

Ohio Department of Job & Family Services Medicaid Section

Senate Finance and Financial Institutions Committee

Ivy Chen, Economist

Legislative Service Commission

May 1, 2003

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LSC Redbook
for the
Ohio Department of Job & Family Services
Medicaid Section

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May 1, 2003

Note: The estimated General Revenue Fund (GRF) spending for FY 2003 used in this LSC Redbook reflects the 2.5% reduction made as a result of the Governor's January 22, 2003 budget cut order. The executive reduction was applied across-the-board to FY 2003 GRF appropriations, subject to certain exceptions. Subsequent to such reductions (and not reflected in the Redbook), state agencies were permitted to reallocate the amount that each of their GRF appropriation line items was reduced, while still absorbing the 2.5% budget cut within the total amount of their GRF appropriations.

HEALTH CARE/MEDICAID

OVERVIEW

The Office of Ohio Health Plans in the Department of Job and Family Services (JFS) operates several state- and federally-funded programs providing health care coverage to certain low-income and medically-vulnerable people of all ages including: Medicaid, the State Children’s Health Insurance Program (SCHIP, created by the Social Security Act as Title XXI), the Hospital Care Assurance Program (HCAP, also created by the Social Security Act as Title XXI), and the state Disability Assistance (DA) Medical program.

Medicaid, the largest health program in Ohio, was created by the Social Security Act as Title XIX, and became law in 1965. Medicaid is an entitlement program and is a state-federal partnership that jointly funds the provision of adequate medical care to eligible needy persons. In this partnership, the federal government establishes broad national guidelines. Each state determines its own eligibility requirements and scope of services, sets its own payment rates, and administers its own program.

The State Children’s Health Insurance Program provides health care coverage to children who were not previously eligible for Medicaid and whose family income is below 200% of the federal poverty guideline (FPG). Through HCAP, hospitals are reimbursed for some of their costs of providing medical care to persons below 100% of FPG. Disability Assistance Medical is a state- and county-funded program that provides limited medical coverage to persons who are not eligible for a federally-funded program.

In FY 2002, Medicaid and SCHIP provided health care coverage to about 1.4 million Ohioans every month to people in the following four distinct insurance markets: children in families with incomes at or below 200% of FPG; pregnant women with incomes at or below 150% of FPG; parents at or below 100% of the FPG; and low-income elderly and persons with disabilities of all ages, commonly referred to as Aged, Blind, and Disabled (ABD). Many consumers with disabilities have medical needs so extensive that commercial plans would deem them “uninsurable.” Even though Medicare provides coverage for most of Ohio’s elderly population, many of these individuals are “dually eligible.” Medicaid supplements their Medicare benefits by providing coverage for services such as prescription medications and long-term care through the Medicaid program. Medicaid also provides assistance with Medicare premiums, co-payments, and deductibles to certain low-income seniors.

Although other state agencies provide Medicaid services, the vast majority of Medicaid spending occurs within the JFS budget. Recognized by the federal government as Ohio’s single Medicaid agency, JFS provides long-term care and basic medical services with state and federal moneys through General Revenue Fund (GRF) line item 600-525, Health Care/Medicaid. Beginning in FY 2003, the 600-525 line item is not only used to fund Medicaid, but also SCHIP, and DA Medical.¹ In addition to the GRF, several provider tax programs and other special revenues are used to pay for Medicaid services.²

¹ Prior to FY 2003, spending for part II of SCHIP was funded through line item 600-426, Children’s Health Insurance Program, and spending for DA Medical was funded through line item 600-511, Disability Assistance/Other Assistance.

² Provider tax programs refer to assessments on hospitals, as well as bed taxes on nursing facilities and intermediate care facilities for the mentally retarded. These programs serve as a mechanism by which to draw additional federal matching funds.

The federal financial share of Ohio's Medicaid program changes every federal fiscal year. In accordance with federal law, the federal government shares in the cost of Medicaid at a matching rate known as the FMAP (Federal Medical Assistance Percentage). The FMAP is calculated based upon each state's per capita income in recent years relative to the entire nation. The general description of how this cost-sharing mechanism works has traditionally been as follows: for every one dollar Ohio spends on Medicaid, the federal government gives Ohio 60 cents. However, while the majority of the spending in line item 600-525, Health Care/Medicaid, is matched at the FMAP rate, a few items, primarily contracts, are matched at 50%, and all family planning services receive a 90% match. In addition, about 15% of Medicare buy-in premiums receive no federal match. Lastly, SCHIP is matched at an enhanced FMAP of about 70%.

Other special revenues include funds for the Disproportionate Share Hospital (DSH) offset, drug rebates, and the franchise fees.

ANALYSIS OF EXECUTIVE PROPOSAL

Ohio Health Plans

Purpose: The activities of the health care program series assure the provision of health care to certain low-income people of all ages who lack the means to pay for medical services and for those for whom health care coverage supports work activity and personal responsibility.

The following table shows the line items that are used to fund this program series, as well as the Governor's recommended funding levels.

Fund	ALI	Title	FY 2004	FY 2005
GRF	600-425	Office of Ohio Health Plans	\$43,793,456	\$45,099,242
GRF	600-525	Health Care/Medicaid	\$8,839,985,860	\$9,305,614,950
5C9	600-671	Medicaid Program Support	\$54,686,270	\$55,137,078
3F0	600-623	Health Care Federal	\$391,658,105	\$394,221,409
3F0	600-650	Hospital Care Assurance Match	\$298,128,308	\$305,879,644
3G5	600-655	Interagency Reimbursement	\$1,138,699,709	\$1,201,385,603
4E3	600-605	Nursing Home Assessments	\$4,759,913	\$4,759,914
4J5	600-613	Nursing Facility Bed Assessment	\$35,060,013	\$35,064,238
4J5	600-618	Residential State Supplement Payment	\$15,700,000	\$15,700,000
4K1	600-621	ICF MR Bed Assessments	\$20,467,050	\$20,428,726
4Z1	600-625	Healthcare Compliance	\$10,000,000	\$10,000,000
5P5	600-692	Health Care Services	\$385,100,993	\$448,932,851
5Q9	600-619	Supplemental Inpatient Hospital Payments	\$30,797,539	\$30,797,539
5R2	600-608	Medicaid-Nursing Facilities	\$113,754,184	\$113,754,184
5S3	600-629	MR/DD Medicaid Administration & Oversight	\$1,620,960	\$1,620,960
5U3	600-654	Health Care Services Administration	\$7,576,322	\$6,119,127
651	600-649	Hospital Care Assurance Program	\$208,634,072	\$214,058,558
Total funding: Health Care			\$11,600,422,754	\$12,208,574,023

Specific program areas within the Ohio Health Plans program series that this analysis will focus on include:

- **OFFICE OF OHIO HEALTH PLANS**
- **HEALTH CARE SERVICES ADMINISTRATION**
- **HEALTH CARE/MEDICAID**
- **FRANCHISE PERMIT FEES**

Office of Ohio Health Plans

Program Description: The Office of Ohio Health Plans (OHP) has the following responsibilities: (1) serves as the primary point of contact with the federal government for the Medicaid program, (2) contracts with other state agencies to carry out certain operations and services of the Medicaid program, (3) oversees policies, rules, and operations carried out by Medicaid, (4) monitors and oversees the Medicaid budget, (5) monitors and evaluates Medicaid programs in collaboration with local communities, (6) administers the Medicaid State Plan, and (7) works with a Medical Care Advisory Committee.

Funding Source: GRF

Line Item: 600-425, GRF

Implication of the Executive Recommendation: The Executive recommends increased funding for OHP of \$3.6 million in fiscal year (FY) 2004 from FY 2003 estimated spending levels, and \$1.3 million in FY 2005 as compared to the FY 2004 recommended appropriation, to support a variety of system changes related to Medicaid cost containment initiatives.

In FY 2003, JFS went to a program budgeting structure and the original appropriations to line items 600-100, Personal Services; 600-200, Maintenance; and 600-300, Equipment; were divided and transferred to other newly created line items by the Controlling Board. Line item 600-425 was one of the newly created line items.

Line item 600-425 is the primary funding source used to pay the operating expenses of the Office of Health Plans. The federal earnings on the payments from this line item are deposited as revenue into the GRF.

The Executive's recommended funding level allows OHP to maintain current administrative capacity. It also provides approximately \$2 million in each fiscal year to pay for the costs of contracts with outside consultants for some of the cost containment initiatives.

Health Care Services Administration

Program Description: Appropriations from the Health Care Services Administration Fund are used to pay for costs associated with the administration of the Medicaid program.

Funding Source: SSR

Line Item: 600-654, SSR

Implication of the Executive Recommendation: The Executive recommends increased funding for line item 600-654, Health Care Services Administration, of \$4.2 million in FY 2004 from FY 2003 estimated spending levels, followed by a decrease in funding of \$1.5 million in FY 2005 as compared to the FY 2004 recommended appropriation, to pay for costs associated with the administration of the Medicaid program. According to JFS, the appropriation amount in FY 2004 is higher than FY 2005 because of start-up, operational, and new staff training costs.

Senate Bill 261 of the 124th General Assembly created the Health Care Services Administration Fund (Fund 5U3) and specified its sources of funding. The bill provided \$3,419,405 in appropriations for FY 2003 to line item 600-623, Health Care Federal, and \$3,419,405 in appropriations for FY 2003 to line item 600-654, Health Care Services Administration, which was newly created in the bill. The bill specified that line item 600-654 is to be used by JFS for costs associated with the administration of the Medicaid program. The bill permitted the Director of JFS, for FY 2003, to deposit into Fund 5U3 any revenue received from federal reimbursement for allowable Medicaid administrative expenditures made by state or local entities. The bill also provided \$175,000 of the amount received during FY 2003, from the first installment of assessments on hospitals for the Hospital Care Assurance Program (HCAP) and intergovernmental transfers under HCAP, to be deposited into the state treasury to the credit of Fund 5U3.

The Executive's recommended budget includes \$350,000 of the amount received each fiscal year during FYs 2004 and 2005, from the first installment of assessments on hospitals for HCAP and intergovernmental transfers under HCAP, to be deposited into Fund 5U3.

The Department of Job and Family Services plans to use these funds to hire additional staff and pay for contracted services for various purposes that, according to JFS, will result in cost avoidance for the Department. Those various purposes include:

- Safeguarding Medicaid funds that are distributed to other state agencies to ensure proper use of the funds, which could result in fewer audit findings by the federal government that result in revenue loss by the state for the Medicaid program;
- Hiring more auditors that can audit Medicaid providers to improve billing accuracy, when appropriate, recover overpayments of Medicaid, and reduce fraud and abuse;
- Refinancing services currently funded with GRF and/or local funds in the mental retardation and developmental disabilities, education, and public health systems; and
- Developing care management strategies for Ohioans with higher medical needs.

As stated earlier, S.B. 261 increased the appropriations for JFS by approximately \$6.8 million in FY 2003. The Department of Job and Family Services estimated that it would take almost two years to get to a point where these initiatives are fully functioning and generating cost savings and revenue. Senate Bill 261 allowed JFS to retain a portion of new revenues or recoveries generated to support these initiatives and JFS expected to be able to do so toward the end of the two-year start-up period. This will allow JFS to sustain these activities in the future. Once these initiatives are fully functioning, JFS estimates that they will generate \$82 million annually in new federal resources for state and local health-related programs and avoid up to \$142 million annually in additional future Medicaid costs to the GRF.

