READER’S GUIDE

The Legislative Service Commission prepares an analysis of the executive budget proposal for each agency. These analyses are commonly called "Redbooks." This brief introduction is intended to help readers navigate the Redbook for the Ohio Department of Medicaid (ODM), which includes the following five sections.

1. Overview: Provides a brief description of the Medicaid Program and ODM, highlights of the current biennium, and an overview of the provisions of the executive budget that affect ODM, including major new initiatives.

2. Facts and Figures: Provides additional data on the Ohio Medicaid Program.

3. Analysis of Executive Proposal: Provides a detailed analysis of the executive budget recommendations for ODM, including funding for each appropriation line item.

4. Attachments: Includes the Catalog of Budget Line Items (COBLI) for ODM, which briefly describes each line item, the LSC budget spreadsheet for ODM, and the Medicaid Primer, which gives an overview of the current Medicaid program.
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OVERVIEW

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 over 3.0 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 about $28 billion in combined federal and state dollars. Medicaid accounts for 4% 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:

- 1.3 million children, from birth to age 18;
- 51% of all Ohio children under age five;
- 200,000 senior citizens;
- 50,000 individuals residing in nursing facilities; and
- 91,000 individuals on home and community-based waivers.

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

Recommended funding of $28.0 billion in FY 2018 and $28.7 billion in FY 2019
Ohio Medicaid provides health care coverage to over 3.0 million Ohioans
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, community behavioral health boards, and area agencies on aging. ODM works with the Governor’s Office of Health Transformation (OHT) to streamline the Medicaid Program and improve the overall quality of the health care system. ODM also contracts with the following state agencies to administer various Ohio Medicaid programs through interagency agreements:

- Ohio Department of Aging (ODA);
- Ohio Department of Developmental Disabilities (ODODD);
- Ohio Department of Health (ODH);
- Ohio Department of Education (ODE); and
- Ohio Department of Mental Health and Addiction Services (ODMHAS).

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 (PACE).

ODODD provides services to disabled individuals through home and community-based Medicaid waiver programs. ODODD also provides services to severely disabled individuals at ten regional developmental centers throughout the state and pays private intermediate care facilities for Medicaid services provided to the disabled. In addition, ODODD provides subsidies to, and oversight of, Ohio’s 88 county developmental disabilities (DD) boards. County boards provide a variety of community-based services including residential support, early intervention, family support, adult vocational and employment services, and service and support administration.

ODMHAS works with local boards to ensure the provision of mental health services. Ohio has community behavioral health 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.

ODH certifies long-term care and hospital providers. ODODD certifies intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) beds. Certification is required for a provider to receive reimbursement from Medicaid.

ODM contracts with county departments of job and family services (CDJFSs) to perform eligibility determination and enrollment. Most of these activities are done utilizing the new integrated eligibility system: Ohio Benefits, starting October 1, 2013. Ohio Benefits replaced the old eligibility system known as the Client Registry Information System-Enhanced (CRIS-E). ODM provides technical assistance to counties and assists them to implement eligibility policy.
The executive budget provides a total appropriation for the Medicaid Program of $27.96 billion in FY 2018, a 6.3% increase over FY 2017's estimated spending of $26.30 billion, and $28.70 billion in FY 2019, a 2.7% increase over FY 2018. Table 1 below first shows the executive's recommendation for the total Medicaid appropriation by agency. Table 2 then shows the executive's recommendation for the breakdown of the appropriation for Medicaid by service versus administrative costs.

| Table 1. Executive Budget Recommendations for Medicaid Services and Administration All Funds by Agency |
|---------------------------------------------------------------|-----------------|-----------------|
| **Ohio Department** | **FY 2018** | **FY 2019** |
| Medicaid* | $24,863,223,215 | $25,554,530,389 |
| Developmental Disabilities | $2,764,885,775 | $2,880,951,453 |
| Job and Family Services | $276,698,330 | $220,511,375 |
| Health | $28,330,029 | $29,040,949 |
| Mental Health and Addiction Services | $13,250,367 | $13,250,367 |
| Aging | $8,088,986 | $8,088,986 |
| Education | $1,050,000 | $1,050,000 |
| **TOTAL** | **$27,955,526,702** | **$28,707,423,519** |

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

<table>
<thead>
<tr>
<th>Table 2. Executive Budget Recommendations for Medicaid Services and Administration All Funds by Expense Type</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expense Type</strong></td>
</tr>
<tr>
<td>Services</td>
</tr>
<tr>
<td>Administration</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
</tr>
</tbody>
</table>

Note: To avoid double counting, the appropriation for line item 651655, Medicaid Interagency Pass-Through, is not included in the Department of Medicaid total.

Tables 1 and 2 above show that the appropriations for Medicaid service expenditures make up a majority of the recommended funding for the Medicaid Program, at about 95% for the biennium, while approximately 5% of Medicaid's budget for the biennium is for Medicaid-related administrative activities.
Table 3 shows the executive recommended appropriations for Medicaid funding for all agencies by fund group.

| Table 3. Executive Budget Recommendations for the Medicaid Program by Fund Group |
|-----------------------------|------------------|------------------|
| Fund Group                  | FY 2018          | FY 2019          |
| General Revenue Fund        | $15,586,536,417  | $16,015,136,562  |
| Federal Share               | $10,278,580,968  | $10,476,333,789  |
| State Share                 | $5,307,955,449   | $5,538,802,773   |
| Dedicated Purpose Fund      | $3,431,181,737   | $3,486,422,254   |
| Federal Fund                | $8,919,808,548   | $9,195,864,703   |
| Internal Service Activity Fund | $17,000,000  | $9,000,000       |
| Holding Account Fund        | $1,000,000       | $1,000,000       |
| **TOTAL**                   | **$27,955,526,702** | **$28,707,423,519** |

General Revenue Fund (GRF) appropriations account for the largest portion (55.8%) of the executive recommended funding for the Medicaid Program. About 65.7% of the GRF funding is federal Medicaid reimbursement. The GRF's share of Medicaid spending under the executive proposal is significantly smaller than its share in FY 2017 (67.8%). This shift out of the GRF and into non-GRF funds is largely due to the executive proposal to replace the sales tax on Medicaid managed care organizations with a franchise fee on all health insuring corporations (HICs). The sales tax is deposited into the GRF whereas the HIC tax will be deposited into a non-GRF fund.

Federal funds account for the next largest share of recommended funding at 32.0%. Federal funds include primarily federal reimbursements for Medicaid services and administrative activities that are not deposited into the GRF.

Dedicated Purpose Fund accounts for 12.2% of the recommended funding. Sources of these funds mainly include the following:

- Revenue generated from the new HIC 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 intermediate care facilities for individuals with intellectual disabilities (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) are appropriated in ODM and ODODD's budgets. The executive recommends replacing the sales and use tax on Medicaid managed care plans with a broad-based franchise fee on all HICs as approved by the federal Centers for Medicare and Medicaid Services (CMS). Table 4 below provides estimates of the revenue that the state is expected to collect from the various provider types.

<table>
<thead>
<tr>
<th>Table 4. Estimated Franchise Fee Revenue ($ in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Type</td>
</tr>
<tr>
<td>------------------</td>
</tr>
<tr>
<td>HIC Class*</td>
</tr>
<tr>
<td>Hospital</td>
</tr>
<tr>
<td>Nursing Facility</td>
</tr>
<tr>
<td>ICF/IID</td>
</tr>
<tr>
<td>TOTAL</td>
</tr>
</tbody>
</table>

*Figures shown reflect the revenue collection of Medicaid managed care organizations (MCOs), it does not include the anticipated collection from Non-Medicaid major medical plans. It is estimated that about $4 million in FY 2018 will be collected from Non-Medicaid major medical plans.

Table 5 below shows the executive's recommended budget for using the various franchise fee revenues and the corresponding estimated federal share by appropriation line item. If the state spends the franchise fee revenue on Medicaid-related services or activities, the state can draw down federal reimbursement. The federal medical assistance percentage (FMAP) represents the portion of total qualified Medicaid spending that is reimbursed by the federal government.

<table>
<thead>
<tr>
<th>Table 5. ALI Appropriations by Franchise Fee Type and the Estimated Corresponding Federal Share ($ in Millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fund</td>
</tr>
<tr>
<td>--------</td>
</tr>
<tr>
<td>5TN0</td>
</tr>
<tr>
<td>3F00</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>5GF0</td>
</tr>
<tr>
<td>3F00</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>5R20</td>
</tr>
<tr>
<td>3F00</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>5GE0</td>
</tr>
<tr>
<td>3A40</td>
</tr>
<tr>
<td></td>
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</tr>
</tbody>
</table>
**Agency Overview**

As stated above, ODM is the single state agency for Ohio under the federal regulation to administer Ohio's Medicaid Program. Ohio's Medicaid Program provides health care coverage to low-income adults, children, pregnant women, seniors, and individuals with disabilities each year. Many of the people served by ODM obtain medical care at no cost; however, some must pay copayments for certain services. Once enrolled, Medicaid consumers gain coverage for doctor visits, hospital care, well-child visits, home health, long-term care, and more.

**Staffing Overview**

On December 30, 2016, ODM had a total of 589 employees. Table 6 below shows an estimate of the distribution of these employees among the agency’s staff sections based on its funded employee levels.

<table>
<thead>
<tr>
<th>Table 6. Estimated Distribution of ODM Employees</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operations</td>
<td>31.5%</td>
</tr>
<tr>
<td>Chief of Staff</td>
<td>22.1%</td>
</tr>
<tr>
<td>Policy</td>
<td>15.3%</td>
</tr>
<tr>
<td>Fiscal Operations</td>
<td>12.3%</td>
</tr>
<tr>
<td>Clinical Quality &amp; Research</td>
<td>7.8%</td>
</tr>
<tr>
<td>Information &amp; Technology Services</td>
<td>6.4%</td>
</tr>
<tr>
<td>Legal</td>
<td>3.0%</td>
</tr>
<tr>
<td>Communications</td>
<td>0.9%</td>
</tr>
<tr>
<td>Office of the Director</td>
<td>0.4%</td>
</tr>
<tr>
<td>Legislation</td>
<td>0.3%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

**Appropriations Overview**

**Appropriations by Fund Group**

The executive budget provides a total appropriation for ODM of $24.99 billion in FY 2018 and $25.68 billion in FY 2019. Table 7 shows the executive recommended appropriations by fund group.
Table 7. Executive Budget Recommendations for ODM by Fund Group

<table>
<thead>
<tr>
<th>Fund Group</th>
<th>FY 2018</th>
<th>FY 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Revenue Fund (GRF)</td>
<td>$14,897,228,357</td>
<td>$15,350,908,997</td>
</tr>
<tr>
<td>Federal Share</td>
<td>$10,278,580,968</td>
<td>$10,476,333,789</td>
</tr>
<tr>
<td>State Share</td>
<td>$4,618,647,389</td>
<td>$4,874,575,208</td>
</tr>
<tr>
<td>Dedicated Purpose Fund (DPF)</td>
<td>$3,018,726,814</td>
<td>$3,038,242,869</td>
</tr>
<tr>
<td>Federal Fund (FED)</td>
<td>$7,071,919,641</td>
<td>$7,290,080,120</td>
</tr>
<tr>
<td>Holding Account Fund (HLD)</td>
<td>$1,000,000</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$24,988,874,812</td>
<td>$25,680,231,986</td>
</tr>
</tbody>
</table>

Chart 1 presents the executive recommended appropriations by fund group as well.

Chart 1: Executive Budget Recommendations for ODM by Fund Group, FY 2018-FY 2019

- GRF 59.7%
- FED 28.3%
- DPF 12.0%
- HLD <1.0%

Note: Percentages may not total 100 due to rounding.

As shown in the chart above, appropriations from the GRF make up a majority of the recommended funding for ODM for the biennium at 59.7%. The GRF appropriations include the Medicare Part D clawback payments, 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 28.3%, which includes federal reimbursement for Medicaid payments for both service and administrative expenditures. The Dedicated Purpose Fund Group accounts for 12.0% and the Holding Account Fund Group accounts for less than 1.0%.
Appropriations by Expense Type

Table 8 shows the executive recommended appropriations by expense type.

<table>
<thead>
<tr>
<th>Table 8. Executive Budget Recommendations for ODM by Expense Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expense Type</td>
</tr>
<tr>
<td>-----------------------</td>
</tr>
<tr>
<td>Services</td>
</tr>
<tr>
<td>Transfers to Other Agencies</td>
</tr>
<tr>
<td>Administrative</td>
</tr>
<tr>
<td>TOTAL</td>
</tr>
</tbody>
</table>

Chart 2 shows the executive recommended appropriations by expense type as well. Approximately 95.5% of ODM’s budget is for payments to providers of Medicaid services.

Chart 2: Executive Budget Recommendations for ODM by Expense Type, FY 2018-FY 2019 Biennium

ODM will spend approximately 4.0% of its recommended budget for the biennium for administration including personal services, purchased services, maintenance, and equipment. Approximately 0.5% of ODM’s budget is federal reimbursement that will be passed through to other agencies for their Medicaid administrative costs.

FY 2018-FY 2019 Biennium New Initiatives with Budget Impact

Table 9 below provides a list of the FY 2018-FY 2019 biennial budget initiatives proposed by the executive and the overall fiscal impact on Ohio’s Medicaid Program of each.\(^1\) Following the table is a brief description of each initiative. The last three

\(^1\) Much of the information regarding the executive's budget initiatives comes from the Office of Health Transformation's white papers.
initiatives in the table do not have an overall budget impact, but do have an impact on the state share GRF spending of the program. This impact is described in the narrative.

<table>
<thead>
<tr>
<th>Initiative Number</th>
<th>Initiatives</th>
<th>FY 2018</th>
<th>FY 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Eliminate the Medicaid sales tax</td>
<td>-$1,123.1</td>
<td>-$1,209.5</td>
</tr>
<tr>
<td>2</td>
<td>Replace sales tax with member month fee</td>
<td>$853.9</td>
<td>$867.8</td>
</tr>
<tr>
<td>3</td>
<td>Premiums for certain Medicaid recipients</td>
<td>-$52.6</td>
<td>-$184.7</td>
</tr>
<tr>
<td>4</td>
<td>Improve academic performance</td>
<td>$0.0</td>
<td>$9.4</td>
</tr>
<tr>
<td>5</td>
<td>Managed care CMS requirements implementation</td>
<td>$6.0</td>
<td>$6.7</td>
</tr>
<tr>
<td>6</td>
<td>Enroll everyone in managed care</td>
<td>$0.0</td>
<td>$493.7</td>
</tr>
<tr>
<td>7</td>
<td>Timing changes member month tax for MLTSS</td>
<td>$0.0</td>
<td>-$447.7</td>
</tr>
<tr>
<td>8</td>
<td>Assisted living rates restructured and increased</td>
<td>$0.0</td>
<td>$34.9</td>
</tr>
<tr>
<td>9</td>
<td>Personal care aid services rates restructured and increased</td>
<td>$0.0</td>
<td>$23.1</td>
</tr>
<tr>
<td>10</td>
<td>Increase rates for adult day, emergency response, and home delivered meals</td>
<td>$0.0</td>
<td>$3.1</td>
</tr>
<tr>
<td>11</td>
<td>Money follows the person demonstration grant</td>
<td>$8.7</td>
<td>$11.0</td>
</tr>
<tr>
<td>12</td>
<td>Support self-directed waiver brokerage services</td>
<td>$0.0</td>
<td>$2.9</td>
</tr>
<tr>
<td>13</td>
<td>Increase options for individuals to avoid institutions</td>
<td>$0.0</td>
<td>$14.7</td>
</tr>
<tr>
<td>14</td>
<td>Increase options for individuals to reduce waiting list</td>
<td>$3.8</td>
<td>$26.8</td>
</tr>
<tr>
<td>15</td>
<td>Increase reimbursements for complex care needs</td>
<td>$10.8</td>
<td>$12.9</td>
</tr>
<tr>
<td>16</td>
<td>Expand shared living support</td>
<td>$7.9</td>
<td>$9.5</td>
</tr>
<tr>
<td>17</td>
<td>Increase wages for direct services staff</td>
<td>$0.0</td>
<td>$12.9</td>
</tr>
<tr>
<td>18</td>
<td>Modernize and increase ICF reimbursements</td>
<td>$0.0</td>
<td>$13.5</td>
</tr>
<tr>
<td>19</td>
<td>Children to Adults receiving care</td>
<td>$2.7</td>
<td>$2.7</td>
</tr>
<tr>
<td>20</td>
<td>Comprehensive Primary Care continuation and expansion</td>
<td>$51.6</td>
<td>$72.0</td>
</tr>
<tr>
<td>21</td>
<td>Hospital rates</td>
<td>-$162.5</td>
<td>-$425.0</td>
</tr>
<tr>
<td>22</td>
<td>Nursing facility rates</td>
<td>-$98.6</td>
<td>-$138.5</td>
</tr>
<tr>
<td>23</td>
<td>PASRR Specialized Services</td>
<td>$0.0</td>
<td>$21.6</td>
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1. **Eliminate the Medicaid Sales Tax**

The executive proposes to repeal the Medicaid managed care sales tax on July 1, 2017. Since 2009, Ohio has levied a 5.75% state sales tax on the capitation amounts paid to Medicaid managed care plans. Since that cost was figured into the payments ODM made to the managed care organizations (MCOs), it effectively increased Medicaid
expenditures by the amount of the tax, which would have been about $1.12 billion in FY 2018 and $1.21 billion in FY 2019. However, CMS determined that Ohio’s Medicaid managed care sales tax is not a permissible taxing method for drawing down Medicaid matching funds from the federal government, and prohibits its use for this purpose as of July 2017. For this reason, the executive proposes to repeal the tax, resulting in a reduction in Medicaid expenditures.

