LSC Greenbook

Analysis of the Enacted Budget

Department of Medicaid

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Legislative Service Commission

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ATTACHMENT:

Budget Spreadsheet By Line Item

Department of Medicaid

- Establishes a cabinet-level Medicaid agency
- Funding of $22.2 billion in FY 2014 and $23.4 billion in FY 2015 for Medicaid for all agencies
- Provisions to prohibit the Medicaid Program from covering the expansion group under ACA vetoed

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 as many as 2.3 million low-income parents, 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 $19 billion in combined federal and state dollars in FY 2013. Medicaid accounts for 4% of Ohio's economy. Medicaid services are an entitlement for those who meet eligibility requirements. Entitlement means that if an individual is eligible for the program then they are guaranteed the benefits and the state is obligated to pay for 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 5;
- 625,000 low-income parents and expectant mothers;
- 165,000 senior citizens;
- 58,000 individuals residing in nursing facilities; and
- 80,000 individuals in home and community-based waivers.

On January 13, 2011, the Governor created the Office of Health Transformation (OHT) to streamline the Medicaid Program and improve the overall quality of the health care system. In Ohio, Medicaid was administered by the Office of Medical

Assistance (OMA) 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.

H.B. 487 of the 129th General Assembly created the OMA as a work unit within the Ohio Department of Job and Family Services (ODJFS) and transferred the legal authority for the Medicaid Program from the ODJFS Director to the OMA Director. H.B. 59 further creates the Ohio Department of Medicaid (ODM) and makes the Medicaid Director (OMA Director) the executive head of ODM. H.B. 59 gives ODM and the ODM Director many of the same types of responsibilities and authorities as ODJFS and the ODJFS Director regarding administrative and program matters. The federal government requires each state to designate a "single state agency" to administer its Medicaid Program. ODM will be 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 states' single agency to contract with other public and private entities to manage aspects of the program. ODM 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).

H.B. 59 merges the Ohio Department of Mental Health (ODMH) and the Ohio Department of Alcohol and Drug Addiction Services (ODADAS), and creates the Ohio Department of Mental Health and Addiction Services (ODMHAS), effective July 1, 2013.

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 four 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 53 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. These activities are done utilizing a common statewide data system known as the Client Registry Information System – Enhanced (CRIS-E). ODM provides technical assistance to counties and assists them to implement eligibility policy.

In H.B. 153 of the 129th General Assembly (the FY 2012-FY 2013 biennial budget act), funding for Medicaid services in ODA, ODMH, and ODADAS were consolidated into the ODJFS budget. In addition, ICFs/IID and the Transitions DD waiver program, which provides home and community-based services to certain individuals with developmental disabilities, were moved from OMA to ODODD in FY 2013.

Prior to the consolidation and program transfer, Medicaid accounted for a significant share of spending in ODA, about 83%; ODADAS, about 28%; ODMH, about 61%; ODODD, about 91%; and ODJFS, about 73%.

H.B. 59 restructures Medicaid-related appropriation line items (ALIs) to capture all Medicaid spending across all agencies. It removes non-Medicaid spending from Medicaid lines. It also splits services from administration and support.

The budget provides a total appropriation for the Medicaid Program of $22.22 billion in FY 2014, and $23.43 billion in FY 2015. Table 1 below, first shows the total Medicaid appropriation by agency. Table 2 then shows the appropriation for Medicaid service spending by agency. Lastly, Table 3 shows the appropriation for Medicaid administration by agency.