Since the establishment of the Health Care Services Administration Fund, OHP has almost completed the first phase of the initiative. The OHP has hired four staff and has deposited its first revenue into the Health Care Services Administration Fund. The next phase focuses on federal compliance and revenue generation activities, including expanding work and staffing for the Surveillance, Utilization, and Review Section, Hospital Care Assurance Program, Upper Payment Limit, Third Party Liability, Payment Adjustments, Medicaid Administrative Claiming, as well as fiscal and legal services. The third phase will focus on expanding the capacity of Subrecipient Monitoring, Provider Network Management, and implementation of a targeted Care Management program for high cost customers. The final phase will result include survey and research activities to guide the future development and management of the Medicaid program.

Permanent Law: Section 5111.94 removes a reference to the scheduled expiration date of HCAP from the provisions that describe the moneys included in Fund 5U3.

Temporary Law: Section 58.04 of H.B. 95, as introduced, specifies that line item 600-654 is to be used to pay for the costs associated with the administration of the Medicaid program.

Section 58.05 of H.B. 95, as introduced, provides that \$350,000 of the amount received each fiscal year during FYs 2004 and 2005, from the first installment of assessments on hospitals for HCAP and intergovernmental transfers under HCAP, be deposited into Fund 5U3.

Health Care/Medicaid

Program Description: The state Medicaid program provides health care to certain low-income people of all ages who lack the means to pay for medical services and for those for whom health care coverage supports work activity and personal responsibility.

Funding Source: GRF and FED

Line Item: 600-525 (GRF), 600-671 (GSF), 600-623 (FED), 600-650 (FED), 600-619 (SSR), 600-629 (SSR), 600-649 (SSR)

Implication of the Executive Recommendation: The Executive recommends increased funding for line item 600-525, Health Care/Medicaid, of \$786 million in FY 2004 from FY 2003 estimated spending levels (a 9.8% increase), and by \$465.6 million in FY 2005 (5.3% above the FY 2004 recommended appropriation).

While individuals can become eligible for Medicaid programs that are funded out of line item 600-525 by meeting any one of many sets of eligibility criteria, all of these various eligibility groups can be categorized into eight major types: Aged, Blind, and Disabled (ABD); Qualified Medicare Beneficiaries (QMBs); Specified Low-Income Medicare Beneficiaries (SLMBs); Healthy Families (HF); Healthy Start (HS); children in families with incomes at or below 150% of the FPG, known as CHIP-I; children in families with incomes between 150% and 200% of the FPG, known as CHIP-II, and DA Medical. Generally, Healthy Families, Healthy Start, CHIP-I, and CHIP-II are grouped as Covered Families and Children (CFC).

The number of monthly eligibles on average for Medicaid grew by approximately 11% from 1.28 million in FY 2001 to 1.42 million in FY 2002. The number of monthly eligibles on average is estimated to reach 1.56 million in FY 2003, approximately a 10% increase over FY 2002. The Legislative Service Commission (LSC) forecasts that the number of persons eligible for Medicaid will continue to grow to 1.64 million in FY 2004 and 1.65 million in FY 2005, approximately a 5% and 1% increase, respectively. Poor labor market conditions associated with the recession have been the primary driving force behind the growth in total caseload. An additional factor behind the recent growth in caseload has been the CHIP-II program expansion that began on July 1, 2000.

Spending from GRF line item 600-525 can generally be placed into one of nine major categories: long-term care (nursing facilities, or NFs, and Intermediate Care Facilities for the Mentally Retarded, or ICFs/MR), hospitals (inpatient and outpatient), physician services, prescription drugs, health maintenance organizations (HMOs), Medicare buy-in, waiver, all other care, and DA Medical. Medicaid program costs depend on caseloads, as well as both utilization and overall health care inflation—Medicaid spending on health care services that are market driven significantly outweighs program payments to providers that are tied to fee schedules. In addition, payment rates for long-term care, inpatient hospital care, and prescription drugs are statutorily connected to market place trends. Consequently, Medicaid, like any other third party payer, is very susceptible to market forces.

Since FY 1990, Ohio Medicaid spending has increased by an average of more than 10% each fiscal year. The executive budget recommendations include various cost containment initiatives in order to moderate the Medicaid spending growth rate. A brief description of each initiative, as presented in the Special Analysis section of the Executive Blue Disk titled “Ohio Medicaid Policy Initiatives,” along with additional information and analysis by LSC, is provided below.

Primary and Acute Care

Freeze rates for the biennium: The Executive recommends holding reimbursement rates to no increase for Medicaid providers for FYs 2004 and 2005 except for the following:

- A select number of provider types may still receive annual increases in accordance with federal policy mandates or contracts negotiated through non-JFS administrative systems.
- Inpatient hospital rates are adjusted on a calendar year basis, rather than a fiscal year basis. The increase scheduled to take effect in January 2003 did not occur, so the two-year period for the inpatient rate freeze began six months prior to the other providers' timeframes. As a result, inpatient hospital rates are assumed to increase by 3% in January 2005.

Many community-based Medicaid providers have already experienced no rate increase in the FY 2002-2003 biennium. The Department of Job and Family Services estimates that the state will avoid approximately \$42 million in FY 2004 and \$74 million in FY 2005 in potential costs for inpatient hospitals as a result of the initiative. Based on LSC's Medicaid forecast figurers, LSC estimates that the state will avoid approximately \$42 million in FY 2004 and \$71 million in FY 2005 in potential costs for inpatient hospitals.

The reimbursement rates for hospitals and community-based providers are adjusted through administrative rules; no statutory change is necessary for this initiative.

Eliminate specific services for adults: The Executive recommends the elimination of five optional services for adults: dental care, chiropractic care, podiatry, vision care, and psychologist services. These policy changes will be effective January 1, 2004.

Federal regulation requires that state Medicaid programs provide a full range of medically-necessary services to children. Thus, the executive budget recommendation includes elimination of these services for adults only. The Executive estimates that the state will avoid approximately:

- \$21 million in FY 2004 and \$59 million in FY 2005 in potential costs for dental care;
- \$2 million in FY 2004 and \$6 million in FY 2005 in potential costs for chiropractic care;
- \$2 million in FY 2004 and \$6 million in FY 2005 in potential costs for podiatry;
- \$4 million in FY 2004 and \$12 million in FY 2005 in potential costs for vision care; and
- \$0.4 million in FY 2004 and \$1 million in FY 2005 in potential costs for psychologist services.

The regulations for dental care, podiatry, vision care, and psychologist services are in administrative rules; therefore, no statutory changes are necessary for the elimination of these services. However, the recommended elimination of chiropractic care for adults is accomplished through changes in Revised Code section 4734.15. These changes are included in H.B. 95, as introduced.

Implement care management for high-cost populations: The Executive recommends a mandate for JFS to develop care management arrangements for high-cost populations that include persons with one or more chronic conditions. This initiative could be developed in several ways, ranging from a comprehensive, full-risk care approach to disease-specific interventions. Various forms of care management require up-front expenditures on primary care, consumer education, and case management. As a result, significant savings are not expected within the first biennium.

The executive recommendations require JFS to establish a task force by October 1, 2003 to assist in resolving issues that arise between health care providers serving Medicaid recipients and managed care organizations under contract with the Department. To address issues of hospital participation in the care management for the aged, blind, and disabled population, the Executive also recommends limits on the reimbursement rate for services provided by a hospital that does not contract with the managed care organizations in which Medicaid recipients are enrolled to the lesser of (1) 95% of the hospital's regular Medicaid reimbursement rate or (2) the amount the hospital charges the organization.

The Department of Job and Family Services estimates that this initiative will require funding of approximately \$5 million in FY 2004 and \$16 million in FY 2005. House Bill 95, as introduced, includes this funding.

Full implementation of prescription drug initiatives currently being developed: Senate Bill 261 of 124th General Assembly (a FYs 2002–2003 biennium budget correction bill) authorizes JFS to establish a supplemental drug rebate program under which drug manufacturers may be required to provide a supplemental rebate to the state as a condition of having their products covered by Medicaid without prior approval. Full implementation of the supplemental rebate program and a Preferred Drug List (PDL) is assumed in the executive budget recommendations. These programs will be initiated in April 2003; however, it is expected that a preferred drug will not be designated for all drug classes immediately. Additional classes of prescription drugs will continue to be added to the list throughout FY 2004.

The Department of Job and Family Services designates the most clinically- and cost-effective drug as the preferred drug in a class; in some cases, more than one drug may be designated as preferred. All other (non-preferred) drugs in that class will remain covered; however, prior authorization from the Medicaid pharmacy benefit manager will be necessary in order to obtain a prescribed, non-preferred drug. The Department of Job and Family Services will seek supplemental rebates from manufacturers for non-preferred prescription drugs.

The Department of Job and Family Services expects this initiative will save the state approximately \$76 million in FY 2004 and \$81 million in FY 2005. These estimated savings are included in LSC's baseline Medicaid forecasts for FYs 2004 and 2005.

Require co-payments for non-preferred drugs: The executive budget recommendations require JFS to establish co-payments for prescription drugs that are not included on the PDL. These co-payments will be sought only from those recipients who are eligible for cost sharing under federal requirements. Services for children and those related to pregnancy are federally exempt from co-payments, as are services for adults who reside in institutional settings. The co-payment will not be required on preferred drugs in each class.

The Department of Job and Family Services expects this initiative will save the state approximately \$5 million in FY 2004 and \$13 million in FY 2005. This estimate is based on the assumption that a \$1 co-payment for non-preferred generic drugs and a \$3 co-payment for non-preferred trade name drugs will be charged.

Long-Term Care

Freeze rates for the biennium: The Executive recommends holding reimbursement rates for long-term care providers at FY 2003 levels throughout the next biennium. This would apply to nursing facilities (NFs), Intermediate Care Facilities for the Mentally Retarded (ICFs/MR), and most home- and community-based provider types. Some home- and community-based rates will be revised during the biennium to reflect reforms in the Home Care and mental retardation/developmental disabilities (MR/DD) Medicaid community programs.

House Bill 94 of 124th General Assembly (the FY 2002-2003 biennium budget bill) established a maximum mean total per diem rate applicable to NFs in FY 2002 and FY 2003. For FY 2002, the mean total per diem rate for all NFs in the state, weighted by Medicaid days and calculated as of July 1, 2001, is not to exceed \$143.92. For FY 2003, the mean total per diem rate for all NFs in the state, weighted by Medicaid days and calculated as of July 1, 2002, was not to exceed \$152.66, plus any difference between \$143.92 and the mean total per diem rate for all NFs in the state for FY 2002, weighted by Medicaid days and calculated as of July 1, 2001, under the law governing the calculation of Medicaid reimbursement rates. Senate Bill 261 of 124th General Assembly raised the NFs mean total per diem rate from \$152.66 to \$153.41 in FY 2003, a \$0.75 increase.

