

LEGISLATIVE
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MEDICAID PRIMER



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Medicaid/State Children's Health Insurance Program (SCHIP) is the largest health insurance program in the country. It covers a broad, low-income population, including working families, individuals with diverse physical and mental disabilities, and seniors. Medicaid's beneficiaries include many of the poorest and sickest people in the nation. Medicaid was enacted in 1965 under Title XIX of the Social Security Act.¹ Medicaid is a publicly funded health insurance program for low-income individuals, initially established to provide medical assistance only to those individuals receiving assistance through Aid to Families with Dependent Children (AFDC), and state programs for the elderly. Over the years, Congress has incrementally expanded Medicaid eligibility to reach more Americans living below or near poverty, regardless of their welfare eligibility.

In 1972, Congress enacted a federal cash assistance program for the aged, blind, and disabled called Supplemental Security Income (SSI), which broadened Medicaid coverage to include this population. Another significant expansion of Medicaid was to provide health insurance coverage not just to the welfare population but also to other low-income families, especially low-income children and pregnant women. In 1996, Medicaid was delinked with the enactment of the Temporary Assistance to Needy Families (TANF) Program. Families who receive TANF benefits do not automatically qualify for Medicaid as they did under the AFDC Program.

In 1997, SCHIP was created. Title XXI of the Social Security Act, enacted by the Balanced Budget Act of 1997, added health care coverage for children in low- and moderate-income families who are ineligible for Medicaid but cannot afford private insurance. SCHIP builds upon the Medicaid Program. States were offered the option of implementing this health care coverage as stand-alone programs with different benefit packages, or as part of their existing Medicaid benefit. Ohio opted to implement SCHIP as a Medicaid expansion in 1998. States receive an enhanced federal match (greater than the state's Medicaid match) to provide SCHIP. Under the program, each state is entitled to a specific allotment of federal funds each year.

In 2009, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), designed to provide coverage to more uninsured children and to improve the quality of their care, reauthorized SCHIP for the period April 1, 2009 to September 30, 2013. It also increased state SCHIP allotments, modernized the formula for dividing funds among the states, and established a mechanism for "re-basing" state allotments

¹ Medicaid services are an entitlement for those who meet eligibility requirements. Entitlement means that if an individual is eligible for the program, then they are guaranteed the benefits and the state is obligated to pay for these benefits.

every two years to ensure that SCHIP funds are targeted to states that are using the funds. The Patient Protection and Affordable Care Act extended authorization and funding for SCHIP through 2015.

The Patient Protection and Affordable Care Act and Medicaid Expansion

On March 23, 2010, the Patient Protection and Affordable Care Act ("ACA," Public Law 111-148) was signed into law. The law requires that nearly all U.S. citizens and legal residents have some form of qualifying private or public health insurance. This requirement is otherwise known as the "individual mandate." The ACA implements the individual mandate through state-based or federally facilitated online insurance exchanges, the availability of federally funded premium credits and cost sharing subsidies for individuals with income between 100% and 400% of the federal poverty line (FPL), and the expansion of the federal-state Medicaid Program. Working in concert, these provisions are intended to ensure that all Americans have access to affordable healthcare.

Since its enactment in 2010, the ACA has been subjected to legal challenges at the federal level. In June 2012, the U.S. Supreme Court, in *National Federation of Independent Business v. Sebelius*, upheld by a 5-4 margin the individual mandate provision as a constitutional exercise of Congress's taxing power. In the same decision, the Supreme Court by a 7-2 margin limited the authority of the Secretary of the U.S. Department of Health and Human Services in enforcing the ACA's expansion of Medicaid; this effectively rendered Medicaid expansion optional at the discretion of the individual states.

Individual Mandate, Insurance Exchanges and Subsidies

The "individual mandate" refers to the ACA provision requiring nearly all U.S. citizens and legal residents to have some form of health insurance. Health insurance includes employer-sponsored health insurance plans, private health insurance purchased in the health insurance marketplace (exchanges), and public programs, including but not limited to Medicaid and SCHIP.

In order to facilitate the purchase of private health insurance, states have the option of establishing state-based online insurance exchanges. Such exchanges provide consumers with insurance packages offered by a number of private and nonprofit insurers. Exchanges must include four levels of benefit categories (bronze, silver, gold, and platinum, with bronze being the lowest level of coverage and platinum being the highest) and a separate catastrophic coverage plan. Each coverage level must offer the consumer a minimum level of benefits. If a state elects not to establish its own exchange, residents of that state are able to use the federally facilitated insurance exchange. Sixteen states and the District of Columbia currently operate state-based exchanges, 7 states operate exchanges under a federal-state partnership, and 27 states (including

Ohio) have chosen not to establish a state-based exchange; residents in these 27 states must use the federally facilitated exchange.

The ACA requires nearly all American citizens and legal residents to have qualifying health insurance. In order to ease the financial burden of purchasing health insurance, the ACA provides for premium subsidies for individuals and/or families with income between 100% and 400% of the FPL. During the initial enrollment period for the federal insurance exchange (October 1, 2013 through April 19, 2014), 87% of individuals purchasing insurance through the federal exchange qualified for premium subsidies which, on average, covered 76% of the cost of the premiums. The subsidy amount an individual/family is eligible to receive is tied to the second lowest-cost (silver) plan in the area and is determined on a sliding scale based on the individual's/family's income level relative to the FPL, such that the individual's premium contribution does not exceed a certain percentage of that individual's annual income.

Income relative to the federal poverty line	Maximum individual premium contribution (percent of income)
Up to 133%	2.0%
133% to 150%	3.0% to 4.0%
150% to 200%	4.0% to 6.3%
200% to 250%	6.3% to 8.05%
250% to 300%	8.05% to 9.5%
300% to 400%	9.5%

The ACA also provides for cost sharing subsidies for eligible individuals and families. These subsidies provide assistance to individuals to pay for cost sharing expenses such as deductibles, co-insurance, and copays. Cost sharing subsidies are limited to silver plans, in which an individual/family typically pays 30% of benefit costs. Cost sharing subsidies reduce the amount of benefit costs an individual or family pays. As with premium subsidies, these amounts are based on income level relative to the FPL.

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Table 2. Individual Cost Sharing Contributions Under the ACA	
Income relative to the federal poverty line (FPL)	Out of pocket expenses paid by an individual or family ² (percent of benefit costs)
100% to 150% FPL	6%
150% to 200% FPL	13%
200% to 250% FPL	27%
250% FPL and Higher	30%

Under the ACA, if an individual elects not to purchase health insurance and is ineligible to enroll in a public health program, that individual is then subjected to a penalty under the Internal Revenue Code. The ACA grants exemptions from the penalty for financial hardship, religious objections, American Indians, individuals without coverage for less than three months, undocumented immigrants, incarcerated individuals, individuals for whom the lowest-cost (bronze) plan is greater than 8% of the individual's income, and individuals with incomes below the tax filing threshold. The penalty schedule for failing to purchase qualifying health insurance is listed in the table below. The penalty is based on the greater of a percentage of an individual's or family's income or a flat penalty assessed on up to three members of a family.³

Table 3. ACA Penalties			
Year	Per individual*	Percent of taxable income	Maximum penalty (amount or percent of taxable income)
2014	\$95	1.0%	Greater of \$285 or 1.0%
2015	\$325	2.0%	Greater of \$975 or 2.0%
2016	\$695	2.5%	Greater of \$2,085 or 2.5%
2017+	2016 rate plus COLA**	2016 rate plus COLA	2016 plus COLA

*Up to three individuals per family

**Cost-of-Living Adjustment

For example, if in 2016 a family of eight with taxable income of \$70,000 does not have qualifying health insurance, that family will be subjected to a penalty of \$2,085 (\$695 x 3); the penalty can be assessed on no more than three family members. The family is subjected to this penalty as it is greater than the penalty it would pay as a percentage of taxable income (\$70,000 x 2.5% = \$1,750).

² Based on the silver level benefit plan.

³ 26 U.S.C. § 5000A.

Medicaid, the State Children's Health Insurance Program, and Medicaid Expansion under the ACA

The ACA provides for the expansion of the federal-state Medicaid Program to all non-Medicare eligible individuals under age 65 (i.e., children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL (plus 5% income disregard) and guarantees a benchmark benefit package which offers the same essential benefits covered by plans on the state and federal exchanges. The ACA requires that states expand their Medicaid programs at risk of losing all federal Medicaid matching funds. However, the June 2012 Supreme Court ruling in *National Federation of Independent Business v. Sebelius* strips the U.S. Secretary of Health and Human Services (HHS) of the authority to enforce that provision, effectively making Medicaid expansion voluntary at the discretion of the individual states.

On October 21, 2013, ODM requested and received Controlling Board approval to increase federal appropriations by \$561.7 million in FY 2014 and \$2.0 billion in FY 2015, which effectively expanded Medicaid in Ohio. As of December 2014, 27 states and the District of Columbia have also expanded their Medicaid programs. The federal government provides funding for nearly all of the costs associated with the Medicaid expansion population (i.e., those individuals who, but for expansion, would not have been eligible for Medicaid): 100% federal funding through 2016, 95% in 2017, 94% in 2018, 93% in 2019, and 90% in 2020 and thereafter). The ACA also requires states to maintain income eligibility levels for children in Medicaid and SCHIP until 2019 and extends SCHIP funding through 2015, while SCHIP benefit package and cost sharing rules remain unchanged. Beginning in 2015, states will be eligible to receive a 23 percentage point increase in the SCHIP match rate, up to a federal match of 100%. Other important ACA provisions related to Medicaid include:

- Increases in the Medicaid drug rebate percentage for brand name and noninnovator, multi-source drugs.
- Reduction in the aggregate Medicaid Disproportionate Share Hospital (DSH) payments by \$18.1 billion through 2020.
- Provisions to better integrate benefits and improve coordination between the states and the federal government to improve access to and quality of care and services for Medicare/Medicaid dual eligible individuals. The state effort in Ohio is known as MyCare Ohio.
- Incentivize demonstration projects and payment bundles to reduce costs and better coordinate care services. The state of Ohio has implemented these efforts through Patient-Centered Medical Home (PCMH) and Episode-Based Payment Models.

Medicaid – a Federal and State Joint Program

Medicaid is a federal-state joint program administered by the states and funded with federal, state, and, in some states like Ohio, local revenues. The federal government establishes and monitors certain requirements concerning funding, eligibility standards, and quality and scope of medical services.

State agencies administer Medicaid subject to oversight by the Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health and Human Services (HHS). State participation in Medicaid is voluntary, but all states participate. The federal government provides reimbursement to the states and offers guidance on how to use those funds, but each state shapes and administers its program to suit the needs of its own population. Consequently, Medicaid operates as more than 50 distinct programs – one for each state, territory, and the District of Columbia.

Because states are entitled to federal reimbursement under Medicaid, and there is no funding cap, they are able to cover optional groups or provide a broad array of services. As long as a state can provide the match, federal funds are virtually unlimited for federally approved activities. To trigger federal Medicaid matching funds, a state must spend some combination of state or local funds on Medicaid. For example, when a Medicaid recipient receives a health care service, the provider incurs the costs and requests to be paid by the state Medicaid agency, at which point the state pays the provider based on the Medicaid rate for that service. The state is then reimbursed by the federal government at an amount equal to that state's match rate.

On the other hand, when it first established the Medicaid Program, Congress gave the HHS Secretary authority to enforce state compliance with federal Medicaid Program rules by withholding all or a portion of a state's federal matching funds.⁴ Such a penalty can only be imposed after notice and the opportunity for a hearing and is subject to judicial review. The Secretary never has withheld a state's entire Medicaid grant as a penalty for noncompliance with federal requirements.⁵

Federal Medical Assistance Percentage

The federal government shares in the states' cost of Medicaid at a matching rate known as the Federal Medical Assistance Percentage (FMAP). The FMAP is calculated for each state based upon the state's per capita income for the last three years relative to the entire nation. The formula is:

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

⁴ 42 U.S.C. § 1396c.

⁵ Source: The Henry J. Kaiser Family Foundation, *A Guide to the Supreme Court's Decision on the ACA's Medicaid Expansion*, August 2012.