2. Replace Sales Tax with Member Month Fee

The executive proposes to replace the repealed Medicaid managed care sales tax with a tax on all health insuring corporations (HICs), also effective on July 1, 2017. The tax rate paid will range from $26 to $56 per Medicaid member month, and $1 to $2 per non-Medicaid member month. The tax revenue will be placed in Fund 5TN0. Medicaid plans will recover their entire cost for the new HIC tax through higher capitation rates and the state will draw down federal reimbursement for that increased cost. The proposal will increase Medicaid expenditures by $853.9 million in FY 2018 and $867.8 million in FY 2019.

3. Premiums for Certain Medicaid Recipients

The executive proposes to impose premiums on childless, nonpregnant adults between 100% federal poverty level (FPL) and 138% FPL beginning January 1, 2018. Currently, no premiums are charged, although this population is responsible for copayments for certain services. Monthly premiums will be capped so as not to exceed 2% of an individual’s household income and are expected to be roughly $20. If an individual is delinquent on premiums for three consecutive months, that individual may experience a disruption in coverage. Section 1115 of the Social Security Act permits CMS to grant states the authority to charge premiums for the Medicaid expansion population. Premiums will be calculated using a similar methodology as premiums charged in the federal marketplace exchange. These premiums will save Medicaid $52.6 million in FY 2018 and $184.7 million in FY 2019 through a combination of increased revenue and enrollee attrition.

4. Improve Academic Performance

The executive proposes to require financial incentives for Medicaid health plans to improve health outcomes for youth beginning January 1, 2019. ODM will reward health plans an amount up to a 0.5% of their child-related capitation payments for achieving improved academic performance among their enrollees in low-performing schools. Specific measures of success that will be tied to the pay-for-value strategy could include absenteeism, kindergarten readiness assessment, third grade reading guarantee, and high school graduation rate. These incentives are expected to cost $9.4 million in FY 2019.
5. Managed Care CMS Requirements Implementation

The executive proposes to make changes to comply with new requirements issued by CMS for managed care plans beginning July 1, 2017. In May 2016, CMS issued a final rule (42 C.F.R. Part 438) to implement the first significant changes to Medicaid managed care regulations in over a decade. The rule contains provisions to support health care delivery system reforms, strengthen the consumer experience and consumer protections, and strengthen program integrity by improving accountability and transparency. Ohio Medicaid will implement the rule over the next biennium, and in doing so will need to make a number of changes to the Ohio Administrative Code, information technology systems, and managed care provider agreements. Making these changes will cost $6.0 million in FY 2018 and $6.7 million in FY 2019.

6. Enroll Everyone in Managed Care

The executive proposes to require nearly all Medicaid enrollees to be in a managed care plan by July 1, 2018. The new populations enrolled in managed care will include individuals receiving community and facility based long-term services and supports, participants in the Medicaid Buy-in Program for workers with disabilities, individuals dually eligible for Medicaid and Medicare who are not participating in MyCare, and eligible individuals receiving refugee medical assistance. ODM will implement a new Managed Medicaid Long-Term Services and Supports (MLTSS) program through a competitive procurement, ideally selecting at least three plans to participate. Exceptions to the new requirement will include individuals served through ODODD; individuals enrolled on ODODD waiver programs will continue to receive long-term care through fee-for-service (FFS), but will have the option to enroll in a health plan for acute care services. This proposal will cost $493.7 million in FY 2019. Most of this cost is due to timing as ODM will need to pay outstanding claims under the FFS system for this population at the same time ODM is paying their managed care capitated amounts. The cost will largely be offset by changes to the timing of member month payments (described in Initiative 7).

7. Timing Changes Member Month Tax for MLTSS

The executive proposes to adjust the timing of managed care payments to minimize any one-time costs related to converting FFS payments to managed care for the MLTSS Program. The current schedule of three payments monthly will be converted into four payments monthly and the last payment in each fiscal year will carry over into the next fiscal year beginning in FY 2019. This timing adjustment will offset $447.7 million of the costs of Initiative 6 in FY 2019.

8. Assisted Living Rates Restructured and Increased

The executive proposes to restructure Medicaid-covered services for assisted living and to increase the rate ODM pays for those services beginning July 1, 2018. ODM will implement a new rate setting methodology that accounts for wages,
productivity, benefits, administrative overhead, program support costs, training time, and staffing ratios, allowing for more flexible service delivery models. Assisted living provides housing for individuals who are elderly or disabled, and includes onsite nursing care, housekeeping, and prepared meals as needed. Access to assisted living has recently become more challenging due to the low reimbursement rates, increasing the rate of individuals being admitted to nursing facilities while they wait for assisted living. The proposed restructuring will cost $34.9 million in FY 2019.

9. Personal Care Aid Services Rates Restructured and Increased

The executive proposes to restructure and increase the rates for Medicaid-covered personal care aides beginning July 1, 2018. ODM will increase the personal care aide rate by 7% and establish a single unit-based rate for the Home Care and PASSPORT waiver programs and for state plan home health aide services. ODM will establish a differential rate for nonskilled agencies and certified or otherwise accredited agencies. Personal care aides provide nonmedical services that help individuals at home with activities of daily living. This proposal is expected to cost $23.1 million in FY 2019.

10. Increase Rates for Adult Day, Emergency Response, and Home Delivered Meals

The executive proposes to require the state to establish a new rate setting methodology for adult day, emergency response, and home delivered meal services. Medicaid will partner with the Ohio Department of Aging (ODA) to align changes in waiver rates and methodologies across the Home Care and PASSPORT programs and increase rates 5% in the aggregate for these services. These increased rates will cost $3.1 million in FY 2019.

11. Money Follows the Person Demonstration Grant

The executive proposes to continue funding the Money Follows the Person (MFP) Rebalancing demonstration grant through the next biennium. The grant provides funding to increase the use of home and community-based services in lieu of institutionally based services. Ohio’s MFP Program, called Helping Ohioans Move, Expanding (HOME) Choice, ranked first in the nation in 2015 for transitioning individuals from long-term care facilities into alternative settings. While the grant ends on December 31, 2018, the executive proposes to continue to fund most of the grant’s activities through FY 2019, using state funds if necessary. The budget supports HOME Choice 2.0, adds MFP transition services to existing waiver programs, and incorporates the existing Access Success Program into HOME Choice to support non-Medicaid reimbursable transition activities. Funding these programs will cost $8.7 million in FY 2018 and $11.0 million in FY 2019.
12. Support Self-Directed Waiver Brokerage Services

The executive proposes to offer expanded supports to individuals self-directing their home and community-based services beginning July 1, 2018. ODM will develop a brokerage service for individuals who are self-directing their care in the Home Care and PASSPORT waiver programs. These individuals will have the option to work with a broker to develop a written plan, individual budget, and seek information and support that helps them avoid common mistakes. This program will increase options for individuals to manage their services, including hiring, managing, training, and letting go of staff. This proposal will cost $2.9 million in FY 2019.

13. Increase Options for Individuals to Avoid Institutions

The executive proposes to add about 300 additional Individual Options (IO) waivers in FY 2019 for individuals preferring not to live in an intermediate care facility (ICF). These waivers are in addition to the 1,100 IO waivers implemented in H.B. 64 of the 131st General Assembly. The additional waivers will cost $14.7 million in FY 2019.

14. Increase Options for Individuals to Reduce Waiting List

The executive proposes to retain funding for 1,800 IO and SELF waivers that were created in H.B. 64 of the 131st General Assembly and add approximately 700 IO and 300 SELF waivers to further reduce waiting lists. These additional waivers will cost $3.8 million in FY 2018 and $26.8 million in FY 2019.

15. Increase Reimbursements for Complex Care Needs

The executive proposes to implement an incentive program that will provide additional funding to providers serving individuals with complex care needs to reduce staff turnover. People with complex care needs are dependent in all areas of daily life (such as feeding and dressing) and may not be able to verbally communicate these needs. High staff turnover for caring for these individuals can harm their quality of life. The additional reimbursements will cost $10.8 million in FY 2018 and $12.9 million in FY 2019.

16. Expand Shared Living Support

The executive proposes to increase the amount of money available to support shared living arrangements for individuals with developmental disabilities. Shared living is where an individual lives with a family member and the family is paid to meet their needs as opposed to having staff come to the individual's home at all times to provide care. This living arrangement is more cost effective, provides a more stable environment, and minimizes the issues created by staff turnover in caring for the individual. This proposal will cost $7.9 million in FY 2018 and $9.5 million in FY 2019.
17. **Increase Wages for Direct Services Staff**

The executive proposes to increase wages of staff that provide direct services to individuals with developmental disabilities in FY 2019 who have at least two years of experience and successfully complete additional training. ODODD’s direct services staff support more than 90,000 individuals and providers are facing increasing challenges in hiring and retaining staff. This provision will cost $12.9 million in FY 2019.

18. **Modernize and Increase ICF Reimbursements**

The executive proposes to reform the ICF reimbursement system through a restructuring process and increase the reimbursement rate 2.5% beginning in FY 2019. The current ICF system is over 20 years old. The restructuring follows the recommendations made by an ODODD workgroup, including: replacing the current Individual Assessment Form with a Developmental Disabilities Profile, expanding the current peer group structure from three to five categories, implementing a fair rental value methodology to replace the current cost-based reimbursement, and collecting data necessary to implement a quality incentive payment program. This provision will increase costs by $13.5 million in FY 2019.

19. **Children to Adults Receiving Care**

The executive proposes to remove the age requirement on children on ventilators being served in an ICF. Over the last four years, ODODD provided an add-on so children on ventilators could be served in an ICF; this change would allow children becoming adults to remain in the same facility and continue receiving care. This change will cost $2.7 million in FY 2018 and FY 2019.

20. **Comprehensive Primary Care Continuation and Expansion**

The executive proposes to continue the Comprehensive Primary Care (CPC) Program through the next biennium and allow open enrollment of primary care practices that want to join the program beginning January 1, 2018. In January 2017, Ohio Medicaid enrolled the first group of 92 primary care practices into CPC. These practices earn an additional $4 per member per month (PMPM) on average by engaging in activities that are known to keep patients well (the payments range from $1 PMPM for healthier patients and $20 PMPM for patients with more health needs). Practices also have the opportunity to earn a performance bonus if they hold down the total cost of care while meeting quality and efficiency targets. The proposal will cost $51.6 million in FY 2018 and $72.0 million in FY 2019.
21. Hospital Rates

The executive proposes several changes that will reduce the rate of reimbursements to hospitals by negating coding inflation, protecting high-Medicaid hospitals from rate reductions, and defaulting to FFS rates for hospitals that do not contract with a Medicaid managed care plan. In total, these changes will save $162.5 million in FY 2018 and $425.0 million in FY 2019.

Ohio Medicaid adopted the tenth edition of the International Classification of Diseases (ICD-10) in October 2015, which accounts for advances in clinical treatment and offers more coding options than the ICD-9 version it replaced. ICD is a clinical cataloging system used by the health care industry and government agencies to properly note diseases on health records and assist in medical reimbursement decisions. The conversion, however, resulted in increased hospital spending due to how the services are coded, separate from increases related to volume or quality. The executive proposal adjusts the hospital reimbursement rate to eliminate this inflation. This provision will save $75.0 million in FY 2018 and FY 2019.

The executive proposal also requires ODM to establish criteria to identify high Medicaid volume hospitals so that when making future rate adjustments, ODM will have the option to tier the changes to minimize the impact on hospitals that use Medicaid caseloads as a larger share of their business. These hospitals, some of which have more than 50% of discharges in the Medicaid population, would otherwise be disproportionately impacted by rate changes compared to hospitals with lower Medicaid caseloads. The proposal will also be used to implement a one-time reduction in hospital reimbursements that will save $175.0 million in FY 2019.

Finally, the proposal will require Medicaid reimbursements of hospitals that do not contract with a Medicaid managed care plan to default to the FFS rate. Medicaid managed care plans on average pay hospitals 104% of the FFS rate. This will allow ODM to see savings from capitation rates and reductions to payments to noncontracting hospitals, some of which have negotiated rates of 160% of the FFS rate. This change will save $87.5 million in FY 2018 and $175.0 million in FY 2019.

22. Nursing Facility Rates

The executive proposes a couple of changes that will reduce the rate of reimbursements to nursing facilities by resetting unintended payment gains resulting from a new payment methodology and lowering payment levels for low-acuity residents. In total, these changes will save $98.6 million in FY 2018 and $138.5 million in FY 2019.

In 2015, ODM updated the resource utilization groups (RUGS) methodology that is used to measure resident acuity and then calculate reimbursement. The transition to RUGS IV, unrelated to changes in enrollment and quality, resulted in an increase in nursing facility reimbursements. While the negotiated per diem rate is about $172 per
day, over time RUGS inflated the rate to $192 per day. The proposal requires ODM to use RUGS IV, but adjust reimbursements in line with previous spending levels. This provision will save $88.1 million in FY 2018 and $117.5 million in FY 2019.

H.B. 64 of the 131st General Assembly included changes that resulted in a tiered reimbursement system for nursing facilities designed to reduce reimbursement for low-acuity individuals. However, the resulting system excluded low-acuity individuals from the facility’s quarterly case-mix acuity score. This artificially inflated the nursing facilities' acuity scores and subsequent reimbursement rate for all other residents. The proposal allows for a higher rate to apply to the low-acuity individuals, but includes them in the calculation of quarterly case-mix scores. This provision will save $10.5 million in FY 2018 and $21.0 million in FY 2019.

23. PASRR Specialized Services

The executive proposes that individuals with severe and persistent mental illness (SPMI) or intellectual or developmental disabilities residing in a nursing facility be able to receive specialized services, funded by Medicaid, beginning July 1, 2018. ODM is required to conduct a Preadmission Screening and Resident Review (PASRR) for every enrollee applying to be admitted to a nursing facility to determine if the applicant has an SPMI or intellectual or developmental disabilities. Facilities are currently not allowed to admit an individual with one of the aforementioned conditions unless ODM determines the services provided by the facility are appropriate, including specialized services if needed. Recent federal guidance however clarifies that federal funding is available for specialized services that are paid in addition to the standard nursing facility rate. This change will allow ODM to draw down federal matching funds for PASRR specialized services. However, because this proposal reflects new spending, it will increases costs by $21.6 million in FY 2019.

24. Lead Funding Partnership

The executive proposes to require ODM to partner with ODH in order to enhance existing lead abatement activities beginning July 1, 2017. The U.S. Department of Housing and Urban Development provides funding to assist property owners in addressing unsafe lead hazards in their homes. However, with more than 750 homes currently under ODH lead hazard control orders or orders to vacate, there is not enough funding to address the current need. This partnership will require ODM to file a State Plan Amendment for the use of State Children's Health Insurance Program (SCHIP) funding for the lead abatement activities; ODM currently receives a federal matching rate of 97% on SCHIP spending. The partnership will cost ODM $5.0 million in FY 2018 and FY 2019, most of which will be reimbursed by the federal government.

25. Program Integrity

The executive proposes to require ODM to fully integrate FFS claims data and managed care encounter data for the purpose of its fraud detection and prevention
activities. While ODM employs field investigators to explore potential fraud in the FFS component of Medicaid, most managed care plans do not. This initiative will encourage managed care plans to establish special investigative units that can further combat fraud. This provision is expected to save $5.0 million in FY 2018 and $10.0 million in FY 2019.

26. ODM & ODJFS Business Simplification

The executive proposes to shift the indirect costs for the Medicaid Program that are still paid by ODJFS from ODM on July 1, 2017. Prior to January 1, 2014, ODJFS was the agency responsible for administering the Medicaid Program in Ohio. While most functions have subsequently been shifted to ODM, ODJFS still incurs indirect costs that are subsequently billed to ODM. The executive proposes to account for these indirect costs in the ODJFS budget, eliminating the need for ODJFS to bill ODM. This will transfer $19.8 million in FY 2018 and $18.1 million in FY 2019 in costs from ODM to ODJFS.

27. Fund Elimination and Reform

The executive proposes to eliminate and change how ODM utilizes several funds. This includes the transfer of the Managed Care Performance Payment Fund (Fund 5KW0) to the GRF, the transfer of the Health Care Services Administration Fund (Fund 5U30) to the Health Care/Medicaid Support and Recoveries Fund (Fund 5DL0), and changes to how it expends funds from certain ODODD dedicated purpose funds. ODM will reduce non-GRF fund balances, resulting in savings to the GRF. In total the proposal will affect $115.6 million in FY 2018 and $182.7 million in FY 2019.