The Executive recommends that the reimbursement rates for NFs and ICFs/MR for FYs 2004 and 2005 be the same as the rates in effect June 30, 2003. The Department of Job and Family Services estimates that the state will avoid approximately \$162 million in FY 2004 and \$340 million in FY 2005 in potential costs for NFs as a result of this initiative. It also estimates that the state will avoid approximately \$15 million in FY 2004 and \$31 million in FY 2005 in potential costs for ICFs/MR. The LSC estimates of the cost savings that would result from a rate freeze for long-term care providers are lower than JFS' estimates. Based on LSC's Medicaid forecast, LSC estimates that the state will avoid approximately \$112 million in FY 2004 and \$258 million in FY 2005 in potential costs for NFs and approximately \$12 million in FY 2004 and \$25 million in FY 2005 in potential costs for ICFs/MR.

The Executive also recommends that state law governing the reimbursement methodologies for NFs and ICFs/MR be repealed and be replaced with a new, Administrative Code-based, reimbursement methodology.

Develop a new reimbursement methodology for nursing facilities: The executive budget recommendations require JFS to develop a new, Administrative Code-based, reimbursement methodology for NFs with the input of consumers, providers, and other stakeholders.

Current law requires JFS to pay the reasonable costs of services that a NF or ICF/MR with a Medicaid provider agreement provides to Medicaid recipients. The amount JFS pays an NF or ICF/MR is determined by formulas established by state law.

Nursing facility and ICF/MR services are divided into four different categories, referred to as cost centers in state law. Each cost center has its own Medicaid reimbursement formula. The four cost centers are capital, direct care, other protected, and indirect care costs.³

³ Capital costs are the costs of ownership and nonextensive renovation. Cost of ownership covers the actual expense incurred for: (1) depreciation and interest on capital assets that cost \$500 or more per item; (2) amortization and interest on land improvements and leasehold improvements; (3) amortization of financing costs; and (4) with certain exceptions, lease and rent of land, buildings, and equipment. Costs of nonextensive renovation covers the actual expense incurred for depreciation or amortization and interest on renovations that are not extensive.

Direct care costs include an NF or ICF/MR's costs for: (1) certain staff, including nurses, nurse aides, medical directors, and respiratory therapists; (2) purchased nursing services; (3) quality assurance; (4) training and staff development, employee benefits, payroll taxes, and workers' compensation premiums or costs for self-insurance claims; (5) consulting and management fees related to direct care; and (6) allocated direct care home office costs. In the case of an ICF/MR, direct care costs also include the facility's costs for physical therapists, physical therapy assistants, occupational therapists, occupational therapy assistants, speech therapists, and audiologists.

Other protected costs are costs for medical supplies; real estate, franchise, and property taxes; natural gas, fuel oil, water, electricity, sewage, and refuse and hazardous medical waste collection; allocated other protected home office costs; and any additional costs included in JFS rules.

The Department of Job and Family Services must determine an NF or ICF/MR's per diem for each cost center as part of the process of calculating the facility's Medicaid payment. Per diem reimbursement must be based upon actual, allowable, desk-reviewed costs for the calendar year (CY) preceding the fiscal year in which the rate is paid (e.g., CY 2001 establishes the rate for FY 2003). Under current law, a facility's occupancy is a factor in determining per diem. Unless an NF has 100% occupancy, its capacity will be greater than its occupancy. When costs are divided to establish a per diem, using capacity will result in a lower per diem than using occupancy.

Since around the mid-1990's, NF reimbursement levels have steadily increased while occupancy has declined. Beginning on July 1, 1993, the Director of Health was ordered to neither grant nor deny any application for a certificate of need. This law was modified in 1995 to cause only facilities wishing to add long-term care beds to prove need before proceeding with the activity. This change meant that no long-term care beds would be added in Ohio under the moratorium put in place on July 1, 1993. This section of the Revised Code expires on June 30, 2003. The Executive recommends the extension of the moratorium for another two years, until June 30, 2005.

Create an Ohio-specific regulatory model for nursing facilities: The Executive recommends a requirement for the Director of Health to seek federal approval to develop an Ohio-specific regulatory model for nursing facilities. If federal approval for a waiver is granted, a task force (i.e., Nursing Facility Regulatory Reform Task Force) consisting of consumers, providers, advocacy groups, and representatives of the Governor's Office and the departments of Health, Aging, and Job and Family Services will be convened to design an alternative regulation and survey process. The Executive also recommends that the Director of Health, at the request of the General Assembly, apply for a federal waiver to implement the Task Force's recommendations.

Reduce the ceiling on Department of Mental Retardation and Developmental Disabilities (DMR) licensed beds: The Executive recommends a revision to the moratorium on the number of beds licensed by DMR.

The Executive recommends the current moratorium on new residential facility beds be repealed and establish a permanent cap on the number of residential facility beds licensed by DMR. A license must be taken out of service as a residential facility bed if any bed in that facility converts to supported living. The number of certified beds must not exceed 10,838 minus the number of beds taken out of service on or after July 1, 2003. The Department of Mental Retardation and Developmental Disabilities is not required to reduce the maximum number of beds by a bed taken out of service if it is determined that an individual with MR/DD who resided in the facility where the bed was located needs it. The Director of DMR is required to keep an up-to-date written record of the maximum number of residential facility beds.

Under current law, a provider with an RFW license can convert it to an ICF/MR and receive a higher reimbursement rate. ICF/MR's are an entitlement pursuant to the state's Medicaid plan and therefore, the Department has no control over growth or costs. According to the Executive, if more RFW licensees were to seek reimbursement as ICFs/MR, it could cost the state millions of dollars.

Indirect care costs are all reasonable costs other than direct care costs, other protected costs, or capital costs. This includes costs of habilitation supplies, pharmacy consultants, medical and habilitation records, program supplies, incontinence supplies, food, dietary supplies and personnel, housekeeping, security, administration, liability and property insurance, travel, dues, license fees, subscriptions, legal services, accounting services, minor equipment, maintenance and repairs, help-wanted advertising, informational advertising, and consumer satisfaction survey fees.

This initiative aligns the number of ICFs/MR beds currently licensed by DMR with the number of beds currently being used in the system. According to the Executive, this initiative will allow the state Medicaid program to control growth in the system and, consequently, limit the fiscal liability. Furthermore, this initiative fits in with the Executive's recommended facility-based reforms. The Executive recommends converting the state ICFs/MR entitlement system to a facility-based Medicaid waiver.

The DMR is responsible for nonfederal share of ICF/MR services: Long-term care beds licensed by the DMR are currently used three ways: as Developmental Center beds (paid by DMR); as private and county-owned ICFs/MR (paid by JFS), and RFW slots (paid by DMR).

The Executive recommends that the MR/DD delivery system (i.e., DMR and its local boards) provide the state share of funding for a licensed bed currently functioning on the RFW Medicaid waiver if that bed transitions to an ICF/MR, or for any new licensed beds that come into the ICFs/MR system. This initiative would make DMR responsible for the non-federal match for any new ICFs/MR as of the effective date of the FY 2004-2005 biennium budget bill.

Reform the provision of facility-based & community services for people with MR/DD: State financial support for Medicaid services for people with MR/DD is included in the budgets of DMR and JFS. The Executive recommends a reform of the facility-based portion of the MR/DD Medicaid delivery system during FYs 2004 and 2005. Specifically, the Executive recommends converting the state ICFs/MR entitlement system to a facility-based waiver. According to the Executive, this will enable the state to eliminate ICFs/MR from Ohio's Medicaid program and increase control over the growth and costs of the system.

The Executive's recommendation requires JFS to file a federal waiver request for this conversion no later than January 1, 2005. Implementation would occur after federal approval is granted.

Reform of the Home Care program: The Executive recommends a reform of the Home Care program for both of its state plan and waiver services.

State Plan Services: There are two levels of state plan services: (1) Core services including nursing and daily living services provided up to 14 hours per week, (2) Core Plus including the same services, but provided in excess of 14 hours per week. The increased service utilization has led to significant expenditure growth in this area of the Medicaid budget.

Waiver Services. The Home Care waiver provides an additional package of services to more than 7,000 recipients with disabilities who have an institutional level of care. These services include home delivered meals, supplemental adaptive/assistive living devices, out-of-home respite care, and adult day health services.

The Executive recommends continuation of the work undertaken in early 2003 to reform the state plan portion of the Home Care program. Under the recommendation, the state plan will be redefined to limit nursing and daily living to 14 hours or less per week for adults. Medicaid waiver programs administered by other state agencies will be affected through state plan service changes. While adult recipients will continue to have access to Core services, they will no longer be able to access Core Plus services to support and augment their waiver services.

The Executive recommends giving authority to the Director of JFS to request an additional waiver that will permit the existing Home Care waiver to be divided into two programs with more specifically targeted services and cost controls. The replacement programs will have a maximum number of enrollees, a maximum amount that may be spent for each enrollee each year, and a maximum aggregate

amount that may be expended for all enrollees each year. Furthermore, the Executive recommends the elimination of the Ohio Home Care program after all eligible individuals have been transferred to the replacement programs. According to the Executive, this initiative also allows JFS to eliminate the private duty nursing services and Core Plus home care services in the state Medicaid program for the purpose of controlling the rate of growth of the cost of Medicaid home care services.

The Department of Job and Family Services estimates that the state will avoid approximately \$6 million in FY 2004 and \$35 million in FY 2005 in potential costs. Under this Home Care reform, JFS' estimate is based on the assumption that the proposed new cost ceilings will restrict the monthly service costs of some existing Home Care waiver recipients and thus result in cost saving for the state.

Expand community-based alternatives in cases where cost neutrality is guaranteed: The Executive recommends the following cost neutral initiatives:

Establish a Targeted Assisted Living Waiver. The Executive recommends giving authority to JFS for seeking federal approval for an assisted living waiver. This waiver will expand community-based options for Medicaid recipients who require a nursing facility level of care. In order to meet the cost neutrality requirement, this waiver will be targeted to two types of individuals:

1. PASSPORT recipients who would otherwise have to move to a nursing facility because their need for services has become greater than their current environment can support; and
2. Elders residing in nursing facilities who desire to live in a different setting and would be able to do so with a PASSPORT service.

Expand Ohio Access Success Project. House Bill 94 of the 124th General Assembly authorized the Director of JFS to establish the Ohio Access Success Project to help Medicaid recipients make the transition from residing in a nursing facility to residing in a community setting. The bill provided \$150,000 in FY 2002 and \$250,000 in FY 2003 to fund one-time benefits to not more than 75 Medicaid recipients in FY 2002 and not more than 125 Medicaid recipients in FY 2003. No person was to receive more than \$2,000 worth of benefits under the project.

The Executive recommends the continuation of this program and appropriates up to \$350,000 in each fiscal year to provide one-time transitional benefits under the Ohio Access Success Project. According to the Executive, this initiative will allow more people with long-term care needs to remain in the community at a lower cost than in nursing facilities.

Expand PACE. The Program of All-Inclusive Care for the Elderly (PACE) enables seniors who reside in nursing facilities to receive managed care services. The program currently operates at two sites in Ohio. The Executive recommends the granting of permissive authority for this program to expand if expansion can be accomplished in a cost neutral manner. House Bill 95, as introduced, also allows, subject to the approval of the federal government, JFS to transfer the day-to-day administration of the PACE program to the Department of Aging.

