

*An Update on the Report of the  
Ohio Medicaid Administrative Study Council*

# Managing Medicaid



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# **Managing Medicaid: An Update on the Report of the Ohio Medicaid Administrative Study Council**

**April 1, 2009**

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The Ohio Medicaid Administrative Study Council (OMASC) released a final report and recommendations on the administration of Ohio's Medicaid program in 2006. The recommendations involved the consolidation of all state Medicaid services into a new Department of Medicaid rather than its existing delivery through the Ohio Department of Job and Family Services (ODJFS) and multiple other cabinet-level agencies. House Bill 66, in 2005, established the Council to develop recommendations on the establishment of a separate Medicaid department that would be responsive, accountable, and efficient and improve health care services for Ohio. OMASC presented its Final Report and recommendations in December, 2006, after a one-year analysis which included considerable public input.

While a new department of Medicaid has not been created, the Strickland administration has attempted to meet many of the objectives suggested for OMASC for this through the Executive Medicaid Management Administration (EMMA), a cabinet level body created by Governor Strickland to coordinate Medicaid across all state agencies.

## **PART I: Overview**

### **Reasons for OMASC**

Governor Bob Taft and the General Assembly created OMASC to continue work initiated in the 2005 report of the Ohio Commission to Reform Medicaid (OCRM). OCRM's recommendations focused on service delivery system problems, eligibility, and finance, focusing considerable attention on ways to control the rising costs of Medicaid. OMASC, focusing on the problems in the state's administration of Medicaid, recommended a separate Medicaid department to streamline the disjointed organizational structure to increase efficiencies and improve overall health outcomes.

Ohio's Medicaid spending had been growing at an unsustainable rate. In the first half of the decade, Medicaid spending had increased almost 70 percent while General Revenue Funds increased only 27 percent.<sup>1</sup> During this period, Medicaid's share of the General Revenue Fund budget grew from 30 percent to 40 percent.<sup>2</sup> Medicaid's share of the budget has stabilized, but caseloads and expenditures continued to grow, with caseload growth accelerating since the recession began in late 2007. Ohio's Medicaid caseload has grown six percent between December, 2007, and January, 2009.<sup>3</sup> Nationally,

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<sup>1</sup> OMASC final report p. 16

<sup>2</sup> OMASC final report p. 16

<sup>3</sup> State Budgeting Matters, FY 2010 – FY 2011 State Budget: 10 Critical Questions, February 13, 2009

Medicaid expenditures are expected to continue growing at 7.9 percent annually through 2017.<sup>4</sup> Medicaid's share of the budget is expected to grow again as caseloads continue to grow with the continuing effects of the recession and as more baby-boomers reach retirement age.

### **Overview of OMASC Final Report**

The OMASC report recommended the development of a separate Medicaid department. The Ohio Department of Medicaid (ODOM) was proposed to centralize management and use a new claims processing system which, through Medicaid Information Technology System (MITS), was already in the process of being implemented. The recommendations also included developing employee skills, increasing accountability for delegated Medicaid responsibilities, obtaining stakeholder input in decision-making, and managing the transition to a new Medicaid department.

### **Progress on Combined State Agency**

Rather than creating an additional state agency, Governor Strickland established EMMA in December, 2007, as an independent cabinet-level coordinating body to manage Ohio's Medicaid program across state departments.<sup>5</sup> ODJFS remains the single state Medicaid agency for the purpose of compliance with federal law and regulations because it has the infrastructure to do so. Approximately 85 percent of expenditures for Medicaid services are budgeted in ODJFS. In addition, ODJFS works with the U.S. Department of Health and Human Services on behalf of Ohio, draws federal matching funds, adjudicates Medicaid claims, and delegates Medicaid responsibilities to sister agencies. Other state agencies that participate in the Medicaid program include Department of Mental Retardation and Developmental Disabilities (\$1.1 billion in fiscal year 2008), Department of Aging (\$397 million), Department of Mental Health (\$450 million), Department of Alcohol and Drug Addiction Services (\$70 million), Department of Health (regulates nursing facilities), and Department of Education.<sup>6</sup>

The executive order that created EMMA listed one of its responsibilities as implementing appropriate recommendations of the Ohio Medicaid Administrative Study Council.<sup>7</sup> EMMA's original goals were the same overall goals (to improve efficiencies, comply with all applicable law, and maximize federal funding) as the agency proposed by OMASC. EMMA is intended to act as a virtual agency to further the intentions of the OMASC recommendations without the creation of a separate state department. It does so by coordinating policies across Ohio's agencies.

EMMA has a cabinet council comprised of the directors of the Departments of Alcohol and Drug Addiction Services, Aging, Health, ODJFS, Mental Health, Mental Retardation and Developmental Disabilities, the Office of Budget and Management (OBM), and the Superintendent of Public Instruction.<sup>8</sup> The EMMA cabinet council meets bi-weekly, and EMMA reports on its progress to the governor and legislature each November.<sup>9</sup> To carry out the agenda of the cabinet council, a number of subcommittees, made up of staff from participating agencies and led by the EMMA staff, were created to coordinate

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<sup>4</sup> 2008 ACTUARIAL REPORT ON THE FINANCIAL OUTLOOK, FOR MEDICAID, U.S. Dept. of Health and Human Services p. 15

<sup>5</sup> Governor Strickland Executive Order 2007-36S, December 10, 2007

<sup>6</sup> Executive Budget for 2010-11

<sup>7</sup> Governor Strickland Executive Order 2007-36S, December 10, 2007

<sup>8</sup> Governor Strickland Executive Order 2007-36S, December 10, 2007

<sup>9</sup> Governor Strickland Executive Order 2007-36S, December 10, 2007

policies. This structure differs from the OMASC concept to have one department have operational and fiscal authority and accountability for Medicaid's various functions.

