



**Executive Medicaid
Management Administration**

Ted Strickland, Governor
Cristal Thomas, Executive Director

Department of Aging

Department of Alcohol
and Drug Addiction Services

Office of Budget
and Management

Department of Education

Department of Health

Department of Job and
Family Services

Department of Mental Health

Department of Mental
Retardation and
Developmental Disabilities

Annual Report 2008

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Working toward a more efficient and effective Ohio Medicaid Program

Letter from Executive Director Cristal A. Thomas



Last year, with leadership from the Governor and the General Assembly, language was included in HB119 authorizing creation of an entity to manage the Ohio Medicaid program, working in partnership with existing state agencies that serve Medicaid clients, to bring about change. Governor Strickland exercised this authority through Executive Order 2007-36S, which created the Executive Medicaid Management Administration (EMMA). With this, we all celebrated a new era for the Ohio Medicaid program.

I am extremely proud to be Executive Director of EMMA and of all we have accomplished in its first year of existence.

I have worked closely with the Directors of the agencies that comprise EMMA to reach consensus on our structure, functions, priorities and goals. We have changed the way we think about the Medicaid program in Ohio, not as separate services provided and paid for by distinct agencies, but as a unified program that must work to achieve shared goals. By coordinating, rather than duplicating, functions we can provide better service and maximize the service dollars going to Ohioans.

I feel privileged to be working with my colleagues on the EMMA Council, who are as committed to the EMMA concept and goals as I am, and under a Governor who has made health care one of his top priorities. In EMMA we now have a powerful tool for managing the largest single program in state government, that is built on our unique structure and strengths and honors the value our Departments of Aging, Alcohol and Drug Addition Services, Education, Mental Health, Health, Mental Retardation, and Job and Family Services bring to the people they serve.

The following annual report describes EMMA activities and accomplishments over the past year and provides helpful background about our structure and staff. We have made great strides, but we are only at the beginning stages of an ongoing process to transform Ohio's Medicaid program. There is much left to be done, but working together the EMMA partner agencies will build on these accomplishments to achieve a more efficient and effective Ohio Medicaid program.

Sincerely,

Cristal A. Thomas

Cristal A. Thomas
Executive Director
Executive Medicaid Management Administration

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Executive Summary

The Executive Medicaid Management Administration (EMMA) was created by Governor Strickland through Executive Order 2007-36S in December of 2007. The purpose of EMMA is to serve as “the central coordinating body for Ohio’s Medicaid program to maximize efficient and effective delivery of health care to Ohioans who rely upon Medicaid services.” EMMA operates as a consortium of agencies working in partnership to:

- Unify and build consistency in Medicaid policy
- Optimize efficiency in operations and services to consumers
- Assure compliance with federal regulations
- Optimize and protect federal matching funds
- Maximize consumer access to quality services

EMMA’s work is organized through five subcommittees and an EMMA Council. Each subcommittee consists of appropriate staff from the partner agencies and is co-chaired by an EMMA staff member and an Agency Lead. The five subcommittees are:

- Strategy and Policy
- Clinical
- Legal and Program Integrity
- Budgeting and Finance
- Administrative Efficiency

The EMMA Council sets the priorities that guide the subcommittee work. The priorities are based on the needs of partner agencies and informed by the recommendations of the Ohio Commission to Reform Medicaid, the Medicaid Administrative Study Council and the Auditor of State Medicaid Performance Audit.

The primary result of EMMA has been a change in the approach to and management of the Ohio Medicaid program. All EMMA partners have benefited from the new paradigm of coordination and collaboration in identifying, discussing and resolving Medicaid-related policy questions.

The enacting executive order for EMMA stipulates that the Executive Director submit an annual report on November 15th of each year. This document describes EMMA and outlines major activities and accomplishments in our first year of existence.

Background

Medicaid is the state/federal health insurance program for low-income Americans, providing health care and long-term care services to nearly 50 million people, including children, parents, the elderly and the disabled. Each state administers its own Medicaid program within broad guidelines. The federal and state governments jointly finance Medicaid, with the federal government funding approximately 60% of national Medicaid spending. Medicaid is an entitlement program, meaning Medicaid enrollment may not be capped based on available state funds. In addition to mandatory services provided to eligible enrollees, states have the ability to offer optional services, or cover optional populations. One way states exercise this option is through Waiver Programs. Medicaid Waivers are so named because states receive approval from the federal Centers for Medicare and Medicaid Services to waive certain program requirements for a designated population. Ohio operates seven waiver programs providing services to 57,000 consumers with chronic medical conditions or severe disabilities.

Federal regulations require each state to designate a single state agency responsible for administering Medicaid and assuring appropriate oversight and compliance. The single state Medicaid agency is the Department of Job and Family Services (ODJFS). On average ODJFS pays for health care and supportive services for 1.7 million Ohioans each month, and a total of 2.1 million people throughout the year. This represented about 17 percent of the state's population in SFY 2006.

Ohio Medicaid categorizes enrollees into two main eligibility groups: Covered Families and Children (CFC) and the Aged, Blind and Disabled (ABD). CFC is the largest covered group, encompassing 1.1 million children and 578,000 low-income parents. The ABD Medicaid population includes approximately 147,000 older adults and 229,000 non-elderly adults and children with disabilities. While smaller in number, the ABD population tends to have the most costly health care needs and accounts for a higher percentage of Medicaid costs. In SFY 2006, the ABD population made up 22 percent of the Medicaid population but accounted for 71 percent of service costs. The CFC population accounted for 78 percent of the Medicaid population but only 29 percent of service costs.

The U.S. Congress enacted the State Children's Health Insurance Program (SCHIP) to increase the availability of health care to children in families above the income levels for Medicaid but who did not have access to, or could not afford, private health insurance. SCHIP provides an incentive through enhanced federal matching funds for states to cover these populations. States had the option of implementing SCHIP as a program with different benefit packages or as part of their existing Medicaid program. Ohio operates its Medicaid and SCHIP programs jointly and uses "Medicaid" to refer to the combined program.

ODJFS covers the Medicaid population under Managed Care or Fee for Service (sometimes referred to as "State Plan"). The majority of Medicaid consumers, including all of the CFC population and a portion of the ABD population, are required to enroll in a Medicaid managed care plan. Specialized populations such as consumers in Medicaid waiver programs, institutions such as nursing homes or intermediate care facilities for the

mentally retarded (ICFs/MR), medically fragile children, and foster care children are exempted from mandatory enrollment in managed care.

The Medicaid program has continually grown over time, from 1.1 million in 1997 to the current 2.1 million in SFY 2006. Medicaid enrollment (or caseload) follows a countercyclical pattern; as economic conditions worsen, Medicaid enrollment increases. Growth has occurred in both the CFC and ABD populations, but the CFC caseload increase has been greater.

The Ohio Medicaid program has experienced caseload increases in the past year, mainly due to a combination of health care inflation and an economy that has resulted in a decrease in employer-sponsored insurance coverage. The total increase for Fiscal Year 2008 (SFY08) was about 68,000 or 4 percent. The following tables present Medicaid enrollment by age group, eligibility category and delivery system.

Medicaid Enrollees as a Percentage of Total Population			
	Enrollees	Population	Percent
Population	2,087,653	11,464,042	18.2%
By Age Group			
0-4	358,971	731,672	49.1%
5-18	775,171	2,192,743	35.4%
19-64	806,685	7,010,197	11.5%
65-84	105,806	1,311,968	8.1%
85+	41,004	217,462	18.9%
By Gender			
Male	929,845	5,587,607	16.6%
Female	1,271,972	5,876,435	21.6%
By Race			
White	1,533,846	9,759,187	15.7%
Black	632,479	1,368,406	46.2%
Other	37,356	336,449	11.1%
By Ethnicity			
Hispanic	68,574	529,250	13.0%
Non-Hispanic	2,133,011	10,934,792	19.5%

Medicaid Enrollees by Aid Category			
Aid Category	Member Months	Recipients	Expenditures
Non Dual Eligibles			
Healthy Families			
FFS	6,084,673	738,842	\$1,368,302,375
MCP	5,923,597	94,044	\$1,214,729,825
Healthy Start			
FFS	1,243,357	204,333	\$325,835,029
MCP	764,762	12,058	\$184,406,740
SCHIP			
FFS	915,670	122,351	\$157,188,995
MCP	761,750	12,401	\$100,060,150
ABD	2,297,564	252,395	\$3,793,842,034
Dual Eligibles	2,147,592	231,363	\$4,692,213,887
Total	20,138,965	1,667,787	\$11,836,579,035

Medicaid Enrollment by Delivery System		
	Member Months	Percent of Total
Fee For Service	12,688,856	62.9%
Managed Care	7,471,583	37.1%

In SFY 2009, the budgeted amount for the ODJFS portion of the Ohio Medicaid program was \$11.9 billion. Because of the size of the Medicaid program, accurate forecasting of caseloads and expenditures is critical to managing the state budget and Medicaid experience has tracked closely to projections. As of September 2008, total Medicaid caseload was 5,726 (0.31%) over the estimate. However, aggressive cost containment strategies, and administrative budget cuts, have enabled the state to successfully manage Medicaid costs. Although we have experienced slightly higher than expected enrollment, total Medicaid expenditures are \$39.8 million (0.94%) under the budgeted estimate.

