Committee on Energy and Commerce
U.S. House of Representatives

Witness Disclosure Requirement - "Truth in Testimony"
Required by House Rule XI, Clause 2(g)(5)

1. Your Name: John McCarthy		
2. Your Title: CEO Upshur Street Consulting and former Medicaid Director		
3. The Entity(ies) You are Representing: John McCarthy		
4. Are you testifying on behalf of the Federal, or a State or local government entity?	**Yes**	**No** X
5. Please list any Federal grants or contracts, or contracts or payments originating with a foreign government, that you or the entity(ies) you represent have received on or after January 1, 2015. Only grants, contracts, or payments related to the subject matter of the hearing must be listed. None		
6. Please attach your curriculum vitae to your completed disclosure form. Attached		

Signatur [redacted] **Date:** 1-30-17

JOHN B. MCCARTHY

WORK EXPERIENCE

Director, Ohio Department of Medicaid
January 2011 - December 2017

Medicaid Director for Ohio Medicaid which is responsible for the Medicaid program and the State Children's Health Insurance Program (SCHIP). Ohio's Medicaid program serves over 3 million people with a budget of approximately $25 billion. The following are a few accomplishments since taking the position:

- Created Ohio's first ever Cabinet level Medicaid agency. The establishment of the new agency allows for a more centralized focus on the care coordination and delivery provided to Ohioans served by the program. The Ohio Department of Medicaid (ODM) also serves as the primary point of management for the many Medicaid reforms that are underway.

- Through reforms to the program and innovative changes was under budget 6 years in a row with a total savings of over $7 billion dollars.

- Implemented value based payment reforms through the use of episodic payments and patient centered medical homes through a State Innovation Model grant that included the largest commercial insurers in Ohio. Over 80% of all Ohioans may be covered by these payment models.

- Successfully launched a new integrated eligibility system that will be used in the administration of programs which requires income verification as a condition of receiving services. Ohio Benefits is slated to be rolled out over a series of phases scheduled to conclude in 2017, in replacing the 32 year old Client Registry Information Systems Enhanced (CRISE). The new system will make way for an improved experience for those seeking assistance through programs such as Medicaid, while also significantly reducing costs associated with these processes – particularly those that rely on information technology.

- Second in the nation moving individuals out of institutions and into home- and community-based settings. Over 8,000 people were able to live in the community under the Ohio Money Follows the Person program.

- Became the third state in the nation to join with the Centers for Medicare and Medicaid Services (CMS) to participate in a Financial Alignment Model for Medicare-Medicaid Enrollees. The model fully integrates both acute and long-term care for individuals enrolled in both Medicare and Medicaid.

- Implemented health homes for Medicaid beneficiaries with serious and persistent mental illness. The model embeds care managers in Medicaid health homes to provide intensive care coordination and develop an individualized care plan for each consumer that addresses their medical and non-medical needs.

- Reformed nursing facility payments by linking nearly 10% of the Medicaid payment to quality measures and increasing the amount of funding for services provided directly to residents. This was in conjunction with enacting common-sense regulatory-reform provisions that provide nursing facilities with greater flexibility in how they provide care, while increasing the focus on quality.

- Improved the oversight and performance of managed care plans by moving to plan that cover the entire state instead of regions, increased beneficiary choice by moving from two plans to chose from to five, and implemented standardized performance measurement attached to payment withholds.

- Reduced churn and the number of uninsured children through eligibility reforms and implementing presumptive eligibility for children and pregnant women which led to three SCHIP bonus awards from CMS.

- Rebased inpatient hospital rates by moving to the most current All Payor Diagnosis Related Grouper (APDRG) and tying a portion of the payments to quality outcomes.

- Implemented a new claims payment system that allowed for greater payment accuracy accounting for savings of over $100 million in the first year of operation.

