

# **Ohio Medicaid Administrative Study Council**

## **Final Report and Recommendations**

**December 7, 2006**



## **COUNCIL MEMBERSHIP**

The Council was comprised of 22 individuals representing many perspectives and stakeholders. Membership included health care professionals, members of the Ohio business community, elected officials, and various directors from the Governor's cabinet. Members of the Council were named in the statute or appointed by the Governor and the Ohio General Assembly. The Council included the following:

### **Voting Membership**

#### *Governor's appointees*

Richard D. Pryce, Chairman	Retired President and CEO, Aultman Health Foundation
John Begala	Representative, Ohio Commission to Reform Medicaid
Brian O. Phillips	CIO, Ohio University College of Osteopathic Medicine
Bill Ryan	President, Center for Health Affairs
Joseph San Fillippo	President, Nationwide Health Plans
Terry White	Retired Chief Executive Officer, MetroHealth
William Wilkins	Tax Commissioner, Department of Taxation

#### *Executive Offices designated in House Bill 66*

Fred Booker	Director, Performance Audits, Bureau of Workers' Compensation
Mary F. Carroll	State Chief Information Officer/Director, Office of Information Technology
Timothy S. Keen	Director, Office of Budget and Management

#### *President of the Senate appointee*

Margaret Richardson	Senior Vice President, National City Bank
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#### *Speaker of the House appointee*

Phil Darrow	President/CEO, Ohio Transmission Corporation
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### **Non-Voting Membership**

#### *Ex officio members designated in House Bill 66*

Carolyn Givens	Director, Department of Alcohol and Drug Addiction Services
Anne Harnish	Assistant Director, Department of Health
Mike Hogan	Director, Department of Mental Health
Merle Kearns	Director, Department of Aging
Barbara Riley	Director, Department of Job and Family Services
Kenneth Ritchey	Director, Department of Mental Retardation and Developmental Disabilities

#### *General Assembly Members designated in Senate Bill 87*

Representative Todd Book	Ohio General Assembly, 89 <sup>th</sup> District
Senator Ray Miller	Ohio General Assembly, 15 <sup>th</sup> District
Senator Tom Niehaus	Ohio General Assembly, 14 <sup>th</sup> District
Representative Jimmy Stewart	Ohio General Assembly, 92 <sup>nd</sup> District

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## Executive Summary

The Ohio Medicaid Administrative Study Council (OMASC) has fulfilled its responsibility of recommending a scope and structure for the new Ohio Department of Medicaid (ODOM):

*The Council recommends the new, cabinet-level Department of Medicaid be developed with a renewed focus on strategy development and clinical leadership. Combined with a centralized Medicaid budget,<sup>1</sup> new claims processing system, and an enhanced utilization of the Decision Support System, the Ohio Department of Medicaid will provide the leadership and knowledge necessary to ensure Ohio's needy citizens are provided with effective and efficient health care.*

To accomplish this, the new Department should be driven by the following mission statement:

*“To assure the provision of effective and efficient health care to Ohio’s eligible low income families, aged, blind, and disabled.”*

In reaching this conclusion, the Council conducted a year-long analysis, held 13 full Council meetings, 29 committee meetings, and twice took public testimony to address the following:

- Recommendations regarding the scope and structure of the Department of Medicaid;
- Structuring the Medicaid program’s administration in a manner that optimizes the program’s fiscal and operational objectives;
- Centralizing financing and information technology functions to coordinate ODOM’s activities with other state agencies that assist in the program’s administration;
- Creating a unified budget for Medicaid-funded long-term care services;
- The fiscal and operating impact that a new administrative structure for the program would have on the Department of Job and Family Services, other state agencies, and local level entities that currently assist in the program’s administration
- A business plan that directs the transition of the Medicaid program’s administration from the Department of Job and Family Services and the other state agencies that assist the Department, to the Department of Medicaid and addresses the transition’s fiscal and operational impact; and
- Identification of the resources needed to implement the business plan.

There is a clear need to create a single focus on management of the Medicaid program through strengthened strategic policy, data-based clinical direction, clear and focused financial reports, and accountability monitoring. The new Department needs a strong, seasoned management

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<sup>1</sup> All Ohio Medicaid budget and program references in this report include the State Children’s Health Insurance Program (SCHIP).



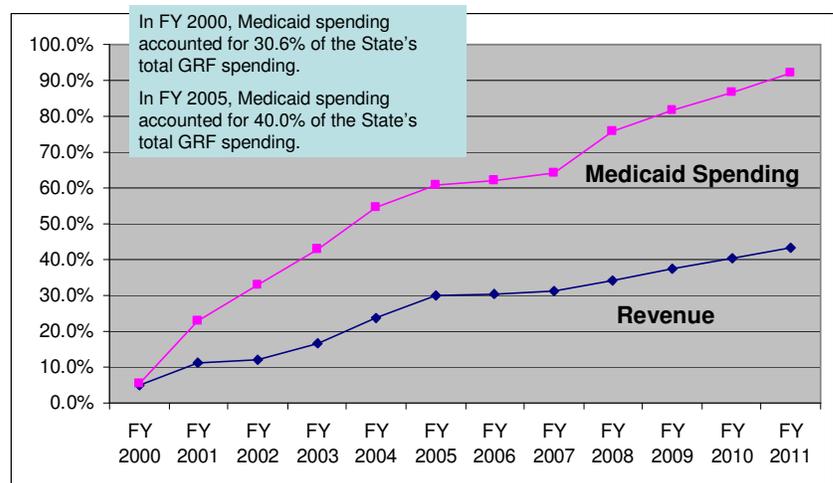
team, with a robust information technology platform. It is essential to centralize budget authority and information technology resources to enable the new Department to achieve its mission. These steps should help to ensure the long-term sustainability of Ohio's Medicaid program by controlling spending growth and improving overall program performance.

### What's at Stake

Management of the Medicaid program is a daunting challenge, involving extraordinary complexity with important economic, policy, and human implications affecting all Ohioans. Medicaid provides health care coverage to over two million Ohioans each year. Half of the people served are children and almost 500,000 are under the age of five. Medicaid pays for 70% of the nursing home care in the state, and serves 152,000 senior citizens providing an array of health care services. It is authorized by the federal government and the program is delivered by the state. Almost 60% of Ohio Medicaid's \$13 billion budget is funded by the federal government. Constituents and stakeholders including the citizens of the State of Ohio, who fund the state and federal shares of the program, have intense interest in the program.

The proposed Department of Medicaid faces one “*overriding reality—the rate of growth in Medicaid spending is unsustainable.*”<sup>2</sup> The Medicaid program is inherently vulnerable to increases in health care costs outside of its control, changes in eligibility caseloads arising from economic conditions, and difficulties in making rapid program changes. As a public program, Medicaid operates in a political environment where cost containment measures must be reconciled with the competing interests of beneficiaries, stakeholders, and constituents.

Ohio's recent experience bears this out. As illustrated in the figure below, Medicaid spending increased nearly 70% from state fiscal year (SFY) 2000 through SFY2005. The General Assembly was faced with balancing Ohio's budget despite dramatic cost increases, even though during the same time period revenue supporting the General Revenue Fund (GRF) grew at only 27%. As a result, Medicaid spending became a much larger percentage of overall GRF spending, growing from 30% in SFY2000 to nearly 40% in SFY2005.



Note: FY 2000-2005 are actual, 2006-2007 are budget, and 2008-2011 are projected based on trend analysis. Revenue and spending data includes federal funds that are credited to the GRF.

Source: Ohio Medicaid Administrative Study Council

<sup>2</sup> Ohio Commission to Reform Medicaid, 2005

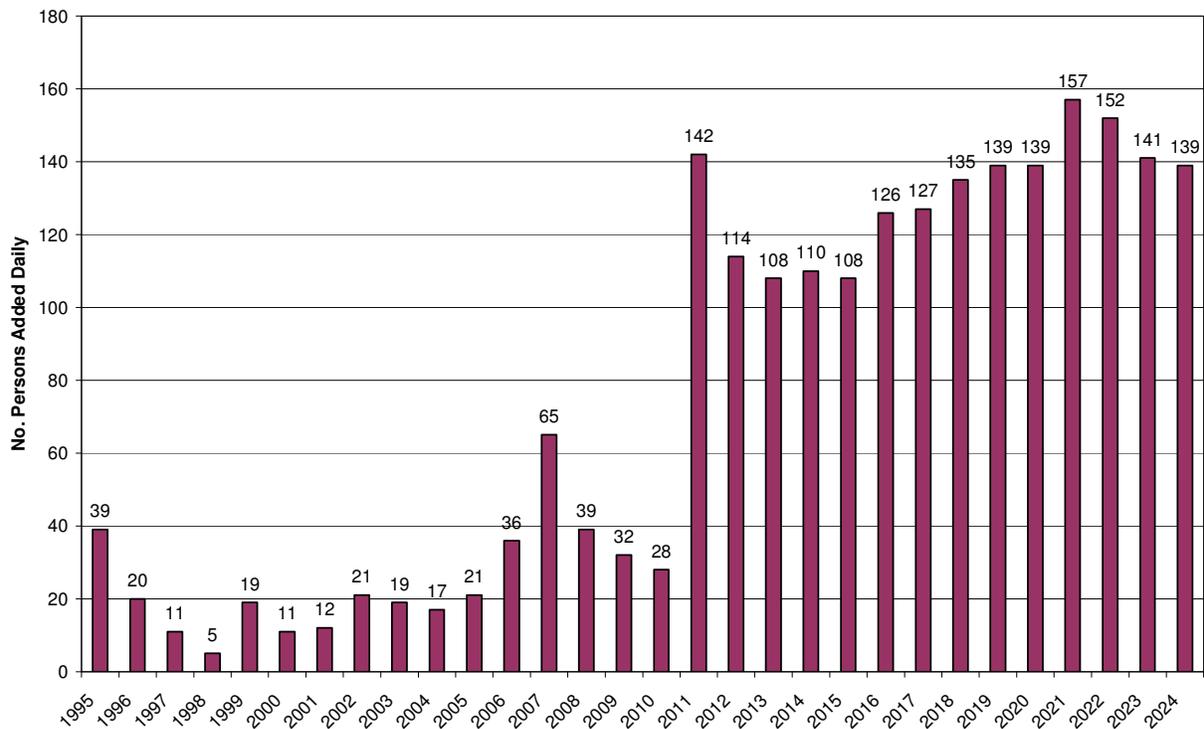


Seeking ways to reduce growth in the rate of spending for the Medicaid program, the *Commission to Reform Medicaid* recommended the creation of an Ohio Department of Medicaid as a means for Ohio to take a more strategic, long-term approach to management of the program. Using this strategy, the Commission believed that the Medicaid program could become financially sustainable.

### Immediate Action is Necessary

State Fiscal Year 2006 has shown some leveling off of spending increases due to one-time cost containment efforts, system reforms, and improving economic conditions. However, temporary conditions cannot be relied upon as the primary method to manage the costs of the program. Like the nation as a whole, Ohio is on the brink of a dramatic demographic change that will have profound effects on the Medicaid program. The following illustration shows the impact of aging baby boomers as they reach the retirement age of 65. This explosion of new retirees looms just five years away.

Average Daily Net Growth in Ohio 65 and Over Population 1995 to 2025



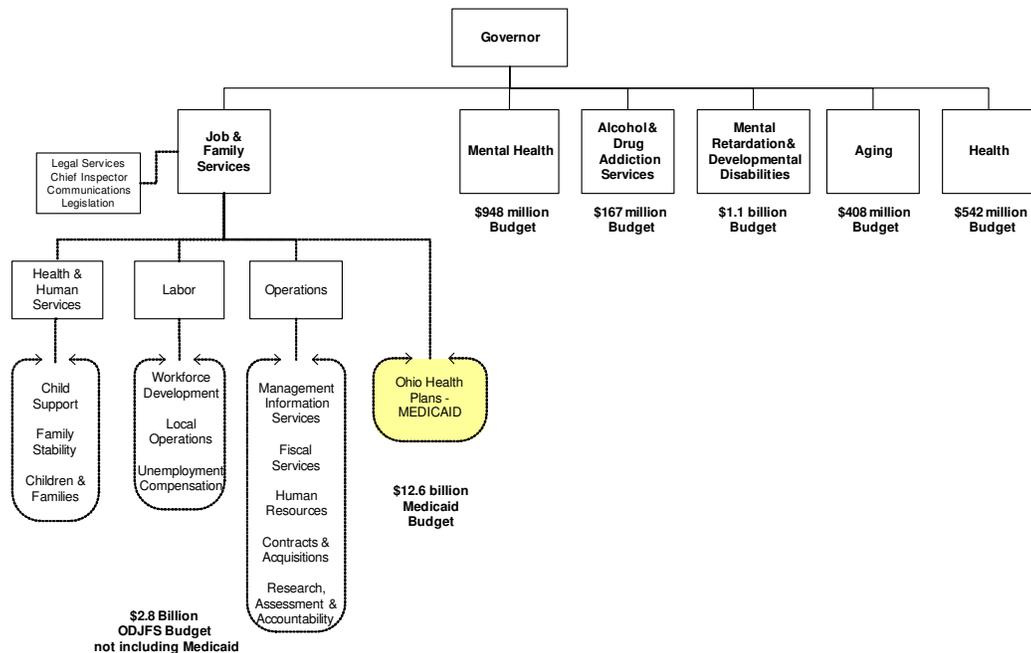
Developed by the Ohio Department of Development using data from "Projections of the total Population of States: 1995 to 2025" U.S. Census Bureau



## A Structure for a New Department with a New Direction

To meet the challenges of the future, the current organizational structure of Ohio’s Medicaid program must change. Establishing an agency exclusively focused on managing the state’s largest single program—one which currently pays for services under the auspices of five other state departments—provides representation in the Governor’s cabinet and a greater likelihood of sufficient administrative resources.

As illustrated in the figure below, the Medicaid program is currently managed at a “sub-department” level within the Ohio Department of Job and Family Services (ODJFS) alongside seven other major state and federal programs that all compete for priority attention from the director and the resources of the ODJFS shared support offices.<sup>3</sup>



Source: Ohio Medicaid Administrative Study Council, 2006

Medicaid program services are also administered through delegated arrangements with eight other state agencies. Of these agencies, the Departments of Aging, Alcohol and Drug Addiction Services, Mental Health, and Mental Retardation and Developmental Disabilities fund and/or deliver specialty population-focused services to hundreds of thousands of Medicaid and non-Medicaid eligible Ohioans, in addition to performing Medicaid administrative functions.<sup>4</sup> The

<sup>3</sup> Child Support Enforcement, Child Care and Adoption Support, Protective Services for Children and Elders, Temporary Assistance to Needy Families, Food Stamps, Unemployment Compensation, and Workforce Development.

<sup>4</sup> The other four state agencies are the Auditor of State, the Attorney General, the Department of Education, and the Department of Health.

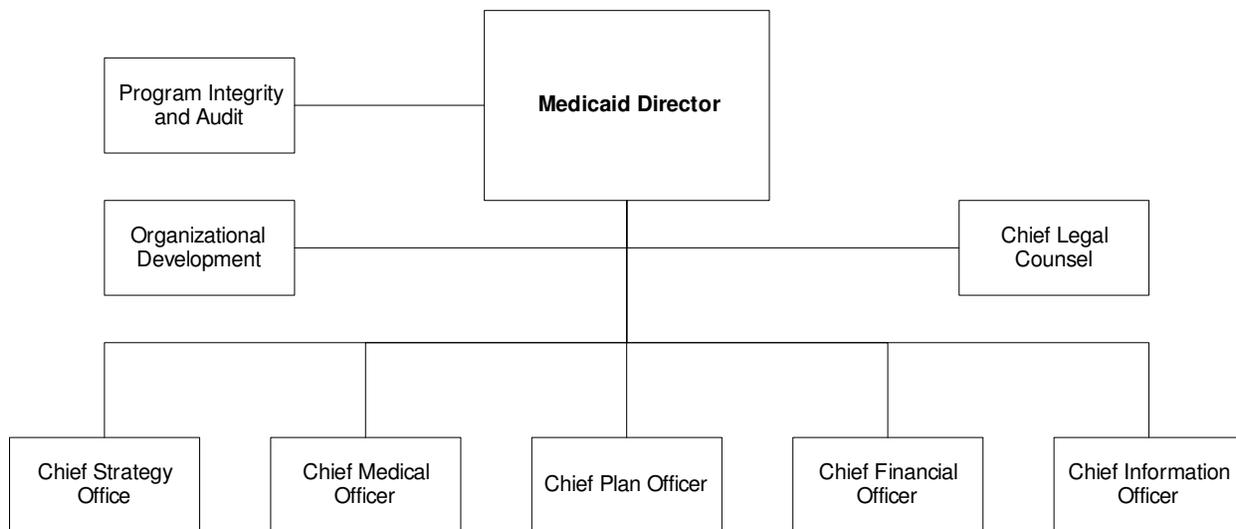


Ohio Medicaid program needs to be in a better position to manage competing or conflicting interests among the state and local agencies. To do this, the Medicaid program director should have the same cabinet-level status as the sister agencies.

In addition to the structural change of establishing a new Department focused on Medicaid, the Council believes a fundamental change in direction is needed. The sustainability of the program depends in large part on controlling unnecessary costs. The new organizational structure and Mission Statement emphasize the importance of strategic initiatives and clinical leadership, both of which are keys to reducing the overall cost of delivering healthcare to Medicaid consumers. Reducing the overall cost could be achieved by avoiding costs of procedures that are not medically necessary or are not performed in accordance with evidence-based standards of care. By directing Medicaid payments toward predefined, evidenced-based procedures and protocols, consumer health outcomes could be improved.

Improving information technology and strengthening accountability for Interagency Agreements are additional components of this transformation. As a standalone department, ODOM could account for all of its business operational needs, many of which are currently supplied by shared service functions in ODJFS.

Within this context, the Council recommends the Executive Level of the Department of Medicaid should be structured as shown in the illustration below.



## Major Recommendations

A summary of major recommendations developed by the Council includes<sup>5</sup>:

<sup>5</sup> See Appendix 2 for a full listing of the Council's recommendations.



- The Council recommends the new, cabinet-level Department of Medicaid be developed with a renewed focus on strategy development and clinical leadership. Combined with a centralized Medicaid budget, new claims processing system and an enhanced utilization of the data warehouse; the Ohio Department of Medicaid will provide the leadership and knowledge necessary to ensure Ohio's needy citizens are provided with efficient and effective health care.
- All funding for Medicaid expenditures should originate in appropriations to the Department of Medicaid, including accounting for state subsidies and local levies that pay for Medicaid services through other state agencies. The appropriations should be structured so that there are distinct Aged, Blind, and Disabled (ABD) and Covered Families and Children (CFC) budgets containing all funds dedicated to providing services to each population. The department should create and maintain Medicaid financial statements that encompass all revenues and expenditures for the program. The report includes budget figures showing what this would have looked like in SFY2005, had the changes been in place (see Section III.E.2).
- ODOM should have the authority to continue to delegate some Medicaid administrative functions to other agencies, with an emphasis on creating more effective and accountable interagency agreements. Other state and local entities should continue to assist in the administration of the program.
- ODOM should have a robust Information Technology architecture and professional staff to provide the information essential to managing this complex department. The hardware must be flexible and scalable, and resources must be provided to hire, train and retain key personnel.
- The Medicaid Decision Support System (DSS), the Pharmacy Data Mart, and the Ohio Health Plans (OHP) project management staff should move to the Department's Information Technology Division as soon as it is established.
- 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.
- Procurement of the new Medicaid Information Technology System (MITS) should continue, without delay.
- The new system's development should continue to be reviewed to evaluate its compatibility with the new Department's business plan. An impact review is warranted should a business plan for the new Department be developed that significantly deviates from the original business assumptions that provided the foundation for the current MITS RFP.
- Develop MITS to provide for a centralized claims processing system that can handle multiple plans, benefit packages, business rules, and provider panels and be flexible enough to eventually be used as a central claims processing system for all state health care agencies. Before a centralized claim system is developed, there must be more consultation with other state and local agencies about MITS.
- Until MITS is implemented, transitional Management Information Systems (MIS) support should be performed under arrangements with ODJFS. ODOM should contract with ODJFS to continue to support MMIS and provide infrastructure support.



- The Transition Plan recommended by the Council is designed to avoid any negative impacts on services to Medicaid consumers or on the state or local agencies currently involved in administration of the Medicaid program.

### **Recommendations for Transition**

Transition tasks should begin as soon as the Governor and the General Assembly accept this report as a plan that establishes the direction for the moving forward. A small, multi-disciplined OMASC transition team appointed by the Governor should begin working on transition decision making, tasks, and associated issues in January 2007. The transition must be accomplished in a way that does not interfere with delivery of Medicaid Services, other ODJFS services, or services delivered by other state agencies.

A Governor appointed OMASC Transition Team should:

- Have the authority and resources to engage services of change management professionals and other consultants as needed to complete transition tasks;
- 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 minimize difficulties at the local level and affected state agencies;
- Support the Governor's Office in hiring the director of the Department of Medicaid to manage the creation of the Department, hire as many of the Department of Medicaid's executive staff as possible, and ensure the proper culture is instilled from the very beginning;
- Prepare the basic elements of the Department of Medicaid so they can be in place by July 1, 2007 as intended by the General Assembly in Am. Sub. H.B. 66.

### **Investment Needed**

The Council identified two types of investment needed to implement ODOM. First, an initial investment in transition team activities is needed.

- Legislative authority could be in place by January 1, 2007 that would allow the Governor to hire a transition team, and take steps necessary to work toward the creation of a new Department. At a minimum, funding left over from the OMASC could be used for this effort, although additional funding will likely be needed for an effective transition between January 2007 and July 2007.
- A small, multidisciplinary OMASC transition team appointed by the Governor should begin working on transition decision making, tasks, and associated issues in January 2007. To accomplish the time-sensitive, critical tasks needed from January 2007 to June 2007 the transition resources required are \$500,000 in addition to the unspent funds from the OMASC appropriation.



Second, the Council prepared an estimate of what it would have cost, in SFY2005 dollars, had ODOM been implemented in the manner recommended in this report. The estimated additional cost for ODOM is not a one-time investment, but would be an ongoing additional cost for administering the program.

If Ohio had operated the program with ODOM in place in SFY2005, it is estimated that the additional administrative cost would have been \$7 million.<sup>6</sup> The Council estimates that ODOM will need approximately 750 employees to operate using the proposed model, of which approximately 600 could be transferred from ODJFS. ODOM will need to hire approximately 150 new employees, including a chief strategy officer, a chief clinical officer, program integrity and audit personnel, and associated divisions that emphasize strategy, the use of clinical best practices, and accountability monitoring. With this emphasis it is hoped that the potential for both short-term and long-term cost savings could justify the investment.

Skeptics may suggest the timetable outlined in these recommendations is too ambitious. There must be a sense of urgency and commitment to address these difficult organizational issues. The rewards for decisive actions are immediate and significant. We believe the dedicated employees within these agencies will both welcome and respond positively to a clear plan to help them improve the services they provide to Ohio's needy residents.

Accordingly, the changes associated with the creation of the Department of Medicaid should be implemented as outlined in the Transition Plan put forth by the Council. It is important to provide employees a stable and less disruptive operating environment by having an implementation period that is well-defined, actively managed, and broadly communicated. This should allow for higher productivity and minimize operational errors during the transition period.

The spending growth pressures and the inherent complexity of the Medicaid program are likely to continue. Ohio cannot afford to maintain the status quo when it comes to managing the Medicaid program. By following the recommendations in this report, Ohio could establish a more focused, accountable, and strategic operational model that will serve the citizens and Medicaid recipients well for years into the future.

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<sup>6</sup> On December 6, 2006, OBM estimated the investment to be \$17.4 million.



## **I. INTRODUCTION**

With this report, the Ohio Medicaid Administrative Study Council (“the Council”) completes a year-long study of the administration of the Medicaid program in the state of Ohio. The Council was created to develop a plan for the future structure and governance of a new, cabinet-level Ohio Department of Medicaid (ODOM). In meeting its charge the full Council met 13 times, conducted 29 public committee meetings, and twice accepted public testimony.

Following recommendations of the Commission to Reform Medicaid, which issued its final report in January 2005, the Ohio General Assembly included language in Am. Sub. H.B. 66, the state’s biennial budget bill, the charge to create a council that would “Study the administration of the Medicaid program under the assumption that the General Assembly will enact by July 1, 2007, a law establishing a new cabinet-level department to administer the program.”

Per this legislation, the Council is required to produce a final written report for the Governor, President of the Senate, and the Speaker of the House of Representatives, no later than December 31, 2006, covering the following:

- Recommendations regarding the scope and structure of the Department of Medicaid;
- A business plan that directs the transition of the Medicaid program’s administration from the Department of Job and Family Services and the other state agencies that assist the Department, to the Department of Medicaid and addresses the transition’s fiscal and operational impact; and
- Identification of the resources needed to implement the business plan.

As directed by the statute, the Council examined the following as a part of this study:

- Structuring the Medicaid program’s administration in a manner that optimizes the program’s fiscal and operational objectives;
- Centralizing financing and information technology functions to coordinate ODOM’s activities with other state agencies that assist in the program’s administration;
- Creating a unified budget for Medicaid-funded long-term care services; and
- The fiscal and operating impact that a new administrative structure for the program would have on the Department of Job and Family Services, other state agencies, and local level entities that currently assist in the program’s administration.

This document represents the final report developed by the Council as required by Am. Sub. H.B. 66.

### **A. COUNCIL APPROACH**

The Council was chaired by Mr. Richard D. Pryce. After establishing mission, principles, and criteria for the new organization, the Council conducted most of its work through four committees consisting of Council members or their designees:



**Unified Long Term Care  
Budget Committee**

Mr. John Begala, Chair

Mr. Tim Keen

Ms. Merle Kearns

Mr. Ken Ritchey

Representative Todd Book

**Information Technology Committee**

Mr. Brian Phillips, Chair

Ms. Cynthia Dougherty

Senator Tom Niehaus

Senator Ray Miller

Ms. Kim Liston

Mr. Don Anderson

**New Medicaid Department Committee**

Mr. Phil Derrow, Chair

Ms. Anne Harnish

Mr. William Wilkins

Senator Tom Niehaus

Ms. Barbara Riley

**Impact of ODOM on State and Local  
Entities Committee**

Mr. Terry White, Chair

Mr. Bill Ryan

Mr. Joe San Fillipo

Mr. Fred Booker

Ms. Carolyn Givens

Representative Jimmy Stewart

Each committee developed its own scope of work that included identification of current issues, guiding principles, goals for measuring success, and tasks to be completed. The conclusions of the Study Council and the findings developed by each committee led to the recommendations provided in this report.

## **B. MEDICAID BACKGROUND**

Medicaid is an entitlement program that covers health care services for certain low income adults and children. The program was created by the federal government as a part of the Social Security Act of 1965. Each state is responsible for implementation and operation of specific Medicaid programs in accordance with federal regulations.

In Ohio, the Medicaid program is primarily administered by the Ohio Department of Job and Family Services (ODJFS) with support from many other state agencies and local entities. Medicaid covers nearly 2 million Ohioans, including more than 1 million children, 152,000 senior citizens, 265,000 non-elderly adults and children with disabilities, and 490,000 low income parents. Despite aggressive cost containment and budget strategies, the cost of the Ohio Medicaid program continues to grow. Currently, Medicaid spending in Ohio represents nearly 40% of the total state budget (including federal matching funds), and if left unchecked threatens to consume more than 50% by the year 2010.<sup>7</sup>

Management of the Medicaid program is a daunting challenge, involving extraordinary complexity with important economic, policy, and human implications affecting all Ohioans. Thousands of federal, state and local regulations must be followed. An enormous volume of business transactions occur every day. Ohio's Medicaid program is administered through a

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<sup>7</sup> Ohio Commission to Reform Medicaid, 2005



decentralized model with eight other state agencies and 245 local entities performing essential functions. As a health care program, Medicaid operates in one of the nation's most highly regulated industries, subject to dynamic and dramatic change. Constituents and stakeholders, including the citizens of the State of Ohio, who fund the state and federal shares of the program, have intense interest in the program.

In this context, few would argue against taking definitive steps to put Ohio's Medicaid program in the best possible position to meet these formidable challenges.

### **C. DEPARTMENT OF MEDICAID MISSION AND PRINCIPLE STATEMENT**

At the commencement of its work, the Council established a mission statement and principle statement for the new Department of Medicaid. The ODOM mission statement recommended by the Council is:

***“To assure the provision of effective and efficient health care to Ohio’s eligible low income families, aged, blind, and disabled.”***

This mission was developed to concisely and clearly describe the priority of the Department. A critical component of the mission involves a clear understanding of effective and efficient health care. The Council offers the following definitions to ensure the proper interpretation of this mission statement:

*Effective health care shall be defined as medically necessary care provided in accordance with evidence-based and generally accepted peer-reviewed protocols and standards.*

*Efficient health care shall be defined as the lowest total cost methodology of providing effective care.*

The Council also developed a principle statement to guide the evaluation of recommendations, many of which were ultimately adopted by the Council and are presented in this report. This principle statement is as follows:

*Consistent with its Mission, the Ohio Department of Medicaid must develop a culture among its staff and the staff to which any Medicaid functions may be delegated that focuses on the use of existing funding.*

*Accordingly, a principal charge for the Ohio Department of Medicaid must be to identify Medicaid spending which is inconsistent with the Department’s Mission and promulgate policy recommendations to redirect such spending toward more effective and efficient uses.*

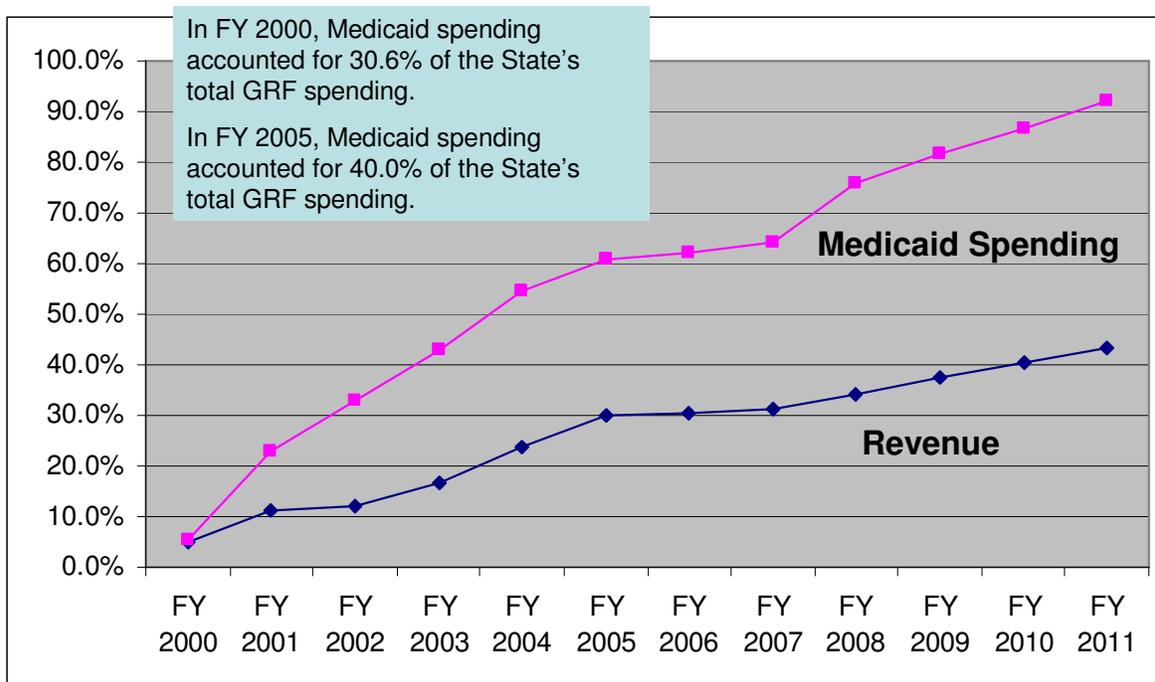


## II. BUSINESS CASE FOR THE NEW DEPARTMENT

This report provides many recommendations that, if implemented, would make essential improvements in the way that Medicaid services are administered in Ohio. Absent change, the Ohio Medicaid program as currently administered is unsustainable.