A state with average per capita income will have an FMAP of 55%. The higher a state's per capita income relative to the national average, the lower its match rate. The operation of the formula is bound by federal statute. The statute limit for FMAP is at least 50% and can be as high as 83%. In FFY 2015, the number of states receiving the minimum 50% FMAP are 13. Mississippi maintains the highest FMAP, of 73.58%.

The FMAP for Ohio for FFY 2015 is 62.64%. The general "rule of thumb" for how this cost sharing mechanism works is as follows: for every one dollar Ohio spends on Medicaid, the federal government gives Ohio about 63 cents.

There are exceptions to the FMAP formula for certain services and certain populations. For example, since 1973, family planning services and supplies are matched at 90%. And under the "Money Follows the Person" (MFP) Rebalancing Demonstration Program, the costs of transitioning individuals out of institutions into the community are matched at an "MFP-enhanced" FMAP which is the state's regular FMAP plus half of the percentage point difference between the FMAP and 100%. Lastly, there are two major exceptions: the matching rates for SCHIP and for administrative activities. SCHIP is reimbursed at an enhanced FMAP. The enhanced FMAP, or eFMAP, is used to determine the federal share of the cost of SCHIP. It is also set by statute and is calculated by reducing each state's Medicaid share by 30%. The cost for the treatment for breast or cervical cancer is also matched at the state's SCHIP FMAP rate.

The costs of administration are, in general, matched at 50%, although some administrative activities have a higher federal matching rate. Table 4 below shows the matching rates for various administrative functions.⁶

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

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Table 4. Federal Matching Rates for Various Administrative Activities	
Activity or Function	Percentage
Adoption and use of electronic health record (EHR) technology	100%
Immigration status verification	100%
Citizenship verification	90%
Design, development, and installation of information systems for citizenship verification	90%
Design, development, and installation of Medicaid Management Information System (MMIS)	90%
Management and operation of information systems for citizenship verification	75%
Management and operation of MMIS	75%
Independent external reviews of managed care plans	75%
Medical and utilization review	75%
Preadmission screening and resident review	75%
Skilled professional medical personnel	75%
State fraud and abuse control unit activities	75%
State survey and certification	75%
Translation and interpretation services for children	75%
Other program administration activities	50%
Identification and education of individuals with sickle cell gene	50%

Under the ACA, federal health care reform, the matching rate for the costs of upgrading eligibility and enrollment systems incurred before December 31, 2015, is 90%. The ACA provides a few more exceptions to the FMAP formula. Under the ACA, the federal government will finance the vast majority of the costs of the new Medicaid coverage to nondisabled adults under 65 with incomes at or below 138% FPL. The federal-state financing partnership that supports the current Medicaid Program will continue. However, the cost of the new Medicaid coverage stemming from health reform will be fully financed by the federal government in the first three years of reform (2014 to 2016). In subsequent years, the federal government will continue to finance the large portion of the costs. Table 5 below shows the phase-down FMAP.

Table 5. Phase-Down FMAP	
Calendar Year	Percentage
2014	100%
2015	100%
2016	100%
2017	95%
2018	94%
2019	93%
2020 and thereafter	90%

As stated above, the ACA also extends SCHIP through most of 2015 and beginning October 1, 2015, the enhanced SCHIP federal matching rate will increase by 23 percentage points and cap at 100%. The enhanced federal matching rate continues until September 30, 2019. This SCHIP increase is not tied to the Medicaid expansion.

Effective January 1, 2013, a 1% increase in FMAP is applied to expenditures for adult vaccines and clinical preventive services in states that provide these benefits without cost sharing.

The federal government will match at a 90% rate, for eight calendar quarters, the cost of providing health home services to beneficiaries with chronic conditions.

Under the Community First Choice option, the costs of home and community-based attendant services and supports a state elects to provide to individuals with disabilities are matched at the state's regular FMAP plus six percentage points.

Under the State Balancing Incentive Payments Program, the costs of furnishing noninstitutionally based long-term care services and supports are matched at a participating state's FMAP plus five percentage points or plus two percentage points, depending upon the percentage of long-term care spending that a state applies to home and community-based services.

Table 6 below provides a summary of these exceptions to the FMAP formula.

Table 6. Summary of FMAP Exceptions	
Population/Services	Percentage
Administrative Activities	50% to 100%
Family Planning Services	90%
Money Follows the Person	$FMAP + (100\% - FMAP) / 2$
Breast and Cervical Cancer Treatment	SCHIP FMAP
Newly eligible, adults under 65 up to 138% FPL	starting at 100%
Health Home Services	90% for 8 quarters
Community First Choice	FMAP + 6%
State Balancing Incentive Payments Program	FMAP + 5% or 2%
Clinical Preventive Services for Adults	FMAP + 1%
State Children's Health Insurance Program (SCHIP)	eFMAP

Congress has two times temporarily increased FMAPs to provide fiscal relief to state Medicaid programs during recession. The first occurred in response to the 2001 recession. During the five-quarter period beginning April 2003 through June 2004, every state's FMAP was increased by 2.95 percentage points, and every state was held harmless against any decline in its FMAP that would otherwise have occurred under the normal operation of the formula. Secondly, the American Recovery and Reinvestment Act of 2009 (ARRA) provided a temporary increase in the FMAP.

ARRA increased the federal share of Medicaid programs for 27 months over the period October 1, 2008 through December 31, 2010. It provided a 6.2 percentage point across-the-board increase and a bonus adjustment related to the change in a state's unemployment rate. Another federal law, P.L. 111-226, provided a two-quarter extension of the enhanced federal matching rates included in ARRA to June 30, 2011, which is the end of FY 2011. P.L. 111-226 also reduced the across-the-board increase from 6.2 to 3.2 percentage points for the third quarter of FY 2011 and to 1.2 percentage points for the fourth quarter of FY 2011. In addition, P.L. 111-226 maintained the formula for the calculation of the bonus adjustments but made certain rule modifications.

State Share

State Medicaid funding comes from several sources, including income, property, sales, and other sources that generally make up states' and counties' general funds. But states can also raise revenue for Medicaid by imposing fees, assessments, and other taxes on health care providers. Health care provider taxes have been commonly used to raise Medicaid match, especially during economic downturns when there are increased revenue pressures on states. Ohio currently has provider taxes on hospitals, nursing homes, and intermediate care facilities for individuals with intellectual disabilities (ICFs/IID).

State Plan Amendment

A State Plan is the basis for a state's claim for federal reimbursement, known as federal financial participation (FFP). The State Plan is the funding agreement between the state Medicaid agency and the federal government. States are required to submit a State Plan Amendment (SPA) to CMS for changes to its Medicaid Program. Each state's plan and any amendments to the plan must be reviewed and approved by CMS in order for a state to receive FFP. Federal regulations allow CMS 90 days to review a SPA and make a determination. This 90-day time period may be stopped if CMS has questions regarding the proposed amendment. Therefore, SPAs are written and submitted long before they can be implemented.

The State Plan includes information regarding groups of consumers served, services provided, payment to providers, and other program requirements. The State Plan must meet the following requirements unless a waiver (exemption) is requested and approved by CMS:

- **Statewideness.** All Medicaid services must be available on a statewide basis. States cannot limit the availability of the health care services to a specific geographic location or fail to provide a covered service in a particular area.

- **Freedom of Choice.** Medicaid consumers are provided the freedom to choose which Medicaid contracting providers they use. States may not restrict Medicaid recipients' access to qualified providers.
- **Amount, Duration, and Scope.** For every covered service, determinations are made regarding the amount, duration, and scope of coverage provided to meet recipients' needs. For example, a state could limit the number of days of hospital care provided. States must cover each service in an amount, duration, and scope that is reasonably sufficient. Services must not be arbitrarily limited for any specific illness or condition.
- **Comparability of Services.** States must ensure that the medical assistance available to any recipient is not less in amount, duration, or scope than what is available to any other recipient.
- **Reasonable Promptness.** States must promptly provide Medicaid to recipients without delay caused by the agency's administrative procedures.
- **Equal Access to Care.** States must set payment rates that are adequate to assure Medicaid recipients reasonable access to services of adequate quality.
- **Coverage of Mandatory Services for Mandatory Populations.** CMS requires state Medicaid programs to provide certain medically necessary services to covered populations.

The federal Deficit Reduction Act of 2005 (DRA) gave states greater flexibility to modify their Medicaid programs. This flexibility allows states to vary the level and range of Medicaid coverage based on recipient characteristics or geographic location. The DRA, however, maintains early and periodic screening, diagnostic, and treatment services as a wraparound for children. Some states have used the DRA to restructure benefits by setting more limited coverage standards for people with relatively good health, while allowing more generous benefits for adults with certain chronic physical or mental conditions and disabilities.

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

There are different types of waivers states may request, each named after the section in the federal Social Security statute that authorizes it. Each waiver has a distinct purpose and distinct requirements.

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

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

Section 1915(b) Managed Care/Freedom of Choice Waivers. Section 1915(b) provides the HHS Secretary with the authority to grant waivers that allow states to implement managed care delivery systems, or otherwise limit individuals' choice of provider under Medicaid. This section also provides waivers allowing states to skip provisions requiring comparability of services and statewideness, which together require states to offer the same coverage to all categorically needy recipients statewide. Prior to the 1997 Balanced Budget Act, which allowed states to implement managed care programs under their state plans, states often used these waivers to implement managed care programs by restricting recipients' choice of providers.

Section 1915(c) Home and Community-Based Services Waivers. Section 1915(c) provides the HHS Secretary with the authority to waive Medicaid provisions in order to allow long-term care services to be delivered in community settings. This program is the Medicaid alternative to providing comprehensive long-term services in institutional settings. These waivers have been critical in state strategies to provide alternative settings for long-term care services.

Section 1915(i) State Plan Home and Community-Based Services. DRA added a new section 1915(i) to the Social Security Act. Section 1915(i) provides states an opportunity to offer services and supports before individuals need institutional care, and also provides a mechanism to provide State Plan home and community-based services to individuals with mental health and substance use disorders. This State Plan service package includes many similarities to options and services available through 1915(c) home and community-based services waivers, a significant difference is that

1915(i) does not require individuals to meet an institutional level of care in order to qualify for home and community-based services. The ACA made changes, which become effective October 1, 2010, to 1915(i) provisions by removing certain barriers of offering home and community-based services through the Medicaid State Plan.

Medicaid and the Economy

Medicaid is important to not only the millions of low-income Americans who receive benefits but also to the economy of the state where Medicaid funds support thousands of health-related jobs, medical education, and workforce development. State and federal dollars spent on health care services help employ health care workers and purchase medical goods and equipment from businesses in the state. Because of this increased employment and steady business in the health sector, other state economic sectors such as grocery stores, retail businesses, automotive services, etc., are also bolstered. Economists call this the multiplier effect. Medicaid spending at the state level injects more money into the state economy than would otherwise be there because of the federal match (i.e., reimbursement). In this way, Medicaid spending, more than other state spending, has uniquely powerful economic impacts on states. The magnitude of the Medicaid multiplier effect varies from state to state, depending on the size of the state's federal match rate, how the initial dollars are spent, and the economic conditions in the state.

Medicaid spending is countercyclical, rising when the economy falls and falling when the economy rises. The Medicaid spending patterns have nearly always tracked enrollment growth and the enrollment is affected by changes in the economic cycles. The business cycle is an important determinant particularly for nondisabled adults and children. As unemployment increases, workers and their dependents may lose access to employer coverage. This can happen because of unemployment, reduced employer contributions to health insurance, reduced eligibility for employer-sponsored insurance, and movement from full-time to part-time work. Individuals may become eligible and enroll in public coverage, purchase nongroup coverage, or become uninsured.

During an economic downturn, while the demand for Medicaid rises, state revenues decline, affecting states' ability to balance their budgets and to fund programs such as Medicaid. As a result, states must grapple with increasing pressures to limit program spending in Medicaid and manage the increased enrollment.

Medicaid vs. Medicare

Medicaid and Medicare are two different programs. Medicare is a federal health insurance program that covers individuals age 65 and over, as well as some disabled individuals. Medicaid is a federal-state medical assistance program for low-income individuals. Medicare provides only partial coverage, and requires beneficiaries to pay premiums, deductibles, and copayments. Medicaid provides more complete coverage,

without significant cost sharing from the recipients. All persons over age 65 (as well as younger individuals disabled for at least two years) who paid into Social Security are eligible for Medicare, but only low-income persons who are aged, blind, disabled, or are low-income families and adults, are qualified for Medicaid. Table 7 shows the differences between Medicaid and Medicare.

