Greenbook

LBO Analysis of Enacted Budget

Ohio Department of Medicaid

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Appropriation Spreadsheet

LBO Greenbook

Ohio Department of Medicaid

Quick look…

- Medicaid is a joint federal-state program that provides health insurance coverage to approximately 3 million low-income Ohioans, including over 1.2 million children.
- With annual spending of $43.18 billion in combined federal and state dollars in FY 2025, Medicaid is the largest single state program and accounts for approximately 5% of Ohio's economy.
  - Medicaid is the largest spending area of the combined state and federal GRF budget and the second largest area (behind K-12 education) in the state-only GRF budget.
- The Ohio Department of Medicaid (ODM) administers Ohio Medicaid with the assistance of the Ohio Department of Developmental Disabilities (DODD), eight other state agencies, and various local partners.
  - About 99% of all-funds expenditures for Ohio Medicaid are disbursed by ODM and DODD.
  - Almost all of all-funds Medicaid service expenditures are disbursed by ODM and DODD. The other eight agencies incur mainly administrative spending.
- There are agencies with zero balances in the following table, as the Department of Higher Education was involved in administering Home and Community Based Services (HCBS) provider relief payments in FY 2024 and FY 2025 and is not anticipated to participate in Medicaid spending in future years. The Department of Children and Youth did not exist until FY 2025, and thus had no expenditures in FY 2024.

All-Funds Medicaid*	FY 2024 Actual	FY 2025 Actual	FY 2026 Appropriation	FY 2027 Appropriation
Agency				
ODM	$34,234,527,534	$37,625,311,855	$39,548,319,293	$41,625,907,375
DODD	$4,282,309,090	$5,080,087,213	$5,426,360,727	$5,669,234,920
Job and Family Services	$271,199,604	$304,543,704	$324,842,438	$326,070,031
Health	$39,115,626	$46,638,106	$45,664,973	$46,089,839
Aging	$33,984,489	$46,834,891	$13,380,997	$14,015,041
Behavioral Health	$3,086,321	$38,607,777	$2,078,055	$2,092,396
Pharmacy Board	$829,278	$756,507	$849,774	$854,589
Education and Workforce	$400,399	$353,918	$150,000	$150,000
Children and Youth	$0	$1,921,066	$2,786,000	$2,786,000
Higher Education	$12,939,752	$32,294,854	$0	$0
Grand Total	$38,878,392,093	$43,177,349,891	$45,364,432,257	$47,687,200,191
ODM Share	88.1%	87.1%	87.2%	87.3%
DODD Share	11.0%	11.8%	12.0%	11.9%
Expense Type				
Services	$37,745,675,767	$42,041,671,326	$44,067,914,346	$46,392,357,342
Administration	$1,132,716,326	$1,135,678,564	$1,296,517,911	$1,294,842,849
Grand Total	$38,878,392,093	$43,177,349,891	$45,364,432,257	$47,687,200,191
Services Share	97.1%	97.4%	97.1%	97.3%
Administration Share	2.9%	2.6%	2.9%	2.7%

*To avoid double counting, the appropriation for line item 651655, Medicaid Interagency Pass-Through, is not included in the Department of Medicaid total. Item 651655 is used to disburse federal reimbursements to other agencies for Medicaid administrative expenses.

All-Agency All-Funds*	FY 2020 Actual	FY 2021 Actual	FY 2022 Actual	FY 2023 Actual	FY 2024 Actual	FY 2025 Actual	FY 2026 Appropriation	FY 2027 Appropriation
	Amount ($ in millions)							
GRF – State	$4,885.6	$5,356.1	$5,188.1	$5,485.9	$6,732.5	$7,765.6	$7,724.4	$8,022.6
GRF – Federal	$10,586.3	$12,738.2	$11,891.2	$12,997.8	$12,597.0	$14,152.2	$14,579.2	$15,361.7
GRF – Total	**$15,471.8**	**$18,094.4**	**$17,079.3**	**$18,483.7**	**$19,329.5**	**$21,917.8**	**$22,303.7**	**$23,384.3**
Non-GRF – State	$3,569.3	$3,158.6	$4,118.5	$4,137.9	$5,200.0	$5,837.2	$6,229.5	$6,487.9
Non-GRF – Federal	$9,191.2	$10,489.7	$13,854.9	$13,509.4	$14,348.9	$15,422.4	$16,831.2	$17,815.0
Grand Total	**$28,232.4**	**$31,742.8**	**$35,052.8**	**$36,131.1**	**$38,878.4**	**$43,177.3**	**$45,364.4**	**$47,687.2**
Annual % Change	--	**12.4%**	**10.4%**	**3.1%**	**7.6%**	**11.1%**	**5.1%**	**5.1%**
	Share							
GRF – State	17.3%	16.9%	14.8%	15.2%	17.3%	18.0%	17.0%	16.8%
GRF – Federal	37.5%	40.1%	33.9%	36.0%	32.4%	32.8%	32.1%	32.2%
Non-GRF – State	12.6%	10.0%	11.7%	11.5%	13.4%	13.5%	13.7%	13.6%
Non-GRF – Federal	32.6%	33.0%	39.5%	37.4%	36.9%	35.7%	37.1%	37.4%
Grand Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Total GRF Share	**54.8%**	**57.0%**	**48.7%**	**51.2%**	**49.7%**	**50.8%**	**49.2%**	**49.0%**
Total Federal Share	**70.1%**	**73.2%**	**73.4%**	**73.4%**	**69.3%**	**68.5%**	**69.2%**	**69.6%**

*To avoid double counting, the appropriation for line item 651655, Medicaid Interagency Pass-Through, is not included.

Medicaid Program overview

Medicaid is a publicly funded health insurance program for low-income individuals. It 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. In Ohio, Medicaid covers approximately 3 million low-income adults, children, pregnant women, seniors, and individuals with disabilities each year. Ohio Medicaid is the largest health insurer in the state. It is also the largest single state program with annual spending of approximately $43.18 billion in combined federal and state dollars in FY 2025. Medicaid accounts for approximately 5% of Ohio's economy. Medicaid services are an entitlement for those who meet eligibility requirements, meaning that if an individual is eligible for the program then they are guaranteed the benefits and the state is obligated to pay for them.

Another federal-state joint health care program, which has been implemented as a Medicaid expansion in Ohio, is the State Children's Health Insurance Program (SCHIP). This program provides health care coverage for children in low- and moderate-income families who are ineligible for Medicaid but cannot afford private insurance.

Ohio's Medicaid Program is among the largest in the nation. It includes coverage for the following:

- More than 1.2 million children, from birth to age 18;
- More than 34,000 children in adoption and foster care;
- More than 256,000 senior citizens over the age of 65; and

- More than 44,000 individuals residing in nursing facilities.

The federal government requires each state to designate a "single state agency" to administer its Medicaid Program. The Ohio Department of Medicaid (ODM) is the single state agency for Ohio under the federal regulation. As Ohio's single state agency, ODM must retain oversight and administrative control of the Ohio Medicaid Program and assure the federal Centers for Medicare and Medicaid Services (CMS) that federally set standards are maintained. Federal law allows a state's single agency to contract with other public and private entities to manage aspects of the program. ODM administers the program with the assistance of other state agencies, county departments of job and family services, county boards of developmental disabilities, and area agencies on aging. ODM contracts with the following state agencies to administer various Ohio Medicaid programs through interagency agreements:

- Ohio Department of Children and Youth (DCY)
- Ohio Department of Developmental Disabilities (DODD);
- Ohio Department of Job and Family Services (ODJFS);
- Ohio Department of Health (ODH);
- Ohio Department of Higher Education (ODHE);
- Ohio Department of Behavioral Health (DBH/MHA);[1]
- Ohio Department of Aging (ODA);
- Ohio Department of Education and Workforce (DEW); and
- Ohio Board of Pharmacy.