28. Single Preferred Drug List for FFS and Managed Care

The executive proposes that Medicaid FFS and managed care plans use the same preferred drug lists (PDL) and prior authorization policies beginning July 1, 2017. PDL is the primary means by which Medicaid encourages the use of high quality, low-cost drugs. Preferred drugs typically do not require prior authorization while nonpreferred drugs require either clinical justification or a trial of one of the preferred drugs (often called step therapy). Financial information is considered with the clinical recommendations to arrive at the PDL. The executive proposal will require that cost-effectiveness be considered as part of the financial information to make a decision. The federal manufacturer drug rebate program mandates a minimum rebate amount for all drugs, but then Ohio Medicaid contracts with individual manufacturers for supplemental rebates that further lower the net cost. This change will additionally allow enrollees who change health plans to continue their medications without any complications. This proposal will increase the amount of drug rebates deposited into the GRF, resulting in savings to the GRF of $13.9 million in FY 2018 and $27.8 million in FY 2019.
29. Transportation Brokerage

The executive proposes to transfer responsibilities for funding the nonemergency medical transportation (NEMT) system from ODJFS to ODM on July 1, 2018. Currently, each county department of job and family services is responsible for coordinating NEMT within its boundaries, which can result in limitations based on geographical borders and inconsistent service delivery. The transition from a county-based transportation system to a state-based brokerage model will allow ODM to contract with a third-party broker to manage NEMT. The broker will be responsible for implementing a provider network, verifying Medicaid eligibility, authorizing the appropriate cost-effective mode of transportation based on medical need, and dispatching the needed vehicles. ODM will be responsible for paying the broker a monthly capitation payment per individual. During the biennium, ODM will be allowed to shift funds back to ODJFS if necessary to avoid any gap in services during the transition. Because ODM will claim these services at the federal FMAP, which is higher than the ODJFS administrative 50% match rate, this provision will save $6.8 million in state GRF funds in FY 2019.

Highlights of Policy Changes in the Current Biennium

The following section highlights major policy changes either implemented or approved during the current biennium (FY 2016-FY 2017).

1. Eliminate Medicaid Coverage for Family Planning Group

Beginning January 1, 2016, Medicaid coverage for individuals with modified adjusted gross income (MAGI) above 138% FPL in the Family Planning group was eliminated. This population was previously served at MAGI levels up to 200% FPL. Individuals with incomes above 138% FPL are eligible for federal subsidies through the health insurance exchange.

2. Reduce the Transitional Medical Assistance Period to Six Months

The Transitional Medical Assistance (TMA) period was reduced from 12 months to six months. The TMA takes effect when a parent or caretaker relative’s earned income increases above the eligibility threshold for the group. The TMA provides temporary continued eligibility in order to ease an individual’s transition from Medicaid due to an improved financial situation. The individual must report their income quarterly to continue receiving coverage. If an individual’s income remains below 185% FPL and they fulfill the quarterly reporting requirement, the individual will be granted six additional months of eligibility.

3. Set Managed Care Rates at the Lower Bound

Beginning January 1, 2016, the managed care capitation rates were set at the lower bound. ODM contracted with Mercer Health & Benefits, LLC, which annually determines a range of actuarially sound capitation rates for different populations for
use by Ohio's Medicaid managed care plans. Setting the capitation rate at the lower bound reinforces efficient operations by the Medicaid managed care plans and streamlines internal processes at the state level.

4. **Use One-Time Unearned Managed Care Quality Incentive Funds**

   Beginning on July 1, 2016, unspent funds from the Medicaid Managed Care Incentive Fund (Fund 5KW0) were used to offset one-time GRF costs associated with transitioning current fee-for-service populations into managed care.

5. **Reform Payment Methodology for Detail-Coded Drugs**

   ODM began to pay for drugs based on the Medicaid physician fee schedule instead of on hospital costs when these drugs are administered by hospitals in an outpatient setting or independently billed by hospitals. Previously, in some cases hospitals were reimbursed at 60% of their hospital-specific costs for administering drugs under the above conditions. Any drug not listed on the Medicaid physician fee schedule, however, still is reimbursed at 60% of cost.

6. **Consolidate Outpatient Charges within 72 Hours of an Inpatient Visit**

   ODM began to require hospitals to include any outpatient charges that occur 72 hours before or after an inpatient stay to be included on that inpatient claim. Hospitals were previously required to include only those outpatient charges which occur 24 hours before or after an inpatient visit. This provision worked in tandem with episodes of care programs, such as the State Innovation Model.

7. **Eliminate 5% Rate Add-on for Outpatient Services**

   ODM eliminated the temporary 5% rate increase for outpatient hospital services for all but children's hospitals. This rate add-on was unnecessary due to Medicaid expansion, as hospital uncompensated care costs were decreasing. This temporary rate increase expired in December 2015.

8. **Reduce Potentially Preventable Hospital Readmissions**

   ODM implemented potentially preventable readmissions (PPR) software to analyze clinically related readmissions across hospital providers. Ohio Medicaid previously targeted PPR claims at the same hospital within 30 days, but did not target PPR claims across providers. Ohio's average inpatient hospital PPR rate was 9.2%. In addition, ODM implemented a PPR benchmark and began assessing a 1% penalty on hospitals that exceed this benchmark.

9. **Implement Correct Coding Standards to Hospital Claims Processing**

   By January 1, 2016, ODM began to implement the National Correct Coding Initiative (NCCI) methodologies and edits into the Medicaid Information Technology System (MITS) to properly process outpatient Medicaid claims in accordance with federal regulations.
10. Reduce NF Reimbursement for Low-Acuity Individuals

ODM began to reduce reimbursement payments to nursing facilities for the lowest acuity individuals from $130 per resident day to $91.70 per resident day (a decrease of roughly 29.5% per bed day); the rate is now more in line with what it would cost to serve these individuals in a community setting.

11. Implement an Electronic Visit Verification System for Home Health

ODM began to implement an Electronic Visit Verification (EVV) system for home health providers to validate service delivery to eligible individuals by authorized service providers. An EVV system reduces fraudulent activity by using technologic solutions, including telephone, GPS tracking, and biometrics, to authenticate the presence of service and by allowing the recipient of care to confirm that they are receiving care at the time of service delivery.

12. Redesign the Home Health and Private Duty Nursing Benefit

ODM redesigned the home health and private duty nursing benefit toward a short-term acute care benefit for those individuals who are not part of a managed care plan or home and community-based services (HCBS) waiver, and toward managed care or an HCBS waiver for those individuals who receive long-term care.

13. Recoup Certain Physician Payments

ODM eliminated its retrospective review and technical denial policy to any physician claim associated with a technical denial received by a hospital. This policy previously only applied toward hospitals themselves.

14. Support Payment Innovation

ODM implemented innovative payment models, including paying for better coordinated care and improved outcomes through patient-centered medical homes. Such payment innovations were developed as a result of the convention in 2013 of Governor Kasich’s Advisory Group on Health Care Payment Innovation to align public and private health care purchasing power to reward the value of services, not the volume.

15. Increase Medicaid Primary Care and Dental Rates

Ohio Medicaid began to provide an enhanced payment amount to any practitioner who bills for the specified primary care codes through both fee-for-service and managed care delivery systems. The dental provider rates were also increased by 1%. This represents the first rate increase for these providers since 2000. The cost, however, was largely offset by savings achieved through the following proposals:

a. Applied the Medicaid Maximum Payment to Medicare Crossover Claims

ODM began to only reimburse up to the Medicaid maximum for all Part B categories of service, including physician services. For dual-eligible individuals, states
have the option to pay either the patient’s Medicare cost-sharing amount (typically 20%) or reimburse up to the Medicaid maximum amount. Ohio previously reimbursed up to the Medicaid maximum for all services except physician services.

b. Converted Subsidies for Medical Education into a Primary Care Rate Increase

ODM transferred $25 million ($9.4 million state share) from Medicaid graduate medical education (GME) to teaching hospitals to support a primary care rate increase in FY 2017.

c. Eliminated Enhanced Payment to Holzer Clinic

ODM eliminated the enhanced reimbursement rate for the Holzer Clinic Network and reverted payment to the standard Medicaid physician fee schedule beginning January 1, 2016. According to OHT, since 1992, the Holzer Clinic has been reimbursed at 140% of the Medicaid physician fee schedule. The enhanced rate was set because the Holzer Hospital did not provide outpatient hospital services, and the enhanced payment approximated what the total payment amount would have been had claims for service been billed by both the hospital and the physician group practice. The enhanced rate supported one rural clinic. However, the Holzer Clinic expanded to ten new delivery sites and expansion continues.

16. Rebase Nursing Facility Rates with a Different Grouper Update

ODM updated the rates beginning in FY 2017 using calendar year 2013 costs as a basis. The update resulted in rates more reflective of current health care costs and Ohio nursing facility service delivery. Rebasing also allowed for the opportunity to update the resource utilization group (RUGS) methodology used to measure resident acuity in the state’s nursing facilities, from RUGS III to RUGS IV to coincide with the calculation of new rate components during the rebasing process.

17. Pay for Quality

ODM, along with the first rebasing of Medicaid payment rates for nursing facilities, placed nursing facilities in Allen and Trumbull counties in the peer groups used to determine the Medicaid payment rates for nursing facilities in Mahoning County or Stark County.

18. Program Integrity Initiatives

ODM procured an advanced data analytics system for pre- and post-payment review. This system uses Ohio Medicaid’s access to enormous amounts of data in order to enhance program integrity efforts and detect billing patterns tied to potential fraud, waste, or abuse.
19. Streamline Medicaid Disability Eligibility and Eliminate Spend Down

ODM completed the transition from what is known as a 209(b) state under Title XIX of the federal Social Security Act (SSA) to what is known as a 1634 state under Title XVI of the SSA. As a 209(b) state, Ohio placed more restrictive qualifications on Medicaid disability eligibility than do states with 1634 status.

ODM also replaced Ohio’s two duplicative disability eligibility determination systems with one system administered by Opportunities for Ohioans with Disabilities (OOD) that determines eligibility for both Medicaid and Supplemental Security Income (SSI). ODM raised the income standard for Medicaid from 64% FPL to 75% FPL (to match SSI) and raised the asset test from $1,500 to $2,000, which results in additional Ohioans qualifying for Medicaid in the aged, blind, and disabled (ABD) group. ODM eliminated the Medicaid spend down provision, which previously allowed individuals to spend down their assets on medical expenses in order to qualify for Medicaid.

20. Create a Special Benefit Program for Adults with Severe Mental Illness

ODM created a special benefit program for adults with severe and persistent mental illness (SPMI) who lost coverage as a result of the spend-down changes detailed above. The majority of those who lost coverage due to these changes are adults with SPMI. While these individuals have access to services through Medicare and private insurance, neither option pays for the types of community support activities and care coordination provided under Medicaid. As such, Ohio Medicaid sought a state plan amendment under section 1915(i) of SSA to provide for eligibility for adults with SPMI with income up to 225% FPL who are not eligible under another Medicaid category and who meet diagnostic and needs assessment criteria established by the state and validated by a third-party entity. Ohio Medicaid identified HCBS services needed by this population to be covered as services under the 1915(i) authority. These services were developed in conjunction with a broader benefit redesign, and ODMHAS staff conducted outreach efforts with behavioral health providers and consumer and family organizations to ensure support for the targeted population.

21. Improve Care Coordination and Outcomes through Managed Behavioral Health Care

ODM restructured all Medicaid-reimbursed behavioral health services under some form of managed care in order to improve care coordination and overall outcomes for people with mental health and addiction services needs. ODM and ODMHAS coordinated this effort, beginning with structured processes for stakeholder input in March 2015.
22. Give Individuals with Developmental Disabilities an Option to Enroll in Managed Care

ODM gave the approximately 40,000 individuals who receive home and community-based services or who reside in developmental centers, and who were excluded from managed care, the option to enroll in a health plan, which in some cases improved their access to primary care physicians, specialists, and dental services.

23. Enroll Adopted and Foster Children in Managed Care

ODM transitioned the 28,000 children in Ohio’s child welfare system from the fee-for-service program to managed care, beginning on January 1, 2017. This transition is being monitored to ensure consistent coverage, better care coordination, and improved access to services.

24. Enroll Individuals into Managed Care Sooner

ODM changed the managed care enrollment process so that an individual is able to enroll in a Medicaid managed care plan of their choosing upon enrollment. It previously took an average of 45 days for an individual who qualifies for Medicaid to be enrolled into one of the five managed care plans.

25. Engage At-Risk Women through Community Health Workers

ODM directed managed care plans to use community health workers who live in the most high-risk neighborhoods to assist with the outreach to and identification of women, particularly pregnant women, to ensure their connection to ideal health care and community supports. The community health worker is expected to remove barriers to care for these women by connecting them with community services outside the health plan that support healthy living and work. Health plans are required to coordinate with local health districts to ensure that all health care and community supports are aligned toward decreasing infant mortality and improving the health of families.
FACTS AND FIGURES

Department of Medicaid Disburses the Majority of Payments for Ohio Medicaid

- GRF Medicaid expenditures were $17.00 billion in FY 2016, of which 96.6% ($16.42 billion) was disbursed by the Ohio Department of Medicaid (ODM). Non-GRF Medicaid expenditures were $8.30 billion in FY 2016, of which 75.1% ($6.23 billion) was disbursed by ODM. Across all funds, Medicaid expenditures totaled $25.29 billion. ODM accounted for 89.6% of this total.

- Ohio Medicaid is administered by ODM with the assistance of five other state agencies – Developmental Disabilities (DD), Job and Family Services (JFS), Mental Health and Addiction Services (MHA), Health, and Aging – and various local entities.

- The Department of Developmental Disabilities had the second largest share of Medicaid expenditures, accounting for 2.9% ($490.6 million) of the GRF total, 22.9% ($1.90 billion) of the non-GRF total, and 9.4% of the all funds total. Together, ODM and DD accounted for 99.0% of the all funds total. The remaining 1.0% was accounted for by the other four agencies.

- In FY 2016, 96.7% of total Medicaid expenditures were for services. Managed care had the largest share of expenditures at $13.74 billion (54.3%) including $3.83 billion for the Medicaid expansion population called Group VIII, followed by hospitals at $2.86 billion (11.3%) across all funds.

- GRF Medicaid expenditures are paid by the combination of state and federal resources. Of the $17.00 billion GRF Medicaid expenditures in FY 2016, $11.67 billion (68.6%) came from federal reimbursements and $5.33 billion (31.4%) was funded with state resources. For FY 2016, Group VIII expenditures were fully reimbursed by the federal government.

- In FY 2016, the federal and state shares of all funds Medicaid expenditures were 69.3% and 30.7%, respectively.
ABD Accounts for 17% of Medicaid Caseloads but 61% of Service Costs

- In FY 2014, the aged, blind, and disabled (ABD) population made up 17% of the Medicaid caseloads in Ohio but accounted for 61% of the service costs. In contrast, the covered families and children (CFC) population made up 83% of the Medicaid caseloads but only accounted for 39% of the service costs.

- Ohio Medicaid caseloads totaled 2.5 million in FY 2014, of which approximately 438,000 were ABD and 2.1 million were CFC. Of the $17.37 billion in total Medicaid service costs in FY 2014, $10.53 billion was incurred for the benefits of the ABD population and the remaining $6.84 billion was incurred for the CFC population.

- Ohio Medicaid provides health insurance coverage to the ABD and CFC populations. The ABD population includes low-income elderly who are age 65 or older and individuals with disabilities. The CFC population includes low-income children and adults who are age 64 or younger.

- In FY 2014, the average monthly Medicaid service cost was approximately $2,002 for an ABD member compared to $275 for a CFC member.

- The cost of long-term care is one of the main reasons for the higher expense of the ABD population. To illustrate, expenditures on nursing facilities alone, which are almost entirely for the benefit of the ABD population, accounted for 13.9% of the total Medicaid service expenditure in FY 2014.
Medicaid Caseloads Continue to Increase

- In FY 2015, total Medicaid caseloads grew by 17.0% (427,000) to 2.94 million. The majority of this increase was the result of Medicaid expansion that started in January 2014, which allowed previously ineligible adults between the ages of 19 to 64 with incomes below 138% of the federal poverty level to qualify for coverage (Group VIII).

- During the previous four-year period from FY 2011 to FY 2014, total caseloads grew at an average annual rate of 5.2% as the economy gradually improved following the Great Recession.

- Due to the Great Recession, total caseloads increased by 6.4% per year on average from FY 2008 to FY 2011. Medicaid caseloads also increased rapidly in the early 2000s as a result of the economic slowdown and several eligibility expansions for family and child coverage. From FY 2000 to FY 2004, total caseloads increased by 10.0% per year on average.

- From FY 1990 to FY 2015, total caseloads increased by 189.7%, from 1.01 million to 2.94 million.

- Due to the decline in the Ohio Works First cash assistance caseload as a result of welfare reform, CFC (covered families and children) caseloads declined steadily in the late 1990s, reaching a low of 723,000 in FY 1999.

- ABD (aged, blind, and disabled) caseloads grew 11.1% annually, on average, in the first half of the 1990s. Growth slowed to 1.5% per year on average from FY 1995 to FY 2000, followed by annual growth averaging 2.2% during the next 15-year period.
Medicaid Managed Care Caseloads Continue to Expand

Following statewide expansions implemented in FY 2006 and FY 2014, Medicaid managed care caseloads increased by 370% from FY 2005 to FY 2015. As a share of total Medicaid caseloads, the managed care portion increased from 27% in FY 2005 to 87% in FY 2015.