Table 7. Medicaid vs. Medicare	
Medicaid	Medicare
State administered under federal guidelines	Federally administered
State and federal funding	Federal funding
Must be low-income	No income limit
Children, parents, adults, disabled, and age 65 plus	Age 65 plus and some people with disabilities
Benefit coverage varies by state	Same benefit coverage nationwide

Medicare has four different benefit packages, or "Parts" commonly referred to as Medicare Parts A, B, C, and D. While Medicare Part A automatically covers most people who qualify, the remaining packages are optional and have associated costs.

Part A Hospital Insurance. Most people do not pay a premium for Part A because they or a spouse already paid for it through their payroll taxes while working. Medicare Part A helps cover inpatient care in hospitals, including critical access hospitals and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice and some home health care. Beneficiaries must meet certain conditions to get these benefits.

Part B Medical Insurance. Most people pay a monthly premium for Part B. Medicare Part B helps cover doctors' services and outpatient care. It also covers some other medical services that Part A does not cover, such as some of the services of physical and occupational therapists and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary.

Part C Advantage Plans. People with Medicare Parts A and B can choose to receive all of their health care services through Medicare Health Plans, which are referred to as Medicare Advantage Plans (MA Plans), under Part C. Medicare beneficiaries may voluntarily select this option and then choose from among a number of MA Plans contracted with the federal government to do business in their state or geographic region. Enrolling in Medicare Part C means the individual transfers their Part A and Part B health care coverage to the responsibility of their MA Plan.

Part D Prescription Drug Coverage. Medicare Part D, Medicare prescription drug coverage, began on January 1, 2006. It is provided through Prescription Drug Plans and MA Plans. It is optional coverage for which Medicare beneficiaries must enroll and pay a monthly insurance premium, an annual deductible, and coinsurance costs.

Dual Eligibles

Individuals who are eligible for both Medicaid and Medicare simultaneously are called "dual eligibles." Medicaid plays different roles for different types of dual eligibles. Most dual eligibles qualify for full Medicaid benefits. For these individuals, Medicaid helps to fill in some of the gaps in Medicare coverage by paying for services that are not part of the standard Medicare benefit package, such as most long-term care services. These individuals account for most of the costs to Medicaid for dual eligibles. For other dual eligibles that do not qualify for full Medicaid benefits, Medicaid helps to make Medicare more affordable by providing assistance with Medicare premiums, deductibles, and other coinsurance requirements. Whether they qualify for full benefits or more limited assistance, most dual eligibles are very low-income individuals – typically have income of less than \$10,000 a year, and often face serious health challenges such as diabetes, heart disease, dementia, or a severe mental illness. The Medicare Premium Assistance Program is Ohio's program that pays Medicare premiums, deductibles, and coinsurance for these low-income individuals enrolled in Medicare. This program is sometimes referred to as the Medicare Buy-In Program and is considered to be a part of the larger Medicaid Program.

Medicare Part D

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

Pharmacy Benefits Under Medicare Part D. Like all other Medicare beneficiaries, dual eligibles have access to the universal Medicare prescription drug benefit starting January 1, 2006. Prior to January 2006, the prescription drug costs of the dual eligibles were paid by Medicaid. Under MMA, Medicaid no longer pays for prescription drugs for dual eligibles. Instead, they are to obtain their drug coverage by enrolling in one of the Medicare drug plans. Dual eligibles can sign up for a Medicare drug plan on their own, but, if they do not do so, the HHS Secretary is required to randomly enroll them in a plan.

Phased-Down State Contribution (Clawback). The mechanism through which the states help finance the Medicare drug benefit is popularly known as the "clawback" (the statutory term is "phased-down state contribution"). In brief, the clawback is a monthly payment made by each state to the federal Medicare Program. The amount of each state's payment roughly reflects the expenditures of its own funds that the state would have made if it continued to pay for prescription drugs through Medicaid on

behalf of dual eligibles. A state's clawback payment for any given month is equal to the product of a three-part formula:

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

Per Capita Expenditures (PCE). This is the state's share of its per capita Medicaid expenditure for covered drugs for dual eligibles in calendar year (CY) 2003, increased by the growth in per capita prescription drug spending nationally, and adjusted for the change in the state's relevant FMAP. In calculating the state Medicaid per capita expenditures for prescription drugs for dual eligibles in CY 2003, it must include pharmacist dispensing fees, adjust for manufacturer rebates, and exclude any expenditure for drugs not covered under Part D.

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

Phase-Down Percentage (P%). This is the phase-down percentage for the year specified in the MMA. As seen in Table 8, the phase-down percentage decreases from 90% in CY 2006 to 75% in CY 2015 and thereafter.

Table 8. Phase-Down Percentage	
Calendar Year	Percentage
2006	90.00%
2007	88.33%
2008	86.67%
2009	85.00%
2010	83.33%
2011	81.67%
2012	80.00%
2013	78.33%
2014	76.67%
2015 and thereafter	75.00%

For example, if, in January 2014, Ohio had 206,000 dual eligibles enrolled in Part D plans, and if the average monthly per capita Medicaid spending for prescription drugs for dual eligibles were \$120, then Ohio's clawback payment amount for the month would be \$18.9 million.

$$\$18.9 \text{ million} = \$120 \times 206,000 \times 76.67\%$$

Medicaid Eligibility

Federal Eligibility Category

Historically, federal law required states to cover certain "mandatory" groups in order to receive any federal matching funds. To qualify for Medicaid, a person had to meet financial criteria and be "categorically eligible" for the program. Financial eligibility was determined by income and assets. Categorical eligibility is determined by the federal government. Individuals had to fall into one of the federally determined population categories covered by Medicaid to qualify for the program. If an individual did not fall into one of these categories, he or she could not qualify for Medicaid even if his or her income and assets met the financial eligibility requirements. For example, adults without dependent children, no matter how poor they were, were categorically excluded from Medicaid unless they were disabled or pregnant. However, changes in ACA provide eligibility for nonelderly, childless adults who do not fit into the traditional categories.

The following Medicaid eligibility groups are examples of traditional mandatory groups under federal law:

- Parents who would meet the eligibility criteria for participation in the cash assistance program Aid to Families with Dependent Children (AFDC) as of July 16, 1996;⁷
- Children under age six in families with incomes up to 133% FPL;
- Children age six and older with family incomes up to 100% FPL, rising to 133% FPL beginning in 2014;
- Recipients of adoption assistance and foster care under Title IV-E of the Social Security Act, expanding to age 26 beginning in 2014;
- Pregnant women with incomes up to 133% FPL. In addition, after giving birth, these women and their infants have mandated coverage throughout the infant's first year, after which women and infants may continue to receive Medicaid coverage if eligible in other eligibility categories.
- Supplemental Security Income (SSI) recipients (or in states using more restrictive criteria – aged, blind, and disabled individuals who meet criteria which are more restrictive than those of the SSI Program and which were in place in the state's approved Medicaid Plan as of January 1, 1972).

Under the ACA, Medicaid eligibility for people under age 65 is based solely on income. With categorical restrictions abolished for this population, beginning 2014, states have an option to extend eligibility to adults under age 65 with income up to

⁷ In Ohio, families with dependent children with incomes no higher than 32% FPL were eligible for AFDC.

133% FPL (plus 5% income disregard), for both parents and those without dependent children. States are to receive enhanced federal financial participating rates for the new eligibility group. The cost of the new eligibility group is fully financed by the federal government from 2014 to 2016. For subsequent years, the federal government will continue to finance the larger share, phasing down to 90% in 2020 and thereafter. Overall, federal funds will finance 96% of the cost of the Medicaid expansion over the first decade. If a state accepts the new ACA Medicaid expansion funds, it must abide by the new expansion coverage rules, but based on the Supreme Court's opinion, a state can refuse to participate in the expansion without losing any of its current federal Medicaid matching funds.

In addition to the expansion of coverage to childless adults, the ACA expands, beginning in 2014, Medicaid coverage to certain individuals who age out of foster care, up to age 26. The ACA, however, did not change Medicaid eligibility for the elderly and people with disabilities.

Under the ACA, as of January 1, 2014, modified adjusted gross income (MAGI) rules apply to most Medicaid enrollees. Also, no asset test will apply. MAGI is defined as the Internal Revenue Code's Adjusted Gross Income (AGI, which reflects a number of deductions, including trade and business deductions, losses from sale of property, and alimony payments), increased (if applicable) by tax-exempt interest and income earned by U.S. citizens or residents living abroad. In addition, for certain eligibility groups, states must disregard dollar amounts equal to 5% FPL, and states are prohibited from applying additional income disregards. MAGI does not apply for specific exempted populations (e.g., those eligible for Medicaid based on their eligibility through another federal or state program such as SSI or foster care, the elderly, certain disabled individuals, and medically needy populations). For such exempted populations, AFDC and SSI income counting rules continue to apply.

CMS's Rules on Eligibility and Enrollment Simplification under the ACA

On March 16, 2012, CMS released its eligibility and enrollment final rule to assist states in implementing the ACA coverage expansion. Major provisions of the rule regarding eligibility, which is effective January 1, 2014, are briefly summarized below.⁸

1. Medicaid eligibility extends to a new "adult group," which includes all nonpregnant individuals ages 19 to 65 with household incomes at or below 133% FPL. Parents enrolling under this category must have their children enrolled in Medicaid, SCHIP, or other "minimum essential coverage." (This is now optional following the Supreme Court's decision.)

⁸ Source: Kaiser Commission on Medicaid and the Uninsured, *Medicaid Eligibility, Enrollment Simplification, and Coordination under the Affordable Care Act: A Summary of CMS's March 23, 2012 Final Rule*, December 2012.

2. Most existing Medicaid eligibility categories are collapsed into three broad groups: (1) parents, (2) pregnant women, and (3) children under age 19. States set income eligibility standards for these groups subject to federally specified minimums and maximums. The transition to these broader groups is not intended to change current eligibility levels for these populations, but rather to streamline and consolidate existing eligibility categories.
3. States may choose to cover nonelderly individuals who are not otherwise eligible for Medicaid, including pregnant women and children, with incomes above 133% FPL up to a maximum standard set by the state. States may phase-in coverage of the new group by category (e.g., pregnant women, children). Any parents enrolled under this category must have their children enrolled in Medicaid, SCHIP, or other "minimum essential coverage."
4. Medicaid financial eligibility for most categories are based on the MAGI definition of household income. For these groups, MAGI methods are used to determine eligibility for new applicants beginning as of January 2014. MAGI methods are not applied to existing beneficiaries who were determined eligible for Medicaid on or before December 31, 2013 until March 31, 2014 or the next regularly scheduled renewal for the individual, whichever is later. Groups listed below are exempt from the use of MAGI. These groups continue to have their financial eligibility determined based on existing Medicaid rules.
 - Individuals eligible for Medicaid on a basis that does not require the determination of income by the Medicaid agency (e.g., SSI beneficiaries);
 - Individuals age 65 and older (only for purposes of being evaluated for an eligibility group related to age);
 - Individuals whose eligibility is determined on the basis of being blind or disabled (only for determining eligibility on such basis);
 - Individuals who request coverage for long-term services and supports, including nursing facility services, home and community-based services, and home health services;
 - Individuals eligible for Medicare cost sharing assistance (only for determining eligibility for Medicare cost sharing assistance);
 - Medically needy individuals (only for determining eligibility for the medically needy category).
5. Although MAGI is determined on an annual basis, Medicaid eligibility will remain based on income at the time of application. Medicaid eligibility determinations for new applicants continue to be based on current monthly

income. For existing Medicaid beneficiaries determined eligible based on MAGI, the rule provides states the option to base continuing financial eligibility on either current monthly income or projected annual income for the remainder of the calendar year. In determining current monthly or projected annual income, a state may take into account reasonably anticipated changes in income. Actual changes in income must be reported by applicants and beneficiaries and acted upon by the state Medicaid agency.