DCY provides services to children and their families and was a newly created cabinet level state government department created by the previous main operating budget, H.B. 33 of the 135th General Assembly. DCY provides support in coordination with ODM to residential infant care centers, and provides supports for Medicaid eligible adoptive children in the state.

DODD provides services to disabled individuals through home- and community-based Medicaid waiver programs. DODD also provides services to severely disabled individuals at eight regional developmental centers throughout the state and pays private intermediate care facilities for Medicaid services provided to individuals with intellectual or other developmental disabilities. In addition, DODD provides subsidies to, and oversight of, Ohio's 88 county developmental disabilities (DD) boards. County boards arrange for more than 95,000 adults and children to receive comprehensive services, which include residential support, early intervention, and family support.

ODJFS provides funding to county departments of job and family services (CDJFSs) to administer Medicaid at the local level and to provide certain transportation services to Medicaid enrollees. Local administrative activities mainly include caseworkers processing eligibility

[1] H.B. 96 changes the name of the Department from the Department of Mental Health and Addiction Services to the Department of Behavioral Health. Historical references to the Department and its programs may use the abbreviation MHA.

determinations. CDJFSs arrange for various transportation services to be provided to Medicaid enrollees.

ODH works with CMS and functions as Ohio's state survey agency for the certification of Medicare and Medicaid health care providers. In this role, ODH, among other things, surveys and certifies facilities, such as long-term care and residential care facilities and hospitals, participating in the Medicaid Program to ensure compliance with state and federal rules and regulations. DODD certifies intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) beds. Certification is required for a provider to receive reimbursement from Medicaid.

ODHE is no longer an actively funded Medicaid partner agency, but is included in historical charts as during previous fiscal years, ODHE was involved in the administration of HCBS provider relief payments.

DBH (formerly the Ohio Department of Mental Health and Addiction Services) works with local boards to ensure the provision of mental health services. Ohio has 50 community behavioral health service boards, which serve all 88 counties. The boards are responsible for planning, monitoring, and evaluating the service delivery system within their geographic areas. The local boards contract with local service providers to deliver mental health services in the community.

ODA administers Medicaid programs such as the Pre-Admission Screening System Providing Options and Resources Today (PASSPORT) Medicaid waiver, the Assisted Living Medicaid waiver, and the Program for All-Inclusive Care for the Elderly (PACE).

DEW (formerly the Department of Education) administers the Medicaid Schools Program, which provides districts with reimbursement for services provided to Medicaid-eligible students and reimburses DEW for the cost of administering the program. These costs include technical assistance and program monitoring to verify federal program mandates and assure program compliance and accountability.

The State Board of Pharmacy uses Medicaid funds for the Ohio Automated Rx Reporting System (OARRS). OARRS is a tool to track the dispensing and personal furnishing of controlled prescription drugs to patients across the state. The goal of OARRS is to provide healthcare providers with information regarding a patient's controlled substance prescription history, support clinician interventions for patients with high-risk behaviors, and reduce the number of patients who present at multiple prescriber sites to obtain controlled substances.

ODM contracts with CDJFSs to perform eligibility determination and enrollment. Most of these activities are done utilizing an integrated eligibility system, Ohio Benefits, which was implemented on October 1, 2013. ODM provides technical assistance to counties and assists them in implementing eligibility policies.

The enacted budget provides a total appropriation for the Medicaid Program of $45.36 billion in FY 2026, a 5.1% increase over FY 2025's spending of $43.18 billion, and $47.69 billion in FY 2027, a 5.1% increase over FY 2026's appropriation. The breakdowns of the total Medicaid budget by agency and by service versus administrative cost can be found on page 1 of this Greenbook. Table 1 below shows the appropriations for Medicaid funding for all agencies by fund group.

Table 1. Medicaid Budget Sources by Fund Group for All Agencies*			
Fund Group	**FY 2025 Actual**	**FY 2026 Appropriations**	**FY 2027 Appropriations**
General Revenue Fund	$21,917,762,917	$22,303,667,428	$23,384,285,888
Federal Share	*$14,152,193,615*	*$14,579,248,389*	*$15,361,659,183*
State Share	*$7,765,569,302*	*$7,724,419,039*	*$8,022,626,705*
Dedicated Purpose Fund	$5,799,715,487	$6,195,543,558	$6,453,880,665
Federal Fund	$15,422,396,716	$16,831,219,606	$17,815,031,973
Internal Service Activity Fund	$30,823,300	$20,000,000	$20,000,000
Holding Account Fund	$6,651,472	$14,001,665	$14,001,665
Total	$43,177,349,891	$45,364,432,257	$47,687,200,191

*To avoid double counting, the appropriation for line item 651655, Medicaid Interagency Pass-Through, is not included.

For the FY 2026-FY 2027 biennium, GRF appropriations account for the largest portion (49.1%) of the appropriations for the Medicaid Program. About 65.5% of the GRF funding is federal Medicaid reimbursement. Federal funds account for the next largest share of recommended funding at 37.2%. Federal funds include primarily federal reimbursements for Medicaid services and administrative activities that are not deposited into the GRF.

Dedicated Purpose Funds account for 13.6% of the recommended funding. Sources of these funds mainly include the following:

- Revenue generated from the managed care franchise fee;
- Revenue generated from hospital assessments;
- Revenue generated from nursing home and hospital long-term care unit franchise permit fees;
- Revenue generated from the ICFs/IID franchise permit fee;
- Prescription drug rebate revenue; and
- Recoveries from third-party liabilities.

The revenues from provider taxes (also referred to as franchise fees or assessments) are appropriated in separate line items for Managed Care, Hospitals, and Nursing Facilities. Table 2 below provides appropriations for these line items.

Table 2. Franchise Fee Line Item Appropriations ($ in millions*)					
Fund and ALI	**Provider Type**	**FY 2024 Actual**	**FY 2025 Actual**	**FY 2026 Appropriation**	**FY 2027 Appropriation**
DPF Fund 5R20 ALI 651608	Nursing Facility	$414	$389	$451	$451
DPF Fund 5GF0 ALI 651656	Hospital	$1,631	$1,684	$2,632	$3,030
DPF Fund 5TN0 ALI 651684	Managed Care	$1,063	$1,138	$880	$869

Of note, ODM plans an increase in the Hospital Franchise Fee, from the approximate previous rate of 4.5% to a new rate of approximately 7%. In total, the new state share revenue generated by this proposed increase is expected to be approximately $912.0 million in FY 2026 and $1.0 billion in FY 2027.

Federal reimbursement

Table 3 below shows the FMAP received or anticipated to be received by quarter for FY 2022 through FY 2027. The regular FMAP is the amount each state typically receives for providing Medicaid services. It is calculated each year for each state and is based on the state's per-capita income. States with higher per-capita incomes will have lower FMAPs and vice versa. An enhanced FMAP (eFMAP) is provided for certain services, including services provided under SCHIP. Under SCHIP, each state is given an allotment of federal funds. Subject to the availability of funds from the state's allotment, the eFMAP is used to determine the federal share of the cost of SCHIP. Each state's eFMAP is calculated by reducing the state's share under the regular FMAP by 30%.

The federal Families First Coronavirus Response Act (FFCRA), enacted in March 2020, provided for a temporary increase in FMAP of 6.2 percentage points for certain expenditures incurred after January 1, 2020. Ohio was eligible for this FMAP increase in return for meeting the five conditions set in the FFCRA, which were to: (1) maintain eligibility standards or procedures that were no more restrictive than those in place on January 1, 2020, (2) not charge premiums that exceeded those in place on January 1, 2020, (3) provide testing, services, and treatments including vaccines, specialized equipment, and therapies related to COVID-19 without cost-sharing requirements, (4) provide continuous coverage to individuals enrolled onto the program during the emergency period, and (5) not require local political subdivisions to pay a greater portion of the nonfederal share of expenditures than was required on March 11, 2020. As Ohio met these five requirements, the state received increased federal reimbursement for most Medicaid services beginning retroactively at the beginning of 2020.