Deputy Director/Medicaid Director, District of Columbia, Department of Health Care Finance
December 2008 – December 2010

Deputy Director and Medicaid Director for the District of Columbia's Department of Health Care Finance which is responsible for the Medicaid program, SCHIP, and the District's locally funded health insurance program which combined provide health care insurance to one third or over 225,000 of the District's residents with total annual expenditures of over $2 billion. The District's medical assistance programs offer coverage to all children at or below 300% of the federal poverty level and to all adults at or below 200% of the federal poverty level.

- A member of the leadership team that created the Department of Health Care Finance as a cabinet level agency that was split from the Department of Health in October of 2008. The creation of the new department entailed developing a new organizational structure for approximately 170 positions, reorganizing the positions through the District's human resources rules and regulations, negotiating with three unions, eliminating nearly 70 positions under the old organizational structure, and hiring 90 positions under the new structure.

- Worked with the Centers for Medicare and Medicaid Services (CMS) to become the second jurisdiction in the nation to implement the expansion of the Medicaid program for childless adults to 133% of the federal poverty level under the Patient Protection and Affordable Care Act.

- Obtained approval of an 1115 waiver to expand Medicaid coverage to childless adults between 133% and 200% FPL using disproportionate share hospital funds.

- Advanced the Department's information technology infrastructure through the implementation of a new Medicaid Management Information System (MMIS) and patient data hub which is the Medicaid portion of the District's health information exchange. The MMIS produced new reporting tools that allowed better management of the program, and the patient data hub created a risk score for all Medicaid beneficiaries, which were to be used to target case management services to individuals with high scores in order to reduce costs and improve health outcomes.

- Provided leadership for the District in health information technology by having the Department named the lead for both the Health Information Exchange and the Health Insurance Exchange.

- Implemented a multi-year initiative to improve the health of babies born to mothers in the Medicaid program. This initiative was a collaboration among the Medicaid managed care organizations, George Washington University, the Department of Health, and health care providers. The goals of this quality improvement collaboration were to reduce the rates of:
  Newborns with birth weight less than 2,500 grams;
  Newborns of 32 weeks or less gestational age;
  Pregnant women not tested for HIV prior to giving birth;
  Pregnancies ending in miscarriage or fetal loss (early or late); and
  Deaths of infants in the first year of life.

- Worked with CMS to obtain approval for a state plan amendment (SPA) to rebase the fee-for-service hospital inpatient diagnosis related grouping (DRG) payment methodology which had not been updated in 10 years and received approval from CMS for a SPA that created a new formula to distribute disproportionate share hospital payments.

- Oversaw the implementation of the Money Follows the Person program in the District that has moved a number of individuals out of ICFMRs and into the community and will be moving individuals out of nursing homes in 2011.

Senior Policy Director, District of Columbia, Department of Health Care Finance (Formerly the Department of Health, Medical Assistance Administration)
February 2006 – December 2008

Senior Policy Director for the District of Columbia's Medical Assistance Administration (MAA) which was responsible for the Medicaid program, State Children's Health Insurance Program (SCHIP), and the District's locally funded health insurance program. Management responsibilities included the management of the Policy Unit, Data Analysis Unit, and Health Care Bill of Rights Unit. Programmatic responsibility included maintaining the Medicaid State Plan, which governs eligibility, scope of benefits, and reimbursement policies for the District's Medicaid and State Children's Health Insurance Program (SCHIP); developing policy for the administration of medical assistance programs administered or monitored by MAA based on sound analysis of local and national health care and reimbursement policies and strategies; and ensuring coordination and consistency among health care and reimbursement policies developed by the various Offices within MAA.

- Developed and obtained approval from the Centers of Medicare and Medicaid Services (CMS) for Medicaid State Plan Amendments (SPAs) that:

  Increased the eligibility level for children in the Medicaid program from 200% of the federal poverty level (FPL) to 300% of the FPL,
  Increased the eligibility level of 19 and 20 year olds from 50% FPL to 200% FPL, which moved individuals from a program funded by only state dollars to the Medicaid program,
  Added a dental benefit for adults in the Medicaid program,
  Increased the eligibility level for individuals enrolled in the Medicare program to 300% FPL,
  Created new reimbursement methodologies for ICFMRs,
  Modified how the Medicaid program pays hospitals that serve a disproportionate share of the uninsured, and
  Expanded the number of days individuals living in ICFMRs can spend at home with their families.