Table 1. Appropriations for Medicaid Services and Administration (Am. Sub. H.B. 59) All Funds by Agency		
Ohio Department	**FY 2014**	**FY 2015**
Medicaid*	$19,584,906,287	$20,644,470,773
Developmental Disabilities	$2,386,296,199	$2,547,436,657
Job and Family Services	$196,914,446	$196,914,446
Health	$24,426,014	$25,692,094
Mental Health and Addiction Services	$16,727,553	$8,736,600
Aging	$6,770,114	$6,770,114
Office of Health Transformation	$923,209	$937,294
TOTAL	**$22,216,963,822**	**$23,430,957,978**

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

Table 2. Appropriations for Medicaid Services (Am. Sub. H.B. 59) All Funds by Agency		
Ohio Department	**FY 2014**	**FY 2015**
Medicaid*	$18,646,974,747	$19,831,212,187
Developmental Disabilities	$2,317,135,390	$2,477,348,326
Job and Family Services	$0	$0
Health	$0	$0
Mental Health and Addiction Services	$5,000,000	$0
Aging	$0	$0
Office of Health Transformation	$0	$0
TOTAL	**$20,969,110,137**	**$22,308,560,513**

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

Table 3. Appropriations for Medicaid Administration (Am. Sub. H.B. 59) All Funds by Agency		
Ohio Department	**FY 2014**	**FY 2015**
Medicaid	$937,931,540	$813,258,586
Developmental Disabilities	$69,160,809	$70,088,331
Job and Family Services	$196,914,446	$196,914,446
Health	$24,426,014	$25,692,094
Mental Health and Addiction Services	$11,727,553	$8,736,600
Aging	$6,770,114	$6,770,114
Office of Health Transformation	$923,209	$937,294
TOTAL	**$1,247,853,685**	**$1,122,397,465**

The tables above show that the appropriations for Medicaid service expenditures make up a majority of the funding for the Medicaid Program, for the biennium at 94.8%, while approximately 5.2% of Medicaid's budget is for the Medicaid-related administrative activities.

Table 4 below shows the appropriations for Medicaid funding for all agencies by fund group.

Table 4. Medicaid Appropriations by Fund Group

Fund Group	FY 2014	FY 2015
General Revenue	$14,701,622,822	$15,614,891,819
Federal Share	*$8,961,692,337*	*$9,502,550,748*
State Share	*$5,739,930,485*	*$6,112,341,071*
General Services	$472,314,317	$524,114,317
State Special Revenue	$1,669,897,219	$1,713,597,989
Federal Special Revenue	$5,344,043,979	$5,549,268,368
Holding Account	$1,000,000	$1,000,000
Locals – ODJFS & ODM*	$28,085,486	$28,085,486
TOTAL	**$22,216,963,823**	**$23,430,957,979**

*ODM passes through the federal reimbursement to local providers under the Medicaid School Program.

General Revenue Fund (GRF) appropriations account for the largest portion (66%) of the budget funding for the Medicaid Program. About 61% of the GRF funding is federal Medicaid reimbursement. Federal funds account for the next largest share of recommended funding at 24%. Federal funds include the federal reimbursement for Medicaid services and administrative activities that are spent out of non-GRF line items.

State Special Revenue funds and General Services funds together account for 9% of the recommended funding. These funds mainly include the following:

- Revenue generated from the hospital assessments;
- Revenue generated from the 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 the third-party liability.

Table 5 below provides estimates of the revenue that the state is expected to collect for the various provider types.

Table 5. Estimated Franchise Fee Revenue (Dollars in millions)		
Provider Type	**FY 2014**	**FY 2015**
Hospital	$524	$524
Nursing Facility	$398	$398
ICF/IID	$47	$45
TOTAL	**$969**	**$967**

Table 6 below shows the budget using the various franchise fee revenue and the corresponding 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.

Please note that the total appropriation amount in the line items associated with a particular type of franchise fee revenue may not be exactly the same amount as the estimated revenue collected. If the appropriation is greater than the amount the franchise fee can generate, the agencies can spend only up to the amount that will be collected.