### A. MEDICAID GROWTH RATE IS UNSUSTAINABLE

The State of Ohio has faced significant growth in Medicaid spending—such that the growth has crowded out other state priorities. Medicaid spending increased nearly 70% from state fiscal year (SFY) 2000 through SFY2005. During the same period, revenue supporting the General Revenue Fund (GRF) grew by only 27%. As a result, Medicaid spending became a much larger percentage of overall GRF spending, growing from 30% in SFY2000 to nearly 40% in SFY2005. The graph shown in Figure 1 tracks the accumulative growth rates of GRF-based Medicaid spending versus GRF revenues (all calculations include federal matching funds).



Note: FY 2000-2005 are actual, 2006-2007 are budget, and 2008-2011 are projected based on trend analysis.  
Revenue and spending data includes federal funds that are credited to the GRF.

Source: Ohio Medicaid Administrative Study Council

**Figure 1 – Accumulative Growth Rates: Medicaid GRF Spending vs. State GRF Revenue**

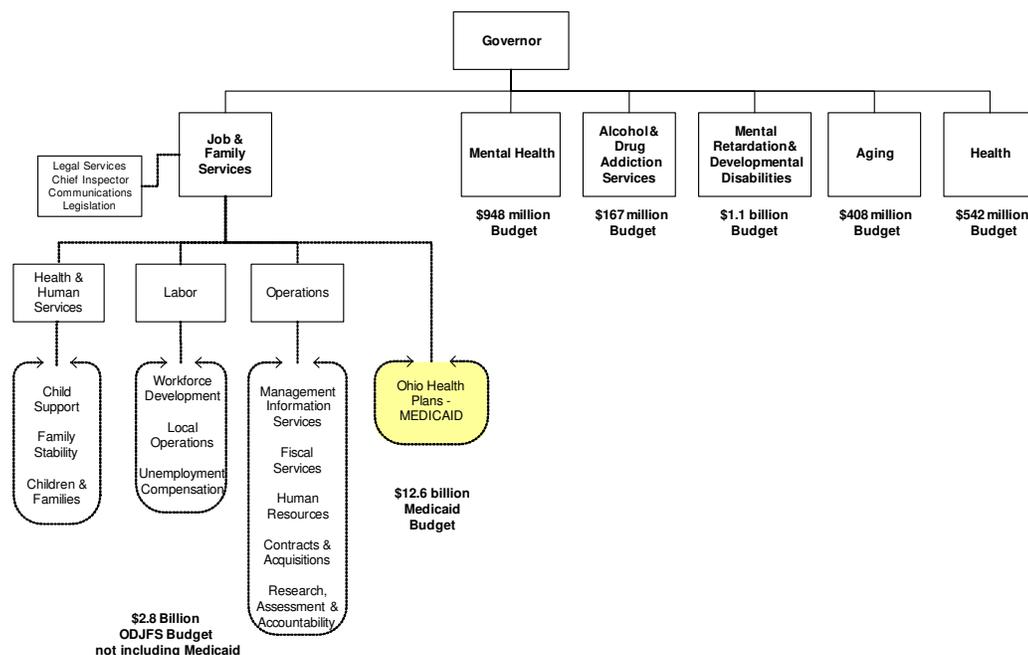


## **B. OHIO COMMISSION TO REFORM MEDICAID RECOMMENDED CHANGES**

The Ohio Commission to Reform Medicaid was convened in December 2003. In his opening remarks at the Commission's first meeting, Governor Bob Taft expressed concerns that the Medicaid program was not well understood by the public at large, yet it has the potential to bankrupt the budget in the State of Ohio and every other state in the nation. After a year of study, more than 40 public meetings, and testimony from hundreds of experts, consumers, and other interested parties, the Commission released its final report in January 2005. Among the many observations presented by the Commission perhaps none is more startling than its conclusion that "the Ohio Medicaid system is broken and must be transformed." Ultimately the Commission recommended the creation of a follow up Council to look at creating a stand alone Medicaid agency.

## **C. MEDICAID IS FRAGMENTED AND MANAGED AT A SUB-DEPARTMENT LEVEL**

Under the current structure, Ohio Medicaid services are delivered through several cabinet-level departments. The ODJFS is the single state agency for Medicaid and provides the administrative support for the majority of Medicaid operations. Medicaid's place within ODJFS is an artifact of Medicaid eligibility being originally tied to federal cash entitlements. Today, however, Medicaid's structural home within ODJFS poses several problems. One organizational issue relates to the fact that Medicaid operates at a program level within the ODJFS structure among seven other major programs: Child Support Enforcement, Child Care and Adoption Services, Protective Services for Children and Elders, Temporary Assistance to Needy Families (TANF), Food Stamps, Unemployment Compensation, and Workforce Development. Figure 2 below illustrates this point. Medicaid, the Office of Ohio Health Plans, must attempt to fulfill its responsibilities as the single state agency charged with adhering to federal requirements that sometimes conflict with state priorities, even when dealing directly with other Cabinet-level department heads who also manage Medicaid funding.



Source: Ohio Medicaid Administrative Study Council, 2006

**Figure 2 – The Medicaid Program’s Position within ODJFS**

This organizational structure is also out of balance with the Medicaid program’s impact on the state budget. Medicaid spending from all agencies tops \$13 billion per year. Medicaid spending by ODJFS alone totals \$12.6 billion and dwarfs all other programs within ODJFS and the other cabinet-level departments that provide certain elements of the Medicaid program. Moreover, the administrative structures within ODJFS do not allow a sufficient and sustained focus on Medicaid, which is the state’s largest program. (For comparison purposes, spending in the state’s second largest program, primary and secondary education was \$9.8 billion in SFY2005.) Within ODJFS, other programs such as Child Support, Child Care, Child Welfare, TANF, Food Stamps, Unemployment Compensation, and Workforce Development all compete for priority attention from the director, and for resources from ODJFS’ shared administrative support offices. This creates an environment where the much larger Medicaid program is often competing for shared service support. This situation has diminished Medicaid’s administrative effectiveness and efficiency and should be addressed.

Medicaid program specialty services are also administered through delegated arrangements with four other state agencies. These other state agencies include the Department of Aging (ODA), the Department of Alcohol and Drug Addiction Services (ODADAS), the Department of Mental Health (ODMH), and the Department of Mental Retardation and Developmental Disabilities (ODMR/DD). These state agencies are responsible for funding and delivery of specialty population-focused services to hundreds of thousands of Medicaid and non-Medicaid eligible Ohioans, while at the same time performing a variety of Medicaid administrative functions. These agencies further delegate some administrative responsibilities to 157 local entities (“sub-



recipients”). In addition, ODJFS delegates eligibility determination for Medicaid to the 88 County Departments of Job and Family Services (CDJFS).

While the state’s reliance on delegated administration through state and local partners has benefits, the Medicaid single state agency needs better accountability and control of these arrangements. The Ohio Medicaid program needs to be in a better position to fulfill its federally mandated single state authority over the Medicaid program, which requires managing competing or conflicting interests among the state and local agencies. At times this fragmentation poses problems with prioritization of policy development and implementation. The Council studied the benefits and risks of Ohio’s delegated administrative arrangements. While concluding that delegation to other departments with particular expertise makes sense, the Council finds that Ohio must improve accountability and the new Department’s capacity to manage and monitor these arrangements.

#### **D. STRUCTURAL AND DIRECTIONAL CHANGES ARE NECESSARY**

To meet the challenges of the future, two essential changes must take place in the organizational structure and direction of Medicaid. Establishing a cabinet-level agency solely focused on managing Medicaid helps put the program in a position to directly advocate for sufficient and dedicated administrative resources and in a position of greater visibility and priority within Ohio state government. There is a critical need to address operational, resource, information technology, and policymaking limitations arising in part from Medicaid’s current subordinate position in the Executive Branch as a program within the ODJFS umbrella and with inferior cabinet status compared to other state agencies involved in the program.

In addition to the structural change of establishing a new Department focused on Medicaid, the Council believes a fundamental change in direction is needed. The sustainability of the program depends in large part on controlling unnecessary costs. The new organizational structure and Mission Statement emphasize the importance of strategic initiatives and clinical leadership, both of which are keys to reducing the overall cost of delivering healthcare to Medicaid consumers. Reducing the overall cost could be achieved by avoiding costs of procedures that are not medically necessary or are not performed in accordance with evidence-based standards of care. By directing Medicaid payments toward predefined, evidenced-based procedures and protocols, program expenses could be decreased and consumer health outcomes could be improved.

Prerequisite to more effective and efficient management of existing program funds is having centralized budgetary authority, and the ability to control administrative infrastructure, especially information technology. The desired level of centralization can only occur if Medicaid is a standalone, cabinet-level department. Within this context, the Council makes its recommendations to the Governor, President of the Senate, and Speaker of the House of Representatives.



### III. RECOMMENDATIONS

As defined by Am. Sub. H.B. 66, the Council's mandate was broad and required analysis in many subject areas. The recommendations provided in this report are presented among the following subject areas:

- Business Model;
- Organizational Structure;
- Cross-Functional Practices;
- Information Technology;
- State and Local Impact;
- Fiscal and Budget;
- Transition; and
- Long Term Care.

The Council's recommendations for each subject area follow.

#### A. BUSINESS MODEL

Recommendations provided in this section pertain to the proposed high-level business model and approach the Council offers for the new Department.

##### 1. Core Business Model

The core business model represents the foundation for the new Department. The intent of the core business model is to establish a strategic platform for more effective and efficient management of the program. The elements of this approach include describing the mission, operating principles, and delegation principles to which the Council believes ODOM should adhere throughout implementation and steady-state operations. In developing the core business model, the Council made the following assumptions:

1. Responsibility for all Medicaid funding, policy development and rule-making should be consolidated into the Department of Medicaid.
2. As the single state Medicaid agency, the Department of Medicaid, with required federal approval, has the sole authority to determine when and how to use delegated arrangements with sister agencies and to set and monitor the terms of these arrangements.
3. The Department of Medicaid needs to take a new direction, expressed in its new mission:

***“To assure the provision of effective and efficient health care to Ohio’s eligible low income families, aged, blind, and disabled.”***

The core business model should be supported by the operating principles and delegation principles described in the paragraphs below.



*a) OPERATING PRINCIPLES*

To achieve its mission, the new Department should adhere to the following operating principles when conducting its business:

1. Policy recommendations shall be consistent with the Department's mission statement and shall be based on timely objective analysis, verifiable data, and evidence-based standards.
2. All operating units of the Department shall use the same central data warehouse and knowledgebase systems for analysis and decision making.
3. The Department should establish clearly defined goals and associated operating measures for each operating unit to assure clarity of purpose and focus for all department personnel, to provide unambiguous and routine performance measurement, and to guide continuous improvement.
4. Department personnel should be empowered to act in accordance with the Department's mission, goals, and performance standards, and should be accountable for achieving relevant and measurable results.
5. The Department should create an internal Strategy and Policy Review Committee to review the policy initiatives recommended the Strategy Division. The committee should be chaired by the Chief Strategy Officer and consist of the Chief Medical Officer, the Chief Plan Officer, the Chief Financial Officer and the Chief Information Officer.
6. The Department will comply with all related federal and state laws and regulations.
7. The Department 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 require the Department to obtain certain exemptions from the Department of Administrative Services for alternative classification specifications and pay ranges.

*b) DELEGATION PRINCIPLES*

As previously described, Ohio Medicaid operates in a multi-agency model at the state level, with local entities assisting in the administration of the program. The Council's study affirms the potential for continuing benefit from this model, while at the same time establishing the need for significant improvements in its administration. To maximize the efficiency and effectiveness of this model, ODOM must tightly manage its delegated relationships. Each party to an Interagency Agreement governing a delegation arrangement must: (1) have a clear understanding of its role and responsibilities; (2) be held accountable for its performance; and (3) have the authority to manage the delegation arrangement.

To that end, the Council developed the following delegation principles that should be considered when the Department delegates any of its responsibilities to sister agencies and/or local entities:

1. Delegated arrangements should be limited in scope and the Department of Medicaid must retain the overall authority over the Medicaid program.
2. Delegated arrangements should include performance standards and be subject to active monitoring by the Department of Medicaid.



3. The Department should be able to pursue strategic opportunities and solutions within the broad guidelines established by the Legislature, and have the capacity and authority to exercise meaningful remedies (e.g. have the ability to renegotiate agreements, terminate agreements, or collect fees and penalties) when necessary for the effective and efficient administration of the Medicaid program.
4. The scope of the delegation, functioning of the infrastructure for implementation, financial barriers, performance, and conflicts of interest impacting the effectiveness and efficiency of the delegation should be continually monitored and addressed.
5. Delegated arrangements are a matter of strategic importance to the ODOM and should be initiated, negotiated, and controlled by the Chief Strategy Officer, with day-to-day administration by the Chief Plan Officer.
6. The Department of Medicaid should have its own clinical expertise, delivery system knowledge, compliance procedures, and quality management practices for services purchased through sister agencies.
7. Provider qualification and contracting, billing, processing and payment pathways should be simple and straightforward.

Within this context, the Council believes that the recommended core business model represents the most appropriate organization for supporting the new Department's mission.

## **B. ORGANIZATIONAL STRUCTURE**

The Council was tasked with developing recommendations “to structure the Medicaid program's administration in a manner that optimizes the program's fiscal and operational objectives.” With this mandate in mind, the Council identified the new Department's functions and responsibilities based on the functions performed in the current Medicaid model. Using the mission statement, operating principles, and delegation principles, the Council developed a proposed organizational structure for the new Department. The Council engaged the consultative services of Milliman, Inc. (Milliman) to review the approach and to propose suggestions for improving the structure. Milliman also assisted with development of the business plan for transition. The organizational structure recommended in this section incorporates many of Milliman's suggestions.

### **1. New Organizational Concepts**

The proposed organizational structure was developed to support compliance with the new Department's mission statement. Within this context, the Council believes that the Department must be thoughtful in development of long-range strategies that include best practices from within Ohio as well as from other states, industry, and academic research. In designing the recommended organizational structure, the Council supplemented the traditional functions that already exist in the agencies that support Medicaid today such as legal, fiscal, human resources, and legislative liaison; with dedicated units focused on strategy and the use of clinical best practices. The Council's analysis found that the current structure of the Ohio Medicaid program limits the strategic and clinical management capacity to meet the challenges of the future.



Given the goal of establishing a strategic platform for a more effective and efficient program, the Council recommends the creation of a Strategy Division. This division, led by a Chief Strategy Officer who reports to the Medicaid Director, should not be burdened with daily operational activities. The new Department must have the ability to look toward the future in developing innovative policies that promote the provision of effective and efficient health care. This division pursues innovation and proposes ways for the Medicaid program to take strategic advantage of the opportunities it identifies. A key component of the Strategy Division should be the implementation of a What Works and What Doesn't (WWWD) unit. The WWWD unit should be charged with reviewing past policy changes to evaluate their effectiveness, making corrective action recommendations, and evaluating initiatives that are implemented in other organizations such as other state Medicaid programs and the private sector.

The Council also recommends that the Department should have a Clinical Division, led by a Chief Medical Officer, who reports to the Medicaid Director. The Chief Medical Officer should provide clinical leadership with more emphasis on evidence-based care, maintain relationships with medical professionals, and develop disease management programs and best practice protocols and procedures designed to ensure that the health care services delivered by ODOM are clinically effective and efficient.

Finally, the Council recommends that the organizational structure should have a Plan Division responsible for day-to-day administration of the Medicaid program focused on delivery of quality care to Medicaid consumers.<sup>8</sup>

## **2. Organizational Structure Principles**

With regard to the general structure of the Department, the Council makes the following recommendations:

1. A new cabinet-level department, the Ohio Department of Medicaid, should be created to manage Ohio's entire Medicaid program.
2. The Department of Medicaid should operate in a manner consistent with the Department of Medicaid's Operating Principles.
3. The Department of Medicaid should operate as part of a broader health care strategy developed by the Ohio Health Care Advisory Committee.<sup>9</sup>
4. The Department of Medicaid should be appropriated the funds for and should 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 Best Rx, and the prescription drug component of the Golden Buckeye Card.

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<sup>8</sup> This recommendation parallels the budget recommendation and includes units that would separately focus on the Aged, Blind and Disabled (ABD) population; and the Covered Families and Children (CFC) population.

<sup>9</sup> See Section IV, Other Organizational Structures



5. Adequate funding should be appropriated to make investments in significantly enhancing the Department's strategic analysis capability.
6. 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 to perform analyses and discuss with the Department of Administrative Services the need to create alternative classifications or pay scales, as appropriate.
7. The changes associated with the creation of the Department of Medicaid should be implemented in accordance with the steps as outlined in the Transition Plan.
8. The Department of Medicaid should use the Delegation Principles to guide its decisions to delegate Medicaid responsibility to other parties.

The Council believes these principles should be considered an integral part of the implementation and operation of the new Department.

### **3. Criteria for Future Organization Structure Recommendations**

The Council adopted the following criteria for evaluating future organizational structure recommendations:

- Budget responsibility and authority to spend or create policy should be placed in the same organizational entity and with the same administrator.
- Billing, processing, and payment pathways should be simple and straightforward.
- The departmental scope of services should minimize conflicts between functions.
- The Department should be organized using contemporary balanced design, flat structures, and appropriate spans of control.
- Staff functions should not be duplicated in each division.
- Purchasing power should be concentrated to increase the state's leverage in each market.
- Information Technology systems should use the best/most appropriate practices of both public and private sectors.
- The Department should establish an internal auditing function governed by Generally Accepted Government Auditing Standards (GAGAS) to provide fiscal as well as operational review and reports to management and other entities with oversight jurisdiction.

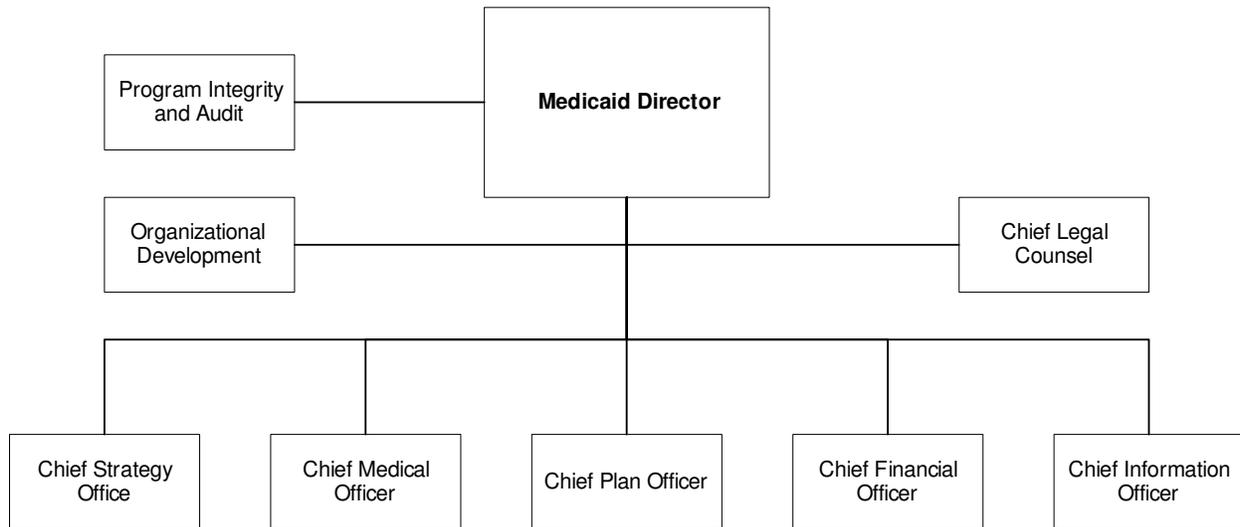
### **4. Recommended Organizational Structure**

The Council considered a variety of options and proposed organizational structures for ODOM. Following many revisions and iterations, the Council accepted and recommends the organizational structure that is described in the paragraphs below.



*a) SENIOR MANAGEMENT*

The proposed senior management structure was designed to provide logical groupings of functions that should be required for the new Department. The senior management structure is shown in Figure 3 below.



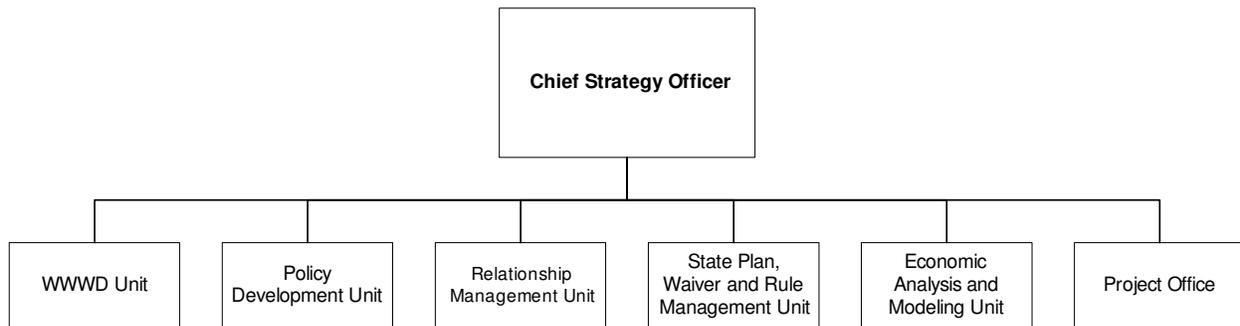
**Figure 3 -- Senior Management Structure**

As shown in Figure 3 the Department should be led by a Medicaid Director. The Medicaid Director would have eight direct reports including officers for the five major functional areas, chief legal counsel, and managers responsible for Program Integrity and Audit, and Organizational Development. Division and subunit descriptions for each of the Medicaid Director's direct reports are provided in the paragraphs below.

For each division, this report provides a description of the major functions and identifies any units or subunits recommended by the Council.

*b) STRATEGY DIVISION*

The current organization does not have a dedicated unit charged with developing overall strategy for the program's management. The Strategy Division is responsible for researching best practices, modeling future trends, and developing innovative future initiatives to ensure Ohio is providing effective and efficiency health care to eligible individuals. This division is first and foremost looking toward, and planning for, the future. The Strategy Division and its subunits are shown in Figure 4 shown below.



**Figure 4 -- Strategy Division**

The Chief Strategy Officer (CSO) is responsible for coordinating activities among the six subunits described in the paragraphs below.

### **What Works and What Doesn't Unit**

The What Works and What Doesn't Unit (WWWD) would be responsible for recommending new strategies to provide effective and efficient health care to the covered populations. The WWWD Unit would achieve this mission by reviewing initiatives undertaken by other states and private sector health care payers to identify those that should be considered for Ohio Medicaid. Also, this Unit would continuously evaluate the performance of existing policies and/or programs to determine if anticipated outcomes were achieved; and as appropriate recommend changes, or termination.

### **Policy Development Unit**

The Policy Development Unit would be responsible for crafting detailed, formal policy documents and policy recommendations based on approved strategy initiatives. Once drafted and internally approved, these policy documents would be used by the Department, the Governor, and/or the Legislature.

### **Relationship Management Unit**

The Relationship Management Unit would manage relationships and communications with constituents and stakeholders as related to the Department's development of strategies and policies. Constituents may include: the Governor's Office, the General Assembly, consumer advocates, provider associations, other cabinet agencies, local boards, and others. The Unit would solicit input from these groups and communicate the Department's strategies to ensure that these interested parties are made aware of Department activities and have an opportunity to provide input as appropriate. The Unit would coordinate with the State Plan, Waiver, and Rule Management Unit to proactively engage CMS to educate and gain preliminary approval for major changes to the Ohio Medicaid program.



### **State Plan, Waiver, and Rule Management Unit**

The State Plan, Waiver, and Rule Management Unit would be responsible for ensuring that recommended state plan amendments, waivers, and administrative rules are consistent with the Department's policies and strategies. This Unit would submit state plan amendments and state administrative rules to the appropriate authorities and manage approval processes. The Unit would closely coordinate its activities with the Centers for Medicare and Medicaid Services (CMS) to ensure the federal government understands and approves requested changes to Ohio's Medicaid program.

### **Economic Analysis and Modeling Unit**

The Economic Analysis and Modeling Unit would be primarily responsible for modeling proposed initiatives to project Ohio-specific outcomes. In coordination with the Office of Budget and Management (OBM) and the Legislative Service Commission (LSC), this Unit would monitor current and projected demographic and economic trends to project Medicaid caseloads and applicable health care cost increases.

### **Project Office**

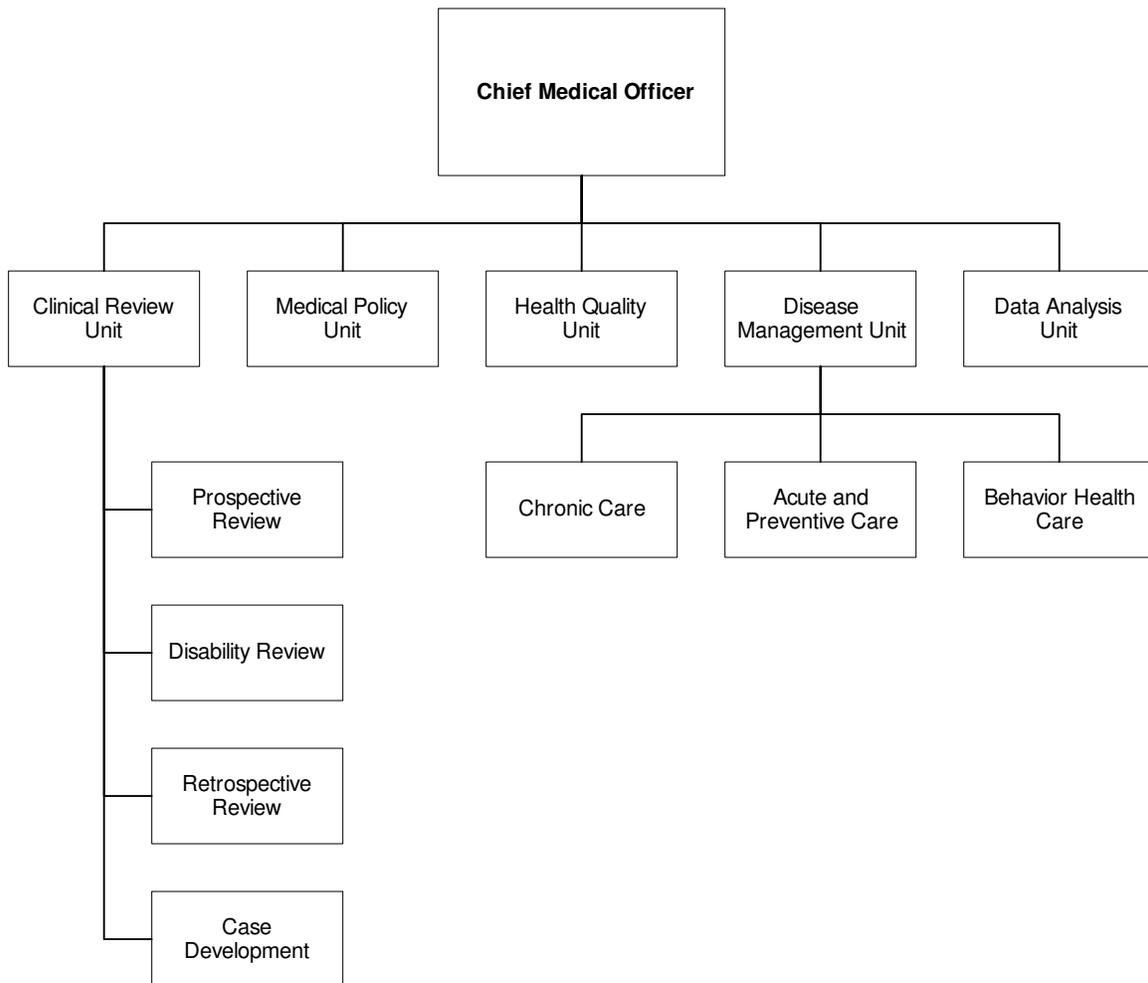
The Project Office would be responsible for overall coordination of projects being conducted throughout the Department. This Office manages the portfolio of projects ongoing within the Department, while individual project managers residing within the other Divisions are responsible for project management of the projects within their division or unit.<sup>10</sup> Staff in the Project Office should be responsible for overseeing the prioritization of new project requests and monitoring existing projects. Other staff should be responsible for evaluation of projects and using lessons learned from those projects to improve project management processes.