Eliminating the Parent Expansion

State Medicaid was expanded to cover parents with family income up to 100% of the FPG in July 2000. Today the expansion insures approximately 30,000 Ohio parents. The executive budget recommendations require these parents to lose coverage as of October 1, 2003; however, in accordance with federal requirements, many of these Medicaid recipients will be eligible for Transitional Medicaid for a six-month period, and some may be eligible for another six-month period beyond that. On October 1, 2003,

income eligibility for parents will revert to federally-mandated minimums, with parent eligibility ranging from about 70% to 90% of the FPG as determined by family size. The Department of Job and Family Services estimates that the state will avoid approximately \$10 million in FY 2004 and \$71 million in FY 2005 in potential costs for the state Medicaid program as a result of this initiative.

Estate Recovery Reform

The Executive recommends a requirement of estate executors to provide notice of probate filings with the Office of the Attorney General if the deceased received Medicaid services. Additionally, estate recovery claims are to be handled in distribution of an estate, clarifying the state's position in the queue. This initiative also creates a process for the release of funds to the state by a financial institution when no estate will be opened and there are no outstanding debts owed to the Attorney General's Office. This provision may assist the Attorney General when attempting to recover Medicaid debts owed. Therefore, the state Medicaid program may receive some additional estate recovery revenue as a result of this provision.

DA Medical Reform

The DA Medical program provides a limited health care benefit package to non-Medicaid eligible individuals based on income, resources, and severity of disability. The program supports individuals while they are applying for long-term federal disability benefits. The benefit package is a limited version of the primary- and acute-care services offered to consumers through Medicaid, and all services are received through the fee-for-service delivery system. Services are limited to prescription drugs, physician, clinic, restricted dental service, and restricted durable medical equipment services. Hospital services for this population are provided through the Hospital Care Assurance Program (HCAP).

Expenditures for the DA Medical program are not eligible for federal reimbursement because the recipients are not Medicaid eligible. In recent years the DA Medical program has experienced a period of significant growth, both in caseload and expenditures:

Fiscal Year	Avg. Caseload	Change	Expenditures	Change
2001	17,375	11.6%	\$54.2 million	24.0%
2002	22,049	26.9%	\$67.9 million	25.3%
2003 estimated	25,905	17.5%	\$95.7 million	41.0%

The Executive recommends a statutory change that would enable the Director of JFS to enact reforms necessary to contain projected costs. Some possibilities include limiting the number of individuals who are eligible for the program, limiting the benefit package, limiting utilization, and limiting the amount of time an individual can receive DA Medical benefits. Specifically, the Executive recommends holding DA Medical expenditures to 6% growth in FY 2004 and 0% growth in FY 2005. The Department of Job and Family Services estimates that the state will avoid approximately \$15 million in FY 2004 and \$47 million in FY 2005 in potential costs for DA Medical as a result. Based on LSC's Medicaid forecast, LSC estimates that the state will avoid approximately \$1 million in FY 2004 and \$26 million in FY 2005 in potential costs for the DA Medical program because of this initiative.

Permanent and Temporary Law: Please refer to the Permanent and Temporary Law section of the redbook.

Franchise Permit Fees

Program Area Description: The Department of Job and Family Services is required to assess an annual franchise permit fee on each long-term care bed in nursing facilities or intermediate care facilities for the mentally retarded.

Funding Source: SSR, FED

Line Items: 600-613 (SSR); 600-621 (SSR), 600-608 (SSR), 600-623 (FED)

Implication of the Executive Recommendation: The Executive recommends increased funding for line item 600-608, Medicaid-Nursing Facilities, by \$8.7 million in FY 2004 from FY 2003 estimated spending levels. Senate Bill 261 of the 124th General Assembly increased the nursing facility franchise fee. The increase in the appropriation reflects this increase.

The Department of Job and Family Services is required to assess an annual franchise permit fee on each long-term care bed in a nursing home or hospital. Until July 1, 2001, the amount of the fee was \$1 for each bed multiplied by the number of days in the fiscal year for which the fee is assessed. The fee is applied to: (1) nursing home beds, (2) Medicare-certified skilled nursing facility beds, (3) Medicaid-certified nursing facility beds, (4) beds in hospitals that are registered as skilled nursing facility beds or long-term care beds, or licensed as nursing home beds.

House Bill 94 of 124th General Assembly raised the franchise permit fee to \$3.30 for FYs 2002 and 2003. Senate Bill 261 of 124th General Assembly raised the franchise permit fee to \$4.30 for FYs 2003 through 2005; a \$1 per bed, per day increase for FY 2003, and a \$3.30 per bed, per day increase for FYs 2004 and 2005. The additional \$1 franchise permit fee would generate a total of about \$63 million in franchise permit fee revenues in FY 2003: \$25.9 million in state share and \$36.9 million in federal share. Furthermore, the additional \$3.30 franchise permit fee would generate a total of about \$276 million per year in franchise permit fee revenues in FYs 2004 and 2005: \$113.8 million in state share and \$162.3 million in federal share.

In addition to the franchise permit fee raised by H.B. 94 for FY 2003, S.B. 261 specifies that the additional money generated from the increase for FYs 2003, 2004, and 2005 be deposited into the Nursing Facility Stabilization Fund, which was newly created in H.B. 94. The Department of Job and Family Services is to use the money in the fund to do all of the following: (1) make payments to NFs under the law governing Medicaid payments to NFs, (2) beginning with payments made to NFs in August 2002, make payments to each NF for each Medicaid day in FYs 2003, 2004, and 2005 in an amount equal to 76.74% of the franchise permit fee the NF pays for the fiscal year the Department makes the payment divided by the nursing facility's inpatient days for the calendar year preceding the calendar year in which that fiscal year begins (in other words, reimburses NFs for the increase in the franchise permit fee on the basis of "Medicaid days,") and (3) make payments of \$2.25 per Medicaid day to all NFs for FYs 2003, 2004, and 2005, to enhance quality of care. Payments to NFs for FY 2004 and FY 2005 are estimated at \$127.9 million per year: \$52.4 million state share (Fund 5R2) and \$75.5 million federal share (Fund 3F0). The Executive recommends the elimination of the requirements on how money in the Nursing Facility Stabilization Fund is to be used, other than a general requirement that the money be used to make Medicaid payments to NFs.

Senate Bill 261 also increased appropriations in line item 600-608, Medicaid-Nursing Facilities, by \$25,853,224 in FY 2003 and increased appropriations in line item 600-623, Health Care Federal, by \$40,362,450 in FY 2003 to allow JFS to spend the franchise fee revenue to fund the Medicaid program. The Executive recommends another \$8.7 million increase in FY 2004 to reflect the increase in the NF franchise fees.

The franchise permit fee for ICFs/MR was not changed during the FY 2002-2003 biennium. The Executive recommends that the amount of the ICFs/MR franchise permit fee for FYs 2004 and 2005 remain the same as in FY 2003, which is \$9.63 per bed, per day.

Permanent and Temporary Law: Sections 3721.56, 3721.561, and 132.13 provide that the moneys in the Nursing Facility Stabilization Fund be used to make Medicaid payments to nursing facilities. Sections 5112.31 and 146.25 provide that the ICFs/MR franchise permit fee remain at \$9.63 per bed, per day for FYs 2004 and 2005.

ADDITIONAL FACTS AND FIGURES

LSC - OBM Reconciliation GRF Line Item 600-525, Health Care/Medicaid

	FY 2004	FY 2005
LSC Baseline Estimate	\$9,818	\$10,551
Other Revenue Offsets	(\$794)	(\$857)
Supplemental Drug Rebates Savings	\$76	\$81
LSC GRF Expenditure Estimate	\$9,100	\$9,774
Governors' Cost Management Initiatives:		
Supplemental Rebates/Preferred Drug	\$76	\$81
Co-Pays on Non-Preferred Drug	\$5	\$13
Nursing Facilities Freeze	\$112	\$258
ICFs/MR Freeze	\$12	\$25
Inpatient Hospital Freeze	\$42	\$71
Eliminate Adult Dental Care	\$30	\$62
Eliminate Adult Chiropractic Care	\$2	\$6
Eliminate Adult Podiatry	\$2	\$6
Eliminate Adult Vision Care	\$4	\$12
Eliminate Adult Psychological Services	\$0	\$1
Care Management for ABD	(\$5)	(\$16)
Home Care Reform	\$6	\$35
ICFs/MR Conversion	\$0	(\$23)
DA Medical Held to 6% growth in FY 2004, 0% in FY 2005	\$13	\$39
Assisted Living Waiver, Success Project, Expand PACE	\$0	\$0
Eliminate Parent Expansion	\$10	\$72
Total Savings	\$308	\$642
LSC GRF Expenditure Estimate (Net of Savings)	\$8,792	\$9,132
OBM Recommendation (Blue Book)	\$8,840	\$9,306
Total Variance: LSC - OBM	(\$49)	(\$174)
State Share	(\$20)	(\$72)

Notes:

1. Amounts are rounded to the nearest million.
2. LSC baseline forecast includes the estimated savings from the Supplemental Drug Rebate program.
3. The savings estimates for NFs, ICFs/MR, Inpatient Hospital Freeze, dental care elimination, and DA Medical reform are based on LSC's baseline forecast.

The Department of Job and Family Services (JFS) estimates that the Governor's cost management initiatives will save the state approximately \$354 million in FY 2004 and \$738 million in FY 2005.

The Legislative Service Commission (LSC) has produced its own costs savings estimates for the following: (1) rate freeze for nursing facilities, ICFs/MR, and inpatient hospital; (2) elimination of dental care services for adults; and (3) reforming of the DA Medical program. The LSC estimated the cost savings for each of these initiatives using its baseline forecast model. However, the other initiatives could not be derived in the same manner. The LSC met with representatives from the Office of Budget and Management (OBM) and JFS to discuss the estimates regarding the other initiatives and concluded that the methodology that OBM and JFS used was reasonable.

Using LSC's costs savings estimates for those initiatives described above and JFS' estimates for the others, LSC estimates that the Governor's cost management initiatives will save the state approximately \$308 million in FY 2004 and \$642 million in FY 2005.

Chart 1 and Table 1 show the trends for each of the Medicaid eligibility groups. The caseload numbers for FYs 2003 to 2005 are LSC's projection.

