

Medicaid Primer



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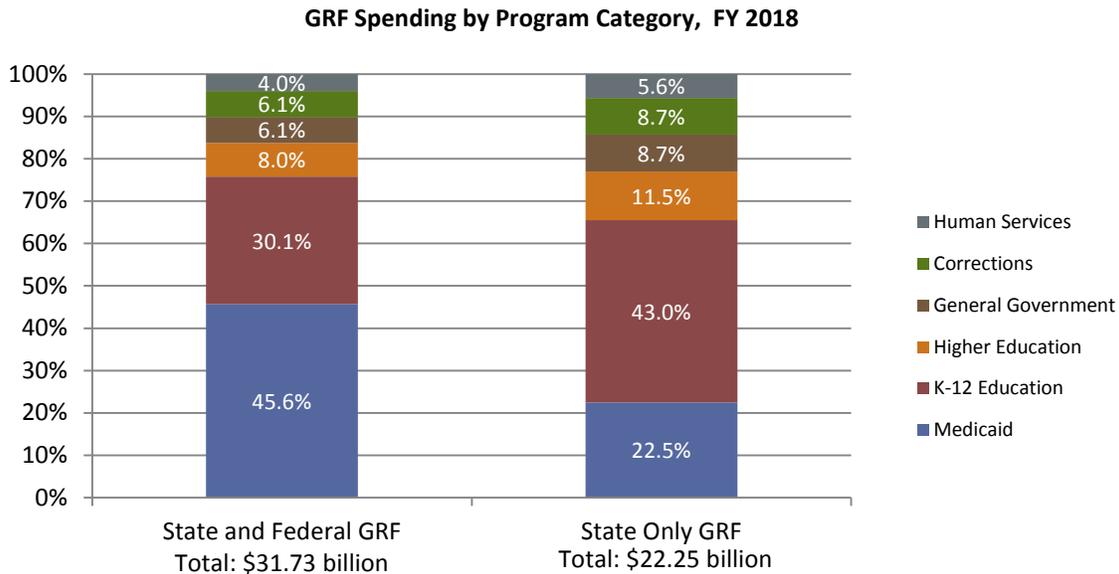
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Overview

Medicaid is a health insurance program for low-income individuals. State governments administer state-specific Medicaid programs subject to federal oversight by the Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health and Human Services (HHS). Funding for the program comes primarily from federal and state government sources.¹ Health care providers participating in a state’s Medicaid Program bill for services provided to covered individuals and receive payments based upon the state’s Medicaid rate for the particular service rendered. The federal government then reimburses the state for a portion of the payment. This reimbursement is known as federal financial participation (FFP).

Medicaid and the Ohio budget

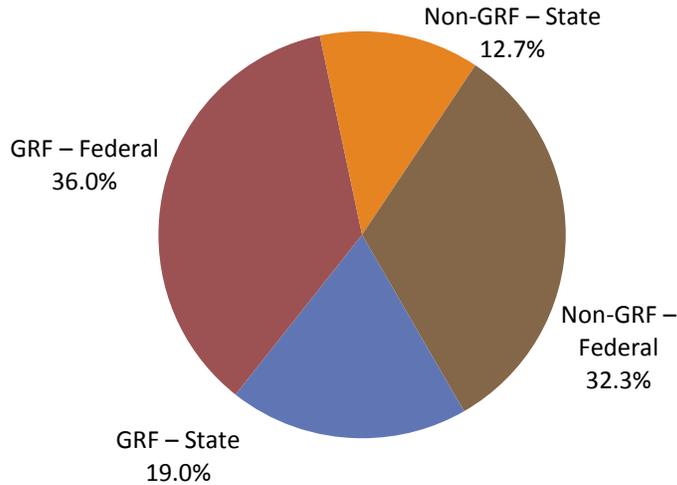
The state of Ohio’s budget is dominated by spending on Medicaid and primary and secondary education. The chart below demonstrates this fact by looking at the state’s general revenue fund (GRF) spending in two different ways. The column on the left shows the state’s total GRF spending in FY 2018 by program area. Medicaid accounted for 45.6% of total GRF spending. The column on the right shows the state’s state-only GRF spending. Federal reimbursements for Medicaid that are deposited into the GRF are removed in this analysis. Medicaid’s share of spending in this view drops, but still remains significant at 22.5%.



While over half of the state’s Medicaid expenditures come from the GRF (\$14.48 billion in FY 2018), non-GRF spending is also important (\$11.86 billion). As with GRF spending, non-GRF spending also includes revenue from state and federal sources. The next chart shows the breakdown of Medicaid spending by state and federal GRF and non-GRF sources.

¹ Some states, including Ohio, also support the program with local government sources.

Ohio Medicaid Spending by Funding Source, FY 2018



Of the total Medicaid spending in FY 2018 of \$26.34 billion, 55% was from the GRF – 36% from federal GRF funds (\$9.48 billion) and 19% from state GRF funds (\$5.00 billion). The remaining 45% was from non-GRF funds – 32.3% from federal funds (\$8.50 billion) and 12.7% from state funds (\$3.36 billion).

Federal financial participation

Federal medical assistance percentage (FMAP)

For most Medicaid service costs, FFP is determined for each state by the state’s federal medical assistance percentage (FMAP). The FMAP is calculated each year for each state based upon the state’s per capita income for the three most recently available years relative to the nation’s per capita income over the same time period. The formula is:

$$1 - \frac{(\text{State per capita income})^2}{(\text{National per capita income})^2} \times 0.45$$

A state with average per capita income (state per capita income equal to national per capita income) will have an FMAP of 0.55 or 55% (1 - 0.45). States with higher per capita incomes will have lower FMAPs and vice versa. However, the federal government has set a minimum FMAP at 50% and a maximum at 83%. In federal fiscal year (FFY) 2019, 13 states have the minimum FMAP of 50.00%, while Mississippi has the highest FMAP of 76.39%. The FMAP for Ohio for FFY 2019 is 63.09%. So, for every dollar Ohio spends on most Medicaid services, it receives 63¢ back from the federal government. Although most FMAP rates are determined by this formula, there are exceptions for certain states, situations, populations, providers, and services. Some of these exceptions are described in more detail below.

Enhanced federal medical assistance percentage (eFMAP)

An enhanced FMAP is provided for both services and administration under the State Children’s Health Insurance Program (SCHIP).² Under SCHIP, each state is given an allotment of federal funds. Subject to the availability of funds from the state’s allotment, the eFMAP is used to determine the federal share of the cost of SCHIP. Each state’s eFMAP is calculated by reducing the state’s share under the regular FMAP by 30%. However, under the Patient Protection and Affordable Care Act (ACA), each state’s eFMAP for most SCHIP expenditures is increased by 23 percentage points, with a maximum of 100%, for FFY 2016 through FFY 2019. In FFY 2019, therefore, Ohio’s eFMAP is 97.16%.³ The Healthy Kids Act modifies the eFMAP for FFY 2020 by specifying an increase of 11.5 percentage points, with a maximum of 100%. Thus, the eFMAP in FFY 2020 will be 85.61%.⁴ The increase is eliminated in FFY 2021.

In addition, the cost of the treatment provided under the Medicaid Program’s Breast and Cervical Cancer Project (BCCP) is reimbursed at the state’s SCHIP eFMAP rate.⁵

Other exceptions to FMAP

Administration

The costs of administration are, in general, reimbursed at 50%, although some administrative activities have a higher rate. The table below shows the matching rates for various administrative functions.⁶

Federal Matching Rates for Various Administrative Activities	
Activity or Function	Percentage
Immigration status verification	100%
Payments to eligible providers for the use of electronic health record (EHR) technology	100%
Administration of incentive payment programs for the adoption of EHR	90%
Administration of family planning services	90%

² SCHIP is a separate program that covers children who are not eligible under the regular Medicaid Program. Many states, including Ohio, opted to incorporate SCHIP as a Medicaid expansion.

³ Ohio’s state share under the regular FMAP is 36.91% (100% - 63.09%), reducing that by 30% results in a state share under eFMAP of 25.84% (36.91% x 70%), which translates into an eFMAP of 74.16% (100% - 25.84%). Finally, adding 23 percentage points results in 97.16% (74.16% + 23%).

⁴ Source: Federal Register, Volume 83, Number 229, November 28, 2018.

⁵ BCCP services are provided to individuals who meet eligibility criteria, including being in need of treatment for breast and/or cervical cancer or pre-cancerous conditions, uninsured, between 45 and 65 years of age, and having an income of 200% of the federal poverty line (FPL) or below.

⁶ Source: Kaiser Commission on Medicaid and the Uninsured, Medicaid Financing: An Overview of the Federal Medicaid Matching Rate (FMAP), September 2012.