In December 2022, Congress passed the Consolidated Appropriations Act, 2023 (CAA). Among other policy changes, the CAA provided for a gradual unwinding of both the increased FMAP and the continuous coverage provision. On March 31, 2023, the CAA ended the continuous coverage requirement, and phased down the increased FMAP over the last nine months of 2023. This phase-down is included in the FMAP table below for quarter 4 of FY 2023 and quarters 1 and 2 of FY 2024. Since quarter 3 of FY 2024, the pandemic related federal supplementation has ended, and the table therefore has "N/A" under the FFCRA/CAA FMAP and SCHIP columns.

Table 3. Federal Match Rates, State FY 2022 Quarter 1-State FY 2027 Quarter 1*

Federal Fiscal Year (FFY) and Quarter	State Fiscal Year (FY) and Quarter	Regular FMAP	SCHIP	FFCRA/CAA FMAP	FFCRA/CAA SCHIP	Group VIII
FFY 2021 Q4	FY 2022 Q1	63.63%	74.54%	69.83%	78.88%	90.00%
FFY 2022 Q1	FY 2022 Q2	64.10%	74.87%	70.30%	79.21%	90.00%
FFY 2022 Q2	FY 2022 Q3	64.10%	74.87%	70.30%	79.21%	90.00%

Table 3. Federal Match Rates, State FY 2022 Quarter 1-State FY 2027 Quarter 1*						
Federal Fiscal Year (FFY) and Quarter	**State Fiscal Year (FY) and Quarter**	**Regular FMAP**	**SCHIP**	**FFCRA/CAA FMAP**	**FFCRA/CAA SCHIP**	**Group VIII**
FFY 2022 Q3	FY 2022 Q4	64.10%	74.87%	70.30%	79.21%	90.00%
FFY 2022 Q4	FY 2023 Q1	64.10%	74.87%	70.30%	79.21%	90.00%
FFY 2023 Q1	FY 2023 Q2	63.58%	74.51%	69.78%	78.85%	90.00%
FFY 2023 Q2	FY 2023 Q3	63.58%	74.51%	69.78%	78.85%	90.00%
FFY 2023 Q3	FY 2023 Q4	63.58%	74.51%	68.58%	78.01%	90.00%
FFY 2023 Q4	FY 2024 Q1	63.58%	74.51%	66.08%	76.26%	90.00%
FFY 2024 Q1	FY 2024 Q2	64.30%	75.01%	65.80%	76.06%	90.00%
FFY 2024 Q2	FY 2024 Q3	64.30%	75.01%	N/A	N/A	90.00%
FFY 2024 Q3	FY 2024 Q4	64.30%	75.01%	N/A	N/A	90.00%
FFY 2024 Q4	FY 2025 Q1	64.30%	75.01%	N/A	N/A	90.00%
FFY 2025 Q1	FY 2025 Q2	64.6%	75.22%	N/A	N/A	90.00%
FFY 2025 Q2	FY 2025 Q3	64.6%	75.22%	N/A	N/A	90.00%
FFY 2025 Q3	FY 2025 Q4	64.6%	75.22%	N/A	N/A	90.00%
FFY 2025 Q4	FY 2026 Q1	64.6%	75.22%	N/A	N/A	90.00%
FFY 2026 Q1	FY 2026 Q2	64.85%	75.40%	N/A	N/A	90.00%
FFY 2026 Q2	FY 2026 Q3	64.85%	75.40%	N/A	N/A	90.00%
FFY 2026 Q3	FY 2026 Q4	64.85%	75.40%	N/A	N/A	90.00%
FFY 2026 Q4	FY 2027 Q1	64.85%	75.40%	N/A	N/A	90.00%

*All references to FY in this table refer to state fiscal year and all references to FFY refer to federal fiscal year. The quarters indicated are the quarters of their respective fiscal year.

ODM budget recommendation summary

Appropriations

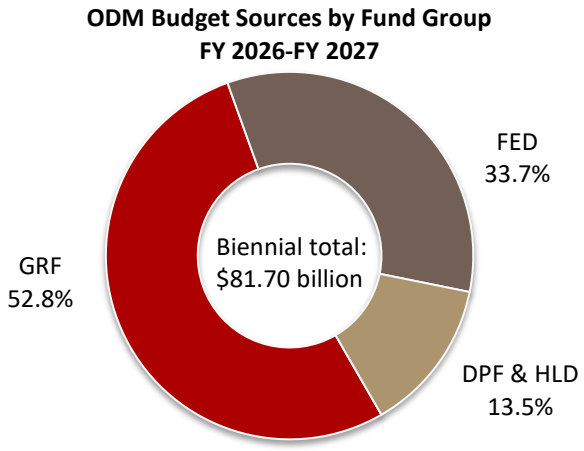
Appropriations by fund group

The budget provides a total appropriation for ODM of $39.81 billion in FY 2026 and $41.89 billion in FY 2027. Table 4 and the chart below show appropriations by fund group.

Table 4. Appropriations by Fund Group for ODM*

Fund Group	FY 2024 Actual	FY 2025 Actual	FY 2026 Appropriation	FY 2027 Appropriation
General Revenue Fund (GRF)	$18,352,954,630	$20,778,146,932	$21,053,495,090	$22,119,628,644
Federal Share	*$12,596,999,157*	*$14,152,193,615*	*$14,579,248,389*	*$15,361,659,183*
State Share	*$5,755,955,473*	*$6,625,953,317*	*$6,474,246,701*	*$6,757,969,461*
Dedicated Purpose Fund (DPF)	$4,481,948,008	$4,917,756,366	$5,401,099,961	$5,595,435,866
Federal Fund (FED)	$11,539,881,915	$12,101,748,733	13,344,375,652	$14,161,485,838
Holding Account Fund (HLD)	$13,743,037	$6,651,472	$14,001,665	$14,001,665
Total	$34,388,527,590	$37,804,303,503	$39,812,972,368	$41,890,552,013
% Change	--	9.9%	5.3%	5.2%
GRF % Change	--	*13.2%*	*1.3%*	*5.1%*

*The appropriation for line item 651655, Medicaid Interagency Pass-Through, is included in the Department of Medicaid's total. Again, item 651655 is used to disburse federal reimbursements to other agencies for Medicaid administrative expenses. In the "**Medicaid Program overview**" section, which details all agency Medicaid spending, this is not included to avoid double counting.



As shown in the chart above, appropriations from the GRF make up a majority of the recommended funding for ODM for the biennium at 52.8%. The GRF appropriations include the

Medicare Part D clawback payments,[2] and the state share for Medicaid expenditures. The GRF appropriations also include federal grant amounts (federal reimbursement) for Medicaid service expenditures.

The Federal Fund Group accounts for the next largest portion of recommended funding for ODM at 33.7%, which includes federal reimbursement for Medicaid payments for both service and administrative expenditures. The Dedicated Purpose Fund Group and Holding Account Fund Group together account for 13.5%.

[2] 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 outpatient prescription drugs through Medicaid on behalf of dual-eligibles.

Major initiatives for the FY 2026-FY 2027 biennium

The enacted budget includes policy focusing on several main areas of Medicaid policy and coverage, as well as smaller programs and objectives. Priority areas include continuation of rate increases and policy changes made by the previous operating budget, engaging in cost containment strategies, and implementing a community engagement and work requirement into the Medicaid Program. Policies that were fully or partially vetoed by the Governor impact several initiatives that will be part of FY 2026-FY 2027 policy changes, and these provisions are discussed in the next section.