Table 6. Franchise Fee Revenue and the Corresponding Federal Share by ALIs (Dollars in millions)				
Fund	**ALIs**	**State or Federal Share**	**FY 2014**	**FY 2015**
5GF0	651656	State	$531	$531
3F00	651623	Federal	$911	$905
	Hospital Total		**$1,442**	**$1,437**
5R20	651608	State	$398	$398
3F00	651623	Federal	$682	$678
	NF Total		**$1,080**	**$1,076**
5GE0	320606	State	$7	$7
5GE1	653606	State	$40	$39
3G60	653639	Federal	$23	$22
3A40	653653	Federal	$46	$45
	ICF/IID Total		**$117**	**$113**
TOTAL			**$2,639**	**$2,626**
Assumed FMAP			**63.16%**	**63.02%**

Note: Numbers may not add up due to rounding.

Appropriation line item (ALI) 320606, Operating and Services, is not used for Medicaid-related services or activities, and thus does not receive federal reimbursement for its expenditures.

Table 7 below shows the appropriations for the Medicaid Program by ALI for all agencies. To avoid double counting, the appropriation for line item 651655, Medicaid Interagency Pass-Through, is not included in the total line.

Table 7. Appropriations by Line Item for All Agencies

CAS	FND	ALI	ALI Title	FY 2014	FY 2015
AGE	GRF	656423	Long-Term Care Program Support – State	$3,385,057	$3,385,057
AGE	3C40	656623	Long-Term Care Program Support – Federal	$3,385,057	$3,385,057
DDD	GRF	653321	Medicaid Program Support – State	$6,186,694	$6,186,694
DDD	GRF	653407	Medicaid Services	$430,056,111	$437,574,237
DDD	3A40	653604	DC & ICF/IID Program Support	$8,013,611	$8,013,611
DDD	3A40	653605	DC and Residential Services and Support	$159,548,565	$159,548,565
DDD	3A40	653653	ICF/IID	$354,712,840	$353,895,717
DDD	3G60	653639	Medicaid Waiver Services	$932,073,249	$1,025,921,683
DDD	3G60	653640	Medicaid Waiver Program Support	$36,934,303	$36,170,872
DDD	3M70	653650	CAFS Medicaid	$3,000,000	$3,000,000
DDD	1520	653609	DC and Residential Operating Services	$3,414,317	$3,414,317
DDD	4890	653632	DC Direct Care Services	$16,497,169	$16,497,169
DDD	5CT0	653607	Intensive Behavioral Needs	$1,000,000	$1,000,000
DDD	5DJ0	653626	Targeted Case Management Services	$91,740,000	$100,910,000
DDD	5EV0	653627	Medicaid Program Support	$685,000	$685,000
DDD	5GE0	653606	ICF/IID and Waiver Match	$40,353,139	$39,106,638
DDD	5S20	653622	Medicaid Admin and Oversight	$17,341,201	$19,032,154
DDD	5Z10	653624	County Board Waiver Match	$284,740,000	$336,480,000
DOH	GRF	654453	Medicaid - HC Quality Assurance	$3,300,000	$3,300,000
DOH	3GD0	654601	Medicaid Program Support	$21,126,014	$22,392,094
JFS	GRF	655522	Medicaid Program Support – Local	$38,267,970	$38,267,970
JFS	GRF	655523	Medicaid Program Support – Local Transportation	$30,680,495	$30,680,495
JFS	3F01	655624	Medicaid Program Support	$110,680,495	$110,680,495
MCD	GRF	651425	Medicaid Program Support – State	$177,071,199	$180,446,636
MCD	GRF	651525	Medicaid/Health Care Services	$13,701,114,114	$14,599,795,041
MCD	GRF	651526	Medicare Part D	$309,349,142	$313,020,518
MCD	R055	651644	Refunds and Reconciliations	$1,000,000	$1,000,000
MCD	3ER0	651603	Medicaid Health Information Technology	$123,074,778	$123,089,607
MCD	3F00	651623	Medicaid Services – Federal	$2,965,609,943	$3,196,808,545
MCD	3F00	651624	Medicaid Program Support – Federal	$565,046,401	$454,423,399
MCD	3FA0	651680	Health Care Grants – Federal	$45,400,000	$44,500,000
MCD	3G50	651655	Medicaid Interagency Pass-Through	$1,712,881,658	$1,895,403,348
MCD	5DL0	651639	Medicaid Services – Recoveries	$462,900,000	$514,700,000
MCD	5FX0	651638	Medicaid Services – Payment Withholding	$6,000,000	$6,000,000