Federal Matching Rates for Various Administrative Activities	
Activity or Function	Percentage
Design, development, and installation of a Medicaid Management Information System (MMIS)	90%
Design, development, and installation of a Medicaid eligibility and enrollment system (E&E)	90%
Management and operation of an MMIS	75%
Maintenance and operation of an E&E	75%
Independent external reviews of managed care plans	75%
Medical and utilization review	75%
Preadmission screening and resident review	75%
Skilled professional medical personnel training	75%
State fraud and abuse control unit activities	75%
State survey and certification of nursing facilities	75%
Translation and interpretation services	75%
Other program administration activities	50%

ACA expansion group (Group VIII)

The ACA permits states to expand Medicaid coverage to nondisabled adults under the age of 65 with no dependents and incomes at or below 138%⁷ of the federal poverty line (FPL). These newly eligible adults are often referred to as Group VIII after the section of the law that describes them. The ACA offers states a higher FMAP for services provided to Group VIII individuals. From calendar year (CY) 2014 to CY 2016, the Group VIII FMAP was 100%. In CY 2017, the FMAP was 95% and in CY 2018, it was 94%. The FMAP is 93% in CY 2019, and will be 90% in CY 2020 and each year thereafter.

Qualifying Individuals Program

States are required to pay Medicare Part B⁸ premiums for Medicare beneficiaries with income between 120% and 135% FPL and limited assets. These beneficiaries are referred to as qualifying individuals. The FMAP for this program is 100%.

⁷ Under the ACA, the eligibility is 133% FPL. However, a 5% income disregard is allowed, which makes the effective minimum threshold 138%.

⁸ Medicare Part B covers some medical services not covered by Part A, such as physician services and outpatient care.

Family planning services

Since 1973, the federal government has offered states an FMAP of 90% for family planning services and supplies.

Community first choice option

This option allows states to provide home and community-based attendant services and supports to eligible Medicaid enrollees under their state Medicaid plan. This state plan option became available under the ACA on October 1, 2011, and provides a six percentage point increase in FMAP to states for service expenditures. Prior to this option, these services were only available through Medicaid Home and Community Based Services Waivers.

Preventive services for adults

Beginning on January 1, 2013, the ACA provides a one percentage point increase in FMAP to states for expenditures for adult vaccines and clinical preventive services if states provide these benefits without requiring a payment from the beneficiary.

Smoking cessation for pregnant women

Beginning on January 1, 2013, the ACA provides a one percentage point increase in FMAP for expenditures for smoking cessation services that are mandatory for pregnant women. This is provided to states that opt to cover the preventive services described above.

Temporary FMAP increases

The federal government will occasionally provide temporary increases in a state’s FMAP to assist in certain circumstances. For example, Congress has temporarily increased FMAPs to provide fiscal relief to state Medicaid programs during recessions. Temporary FMAP increases may also be given as a type of grant to incentivize states’ adoption of certain programs. For example, the ACA created an optional benefit for states to establish Health Home to coordinate care for certain people with chronic conditions. States receive a 90% federal match for eight calendar quarters for specific Health Home services.

Summary

The table below summarizes most of the instances when a reimbursement rate other than the regular FMAP is currently used.

Summary of Current Federal Match Rates	
Population/Services	Percentage
Qualifying Individuals Program	100%
Newly Eligible, Adults under 65 up to 138% FPL	Phasing down to 90% from 100%
Family Planning Services and Administration	90%
Health Home Services	90% for 8 quarters
State Children’s Health Insurance Program (SCHIP)	eFMAP

Summary of Current Federal Match Rates	
Population/Services	Percentage
Breast and Cervical Cancer Treatment	eFMAP
Community First Choice	FMAP + 6%
Smoking Cessation for Pregnant Women	FMAP + 1%
Clinical Preventive Services for Adults	FMAP + 1%
Administrative Activities	50% to 100%

Federal oversight

As shown above, over half of Ohio’s Medicaid expenditures are paid with federal funding. The federal government establishes requirements for the program that states must meet in order to receive FFP. Major changes to federal Medicaid policy were made most recently through the ACA, which was signed into law on March 23, 2010.

State plan

Each state has a state plan, which is an agreement between the state Medicaid agency and CMS that describes how the state will administer its Medicaid Program, including individuals to be covered, services to be provided, and methodologies for reimbursement. The state plan must be reviewed and approved by CMS in order for a state to receive FFP. To make changes to its Medicaid Program, a state must get CMS approval of a state plan amendment (SPA). Federal regulations allow CMS 90 days to review an SPA, but this time can be extended if CMS has questions. Therefore, SPAs generally are written and submitted long before they can be implemented.

Unless the state receives a waiver, a state plan must meet the following general requirements to receive CMS approval:

1. **Statewideness.** All Medicaid services must be available on a statewide basis. States cannot limit the availability of health care services to a specific geographic location or fail to provide a covered service in a particular area.
2. **Freedom of choice.** Medicaid consumers are provided the freedom to choose which Medicaid providers they use. States may not restrict Medicaid recipients’ access to qualified providers.
3. **Amount, duration, and scope.** For every covered service, determinations are made regarding the amount, duration, and scope of coverage provided to meet recipients’ needs. For example, a state could limit the number of days of hospital care provided. States must cover each service in an amount, duration, and scope that is reasonably sufficient. Services must not be arbitrarily limited for any specific illness or condition.
4. **Comparability of services.** States must ensure that the medical assistance available to any recipient is not less in amount, duration, or scope than what is available to any other recipient.

5. **Reasonable promptness.** States must promptly provide Medicaid to recipients without delay caused by the agency's administrative procedures.
6. **Equal access to care.** States must set payment rates that are adequate to assure Medicaid recipients reasonable access to services of adequate quality.
7. **Coverage of mandatory services for mandatory populations.** CMS requires state Medicaid programs to provide certain medically necessary services to covered populations.

Federal waivers

States may seek federal waivers to operate their Medicaid programs outside of federal guidelines. The Social Security Act gives the HHS Secretary authority to waive compliance with certain provisions of Medicaid law. Some states have used waivers to expand coverage, provide services that could not otherwise be offered, expand home and community-based services, and require recipients to enroll in managed care programs. Waivers have also been approved to allow states to limit Medicaid-covered services to existing Medicaid eligibility groups in order to cut spending and to expand coverage to the uninsured.

Section 1115 research and demonstration projects

Section 1115 provides the HHS Secretary with broad authority to approve experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. Flexibility under Section 1115 is sufficiently broad to allow states to test the merit of substantially new ideas of policy. These projects are intended to demonstrate and evaluate a policy or approach that has not been demonstrated on a widespread basis. Some states expand eligibility to cover groups of individuals and services not otherwise eligible for federal match and to demonstrate alternative approaches to providing or extending services to recipients.

The 1115 projects are generally approved to operate for a five-year period; states may submit renewal requests to continue the project for additional periods of time. Demonstrations must be "budget neutral" over the life of the project, meaning they cannot be expected to cost the federal government more than it would cost without the waiver.

Section 1915(b) managed care/freedom of choice waivers

Section 1915(b) provides the HHS Secretary with the authority to grant waivers that allow states to implement managed care delivery systems, or otherwise limit individuals' choice of provider under Medicaid. This section also provides waivers allowing states to skip provisions requiring comparability of services and statewideness, which together require states to offer the same coverage to all categorically needy recipients statewide. These waivers are generally approved for a two-year initial period with two-year renewal periods. These waivers are required to be cost effective and efficient.

Section 1915(c) home and community-based services waivers

Section 1915(c) provides the HHS Secretary with the authority to waive Medicaid provisions in order to allow long-term care services to be delivered in community settings. This program is the Medicaid alternative to providing comprehensive long-term care services in

institutional settings. These waivers have been critical in state strategies to provide alternative settings for long-term care services. State waiver programs provided under this section must meet the following criteria: demonstrate that providing waiver services will not cost more than providing the same services in an institution, provide adequate and reasonable provider standards to meet the needs of the targeted population, and ensure that services follow an individualized and person-centered plan of care. Under these waivers, states can waive statewideness, comparability of services, and certain income and resource rules.

Section 1915(i) State Plan home and community-based services

Section 1915(i) provides states an opportunity to offer services and supports before individuals need institutional care, and also provides a mechanism to provide State Plan home and community-based services to individuals with mental health and substance use disorders. This State Plan service package includes many similarities to options and services available through 1915(c) home and community-based services waivers; however, a significant difference is that 1915(i) does not require individuals to meet an institutional level of care in order to qualify for home and community-based services. The ACA made changes to 1915(i) provisions by removing certain barriers to offering home and community-based services through the Medicaid State Plan. These waivers must: target the home and community-based service benefit to one or more specific populations, establish separate additional needs-based criteria for individual services, establish a new Medicaid eligibility group for people who get State Plan home and community-based services, and provide an option to allow any or all home and community-based services to be self-directed. Under these waivers, states can waive comparability of services and certain income and resource rules.