The following table presents information on Medicaid expenditures in SFY 2006 by category of service.

Medicaid Spending by Category of Service		
Category	Patients	Expenditures
Inpatient Hospital	219,360	\$1,451,038,748
Outpatient Hospital	878,601	\$669,982,133
Prescription Drugs	1,108,674	\$1,597,177,630
Nursing Facility	88,149	\$2,606,141,826
ICFMR	8,027	\$732,040,466
Physician/Extenders	1,166,831	\$631,082,966
FQHC	129,706	\$36,790,814
Clinics	119,619	\$73,357,105
Dental	429,988	\$116,299,059
Vision	261,338	\$19,969,241
ODADAS	35,000	\$65,010,448
CMH	217,971	\$414,573,396
ODMR Services	30,325	\$37,246,631
Waiver Services	58,481	\$1,331,478,593
Home Health	43,828	\$183,505,074
Hospice	11,687	\$128,297,012
Chiropractor	12,360	\$1,692,801
Podiatry	110,626	\$12,663,158
DME	236,871	\$167,506,750
Transportation	159,186	\$79,868,221
Lab	224,137	\$31,112,630
Therapies	16,217	\$15,932,927
Other	41,533	\$34,511,607
MCP Capitation	-	\$1,399,299,797
Total	5,608,515	\$11,836,579,033

This data is for SFY2006 (July 1, 2005 - June 30, 2006)

Medicaid and Related Programs

In addition to its direct coverage of Medicaid and SCHIP enrollees in Fee-For-Service and Managed Care, ODJFS administers two Medicaid Waiver programs and several Medicaid-Related Programs. The ODJFS-Administered Medicaid Waivers are the Ohio Home Care Waiver and the Transitions II Carve Out Waiver. Medicaid-related programs administered by ODJFS are:

- Medicare Premium Assistance Program
- Hospital Care Assurance Program
- Disability Medical Assistance Program
- Children's Buy In Program

ODJFS delegates responsibility for administering certain waiver programs and specialized services to six other state agencies. This allows partner state agencies to receive federal revenue for eligible programs and services they administer for their target populations. These agencies are:

- The Ohio Department of Aging (ODA) for the PASSPORT Waiver, Choices Waiver, and Assisted Living Waiver programs
- The Ohio Department of Alcohol and Drug Addiction Services (ODADAS) for specialized treatment services under the Medicaid State Plan
- The Ohio Department of Education (ODE) for the Medicaid in Schools Program (MSP)
- The Ohio Department of Health (ODH) for Medicaid related activities and programs such as certification of nursing facilities, Breast and Cervical Cancer Screening Program, and Children with Medical Handicaps program
- The Ohio Department of Mental Health (ODMH) for specialized treatment services under the Medicaid State Plan
- The Ohio Department of Mental Retardation and Developmental Disabilities (ODMRDD) for care provided in Intermediate Care Facilities for the Mentally Retarded (ICF/MR), Transitions MR/DD Waiver, and Level One Waiver

Business Case for EMMA

The Ohio Medicaid program faces many challenges. Medicaid is one of the largest programs in Ohio in terms of its budget and number of Ohioans it serves and the rate of cost growth is a continuing area of concern. As an entitlement, Medicaid has the potential to crowd out other spending priorities and states have limited options for controlling growth.

Medicaid also has operational challenges. As a result of the construction of Ohio's Medicaid program, its scope and magnitude, and our state's local government structure, responsibility for the administration of Ohio Medicaid is shared by multiple state departments. Further, each of these departments oversees its own structure of local

partners, such as the 88 county departments of job and family services, 88 county boards of mental retardation and developmental disabilities, 56 county behavioral health boards, and 12 regional Area Agencies on Aging. This structure has allowed delivery systems to develop with the expertise and ability to focus on the needs of special populations in the communities in which they live. But it has also created a very complex program prone to fragmentation, duplication of functions, contradictory policies, unnecessary expenditures, and operational inefficiencies in the way Medicaid is administered. These characteristics have become a source of frustration for many stakeholders, particularly those involved in funding Medicaid services and those who interact with multiple systems.

These frustrations have generated multiple external reviews of the Medicaid program in recent years to assess its operations and identify opportunities for improvement and cost containment. The most prominent of these have been the Ohio Commission to Reform Medicaid (OCRM), the Ohio Medicaid Administrative Study Council (MASC) and the Ohio Auditor of State Medicaid Performance Audit. Each of these entities issued reports with findings and recommendations to improve the Medicaid program in Ohio. Many of the recommendations have been implemented and others are in progress. However, all the reports pointed to an underlying problem in the structure of the Medicaid program in Ohio that needed to change. Informed by these reviews, the Strickland Administration recognized early on the need to address problems in the Medicaid program, improve coordination across agencies and eliminate fragmentation of Medicaid policies, processes and accountability.

For example, a recommendation of both the Medicaid Administrative Study Council and the Auditor of State was that Medicaid function as part of a broader health care strategy and operate in accordance with a clear mission and vision. Upon coming into Office, the Strickland Administration convened the leadership of all health care related agencies to develop a health care vision for Ohio and identify the role of Medicaid in supporting that vision. We developed the following Envisioned Future State for a Healthy Ohio:

Ohioans are achieving and maintaining optimal health through personal wellness management and a health care delivery system that focuses on the promotion of health and the prevention of disease. At each stage of life, every Ohioan has access to timely, patient-centered, holistic and efficient health care choices. All Ohioans have access to primary and preventive services as well as education and opportunities for healthy lifestyles, and the incidence of preventable diseases are at the lowest levels in the nation across all population groups. Services and care are coordinated through widespread use of health information technology, thereby improving health outcomes and delivering effective, efficient and culturally competent health care.

The Administration recognized that Medicaid, as the state's largest health care program and a major funding mechanism for health care services, would play a key role in supporting the Administration's health care agenda. For the first time, Medicaid was viewed not only as a government program outside of the "private" health care system, but as an integral part of the health care system in Ohio. The following Mission Statement was developed for the Ohio Medicaid program:

Medicaid is a financing and service delivery system interfaced with the Ohio healthcare system to: (1) provide health care coverage to the Medicaid-eligible population to improve their health and well-being while being accessible to consumers, accountable to stakeholders and affordable for the state and (2) leverage its influence as a major

purchaser within the service delivery system to improve the health and well-being of all Ohioans and encourage improvements in the Ohio healthcare system.

These vision and mission statements highlight the need for a coordinated Medicaid program capable of promoting the health and well-being of Medicaid consumers across all population groups and delivery systems and working cohesively and effectively to maximize its leverage as a purchaser and influencer within the health care system. Successful implementation of this vision requires Ohio to change the management philosophy of Medicaid from distinct programs to a single enterprise working efficiently and effectively toward shared goals. There were recommendations to accomplish this through creation of a new Ohio Department of Medicaid. However, the Governor, with leadership of the General Assembly, conceptualized a virtual agency to manage the Ohio Medicaid program in partnership with existing state agencies that serve Medicaid clients to bring about change. The Executive Medicaid Management Administration emerged as Ohio's solution.

Creation of EMMA

Prior to the formal creation of the Executive Medicaid Management Administration, the directors of agencies responsible for Medicaid-funded programs or services began meeting to improve collaboration and reach consensus on the structure, functions and responsibilities of EMMA. This group would become the EMMA Council.

The council began discussing the appropriate role for EMMA, and developing guidelines for EMMA operations. They recognized that there are many points of interconnection between the Medicaid and Medicaid-related programs in Ohio and the people who receive services through those programs. Therefore, there is a need for a centralized body to 1) recommend priorities for the Ohio Medicaid program across delivery systems, 2) provide strategic direction around key Medicaid policies and multi-agency functions including, but not limited to, policy, information technology, program integrity, resource optimization, and local governments, and 3) coordinate Ohio's Medicaid policies and business processes to facilitate program and operational efficiency and to eliminate duplication of functions, in order to achieve a more seamless experience for consumers.

The council developed the following principles for EMMA's role:

- Assure compliance with federal regulations
- Optimize and protect federal matching funds
- Maximize consumer access to quality services
- Optimize efficiency of operations and the provision of services to consumers.

The council further agreed that EMMA activities should be value added, rather than duplicative or substitutive of existing agency functions. As such, EMMA focuses on issues that:

- Impact multiple agencies or populations served by multiple agencies; and
- Represent a significant change in Ohio Medicaid policy, operations or expenditures.

Finally, the Council agreed that the Department of Job and Family Services would continue as the designated single state agency with responsibility for administering the State Plan for Medicaid and would retain all of its oversight and decision-making authority as such.

The Executive Medicaid Management Administration (EMMA) was created by Governor Strickland through Executive Order 2007-36S in December of 2007 to serve as “the central coordinating body for Ohio’s Medicaid program to maximize efficient and effective delivery of health care to Ohioans who rely upon Medicaid services.” The Executive Order is included in Appendix A. EMMA became the first formal state entity established to focus exclusively on coordination and process improvement within a state Medicaid program.