1. Maintaining provider rate increases

H.B. 96 includes funding for maintained provider rate increases, initially enacted by H.B. 33 of the 135th General Assembly, which ODM intended to assist in combatting the workforce shortages facing many types of Medicaid health care providers. ODM estimates these maintained provider rate increases impact the care providers for more than 140,000 Ohio Medicaid recipients. The enacted budget also contains continued funding of increases in HCBS waiver rates, as well as funding for the Program of All-Inclusive Care for the Elderly (PACE).

ODM has estimated that maintaining these rate increases will require $241.6 million ($84.9 million state share) in FY 2026 and $241.1 million ($82.9 million state share) in FY 2027.

2. Statewide expansion of MyCare

H.B. 33 of the 135th General Assembly required ODM to seek federal approval to expand MyCare to all Ohio counties. ODM is working to bring the Next Generation MyCare Program statewide, to serve eligible individuals who receive coverage from both Medicaid and Medicare. Beginning in January 2026, selected managed care plans will cover the full Medicare and Medicaid benefits for those who qualify in the current 29 demonstration counties. According to ODM, the statewide expansion will follow as quickly as possible. ODM assumes budget neutrality for this statewide expansion.

3. Lower bound estimates for managed care costs

As part of the main ODM budget projection of managed care payments, the Department used the actuarially set lower bound to project managed care costs for the upcoming biennium. ODM reports that using this lower bound rate will help drive down costs, as managed care spending represents a large portion of Medicaid Program costs.

ODM estimated that this lower bound selection would reduce Medicaid costs by $80.0 million ($23.1 million state share) in FY 2026 and $260.0 million ($74.0 million state share) in FY 2027.

4. Hospital payments increase

The enacted budget accommodates an increase in the Hospital Franchise Fee, which will generate additional federal funds if allocated to Medicaid programs. Additionally, the enacted budget realigns intergovernmental transfers/State Directed Payments (SDPs), consolidating the

Care Innovation and Community Improvement Program (CICIP) and the Ohio Invests in Improvements for Priority Populations (OIPP) into SDPs.[3]

ODM estimated that the new state share revenue generated by this franchise fee increase will be approximately $912.3 million in FY 2026 and $1.01 billion in FY 2027. Of this, approximately $531.0 million and $608.3 million would be used to increase payments to the hospitals.

5. Rural Ohio Hospital Pilot Program

The enacted budget sets up the option for the ODM Director to establish a new hospital pilot program to provide support to hospitals and their related health systems serving rural populations in Ohio. The program, as it is structured in H.B. 96, creates a system by which a local government may create a local hospital assessment to provide the nonfederal share of Medicaid payments for the program. Conditional on meeting qualifications set by the bill, the assessment will provide the nonfederal share of Medicaid payments that will become the basis of directed payments to qualifying Medicaid provider hospitals in rural areas.

Under the pilot program, directed payments may not exceed the average commercial rate under a preprint form approved by the federal government. A participating hospital must also comply with (1) average commercial rate reporting requirements established by ODM and (2) ODM's quality measure set, including the metrics and targets set by ODM to advance the goals and objectives of ODM's quality strategy, as required under federal regulations.

Hospitals will also be required to cooperate with any evaluation or reporting requirements established by ODM. Importantly, the ODM Director has the option to cease the pilot program's operations if the local assessments are insufficient to provide the nonfederal share of the program's funding.

6. 340B drug rebate initiative

H.B. 96 revises 340B program eligibility to align with fee-for-service policies and its original intent. The program's original beneficiaries, known as "grantees," will continue to access it through their in-house pharmacies. ODM will implement a fee-for-service-style reimbursement methodology for 340B hospitals, excluding contract pharmacies (except for those under contract with a qualifying 340B entity). According to ODM, Medicaid is currently losing drug rebates due to previous legislative changes related to the 340B program.

The enacted budget seeks to improve upon these problems by eliminating a prohibition against a contract between a Medicaid MCO, third-party administrator, and 340B grantee including a payment rate for a prescribed drug that is less than the national average drug acquisition costs rate for the drug as determined by CMS, or if no rate is available, a reimbursement rate that is less than the wholesale acquisition cost of the drug. Instead, H.B. 96

[3] Effective July 1, 2018, CICIP was developed to increase the alignment of quality improvement strategies and goals between ODM, MCOs, and both public and nonprofit hospital agencies.

The FY 2022-FY 2023 biennium established OIPP. The OIPP Program is a directed payment program regarding inpatient and outpatient hospital services provided to Medicaid managed care enrollees receiving care at state university owned hospitals with less than 300 beds.

prohibits a contract between the entities described above from including a provision for a payment rate for a prescribed drug provided by a 340B grantee to an individual as a result of health care services provided by the grantee directly to the individual, that is less than the payment rate applied to health care providers that are not 340B grantees.

In addition, H.B. 96 requires a Medicaid MCO and third-party administrator pay the same rate for all prescribed drugs obtained under the 340B Drug Pricing Program by providers that are not 340B grantees as they would under the Medicaid state plan. H.B. 96 also provides that any payments made under contract rates between Medicaid MCOs, third-party administrators, and 340B grantees are subject to audit by ODM.

7. Community engagement and work requirement

The enacted budget will work towards implementing a community engagement and work requirement waiver for the Group VIII expansion population. As was required by the previous operating budget, ODM is currently in the process of applying for federal approval of such a waiver. H.B. 96 appropriations include both the administrative costs of applying for and implementing this program, and the service cost savings of the expected disenrollments to come from this program for Group VIII Medicaid recipients who are not in compliance with the requirements of the waiver.

As was discussed previously, the FMAP for the Group VIII population is 90%, which means that approximately 10% of any savings realized from the implementation of this community engagement and work requirement waiver will be savings reflected in state financial resources.

Vetoed provisions

The Governor vetoed or partially vetoed several provisions impacting ODM. These provisions and their connections to policy initiatives for the FY 2026-FY 2027 biennium are discussed below.

1. Continuous Medicaid enrollment for children

The Governor vetoed provisions of H.B. 96 that would have eliminated the requirements originally set by H.B. 33 of the 135th General Assembly requiring ODM to seek federal approval to provide continuous Medicaid coverage for infants and children from birth through age 3. The veto of the elimination of these legal requirements means that ODM will continue to be required to seek approval to implement a program to provide continuous Medicaid enrollment for Medicaid-eligible infants and children ages 0-3, as the Department is currently doing.

2. Medicaid personal needs allowance

The Governor vetoed provisions mandating an increase in the minimum Medicaid monthly personal needs allowance from the current values of $50 per individual and $100 per couple to new minimum values of $75 per individual and $150 per couple. The Governor's veto did not impact the funding to provide for this increase, but rather vetoed the specific language setting the minimum amounts. The Governor's Veto Message states that ODM will implement the increase through their administrative rulemaking authority, but that the specific language in the bill could have led to unintended consequences and complicated ODM's efforts to implement these increases.

3. Nursing facility dialysis services rate add-on

The Governor vetoed provisions requiring that nursing facilities begin awarding a rate add-on for each dialysis treatment provided to Medicaid recipients living in qualifying nursing facilities. The Governor's veto did not impact the funding to provide for this increase, but rather vetoed the specific language regarding the rate add-on. The Governor's Veto Message states that while his administration supports the increase, setting the increase in statute would restrict ODM's efforts to effectively manage their costs.

4. Transfer agreements with freestanding birthing centers

The Governor vetoed provisions requiring that a hospital with a maternity unit that accepts Medicaid enter into a transfer agreement with any freestanding birthing center located within a 30-mile radius of the hospital that requests such a transfer agreement. The Governor's Veto Message states that not allowing hospitals to independently set their own standards for facilities entering into transfer agreements with them could compromise patient safety in the state.

5. 340B reporting requirements

The Governor partially vetoed provisions pertaining to the reporting requirements the enacted budget placed on 340B covered entities. The partial veto leaves in place most of the provisions of the reporting requirements, but eliminates specific provisions that the Governor's Veto Message states would have been overly prescriptive and infringed on the Department of

Health's ability to accurately carry out the reporting objectives and produce a report on 340B covered entities and their prescription drug expenditures.