For the covered families and children (CFC) category, managed care caseloads grew from 469,000 in FY 2005 to 1.7 million in FY 2015, increasing its share from 36% to 91%. For the aged, blind, and disabled (ABD) category, managed care caseloads grew from 2,000 to 168,000, increasing its share from 0.5% to 81%. Under the new Group VIII category, managed care caseloads were 395,000 in FY 2015, or 75% of the Group VIII caseload total.

H.B. 66 of the 126th General Assembly required that the CFC population and certain ABD populations be enrolled in managed care plans.

Medicaid expansion through the federal Affordable Care Act began in January 2014 in Ohio. These individuals (Group VIII) are generally enrolled in managed care, but can receive services through fee-for-service until they choose a Medicaid managed care plan.

Under the fee-for-service system, Medicaid reimburses health care service providers for approved medical services and products based on set fees for the specific types of services rendered.

Under the managed care system, a Medicaid enrollee typically receives all care through a single point of entry. The state pays a fixed monthly premium per enrollee for any health care included in the benefit package, regardless of the amount of services actually used.
Ohio Medicaid is mainly funded by the GRF but it is also supported by various non-GRF funds. From FY 2008 to FY 2016, on average approximately two-thirds of Medicaid expenditures were made from the GRF, which consists of state tax receipts, state nontax receipts, and federal grants. The vast majority of federal grants deposited into the GRF are federal reimbursements for Medicaid.

The lowest GRF share during this nine-year period was recorded in FY 2010 at 57.7% due to the fact that enhanced federal reimbursements for Medicaid during the Great Recession were largely deposited into non-GRF funds.

The GRF share increased from 63.3% in FY 2015 to 67.2% in FY 2016 due largely to an accounting practice change related to Group VIII individuals who became eligible for Ohio Medicaid beginning in January 2014 through the ACA expansion. Medicaid expenditures for these individuals were accounted for in non-GRF funds in FY 2014 and FY 2015 but in the GRF beginning in FY 2016.

The practice of depositing federal reimbursements for Medicaid expenditures made with state GRF dollars into the GRF started in FY 1976. Since then GRF appropriations for Medicaid include both state and federal dollars.

State non-GRF funds for Medicaid come from sources such as hospital assessments and nursing facilities franchise fees that have specific purposes. Federal non-GRF funds for Medicaid are federal reimbursements for expenditures made with non-GRF funds.
Medicaid Expenditures Continued to Rise in FY 2015

Ohio’s Medicaid expenditures continued to rise rapidly in FY 2015 due largely to the ACA Medicaid coverage expansion for Group VIII, which began in January 2014. Total expenditures increased by 9.9% from FY 2013 to FY 2014 and by 12.6% from FY 2014 to FY 2015. In contrast, expenditures grew by just 2.9% per year from FY 2011 to FY 2013 as the economy gradually expanded following the Great Recession.

Medicaid expenditures in FY 2015 totaled $23.2 billion, over eight times greater than FY 1990 expenditures of $2.7 billion. The average annual growth rate during this period was 9.2%.

Medicaid expenditures also rose rapidly in the early 1990s and 2000s, averaging 23.2% per year from FY 1990 to FY 1994 and 10.9% per year from FY 2000 to FY 2005. Those high growth rates were a result of an economic downturn, increasing health care costs, and eligibility expansions.

Since FY 1990, the federal government has reimbursed around 60% of Ohio’s Medicaid expenditures. For Group VIII, the federal government will reimburse 100% through 2016, gradually stepping down to 90% by 2020. The non-Group VIII federal share is determined annually based upon the most recent per capita income for Ohio relative to that of the nation; the federal share has been around 64% in recent years. From October 1, 2008 to June 30, 2011, federal reimbursement for Medicaid was enhanced under the American Recovery and Reinvestment Act of 2009 and P.L.111-226.
Managed Care Comprises Over Half of Total Medicaid Service Expenditures

In FY 2016, Medicaid service (excluding administration) expenditures totaled $24.5 billion. Managed Care comprised the largest share at $13.7 billion (56.2%), including $3.8 billion (15.7%) for Ohioans (Group VIII) who became eligible for Medicaid through the federal Affordable Care Act (ACA).

The ACA expansion, which started in January 2014 in Ohio, extended Medicaid benefits to previously uncovered Ohioans who earn less than 138% of the federal poverty level. The Group VIII caseload averaged 677,000 in FY 2016. The federal reimbursement rate for this group is 100% through 2016, 95% in 2017, 94% in 2018, 93% in 2019, and 90% in 2020 and beyond.

In FY 2016, spending totaled $2.9 billion (11.7%) for Hospitals, $468.2 million (1.9%) for Prescription Drugs, and $259.7 million (1.1%) for Physicians, all encompassing fee-for-service expenditures.

Spending by the Department of Developmental Disabilities (DDD), which totaled $2.3 billion (9.5%) in FY 2016, funds Medicaid waivers and intermediate care facilities for individuals with intellectual disabilities.

Spending on Nursing Facilities totaled $1.4 billion (5.7%) in FY 2016 and primarily serves the aged, blind, and disabled population. Medicaid is the largest payer of nursing facilities in Ohio.

Behavioral Health spending, which totaled $1.1 billion (4.4%) in FY 2016, supports enrollees with mental health or addiction-related needs.

The $2.3 billion spending in the All Other category includes $472.9 million (1.9%) for Medicare Buy-In, which assists certain enrollees with premiums, deductibles, and coinsurance payments, and $305.6 million (1.2%) for Medicare Part D, which repays the federal government the amount the state would have spent on Medicaid prescription drugs for dual eligible enrollees.
ANALYSIS OF EXECUTIVE PROPOSAL

This section provides an analysis of the Governor’s recommended funding for each line item in ODM’s budget.

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<th>Fund</th>
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Medicaid/Health Care Services (651525)

This GRF line item is used to reimburse health care providers for covered services to Medicaid recipients. The federal earnings on the payments that are made entirely 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, Group VIII (i.e., those individuals who become eligible for Medicaid through the ACA), and All Other Care. The majority of expenditures from this line item earn the regular Federal Medical Assistance Percentage (FMAP) reimbursement rate at approximately 63%. However, Group VIII receives 95% federal matching in 2017, 94% in 2018, 93% in 2019, and 90% in 2020 and thereafter. Expenditures for the State Children’s Health Insurance Program (SCHIP) from this line item earn an enhanced federal participation rate of approximately 74%. The Affordable Care Act (ACA) further increases the already enhanced SCHIP federal matching rate by 23 percentage points beginning October 1, 2015 until September 30, 2019.

The executive recommends $14.26 billion for FY 2018, a 14.3% decrease over the FY 2017 estimated expenditures of $16.63 billion and $14.66 billion for FY 2019, a 2.8% increase over FY 2018. The large decrease in FY 2018 is primarily due to the replacement of the sales tax on Medicaid managed care plans with the HICs tax. Transactions associated with the sales tax were performed out of the GRF, whereas transactions associated with the HIC tax will be performed out of non-GRF Fund 5TN0.

Medicaid Program Support – State (651425)

This GRF line item is used to fund ODM’s operating expenses. It is a purely administrative, purely state share GRF line item. The associated federal match is appropriated in line item 651624, Medicaid Program Support – Federal.

The executive recommends appropriations in this line item of $196.8 million for FY 2018, a 15.4% increase over the FY 2017 estimated expenditures and $210.8 million for FY 2019, a 7.1% increase over FY 2018. The increases in the appropriation levels are due to the increase in caseload driven contracts, and policies such as Managed Care CMS requirements implementation, PASRR Specialized Services implementation, and Money Follows the Person demonstration grant planning, as discussed in the "FY 2018-FY 2019 Biennium New Initiatives with Budget Impact" section of this Redbook.

Medicare Part D (651526)

This GRF line item is used for the phased-down state contribution, otherwise known as the clawback payments, 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 that began in January 2006. 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, those individuals eligible for both Medicare and Medicaid.

The executive recommends appropriations in this line item of $440.6 million for FY 2018, a 14.6% increase over the FY 2017 estimated expenditures, and $479.7 million for FY 2019, a 8.9% increase over FY 2018. The recommended funding levels are based on the executive's projected spending for the clawback payments. During FY 2016, Ohio Medicaid made over $305.6 million in clawback payments for approximately 200,000 dual eligibles. ODM expects the FY 2017 clawback payments to total $341.6 million. The executive projects increases in the clawback payments based on assumptions such as an upward trend in pharmaceutical costs.

The executive recommends, as was also included in H.B. 64 of the 131st General Assembly, to allow the Ohio Department of Budget and Management (OBM) Director to transfer a portion of the state share of appropriations in GRF line item 651525, to this item, if necessary to allow ODM to implement the Medicare Part D requirements for FY 2018 and FY 2019.

Resident Protection Fund (651605)

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 the facility.

The source of funding for this line item is all fines collected from facilities in which the Ohio Department of Health finds deficiencies. The fines collected are deposited into the Resident Protection Fund (former Nursing Home Assessments Fund) (Fund 4E30). Funds in the line item are transferred to the Department of Aging and the Department of Health.

The executive recommends flat funding at $4.9 million for FY 2018 and FY 2019, which is $2 million more than FY 2017's estimated spending level. The increase is due to the executive's policy of using available non-GRF balances to reduce GRF spending.

Money Follows the Person (651631)

This line item is used to support the federal Money Follows the Person grant initiative. The executive recommends appropriations of $12.8 million in FY 2018, a 43.2% increase over the FY 2017 estimated expenditures, and $12.4 million in FY 2019, a 3.0% decrease from FY 2018. The recommended funding levels are the executive's projected spending. Ohio's grant is used for the Helping Ohioans Move, Expanding (HOME) Choice Program. This program assists in relocating seniors and persons with disabilities from institutions to home and community-based settings. The federal
government allocates a portion of the grant each year based upon the projected enrollment numbers as estimated by Ohio Medicaid. Ohio Medicaid cannot enroll more than their estimated projected enrollment. The grant is realized by the state as federal reimbursement on expenditures for transitioning eligible Medicaid members out of institutional settings and into home or community-based care. More specifically, for qualified and demonstrative services the federal government reimburses Ohio at an enhanced federal match rate of nearly 80% for Medicaid members for their first 12 months in home or community-based care, while other supplemental services are reimbursed at the regular federal Medicaid reimbursement rate. After the 12-month period, Ohio Medicaid draws down the regular federal reimbursement for each transitioned Medicaid member.

The executive budget permits the ODM Director to use state funds to operate the HOME Choice Program if the federal funds become unavailable and to integrate the program into a Medicaid waiver program. The budget also eliminates the Ohio Access Success Project on January 1, 2019, and requires ODM to transfer its enrollees to the HOME Choice Program.

**Medicaid Services – Recoveries (651639) and Medicaid Recoveries – Program Support (651685)**

These line items are used by ODM to pay for Medicaid services and contracts. The Health Care/Medicaid Support and Recoveries Fund (Fund 5DL0) provides funding for this line item.

All of the following are credited to the Health Care/Medicaid Support and Recoveries Fund:

1. The nonfederal share of all Medicaid-related revenues, collections, and recoveries;
2. Federal reimbursement received for payment adjustments made under the Medicaid Program to state mental health hospitals maintained and operated by the Department of Mental Health and Addiction Services;
3. Revenues ODM receives from another state agency for Medicaid services pursuant to an interagency agreement, other than such revenues required to be deposited into the Health Care Services Administration Fund;
4. The first $750,000 ODM receives in a fiscal year for performing eligibility verification services necessary for compliance with the independent, certified audit requirement of the federal law (42 C.F.R. 455.304);
5. The nonfederal share of all rebates paid by drug manufacturers to ODM in accordance with rebate agreements required by federal law; and
6. The nonfederal share of all supplemental rebates paid by drug manufacturers to ODM in accordance with the Supplemental Drug Rebate Program established by continuing state law.

In addition, the executive recommends abolishing the Health Care Services Administration Fund (Fund 5U30), transferring the balance in that fund to Fund 5DL0, and providing for the revenue that would otherwise be deposited into that fund to be deposited into Fund 5DL0. The revenue currently deposited to Fund 5U30 includes tort and audit recoveries made by Department auditors, audit contractors, and the Attorney General’s Office, and the state share of vendor offsets.

The executive recommends appropriations in this line item 651639 of $845.7 million for FY 2018, a 50.7% increase over the FY 2017 estimated expenditures, and $772.4 million for FY 2019, a 8.7% decrease from FY 2018. The increase in appropriation in FY 2018 for this line item is due to (1) the executive’s policy of using available non-GRF balances to reduce GRF spending, and (2) the increased drug rebates expected. ODM estimates drug rebates based on a historical ratio of rebates to projected pharmacy spending. Line item 651685, is a new item proposed in the executive budget. The executive recommends appropriations in this new line item of $41.2 million for FY 2018 and $46.3 million for FY 2019.

**Medicaid Services – Payment Withholding (651638)**

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. The executive recommends flat funding at $12.0 million for FY 2018 and FY 2019. The recommended level is ODM’s projection, which is based on the historical trend. The actual collection arises from activities of nursing facilities that have a change of operator.

**Medicaid Services – Hospital/UPL (651656)**

This line item is used to support hospital upper payment limit (UPL) programs and provides offsets to Medicaid GRF spending. 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 federal match for expenditures from this line item is made from line item 651623, Medicaid Services – Federal. This fee is separate from the established assessment fee currently used to support the state’s Disproportionate Share Hospital (DSH) Program.
The executive recommends appropriations in this line item of $619.1 million in FY 2018, a 0.9% increase over the FY 2017 estimated expenditures, and $647.6 million in FY 2019, a 4.6% increase from FY 2018. The increase in the appropriation is attributable to the projected increase in the hospital total facility costs. The executive recommends maintaining the current assessment rate of 2.66% for FY 2018 and FY 2019.

Health Care Grants – State (651682)

This line item is used to fund planning and implementation grants related to the ACA. Ohio Medicaid deposits funds it receives pursuant to the administration of the Medicaid Program in Fund 5KC0, other than any such funds that are required by law to be deposited into another fund. Typically, this is in the form of intrastate transfer vouchers from other agencies for specific projects associated with the Health Innovation Fund. There are currently no agreements to receive grants or moneys to Fund 5KC0. However, in anticipation of receipt, the executive recommends flat funding for this line item at $20.0 million for FY 2018 and FY 2019. The appropriation level is a placeholder for possible receipts.

Medicaid Services – Long Term Care (651608)

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. The assessment amount is calculated each year at the maximum percentage allowed by federal law (not to exceed 6%). The franchise fee payments are due to the state in February, May, August, and November of each year and are deposited in the Nursing Home Franchise Permit Fee Fund (Fund 5R20).

Ohio Medicaid is required to assess an annual franchise permit fee on each long-term care bed in a nursing home or hospital.

H.B. 59 of the 130th General Assembly replaced the specific dollar amount of the per bed per day rate of the fee with a formula to be used to determine the per bed per day fee rate. Effective July 1, 2013, the franchise permit fee rate is determined each fiscal year as follows:

1. Determine the estimated total net patient revenues for all nursing homes and hospital long-term care units for the fiscal year;
2. Multiply the amount estimated above by the lesser of (a) the indirect guarantee percentage\(^2\) or (b) 6%;

\(^2\) The indirect guarantee percentage is the percentage specified in federal law that is to be used to determine whether a class of providers is indirectly held harmless for any portion of the costs of a broad-based healthcare-related tax. The indirect guarantee percentage is currently 6%. (42 U.S.C. § 1396b(w)(4)(C)(ii).)
3. Divide the product determined above by the number of days in the fiscal year;

4. Determine the sum of (a) the total number of beds in all nursing homes and hospital long-term care units that are subject to the franchise permit fee for the fiscal year and (b) the total number of nursing home beds that are exempt from the fee for the fiscal year because of a federal waiver;

5. Divide the quotient determined pursuant to (3) above by the sum determined under (4) above.

The executive recommends flat funding for this line item at $405.7 million each year in FY 2018 and FY 2019. This funding level is based on FY 2017’s franchise fee rates.

**Medicaid Services – Physician UPL (651683)**

This line item is used by ODM to spend intergovernmental transfers for a Supplemental Upper Payment Limit (UPL) Program for physicians of the Ohio State University’s Wexner Medical Center. The funding arrangement is similar to the Hospital UPL Program in that they both close the gap between Medicaid and Medicare payment rates for the given subset of providers.

The source of funds for this line item is from intergovernmental transfers. The revenue is deposited into Medicaid Services – Physician UPL Fund (Fund 5SC0). The executive recommends flat funding at the FY 2017 estimated expenditure level of $30.0 million for FY 2018 and FY 2019.

**Medicaid Services – HIC Fee (651684)**

The executive recommends creating this new line item 651684, Medicaid Services – HIC Fee, to reimburse health care providers for covered services to Medicaid recipients. The federal match for expenditures from this line item will be made from line item 651623, Medicaid Services – Federal.

This new line item is created to accommodate the executive's policy of replacing the sales tax on Medicaid managed care plans with the HIC tax, as discussed in the "FY 2018-FY 2019 Biennium New Initiatives with Budget Impact" section of this Redbook. The source of funds for this line item is a proposed franchise fee on all HICs. The revenue will be deposited into HIC Class Franchise Fee Fund (Fund 5TN0).