### *c) CLINICAL DIVISION*

The current organization does not have a unit charged with establishing clinical management over the entire program. The Clinical Division would be responsible for providing clinical leadership within the Department and direct the overall clinical management of the program with more emphasis on evidence-based care. The Division would evaluate the clinical effectiveness and efficiency of the Department's policies and programs, and help to identify health care trends occurring among Medicaid consumers. A goal is to identify medically unnecessary procedures and to identify evidence-based clinical protocols, so that overall costs could be reduced. The Clinical Division and its subunits are shown in Figure 5 below.

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<sup>10</sup> Major IT projects would be managed by the IT Division with progress tracked by the Strategy Division.



**Figure 5 -- Clinical Division**

The Chief Medical Officer would be the Department's clinical leader. The Chief Medical Officer would develop and maintain direct relationships with medical professionals in the provider community. In conjunction with the Chief Strategy Officer, the Chief Medical Officer would solicit input from, and provide education to, these medical providers as it relates to clinical evidence-based, and promising or emerging best practices and treatment protocols. The five subunits of the Clinical Division are described in the paragraphs below.

### **Clinical Review Unit**

The Clinical Review Unit would be responsible for performing clinical review activities in support of the administration of the Medicaid program. These activities would involve pre-authorization of specific health care services, comparing health status information to established criteria for a determination of disability, post-payment review for the purpose of assuring coverage policies were followed when the service was rendered, and specialized case



management activities for consumers meeting criteria for case management. These activities include: (1) prospective review, (2), disability review, (3) retrospective review, and (4) case development.

### **Medical Policy Unit**

The Medical Policy Unit would be responsible for developing and maintaining written documentation of clinical coverage policies based on accepted research and evidence. This documentation should provide consistent and standardized information on what services are covered, for what conditions, and under what circumstances and limitations.

### **Health Quality Unit**

The Health Quality Unit would be responsible for monitoring and managing the health outcomes of all covered Medicaid beneficiaries, including those covered by managed care plans. Along with Strategy Division, this Unit would use accepted performance measures like the Health Plan Employer Data and Information Set (HEDIS) and develop appropriate standards and benchmarks to measure the Department's success in providing effective and efficient health care to the covered beneficiary groups.

### **Disease Management Unit**

The Disease Management Unit would be responsible for determining a set of interventions designed to improve the health of individuals, especially those with chronic diseases. This Unit should focus on: chronic care, acute and preventive care, and behavioral health care. Disease management programs typically include: (1) identifying patients with specific diseases and directing them to specific interventions; (2) supporting adherence to evidence-based medical practice guidelines; (3) providing services designed to enhance patient management and adherence to individualized treatment plans; and (4) collecting data, and analysis processes and outcomes compared to standards and benchmarks.

### **Data Analysis Unit**

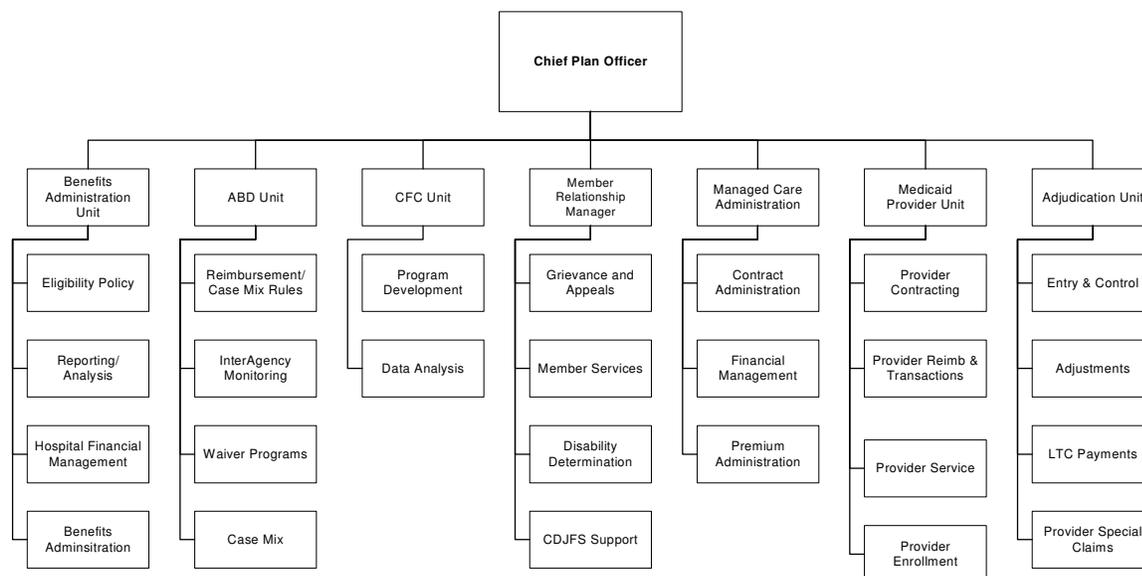
The Data Analysis Unit would be the Department's center of excellence for accessing and utilizing health care data. This Unit's primary focus would be on helping staff in the Clinical Division to monitor health care data for trends and abnormalities. The Unit would serve as a resource for the entire Department's clinical analysis needs. The Unit would also work with the Strategy Division to recommend policy adjustments as necessary to help meet the Department's goals and objectives.

### *d) PLAN DIVISION*

The Plan Division would be responsible for implementing and administering the strategies, policies, and programs developed by the new Department. This Division, led by the Chief Plan Officer who reports to the Medicaid Director, would have broad accountability for managing the



day-to-day plan operations. Much of the current Medicaid organization's resources would be located here.<sup>11</sup> The Plan Division and its subunits are shown in Figure 6 below.



**Figure 6 -- Plan Division**

The seven subunits of the Plan Division are described below.

### **Benefits Administration Unit**

The Benefits Administration Unit would house areas that support both the ABD and CFC populations from an operational perspective, including rate setting analysis, along with activities such as:

- Eligibility policy;
- Hospital financial management;
- Reporting and analysis; and
- Benefits management.

Functions that are specialized or dedicated to ABD and CFC populations would be located in those units (see ABD Unit and CFC Unit below). Reporting and analysis functions would exist in all three units allowing for cross-unit teams and coordination of analytic projects.

<sup>11</sup> The Council recognizes that there are alternative ways to organize these activities, including imbedding the functional units within the ABD and CFC Units.



### **ABD Unit**

The ABD Unit would be responsible for implementing and coordinating the health care service and reimbursement policies related to the Aged, Blind, and Disabled population. This Unit would provide oversight, consultation, and technical assistance to ensure that policies and procedures are followed by providers, other state agencies, and local organizations. Staff in this Unit would monitor the performance standards developed by the Clinical Division to measure the effectiveness and efficiency of the program. This Unit would also ensure that emerging policy issues related to long-term and community-based care are communicated to the Strategy Division. The Unit would work collaboratively with the Benefits Administration Unit.

### **CFC Unit**

The CFC Unit would be responsible for implementing and coordinating the health care service and reimbursement policies related to the Covered Families and Children population. This Unit would provide oversight, consultation, and technical assistance to ensure that policies and procedures are followed by providers, other state agencies, and local organizations. Staff in this Unit would monitor the performance standards developed by the Clinical Division to measure the effectiveness and efficiency of the program. This Unit would also work to ensure that emerging policy issues related to the Covered Families and Children population are communicated to the Strategy Division. The Unit would work collaboratively with the Benefits Administration Unit.

### **Member Relationship Manager**

The Member Relationship Manager would have overall responsibility for managing the new Department's relationship with Medicaid-eligible consumers. This Manager would be responsible for managing the Grievance and Appeals Unit, the Member Services Unit, the Disability Determination Unit, and the CDJFS Unit. The responsibilities of these subunits are described in the paragraphs below.

#### ***Grievance and Appeals Unit***

The Grievance and Appeals Unit would be responsible for providing non-legally binding arbitration for member grievances related to decisions made by the Department, its sub-recipients, or contracted providers and health plans.

#### ***Member Services Unit***

The Member Services Unit would be responsible for coordinating member enrollment and disenrollment, call centers, and related activities, as well as providing member communications.

#### ***Disability Determination Unit***

The Disability Determination Unit would be responsible for all state-level tasks associated with determining eligibility based on beneficiary disability. This Unit would



work closely with the CDJFS offices and the Rehabilitation Services Commission to provide an efficient and cost-effective disability determination process.

### ***CDJFS Support Unit***

The CDJFS Support Unit would manage and support the day-to-day relationship with the CDJFS offices. This Unit would coordinate training, communications, and policy coordination to the county offices. Staff in this Unit would establish performance standards with the CDJFS offices to measure the effectiveness and efficiency of the eligibility process.

### **Managed Care Administration Unit**

The Managed Care Provider Unit would be responsible for managing the managed care plans contracted to provide coverage to covered populations. The scope of responsibility for this Unit should include contract development and contract management, contract loading, provider manual creation, and communications.

### **Medicaid Provider Unit**

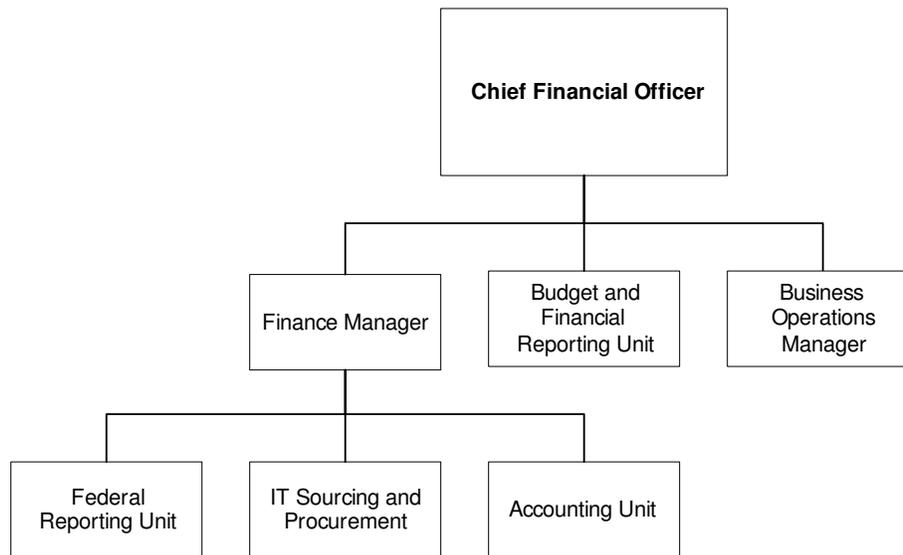
The Medicaid Provider Unit would be responsible for managing the health care providers contracted to provide services to covered populations under the fee-for-service plan. The scope of responsibility for this Unit should include contract development and contract management, provider contract loading, and communications.

### **Adjudication Unit**

The Adjudication Unit would be responsible for adjudicating all claims that require manual processing. Staff in this Unit would coordinate with the Chief Medical Officer, and the Program Integrity and Audit Unit when technical assistance is required.

### ***e) FINANCE DIVISION***

As a new department, ODOM will need its own finance and accounting functions. The Finance Division is responsible for developing the Department's budget, performing all accounting functions, monitoring and reporting of revenue and spending activities, and paying providers. The Finance Division and its subunits are shown in Figure 7 below.



**Figure 7 -- Finance Division**

The Chief Financial Officer (CFO) would act as the leader of all finance, budgeting, and business operations activities. In this capacity, the CFO would manage the disbursement of resources required to efficiently and effectively operate the Department. The four subunits of the Finance Division are described in the paragraphs below.

### **Finance Manager**

The Finance Manager would be responsible for performing detailed financial transactions such as accounts payable and accounts receivable, and meeting both state and federal appropriations accounting standards. This manager would be responsible for the Accounting Unit, IT Sourcing and Procurement, and the Federal Reporting Unit described below.

#### ***Accounting Unit***

The Accounting Unit would perform all accounting functions including: (1) accounts payable including processing reimbursement of providers, and payment of managed care plans and sub-recipients, (2) accounts receivable, (3) cash management (including the federal monies draw-down process), and (4) cost allocation, to ensure that the Department meets state and federal financial processing standards. In coordination with OBM, this unit should be responsible for reviewing expenditures to ensure that revenue is properly claimed for all eligible expenses.

#### ***IT Sourcing and Procurement***

Within the Business Operations unit there would be specialists to play a liaison role with respect to IT Sourcing and Procurement and IT Financial Management (including IT Budgeting, Service Accounting, Asset Management, and Human Resources). This



position would be located in the Finance Division but have a close working relationship with the Information Technology Division and the Ohio Office of Information Technology (OIT) for procurement, vendor, and supplier relationships and other procurement and sourcing issues. The role would specifically oversee the federal Advance Planning Document process to pursue enhanced federal funding for Medicaid IT projects.

### ***Federal Reporting Unit***

The Federal Reporting Unit would be responsible for ensuring the Department meets all federal financial reporting requirements to support the Department's designation as the single state agency for the Ohio Medicaid program.

### **Budget and Financial Reporting Unit**

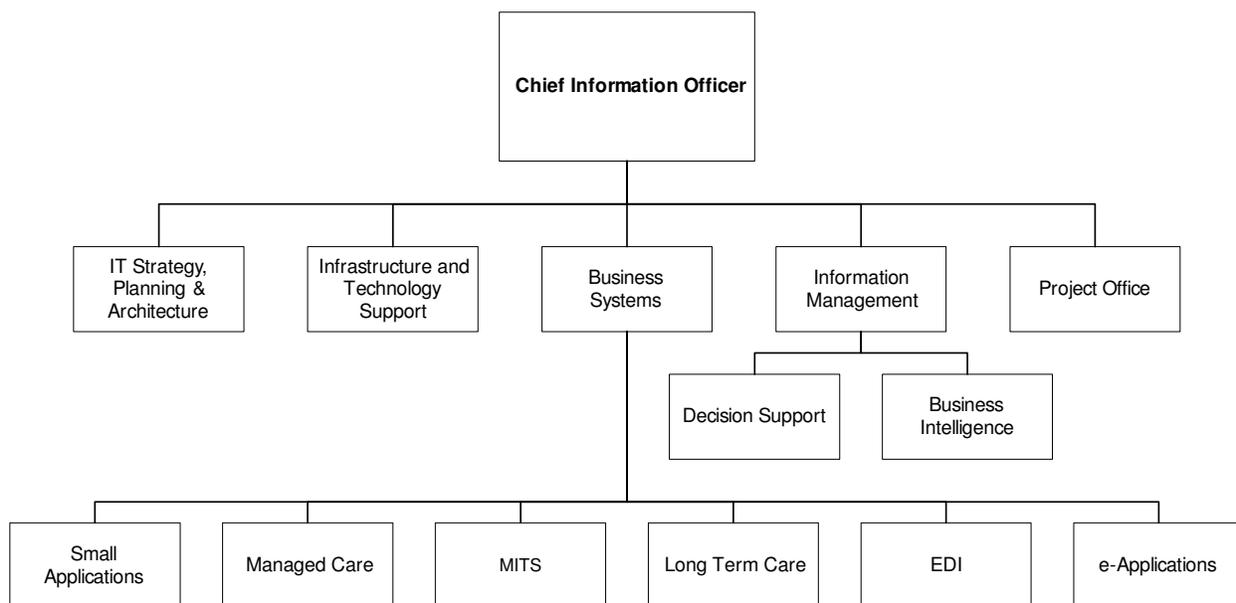
The Budget and Financial Reporting Unit would develop the Department's official biennial budget, monitor spending, and publish monthly variance reports. This Unit would be responsible for developing comprehensive financial reports for distribution within the Department, and for use by external policy makers and assisting those stakeholders in interpreting the reports and developing corrective action plans when trend variances are identified.

### **Business Operations Manager**

The Business Operations Manager would manage the business support services required to operate the Department. These services may include facilities management, contracting and procurement, human resources, mail functions, internal communications, and other essential functions.

### ***f) INFORMATION TECHNOLOGY DIVISION***

As a new Department, ODOM will need its own Information Technology (IT) Division. While ODJFS would provide transitional Management Information Systems (MIS) support, and the eligibility function and system would remain with ODJFS and the CDJFS, stand-alone capacity will be needed at ODOM. Ultimately MITS will reside at ODOM. The IT Division is responsible for all activities related to the IT and Information Systems (IS) needs of the Department. The recommended configuration corresponds with the Council recommendations for centralizing IT. The IT Division and its subunits are shown in Figure 8 below.



**Figure 8 -- Information Technology Division**

The Information Technology Division will be led by the Chief Information Officer (CIO). The CIO participates in the development of the ODOM Strategic Plan, leads the development of an IT Strategic Plan, and participates in organizational reengineering and process improvement initiatives. This position requires a strong relationship manager who can establish trust with peers, and with the IT personnel within the organization by knowing how a public health care payer system works and how to lead an effective and efficient IT organization to deliver technology solutions for business problems. The CIO is owner of all the day-to-day operations of IT and is responsible for the IT sourcing strategy and oversight. The five subunits of the IT Division are described in the paragraphs below.

### **IT Strategy, Planning and Architecture**

The IT Strategy, Planning, and Architecture Unit would be responsible for researching best practices, modeling future trends, and developing future initiatives regarding deployment of IT infrastructure and resources. The Unit would also be responsible for development and definition of data, security, and enterprise architecture standards and policies for the Department. The starting point for these materials should be the standards and policies promulgated by OIT.

### **Infrastructure and Technology Support Unit**

The Infrastructure and Technology Support Unit would be responsible for executing the strategy and architecture established by the IT Strategy, Planning, and Architecture Unit. This Unit would manage server platforms, middleware, storage devices, voice and data networks,



web/portal infrastructure, operating systems, database management, end-user devices, hardware support, and the help desk. A key part of this activity would be based in service level agreements with the business areas.

### **Business Systems Unit**

The Business Systems Unit would be comprised of a production group that maintains, enhances, and supports the systems that process Medicaid transactions and data for end-users through six teams described below:

- **Small Applications Team:** Services the small applications such as the Internal Tracking System, and various MS Access databases within the organization.
- **Managed Care Systems Team:** Maintains the managed care related systems such as Athena/HMO and the Encounter Claim Process.
- **MITS Team:** Supports those systems impacting the claims process (including the Disability Determination system, eQuIL).
- **Long Term Care Systems Team:** Supports applications such as Pegasus, Perseus, Minimum Data Set, Automatic Cost Reporting, Individual Assessment Software, and the ICF/MR system.
- **Electronic Data Interchange Team:** Responsible for maintaining and updating Electronic Data Interchange (EDI) infrastructure.
- **E-Applications Team:** Supports new and existing portal and web requirements from the Department.

This Unit would manage and evaluate the effectiveness and efficiency of the business systems, and the processes that serve the Department's internal and external customers. The staff would include relationship managers who would work with and advocate for the business units regarding business requirements, service level agreements, and other negotiation needs. Software testing and release management activities would also be a part of this Unit.

### **Information Management Unit**

The Information Management Unit would maintain the Medicaid Decision Support System (DSS) and Cognos reporting environment used by the other senior management offices via two teams: (1) Decision Support System Team; and (2) Business Intelligence Team. Working with an existing steering sub-committee and users group, staff in this department would develop an information governance structure, define information requirements, and undertake iterative development of the knowledge system. Staff in this Unit would closely work with the Data Warehouse Team, and also manage any specialized data marts.

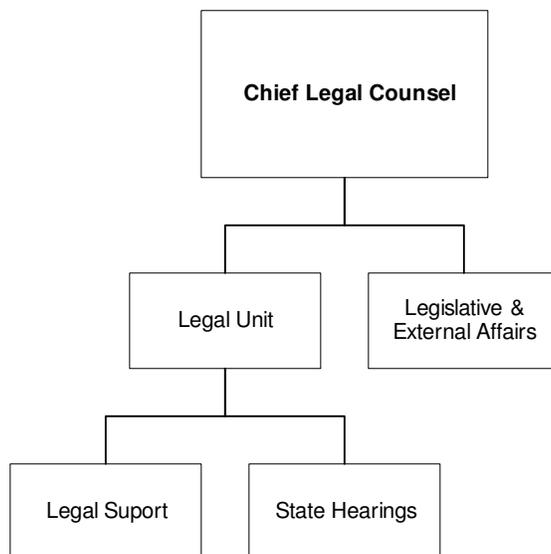
### **IT Project Office**

The IT Project Office would be responsible for managing all IT projects. This Unit would be staffed with trained and proven project managers in a resource pool for organizational projects. IT project managers would communicate frequently with the Strategy Division Project Office.



*g) LEGAL DIVISION*

As a new Department, ODOM needs its own legal capabilities. This is especially important given the complexity of Medicaid and the proclivity for legal issues to arise. The Legal Division would be responsible for handling the Department's legal and legislative affairs. The Legal Division and its subunits are shown in Figure 9 below.



**Figure 9 -- Legal Division**

The Legal Division, led by the Chief Legal Counsel who reports to the Medicaid Director, would manage the legal staff and the Department's relationship with the State Attorney General. Within the Legal Division, there would be two units: the Legal Unit, which would include two teams: (1) Legal Support; and (2) State Hearings; and the Legislative Liaison and the External Affairs staff. The External Affairs staff would be primarily responsible for managing and responding to inquiries from the public and the press.

*h) ORGANIZATIONAL DEVELOPMENT MANAGER*

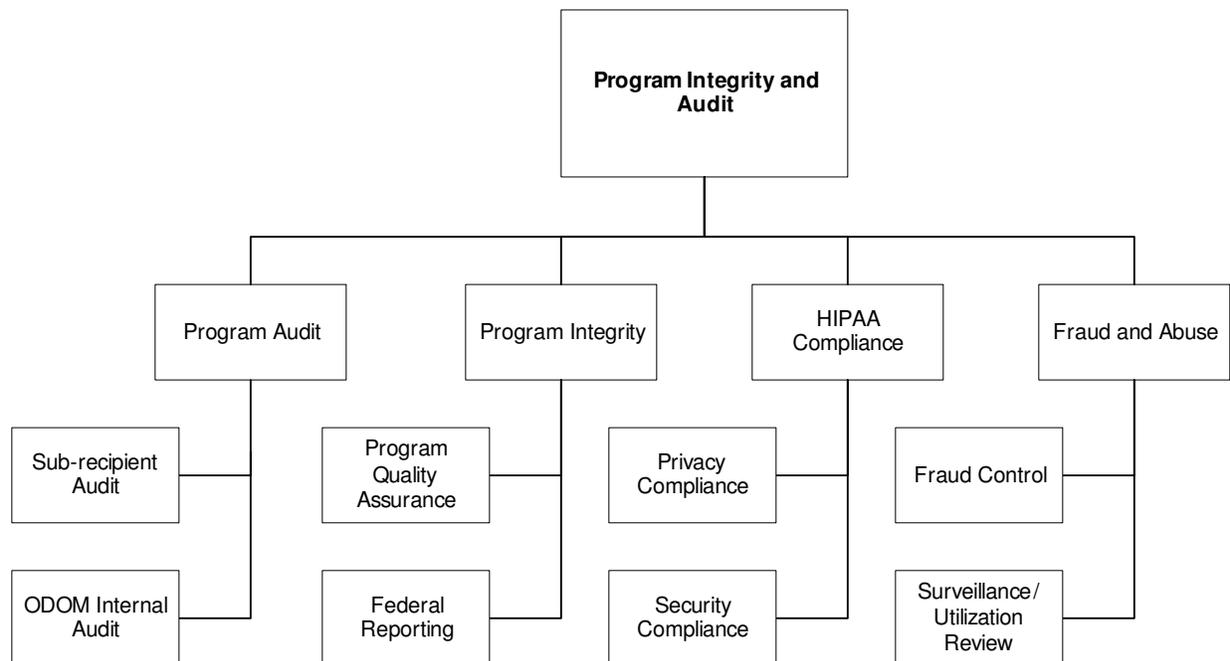
As a new department charged with taking a new direction, the Organizational Development Unit is essential to transforming the culture of the Medicaid organization. The Organizational Development Manager would be accountable for attracting, developing, and retaining high-performing employees. This role would include: (1) supporting development of a culture that fosters teamwork among the management team and throughout the entire organization; (2) fostering a results driven organization; (3) working with the Department of Administrative Services to explore creation of alternative classifications and pay scales to attract and retain high performing employees; and (4) providing the necessary training and educational opportunities to



further each employee's professional development. The day-to-day human resources function is located in the Finance Division, Business Operations Unit.

*i) PROGRAM INTEGRITY AND AUDIT UNIT*

As a new Department, ODOM needs its own program integrity and audit functions.<sup>12</sup> The Program Integrity and Audit Unit would be responsible for ensuring that the Department is compliant with all of the operating and financial standards outlined by state and federal regulations and laws. The Unit supports audits of health payments activities and reviews to support the operational objectives of the Department. The Program Integrity and Audit Unit and its subunits are shown in Figure 10 below.



**Figure 10 -- Program Integrity and Audit Unit**

The unit would be comprised of four teams described below:

- Program Audit;
- Program Integrity;
- HIPAA Compliance; and
- Fraud and Abuse.

<sup>12</sup> The scope of the Council's recommendations does not include activities currently performed by the Attorney General or the Auditor of the State.



### **Program Audit**

The Program Audit team would focus on program audits and the regulatory compliance of providers and sub-recipients, as well as compliance issues with the Department's divisions and units.

### **Program Integrity**

The Program Integrity team would focus on monitoring operational activities and conducting reviews to support the operational objectives of the Department. The team would also focus on quality assurance for the Medicaid program as well as federal reporting as it relates to data quality issues.

### **HIPAA Compliance**

The HIPAA Compliance team would be responsible for compliance with the privacy and security requirements mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This team would also house the HIPAA Privacy Officer mandated by this federal legislation.

### **Fraud and Abuse**

The Fraud and Abuse team should provide oversight and guidelines for the Department's anti-fraud and abuse efforts, including management of the federal Surveillance and Utilization Review (SUR) program.

## **C. CROSS-FUNCTIONAL PRACTICES**

One of the primary attributes envisioned for the new Department is that organizational units should work in concert to achieve the mission. Given the complexity of the Medicaid program and the volume and nature of its business transactions, the Council identified many "connecting pathways" needed for the organization to achieve its work in an effective and efficient manner.

It is important that organizational units and individual staff understand their role in the new organization and how they connect to the activities and overall performance of the entire Department. These mechanisms can play a critical role in minimizing operational errors, and providing a structure to help bring about the desired organizational culture. To support implementation of an effective and efficient organization, cross-functional practices were designed to highlight the type of coordination among the many divisions and units of the proposed organizational structure that will be needed to make the program more effective.

Selected protocols for each division or major unit are provided in Appendix 3. It is important to note that these cross-functional protocols are provided to illustrate the ways in which different divisions and units should coordinate. The list provided in Appendix 3 is not all-inclusive, but rather contains a sufficient number of protocols to illustrate the Council's intent. The Council



anticipates that additional cross-functional protocols should be developed and implemented during transition.

## **D. INFORMATION TECHNOLOGY**

The Council was required to evaluate “centralizing financing and information technology functions to coordinate the Department’s activities with other state agencies that assist in the program’s administration.” The new Department’s IT infrastructure is a critical element to its success. The CIO plays a key role in the Department (this role is described in Appendix 10, Principles for the Chief Information Officer).

### **1. Information Technology Goals**

Using the legislative mandate as a guide, the Council established the following goals to guide its IT Recommendations:

- Develop a plan for a single, efficient Medicaid claims processing system that eliminates excess steps in claims processing and is controlled by the Department.
- Evaluate current managed care encounter claim data collection and analysis by ODJFS.
- Determine the effectiveness of the ODJFS Data Warehouse and information retrieval system and identify improvements needed to support the Department, including the functions of strategic planning, risk management, financial management, and program management (including the ability to access care management information across all Medicaid services).
- Determine ODJFS’ approach for replacing the CRIS-E program eligibility system, and whether Medicaid requirements for all categories of eligibility, including waiver enrollment, can be met by the new system.
- Determine the ODJFS MIS operational and infrastructure transition plan.
- Determine governance structure for IT management and IT project requests for the new Medicaid Department.

### **2. Information Technology Recommendations**

Within the context of the goals identified in the previous section, the Council completed its evaluations and developed the recommendations that are provided in the paragraphs below.

#### ***a) SINGLE MEDICAID CLAIMS PROCESSING SYSTEM***

Currently, the information systems that support the Ohio Medicaid program reside in five state agencies: ODMH, ODADAS, ODMR/DD, ODA, and ODJFS. Medicaid claims flow through each of these systems and then are adjudicated by the current Medicaid Management Information System (MMIS).

This multi-agency approach has evolved over many years. The disparate systems each apply pricing and service authorization edits that cannot be easily handled by the MMIS. In some



cases, these systems also process claims for non-Medicaid services. Centralizing the claims systems into a single system that is flexible enough to handle multiple plans, benefit packages, benefit rules, provider panels, and funding sources should be more efficient than the current multi-agency arrangement.

At this time none of the existing systems has the flexibility and capacity to manage the volume of claims generated by the Medicaid program. However, using modern technology, a single claims system could be developed. ODJFS is evaluating proposals to replace the more than 20-year old MMIS claim system with a current generation Medicaid Information Technology System (MITS). It is expected that ODJFS will select a vendor in the first quarter of 2007. Although MITS meets the requirements for a centralized claims processing system, the procurement was not specifically designed with this multi-agency concept in mind; other state agencies' involvement in developing the MITS Request for Proposals (RFP) was minimal. There were, however, extra project hours incorporated in the RFP that could be used to meet some of the requirements so that the system could be used as a centralized claims processing system.

Although the MITS RFP was developed prior to the state's decision to move forward with a new Department of Medicaid, it appears to have sufficient flexibility for future development and modification to support centralized claims processing.

Within this context, the Council makes the following recommendations for the single claims processing platform:

1. Procurement of the new MITS system should continue, without delay.
2. The new system's development should continue to be reviewed to evaluate its compatibility with the new Department's business plan. An impact review is warranted should a business plan for the new Medicaid department be developed that significantly deviates from the original business assumptions that provided the foundation for the current MITS RFP.
3. The Council does not endorse any specific vendor solution. However, MITS should 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 health care agencies. There are extra project hours built into the MITS RFP that could be used for creating a claim system that would be available to other state health care agencies. Before a centralized claim system is developed, however, there must be more consultation with other state agencies about MITS.
4. During the transition phase to the new claims processing system, the ODJFS Medical Systems Section staff should remain in ODJFS to manage the maintenance of, and enhancements to, MMIS. All MITS development and operations should be managed in



the new Department. Furthermore, any personnel positions for the new replacement system for MMIS should be created in the new Department; and ODJFS MMIS staff should have the opportunity to transition to new positions in ODOM.