Section 1915(j) self-directed personal assistant services

Section 1915(j) allows a state the option to provide, as medical assistance, payment for costs of self-directed personal assistance services (PAS) provided pursuant to a written plan of care to individuals for whom there has been a determination that the individuals would require and receive these services under a State Plan or section 1915(c) waiver. Section 1915(j) waivers allow states to target people already getting section 1915(c) waiver services, limit the number of people who will self-direct these services, and limit the option to certain areas of the state or offer it statewide. Under a state's option, people enrolled in this waiver can: hire legally liable relatives, manage a cash disbursement, and purchase goods, supports, and services that increase independence. Self-directed PAS are personal care and related services. Participation in these services is voluntary, but allows the individual to set provider qualifications and train their providers.

Section 1915(k) community first choice

Section 1915(k) allows states, as previously mentioned, to provide home and community-based attendant services and supports to eligible individuals under their State Plan in return for an eFMAP.

Medicaid eligibility

Federal eligibility criteria

Generally, the federal government requires Medicaid beneficiaries to be U.S. citizens⁹ and residents of the state in which they receive benefits. States set income eligibility standards for various groups subject to federally specified minimums and maximums. For most groups, eligibility is based on the modified adjusted gross income (MAGI)¹⁰ of the household as compared to the federal poverty line (FPL).¹¹ FPL is the income guideline established and issued each year in the Federal Register by HHS. In general, individuals under the age of 65 may be eligible for Medicaid under federal criteria if their household income is at or below 133% FPL.¹² Although some groups (primarily children and pregnant women) with higher household incomes also may be eligible. The table below provides the FPL and 133% of the FPL for various family sizes in 2019.

Federal Poverty Lines 2019		
Family Size	FPL	133% FPL
1	\$12,490	\$16,612
2	\$16,910	\$22,490
3	\$21,330	\$28,369
4	\$25,750	\$34,248
5	\$30,170	\$40,126
6	\$34,590	\$46,005
7	\$39,010	\$51,883
8	\$43,430	\$57,762

⁹ Some noncitizens are also eligible, such as lawful permanent residents. Lawful permanent residents entering after August 22, 1996 are usually barred from receiving full benefits for five years after which coverage becomes a state option. However, children and pregnant women lawfully present may be covered during this period at the state’s option. <https://www.macpac.gov/subtopic/noncitizens/>.

¹⁰ MAGI is the Internal Revenue Code’s Adjusted Gross Income increased by tax-exempt interest and income earned by U.S. citizens or residents living abroad.

¹¹ A different methodology is used for the aged, blind, and disabled eligibility group.

¹² Under the MAGI methodology, there is generally a 5% income disregard, so that the income limit is effectively 138% FPL.

Prior to the ACA, Medicaid eligibility was limited to children, pregnant women, parents, and disabled or older adults (over age 65).¹³ The ACA expanded Medicaid coverage to certain nondisabled adults under the age of 65 and without dependents. Although the ACA intended to make coverage of this group mandatory, in June 2012, the U.S. Supreme Court limited HHS's authority to enforce the expansion, effectively making it optional for states.

Whether or not states choose to expand coverage under the ACA, all are still required to cover certain groups in order to receive FFP. The following are examples of groups that must be covered:

- Parents who would have met the eligibility criteria for participation in the cash assistance program Aid to Families with Dependent Children (AFDC) as of July 16, 1996;¹⁴
- Children in families with incomes up to 133% FPL;
- Recipients of adoption assistance and foster care under Title IV-E of the Social Security Act and young adults aging out of foster care up to age 26;
- Pregnant women with incomes up to 133% FPL;¹⁵
- Elderly and disabled individuals receiving Supplemental Security Income (SSI) benefits.

Ohio Medicaid eligibility

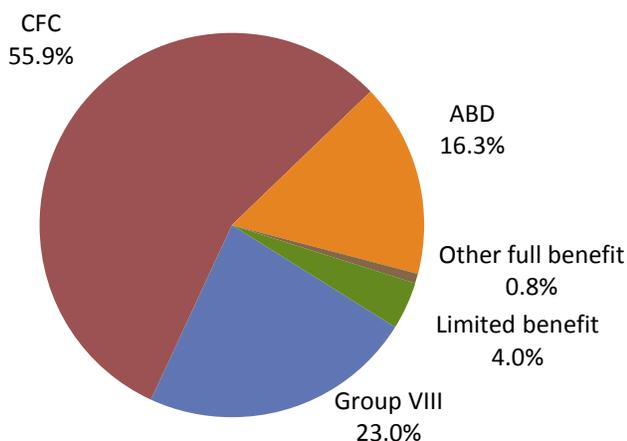
Ohio chose to expand coverage under the ACA to the Group VIII population and also has taken advantage of flexibility offered by the federal government to expand coverage above the federal minimum for other groups. In FY 2018, Ohio provided Medicaid coverage to over 3.0 million people. The Ohio Department of Medicaid (ODM) recognizes a number of different categories of Medicaid beneficiaries. This categorization is not specified in state law, but rather has been created administratively and there may not be a clear consensus as to the specific composition of the different categories. The three main categories are: Group VIII, covered families and children (CFC), and aged, blind, and disabled (ABD). There are other smaller categories that provide full benefits or limited benefits. The following chart shows the breakdown of Ohio's Medicaid caseload by these different eligibility categories.

¹³ Generally, for the purposes of Medicaid, children are under the age of 19, adults are between the ages of 19 and 65, and older adults (also termed "aged") are over the age of 65 (and thus eligible for Medicare).

¹⁴ In Ohio, families with dependent children with incomes no higher than 32% FPL were eligible for AFDC.

¹⁵ In addition, after giving birth, an infant has mandated coverage throughout the infant's first year if the infant's mother was enrolled in Medicaid on the date of the infant's birth.

Ohio Medicaid Caseload by Eligibility Category, FY 2018



Group VIII

Group VIII consists of adults under the age of 65 with household income at or below 138% FPL¹⁶ who would not be eligible except for the ACA expansion. In other words, they are not eligible under any other category. Ohio’s Group VIII caseload in FY 2018 was 692,319.

Covered families and children (CFC)

CFC includes: insured and uninsured children up to age 19 in families with income up to 156% FPL, pregnant women in families with income up to 200% FPL, uninsured children up to age 19 in families with income up to 206% FPL, and families with income up to 90% FPL with a child under age 19.¹⁷

Pregnant women in Ohio are eligible for expedited enrollment into Medicaid that allows them to receive covered services within 24 hours of applying. Eligible women are included in CFC for the duration of their pregnancies and up to 60 days after the baby is born.

Aged, blind, and disabled (ABD)

Eligibility for the ABD population does not follow the MAGI methodology used for Group VIII and CFC. Instead, this population must meet both the income and asset limits used to determine eligibility for SSI. Currently, the income limitation is about 75% FPL and the asset limitation is \$2,000. In addition to meeting income and asset limits, ABD individuals must be age 65 or older, significantly visually impaired, or have a disabling condition that meets SSI requirements. Older adults in this category may also be eligible for Medicare. These individuals are referred to as dual-eligible.

¹⁶ 133% FPL with a 5% income disregard.

¹⁷ Also eligible are young adults up to age 26 who have aged out of foster care.

Also counted in the ABD category are individuals enrolled in the Medicaid Buy-In for Workers with Disabilities Program (MBIWD). This program provides Medicaid coverage to employed, disabled individuals, who are at least 16 but younger than 65 years of age, have countable income not exceeding 250% FPL, and have less than \$11,901¹⁸ in assets. Individuals in this program with income exceeding 150% FPL must pay an annual premium.

Other full benefit categories

Breast and Cervical Cancer Project (BCCP)

Uninsured women between the ages of 40 and 65 with an income of 200% FPL or less who have been screened for breast or cervical cancer through the Ohio Department of Health and are in need of treatment are eligible for full Medicaid benefits through the Breast and Cervical Cancer Project (BCCP) until their treatment is completed. Since the expansion of Medicaid, BCCP enrollment has declined, and the program has been integrated into ABD managed care.

Presumptive eligibility

Some uninsured individuals are able to receive immediate health care services through Medicaid if they are presumed to be eligible. These individuals are temporarily counted in this category until their Medicaid applications are approved. Certain aliens and newly arrived refugees may also receive emergency health care services temporarily through Medicaid.

Limited benefit categories

Medicare premium assistance

Individuals in this category are enrolled in Medicare and do not receive full Medicaid benefits. Instead, these individuals receive assistance through Medicaid in paying their Medicare Part A or Part B premiums and other cost-sharing expenses such as copayments, coinsurance, and deductibles. Medicare Part A helps cover inpatient care in hospitals and Medicare Part B covers physician and outpatient care as well as other medically necessary health services.