### **MITS: Replacement of Medicaid Claims Processing and Information System**

The Medicaid Information Technology System (MITS), initiated by ODJFS during the period OMASC was meeting, is intended to replace the 25-year-old legacy Medicaid Management Information System (MMIS) to process claims and to collect and use program data. A topic of considerable importance to OMASC as it provided a vehicle for improved efficiency envisioned by the Council, MITS will have the capacity to centralize many IT functions, provide greater flexibility, and improve the timeliness of Medicaid's massive data processing. MITS is based on a framework designed by the federal government, called Medicaid Information Technology Architecture (MITA), and will automate many processes and reduce the use of paper. Ohio was chosen as an early adopter of this IT system, which will eventually be required in all states. It will use the Internet in an attempt to provide better access and timely information to consumers, county departments, sister state agencies, fee-for-service providers, and managed care plans. MITS is being developed to be adaptable to the future needs of broader health care policy, and be able to integrate state and federal policy changes. It will also have the potential for future enhancements to operate some non-Medicaid health care programs. MITS is scheduled to begin managing the functions that MMIS currently handles in late, 2009. At initial roll-out, MITS will have the capacity to better integrate Medicaid services, and focus should be on finding ways to hasten the progress of this potential.

### **EMMA: Intent and Reality**

EMMA is undergoing a structural reorganization in early 2009—a little over a year after its creation. EMMA was organized to coordinate Medicaid while programs remain in the same agencies. The pending EMMA reorganization raises questions about the success of this approach thus far. However, the reorganization is expected to build on and improve the work done by the original EMMA subcommittees. The organizational changes are designed to remove silos to better focus on achieving the goals of EMMA.

EMMA's five subcommittees have carried out the majority of EMMA's work based on guidance from an EMMA Council. The EMMA Council has set its priorities based on the needs of partner agencies and the recommendations of OCRM, OMASC, and the Auditor of State Medicaid Performance Audit.<sup>10</sup> There have been changes in personnel, and the subcommittees are also undergoing changes. Each subcommittee has been co-chaired by one EMMA staff member and one representative of a partner state agency. The five EMMA subcommittees that operated during 2008 aligned with the divisions that OMASC recommended for ODOM. The EMMA subcommittees included:

- Administrative Efficiency, operated as the Consolidation Exploration Team (CET) to address business processes
- Budgeting and Finance
- Clinical
- Legal and Program Integrity
- Strategy and Policy

While the divisions recommended by OMASC may have worked in a separate Medicaid agency, when used by an independent coordinating body, this model proved to be ineffective at achieving true

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<sup>10</sup> EMMA Annual Report, 2008

coordination. EMMA has addressed this by organizing interdisciplinary teams around the established goals to continue its work. It is expected that this will increase efficiency and effectiveness.

EMMA's staff no longer includes the positions that co-chaired the Administrative Efficiency, Budgeting and Finance, Clinical, and Strategy and Policy subcommittees. The Administrative Efficiency and the Budgeting and Finance subcommittees had been co-chaired by EMMA's Fiscal Officer. The Clinical and the Strategy and Policy subcommittees had been co-chaired by EMMA's Policy Advisor. EMMA continues to staff a legal counsel position, which co-chaired the Legal and Program Integrity subcommittee in 2008.

Meanwhile, EMMA has added a Project Manager and a Policy Analyst to its staff. The Project Manager, who focuses on streamlining business operations, is working with partner agencies to align business processes across agencies with the federal MITA framework with the goal to improve efficiencies to make the process easier to understand and navigate. The Policy Analyst will take on the functions of the Policy Advisor with a more specific focus on policy areas highlighted by OMASC, including the creation of a unified long-term care system, and policies related to aligning business processes.

In addition, EMMA has adopted the following goals for 2009:

- Develop a five year plan to align agency Medicaid and related non-Medicaid business processes with the federal Medicaid Information Technology Architecture (MITA) Framework ;
- Develop a transparent process for establishing and reviewing provider rates for similar Medicaid and non-Medicaid services across state agencies;
- Coordinate long-term care planning activities for a comprehensive and balanced long-term care system; and
- Coordinate Medicaid-related program integrity activities across state agencies to avoid duplication, reduce administration, and prioritize activities based on risk.

The new goals further define the role that EMMA will have in reforming Medicaid. They support the OMASC recommendations by facilitating implementation of the unified long-term care budget and improving coordination of long-term care services within and outside of the Medicaid program.

However, EMMA's pending organizational changes may suggest the difficulty of having an independent office lead reform while accountability remains with each administering agency. The success of the various Medicaid administering units is not measured on the basis of metrics as was envisioned by OMASC. As long as multiple agencies provide Medicaid, those agencies will have to compete for resources and authority. This again begs the question considered by OMASC and, before it, by the Ohio Commission to Reform Medicaid, of whether achieving Medicaid coordination requires a single agency to maintain overall program authority and accountability.

Short of this, Ohio could more strongly align funding during the next biennium to create a unified long-term care budget. This could be done in steps, for example by beginning with discrete line-items for state and federal funds supporting health care services for older adults. In doing so, consideration could be given to sun-setting statutes defining nursing home payments (repeal of which was recommended by OCRM), providing flexible authority to expand assisted living and community-based services consistent with demand, authorizing aggressive efforts to reduce nursing home utilization (specifically including

hospital discharges of non-elderly patients with mental illness), and authorizing alternative uses of state funds for non-Medicaid services such as housing.

## **Part II: Progress Notes**

This section provides brief summaries of OMASC recommendations together with progress notes on their status.

A new cabinet-level department, The Ohio Department of Medicaid, should be created to manage Ohio's entire Medicaid program. The Department of Medicaid's organizational structure is outlined in the Department of Medicaid Organizational Structure Document

As previously described, Governor Strickland established EMMA as a cabinet level office that coordinates Medicaid services across agencies. While this is not a new department, it does appoint a cabinet-level position with the duty to coordinate services. As previously described, EMMA has five subcommittees to integrate the delivery of Medicaid services and further the administration's health care vision.

OMASC recommended the following divisions for the ODOM: Strategy, Clinical, State Plan, Finance, IT, Legal, Organizational Development, and Program Integrity and Audit. The five EMMA subcommittees are undergoing change, but as of early 2009, they align with the strategic divisions recommended by OMASC. The consolidation of operational units envisioned by OMASC has not been accomplished. The organizational structure envisioned by OMASC may be better suited for a Medicaid agency. When used by EMMA, as an independent coordinating body, it resulted in an unintended silo approach to issues. The new EMMA structure will instead use interdisciplinary teams focused on the established goals.

EMMA's Clinical subcommittee focuses on evidence-based care that is clinically effective and efficient. This corresponds to the OMASC recommendation for a clinical division to put an emphasis on evidence-based care, identify health care trends, and identify medically unnecessary procedures. The development of the evidence-based practices that are essential to improve program delivery requires knowledgeable clinical people from the field. This is also expected to be a focus of the newly created Health Care Coverage and Quality Council.