An Executive Director was appointed and began the work of establishing EMMA’s administrative structure and legal framework. The Administration created EMMA as a “virtual” agency, determining that EMMA should not duplicate existent administrative infrastructure and support services such as Information Technology, Human Resources, and Fiscal Operations, but would utilize resources from partner agencies as needed. This design allows the state to achieve program goals with minimal administrative costs. The Office of Budget and Management (OBM) agreed to serve as the administrative and fiscal agent for EMMA. EMMA appropriation is under the OBM budget and EMMA staff positions were created under the OBM umbrella, although EMMA is a Cabinet Agency reporting directly to the Governor.

EMMA operates under a cross-functional business model, known as a “matrix management model”, based on the concept that resources within an enterprise can and should be shared across operating divisions to meet common goals. EMMA Council members report to the Governor, but are also responsible to each other for Medicaid related work. Similarly, EMMA partners designate staff and resources for EMMA priorities and designated staff reports to both their respective Director and the EMMA Executive Director for EMMA-related work. This model enhances communication, improves coordination and information sharing between operating divisions, and increases consistency and efficiency in the Medicaid program.

EMMA completed the following activities in the beginning months of calendar year 2008:

- Identified Medicaid-related activities and decisions across EMMA partner agencies
- Established clear roles and responsibilities for the EMMA Council, Executive Director and Staff
- Developed budget and funding structure for SFY 2008
- Entered into Interagency Agreements with partner agencies
- Wrote Position Descriptions
- Created and filled EMMA positions
- Completed work plan
- Designated and convened EMMA subcommittees

Budget & Funding

HB 119 included a “Medicaid Transition” line item with \$1.5 million in the OBM appropriation for SFY 2009. The Governor and General Assembly agreed that EMMA would be funded out of this line. However, the Administration had to determine how to fund EMMA for the second half of SFY 2008, from its creation in January 2008 until the SFY 2009 appropriation could begin to be utilized on July 1, 2008. The Council agreed to fund EMMA through funds transferred from the partner agencies during this period.

The EMMA SFY 2008 budget was \$336,290 all funds. This funding covered the costs of EMMA staff, equipment and maintenance. The budget was funded by the EMMA partners in accordance with a formula developed by the Office of Budget and Management and included in the EMMA Interagency Agreement. As Ohio’s strategy for improving the efficiency and effectiveness of the Medicaid program, the work done by the partner agencies through the EMMA subcommittees is a Medicaid administrative activity and thus eligible for 50% federal match as part of their Medicaid administrative claiming.

The Medicaid Transition line used to fund EMMA in SFY 2009 was reduced in the two rounds of budget cuts ordered by the Governor. The current appropriation is \$1.2 million. The EMMA operating budget for SFY 2009 is \$472,800 for personnel, maintenance and equipment costs. The EMMA Council decided to use the remaining appropriation to fund priority projects identified by EMMA subcommittees to improve the efficiency of Medicaid operations.

EMMA Structure

EMMA is comprised of:

- a. an Executive Director and staff
- b. a council of cabinet-agency partners consisting of Directors from the Departments of Alcohol and Drug Addiction Services, Aging, Budget and Management, Health, Job and Family Services, Mental Retardation and Developmental Disabilities, Mental Health; and the Superintendent of Public Instruction;
- c. the following subcommittees, with representation from the cabinet agencies that have Medicaid-related responsibilities:
 - Administrative Efficiency
 - Budget and Finance
 - Clinical
 - Legal and Program Integrity
 - Strategy and Policy

Executive Director & Staff

Governor Strickland appointed Cristal Thomas as the first Executive Director of EMMA effective January 1, 2008. In addition to the Executive Director, EMMA has a small staff dedicated exclusively to coordination and process improvement within the Medicaid program. The EMMA staff consists of:

- **Policy Advisor**, which chairs the EMMA Strategy and Policy Subcommittee and Clinical Subcommittee; performs research; and serves as a senior advisor to the Executive Director and EMMA Council on Medicaid policy and operational issues.
- **Chief Legal Counsel**, which chairs the EMMA Legal and Program Integrity Subcommittee; conducts legal research; and advises the Executive Director and EMMA Council on Medicaid-related matters.
- **Fiscal Advisor**, which chairs the EMMA Budget and Finance Subcommittee; supports the EMMA Consolidation Exploration Team; and advises the Executive Director and EMMA Council on coordination of budget issues and fiscal operations.
- **Executive Assistant**, which provides administrative support to the Executive Director, the Policy Advisor, Chief Legal Counsel, Fiscal Advisor, and to the EMMA subcommittees.

More information on these roles, and bios of current staff, are included in Appendix B.

EMMA Council

The EMMA Council is comprised of the Directors of the Departments of Alcohol and Drug Addiction Services, Aging, Health, Job and Family Services, Mental Health, Mental Retardation and Developmental Disabilities, the Office of Budget and Management, and the Superintendent of Public Instruction. The Council is responsible for providing advice and guidance for the implementation of EMMA work and policy changes in the Medicaid program. The Council meets on a regular basis to jointly discuss EMMA activities and cross-cutting Medicaid related issues.

Subcommittees

The majority of EMMA work is done through subcommittees, which provide a forum for communication, information sharing and developing common perspectives and goals. The five subcommittees were created to advance the EMMA role in assuring compliance, optimizing federal matching funds, maximizing efficiency of operations, and unifying Medicaid policy. More detailed descriptions of the five subcommittees are provided below and in the Activities and Accomplishment sections of the Report. The

Subcommittees are organized around charters that were created from the EMMA work plan and approved by the EMMA Council. The charters are included in Appendix C.

- Administrative Efficiency

The Administrative Efficiency Subcommittee is currently operating as the Consolidation Exploration Team (CET). The CET was convened by the EMMA Council to develop a vision for a consolidated back office for Medicaid, determine its cost benefit, and make recommendations for the best course of action in achieving the vision. The CET is co-chaired by ODMRDD and EMMA and is comprised of staff with varying areas of expertise from all the EMMA partner agencies except Public Instruction. The CET approaches its work by comparing business processes across the agencies, based on the Center for Medicare and Medicaid Services' Medicaid Information Technology Architecture (MITA) framework.

- Budget and Finance

The Budget and Finance Subcommittee (B&F) is comprised of financial professionals from the EMMA partner agencies. The B&F subcommittee is co-chaired by OBM and EMMA. The purpose of B&F is to maximize federal funding, optimize efficiency, accountability and consistency and support the agencies' efforts in managing the costs for the Medicaid program. B&F approaches the work with the intent to focus on open and frank discussions from all agencies to promote cooperation, and identify potential areas for improvements.

- Clinical

The Clinical Subcommittee was created to provide clinical leadership and expertise to the Medicaid program and contribute to the development of principles and strategic direction based on the best clinical evidence. The subcommittee is co-chaired by EMMA and ODMH and consists of agency staff from partner agencies with clinical expertise and understanding of evidence-based decision models. The Clinical subcommittee has focused on developing a common understanding of the different definitions used in each clinical field to describe the use of evidence as the basis of effective and efficient medical care and has used this common understanding across agencies as the foundation to approach its work.

- Legal and Program Integrity

The Legal and Program Integrity Subcommittee (LPI) consists of staff from each of the partner agencies focused on developing standards and implementing processes surrounding the roles, responsibility, and accountability for the integrity and legality of the state Medicaid system. The subcommittee is co-chaired by EMMA Legal Counsel and Legal Counsel from ODMRDD. The LPI encourages members to give feedback to the most pressing issues within their respective agencies, which are then juxtaposed against the goals and measures in the Charter.

- Strategy and Policy

The Strategy and Policy Subcommittee was convened to guide the strategic direction of Medicaid across agencies and to ensure Medicaid operates as part of and supports a broader health care strategy. The subcommittee is co-chaired by the EMMA Policy Advisor and the State Medicaid Director and is made up of Medicaid policy experts from each EMMA agency with a tremendous range of expertise and knowledge of the health care system. The subcommittee results can be categorized in two groups: conceptual product and strategic planning. In addition to the goals described in the charter, the subcommittee also assists other EMMA groups with policy questions as assigned by the EMMA Council.

Activities and Accomplishments

The EMMA first year priorities were developed by the Executive Director with input from partner agencies and guided by recommendations of the Ohio Commission to Reform Medicaid, the Medicaid Administrative Study Council and the Auditor of State. The EMMA Council approved the priorities and assigned staff to the subcommittees with the expertise needed to accomplish the work. Subcommittee priorities were revisited and adjusted throughout the year to accommodate evolving needs within the Medicaid program. The activities and accomplishments described below represent significant progress toward the EMMA Council priorities and the Administration's vision for an efficient and effective Ohio Medicaid program.