5. During the claims system transition, there should be an interagency agreement between the new Department and ODJFS for the defined MMIS services, including a governance structure with measurable service delivery measures. The interagency agreement should state that adequate staffing for operation of the MMIS must be maintained by ODJFS until MITS is operational.

*b) CONTRACTUAL AGREEMENTS WITH MANAGED CARE PLANS FOR PLAN CARE INFORMATION AND ENCOUNTER CLAIM DATA*

The Council recommends 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.

Currently, each managed care plan (MCP) is required to report encounter data to ODJFS in accordance with Ohio Administrative Code rule 5101:3-26-06. ODJFS is required to collect this data pursuant to federal requirements. Data quality and performance measures and standards are described in all MCP Provider agreements along with penalties for poor quality or lack of submission. The encounter data is loaded in the Medicaid Decision Support System and used to measure clinical performance, conduct access and utilization review, reimburse MCPs for newborn deliveries, and help set MCP capitation rates.

*c) DATA WAREHOUSE AND MEDICAID DECISION SUPPORT SYSTEM*

The Council has determined that the ODJFS data warehouse (DW) and Medicaid DSS serve as valuable tools for the Medicaid organization, and should continue to be important for the new Department's Strategy, Finance, Clinical, Program Integrity, and Plan divisions.

Recommendations from the Fox Systems report on the ODJFS DW and Medicaid DSS are being included in a new RFP for Medicaid Enhancements to the DW and replacement of the DSS (due to the expiration of the vendor contract). Ohio Health Plans, within ODJFS, is currently developing this RFP and creation and release of the RFP should continue through ODOM.

The Medicaid DSS is being used by every area of OHP, the ODJFS Surveillance and Utilization Review section for fraud detection and over utilization, and other state agencies.<sup>13</sup> Data and reporting capabilities are being added in an iterative process based on user needs. Decreasing response time for queries is being addressed.

With regard to the DW and Medicaid DSS, the Council makes the following recommendations:

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<sup>13</sup> Including the Auditor of State, Attorney General, ODA, ODADAS, ODH, ODMH, ODMR/DD.



1. The Council recommends that the Medicaid DSS and associated data mart, the Pharmacy Data Mart, and the OHP project staff move to the new Department's Information Technology Division.
2. The Council supports the continued sharing of information and the capabilities of the DSS system for all divisions within the new Department and other state agencies (within HIPAA and state privacy guidelines).
3. A steering sub-committee may be needed to incorporate the needs of all stakeholders in the Medicaid DSS and evaluate resources needed to make the DSS an effective tool for the new Department.
4. The Council has determined that moving all or part of the ODJFS DW to the new Department is an issue on which the Council cannot make a recommendation within the timeframe allowed. The Council recommends that an independent party or consultant be engaged to evaluate the situation and recommend the agency (or agencies) best suited to manage the DW; the DW governance structure; and future expansion of, and funding for, the DW.

*d) BENEFIT ELIGIBILITY NETWORK*

The CRIS-E eligibility system is used by the CDJFS offices to determine eligibility for Medicaid and other programs such as Food Stamps, Temporary Assistance to Needy Families/Ohio Works First (TANF)/ (OWF), and Child Care. A planned procurement, the Benefit Eligibility Network (BEN), will solicit proposals for a software solution to replace CRIS-E. This procurement is just starting, and the replacement will not be in place until the year 2011 or 2012.

Within this context, the Council makes the following recommendation. The BEN is currently in the requirements gathering phase. Because BEN will be used to determine eligibility for many social programs, including Medicaid, the Department should be involved in the RFP creation and decision process, and the ODOM CIO should be a member of the BEN Executive Management Committee.

*e) OPERATIONAL AND INFRASTRUCTURE TRANSITION PLAN*

The Council recommends that the Information Technology Division should develop a Strategic Plan based on the new Department's overall Strategic Plan. The OIT *Statewide Information Technology Strategic Plan of Ohio* should be used as a framework for this plan. The Strategic Plan must be dynamic, and proactively validated to confirm that current IT projects and initiatives are achieving stated goals.

To create an agile and effective IT organization, the new Department should implement a formal mentoring program, ensuring adequate cross-training opportunities exist, and participation of external organizations should be encouraged. There should be two career paths for IT professionals: a technical path and a parallel management path. Both paths should have



comparable compensation and benefits to avoid the pitfall of forcing excellent technical staff to become managers, even when management is not their strength. The Council recognizes that there may be challenges associated with this recommendation within the state human resources environment. The concern is that the state's compensation programs will make it difficult to hire and retain the services of highly skilled workers. Funds for training in current and planned technologies needed for ODOM IT systems should be included in department and project budgets.

*f) IT GOVERNANCE STRUCTURE*

An IT governance structure is a formal framework for defining how IT policies, resources, projects, priorities, and architectures are established, deployed, and managed. Because the new Department will be dependent on ODJFS for infrastructure support and computing services during the MITS transition, for the CRIS-E and BEN Medicaid eligibility transition, and for the data warehouse (for source data for the Medicaid DSS) IT governance will be an important part of the Interagency Agreements between ODOM and ODJFS. An internal governance structure will also be necessary for new and existing ODOM systems. Additionally, it is important that the IT environment remain current with business and technology innovations and their efficient and cost-effective use. Recognizing the importance of IT governance, the Council makes the following recommendations regarding the ODOM IT Governance Structure:

- The new Department's executive team should define an effective Information Technology Governance Policy to support the organization's strategies using the following principles:
  - The IT governance policy should define what decisions must be made to ensure effective management and use of IT.
  - The IT governance policy should designate who has input to the decisions and who actually makes them.
  - The governance process should define the steps for making the decisions including prioritization and monitoring the outcome of the decisions.
  - The governance process should be monitored (with its own process measures) and annually evaluated for effectiveness.
  - The governance process should accommodate formal input from stakeholders involved on inter-agency projects that affect their programs.

The IT Governance Structure should be developed by the executive team with input from stakeholders, including ODJFS and OIT, during the transition period.

**E. FINANCING AND BUDGET**

As directed by its legislative mandate the Council considered many issues related to the centralization of financing for the new Department. Developing a budget model for ODOM proved to be a challenge given the many state and local agencies that contribute to, and support administration of, the Medicaid program. Nonetheless, the Council was able to develop a



proposed budget model to be used as a planning tool. Additional work will be needed to develop an actual budget as the details of the Council's recommendations are worked out.

## **1. Council's Recommendations**

With regard to financing of the Medicaid program, the Council makes the following recommendations:

1. All funds for Medicaid expenditures should be appropriated to ODOM. This includes funds for both subsidy payments and administrative functions. In those cases where ODOM delegates responsibilities to other state agencies, ODOM would transfer funds to the delegated agency those funds required to support the delegated responsibilities.
2. The Medicaid budget should contain distinct budgets for both the ABD and CFC populations. These budgets should contain all funds dedicated to providing services to each population.
3. Any local funds used to pay for Medicaid services should first be credited into a designated rotary fund in the State Treasury to make payments for services provided under delegated arrangements within the local jurisdiction making the deposit. Such appropriations should 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.<sup>14</sup>
4. The addition of new functionality included in the Strategy Division and Medical Division along with several new staff positions will require an investment. Assumptions have also been made based on other Council recommendations, such as maintaining the MMIS, county fiscal functions, and hearing officers at ODJFS. Using SFY2005 data, the Council estimates an additional ongoing investment of approximately \$7 million<sup>15</sup> will be required to cover the increased costs in ODOM. This cost estimate will need to be updated through the transition process to reflect details that will emerge with a detailed human resources plan and SFY2008 budget assumptions.<sup>16</sup>

The budget shown in Figure 11 represents what the Department's budget would have looked like in SFY2005 had these recommendations been in effect. The Council estimates the total budget for ODOM to be approximately \$13 billion.

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<sup>14</sup> The Transition Team should work with all involved parties to develop a detailed plan that addresses how to implement each department's state subsidy and local levy financing plan, to include agreeing upon schedules for payments, procedures for transferring funds, and mechanisms to avoid unintended cash flow or revenue management problems for all agencies.

<sup>15</sup> On December 6, 2006, OBM estimated the investment to be \$17.4 million.

<sup>16</sup> The budget model does not include the additional funds needed for ODOM identified by the Council and does not include any other administrative or policy changes implemented since SFY2005.



Note, however, that this budget model does not reflect the actual budgeted needs of ODOM. Rather, additional administrative budget amounts may be necessary to reflect the investment in strategy and clinical expertise added to ODOM. In developing the budget model, the Council used SFY2005 because this was the most recent year for which detailed Medicaid spending was available by budget line item for all affected agencies.

Budget Item	Administrative Appropriations			SFY2005		
	Fund	ALI	ALI Name			
1	GRF	650-321	Operating - ODOM (state and federal)	\$	74,932,395	
2		650-322	Operating - Other Agencies			
3		650-323	Operating - County Operations	\$	66,889,685	
4	SSR	650-421	Operating - ODOM	\$	33,942,077	
5		650-422	Operating - Other Agencies			
6	FED	650-521	Operating - ODOM	\$	12,514,185	
7		650-522	Operating - Other Agencies			
8		650-523	Operating - County Operations	\$	66,141,514	
9	<b>Total Administrative*</b>			<b>\$</b>	<b>254,419,856</b>	
	ABD & RSS Appropriations			SFY2005		
	Fund	ALI	ALI Name			
10	GRF	660-525	ABD & RSS Services (state and federal)	\$	6,536,495,714	
11	GRF	660-526	MR/DD Services (1)	\$	650,437,533	
12	SSR	660-625	ABD & RSS Services	\$	542,245,619	
13	SSR	660-626	MR/DD Services	\$	26,036,091	
14	Fed	660-627	ABD Federal - ODOM	\$	217,395,880	
15	Fed	660-628	MR/DD Services (2)	\$	693,840,564	
16	Fed		ABD Federal - Other Agencies	\$	309,914,588	
<i>State and Local Funds Received from Local Boards</i>						
17	SSR	660-700	MH/ADAS Services	\$	91,349,417	
18	SSR	660-800	MR/DD Services	\$	241,609,135	
19	<b>Total ABD Budget</b>			<b>\$</b>	<b>9,309,324,541</b>	
	CFC Appropriations			SFY2005		
	Fund	ALI	ALI Name			
20	GRF	670-525	CFC Services - ODOM	\$	2,502,720,293	
21	SSR	670-625	CFC Services - ODOM	\$	142,535,149	
22	Fed	670-626	CFC Services - ODOM	\$	21,406,510	
23		670-627	CFC Services - Other Agencies	\$	147,986,181	
24	<i>State and Local Funds Received from Local Boards</i>					
	SSR	671-700	MH/ADAS Services	\$	96,960,172	
25	<b>Total CFC Budget</b>			<b>\$</b>	<b>2,911,608,305</b>	
	Other Care			SFY2005		
	Fund	ALI	ALI Name			
26		651-400	HCAP - State	\$	266,261,543	
27		651-300	HCAP - Federal	\$	328,502,069	
28		651-513	Disability Medical	\$	25,500,000	
29	<b>Total Other</b>			<b>\$</b>	<b>620,263,612</b>	
30	<b>Total Medicaid Program Budget</b>			<b>\$</b>	<b>13,095,616,314</b>	

\* The administrative total of \$254 million does not include administrative funding for agencies other than ODOM. Additionally, the total does not include additional funding identified by the council or funding necessary to support administrative or policy changes made since SFY 2005.

Source: Ohio Medicaid Administrative Study Council, 2006

Figure 11 -- ODOM Appropriation Model (Based on SFY2005 Actual Expenditures)



## **2. Budget Model Commentary**

Each section shown in Figure 11 above is described below. Each line in the above budget model is labeled with a number at the end of each line. The corresponding line numbers are used in the following text for reference purposes.

### *a) ADMINISTRATIVE APPROPRIATIONS*

The Administration Appropriations section identifies the funds that were used to support the Medicaid program within ODJFS in SFY2005. This includes funds for payroll, personnel services, supplies, travel, and equipment purchases. The amounts are based on actual expenditures and do not include the estimated investment needed to fund the recommended ODOM changes.

The line items labeled *Operating ODOM* (Budget items 1, 4, and 6) reflect the funds which would have been used to operate ODOM had a single department existed. The line items labeled *Operating – County Operations* (budget items 3 and 8) represent the state and federal funds transferred to ODJFS for local Medicaid eligibility operations performed by the CDJFS.

The line items labeled *Operating – other Agencies* (budget items 2, 5, and 7) are place holders for Medicaid administrative funds for other state agencies. In accordance with the Council's recommendations, these funds would be appropriated to ODOM and then transferred to other state agencies based on delegation arrangement. The line items assume that sister agency staff would remain intact.

Data exists showing what administrative costs from the other state agencies were claimed to the federal government for reimbursement in SFY2005. However, it is likely that this data does not reflect the total amount spent by the other agencies on Medicaid administration. During the SFY2008 – SFY2009 budget development cycle the other agencies should clearly identify the amount of funds projected to be spent on Medicaid administration and provide those figures to OBM and ODOM to complete the ODOM budget.

### *b) ABD & RSS APPROPRIATIONS*

The ABD and Residential State Supplement (RSS) Appropriations section identifies the funds associated with providing services to the entire Medicaid ABD population. The amounts are based on actual spending. The Medicaid DSS was used to develop the costs paid for ABD services through several line items.

The line items labeled *ABD & RSS Services* (budget items 10 and 12) are the funds associated with services to the ABD eligible population. This includes card costs for all ABD eligible individuals, and costs associated with the PASSPORT and RSS programs.



The line items labeled *MR/DD Services* (budget items 11, 13, 15, and 18) represent the funds necessary to provide specialty services for the MR/DD population. This includes costs for publicly run development centers, private Intermediate Care Facilities for persons with Mental Retardation (ICF/MR), and MR/DD waivers.

The line item labeled *MH/ADAS Services* (budget item 17) represents the non-federal share of spending on community mental health and alcohol and drug addiction Medicaid services by the local boards. These funds include both levy dollars and state subsidy dollars transferred from the local boards.

The *ABD Federal – ODOM* line item (budget item 14) is the federal reimbursement for ABD services which should remain in ODOM. The *ABD Federal – Other Agencies* line item (budget item 16) represents the federal reimbursement for ABD expenditures that should be transferred to other state agencies.

*c) CFC APPROPRIATIONS*

Appropriations in the CFC Appropriations section represent other Medicaid subsidy payments not made to the ABD population. The line items labeled *CFC Services – ODOM* (budget items 20, 21, and 22) represent spending on the non-ABD population from ODOM. The *MH/ADAS Services* line item (budget item 24) represents the non-federal share of spending on Medicaid services by the local boards. These funds include both local levy dollars and state subsidy dollars transferred from the local boards. The *CFC Services – Other Agencies* line item (budget item 23) represents federal reimbursement transferred to other state agencies for non-ABD expenditures.

*d) OTHER CARE*

Appropriations in the Other Care category support the Hospital Care Assurance and the Disability Medical Assistance (DMA) programs. The Hospital Care Assurance Program (HCAP) is Ohio's version of the federally required Disproportionate Share Hospital program. Funding includes intergovernmental transfer and provider tax funding mechanisms and federal disproportionate share payments. HCAP compensates hospitals that provide a disproportionate share of care to indigent patients (Medicaid consumers, people below poverty, and people without health insurance). The Disability Medical Assistance program provides a limited health care benefit (primarily physician and prescription drugs) to non-Medicaid eligible individuals based on income, resources, and severity of disability. Hospital services for this population are provided through the Hospital Care Assurance Program. Expenditures for the DMA program are not eligible for federal reimbursement because the recipients are not Medicaid eligible.

## **F. UNIFIED MEDICAID BUDGET FOR LONG TERM CARE**

A major issue for Ohio's Medicaid program is more strategic management of long term care services. The Ohio Commission to Reform Medicaid recommended the creation of a cost-effective long-term care system with a unified budget managed across all state and local



governmental agencies and service settings. In Am. Sub. H.B. 66 the General Assembly directed the Council to study the feasibility of creating a unified budget for Medicaid-funded long-term care services.

Ohio Medicaid budgets have historically separated long term care (LTC) services from most home and community based services. Medicaid covered services in institutions such as nursing facilities and intermediate care facilities for MR/DD are budgeted along with most other non-waiver Medicaid services. These services are federal entitlements, and budgeted separately from home and community waiver services. Home and community based services are a limited set of services, with a limited number of people being served through budgets in three state agencies: ODJFS, ODMR/DD, and ODA.

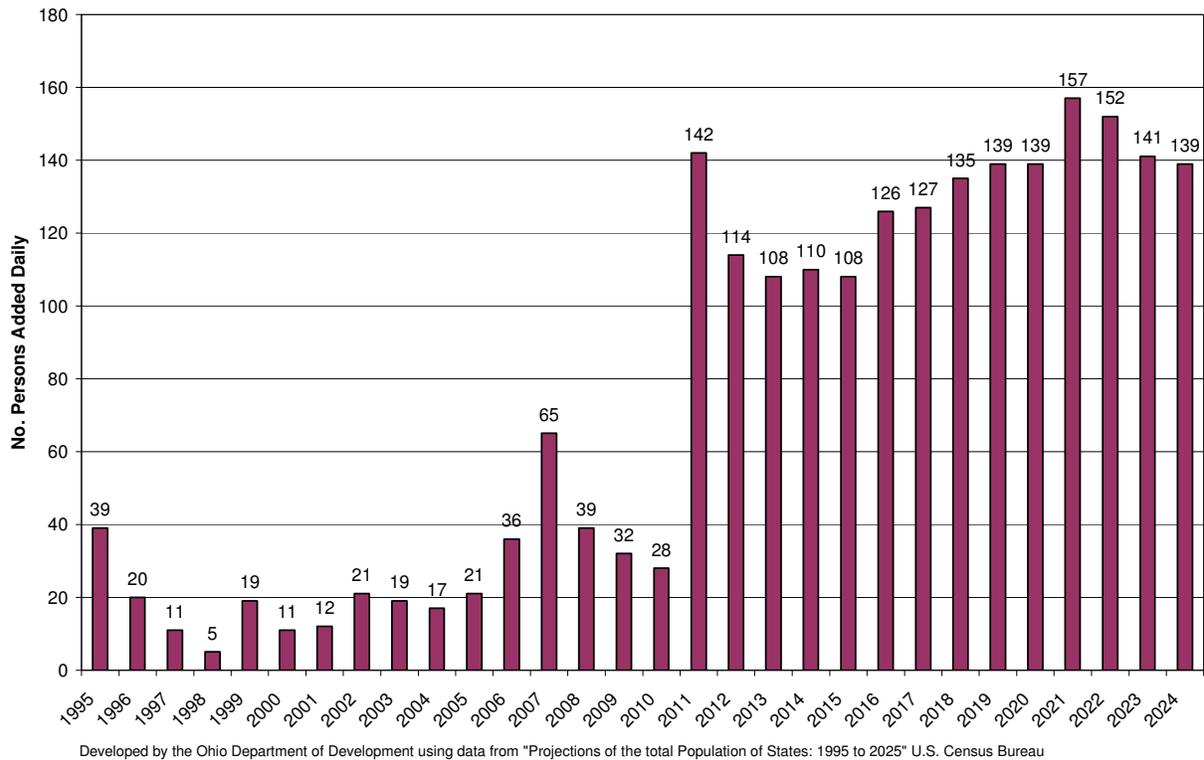
This federal entitlement has created an institutional care bias. That is, the LTC system is not necessarily rooted in the best clinical practice, the client's need, or choice of service. This has created a situation where the delivery system focus has largely been service type and location, rather than based on population need.

Ohio citizens that become eligible for Medicaid by meeting ABD criteria make up roughly 25% of all people receiving Medicaid in Ohio. However, ABD expenditures comprise approximately 73% of all Medicaid expenditures in Ohio. These expenditures include not only nursing facility care and home and community based services, but many other acute care services including but not limited to hospitalization, pharmacy, physician services, and durable medical equipment. To add additional complexity, 35% of all nursing facility admissions are short stays and should not necessarily be considered "long-term" care.

In the coming years, the overall number of Ohioans turning age 65 is expected to nearly triple, increasing from approximately 40 people per day presently to more than 110 people a day starting in 2011.<sup>17</sup> This trend is illustrated in Figure 12 below.

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<sup>17</sup> According to U.S. Census Bureau.



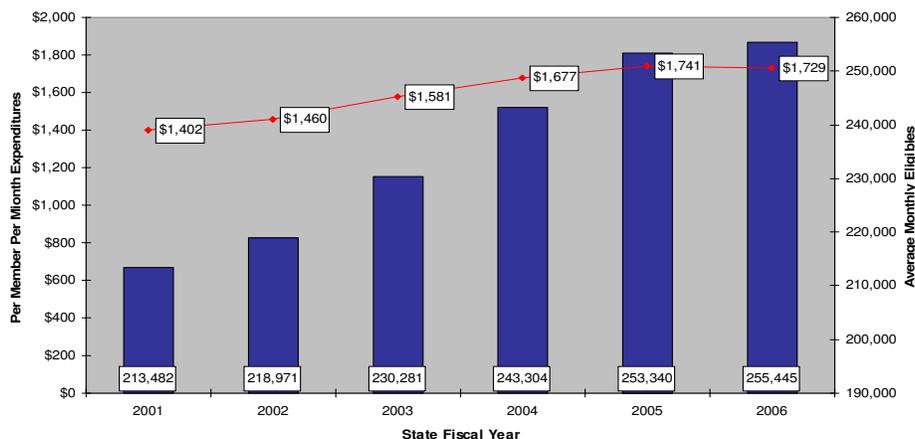
**Figure 12 -- Average Daily Net Growth in Ohio's 65+ Population**

While not all of these Ohioans will be eligible for Medicaid at age 65, many of them will become eligible later in life. Medicaid pays for 70% of all nursing facility care. Planning for ABD as a population should be a priority since it appears likely that this category of Medicaid consumers -- the population most often in need of costly LTC services-- will grow in the coming years.

In addition, the disabled population under age 65 receiving Medicaid benefits has grown substantially. Figure 13 below shows the increase in number of individuals served and their average monthly cost.



Medicaid Disabled Population under Age 65  
Changes in number of eligible persons and per member per month costs, by State Fiscal year 2001 thru 2006



Source: Medicaid Decision Support System

**Figure 13 -- Size and Cost of Medicaid Disabled Population under Age 65**

### **1. Unified ABD/Long-Term Care Budget Principles**

To achieve the level of system change needed to address these issues, the Council recommends that several principles be adopted. If accepted, the consistent support of policymakers and managers will be required to achieve and periodically adjust the relative balance between these principles:

1. Medicaid should provide coverage for a continuum of LTC services ranging from home-based and community-based support to institutional care.
2. Consumer choice should play a prominent role in determining service settings.
3. Medicaid LTC services should be managed in a manner that is broadly supportive of informal care by family, friends and communities.
4. The public's interest in containing costs and assuring financial accountability should play a prominent role in setting parameters for service utilization, as well as in determining the terms and conditions of provider contracts.
5. To the extent that federal and state laws and regulations favor certain services or service settings over others, state law and regulation should seek to provide parity among service options for consumers.
6. The scope and management of a unified long-term care budget should be based on current and anticipated: (a) population demographics; (b) a generally accepted range of services; (c) service duration; and (d) prices.



7. Management of a unified LTC budget should account for the concurrent operation of several models of care and financial management (e.g., public/quasi-public case management, fee-for-service, managed care enrollment, and disease management).

## **2. Long Term Care Recommendation**

The Council recommends that ODOM should have a consolidated budget for 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 ABD population (including waiver recipients) as a group, rather than by provider type.

The rationale for this recommendation is to organize provision and management of a continuum of needed services to the ABD population, rather than organizing the program around provider type. In this manner, program managers in consultation with sister state agencies should be able to better adjust to changes in consumption and delivery trends, such as new service modalities and reduced average lengths of treatment in institutional settings. Health care needs of individuals in traditionally defined “long-term care” settings are increasingly diverse and intertwined with acute care services.

Within this context, the Council makes the following recommendations:

- An ABD unit should be established in ODOM that should have responsibility for implementing and coordinating the health care service and reimbursement policies related to the ABD population. This Unit should provide oversight, consultation, and technical assistance to ensure that policies and procedures are followed by providers, other state agencies, and local organizations. The Unit should be involved in monitoring the performance measures developed by the Department to measure the efficiency and effectiveness of the program. This Unit would assure that emerging policy issues related to long-term and community-based care are communicated to the Strategy Division. The Unit would work collaboratively with the Benefits Administration Unit.
- As the single state Medicaid agency, ODOM should be appropriated all funding for Medicaid. The budget appropriations should be organized to reflect a distinct set of appropriations for services to ABD recipients (see Section III.E). With required federal approval, ODOM has the sole authority to determine whether to use delegated arrangements with sister agencies, to transfer such amounts necessary for the delegation, and to set and monitor the terms of these arrangements.
- Functions other than those reflected in the first two recommendations, should be carried out in the associated functional ODOM units, while continuing to recognize the importance of principles contained in the recommendations contained in this section.



## **G. STATE AND LOCAL IMPACT**

The legislative mandate required the Council to study the fiscal and operating impact of the new Department on other state departments and local agencies. Furthermore, the Council determined that creation of ODOM without appropriate attention to the processes and systems that support the current structure could have significant impacts on consumers, providers, and the state and local entities that currently support administration of the Medicaid program. Recognizing this risk, the Council studied the impact of ODOM on state and local entities and made recommendations to mitigate impacts.

### **1. Local Impact Committee Goals and Approach**

The Council adopted specific goals and principles to guide its recommendations and mitigate and safeguard against certain impacts, and particularly avoid any disconnect with Medicaid consumers including:

1. Continuing to utilize local connections with the system for consumers;
2. Strengthening accountability, at all levels, when the Department of Medicaid uses “delegated arrangements” with state and local entities;
3. Providing a more efficient and effective way for Medicaid to help state and local entities serve their constituents;
4. Minimizing difficulties local agencies may have in transition; and
5. Guiding the deployment of currently decentralized administrative resources consistent with the overall recommendations for the Department of Medicaid and other state agencies involved in administering the program.

In developing its overall recommendations and in order to assess the impact of creating the Department of Medicaid, the Council examined the following:

- Changes and resources needed to establish the proposed new Department while minimizing the negative impact on affected state and local agencies;
- Current resources supporting Medicaid administration;
- Current local system connections with consumers and providers; and
- Strengths and weaknesses of current delegated arrangements with state and local entities (i.e., ODA, ODADAS, ODH, ODMH, and ODMR/DD and their local counterparts)

The Council solicited input in the form of testimony from the public, agency directors, and other interested parties. All external recommendations were considered and where appropriate safeguards were developed to mitigate disruption.

### **2. Impact Assessment**

The Council’s recommendations include continuing the practice of using delegated arrangements between Medicaid and other state agencies, but with greater emphasis on accountability. The Council’s recommendations do not affect staff at the sister state agencies, except that eventually



there could be some changes in IT staffing if MITS is fully implemented with a centralized claims payment capability that could replace claims operations in the sister agencies.

The Council's recommendations do change the way that Medicaid matching funds are appropriated, although the Council is recommending several safeguards suggested by agency directors and other constituents in order to assure that services are not disrupted. During the detailed budget development process, safeguards should be implemented to ensure there are no unintended effects on GRF revenue or GRF cash flow (safeguards from agency directors are set forth in Appendix 6). The budget changes and their impact are described below.

*a) IMPACT ON STATE AGENCIES*

The ODJFS is a large umbrella agency providing a broad array of services, including adoption/kinship/foster care, child care, child support, disability assistance, financial assistance, food stamps, health care, labor market information, adult and child protective services, unemployment compensation, veteran's services, and workforce development. In SFY2005, the ODJFS total operating budget was \$15.4 billion and the Department employed approximately 3,800 people. Approximately \$12.6 billion, or 81%, of ODJFS' SFY2005 spending was Medicaid-related. Approximately \$254 million in administrative spending was related to Medicaid and should be transferred to ODOM.

ODJFS is organized into seven program offices, including OHP, and nine offices providing operational services to all of ODJFS. The Offices of Fiscal Services, Legal Services, Chief Inspector, Communications, Contracts and Acquisitions, Legislation, Research, Assessment and Accountability, Management Information Services, Employee and Business Services all provide administrative support functions for Ohio's Medicaid program.

OHP is the organizational unit within ODJFS that is responsible for managing the Medicaid program. OHP employs approximately 480 people at any given time. However, OHP is supported by several other business units within ODJFS. Calculating the exact number of employees and FTEs from the support units working on Medicaid activities is a difficult task, since as many as another 400 employees spend only a small portion of their time supporting the Medicaid program. In several areas, personnel do "production" work that does not require Medicaid-specific expertise, such as processing invoices for payment across all of the programs. In other support areas, personnel perform Medicaid-related activities that could be contracted back to ODJFS (e.g., mail room operations, where specialized equipment and economies of scale make it very difficult to extract the Medicaid activities without additional cost or creating adverse impact on ODJFS' continued operations).

It is clear that funding should be transferred back to ODJFS based on Interagency Agreements for ongoing operation of the MMIS, and for eligibility activities performed by the CDJFS. Of the remaining administrative resources, a "one-for-one" transfer of positions can only be accomplished with the 480 OHP FTEs, and to some extent current staff in the Offices of Legal Services and Research, Assessment, and Accountability. In the remaining support areas, a "one-



for-one” transfer is difficult to accomplish, due to current operational limitations, or because the skills needed in ODOM will need to be Medicaid-specific.<sup>18</sup>

Additional work is needed to develop a detailed human resources plan, to identify staff in the support offices which could be transferred to ODOM without adversely impacting ODJFS’ continued operations. In some cases ODOM will need to hire new staff. Based on the assumption that approximately \$44.2 million would be transferred back to ODJFS for Medicaid IT and other support services, and that all support staff spending 75% (excluding MIS staff) or more of their time on Medicaid would be transferred to ODOM, it is estimated that ODJFS would not require any transitional funding to support current employees and functions that are not transferable. However, the support areas requiring the most additional study include Employee and Business Services, and Fiscal Services.

The Council’s responses and recommendations regarding concerns and issues raised by the directors of the sister agencies may be found in Appendix 6.

Moving all funds for Medicaid expenditures to appropriations in the ODOM budget, and establishing rotary funds designated for Medicaid state subsidy and local levy expenditures made through delegated arrangements results in changes to appropriations for ODJFS, ODA, ODADAS, ODMH and ODMR/DD. All Medicaid expenditures are included in the ODOM budget, with funds being transferred to other state agencies performing delegated administrative activities. This is discussed further in the Impact Recommendations, *Establishment of Rotary Funds for Local Matching Funds*.