The executive recommends appropriations in this new line item of $789.4 million for FY 2018, and $887.7 million for FY 2019. The appropriation levels are based on the executive's projection of the franchise fee revenue.
Medicaid Services – HCAP (651649)

This line item is to fund the state share of the Hospital Care Assurance Program (HCAP). The federal share of HCAP is funded through line item 651623, Medicaid Services – Federal. Fund 6510 is used to support line item 651649. The only 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 program formula.

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 Medicaid 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.

The executive recommends appropriations of $238.1 million for FY 2018, and $199.3 million for FY 2019. The recommended funding levels for HCAP are based on the executive’s projected assessment revenue and spending. The maximum amount of the HCAP program is capped in federal law. ACA and subsequent federal legislation require annual aggregate reductions in federal funding starting in FFY 2014.

Medicaid Health Information Technology (651603)

This federal line item is used for provider electronic health record (EHR) incentives and administrative costs related to the Health Information Technology (HIT) grant. The executive recommends flat funding at the FY 2017 estimated expenditure level of $61.9 million for FY 2018 and FY 2019.

Medicaid Services – Federal (651623)

This federally funded line item is used for the Medicaid federal share when the state share is provided from a source other than GRF line item 651525, Medicaid/Health Care Services, or GRF line item 651425, Medicaid Program Support – State, or line item 651682, Health Care Grants – State. 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 the funds is federal Medicaid reimbursement; however, it also includes Health Care Financing Research, Demonstrations, and Evaluations grants and the federal share of drug rebates. These moneys are deposited into the Health Care Federal Fund (Fund 3F00).
The executive recommends appropriations for this line item of $6.21 billion for FY 2018, a 73.1% increase over the FY 2017 estimated expenditures, and $6.34 billion for FY 2019, a 2.0% increase over FY 2018. The increases in the appropriation levels are mainly due to the replacement of the sales tax on Medicaid managed care plans with the HIC tax, the executive’s policy of shifting GRF payments to non-GRF, and other policies discussed in the "FY 2018-FY 2019 Biennium New Initiatives with Budget Impact" section of this Redbook.

**Medicaid Program Support – Federal (651624)**

This line item is used for the Medicaid federal share when the state share is provided for Medicaid administrative expenditures, mostly from GRF line item 651425, Medicaid Program Support – State. This line item also includes contracts.

The executive recommends appropriations for this line item of $631.8 million for FY 2018, a 12.1% increase over FY 2017, and $725.0 million for FY 2019, a 14.8% increase over FY 2018. The increases in the appropriation levels are mainly due to policies such as Managed Care CMS requirements implementation, PASRR Specialized Services implementation, and Money Follows the Person demonstration grant planning, as discussed in the "FY 2018-FY 2019 Biennium New Initiatives with Budget Impact" section of this Redbook.

**Health Care Grants – Federal (651680)**

This line item funds Medicaid/SCHIP and non-Medicaid/SCHIP Program initiatives stemming from the ACA of 2010. The executive recommends appropriations in this line item of $38.7 million for FY 2018 and FY 2019, a 6.5% increase over the FY 2017 estimated expenditures. The spending level is based on the revenue received for various federal grants.

**Medicaid Interagency Pass-Through (651655)**

This line item is used to disburse federal reimbursements to other agencies for Medicaid expenditures they have made. The departments of Aging, Developmental Disabilities, Health, Job and Family Services, and Mental Health and Addiction Services assist ODM in administering certain Medicaid programs/services and receive reimbursements, for services provided and related administration, out of line item 651655. The executive recommends appropriations for this line item of $125.7 million for FY 2018 and FY 2019, a 7.9% decrease from the FY 2017 estimated expenditures.

**Refunds and Reconciliations (651644)**

This line item is used to disburse funds that are held for checks 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. In addition, unidentified federal
reimbursement is temporarily drawn into this account until distribution can be made into the appropriate account.

The executive recommends flat funding for this line item of $1.0 million for FY 2018 and FY 2019.
General Revenue Fund

**Medicaid Program Support-State**

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<tbody>
<tr>
<td>$119,865,001</td>
<td>$136,452,386</td>
<td>$137,428,170</td>
<td>$170,522,987</td>
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<td>$210,754,197</td>
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**Source:** General Revenue Fund

**Legal Basis:** Section 327.10 of H.B. 64 of the 131st G.A. (originally established by Section 323.10 of H.B. 59 of the 130th G.A.)

**Purpose:** This line item funds the Ohio Department of Medicaid’s (ODM) operating expenses. Beginning in FY 2014, the state share of administrative funding previously appropriated in GRF line items 600321, Program Support, 600416, Information Technology Projects, 600417, Medicaid Provider Audits, 600425, Health Care Programs, and 600525, Health Care/Medicaid, and non-GRF line items 600639, Health Care/Medicaid Support - Recoveries, 600629, Health Care Program and DDD Support, and 600608, Long-Term Care Support, which were all under the Ohio Department of Job and Family Services (ODJFS), is appropriated in this line item. As a result, this line item exists as a purely administrative, purely state share GRF line item. The associated federal match is appropriated in line item 651624, Medicaid Program Support - Federal.
## Department of Medicaid

### GRF 651525  Medicaid Health Care Services

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<td>$15,979,052,611</td>
<td>$16,629,556,558</td>
<td>$14,259,803,761</td>
<td>$14,660,459,997</td>
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<td>10.0%</td>
<td>14.8%</td>
<td>4.1%</td>
<td>-14.3%</td>
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**Source:** General Revenue Fund

**Legal Basis:** Section 327.10 of H.B. 64 of the 131st G.A. (originally established by Section 323.10 of H.B. 59 of the 130th G.A.)

**Purpose:** This line item reimburses health care providers for covered services to Medicaid recipients. Beginning in FY 2014, this line item replaced GRF line item 600525, Health Care/Medicaid, which was under ODJFS. It is used for the same purpose as item 600525 except that the costs of administrative activities and certain health care related contracts such as eyeglass purchases, inpatient hospital peer review, enrollment information centers, and contracted case management are not funded through this line item. The federal earnings on the payments that are made from this line item are deposited as revenue into the GRF. The majority of expenditures from this line item earn the regular Federal Medical Assistance Percentage (FMAP) reimbursement rate at approximately 63%; however, expenditures for the State Children's Health Insurance Program (SCHIP) from this line item earn an enhanced federal participation rate.

Beginning in FY 2016, the expenditures for covering the Medicaid expansion population through the federal Affordable Care Act (ACA) are made out of this line item. During FY 2016 and the first half of FY 2017, federal funds provide 100% of the expenditures associated with covering this population. During the second half of FY 2017, federal funds provide 95% of these expenditures and the state provides the remaining 5%. The federal match for the ACA expansion population will be 94% in 2018, 93% in 2019, and 90% in 2020 and thereafter. In the FY 2014-FY 2015 biennium, Fund 3F00 line item 651623, Medicaid Services - Federal, was used to fund expenditures related to the ACA expansion population.
## Department of Medicaid

### GRF 651526  Medicare Part D

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<tr>
<td>Source:</td>
<td>General Revenue Fund</td>
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<tr>
<td>Legal Basis:</td>
<td>Section 327.10 of H.B. 64 of the 131st G.A. (originally established by Section 323.10 of H.B. 59 of the 130th G.A.)</td>
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<tr>
<td>Purpose:</td>
<td>This 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). Prior to FY 2014, funds for this purpose were provided for in GRF line item 600526, Medicare Part D, which was used by the Ohio Department of Job and Family Services.</td>
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### Dedicated Purpose Fund Group

#### 4E30 651605  Resident Protection Fund

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<tr>
<td>Source:</td>
<td>Dedicated Purpose Fund Group: Assessments against nursing facilities for deficiencies</td>
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<td>Legal Basis:</td>
<td>ORC 5162.66; Section 327.10 of H.B. 64 of the 131st G.A. (originally established by Section 323.10 of H.B. 59 of the 130th G.A.)</td>
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<tr>
<td>Purpose:</td>
<td>This line item pays 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 the facility. Prior to FY 2014, funds for this purpose were provided for in 600605, Resident Protection Fund, which was under ODJFS.</td>
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Department of Medicaid

5AJ0  651631  Money Follows the Person

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<td>$2,012,394</td>
<td>$1,689,928</td>
<td>$8,910,000</td>
<td>$12,760,900</td>
<td>$12,373,500</td>
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**Source:** Dedicated Purpose Fund Group: CFDA 93.791, earned reimbursement from the Money Follows the Person Grant

**Legal Basis:** Section 327.10 of H.B. 64 of the 131st G.A. (originally established by Section 323.10 of H.B. 59 of the 130th G.A.)

**Purpose:** This line item supports the federal Money Follows the Person Grant initiative. The initiative provides federal reimbursement for the costs of transitioning eligible Medicaid individuals out of institutional settings and into home or community-based care. Prior to FY 2014, funds for this purpose were provided for in line item 600631, Money Follows the Person, which was under ODJFS.

5DL0  651639  Medicaid Services-Recoveries

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<td>$537,876,341</td>
<td>$561,317,000</td>
<td>$845,691,438</td>
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**Source:** Dedicated Purpose Fund Group: (1) The nonfederal share of all Medicaid-related revenues, collections, and recoveries; (2) Federal reimbursement received for payment adjustments made under the Medicaid Program to state mental health hospitals maintained and operated by the Department of Mental Health and Addiction Services; (3) Revenues ODM receives from another state agency for Medicaid services pursuant to an interagency agreement, other than such revenues required to be deposited into the Health Care Services Administration Fund; (4) The first $750,000 ODM receives in a fiscal year for performing eligibility verification services necessary for compliance with the independent, certified audit requirement of the federal law (42 C.F.R. 455.304); (5) The nonfederal share of all rebates paid by drug manufacturers to ODM in accordance with rebate agreements required by federal law; (6) The nonfederal share of all supplemental rebates paid by drug manufacturers to ODM in accordance with the Supplemental Drug Rebate Program established by continuing state law.

**Legal Basis:** ORC 5162.54; Section 327.10 of H.B. 64 of the 131st G.A. (originally established by Section 323.10 of H.B. 59 of the 130th G.A.)

**Purpose:** This line item provides offsets to Medicaid GRF spending and pays for costs associated with the administration of the Medicaid Program. Prior to FY 2014, funds for this purpose were provided for in line item 600639, Health Care/Medicaid Support - Recoveries, which was under ODJFS.
5DL0  651685  Medicaid Recoveries-Program Support

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Source: Dedicated Purpose Fund Group: Variety of Medicaid financing activities

Legal Basis: Section 333.10 of H.B. 49 of the 132nd G.A., As Introduced

Purpose: This new line item will use to pay costs associated with the administration of Medicaid. H.B. 49 of the 132nd G.A., As Introduced, merges Fund 5U30 with Fund 5DL0, and creates this new line item to replace 651654, Medicaid Program Support.

5FX0  651638  Medicaid Services-Payment Withholding

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<td>$7,888,065</td>
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<td>$21,000,000</td>
<td>$12,000,000</td>
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Source: Dedicated Purpose Fund Group: Withheld funds from providers that change ownership

Legal Basis: Section 327.10 of H.B. 64 of the 131st G.A. (originally established by Section 323.10 of H.B. 59 of the 130th G.A.)

Purpose: This line item is used to release payments that are withheld from providers that change ownership and 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. Prior to FY 2014, funds for this purpose were provided for in line item 600638, Medicaid Payment Withholding, which was under ODJFS.
Department of Medicaid

5GF0  651656  Medicaid Services - Hospital Upper Payment Limit

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<tbody>
<tr>
<td>Source</td>
<td>Dedicated Purpose Fund Group: Money generated by assessment on hospital total facility costs</td>
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<tr>
<td>Legal Basis</td>
<td>ORC 5168.25; Section 327.10 of H.B. 64 of the 131st G.A. (originally established by Section 323.10 of H.B. 59 of the 130th G.A.)</td>
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<tr>
<td>Purpose</td>
<td>This line item supports hospital upper payment limit programs and provides offsets to Medicaid GRF spending. Prior to FY 2014, funds for this purpose were provided for in line item 600656, Health Care/Medicaid Support - Hospital/UPL, which was under ODJFS. The federal match for expenditures from this line item is made from line item 651623, Medicaid Services - Federal.</td>
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5KC0  651682  Health Care Grants-State

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<tr>
<td>Source</td>
<td>Dedicated Purpose Fund Group: All non-federal funds and grants received pursuant to the administration of the Medicaid Program other than any such funds that are required by law to be deposited into another fund</td>
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<tr>
<td>Legal Basis</td>
<td>ORC 5162.56; Section 327.10 of H.B. 64 of the 131st G.A. (originally established by Section 323.10 of H.B. 59 of the 130th G.A.)</td>
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<tr>
<td>Purpose</td>
<td>This line item funds expenses related to the services provided under, and the administration of, the Medicaid Program. Prior to FY 2014, funds for this purpose were provided for in line item 600682, Health Care Grants - State, which was under ODJFS.</td>
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Department of Medicaid

5KW0  651612  Managed Care Performance Payment

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<td>-5.2%</td>
<td>-100%</td>
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**Source:** Dedicated Purpose Fund Group: moneys withheld under the Performance Payments for Medicaid Managed Care program

**Legal Basis:** Section 327.80 of H.B. 64 of the 131st G.A. (originally established by Section 323.10 of H.B. 59 of the 130th G.A.)

**Purpose:** This line item is used to make performance payments under the Performance Payments for Medicaid Managed Care program. H.B. 59 of the 130th G.A. authorized ODM to withhold up to two percent of health plan payments, pending the plan’s ability to meet certain performance outcomes. At the beginning of each quarter, the Medicaid Director certifies to the OBM Director the amount withheld. The OBM Director transfers cash in the amount certified from the GRF to the Managed Care Performance Payment Fund (Fund 5KW0) and reduces appropriation item 651525, Medicaid/Health Care Services by the same amount.

In H.B. 49 of the 132nd G.A., As Introduced, this line item is discontinued. H.B.49 requires that (1) OBM Director to transfer the cash balance in Fund 5KW0 to the GRF on July 1, 2017 or as soon as possible thereafter; (2) abolishing Fund 5KW0 upon completion of the transfer; and (3) OBM Director to cancel any existing encumbrances against line item 651612, and reestablish them against GRF appropriation item 651525, Medicaid Health Care Services.

5R20  651608  Medicaid Services-Long Term

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<td>$396,708,845</td>
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<td>$399,818,149</td>
<td>$403,311,000</td>
<td>$405,666,000</td>
<td>$405,666,000</td>
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<tr>
<td>-0.8%</td>
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<td>0.9%</td>
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**Source:** Dedicated Purpose Fund Group: Franchise fee assessment on nursing facilities

**Legal Basis:** ORC 5168.54; Section 327.10 of H.B. 64 of the 131st G.A. (originally established by Section 323.10 of H.B. 59 of the 130th G.A.)