There are four levels of assistance provided in this category. The first level of assistance is for a Qualified Medicare Beneficiary (QMB). In general, to qualify as a QMB, a Medicare recipient must have family income not exceeding 100% FPL. Medicaid pays QMB beneficiaries' Medicare Part A and B premiums and other Medicare cost-sharing expenses. The second level is for a Specified Low-Income Medicare Beneficiary (SLMB). In general, to qualify as an SLMB, a Medicare beneficiary must have family income between 100% FPL and 120% FPL. Medicaid pays SLMB beneficiaries' Medicare Part B premiums. The third level is for a Qualified Individual (QI). In general, to qualify as a QI, a Medicare recipient must have family income that does not exceed 135% FPL. Medicaid pays QI beneficiaries' Medicare Part B premiums, subject to an annual federal funding cap. The QMB, SLMB, and QI programs also have resource limits. Finally, the fourth level is a Qualified Disabled and Working Individual (QDWI). In general, to qualify as

¹⁸ This number is adjusted annually. The number provided is for 2018.

a QDWI, an individual must have lost Medicare Part A benefits due to losing eligibility for disability benefits under Title II of the Social Security Act following a return to work, but be eligible to purchase Medicare Part A benefits by paying premiums, have family income not exceeding 200% FPL, and assets that do not exceed twice the SSI limit. Medicaid pays QDWI beneficiaries' Medicare Part A premiums.

Delivery systems

Fee-for-service and managed care

Medicaid does not provide medical services to eligible individuals enrolled in the program directly. It provides financial reimbursement to health care professionals and institutions for providing approved medical services, products, and equipment to Medicaid enrollees. The reimbursements are provided through one of two delivery systems: fee-for-service or managed care. Both delivery systems provide medically necessary primary care, specialty and emergency care services, and preventive services. Under fee-for-service, Medicaid pays most service providers a set fee for the specific type of service rendered. Payments are based on the lowest of the state's fee schedule, the actual charge, or federal Medicare allowances. An alternative to fee-for-service reimbursement is managed care. The two main models of managed care in Medicaid are managed care organizations (MCOs) and primary care case management (PCCM).

An MCO is a capitated at-risk plan in which the beneficiary and the managed care provider is paid a fixed monthly premium per beneficiary for any health care included in the benefit package, regardless of the amount of services actually used. The beneficiary is responsible for, at most, modest copayments for services; the MCO is at risk for the remaining cost of care. MCOs are at financial risk for losses if they spend more on services and health plan administration than they are paid by the state. On the other hand, MCOs are allowed to retain a portion of excess payments for profit or reinvestment, assuming that they spend at least a certain amount on medical care and quality initiatives.¹⁹ A capitated plan can be a network of physicians and clinics, all of whom participate in the plan and also participate in other plans or fee-for-service systems, or it can be a plan that hires the physicians who provide all of the care required.

In PCCM, the primary care provider receives a small fee per person per month to provide basic care and coordinate specialist care and other needed services, which are usually paid fee-for-service. Many states are building into their PCCM programs features to enhance the coordination and management of care for enrollees with chronic illnesses and disabilities. Some disease and care management programs are targeted to people with specific conditions and others target individuals with multiple conditions. A number of states are structuring payment strategies and incentives to support the "patient-centered medical home" model for Medicaid recipients. This model emphasizes continuous and comprehensive care, care teams directed by a personal physician, and care for all stages of life. It also seeks to enhance access through expanded hours and other improvements. Information technology and quality improvement activities promote quality and safety.

Other than MCO and PCCM, federal managed care regulations recognize two other types of managed care entities, which are limited-benefit plans that generally manage a subset of benefits or manage services for certain populations. First is a Prepaid Inpatient Health Plan (PIHP), which provides limited benefits that include inpatient hospital or institutional services. For example, such a plan may be used to provide mental health services. Second is a Prepaid

¹⁹ <https://www.macpac.gov/subtopic/types-of-managed-care-arrangements/>.

Ambulatory Health Plan (PAHP), which provides limited benefits that do not include inpatient hospital or institutional services. PAHPs are usually very narrow in scope of the services provided. For example, such a plan may be used to provide dental or transportation services.

Federal authority to implement managed care delivery systems

States can implement a managed care delivery system using three basic types of federal authority provided in different sections of federal law:

- State plan authority [Section 1932(a)]
- Waiver authority [Section 1915(a) and (b)]
- Waiver authority [Section 1115]

Regardless of the authority, states must comply with the federal regulations that govern managed care delivery systems. These regulations include requirements for a managed care plan to have a quality program and provide appeal and grievance rights, reasonable access to providers, and the right to change managed care plans, among others. All three types of authority give states the flexibility to not comply with the following Medicaid general requirements that were described in the Federal Oversight section:

1. **Statewideness.** States may implement a managed care delivery system in specific areas of the state rather than the whole state.
2. **Comparability of Services.** States may provide different benefits to people enrolled in a managed care delivery system.
3. **Freedom of Choice.** States may require people to receive their Medicaid services from a managed care plan.

Demonstration models of care delivery

Under the ACA, more opportunities for states to experiment in an attempt to improve care delivery in Medicaid were provided. The ACA established the Center for Medicare and Medicaid Innovation (CMMI) to test, evaluate, and expand innovative care and payment models to foster patient-centered care, improve quality, and slow cost growth in Medicare, Medicaid, and SCHIP. The ACA also established the Federal Coordinated Health Care Office (FCHCO) within CMS. FCHCO works to align Medicare and Medicaid benefits and improve state and federal coordination when distributing benefits to dual-eligible beneficiaries.

The ACA included several demonstrations that enabled some states to test approaches such as bundling payments around hospital care, setting global payments for safety-net hospital systems, allowing pediatric providers to organize as Accountable Care Organizations (ACOs), and encouraging healthy lifestyle changes. The following provides brief descriptions of some of the programs and initiatives authorized by the ACA for reducing the rate of cost growth and improving the quality of care delivery through more coordinated care delivery models and reimbursement methods that reward coordinated care.

Medicare Shared Savings Program (MSSP)

MSSP provides incentives for health care providers to organize into ACOs as a means of providing coordinated, quality care to Medicare FFS beneficiaries at a reduced cost. A participating ACO agrees to be held accountable for quality and costs of care provided to these individuals. In return, ACOs that lower growth in health care costs and meet quality performance benchmarks may share in the savings. The ACA granted the HHS Secretary discretion to include electronic health record and electronic prescribing requirements in the MSSP.

Patient-centered medical homes

ACA authorized funding for the creation of “health teams” that would support primary care providers and patient-centered medical homes. Methods of support include: (1) offering care coordination, care transition, disease management, and disease prevention services, (2) collecting and reporting quality data, and (3) facilitating electronic health record (EHR) implementation that meets the Health Information Technology for Economic and Clinical Health (HITECH) Act’s meaningful use requirements.

State option to provide Health Homes for enrollees with chronic conditions

States may offer Health Home services to Medicaid enrollees with a mental health condition, a substance use disorder, asthma, diabetes, heart disease, or obesity. The ACA defined Health Home services as including care management, care coordination, transitional care, and patient and family support services linked together by the use of health information technology.

Hospital Readmissions Reduction Program (HRRP)

HRRP imposes a financial penalty on hospitals that have high readmission rates for conditions specified by the HHS Secretary. The ACA required the Secretary to establish the HRRP and reduce payments to Inpatient Prospective Payment System hospitals for excess readmissions beginning FFY 2013. In addition, the 21st Century Cures Act requires, beginning in FFY 2019, CMS to assess penalties based on a hospital’s performance relative to other hospitals with a similar proportion of dual-eligibles.²⁰

Ohio’s Medicaid managed care

Although Ohio has contracted with managed care plans (MCPs) since the late 1970s to provide care for certain Medicaid recipients, the use of capitated rates was not given major emphasis in Ohio’s program until the state received an 1115 demonstration waiver in January 1995. As one initiative of the federally approved OhioCare proposal, the state was given the freedom to require mandatory managed care enrollment by Medicaid recipients eligible under the CFC category. However, mandatory enrollment of certain populations did not occur for several years – until the enactment of H.B. 66 of the 126th General Assembly, which required

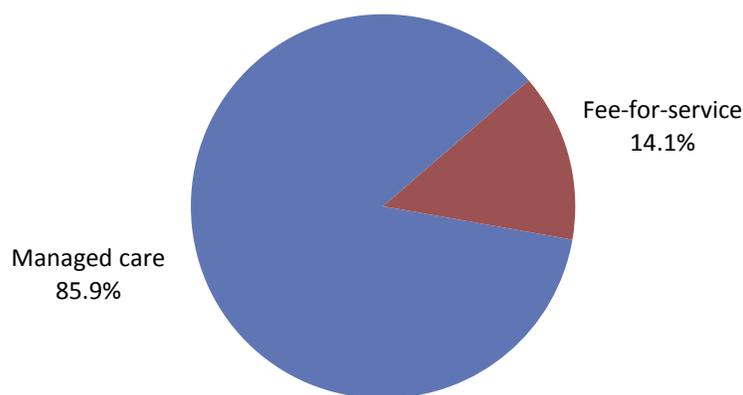
²⁰ <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html>.