Chart 1: Medicaid Eligibility - Monthly Averages

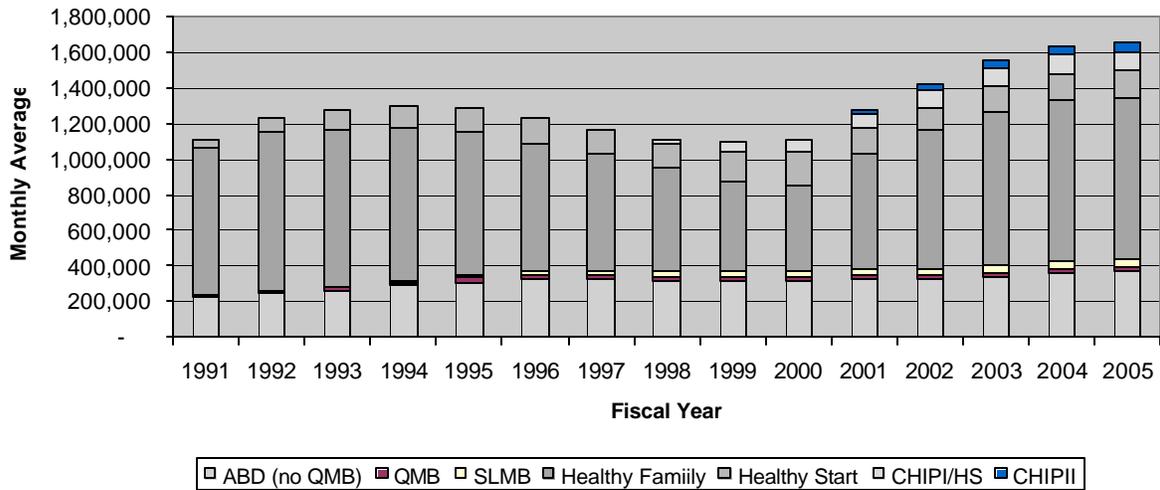


Table 1: Medicaid Caseload by Eligibility Group

Fiscal Year	ABD & CFC		ABD							
	Total		Total ABD		ABD (no QMB)		QMB		SLMB	
	mo. avg.	% change	mo. avg.	% change	mo. avg.	% change	mo. avg.	% change	mo. avg.	% change
1991	1,108,464		232,629		228,955		3,674			
1992	1,232,398	11.18%	255,971	10.03%	246,369	7.61%	9,602	161.38%		
1993	1,270,110	3.06%	280,162	9.45%	263,676	7.02%	16,067	67.32%	420	
1994	1,294,972	1.96%	313,240	11.81%	286,655	8.71%	20,191	25.67%	6,395	
1995	1,284,005	-0.85%	345,304	10.24%	309,576	8.00%	22,773	12.79%	12,955	102.58%
1996	1,228,262	-4.34%	366,783	6.22%	321,978	4.01%	22,736	-0.16%	22,069	70.35%
1997	1,166,169	-5.06%	370,047	0.89%	323,023	0.32%	23,791	4.64%	23,233	5.27%
1998	1,107,999	-4.99%	365,493	-1.23%	315,884	-2.21%	23,683	-0.46%	25,925	11.59%
1999	1,095,716	-1.11%	373,158	2.10%	314,855	-0.33%	23,538	-0.61%	34,764	34.09%
2000	1,109,202	1.23%	372,357	-0.21%	318,720	1.23%	23,635	0.41%	30,002	-13.70%
2001	1,276,967	15.12%	376,886	1.22%	323,150	1.39%	22,451	-5.01%	31,284	4.28%
2002	1,419,856	11.19%	383,846	1.85%	327,427	1.32%	20,800	-7.35%	35,619	13.86%
2003*	1,559,487	9.83%	404,035	5.26%	342,955	4.74%	22,138	6.43%	38,942	9.33%
2004*	1,637,550	5.01%	421,222	4.25%	358,636	4.57%	22,775	2.88%	39,810	2.23%
2005*	1,650,731	0.80%	434,715	3.20%	370,959	3.44%	23,048	1.20%	40,708	2.25%

Fiscal Year	CFC									
	Total		Healthy Families		Healthy Start		CHIP I/HS Exp		CHIP II	
	mo. avg.	% change	mo. avg.	% change	mo. avg.	% change	mo. avg.	% change	mo. avg.	% change
1991	875,835		828,828		47,007					
1992	976,427	11.49%	894,261	7.89%	82,166	74.80%				
1993	989,948	1.38%	880,786	-1.51%	109,162	32.86%				
1994	981,732	-0.83%	858,069	-2.58%	123,663	13.28%				
1995	938,701	-4.38%	808,875	-5.73%	129,826	4.98%				
1996	861,479	-8.23%	721,950	-10.75%	139,529	7.47%				
1997	796,122	-7.59%	662,403	-8.25%	133,719	-4.16%				
1998	742,506	-6.73%	580,827	-12.32%	137,912	3.14%	23,767			
1999	722,558	-2.69%	500,840	-13.77%	169,210	22.69%	52,509	120.93%		
2000	736,846	1.98%	481,064	-3.95%	185,127	9.41%	70,655	34.56%		
2001	900,081	22.15%	657,175	36.61%	141,385	-23.63%	81,310	15.08%	20,210	
2002	1,036,010	15.10%	774,752	17.89%	130,898	-7.42%	91,897	13.02%	38,464	90.32%
2003*	1,155,452	11.53%	863,707	11.48%	143,126	9.34%	103,235	12.34%	45,385	17.99%
2004*	1,216,328	5.27%	906,511	4.96%	151,280	5.70%	109,721	6.28%	48,816	7.56%
2005*	1,216,016	-0.03%	906,935	0.05%	151,010	-0.18%	109,441	-0.25%	48,630	-0.38%

* LSC baseline estimates

Chart 2 shows the Aged, Blind, and Disabled (ABD) and Covered Families and Children (CFC) eligibility groups as a percentage of the total Medicaid population and the percentage of total service costs for each of these groups utilizes. The CFC population made up 71% of the Medicaid population, but accounted for 23% of service costs in FY 2001. In comparison, the ABD population made up 29% of the Medicaid population, but accounted for 77% of service costs.

Chart 2

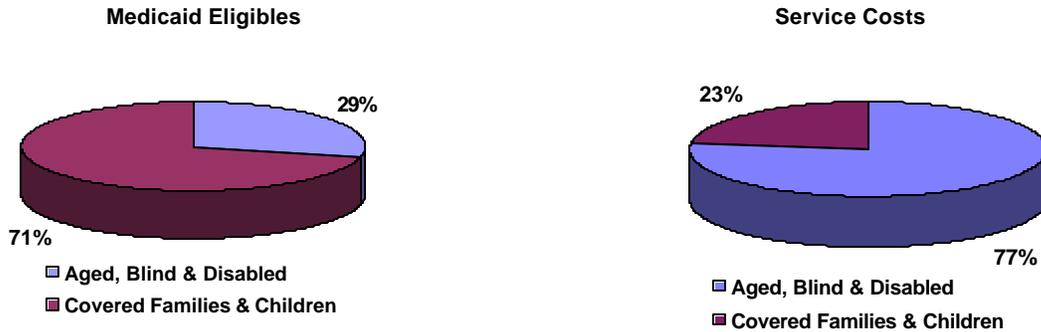


Chart 3 and Table 2 show Medicaid spending history for line item 600-525. Since FY 1990, Medicaid spending has increased by an average of more than 10% each fiscal year. The spending growth for the first half of the 1990s was driven by rapid health care cost increases generally, and specifically by increased caseloads associated with eligibility expansions. Spending decreased slightly in FY 1995 as a result of an improving economy and savings from a prospective reimbursement system for long-term care, which was introduced in FY 1993. The growth in Medicaid spending rose dramatically again in the early 2000s. Increases in medical inflation, utilization, and caseloads have been the driving forces behind the Medicaid spending increases in the early 2000s.

Chart 3: Health Care (600-525 Only) Spending History

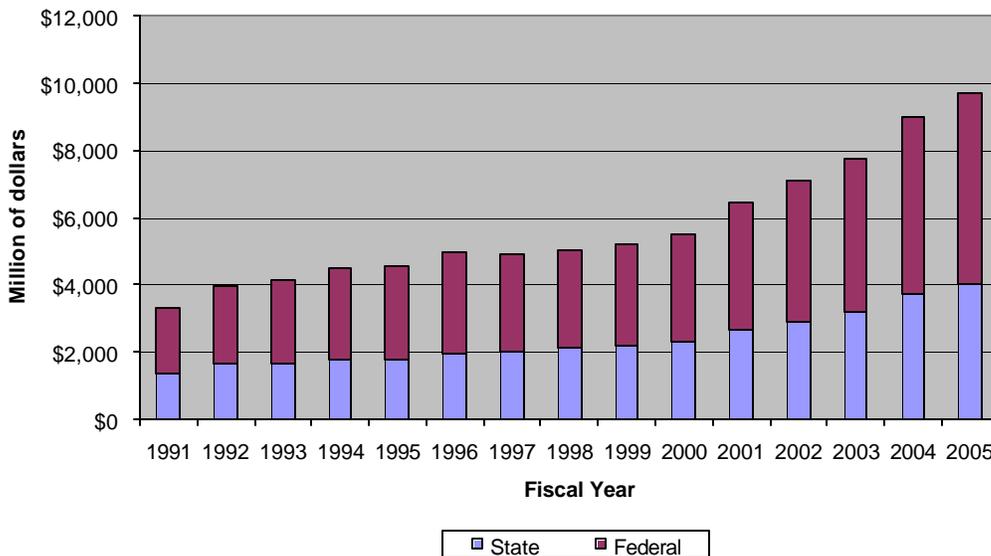


Table 2: Health Care Spending

Fiscal Year	ALI 600-525		Financial Participation			
	Total	% Change	State	% Change	Federal	% Change
1991	\$3,304,346,333	17.92%	\$1,350,486,346	17.66%	\$1,953,859,987	18.10%
1992	\$3,941,073,001	19.27%	\$1,661,556,377	23.03%	\$2,279,516,624	16.67%
1993	\$4,149,379,774	5.29%	\$1,686,307,940	1.49%	\$2,463,071,834	8.05%
1994	\$4,521,872,195	8.98%	\$1,779,356,709	5.52%	\$2,742,515,486	11.35%
1995	\$4,585,549,544	1.41%	\$1,791,624,838	0.69%	\$2,793,924,706	1.87%
1996	\$4,941,254,040	7.76%	\$1,971,066,236	10.02%	\$2,970,187,804	6.31%
1997	\$4,897,184,802	-0.89%	\$1,987,767,311	0.85%	\$2,909,417,491	-2.05%
1998	\$5,056,299,328	3.25%	\$2,107,465,560	6.02%	\$2,948,833,768	1.35%
1999	\$5,229,514,139	3.43%	\$2,214,699,238	5.09%	\$3,014,814,901	2.24%
2000	\$5,525,569,750	5.66%	\$2,294,216,560	3.59%	\$3,231,353,190	7.18%
2001	\$6,481,731,098	17.30%	\$2,657,509,750	15.84%	\$3,824,221,348	18.35%
2002	\$7,126,610,366	9.95%	\$2,926,186,216	10.11%	\$4,200,424,150	9.84%
2003*	\$7,736,418,008	8.56%	\$3,221,176,777	10.08%	\$4,515,241,231	7.49%
2004*	\$9,023,871,882	16.64%	\$3,733,837,506	15.92%	\$5,290,034,376	17.16%
2005*	\$9,693,030,918	7.42%	\$4,012,354,011	7.46%	\$5,680,676,907	7.38%