Table 7. Appropriations by Line Item for All Agencies					
CAS	FND	ALI	ALI Title	FY 2014	FY 2015
MCD	5KW0	651612	Managed Care Performance Payments	$0	$0
MCD	4E30	651605	Resident Protection Fund	$2,878,319	$2,878,319
MCD	5AJ0	651631	Money Follows the Person	$5,555,000	$4,517,500
MCD	5GF0	651656	Medicaid Services – Hospitals/UPL	$531,273,601	$531,273,601
MCD	5KC0	651682	Health Care Grants – State	$10,000,000	$10,000,000
MCD	5R20	651608	Medicaid Services – Long Term	$398,000,000	$398,000,000
MCD	5U30	651654	Medicaid Program Support	$54,305,843	$37,903,126
MCD	6510	651649	Medicaid Services – HCAP	$215,527,947	$215,314,482
MHA	GRF	652507	Medicaid Support	$1,727,554	$1,736,600
MHA	3B10	652635	Community Medicaid Expansion – Service	$5,000,000	$0
MHA	3B10	652636	Community Medicaid Expansion – Support	$7,000,000	$7,000,000
MHA	3J80	652609	Medicaid Legacy Costs Support	$3,000,000	$0
OBM	GRF	042416	Office of Health Transformation	$484,486	$498,571
OBM	3C40	042606	Office of Health Transformation – Federal	$438,723	$438,723
			Local JFS	$17,285,486	$17,285,486
			Local MCD	$10,800,000	$10,800,000
Total Medicaid Funding (Excluding ALI 651655)				**$22,216,963,823**	**$23,430,957,979**

Major Medicaid Initiatives

- The Governor vetoed the provisions of the budget that prohibits the Medicaid Program from covering the expansion group under the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010. The Governor also vetoed the provisions of the budget that specify that the prohibition does not affect the Medicaid eligibility of any individual who begins to participate in the MetroHealth Care Plus Medicaid waiver program.
- Due to an ACA requirement, the budget includes $398.1 million in FY 2014 and $261.9 million in FY 2015 of GRF Medicaid appropriations to pay certain primary care physicians at the higher Medicare rate. The federal government will reimburse 100% of the increased costs.
- The budget transitions the Office of Medical Assistance within the Department of Job and Family Services to the Department of Medicaid to lead and improve efficiency of Ohio Medicaid. The budget assumes that various cost avoidance initiatives will reduce Medicaid costs by $345.3 million in FY 2014 ($127.6 million state share) and $514.4 million in FY 2015 ($190.2 million state share).
- The budget includes $357.5 million ($131.7 million state share) in FY 2014 and $449.3 million ($166.2 million state share) in FY 2015 for an Integrated Care Delivery System to provide coordinated care for 114,000 individuals who are eligible for both Medicare and Medicaid. Enrollment is to begin in FY 2014.

- The budget includes $83.3 million ($30.7 million state share) in FY 2014 and $176.7 million ($65.3 million state share) to continue a 5% rate add-on for hospital inpatient and outpatient services.
- The budget includes $7.2 million in each fiscal year in GRF appropriations and the corresponding federal shares for county departments of job and family services for costs related to transitioning to a new public assistance eligibility determination system.

Unless otherwise specified, the remainder of this Greenbook will focus on the Medicaid budget within ODM. For the Medicaid budget in other Medicaid agencies, please refer to each agency's specific Greenbook.