6. The rule generally adopts MAGI methods for counting household income and eliminates the variety of income disregards and deductions currently used by states. In addition, there are no resource tests under MAGI. Using MAGI methods, household income is the sum of the income of every individual who is in the household, minus a standard income disregard of 5% of the FPL for the applicable household size.
7. The rule generally aligns references to "family size" in the current Medicaid rules with the definition of "household" used under MAGI.

Federal Poverty Lines

States use FPL in developing their income eligibility criteria for various Medicaid groups. FPL is the income guideline established and issued each year in the Federal Register by HHS. Public assistance programs usually define income standards in relation to FPL. Table 9 below provides the 2015 poverty lines for various family sizes for the 48 contiguous states and the District of Columbia. Alaska and Hawaii are provided a different set of federal poverty lines.

Table 9. 2015 Federal Poverty Lines	
Family Size	Poverty Line
1	\$11,770
2	\$15,930
3	\$20,090
4	\$24,250
5	\$28,410
6	\$32,570
7	\$36,730
8	\$40,890

Ohio Medicaid Eligibility

While the federal government requires that certain groups be covered, it grants states flexibility in setting Medicaid eligibility. Optional eligibility groups include pregnant women, children, and parents with income exceeding the mandatory thresholds; persons residing in nursing facilities with income below 300% of the SSI

standard, and "medically needy" individuals, who have high health expenses relative to their income. Between state expansions of Medicaid and eligibility under SCHIP, Ohio has expanded its coverage above the federal minimum.

To be qualified for Ohio Medicaid, an individual must meet basic requirements:

- Be a U.S. citizen or meet Medicaid citizenship requirements;⁹
- Be an Ohio resident;
- Have or get a Social Security number; and
- Meet certain financial requirements.

Various covered groups under Ohio Medicaid are described in the following sections.

Covered Families and Children and Group VIII

Covered Families and Children (CFC) includes families, children, and pregnant women. CFC is itself made up of several categories, including Healthy Start and Healthy Families. Generally, state law does not specify which persons fit into which categories. Rather, the categories have in large part been created administratively and there may not be a clear consensus as to the specific composition of the different categories.

Healthy Start

Healthy Start includes children under age 19 with family incomes not exceeding 200% FPL and pregnant women with family incomes not exceeding 200% FPL.

Children in families whose income is between 150% and 200% FPL must be considered "uninsured" to be eligible for Healthy Start. Children in families with income below 150% FPL can have other health insurance and still qualify for Healthy Start.

Part of Healthy Start is funded with regular Medicaid funds. Another part, covering uninsured children under age 19 who do not otherwise qualify for Medicaid, is funded with SCHIP funds. The state receives a higher federal match for SCHIP.

In Ohio, SCHIP is commonly discussed as consisting of two parts: CHIP I and CHIP II. CHIP I began January 1998 and provides coverage for low-income children up

⁹ The citizenship requirement, which became effective September 25, 2006, is a result of the Deficit Reduction Act of 2005. The citizenship requirement is meant to ensure those receiving public assistance are U.S. citizens. The law requires everyone applying for Medicaid to provide original documents to establish legal citizenship. Previously, Medicaid applicants could self-declare their U.S. citizenship. (Immigrants applying for Medicaid have always been required to document their status.) Additionally, Medicaid recipients who were approved before the Deficit Reduction Act was enacted must verify their citizenship status at the time of their reapplication for Medicaid benefits. Citizenship needs to be established only once.

to age 19 in families at or below 150% FPL. Am. Sub. H.B. 283 of the 123rd General Assembly (the FY 2000-FY 2001 budget) established CHIP II to cover uninsured individuals under age 19 in families with incomes between 150% and 200% FPL. CHIP II commenced on July 1, 2000.

Pregnant women are eligible for Healthy Start coverage during the entire pregnancy and up to 60 days after the baby is born. Babies born to mothers on Healthy Start are automatically eligible for free health coverage for one full year from the date of birth. Furthermore, pregnant women are allowed to receive expedited enrollment into Medicaid by meeting certain criteria. Expedited enrollment allows pregnant women to receive services under the fee-for-service (FFS) delivery system within 24 hours of applying for Medicaid. Once their eligibility is approved, they may continue to receive services under the FFS delivery system until they enroll in a managed care plan. After a pregnant woman selects a managed care plan, the state pays monthly capitation rates for the woman for the remainder of her pregnancy and pays a separate delivery payment upon birth.

Healthy Families

Healthy Families includes families with children. This category too can be broken down into different subcategories, including families that receive cash assistance under Ohio Works First and other families with family income not exceeding 90% FPL.

Other subcategories of CFC include the following:

- Extended eligibility (up to four months) for families that lose eligibility under the Healthy Families due to collection or increased collection of child or spousal support.
- Transitional Medicaid (up to 12 months) for families that lose eligibility under Healthy Families because their income exceeds 90% FPL due to increased earned income. The family must have received Medicaid under Healthy Families for at least three of the six months before losing eligibility due to the increased earned income.
 - Certain low-income individuals age 19 or 20 who do not qualify for Medicaid under Healthy Families.
 - Children for whom adoption assistance or foster care maintenance payments are provided.¹⁰

¹⁰ Children receiving a federally funded (Title IV-E) subsidy are automatically eligible for Medicaid. Children receiving a state-funded (non-Title IV-E) adoption subsidy can be eligible for Medicaid, based upon the child's income, resources, and special needs for medical, mental health, or rehabilitative care.

- Individuals under age 21 who were in foster care on their 18th birthday and for whom foster care maintenance payments or independent living services were furnished before they turned 18.

Group VIII

Beginning January 1, 2014, Medicaid coverage expands to adults between the ages of 19 and 64, who have family income less than 133% of FPL (with a 5% income disregard) and who are not eligible under other categories of Medicaid. In addition, parents whose family income is between 91% and 133% of the FPL (with a 5% income disregard) are eligible as Group VIII adults.

Aged, Blind, and Disabled

Medicaid covers certain low-income individuals who are aged (age 65 or older), blind, or disabled (ABD). ABD applicants must meet both income and resource criteria to qualify for Medicaid. Assets and resources are items such as: cash, stocks, bonds, bank accounts, and property. Some resources, such as the home in which the person is living, are considered exempt and are not counted when determining Medicaid eligibility. ABD applicants also must meet transfer of resources criteria that are in place to prevent a person from impoverishing themselves by giving away money to be qualified for Medicaid. In addition to meeting income and resources limits, ABD individuals must be elderly (age 65 or older), significantly visually impaired, or have a disabling condition that meets SSI requirements.

In some states, recipients of SSI are automatically eligible for Medicaid. Ohio is a 209(b) state, however, which means persons who receive SSI benefits do not automatically qualify for Medicaid in this state. Ohio uses more restrictive eligibility requirements for ABD. There are different standards for different services, but in general, ABD populations with annual incomes up to approximately 64% FPL are eligible for Medicaid in Ohio. ABD applicants whose income exceeds the Medicaid limit may qualify for Medicaid on a month-to-month basis after they "spend down" some of their income on health care expenses.

Tables 10 and 11 show the annual and monthly income limits for various eligible populations.

MEDICAID PRIMER

Table 10. Annual Income Guidelines					
		Annual Income Guidelines by Persons in Family			
Eligible Population	Income Guidelines	1	2	3	4
Workers with disabilities	<= 250%	\$29,425	\$39,825	\$50,225	\$60,625
Children to age 19	<= 200%	\$23,540	\$31,860	\$40,180	\$48,500
Pregnant women	<= 200%	\$23,540	\$31,860	\$40,180	\$48,500
Parents	<= 133%	\$15,654	\$21,187	\$26,720	\$32,253
Adults age 19 to 65	<= 133%	\$15,654	\$21,187	\$26,720	\$32,253
Disabled persons	<= 64%	\$7,533	\$10,195	\$12,858	\$15,520
Persons 65 & over	<= 64%	\$7,533	\$10,195	\$12,858	\$15,520

These figures are based on 2015 Federal Poverty Lines and change annually.

Some eligibility categories consider resources other than income.

Persons with incomes higher than 64% FPL may have medical expenses deducted from income calculations to "spend down" to this level.

Table 11. Monthly Income Guidelines					
		Monthly Income Guidelines by Persons in Family			
Eligible Population	Income Guidelines	1	2	3	4
Workers with disabilities	<= 250%	\$2,452	\$3,319	\$4,185	\$5,052
Children to age 19	<= 200%	\$1,962	\$2,655	\$3,348	\$4,042
Pregnant women	<= 200%	\$1,962	\$2,655	\$3,348	\$4,042
Parents	<= 133%	\$1,305	\$1,766	\$2,227	\$2,688
Adults age 19 to 65	<= 133%	\$1,305	\$1,766	\$2,227	\$2,688
Disabled persons	<= 64%	\$628	\$850	\$1,071	\$1,293
Persons 65 & over	<= 64%	\$628	\$850	\$1,071	\$1,293

These figures are based on 2015 Federal Poverty Lines and change annually.

Some eligibility categories consider resources other than income.

Persons with incomes higher than 64% FPL may have medical expenses deducted from income calculations to "spend down" to this level.

Medicare Cost Sharing Assistance

Medicaid helps certain Medicare beneficiaries with various Medicare cost-sharing expenses. The four major categories of Medicare cost sharing assistance are described below.

The first category is Qualified Medicare Beneficiary (QMB). In general, to qualify for the QMB category a Medicare recipient must have family income not exceeding 100% FPL. Medicaid pays QMB beneficiaries' Medicare Part A and B premiums and other Medicare cost sharing expenses (copayments, deductibles, and coinsurance).

The second category is Specified Low-Income Medicare Beneficiary (SLMB). In general, to qualify for SLMB a Medicare beneficiary must have family income above 100% FPL but less than 120% FPL. Medicaid pays SLMB beneficiaries' Medicare Part B premiums.

The third category is Qualified Individual (QI). In general, to qualify for the QI category a Medicare recipient must have family income of at least 120% FPL but not exceeding 135% FPL. Medicaid pays QI beneficiaries' Medicare Part B premiums, subject to an annual federal funding cap.

The income and asset limits for these programs are summarized in Tables 12 and 13.

Table 12. Monthly Income Limits		
	Individual Income Limit	Couple Income Limit
QMB	\$1,001 or less	\$1,348 or less
SLMB	\$1,197 to \$1,332	\$1,613 to \$1,789
QI	\$1,345	\$1,813

Note: Income based on the 2015 Federal Poverty Guideline and changes annually.
<http://www.medicare.gov/your-medicare-costs/help-paying-costs/medicare-savings-program/medicare-savings-programs.html#qmb>

Table 13. Asset Limits	
Individual Income Limit	Couple Income Limit
\$7,280	\$10,930

The fourth category is Qualified Disabled and Working Individual (QDWI). In general, to qualify for the QDWI category, an individual must have lost Medicare Part A benefits due to losing eligibility for disability benefits under Title II of the Social Security Act following a return to work, but be eligible to purchase Medicare Part A benefits by paying premiums, have family income not exceeding 200% FPL, and resources that do not exceed twice the limit for SSI. Medicaid pays QDWI beneficiaries' Medicare Part A premiums.

Breast and Cervical Cancer

Medicaid covers women under age 65, who have been screened for breast and cervical cancer under the federal Breast and Cervical Cancer Early Detection Program, and need treatment for the cancer. To qualify for the component, a woman cannot be covered by insurance considered to be "creditable coverage." Eligibility for Medicaid is limited to the period in which the woman requires treatment for breast or cervical cancer. The federal government reimburses a higher share of the costs of Medicaid provided under this group than the regular federal reimbursement rate.

Medicaid Buy-In for Workers with Disabilities

The Medicaid Buy-In for Workers with Disabilities Program is available to employed, disabled individuals, who are at least 16 but younger than 65 years of age, have countable income not exceeding 250% FPL, and meet other eligibility requirements including a resource requirement. Individuals with income exceeding 150% FPL must pay an annual premium to be qualified.

Family Planning Services

The ACA adds a new Medicaid eligibility option for states to improve access to family planning care without applying for waivers from the federal government. States can amend their Medicaid plans to create a new eligibility group of low-income individuals through a State Plan Amendment. On January 8, 2012, Ohio Medicaid implemented a new eligibility category that allows men and women of childbearing age who are under 200% FPL to receive family planning services.