**Purpose:** This line item makes Medicaid payments to nursing facilities. Prior to FY 2014, funds for this purpose were provided for in line item 600608, Long-Term Care Support, which was under ODJFS.
### Department of Medicaid

**5SA0  651628  Maternal and Child Health**

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<tbody>
<tr>
<td>Source</td>
<td>Dedicated Purpose Fund Group: Cash transfer from the excess FY 2015 GRF ending balance</td>
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<tr>
<td>Legal Basis</td>
<td>Sections 327.10, 327.245, and 512.30 of H.B. 64 of the 131st G.A.</td>
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<tr>
<td>Purpose</td>
<td>This line item is allocated to Integrating Professionals for Appalachian Children to improve maternal and child health outcomes in the service area comprised of Athens, Gallia, Hocking, Jackson, Meigs, Perry, Ross, Vinton, and Washington counties. H.B. 49 of the 132nd G.A., As Introduced, does not provide any funding for this line item.</td>
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**5SC0  651683  Medicaid Services-Physician UPL**

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<tbody>
<tr>
<td>Source</td>
<td>Dedicated Purpose Fund Group: Intergovernmental transfer with The Ohio State University’s Wexner Medical Center</td>
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<tr>
<td>Legal Basis</td>
<td>Established by Controlling Board on August 17, 2015</td>
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<tr>
<td>Purpose</td>
<td>This line item is used by ODM to spend intergovernmental transfers for a Supplemental Upper Payment Limit (UPL) program for physicians of The Ohio State University’s Wexner Medical Center. The funding arrangement is similar to the Hospital UPL program in that they both close the gap between Medicaid and Medicare Payment rates for the given subset of providers.</td>
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**5TN0  651684  Medicaid Services-HIC Fee**

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<tr>
<td>Source</td>
<td>Dedicated Purpose Fund Group: Monthly franchise fee on health insuring corporations</td>
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<tr>
<td>Legal Basis</td>
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<tr>
<td>Purpose</td>
<td>This new line item will be used to reimburse health care providers for covered services to Medicaid recipients. The federal match for expenditures from this line item will be made from line item 651623, Medicaid Services – Federal.</td>
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</table>
**5U30  651654  Medicaid Program Support**

| Source: | Dedicated Purpose Fund Group: Variety of Medicaid financing activities |
| Legal Basis: | ORC 5162.54; Section 327.10 of H.B. 64 of the 131st G.A. (originally established by Section 323.10 of H.B. 59 of the 130th G.A.) |
| Purpose: | This line item pays costs associated with the administration of Medicaid. Prior to FY 2014, funds for this purpose were provided for in line items 600654, Health Care Program Support, and 600625, Healthcare Compliance, which were under ODJFS. In H.B. 49 of the 132nd G.A., As Introduced, this line item will be discontinued and will be replaced by the new line item 651685, Medicaid Recoveries Program Support, which will be supported by Fund 5DL0. |

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<td>314.3%</td>
<td>-100%</td>
<td>N/A</td>
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</tbody>
</table>

**6510  651649  Medicaid Services-Hospital Care Assurance Program**

| Source: | Dedicated Purpose Fund Group: Hospital Care Assurance Program (HCAP) assessments on hospitals |
| Legal Basis: | Section 327.10 of H.B. 64 of the 131st G.A. (originally established by Section 323.10 of H.B. 59 of the 130th G.A.) |
| Purpose: | This line item funds the Hospital Care Assurance Program (HCAP), which provides subsidy payments to hospitals that provide uncompensated, or charity, care to certain low-income and uninsured individuals. Prior to FY 2014, funds for this purpose were provided for in line item 600649, Hospital Care Assurance Program Fund, which was under ODJFS. Due to a delay in receiving federal approval, the payments for FY 2015 were not made until FY 2016. |

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<tbody>
<tr>
<td>$210,934,631</td>
<td>$0</td>
<td>$445,516,981</td>
<td>$237,049,000</td>
<td>$238,057,429</td>
<td>$199,250,372</td>
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### Holding Account Fund Group

**Refunds and Reconciliation**

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<tr>
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</thead>
<tbody>
<tr>
<td>Source</td>
<td>R055 651644</td>
<td>R055 651644</td>
<td>R055 651644</td>
<td>R055 651644</td>
<td>R055 651644</td>
<td>R055 651644</td>
</tr>
<tr>
<td>FY 2014 Actual</td>
<td>$590,001</td>
<td>$163,063</td>
<td>$264,618</td>
<td>$1,000,000</td>
<td>$1,000,000</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>Actual</td>
<td>-72.4%</td>
<td>62.3%</td>
<td>277.9%</td>
<td>0.0%</td>
<td>0.0%</td>
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</table>

**Source:** Holding Account Fund Group: Unidentified checks received by ODM

**Legal Basis:** Section 327.10 of H.B. 64 of the 131st G.A. (originally established by Section 323.10 of H.B. 59 of the 130th G.A.)

**Purpose:** This line item is used to disburse funds that are held for checks 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.

### Federal Fund Group

**Medicaid Health and Transformation Technology**

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Source</td>
<td>3ER0 651603</td>
<td>3ER0 651603</td>
<td>3ER0 651603</td>
<td>3ER0 651603</td>
<td>3ER0 651603</td>
<td>3ER0 651603</td>
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<tr>
<td>FY 2014 Actual</td>
<td>$94,218,038</td>
<td>$75,081,691</td>
<td>$55,705,287</td>
<td>$61,896,000</td>
<td>$61,896,000</td>
<td>$61,896,000</td>
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<tr>
<td>Actual</td>
<td>-20.3%</td>
<td>-25.8%</td>
<td>11.1%</td>
<td>0.0%</td>
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</table>

**Source:** Federal Fund Group: CFDA 93.778. The American Reinvestment and Recovery Act of 2009 (Public Law 111-5) Section 4201, Medicaid Provider HIT Adoption and Operation Payments Implementation

**Legal Basis:** ORC 5164.93; Section 327.10 of H.B. 64 of the 131st G.A. (originally established by Section 323.10 of H.B. 59 of the 130th G.A.)

**Purpose:** This line item is used for provider electronic health record (EHR) incentives and administrative costs related to the Health Information Technology (HIT) grant. Prior to FY 2014, funds for this purpose were provided for in line item 600603, Health Information Technology, which was under ODJFS.
**Department of Medicaid**

<table>
<thead>
<tr>
<th>3F00 651623</th>
<th>Medicaid Services-Federal</th>
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</thead>
<tbody>
<tr>
<td>$3,297,569,129</td>
<td>$4,747,960,860</td>
</tr>
<tr>
<td>44.0%</td>
<td>-19.1%</td>
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</table>

**Source:** Federal Fund Group: CFDA 93.778 Medical Assistance Grants (Medicaid); CFDA 93.779, Health Care Financing Research, Demonstrations and Evaluations; and the federal share of drug rebates and other Medicaid revenues

**Legal Basis:** ORC 5162.50; Section 327.10 of H.B. 64 of the 131st G.A. (originally established by Section 323.10 of H.B. 59 of the 130th G.A.)

**Purpose:** This line item provides the Medicaid federal share when the state share is provided from a source other than GRF line item 651525, Medicaid/Health Care Services, GRF line item 651425, Medicaid Program Support – State, or line item 651682, Health Care Grants – State. Major activities in this line item include the federal share of nursing facility, hospital, prescription drug expenditures, and general Medicaid services. Prior to FY 2014, funds for this purpose were provided for in federal line item 6000623, Health Care Federal, which was under ODJFS.

In FY 2014 and FY 2015, this line item was also used to fund expenditures relating to the Medicaid expansion population through the federal Affordable Care Act (ACA). Beginning in FY 2016, the expansion population is funded through GRF line item 651525, Medicaid/Health Care Services.
### Department of Medicaid

**3F00  651624  Medicaid Program Support - Federal**

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</thead>
<tbody>
<tr>
<td>$267,394,937</td>
<td>$293,528,874</td>
<td>$292,426,416</td>
<td>$563,687,365</td>
<td>$631,793,871</td>
<td>$725,032,537</td>
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</tr>
</tbody>
</table>

**Source:** Federal Fund Group: CFDA 93.778 Medical Assistance Grants (Medicaid); federal share of Medicaid administrative expenses

**Legal Basis:** ORC 5162.50; Section 327.10 of H.B. 64 of the 131st G.A. (originally established by Section 323.10 of H.B. 59 of the 130th G.A.)

**Purpose:** This line item provides for the federal share of Medicaid administrative expenses while the state share of these expenditures is provided mostly from GRF line item 651425, Medicaid Program Support – State. This line item also includes contracts previously funded through GRF line item 600525, Health Care/Medicaid, and the federal share of other administrative spending previously funded through line items 600623, Health Care Federal, 600321, Program Support, and 600416, Information Technology Projects, which were under ODJFS.

**3FA0  651680  Health Care Grants-Federal**

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<tbody>
<tr>
<td>$15,083,108</td>
<td>$23,716,650</td>
<td>$15,377,474</td>
<td>$36,296,000</td>
<td>$38,658,704</td>
<td>$38,664,967</td>
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</table>

**Source:** Federal Fund Group: CFDA 93.525. The State Planning and Establishment Grants for the Affordable Care Acts Exchanges; performance bonuses under the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

**Legal Basis:** Section 327.10 of H.B. 64 of the 131st G.A. (originally established by Section 323.10 of H.B. 59 of the 130th G.A.)

**Purpose:** This line item funds Medicaid/SCHIP and non-Medicaid/SCHIP Program initiatives stemming from the Affordable Care Act of 2010. Prior to FY 2014, funds for this purpose were provided for in federal line item 600680, Health Care Grants - Federal, which was under ODJFS.
Department of Medicaid

3G50  651655  Medicaid Interagency Pass Through

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<tbody>
<tr>
<td>$1,084,811,781</td>
<td>$863,923,976</td>
<td>$149,123,953</td>
<td>$136,406,000</td>
<td>$125,651,597</td>
<td>$125,701,597</td>
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</table>

**Source:** Federal Fund Group: CFDA 93.658, State Survey and Certification of Health Care Providers and Suppliers; CFDA 93.778, Medical Assistance Program (Medicaid: Title XIX); CFDA 93.777 Children’s Health Insurance Program

**Legal Basis:** Sections Section 327.10 of H.B. 64 of the 131st G.A. (originally established by Section 323.10 of H.B. 59 of the 130th G.A.)

**Purpose:** This line item is used to disburse federal reimbursement to other agencies for Medicaid expenditures they have made. Prior to FY 2014, funds for this purpose were provided for in federal line item 600655, Interagency Reimbursement, which was under ODJFS. The departments of Aging, Developmental Disabilities, Health, Job and Family Services, and Mental Health and Addiction Services assist ODM in administering certain Medicaid programs/services and receive federal reimbursements for services provided and related administration. Prior to FY 2016, federal reimbursements for services provided were appropriated to this line item and to the agency line items that received transfers from this line item. Beginning in FY 2016, federal reimbursements for services provided are appropriated to the applicable agency only. However, reimbursements related to administration remain in this line item.
## FY 2018 - FY 2019 Introduced Appropriation Amounts

### Line Item Detail by Agency

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<thead>
<tr>
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<tbody>
<tr>
<td><strong>Main Operating Appropriations Bill</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Department of Medicaid</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GRF 651425 Medicaid Program Support-State</td>
<td></td>
<td>$137,428,170</td>
<td>$170,522,987</td>
<td>$196,812,968</td>
<td>15.42%</td>
<td>$210,754,197</td>
<td>7.08%</td>
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<tr>
<td>GRF 651425 Medicaid Health Care Services-State</td>
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<td>$4,311,563,837</td>
<td>$4,597,553,800</td>
<td>$3,981,222,793</td>
<td>-13.41%</td>
<td>$4,184,126,208</td>
<td>5.10%</td>
</tr>
<tr>
<td>GRF 651425 Medicaid Health Care Services-Federal</td>
<td></td>
<td>$11,667,488,774</td>
<td>$12,032,002,758</td>
<td>$</td>
<td>-14.57%</td>
<td>$10,746,333,789</td>
<td>1.92%</td>
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<tr>
<td>GRF 651525 Medicaid Health Care Services - Total</td>
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<td>$15,979,052,611</td>
<td>$16,629,556,558</td>
<td>$14,259,803,761</td>
<td>-14.25%</td>
<td>$14,660,459,997</td>
<td>2.81%</td>
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<tr>
<td>GRF 651526 Medicare Part D</td>
<td></td>
<td>$3,981,222,793</td>
<td>$4,184,126,208</td>
<td>$4,597,553,800</td>
<td>5.10%</td>
<td>$4,776,894,803</td>
<td>8.87%</td>
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<tr>
<td>GRF - State</td>
<td></td>
<td>$4,754,626,140</td>
<td>$5,152,614,730</td>
<td>$4,618,647,389</td>
<td>-10.36%</td>
<td>$4,874,575,208</td>
<td>5.54%</td>
</tr>
<tr>
<td>GRF - Federal</td>
<td></td>
<td>$11,667,488,774</td>
<td>$12,032,002,758</td>
<td>$10,278,580,968</td>
<td>-14.57%</td>
<td>$10,476,333,789</td>
<td>1.92%</td>
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<td><strong>General Revenue Fund Total</strong></td>
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<td>$16,422,114,914</td>
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<td>$14,629,556,558</td>
<td>2.81%</td>
<td>$15,389,459,997</td>
<td>3.05%</td>
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<td>4E30 651605 Resident Protection Fund</td>
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<td>$0</td>
<td>$2,878,000</td>
<td>$4,878,000</td>
<td>69.49%</td>
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<td>5AJO 651631 Money Follows the Person</td>
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<td>$1,889,928</td>
<td>$8,910,000</td>
<td>$12,760,900</td>
<td>43.22%</td>
<td>$12,376,500</td>
<td>3.04%</td>
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<td>5DL0 651639 Medicaid Services-Recoveries</td>
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<td>$537,876,341</td>
<td>$561,317,000</td>
<td>$845,691,438</td>
<td>50.66%</td>
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<td>5DL0 651685 Medicaid Recoveries-Program Support</td>
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<td>$0</td>
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<td>$41,146,571</td>
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<td>5FX0 651638 Medicaid Services-Payment Withholding</td>
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<td>$6,383,192</td>
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<tr>
<td>5GF0 651656 Medicaid Services - Hospital Upper Payment Limit</td>
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<td>$568,275,051</td>
<td>$613,303,715</td>
<td>$619,104,791</td>
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<td>$647,635,236</td>
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<td>5KW0 651612 Managed Care Performance Payment</td>
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<td>$48,507,051</td>
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<td>5R20 651608 Medicaid Services-Long Term</td>
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<td>0.58%</td>
<td>$405,666,000</td>
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<td>5SA0 651628 Maternal and Child Health</td>
<td></td>
<td>$500,000</td>
<td>$0</td>
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<td>5SC0 651683 Medicaid Services-Physician UPL</td>
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<td>$3,503,537</td>
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<td>$0</td>
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<td>$33,834,000</td>
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<td>$0</td>
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<tr>
<td>4E30 651644 Refunds and Reconciliation</td>
<td></td>
<td>$264,618</td>
<td>$1,000,000</td>
<td>$</td>
<td>0.00%</td>
<td>$1,000,000</td>
<td>0.00%</td>
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**Prepared by the Legislative Service Commission**
## FY 2018 - FY 2019 Introduced Appropriation Amounts

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<tr>
<th>Line Item Detail by Agency</th>
<th>FY 2016</th>
<th>FY 2017</th>
<th>Introduced FY 2018</th>
<th>FY 2017 to FY 2018 % Change</th>
<th>Introduced FY 2019</th>
<th>FY 2018 to FY 2019 % Change</th>
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<tr>
<td><strong>MCD Department of Medicaid</strong></td>
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</tr>
<tr>
<td>Holding Account Fund Group Total</td>
<td>$ 264,618</td>
<td>$ 1,000,000</td>
<td>$ 1,000,000</td>
<td>0.00%</td>
<td>$ 1,000,000</td>
<td>0.00%</td>
</tr>
<tr>
<td>3ER0 651603 Medicaid Health and Transformation Technology</td>
<td>$ 55,705,287</td>
<td>$ 61,896,000</td>
<td>$ 61,896,000</td>
<td>0.00%</td>
<td>$ 61,896,000</td>
<td>0.00%</td>
</tr>
<tr>
<td>3F00 651623 Medicaid Services-Federal</td>
<td>$ 3,841,522,208</td>
<td>$ 3,589,139,022</td>
<td>$ 6,213,919,469</td>
<td>73.13%</td>
<td>$ 6,336,785,019</td>
<td>2.01%</td>
</tr>
<tr>
<td>3F00 651624 Medicaid Program Support - Federal</td>
<td>$ 292,426,416</td>
<td>$ 563,687,365</td>
<td>$ 631,793,871</td>
<td>12.08%</td>
<td>$ 725,032,537</td>
<td>14.76%</td>
</tr>
<tr>
<td>3FA0 651680 Health Care Grants-Federal</td>
<td>$ 15,377,474</td>
<td>$ 36,296,000</td>
<td>$ 36,858,704</td>
<td>6.51%</td>
<td>$ 36,664,967</td>
<td>0.02%</td>
</tr>
<tr>
<td>3G50 651655 Medicaid Interagency Pass Through</td>
<td>$ 149,123,953</td>
<td>$ 136,406,000</td>
<td>$ 125,651,597</td>
<td>-7.88%</td>
<td>$ 125,701,597</td>
<td>0.04%</td>
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<td><strong>Federal Fund Group Total</strong></td>
<td>$ 4,354,155,338</td>
<td>$ 4,387,424,387</td>
<td>$ 7,071,919,641</td>
<td>61.19%</td>
<td>$ 7,290,080,120</td>
<td>3.08%</td>
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<tr>
<td><strong>Department of Medicaid Total</strong></td>
<td>$ 22,802,863,214</td>
<td>$ 23,560,644,590</td>
<td>$ 24,988,874,812</td>
<td>6.06%</td>
<td>$ 25,680,231,986</td>
<td>2.77%</td>
</tr>
</tbody>
</table>

Prepared by the Legislative Service Commission
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OVERVIEW

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

Medicaid and the Ohio budget

The state of Ohio’s budget is dominated by spending on Medicaid and primary and secondary education. The chart below demonstrates this fact by looking at the state's general revenue fund (GRF) spending in two different ways. The column on the left shows the state's total GRF spending in FY 2016 by program area. Medicaid dominates this spending at 50.6%. The column on the right shows the state's state-only GRF spending. Federal reimbursements for Medicaid that are deposited into the GRF are removed in this analysis. Medicaid’s share of spending in this view drops, but still remains significant at 24.3%.

1 Some states, including Ohio, also support the program with local government sources.
Whereas about two-thirds of the state's Medicaid expenditures come from the GRF ($17.00 billion in FY 2016), non-GRF spending is also important ($8.30 billion). As with GRF spending, non-GRF spending also includes revenue from state and federal sources. The next chart shows the breakdown of Medicaid spending by state and federal GRF and non-GRF sources.

![Ohio Medicaid Spending by Funding Source, FY 2016](image)

Of the total Medicaid spending in FY 2016 of $25.29 billion, 67.2% was from the GRF – 46.1% from federal GRF funds ($11.67 billion) and 21.1% from state GRF funds ($5.33 billion). The remaining 32.8% was from non-GRF funds – 23.2% from federal funds ($5.87 billion) and 9.6% from state funds ($2.43 billion).