6. Automatic enrollment in Medicaid MCO plan

The Governor vetoed provisions requiring that if Medicaid recipients did not select their own Medicaid managed care plan, they be randomly assigned to a managed care plan by ODM, without giving preference to a specific plan or group of plans. The Governor's Veto Message states that this provision would have curtailed ODM's ability to consider a managed care plan's quality of service, and degraded the ability of ODM to encourage quality outcomes from their managed care organizations.

7. Electronic visit verification system

The Governor vetoed provisions requiring that ODM, ODODD, and Medicaid managed care organizations take certain actions regarding an electronic visit verification system, if the ODM Director establishes such an electronic visit verification system. The Governor's Veto Message states that these provisions would have required ODM and managed care organizations to in fact pay Medicaid claims without credible information, and would have further hindered ODM and the federal government's efforts to improve visit verification and reduce fraud, waste, and abuse.

8. Transfers from the Health and Human Services Reserve Fund to the General Revenue Fund

The Governor partially vetoed a provision pertaining to the transfers the enacted budget provided for the Controlling Board to have the option to approve as a funding mechanism for ODM in the event that the Director of Budget and Management (OBM) determined during the FY 2026-FY 2027 biennium that ODM would exhaust funds provided in GRF ALI 651525. The partial veto leaves in place most of the provisions of the transfers under the scenario ODM exhausts the funds appropriated in this ALI and the OBM Director requests transfers from the Controlling Board from Fund 5SA4, the Health and Human Services Reserve Fund, but specifically vetoes the limit on the total amount the OBM Director may transfer in a given fiscal year, with Controlling Board approval, from Fund 5SA4 to the GRF. The Governor's Veto Message states that this limit placed on the transfer authority could restrict critical funding needed by ODM.

Analysis of FY 2026-FY 2027 budget

This section provides an analysis of the enacted appropriations for each appropriation line item (ALI) in ODM's budget. For organizational purposes, these ALIs are grouped into three major categories based on their funding purposes. The analysis for an ALI with a lower category or subcategory designation will appear before that for an ALI with a higher category or subcategory designation. That is, the analysis for an ALI with a category designation of C1:8 will appear before the analysis for an ALI with a category designation of C2:1 and the analysis for an ALI with a category designation of C1:3 will appear before the analysis for an ALI with a category designation of C1:8.

To aid the reader in locating each ALI in the analysis, the following table shows the category in which each ALI has been placed, listing the ALIs in order within their respective fund groups and funds. This is the same order the ALIs appear in the MCD section of the budget bill.

In the analysis, each appropriation item's expenditures for FY 2025 and appropriations for FY 2026 and FY 2027 are listed in a table. Following the table, a narrative describes how the appropriation is used and any changes affecting the appropriation.

Categorization of ODM's Appropriation Line Items for Analysis of FY 2026-FY 2027 Budget				
Fund	**ALI**	**ALI Name**		**Category**
General Revenue Fund Group				
GRF	651425	Medicaid Program Support – State	2	Medicaid Administration
GRF	651525	Medicaid Health Care Services	1	Medicaid Services
GRF	651526	Medicare Part D	1	Medicaid Services
Dedicated Purpose Fund Group				
4E30	651605	Resident Protection Fund	2	Medicaid Administration
5AN0	651686	State Directed Payment Program	1	Medicaid Services
5DL0	651639	Medicaid Services – Recoveries	1	Medicaid Services
5DL0	651685	Medicaid Recoveries – Program Support	2	Medicaid Administration
5DL0	651690	Multi-System Youth Custody Relinquishment	1	Medicaid Services
5FX0	651638	Medicaid Services – Payment Withholding	1	Medicaid Services
5GF0	651656	Medicaid Services – Hospital Franchise Fee	1	Medicaid Services
5HC8	651698	MCD Home and Community Based Services	1	Medicaid Services
5R20	651608	Medicaid Services – Long Term	1	Medicaid Services
5TN0	651684	Medicaid Services – HIC Fee	1	Medicaid Services
5XY0	651694	Improvements for Priority Populations	1	Medicaid Services
6510	651649	Medicaid Services – Hospital Care Assurance Program	1	Medicaid Services
Holding Account Fund Group				
R055	651644	Refunds and Reconciliation	1	Medicaid Services

Categorization of ODM's Appropriation Line Items for Analysis of FY 2026-FY 2027 Budget				
Fund	ALI	ALI Name		Category
Federal Fund Group				
3ER0	651603	Medicaid Health and Transformation Technology	2	Medicaid Administration
3F00	651623	Medicaid Services – Federal	1	Medicaid Services
3F00	651624	Medicaid Program Support – Federal	2	Medicaid Administration
3FA0	651680	Health Care Grants – Federal	2	Medicaid Administration
3G50	651655	Medicaid Interagency Pass Through	3	Transfers
3HC8	651699	MCD Home and Community Based Services – Federal	1	Medicaid Services

Category 1: Medicaid Services

This category of appropriations provides funds for all Medicaid services, including payments for Medicaid providers, prescription drugs, long-term care services, as well as managed care capitation payments.

C1:1: Medicaid Health Care Services (ALI 651525)

Fund/ALI		FY 2025 Actual	FY 2026 Appropriation	FY 2027 Appropriation
GRF ALI 651525, Medicaid Health Care Services		$19,957,430,851	$20,192,404,766	$21,200,705,831
	% change	--	1.2%	5.0%

This GRF line item is used to reimburse healthcare providers for covered services to Medicaid recipients and to make managed care capitation payments. The federal earnings on the payments made from this line item are deposited as revenue into the GRF. Spending within this line item generally can be placed into one of several major service categories: managed care plans, nursing facilities (NFs), hospital services, behavioral health, aging waivers, prescription drugs, physician services, Home Care waivers, and all other care.

The funding levels for this line item are based on many factors, but principally include the proposed budget's forecast of increased caseload among the most costly Medicaid populations of the Aged, Blind, and Disabled (ABD) population and the dually eligible population of seniors eligible for Medicaid and Medicare. Other factors influencing the increases in this line item include pharmacy costs, inflation, and managed care capitation rates.

C1:2: Medicare Part D (ALI 651526)

Fund/ALI		FY 2025 Actual	FY 2026 Appropriation	FY 2027 Appropriation
GRF ALI 651526, Medicare Part D		$648,181,053	$696,563,080	$760,700,223
	% change	--	7.5%	9.2%

This GRF line item is used for the phased-down state contribution, otherwise known as the clawback payment, under the Medicare Part D requirements contained in the federal Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. 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 outpatient prescription drugs through Medicaid on behalf of dual-eligibles (individuals eligible for both Medicare and Medicaid). Increases in this line item are attributable to expected future increases in clawback payments, due both to Ohio's aging population and to expected increases in the dually eligible population in Ohio.

H.B. 96 allows the OBM Director to transfer the state share of appropriations between GRF line item 651525 and this item.

C1:3: State Directed Payment Program (ALI 651686)

Fund/ALI	FY 2025 Actual	FY 2026 Appropriation	FY 2027 Appropriation
5AN0 ALI 651686, State Directed Payment Program	$71,268,989	$50,000,000	$50,000,000
% change	--	-29.8%	0.0%

This line item is used to provide funding for ODM's State Directed Payment Program. Funding for this line item comes from the State Directed Payment Program Fund (Fund 5AN0). Both the ALI and the fund have been renamed by H.B. 96. Previously, the program under this ALI was known as the Care Innovation and Community Improvement Program, and the fund was known as the Care Innovation and Community Improvement Fund. Under the program, each participating hospital entity receives supplemental Medicaid payments for physicians and other professional services covered by Medicaid. However, the participating entity is responsible for the state share of costs.