MCPs to be implemented in all counties and required ODJFS²¹ to enroll the CFC population in MCPs. H.B. 66 also required ODJFS to implement the MCPs for certain aged, blind, and disabled Medicaid recipients in all counties.

H.B. 153 of the 129th General Assembly further expanded MCP coverage to an even broader population by requiring Ohio Medicaid to (1) implement Health Homes, under which Medicaid recipients with chronic conditions are provided with coordinated care, (2) establish a pediatric accountable care organization (ACO) recognition system for children under age 21 who are blind or disabled, and (3) implement the Integrated Care Delivery System (ICDS), now known as MyCare Ohio, that coordinates the delivery of Medicare and Medicaid services for participating dual-eligibles.

Managed care in Ohio has grown in the last decade, which has dramatically shifted expenditures from fee-for-service to managed care. The structure of the managed care rollout evolved from voluntary enrollment to mandatory enrollment. Now, most Medicaid recipients are required to enroll in managed care. Generally, non-dual recipients who are on waivers or institutionalized, still are served on a fee-for-service basis. However, some recipients, such as individuals on developmental disabilities waivers may enroll in managed care on a voluntary basis. The following chart shows that 85.9% of Ohio’s Medicaid caseload for FY 2019 was in managed care, while 14.1% was in fee-for-service. It should also be noted, that the fee-for-service caseload includes new enrollees who are in the process of choosing and becoming enrolled in a managed care plan.

Ohio Medicaid Caseload by Delivery System, FY 2018



²¹ ODJFS administered the Medicaid program during the 126th General Assembly. Medicaid did not become a standalone agency until the 130th General Assembly.

Ohio Comprehensive Primary Care (CPC)

Beginning in 2017, a portion of the managed care population was enrolled in the Ohio Comprehensive Primary Care (CPC) Program. CPC is a team-based care delivery model led by a primary care practice that comprehensively manages a patient's health needs. Practices that participate in CPC will receive a per member per month payment to support activities required by the program as well as a shared savings payment to reward practices for achieving total cost of care savings. CPC's goal is to deliver the best care to patients while improving quality and lowering costs.

Program of All-Inclusive Care for the Elderly (PACE)

Ohio Medicaid offers a unique type of managed care program: the Program of All Inclusive Care for the Elderly (PACE). PACE provides home and community-based care, allowing seniors to live in the community. There is currently one PACE site – McGregor PACE Center for Senior Independence, which is located in Cleveland. The PACE site provides participants with all of their needed health care, medical care, and ancillary services at a capitated rate (from both Medicare and Medicaid). All PACE participants must be 55 years of age or older and qualify for a nursing facility level of care. The PACE site assumes full financial risk for the care of the participants. Indeed, if PACE participants must be moved to a nursing facility, the PACE site continues to be responsible for the cost of the participant's care. Consequently, there is an incentive that a broad range of preventive and community-based services be provided as alternatives to more costly care.

Currently, ODA administers PACE; however, funding for services is provided by ODM. In FY 2018, PACE served an average of approximately 422 consumers per month.

Medicaid Benefits

Federal benefit criteria

The federal government sets minimum services that must be provided in a state's Medicaid plan as well as optional services that a state may provide and for which the state will receive federal reimbursement. Most services provided under a state's Medicaid plan must be available to all covered individuals who have a medical need for that service. Exceptions include services provided only to children or only to individuals enrolled on waivers, which are described below. Federal rules do allow states to limit the amount, duration, or scope of most services. For example, state Medicaid programs may choose the setting in which covered services are provided, limit the number of visits for a certain service, and cap the annual spending per person for a particular service. States are also allowed to use numerous tools to manage utilization, such as copayment, prior authorization, and case management.

Ohio Medicaid benefits

Ohio's Medicaid Program offers a comprehensive package of services for Medicaid recipients. Some of the mandatory and optional services are listed below, followed by more detailed descriptions of some of the basic covered services.

Mandatory services

- Healthchek (EPSDT)
- Physician services
- Family planning
- Pregnancy, including free standing birth centers and nurse midwives, and tobacco cessation counseling
- Inpatient hospital
- Outpatient hospital
- Nursing facility
- Certified family nurse practitioner
- Certified pediatric nurse practitioner
- Rural health clinic
- Federally qualified health center
- Medical and surgical vision
- Medical and surgical dental
- Laboratory and x-ray
- Home health
- Nonemergency transportation

Optional services

- Acupuncture for lower back pain
- Dental care, including dentures
- Vision services, including eyeglasses
- Podiatrist services
- Private duty nurse
- Chiropractic services for individuals under age 21
- Occupational therapy
- Physical therapy
- Prescription drugs

- Speech/language pathology and hearing
- Respiratory care
- Home and community-based services (HCBS)
- Other diagnostic, screening, preventive, and rehabilitative
- Prosthetics
- Personal care
- Services for individuals 65+ in an institution for mental disease
- Inpatient psychiatric services for individuals under age 21
- Community alcohol and drug addiction services, including screening, counseling, medication-assisted treatment, case management
- Community mental health services
- Medical equipment
- Health Home
- ICF/IID
- Hospice
- Ambulance/ambulette transportation

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

EPSDT, known as Healthchek in Ohio, is a federally mandated program established to ensure Medicaid recipients under age 21 have access to periodic preventive care examinations and medically necessary treatment. The purpose of Healthchek is to discover and treat health problems as early as possible to prevent them from progressing. It requires state Medicaid programs to provide for any medical service a physician determines is needed for a Medicaid-eligible child. Under this program, children covered by Medicaid receive all the basic medical services such as well-child visits, immunizations, dental, hearing, and other screening services, including lead screening. Other services and screenings are available as needed. In addition, they are also able to access a wide array of services that states do not otherwise cover in their Medicaid programs. In Ohio, a Healthchek coordinator is available in each Ohio county department of job and family services to assist Medicaid recipients in getting these services. All children eligible for Medicaid qualify for this program regardless of their eligibility category.

Institutional long-term care

Institutional long-term care is provided to eligible individuals residing in a facility. A nursing facility provides skilled and intermediate nursing care, rehabilitation services, and other health-related care services on a regular basis to individuals with illness or physical or mental impairment. Nursing facility services are provided by nursing homes licensed by the Ohio Department of Health (ODH), county-operated homes, or separate hospital units. To receive Medicaid payment for services, nursing facilities must meet state and federal requirements. ODM delegates the certification of these facilities to ODH, which also certifies their participation in the federal Medicare Program. Nursing facility Medicaid services are administered and paid for by ODM. There are about 960 nursing facilities in Ohio.

Intermediate care facilities for individuals with intellectual disabilities (ICF/IID) provide health, rehabilitation, and active treatment services to individuals with intellectual disabilities. ICFs/IID are licensed by ODODD. However, ODH certifies the licensed facility as meeting the federal requirements for funding as an ICF/IID. The provider is responsible for all aspects of care for the individual, including financial matters, transportation, habilitation, and medical needs. ICF/IID Medicaid services are administered and paid for by ODODD. While ICF/IID services are an optional Medicaid benefit, the majority of state Medicaid programs cover ICF/IID services. In Ohio, there are 436 ICFs/IID.

Nursing facility and ICF/IID services are the only Medicaid services for which the Ohio Revised Code establishes the reimbursement formula.

Nursing facility payment rate

The regular Medicaid payment rate for a nursing facility is based on four cost centers and one or, in the case of a critical access nursing facility, two special payments. The four cost centers are ancillary and support costs, capital costs, direct care costs, and tax costs. The special payment available to all nursing facilities is the quality incentive payment. The second special payment available to a critical access nursing facility is the critical access incentive payment.

A nursing facility's total rate, as shown below, is the sum of its rate for each cost center, its quality incentive payment, and, if applicable, its critical access incentive payment.

$$\begin{aligned} & \text{Regular total Medicaid payment rate} \\ & \quad = \text{rate for direct care costs} \\ & \quad + \text{rate for ancillary and support costs} \\ & \quad \quad + \text{rate for capital costs} \\ & \quad + \text{rate for tax costs} + \text{rate for quality add-on} - \$1.79 \text{ (quality deduction)} \\ & \quad \quad \quad + \text{quality payment} \\ & \quad \quad \quad + \text{critical access incentive payment} \end{aligned}$$

Direct care costs are costs incurred for nursing and other direct care staff such as respiratory therapists, quality assurance activities, training and staff development, habilitation staff, medical equipment and supplies, among others. Ancillary and support costs are all reasonable costs incurred by a nursing facility other than direct care, tax, or capital costs and include things such as activity costs, social services, program directors, food, laundry, and dietary supplies and personnel. Capital costs are actual expenses related to depreciation and interest on certain capital assets that include buildings, transportation equipment, amortization, and lease and rent of land, buildings, and equipment. Tax costs are costs imposed for real estate, personal property, and corporate franchise taxes. Quality payments are made to nursing facilities that meet certain quality indicators. Moneys for these payments are withheld from nursing facilities' reimbursements and then used to provide incentive payments. Critical access payments are made to those nursing facilities that are located in certain federally designated locations, have an 85% occupancy rate, and a Medicaid utilization rate of at least 65%.