EMMA's Policy and Strategy subcommittee took on essentially the same role as the OMASC recommendation for a State Plan division by coordinating strategies, policies, and programs. The EMMA Policy Analyst will now perform this coordinating role.

EMMA's Budget and Finance subcommittee fulfilled a role envisioned by OMASC for a finance division, by coordinating budgets. This subcommittee will not continue because it was found to be duplicative of the role of OBM.

EMMA did not have a subcommittee that specifically aligned with OMASC's recommendations for an Information Technology division; however EMMA's Project Manager is now working in this area.

The EMMA Legal and Program Integrity subcommittee, chaired by EMMA's Chief Legal Counsel, assures compliance with state and federal law and largely fits OMASC's recommendation for a Legal division. EMMA's Legal and Program Integrity subcommittee also meets the purposes of the OMASC Program Integrity and Audit division because it develops standards and implements processes to

improve program integrity including audit and utilization review. This work will continue under the leadership of the EMMA Legal Counsel.

OMASC's recommendation for an organizational development manager to attract good employees has not been accomplished. In fact, due to budget cuts, administrative positions in many of the EMMA-member agencies have been eliminated.

The Department of Medicaid should operate in a manner consistent with the Department of Medicaid's Mission Statement and Operating Principles.

Governor Strickland established the office of EMMA to coordinate Medicaid policies, implement appropriate OMASC recommendations, and facilitate compliance with federal law and enable effective decision-making.<sup>11</sup>

The EMMA Budget and Finance subcommittee, the Clinical subcommittee, and Legal and Program Integrity subcommittee have mandates requiring them to work consistently with the Administration's Health Care Vision, which follows:

The administration's vision for health care in Ohio's future is: 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, and efficient physical and behavioral 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.<sup>12</sup>

The OMASC recommendation for the mission of the ODOM was "[t]o assure the provision of effective and efficient health care to Ohio's eligible low income families, aged, blind, and disabled." OMASC described effective and efficient care as that which is medically necessary according to evidence-based and generally accepted standards. It described efficient health care as the lowest total cost methodology of providing effective care.

The Administration's Health Care Vision and ODOM's operating principles share an emphasis on efficiency and coordinated information technology to inform decision making. The Administration's Health Care Vision is notable for including proactive approaches such as education and lifestyle to promote good health. However, some observers note that our health care system first needs to make progress using evidence-based practices to improve the effectiveness and efficiency of clinical services.

The Department of Medicaid should operate as part of a broader Health Care strategy developed by the Ohio Health Policy Advisory Committee.

The administration is developing broad health care goals and objectives, which the EMMA Strategy and Policy subcommittee had planned to incorporate in its work as it guides Medicaid policy.<sup>13</sup>

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<sup>11</sup> Governor Strickland Executive Order 2007-365, December 10, 2007

<sup>12</sup> ODJFS Medicaid Performance Report, December 18, 2008

<sup>13</sup> OMASC Update, Appendix 2 of ODJFS Medicaid Performance Audit, December 18, 2008

The Department of Medicaid should be appropriated the funds for and manage the programs that provide health care related services to Ohioans with demographic characteristics similar to Medicaid eligible consumers. Examples include: the Disability Medical Assistance program, the Residential State Supplement program, and Best Rx, the prescription drug component of the Golden Buckeye Card. The administration has taken some steps to plan to integrate the delivery of appropriate non-Medicaid programs with Medicaid services. For example, when MITS becomes fully operational, it will help with the administration of Disability Medical Assistance along with Medicaid programs.<sup>14</sup> Disability Medical Assistance (DMA) is a state-funded program available to people who are medication dependent who are not eligible for Medicaid.<sup>15</sup> With a shorter disability determination period for Medicaid, participants will spend less time in DMA. However, DMA's caseload continues to fall as it remains closed to enrollment. This recommendation will no longer apply well to Best RX, which will be eliminated in 2010, or to RSS, which provides a supplement to some people who also receive Medicaid.

If MITS is eventually able to manage some non-Medicaid services, such as those offered in mental health and alcohol and drug addiction systems, it could improve overall health care coordination.

One example of where Medicaid programs can serve demographically similar participants is in disability determination. There are currently two disability determination processes – one used by ODJFS and another for Rehabilitation Services Commission Bureau of Disability Determination, which results in administrative redundancy in the disability determination application, clinical evidence collection, and case processing. In September, 2008, ODJFS, the Ohio Rehabilitation Services Commission, and representatives from county agencies met and selected a model for a consolidated disability determination process, which is being further developed.<sup>16</sup>

The Department of Medicaid should develop employment positions that have career paths which encourage and allow employees to advance their career in their area of competency while minimizing the need for the department to create unnecessary management positions. This may include the need for the department to get certain exemptions from the Department of Administrative Services for alternative classification specifications and pay ranges.

The Office of Ohio Health Plans (OHP), the unit within ODJFS that administers much of the Medicaid program, has done a knowledge, skills, and abilities assessment of most employees to ensure that their skills match the department's needs, and to provide employee training where needed.<sup>17</sup> However, budget cuts have significantly reduced staffing levels.

The changes associated with the creation of the Department of Medicaid should be implemented as quickly and completely as possible as outlined in the Transition Plan while avoiding unnecessary disruptions at the local level and affected state agencies.

Because the advent of EMMA left state Medicaid administering agencies intact, the disruption anticipated from reorganization did not occur. As MITS implementation progresses, more of the OMASC recommendations will be followed. ODJFS is conducting both internal and external training well ahead

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<sup>14</sup> Frequently Asked Questions on Medicaid Information Technology System Design, Development, Implementation & Business Transformation, Q1.

<sup>15</sup> ORC 5101:1-42-01

<sup>16</sup> September, 2008 memo from John Corlett, and John Connelly

<sup>17</sup> Ohio Medicaid Program Follow-up Performance Audit, December 18, 2008

of time to minimize disruption. It reports on the progress of MITS in *Ohio MITS Renaissance*, a monthly newsletter, and management staff continues to meet weekly to discuss implementation.<sup>18</sup>

The Department of Medicaid should use the Delegation Assumptions and Principles created by the Council to guide its decision to delegate Medicaid responsibility to other parties. The Delegation Assumptions and Principles should be consistently applied, emphasizing accountability, to all delegated arrangements with sister state agencies and local entities. The ODOM should be held accountable for the outcomes of its delegated arrangements and must actively monitor for compliance and overall performance.