Medicaid Benefits

Prior to 2006, in general, states were required to provide mandatory and optional services to their Medicaid recipients, referred to as "traditional" benefits. Under the DRA, states were given the option to provide "benchmark" and benchmark-equivalent benefit packages, as an alternative to the traditional benefits, to certain Medicaid populations or in certain state areas. However, most groups are exempt from benchmark coverage, including mandatory pregnant women and parents, individuals with severe disabilities, individuals who are medically frail or have special needs, dual eligibles, people with long-term care needs, and specified other groups.

Traditional Medicaid Benefits

Medicaid covers seniors, families, pregnant women, and people with physical and mental illness and chronic diseases. To address the various health care needs of its diverse recipients, Medicaid provides a rich benefit package not typically covered by private insurance, but also many additional services, such as dental and vision care and transportation, as well as long-term care services.

The Social Security Act specifies a set of mandatory health care services state Medicaid programs must cover and a set of optional services states may choose to cover. Most services provided under a state's Medicaid plan must be available to all covered individuals who have a medical need for that service. Exceptions include services provided only to children or only to individuals enrolled in home and community-based services waivers. As long as these benefits are provided in accordance with federal guidelines, states will receive federal financial participation (reimbursement) for eligible services provided to covered populations. As with private insurance, most of the services can be limited on the amount, duration, or scope of the benefits. For example, state Medicaid programs can choose the setting in which covered

services can be provided, limit the number of visits for a certain service, and cap the annual spending per person for a particular service. States are also allowed to use numerous tools to manage utilization, such as copayment, prior authorization, and case management.

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

Medicaid long-term care includes comprehensive services provided in institutions, such as a nursing home or ICF/IID, and a wide range of services and supports needed by people to live independently in the community, such as home health care, personal care, medical equipment, rehabilitative therapy, adult day care, case management, and respite for caregivers.

All states must provide nursing home care as part of their Medicaid programs for seniors and other individuals with severe physical disabilities. Medicaid is by far the largest payer in Ohio, accounting for almost 70% of all nursing home costs.

Although technically an optional benefit, prescription drugs are covered in all states. Many of the services that are technically optional are particularly vital for persons with chronic conditions or disabilities and the elderly. Despite their "optional" designation in statute, the inclusion of many of these services in state Medicaid packages is evidence that they are often essential as a practical matter. Notably, more than 20% of Medicaid spending in Ohio is attributable to optional services.

Table 14 shows the services covered under Ohio Medicaid that are mandatory (M) and optional (O).

Table 14. Mandatory Services vs. Optional Services	
Mandatory Services	Optional Services
Ambulatory surgery centers	Ambulance & ambulette
Certified nurse practitioners	Chiropractic
Dental (medical & surgical)	Community alcohol & drug addiction treatment
Family planning and supplies	Community behavioral mental health
Home health	Dental
Inpatient hospital	Durable medical equipment and supplies
Lab & x-ray	Home & community-based service waivers
Nonemergency transportation	Hospice care
Nursing facility care	Independent psychology
Nurse midwife	Intermediate care facility
Outpatient hospital	Occupational therapy
Physician	Physical therapy
Vision (medical & surgical)	Podiatry
	Prescription drugs
	Private duty nursing
	Speech therapy
	Targeted case management
	Vision care

Benchmark Benefits

In general, benchmark benefit packages may cover fewer benefits than traditional Medicaid, but there are some requirements, such as coverage of EPSDT services and transportation to and from medical providers, that might make them more generous than private insurance. The benchmark options include:

- The Blue Cross/Blue Shield standard provider plan under the federal employees Health Benefits Program;
- A plan offered to state employees;
- The largest commercial HMO in the state; and
- Other U.S. Secretary-approved coverage appropriate for the targeted population.

Benchmark-equivalent coverage must have the same actuarial value as one of the benchmark plans identified above. Such coverage must include: (1) inpatient and outpatient hospital services, (2) physician services, (3) lab and x-ray services, (4) emergency care, (5) well-child care, including immunizations, (6) prescribed drugs, and (7) other appropriate preventive care (designated by the Secretary). Such coverage must also include at least 75% of the actuarial value of coverage under the benchmark plan for vision care and hearing services (if any). For any child under age 21 in one of the major mandatory and optional Medicaid eligibility groups, benchmark and benchmark-equivalent coverage must include EPSDT. Also, Medicaid recipients enrolled in such coverage must have access to services provided by rural health clinics and federally qualified health centers.

Under the ACA, the newly eligible Medicaid adults with income up to 138% FPL, unless they belong to one of the exempt groups mentioned above, will be enrolled in benchmark or benchmark-equivalent plans instead of traditional Medicaid. The reform law establishes a new minimum standard for benchmark benefits. Starting in 2014, both benchmark and benchmark-equivalent packages must cover at least essential health benefits that will also apply to plans in the private individual and small group markets. There are ten such essential health benefits: (1) ambulatory services, (2) emergency services, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance abuse services, (6) prescribed drugs, (7) rehabilitative and habilitative services and devices, (8) lab services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care. Many of these essential health benefits are already coverable under benchmark packages. All benchmark packages must also cover family planning services.

Ohio's Medicaid Benefits

Ohio's Medicaid Program provides a comprehensive package of services that includes preventive care for Medicaid recipients. Benefits include primary and acute-care as well as long-term care. Some services are limited by dollar amount, number of visits per year, or setting in which they can be provided.

Basic covered services under Ohio Medicaid are described in the following sections.

Nursing Facility

A nursing facility provides skilled and intermediate nursing care, rehabilitation services, and other health-related care services on a regular basis. Nursing facility services are provided by nursing homes licensed by the Ohio Department of Health (ODH), county operated homes, or separate hospital units. To receive Medicaid payment for services, nursing facilities must meet state and federal requirements. ODM delegates the certification of these facilities to ODH, which also certifies their

participation in the federal Medicare Program. There are about 900 nursing facilities with more than 88,000 Medicaid-certified beds providing services to Medicaid recipients in Ohio.

Nursing Facility and Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) are the only Medicaid services for which the Ohio Revised Code establishes the reimbursement formula. The manner in which Medicaid is to pay for the services has undergone extensive changes since it was first enacted into state law. The General Assembly first enacted the law establishing a Medicaid payment system for long-term care services in 1980. This payment system was retrospective in nature. In 1991, the General Assembly replaced the retrospective system with a temporary prospective system. In 1992, a prospective system was codified. For FY 2002 to FY 2006, temporary caps on the system were put in place. Medicaid payments for nursing facility services was based on the facilities' reported costs, with adjustments made to reflect the resident care needs and other limiting parameters. However, Am. Sub. H.B. 66 of the 126th General Assembly (the FY 2006 and FY 2007 biennial budget bill) substantially revised the Medicaid reimbursement formula for nursing facilities. The reimbursement formula was modified from a cost-based formula to a price-based model.

Regular Medicaid Payment Rate

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

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

$$\begin{aligned} & \textit{Regular total Medicaid payment rate} \\ & = \textit{rate for ancillary and support costs} + \textit{rate for capital costs} \\ & + \textit{rate for direct care costs} + \textit{rate for tax costs} + \textit{quality incentive payment} \\ & + \textit{(in the case of a critical access nursing facility) critical access incentive payment} \end{aligned}$$

Ancillary and Support Costs. A nursing facility's rate for ancillary and support costs is its peer group's rate for ancillary and support costs. A peer group's rate for ancillary and support costs is determined as follows:

1. Determine the rate for ancillary and support costs for each nursing facility in the peer group by using the greater of the facility's actual inpatient days or the inpatient days the facility would have had if its occupancy rate had been 90%;

2. Identify which nursing facility in the peer group is at the 25th percentile of the rate for ancillary and support costs determined under (1) above;
3. Multiply the rate for ancillary and support costs determined under (1) above for the nursing facility identified under (2) above by the rate of inflation for an 18-month period; and
4. Until the first rebasing of the rate for ancillary and support costs occurs, increase the amount calculated under (3) above by 5.08%.¹¹

Capital Costs. A nursing facility's rate for capital costs is its peer group's rate for capital costs. A peer group's rate for capital costs is determined as follows:

1. Determine the rate for capital costs for the nursing facility in the peer group that is at the 25th percentile of the rate for capital costs; and
2. Until the first rebasing of the rate for capital costs occurs, increase the amount calculated under (1) above by 5.08%.

Direct Care Costs. A nursing facility's rate for direct care costs is determined semiannually by multiplying the cost per case-mix unit determined for the facility's peer group by the facility's semiannual case-mix score. A peer group's cost per case-mix unit is determined as follows:

1. Determine the cost per case-mix unit for each nursing facility in the peer group by dividing each facility's allowable per diem direct care costs by the facility's annual average case-mix score;
2. Identify which nursing facility in the peer group is at the 25th percentile of the cost per case-mix units determined under (1) above;
3. Calculate the amount that is 2% above the cost per case-mix unit determined under (1) above for the nursing facility identified under (2) above;
4. Multiply the rate of inflation for an 18-month period by the amount calculated under (3) above;
5. Until the first rebasing of the rate for direct care costs occurs, add \$1.88 to the amount calculated under (4) above; and
6. Until the first rebasing occurs, increase the amount calculated under (5) above by 5.08%.

A case-mix score is the measure of the relative direct-care resources needed to provide care and habilitation to a nursing facility resident. A nursing facility's annual average case-mix score is determined, in part, by using data from an assessment of each

¹¹ A rebasing is a redetermination of the rates for nursing facilities' different costs (or, in the case of direct care costs, their costs per case-mix units) using information from Medicaid cost reports for a calendar year that is later than the calendar year used for the previous determination of the rates or costs per case-mix units.

resident, regardless of payment source. A nursing facility's semiannual case-mix score is determined, in part, by using data from an assessment of each resident who is a Medicaid recipient and not a low resource utilization resident.

Tax Costs. A nursing facility's rate for tax costs is determined as follows:

1. Divide the nursing facility's allowable tax costs by the number of inpatient days the facility would have had if its occupancy rate had been 100%; and
2. Until the first rebasing of the rate for tax costs occurs, increase the amount calculated under (1) above by 5.08%.

Quality Incentive Payment. The amount of a nursing facility's quality incentive payment depends on how many points it is awarded for meeting accountability measures. To determine a nursing facility's quality incentive per diem payment, the number of such points so awarded is multiplied by \$3.29. There is, however, a cap on the quality incentive payment that may be paid. The maximum payment is \$16.44 per Medicaid day for a nursing facility that is awarded at least one point for meeting accountability measures regarding pain, pressure ulcers, physical restraints, urinary tract infections, and vaccinations. However, the maximum payment is to be reduced to \$13.16 per Medicaid day for a nursing facility that fails to be awarded at least one point for the accountability measures specified in the law.

Critical Access Incentive Payment. A critical access nursing facility's critical access incentive payment equals 5% of the sum of its rate for ancillary and support costs, rate for capital costs, rate for direct care costs, rate for tax costs, and quality incentive payment.

Low Resource Utilization Residents

H.B. 153 of 129th General Assembly established an exception to the Medicaid payment rate based on the formula discussed above. A nursing facility is paid \$130 per Medicaid day for services provided to low resource utilization residents during FY 2013 instead of the rate based on the formula. A low resource utilization resident is a Medicaid recipient residing in a nursing facility who, for purposes of calculating the nursing facility's Medicaid payment rate for direct care costs, is placed in either of the two lowest resource utilization groups, excluding any resource utilization group that is a default group used for residents with incomplete assessment data.

H.B. 303 of the 129th General Assembly provided for the \$130 per Medicaid day rate to continue indefinitely for nursing facility services provided to low resource utilization residents.¹² This rate for low resource utilization rates continues beyond the first rebasing.

Inpatient Hospital Services

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

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

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

Medicaid Prescription Drug Services

Prescription drugs often provide an alternative to expensive surgery, shorten hospital stays, and prevent illness. However, prescription drugs can be expensive. The effort to make prescription drugs available and, at the same time, contain costs has created diverse legislative proposals that seek to monitor expenditures, utilization, and access.

¹² R.C. 5111.222.