- Create an integrated and coordinated Medicaid program

The primary goal and function of EMMA is to create a single Medicaid enterprise for Ohio. In pursuit of this vision, EMMA creates a forum for ongoing communication and collaboration between Medicaid partner agencies, to resolve complex issues, ensure that policies are consistent, business processes are integrated to the extent possible, and the program moves in a common direction toward achievement of shared goals.

Regular, open, and consistent communication has been critical to promoting the cultural changes needed to realize this vision. EMMA has helped agencies build relationships beyond the traditional "Medicaid staff" to reach multiple management levels and operational areas. All partner agencies have reported improvements in information sharing and, as a result, knowledge of Medicaid programs at all management levels. This includes participation of staff that historically has not been regularly involved in Medicaid decision-making, such as fiscal, IT, legislative, and quality improvement staff. Improved collaboration through EMMA has resulted in better understanding of the roles and responsibilities of each agency and has begun to create efficiencies in managing the Ohio Medicaid program.

Agreeing on a common set of principles is another essential step for a unified Medicaid program. Building on work done internally by partner agencies in collaboration with their respective stakeholders, such as the Unified Long Term Care Budget and Futures Committees, the Strategy and Policy Subcommittee developed a set of principles to guide decision-making about Medicaid policy changes and resource allocation. In addition, the Clinical subcommittee is developing clinical principles to promote decision-making based on the best available evidence.

One of the populations served by the Medicaid program that requires significant coordination of resources across all agencies is children. The Administration identified coordination of children's health as an important area to address in an integrated Medicaid program. This also presented an opportunity to apply and refine the Medicaid principles. The Strategy and Policy subcommittee focused on the provision of Medicaid services as they relate to children's health, particularly EPSDT (Early and Periodic Screening Diagnosis and Treatment) services. The subcommittee evaluated the structure in which Medicaid provides these services to children within the context of the federal EPSDT requirements. Following this evaluation, the subcommittee recommended that the state build upon the strengths of our existing programs and structure by developing a plan to improve coordination, refine benefit packages and create a unified marketing strategy for these services across programs. This plan will improve access to breadth of services available to children in Ohio.

- Improve Operational Efficiency

An important goal for the EMMA Council in creating a unified Medicaid enterprise is to improve efficiency in Medicaid-related "back office" operations and business processes. The Council established the principle that agencies should be more alike than they are different in conducting Medicaid-related functions, and business processes should be consolidated where possible. By operating more efficiently, Ohio will be able to maximize the dollars going toward direct provision of services rather than administrative costs. EMMA subcommittees focused on three areas of opportunity under this priority area: Fiscal Operations, Business Processes, and Information Technology.

The Budget and Finance Subcommittee is helping agencies improve efficiency in their fiscal operations and maximize federal match. The subcommittee is reviewing each agency's cash transfer process and identifying best practices from other agencies and other states to simplify and expedite the process. The Subcommittee is also reviewing each agency's cost allocation plan/indirect cost proposal and methods for claiming administrative expenditures for opportunities to maximize federal financial participation (FFP) for central office operations. In addition, the subcommittee is reviewing agency activities to determine any opportunities to leverage local funds for FFP. An area that has been identified for improvement is modifying an Indirect Cost Proposal to increase federal support for administrative expenses such as central office salaries, rent and overhead.

The Consolidation Exploration Team (CET) was asked to identify barriers to consolidated claims processing through the new Medicaid Information Technology System (MITS) being implemented in ODJFS, and to develop a plan for partner agency integration into MITS. The CET has reviewed the major Medicaid business processes, including member management, provider management, program integrity management, operations management and program management to identify similarities across agencies

and determine whether there is a compelling business case for consolidation within MITS.

The CET recommended that the partner agencies have a detailed “As Is” Assessment conducted. This is a critical step to prepare for partner agency integration of claims processing and other key Medicaid-related functions into MITS. OHP procured a vendor to conduct an “As Is” assessment of their processes in preparing for MITS. The CET is currently drafting an Advance Planning Document (APD) to request enhanced matching funds from CMS for the MITS Assessment and will then begin drafting business requirements for the Request for Proposal (RFP).

In addition, the CET has identified the provider certification process as an initial area of opportunity for streamlining and/or consolidation prior to MITS implementation and is preparing to conduct a Kaizen event to develop a more efficient provider certification process.

- Standardize Program Integrity Activities

Medicaid funds services through multiple delivery systems in Ohio, each with its unique structure of local partners. ODJFS, as the Medicaid single state agency, is responsible for ensuring the integrity of Medicaid funds; that they are spent for the intended purpose in compliance with federal law. However, program integrity activities vary greatly by system. The EMMA Council charged the Legal & Program Integrity Subcommittee with developing recommendations for a revised program integrity model that would clearly define roles, responsibilities and accountability for program integrity functions; be fully compliant with Federal regulations; be consistently applied across systems; and be based on a risk assessment that focused activities on areas of greatest liability.

- Inventory Activities, Business Processes and Unmet Needs

To support the principle that Medicaid should operate as a single enterprise with processes that are more alike than different, several EMMA subcommittees completed inventories of existing activities to identify areas of similarity and difference.

The Consolidation Exploration Team has completed a business process inventory of agencies’ processes related to the CMS Medicaid Information Technology Architecture (MITA) Framework. This is an important step in preparing for integration of claims processing and other business processes into the Medicaid Information Technology System or MITS.

The Legal and Program Integrity (LPI) Subcommittee has developed a matrix of the sub-recipient relationships and program integrity activities of each agency. In completing this work, the subcommittee established common terminology and definitions for program integrity across agencies. The matrix has helped to identify duplicate activities and gaps and will be used to develop standards for state agency roles in Medicaid program integrity activities, including audits and utilization review.

To support the process of implementing a unified budget and a unified program for care services, the Strategy and Policy Subcommittee developed a matrix of existing waiver programs and unmet needs to assist in program planning around services for special populations. Through this, it was decided that two of the waivers in the Department of

Aging, Passport and Choices, would be renewed under one Passport waiver application to simplify the administration and access to services.

- Support Partner Agency Initiatives and Needs

EMMA was not created, and does not operate, in a vacuum. The EMMA partner agencies have both Medicaid and non-Medicaid programs that interact to varying degrees. In addition, many of these agencies have engaged in broad based stakeholder initiatives related to reforming their delivery systems that also impact Medicaid. These include the MRDD Futures, Unified Long Term Care Budget, and the Behavioral Health system reform. The EMMA Council recognized the value of EMMA in bringing a global Medicaid perspective to issues. Below are a few examples of how EMMA has supported Partner agency initiatives.

- Futures Committee

House Bill 119 charged the Ohio Department of Mental Retardation and Developmental Disabilities (ODMRDD) with engaging a broad group of stakeholders in a “Futures” initiative to make recommendations about the future structure of the MRDD system in Ohio. Two of the EMMA agencies, JFS and OBM, officially participated in this process, ensuring communication and alignment of the Futures work with other Medicaid initiatives. Once EMMA was created, the Strategy and Policy subcommittee took the outcome of the Futures work, and put it on a grid with similar projects from other Medicaid agencies to ensure congruence, inform the development of common Medicaid principles, and to stage work products with like work products coming out of other EMMA agencies.

- Interagency Workgroup on Autism

ODMRDD has taken the lead in developing the Administration’s autism strategy. The Department convened an Interagency Work Group on Autism (IWG). EMMA staff participates on the IWG and provides a mechanism for ODMRDD to communicate the IWG work plan with the Cabinet directors.

- Behavioral Health Fee Schedule

EMMA staff had significant involvement in three system reform projects occurring in the Behavioral Health (AoD and MH services) system that are directly related to Medicaid: the development of a federally compliant Medicaid surveillance and utilization review (SUR) process; the development of a web-based modified certified public expenditure (CPE) process to document and validate Medicaid payments and funding sources between ADAMH/ADAS/CMH Boards and providers; and the development and submission to the Centers for Medicare and Medicaid Services (CMS) of a State Plan Amendment (SPA) to implement a fee schedule reimbursement methodology for Medicaid covered behavioral health services. EMMA staff convened the impacted partner agencies and assured ongoing and timely coordination across the involved agencies to

successfully meet key project development expectations, and promote consistency in the surveillance and utilization review process across agencies.

- Pre-Admission Screening and Resident Review (PASRR)

EMMA has helped coordinate the development of a unified strategic plan to address the inappropriate placement of individuals with behavioral needs in nursing facilities. This plan is a multi-prong approach that includes strategies such as the identification and diffusion of best practices; policy analysis to evaluate program options; regulatory changes to eliminate unanticipated negative incentives; and an updated oversight process to prevent misuse, under-use and abuse of the PASRR process.

- Unified Long Term Care Budget

House Bill 119 charged the Department of Aging with convening a stakeholder workgroup to develop recommendations and an implementation plan for a unified long term care budget (ULTCB). The ULTCB Workgroup envisioned a central role for EMMA in implementation and management of the unified budget. Following submission of the final report and recommendations of the ULTCB Workgroup, several EMMA subcommittees began preparing for next steps.

The Budget and Finance Subcommittee was charged with developing reporting mechanisms to support implementation and management of the unified budget. The Subcommittee has designed a report to help the EMMA Council manage and make decisions about transfer of funds between long-term care budget lines. The report will be compiled by JFS and submitted to the EMMA Council on a quarterly basis, beginning November 2008.