ICF/IID payment rate

The regular Medicaid payment rate for ICFs/IID is based on four cost centers. The four cost centers are direct costs, capital costs, indirect care costs, and other protected costs. The per Medicaid day payment is the following:

Regular total Medicaid payment rate
= rate for direct care costs
+ rate for indirect care costs
+ rate for capital costs
+ rate for other protected costs

Direct care costs are costs incurred for nursing and other direct care staff such as respiratory and physical therapists, quality assurance activities, training and staff development, habilitation staff, and off-site day programming, among others. Indirect care costs are all reasonable costs incurred by an ICF/IID other than direct care, other protected, and capital costs and include things such as food, laundry, dietary supplies and personnel, bookkeeping, minor equipment, maintenance and repair expenses, among others. Capital costs are ICFs/IID ownership and costs of nonextensive renovation. Other protected costs include: medical supplies; gas, fuel, electricity, water, sewage, and hazardous medical waste collection; protected home office costs; and real estate, franchise and property taxes.

Beginning in FY 2021, ODODD anticipates that it will implement a quality incentive payment for each ICF/IID that earns points for meeting quality indicators. These include creating and promoting diverse opportunities for residents to participate in the community, offering off-site day programming activities, and identifying and placing all residents 18 years of age or older who have an interest in employment on the path to community employment.

Inpatient hospital services

Ohio pays hospitals for Medicaid inpatient admissions using a prospective payment system that includes a pre-established amount for each admission based on a diagnosis-related group (DRG). A small portion of hospital services provided in freestanding rehabilitation or long-term hospitals, in hospitals that are licensed as Health Maintenance Organizations (HMOs), and in cancer hospitals, are paid on a “reasonable cost” basis. Under the DRG system, hospitals are reimbursed based on the principal diagnosis or condition requiring the hospital admission. The DRG system is designed to classify patients into groups that are clinically coherent with respect to the amount of resources required to treat a patient with a specific diagnosis.

Ohio Medicaid creates DRGs by examining hospital charges statewide and comparing charges for each DRG to the average charges for all discharges. With constant changes in the resources required for health care services, including shifts in technology and more efficient methods of providing patient care, hospital resource consumption changes over time. To recognize these changes, Ohio Medicaid updated payment systems in July 2013 by implementing the 3M Health Information System’s All Patient Refined – Diagnosis Related Groups (APR-DRG).

Although a hospital's costs can vary significantly among patients within a specific DRG, the DRG payment is fixed. To compensate hospitals that incur significantly higher costs for Medicaid patients, the state established outlier payments similar to those enacted for Medicare. Congress established Medicare outlier payments for situations in which the costs of treating a Medicare patient are extraordinarily high in relation to the average costs of treating comparable conditions or illnesses. These outlier policies are intended to promote access to care for patients with extremely costly illnesses. Additional payments are also provided, if applicable, for capital costs and graduate medical education.

Ohio prescription drug coverage

Medicaid prescription drug services in Ohio presently encompass over 30,000 line items of drugs from nearly 300 different therapeutic categories. Pharmacy claims are processed by ODM's contracted pharmacy benefits manager (PBM) in an online, real-time environment, which allows the dispensing pharmacist access to the terms of coverage. In the event a particular product is not approved, the dispensing pharmacist can notify the prescribing physician of possible alternatives in a timely fashion. The prescribing physician may choose an alternative product or may call a designated toll-free number to request prior authorization for the product originally prescribed.

Pharmacy providers are paid a dispensing fee and a drug ingredient cost on dispensed medications with some exceptions. Reimbursement for the drug ingredient cost is the lesser of (1) the submitted charge, or (2) the maximum allowable cost or estimated acquisition cost. Ohio receives two types of drug rebates under Medicaid: drug rebates under the federal Medicaid Drug Rebate Program, and supplemental drug rebates under state law.

MCOs contract with PBMs to manage and fill prescriptions. In turn, PBMs provide claim adjudications and customer service, negotiate drug manufacturer rebates, conduct drug utilization reviews, and operate mail order and specialty pharmacies. In addition, PBMs establish pharmacy networks, which allow them to negotiate discounted prices for prescription drugs. In the summer of 2018, ODM required all five MCOs to terminate their contracts with PBMs by the end of calendar year 2018. Effective January 1, 2019, PBM contracts must be based on a "pass-through" pricing model instead of a "spread pricing." Under a pass-through pricing model, PBMs would charge Medicaid the same price that was paid to the pharmacy for the medication and would receive an administrative fee for doing so.

Behavioral health redesign

On January 1, 2018, a redesign of the behavioral health system was implemented, which resulted in an updated benefit package for community behavioral health services. The redesign is an ongoing effort between ODM and the Ohio Department of Mental Health and Addiction Services (OhioMHAS) to enhance the quality and delivery of care for mental health and substance use disorder treatment. This phase of the redesign did the following: updated Medicaid behavioral health billing codes to align with national standards, developed a single fee schedule for mental health and substance use disorder services, tied rates to the qualifications of the provider, and expanded services for individuals with the most intensive needs. The changes implemented on this date only impacted fee-for-service claims and claims for individuals enrolled onto MyCare Ohio. The last phase of the redesign, which occurred on

July 1, 2018, integrated behavioral health into Medicaid managed care. Thus, as of July 1, behavioral health services are now covered by MCPs instead of paid for directly by ODM. To assist with this integration, ODM included a number of safeguards to help both service providers and Medicaid recipients. These safeguards include: a grace period that required MCOs to allow Medicaid recipients to continue receiving services through out-of-network providers through December 31, 2018, a requirement that MCOs maintain minimum reimbursement rates equivalent to fee-for-service rates for behavioral health services through June 30, 2019, and the establishment of a task force devoted to post-implementation concerns. The task force consists of ODM, OhioMHAS, MCPs, and various other involved entities.

Home and community-based service waivers

Home and community-based service (HCBS) waivers provide alternatives to institutional long-term care under state Medicaid programs. The term “waiver” refers to an exception to federal law that is granted to a state by CMS. Medicaid waivers allow participants, who have disabilities and chronic conditions, to have more control of their lives and remain active participants in their community. Without HCBS waivers, many consumers would live in a hospital, nursing home, or ICF/IID. In addition to providing alternatives to institutional care, waivers allow the state Medicaid Program to limit enrollment, limit the locations where services are provided, and waive certain eligibility requirements.

There are several waivers within Ohio Medicaid. ODM currently administers the Ohio Home Care Waiver (OHCW). The Ohio Department of Aging (ODA) manages the PASSPORT and Assisted Living waivers. ODODD manages the Level One Waiver, Individual Options Waiver, and the Self-Empowered Life Funding (SELF) Waiver. In addition, MyCare Ohio enrollees are eligible to receive HCBS waiver services. Together these waivers provided alternative access to long-term care to almost 97,000 individuals as of November 2018.

A level of care is used to approve enrollment on a Medicaid waiver or authorize Medicaid payment to a nursing facility. A person who wants to be enrolled on a Medicaid waiver must meet the specific level of care that is required for that waiver. All individuals must meet and exceed the requirements of a protective level of care, which includes a need for assistance with instrumental activities of daily living (IADLs) and/or supervision of one activity of daily living (ADL) or medication administration.

There are currently two levels of care associated with Medicaid waivers:

1. ICF/IID level of care. This level of care includes a presence of a substantial developmental delay or a severe, chronic disability. A Medicaid waiver that requires an ICF/IID level of care provides services as an alternative to institutional care.
2. Nursing facility-based (NF-Based) level of care. A Medicaid waiver that requires an NF-Based level of care provides services as an alternative to nursing facilities, hospitals, or rehabilitation facilities. This level of care includes the Intermediate and Skilled levels of care:
 - a. Intermediate level of care includes a need for assistance with ADLs, medication administration, and/or a need for at least one skilled nursing or skilled rehabilitation service; and

- b. Skilled level of care indicates a higher level of need than the Intermediate and ICF/IID levels of care and includes a presence of an unstable medical condition and a need for a specific amount of skilled nursing or skilled rehabilitation services.

ODM's "Ohio Medicaid Waiver Comparison Chart – Enrollment Figures for November 2018" provides a summary of these waiver programs. Their basic descriptions are provided below followed by a table showing enrollment and costs as of December 2018.

Assisted Living Waiver

This waiver is administered by ODA and is for adults age 21 or older who need a nursing facility level of care. The waiver offers assisted living and, for nursing home residents, community transition services. Assisted living services include: on-site response, personal care, supportive services (e.g., housekeeping, laundry), nursing, and transportation. The individual is responsible for room and board expenses. PASSPORT Administrative Agencies provide administrative case management services to individuals enrolled onto this waiver.