H.B. 96 provides $50 million in appropriations in each fiscal year for this line item and permits the ODM Director to certify to the OBM Director any additional amounts needed to support State Directed Payment Programs, subject to a limit of $850 million in each fiscal year. The enacted budget requires the OBM Director to increase appropriations in this line item by any such certified amounts. The OBM Director would also be required, under this scenario, to increase FED ALI 651623, Medicaid Services – Federal, which provides the federal match for expenditures from this line item.

A specific earmark is made of this line item of $16 million in FY 2026 and $32 million in FY 2027 (as well as corresponding federal shares), to support a state directed payment program at Bon Secours Mercy Health health system locations in Ohio.

C1:4: Medicaid Services – Recoveries (ALI 651639)

Fund/ALI	FY 2025 Actual	FY 2026 Appropriation	FY 2027 Appropriation
5DL0 ALI 651639, Medicaid Services – Recoveries	$1,134,423,328	$938,907,575	$896,537,969
% change	--	-17.2%	-4.5%

This line item is used by ODM to pay for Medicaid services and support. The Health Care/Medicaid Support and Recoveries Fund (Fund 5DL0) provides funding for this line item. The appropriations for this line item are based on reductions in expected rebate collections.

The major revenue sources for Fund 5DL0 are prescription drug rebates, Institutions for Mental Diseases Disproportionate Share (IMD DSH), third-party liability, hospital settlements, and other recoveries. A key factor in the expected decrease in drug rebate collections is the growing participation of Medicaid providers in the 340B prescription drug program. This results in more claims being excluded from rebates, leading to a corresponding decline in available revenues for this line item. The drug rebate revenue is shared by the state and the federal government based on the FMAP.

C1:5: Multi-System Youth Custody Relinquishment (ALI 651690)

Fund/ALI	FY 2025 Actual	FY 2026 Appropriation	FY 2027 Appropriation
5DL0 ALI 651690, Multi-System Youth Custody Relinquishment	$24,519,465	$20,000,000	$20,000,000
% change	--	-18.4%	0.0%

This line item was created by H.B. 166 of the 133rd General Assembly with the line item name Multi-System Youth Innovation and Support, and the name was changed to Multi-System Youth Custody Relinquishment by H.B. 33 of the 135th General Assembly The line item is used to fund programs that serve youth involved with multiple governmental agencies and other innovative approaches that support health care access or result in long-term savings to the state, and prevent custody relinquishment of multi-system children and youth. Funding to support Fund 5DL0 comes from a variety of sources including prescription drug rebates, IMD DSH, third-party liability, hospital settlements, and other recoveries. Appropriation levels for this line item are decreased over the biennium due to overall cost containment within the department, and decreased sister agency participation.

C1:6: Medicaid Services – Payment Withholding (ALI 651638)

Fund/ALI	FY 2025 Actual	FY 2026 Appropriation	FY 2027 Appropriation
5FX0 ALI 651638, Medicaid Services – Payment Withholding	$3,171,105	$12,000,000	$12,000,000
% change	--	278.4%	0.0%

This line item is used for provider payments that are withheld from providers that change ownership. It is used to transfer the withheld funds to the appropriate fund used by ODM at final resolution. The funds are withheld and temporarily deposited into the Exiting Operator Fund (Fund 5FX0) until all potential amounts due to ODM or the provider reach final resolution. There is no particular pattern to deposits into Fund 5FX0 as deposits only occur when there is a change of ownership.

C1:7: Medicaid Services – Hospital Franchise Fee (ALI 651656)

Fund/ALI	FY 2025 Actual	FY 2026 Appropriation	FY 2027 Appropriation
5GF0 ALI 651656, Medicaid Services – Hospital Franchise Fee	$1,683,732,524	$2,632,211,017	$3,030,014,270
% change	--	56.3%	15.1%

This line item is used to support Hospital Franchise Fee (HFF) programs and provides offsets to Medicaid GRF spending.[4] The source of funds for this line item is the revenue generated from a hospital assessment. Assessment revenue is deposited into the Hospital Assessment Fund (Fund 5GF0). The assessment is based on a percentage of total facility costs, and is collected over the course of three payments during each year.

The assessment rates for each program year (October 1 through September 30) are established in administrative rules.[5] However, the administrative rule also allows ODM to decrease or increase the assessment rate needed to run the current program year.[6] For the program year ending in 2019, the rate was 2.65%. For the program year ending in 2020, the rate was approximately 3.20%. For the program year ending in 2021, the rate was approximately 3.35%. The rate was 3.36 and 3.53 percentage points for FY 2022 and FY 2023, respectively. For the FY 2022-FY 2023 biennium, ODM obtained Controlling Board approval of appropriation increases for ALI 651656 to make additional COVID-19 relief payments to hospitals. To finance this relief payment, ODM increased the HFF assessment rate by 1.3 percentage points. Adding the additional 1.3 percentage points brought the rates to 4.66 and 4.83 percentage points for FY 2022 and FY 2023, respectively.

According to ODM, the current hospital franchise fee has remained at the approximate rate of 4.5% as calculated as the total adjusted facility cost. H.B. 96's appropriations in line item 651656 are calibrated to planned increases over the biennium, as ODM plans increases in the HFF assessment to approximately 7%, again measured as a percentage of total adjusted facility cost.

[4] Ohio Administrative Code (O.A.C.) 5160-2-30.

[5] The program year for the Hospital Franchise Fee Program begins the first day of October of a calendar year and ending on the 30th day of September of the following calendar year.

[6] O.A.C. 5160-2-30(B)(4).

The federal match for expenditures from this line item is made from line item 651623, Medicaid Services – Federal.

C1:8: Medicaid Services – Long Term (ALI 651608)

Fund/ALI	FY 2025 Actual	FY 2026 Appropriation	FY 2027 Appropriation
5R20 ALI 651608, Medicaid Services – Long Term	$389,044,758	$451,000,000	$451,000,000
% change	--	15.9%	0.0%

This line item is used to make Medicaid payments to nursing facilities. The source of funds for this line item is the franchise fee payments from nursing facilities and long-term care units in hospitals. Ohio Medicaid is required to assess an annual franchise permit fee on each long-term care bed in a nursing home or hospital. The assessment amount is calculated each year at the maximum percentage allowed by federal law (not to exceed 6% of the total estimated net patient revenue). The franchise fee payments are deposited into the Nursing Home Franchise Permit Fee Fund (Fund 5R20). The appropriations reflect ODM's projection of the franchise fee revenue and the increase in appropriations for FY 2026 are due to an anticipated increase in GRF offsets for each year of the biennium.

C1:9: MCD Home and Community Based Services (ALI 651698)

Fund/ALI	FY 2025 Actual	FY 2026 Appropriation	FY 2027 Appropriation
5SA4 ALI 651698, MCD Home and Community Based Services	$103,040,036	$0	$0
% change	--	-100.0%	--

This line item was used to provide the state share of home and community based service (HCBS) rate increases planned for the FY 2024-FY 2025 biennium. During FY 2025, funding of HCBS rate increases was split between this line item and Medicaid GRF spending, during a phase-out of using this line item. This ALI receives no funding in H.B. 96 as the programming has ended due to the end of pandemic federal support.

C1:10: Medicaid Services – HIC Fee (ALI 651684)

Fund/ALI	FY 2025 Actual	FY 2026 Appropriation	FY 2027 Appropriation
5TN0 ALI 651684, Medicaid Services – HIC Fee	$1,138,441,111	$879,876,850	$869,039,656
% change	--	-22.7%	-1.2%

This line item is used to reimburse health care providers for covered services to Medicaid recipients. Funding for line item 651684 comes from the Health Insuring Corporation Class Franchise Fee Fund (Fund 5TN0). Revenues are collected from the tax on all health insuring corporation (HIC) plans. The tax rate ranges from $26 to $56 per Medicaid member month and

$1 to $2 per non-Medicaid member month. Revenue assumptions are based on projected member months. The federal match for expenditures from this line item is made from line item 651623, Medicaid Services – Federal. Appropriations are based on ODM's projected revenue and predicted member months, which are expected to be lower than they were during the FY 2024-FY 2025 biennium, due to the resumption of routine eligibility redeterminations and disenrollments of ineligible Medicaid members.