The Strategy and Policy Subcommittee was charge with supporting the implementation of the Unified Long Term Care Budget recommendations. The first priority was the recommendation to ensure that consumer self-directed options are available in every system. The subcommittee adopted the CMS framework definition of consumer directed services as the working definition, when applicable, to ensure that self-directed options were available and summarized how each system is currently offering or planning to include self-directed options in their programs.

- Health Care Reform

Governor Strickland made health care one of his top priorities and has convened two stakeholder workgroups on health care reform: the State Coverage Initiative (SCI) Team, and the State Quality Improvement Institute (SQII) Team. Because the Medicaid program operates within the broader health care system, it was determined that EMMA should participate on these and other initiatives that may significantly impact Medicaid, even if they are not directly related to Medicaid. The EMMA Executive Director was appointed to both teams, and the EMMA Policy Advisor participates on a SQII workgroup. It is anticipated that EMMA will play a role in coordinating the implementation of Medicaid-related reform strategies that emerge from these initiatives.

Next Steps and Future Challenges

EMMA has made great strides in the past year, but we are only at the beginning of an ongoing process to transform Ohio's Medicaid program. We will build on these accomplishments in the next year to improve the efficiency and effectiveness of the Ohio Medicaid program.

Together, the EMMA partner agencies will move toward consolidation of Medicaid claims processing and integration of certain partner agencies' Medicaid processes into the Medicaid Information Technology System once it is implemented and stabilized within ODJFS. Outdated, fragmented technology often limits effective data sharing between agencies, and serve as a barrier to efficiency. Adopting a single information technology platform will go a long way in addressing this barrier and moving Ohio toward a single Medicaid enterprise. As with any major IT project, this will be a long-term effort to ensure a successful transition with minimal disruption to the new system as well as to stakeholders.

To provide appropriate and effective care at the lowest cost possible, EMMA is in the process of developing a clinical evidence-based framework that will ensure that the best available evidence for clinical effectiveness and efficiency is used uniformly and consistently at the core of the decision making process for coverage and payment of Medicaid services.

Ultimately, the success of EMMA and the Medicaid program lays on the ability to provide access to efficient and effective health care to eligible individuals. Therefore, EMMA will continue its work with partner agencies to strengthen their delivery systems. Medicaid relies on networks of providers to deliver needed health care and supportive services to consumers. When these networks are weakened, it can limit access for those who rely on Medicaid services. EMMA partner agencies have engaged in efforts to strengthen the delivery system, some of which were described above. Future priorities in support of these efforts may include care coordination, payment reform, and use of technology such as electronic health records and telemedicine to improve outcomes and access. In addition, in the coming year EMMA will start working with professional associations to lead and support transformative initiatives in the delivery system that would result in the right care, at the right place, at the right time not just for Medicaid members but for all Ohioans.

We look forward to these and other next steps for EMMA. As a new state body, EMMA has evolved over the past year, and will continue to evolve as the EMMA partnerships mature in pursuit of an efficient and effective Ohio Medicaid Program.

Appendix A



TED STRICKLAND
GOVERNOR
STATE OF OHIO

Executive Order 2007 – 36S

Creating the Executive Medicaid Management Administration

- 1. The Provision of Health Services through the Ohio Medicaid Program.** The Ohio Medicaid Program is a medical financing and service delivery system. It impacts all facets of Ohio’s healthcare system by providing health care coverage as a safety net to uninsured Ohioans and incorporating cost sharing, disease prevention and personal wellness principles. Consequently, the provision of health services through the Program allows the State to facilitate improving the health and well-being of enrollees, while remaining accountable to all Ohioans and affordable for the State.
- 2. The Decentralization of Ohio’s Medicaid Program Reduces the Provision of Efficient Services.** Medicaid is one of the largest programs in Ohio in terms of its budget and the number of Ohioans it serves. Because of the scope and magnitude of Ohio’s Medicaid Program, responsibility for its administration has been shared by multiple state departments, resulting in fragmentation of Medicaid policies, processes, and accountability.
- 3. Creation of the Executive Medicaid Management Administration.** In order for the State to maximize efficient and effective delivery of health care to its citizens that rely upon Medicaid services, I hereby order the creation of the Executive Medicaid Management Administration (“EMMA”), which shall serve as the central coordinating body to manage the Ohio Medicaid Program across all state agencies. The role of the EMMA will be to coordinate the management of Ohio’s Medicaid Program by:

- a. coordinating Ohio's Medicaid policies to facilitate program and operational efficiency, including the elimination of duplication of functions;
 - b. implementing appropriate recommendations of the Ohio Medicaid Administrative Study Council;
 - c. facilitating Ohio's compliance with federal Medicaid laws, regulations, and policies, avoiding conflicting policy decisions, and enabling timely and effective decision making in order to maximize federal funding.
4. **Appointment and Duties of the Executive Director for the EMMA.** I will appoint an Executive Director to lead the EMMA. The Executive Director will be responsible for the effective operation of the EMMA by:
- a. developing a governance structure for decision-making;
 - b. preparing an operating budget;
 - c. providing strategic direction and management around key Medicaid policies and functions including, but not limited to, information technology, program integrity, resource optimization, and interaction with local governments.

In order to carry out these responsibilities, the Executive Director of the EMMA shall employ and fix the compensation of the EMMA personnel, who shall be in the unclassified civil service. The Executive Director will be the appointing authority for the EMMA and will be responsible for making all employment decisions relating to the EMMA including, but not limited to, hiring, firing, disciplining, and promoting employees.

5. **Composition of the EMMA.** In addition to the Executive Director, the EMMA will be comprised of:
- a. a council of cabinet-agency partners consisting of Directors from the Departments of Alcohol and Drug Addiction Services, Aging, Budget and Management, Health, Job and Family Services, Mental Retardation and Developmental Disabilities, Mental Health; and the Superintendent of Public Instruction, who will provide advice and guidance for the implementation of the EMMA's responsibilities;
 - b. the EMMA staff;
 - c. subcommittees with representation from the Medicaid staff of the cabinet agencies that have Medicaid-related responsibilities.
6. **The Ohio Department of Job and Family Services Will Remain the Single State Medicaid Agency.** Federal law requires every state to appoint one agency to be responsible for applying for Medicaid grants or waivers,

administering and amending the state Medicaid plan, and ensuring that activities such as claims processing, drawing down Federal matching funds, and program integrity are conducted in compliance with federal law and regulations. Traditionally, the Ohio Department of Job and Family Services (“ODJFS”) has fulfilled this responsibility and, because it has established the infrastructure to competently fill this need, ODJFS will continue to serve as the single state Medicaid agency.

7. **The Ability of the EMMA to Enter into Contracts.** As the Executive Director deems necessary, the EMMA shall contract with state and/or private agencies for services in order to facilitate the implementation and operation of the EMMA's responsibilities, based on demonstrated experience and expertise in administration, management, data handling, actuarial studies, quality assurance, or other necessary skills.
8. **Annual Report Regarding the EMMA’s Progress.** Beginning November 15, 2008, and every November 15 thereafter, the Executive Director of the EMMA shall submit a written report to me, the Speaker of the House of Representatives, the Minority Leader of the House of Representatives, the President of the Senate, the Minority Leader of the Senate, and the members of the Joint Legislative Committee on Medicaid Technology and Reform, describing the activities of the EMMA and providing an update on its progress.

9. I signed this Executive Order on December 10, 2007 in Columbus, Ohio and it will not expire unless it is rescinded.



Ted Strickland
Ted Strickland, Governor

ATTEST:

Jennifer Brunner, Secretary of State

Appendix B

Executive Director

Cristal Thomas, MPP

Cristal Thomas was appointed Executive Director of the Executive Medicaid Management Administration (EMMA) effective January 1, 2008. Cristal has focused on health care throughout her career. She served as a policy and regulatory analyst in the White House Office of Management and Budget, where she focused on many aspects of federal health care policy. After leaving OMB, Cristal served as Director of Strategic Planning at the Illinois Department of Healthcare and Family Services (HFS), the state agency responsible for the Illinois Medicaid program and was later appointed Assistant Director of that agency.

In January 2007, Governor Ted Strickland named Cristal as the Ohio Medicaid Director. In this role, she was responsible for administration of the Medicaid and SCHIP programs in Ohio, as well as implementing many of the Governor's healthcare initiatives. As Executive Director of EMMA, Cristal is responsible for providing strategic direction and coordinating Medicaid policy across agencies and delivery systems.

EMMA Staff

Sandra Solano-McGuire, MD, MS Policy Advisor

Dr. Solano-McGuire was appointed Policy Advisory of the Executive Medicaid Management Administration on March 3, 2008. She has more than 15 years' experience in health care policy, quality of care and health statistics. Immediately prior to this position, she served as the Assistant Deputy Director for Benefits in the Ohio Department of Job and Family Services Office of Ohio Health Plans. Dr. Solano-McGuire also held the position of Director of Clinical Quality Management at the Ohio State University and was responsible for re-engineering Ohio's vital statistics system while at the Department of Health. As EMMA policy advisor, Dr. Solano-McGuire chairs the EMMA Strategy and Policy Subcommittee, Clinical Subcommittee, performs research, and serves as a senior advisor to the Executive Director and EMMA Council on Medicaid policy and operational issues.