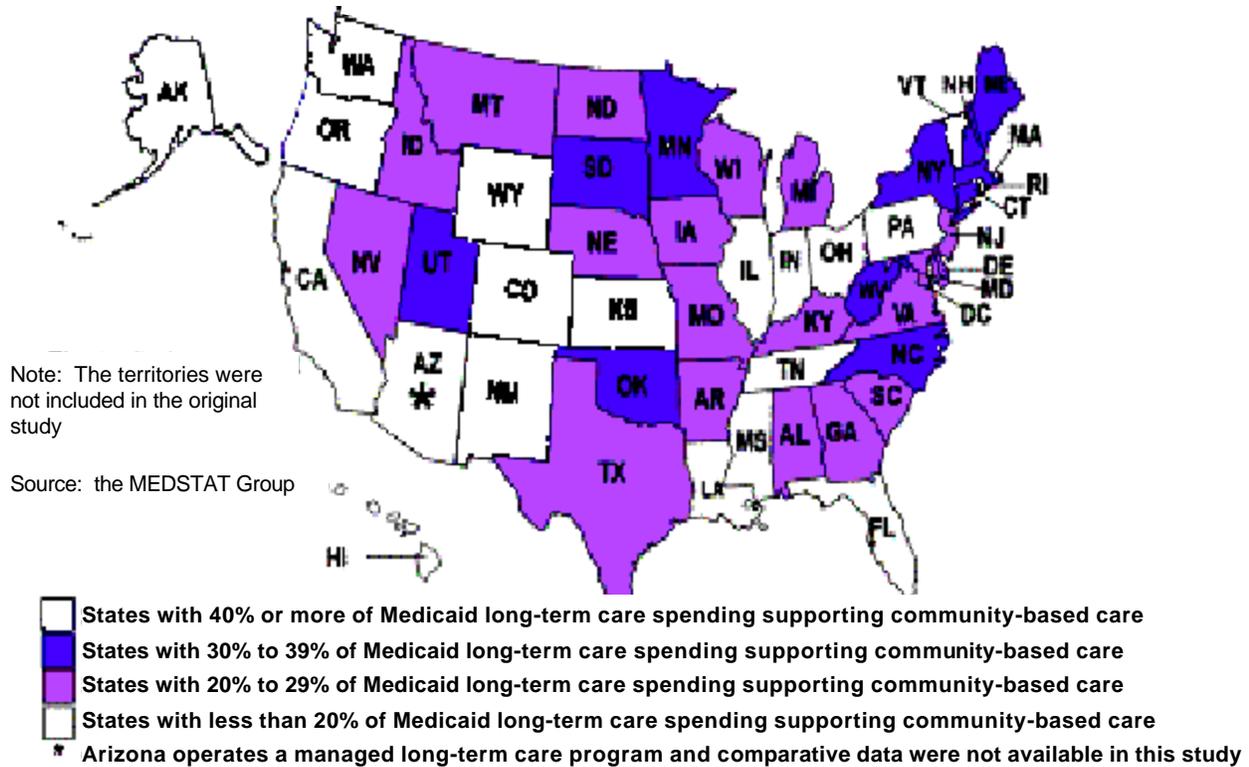
* LSC baseline estimates

Note:

1. This table only includes health care spending through the Department of Job and Family Services' 600-525 line item. Beginning in FY 2003, it includes spending for CHIPPII, and DA Medical.
2. The LSC baseline forecast assumes no change in the state health care policies and program for the upcoming biennium.

Map 1

Medicaid Long-Term Care Spending for
Community-Based Care, FY 1999



Map 1 shows that Ohio is one of nine states in the nation with less than 20% of Medicaid long-term care spending supporting community-based care.⁴

According to the National Conference of State Legislatures (NCSL), in 2001, the nation’s Medicaid long-term care spending topped \$75 billion, approximately 35% of total Medicaid expenditures. Of this amount, 71%, or \$53 billion, was allocated to fund long-term care institutions. The remaining \$22 billion was spent on community-based care for people who otherwise would be in an institution.

A historic Supreme Court decision, *Olmstead vs. LC* (1999), encourages states to reevaluate how they deliver publicly funded long-term care services to people with disabilities. The Supreme Court ruled that it is a violation of the Americans with Disabilities Act to discriminate against people with disabilities by providing services only in institutions when certain individuals could be served in a community-based setting. As a result, legislators, executive branch officials, consumer advocacy groups, and individual citizens are working together to implement the *Olmstead* decision around the country. In some states, almost half of Medicaid long-term care spending supports community-based care for people who qualify for institutional services. As a result, many more people with disabilities receive services in their homes and communities, which generally are less expensive than institutions.

⁴ Source: National Conference of State Legislatures, “Medicaid Long-Term Care Spending for Community-Based Care, FY 1999.”

Tables 3a and 3b provide detail eligibility criteria under the Ohio Medicaid program.

Table 3a: Eligibility Programs in Ohio Medicaid			
Eligibility Programs	Eligibility Cut Off as % of FPG*	# of Individuals Recently Being Served	Note(s)
Covered Families and Children (CFC)			
Healthy Families	100%	801,329	This program provides health coverage to children and their parents in families with incomes below 100% of FPG.
Healthy Start	133% for pregnant women, 100% for children	266,062	This program is at the federally mandated income level. This program provides health insurance for pregnant women, infants, and children to age 6 with a family income at or below 133% of FPG. It also covers children between age 6 and 18 in families with incomes at or below 100% of FPG.
Health Start/ CHIP I Expansion	150%	149,909	This program provides health care coverage to pregnant women, infants, and children to age 6 with incomes between 134% and 150% of poverty and for children between age 6 and 18 in families with incomes between 101% and 150% of FPG.
CHIP II	200%	51,057	This program is for uninsured children with a family income between 154% and 200% of FPG.

Table 3b: Eligibility Programs in Ohio Medicaid			
Eligibility Programs	Eligibility Cut Off as % of FPG*	# of Individuals Recently Being Served	Note(s)
Aged, Blind, and Disabled (ABD)			
Community ABD - Regular Medicaid	64% to 78%	159,978	This program allows persons who meet the aged, blind, or disabled criteria obtain health coverage if their countable income is at \$472 a month for an individual (64% of FPG) or \$817 for a couple (78% of FPG). Ohio is the most restrictive state in the U.S.
Community ABD - Spend Down	varies by \$ of spend down	8,409	This program is a federal requirement that allows consumers whose income is above the income standard to obtain Medicaid coverage on a monthly basis once they incur medical expenses that equal the difference between their countable income and the need standard.
Community ABD - QMB	64% to 78%	117,730	This program is for aged, blind, or disabled persons who meet federally required income eligibility and also have Medicare coverage as their primary payer.
Institutional ABD - Regular Medicaid	300% of SSI	10,582	The federal government requires Medicaid to cover long-term care for persons in an institutional setting at this income standard. Ohio is at the federal required minimum.
Institutional ABD - Spend Down	income less than cost of care	1,098	This program is a federal requirement that allows consumers whose income is above the income standard to obtain Medicaid coverage on a monthly basis once they incur medical expenses that equal the difference between their countable income and the need standard.
Institutional ABD - QMB	300% of SSI	76,334	The federal government requires Medicaid to cover long-term care for persons in an institutional setting at this income standard. Ohio is at the federal minimum standard. The population in this group also has Medicare coverage as its primary payer, but Medicare does not cover long-term stays in long-term care.
Home and Community Based Waiver - Regular Medicaid	300% of SSI	8,202	Ohio currently has PASSPORT (Preadmission Screening System Providing Options and Resources Today, administered by the Department of Aging), the Ohio Home Care Waiver (administered by the Department of Job and Family Services), and the waivers administered by the Ohio Department of Mental Retardation and Developmental Disabilities.
Home and Community Based Waiver - Spend Down		325	
Home and Community Based Waiver - QMB	300% of SSI	25,157	This program is for persons who meet the aged, blind, or disabled eligibility criteria and who also have an institutional level of care. It allows these persons the opportunity to obtain care and still live in the community. This program is an optional one that Ohio has chosen to implement. This program has allowed some state agencies to refinance the provisions of previously state funded only services with federal matching funds of 58 cents federal per \$1 of expenditure.
Breast and Cervical Cancer	200%	73	This program provides health coverage to women screened through the Ohio Department of Health breast and cervical cancer screening program and found to require treatment services.

Note: SSI = Supplemental Security Income
 Source: Department of Job and Family Services. 2002

PERMANENT AND TEMPORARY LAW

This section describes permanent and temporary law provisions contained in the executive budget that will affect the health care programs within the Office of Ohio Health Plans in the Department of Job and Family Services (JFS) and spending decisions during the next biennium.

Permanent Law

"Healthy Families" Medicaid expansion (R.C. Section 5111.019)

The bill makes permissive the JFS director's duty to submit an amendment to the state Medicaid plan to make an individual eligible for Medicaid benefits for a limited time if the individual is a parent of a child under age 19, has a family income that does not exceed 100% of the federal poverty guideline (FPG), and is not otherwise eligible for Medicaid.

The state Medicaid program was expanded to cover parents with family income up to 100% of the FPG in July 2000. This provision gives authority to JFS to eliminate eligibility for parents whose family income is between 100% of FPG and the federally-mandated minimums. The Department estimates that the state will avoid approximately \$6 million in FY 2004 and \$71 million in FY 2005 in potential costs for the state Medicaid program as a result of this provision.

Medicaid Estate Recovery (Primary R.C. sections 2113.041 and 2117.06 - R.C. sections 2117.25 and 5111.111)

The bill requires the executor, administrator, or commissioner of an estate of a decedent aged 55 or older to investigate whether a decedent received services under Medicaid and, if so, to notify the Medicaid Estate Recovery Program. It requires the entity responsible for administering the Medicaid Estate Recovery Program to file a claim against the estate within 90 days of receiving notice or one year of the decedent's death, whichever is later. The bill also permits a financial institution that receives an affidavit from the entity responsible for administering the Medicaid Estate Recovery Program to release a decedent's account proceeds in certain circumstances.

This provision will result in a requirement that the estate executor provide notice of probate filings with the Office of the Attorney General if the deceased received Medicaid services, change the priority of estate recovery claims in the distribution of an estate, and create a process for the release of funds to the state by a financial institution when no estate will be opened and there are outstanding debts owed to the Attorney General. This provision may assist the Attorney General when attempting to recover Medicaid debts owed. Therefore, the state Medicaid program may receive some additional estate recovery revenue as a result of this provision.

Examination of a Medicaid Co-Payment Program (R.C. section 5111.0112)

The bill eliminates from the JFS director's examination of the possibility of a Medicaid co-payment program a determination of which groups of recipients are appropriate for a program designed to reduce inappropriate and excessive use of medical goods and services.

This provision will clarify that there is not a limitation on the reasons JFS can implement a co-payment requirement. According to JFS, pharmacists would collect and keep any co-payment. Then the amount that the pharmacist could claim from the state would be reduced by the amount of the co-payment. If a co-payment of \$1 for the non-preferred generic drugs and \$3 for non-preferred trade name drugs in the Preferred Drug List program is implemented, JFS estimates that it will save the state approximately \$5 million in FY 2004 and \$13 million in FY 2005.

Medicaid Coverage of Chiropractic Services (R.C. Section 4734.15)

The bill eliminates chiropractors from the definition of "physician" for the purposes of the Medicaid program.

This provision allows JFS to eliminate coverage of chiropractic care for adults under Medicaid. The Department of Job and Family Services estimates that the state will avoid approximately \$2 million in FY 2004 and \$6 million in FY 2005 in potential costs for chiropractic care as a result of this provision.