**Federal financial participation**

**Federal medical assistance percentage (FMAP)**

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

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

A state with average per capita income (state per capita income equal to national per capita income) will have an FMAP of 0.55 or 55% (1 – 0.45). State's with higher per capita incomes will have lower FMAPs and vice versa. However, the federal government has set a minimum FMAP at 50% and a maximum at 83%. In FFY 2017, 13 states have the minimum FMAP of 50%. Mississippi has the highest FMAP of all the
states at 73.63%. The FMAP for Ohio for FFY 2017 is 62.32%. So, for every dollar Ohio spends on most Medicaid services, it receives 62¢ back from the federal government.

**Enhanced federal medical assistance percentage (eFMAP)**

An enhanced FMAP is provided for both services and administration under the State Children’s Health Insurance Program (SCHIP). 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%. Under the ACA, each state's eFMAP is increased by 23 percentage points, with a maximum of 100%, for FFY 2016 through FFY 2019. In FFY 2017, therefore, Ohio's eFMAP is 96.62%. In addition to SCHIP, the cost of the treatment for breast or cervical cancer under the Medicaid Program is also reimbursed at the eFMAP rate.

**Other exceptions to FMAP**

**Administration**

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

<table>
<thead>
<tr>
<th>Activity or Function</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immigration status verification</td>
<td>100%</td>
</tr>
<tr>
<td>Payments to eligible providers for the use of electronic health record (EHR) technology</td>
<td>100%</td>
</tr>
<tr>
<td>Administration of incentive payment programs for the adoption of EHR</td>
<td>90%</td>
</tr>
<tr>
<td>Administration of family planning services</td>
<td>90%</td>
</tr>
<tr>
<td>Design, development, and installation of a Medicaid Management Information System (MMIS)</td>
<td>90%</td>
</tr>
<tr>
<td>Design, development, and installation of a Medicaid eligibility and enrollment system (E&amp;E)</td>
<td>90%</td>
</tr>
<tr>
<td>Management and operation of an MMIS</td>
<td>75%</td>
</tr>
<tr>
<td>Maintenance and operations of an E&amp;E</td>
<td>75%</td>
</tr>
<tr>
<td>Independent external reviews of managed care plans</td>
<td>75%</td>
</tr>
<tr>
<td>Medical and utilization review</td>
<td>75%</td>
</tr>
<tr>
<td>Preadmission screening and resident review</td>
<td>75%</td>
</tr>
</tbody>
</table>

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

3 Ohio’s state share under the regular FMAP is 37.68% (100% - 62.32%), reducing that by 30% results in a state share under eFMAP of 26.38% (37.68% x 70%), which translates into an eFMAP of 73.62% (100% - 26.38%). Finally, adding 23 percentage points results in 96.62% (73.62% + 23%).

4 Source: Kaiser Commission on Medicaid and the Uninsured, Medicaid Financing: An Overview of the Federal Medicaid Matching Rate (FMAP), September 2012.
### Federal Matching Rates for Various Administrative Activities

<table>
<thead>
<tr>
<th>Activity or Function</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled professional medical personnel</td>
<td>75%</td>
</tr>
<tr>
<td>State fraud and abuse control unit activities</td>
<td>75%</td>
</tr>
<tr>
<td>State survey and certification</td>
<td>75%</td>
</tr>
<tr>
<td>Translation and interpretation services for children</td>
<td>75%</td>
</tr>
<tr>
<td>Other program administration activities</td>
<td>50%</td>
</tr>
</tbody>
</table>

**ACA expansion group (Group VIII)**

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

**Qualifying Individuals Program**

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

**Family planning services**

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

**Community first choice option**

This option allows states to provide home and community-based attendant services and supports to eligible Medicaid enrollees. This state plan's option became available under the ACA on October 1, 2011, and provides a six percentage point increase in FMAP to states for service expenditures.

**Preventative services for adults**

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

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5 Medicare Part B covers some medical services not covered by Part A, such as physician services and outpatient care.
Temporary FMAP increases

The federal government will occasionally provide temporary increases in a state’s FMAP to assist in certain circumstances. For example, Congress has temporarily increased FMAPs to provide fiscal relief to state Medicaid programs during recessions. Temporary FMAP increases may also be given as a type of grant to incentivize state’s adoption of certain programs. For example, the ACA created an optional benefit for states to establish Health Home to coordinate care for certain people with chronic conditions. States receive a 90% federal match for eight calendar quarters for specific Health Home services. Another example is the Money Follows the Person (MFP). Rebalancing Demonstration Program Under MFP, 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 that FMAP and 100%. CMS began awarding MFP demonstration grants in January 2007 with 17 initial awards, the ACA extended the MFP Program through September 30, 2016. Ohio was one of the 17 initial states and used the additional funding to establish the Helping Ohioans Move, Expanding (HOME) Choice program.

Summary

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

<table>
<thead>
<tr>
<th>Summary of Current Federal Match Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population/Services</td>
</tr>
<tr>
<td>Qualifying Individuals Program</td>
</tr>
<tr>
<td>Newly Eligible, Adults under 65 up to 138% FPL</td>
</tr>
<tr>
<td>Family Planning Services and Administration</td>
</tr>
<tr>
<td>Health Home Services</td>
</tr>
<tr>
<td>State Children’s Health Insurance Program (SCHIP)</td>
</tr>
<tr>
<td>Breast and Cervical Cancer Treatment</td>
</tr>
<tr>
<td>Community First Choice</td>
</tr>
<tr>
<td>Clinical Preventive Services for Adults</td>
</tr>
<tr>
<td>Administrative Activities</td>
</tr>
</tbody>
</table>

**FEDERAL OVERSIGHT**

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

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

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

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

2. **Freedom of choice.** Medicaid consumers are provided the freedom to choose which Medicaid providers they use. States may not restrict Medicaid recipients' access to qualified providers.

3. **Amount, duration, and scope.** For every covered service, determinations are made regarding the amount, duration, and scope of coverage provided to meet recipients' needs. For example, a state could limit the number of days of hospital care provided. States must cover each service in an amount, duration, and scope that is reasonably sufficient. Services must not be arbitrarily limited for any specific illness or condition.

4. **Comparability of services.** States must ensure that the medical assistance available to any recipient is not less in amount, duration, or scope than what is available to any other recipient.

5. **Reasonable promptness.** States must promptly provide Medicaid to recipients without delay caused by the agency's administrative procedures.

6. **Equal access to care.** States must set payment rates that are adequate to assure Medicaid recipients reasonable access to services of adequate quality.

7. **Coverage of mandatory services for mandatory populations.** CMS requires state Medicaid programs to provide certain medically necessary services to covered populations.

Federal waivers

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

**Section 1115 research and demonstration projects**

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

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

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

Section 1915(b) provides the HHS Secretary with the authority to grant waivers that allow states to implement managed care delivery systems, or otherwise limit individuals' choice of provider under Medicaid. This section also provides waivers allowing states to skip provisions requiring comparability of services and statewideness, which together require states to offer the same coverage to all categorically needy recipients statewide.

**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**

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 to 1915(i) provisions by removing certain barriers to offering home and community-based services through the Medicaid State Plan.

**MEDICAID ELIGIBILITY**

**Federal eligibility criteria**

Generally, the federal government requires Medicaid beneficiaries to be U.S. citizens\(^6\) and residents of the state in which they receive benefits. States set income eligibility standards for various groups subject to federally specified minimums and maximums. For most groups, eligibility is based on the modified adjusted gross income (MAGI)\(^7\) of the household as compared to the federal poverty line (FPL)\(^8\). FPL is the income guideline established and issued each year in the Federal Register by HHS. In general, individuals under the age of 65 may be eligible for Medicaid under federal criteria if their household income is at or below 133% FPL\(^9\). Although some groups (primarily children and pregnant women) with higher household incomes also may be eligible. The table below provides the FPL and 133% of the FPL for various family sizes in 2017.

<table>
<thead>
<tr>
<th>Family Size</th>
<th>FPL</th>
<th>133% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$12,060</td>
<td>$16,040</td>
</tr>
<tr>
<td>2</td>
<td>$16,240</td>
<td>$21,599</td>
</tr>
<tr>
<td>3</td>
<td>$20,420</td>
<td>$27,159</td>
</tr>
<tr>
<td>4</td>
<td>$24,600</td>
<td>$32,718</td>
</tr>
<tr>
<td>5</td>
<td>$28,780</td>
<td>$38,277</td>
</tr>
<tr>
<td>6</td>
<td>$32,960</td>
<td>$43,837</td>
</tr>
<tr>
<td>7</td>
<td>$37,140</td>
<td>$49,396</td>
</tr>
<tr>
<td>8</td>
<td>$41,320</td>
<td>$54,956</td>
</tr>
</tbody>
</table>

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\(^6\) Some noncitizens are also eligible, such as lawful permanent residents.

\(^7\) MAGI is the Internal Revenue Code’s Adjusted Gross Income increased by tax-exempt interest and income earned by U.S. citizens or residents living abroad.

\(^8\) A different methodology is used for the aged, blind, and disabled eligibility group.

\(^9\) Under the MAGI methodology, there is generally a 5% income disregard, so that the income limit is effectively 138% FPL.
Prior to the ACA, Medicaid eligibility was limited to children, pregnant women, parents, and disabled or older adults (over age 65).\textsuperscript{10} The ACA expanded coverage to certain nondisabled adults under the age of 65 and without dependents. Although the ACA intended to make coverage of this group mandatory, in June 2012, the U.S. Supreme Court limited HHS’s authority to enforce the expansion, effectively making it optional for states.

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

- Parents who would have met the eligibility criteria for participation in the cash assistance program Aid to Families with Dependent Children (AFDC) as of July 16, 1996;\textsuperscript{11}
- Children in families with incomes up to 133% FPL;
- Recipients of adoption assistance and foster care under Title IV-E of the Social Security Act and young adults aging out of foster care up to age 26;
- Pregnant women with incomes up to 133% FPL;\textsuperscript{12}
- Supplemental Security Income (SSI) recipients.\textsuperscript{13}

**Ohio Medicaid eligibility**

Ohio chose to expand coverage under ACA to the Group VIII population and also has taken advantage of flexibility offered by the federal government to expand coverage above the federal minimum for other groups. In FY 2016, Ohio provided Medicaid coverage to over 3.0 million people. ODM recognizes a number of different categories of Medicaid beneficiaries. This categorization is not specified in state law, but rather has been created administratively and there may not be a clear consensus as to the specific composition of the different categories. The three main categories are: Group VIII, covered families and children (CFC), and aged, blind, and disabled (ABD). There are other smaller categories that provide full benefits and two limited benefit programs. The following chart shows the breakdown of Ohio’s Medicaid caseload by these different eligibility categories.

\textsuperscript{10} Generally, for the purposes of Medicaid, children are under the age of 19, adults are between the ages of 19 and 65, and older adults (also termed “aged”) are over the age of 65 (and thus eligible for Medicare).

\textsuperscript{11} In Ohio, families with dependent children with incomes no higher than 32% FPL were eligible for AFDC.

\textsuperscript{12} In addition, after giving birth, these women and their infants had mandated coverage throughout the infant’s first year.

\textsuperscript{13} Or in some state of aged, blind, and disabled individuals who meet more restrictive criteria if those criteria were in place in the state’s approved Medicaid Plan as of January 1, 1972. Ohio switched from more restrictive criteria to the SSI standard on August 1, 2016.
Group VIII

Group VIII consists of adults under the age of 65 with household income at or below 138% FPL who would not be eligible except for the ACA expansion. In other words, they are not eligible under any other category. Ohio's Group VIII caseload in FY 2016 was 685,914.

Covered families and children (CFC)

CFC includes children with household income at or below 206% FPL. SCHIP covers children with household income between 156% FPL and 206% FPL who would otherwise be uninsured, whereas regular Medicaid covers children with household income below 156% FPL and children with household income between 156% FPL and 206% FPL who would otherwise be underinsured. CFC also includes children who receive federally funded adoption or foster care subsidies. These children are eligible for Medicaid regardless of household income.

CFC also includes pregnant women with household incomes at or below 200% FPL. Pregnant women in Ohio are eligible for expedited enrollment into Medicaid that allows them to receive covered services within 24 hours of applying. Eligible women are included in CFC for the duration of their pregnancies and up to 60 days after the baby is born. Finally, CFC includes families (parents and children) who receive cash assistance under Ohio Works First or who have household incomes at or below 90% FPL.

Ohio's CFC caseload was 1,798,752 in FY 2016, of which 68.7% were children and 31.3% were adults.

14 133% FPL with a 5% income disregard.
15 Also eligible are young adults up to age 26 who have aged out of foster care.
Aged, blind, and disabled (ABD)

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

Also counted in the ABD category are individuals enrolled in the Medicaid Buy-In for Workers with Disabilities Program (MBIWD). This program provides Medicaid coverage to employed, disabled individuals, who are at least 16 but younger than 65 years of age, have countable income not exceeding 250% FPL, and have less than $11,473 in assets. Individuals in this program with income exceeding 150% FPL must pay an annual premium.

Ohio's ABD caseload was 383,770 in FY 2016, of which 55.4% were dual eligible, 37.6% were adults who were not eligible for Medicare, and 7.0% were children.

Other full benefit categories

Breast and Cervical Cancer Project (BCCP)

Uninsured women between the ages of 40 and 65 who have been screened for breast or cervical cancer through the Ohio Department of Health and are in need of treatment are eligible for full Medicaid benefits through the Breast and Cervical Cancer Project (BCCP) until their treatment is completed. Ohio’s BCCP caseload in FY 2016 was 604.

Presumptive eligibility

Some uninsured individuals are able to receive immediate health care services through Medicaid if they are presumed to be eligible. These individuals are temporarily counted in this category until their Medicaid applications are approved. Certain aliens and newly arrived refugees may also receive emergency health care services temporarily through Medicaid. Ohio’s caseload in this category in FY 2016 was 34,189.

Limited benefit categories

Medicare premium assistance

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

There are four levels of assistance provided in this category. The first level of assistance is for a Qualified Medicare Beneficiary (QMB). In general, to qualify as a QMB, a Medicare recipient must have family income not exceeding 100% FPL. Medicaid pays QMB beneficiaries' Medicare Part A and B premiums and other Medicare cost-sharing expenses. The second level is for a Specified Low-Income Medicare Beneficiary (SLMB). In general, to qualify as an SLMB, a Medicare beneficiary must have family income between 100% FPL and 120% FPL. Medicaid pays SLMB beneficiaries' Medicare Part B premiums. The third level is for a Qualified Individual (QI). In general, to qualify as a QI, a Medicare recipient must have family income between 120% FPL and 135% FPL. Medicaid pays QI beneficiaries' Medicare Part B premiums, subject to an annual federal funding cap. Finally, the fourth level is a Qualified Disabled and Working Individual (QDWI). In general, to qualify as a QDWI, an individual must have lost Medicare Part A benefits due to losing eligibility for disability benefits under Title II of the Social Security Act following a return to work, but be eligible to purchase Medicare Part A benefits by paying premiums, have family income not exceeding 200% FPL, and assets that do not exceed twice the limit for SSI. Medicaid pays QDWI beneficiaries' Medicare Part A premiums.

Ohio's caseload for Medicare premium assistance in FY 2016 was 122,033.

**Family planning services**

Another limited benefit category offered by Ohio Medicaid from January 8, 2012, to January 1, 2016, was family planning services. These services were offered to men and women of childbearing age with incomes under 200% FPL. Ohio's caseload under this program in FY 2016 was 9,026.

**DELIVERY SYSTEMS**

**Fee-for-service and managed care**

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

A managed care organization (MCO) 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.

Other than MCO and PCCM, federal managed care regulations recognize two other types of managed care entities. First, a Prepaid Inpatient Health Plan (PIHP), which provides limited benefits that include inpatient hospital or institutional services. For example, such a plan may be used for mental health services. Second, a Prepaid Ambulatory Health Plan (PAHP), which provides limited benefits that do not include inpatient hospital or institutional services. For example, such a plan may be used to provide dental or transportation services.

**Federal authority to implement managed care delivery systems**

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

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

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

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

**Demonstration models of care delivery**

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

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

**Medicare Shared Savings Program (MSSP)**

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 granted the HHS Secretary discretion to include electronic health record and electronic prescribing requirements in the MSSP.
**Patient-centered medical homes**

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

**State option to provide Health Homes for enrollees with chronic conditions**

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

**Hospital Readmissions Reduction Program (HRRP)**

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**

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

H.B. 66 of the 126th General Assembly required MCPs be implemented in all counties and required ODJFS to enroll the CFC population in MCPs. H.B. 66 also required ODJFS to implement the MCPs for certain aged, blind, and disabled Medicaid recipients in all counties. 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.

H.B. 153 of the 129th General Assembly further expanded MCP coverage to an even broader population by requiring Ohio Medicaid (1) to implement Health Homes, under which Medicaid recipients with chronic conditions are provided with coordinated care, (2) 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 coordinates the delivery of Medicare and Medicaid services for participating dual eligibles.
Managed care in Ohio has grown in the last decade, which has dramatically shifted expenditures from fee-for-service to managed care. The structure of the managed care rollout evolved from voluntary enrollment to mandatory enrollment. Now, most Medicaid recipients are required to enroll in managed care. Generally, nondual recipients who are on waivers or institutionalized, still are served on a fee-for-service basis. However, some recipients, such as individuals on developmental disabilities waivers may enroll in managed care on a voluntary basis. The following chart shows that 80.4% of Ohio’s Medicaid caseload for FY 2016 was in managed care, while 19.6% was in fee-for-service. It should also be noted, that the fee-for-service caseload includes new enrollees who are in the process of choosing and becoming enrolled in a managed care plan.