With nearly two million participants each month, Ohio Medicaid must rely heavily on partner agencies for service delivery. Ohio Medicaid is administered through seven state agencies,<sup>19</sup> 88 county departments of Job and Family Services in addition to county boards of MRDD, behavioral health boards, 12 Area Agencies on Aging, eight managed care organizations, and over 64,000 health care providers.<sup>20</sup> This requires consistent and reliable accountability. The Council's Delegation Assumption and Principles require that each party to an interagency agreement understand its role and responsibilities, be held accountable for performance, and have the authority to manage delegated duties.

The EMMA Legal and Program Integrity subcommittee is devising standards to be used when delegating Medicaid responsibilities. The standards will better define the relationships between the state and its partners, including data sharing for better analysis of program data across agencies.<sup>21</sup> Interagency agreements speak to the Medicaid responsibilities shared between ODJFS and its sister agencies.<sup>22</sup>

One example of restructuring delegated responsibilities is the administration of the community behavioral health Medicaid program. The 2010-2011 executive budget creates an advisory group to study the issue of transferring the responsibility for paying providers of Medicaid-covered community behavioral health services and related management responsibilities from boards to the departments of Mental Health and Drug and Alcohol Addiction Services. This change would give the state both the responsibility for financing and management control over the Medicaid program. This could relieve some of the strain on county budgets by reducing administrative costs needed to process claims and freeing up county levy dollars for other local mental health needs. Many county boards were supplementing their allocations from the state with local funds to cover Medicaid expenses. The economic downturn has increased demand for services while the 2005 tax reforms will diminish some local dollars.

ODOM should develop its own expertise with regard to the overall health needs of the aged, blind and disabled, in addition to leveraging the specialty expertise already present in the sister agencies. The purpose of this recommendation was to allow the state to serve aged, blind, and disabled (ABD) consumers based on their needs and preferences rather than organizing services by the type of provider. ODJFS reported in its December 18, 2008, Medicaid Performance Report that it and its partner agencies

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<sup>18</sup> ODJFS quarterly cost containment report October, 2008

<sup>19</sup> ODJFS administers Ohio Medicaid. The state Departments of Aging, Alcohol and Drug Addiction Services, Education, Health, Mental Health, and Mental Retardation and Developmental Disabilities administer various elements of the Medicaid program through interagency agreement with ODJFS.

<sup>20</sup> Ohio Medicaid Basics 2009

<sup>21</sup> EMMA Annual Report, November, 2008, Appendix C

<sup>22</sup> ODJFS Medicaid Performance Report, December 18, 2008, Appendix 2

have the expertise to successfully serve ABD populations, and it plans to continue to build this expertise. As Ohio implements the Unified Long-term Care Budget with ODJFS, sister agencies, and OBM, it will be able to better track information on the ABD population. The HOME Choice program will provide information about the state's capacity to provide community-based long-term care services, and ODJFS is developing a tool to measure the success of Money Follows the Person over time.<sup>23</sup> Additionally, ODJFS collects clinical performance data on the ABD population from managed care providers.<sup>24</sup>

The new department should have a consolidated budget for aged, blind and disabled (ABD) recipients, including waivers for the ABD population, and should be organized to establish expertise, strategically plan, and perform, delegate or contract those functions necessary to assure the delivery of services for the aged and disabled (including waiver recipients) as a group rather than by service type (either Long-Term Care or acute care).

The OMASC final report recommended a unified budget for Medicaid-funded long-term care services including waivers for the ABD population, to provide a continuum of needed services rather than organizing programs by provider type. The purpose for this recommendation was to increase flexibility to be able to adjust services and reduce the average length of institutional treatment. This would help shift consumers from institutional care to home and community-based care to meet consumer preference and reduce Medicaid expenses. Existing programs steer consumers to institutional care, as they face waiting lists when seeking home and community-based care. The state has spent approximately \$4.7 billion annually for long-term care, most of which has paid for institutional care.<sup>25</sup> The year OMASC released its final report, Ohio spent 28.2 percent of its long-term care Medicaid expenditures on community-based care while the national average was 40.9 percent.<sup>26</sup> Ohio offers more institutional options and fewer community-based options than other states.<sup>27</sup>

The Ohio Department of Aging (ODA), pursuant to a legislative directive in House Bill 119, convened a workgroup and developed recommendations for a unified long-term care budget (ULTCB). The goal for the ULTCB is to provide long-term care services based on consumer need and choice rather than funding stream. Most consumers prefer to stay in the community as long as possible, and this is also less costly than institutional care. The workgroup recommendations include four phases to address all Ohioans in need of long-term care services. Phase one addresses those needing Medicaid-funded facility-based services and those in home and community-based settings. Phase two includes people without access to Medicaid waiver programs, mostly those in need of behavioral health services. Phase three focuses on those who received services for MRDD. Phase four expands the ULTCB to address people who are not eligible for Medicaid.<sup>28</sup>

The ULTCB workgroup recommended a plan that would implement a unified long-term care budget in three stages over the course of five years. The first stage would identify line items that fund long-term care in various state agencies (ODJFS, ODA, Ohio Department of Mental Health, and Ohio Department of Mental Retardation and Developmental Disabilities) and transfer funds from these line items, with

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<sup>23</sup> ODJFS Medicaid Performance Report, December 18, 2008, Appendix 1

<sup>24</sup> ODJFS Medicaid Performance Report, December 18, 2008, Appendix 1

<sup>25</sup> Legislative Services Commission analysis of 2010-11 executive budget

<sup>26</sup> The Henry J. Kaiser Family Foundation State Health Facts

<sup>27</sup> FY2010-11 Executive Budget analysis p. D-50

<sup>28</sup> 'Unified Long-Term Care Budget Offers Changes for the Better,' by Peg McCarthy, *Planning & Action, The Journal of the Center for Community Solutions*, December, 2008

approval of the Controlling Board, to new long-term care line items that were established in House Bill 119. The second stage would appropriate funds directly to each agency's new long-term care line items in the 2010-2011 budget. The third stage would create a single long-term care line item for ODJFS to include all long-term care spending starting in the 2012-2013 budget.<sup>29</sup>

ODA administers three Medicaid waiver programs that give consumers the option to receive home or community-based care – PASSPORT, Choices, and Assisted Living. A waiver allows a state, with permission from the federal government, to use Medicaid funds in a program that has some of the federal Medicaid restrictions waived. Ohio has five other waivers administered by ODMRDD and ODFJS.