Mental Health and Alcohol and Drug Addiction Services (R.C. sections 340.03, 5101.11, 5111.022, 5111.025, 5111.911, and 5119.61)

The bill eliminates the requirement that Medicaid reimbursement for community mental health services be based on the prospective cost of providing the services, and permits the Director of JFS to modify the manner or establish a new manner in which community mental health facilities and providers of alcohol and drug addiction services are paid under the Medicaid program.

The bill subjects contracts between JFS and the Department of Mental Health (DMH) or Department of Alcohol and Drug Addiction Services (ODADAS) regarding the administration of a Medicaid component to the approval of the Director of Budget and Management. The bill also provides that such a contract must require DMH, ODADAS, and boards of alcohol and drug addiction services to pay the nonfederal share of Medicaid payments for services under the contract and specify how providers will be paid and the Departments' responsibilities for reimbursing providers.

This provision gives permissive authority to JFS to modify or change how providers in the DMH and ODADAS delivery systems are reimbursed. This provision of the bill could have fiscal impact on the state Medicaid program if the reimbursement methodology for providers in the DMH and ODADAS delivery systems changes substantially.

Care Management System Within Medicaid (R.C. section 5111.16)

The bill requires JFS to establish in some or all counties a "care management system" in which designated Medicaid recipients must participate. It requires, by July 1, 2004, that some of the designated participants include Medicaid recipients who are aged, blind, and disabled.

According to JFS this provision of the bill will require funding of approximately \$5 million in FY 2004 and \$16 million in FY 2005. The additional funds are included in H.B. 95, as introduced.

Managed Care Organizations Under Medicaid Contracts (R.C. sections 5111.17 and 5111.171 to 5111.176)

The bill requires, by October 1, 2003, that JFS establish a task force to assist in resolving issues that arise between health care providers serving Medicaid recipients and managed care organizations under contract with the Department.

To address issues of hospital participation in the care management for the aged, blind, and disabled population, the bill limits the reimbursement rate for services provided by a hospital that does not contract with the managed care organizations in which Medicaid recipients are enrolled to the lesser of (1) 95% of the hospital's regular Medicaid reimbursement rate or (2) the amount the hospital charges the organization.

Temporary Manager for Medicaid Managed Care Organizations (R.C. sections 5111.172, 5111.173 (repealed), and 5111.173 (new enactment))

The bill requires JFS to appoint a temporary manager for a managed care organization under contract with the JFS, if JFS determines that the managed care organization has repeatedly failed to meet substantive requirements in federal Medicaid law. The bill also permits JFS to disenroll Medicaid recipients from a managed care organization if JFS proposes to terminate or not to renew the organization's contract and determines that access to medically necessary services is jeopardized. Furthermore, the bill repeals law regarding the defunct Medicaid Managed Care Study Committee, which no longer exists.

Federal regulations require states to impose temporary management if it finds that a managed care organization has repeatedly failed to meet substantive requirements in the law. This provision is to assure coordination with federal regulations, as well as, establish authority to require the affected managed care organizations to pay for such temporary management.

Health Insuring Corporations Coverage of Medicaid Drugs (R.C. section 5111.02)

The bill requires each Medicaid contract JFS enters into with a health insuring corporation to require the health insuring corporation to cover prescription drugs that the Medicaid program covers and to use appropriate utilization management strategies.

This provision removes a prohibition on Medicaid managed care plans from restricting the availability of prescription drugs if the drugs are on the Medicaid formulary. This provision makes the requirement for Medicaid managed care plans consistent with other changes to Medicaid coverage provided through the fee-for-service system.

Medicaid-Funded Long-Term Care Services (Primary section R.C. 5111.20, - R.C. sections 127.16, 173.20, 173.21, 173.55, 173.57, 3721.19, 3721.56, 3721.561, 3722.16, 5101.75, 5111.02, 5111.03, 5111.06, 5111.204, 5111.21, 5111.22, 5111.221 (repealed), 5111.221 (new enactment), 5111.23 (repealed), 5111.231, 5111.235 (repealed), 5111.24 (repealed), 5111.24 (new enactment), 5111.241 (repealed), 5111.241 (new enactment), 5111.25 (renumbered 5111.27), 5111.25 (new enactment), 5111.251 (repealed), 5111.251 (new enactment), 5111.252 (renumbered 5123.196), 5111.252 (new enactment), 5111.253, 5111.254, 5111.255 (repealed), 5111.255 (new enactment), 5111.256, 5111.257 (repealed), 5111.257 (new enactment), 5111.26 (renumbered 5111.23), 5111.26 (new enactment), 5111.261 (repealed), 5111.261 (new enactment), 5111.262 (repealed), 5111.262 (new enactment), 5111.263 (renumbered 5111.30), 5111.263 (new enactment), 5111.264 (repealed), 5111.264 (new enactment), 5111.265, 5111.266, 5111.267, 5111.268, 5111.269, 5111.2610, 5111.27 (repealed), 5111.28, 5111.29 (renumbered 5111.31), 5111.291 (repealed), 5111.30 (renumbered 5111.224), 5111.31 (renumbered 5111.222), 5111.32 (renumbered 5111.223), 5111.32 (new enactment), 5111.33 (renumbered 5111.29), 5111.34, 5111.99, 5112.31, and 5123.051; Section 63.37 of Am. Sub. H.B. 94 of the 124th General Assembly; Sections 127.16, 173.20, 173.55, 132.13, 142.01, 142.02, 173.57, 146.046, and 146.25)

The bill:

- repeals state law governing the Medicaid reimbursement methodology and procedures for nursing facilities(NFs) and intermediate care facilities for the mentally retarded (ICFs/MR);
- revises the law governing the submission of NF and ICFs/MR resident assessment information;
- provides that the Medicaid reimbursement rates for NFs and ICFs/MR for FYs 2004 and 2005 are the same as the rates in effect June 30, 2003;
- eliminates requirements on how money in the Nursing Facility Stabilization Fund is to be used, other than a general requirement that the money be used to make Medicaid payments to nursing facilities;
- provides that the only duty of the Nursing Facility Reimbursement Study Council is to advise JFS in the development of a new method of reimbursing NFs under Medicaid, and abolishes the Council on July 1, 2005;
- establishes requirements for NFs and ICFs/MR that undergo a change of operator, facility closure, voluntary termination, or voluntary withdrawal of participation in the Medicaid program;
- requires a NF operator participating in Medicaid to qualify all of the facility's Medicaid-certified beds in the Medicare program;
- provides that a NF or ICFs/MR operator may hold provider agreements for more than one NF or ICFs/MR; and
- provides that the amount of the ICFs/MR franchise permit fee for FYs 2004 and 2005 is the same as in FY 2003 (\$9.63 per bed per day).

As stated above, the Executive recommends that the reimbursement rates for NFs and ICFs/MR for FYs 2004 and 2005 be the same as the rates in effect June 30, 2003. The Department of Job and Family

Services estimates that the state will avoid approximately \$162 million in FY 2004 and \$340 million in FY 2005 in potential costs for NFs as a result of this initiative. It also estimates that the state will avoid approximately \$15 million in FY 2004 and \$31 million in FY 2005 in potential costs for ICFs/MR. Based on LSC's Medicaid forecast figurers, LSC estimates that the state will avoid approximately \$112 million in FY 2004 and \$258 million in FY 2005 in potential costs for NFs and approximately \$12 million in FY 2004 and \$25 million in FY 2005 in potential costs for ICFs/MR.

Copies of Medicaid Rules (R.C. sections 5111.22, 5111.25, and 5111.251)

The bill eliminates a requirement that the JFS provide copies of Medicaid rules and proposed rules to nursing facilities and intermediate care facilities for the mentally retarded that participate in Medicaid.

This provision will update long-term care regulations and bring them into conformance with the majority of Medicaid programs by allowing JFS to publish rules in electronic format. Hard copy distributions can be made upon request. This provision will increase public access to some Medicaid rules and reduce copying costs for the Department.

Extend Certificate of Need Moratorium on Long-Term Care Beds (R.C. section 3702.68, Section 137)

The bill extends the Certificate of Need moratorium for another two years, until June 30, 2005.

Beginning on July 1, 1993, the Director of Health was ordered to neither grant nor deny any application for a certificate of need. This law was modified in 1995 to cause only facilities wishing to add long-term care beds to prove need before proceeding with the activity. This change meant that no long-term care beds would be added in Ohio under the moratorium put in place on July 1, 1993. This section of the Revised Code expires on June 30, 2003.

Cap on the Number of Residential Facility Beds (R.C. sections 5123.19, 5123.196, and 5123.197)

The bill repeals the current moratorium on new residential facility beds and establishes a permanent cap on the number of residential facility beds licensed by the Ohio Department of and Mental Retardation and Developmental Disabilities (DMR). A license must be taken out of service as a residential facility bed if any bed in that facility converts to supported living. The number of certified beds must not exceed 10,838 minus the number of beds taken out of service on or after July 1, 2003. The DMR is not required to reduce the maximum number of beds by a bed taken out of service if it is determined that an individual with MR/DD who resided in the facility where the bed was located needs it. The director of DMR is required to keep an up-to-date written record of the maximum number of residential facility beds.

Under current law, facilities licensed under the residential facility waiver (RFW) can also use that license for intermediate care facilities for the mentally retarded reimbursement, which has much higher reimbursement rates. The Department has no control over this transition since ICF/MR is an entitlement under Ohio's Medicaid Plan. According to the Executive, if more RFW licensees were to seek ICF/MR reimbursement, it could cost the state millions of dollars.

This provision aligns the number of ICF/MR beds currently licensed by DMR with the number of beds currently being used in the system. The provision will allow the Department to control growth in the system and, consequently, limit their fiscal liability.

Medicaid Waivers for Alternatives to ICF/MR Placement (R.C. section 5111.87)

The bill permits the Director of Mental Retardation and Developmental Disabilities to request that the Director of JFS apply for one or more Medicaid waivers under which home and community-based services are provided to individuals with mental retardation or a developmental disability as an alternative to placement in an intermediate care facility for the mentally retarded.

Replacing ICF/MR Services with Waiver Services (Primary R.C. section 5111.88 - R.C. sections 5111.21, 5111.26, 5111.88, 5111.881, 5111.882, and 5126.12; Section 143)

The bill requires the Director of JFS to: (1) apply for a waiver under which individuals with mental retardation or a developmental disability who would qualify for the intermediate care facility for the mentally retarded (ICF/MR) service receive instead home and community-based services; and (2) submit an amendment to the state Medicaid plan to terminate the ICF/MR service. The bill also requires the Department of JFS to contract with the Department of Mental Retardation and Developmental Disabilities (DMR) for the administration of the new home and community-based services waiver.

This provision will require JFS to convert the entire ICFs/MR program to a facility-based Medicaid waiver to be administered by DMR.

Responsibility for Nonfederal Share of ICFs/MR Services (Primary R.C. section 5111.211 - R.C. section 5111.21)

The bill provides that the Department of Mental Retardation and Developmental Disabilities (DMR) is responsible for the nonfederal share for Medicaid claims for intermediate care facility services for the mentally retarded if (1) the services are provided on or after July 1, 2003, (2) the facility receives initial certification as an intermediate care facility for the mentally retarded on or after January 1, 2003, (3) the facility, or a portion of the facility, is licensed as a residential facility by the Director of DMR, and (4) there is a valid Medicaid provider agreement for the facility.