Federal law governing Medicaid drug reimbursement has sought to contain costs by placing limits on pharmacy reimbursement and mandatory manufacturer rebates on pharmaceutical products. In 1987, the federal government established a set of limits on payments for drugs in the Medicaid Program. These regulations established several guidelines that have significantly affected public spending on Medicaid and other state-funded programs. The federal government sets a maximum allowable cost for multiple-source drugs and requires state payments for all other drugs not exceed the lesser of the pharmacy's usual and customary charge or the estimated acquisition cost determined by the state. States are allowed to pay pharmacists a reasonable "dispensing fee" to cover pharmacy overhead and profit. Ohio Medicaid presently pays 7% above the wholesale acquisition cost for brand name drugs.

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

Ohio receives two types of drug rebates under Medicaid: drug rebates under federal law, and supplemental drug rebates under state law. Federal law requires that pharmaceutical manufacturers enter into rebate agreements with the federal government in order for their products to be eligible for outpatient drug coverage by state Medicaid programs. Prior to the implementation of the supplemental drug rebate program in Ohio, the only rebates the state received were the drug rebates under federal law.

Am. Sub. S.B. 261 of 124th General Assembly authorized ODJFS 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. Am. Sub. H.B. 95 of the 125th General Assembly continued this provision of the law and allowed the full implementation of the Supplemental Drug Rebate Program and a preferred drug list (PDL).

These programs were initiated in April 2003. ODJFS designated 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 (nonpreferred) drugs in that class are covered; however, prior authorization from the Medicaid pharmacy benefit manager is necessary in order to obtain a prescribed, nonpreferred drug. ODJFS sought supplemental rebates from manufacturers for preferred prescription drugs.

Am. Sub. H.B. 66 of the 126th General Assembly eliminated a requirement that any drug product used to treat mental illness or HIV or AIDS be exempted from the Supplemental Drug Rebate Program. H.B. 66 also authorized ODJFS to receive a supplemental rebate in a provider's primary place of business.

Am. Sub. H.B. 95 of the 125th General Assembly allowed ODJFS to establish copayments for prescription drugs that are not included on the PDL. Beginning January 1, 2004, certain Medicaid consumers are charged copayments for prescription drugs that are not found on the PDL. These copayments are 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 copayments, as are services for adults who reside in institutional settings. ODJFS did not actually collect the copayments. Instead, the pharmacist's reimbursement is reduced by the amount of the copayments. Am. Sub. H.B. 66 of the 126th General Assembly also allowed copayments on brand name drugs. Am. Sub. H.B. 59 of the 130th General Assembly further allowed copayments on generic drugs.

Home and Community-Based Service Waivers

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

There are several waivers within Ohio Medicaid. ODM currently administers the Ohio Home Care Waiver (OHCW) and the Transitions Carve-Out Waiver (T2).¹³ The Ohio Department of Aging (ODA) manages the PASSPORT and Assisted Living waivers.¹⁴ ODODD manages the Level One Waiver, Individual Options Waiver, Self-Empowered Life Funding (SELF) Waiver, and the Transitions Developmental Disabilities (DD) Waiver. Together these waivers provided alternative access to long-

¹³ According to ODM's website, the T2 waiver will be phased out by June 30, 2015 and individuals enrolled on the waiver will be enrolled onto PASSPORT. Transitioning from T2 to PASSPORT is expected to begin in February 2015. This is estimated to impact 1,300 individuals.

¹⁴ ODA also managed the Choices waiver until the program ceased operations on June 30, 2014, when consumer directed services became available statewide under PASSPORT and enrollees were transitioned onto PASSPORT.

term care to almost 70,000 individuals. In addition, MyCare Ohio enrollees are eligible to receive HCBS waiver services.

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

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

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

Table 15 based on OHT's "Blueprint for a New Ohio Budget Detail, February 2015" provides a summary of these waiver programs.

Table 15. Medicaid Waivers		
Eligibility	Services	Administrative Agency
Assisted Living Waiver		
<ul style="list-style-type: none"> • Specific financial criteria • Be age 21 or older • Nursing facility level of care 	<ul style="list-style-type: none"> • Assisted living • Community transition (for nursing home residents only) 	<ul style="list-style-type: none"> • ODA administers this waiver program under the direction of ODM • PAAs act as regional administrators and provide case management services

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Table 15. Medicaid Waivers		
Eligibility	Services	Administrative Agency
PASSPORT		
<ul style="list-style-type: none"> • Specific financial criteria • Nursing facility-based level of care • Age 60 or older 	<ul style="list-style-type: none"> • Adult day health • Alternative meal services • Choices home care attendant • Home care attendant • Environmental accessibility adaptations • Home-delivered meals • Personal emergency response systems • Specialized medical equipment and supplies • Chore assistance • Community transition • Independent living assistance • Nonmedical transportation • Nutritional consultation • Out-of-home respite • Social work and counseling • Transportation • Homemaker/Personal Care • Enhanced community living • Waiver nursing 	<ul style="list-style-type: none"> • ODA administers this waiver program under the direction of ODM • PAA acts as regional administrator and provides case management services
Level One Waiver		
<ul style="list-style-type: none"> • Specific financial criteria • ICF/IID level of care • All ages 	<ul style="list-style-type: none"> • Habilitation (day and vocational) • Environmental accessibility and adaptations • Homemaker/personal care • Personal emergency response system • Respite – informal • Respite – institutional • Specialized medical equipment and supplies • Emergency assistance • Supported employment • Transportation • Nonmedical transportation 	<ul style="list-style-type: none"> • ODODD administers this waiver program under the direction of ODM • Local county boards of developmental disabilities provide case management

MEDICAID PRIMER

Table 15. Medicaid Waivers		
Eligibility	Services	Administrative Agency
Individual Options Waiver		
<ul style="list-style-type: none"> • Specific financial criteria • ICF/IID level of care • All ages 	<ul style="list-style-type: none"> • Homemaker/personal care • Transportation • Community and residential respite • Adult day support • Adult family living • Adult foster care • Environmental accessibility modifications • Homemaker/personal care • Adaptive and assistive equipment • Remote monitoring equipment • Vocational habilitation • Supported employment (community and enclave) • Social work • Interpreter • Home delivered meals • Nonmedical transportation • Nutrition 	<ul style="list-style-type: none"> • ODODD administers this waiver program under the direction of ODM
Self-Empowered Life Funding (SELF) Waiver		
<ul style="list-style-type: none"> • Specific financial criteria • ICF/IID level of care • All ages 	<ul style="list-style-type: none"> • Participant-directed goods and services • Participant/family stability assistance • Support brokerage • Clinical/therapeutic intervention • Community inclusion • Residential respite • Community respite • Nonmedical transportation • Functional behavioral assessment • Habilitation – adult day support • Habilitation – vocational • Integrated employment • Supported employment enclave • Remote monitoring equipment 	<ul style="list-style-type: none"> • ODODD administers the day-to-day operations of the SELF waiver program under the direction of ODM

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Table 15. Medicaid Waivers		
Eligibility	Services	Administrative Agency
Ohio Home Care Waiver (OHCW)		
<ul style="list-style-type: none"> • Specific financial criteria • Nursing facility-based level of care • Age 59 or younger 	<ul style="list-style-type: none"> • Adult day health • Emergency response • Home-delivered meals • Home modification • Out-of-home respite • Personal care aide • Supplemental adaptive and assistive device • Supplemental transportation • Waiver nursing • Home care attendant 	<ul style="list-style-type: none"> • ODM administers this waiver program • ODM contracts with agencies to provide case management
Transitions Developmental Disabilities (DD) Waiver		
<ul style="list-style-type: none"> • Specific financial criteria • ICF/IID level of care • All ages • Available only to individuals enrolled on OHCW whose level of care is determined to be an ICF/IID level 	<ul style="list-style-type: none"> • Adult day health • Emergency response • Home-delivered meals • Home modification • Out-of-home respite • Personal care aide • Supplemental adaptive and assistive device • Supplemental transportation • Waiver nursing 	<ul style="list-style-type: none"> • ODM administered the day-to-day operations of the Transitions Developmental Disabilities waiver program until January 2013 at which time ODODD became responsible for administration • Local county boards of DD provide case management services
Transitions Carve-Out Waiver (T2)		
<ul style="list-style-type: none"> • Specific financial criteria • Nursing facility-based level of care • Age 60 or older and must transfer from the OHCW 	<ul style="list-style-type: none"> • Adult day health • Emergency response • Home-delivered meals • Home modification • Out-of-home respite • Personal care aide • Supplemental adaptive and assistive device • Supplemental transportation • Waiver nursing • Home care attendant 	<ul style="list-style-type: none"> • ODM administers this waiver program • ODM contracts with agencies to provide case management

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Table 15. Medicaid Waivers		
Eligibility	Services	Administrative Agency
MyCare Ohio		
<ul style="list-style-type: none"> • Eligible for Medicare Parts A, B, and D and full Medicaid benefits • Age 18 or over • Reside in a demonstration county • Enrolled on MyCare • Intermediate or skilled level of care • Require NF or hospital in the absence of MyCare • Require at least one waiver service monthly • Not reside in NF or ICF/IID 	<ul style="list-style-type: none"> • Adult day health • Alternative meal services • Assisted living service • Choices home care attendant • Home care attendant • Home-delivered meals • Emergency response • Home medical equipment and supplemental adaptive and assistive devices • Home modification • Chore assistance • Independent living assistance • Nutritional consultation • Out-of-home respite • Social work and counseling • Homemaker/Personal Care • Enhanced community living • Waiver nursing • Waiver transportation 	<ul style="list-style-type: none"> • ODM administers this waiver program • ODM contracts with MyCare Managed Care plans

Medicaid Cost Sharing

Medicaid has historically limited patient cost sharing because the program serves a much poorer and sicker population than private health insurance. The Deficit Reduction Act of 2005 (DRA) loosened the rules that restricted states' use of premiums and cost-sharing in Medicaid. Under DRA, states may impose premiums and cost sharing through Medicaid state plan amendments rather than through waiver authority, subject to specific restrictions.

In general, for individuals with income under 100% FPL:

- No premiums may be imposed;
- Service-related cost sharing cannot exceed nominal amounts; and
- The total aggregate amount of all cost sharing cannot exceed 5% of monthly or quarterly family income.

For individuals in families with income between 100% and 150% FPL:

- No premiums may be imposed;¹⁵

¹⁵ The executive proposes to seek CMS approval to charge a premium to childless, nonpregnant adults who have income between 100% FPL to 138% FPL.

- Service-related cost sharing cannot exceed 10% of the cost of the item or service rendered; and
- The total aggregate amount of all cost sharing cannot exceed 5% of monthly or quarterly family income.

For individuals in families with income above 150% FPL:

- Service-related cost sharing cannot exceed 20% of the cost of the item or service rendered; and
- The total aggregate amount of all cost sharing (including any applicable premiums) cannot exceed 5% of monthly or quarterly family income.

There are exemptions to DRA cost sharing for certain groups and services. Groups such as most children, pregnant women, and individuals with special needs are exempt from paying premiums regardless of their income. Also, certain services such as preventive care for children, emergency care, and family planning services are exempt from the service-related cost sharing. Under the DRA option, special rules apply to cost sharing for nonpreferred prescription drugs and for emergency room copayments for nonemergency care, and such cost sharing can be adjusted for medical inflation over time. Finally, DRA give states the option to terminate Medicaid coverage if premiums are not paid and, except for mandatory children and adults under 100% FPL, to grant health care providers the right to deny care if Medicaid patients do not pay their cost-sharing charges.

Over the past few years, most states have introduced or increased cost sharing requirements for their Medicaid recipients for reasons such as encouraging personal responsibility and controlling prescription drug costs. Cost sharing may make Medicaid recipients less likely to make unnecessary doctor visits or treatments, and copayments on brand name drugs can encourage the use of generic drugs. However, it is possible that cost sharing may force Medicaid recipients to forego needed health care, causing them to become sicker and need more expensive care later on, increasing costs in the long run.

Cost sharing requirements for Medicaid recipients are determined by states, but are subject to federal guidelines. Table 16 shows the current copayments required under Ohio Medicaid.

Table 16. Medicaid Copayments	
Services	Copayments
Nonemergency services obtained in a hospital emergency room	\$3 per visit
Dental services	\$3 per visit
Routine eye examinations	\$2 per examination
Eyeglasses	\$1 per fitting
Most brand name (nongeneric) medications	\$2 per prescription or refill
Medications that require prior authorization	\$3 per prescription or refill

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

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

Delivery Systems

Fee-for-Service and Managed Care

There are two delivery systems for Ohio Medicaid: "fee-for-service" and "managed care." Both delivery systems provide medically necessary primary care, specialty and emergency care services, and preventive services. Ohio Medicaid also provides home and community-based, and facility-based long-term care services, exclusively through the fee-for-service system for nondual population.