C1:11: Improvements for Priority Populations (ALI 651694)

Fund/ALI	FY 2025 Actual	FY 2026 Appropriation	FY 2027 Appropriation
5XY0 ALI 651694, Improvements for Priority Populations	$12,478,602	$0	$0
% change	--	-100.0%	0.0%

This line item was used to fund the state share of the Ohio Invests in Improvements for Priority Populations Program, which was created by H.B. 110 of the 134th General Assembly. The program provided directed payments for inpatient and outpatient hospital services provided to Medicaid recipients enrolled in a Medicaid managed care plan and receiving care at state university-owned hospitals with less than 300 beds. No appropriations are included in H.B. 96 as programs funded by this ALI are being shifted and consolidated into ALI 651686, State Directed Payment Program.

C1:12: Medicaid Services – Hospital Care Assurance Program (ALI 651649)

Fund/ALI	FY 2025 Actual	FY 2026 Appropriation	FY 2027 Appropriation
6510 ALI 651649, Medicaid Services – Hospital Care Assurance Program	$296,858,297	$320,543,800	$168,455,600
% change	--	8.0%	-47.4%

This line item is to fund the state share of the Hospital Care Assurance Program (HCAP). The source of revenue for Fund 6510 is HCAP assessments from Ohio hospitals. Shortly after assessment revenue is received, it is disbursed back to hospitals using the HCAP formula. The federal share of HCAP expenditures is funded through federal line item 651623, Medicaid Services – Federal. Under the Affordable Care Act (ACA) and other federal legislation, payments for HCAP are expected to be reduced during the biennium, which is why appropriations for FY 2027 represent a significant decrease from FY 2025 actuals and appropriations for FY 2026.

C1:13: Refunds and Reconciliation (ALI 651644)

Fund/ALI	FY 2025 Actual	FY 2026 Appropriation	FY 2027 Appropriation
R055 ALI 651644, Refunds and Reconciliation	$6,651,472	$14,001,665	$14,001,665
% change	--	110.5%	0.0%

Revenue to the Refunds and Reconciliation Fund (Fund R055) is from checks received by ODM whose disposition cannot be determined at the time of receipt. Upon determination of the appropriate fund into which the check should have been deposited, a disbursement is made from this line item to the appropriate fund. Appropriations are increased for the biennium due to increased anticipated usage of Fund R055 and a corresponding increase in usage of this line item.

C1:14: Medicaid Services – Federal (ALI 651623)

Fund/ALI	FY 2025 Actual	FY 2026 Appropriation	FY 2027 Appropriation
3F00 ALI 651623, Medicaid Services – Federal	$11,379,610,619	$12,572,748,083	$13,394,507,208
% change	--	10.5%	6.5%

This line item provides the federal share for certain Medicaid expenditures, including most Medicaid services. Major activities in this line item include the federal share of nursing facility, hospital, prescription drug expenditures, and general Medicaid services. The primary source of revenue for Fund 3F00 is federal Medicaid reimbursement; however, it also includes Health Care Financing Research, Demonstrations, and Evaluations grants, as well as the federal share of drug rebates. In addition, the federal share of both the Hospital Franchise Fee Program and HCAP is expended through this line item.

Many factors influence spending in this federal line item, including Medicaid caseloads, and increases in franchise fee revenue and increases in the State Directed Payment Program made by H.B. 96.

C1:15: MCD Home and Community Based Services – Federal (ALI 651699)

Fund/ALI	FY 2025 Actual	FY 2026 Appropriation	FY 2027 Appropriation
3HC8 ALI 651699, MCD Home and Community Based Services – Federal	$164,137,624	$0	$0
% change	--	-100.0%	--

This line item was used to provide the federal share of HCBS rate increases for the FY 2024-FY 2025 biennium. It provided the federal match for appropriations made in Fund 5HC8 line item 651698. This ALI receives no funding in H.B. 96 as the programming has ended due to the end of pandemic federal support.

Category 2: Medicaid Administration

This category of appropriations provides funds for the administration of Medicaid programs.

C2:1: Medicaid Program Support – State (ALI 651425)

Fund/ALI	FY 2025 Actual	FY 2026 Appropriation	FY 2027 Appropriation
GRF ALI 651425, Medicaid Program Support – State	$172,535,028	$164,527,244	$158,222,590
% change	--	-4.6%	-3.8%

This GRF line item is used to fund ODM's operating expenses. This line item provides the state share GRF for payroll, purchased personal services, conference fees, maintenance, and equipment, etc. The associated federal match is appropriated in line item 651624, Medicaid Program Support – Federal.

During the FY 2022-FY 2023 biennium, ODM shifted to a single pharmacy benefit manager (SPBM) for Medicaid managed care plans, Gainwell Technologies. The administrative costs associated with the SPBM were shifted from GRF line item 651525, Medicaid Health Plans, to this line item. Prior to the SPBM implementation, pharmacy benefit management costs were included in managed care capitation rates, which is primarily paid out of line item 651525. This structure will continue during the FY 2026-FY 2027 biennium, and appropriations in this ALI include these continuing administrative responsibilities.

C2:2: Resident Protection Fund (ALI 651605)

Fund/ALI	FY 2025 Actual	FY 2026 Appropriation	FY 2027 Appropriation
4E30 ALI 651605, Resident Protection Fund	$134,414	$7,000,000	$7,000,000
% change	--	5,107.8%	0.0%

This line item is used to pay the costs of relocating residents to other facilities, maintaining or operating a facility pending correction of deficiencies or closure, and reimbursing residents for the loss of money managed by a facility. The source of funding for this line item is from fine revenues collected from facilities in which the Ohio Department of Health finds deficiencies. The fines collected are deposited into the Resident Protection Fund (Fund 4E30). Some of the funds deposited into this fund are transferred to the Department of Aging and used for ombudsmen-related activities. Ombudsmen advocate for people receiving home care, assisted living, and nursing home care and help resolve complaints about services.

The increase in funding in FY 2026 is intended to allow for use of accumulated cash balances in Fund 4E30 which accumulated during COVID-19 related nursing facility restrictions. ODM also forecasts an increase in CMS approved projects over the biennium, which would be funded by the increase in this line item.

C2:3: Medicaid Recoveries – Program Support (ALI 651685)

Fund/ALI	FY 2025 Actual	FY 2026 Appropriation	FY 2027 Appropriation
5DL0 ALI 651685, Medicaid Recoveries – Program Support	$60,643,739	$89,560,719	$91,388,371
% change	--	47.7%	2.0%

This line item is used to pay costs associated with the administration of Medicaid. The line item also supports the state share of operational and initial building costs for the Ohio Medicaid Enterprise System provider network management module, centralized credentialing, single pharmacy benefit manager, fiscal intermediary, and children's initiatives programs. Revenues from a variety of sources including prescription drug rebates, IMD DSH, third-party liability, hospital settlements, and other recoveries are deposited into the Health Care/Medicaid Support and Recoveries Fund (Fund 5DL0) to support this line item. ODM estimates that increases for the biennium are necessary due to the continuation of work related to provider credentialing and pharmacy benefit management which were put into effect during the FY 2024-FY 2025 biennium.