As Figure 14 illustrates there is a significant decrease in the ODJFS appropriation, however, other agencies’ budgets are either unaffected or increased (also see Appendix 4). The increases in appropriations for ODADAS, ODMH, ODMR/DD reflect a level of double counting associated with community Medicaid subsidy and local levy funds. Changes in total agency expenditures are shown in Figure 14:

Agency	SFY2005 Total Actual Expenditures	SFY2005 Total Expenditures Remodeled
ODJFS	\$15,424,512,277	\$2,920,485,877
ODA	\$407,680,092	\$407,680,092
ODADAS	\$167,439,303	\$190,252,507
ODMH	\$948,517,048	\$1,119,076,593
ODMR/DD	\$1,138,287,424	\$1,343,658,642

**Figure 14 -- Summary of SFY2005 Agency Total Actual Expenditures and Expenditures to Reflect OMASC Recommendations**

<sup>18</sup> See Appendix 4 for the assumptions used by the Council in its budget modeling.



Line item details of these changes are shown in the budgets included in Appendix 4.

*b) IMPACT ON LOCAL ENTITIES*

Many impact issues were discussed throughout the Council's process. While none of the Council's recommendations were deemed to have direct impact on services delivered through local systems, several safeguards are recommended. For example, an implementation plan to be addressed by the Transition Team should address timelines for funding to flow in connection with the recommended changes in how Medicaid funds are appropriated. Each state agency and its respective local system will submit to ODOM an annual financing plan, which will be subject to OBM approval. The Council's responses and recommendations regarding state and local impact issues may be found in Appendix 7.

**3. Impact Recommendations**

Based on the voluminous comments and recommendations submitted by constituents and stakeholders, the Council developed and makes the following recommendations designed to mitigate negative consequences of the ODOM implementation:

*a) IMPROVING ACCOUNTABILITY IN DELEGATED ARRANGEMENTS*

1. Medicaid delegated arrangements require immediate and sustained improvements in order to protect the integrity of the Medicaid program, provide access to needed federal funds, and maintain services for consumers. The Transition Team should be given resources to facilitate work among state agencies and affected constituents to clarify, recalibrate, and emphasize greater accountability in all delegated administration arrangements.
2. The Delegation Assumptions and Principles (see Section III.A.1.b)) should be *consistently* applied, emphasizing accountability, to all delegated arrangements involving sister state agencies or local entities.
3. ODOM should be held accountable for the outcomes of its delegated arrangements and must actively monitor compliance with overall performance.
4. Great care should be taken to avoid disruptions to access to needed services by beneficiaries.

*b) ESTABLISHMENT OF ROTARY FUNDS FOR LOCAL MATCHING FUNDS*

Historically, Ohio has leveraged state subsidy and some local levy funds as Medicaid matching funds for services provided locally through ODMR/DD, ODMH, and ODADAS. However, local funds being used for Medicaid match have never appeared as an appropriation or a source of



revenue for the Medicaid program and therefore the single state agency's budget has not accounted for these resources. The federal government requires that the state be able to account for its use of local funds as Medicaid match; these arrangements receive federal scrutiny, not just in Ohio, but throughout the nation as a whole.

The Council recommends the establishment of Non-GRF funds (rotary funds) to which local funds used for Medicaid match would be deposited and from which payments for locally matched services would be made. There would be *no pooling of funds*; rather such appropriations would be used 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 would be returned to the local board where they originated. Amounts would be determined by local boards in community planning processes currently used by ODMR/DD, ODMH, and ODADAS.

The Council believes this recommendation would assist in meeting the federal matching requirements and improve budget transparency and accountability. However, further work is needed on this issue before implementing the recommendation. It will be important to avoid cash flow issues for the state and local entities. Moreover, care must be taken to avoid any unintended direct impact on the ability of local systems to deliver services. Other remedies could be developed that would meet federal approval and also improve budget transparency and accountability.

### **ODMR/DD**

The budgetary changes should have the least impact on ODMR/DD, since ODMR/DD already uses rotary funds for local boards pledging or paying state subsidy and local levy dollars as Medicaid match. Funds appropriated for Developmental Centers and Waiver Subsidy should be first appropriated to ODOM, and then transferred to ODMR/DD. The detailed implementation plan should address any cash flow concerns.

### **ODMH/ODADAS**

The current method for appropriating state subsidy funding to ODMH and ODADAS would not change. ODMH and ODADAS would continue to distribute these funds by formula to the local boards. Instead of tracking these expenditures after they have been made, however, local boards would pay into the rotary funds the state subsidy and local levy funds they budget to use as Medicaid match for community mental health and alcohol and drug addiction services.

The Transition Team should work with affected state and local entities to develop a detailed plan that addresses how to implement each department's state subsidy and local levy financing plan. The implementation plan should address schedules for payments, procedures for transferring funds, and mechanisms to avoid unintended cash flow or revenue management problems for all agencies involved. The detailed implementation plan should use the following principles for the establishment of rotary funds for local matching funds:



1. A state agency performing delegated Medicaid administration and agreeing to assure the availability of state/local matching funds for specified services should submit an annual financing plan to ODOM.
2. The financing plan should be a part of the Interagency Agreement with ODOM.
3. The financing plan should be developed by the delegated state agency in consultation with its system's local entities, utilizing its community planning process.
4. The financing plan must enable ODOM to meet federal Medicaid public matching funds requirements.
5. The financing plan should identify by county or board area the amount and source(s) of state subsidy or local levy matching funds each local entity should pay into the rotary fund.
6. Audit standards and procedures should be in place so that source(s) of payments into the fund can be verified. Rotary funds should be reconciled on an annual basis; and rotary funds no longer needed for local Medicaid matching funds purposes should be returned to the local entity that paid them into the fund.
7. There will be an ongoing need for good communication with constituents as the detailed plan is formulated, and then to ensure that implementation causes no unintended consequences or disruptions.

c) *INFORMATION TECHNOLOGY:*

1. It is absolutely essential to have a mechanism, on an immediate and continuing basis, for the Transition Team to verify assertions about the suitability of MITS to support the activities of ODOM.

During implementation of the replacement system for MMIS, affected state agencies and local representatives should be involved in the decision-making process. It is important to communicate with major Medicaid vendors and service providers as changes are implemented.

2. It is essential that resources on legacy systems remain stable.
3. Current information systems operated by the sister agencies will need to continue until a decision is made about a new centralized claims processing system. Resources should continue to be made available for an appropriate period of time to enable a transition.
4. The Transition Team should be given the authority and the resources to guide the establishment of the Interagency Agreement between ODOM and ODJFS.
5. The Transition Team should be provided with resources to obtain an independent recommendation regarding eventual location and governance of the Data Warehouse.



6. It is essential to improve IT governance and doing so should positively impact all agencies. The Transition Plan should include steps and resources to put improved IT governance in place from the inception of the new Department. IT deliverables (service level agreements) and governance procedures should be incorporated into ODOM's Interagency Agreements with state agencies performing delegated Medicaid administration.

## **H. TRANSITION**

The Council's authority to plan for ODOM ends with completion of this report in December 2006. However, the General Assembly's intent is to authorize ODOM by July 1, 2007. In order to effectively complete the planning for establishing the new Department several steps must be taken.

### **1. Immediate Actions**

Ultimately, the duration of the transition from the current state to the planned future state will be dependent on several factors. First, before initiating the transition planning effort that is described below, it will be important for the Governor and the General Assembly to accept this report as a plan that establishes the direction for the future.

Second, once this report is accepted, a transition team should be established with authority to maintain the Council's momentum, along with intent expressed by the General Assembly, and to optimize the use of time between the completion of the Council's report and the enactment of the SFY2008–2009 biennial budget. Recommended characteristics of the transition team include:

- A small, multi-disciplinary team should be identified in January 2007 to begin work on transition decision-making, tasks, and issue resolution.
- The team should have the authority and resources to engage the services of change management professionals and 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 limit difficulties at the local level and within affected state agencies.
- The team should play a key role in any Medicaid-related IT initiatives underway during the transition period, with emphasis on the MITS project, the ODJFS data warehouse, and the Medicaid DSS.

The efficiency with which this transition team is established, and the availability of adequate resources, will be important to ensuring that the transition can begin as soon as possible.

In addition to authorizing the transition team, the Council recommends that the Medicaid Director should be hired as early as possible to manage the creation of the Department, lead the transition team, and ensure the proper culture is instilled from the very beginning. Also, hiring



of the executive staff (e.g. Chief Plan Officer, Chief Financial Officer, Chief Information Officer, Chief Strategy Officer, and Chief Medical Officer) and certain key personnel, such as the Organizational Development Manager, should be a priority.

Legislative authority could be in place by January 1, 2007 that would allow the Governor to hire a transition team, and take steps necessary to work toward the creation of a new Department. At the minimum, funding left over from the Council could be used for this effort, although additional funding would likely be needed to accomplish the transitions tasks between January 2007 and July 2007.

## **2. Transition Principles**

The Council's approach to transition is based on the General Assembly's intention to establish a new Department by July 1, 2007. The Council believes that basic elements of ODOM could be in place by this date to support operations, but that transition activities will continue well into 2008. The transition tasks should be prioritized in the transition plan to ensure that the July 1, 2007 date for establishing basic elements is achieved. These basic elements include statutory authorization for establishing the Department of Medicaid, budget appropriations that can be accessed by the Department once it is operational, and resources needed to hire the executive team. However, care should be taken to minimize transition risk which could result from a lack of careful planning.

The changes associated with the creation of ODOM should be implemented in accordance with the steps outlined in the transition plan. Some tasks can be completed concurrently, while others will be interdependent and require sequential implementation. To minimize disruptions to employees and operations, changes related to the transition should occur infrequently and in large doses. A clearly communicated and quick transition provides a more stable environment for the employees impacted by the transition. Additionally, a quick transition can ensure a more stable and less disruptive operating environment. This should allow for higher productivity and minimize operational errors during the transition period.

## **3. General Transition Recommendations**

The Council evaluated a variety of issues related to the transition from the current state of the Medicaid program to ODOM.<sup>19</sup> Based on extensive work in this area, the Council makes the following general recommendations regarding the transition:

- The Governor-elect should establish a transition team as soon as possible, preferably led by the new Medicaid director.

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<sup>19</sup> Detailed transition steps are outlined in Appendix 9.



The transition team should be responsible for continuing the work of the Council after January 1, 2007, including development of specific transition related materials such as the Human Resources Plan, Communications Plan, and detailed implementation plan.

- As part of the transition team, establish an IT group that will provide technology expertise and input into new agency business decisions as required.

There are many issues related to IT that need attention during the transition effort. These issues, like many others, should need to be viewed differently given that they need to be guided by the business planning for the new Department.

- Create a detailed and definitive implementation plan for transitioning from the current state to the future state.

Items necessary for inclusion in statutory changes that create ODOM should be identified in the January 2007 to March 2007 timeframe, and communicated to the Governor and the General Assembly. This process should include developing protocols and processes to involve all appropriate parties including ODJFS, OBM, sister agencies, and representation from employees and other stakeholders.

- Develop a budget for ODOM and create appropriations.

This process should include participation from ODJFS, OBM, ODOM, other state agencies that support Medicaid, and LSC. The budget development process should be completed by March 2007.

- Begin development of the ODOM business plan

While a detailed business plan may take some time to create, it is necessary to inform other transition steps such as the detailed human resources plan, the IT strategic and implementation plans, and to guide efforts involving other state agencies that support Medicaid.

- Strategic sourcing options, including current state contracts, existing procurements, and best practices from other states should be evaluated.

Develop protocols and processes to involve all appropriate parties including ODJFS, OBM, DAS, Controlling Board, employee representation, and others.

- Develop a detailed human resources plan including protocols and processes to involve all appropriate parties including DAS, ODJFS, OBM, employee representation, and others.

The transition team should engage professionals in organizational design to guide the development of the detailed human resources plan. The plan should address how the



ODOM Operating Principles should be used to inform selection processes, and should identify whether outside resources may be needed for ODOM to achieve this.

The plan should also include incentives to encourage key personnel in all of the affected state agencies to remain throughout the transition and system development life cycle processes of the IT conversions.

The detailed human resources plan is intended to include a position-by-position plan to transition staff from ODJFS to ODOM. It should identify where ODJFS may need to hire new personnel to re-fill certain positions, and where ODOM will need to hire new personnel rather than transfer personnel from ODJFS. Some of the ODOM positions will be new and require position description development, such as the Chief Strategy Officer, the Chief Medical Officer, and additional DSS staffing.

- Begin development of the cost allocation plan for ODOM and the changes necessary in ODJFS.

This cost allocation development process should include ODJFS, OBM, and representation from ODOM. Contact with the appropriate federal agency for cost allocations should be made early to discuss best practices regarding the development of this plan.

- IT governance should be reviewed and Interagency Agreements developed between ODOM and ODJFS for all computer applications such as MMIS and IT infrastructure to support the new Departments. Costs and service level agreements should be identified and included in these Interagency Agreements.

During the transitional phase and the creation of the new Medicaid IT department, and before a new claims processing system is implemented, ODOM will be dependent on ODJFS for the business IT systems, and any existing IT infrastructure provided by ODJFS. This includes the current DSS and MMIS systems in addition to new systems development. This transition step is necessary to keep current systems running, there by avoiding any disruption in payments or services.

- Implement a process to ensure that local entities and sister agencies have a formal avenue to provide input into the strategy and policy-making process.

The creation of this process should include the local entities and sister agencies. It should begin early in the transition process and exist until it is superseded by input processes established by ODOM.

- Representatives from ODJFS, ODOM, the Governor's Office, and/or the Transition Team should begin communication with CMS regarding the transition of the single state agency designation to ODOM.



Communications with CMS should begin early in the transition process and remain focused on establishing ODOM as the single state agency.

The Council's transition plan recommendations are set forth in Appendix 9.

#### **4. Transition Budget**

The General Assembly appropriated approximately \$1.5 million to fund the work of the OMASC. The Council anticipates that approximately \$500,000 of this appropriation will remain unused at the end of calendar year 2006. The Council recommends that this funding be used to partially cover the cost of implementing the transition team; however, it is anticipated that additional resources will be needed.

The Council estimates that a fully-dedicated team of five FTEs will be required to manage the transition. Preferably, this team would be led by the new Medicaid Director, with assistance from at least three project managers and an administrative assistant. The transition team would be responsible for developing the initial project planning materials, such as the detailed project plan, and then managing implementation progress against those materials. Actual completion of tasks within ODJFS and other entities would be completed by "loaned staff" designated by the Governor.

A supplemental transition budget, in addition to the remaining OMASC appropriation, would likely be required to fund transition team activities through July 1, 2007. This budget would be used for payroll, overhead expenses, and use of outside consultants. This budget would not include the expenses required to operate the Medicaid department functions. In total, the Council estimates that an additional \$500,000 would be needed to support the transition as shown in Figure 15 below.

<b>Expense Item</b>	<b>Estimated Amount</b>
Payroll	\$250,000
Overhead	\$250,000
Consulting Fees	\$500,000
Existing OMASC Appropriation	(\$500,000)
<b>Total Additional Estimate</b>	<b>\$500,000</b>

**Figure 15 -- Transition Budget Estimate**

## **IV. OTHER ORGANIZATIONAL STRUCTURES**

The Council is cognizant that its mandate was focused on the creation of a new cabinet-level Medicaid department; however the Council members felt it was important for Ohio to consider the benefit of having a policy development process that recognizes the state's diversity by



seeking various input from throughout the state. This section contains two recommendations for dealing with broader health care issues facing the state, and then also provides information on structures reviewed by the Council, but not recommended.

### **Ohio Health Policy Advisory Committee**

The Council recommends creating an Ohio Health Policy Advisory Committee that would develop health policy recommendations for the Governor and the General Assembly. Health care policies in various systems of care would be reviewed regardless of the payment source and therefore extend beyond Medicaid. The goal of forming this committee would be to take advantage of all resources available to provide effective and efficient health care to all Ohioans.

The Council recommends that this committee should at the minimum: (1) review policy decisions to ensure that needy Ohioans are covered by the most effective program; (2) investigate ways to improve how the state's purchasing power is leveraged; and (3) share best practices from throughout the health care system. Coordination should occur with the Governor's Executive Health Council, described below.

### **Governor's Executive Health Council**

Also, and separately, there should be a strong coordinating body for health care delivered through State cabinet-level agencies.

In addition to the Medicaid program, the State of Ohio provides for the delivery of health care services to a very large number of Ohioans. Many of the state agencies that support the Medicaid system also provide services to non-Medicaid consumers. These agencies include ODA, ODADAS, ODOH, ODMR/DD, and ODJFS. Other state agencies and entities such as the Department of Rehabilitation and Correction, the Bureau of Workers' Compensation, and the Ohio Public Employee Retirement System, also provide for non-Medicaid health care services.

Recognizing the complexity of this system, and the many opportunities for interagency collaboration, the Council recommends the creation of a Governor's Executive Health Council.

The Governor's Executive Health Council membership should primarily represent leadership from the state systems involved in procuring or delivering health care, and focus on interagency collaboration and coordination on health care issues that transcend the state government funded health care delivery system. Input from various interested groups should also be a primary focus to determine where better coordination and effectiveness is needed. Coordination with the Health Policy Advisory Committee, described above, should occur.

The Health Policy Advisory Committee and the Governor's Executive Health Council could have some overlapping members among the agency directors.



## **Agency Structures Not Recommended**

The Council considered various organizational structures before recommending the creation of a Department of Medicaid. These various structures are briefly discussed in the paragraphs below.

### **Administrative/Policy Consolidation**

This option would consolidate all fiscal, IT, policy and legal functions, leaving operational functions in current agencies. Generally, this option would not meet some of the goals established by the Council including the capacity to align program operations with policy and budget responsibility.

### **Medicaid Consolidation**

This option would consolidate all Medicaid functions from the six agencies administering Medicaid services and move the resulting department up to executive level status. Many of the existing agencies have expertise in delivering specialty services to distinct populations. Some services in these areas are for Medicaid and non-Medicaid recipients. The option also would to some degree fail to recognize the state structures that are currently supporting local delivery systems.

### **Umbrella Organization Structure**

This option would consolidate all health functions including Medicaid under one “umbrella” structure with a single cabinet-level executive. The Council determined that it was beyond its mandate to recommend consolidation, recognizing the potential that this type of consolidation could overwhelm the more urgent needs of the core Medicaid program, and that there was a risk of disruptions for local consumers. Instead, the Council recommended improvements in the interagency framework used by Medicaid today.

### **Secretary of Health and Human Services to Oversee Cabinet Agencies**

In this option, the health related agencies would report to a Secretary that would oversee all health and human services activities. This is different from an umbrella structure in that each agency would continue to exist and have a director. Most of the coordination and significant decision making functions would rest with the Secretary. The Council concluded that such a structure, while viable, should be left up to the Governor in structuring his cabinet.



## APPENDIX 1 – Council Meetings and Committees

The full Council met thirteen times over a thirteen month period. Meeting dates included:

- December 8, 2005
- January 19, 2006
- February 2, 2006
- March 2, 2006
- April 6, 2006
- May 3, 2006
- May 4, 2006
- July 13, 2006
- August 3, 2006
- September 7, 2006
- October 5, 2006
- November 2, 2006
- December 7, 2006

The meeting on May 4, 2006 allowed for public testimony to the Council members.

### Committees and Dates of Meetings

The **Unified Long Term Care Budget Committee** included chair, John Begala, Tim Keen, Merle Kearns, Ken Ritchey and Representative Todd Book. Quentin Potter, the Council Executive Director was the staff member assigned to work with this group. This committee met six times: May 18, May 31, June 21, July 12, July 26, August 2, and September 7.

The members of the **New Medicaid Department Committee** included chair, Phil Derrow, Anne Harnish, William Wilkins, Barbara Riley and Senator Tom Niehaus. Rex Plouck was the staff member assigned to work with this group. This sub-committee met nine times: May 23, June 15, July 6, July 27, August 2, August 15, August 28, September 13, and September 27.

The **Information Technology Committee** included chair, Brian Phillips, Cynthia Dougherty of OIT, Senator Tom Niehaus, Senator Ray Miller, Kim Liston of ODJFS, and Don Anderson of ODMH. J. Patrick Doust was assigned as staff to work with this group. This sub-committee met eight times: June 1, July 18, August 3, September 7, September 14, September 20, September 28, and October 5.

The **Impact of the New Department on State & Local Entities Committee** included chair, Terry White, Bill Ryan, Joe San Fillipo, Fred Booker, Carolyn Givens, and Representative Jimmy Stewart. Patrick M. Lanahan was the staff member assigned to work with this group. This sub-committee met six times: June 1, August 3, September 7, October 4, October 5, and October 19. Public testimony was given to the sub-committee members on October 4, 2006.



## Appendix 2 – Summary of Recommendations

<b>Recommendations for the New Department</b>
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
The Department of Medicaid should operate in a manner consistent with the Department of Medicaid's Mission Statement and Operating Principles.
The Department of Medicaid should operate as part of a broader Health Care strategy developed by the Ohio Health Policy Advisory Committee.
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 Best Rx, and the prescription drug component of the Golden Buckeye Card.
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 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.
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.
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 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).



<b>Recommendations for the New Department</b>
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.
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.
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.
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.
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).
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.
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.
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.
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.



<b>Recommendations for the New Department</b>
<p>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.</p>
<p>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.</p>
<p>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.</p>
<p>The recommended Information Technology (IT) organization is outlined in the ODOM Information Technology Division Organization Chart</p>
<p>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.</p>
<p>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.</p>
<p>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.</p>
<p>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 Sub-committee. 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.</p>
<p>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.</p>



<b>Recommendations for Transition</b>
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 detail human resources plan identifying resource to be transferred from ODJFS to ODOM, resources needed to backfill position within ODJFS, and new positions to be created and filled within ODOM.
Develop an implementation plan
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 they are in place by July 1, 2007 as requested by the General Assembly in Am. Sub. H.B. 66.



## APPENDIX 3 -- Cross Functional Protocols

### 1. Strategy Division

The Strategy Division, in coordination with the Clinical Division, would be responsible for evaluating the efficiency and effectiveness of the Department's programs and practices. This division would also develop new strategies and policies to provide direction to Medicaid and sub-recipient programs. To support this mission, the Strategy Division should both closely work with internal units and collaborate with external agencies and sub-recipients. Examples of cross-functional practices for the Strategy Division are shown in the table below.

Unit	Cross-Functional Need	Areas Involved	Needed Response
WWWD Unit	Inventory of current program initiatives	Programs and sub-recipient programs	Provide operations information as requested.
	Evaluate program effectiveness	Agencies	Respond to WWWD findings and recommendations with program modifications if needed.
	Coordination of medical and clinical management priorities with strategic initiatives	Medical Division	
Economic Analysis and Modeling Unit	Increased proactive data analysis of strategies	WWWD Unit Finance Division Medical Division	Measure economic impact of strategic initiatives and concepts
Policy Development Unit	Coordination in the formulation and development of policy	WWWD Unit Senior management External constituents Director's Office Sub-recipient organizations	Respond to informational requests Participate in policy development
State Plan, Waiver and Rule Management Unit	Identify and assess current waivers, plan amendments and administrative rules  Work with Policy Development Unit to determine consistency of current initiatives with compliance needs	Operations Units responsible for state plan amendments and waiver programs  Medical Office when waivers involve clinical projects	Details on current Medicaid waiver initiatives and programs under those initiatives
Relationship Management Unit	Prepare communications strategy  Develop plan for soliciting input from external agencies, etc.  Prepare initial communications on ODOM goals and strategies	Stakeholders	Participate in communications initiatives as requested  Provide input



Unit	Cross-Functional Need	Areas Involved	Needed Response
Project Managers in Other Divisions	Monitor status of projects	All Divisions	Coordination
	Coordinate implementation of new projects		
	Evaluate results of projects		

The Strategy Division would also be responsible for implementing and supporting a standing Medicaid Strategy Policy Committee, and associated ad-hoc groups necessary to implement the initiatives designed by this committee.

## 2. Clinical Division

The Clinical Division should closely coordinate with:

- The Strategy Office in order to contribute to strategic thinking and in order to align medical initiatives with strategic initiatives;
- External providers and clinical experts in order to ensure clinical appropriateness of recommendations and actively include practicing clinicians in Medicaid initiatives; and
- Agencies and community-based providers in order to incorporate their expertise and gain their input in program design.

## 3. Plan Division

Cross-functional practices would be important for the Plan Division since this division would be responsible for implementing policies, procedures and practices developed in the Strategy Division and Clinical Division. The Program Integrity and Audit Unit may also have responsibilities for working with the Plan Division through program audits and anti-fraud program activities. Cross-functional practices that support this mission are provided in the table below.



Unit	Cross-Functional Need	Areas Involved	Needed Response
Benefits Administration ABD CFC	New strategies, policies and procedures ABD and CFC eligible beneficiaries.	Strategy Division	Developed detailed benefit administration policies for target groups
Managed Care Oversight		Clinical Division: Policy Development Unit	Modify and re-negotiate managed care contracts to reflect strategic goals
All Units	Program success measures	Strategy Division  Clinical Division: Policy Development Unit	Develop performance measures in coordination with the Strategy Unit
All Units	Program evaluation of operations Identification of best practices	WWWD Unit	Provide best practice examples and modify operational practices based on evaluation and best practice findings
Managed Care Oversight	Program directives for managing Medicaid provider and claimant fraud	Fraud and Abuse Unit	Change contracting practices Report suspicious behaviors Provide data to auditors
Medicaid Provider services			
Adjudication Unit			
Adjudication Unit	Audits and directives for HIPAA compliance	HIPAA Unit	Respond to directives as required for assuring compliance
Managed Care Unit	Evaluation of initiatives involving Protected Health Information		

#### 4. **Finance**

The Finance Division should closely coordinate with all other offices to support the needs of the budgeting process, and through its provision of business operations services. In addition, specific activities that require cross-functional coordination include:

- IT purchasing, budgeting, and planning must be coordinated with the Information Technology Division;
- Provision and interpretation of enterprise and business unit financial reports;
- Health payments activities (and subunits) must be coordinated with counterparts in the Plan Division; and
- Program Integrity and Audit to support audits of health payments activities.



While most of the cross-functional coordination activities related to the Finance Division involve existing processes, it must be remembered that these activities will take place in a new Department. In this case cross-functional coordination would be most effectively achieved through formal policies and procedures.

## **5. Information Technology Division**

The IT Division should partner with the other Divisions to achieve their strategies and goals using technology. In particular, they should coordinate closely with:

- The Strategy Division to ensure clear delineation of tasks, an understanding of the projects being managed by IT, and the overall project priority to be determined by the Strategy Division;
- The Strategy Project Office to report the status and updates of the projects being managed by IT project managers;
- All Divisions and outside agencies to provide required automation, infrastructure, support and technology; and
- External third parties as required to provide services.

The proposed cross functional coordination mechanism for the IT Division should be the formation of a Governance structure developed by the transition team. In addition, the IT Division should participate in industry organizations in order to stay current with technology used by other health care organizations.

## **6. Legal Division**

The Legal Division functions as a service bureau to all other operational units. The needs of Counsel and of units for Counsel will vary depending on the specific situation.

## **7. Organizational Development Office**

The Organizational Development Office should interact with all divisions and units. The needs of each unit or office, and the way in which those entities collaborate will be unique to each situation.

## **8. Program Integrity and Audit Office**

The Program Integrity and Audit Office must coordinate closely with both internal offices and units, and external entities. Cross-functional practices that support this unit are provided in the table below.



Unit	Cross-Functional Need	Areas Involved	Needed Response
Program Audit Unit	Compliance with Federal law of all units with Medicaid funded operations or which disperse Medicaid Funds	All ODOM units All sub-recipients	Cooperation with audits Responses to audit findings
Program Integrity Unit	Monitoring for compliance with ODOM strategic and policy initiatives  Technical support for meeting those initiatives	All ODOM Plan office units All sub-recipients	Provide requested information Response to findings Modify program operations and initiatives as need is identified
HIPAA Compliance Unit	Assure compliance with HIPAA Privacy and Security requirements	All ODOM Plan office units All sub-recipients	Report non-compliant activities  Report on requests for personal records Report PHI disclosures Cooperate with compliance audits  Change operations and practices as needed to support HIPAA compliance
Fraud and Abuse Unit	Program directives for managing claimant fraud	Adjudication unit	Provide information on claim payments and report suspicious activities  Support changes in adjudication practices based on audit results
	Program directives for managing provider fraud	Managed Care Oversight Medicaid Provider services	Change contracting Report suspicious behaviors



## Appendix 4 – Agency Budgets by Line Item (Model)

To help identify the detailed changes in each agency’s budget, the Council has developed the following tables outlining the before and after views of each budget. The SFY2005 Actual Expenditure column reflects actual SFY2005 spending by budget line item. The SFY2005 Remodeled Expenditures reflects how each budget would have looked had the Council’s recommendations been in place during this time period. Each agency has some non-Medicaid related spending; those items that involve Medicaid are highlighted.