The 2010-2011 executive budget proposes to implement the first stage of the ULTCB recommendations by collapsing the budgets for PASSPORT, Assisted Living, and PACE into a single long-term care line. ODA has reported that it plans to explore the possibility of combining these three waiver programs into a single waiver.<sup>30</sup> EMMA's Consolidation Exploration Team Workgroup will also begin to examine current home and community-based waiver services to identify opportunities for coordination. ODA plans also include implementation of phases two through four of the ULTCB recommendations at a later time as the information technology (IT) systems become more integrated across agencies.<sup>31</sup> The 2010-2011 executive budget proposes to continue the ULTCB workgroup. EMMA's Policy Analyst will also work with a stakeholder group to implement the ULTCB.

Collectively, Ohio's eight Medicaid waivers served 61,000 people with alternative long-term care in fiscal year 2007.<sup>32</sup> The 2010-2011 executive budget would increase this number. In ODA, it would fund 31,900 PASSPORT slots, which is anticipated to be sufficient to meet demand during the budget period. The executive budget would also fund 1,800 slots in Assisted Living and 880 slots for PACE. It would continue Ohio's Home Choice program funded through the Money Follows the Person grant (established in the Federal Deficit Reduction Act of 2005) to return an estimated 2,231 people from institutional care back into a community setting. This program provides an enhanced federal match of almost 80 percent for the first 12 months in home or community-based care.<sup>33</sup> The state is also working with the Area Agencies on Aging to update the *Ohio Long-term Care Consumer Guide* to provide more information about community-based services.

ODJFS is working with ODA and the Ohio Department of Mental Health to make improvements in PASRR (pre-admission screening and resident review) to prevent inappropriate institutionalization of people with behavioral health needs and to identify appropriate community resource that can better meet their needs. ODJFS plans to have rules promulgated in 2010, and to work regionally with partners during implementation.<sup>34</sup>

The executive budget relies partially on federal stimulus funds to expand community-based long-term care options. In total, ODJFS expects to receive \$2.9 billion in federal fiscal relief for Medicaid.<sup>35</sup> While

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<sup>29</sup> Legislative Services Commission analysis of 2010-11 executive budget

<sup>30</sup> Testimony of Barbara Riley, Director of Department of Aging, March 5, 2009

<sup>31</sup> Testimony of Barbara Riley, Director of Department of Aging, March 5, 2009

<sup>32</sup> Legislative Services Commission analysis of 2010-11 executive budget

<sup>33</sup> Legislative Services Commission analysis of 2010-11 executive budget

<sup>34</sup> Testimony of John Corlett, Director of Medicaid, February 25, 2009

<sup>35</sup> Legislative Services Commission analysis of 2010-11 executive budget

these dollars are crucial to meet the increased need during the recession, Ohio will need to find sustained revenues once those one-time sources are gone. The hope is that increasing community-based care will decrease Medicaid expenditures by avoiding more costly institutional care.

Recommendation to establish Non-GRF funds (rotary funds) to which local funds used for Medicaid match are deposited and from which payments for locally matched services will be made. Such appropriations will be used exclusively to meet Medicaid obligations in the local board jurisdiction from which they were remitted. Any local funds collected that are no longer needed for local Medicaid matching purposes will be returned to the local board where they originated. The implementation of these rotary funds should be implemented following the impact committee's recommendations.

Federal law requires that the state be able to account for the use of funds used for match. Medicaid expenses for behavioral health services do not appear in the state budget. OMASC recommended rotary funds be used to assure compliance with federal law and to improve transparency and accountability. The recommendation cautioned that further work would be first needed to avoid cash flow problems, and acknowledged that other approaches could also meet the objectives.

As an alternative to the OMASC recommendation, Ohio Department of Alcohol and Drug Addiction Services and Ohio Department of Mental Health implemented a Certified Public Expenditure (CPE) process to verify amounts and sources of Medicaid match within the system prior to drawing federal match. In addition, the 2010-2011 executive budget proposes to elevate behavioral health financing responsibilities to the state level by July 1, 2011. ODMH and ODADAS would make these Medicaid expenditures rather than the county boards of Alcohol, Drug Addiction and Mental Health Services, subject to the passage of needed statutory change. The executive budget creates a Medicaid Elevation Advisory Group to study the analysis and recommendations for moving the responsibility to pay Medicaid providers of community behavioral health (including mental health and alcohol and drug addiction services) and submit a report to the Governor and General Assembly by June 30, 2010.<sup>36</sup>

The Council believes the business requirements in the current Medicaid Information Technology System (MITS) RFP will meet the original intention and criteria for the MITS system, but they were developed prior to the plan for a new Medicaid department. The current MITS RFP does not have a business requirement to support a centralized claims payment system. The Council recommends that the procurement of the new MITS system should continue. During the implantation planning phase the requirements should be evaluated for compatibility with the new ODOM business plan. The plan needs to be developed in conjunction with an efficient Medicaid claims processing system and a comprehensive business plan for effective management.

ODJFS is working with EMMA to assure that the second phase of MITS will incorporate the needs of sister agencies. The EMMA Consolidation Team is looking into consolidating the functions of sister agencies and local partners in the next phases of MITS.<sup>37</sup> MITS will coordinate the multiple state agencies that administer Medicaid and improve communications among them. There is potential that, with additional investment later, agencies will have access to sister-agency records. There is a five-year plan to align sister agency Medicaid business processes. Some business processes, such as claims processing, could be integrated into MITS, and EMMA will continue to explore opportunities to integrate other business processes.<sup>38</sup> However, this could present a funding challenge because the enhanced federal

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<sup>36</sup> Legislative Services Commission Documents of H.B. 1 as Introduced

<sup>37</sup> ODJFS OMASC update December 18, 2008

<sup>38</sup> Interview with Cristal Thomas

match for IT investments (approximately 79 percent on average)<sup>39</sup> applies only to Medicaid enhancements.

