you and all Ohioans this past year.