### Ohio Department of Aging

Fund	ALI	ALI Name	FY 2005	FY 2005
			Actual Expenditures	Remodeled Expenditures
GRF	490-321	Operating Expenses	\$2,312,578	\$2,312,578
	490-403	PASSPORT	\$103,662,310	\$0
	490-405	Golden Buckeye Card	\$296,802	\$296,802
	490-406	Senior Olympics	\$15,638	\$15,638
	490-409	Ohio Community Service Council Operations	\$214,365	\$214,365
	490-410	Long-Term Care Ombudsman	\$722,526	\$722,526
	490-411	Senior Community Services	\$10,816,152	\$10,816,152
	490-412	Residential State Supplement	\$9,194,186	\$0
	490-414	Alzheimer's Respite	\$4,363,754	\$4,363,754
	490-416	JCFS Elderly Transportation	\$130,067	\$130,067
	490-419	Prescription Drug Discount Program	\$166,733	\$166,733
	490-421	PACE	\$46,863	\$0
	490-506	National Senior Service Corps	\$370,073	\$370,073
<b>GRF Total</b>			<b>\$132,312,047</b>	<b>\$19,408,688</b>

GSF	490-606	Senior Community Outreach and Education	\$15,344	\$15,344
<b>GSF Total</b>			<b>\$15,344</b>	<b>\$15,344</b>

SSR	490-602	PASSPORT Fund	\$3,854,716	\$0
	490-604	OCSC Community Support	\$103,692	\$103,692
	490-609	Regional Long-Term Care Ombudsman Program	\$907,044	\$907,044
	490-610	PASSPORT/Residential State Supplement	\$33,263,983	\$0
	490-615	Aging Network Support	\$560	\$560
	490-616	Resident Services Coordinator Program	\$506,128	\$506,128
	490-620	Ombudsman Support	\$615,000	\$615,000
	490-624	Special Projects	\$0	\$0
	New	Medicaid Delegation Transfer from ODOM		\$150,022,058
<b>SSR Total</b>			<b>\$39,251,124</b>	<b>\$152,154,483</b>

FED	490-607	PASSPORT	\$171,954,472	\$171,954,472
	490-611	Federal Aging Nutrition	\$23,597,863	\$23,597,863
	490-612	Federal Independence Services	\$23,451,495	\$23,451,495
	490-617	Ohio Community Service Council Programs	\$5,561,179	\$5,561,179
	490-618	Federal Aging Grants	\$11,536,569	\$11,536,569
	490-621	PACE - Federal		
<b>FED Total</b>			<b>\$236,101,577</b>	<b>\$236,101,577</b>

<b>Grand Total</b>			<b>\$407,680,092</b>	<b>\$407,680,092</b>
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Ohio Department of Alcohol and Drug Addiction Services

Fund	ALI	ALI Name	FY 2005	FY 2005
			Actual Expenditures	Remodeled Expenditures
GRF	038-321	Operating Expenses	\$1,120,257	\$1,120,257
	038-401	Treatment Services	\$34,675,796	\$34,675,796
	038-404	Prevention Services	\$1,000,731	\$1,000,731
	<b>GRF Total</b>		<b>\$36,796,784</b>	<b>\$36,796,784</b>
GSF	038-616	Problem Gambling Services	\$280,636	\$280,636
	<b>GSF Total</b>		<b>\$280,636</b>	<b>\$280,636</b>
SSR	038-604	Education and Conferences	\$160,362	\$160,362
	038-615	Credentialing	\$9,265	\$9,265
	038-621	Statewide Treatment & Prevention	\$16,534,292	\$16,534,292
	New	Medicaid State Subsidy and Local Funds		\$22,813,204
	<b>SSR Total</b>		<b>\$16,703,919</b>	<b>\$39,517,123</b>
FED	038-603	Drug Free Schools	\$2,974,453	\$2,974,453
	038-609	Demonstration Grants	\$4,607,470	\$4,607,470
	038-610	Medicaid	\$35,784,070	\$35,784,070
	038-611	Admin. Reimbursement	\$512,074	\$512,074
	038-614	Substance Abuse Block Grant	\$69,779,896	\$69,779,896
<b>FED Total</b>		<b>\$113,657,964</b>	<b>\$113,657,964</b>	
<b>Grand Total</b>			<b>\$167,439,303</b>	<b>\$190,252,507</b>

Variance is \$22.8 million of community Medicaid subsidy & local levy funds.



**Ohio Department of Job and Family Services**

Fund	ALI	ALI Name	FY 2005	FY 2005
			Actual Expenditures	Remodeled Expenditures
GRF	600-321	Support Services	\$56,127,550	\$41,779,596
	600-410	TANF State	\$272,619,055	\$272,619,055
	600-413	Child Care Match/MOE	\$84,119,965	\$84,119,965
	600-416	Computer Projects	\$123,048,763	\$98,886,100
	600-420	Child Support Administration	\$4,328,150	\$4,328,150
	600-421	Office of Family Stability	\$4,094,307	\$4,094,307
	600-422	Local Operations	\$2,158,104	\$2,158,104
	600-423	Office of Children and Families	\$4,917,848	\$4,917,848
	600-424	Office of Workforce Development	\$259,870	\$259,870
	600-425	Office of Ohio Health Plans	\$36,421,778	\$0
	600-435	Unemployment Compensation Review Committee	\$3,197,622	\$3,197,622
	600-439	Com. to Reform Med -- state	\$131,614	\$0
	600-440	Ohio's Best Rx Start Up Costs	\$742,562	\$742,562
	600-502	Child Support Match	\$16,788,614	\$16,788,614
	600-511	Disability Financial Assistance	\$23,068,540	\$23,068,540
	600-521	Family Stability Subsidy-State	\$55,523,338	\$16,497,807
	600-523	Children and Families Subsidy	\$70,579,591	\$70,579,591
	600-525	Health Care/Medicaid	\$9,446,177,653	\$0
	600-528	Adoption Services	\$65,552,070	\$65,552,070
	600-534	Adult Protective Services	\$0	\$0
	600-552	County Social Services	\$0	\$0
	N/A	Other State Level Admin from Cost Allocation		-\$5,725,904
<b>GRF Total</b>			<b>\$10,269,856,992</b>	<b>\$703,863,896</b>

GSF	600-645	Training Activities	\$164,072	\$164,072
	600-658	Child Support Collections	\$23,702,014	\$23,702,014
	600-665	BCII Service Fees	\$6,042	\$6,042
	600-671	Medicaid Program Support	\$57,206,108	\$0
	600-677	County Technologies	\$393,728	\$393,728
	600-692	Health Care Services	\$541,958,429	\$0
<b>GSF Total</b>			<b>\$623,430,393</b>	<b>\$24,265,856</b>

SSR	600-601	Food Stamp Intercept	\$1,533,697	\$1,533,697
	600-604	Child and Family Services Collections	\$51,935	\$51,935
	600-605	Nursing Home Assessments	\$611,301	\$0
	600-607	Unemployment Compensation Admin Fund	\$124,746	\$124,746
	600-608	Medicaid Nursing Facility	\$105,470,419	\$0
	600-609	Foundation Grants/Child & Family Services	\$0	\$0
	600-613	NF Assessment	\$34,044,246	\$0
	600-618	Residential State Supplement Payments	\$10,406,875	\$0
	600-619	Supplemental Inpatient Hosp	\$40,105,285	\$0
	600-621	ICF/MR Assessment	\$19,399,403	\$0
	600-625	Health Care Compliance	\$206,543	\$0
	600-629	MR DD Medicaid Admin & Over	\$204,859	\$0
	600-642	Support Intercept-State	\$10,577,236	\$10,577,236
	600-643	Refunds and Audit Settlements	\$1,336,265	\$1,336,265
	600-646	Support Intercept-Federal	\$88,225,050	\$88,225,050



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Fund	ALI	ALI Name	FY 2005 Actual Expenditures	FY 2005 Remodeled Expenditures
	600-647	Children's Trust Fund	\$4,396,536	\$4,396,536
	600-649	HCAP	\$226,156,258	\$0
	600-652	Child Support Special Payment	\$13,200	\$13,200
	600-654	Health Care Services Admin.	\$2,833,762	\$0
	600-663	Children and Family Support	\$2,954,026	\$2,954,026
	600-664	Health Care Grants	\$2,221	\$2,221
	600-667	Building Consolidation	\$178,138	\$178,138
	600-668	Building Consolidation	\$1,899,460	\$1,899,460
	600-672	TANF QC Reinvestments	\$404,348	\$404,348
	600-685	Unemployment Benefit Automation	\$10,594,384	\$10,594,384
	600-687	Banking Fees	\$364,539	\$364,539
	600-697	Public Assistance Reconciliation	\$133,000,000	\$130,765,522
	New	Transfer from ODOM for county administration (1)		\$39,025,531
<b>SSR Total</b>			<b>\$695,094,730</b>	<b>\$292,446,832</b>

FED	600-602	State & Local Training	\$984,861	\$984,861
	600-606	Child Welfare	\$14,598,059	\$14,598,059
	600-610	Food Stamps and State Administration	\$119,103,381	\$119,103,381
	600-614	Refugee Services	\$5,242,482	\$5,242,482
	600-616	Special Activities/Child and Family Services	\$3,068,490	\$3,068,490
	600-617	Child Care Federal	\$169,493,158	\$169,493,158
	600-620	Social Services Block Grant	\$72,987,850	\$72,987,850
	600-622	Child Support Projects	\$288,244	\$288,244
	600-623	Health Care Federal	\$403,047,748	\$0
	600-626	Child Support	\$232,012,110	\$232,012,110
	600-627	Adoption Maintenance/Administration	\$220,890,201	\$220,890,201
	600-628	IV-E Foster Care Maintenance	\$120,642,812	\$120,642,812
	600-641	Emergency Food Distribution	\$2,701,662	\$2,701,662
	600-648	Children's Trust Fund Federal	\$22,511	\$22,511
	600-650	HCAP Match	\$328,502,069	\$0
	600-655	Interagency Reimbursement	\$1,198,945,148	\$0
	600-659	TANF/ Title XX Transfer	\$47,985,431	\$47,985,431
	600-662	WIA Ohio Option #7	\$3,231,612	\$3,231,612
	600-675	Faith Based Initiatives	\$361,574	\$361,574
	600-678	Federal Unemployment Programs	\$145,191,484	\$145,191,484
	600-679	Unemployment Comp Review Commission - Federal	\$2,445,009	\$2,445,009
	600-681	JOB Training Program	\$23,334	\$23,334
	600-686	Federal Operating	\$39,561,687	\$39,561,687
	600-688	Workforce Investment Act	\$129,841,575	\$129,841,575
	600-689	TANF Block Grant	\$574,957,671	\$574,957,671
	N/A	Other State Level Admin from Cost Allocation		-\$5,725,904
<b>FED Total</b>			<b>\$3,836,130,162</b>	<b>\$1,899,909,293</b>

**Grand Total** **\$15,424,512,277** **\$2,920,485,877**

(1) This figures are actual expenditures and do not reflect changes associated with the county consolidate fix. Future appropriations should reflect appropriations based on current allocation process.



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Ohio Department of Mental Health

Fund	ALI	ALI Name	FY 2005	FY 2005
			Actual Expenditures	Remodeled Expenditures
GRF	332-401	Forensic Services	\$4,352,826	\$4,352,826
	333-321	Central Administration	\$23,887,793	\$23,887,793
	333-402	Resident Trainees	\$1,180,040	\$1,180,040
	333-403	Preadmission Admin. Cost	\$650,135	\$650,135
	333-415	Lease Rental Payments	\$22,380,819	\$22,380,819
	333-416	Research Program Evaluation	\$1,001,428	\$1,001,428
	334-408	Comm. & Hosp. MH Services	\$386,495,116	\$386,495,116
	334-506	Court Costs	\$989,364	\$989,364
	335-419	Community Medication Subsidy	\$7,959,798	\$7,959,798
	335-505	Local MH Systems of Care	\$89,441,409	\$89,441,409
<b>GRF Total</b>			<b>\$538,338,728</b>	<b>\$538,338,728</b>
GSF	333-609	Central Office Rotary - Operating	\$760,890	\$760,890
	334-609	Hospital Rotary - Operating Expenses	\$15,231,455	\$15,231,455
	334-620	Special Education	\$97,899	\$97,899
	235-601	General Administration	\$85,045,107	\$85,045,107
	335-604	Community Mental Health Projects	\$30,000	\$30,000
<b>GSF Total</b>			<b>\$101,165,351</b>	<b>\$101,165,351</b>
SSR	333-607	Behavioral Health Medicaid Services	\$3,638,395	\$3,638,395
	333-632	Mental Health Operating	\$8,654	\$8,654
	334-632	Mental Health Operating	\$1,748,114	\$1,748,114
	335-615	Behavioral Healthcare	\$2,574,110	\$2,574,110
	335-616	Community Capital Replacement	\$44,540	\$44,540
	New	Medicaid State Subsidy and Local Funds		\$170,559,545
<b>SSR Total</b>			<b>\$8,013,813</b>	<b>\$178,573,358</b>
FED	333-605	Medicaid/Medicare	\$97,110	\$97,110
	333-608	Community & Hospital Services	\$19,085	\$19,085
	333-613	Federal Grant-Administration	\$176,590	\$176,590
	333-614	Mental Health Block Grant	\$749,177	\$749,177
	333-635	Comm. Medicaid Expansion	\$6,468,207	\$6,468,207
	334-605	Medicaid/Medicare	\$10,388,405	\$10,388,405
	334-608	Subsidy for Federal Grants	\$254,236	\$254,236
	334-617	Elementary and Secondary Education Act	\$153,664	\$153,664
	334-635	Hospital Medicaid Expansion	\$320,811	\$320,811
	335-608	Federal Miscellaneous	\$515,820	\$515,820
	335-612	Social Services Block Grant	\$8,473,650	\$8,473,650
	335-613	Community Mental Health Board Subsidy	\$1,728,940	\$1,728,940
	335-614	Mental Health Block Grant	\$15,183,131	\$15,183,131
	335-635	Comm. Medicaid Expansion	\$256,470,330	\$256,470,330
<b>FED Total</b>			<b>\$300,999,156</b>	<b>\$300,999,156</b>
<b>Grand Total</b>			<b>\$948,517,048</b>	<b>\$1,119,076,593</b>

Variance is \$170.6 million of community Medicaid subsidy & local levy funds.



**Ohio Department of Mental Retardation and Developmental Disabilities**

Fund	ALI	ALI Name	FY 2005	FY 2005
			Actual Expenditures	Remodeled Expenditures
GRF	320-321	Central Administration	\$9,285,061	\$5,039,155
	320-412	Protective Services	\$2,008,330	\$0
	320-415	Lease-Rental Payments	\$22,380,819	\$22,380,819
	322-405	State Use Program	\$257,112	\$257,112
	322-413	Residential & Support Services	\$7,702,390	\$6,719,945
	322-416	Waiver State Match	\$99,190,711	\$0
	322-417	Supported Living	\$42,591,071	\$42,591,071
	322-451	Family Support Services	\$8,018,972	\$8,018,972
	322-452	Service and Support Administration	\$8,672,724	\$8,672,724
	322-501	County Boards Subsidies	\$35,927,589	\$35,927,589
	322-503	Tax Equity	\$14,981,203	\$14,981,203
	323-321	Residential Facilities Operations	\$103,092,781	\$0
	<b>GRF Total</b>			<b>\$354,108,763</b>
SSR	322-604	Waiver-Match	\$11,433,571	\$0
	322-620	Supplement Service Trust	\$125,375	\$125,375
	322-624	County Board Waiver Match	\$36,237,917	\$36,237,917
	323-632	Developmental Center Direct Care Support	\$8,163,898	\$0
	590-622	Medicaid Administration & Oversight	\$5,722,591	\$0
	New	Medicaid State Subsidy and Local Funds		\$205,371,218
	New	Medicaid Delegation Transfer from ODOM		\$235,567,287
<b>SSR Total</b>			<b>\$61,683,352</b>	<b>\$477,301,797</b>
GSF	323-609	Residential Facilities Support	\$727,055	\$0
	320-640	Conference/Training	\$4,669	\$4,669
	322-645	Intersystem Services for Children	\$2,316,897	\$2,316,897
	322-611	Family and Children First	\$471,844	\$471,844
	322-603	Provider Audit Refunds	\$212,509	\$212,509
<b>GSF Total</b>			<b>\$3,732,975</b>	<b>\$3,005,919</b>
FED	320-605	Administrative Support	\$10,052,740	\$10,052,740
	320-613	DD Council Operating Expenses	\$832,884	\$832,884
	320-634	Protective Services	\$100,000	\$100,000
	322-605	Community Program Support	\$1,603,977	\$1,603,977
	322-608	Grants for Infants and Families with Disabilities	\$1,579,824	\$1,579,824
	322-612	Community Social Service Programs	\$9,640,795	\$9,640,795
	322-613	DD Council Grants	\$2,335,564	\$2,335,564
	322-639	Medicaid Waiver	\$306,701,920	\$306,701,920
	322-650	CAFS Medicaid	\$276,798,470	\$276,798,470
	323-605	Developmental Center Operation Expenses	\$108,736,198	\$108,736,198
323-608	Foster Grandparent Program	\$379,964	\$379,964	
<b>FED Total</b>			<b>\$718,762,334</b>	<b>\$718,762,334</b>
<b>Grand Total</b>			<b>\$1,138,287,424</b>	<b>\$1,343,658,642</b>

Variance is \$205.4 million of community Medicaid subsidy & local levy funds.



## Appendix 5 – Impact Overview

The Council used several assumptions in developing the administrative impact analysis. These assumptions should be reviewed by the transition team as they begin work on the detailed human resources plan. Changes to the assumptions are likely to change the number of staff and administrative funds required by ODJFS and ODOM.

The Council began its impact analysis by deciding that those people currently working at ODJFS spending more than 75% of their time supporting the Medicaid program will be transferred to ODOM. The support staff in MIS is an exception to this assumption. The Council recommended that all the current MIS employees remain at ODJFS and that ODOM should contract with ODJFS for support of the current information systems. ODOM will transfer funds to ODJFS for MIS and other administrative support services.

The impact analysis also assumes that ODOM will contract with the CDJFS offices to continue to provide eligibility determination services. ODOM will transfer funds to ODJFS for these services.

An investment in ODOM administration will be required to hire additional staff, principally in the Strategy Division and Clinical Division.

The figures below represent the administrative costs associated with the OHP and other administrative costs associated with Medicaid via cost pools and the federally approved cost allocation plan.

These figures represent an example of what SFY2005 expenditures would have been had the Council's recommendations been implemented. This model is to be used as a planning guide; however more work should be done to determine funding needed for the SFY2008 – 2009 budget.



### **Pre-Recommendation Environment**

#### ODJFS Statistics

- Employees: 3,798
- Total Budget: \$15,424,512,277
- Administrative Budget: \$587,055,881

### **Council Recommendations and Impacts**

- Appropriate all Medicaid related funds to ODOM: \$13,095,616,315
- Transfer all employees spending more than 75% of their time supporting Medicaid to ODOM: 598
- Contract to ODJFS for current MIS and other support services: \$44,190,068
- Hire new employees to fully staff ODOM: 150 employees and \$17,443,500
- An additional \$7 million<sup>20</sup> would be required to fund ODOM at these levels.

### **Post-Recommendation Environment**

#### ODOM Statistics

- Employees: 748 employees
- Total Budget: \$13,095,616,315
- Administrative Budget: \$261,357,431

#### JFS Post-Recommendation Statistics

- Employees: 3,200
- Total Budget: \$2,920,485,877
- Administrative Budget: \$509,857,292

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<sup>20</sup> On December 6, 2006, OBM estimated the investment to be \$17.4 million.



## Appendix 6 – Agency Director Safeguards

<b>Additional Safeguards Received from Agency Directors</b>	<b>Impact Committee Recommendations</b>
<p>Make the timelines for creation of ODOM workable.</p>	<p>The Impact Committee recognizes the need for more detailed planning to occur to ensure a successful transition and recommend that resources and mechanisms be made available during the transition period.</p>
<p>Structure a transition arrangement that is managerially sound, not just an acceptable compromise. (The implications that I believe are straightforward are that the person and office charged with effecting the transition must be accountable to the Governor and must have whole responsibility for the functions being managed.)</p>	<p>The Impact Committee recognizes the need for more detailed planning to occur to ensure a successful transition and recommend that resources and mechanisms be made available during the transition period. See Impact on State and Local Entities Matrix (Appendix 7).</p>
<p>Abandon the idea of trying to re-appropriate match resources for the MH/AOD benefits, since such an "appropriation" does not address or provide managerial controls, since the claims data on services/trends is NOW available for accountability, and since in the case of MH this step is potentially destabilizing. Under state law, local Boards are responsible for state hospital costs. With a significant change in finances, they have the option to shift these costs back to the state (they could do this along with Medicaid match). The local control option (responsibility to manage both community and institutional care) is why we have less than 500 non-forensic patients in state hospitals, compared with 5000 individuals in ICF-MRs and however many thousands in NF's. In the other systems, despite the significant advances during this Administration, institutional utilization is not directly controlled vis-à-vis community services, and expansion community services via waivers--while urgently needed--has not significantly reduced institutional utilization.</p>	<p>The Impact Committee determined that the annual financing plan is an appropriate mechanism for ODOM, OBM, the sister agencies, and local entities to address the details implementing improved accounting of state and local matching funds.</p> <p>The Impact Committee understands the extent to which Medicaid financing is imbedded in the overall financing of the population-focused agencies and recommended the finance plan should be built upon existing community planning processes, involving state and local entities. See Impact on State and Local Entities Matrix (Appendix 7).</p>
<p>Proceed first with the actions needed to create an effective core Medicaid program. Defer the actions needed to change relationships with the sister agency/local government components of the program until the first stage is completed. Trying to do everything at once threatens to derail the overall operation. The Aging/ MRDD/ MH/ ODADAS components of the program are a minor component of Medicaid overall, and are mostly either distinct benefits (MH/AOD) or specific HCBS waivers. But the shareholders and intergovernmental dynamics here are volatile. Put these issues on the back burner until there is capacity to manage them.</p>	<p>The Transition Plan, once fully developed, is likely to address core Medicaid capacities first. The Impact Committee recognizes that not everything can be done at once. The Impact Committee determined that improving accountability of Ohio Medicaid's delegated arrangements is a prerequisite to an effective and efficient core Medicaid program, and that resources should be made available to begin work to strengthen the delegated arrangements. See Impact on State and Local Entities Matrix (Appendix 7).</p>



<b>Additional Safeguards Received from Agency Directors</b>	<b>Impact Committee Recommendations</b>
<p>We are concerned that the creation of new Department of Medicaid to manage Ohio's Medicaid program could impact ODA's ability to sustain and continue to develop a comprehensive and coordinated system of aging services to serve our growing aging population, which ranges from the frail elders of our greatest generation to the over 12,000 active baby boomers turning age 60 every month. We urge you to build on the strengths of Ohio's efficient, innovative and well coordinated aging network.</p>	<p>The Council's recommended Delegation Assumptions and Principles contemplate continued delegation to sister agencies. Delegated arrangements with sister agencies and their local government counterparts should be considered when they provide efficient and effective population-focused system management and local connections for consumers with unique service needs. The Impact Committee's recommendations regarding Transition Plan/Transition Team and Improving Accountability in Delegated Arrangements are intended to ensure local connections for consumers are not interrupted.</p>
<p>We propose that population focused agencies, like ODA, have agency, stakeholder (e.g., AAAs) and constituent representation on the Ohio Health Care Advisory Committee.</p>	<p>The Council's recommendations included the concept of an Ohio Health Care Advisory Committee in its recommendations. The general concept would be consistent with a Medicaid management environment which includes coordinated involvement of the population-focused state and local entities. While there is no recommendation from the Impact Committee with respect to an Ohio Health Care Advisory Committee, the Impact Committee's other recommendations reflect the need for a Medicaid management environment which includes coordinated involvement of the population-focused state and local entities.</p>
<p>We propose that programs be located in the agency/system that is best able to meet the needs of the consumer population to be served (e.g., seniors). We also believe that consolidating oversight functions (e.g., provider monitoring) based on funding (e.g., Medicaid) rather than population to be served (e.g., seniors, persons with disabilities) and service delivery network (e.g., aging network) will have a negative impact on quality of service, consumer satisfaction and existing efficiencies and coordination efforts (e.g., similar service specifications and conditions of service, coordination across funding streams).</p>	<p>The Council's recommended Delegation Assumptions and Principles contemplate continued delegation to sister agencies. Delegated arrangements with sister agencies and their local government counterparts should be considered when they provide efficient and effective population-focused system management and local connections for consumers with unique service needs.</p> <p>At the same time, federal law requires that the Department of Medicaid (single state agency) retain final authority over Medicaid administration. The Impact Committee determined that clarifying roles and responsibilities is necessary to strengthen Ohio's delegated arrangements. See Impact on State and Local Entities Matrix (Appendix 7).</p>
<p>We propose that a transition plan take into consideration the needs of consumers that may be impacted by proposed changes, especially older and disabled consumers who have been receiving services from a familiar network, service provider and, possibly, care worker for many years.</p>	<p>This safeguard is consistent with the Impact Committee's goals and is reflected in the recommendations. See Impact on State and Local Entities Matrix (Appendix 7).</p>



Additional Safeguards Received from Agency Directors	Impact Committee Recommendations
<p>We support the continued delegation of Medicaid responsibilities to the sister agencies that are best able to and have the expertise to serve the population in need. If agencies are delegated the responsibility of operating a program, they must be given the full authority to ensure quality service delivery, including, but not limited to, oversight and payment of service providers.</p>	<p>The Council's recommended Delegation Assumptions and Principles contemplate continued delegation to sister agencies. Delegated arrangements with sister agencies and their local government counterparts should be considered when they provide efficient and effective population-focused system management and local connections for consumers with unique service needs.</p> <p>At the same time, federal law requires that the Department of Medicaid retain final authority over Medicaid administration. The Impact Committee has determined that clarifying roles and responsibilities is necessary to strengthen Ohio's delegated arrangements. See Impact Committee Recommendations regarding Improving Accountability in Delegated Arrangements.</p>
<p>In designing a claims processing system keep in mind the current role in this process the sister agencies play. Allowing the sister agencies to continue paying the provider directly and ensuring the claims information gets into a centralized data base ensures a relationship between the provider and the sister agency. This relationship is the basis for ensuring responsiveness to consumer's needs and compliance to provider requirements.</p>	<p>The Impact Committee recognizes the need for resources to continue to be appropriated for sister agency claims payment processes throughout the transition to a centralized system. See Impact on State and Local Entities Matrix (Appendix 7).</p>
<p>Any recommendations being proposed by the State and Local Impact Sub-Committee, as well as the other three Sub-Committees and the full OMASC, need to be seamless to the consumers we serve and assure services are neither interrupted nor limited in any manner during the transition period.</p>	<p>This safeguard is consistent with the Impact Committee's goals and is reflected in its recommendations. See Impact on State and Local Entities Matrix (Appendix 7).</p>
<p>A particular instance where there may be an unintended negative impact is the financing arrangements being proposed, specifically how ODADAS' current state dollars used for Medicaid claims payments would appear in two Department (ODADAS' and ODOM's) budgets. These state dollars currently "count" towards ODADAS' Maintenance of Effort (MOE) when the our federal Substance Abuse Prevention and Treatment (SAPT) block grant funding is calculated by the Substance Abuse and Mental Health Services Administration (SAMHSA). Any reduction, either actual or on paper, could result in SAMHSA no longer "counting" these state dollars as MOE and the SAPT block grant would begin to decrease. Because of the way the SAPT is calculated (an average of the last two years MOE expenditures), the loss of federal funding would happen for at least two years, possibly longer.</p>	<p>The Council's recommendations appear to make no changes that affect Ohio's compliance with the federal block grant maintenance of effort requirements. State GRF currently appropriated to ODADAS will continue to be directly appropriated to ODADAS. Only the local contributions to the rotary funds for matching funds will be reflected in the ODOM budget. See Impact on State and Local Entities Matrix (Appendix 7).</p>



Additional Safeguards Received from Agency Directors	Impact Committee Recommendations
<p>The continued existence of an agency dedicated to serving people with MRDD is absolutely essential to the continued health and welfare of these individuals. The State of Ohio should maintain Medicaid expertise in ODMR/DD.</p>	<p>The Council’s recommended Delegation Assumptions and Principles contemplate continued delegation to sister agencies. Delegated arrangements with sister agencies and their local government counterparts should be considered when they provide efficient and effective population-focused system management and local connections for consumers with unique service needs.</p>
<p>Current and future recommendations regarding the new Medicaid agency need to be formulated to ensure that ODMR/DD budgets and delegated authority are not disrupted.</p>	<p>The Council’s recommended Delegation Assumptions and Principles contemplate continued delegation to sister agencies. Delegated arrangements with sister agencies and their local government counterparts should be considered when they provide efficient and effective population-focused system management and local connections for consumers with unique service needs.</p>
<p>The Council should more clearly define the “delegation arrangement” of the new Medicaid agency outlined by the work of ODOM Sub-Committee.</p> <p>Current and future recommendations regarding the new Medicaid agency need to be formulated to ensure that ODMR/DD budgets and delegated authority are not disrupted.</p> <p>ODMR/DD and county boards must maintain the ability to manage specific service provisions. This would include management of local dollars in support of these services.</p>	<p>The Council’s recommended Delegation Assumptions and Principles contemplate continued delegation to sister agencies. Delegated arrangements with sister agencies and their local government counterparts should be considered when they provide efficient and effective population-focused system management and local connections for consumers with unique service needs. At the same time, federal law requires that the Department of Medicaid retain final authority over Medicaid administration. The Impact Committee has determined that clarifying roles and responsibilities is necessary to strengthen Ohio’s delegated arrangements. See Impact on State and Local Entities Matrix (Appendix 7).</p>
<p>During organization of these career paths, ODMR/DD would recommend discussion and coordination with DAS to ensure compliance with Civil Service rules and bargaining unit parameters</p>	<p>See Impact on State and Local Entities Matrix (Appendix 7).</p>
<p>The transition timeline should be based on realistic goals and assumptions.</p>	<p>The Impact Committee recognizes the need for more detailed planning to occur to ensure a successful transition and recommend that resources and mechanisms be made available during the transition period. See Impact on State and Local Entities Matrix (Appendix 7).</p>
<p>Current and future recommendations regarding the new Medicaid agency need to be formulated to ensure that ODMR/DD budgets and delegated authority are not disrupted at the state and local levels.</p>	<p>The Council’s recommended Delegation Assumptions and Principles contemplate continued delegation to sister agencies. Delegated arrangements with sister agencies and their local government counterparts should be considered when they provide efficient and effective population-focused system management and local connections for consumers with unique service needs.</p>



Additional Safeguards Received from Agency Directors	Impact Committee Recommendations
<p>Health and human services agencies should have the authority to manage the funds and determine their specific purpose and use.</p> <p>It is strongly recommended that ODMR/DD maintain operational control of its developmental centers and licensure and quality assurance functions, including residential facility licensing, provider certification and compliance, incident investigation, and the Abuser Registry, in order to ensure the health and safety of the individuals served.</p>	<p>The Council has not recommended that the Department of Medicaid assume operational control or licensure and quality assurance functions, including residential facility licensing, provider certification and compliance, incident investigation, and the Abuser Registry,</p> <p>The Council's recommended Delegation Assumptions and Principles contemplate continued delegation to sister agencies. Delegated arrangements with sister agencies and their local government counterparts should be considered when they provide efficient and effective population-focused system management and local connections for consumers with unique service needs. At the same time, federal law requires that the Department of Medicaid retain final authority over Medicaid administration. The Impact Committee has determined that clarifying roles and responsibilities is necessary to strengthen Ohio's delegated arrangements. See Impact on State and Local Entities Matrix (Appendix 7).</p>
<p>More specific information needs to be developed in the Council's recommendations insuring the protection of local dollars by rotary funds and that each dollar is determined by the needs of the county.</p> <p>Local dollars should be reconciled and returned to each county if the dollars are not utilized within a specific time period (two years).</p> <p>Local dollars raised by specific agencies should be used for the purpose for which they were raised. Actions that significantly affect local systems should be avoided at this time.</p>	<p>The Impact Committee determined that the annual financing plan is an appropriate mechanism for ODOM, OBM, the sister agencies, and local entities to address the details implementing improved accounting of state and local matching funds. The Impact Committee understands the extent to which Medicaid financing is imbedded in the overall financing of the population-focused agencies and recommended the finance plan should be built upon existing community planning processes, involving state and local entities. See Impact on State and Local Entities Matrix (Appendix 7).</p>