- Managed the District's Medicaid Transformation Grant. The purpose of the $9.7 million grant from CMS is to develop a patient data hub that will combine Medicaid claims data, electronic health records from six clinics and three hospitals, and District of Columbia Department of Health databases. The patient data hub can be used by clinicians to better serve the patient, reduce redundancy, improve health outcomes, and reduce health care expenditures.

- Transitioned 130,000 managed care beneficiaries through an open enrollment process due to a change in managed care plans serving Medicaid beneficiaries. Participated in numerous public forums in order to engage beneficiaries to make informed choices about their health care providers. Pre-transition activities included federally required readiness reviews of the managed care organizations, development of an algorithm to auto-assign beneficiaries that do not choose a managed care entity that balances enrollment between managed care organizations, and negotiations with CMS on the transition process.

- Developed the Medicaid Monthly Management Report which was used by senior MAA staff to manage the $1.8 billion medical assistance programs. The monthly report contained over 60 tables and graphs that track data such as enrollment, expenditures, services provided, and demographics. The report shows both snapshots in time and five year trends.

- Developed with the District of Columbia's Department on Disability Services (DDS) the 1915(c) home- and community-based waiver renewal. Development including determining the need for new services, changes to current services, holding public meetings to obtain stakeholder input and developing the fiscal impact of the waiver.

- As a member of the MAA managed care contract rate negotiating team, negotiated new rates with the managed care organizations for each contract year. The negotiations resulted in millions of dollars of savings to the District's Medicaid program.

Corporate Manager, EP&P Consulting, Washington, DC
September 1996 – February 2006

Corporate manager for a healthcare policy consulting firm specializing in budgeting, Medicaid reimbursement, program analysis, program monitoring, program implementation, and policy development. Management responsibilities included project management, managing the administrative staff, and IT projects. Project work consisted of projects in the areas of fiscal analysis, rate setting, budgeting, program analysis and program monitoring. Projects included program implementation, public meeting facilitation, cost report development, financial evaluation, and community relations.

- Served as the Project Manager and lead analyst of a system redesign project for the Ohio Department of Mental Retardation and Developmental Disabilities (ODMRDD).

- Managed the design, administration, collection, and analysis of cost survey data received from Ohio's developmental disabilities community service providers. The surveys were designed to be used in conjunction with a statewide needs assessment so that individual funding levels and a fee schedule are used in a new Medicaid waiver the State developed for its individuals with MR/DD. Oversaw the development of funding ranges developed using multivariate regressions and discriminant function analysis that places individuals in a funding range to develop the individual's service plan. Assisted in the creation of statewide rates for waiver services using models that built the rate from the "bottom-up" using independent data sources. Developed budget projection models that predicted the economic impact of the system at the county and state level. Worked with the Department and Centers of Medicare and Medicaid Services (CMS) to modify the associated 1915(c) Medicaid waiver to meet the requirements of CMS, state law, and federal law. Participated with the State in public meetings with the provider community and county boards of MR/DD to develop the new reimbursement system, in addition to assisting ODMRDD with implementation issues including writing rules, meeting with stakeholders, and briefing the Governor's office and Director of the Department.

- Served as the Project Manager and lead analyst on a number of Medicaid redesign projects for the Ohio Department of Jobs and Family Services (ODJFS).

- Assisted ODJFS in the termination of a Medicaid State Plan program that provided services to individuals with long-term care needs that was not compliant with CMS requirements, and in the design and implementation of a new program that was compliant with CMS requirements. The development of the new program included creating new program policies and procedures, designing a new reimbursement system and payment rates, and modifying the Medicaid State Plan.