Brad Singer, JD, Chief Legal Counsel

Brad Singer was appointed Chief Legal Counsel of the Executive Medicaid Management Administration on March 3, 2008. Mr. Singer has a strong record of community service, including a dual role as Board Chair and Legal Counsel of the Mental Health, Drug and Alcohol Services Board of Logan and Champaign Counties. He worked to create the Western Ohio Rural Federation and served on the Board of Directors of Champaign Residential Services, Inc., a provider of MRDD services. As legal counsel, Mr. Singer chairs the EMMA Legal and Program Integrity subcommittee, conducts legal research and advises the Executive Director and EMMA Council on Medicaid-related matters.

Mel Garner, Fiscal Advisor

Mel Garner was appointed as Fiscal Advisor of EMMA on March 31, 2008. Mr. Garner has a bachelors and masters degree in business administration and over 20 years' experience in systems auditing and fiscal operations. He began is career as a Systems Auditor at General Tire and Rubber and has held Systems Auditor and Audit Supervisor roles at Borden Corporation and BancOhio National Bank. Prior to joining EMMA, Mr. Garner served as the Manager of Payroll and Employee Benefits at Columbus Public Schools. Mr. Garner chairs the EMMA Budget and Finance subcommittee and supports the EMMA Consolidation Exploration Team.

Margo Pettis, Executive Assistant

Margo Pettis was appointed as Executive Assistant of the Executive Medicaid Management Administration on April 14, 2008. Ms. Pettis has over 30 years' of administrative experience in the private and public sectors supporting Senior Vice Presidents, Vice Presidents and other executive staff in the areas of real estate, legal, financing, administration and medical administration. Prior to joining EMMA, she served as the Administrative Assistant to the Deputy Director of the Division of Community Services in the Ohio Department of Mental Retardation and Developmental Disabilities for 10 ½ years. Ms. Pettis provides administrative support to the Executive Director, the Policy Advisor, Chief Legal Counsel, Fiscal Advisor, and to the EMMA subcommittees.

Appendix C

Consolidation Exploration Team (CET) Work Plan

Guiding Principles to the CET from the EMMA Council

1. EMMA wants to find the optimum balance between quality health care and cost.
2. EMMA wants to provide seamless service to the consumer and seamless participation to the providers.
 - a. EMMA sees technology as a primary enabler of seamlessness
 - b. Seamlessness includes one-stop-shopping for consumers regardless of how many agencies now serve them
3. EMMA believes that some level of consolidation would improve the collective analytical capabilities which are critical to improved quality of care and positive health care outcomes.
4. EMMA wants to maximize the service dollar by driving down overhead and transaction costs.
5. EMMA, while providing seamlessness, wants to maintain deep programmatic expertise and advocacy in its member agencies, as well as maintaining interactions with the consumers each serves.

Revised Charge

Identify opportunities for consolidation of business processes across EMMA Agencies. Using the MITA Framework, identify major business processes which support the delivery of the quality services balance against overhead and transaction costs for the state.

- Consolidation of business processes should be done in such a way that consumers and providers have an integrated experience with the health care providing state agencies.
- Integrating business processes and using shared technology will support data informed decision making and policy development to improve outcomes.

Challenges:

- Existing business processes are designed to support specific processes within agencies and organization systems.
- Agency processes are not easily comparable across agencies.
- Identifying consolidation opportunities for business processes that support multiple lines of business (Medicaid, non-Medicaid, health-related, other supports)
- Maintaining Policy expertise and consumer connections within agencies

Roles and Responsibilities

EMMA CET

- To identify business processes that can be consolidated and outline options for consolidation, including existing and shared technology.
- Identify issues that may need resolved to achieve sufficient efficiency for consolidation and refer to the EMMA Policy and Strategy Committee
- Identify options for consolidation that meet the operational needs of all agencies
- Use MITS or other existing technology to support processes when possible

EMMA Policy and Strategy Committee

- Review identified issues for policy considerations.
- Offer strategic direction on areas for consolidation, including framework for any “to be” states for consolidated processes.

Appendix C

Budget and Finance Subcommittee Charter

I. Mission

Provide coordination, guidance and analysis in support of agency budgeting and fiscal activities, consistent with the Administration's Health Care Vision. The Subcommittee work will:

1. Optimize efficiency, accountability and consistency of operations within the Medicaid program, across multiple agencies.
2. Support the agencies efforts in managing the costs of the Medicaid programs to achieve effective and efficient health care to Ohio's eligible low income families, aged, blind and disabled,
3. Support the implementation of a unified long term care budget and promote budgeting transparency,
4. Maximize federal funding in the Medicaid program by addressing statewide concerns with particular attention to federal matching funds.

II. Challenge

The Medicaid program is administered by the Ohio Department of Job and Family Services as the single state agency. In addition, the Ohio Department of Aging, the Ohio Department of Alcohol and Drug Addiction Services, the Ohio Department of Health, the Ohio Department of Mental Health and the Ohio Department of Mental Retardation and Developmental Disabilities administer significant Medicaid programs.

The sustainability of the Medicaid program depends in large part on managing costs, maximizing revenues and implementing a unified budget development methodology across all Medicaid programs.

The Budget and Finance Subcommittee will accomplish the goal of helping to contain costs through efficient budgeting methodology, cost effective reimbursement methods and transparent fund allocation. The result will be a Medicaid program that is able to serve the needs of our most vulnerable citizens while controlling the rate of growth.

III. Top Level Goals

GOAL AREA	GOAL DESCRIPTION
A. Support and monitor implementation of Phase 1 of the Unified Long Term Care Budget (ULTCB).	Coordinate and support the development of strategies to implement recommendations of the Unified Long Term Care Budget Workgroup Administrative Subcommittee.
B. Assist EMMA agencies in changing the provider reimbursement methodology in the behavioral health system from a cost-based and subsequently reconciled methodology to a fee schedule methodology, in collaboration with ODMH, ODADAS and OBM.	Support work of MH, ODADAS and JFS to implement a fee schedule reimbursement methodology that will improve access to services within a financially stable system that is compliant with federal law and the TCN settlement agreement.
C. Evaluate options for a single state fiscal intermediary.	The agencies have three separate Medicaid waiver program providers (Choices, Transitions and Home Choice) that provide home and community-based services and support to needy individuals. Evaluate the option of consolidating these services into a single provider to increase efficiency and obtain the most value for the cost.
D. Maximize federal funding across all Medicaid programs.	Review current system of financing Medicaid through a combination of local, state and federal funds and develop recommendations for a financing system that is predictable, equitable, transparent and efficient in delivering Medicaid services. Identify ways to address county inequities in the current financing structure.
E. Recommend EMMA initiatives to improve budgeting process and fiscal operations including identification and implementation of “best practices”.	Review “best practices” of other states in the areas of financing, budgeting and forecasting.
F. Track budget development and implementation from “global” Medicaid perspective.	Support decision making by EMMA Council and leadership within the Administration by creating global view of Medicaid budget and proposed budget initiatives across agencies.

IV. Objectives and Projects

A. Support and monitor implementation of Phase 1 of the Unified Long Term Care Budget (ULTCB) Administrative Subcommittee Recommendations.

OBJECTIVE	PROJECT	TARGET DATE
1. Develop common understanding of the recommendations from the Unified Long Term Care Budget Workgroup.	Produce a document that identifies and interprets the ULTCB recommendations related to EMMA and translate each recommendation into 'Actions Steps' review by the EMMA Council.	July 2008
2. The implementation of the ULTCB will be guided by an implementation plan with clear milestones, roles, and responsibilities	Produce an implementation plan based upon Action Steps discussed above with clear timelines, roles, responsibilities and milestones for the ULTCB recommendations and present to the EMMA Council.	Aug. 2008
3. The administration and decision making process of the ULTCB will be driven by performance management principles and informed by data.	Develop a reporting structure for the three levels of reports (performance, decision-making and management) recommended by the ULTCB Workgroup.	Aug. 2008
4. The administration and decision making process of the ULTCB will be driven by performance management principals and informed by data.	Develop performance metrics for the ULTCB and a process for tracking those metrics.	Oct. 2008

B. Assist EMMA agencies in changing the provider reimbursement methodology in the behavior health system from a cost-based and subsequently reconciled methodology to a fee schedule methodology, in collaboration with ODMH, ODADAS and OBM.