Additional Safeguards Received from Agency Directors	Impact Committee Recommendations
<p>ODMR/DD believes it would be more logical to create a design direction/requirements list and allow the RFP team to incorporate the requirements.</p> <p>Also note that until ODOM is up and running and delegation has occurred, it may be difficult to determine who will be doing what. MITS may need rework in light of the final arrangements.</p> <p>Delay of the RFP pushes implementation of the billing system replacement out further into the future. It might be wise to identify critical requirements (like the central billing system concept) and move forward, with a plan to phase in the additional needs for the new setup.</p>	<p>The Impact Committee recommends that state and local agencies be involved in the decision-making around the transition to MITS.</p>
<p>The new MITS system needs to identify the edits currently performed by the sister Medicaid agencies and ensure that all edits are incorporated into the new centralized system.</p> <p>The IT management model should capitalize on the expertise of the various state agencies, their local counterparts, and people served by the system.</p>	<p>The Impact Committee recommends that state and local agencies be involved in the decision-making around the transition to MITS.</p>
<p>Controls and turn-around for data sharing data warehouse information should be in place at initial set-up.</p> <p>Decisions on centralized versus local control of data should consider response time, efficiency, HIPAA and privacy issues, and outcomes for people.</p>	<p>The Impact Committee recommends that state and local agencies be involved in the decision-making around the transition to MITS.</p>
<p>During organization of these career paths, ODMR/DD would recommend discussion and coordination with DAS to ensure compliance with Civil Service rules and bargaining unit parameters.</p>	<p>The Impact Committee's recommendations for Transition Plan/Transition Team include this.</p>
<p>The IT management model should capitalize on the expertise of the various state agencies, their local counterparts, and people served by the system.</p>	<p>The Impact Committee recommends that state and local agencies be involved in the decision-making around the transition to MITS.</p>



<b>Additional Safeguards Received from Agency Directors</b>	<b>Impact Committee Recommendations</b>
<p>The proposed transfers among agencies will have an impact on the GRF. Additional work is needed to clarify in the budget any diversions from current practices. Changing the placement of expenditures will affect federal revenue deposited into the GRF. Care must be taken to ensure that there will be no unintended consequences to GRF revenue or GRF cash flow.</p>	<p>Care must be taken to ensure that there will be no unintended consequences to GRF revenue or GRF cash flow.</p>



## Appendix 7 – Impact on State and Local Entities Matrix

Council/Committee Recommendation	Impact Issue	Stakeholders Proposed Safeguard	Impact Committee Recommendation
<p><b>ITEM 1:</b> A new cabinet-level department, The Ohio Department of Medicaid, will be created to manage Ohio’s entire Medicaid program. ODOM’s organizational structure is outlined in the Department of Medicaid Organizational Structure Document.</p>	<p>Current Medicaid administration through ODJFS is \$ 242.1 million. Of this amount, \$92.3 million is passed through to sister agencies. ODJFS’ total Medicaid administrative spending is \$149.8 million.</p> <p>Assumptions include that \$92.3 million would be passed through ODOM to the sister agencies pursuant to delegated arrangements. \$149.8 million would be transferred from ODJFS to ODOM. Some portion of this would be contracted back to ODJFS for transitional operations.</p> <p>Of ODJFS’ 3400 employees, 480 are Ohio Health Plans employees. It is estimated that another 400 full-time-equivalents (spread across perhaps double this number of employees) support the Office of Ohio Health Plans under the ODJFS “shared services” model. More work is needed to determine the optimal mix of transfers and new hires to maintain operations at ODJFS and to adequately staff ODOM.</p>	<p>See Recommendations/ Safeguards Grouped by Subject (New Department) (Appendix 8)</p> <p>See Additional Safeguards Received from State Agency Directors (Appendix 6)</p>	<p>Funding should be appropriated for the Transition Team to use while implementing the Transition Plan.</p> <p>The Transition Plan needs to include development of a detailed Human Resources plan. The Transition Team should engage professionals in organizational design to guide the development of the plan. The plan should address how ODOM’s Operating Principles will inform selection processes.</p> <p>The Transition Team should work with ODJFS, DAS, other affected state agencies, and employee representatives to include recommendations regarding how to target any additional hiring either to replace lost functionality in ODJFS or to adequately equip ODOM.</p>



<b>Council/Committee Recommendation</b>	<b>Impact Issue</b>	<b>Stakeholders Proposed Safeguard</b>	<b>Impact Committee Recommendation</b>
<b>ITEM 2:</b> The Department of Medicaid will operate in a manner consistent with the Department of Medicaid's Operating Principles.	The success of ODOM will require significant culture change; there are no current resources for this	See Recommendations/ Safeguards Grouped by Subject (New Department) (Appendix 8)	ODOM and the affected existing departments should have additional, one-time resources to engage services of change management professionals.
<b>ITEM 3:</b> The Department of Medicaid will operate as part of a broader Health care strategy developed by the Ohio Health Care Advisory Committee.	TBD	See Additional Safeguards Received from State Agency Directors (Appendix 6).	While there is no recommendation from the Impact Committee with respect to an Ohio Health Care Advisory Committee, the Impact Committee's other recommendations reflect the need for a Medicaid management environment which includes coordinated involvement of the population-focused state and local entities.
<b>ITEM 4:</b> The Department of Medicaid will be appropriated the funds for and will 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 Best Rx, and the prescription drug component of the Golden Buckeye Card.	Staff resources associated with DMA, RSS, Best Rx and Golden Buckeye Card may need to transition to DOM.	See Recommendations/ Safeguards Grouped by Subject (Long Term Care Budget) (Appendix 8)  See Additional Safeguards Received from State Agency Directors (Appendix 6)	The Transition Plan needs to include development of a detailed Human Resources plan.



<b>Council/Committee Recommendation</b>	<b>Impact Issue</b>	<b>Stakeholders Proposed Safeguard</b>	<b>Impact Committee Recommendation</b>
<p><b>ITEM 5:</b> 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.</p>	<p>TBD</p>	<p>See Recommendations/ Safeguards Grouped by Subject (Transition) (Appendix 8)</p>	<p>The Transition Plan needs to include development of a detailed Human Resources plan.</p>
<p><b>ITEM 6:</b> 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.</p>	<p>TBD: Dependent upon final Transition Plan and resources</p>	<p>See Recommendations/ Safeguards Grouped by Subject (Transition) (Appendix 8)</p> <p>See Additional Safeguards Received from State Agency Directors (Appendix 6)</p>	<p>The Transition Plan should avoid causing unnecessary disruptions at the local level and affected state agencies.</p>



<b>Council/Committee Recommendation</b>	<b>Impact Issue</b>	<b>Stakeholders Proposed Safeguard</b>	<b>Impact Committee Recommendation</b>
<p>ITEM 7: The Department of Medicaid should use the Delegation Assumptions and Principles created by this committee to guide its decision to delegate Medicaid responsibility to other parties.</p>	<p>Council's proposal contemplates continued use of delegated arrangements with the sister agencies. At the same time, delegated arrangements with sister agencies need to be strengthened and clarified in order to reflect the increased centralization of Medicaid responsibilities in ODOM. There are areas for improvement in all of ODOM's delegated arrangements; improvement strategies to be adopted may alter the current relationships, roles, and responsibilities of the agencies involved.</p>	<p>See Recommendations/ Safeguards Grouped by Subject (Delegation to Sister Agencies) (Appendix 8)</p> <p>See Additional Safeguards Received from State Agency Directors (Appendix 6)</p>	<p>The Delegation Assumptions and Principles should be consistently applied, emphasizing accountability, to all delegated arrangements with sister state agencies and local entities. Great care should be taken to avoid disruptions in service to consumers. The Transition Team should be given resources to facilitate work among affected state and local agencies to clarify, to recalibrate, and to emphasize accountability in all delegated administration arrangements ODOM should be held accountable for the outcomes of its delegated arrangements and must actively monitor for compliance and overall performance.</p> <p>Further study is recommended regarding local administrative costs.</p>
<p>ITEM 8: ODOM 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).</p>	<p>All Medicaid appropriations will be centralized in ODOM. Funds will be transferred to agencies pursuant to delegated arrangements. Emphasis will be on managing by population rather than provider type or category of services. Long term impact envisioned is an improvement in the ability to have money follow the person and to remove barriers to alternatives to costly institutional care.</p>	<p>See Recommendations/ Safeguards Grouped by Subject (Long Term Care Budget) (Appendix 8)</p> <p>See Additional Safeguards Received from State Agency Directors (Appendix 6)</p>	<p>ODOM must 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.</p>



<b>Council/Committee Recommendation</b>	<b>Impact Issue</b>	<b>Stakeholders Proposed Safeguard</b>	<b>Impact Committee Recommendation</b>
<p><b>ITEM 9:</b> 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</p>	<p>Impact varies by system. MR/DD boards state there is “no impact” for them. There is no impact for the AAA’s. ODADAS, ODMH and ADAMH/ADAS/CMH Boards have concerns:</p> <ul style="list-style-type: none"> <li>a) could have the unintended effect of making it more difficult to pass local levies;</li> <li>b) could affect cash flow for local entities;</li> <li>c) could disrupt local community planning and in particular current local funding responsibilities for mental health hospitalizations in state-operated facilities;</li> <li>d) could result in some local entities refusing to participate in the Medicaid program, which would cause statewide problems and would require state agencies to find ways to replace current local match funding commitments.</li> <li>e) fear of losing control over the uses of the local funds;</li> <li>f) concern that reconciliation could take too long.</li> </ul> <p>Implementing the recommendation requires changes to current interagency agreements at all levels of the system, possible statutory changes, and changes in claims payment systems.</p>	<p>See Recommendations/ Safeguards Grouped by Subject (Local Funding/Local Administration) (Appendix 8)</p> <p>See Additional Safeguards Received from State Agency Directors (Appendix 6)</p>	<p>Transition Team, with affected state/local entities, should develop a detailed implementation plan, using the following principles: 1) A state agency performing delegated Medicaid administration and agreeing to assure the availability of state/local matching funds for specified services will submit an annual financing plan to ODOM; 2) Plan to be approved by OBM and part of the Inter- agency Agreement with ODOM; 3) Plan will be developed by the delegated state agency in consultation with its system’s local entities, utilizing its community planning process; 4) Plan must enable ODOM to meet federal Medicaid public matching funds requirements; 5) Plan to identify by county or board area the amount and source(s) of state subsidy or local levy matching funds each local entity will pay into the rotary fund; 6) There must be audit standards and procedures so that source(s) of payments into the fund can be verified; 7) Rotary funds to be reconciled on an annual basis; rotary funds no longer needed for local Medicaid matching funds purposes will be returned to the local entity that paid them into the fund; 8) need communication as detailed plan worked out, then during implementation</p>



<b>Council/Committee Recommendation</b>	<b>Impact Issue</b>	<b>Stakeholders Proposed Safeguard</b>	<b>Impact Committee Recommendation</b>
<p><b>ITEM 10:</b> The Information Technology Sub-committee 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 Sub-committee recommends that the procurement of the new MITS system should continue to be reviewed by the full Ohio Medicaid Administrative Study Council to evaluate its compatibility with the new 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.</p>	<p>TBD</p>	<p>See Recommendations/ Safeguards Grouped by Subject (Information Technology) (Appendix 8)</p> <p>See Additional Safeguards Received from State Agency Directors (Appendix 6)</p>	<p>It is essential to have a mechanism to verify assertions about the suitability of MITS to support the activities of ODOM.</p>



<b>Council/Committee Recommendation</b>	<b>Impact Issue</b>	<b>Stakeholders Proposed Safeguard</b>	<b>Impact Committee Recommendation</b>
<p><b>ITEM 11:</b> The IT Sub-committee does not endorse any specific vendor solution; however, the Sub-committee 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 health care agencies.</p>	<p>Sister agencies' current Medicaid-related information systems could eventually be replaced by ODOM's new system</p>	<p>See Recommendations/ Safeguards Grouped by Subject (Information Technology) (Appendix 8)</p> <p>See Additional Safeguards Received from State Agency Directors (Appendix 6)</p> <p>State agencies and their local counterparts will need to be involved in the decision-making process as this moves forward. Communication with major vendors will be an important part of the transition process.</p>	<p>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.</p>
<p><b>ITEM 12:</b> 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).</p>	<p>The Department of Medicaid will need to have sufficient resources to manage the relationship with ODJFS.</p>	<p>See Recommendations/ Safeguards Grouped by Subject (Information Technology and Transition) (Appendix 8)</p> <p>See Additional Safeguards Received from State Agency Directors (Appendix 6)</p>	<p>It is essential that resources on the old systems must remain stable.</p> <p>The detailed human resources plan should include incentives to encourage key personnel in all of the affected state agencies to stay throughout the conversion's system development life cycle process.</p> <p>The Transition Team should be given the authority and the resources to guide the establishment of the service level agreement between ODOM and ODJFS.</p>



<b>Council/Committee Recommendation</b>	<b>Impact Issue</b>	<b>Stakeholders Proposed Safeguard</b>	<b>Impact Committee Recommendation</b>
<p><b>ITEM 13:</b> Based on a presentation by Mina Chang, Section Chief in Ohio Health Plans' Bureau of Managed Health Care, the Sub-committee 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.</p>	<p>None identified</p>	<p>N/A</p>	<p>N/A</p>
<p><b>ITEM 14:</b> The Sub-committee 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.</p>	<p>None identified</p>	<p>See Recommendations/ Safeguards Grouped by Subject (Information Technology and Transition) (Appendix 8)</p>	<p>N/A</p>
<p><b>ITEM 15:</b> The Sub-committee recommends that the Decision Support System (DSS), Pharmacy Data Mart, and the all OHP project staff move to the ODOM Office of Information Management.</p>	<p>ODOM and the sister agencies' uses of the DSS will continue to evolve and increase; current staffing is inadequate to support more users, broader applications, increased demand for training.</p>	<p>See Recommendations/ Safeguards Grouped by Subject (Information Technology and Transition) (Appendix 8)</p>	<p>The Transition Team's detailed human resources plan should include identifying additional positions needed to adequately staff the DSS.</p>



<b>Council/Committee Recommendation</b>	<b>Impact Issue</b>	<b>Stakeholders Proposed Safeguard</b>	<b>Impact Committee Recommendation</b>
<p><b>ITEM 16:</b> The IT Sub-committee has determined that moving all or part of the Data Warehouse to ODOM is an issue on which the Sub-committee or the Council cannot make a recommendation on within the Council's timeframe. The Sub-committee is recommending that an unbiased party or consultant be utilized to recommend the best agency (or agencies) to manage the Data Warehouse and the DW governance structure.</p>	<p>None identified</p>	<p>N/A</p>	<p>The Committee recommends that the Transition Team be provided with resources to obtain a consultant's recommendation.</p>
<p><b>ITEM 17:</b> 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.</p>	<p>TBD: Impact dependent upon future decisions to be made by ODOM</p>	<p>N/A</p>	<p>State agencies and local representatives should be involved in the decision-making before decisions are finalized. Communication with major vendors is important as changes are implemented</p>
<p><b>ITEM 18:</b> The recommended Information Technology (IT) organization is outlined in Figure 8</p>	<p>None identified</p>	<p>N/A</p>	<p>N/A</p>



<b>Council/Committee Recommendation</b>	<b>Impact Issue</b>	<b>Stakeholders Proposed Safeguard</b>	<b>Impact Committee Recommendation</b>
<p><b>ITEM 19:</b> The Information Technology (IT) Division should develop a Strategic Plan based on the new Ohio Department of Medicaid's (ODOM) Strategic Plan.</p>	<p>None identified</p>	<p>N/A</p>	<p>ODOM should involve local entities and sister agencies in its strategic planning processes.</p>
<p><b>ITEM 20:</b> The IT Division should adopt the Principles for the ODOM Chief Information Officer (see Appendix 10) that has 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.</p>	<p>None identified</p>	<p>N/A</p>	
<p><b>ITEM 21:</b> 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.</p>	<p>No current resources identified</p>	<p>none</p>	<p>The ODOM organizational development function should be given resources to achieve this goal.</p>



<b>Council/Committee Recommendation</b>	<b>Impact Issue</b>	<b>Stakeholders Proposed Safeguard</b>	<b>Impact Committee Recommendation</b>
<p><b>ITEM 22:</b> The new ODOM executive team must define an effective Information Technology governance policy to support the organization's strategies using the following principles.</p>	<p>IT governance has emerged as a major area of improvement.</p>	<p>State agencies and local entities alike support the need for clear IT governance structures and protocols to be put in place at the outset.</p>	<p>It is essential to improve Information Technology governance and doing so will have positive impacts on all agencies. The Transition Plan should include steps and resources to put improved IT governance in place from ODOM'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.</p>
<p><b>ITEM 23:</b> To facilitate statewide health care IT initiatives, the Subcommittee recommends utilizing an existing group created by the Ohio Office of Information Technology (OIT), the Health care Community of Interest Group (COI) for Health and Human Services.</p>	<p>None identified</p>	<p>N/A</p>	<p>N/A</p>



## Appendix 8 – Community Recommendations Grouped By Subject

The recommendations provided in this Appendix were provided to the Council in the form of public testimony.

### **New Department Structure**

1. A single state agency must have the statutory authority, necessary resources through fiscal consolidation and adequate administrative and clinical staff to be responsible and accountable for the legal, uniform and efficient operation of the Medicaid program. Any restructuring of Medicaid into a separate state agency must include a level of functionality and knowledge of the various specialty health care components of the Medicaid program such as addiction and mental health services.
2. The management model must capitalize on the expertise of the various state agencies, their local counterparts, and people served by the system
3. We strongly believe that the sister agencies should maintain their status as part of the Governor's cabinet and not be rolled under the Department of Medicaid. While it is not clear as to the Council's intent, we encourage the Council to not opine on that matter as it appears outside of the legislative mandate and a decision point better left with Ohio's new Governor.
4. I believe that the new Department would not be best served for directly operating programs, because the current structure already supports this.
5. I can see the need for more focus on Medicaid that a separate agency might give. There could certainly be a benefit to more central strategic planning. Setting a direction and philosophy that helps the Departments do their jobs or creates efficiencies could be helpful. For example, we believe there is benefit to building on the community networks that are successfully in place, rather than trying to create new ones with each initiative or grant. More focused planning across Medicaid programs could help. However, we would hope that a new agency allows us to be even more creative in our approaches to long-term care in our communities. That means more than creating another government structure that has potential to make it harder to do business or make changes when necessary.
6. If Ohio creates a new Medicaid agency, individual departments that focus on the needs of specialized populations should be maintained. Taking away advocacy for those populations within state government would be detrimental in my opinion.



7. As you recall, our CDJFS offices perform financial eligibility determinations for Medicaid. Please make sure that our CDJFS offices do not have to answer to yet another state agency or have to grapple with receiving allocations and rules from more than one agency.
8. Training and technical assistance is critical to counties. Please be clear about where that training and technical assistance will reside at the state level. The
9. For that reason, OLMR members believe that there must continue to be a Cabinet-level State Agency devoted to the needs of this population. That agency must continue to have control over the state's residential centers, and over state funds designated for persons with mental retardation and developmental disabilities. OLMR does not support a unified budget that would force consumers to fight for Medicaid dollars which they themselves generate in the form of Medicaid reimbursement. Ohio history has shown us that when we merge some agencies, efficiency, transparency and access to service decrease.
10. CDJFS currently participate in Medicaid policy development given our face to face relationship with program participants. This input needs to be built into the new system.
11. The Department design is clear on accountability and oversight. It needs to be equally clear on technical assistance. Counties need clear policy and technical assistance to serve people better while achieving the compliance that auditors and monitors ensure.
12. The Department should include a strong provider relations function to prevent the CDJFS from getting caught between the Department and providers simply because the CDJFS is the local face and point of entry.
13. Must deal with problems concerning conflict of interest, and problems with the single state agency being able to carry out their role.
14. Role of the Single State Agency - Is it "delegation" or "abdication"?
15. Is it a lack of will or are they lacking essential tools?

### **Delegation to Sister Agencies**

1. A new state Medicaid agency must be very careful in delegating any Medicaid implementation and administrative responsibilities. In order to establish clear statewide authority and accountability for delegation, this policy responsibility must be established in state statute. The current system of delegation by ODJFS to ODMH and ODADAS, and in turn to over 50 county ADAMH Boards is costly, inefficient and lacking in clear accountability.



2. The management model must capitalize on the expertise of the various state agencies, their local counterparts, and people served by the system
3. Our first request is that whatever structure you ultimately recommend, please take care to ensure that it does not result in the creation of a duplicate public behavioral health system, one for Medicaid and one for non-Medicaid. Since some consumers move in and out of the Medicaid system, there needs to be the guarantee of an integrated public system. To do otherwise would create huge gaps in services and would be a real disservice to Ohioans with behavioral health disorders.
4. We suggest that the new agency focus on strategic direction and policy, leaving specific program administration to the sister agencies – including the Department of Job & Family Services – and the local governmental entities that currently bear that responsibility. By not directly administering specific programs, the new agency would be in an optimum position to set direction, develop policy and carry out due process in a fair and impartial manner. Those factors should be strongly considered and discussed before the Council makes final recommendations regarding the new agency.
5. From my understanding of the recommendations, the new Medicaid management agency might be structured as to provide managerial support, including information technology, to Medicaid programs. This could lead each individual department to its own proficiencies.
6. The Aging network works to make our system as seamless as possible through collaboration with ODA on rules, policies and practice and it requires expertise on both levels. We would be concerned if a Medicaid Department interrupted the well-developed billing, data collection and quality improvement measures in place. For example, my organization monitors 150 agencies and quality improvement is very important to us. We have coordinated PASSPORT quality improvement activities, with the oversight of other state, federal and local funds. Often the same local agencies are providing the services across funding sources. We have contracts from local levy organizations to monitor their services while we are out monitoring PASSPORT services. This achieves an efficiency and focus on quality improvement that we would be concerned about disrupting.
7. We support the operations of the Developmental Centers (DCs) remaining in ODMR/DD and feel strongly that fiscal responsibility and oversight for these centers should remain there as well.
8. The entire function of eligibility should be delegated to ODJFS, including working with CDJFS on procedures and systems to support eligibility functions.
9. The delegation process should clearly define roles and allow the delegated agency to define its functions and procedures without having to come back constantly to the



Medicaid Department for approval. Every effort should be taken to avoid local agencies serving two masters, with different rules and regulations.

10. Since the HMO's would be dealing with the Medicaid Department and CDJFS' would be dealing with ODJFS, there needs to be clear policy on the responsibilities of each system.
11. Aging's existing system is working amazingly well, holding costs down and satisfying clients. I am here to urge you to take great care not to undermine what works well unless you can be close to certain the change will be better.
12. Maintain the system that the Ohio Department of Aging and its Network already have in place for assuring that the State serves older adults properly.
13. Must deal with problems concerning conflict of interest, and problems with the single state agency being able to carry out their role.
14. "A state plan must specify a single State agency established or designated to administer or supervise the administration of the plan. That agency must have legal authority to administer or supervise the administration of the plan and make rules and regulations that it follows in administering the plan or that are binding upon local agencies that administer the plan. In order for an agency to qualify as the Medicaid agency, it must not delegate, to other than its own officials, authority to exercise administrative discretion in the administration or supervision of the plan, or issue policies, rules and regulations on program matters. The authority of the Medicaid agency must not be impaired if any of its rules, regulations, or decisions are subject to review, clearance, or similar action by other offices or agencies of the state. If other state or local agencies or offices perform services for the Medicaid agency, they must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment for that of the Medicaid agency with respect to the applications of policies, rules and regulations issues by the Medicaid agency."
15. Role of the Single State Agency - Is it "delegation" or "abdication"?
16. Is it a lack of will or are they lacking essential tools?
17. Current and future recommendations regarding the new Medicaid agency must be formulated to ensure that ODMR/DD budgets and delegated authority is not disrupted.
18. Must maintain Medicaid expertise in ODMR/DD
19. The Council should more clearly define the "delegation arrangement" of the new Medicaid agency outlined by the work of the New Department Sub-Committee



20. ODMR/DD and county boards must maintain the ability to manage specific service provisions
21. Strongly recommends that ODMR/DD maintain operational control of its licensure and quality assurance functions, including residential facility licensing, provider certification and compliance, incident investigation, and the Abuser Registry, in order to ensure the health and safety of the individuals served.

### **Policy Recommendations beyond Scope of Council Mandate**

1. Given the pressure on the state budget of the continued growth in Medicaid expenditures, we support the implementation of service utilization and compliance standards and tools that enhance the state's ability to effectively manage the program. However, this must be done by a single entity with clear standards that are efficiently and uniformly applied in an accountable manner. As the examples in #2 demonstrate, delegating this critical function to multiple other state agencies and political subdivisions is unnecessary, inefficient and administratively costly.
2. We do not support any type of limitation on any willing provider in the behavioral health system. This system is already facing the threat of serious erosion of core clinical capacity and increasingly difficult access to services. Also, the system's focus on "consumer-driven" health care and "consumer empowerment" are not supported by limiting consumer choice of providers.
3. Third, we ask that you include a strong recommendation that the individuals appointed to leadership positions in the Department are supportive of providing local Boards the tools they need to manage the Medicaid system. Specifically, behavioral health Boards need to know that someone will be at the helm that is willing to work with us to put the tools in place that we need to make our system of behavioral health care one of the best in the nation.
4. One tool that Boards have been requesting for years, and which would go a long way toward helping to control Medicaid costs, is utilization review. Under this process, Boards would be able to review the services that are delivered to ensure that they are provided in the proper amount, duration and intensity to address the client's presenting problem or problems. This is a standard tool that ODJFS itself already utilizes to ensure that providers are using Medicaid properly for health care. Boards unfortunately, do not have the same authority to monitor Medicaid usage for behavioral health care. A general consequence for non-compliance in Medicaid health care is denial of the claim for the period in which the service was not delivered, according to the established criteria. The same could be, and should be implemented for behavioral health care.
5. Another tool we need is the ability to select Medicaid providers to serve our respective Board areas.



6. However, there are operational concerns that impact the quality of care that must be addressed. We need a plan for the future to update or modernize state policy regarding ICF/MRs. This includes the need to address the current reimbursement situation, and the incentives/disincentives that exist.

### **Information Technology**

1. Medicaid should use the latest technology and electronic capabilities to streamline the eligibility determination, enrollment and payment system between the single state agency and Medicaid providers so that it is consistent statewide. The current MACSIS payment system, built on a 1980's technology platform, is burdened by unnecessary governmental administrative layers and "business rules" (they are not Ohio Administrative Code rules) that are variable around the state. This system as currently implemented does not meet all Medicaid and HIPAA requirements.
2. There is still concern at the county level about the computer systems under development and timing issues. The MITS and BEN systems are both already in process, impacting significantly the choices available for a new Department. The timelines for these new systems are projected to be 2008 and 2010. Additionally, a new Governor and the next General Assembly will be in play, along with a statutory cap on spending. Together, these factors make the implementation date of July 1, 2007 seem precarious if the transition is to avoid unintended consequences to Ohio's Medicaid recipients.
3. Continue to procure MITS via the current RFP procurement
4. Move the DSS component of the DW to new Department
5. Asks that report recommends leaving DW in ODJFS until such time that OIT has sufficient resources to transition the DW to OIT in order to assure a smooth transition and that data remains continually available
6. Need to include in Council recommendations sufficient resources and funding necessary to make information technology a top priority in the new Medicaid agency
7. Controls and turn-around for data sharing data warehouse information must be in place at initial set-up.

### **Local Funding/Local Administration**

1. The current state/local Medicaid matching structure for federal financial participation is increasingly untenable. Consideration should be given to placing this Medicaid match responsibility at the state level since Medicaid is a federal-state program and a key component of Ohio's health care system. County behavioral health tax levy funds would



then be available to meet the increasing behavioral health needs of Ohio consumers who are not Medicaid eligible and who have little or no health insurance. This is particularly important in a system where state funding support for community addiction treatment and mental health services has not fared well over the past 10 years.

2. Recently, the Study Council accepted a proposal to establish a rotary account whereby local boards would send their local funds to the state to cover their cost of Medicaid match. When we first learned about the proposal, we had many concerns. We have since had the opportunity to sit down with representatives from OBM who have helped us to understand that the intent of the proposal is to improve transparency in the Medicaid payment system. We certainly support transparency; however, we continue to have concerns related to cash flow, ensuring Boards maintain control over local planning processes, restrictive ballot language, loss of match for non-governmental funds and the potential loss of interest to local County budgets. We have been assured by the Director of OBM that we will continue to meet to determine if these issues can be resolved.
3. We believe funding for the MRDD service delivery system is a multi-pronged partnership comprised of Ohio's 88 County Boards of MRDD, the State of Ohio (i.e., the Department of MRDD and the State Medicaid Agency) and the United States Government (i.e., the Centers for Medicare & Medicaid Services). If the structure of a new Department of Medicaid recognizes and values that partnership, then we should expect positive outcomes for individuals.
4. Be very mindful of preserving local decision making and planning to ensure the best possible environment to pass local levies which are so critical to overall services for the populations being served.
5. CCAO is concerned with a proposal brought forth by the LTC Budget Committee that recommends depositing non-GRF local funds into a rotary fund for Medicaid match. There are significant implications that could exist for counties. We have met with OBM to discuss these implications and OBM has agreed to convene a group to see if we can find common ground.
6. OLMR believes that the Council's report should include some recommendations that encourage the County Board system in Ohio to look at new ways of combining administrative efforts through the existing COGS or by reducing and sharing administrative personnel. In one county, the county board administration cost per person served is \$400 higher than the direct care cost per person served. Because so much of the MRDD Medicaid system in Ohio is directly linked to County MRDD Board generated money and administration, the Council should consider recommendations for changes in statute that would ensure that more of each Medicaid dollar is spent on direct care-not administrative costs at the Board level.