Agency Overview

H.B. 59 creates the Ohio Department of Medicaid (ODM) to administer Ohio's Medicaid Program. Ohio's Medicaid Program provides health care coverage to children, pregnant women, families, seniors, and people with disabilities who have limited income. Many of the people served by Medicaid obtain medical care at no cost; however, some must pay monthly premiums or 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.

Appropriations Overview

Appropriations by Fund Group

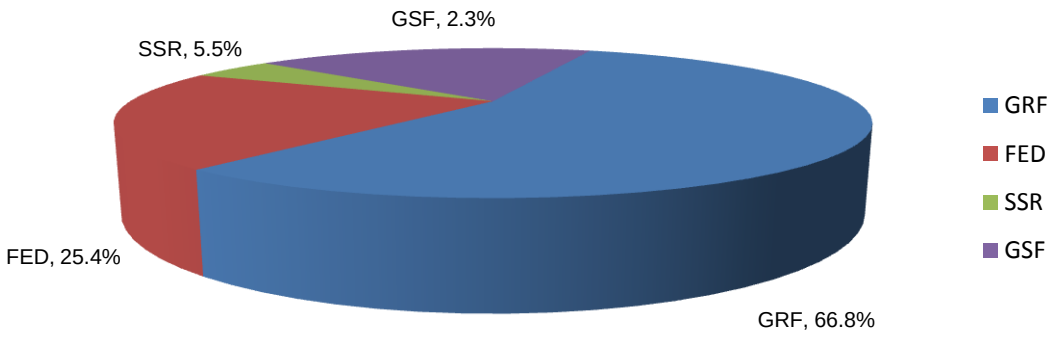
The budget provides a total appropriation for ODM of $21.29 billion in FY 2014 and $22.53 billion in FY 2015. Table 8 shows the appropriations by fund group.

Table 8. Appropriations by Fund Group, FY 2014-FY 2015 (Am. Sub. H.B. 59)

Fund Group	FY 2014	FY 2015	% Change
General Revenue	$14,187,534,455	$15,093,262,195	6%
General Services	$468,900,000	$520,700,000	11%
Federal Special Revenue	$5,412,012,780	$5,714,224,898	6%
State Special Revenue	$1,217,540,710	$1,199,887,028	-1%
Holding Account	$1,000,000	$1,000,000	0%
TOTAL	**$21,286,987,945**	**$22,529,074,121**	**6%**

Chart 1 presents the appropriations by fund group as well.

Chart 1: ODM Appropriations, FY 2014-FY 2015



As shown in the chart above, appropriations from the GRF make up a majority of the funding for ODM for the biennium at 66.8%. The GRF appropriations include the Medicare Part D clawback payments, and the state share for Medicaid service expenditures as well as the state share for administrative activities and computer projects related to Medicaid expenditures. The GRF appropriations also include the federal grant amounts (federal reimbursement) for Medicaid service expenditures.

Federal funds account for the next largest portion of funding for ODM at 25.4%, which include federal reimbursement from Medicaid payments for both service and administrative expenditures. The State Special Revenue Fund Group accounts for 5.5%, and General Services Fund Group represents 2.3%.

Appropriations by Expense Type

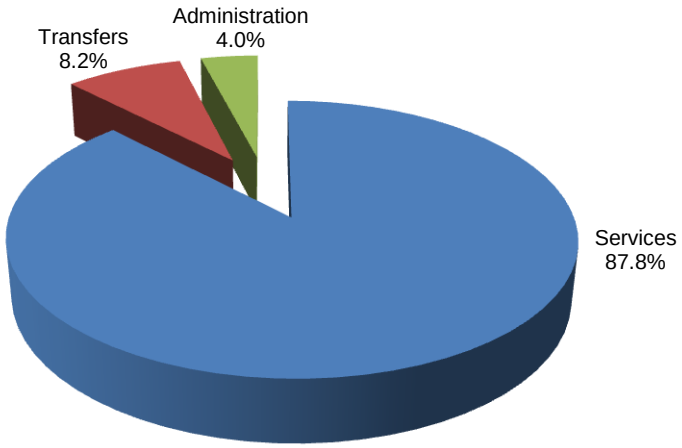
Table 9 shows the appropriations by expense type.