Ohio Home Care Program (R.C. section 5111.88)

The bill authorizes a request to be made for federal Medicaid waivers under which two programs for home and community-based services may be created and implemented in place of the existing Ohio Home Care Program. The bill also allows the replacement programs to have a maximum number of enrollees, a maximum amount that may be spent for each enrollee each year, and a maximum aggregate amount that may be expended for all enrollees each year. Furthermore, the bill provides for the elimination of the Ohio Home Care Program after all eligible individuals have been transferred to the replacement programs.

This provision gives authority to JFS for replacing the existing Ohio Home Care waiver with two new waivers, each having a single, lower cost ceiling in an attempt to achieve cost-effectiveness. The Department of Job and Family Services estimates that this Home Care Reform will allow the state to avoid approximately \$6 million in FY 2004 and \$35 million in FY 2005 in potential costs for state Medicaid. This provision also allows JFS to eliminate the private duty nursing services and Core Plus home care services in the state Medicaid program for the purpose of controlling the rate of growth of the cost of Medicaid home care services.

Personal Care Services Waiver For Residential Care Facility Residents (R.C. sections 5111.88, 5111.881, and 5111.882)

The bill permits the Director of JFS to apply for a Medicaid waiver to provide personal care services to qualified individuals in residential care facilities. The bill also allows JFS to enter into an interagency

agreement with the Department of Aging to operate the waiver program. If the waiver is approved, the bill requires the Department to adopt rules governing the program.

This provision allows JFS to create an assisted living facility waiver. This waiver will expand the community-based options for people in need of a nursing home level of care. This waiver will allow more people with long-term care needs to live in the community at a lower cost than in nursing homes. This provision is expected to be budget neutral to the state.

Ohio Access Success Project (R.C. section 5111.206)

The bill includes in the Revised Code law enacted by Am. Sub. H.B. 94 of the 124th General Assembly as uncodified (or "temporary") law authorizing the creation of the Ohio Access Success Project under JFS. The bill specifies that the purpose of the project is to provide help to Medicaid recipients making the transition from a nursing facility to a community setting by providing assistance with such things as moving expenses and rental deposits.

Criminal records checks for employment in home and community-based waiver services (R.C. sections 109.57, 109.572, 5111.95, and 5111.96)

The bill requires criminal records checks of applicants for employment with agencies participating in JFS administered waivers or independent providers in Department-administered home and community-based service programs in positions that involve providing home and community-based waiver services to consumers with disabilities.

Changes to HCAP Penalties (R.C. section 5112.99)

The bill grants the Director of JFS authority to set penalties for failure of hospitals to comply with Hospital Care Assurance Program (HCAP) requirements. The bill shifts the deposit of penalty revenue from the General Revenue Fund to the Health Care Services Administration Fund, which is to be used to pay costs of administering the Medicaid program.

The last time the penalty was updated was in 1991.

Hospital Care Services Administration Fund (R.C. section 5111.94)

The bill removes a reference to the scheduled expiration date (sunset) of the Hospital Care Assurance Program from the provisions that describe the moneys included in the Health Care Services Administration Fund, which is used for Medicaid administrative costs.

Disability Assistance Program (R.C. Chapter 5115.)

The bill:

- replaces the current Disability Assistance program with separate programs for financial assistance (Disability Financial Assistance) and medical assistance (Disability Medical Assistance);
- limits eligibility for Disability Financial Assistance to persons who are either (1) unable to do any substantial or gainful activity due to physical or mental impairment lasting at least nine months or (2) age 60 or older by the 90th day after the act's effective date and applied on or before that deadline;
- limits eligibility for Disability Medical Assistance to persons who are "medication dependent," but permits medical assistance to continue for persons receiving it under the current program until their eligibility has been redetermined;

- authorizes the adoption of rules for either program that establish maximum amounts of benefits, time-limits for receiving assistance, limits on the total number of persons to receive assistance, procedures for suspending acceptance of new applications, and other revisions for limiting program costs; and
- permits contracts to be entered into with any public or private entity for the administration of Disability Medical Assistance.

This provision separates statutory authority for DA Medical from DA Financial and allows JFS to transfer administration of the program to another state agency or other entity. This provision will give the Director of JFS broad authority to promulgate rules that would impose and update existing statute. Specifically, the Executive recommends holding DA Medical expenditures to 6% in FY 2004 and 0% in FY 2005. The Department of Job and Family Services estimates that the state will avoid approximately \$15 million in FY 2004 and \$47 million in FY 2005 in potential costs for DA Medical. Based on LSC's Medicaid forecast, LSC estimates that the state will avoid approximately \$1 million in FY 2004 and \$26 million in FY 2005 in potential costs for DA Medical.

Temporary Law

Sunset of Nursing Home Resident Insurance Coverage (Section 3)

The bill extends to October 16, 2005 the date of repeal (sunset) of a provision requiring a health insuring corporation (HIC) to cover medically necessary skilled nursing care provided to a person in a facility that does not have a contract with the HIC if certain conditions are met.

Nursing Facility Regulatory Reform (Section 51.01)

The bill creates the Nursing Facility Regulatory Reform Task Force to develop an alternative regulatory procedure for nursing facilities subject to federal regulation. The bill requires the Task Force to submit a report of its findings and recommendations to the General Assembly.

The bill also requires the Director of Health, at the request of the General Assembly, to apply for a federal waiver to implement the Task Force's recommendations.

Medicaid Program Support Fund – State (Section 58.03)

The bill requires that line item 600-671, Medicaid Program Support, be used to pay for Medicaid services and contracts. Currently, this line item is primarily used to support the state share of offsets to line item 600-525 (Disproportionate Share Hospitals (DSH) Offsets) and transfers to the Department of Mental Health. The bill also allows JFS deposits to Fund 5C9 revenue received from other state agencies for Medicaid services under the terms of interagency agreements between JFS and other state agencies.

Health Care Services Administration (Section 58.04)

The bill requires that line item 600-654, Health Care Services Administration, be used to pay for the costs associated with the administration of the Medicaid program. Senate Bill 261 of the 124th General Assembly created this line item.

Health Care Services Administration Fund/Hospital Care Assurance Match Fund (Section 58.05)

The bill specifies that, of the amount received during FYs 2004 and 2005, from the first installment of assessments on hospitals for the Hospital Care Assurance Program and intergovernmental transfers under the Hospital Care Assurance Program, \$350,000 must be deposited into the state treasury to the credit of the Health Services Administration Fund (Fund 5U3). Senate Bill 261 of the 124th General Assembly specifically deposited, of the amount received during FY 2003, \$175,000 into the state treasury to the credit of the Health Services Administration Fund (Fund 5U3).

The bill also specifies that appropriation line item 600-650, Hospital Care Assurance Match, will be used solely for distributing funds to hospitals for their indigent care.

Prescription Drug Rebate Fund (Section 58.07)

The bill requires that line item 600-692, Health Care Services, be used to pay for Medicaid services and contracts. Moneys recovered from state Medicaid's rights of recovery that are not directed to the Health Care Services Administration Fund (Fund 5U3) must be deposited into Prescription Drug Rebate Fund (Fund 5P5).

Transfer of Funds/Transfers of IMD/DSH Cash (Section 58.10)

The bill requires JFS to transfer moneys from State Special Revenue Fund 4K1, ICF/MR Bed Assessments, to Fund 4K8, Home and Community-Based Services, in the Ohio Department of Mental Retardation and Developmental Disabilities, in the amount of \$12 million each year of FY 2004 and FY 2005. In addition, the bill requires JFS to transfer moneys from State Special Revenue Fund 4J5, Home and Community-Based Services for the Aged, to Fund 4J4, PASSPORT, in the Ohio Department of Aging, in the amount of \$33,268,052 in FY 2004 and \$33,263,984 in FY 2005.

The bill also requires JFS to transfer money from Fund 5C9, Medicaid Program Support, to the Department of Mental Health's Fund 4X5, OhioCare, for administering specified Medicaid services.

Funding for Habilitative Services (Section 58.12)

The bill requires that, in each fiscal year, moneys from Fund 4K1, ICF/MR Bed Assessments, in excess of \$12 million may be used to cover costs of care provided to participants in a waiver with and ICF/MR level of care requirement administered by JFS.

Funding for Institutional Facility Audits and The Ohio Access Success Project (Section 58.13)

The bill specifies that, in each fiscal year, moneys from the State Special Revenue Fund 4J5, Home and Community-Based Services for the Aged, in excess of the amounts needed for the transfers may be used for two purposes: (1) up to \$1 million in each fiscal year to fund the state share of audits of Medicaid cost reports filed with JFS by nursing facilities and ICF/MR, and (2) up to \$350,000 in each fiscal year to provide one-time transitional benefits under the Ohio Access Success Project that the Director of JFS may establish under section 5111.206 of the Revised Code.

House Bill 94 of the 124th General Assembly authorized the Director of JFS to establish the Ohio Access Success Project to help Medicaid recipients make the transition from residing in a nursing facility to residing in a community setting. The bill provided \$150,000 in FY 2002 and \$250,000 in FY 2003 to fund one-time benefits to not more than 75 Medicaid recipients in FY 2002 and not more than 125 Medicaid recipients in FY 2003. No person was to receive more than \$2,000 worth of benefits under the project.

Program of All-Inclusive Care for the Elderly (PACE) (Section 58.15)

The bill allows, subject to the approval of the federal government, JFS to transfer the day-to-day administration of the PACE program to the Department of Aging (AGE). If JFS and AGE enter into an interagency agreement, the Director of Budget and Management must reduce the amount appropriated in line item 600-525 by the estimated cost of PACE services and associated administration, and appropriate the reduced amount to AGE. The Director of Budget and Management must establish a new line item for the appropriation.

Medicaid Eligibility Reductions (Section 58.16)

The bill requires the Director of JFS to submit to the federal government an amendment to the state Medicaid plan to eliminate the expansion of eligibility for certain parents in Healthy Family. State Medicaid was expanded, from federally-mandated minimums (with parent eligibility ranging from about 70% to 90% of the federal poverty guide line (FPG) as determined by family size), to cover parents with family incomes up to 100% of the FPG in July 2000. The bill requires these parents to lose coverage as of October 1, 2003.

Assisted Living Waiver (Section 58.17)

The bill allows JFS and Department of Aging (AGE) enter into an interagency agreement, and requires the Director of Budget and Management to reduce the appropriation in appropriation item 600-525 by the amount that JFS estimates its spending will be reduced as a result of the transfer of persons approved for the budget-neutral Medicaid home and community-based services for assisted living services waiver. The reduced amount will be appropriated to AGE in new appropriation items.

Hospital Care Assurance Program Extension (Sections 132.07 and 132.08)

The bill extends for two years (until October 16, 2005), the scheduled expiration of the Hospital Care Assurance program.

REQUESTS NOT FUNDED

The Executive has recommended full funding for all of the Department of Job and Family Services' requests for the Office of Ohio Health Plans, its health care programs, and related activities.