PASSPORT

This waiver is also administered by ODA. It is for adults age 60 or older who need a nursing facility level of care. Additionally, the individual must be able to remain safely at home with the consent of their physician. PASSPORT Administrative Agencies provide administrative case management services to individuals enrolled onto this waiver. The waiver offers the following services:

- Adult day health services
- Alternative meal services
- Home care attendant
- Home-delivered meals
- Emergency response systems
- Nutritional consultation
- Out-of-home respite
- Social work and counseling
- Transportation
- Homemaker and personal care
- Home medical equipment and supplies
- Chore assistance
- Community transition
- Independent living assistance
- Nonmedical transportation
- Enhanced community living
- Minor home repair, maintenance, and modification
- Waiver nursing

Level One Waiver

This waiver is administered by ODODD and is for individuals of all ages who require an ICF/IID level of care. County boards of developmental disabilities provide administrative case management services to individuals enrolled onto this waiver. The waiver offers the following services:

- Adult day support
- Environmental accessibility adaptations
- Homemaker/personal care
- Home-delivered meals
- Group employment support
- Respite – informal
- Respite – community and residential
- Individual employment support
- Money management
- Participant-directed homemaker/personal care
- Supported employment
- Transportation
- Nonmedical transportation
- Vocational habilitation
- Waiver nursing delegation
- Assistive technology
- Community transition

Individual Options Waiver

This waiver is administered by ODODD and is for individuals of all ages who require an ICF/IID level of care. County boards of developmental disabilities provide administrative case management services to individuals enrolled onto this waiver. The waiver offers the following services:

- Waiver nursing
- Transportation
- Community and residential respite
- Adult day support
- Respite – residential and community
- Money management
- Social work
- Interpreter
- Home-delivered meals
- Nonmedical transportation
- Nutrition
- Environmental accessibility modifications
- Homemaker/personal care
- Adaptive and assistive equipment
- Vocational habilitation
- Supported employment (individual and group)
- Waiver nursing delegation
- Shared living
- Participant-directed homemaker/personal care
- Assistive technology

Self-Empowered Life Funding (SELF) Waiver

This waiver is administered by ODODD and is for individuals of all ages who require an ICF/IID level of care. This waiver follows a participant-directed model with cost limitations of \$25,000/year for children (under age 22) and \$40,000/year for adults. County boards of developmental disabilities provide administrative case management services to individuals enrolled onto this waiver. The waiver offers the following services:

- Participant-directed goods and services
- Participant/family stability assistance
- Participant-directed homemaker/personal care
- Adult day supports
- Career planning
- Support brokerage
- Clinical/therapeutic intervention
- Transportation
- Residential respite
- Community respite
- Nonmedical transportation
- Functional behavioral assessment
- Waiver nursing delegation
- Habilitation – vocational
- Group employment support
- Individual employment support
- Assistive technology

Ohio Home Care Waiver (OHCW)

This waiver is administered by ODM. It is for adults under the age of 60 who need a nursing facility level of care. ODM contracts with case management agencies to provide administrative case management services. The waiver offers the following services:

- Adult day health
- Emergency response
- Home care attendant
- Home-delivered meals
- Home modification
- Out-of-home respite
- Personal care aide
- Supplemental adaptive and assistive device
- Supplemental transportation
- Waiver nursing

MyCare Ohio

This waiver is administered by ODM by contracting with managed care plans to offer services. It is for individuals age 18 and over who are eligible for both Medicare and Medicaid (dual-eligibles). MyCare is a demonstration project that is available only in certain counties. The waiver offers the following services:

- Adult day health
- Alternative meal services
- Assisted living service
- Choices home care attendant
- Home care attendant
- Home-delivered meals
- Emergency response
- Home medical equipment and supplemental adaptive and assistive devices
- Home modification, maintenance, and repair
- Chore assistance
- Community transition
- Independent living assistance
- Nutritional consultation
- Out-of-home respite
- Personal care aide
- Social work counseling
- Homemaker
- Enhanced community living
- Waiver nursing
- Waiver transportation
- Pest control

Ohio Medicaid Enrollment, November 2018		
	Unduplicated Capacity	Enrollment
MyCare Ohio	46,360	28,219
Ohio Home Care Waiver (OHCW)	8,600	5,719
PASSPORT	32,031	20,166
Assisted Living Waiver	5,078	3,144
Individual Options Waiver	24,300	23,050
Level One Waiver	17,250	14,781
Self-Empowered Life Funding (SELF) Waiver	2,600	1,704

Medicaid cost sharing

Federal restrictions on cost sharing

The federal government limits patient cost sharing, such as premiums, copayments, and deductibles. Out-of-pocket costs cannot be imposed for emergency services, family planning services, pregnancy-related services, or preventive services for children. Additionally, certain vulnerable populations are exempt from most out-of-pocket costs. These groups include children, individuals living in an institution, and individuals who are terminally ill and receiving hospice care. Most nonexempt populations and services are restricted to only nominal out-of-pocket costs. Furthermore, generally services cannot be withheld from Medicaid enrollees for failure to pay their out-of-pocket costs. In some cases, enrollees with income above 100% FPL may be charged alternative out-of-pocket costs that are higher than a state’s nominal charges with certain exceptions. Medicaid enrollees subject to alternative out of pocket costs also may be denied services for nonpayment.

States’ use of premiums and cost sharing

A survey by the Kaiser Family Foundation found that, as of January 2018, 30 states charge premiums or enrollment fees and 24 states charge cost sharing for children in Medicaid or SCHIP.²² A majority of these charges are limited to children in SCHIP, because SCHIP covers children with higher family incomes than those in Medicaid and the program has different premium and cost-sharing rules. Most states do not charge adults premiums because of their low incomes. Overall, 39 states charge parents cost sharing, and 22 of the 32 states that have ACA expansion charge cost sharing for expansion adults. Five states have received waivers to charge premiums or monthly contributions for adults that are not otherwise allowed under law.

Cost sharing in Ohio

Ohio Medicaid copayments

The table below shows the current copayments required under Ohio Medicaid.

Ohio Medicaid Copayments	
Services	Copayments
Nonemergency services obtained in a hospital emergency room	\$3 per visit
Dental services	\$3 per visit
Eye examinations	\$2 per examination
Eyeglasses	\$1 per fitting
Most brand name (nongeneric) medications	\$2 per prescription or refill
Medications that require prior authorization	\$3 per prescription or refill

²² “Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost Sharing Policies as of January 2018: Findings from a 50-State Survey,” January 2018, Kaiser Family Foundation

If a Medicaid recipient is unable to pay the copayment, they cannot be refused medical services. However, they still owe the copayment to the health care provider. The health care provider may refuse medical services to a Medicaid recipient if there are outstanding unpaid copayments. Copayments are not charged for individuals who are:

- Younger than age 21;
- Pregnant or the pregnancy ended up to 90 days prior;
- Living in a nursing home or an ICF/IID;
- Receiving emergency services in a hospital, clinic, office, or other facility;
- Receiving family planning-related services;
- Receiving hospice care; or
- In a managed care plan that does not charge copayments.

Ohio Medicaid premiums

Monthly premiums are required for those eligible for Medicaid Buy-In for Workers with Disabilities (MBIWD) with a household annual gross income greater than 150% FPL. Enrollees who do not pay their premium for two consecutive months are subject to MBIWD termination. To re-enroll in MBIWD, an individual must pay all MBIWD delinquent premiums and meet eligibility requirements. Premiums are determined through a set of calculations based on household income, family size, and certain standard deductions.

Medicaid provider taxes

In addition to using its general revenue funds to pay the state share of the cost of its Medicaid program, states may also use other sources. One type of tax that is commonly relied on by many states to fund a portion of their share of Medicaid program costs is a tax on health care providers. These taxes, called provider taxes, however, must comport with federal law in order to qualify for receiving federal reimbursement. Many states use provider tax revenue to increase Medicaid payment rates for the class of providers, such as hospitals, responsible for paying the provider tax. This financing strategy allows states to fund increases to Medicaid payment rates without the use of state funds as the increased Medicaid payment rates are funded with provider tax revenue and federal Medicaid matching funds. States also use provider tax revenues to fund other Medicaid or non-Medicaid purposes.

Federal restrictions on provider taxes

With respect to provider-specific taxes, the federal law:

- Requires provider taxes be “broad-based” and uniformly applied to all providers within specified classes of providers – in other words, states cannot limit the provider taxes only to Medicaid providers; the same tax has to be imposed on all providers within a specified class of providers.
- Prohibits taxes that exceed 25% of the state (or nonfederal) share of Medicaid expenditures.
- Prohibits states from a direct or indirect guarantee that providers receive their money back or be held harmless. However, states can avoid scrutiny under this provision as long as the provider tax is less than 6% of the taxpayer’s net operating revenue.