Table 9. ODM Appropriations by Expense Type

Expense Type	FY 2014	FY 2015
Services	$18,635,174,747	$19,819,412,187
Transfers to Other Agencies	$1,713,881,658	$1,896,403,348
Administrative	$937,931,540	$813,258,586
TOTAL	**$21,286,987,945**	**$22,529,074,121**

Chart 2 shows the appropriations by expense type as well. Approximately 88% of ODM's budget is paid out as subsidies to persons receiving Medicaid services.

Chart 2: ODM Appropriations, FY 2014-FY 2015



ODM will pass through approximately $3.61 billion of federal reimbursement over the biennium to ODODD for providing services to disabled Medicaid individuals and to other agencies including ODODD for their Medicaid administration. ODM will spend approximately $1.75 billion (4%) of its budget for the biennium for operating expenses including personal services, purchased services, maintenance, and equipment.

List of Acronyms

ABD – Aged, Blind, and Disabled
ACA – Patient Protection and Affordable Care Act
ACO – Accountable Care Organization
ARRA – American Recovery and Reinvestment Act of 2009
CBO – Congressional Budget Office
CDJFS – County Department of Job and Family Services
CFC – Covered Families and Children
CHIPRA – Children's Health Insurance Program Reauthorization Act of 2009
CMMI – Centers for Medicare and Medicaid Innovation
CMS – Centers for Medicare and Medicaid
CRIS-E –Client Registry Information System – Enhanced
DAS – Ohio Department of Administrative Services
DD – Developmental Disabilities
DRG – Diagnosis-Related Group
DSH – Disproportionate Share Hospital
DVS – Department of Veterans Services
eFMAP – Enhanced Federal Medical Assistance Percentage
EHR – Electronic Health Record
FFS – Fee for Service
FMAP – Federal Medical Assistance Percentage
FPG – Federal Poverty Guidelines
GME – Graduate Medical Education
HCAP – Hospital Care Assurance Program
HCBS – Home and Community-Based Services
HIC – Health Insuring Corporation
HIT – Health Information Technology
ICDS – Integrated Care Delivery System
ICF – Intermediate Care Facility
ICF/MR – Intermediate Care Facility for the Mentally Retarded
ICF/IID – Intermediate Care Facility for Individuals with Intellectual Disabilities
LTACH – Long-Term, Acute-Care Hospitals
MAC – Maximum Allowable Cost
MCO – Managed Care Organization
MCP – Managed Care Plan
MMA – Medicare Prescription Drug, Improvement, and Modernization Act
MMIS – Medicaid Management Information System
NF – Nursing Facility
OARRS – Ohio Automated Rx Reporting System
OBM – Ohio Office of Budget and Management

ODA – Ohio Department of Aging
ODADAS – Ohio Department of Alcohol and Drug Addiction Services
ODE – Ohio Department of Education
ODH – Ohio Department of Health
ODJFS – Ohio Department of Job and Family Services
ODMH – Ohio Department of Mental Health
ODODD – Ohio Department of Developmental Disabilities
OHP – Ohio Health Plans
PACE – Program of All-Inclusive Care for Elders
RAC – Recovery Audit Contractor
RFP – Request for Proposals
SCHIP – State Children's Health Insurance Program
SELF – Self-Empowered Life Funding
SPA – State Plan Amendment

Vetoed Provisions

Medicaid Expansion

H.B. 59 prohibits the Medicaid Program from covering the expansion group under the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010. The Governor vetoed this prohibition and the provisions of the budget that specify that the prohibition does not affect the Medicaid eligibility of any individual who begins to participate in the MetroHealth Care Plus Medicaid waiver program.