7. Ohio's locally managed system has many positive attributes. However, we have lost significant federal funds in recent years that have not been replaced; because of non-compliance with federal Medicaid requirements. We do not want an Achilles Heel to jeopardize our entire system.
8. Issue #1 Public Provider as System Manager = Conflict of Interest
9. Significant safeguards will be needed if local levy funding being used to pay for Medicaid s
10. More specific information needs to be developed in the Council's recommendations insuring the protection of local dollars by rotary funds and that each dollar is determined by the needs of the county.
11. Local dollars should be reconciled and returned to each county if the dollars are not utilized within a specific time period (two years)
12. Do not "re-appropriate" matching funds from local mental health authorities since a) claims accountability already exists; b) the change could prompt a costly and disruptive shift back to the state for both community Medicaid and institutional costs, with major impact on the quality and continuity of care, and the safety of clients and communities.

## **Transition**

1. We also ask that you take every precaution to ensure that the creation of a new Department does not result in a disruption in services or clients getting lost in the system. Throughout this process, we all need to be careful not to get so caught up in system design and program administration issues that we lose sight of the people we are here to help.
2. There is still concern at the county level about the computer systems under development and timing issues. The MITS and BEN systems are both already in process, impacting significantly the choices available for a new Department. The timelines for these new systems are projected to be 2008 and 2010. Additionally, a new Governor and the next General Assembly will be in play, along with a statutory cap on spending. Together, these factors make the implementation date of July 1, 2007 seem precarious if the transition is to avoid unintended consequences to Ohio's Medicaid recipients.
3. The Council must insure that the recommendations they make do not increase the administrative costs of Medicaid, either on a temporary or permanent basis. The Council recommendations must insure that the maximum amount of each Medicaid dollar can actually be spent on services. Consumers simply cannot allow more of their Medicaid dollar to be spent on administrative costs at any level of government-state or county.



4. OLMR believes that much more work must be done before any conclusion can be drawn or recommendations made regarding the streamlining of Medicaid administration. It is far better to continue the investigative work of this Council to be certain that every question has been answered, not only to the Council's satisfaction, but to the satisfaction of every Ohio consumer, than to recommend creating a new state agency that may not meet the needs of the Medicaid consumer.
5. On top of that, increased administrative costs on the front end of the creation of a new agency could create budget tightening elsewhere.
6. A lot of coordinated work will have to be done by a large number of people, making an implementation date of July 1, 2007 unrealistic. July 1 of 1998 might be a realistic timeframe to have basics in place, but the design envisioned by the Council will require a lot more time.
7. Build additional space into the timeframe so that the new Governor can solidify his plans in this area, identify staff for the transition, reflect his plan in the SFY08/09 budget documents, etc.
8. The work of keeping vital programs running while a new administration sorts through and realigns state structures will be a major priority. To allow the structural changes undertaken to work, we propose limiting the number of additional and unrelated policy changes undertaken throughout the transition period.
9. Many more specific of infrastructure design need to be defined before ODJFS can evaluate and plan a course of action, including mitigation recommendations. To better understand and plan for staffing and support for what will be two departments, we will need to have very specific information about HR, Fiscal, IT and other issues.
10. Recommend not that Council provides this detail, but that Council understands and provides for means to make those fundamental decisions
11. Include all affected parties in these discussions
12. In order to mitigate possible delays or missteps, detailed decisions should be done by individuals who understand the federal and state requirements for both departmental structures
13. Creating a new Department of Medicaid and maintaining a functional ODJFS will have a monetary cost, at least in the short run
14. Mitigating strategies should look more globally at what types of governmental reorganization would be necessary to avoid cost duplication while assuring the delivery of effective and efficient services to eligible Ohioans



15. Recommend entrusting to the new executive team task of crafting optimal service delivery mechanisms and the operational details of for achieving the Council's general guidance on desired structure and outcomes
16. Actions that would significantly affect local systems should be avoided at this time.
17. Set reasonable timetables for the transition of Medicaid into a new Department
18. Create a managerially sound structure/process for managing the transition, not one that can be thwarted by split responsibility
19. Defer potentially destabilizing actions regarding the distinct waiver and benefit programs that impact on local governments until the new Department is up and running

### **Long Term Care Budget**

1. Our care management system could be improved with the concept of a unified budget with money following the person. A new Medicaid agency should make that their goal.
2. We also have concerns with respect to a unified long-term care budget.
3. We have concerns that unified budgeting would make this way of budgeting "standard operating procedure." We fear that a unified budget would operate like block granting and put us in a position of having to justify our existence, no matter what the economic forecast is.
4. Safeguard needed to make sure operation of developmental centers is not withdrawn from ODMR/DD which would disrupt local cooperative relationships
5. Current and future recommendations regarding the new Medicaid agency must be formulated to ensure that ODMR/DD budgets and delegated authority is not disrupted.



## APPENDIX 9 – Transition Plan Details

The transition from the current department structure within ODJFS to a newly created ODOM that will meet the minimal readiness needs will require an approach comprised of the following three phases:

**Phase 1** will be the planning phase that will begin immediately after the completion of the pre-phase 1 work and will focus on finalizing the design of the new Department of Medicaid. This phase includes all planning efforts for the new department such as finalizing and submitting the statute for establishing the Department of Medicaid, determining minimal organizational and operating requirements for the Department of Medicaid, and obtaining statutory approval of the new department. It is also envisioned that the initial hiring of the Director of Medicaid and the executive team will happen during this phase and within the current department funding framework of ODJFS.

**Phase 2** is the development segment of the transition process for ODOM. During this phase, the new department will be built to meet the minimum requirements necessary to support the department within the existing department funding structure. This includes initiating the hiring of personnel. The end of this phase is the receipt of the federal approval of the new department.

**Phase 3** is the primary implementation segment of the transition for the ODOM. At the beginning of this phase, the funds are shifted from the ODJFS budget to the new department's independently funded budget and a new department that is ready to support the minimal required operational tasks is initiated. Phase 3 also involves transitioning over time, all functions that will be supported by the new department.

Each of the transition plan phases is discussed in the sections below.

### Phase 1

The focus of Phase 1 is on planning, including activities that define the key tasks in transition, identify the responsible parties, establish sequences and timeframes, and document interdependencies, risks and contingency plans. The key milestones that occur early in this phase include establishing and empowering the transition team and initiating the detailed transition planning process to be led by the transition team with close involvement by other key stakeholders such as ODJFS.

In addition, the development of the statutory and critical legal documents (examples include contracts and Service Level Agreements) is a key task that should be completed in this phase. Phase 1 is heavily reliant on resources from other areas of the State of Ohio such as ODJFS, Legislative Service Committee (LSC), and Department of Administrative Services (DAS).



### **Key Tasks Prior to the Initiation of Phase 1**

The primary tasks that need to be completed before this phase can begin include:

- a) Submission of a final report to the Governor elect and the Legislature.
- b) Finalization of the decision by Governor elect and Legislature on the direction of the new department creation.
- c) Creation of additional funding for the transition team and activities.

### **Phase 1 Milestones**

The key milestones in Phase 1 provide the framework for final design and steps to fully transition the Department of Medicaid. These milestones include:

- a) Establish and empower the transition team.
- b) Determine minimal requirements for establishment of the Department of Medicaid (readiness checklist).
- c) Determine sources of required funding for resources and expenses (either through the existing departments or appointed from the Legislature).
- d) Ensure continuity of service for those impacted by Medicaid (employees, recipients and providers). Draft, finalize, and receive signature on contracts to provide required goods and services received from other departments, agencies, and third parties.
- e) Focus significantly on the continuation of the current Information Technology projects (especially Medicaid Information System (MITS), Ohio Administrative Knowledge System (OAKS), Decision Support System (DSS), and the data warehouse)
- f) Initiate the federal approval process of the new department.
- g) Initiate and obtain statutory approval for the establishment of a new Department of Medicaid.
- h) Conduct a thorough summary review of current activities and key initiatives both as delivered by affiliated organizations and entities as well as vendors. Inventory key vendors and external organization contracts and relationships.
- i) Develop a detailed Human Resource Plan.
- j) Develop a Communications Plan.
- k) Draft a Transition Project Plan and associated sub-workplans that incorporates all tasks required in transition.
- l) Staff the director of Medicaid and the executive team by the end of the phase.

### **Detailed Tasks to be Accomplished in Phase 1**

Phase 1 concentrates on transition and department planning. In this phase, the various departments, agencies and third party suppliers will need to work in a coordinated effort to provide a cohesive plan. The major tasks are:



a) *ESTABLISH TRANSITION TEAM*

Prior to commencement of the ODOM implementation, the State must establish a transition team responsible for developing the transition project plan, and driving the process. The transition team should be comprised of individuals with specific subject matter expertise. It is envisioned that the transition team would be chaired by the new Director of the Department of Medicaid. The tenure of the transition team will end with the establishment the executive team for the new department. High-level tasks for the establishment of the Transition Team include:

1. Define the team's role and responsibilities.
2. Select and appoint the transition team leader.
3. Identify the skill sets for the transition team members.
4. Develop a team scope and charter.
5. Identify and define the team's authority for interaction with other departments, agencies, and agents.
6. Select and appoint the non-executive team members.
7. Develop a transition project plan including milestones.
8. Assist in developing a transition team for ODJFS.
9. Ensure ODJFS transition plan development is in alignment with ODOM planning.

b) *HUMAN RESOURCES PLAN*

To support the transition it is important that the Transition Team develop a detailed Human Resources Plan. This plan should provide for the creation of all new positions needed for the new ODOM as well as provide for the transition of any exiting ODJFS and other agency personnel who will ultimately reside in the new ODOM. High level tasks for development of the Human Resources Plan include:

1. Partner with the DAS and all appropriate departments and sources including coordinating bodies such as Steering Committees (examples being organizations that represent unions or other involved entities).
2. Determine approvals necessary for the new Human Resources Plan.
3. Obtain approval for outside resources to assist with the Human Resource plan development.
4. Consider hiring consultants or external expertise to assist with organizational design and change management.
5. Identify all current staff doing Medicaid work (internal and external).
6. Create any newly required job classifications.
7. Identify personnel rules affecting workforce changes.
8. Ensure plan encompasses all ODJFS current personnel and determines who is transitioning to ODOM.
9. Address transitioned, additional and newly designed positions that require specialized expertise such as aged, blind and disabled or specific IT skills. Leverage expertise from departments and sister agencies where warranted.



10. Staff key areas such as the Department Director, the Chief Strategy Officer (CSO), the Chief Medical Officer (CMO), the Chief Information Officer (CIO), the Decision Support System (DSS) team, and other executive positions.
11. Staff key areas within current departments but with the new mid-level design organization. Use current department funding and level job positions and levels.
12. Address and create incentive programs as needed in order to retain key personnel through transition.
13. Work with ODJFS and DAS to target additional hiring due to lost functionality in ODJFS or to provide adequate staffing for new department.
14. Obtain approval of the Human Resource plan and monitoring by the Transition team.
15. Work closely with the finance and budgeting staff to ensure that the budget reflects decisions and changes being finalized in this phase.
16. Obtain necessary approvals for Human Resources plan.

c) *COMMUNICATION PLAN*

The development of a Communication Plan ensures proactive and comprehensive communication of the intent and direction of the transition and it supports the integrity and progress of the transition process. The Communications plan should be established early and should provide detailed communication strategies for each of the constituent groups that will be impacted by the implementation, including employees, Medicaid beneficiaries, providers, the Legislature, the Governor's office, and other State departments and agencies. High level tasks for the Communication Plan include:

1. Develop the Phase 1 communication strategy for each major constituency.
2. Determine approvals necessary for the Communications Plan.
3. Identify strategic messages, methods and tools that will be used in the implementation of the Communication plan.
4. Determine the ongoing communication method for all phases.
5. Develop the Phase 2 communication strategy.

d) *FUNDING*

The OMASC currently has funding which has been appropriated to the organization to support the design activities in Pre-Phase 1. Some of the funds remaining can be used in the transition. Additional funds will be required to support key activities in the transition phase and these requirements are described at a high level in the Transition Budget section of this report. In addition to funding for planning activities, funding for the existing general Medicaid department functions will need to be finalized and incorporated into the budget and funding planning for the new organization. Funding activities must also take into account all state and local agencies including the handling of rotary accounting and the ability to obtain federally matched funds. High level tasks for funding include:



1. Study local administrative costs including administration of delegated arrangements.
2. Determine how the organization is going to use current OMASC funding.
3. Determine additional transition funding that will be needed.
4. Develop Phase 1, Phase 2, and Phase 3 budgets.
5. Receive approval for Phase budgets.
6. Determine a cost allocation method.
7. Receive approval of the cost allocation method and results.
8. Provide processes and procedures for state agencies to submit annual financing plans to ODOM.
9. Develop an understanding of the community planning process.
10. Incorporate consultation from state agencies, local entities per community planning process:
  - a. Draft new procedure for annual financing plan submission.
  - b. Incorporate accounting and audit standards into the procedure.
  - c. Incorporate mechanism for return of unused funds.
  - d. Ensure annual financing submission incorporated into interagency agreement.

*e) FEDERAL APPROVAL*

Federal approval of all planning initiatives and budgets must be obtained in order for the new department to be created and staffed. Submission of this paperwork must be completed in Phase 1 in order to receive approval by Phase 2. High level tasks for federal approval include:

1. Development and submission of a concept paper to the federal government to provide background information on the proposed formation of the new department.
2. Completion and submission of Change Designation form.
3. Receive and incorporate feedback from the federal government (CMS).

*f) STATUTORY APPROVAL*

Statutory approval of all planning and budgets must be obtained in order for the new department to be created. Statutory approval is achieved during Phase 1. High level tasks for statutory approval include:

1. Develop and finalize a statute to establish and give authority to ODOM using the resources of appropriate partners such as the Office of Budget and Management (OBM), LSC, ODJFS and DAS.
2. Obtain approval of the proposed statute language from the Transition team.
3. Obtain approval of the proposed statute language from key stakeholders (OBM, ODJFS, and other involved organizations.).
4. Submit the proposed statute to the Governor's office.
5. Submit the draft statute to the House and Committee.



6. Introduction and approval of the statute to and by the House and Finance and Appropriations Committee.
7. Introduction and approval of the statute to and by the Senate and Finance and Appropriations Committee.
8. Review, approval and submission of the statute by the Conference Committee.
9. Obtain the signature of the statute by the Governor.

g) *CONTRACTS AND SERVICE LEVEL AGREEMENTS*

In order to provide continuity of service, all existing contracts, software licenses, leased equipment, and other agreements that are needed to render Medicaid services must be identified and evaluated. In addition, any services that will continue to be rendered in ODJFS or other agencies after ODOM is created need to have service level agreements created for these services. High level tasks related to contract identification and evaluation and establishment of service level agreements include:

1. Determine what equipment is owned or leased through Medicaid funds.
2. Identify current licenses and software applications that are being used.
3. Review and inventory current maintenance agreements for equipment and software.
4. Identify and inventory contractors who are currently being used.
5. Review existing employee core services, determine the services that are required, the source of these services and identify where there are services that are shared by Medicaid and by other non-Medicaid state functions.
6. Review existing Service Level Agreements (SLAs)/contracts and determine what additional SLAs/contracts are needed.
7. Amend SLAs and contracts to meet the new department mission and activities for Phase 2.
8. Develop a readiness list for ODOM and minimum requirements for department creation. Include the following in this readiness list:
  - a. Ensure continuity of services for all Medicaid recipients including Medicaid enrollment, claim adjudication and payment.
  - b. Human Resources: Review services and implement a mechanism for continuity (i.e. forms, benefits, building access, ID cards).
  - c. Finance: Review services and implement mechanisms for continuity (such as bill generation, employee payroll maintenance, claims payment, general ledger software and systems).
  - d. Procurement: Review services and implement mechanisms for continuity. Ensure services such as: office supplies, office equipment (fax, mail equipment, copiers, and printers), printing services (letterhead, envelopes, forms, warehousing, and business cards), direct mailing, fleet services (if appropriate), human resources (temporary services, consultants, recruiting), shipping services (air/ground, local courier), travel services, corporate credit card services are addressed and maintained.



- e. Facilities: Review services and implement mechanisms for continuity. Ensure the following services are available: furniture/fixtures, space moves/relocations, telephones, capital projects, conference rooms/equipment, mailroom services, record storage (meets regulatory requirements), building services, and security.
- f. Information Technology: Review services and implement mechanisms for continuity such as: Mainframe and hardware, servers, telecommunications (phones, long distance, laptop connections, VAN/VPN, teleconference equipment), cell phones, blackberries, pagers, wireless cards, personal computers (desktop hardware, desktop software, configuration, pc disposal, etc.), technology equipment, application/software, switches and routers.
- g. Maintenance and Support: Review services and implement mechanisms for continuity of services such as the help desk, application assistance, personal computers, mainframes and other systems architecture requirements.
- h. Develop, negotiate, and finalize amendments to existing contracts and SLAs with appropriate partners including OBM, LSC, ODJFS, OIT, and DAS, agencies, third party vendors and start developing and negotiating agreements for the new department.
  - i. Engage CMS to verify appropriate delegation.
  - ii. Encompass the single state authority in agreements.
  - iii. Ensure clarification, recalibration and accountability of work in SLAs and contracts including performance metrics and monitoring activities.
  - iv. Incorporate IT governance into newly drafted SLAs and contracts and amendments.
  - v. Obtain feedback from the transition team and key stakeholders and incorporate as warranted.
  - vi. Obtain relevant signatures on the SLAs.

*h) PLAN FOR CONTINUITY OF INFORMATION TECHNOLOGY PROJECTS*

In order to provide continuity of service, ODOM should create a plan to participate in and where appropriate, lead the governance and management of information technology projects that are of vital interest to ODOM and are currently managed by other agencies such as ODJFS. Due to the long lead times and substantial resource investments in many of these projects, it is important that the transition to ODOM not disrupt existing projects. High level tasks for this planning include:

1. Review systems and determine methods for securing data for department employees or designated agents.
2. Identify IT projects that are funded, but not started or completed.
3. Inventory and determine desired involvement with the implementation of IT projects.



4. Develop a list of inherited IT projects.
5. Develop a list of ongoing IT projects.
6. Lead the implementation of MITS.
7. Appoint a leader of the transition team as the executive sponsor of MITS.
8. Task the transition team with verifying the documentation and assertions of suitability of MITS for ODOM.
9. Implement mechanisms for validating that MITS requirements align with ODOM needs.
10. Involve and communicate to state agencies and local representatives, status and decisions in MITS implementation.
11. Communicate with major vendors on the MITS implementation (within appropriate procurement laws).
12. Ensure that the MMIS system maintains stability until the MITS implementation is finalized.
13. Review MITS architecture strategy and incorporate in emerging ODOM architecture.
14. Establish, finalize and maintain the MITS implementation project plan.
15. Participate and ensure OAKs project meets ODOM requirements.
16. Determine the data warehouse governance and management based on the State Medicaid, health and human services needs.
17. Act as the primary business owner for the in-progress DSS/DW RFP

### **Potential Operational Impact of Phase 1**

The focus on Phase 1 is on finalizing planning. Given that focus there is limited direct impact on operations. However, understanding and reviewing operations is a critical task in Phase 1 in order to determine the future impact of the transition. Phase 1 should include development of a comprehensive risk assessment and contingency plan that includes early alerts of operational concerns and addresses those concerns so as to maintain continuity of service and operations.

### **Phase 2**

Phase 2 is the development component of the transition process for ODOM. This phase is dependent upon statutory approval of the new department and the initial submission of the documentation supporting the new department to the federal government for approval. The federal approval step and the formal creation of the new department will occur at the end of this phase.

The role of the transition team will be concluded during Phase 2 once the executive team is hired. The execution of the detailed Human Resource (HR) plan will be a core activity during this phase. Another goal of Phase 2 will be to build the initial ODOM department by hiring critical staff members and ensuring the primary readiness functions will be available when final federal approval is received. These staff members will reside within the current department (ODJFS) until the end of this phase when federal approval for the new department is received.



At that point, the staff and related functions will be transferred to the new Ohio Department of Medicaid.

### **Key Tasks Prior to the Initiation of Phase 2**

The critical tasks that must occur before this phase can begin are:

- a) Submit and obtain approval of the statute to establish the Department of Medicaid.
- b) Present the business case and plans for the new department to the federal government to begin approval process of the new department.
- c) Hire the new director and executive team.
- d) Finalize agreements with other departments, state agencies and third party vendors to continue required services.

### **Phase 2 Milestones**

The tasks to be completed during the development phase will create the initial Department of Medicaid. These tasks include:

- a) Implement a detailed HR plan and hire personnel within the current departments to be integrated into the new organization.
- b) Initiate the execution of the policies and procedures for the new department.
- c) Receive federal approval for the new department, designating the completion of this phase.

### **Detailed Tasks to be Accomplished During Phase 2**

The tasks to be included in this phase include:

#### ***a) INITIATE IMPLEMENTATION OF THE HR PLAN***

In Phase 1, a detailed HR plan was developed and approved. During Phase 2, ODOM will begin implementing this plan. The tasks involved in the implementation of the plan include hiring new staff and transitioning existing ODJFS Medicaid staff into the new mid level design. However, the staff positions will remain in ODJFS during this phase. High level tasks for the execution of the HR plan include:

1. Partner with DAS staff on planning and implementation.
2. Hire and transition staff within OHP to the new mid-level organizational design to meet minimum readiness requirements; Utilize current job levels and descriptions where appropriate.
3. Recruit and hire new staff with appropriate skill sets to focus on initial needs such as Strategy, Medical and Information Technology.



b) *INITIATE IMPLEMENTATION OF THE ODOM AND ODJFS TRANSITION PLANS*  
During Phase 2, the detailed Transition Plans for ODOM and ODJFS, developed and approved during Phase 1, will be implemented.

c) *COMMUNICATION PLAN*

In Phase 1, a detailed Communication Plan was developed and approved. This plan documents the communication processes to all constituent groups that will be impacted by the implementation, including employees, Medicaid beneficiaries, providers, the Ohio State Legislature, the Governor's office, and other State departments and agencies. During this phase, the Communication Plan should be fully implemented. In addition to the tasks previously described, the following communication steps should also be taken during Phase 2:

1. Refine and implement the Communication Plan.
2. Review web and information technology requirements (add a new website if required for the Medicaid Department).
3. Aggregate channels of communication and obtain the data necessary for implementation (such as phone numbers used by enrollees and physicians).

d) *FUNDING*

In Phase 1, high level funding issues were discussed. During Phase 2, additional activities related to funding are necessary. These high level tasks include:

1. Refine agency funding development and approval including the following topics:
  - a. Meet with state agencies to review new procedures.
  - b. Submit annual financing plan by state agencies to ODOM.
  - c. Ensure plan identifies by county or board area the amount and source of state subsidy or local levity which will be paid into the rotary fund.
  - d. Ensure financing plan enables ODOM to obtain matching Federal Medicaid public funds.
  - e. Review for compliance and reconciliation of rotary funds.
  - f. Approve annual financing plans.
  - g. Return unused rotary funds to local entity.
2. Develop and obtain approval of the ODOM budget.
3. Develop and obtain approval of the Phase 3 budget.

e) *FEDERAL APPROVAL*

One of the main goals of Phase 2 is to achieve federal approval for the new Ohio Department of Medicaid. High level tasks for Federal Approval include:

1. Work with Centers for Medicare and Medicaid Services (CMS) to obtain feedback and issue responses from the initial documents.
2. Completion and submission of a Change Designation form
3. Formal approval of the Ohio Department of Medicaid by CMS.



f) *CONTRACTS AND SERVICE LEVEL AGREEMENTS (SLA)*

In Phase 2, the contracts and SLAs will be refined, negotiated and finalized. The contracts and SLAs need to ensure continuity of service; therefore, they need to account for all services required in the readiness checklist. Once federal approval is received for the creation of this department, these documents will need to be signed by the appropriate parties at the end of this phase. Additional high level tasks for the contracts and service level agreements include:

1. Develop and finalize readiness checklist for goods and services for the department.
2. Finalize language and negotiation of contracts and SLAs.
3. Obtain approval from key stakeholders.
4. Obtain approval from the executive team and director.
5. Obtain the appropriate signatures after department approval.

g) *PLAN FOR GOVERNANCE AND CONTINUITY OF INFORMATION TECHNOLOGY PROJECTS*

The new Department of Medicaid must have an effective governance process and must be able to seamlessly continue the inherited and new requests required by the business to meet their goals. The high level tasks for Information Technology projects include:

1. Continue to participate in and implement agreed upon Information Technology projects.
2. Initiate Governance structure developed in Phase 1.
3. Refine and continue development of Governance Policies and Procedures.
4. Review and enact Governance Policies and Procedures.
5. Review the new and inherited projects and determine the priority utilizing the Governance structure.
6. Continue to execute the service requests/projects. This includes:
  - a. MITS: Continue the implementation process.
  - b. OAKs: Work to ensure required outcome.
  - c. Data warehouse: Continue the review and implementation process.
7. Act as the primary business owner for the in-progress DSS/DW RFP.
8. Complete methods for securing data for new department employees or designated agents.

h) *POLICY AND PROCEDURES*

The new Department of Medicaid must have policies and procedures in place that will ensure continuity for all goods and services. The high level tasks for the policies and procedures are:



1. Review and adjust current policies as well as communicate changes to appropriate parties.
2. Develop Disaster Plan for ODOM based on current department plans.
3. Develop ODOM Fraud Program from current ODJFS program.
4. Begin enacting policies and procedures for new hires to ODJFS for ODOM (i.e. DSS Data Analysis).

### **Potential Operational Impact of Phase 2**

Phase 2 has significant operational impact. This phase is focused on ensuring continuity of service while creating the basic mid level structure of the new department within ODJFS. In Phase 1, new critical staff was hired within ODJFS for the new department. In this phase, new organizational structures and policies and procedures will be applied and the transition of existing ODJFS Medicaid staff will be implemented. The impact in this phase will be felt by existing ODJFS staff as well as by newly hired staff. Funding is important and must be approved for this phase to occur.

### **Phase 3**

The actual implementation of the transition for the Ohio Department of Medicaid will be done in Phase 3. After receiving federal approval for the new department at the end of Phase 2, Phase 3 will designate the creation of the new Ohio Department of Medicaid. It is critical in Phase 3 that the department is ready to support the minimally required operational tasks and has agreements in place for the full continuity of service. In Phase 3, the existing departments will shift from ODJFS to ODOM.

### **Key Tasks Prior to the Initiation of Phase 3**

The following tasks need to be completed before this phase can begin:

- a) Initiate the project plans (ODJFS and ODOM).
- b) Activate contracts and SLAs that ensure continuity of service.
- c) Enact initial policies and procedures.
- d) Approve funding for the new department.
- e) Receive federal approval for the new department.

### **Phase 3 Milestones**

The development of the Transition Plan will define the key milestones for this phase. The milestones should include a functioning Department of Medicaid, the finalizing of services to be performed by other parties and those to be done by the new department, the implementation of the Information Technology applications (such as MITS, OAKS, DSS), a functioning Governance structure, and monitoring performance to ensure continuity of service and an effective department.



### **Detailed Tasks to be accomplished in Phase 3**

The tasks for this phase will be determined with the definition of the detailed transition and project plan developed in Phase 1.

### **Potential Operational Impact of Phase 3**

At the beginning of Phase 3, the new department is functioning as a separate entity. Phase 3 is the final transitioning phase. The operational impact for Phase 3 is critical. This phase involves evaluating all aspects of the department over time and implementing short and long term solutions. Initially, several of the operational components will be handled by Service Level Agreements with ODJFS and other agencies. These tasks may be performed within ODOM at a later point in this phase. A key task will be determining the point for services to be obtained in the future. This phase may be several years depending on the functional area.



## Appendix 10 – Principles for the Chief Information Officer

- 1. Recognize the Role of Information Management in Creating Value**
  - a. The ODOM Information management organizational functions and processes are incorporated into the overall business process.
  - b. Mechanisms and structures are adopted that facilitate an understanding of information management and its impact on the organization's overall strategic direction.
  
- 2. Position the CIO for Success**
  - a. The CIO model is consistent with organizational and business needs and the position is empowered and accountable for the strategic direction of the division.
  - b. The roles, responsibilities, and accountabilities of the CIO position are clearly defined.
  - c. The CIO has the appropriate technical and management skills to meet business needs and has the ability to work within the state government environment.
  - d. The CIO is on the ODOM executive management team and is a full participant on all strategic planning and major initiatives.
  
- 3. Ensure the Credibility of the CIO Organization<sup>21</sup>**
  - a. The CIO has a legitimate and influential role in leading top managers to apply information management to meet business objectives.
  - b. The CIO has the commitment of line management and its cooperation and trust in carrying out projects and initiatives.
  - c. The CIO accomplishes quick, high-impact, and visible successes in balance with longer term strategies.
  - d. The CIO learns from and partners with other successful state agency CIO's and information managers external to the state.
  
- 4. Measure Success and Demonstrate Results**
  - a. Managers take responsibility for the success of the complete business process that their systems support and are active participants in developing these processes with the other ODOM divisions.
  - b. Managers engage both their internal and external partners and customers when defining measures.
  - c. Management at all levels ensures that technical measures are balanced with business measures.
  - d. Managers continually work at establishing active feedback between performance measures and businesses.

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<sup>21</sup> CIO Organization defined as the CIO, the IT high-level and line management team.



**5. Organize Information Resources to Meet Business Needs**

- a. Because the ODOM is an organization that must be agile and adaptive to the changing healthcare environment, the IT division must model this structure and philosophy.
- b. The CIO organization team has a clear understanding of its responsibilities in meeting business needs.
- c. The extent of decentralization of information management resources and decision-making is driven by business needs.
- d. Outsourcing decisions are made based on business requirements and the CIO organization's human capital strategy (aligning the workforce requirements with the ODOM strategic initiatives).
- e. Ability and capacity must be maintained within the IT organization to manage all IT outsourcing relationships.
- f. The CIO organization executes its responsibilities reliably and efficiently.

**6. Develop Information Management Human Capital**

- a. The CIO organization identifies the skills necessary to effectively implement information management in line with business needs.
- b. The CIO organization develops innovative ways to attract and retain talent.
- c. The CIO organization provides training, tools, and methods that allow skilled IT professionals to use in performing their duties.