The Council does not endorse any specific vendor solution; however, the Council supports the requirements that allows for MITS to be developed to provide for a centralized claims processing system that can handle multiple plans, benefit packages, business rules, and physician panels and is flexible enough to eventually be used as a centralized claims processing system for all state healthcare agencies. MITS is scheduled to go live in late 2009. The first phase of MITS will perform all the functions that MMIS currently handles. MITS is being developed to be accessible through a web portal, which will provide users with self-service functions through Internet access to consumers, fee-for-service providers, and managed care providers, and will have centralized claims acceptance.<sup>40</sup> MITS is already being used for several functions. Service providers and consumers can check consumer eligibility status through the Ohio Medicaid Eligibility Web Portal, and many providers are already submitting claims electronically without cost via Electronic Data Interchange (EDI); paper claims have been reduced 15 percent in the past year.<sup>41</sup> MITS will be used to make claims adjustments electronically, to pay providers through electronic benefits transfer, to submit requests for prior authorization for services and equipment to avoid backlogs, to submit provider applications and renewals including those providing waiver services, and for a provider referral service. Emergency hospitals have first access to e-prescribing and to see the fee-for-service claims history for patients, which is especially helpful since emergency rooms do not generally have access to patient records. There are plans to expand this capability to other providers as well.<sup>42</sup>

State agencies and local representatives should be involved in the decision-making before decisions are finalized as ODOM implements the replacement system for MMIS. Important to communicate with major vendors. Current information systems operated by the sister agencies will need to continue during the transition to a new system and resources should continue to be made available for an appropriate period of time to enable this transition.

As MITS implementation progresses, ODJFS is working with EMMA to establish ways to gain input from state agencies and local partners.<sup>43</sup> County departments of JFS have not had much input on the development of MITS to date because they work primarily with Client Registry Information System – Enhanced (CRIS-E) for client eligibility, enrollment, and case management services, and MITS development will not impact them as much as other partners. ODJFS will seek feedback from counties once MITS rolls out. ODJFS provides information to health care providers as MITS implementation progresses.

During the transition phase to the new claims processing system, the Ohio Department of Job and Family Services (ODJFS) Medical Systems Section staff should remain in ODJFS to manage the maintenance of and enhancements to the current claims system, the Medicaid Management Information System (MMIS). All MITS development and operations should be managed in the new Ohio Department of Medicaid (ODOM).

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<sup>39</sup> MITS Frequently Asked Questions updated March 3, 2009

<sup>40</sup> Ohio Medicaid Program Follow-Up Performance Audit, December 18, 2008

<sup>41</sup> Testimony of John Corlett, March 11, 2009

<sup>42</sup> ODJFS quarterly cost containment report October 1, 2008

<sup>43</sup> ODJFS update 12/18/08

ODJFS reported in its December, 2008, Medicaid Performance Report update that this recommendation would be addressed as part of the MITS contract requirements with its vendor, EDS. ODJFS will continue to manage development and operations of MITS.

It is essential that resources on the old systems must remain stable. The Transition Team should be given the authority and the resources to guide the establishment of the service level agreement between ODOM and ODJFS.

ODJFS reported in its December, 2008, Medicaid Performance Report update that this recommendation would also be addressed as part of the MITS contract requirements with its vendor, EDS. ODJFS will continue to manage development and operations of MITS.

Based on a presentation by Mina Chang, Section Chief in Ohio Health Plans' Bureau of Managed Health Care, the Council is recommending continued support of the current infrastructure that is in place to support the data submission and analysis of encounter claim data in a timely manner.

ODJFS maintains support of these operations.

The Council has determined that the Data Warehouse (DW) and Decision Support System (DSS) serve as valuable tools for the Medicaid organization and should continue to be important for ODOM's strategic, fiscal, quality, and operations areas.

DSS works with other data sources to support the decision support environment. ODJFS did an analysis of the extent that MITS can service the DW and DSS functions to assure ODJFS continues to have DW and DSS data available. Based on this analysis, ODJFS will make a recommendation and will work with the Office of Information Technology and EMMA before proceeding.<sup>44</sup> The development of evidence-based practices relies on continued use of DW and DSS data.

The Council recommends that the Decision Support System (DSS), Pharmacy Data Mart, and the all OHP project staff move to the ODOM Office of Information Management.

The administration has not adopted this recommendation because a separate department of Medicaid has not been created.

The Council has determined that moving all or part of the Data Warehouse to ODOM is an issue on which the Council cannot make a recommendation on within the Council's timeframe. The Council recommends that an independent, unbiased party should be utilized to recommend the best agency or agencies to manage the current ODJFS Data Warehouse, the DW governance structure, and future expansion and funding of the Data Warehouse.

The administration has not adopted this recommendation because a separate department of Medicaid has not been created.

The Benefit Information Network (BEN - CRIS-E eligibility system replacement project) is currently in the requirements gathering phase. Because BEN will be used to determine eligibility for many social programs including Medicaid, the ODOM CIO should be a member of the BEN Executive Management Committee (EMC) and ODOM needs to be involved in the decision process.

House Bill 66 and House Bill 119 did not fund development of BEN. ODJFS has instead begun to modernize CRIS-E to continue as the eligibility system used by county departments of Job and Family Services for Medicaid as well as Food Stamps and Temporary Assistance for Needy Families.

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<sup>44</sup> ODJFS quarter cost savings report October 1, 2008

However, the Ohio Benefit Bank is a pilot project that provides a Web-based counselor-assisted service that gives applicants preliminary information about program eligibility and estimations of benefit levels. The Ohio Benefit Bank is a partnership between the Governor's Office of Faith-Based and Community Initiatives and the Ohio Association of Second Harvest Foodbanks, and it is available through partners at over 900 Benefit Bank sites across Ohio. It has been very successful at providing the public with comprehensive information about available services. Federal law requires the agency that administers Medicaid to determine eligibility, and the Benefit Bank therefore cannot process applications itself, but it does electronically transmit application information to county departments of Job and Family Services for processing. Caseworkers can enter the data directly into CRIS-E without re-entering it, which increases efficiency and accuracy.

State agencies and local representatives should have input in the decision-making before decisions are finalized. Communication with major healthcare provider organizations is important as changes are implemented.

EMMA serves as the means through which state partner agencies (ODA, Alcohol and Drug Addiction Services, Education, Mental Health, Health, Mental Retardation and ODJFS) provide regular input throughout decision-making processes. Those partner agencies also share input they have gathered from their stakeholders.

Ohio's Medical Care Advisory Committee is another forum for ODJFS to disseminate information and for the committee members, which include physicians, health care providers, advocates, and Medicaid consumers, to provide input on health care programs administered by the Department. The Committee meets on a bi-monthly basis and has subcommittees focused on developing issues.