For the purpose of claiming federal matching payments, the specified classes of providers used to ensure that tax programs are “broad-based” are those that provide the following:

- | | |
|---|--|
| ▪ Inpatient hospital services | ▪ Dental services |
| ▪ Outpatient hospital services | ▪ Podiatric services |
| ▪ Nursing facility services | ▪ Chiropractic services |
| ▪ Services of intermediate care facilities for individuals with intellectual disabilities | ▪ Optometric/optician services |
| ▪ Physicians’ services | ▪ Psychological services |
| ▪ Home health care services | ▪ Therapist services |
| ▪ Outpatient prescription drugs | ▪ Nursing services |
| ▪ Services of managed care organizations | ▪ Laboratory and x-ray services |
| ▪ Ambulatory surgical centers | ▪ Emergency ambulance services |
| | ▪ Other health care items or services for which the state has enacted a licensing or certification fee |

While federal requirements allow states to impose provider taxes on these 19 classes of health care providers, the classes of providers that are most often taxed include nursing facilities, hospitals, ICFs/IID, and managed care organizations. Requiring that all providers within a class be taxed, as opposed to only Medicaid providers, dampens the ability of states to establish such taxes. The reason is that Medicaid providers can easily be held harmless by inflating Medicaid payments. Other providers cannot be repaid so simply, and therefore are more likely to oppose the imposition of such taxes.

Ohio's Medicaid provider taxes

Ohio currently charges taxes on four types of providers: nursing facilities, ICFs/IID, hospitals, and managed care organizations.

Nursing facility franchise permit fees

ODM assesses an annual franchise permit fee on each long-term care bed in a nursing home or hospital. The fee is calculated according to a statutory formula²³ as follows:

1. Determine the estimated total net patient revenues for all nursing homes and hospital long-term care units for the fiscal year;
2. Multiply the amount estimated above by 6%;
3. Divide the product determined above by the number of days in the fiscal year;
4. Determine the sum of (a) the total number of beds in all nursing homes and hospital long-term care units that are subject to the franchise permit fee for the fiscal year and (b) the total number of nursing home beds that are exempt from the fee for the fiscal year because of a federal waiver;
5. Divide the quotient determined pursuant to (3) above by the sum determined under (4) above.

Total revenue from the fee was about \$410.2 million in FY 2018.

ICF/IID franchise permit fees

ICFs/IID, including developmental centers operated by ODODD, are charged a franchise permit fee per bed per day. The rate is \$18.02.²⁴

Hospital care assessments

ODM charges hospitals an annual assessment equal to a percentage of the hospital's total facility costs. A hospital's total facility costs are the hospital's total costs for all care provided to all patients, including the direct, indirect, and overhead costs to the hospital of all services, supplies, equipment, and capital related to the care of patients, regardless of whether patients are enrolled in a health insuring corporation. However, total facility costs exclude all of

²³ R.C. 5168.41.

²⁴ R.C. 5168.60 sets the rate for FY 2017 and beyond at this amount. In FY 2016 it was \$18.07.

the following costs: Medicare costs, skilled nursing services provided in distinct-part nursing facility units, home health services, hospice services, ambulance services, renting durable medical equipment, and selling durable medical equipment. The hospital assessment rate is generally set in the main operating appropriations bill. It is about 2.65% in FY 2018 and FY 2019.²⁵ The revenue generated by the assessment in FY 2018 was \$641.2 million.

Managed care franchise fee

Currently, the state subjects all health insuring corporations (HICs) with a tax rate ranging from \$26 to \$56 per Medicaid member month, and \$1 to \$2 per non-Medicaid member month. The amount varies depending on the size of the enrollment for each corporation. This HIC tax replaced a sales and use tax imposed on Medicaid managed care organizations. The sales and use tax was determined by CMS to be an impermissible taxing method for drawing down Medicaid matching funds from the federal government, since non-Medicaid health insuring corporations were not subject to it. The previous tax generated over \$900 million in state taxes and \$200 million in local taxes. Ohio received an approval letter from CMS on December 7, 2016, permitting it to charge a tax on all health insuring corporations. H.B. 49 of the 132nd General Assembly replaced the sales tax with this new HIC tax. This tax generated \$778.7 million in revenues in FY 2018.

²⁵ O.A.C. 5160-2-30.

Additional Medicaid programs

Hospital Care Assurance Program

The federal government requires state Medicaid programs to make subsidy payments to hospitals that provide uncompensated, or charity, care to low-income and uninsured individuals at or below 100% FPL under the Disproportionate Share Hospital (DSH) Program. The Hospital Care Assurance Program (HCAP) is the system Ohio uses to comply with the DSH Program requirement. Under HCAP, hospitals are assessed an amount based on their total facility costs and government hospitals make intergovernmental transfers to ODM. ODM then redistributes back to hospitals money generated by the assessments, intergovernmental transfers, and federal matching funds based on uncompensated care costs.

Medicare Part D clawback payments

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 established the “Part D” in Medicare that gives people access to a private Medicare prescription drug plan. This Medicare pharmacy benefit, which provides drug coverage for many individuals that previously had none, has broad implications for states. The MMA requires state Medicaid programs to determine eligibility for Part D Medicare beneficiaries, and to contribute to the cost of federal prescription drug coverage for dual-eligibles.

Pharmacy benefits under Medicare Part D

Like all other Medicare beneficiaries, dual-eligibles gained access to the universal Medicare prescription drug benefit starting January 1, 2006. Prior to January 2006, the prescription drug costs of the dual-eligibles were paid by Medicaid. Under MMA, Medicaid no longer pays for prescription drugs for dual-eligibles. Instead, they are to obtain their drug coverage by enrolling in one of the Medicare drug plans.

Phased-down state contribution (clawback)

The mechanism through which the states help finance the Medicare drug benefit is popularly known as the “clawback” (the statutory term is “phased-down state contribution”). In brief, the clawback is a monthly payment made by each state to the federal Medicare Program. The amount of each state’s payment roughly reflects the expenditures of its own funds that the state would have made if it continued to pay for prescription drugs through Medicaid on behalf of dual-eligibles. A state’s clawback payment for any given month is equal to the product of a three-part formula:

$$\text{Payment} = (\text{PCE}/12) \times \text{DE} \times \text{P}\%$$

Per capita expenditures (PCE)

This is the state’s share of its per capita Medicaid expenditure for covered drugs for dual-eligibles in CY 2003, increased by the growth in per capita prescription drug spending nationally, and adjusted for the change in the state’s relevant FMAP. The state Medicaid per capita expenditures for prescription drugs for dual-eligibles in CY 2003 must include pharmacist

dispensing fees, adjust for manufacturer rebates, and exclude any expenditure for drugs not covered under Part D.

Dual-eligibles (DE)

This is the number of dual-eligibles in the month who are enrolled in Medicare Part D and have been determined by the state to be eligible for full Medicaid benefits, not just subsidies for Medicare premiums and cost sharing.

Phase-down percentage (P%)

This is the phase-down percentage for the year specified in the MMA. The phase-down percentage decreased from 90% in CY 2006 to 75% in CY 2015 and thereafter.

For example, if, in January 2018, Ohio had 240,000 dual-eligibles enrolled in Part D plans, and if the average monthly per capita Medicaid spending for prescription drugs for dual-eligibles was \$155, then Ohio's clawback payment amount for the month would be \$27.9 million.

$$\$27.9 \text{ million} = \$155 \times 240,000 \times 75\%$$

Summary of expenditures

Expenditures for Ohio’s Medicaid Program totaled \$26.3 billion in FY 2018, of which 68.3% (\$17.98 billion) was funded by the federal government. The following table breaks down FY 2018 expenditures by payment category. Managed care for the CFC and ABD populations was the largest expense at \$11.16 billion, followed by managed care for the Group VIII population at \$4.07 billion. Together expenditures on managed care accounted for 57.9% of the total. Services provided through ODODD totaled \$2.57 billion (9.7%). Combined with ODA waivers and the Home Care waiver administered by ODM, waiver costs were 2.0% of the total.²⁶ Administration at \$925.8 million made up just 3.5% of total expenditures in FY 2018.

Medicaid Expenditures by Payment Category, FY 2018 (\$ in thousands)		
Payment Category	Expenditure	Percentage of Total
Managed Care – CFC and ABD	\$11,160,370	42.4%
Managed Care – Group VIII	\$4,074,788	15.5%
DDD Services	\$2,567,200	9.7%
Hospitals	\$1,925,444	7.3%
Nursing Facilities	\$1,503,539	5.7%
Physicians/All Other	\$1,157,913	4.4%
Behavioral Health	\$1,142,840	4.3%
Administration	\$925,753	3.5%
Medicare Premium Assistance	\$612,109	2.3%
Medicare Part D	\$461,884	1.8%
Prescription Drugs	\$304,705	1.2%
ODA Waivers	\$385,624	1.5%
Home Care Waivers	\$120,489	0.5%
Total All Funds	\$26,342,659	100.0%

²⁶ This is not the total waiver expense as ODODD-administered waivers are included in the DDD Services total.