Medicaid does not directly provide medical services to eligible individuals enrolled in the program. It provides financial reimbursement to health care professionals and institutions for providing approved medical services, products, and equipment to Medicaid enrollees. Under fee-for-service, Medicaid pays most service providers a set fee for the specific type of service rendered. Payments are based on the lowest of the state's fee schedule, the actual charge, or federal Medicare allowances.

An alternative to fee-for-service reimbursement is managed care. The two main models of managed care in Medicaid are managed care organizations and primary care case management (PCCM).

A managed care organization, also called a managed care plan (MCP) under Ohio Medicaid, is a capitated at-risk plan in which the beneficiary receives all care

through a single point of entry, and the managed care provider is paid a fixed monthly premium per beneficiary for any health care included in the benefit package, regardless of the amount of services actually used. The beneficiary is responsible for, at most, modest copayments for services; the provider is at risk for the remaining cost of care. A capitated plan can be a network of physicians and clinics, all of whom participate in the plan and also participate in other plans or fee-for-service systems, or it can be a plan that hires the physicians who provide all of the care required.

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

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

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

1. **Medicare Shared Savings Program (MSSP).** The MSSP provides incentives for health care providers to organize into ACOs as a means of providing coordinated, quality care to Medicare beneficiaries at a reduced cost. ACOs that meet quality performance benchmarks while saving costs may share in the savings. The ACA grants the HHS Secretary discretion to include electronic health record and electronic prescribing requirements in the MSSP.
2. **Patient-Centered Medical Homes.** The ACA authorizes funding for the creation of "health teams" that will support primary care providers and patient-centered medical homes. Methods of support include: (1) offering care coordination, care transition, disease management, and disease prevention services, (2) collecting and reporting quality data, and (3) facilitating EHR implementation that meets the Health Information Technology for Economic and Clinical Health Act's ("HITECH") "meaningful use" requirements.
3. **State Option to Provide Health Homes for Enrollees with Chronic Conditions.** States may offer health home services to Medicaid enrollees with a mental health condition, a substance use disorder, asthma, diabetes, heart disease, or obesity. The ACA defines health home services as including care management, care coordination, transitional care, and patient and family support services linked together by the use of health information technology.
4. **Hospital Readmissions Reduction Program (HRRP).** The HRRP imposes a financial penalty on hospitals that have high readmission rates for conditions specified by the HHS Secretary.

Ohio's Medicaid Managed Care

Ohio Medicaid has incorporated the use of managed care since 1978. Although Ohio has contracted with managed care plans since the late 1970s to provide care for certain Medicaid eligibles, the use of capitated rates was not given major emphasis in Ohio's program until the state received an 1115 demonstration waiver in January 1995. As one initiative of the federally approved OhioCare proposal, the state was given the freedom to require mandatory managed care enrollment by CFC Medicaid eligibles.

In FY 2004, Medicaid provided health care coverage to approximately 500,000 Ohioans per month through managed care. ODJFS contracted with six managed care providers that served 15 Ohio counties. Managed care membership was mandatory for the CFC population in four counties (Cuyahoga, Stark, Lucas, and Summit) and optional in the other 11 (Butler, Clark, Clermont, Franklin, Greene, Hamilton, Lorain, Montgomery, Pickaway, Warren, and Wood).

Am. Sub. H.B. 66 of the 126th General Assembly (the FY 2006-FY 2007 biennial budget) required MCPs be implemented in all counties and required ODJFS to

designate the CFC population for participation.¹⁶ The bill also required ODJFS to designate the participants not later than January 1, 2006. Not later than December 31, 2006, all designated participants were required to enroll in Medicaid MCPs. H.B. 66 also required ODJFS to implement the MCPs for certain aged, blind, and disabled Medicaid recipients in all counties. This requirement did not apply to: (1) individuals under age 21, (2) institutionalized individuals, (3) individuals eligible for Medicaid by spend-down, (4) dual eligibles, and (5) Medicaid waiver recipients. Not later than December 31, 2006, all designated participants were required to enroll in Medicaid MCPs. Prior to these mandated expansions in H.B. 66, Ohio Medicaid MCPs were limited to large metro areas and exclusively focused on the CFC population. The statewide expansion in H.B. 66 included rural areas such as Appalachia where access to health care can be difficult. And for the first time, the elderly population was included in managed care.

In FY 2010, Medicaid provided health care coverage to 173,000 CFC and 373,000 ABD per month through fee-for-service and 1.4 million CFC and 115,000 ABD per month through managed care.

As a result, this statewide expansion of Medicaid managed care that began in July 2005 has dramatically shifted expenditures from fee-for-service to the managed care. In FY 2012, expenditures for the managed care categories were \$6.4 billion and represented 44% of the total Medicaid service expenditures in the Office of Medical Assistance. In FY 2012, Ohio Medicaid provided health care coverage to 146,582 CFC and 90,389 ABD per month through fee-for-service and 1.5 million CFC and 127,793 ABD per month through managed care plans.

H.B. 153 of the 129th General Assembly (the FY 2012-FY 2013 biennial budget) further expanded managed care plan coverage to an even boarder population by requiring Ohio Medicaid (1) to implement Health Homes, (2) not later than July 1, 2012, to establish a pediatric accountable care organization (ACO) recognition system for children under age 21 who are blind or disabled, and (3) to implement the Integrated Care Delivery System (ICDS), now known as MyCare Ohio, that will coordinate the delivery of and be accountable for all covered Medicare and Medicaid services for participating dual enrollees. The details of each of the programs are provided as following:

Health Homes

Health Homes is a system under which Medicaid recipients with chronic conditions are provided with coordinated care. Beginning in October 2012, Ohio

¹⁶ According to both state and federal regulations, managed care enrollment is optional for children receiving adoption assistance under the Federal Title IV-E Program, foster care assistance, or out-of-home placement.

Medicaid received federal approval for enhanced federal match to pay for care coordination in serious and persistent mental illness (SPMI)-focused health homes. Under the new system, care managers in patient-centered medical homes provide intensive care coordination and develop an individualized care plan for each consumer to address both medical and nonmedical needs.

Health homes are an intense form of care management that includes a comprehensive set of services and meaningful use of health information technology. A health home can operate within FFS, managed care, or other service delivery systems. The ACA allows states to claim a 90% federal match for eight quarters for a defined set of care coordination services for individuals who are severely chronically ill or have multiple chronic conditions.

Pediatric Accountable Care Organizations

A pediatric accountable care organization provides pediatric accountable care for children under age 21 who are blind or disabled. The standards of recognition are to be the same as, or not conflict with, those adopted under the ACA. More than 37,000 children with special health care needs were transitioned to managed care in July 2013.

MyCare Ohio

In December 2012, ODJFS announced that Ohio had reached an agreement with CMS regarding the creation of an integrated care delivery system – otherwise known as "MyCare Ohio." MyCare Ohio allows care to be coordinated for individuals that are eligible for both Medicare and Medicaid. The goal of the program is to improve access to care and to improve quality of that care, as well as promoting participant independence within the community, eliminating cost shifting between the two programs, and achieving cost savings through care coordination. Services are provided in the setting of choice and individuals are able to transition to different settings as their needs change.

MyCare Ohio is a three-year demonstration project that covers 29 counties, which are grouped into seven regions. The counties covered are in the state's more metropolitan areas. Program enrollment began in the northeast region in May 2014 and continued with the remaining regions in June and July 2014. At least two managed care organizations in each region are contracting with the state and CMS to administer the program. These organizations must subcontract with Area Agencies on Aging (AAAs) and other entities to provide care coordination services such as information and referral, screening, pre-admission and resident review, long-term care consultations, and level of care determinations. Seven AAA and eight independent living centers provided hands-on assistance during the enrollment process. The AAAs and the centers were able to contract with other local entities to help provide enrollment assistance counseling.

Eligible individuals are those that are 18 and older, meet requirements to receive full Medicare Parts A, B, and D and full Medicaid benefits, and live in a participating county. However, there are some individuals excluded from the program such as children, those enrolled in the Program for All-Inclusive Care for the Elderly (PACE), and those with a developmental disability. Under the program, individuals receive Medicare and Medicaid services and additional items and services at a capitated rate (Medicare and Medicaid will both contribute to this rate). Individuals enrolled in MyCare Ohio had until the end of calendar year 2014 to choose a MyCare Ohio plan for their Medicare benefits. However, while individuals have to receive their Medicaid benefits through MyCare Ohio, individuals have the option of choosing to continue receiving Medicare benefits in the same manner that they currently do.

There are currently about 182,000 dual eligible individuals in Ohio. As of December 31, 2014, over 100,000 of these individuals were enrolled onto MyCare.

Program of All-Inclusive Care for the Elderly

In addition to the MCPs mentioned above, Ohio Medicaid offers a unique managed type of program: the Program of All-Inclusive Care for the Elderly (PACE). PACE is authorized through the Medicaid State Plan and operated under an agreement with CMS.

PACE provides home and community-based care, allowing seniors to live in the community. There is currently one PACE site – McGregor PACE, which is located in Cleveland. Prior to August 2014, there were actually two PACE sites. The other site was Tri-Health Senior Link, which was located in Cincinnati. The site stopped providing services at the end of August 2014 and consumers were transitioned onto other waiver programs. The PACE sites provide participants with all of their needed health care, medical care, and ancillary services at a capitated rate. All PACE participants must be 55 years of age or older and qualify for a nursing home level of care. The PACE sites assume full financial risk for the care of the participants. Indeed, if PACE participants require nursing facility care, the PACE site continues to be responsible for the cost of the participant's care. Consequently, there is an incentive that a broad range of preventive and community-based services be provided as alternatives to more costly care.

Currently, ODA administers PACE; however, funding for services is provided by ODM. In FY 2014, PACE served an average of 717 consumers per month. In FY 2015, that number is anticipated to be 401 due to the elimination of the PACE site in Cincinnati. The monthly capitated rate for the Cleveland facility in FY 2014 and FY 2015 was/is \$2,394 for dual eligibles and \$3,553 for individuals enrolled only in Medicaid. The monthly capitated rate for the Cincinnati facility in FY 2014 was \$2,694 for dual eligibles and \$3,769 for Medicaid-only individuals.

Medicaid Provider Taxes

States have the authority to establish taxes to fund various activities. Sometimes states establish taxes to fund specific purposes. Other times, taxes may be credited to the states' general treasury to be used for any state purpose. One type of tax that is commonly relied on by many states to fund a portion of their share of Medicaid program costs is a tax on health care providers. These taxes, called provider taxes, are required to comport with certain federal laws established by Congress in 1991 and subsequent changes made in 2005, 2006, and 2008.

A vast majority of states use at least one provider tax to help finance Medicaid. Many of these states use the provider tax revenue to increase Medicaid payment rates for the class of providers, such as hospitals, responsible for paying the provider tax. This financing strategy allows states to fund increases to Medicaid payment rates without the use of state funds as the increased Medicaid payment rates are funded with provider tax revenue and federal Medicaid matching funds. States also use provider tax revenues to fund other Medicaid or non-Medicaid purposes. States first began using health care provider taxes to help finance the state's share of Medicaid expenditures in the mid-1980s. Some states were particularly aggressive in their use of provider taxes. As a result, in the early 1990s, the federal government imposed statutory and regulatory limitations on states' use of health care provider tax revenue to finance Medicaid.

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

- Requires provider taxes be "broad-based" and uniformly applied to all providers within specified classes of providers – in other words, states cannot limit the provider taxes only to Medicaid providers; the same tax has to be imposed on all providers within a specified class of providers.
- Prohibits taxes that exceed 25% of the state (or nonfederal) share of Medicaid expenditures.
- Prohibits states from a direct or indirect guarantee that providers receive their money back (or be "held harmless") – in other words, hold the providers harmless for the cost of the provider tax.