C2:4: Medicaid Health and Transformation Technology (ALI 651603)

Fund/ALI	FY 2025 Actual	FY 2026 Appropriation	FY 2027 Appropriation
3ER0 ALI 651603, Medicaid Health and Transformation Technology	$169,601	$0	$0
% change	--	-100.0%	--

This line item was previously used for provider electronic health record (EHR) incentives and administrative costs related to the Health Information Technology (HIT) grant. EHR incentives were provided by CMS to healthcare providers to encourage their use of EHR technology in ways that can improve patient care. These programs have ended and were phased out during the FY 2024-FY 2025 biennium. FY 2025 thus had a small amount of expenditures but the ALI receives no funding in H.B. 96.

C2:5: Medicaid Program Support – Federal (ALI 651624)

Fund/ALI	FY 2025 Actual	FY 2026 Appropriation	FY 2027 Appropriation
3F00 ALI 651624, Medicaid Program Support – Federal	$379,008,842	$499,974,494	$495,333,992
% change	--	31.9%	-0.9%

This line item is used for the Medicaid federal share of administrative costs. This line item may also be used to support various contracts. The state share for these activities is primarily provided from GRF line item 651425, Medicaid Program Support – State.

In the past, expenditures for pharmacy benefit management were previously expended out of GRF line item 651525 as part of the managed care capitation rates. The federal reimbursement for spending from line item 651525 is deposited into the GRF as federal share and expended as such. As part of the move to an SPBM, ODM is now paying for these services out of GRF line item 651425. Federal reimbursements for services paid from line item 651425 are received in FED Fund 3F00 line item 651624. The funding for the biennium continues operations of the new responsibilities that are now funded by this line item.

C2:6: Health Care Grants – Federal (ALI 651680)

Fund/ALI	FY 2025 Actual	FY 2026 Appropriation	FY 2027 Appropriation
3FA0 ALI 651680, Health Care Grants – Federal	$0	$7,000,000	$7,000,000
% change	--	--	0.0%

This line item funds Medicaid Program initiatives stemming from the ACA. The spending level is based on the revenue received for various federal grants. The funding in FY 2026 and FY 2027 is an appropriated placeholder to provide for potential federal grant funding.

Category 3: Transfers

C3:1: Medicaid Interagency Pass Through (ALI 651655)

Fund/ALI	FY 2025 Actual	FY 2026 Appropriation	FY 2027 Appropriation
3G50 ALI 651655, Medicaid Interagency Pass Through	$178,991,648	$264,653,075	$264,644,638
% change	--	47.9%	0.0%

This line item is used to disburse federal reimbursement to other agencies for Medicaid-related expenditures they have made. Funding for this line item is through the Interagency Reimbursement Fund (Fund 3G50). The departments of Aging, Behavioral Health, Children and Youth, Developmental Disabilities, Education and Workforce, Health, Higher Education, Job and Family Services, and the State Board of Pharmacy assist ODM in administering certain Medicaid programs/services and receive federal reimbursements for doing so.

MCD/lb

Detail by Agency			FY 2024	FY 2025	Appropriation FY 2026	Appropriation FY 2027	FY 2025 to FY 2026 % Change	FY 2026 to FY 2027 % Change
MCD	**Ohio Department of Medicaid**							
GRF	651425	Medicaid Program Support - State	$173,871,438	$172,535,028	$164,527,244	$158,222,590	-4.64%	-3.83%
GRF	651525	Medicaid Health Care Services	$17,505,889,456	$19,957,430,851	$20,192,404,766	$21,200,705,831	1.18%	4.99%
		651525 - State	$4,908,890,299	$5,805,237,236	$5,613,156,377	$5,839,046,648	-3.31%	4.02%
		651525 - Federal	$12,596,999,157	$14,152,193,615	$14,579,248,389	$15,361,659,183	3.02%	5.37%
GRF	651526	Medicare Part D	$673,193,735	$648,181,053	$696,563,080	$760,700,223	7.46%	9.21%
General Revenue Fund Subtotal			**$18,352,954,630**	**$20,778,146,932**	**$21,053,495,090**	**$22,119,628,644**	**1.33%**	**5.06%**
		GRF - State	$5,755,955,473	$6,625,953,317	$6,474,246,701	$6,757,969,461	-2.29%	4.38%
		GRF - Federal	$12,596,999,157	$14,152,193,615	$14,579,248,389	$15,361,659,183	3.02%	5.37%
4E30	651605	Resident Protection Fund	$308,505	$134,414	$7,000,000	$7,000,000	5,107.80%	0.00%
5AN0	651686	State Directed Payment Program	$73,704,231	$71,268,989	$50,000,000	$50,000,000	-29.84%	0.00%
5DL0	651639	Medicaid Services - Recoveries	$897,198,732	$1,134,423,328	$938,907,575	$896,537,969	-17.23%	-4.51%
5DL0	651685	Medicaid Recoveries - Program Support	$70,037,900	$60,643,739	$89,560,719	$91,388,371	47.68%	2.04%
5DL0	651690	Multi-system Youth Custody Relinquishment	$32,062,425	$24,519,465	$20,000,000	$20,000,000	-18.43%	0.00%
5FX0	651638	Medicaid Services - Payment Withholding	$4,679,496	$3,171,105	$12,000,000	$12,000,000	278.42%	0.00%
5GF0	651656	Medicaid Services - Hospital Franchise Fee	$1,631,449,120	$1,683,732,524	$2,632,211,017	$3,030,014,270	56.33%	15.11%
5HC8	651698	MCD Home and Community Based Services	$61,198,503	$103,040,036	$0	$0	-100.00%	N/A
5R20	651608	Medicaid Services - Long Term	$414,121,521	$389,044,758	$451,000,000	$451,000,000	15.92%	0.00%
5TN0	651684	Medicaid Services - HIC Fee	$1,063,227,826	$1,138,441,111	$879,876,850	$869,039,656	-22.71%	-1.23%
5XY0	651694	Improvements for Priority Populations	$7,499,581	$12,478,602	$0	$0	-100.00%	N/A
6510	651649	Medicaid Services - Hospital Care Assurance Program	$226,460,168	$296,858,297	$320,543,800	$168,455,600	7.98%	-47.45%
Dedicated Purpose Fund Group Subtotal			**$4,481,948,008**	**$4,917,756,366**	**$5,401,099,961**	**$5,595,435,866**	**9.83%**	**3.60%**
R055	651644	Refunds and Reconciliation	$13,743,037	$6,651,472	$14,001,665	$14,001,665	110.50%	0.00%
Holding Account Fund Group Subtotal			**$13,743,037**	**$6,651,472**	**$14,001,665**	**$14,001,665**	**110.50%**	**0.00%**
3ER0	651603	Medicaid and Health Transformation Technology	$169,601	$0	$0	$0	N/A	N/A
3F00	651623	Medicaid Services - Federal	$10,848,262,928	$11,379,610,619	$12,572,748,083	$13,394,507,208	10.48%	6.54%

Detail by Agency			FY 2024	FY 2025	Appropriation FY 2026	Appropriation FY 2027	FY 2025 to FY 2026 % Change	FY 2026 to FY 2027 % Change
MCD	**Ohio Department of Medicaid**							
3F00	651624	Medicaid Program Support - Federal	$427,559,600	$379,008,842	$499,974,494	$495,333,992	31.92%	-0.93%
3FA0	651680	Health Care Grants - Federal	$0	$0	$7,000,000	$7,000,000	N/A	0.00%
3G50	651655	Medicaid Interagency Pass Through	$154,000,056	$178,991,648	$264,653,075	$264,644,638	47.86%	0.00%
3HC8	651699	MCD Home and Community Based Services - Federal	$109,889,730	$164,137,624	$0	$0	-100.00%	N/A
Federal Fund Group Subtotal			**$11,539,881,915**	**$12,101,748,733**	**$13,344,375,652**	**$14,161,485,838**	**10.27%**	**6.12%**
Ohio Department of Medicaid Total			**$34,388,527,590**	**$37,804,303,503**	**$39,812,972,368**	**$41,890,552,013**	**5.31%**	**5.22%**