Nursing Facilities' Quality Bonuses

A qualifying nursing facility may receive a quality bonus for a fiscal year if the total amount budgeted for quality incentive payments for that fiscal year is not spent. H.B. 59 provides for a total of at least $30 million to be spent each fiscal year for quality bonuses. In addition, H.B. 59 provides that any amount budgeted for quality incentive payments for a fiscal year but not spent is to be added to the $30 million to determine the total amount to be spent on quality bonuses for that fiscal year. The Governor vetoed provisions of the budget that provides for a total of at least $30 million to be spent each fiscal year for quality bonuses.

Rates for Physician Groups Acting as Outpatient Hospital Clinics

The Governor vetoed provisions of the budget that requires the Medicaid payment rates for certain services provided by physician practice groups meeting requirements regarding hospital outpatient clinic services to be determined in accordance with an existing Medicaid rule. The Governor also vetoed the provision that requires ODM to report to the General Assembly on this provision within four years.

An existing administrative rule requires different Medicaid payment amounts (generally the regular Medicaid payment multiplied by 1.4) for physician group practices that meet both of the following criteria:

1. The physician group practice is physically attached to a hospital that does not provide physician clinic outpatient services and the hospital and physician group practice have signed a letter of agreement indicating that the physician group practice provides the outpatient hospital clinic service for that hospital;

2. The state Medicaid provider utilization summary for calendar year 1990 establishes that the physician group practice, in that year, provided at least 40% of the total number of Medicaid physician visits provided in the county in which the physician group practice is located and an aggregate total of at least 10% of the physician visits provided in the contiguous counties.

Eligibility Changes

Elimination and Alteration of Optional Eligibility Groups

Federal law establishes mandatory and optional eligibility groups for the Medicaid Program. A state's Medicaid program must cover all of the mandatory eligibility groups and may cover one or more of the optional eligibility groups. Previous state law included provisions providing for Medicaid to cover various groups.

H.B. 59 eliminates the provisions of law regarding eligibility groups that Medicaid may or must cover. Removal of these provisions from statute does not necessarily mean that the Medicaid Program will cease to cover any or all of the groups covered by the provisions. The bill includes a general provision that requires the Medicaid Program to cover all mandatory eligibility groups and all of the optional eligibility groups that state statutes require Medicaid to cover. The bill permits Medicaid to cover optional eligibility groups that state statutes expressly permit Medicaid to cover or do not address whether Medicaid may cover. Medicaid is prohibited from covering any eligibility group that state statutes prohibit Medicaid from covering.

The bill requires the Medicaid Program to cover the following optional eligibility groups: (1) employed individuals with disabilities and employed individuals with medically improved disabilities who qualify for the Medicaid Buy-In for Workers with Disabilities Program, (2) children placed with adoptive parents, (3) pregnant women with household incomes too high to qualify for Medicaid under a mandatory eligibility group but not exceeding 200% FPG, (4) children with household incomes too high to qualify for Medicaid under a mandatory eligibility group, (5) independent foster care adolescents, (6) women in need of treatment for breast or cervical cancer, (7) nonpregnant individuals who may receive family planning services and supplies, (8) pregnant women presumptively determined Medicaid eligible, (9) children presumptively determined Medicaid eligible, and (10) parents and caretaker relatives with household incomes not exceeding 90% FPG.

Transitional Medicaid

Federal law includes a provision for transitional Medicaid. The transitional Medicaid provision requires a state's Medicaid program to continue to cover certain low-income families with dependent children that would otherwise lose Medicaid eligibility because of changes to their incomes for an additional six months and, if certain requirements are met, up to another additional six months. The requirements for the second 6-month period of eligibility include reporting and income requirements. Federal law gives states the option to provide the low-income families transitional Medicaid for a single 12-month period rather than an initial 6-month period followed by a second 6-month period. The 12-month option enables the low-income families to

receive transitional Medicaid for up to a year without having to meet the additional requirements for the second 6-month period.