The recommended Information Technology (IT) organization is outlined in the ODOM Information Technology Division Organization Chart

The administration has not adopted this recommendation because a separate department of Medicaid has not been created. However, Ohio Health Plans reorganized in October, 2008, to better accommodate implementation of MITS.<sup>45</sup>

The Information Technology (IT) Division should develop a Strategic Plan based on the new Ohio Department of Medicaid's (ODOM) Strategic Plan. Local entities and sister agencies should be involved in its strategic planning processes.

The administration has not adopted this recommendation because a separate department of Medicaid has not been created, however the EMMA Strategy and Policy subcommittee was in the process of developing direction for the Medicaid program across the state agencies and was seeking input to do so.<sup>46</sup>

The IT Division should adopt the Principles for the ODOM Chief Information Officer (see Appendix 10) that have been modified from the United States General Accounting Office's report: Maximizing the Success of Chief Information Officers [GAO-01-376G, February 2001]. The principles are simple and describe the role needed for a CIO and the culture surrounding the IT Division.

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<sup>45</sup> ODJFS Medicaid Performance Report, Appendix 1

<sup>46</sup> EMMA Annual Report, 2008

While there is not a separate department of Medicaid with its own CIO, ODJFS's CIO and CFO now report directly to the ODJFS Director, which, according to ODJFS, brings ODJFS into better alignment with this recommendation.<sup>47</sup>

To create an agile and effective IT organization, there should be a formal mentoring program, cross-training opportunities, and participation in external organizations should be encouraged. There should be two career paths established: a technical path and a parallel management path.

OHP is planning for the business and culture organizational changes that will be needed before MITS can go live. Several of EMMA's sister agencies have reported that EMMA has been successful in increasing communications across agencies, and Medicaid decision-making has relied more on staff with diverse areas of expertise, such as fiscal, legislative, and IT.

The new ODOM executive team must define an effective Information Technology governance policy to support the organization's strategies using the principles recommended by the OMASC IT Subcommittee. The Transition Plan should include steps and resources to put improved IT governance in place from the new department's inception. IT deliverables (service level agreements) and governance procedures should be incorporated into ODOM's Interagency Agreements with state agencies performing delegated Medicaid administration.

As MITS implementation continues, clear principles for governance and decision-making will be established, and is a part of the contractual requirements of the vendor, EDS.<sup>48</sup>

To facilitate statewide healthcare IT initiatives, the Council recommends utilizing the membership in an existing group created by the Ohio Office of Information Technology (OIT), the Healthcare Community of Interest Group (COI) for Health and Human Services.

ODJFS reported in its December, 2008, OMASC update that ODJFS and EMMA are working with OIT staff to facilitate statewide health care initiatives.

The following OMASC recommendations have not been adopted because a separate department of Medicaid has not been created:

- A small, multi-disciplined transition team should be appointed by the Governor and begin working on transition decision making, tasks, and associated issues in January 2007
- The transition team should have the authority and resources to operate during the transition period, to engage services of change management professionals and to hire other consultants as needed to complete transition tasks.
- The team should facilitate work with ODJFS, other state agencies, local entities, and other constituents to avoid disruption of needed services for Medicaid consumers, maintain good communications, and to limit difficulties at the local level and affected state agencies.
- Develop a cost allocation plan, budget and appropriations
- Develop a detailed human resources plan identifying resources to be transferred from ODJFS to ODOM, resources needed to backfill positions within ODJFS, and new positions to be created and filled within ODOM.
- Develop an implementation plan.

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<sup>47</sup> ODJFS Medicaid Performance Report, December 18, 2008

<sup>48</sup> ODJFS Medicaid Performance Report, December 18, 2008

- The team should work with the Governor's Office to hire the director of the Department of Medicaid to manage the creation of the department and ensure the proper culture is instilled.
- Working with the new director, the transition team should hire as many of the Department of Medicaid's executive staff as possible during this period.
- The transition team should prepare the basic elements of the Department of Medicaid so that are in place by July 1, 2007 as required by the General Assembly in Am Sub HB 66