OBJECTIVE	PROJECT	TARGET DATE
1. Create plan for ongoing review of fee schedule that allows for a transparent and efficient process for rate updating.	Produce a document that recommends a “Beyond SFY 09” strategy for the Fee Schedule, including transparent process for periodic review and updating of rates and present to the EMMA Council.	Dec. 2008
2. The reimbursement rate process is informed by predetermined benchmarks, best practices and indicators of market changes.	Identify appropriate indicators of performance that would be used in the evaluation of the success and efficiency of the fee schedule.	Dec. 2008

C. Evaluate options for a single state fiscal intermediary.

OBJECTIVE	PROJECT	TARGET DATE
1. Contracting decisions regarding fiscal intermediary will be based upon an informed cost-benefit analysis.	Develop a comprehensive cost-benefit analysis that includes the particular business needs and risks of each agency and the potential efficiencies for the system as a whole. Present recommendations to the EMMA Council.	Aug. 2008
2. The acquisition process for a fiscal intermediary for waiver services will be informed and supported by the decision of the EMMA council.	Coordinate and support the development of a procurement process and implementation that follows the timeline and strategic objectives of the EMMA council. A detailed project plan will be presented to the EMMA Council.	Oct. 2008

D. Maximize federal funding across all Medicaid Programs.

OBJECTIVE	PROJECT	TARGET DATE
1. All eligible Medicaid services are provided and paid in a manner that maximizes federal contribution to the program.	Review health services to Medicaid-eligible provided by agencies and agency cost allocation plans to ensure federal revenue are being maximized. Recommend policies to maximize federal revenue.	Dec. 2008
2. Transfer processes between agencies will be timely and efficient.	Review cash transfer processes between agencies to identify ways to speed up transfer process. Recommend methods to speed up cash transfer process.	Aug 2008
3. Cash management policies and procedures are conducive to maximization of revenue.	Recommend policies to maximize cash flow.	Aug 2008

E. Recommend EMMA initiatives to improve budgeting process and fiscal operations including identification and implementation of “best practices”.

OBJECTIVE	PROJECT	TARGET DATE
1. Ohio Medicaid will be managed in accordance with best practices in financing, budgeting and forecasting.	Review “best practices” of other states in Medicaid financing, budgeting and forecasting. Prepare a gap analysis and correction plan and present to the EMMA Council.	Mar. 2009

F. Track budget development and implementation from “global” Medicaid perspective.

OBJECTIVE	PROJECT	TARGET DATE
1. Medicaid will have a process for coordinating budget development across agencies; including a consistent forecasting methodology.	Develop a process for tracking budget development across agencies, including forecasting and budget initiatives.	Oct. 2008
2. Support decision making by EMMA Council and leadership within the Administration by creating global view of Medicaid budget and proposed budget initiatives across agencies.	Create a budget document with a “global” view of the Medicaid budget proposals to facilitate decision making by the EMMA Council and Administration.	Dec. 2008

V. Critical Success Factors

- Each participating agency is committed to the success of the process.
- Each team member and his/her leadership do view participation as an essential part of their duties and important to the success of the program.
- The best interest of the consumer will always be a main concern.
- All actions and processes are undertaken with the goal to unify and build consistency in Medicaid policy and operations across all state agencies.
- Remain mindful of the issue of statewide, effective (results oriented), efficient (lowest total cost) and protection of the federal match.

VI. Team Norms

Acceptable Behavior

- Begin and end meetings on time.
- Be open, honest, and respectful in communication.
- Meet individual and team commitments.
- Maintain confidentiality of subcommittee.

Unacceptable Behavior

- Failure to give ideas and possibilities due consideration.
- Outright rejection of suggestions based solely on the status of state law.

VII. Communication Expectation

- The chair will provide a weekly update of subcommittee progress to the EMMA Executive Director. The update will highlight any milestones in danger of falling behind schedule.
- The subcommittee will review and approve a monthly written update to the EMMA Council.
- Each subcommittee member will communicate to his/her agency's leadership any outstanding/hot issues to avoid surprises (the monthly report should not be the first time that an EMMA Council Member learns of an issue).
- Each subcommittee member will seek expertise, as needed within his/her agency to gather information required for an informed recommendation.

Appendix C

Clinical Subcommittee Charter

Mission

Develop principles to guide the strategic direction of Medicaid across agencies, consistent with the Administration's Health Care Vision and with a focus on the Medicaid Administrative Study Council recommendations. The Subcommittee work will help ensure that:

- Medicaid provides clinical leadership with more emphasis on evidence-based care; and,
- Medicaid consumers receive health care services that are clinically effective and efficient.

Challenge

The Medicaid program accounts for 40%, all funds included, of the state's budget and its rate of growth has consistently outpaced the increase of revenue for the state. The costs related to the Medicaid program are driven by enrollment, covered services, and the payment for those services. As an entitlement, Medicaid has no control over the changes in caseloads, which are affected by economic conditions, and the cost increases in the health care market. As documented in the MASC report, 'Medicaid operates in a political environment where cost containment measures must be reconciled with the competing interest of beneficiaries, stakeholders, and constituents.' In order to achieve a sustainable, effective, and efficient program, it is essential that benefits decisions be grounded in the best scientific evidence available. This subcommittee will develop the framework in which policy decisions regarding coverage and reimbursement are supported by best clinical practice for each population and specific conditions. The first focus of this group will be related to children population and their specific needs.

These principles will help the program to

- Coordinate benefit coverage and payment decisions that support the most clinically effective and efficient health care delivery system.
- Transform the Medicaid system in support of the vision for the future state of the health care system in Ohio
- Establish a uniformed and informed process that would be informed by the political process but grounded in the best clinical evidence and practice.

The subcommittee will create the strategic principles that would allow for the provision of healthcare in the most effective and efficient way in accordance with the health care vision of the administration. In addition, the subcommittee will work with the provider community to transform the delivery system to support these principles. The result will be a Medicaid program that is able to serve the needs of our most vulnerable citizens with high quality of care while controlling the rate of growth of the program to an affordable and sustainable level.

Top Level Goals

GOAL AREA	GOAL DESCRIPTION
Develop a consistent, integrated and effective policy and strategy for EPSDT services	Develop the principles, policy and strategic plan to address the health care needs of Medicaid children, including the needs of children with Persistent Developmental or Mental Health Disorders, across the continuum of care with emphasis in the issues associated with the Early Periodic Screening, Diagnosis and Treatment.
Develop evidence-based approaches in Medicaid coverage and reimbursement policy.	Recommend strategic and operational principles that will allow policy decisions regarding coverage and reimbursement to be grounded in the best available scientific evidence of effectiveness and efficacy.
Improve coordination of covered services across systems.	Review and resolve differences in coverage of non-waiver services in sister agency systems in comparison with State Plan services, particularly coverage of prescription drugs and out of state services, to ensure that consumers are receiving the most appropriate and effective care.

Measures and Objectives

- **Develop a consistent, integrated and effective policy and strategy for EPSDT services**

OBJECTIVE	PROJECT	TARGET DATE
Have a consistent measurement strategy to evaluate the efficiency and effectiveness of the current services to meet the health care need of Medicaid children	Develop a dashboard to evaluate the current health status of Medicaid children and is able to evaluate the success of policy changes.	September, 2008
	Recommend improvements to current system for documentation of EPSDT services	December 2008
Strategic principles based on sound clinical evidence will guide EPSDT health coverage decisions.	Establish a list of principles to frame policy and strategy regarding the delivery of EPSDT services to children.	December 2008

OBJECTIVE	PROJECT	TARGET DATE
Integrated and coordinated delivery system that fulfills the screening, prevention, diagnosis, and treatment needs of children.	Develop policy and strategic plan with clear time lines to move the current payment and delivery system from a fragmented and overlapping system to an integrated and coordinated system that is able to deliver the most effective and efficient care.	Dec 2008

- **Develop evidence-based approaches in Medicaid coverage and reimbursement policy.**

OBJECTIVE	PROJECT	TARGET DATE
Medicaid supports the Administration's health care vision and Healthy Ohio principles.	Identify the synergy between current Medicaid programs and benefits and the Administration's vision and principles. Answer the questions: What is/should be the role of Medicaid in reaching the vision state.	Sept 2008
Best evidence available grounds the framework in which the administration makes new policy decisions.	Propose a set of policies and procedures to be adopted by the EMMA council that will ensure that the best available evidence for clinical effectiveness and efficiency is uniformly and consistently at the core of the decision making process for coverage and payment structure.	June 2009
The health care system which supports the delivery of services to Medicaid beneficiaries will be transformed to support the provision of the most effective and efficient care	Work with professional associations to recommend compensation models that will support innovative, evidence based, effective and efficient models of health care delivery.	June 2009

- **Improve coordination of Medicaid covered services across systems.**

OBJECTIVE	PROJECT	TARGET DATE
Consistent coverage of non-waiver services across the system	Review and guide resolution of differences in coverage of non-waiver services particularly coverage of prescription drugs and out of state services	June 2009
Consumers access the most appropriate and effective care	Develop a set of strategic and operational principles to be adopted by EMMA council that would allow for	Dec 2009

OBJECTIVE	PROJECT	TARGET DATE
	policy decisions for services across agencies to be coordinated and funded supporting the most appropriate and effective care.	