- Assisted ODJFS in the redesign of the Ohio Home Care waiver, which provides long-term care services to individuals with disabilities in Ohio. Tasks included working with the Department to create and submit a waiver application to CMS, negotiations with CMS on the waiver, developing administrative rules for the program, and developing a new reimbursement system that will assign individuals an annual budget amount. The annual budget will then be used to establish the individual's personal budget within which they must purchase their waiver services.

- Assisted ODJFS in analyzing the impact of changing the Medicaid payment system for institutional providers (nursing facilities, ICFs-MR, and hospitals). The analysis included writing a report that was used in the federally required public process whenever Medicaid rates are changed. Analysis has included creating impact models to predict the change of various Executive and Legislative proposals. The models compare the impacts of the proposals examining differences between urban vs. rural, large vs. small, for-profit vs. not-for-profit, and high Medicaid utilization vs. low Medicaid utilization. Additionally, the report provides a review of the overall health of the specific provider industries nationwide and in Ohio and also compares Ohio's policies, reimbursement levels, and payment system to other states.

- Served as project manager and provided both fiscal and policy analysis to Georgia's Department of Medical Assistance for the development and implementation of a new hospital Diagnosis Related Grouping (DRG) payment system. Project work included modeling the financial impact of several reimbursement methodologies, testifying at public meetings, providing post-implementation analysis that resulted in annual updates to the DRG system, creating

hospital-specific rate sheets that explained the payment methodologies, and developing Medicaid State Plan amendments.

- Developed a per diem reimbursement system for Oklahoma's Department of Human Services, Developmental Disabilities Services Division (DDSD). The first phase of the project included creating and analyzing person-level files for service utilization, modeling the impact of various reimbursement systems on both providers and consumers, identifying both policy and operational issues associated with the various reimbursement systems, and creating provider-specific rate sheets that explained the payment methodologies. The second phase of the project included creating a cost report to be completed by the providers that offer services to participants in the DDSD programs. The cost reports were designed to gather information from a wide range of agencies, from those that operate out of a person's home and serve one participant, to large for-profit corporations that serve hundreds of participants.

- Drafted the Commonwealth of Pennsylvania's HealthChoices Physical Health Monitoring Manual, which is used by Commonwealth employees to monitor the HealthChoices health plans. The manual was designed as a user-friendly easily expandable document that provided matrices to prioritize monitoring items and detailed action steps on how to monitor the items such as the financial reports, provider networks, service delivery, and data reporting.

- Worked with the Arizona Health Care Cost Containment System's proposal evaluation teams on the procurement of health plans as a third party verification agent. Verification entailed ensuring that all proposals were scored both consistently and accurately for items such as provider network development, proposed services, member services, quality/utilization management, and network management.

- Managed the claims requirements analysis that explored the feasibility and costs associated with transferring the claims processing services performed by Hawaii's existing fiscal agent to the Arizona Health Care Cost Containment System's Prepaid Medical Management Information System.

Budget Analyst, Governor's Office of Strategic Planning and Budgeting, State of Arizona
September 1994 – September 1996

- Analyzed agency budget requests and developed budget recommendations for the Executive budget. Analysis included: Department of Corrections, Department of Juvenile Corrections, State Parks Board, Universities, Department of Agriculture, and various licensing boards.

- Evaluated programs focusing on effectiveness, efficiency, and statutory compliance. Evaluations were included in the Executive budget and presented to the Legislature.

- Assisted in the publishing of the Executive Budget, the Master List of State Government Programs, and the Budget Development Guidelines.

EDUCATION & ACADEMIC QUALIFICATIONS

Indiana University, Bloomington, IN
School of Public and Environmental Affairs
Master of Public Affairs – 1994

Indiana University, Bloomington, IN
College of Arts & Sciences
Bachelor of Arts in Chemistry – 1992

BOARDS

Vice-President, National Association of Medicaid Directors 2015 - 2016
Midwest Region Board Representative, National Association of Medicaid Directors 2013 - 2014