## Sources

- Corlett, John R., Medicaid Director. Testimony before House Committee on Health and Human Services, March 11, 2009. (<http://jfs.ohio.gov/oleg/testimony/Corlettestimony-31109.pdf>)
- Corlett, John R., Medicaid Director. Testimony before House Committee on Finance and Appropriations, February 25, 2009. (<http://jfs.ohio.gov/oleg/Corlettestimony2-25-09.pdf>)
- Corlett, John R., Medicaid Director. Testimony before Ohio Job and Family Services Joint Committee on Agency Rule Review August 25, 2008. ([http://jfs.ohio.gov/oleg/testimony/ICARR\\_PDL\\_Testimony\\_082508.pdf](http://jfs.ohio.gov/oleg/testimony/ICARR_PDL_Testimony_082508.pdf))
- Cornelius Dawson, Angela, Director of ODADAS. Testimony before the Ohio House Finance and Appropriations Human Services Sub-Committee, March 10, 2009.
- Dept. of Aging. *Building a Cost-effective, Consumer-friendly Long-term Services and Supports System - Final Report of the Unified Long-Term Care Budget Workgroup*, May 30, 2008. (<http://www.governor.ohio.gov/Default.aspx?alias=www.governor.ohio.gov/fbci>)
- EMMA. *Annual Report 2008*. (<http://emma.ohio.gov/reports/EMMA-2008-AnnualReport.pdf>)
- EMMA. Cristal Thomas, Executive Director of Executive Medicaid Management Administration. Conversation on March 2, 2009.
- EMMA. Ohio Executive Medicaid Management Administration Status Reports, July, 2008, October, 2008, January, 2009. (<http://emma.ohio.gov/reports/quarterly.stm>)
- Governor Strickland. Executive Order 2009-03S Establishing the Ohio Health Care Coverage and Quality Council
- Health Policy Institute of Ohio. *Ohio Medicaid Basics 2009*. ([http://www.healthpolicyohio.org/pdf/MedicaidBasics\\_2009.pdf](http://www.healthpolicyohio.org/pdf/MedicaidBasics_2009.pdf))
- Jones-Kelley, Helen E. 2008. *Quarterly Cost Management Report on Ohio's Medicaid Program*. Ohio Department of Job and Family Services (ODJFS). November 9, 2007. (<http://jfs.ohio.gov/oleg/docs/2007OHPCostContainment.pdf>)
- Lumpkin, Douglas E., Director of ODJFS. Testimony before House Finance and Appropriations Committee Ohio, February 25, 2009. (<http://jfs.ohio.gov/oleg/LumpkinTestimony2-25-09.pdf>)
- Martin, John L, Director of ODMRDD. Testimony before House Committee on Finance and Appropriations, Human Services subcommittee, March 3, 2009. (<http://odmrdd.state.oh.us/topics/Department-of-MRDD-Testimony.pdf>)
- McCarthy, Peg. *Unified Long-Term Care Budget Offers Changes for the Better*. Planning & Action Journal of The Center for Community Solutions. December, 2008. ([http://www.communitysolutions.com/store/item.asp?ITEM\\_ID=1521&DEPARTMENT\\_ID=35](http://www.communitysolutions.com/store/item.asp?ITEM_ID=1521&DEPARTMENT_ID=35))
- OBM. Ohio Executive Budget for FYs 2010 and 2011, Special Analysis – Health Care. (<http://obm.ohio.gov/SectionPages/Budget/FY1011/ExecutiveBudget.aspx>)
- ODJFS. Cynthia Callender. Conversation on March 3, 2009.
- ODJFS. *Disability Determination Consolidation Study Council Final Report*, December 30, 2005. (<http://jfs.ohio.gov/oleg/DisabilityDeterminRpt.pdf>)
- ODJFS. *Frequently Asked Questions – MITS*, updated March 3, 2009. (<http://jfs.ohio.gov/mits/faq1.pdf>)
- ODJFS. *Frequently Asked Questions on MITS*, updated April 24, 2008.
- ODJFS. *FY08-09 Information Technology Plan*, version 11, November 21, 2007. (<http://jfs.ohio.gov/omis/itplan/0809ITPlanUpdate.pdf>)
- ODJFS. Jones-Kelley, Helen E. 2008. *Quarterly Cost Management Report on Ohio's Medicaid Program*. October 1, 2008. ([http://jfs.ohio.gov/Ohp/bcps/OHMedAdvComm/2008/Quarterly%20Cost%20Containment\\_1008.pdf](http://jfs.ohio.gov/Ohp/bcps/OHMedAdvComm/2008/Quarterly%20Cost%20Containment_1008.pdf).)
- ODJFS. Medicaid Performance Report, December 18, 2008, response to Ohio Medicaid Program Follow-up Performance Audit of December 18, 2008.

- ODJFS. *Medical Care Advisory Committee September 26, 2008 - Meeting Minutes*. [http://jfs.ohio.gov/OHP/bcps/OHMedAdvComm/2008/minutes\\_092608.pdf](http://jfs.ohio.gov/OHP/bcps/OHMedAdvComm/2008/minutes_092608.pdf)
- ODJFS. Memo from John Corlett, Medicaid Director, and John Connelly, Executive Director of Rehabilitation Services Commission, September, 2008 ([http://jfs.ohio.gov/ohp/bcps/OHMedAdvComm/2008/ddu\\_workgroup\\_kickoff.pdf](http://jfs.ohio.gov/ohp/bcps/OHMedAdvComm/2008/ddu_workgroup_kickoff.pdf))
- ODJFS. MITS monthly newsletters: April 2008, May 2008, July 2008, September 2008, October 2008, November 2008, December 2008, February 2009. (<http://jfs.ohio.gov/mits/communication.stm>)
- ODJFS. MITS Project Background. (<http://jfs.ohio.gov/mits/background.stm>)
- Ohio Auditor of State. *Ohio Medicaid Program Follow-up Performance Audit*. December 18, 2008. ([http://www.auditor.state.oh.us/AuditSearch/Reports/2008/Ohio\\_Medicaid\\_Program\\_Follow\\_Up\\_08\\_Performance-Franklin.pdf](http://www.auditor.state.oh.us/AuditSearch/Reports/2008/Ohio_Medicaid_Program_Follow_Up_08_Performance-Franklin.pdf))
- Ohio Health Plans. *Strategic Plan*, August 8, 2007 <http://jfs.ohio.gov/OHP/aboutus/StratPlan07final.pdf>
- Ohio Legislative Service Commission. *Analysis of the 2010-11 Executive Budget Proposal*, ODJFS. <http://www.lbo.state.oh.us/fiscal/budget/redbooks128/jfs.pdf>
- Ohio Legislative Service Commission. *Budget in Detail - H.B. 1 as Introduced* (<http://www.lbo.state.oh.us/fiscal/budget/BudgetInDetail/BID128/BudgetInDetail-HB1-IN.pdf>)
- OMASC. *Final Report and Recommendations*, December 7, 2006. (<http://www.medicaidstudycouncil.ohio.gov/Final-Report.pdf>)
- Pryce, Richard, Former Chair of Ohio Medicaid Administrative Study Council, interview February 12, 2009
- Riley, Barbara, Director of Ohio Department of Aging. *Testimony before the Ohio House Finance and Appropriations Human Services Sub-Committee*, March 5, 2009. (<http://www.aging.ohio.gov/news/pressreleases/2009/20090305.pdf>)
- Sheridan, Richard. *FY 2010 – FY 2011 State Budget: 10 Critical Questions*. State. Budgeting Matters. February 13, 2009. (<http://www.communitysolutions.com/images/upload/resources/sbmv5n4.pdf>)
- Stephenson, Sandra, Director, Ohio Department of Mental Health. *Testimony before the Ohio House of Representatives' Human Services Subcommittee*, March 10, 2009. (<http://b9962ed140049a571a710839f1f71c989aaf09ce.gripelements.com/legislation/budget-testimony-house-20090310.pdf>)
- The Henry J. Kaiser Family Foundation. *State Medicaid Fact Sheet*. 2006-07. (<http://www.statehealthfacts.org/mfs.jsp?rgn=37&rgn=1>)
- Thomas, Cristal. *Testimony before Joint Legislative Committee on Medicaid Technology and Reform*, October 3, 2007. (<http://jfs.ohio.gov/oleg/testimony/CristalTestimony10-3-07.pdf>)
- U.S. Dept. of Health and Human Services. *Actuarial Report on the Financial Outlook for Medicaid for 2008*. ([http://www.cms.hhs.gov/ActuarialStudies/03\\_MedicaidReport.asp](http://www.cms.hhs.gov/ActuarialStudies/03_MedicaidReport.asp))

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