**Ohio Medicaid Caseload by Delivery System, FY 2016**

<table>
<thead>
<tr>
<th>Delivery System</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managed care</td>
<td>80.4%</td>
</tr>
<tr>
<td>Fee-for-service</td>
<td>19.6%</td>
</tr>
</tbody>
</table>

**Ohio Comprehensive Primary Care (CPC)**

Starting in 2017, a portion of the managed care population will be enrolled in the Ohio Comprehensive Primary Care (CPC) Program. CPC is a team-based care delivery model led by a primary care practice that comprehensively manages a patient’s health needs. Practices that participate in CPC will receive a per member per month payment to support activities required by the program as well as a shared savings payment to reward practices for achieving total cost of care savings.

**Program of All-Inclusive Care for the Elderly**

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

Currently, ODA administers PACE; however, funding for services is provided by ODM. In FY 2016, PACE served an average of approximately 400 consumers per month. The monthly capitated rate in FY 2016 and FY 2017 was $2,394 for dual and $3,553 for individuals enrolled only in Medicaid.

**MEDICAID BENEFITS**

**Federal benefit criteria**

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

Three important Medicaid benefits are the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program, long-term care services, and prescription drug coverage. These are described below.

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

EPSDT, known as Healthchek in Ohio, is a federally mandated program established to ensure Medicaid recipients under age 21 have access to periodic preventive care examinations and medically necessary treatment. The purpose of Healthchek is to discover and treat health problems as early as possible to prevent them from progressing. It requires state Medicaid programs to provide for any medical service a physician determines is needed for a Medicaid-eligible child. Under this program, children covered by Medicaid receive all the basic medical services such as well-child visits, immunizations, dental, hearing, and other screening services. 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.

**Long-term care**

Medicaid long-term care includes comprehensive services provided in institutions, such as a nursing home or an intermediate care facility for individuals with intellectual disabilities (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 of nursing home care in Ohio, accounting for almost 70% of all nursing home costs.

**Prescription drugs**

Prescription drugs often provide an alternative to expensive surgery, shorten hospital stays, and prevent illness, and can be vital for persons with chronic conditions or disabilities and the elderly. Therefore, although prescription drugs are an optional benefit under federal law, they are covered in all state Medicaid programs. Since prescription drugs can be expensive, the federal government has a number of regulations attempting to control the cost of this benefit.

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 actual acquisition costs. States are allowed to pay pharmacists a reasonable professional dispensing fee to cover pharmacy overhead and profit. Federal and state governments have also negotiated rebates with drug manufacturers to decrease the cost of this benefit.

**Ohio Medicaid benefits**

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

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

Optional services

- Prescription drugs
- Dental care
- Vision services, including eyeglasses
- Chiropractor
- Occupational therapy
- Physical therapy
- Podiatrist services
- Private duty nurse
- Speech/language pathology
- Alcohol and drug addiction services, including screening, counseling, medication-assisted treatment, case management
- Mental health services
- Medical equipment
- Health Home
- ICF/IID
- Hospice
- Ambulance/ambulette transportation

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.

**Nursing facility payment rate**

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

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

\[
\text{Regular total Medicaid payment rate} = \text{rate for direct care costs} + \text{rate for ancillary and support costs} + \text{rate for capital costs} + \text{rate for tax costs} + \$16.44 \text{ (quality add-on)} - \$1.79 \text{ (quality deduction)} + \text{quality payment} + \text{critical access incentive payment}
\]

**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%.

**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 resident, regardless of payment source. A nursing facility’s semiannual case-mix score is

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16 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.
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 payment**
ODM is required to use all of the funds made available by the $1.79 reduction to determine the amount of each nursing facility’s quality payment. To qualify for a quality payment, a nursing facility must meet at least one of five quality indicators. The largest quality payment is to be paid to nursing facilities that meet all of the quality indicators for the measurement period.

**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.

**Rebase nursing facility rates with a grouper update**
In FY 2017, ODM began to rebase the prices for rates paid using calendar year 2013 cost reports. This is the first rebasing since the price-based model was put in place in FY 2006. Additionally, ODM updated its resource utilization group (RUG) methodology fused to measure resident acuity. The relative weights for the acuity groups were also updated to reflect current wage rates in Ohio. Prior to these changes, ODM determined a facility specific rate for each nursing facility using prices established for each peer group and made adjustments (as stated in above section titled "Nursing facility payment rate") for changes in resident acuity. The prices were based on the calendar year 2003 nursing facility cost reports filed with ODM. Rates were adjusted semiannually using a case-mix score for Medicaid eligible residents.

**Low resource utilization residents**
H.B. 153 and H.B. 303 of 129th General Assembly established an exception to the Medicaid payment rate for services provided to low resource utilization residents, by setting the rate for these services at $130 per Medicaid day. 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.
Nursing facility alternative purchasing model

Effective February 1, 2017, ODM implemented an alternative payment system for ventilator-dependent nursing home patients to increase access to care for those individuals by reimbursing nursing facility providers for the higher costs associated with caring for them. The enhanced payment rate is approximately $640 per Medicaid day for nursing facilities that provide services to ventilator-dependent individuals and that meet the criteria and conditions to participate in ODM's alternative purchasing model for the provision of services to ventilator-dependent individuals.

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 graduate medical education.

Ohio prescription drug coverage

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

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

**Home and community-based service waivers**

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

There are several waivers within Ohio Medicaid. ODM currently administers the Ohio Home Care Waiver (OHCW). The Ohio Department of Aging (ODA) manages the PASSPORT and Assisted Living waivers. ODODD manages the Level One Waiver, Individual Options Waiver, Self-Empowered Life Funding (SELF) Waiver, and the Transitions Developmental Disabilities (DD) Waiver. In addition, MyCare Ohio enrollees are eligible to receive HCBS waiver services. Together these waivers provided alternative access to long-term care to more than 90,000 individuals.

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:
   a. Intermediate level of care includes a need for assistance with ADLs, medication administration, and/or a need for at least one skilled nursing or skilled rehabilitation service; and
   b. Skilled level of care indicates a higher level of need than the Intermediate and ICF/IID levels of care and includes a presence of an unstable medical condition and a need for a specific amount of skilled nursing or skilled rehabilitation services.

ODM's "Ohio Medicaid Waiver Comparison Chart – Enrollment Figures for December 2016 (SFY17)" provides a summary of these waiver programs. Their basic descriptions are provided below followed by a table showing enrollment and costs as of December 2016.

**Assisted Living Waiver**

This waiver is administered by ODA and is for adults age 21 or older who need a nursing facility level of care. The waiver offers assisted living and, for nursing home residents, community transition services.

**PASSPORT**

This waiver is also administered by ODA. It is for adults age 60 or older who need a nursing facility level of care. The waiver offers the following services:

- Adult day health services
- Alternative meal services
- 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 and personal care
• Enhanced community living

**Level One Waiver**

This waiver is administered by ODODD and is for individuals of all ages who require an ICF/IID level of care. The waiver offers the following services:

- Habilitation (adult day support and vocational)
- Environmental accessibility and adaptations
- Homemaker/personal care
- Home-delivered meals
- Personal emergency response system
- Respite – informal
- Respite – community

**Individual Options Waiver**

This waiver is administered by ODODD and is for individuals of all ages who require an ICF/IID level of care. The waiver offers the following services:

- Waiver nursing
- Transportation
- Community and residential respite
- Adult day support
- Adult family living
- Adult foster care
- Environmental accessibility modifications
- Homemaker/personal care

- Waiver nursing
- Pest control

- Residential respite
- Specialized medical equipment and supplies
- Remote monitoring and equipment
- Supported employment
- Transportation
- Nonmedical transportation

- Adaptive and assistive equipment
- Remote monitoring and equipment
- Vocational habilitation
- Supported employment (community and enclave)
- Social work
- Interpreter
- Home-delivered meals
• Nonmedical transportation

**Self-Empowered Life Funding (SELF) Waiver**

This waiver is administered by ODODD and is for individuals of all ages who require an ICF/IID level of care. The state funds 100 SELF waivers that are reserved for children with intensive behavioral needs. This waiver follows a participant-directed model with cost limitations of $25,000/year for children (under age 22) and $40,000/year for adults. The waiver offers the following services:

- 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 and equipment

**Ohio Home Care Waiver (OHCW)**

This waiver is administered by ODM. It is for adults under the age of 60 who need a nursing facility level of care. The waiver offers the following services:

- 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
**Transitions Developmental Disabilities (DD) Waiver**

This waiver is administered by ODODD and is available for individuals enrolled in OHCW whose level of care is determined to be an ICF/IID level. The waiver offers the following services:

- 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

**MyCare Ohio**

This waiver is administered by ODM by contracting with managed care plans to offer services. It is for individuals age 18 and over who are eligible for both Medicare and Medicaid (dual eligibles). Through FY 2017, MyCare is a demonstration project that is available only in certain counties. The waiver offers the following services:

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

#### Federal restrictions on cost sharing

The federal government limits patient cost sharing, such as premiums, copayments, and deductibles. Out of pocket costs cannot be imposed for emergency services, family planning services, pregnancy-related services, or preventive services for children. Additionally, certain vulnerable populations are exempt from most out of pocket costs. These groups include children, individuals living in an institution, and individuals who are terminally ill and receiving hospice care. Most nonexempt populations and services are restricted to only nominal out of pocket costs. Furthermore, generally services cannot be withheld from Medicaid enrollees for failure to pay their out of pocket costs. In some cases, enrollees with income above 100% FPL may be charged alternative out of pocket costs that are higher than a state’s nominal charges, but they cannot be more than 5% of income. Medicaid enrollees subject to alternative out of pocket costs also may be denied services for nonpayment.

#### States' use of premiums and cost sharing

A survey by the Kaiser Family Foundation found that, as of January 2017, 30 states charge premiums or enrollment fees and 25 states charge cost sharing for children in Medicaid or SCHIP. A majority of these charges are limited to children in SCHIP, because SCHIP covers children with higher family incomes than those in Medicaid and the program has different premium and cost-sharing rules. Most states do not charge adults premiums because of their low incomes. Overall, 39 states charge parents cost sharing, and 23 of the 32 states that have ACA expansion charge cost sharing for

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expansion adults. Six states have received waivers to charge premiums or monthly contributions for adults that are not otherwise allowed under law.

**Cost sharing in Ohio**

**Ohio Medicaid copayments**

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

<table>
<thead>
<tr>
<th>Services</th>
<th>Copayments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nonemergency services obtained in a hospital emergency room</td>
<td>$3 per visit</td>
</tr>
<tr>
<td>Dental services</td>
<td>$3 per visit</td>
</tr>
<tr>
<td>Routine eye examinations</td>
<td>$2 per examination</td>
</tr>
<tr>
<td>Eyeglasses</td>
<td>$1 per fitting</td>
</tr>
<tr>
<td>Most brand name (nongeneric) medications</td>
<td>$2 per prescription or refill</td>
</tr>
<tr>
<td>Medications that require prior authorization</td>
<td>$3 per prescription or refill</td>
</tr>
</tbody>
</table>

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

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

**Ohio Medicaid premiums**

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

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

Federal restrictions on provider taxes

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

- Requires provider taxes be "broad-based" and uniformly applied to all providers within specified classes of providers – in other words, states cannot limit the provider taxes only to Medicaid providers; the same tax has to be imposed on all providers within a specified class of providers.

- Prohibits taxes that exceed 25% of the state (or nonfederal) share of Medicaid expenditures.

- Prohibits states from a direct or indirect guarantee that providers receive their money back or be held harmless. However, states can avoid scrutiny under this provision as long as the provider tax is less than 6% of the taxpayer’s net operating revenue.

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

- Inpatient hospital services
- 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 managed care organizations
- 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
- Other health care items or services for which the state has enacted a licensing or certification fee.

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

**Ohio’s Medicaid provider taxes**

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

**Nursing facility franchise permit fees**

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

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

Total revenue from the fee was about $396.7 million in FY 2016.
ICF/IID franchise permit fees

ICFs/IID, including developmental centers operated by ODODD, are charged a franchise permit fee per bed per day. The rate is generally set in the main operating appropriations bill. H.B. 64 of the 131st General Assembly set the rate for the franchise permit fee charged ICFs/IID at $18.07 for FY 2016 and $18.02 for FY 2017. The revenue generated by the fee was $42.5 million in FY 2016.

Hospital care assessments

ODM charges hospitals an annual assessment equal to a percentage of the hospital’s total facility costs. A hospital's total facility costs are the hospital’s total costs for all care provided to all patients, including the direct, indirect, and overhead costs to the hospital of all services, supplies, equipment, and capital related to the care of patients, regardless of whether patients are enrolled in a health insuring corporation. However, total facility costs exclude all of the following costs: Medicare costs, skilled nursing services provided in distinct-part nursing facility units, home health services, hospice services, ambulance services, renting durable medical equipment, and selling durable medical equipment. The hospital assessment rate is generally set in the main operating appropriations bill. H.B. 64 of the 131st General Assembly maintained the rate of about 2.65% in FY 2016 and FY 2017. The revenue generated by the assessment in FY 2016 was $574.3 million.

Managed care assessments

Currently, the state subjects Medicaid managed care organizations to the sales and use tax. The total tax rate is about 7.05% (5.75% state sales tax and 1.3% average local sales 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. The tax generates over $900 million in state taxes and $200 million in local taxes. However, CMS determined that Ohio’s Medicaid managed care sales tax is not a permissible taxing method for drawing down Medicaid matching funds from the federal government, since non-Medicaid health insuring corporations are not subject to it. CMS prohibits the tax being used to draw down federal reimbursement as of July 2017. Ohio received an approval letter from CMS on December 7, 2016, permitting it to charge a tax on all health insuring corporations (HICs) with a tax rate ranging from $26 to $56 per Medicaid member month; and $1 to $2 per non-Medicaid member month. H.B. 49 of the 132nd General Assembly, As Introduced, proposes to replace the sales tax with this new HIC tax.
ADDITIONAL MEDICAID PROGRAMS

Hospital Care Assurance Program

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

Medicare Part D clawback payments

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

Pharmacy benefits under Medicare Part D

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

Phased-down state contribution (clawback)

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

\[
\text{Payment} = \left( \frac{\text{PCE}}{12} \right) \times \text{DE} \times \text{P%}
\]
**Per capita expenditures (PCE)**

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

**Dual eligibles (DE)**

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

**Phase-down percentage (P%)**

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

For example, if, in January 2016, Ohio had 207,000 dual eligibles enrolled in Part D plans, and if the average monthly per capita Medicaid spending for prescription drugs for dual eligibles was $119, then Ohio's clawback payment amount for the month would be $18.5 million.

\[
$18.5 \text{ million} = $119 \times 207,000 \times 75\%
\]

**SUMMARY**

Expenditures for Ohio's Medicaid Program totaled $25.29 billion in FY 2016, of which 69.3% ($17.54 billion) was funded by the federal government. The following table breaks down FY 2016 expenditures by payment category. Managed care for the CFC and ABD populations was the largest expense at $9.91 billion, followed by managed care for the Group VIII population at $3.83 billion. Together expenditures on managed care accounted for 54.3% of the total. Services provided through ODODD totaled $2.32 billion (9.2%). Combined with ODA waivers and the Home Care waiver administered by ODM, waiver costs were 10.9% of the total. Administration at $837.3 million made up just 3.3% of total expenditures in FY 2016.
## Medicaid Expenditures by Payment Category, FY 2016

($ in thousands)

<table>
<thead>
<tr>
<th>Payment Category</th>
<th>Expenditure</th>
<th>Percentage of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managed Care – CFC and ABD</td>
<td>$9,911,253</td>
<td>39.2%</td>
</tr>
<tr>
<td>Managed Care – Group VIII</td>
<td>$3,832,435</td>
<td>15.2%</td>
</tr>
<tr>
<td>Hospitals</td>
<td>$2,858,358</td>
<td>11.3%</td>
</tr>
<tr>
<td>Nursing Facilities</td>
<td>$1,397,804</td>
<td>5.5%</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>$1,078,279</td>
<td>4.3%</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>$468,245</td>
<td>1.9%</td>
</tr>
<tr>
<td>Physicians</td>
<td>$259,666</td>
<td>1.0%</td>
</tr>
<tr>
<td>Other Services</td>
<td>$1,106,915</td>
<td>4.4%</td>
</tr>
<tr>
<td>ODA Waivers</td>
<td>$2,319,676</td>
<td>9.2%</td>
</tr>
<tr>
<td>Home Care Waivers</td>
<td>$126,074</td>
<td>0.5%</td>
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<tr>
<td>Medicare Premium Assistance</td>
<td>$472,877</td>
<td>1.9%</td>
</tr>
<tr>
<td>Medicare Part D</td>
<td>$305,634</td>
<td>1.2%</td>
</tr>
<tr>
<td>Administration</td>
<td>$837,318</td>
<td>3.3%</td>
</tr>
<tr>
<td><strong>Total All Funds</strong></td>
<td><strong>$25,293,850</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>