Critical Success Factors

- Each participating agency is committed to the success of the process
- Each team member and their leadership sees participation in the team as essential and important part of his/her duties and the success of the program.
- The best interest of the consumer will be always above turf.
- The team will always recommend the best policy even if today’s political/legal/financial environment would not allow for its full implementation. The team will recommend intermediary steps towards the optimal policy.

Team Norms

Acceptable behavior

- Open and frank communication
- Start on time, end on time
- Meet individual and team commitments
- Maintain confidentiality

Unacceptable behavior

- Reject an idea or opinion without exploring its potential.

Communication expectation

- The chair will provide a weekly update of activities to the EMMA Executive Director. The update will highlight if any of the milestones is in danger of falling behind.
- The subcommittee will review and approve a monthly written update to EMMA Council
- Each subcommittee member will communicate to his/her agency’s leadership any outstanding/hot issues and avoid any surprises (the monthly report should not be the first time that an EMMA council member hears of an issue).
- Each subcommittee member will seek expertise within his/her agency to gather information required for an informed recommendation.

Appendix C

Legal and Program Integrity Subcommittee

Mission

Provide advice, legal analysis, and guidance consistent with the Administration's Health Care Vision and with a focus on the Medicaid Administrative Study Council recommendations. The Subcommittee work will:

- Contain growth in costs in the Medicaid program by enhancing program integrity activities across state agencies,
- Protect federal funding in the Medicaid program by supporting JFS' role in assuring compliance with federal and state Medicaid laws and regulations,
- Improve accountability and consistency in sub-recipient relationships in delegated arrangements; and,
- Support consistency and the adoption of best practices in Medicaid program integrity activities.

Challenge

The Medicaid program is administered by the Ohio Department of Job and Family Services as the single state agency. Because of the scope and magnitude of the Medicaid program, significant responsibilities are carried out through delegated arrangements with other state agencies. In turn, there are sub-recipient agreements which further delegate functions to local agencies.

The sustainability of the Medicaid program depends in large part on controlling unnecessary costs and on the development of a single focus in the management of Medicaid. Several recent reports on the Ohio Medicaid program emphasize that a significant component of the necessary transformation of Medicaid is the need to strengthen accountability for interagency and sub-recipient agreements.

The Legal and Program Integrity Subcommittee will accomplish the goal of stronger accountability through the development of clear, definite, and consistent standards for use in all delegated arrangements. The result will be better managed and better monitored relationships between parties. In support of the coordination of Medicaid policies and functions across agencies, the subcommittee will review, develop, and recommend practices to ensure consistency with the strategic direction of Medicaid and which maximize the efficient and effective delivery of Medicaid services.

Top Level Goals

GOAL AREA	GOAL DESCRIPTION
Develop consistent policy for sub-recipients in Medicaid and a framework for accountability.	Clearly define the legal parameters of the relationship between the State and entities that are funded by the State.
Develop standards for State agency roles in Medicaid program integrity (audits and utilization review).	Recommend legally appropriate roles for State agencies in the implementation of audit and utilization review functions.
Review recommendations from the TCN MOU workgroup on developing a utilization review program for the community behavioral health Medicaid program.	Review recommendations for compliance with federal and state requirements. Support and assist in the implementation of adopted recommendations of the workgroup to assure that utilization review is established and performed in a legally appropriate and efficient manner.
Develop a consistent presumptive enrollment policy for the Medicaid program.	Evaluate current enrollment procedures and policy. Create, recommend, and pursue implementation of policy to result in a more efficient and consistent enrollment process.
Develop framework for data sharing to support coordinated analysis across agencies (particularly in the context of the unified long-term care budget).	Identify sensitive data and legal requirements for construction of cross data sharing agreements. Recommend common outline and necessary elements for agreements. Particular attention on data sharing between agencies serving the Aged, Blind, and Disabled.

Measures and Objectives

- **Develop consistent policy for sub-recipients in Medicaid and a framework for accountability.**

MEASURE	OBJECTIVE	TARGET DATE
Determine areas common to agency sub-recipient agreements and develop policy guidelines.	Produce document that sets forth commonalities across agency S-R agreements and contains additional recommendations to strengthen accountability.	August 2008

Establish guidelines for consistent application in all sub-recipient arrangements.	Produce document that recommends the adoption of template language and/or a template agreement for use in Medicaid sub-recipient agreements that clearly defines the legal authority/liability of each party and emphasizes accountability.	Dec. 2008
Pursue Statutory and/or Rule changes as needed to implement policy.	Produce framework to coordinate legal authority and procedures necessary to allow for implementation as part of SFY 2010-2011 budget.	June 2009

- **Develop standards for State agency roles in Medicaid program integrity (audits and utilization review).**

MEASURE	OBJECTIVE	TARGET DATE
Reduce confusion and conflict between ODJFS and sister agencies in oversight functions.	Identify legally required roles and areas that cannot be delegated by ODJFS. Identify functions that can/should be delegated to sister agencies, remaining mindful of protection of the federal match.	August 2008
Determine common functions for delegation that are able to be clearly delineated, maximize efficiency, and provide for accountability of performance.	Produce document that establishes and supports the roles, authorities, and liabilities between ODJFS and sister agencies in the context of auditing and utilization review.	Sept. 2008
Establish guidelines for consistent application in all delegated arrangements.	Recommend adoption of standards of responsibility and accountability for Medicaid audit and utilization review functions.	Dec.2008

- **Review recommendations from the TCN MOU workgroup on developing utilization review program for the community behavioral health Medicaid program.**

MEASURE	OBJECTIVE	TARGET DATE
Review the recommendations from the TCN MOU workgroup for development of utilization review.	Develop document based from those recommendations that establishes a UR program that supports move to fee schedule reimbursement and improves program integrity in BH system.	August 2008
Implementation of utilization review for the behavioral health system.	Recommend a strategic plan for implementation of the utilization review program in behavioral health system.	Oct. 2008

- **Develop a consistent presumptive enrollment policy for the Medicaid program.**

MEASURE	OBJECTIVE	TARGET DATE
Develop policy options and evaluate impact.	Identify ways to improve the efficiency of the process and to improve access to medically necessary services. Explore opportunity to standardize enrollment across Medicaid program, with awareness of budget impact. Produce document outlining policy choices to present for implementation.	Jan. 2009
Pursue Statutory and/or Rule changes as needed to implement policy.	Produce framework to coordinate legal authority and procedures necessary to allow for implementation.	June 2009

Implementation of policy.	As implemented, policy is clear and easily navigated by consumers. Service dollars may be increased but administrative costs are generally reduced.	July 2009
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- **Develop framework for data sharing to support coordinated analysis across agencies (particularly in the context of the unified long-term care budget).**

MEASURE	OBJECTIVE	TARGET DATE
Evaluate current practices used by agencies when sharing data.	Develop a framework for understanding agency specific legal requirements surrounding the dissemination of data. Focus on issues germane to the ABD population.	July 2008
Establish standards for data sharing agreements.	Produce document(s) with standard and accepted language and conditions to be recommended for inclusion in all agreements; allowing for data sharing necessary to improve the management of the Medicaid program through more accurate planning, forecasting, and budgeting.	Dec. 2008

Critical Success Factors

- Each participating agency is committed to the success of the process.
 - Each team member and his/her leadership see participation in the team as an essential and important part of their duties and to the success of the program.
 - The best interest of the consumer will always be above turf.
 - All actions and processes are undertaken with the goal to unify and build consistency in Medicaid policy and operations across all state agencies.
 - Remain mindful of the single state agency, the issue of state-wideness, and protection of the federal match.

Team Norms

Acceptable behavior

- Begin and end meetings on time.
- Be open, honest, and respectful in communication.
- Meet individual and team commitments.
- Maintain confidentiality of subcommittee.

Unacceptable behavior

- Failure to give ideas and possibilities due consideration.
- Outright rejection of suggestions based solely on the current status of the law.

Communication expectation

- The chair will provide a weekly update of subcommittee progress to the EMMA Executive Director. The update will highlight if any of the milestones is in danger of falling behind.
- The subcommittee will review and approve a monthly written update to the EMMA Council.
- Each subcommittee member will communicate to his/her agency's leadership any outstanding/hot issues to avoid surprises (the monthly report should not be the first time that an EMMA Council Member learns of an issue).
- Each subcommittee member will seek expertise as needed within his/her agency to gather information required for an informed recommendation.

Appendix D

EMMA FY08 Actual Expenses

Expense Account Code	Expense Account Code Description	SFY08 Actual Expenses
5010	Payroll Expense	\$152,878.64
5100	Purchased Personal Services	\$265.00
5210	Supplies, Materials and Minor Expenditures	\$68.00
5230	Travel	\$819.49
5290	General and Other Expenses	\$502.40
	Total:	\$154,533.53

Executive Medicaid Management Administration (EMMA) – SFY09 Budget

Expense Account Code	Expense Account Code Description	SFY09 Budget
5010	Payroll Expense	\$452,766.00
5100	Purchased Personal Services	\$719,106.00
5210	Supplies, Materials and Minor Expenditures	\$5,000.00
5230	Travel	\$10,000.00
5290	General and Other Expenses	\$5,000.00
	Total:	\$1,191,872.00