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

- Inpatient hospital services;
- Outpatient hospital services;
- Nursing facility services;
- Services of intermediate care facilities for individuals with intellectual disabilities;
- Physicians' services;

- Home health care services;
- Outpatient prescription drugs;
- Services of Medicaid managed care organizations (including health maintenance organizations, preferred provider organizations, and such other similar organizations as the HHS Secretary may specify by regulation);
- Ambulatory surgical centers;
- Dental services;
- Podiatric services;
- Chiropractic services;
- Optometric/optician services;
- Psychological services;
- Therapist services;
- Nursing services;
- Laboratory and x-ray services;
- Emergency ambulance services; and
- Other health care items or services for which the state has enacted a licensing or certification fee.

While federal requirements allow states to impose provider taxes on 19 classes of health care providers, the classes of providers that are most often taxed include nursing facilities, hospitals, intermediate care facilities for individuals with intellectual disabilities (ICFs/IID), and managed care organizations.

Requiring that all providers within a class be taxed, as opposed to only Medicaid providers, dampened the ability of states to establish such taxes. The reason is that Medicaid providers could easily be held harmless by inflating Medicaid payments. Other providers could not be repaid so simply, and therefore would be more likely to oppose the imposition of such taxes.

Changes to law include a provision in the Deficit Reduction Act of 2005 (DRA, P.L. 109-171), which altered one of the specified classes of providers. The "Medicaid managed care organizations" class was changed to all "managed care organizations."

The Tax Relief and Health Care Act of 2006 (TRHCA, P.L. 109-432) included a provision changing the rules exempting taxes from scrutiny of their hold harmless provisions. The rule changed the threshold under which tax programs could avoid scrutiny of hold harmless provisions from 6% of a taxpayer's revenue to 5.5% for fiscal years beginning on or after January 1, 2008, through September 30, 2011. In addition, the regulation further specified that the revenues against which the 5.5% threshold should be applied are "net operating revenues." The former regulation had not specified

the type of revenues against which to apply the threshold test. On October 1, 2011, the threshold reverted to 6% of net patient service revenues.

Ohio's Medicaid Provider Taxes

In addition to funding from the GRF, several provider tax programs and other special revenues are used to pay for Medicaid services. The revenues from the provider taxes mentioned below are appropriated in ODM's budget although some of the revenues are transferred to the other state agencies that also administer Medicaid programs.

Nursing Facility Franchise Permit Fees

ODM 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 was applied to: (1) nursing home beds, (2) Medicare-certified skilled nursing facility beds, (3) Medicaid-certified nursing facility beds, and (4) beds in hospitals that are registered as skilled nursing facility beds or long-term care beds, or licensed as nursing home beds.

Am. Sub. H.B. 94 of the 124th General Assembly (the FY 2002-FY 2003 biennial budget) raised the franchise permit fee to \$3.30 for FY 2002 and FY 2003. Am. Sub. S.B. 261 of the 124th General Assembly (the FY 2002-FY 2003 corrective bill) raised the franchise permit fee to \$4.30 for FYs 2003 through 2005, a \$1.00 per bed per day increase for FY 2003, and a \$3.30 per bed per day increase for FY 2004 and FY 2005. Am. Sub. H.B. 66 of the 126th General Assembly (the FY 2006-FY 2007 biennial budget) increased the fee to \$6.25 for FY 2006 and FY 2007. H.B. 119 of the 127th General Assembly (the FY 2008-FY 2009 biennial budget) maintained the fee at \$6.25 for FY 2008 and FY 2009. H.B. 1 of the 128th General Assembly (the FY 2010-FY 2011 biennial budget) increased the fee to \$12.01 for FY 2010 and \$11.95 for FY 2011.

H.B. 153 of the 129th General Assembly kept the nursing facility franchise fee at about \$11.38 in FY 2012 and \$11.60 in FY 2013 in order to maximize federal reimbursement for nursing facility services. H.B. 59 of the 130th General Assembly (the FY 2014-FY 2015 biennial budget) requires, effective July 1, 2013, the franchise permit fee rate to be determined each fiscal year by the formula specified in the statute. The franchise fees for FY 2015 are calculated to be \$12.10 for all licensed beds.

ICF/IID Franchise Permit Fees

ICFs/IID are required to pay a franchise permit fee. Beginning August 1, 2009, developmental centers (ICFs/IID that ODODD operates) are also subject to the franchise permit fee. Revenue raised by the franchise permit fee is to be used for the expenses of the programs ODODD administers and ODODD's administrative expenses.

The franchise permit fee for ICFs/IID, at \$9.63 per bed per day, was unchanged from FY 2002 through FY 2007. H.B. 119 of the 127th General Assembly did not change the amount of the ICF/IID franchise permit fee, but added an annual composite inflation factor adjustment. H.B. 562 of the 127th General Assembly increased the franchise permit fee on ICFs/IID to \$11.98 effective July 1, 2008. H.B. 1 of the 128th General Assembly maintained the fee at \$11.98 until August 1, 2009. The fee was raised to \$14.75 for the period beginning August 1, 2009, and ending June 30, 2010. For FY 2011, the fee was lowered to \$13.55. H.B. 153 of the 129th General Assembly set the ICFs/IID franchise permit fee rate at \$17.99 for FY 2012 and \$18.32 for FY 2013 and thereafter. H.B. 59 of the 130th General Assembly sets the rate for the franchise permit fee charged ICFs/IID at \$18.24 for FY 2014 and \$18.17 for FY 2015 and thereafter.

Managed Care Assessments

H.B. 66 of the 126th General Assembly required each Medicaid health insuring corporation to pay a franchise permit fee for each calendar quarter between January 1, 2006, and June 30, 2007, to help offset the statewide CFC managed care expansion that biennium. The fee was 4.5% of the managed care premiums the health insuring corporation received in the applicable calendar quarter, unless (1) ODM adopted rules decreasing the percentage or increasing it to not more than 6%, or (2) the fee was reduced or terminated to comply with federal law or because the fee did not qualify for matching federal funds.

Am. Sub. S.B. 190 of the 126th General Assembly changed the effective date of the managed care plan assessment from January 1, 2006 to December 1, 2005. The Medicaid managed care assessment continued for the FY 2008-FY 2009 biennium, and the managed care assessment fee was increased from 4.5% to 5.5% on July 1, 2008.

The money collected from the franchise permit fee was used to pay for Medicaid services, administrative costs, and contracts with Medicaid health insuring corporations. Under prior federal law, Medicaid managed care organizations were identified as a separate class of providers, and were therefore not subject to the provisions of the Social Security Act that require provider-based taxes to be broad-based in nature. However, effective October 1, 2009, the Deficit Reduction Act of 2005, removed this distinction for Medicaid managed care organizations. Accordingly, Ohio's Medicaid managed care franchise fee was terminated.

To replace the \$194 million in revenue generated from the managed care franchise fee to the state, as well as the resulting federal match received when these funds would be used to pay for Medicaid services (roughly \$550 million including both state and federal shares), H.B. 1 of the 128th General Assembly (the FY 2010-FY 2011 biennial budget) requires managed care organizations (MCOs) to be subjected to the state sales and use tax and to the existing health insuring corporation (HIC) tax on payments received from the state to provide Medicaid services. MCOs were previously

exempted from the latter tax. The total tax rate is about 7.7% (5.5% state sales tax, 1.2% average local sales tax, and 1.0% HIC tax). To cover the MCOs' tax costs, the state-contracted actuary adds to the capitated rate an amount equal to the taxes assessed on MCOs. MCOs pay the taxes back to the state when the taxes are assessed.¹⁷ The state deposits most of the state sales and HIC tax receipts into the GRF. A small portion (5.9%) of the state sales and HIC tax revenues are diverted to the Local Government Fund (3.68%) and the Public Libraries Fund (2.22%), and then disbursed to counties and public libraries. Counties receive the local sales tax revenue based on the residence of Medicaid clients covered by the MCOs.

The state's cost of the tax included in the capitated rate is considered an allowable cost under federal Medicaid law and is therefore eligible for federal Medicaid reimbursement. If the initial draw of federal reimbursement on the cost of taxes were spent entirely on Medicaid services, it would constitute the state share and earn additional federal reimbursement. In the end, revenue from the collection of taxes and earned federal reimbursement offset the cost of the taxes and result in a net gain to the GRF.

Hospital Care Assessments

H.B. 1 of the 128th General Assembly created a hospital assessment to raise money to help pay for the Medicaid Program. The assessment was collected over the course of three payments during each year of 2010 and 2011 as follows:

1. 28% of a hospital's assessment for a year is due on the last business day of October;
2. 31% is due on the last business day of February; and
3. 41% is due on the last day of May.

The percentage of a hospital's total facility costs that was to be the hospital's assessment for the first year of the assessment is 1.52%. The percentage to be used for the second and successive years was 1.61%. This fee is separate from the established assessment fee under the Health Care Assurance Program (HCAP).

The amount of a hospital's assessment for a year is to equal a percentage of the hospital's total facility costs. A hospital's total facility costs are the hospital's total costs for all care provided to all patients, including the direct, indirect, and overhead costs to the hospital of all services, supplies, equipment, and capital related to the care of patients, regardless of whether patients are enrolled in a health insuring corporation. However, total facility costs exclude all of the following costs: skilled nursing services provided in distinct-part nursing facility units, home health services, hospice services,

¹⁷ HIC tax payments are due in March for services provided in the previous calendar year. State and local sales taxes are collected on an ongoing basis.

ambulance services, renting durable medical equipment, and selling durable medical equipment. And, the ODM Director is permitted to adopt rules to exclude certain program costs from a hospital's total facility costs. The amount of a hospital's total facility costs is to be derived from cost-reporting data for the hospital submitted to ODM for purposes of HCAP. The cost-reporting data used to determine a hospital's assessment is subject to the same type of adjustments made to the data under HCAP.

Effective October 14, 2010, the following changes were made to the hospital assessment due to an Executive Order:

1. Changing the basis upon which hospitals are assessed, by removing Medicare costs from the calculation of each hospital's total facility costs;
2. Lowering the assessment rate for the second year to 1.38%; and
3. Delaying the collection of the October hospital franchise fee payment until November 30, 2010.

H.B. 153 of the 129th General Assembly continued the assessments imposed on hospitals for two additional years, ending October 1, 2013, rather than October 1, 2011. H.B. 153 required ODJFS to adopt rules specifying the percentage of hospitals' total facility costs that hospitals are to be assessed. A hospital's total facility costs are derived from cost-reporting data submitted to ODJFS for purposes of HCAP. The estimated assessment rate for FY 2013 is about 2.67%. H.B. 153 also allowed ODJFS to establish a different payment schedule in rules in order to reduce hospitals' cash flow difficulties. It required ODJFS to impose a penalty of 10% of the amount due on any hospital that fails to pay its assessment by the due date.

H.B. 59 continued the assessments imposed on hospitals for two additional years, ending October 1, 2015, rather than October 1, 2013.

Hospital Care Assurance Program

The federal government requires state Medicaid programs to make subsidy payments to hospitals that provide uncompensated, or charity, care to low-income and uninsured individuals at or below 100% FPL under the Disproportionate Share Hospital (DSH) Program. HCAP is the system Ohio uses to comply with the DSH Program requirement. Under HCAP, hospitals are assessed an amount based on their total facility costs, and government hospitals make intergovernmental transfers to ODM. ODM then redistributes back to hospitals money generated by the assessments, intergovernmental transfers, and federal matching funds based on uncompensated care costs. In federal fiscal year (FFY) 2010, HCAP collected \$208 million from Ohio hospitals, matched it with federal dollars, and redistributed \$568 million back to the hospitals.

ARRA provided additional fiscal relief to states by increasing most states' FFY 2009 and FFY 2010 Medicaid DSH allotments by 2.5%. As a result, Ohio received about an additional \$20.1 million in DSH allotments.

Under ACA, the federal DSH allotments to states were to be reduced starting in 2014. From FFY 2009 forward, state DSH allotments equal the prior year amount increased by the change in the consumer price index for all urban consumers. That overall amount will increase over time under the current formula until 2014, when there should be fewer uninsured people as a result of ACA. Thus, there may be less need for Medicaid DSH payments going forward. Under ACA, there will be specific reductions in overall DSH allotments by year that must be implemented by the Secretary of Health and Human Services. ACA required the Secretary to use certain general parameters and develop a methodology to achieve specific reductions.