H.B. 59 requires the Medicaid Director to implement the single 12-month eligibility period for transitional Medicaid.

Medicaid Expansion

The federal health care reforms enacted in 2010, the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, include a major expansion of the Medicaid Program. As enacted, a state's Medicaid program is required to cover, beginning January 1, 2014, individuals who (1) are under age 65, (2) not pregnant, (3) not entitled to (or enrolled for) benefits under Medicare Part A, (4) not enrolled for benefits under Medicare Part B, (5) not otherwise eligible for Medicaid, and (6) have incomes not exceeding 133% FPG (138% after 5% income disregard and using individuals' modified adjusted gross incomes (MAGI)). However, although the federal health care reforms made the Medicaid expansion a mandatory eligibility group, the U.S. Supreme Court, in its 2012 ruling on the reforms, effectively made the expansion an optional eligibility group by prohibiting the U.S. Secretary of Health and Human Services from withholding all or part of a state's other federal Medicaid funds for failure to implement the expansion.

Based on an estimate by Mercer, the state's current contracted actuarial firm, if Ohio chooses to expand Medicaid, about 366,000 individuals will enroll, including 270,000 previously uninsured Ohioans. The total cost of services for this group is estimated to be $2.6 billion over the biennium, all of which will be paid by the federal government. In some cases, state and local governments will see savings result when Ohioans who are covered by other programs move onto Medicaid. For example, the Ohio Department of Rehabilitation and Correction estimates it will save $27 million over the biennium on inpatient hospital costs for prisoners, and the county community mental health and addiction services system is expected to save $105 million over the biennium on services that shift to Medicaid, primarily for adults who do not currently have access to coverage.

H.B. 59 prohibits the Medicaid Program from covering the expansion group. The Governor vetoed this prohibition and the provisions of the budget that specify that the prohibition does not affect the Medicaid eligibility of any individual who begins to participate in the MetroHealth Care Plus Medicaid waiver program.

FY 2014-FY 2015 Biennium New Initiatives with Budget Impact

Table 10 below provides a summary of the FY 2014-FY 2015 biennial budget initiatives assumed or included in H.B. 59 and the fiscal impact of each.[1] It also serves as a crosswalk to guide the reader to the corresponding brief summary for each of the initiatives. For example, as seen in the table, the summary for the first initiative listed, "MCP Rx 5% Adjustment," can be found under Initiative Number 1 below.

Table 10. FY 2014-FY 2015 Biennium New Initiatives with Budget Impact (Dollars in millions)

		FY 2014		FY 2015		Biennium	
Initiative Number	Initiatives	State Share	All Funds	State Share	All Funds	State Share	All Funds
1	MCP Rx 5% Adjustment	-$24.46	-$66.40	-$25.70	-$69.50	-$50.16	-$135.90
2	MCP Cap Growth at 3%	-$49.96	-$135.60	-$86.76	-$234.60	-$136.71	-$370.20
3	Reduce Hospital Readmissions by 25%	-$12.69	-$34.46	-$25.48	-$68.91	-$38.18	-$103.37
4	DRG Exempt Hospitals at 90%, No FFS Settlement	-$1.52	-$4.12	-$3.04	-$8.23	-$4.56	-$12.35
5	NF Peer Group Change	$6.28	$17.03	$8.40	$22.71	$14.68	$39.75
6	Adjust Rates for Aide and Nursing Services	$0.00	$0.00	$8.51	$23.00	$8.51	$23.00
7	Adult Day Care Rate Adjustment	$0.92	$2.50	$1.07	$2.90	$1.99	$5.40
8	Increase in Personal Needs Allowance	$0.59	$1.59	$1.76	$4.77	$2.35	$6.36
9	Daily Rate for Caregiver Living with Consumer	$0.00	$0.00	-$0.37	-$1.00	-$0.37	-$1.00
10	Shared Savings Initiative for Home Health	$0.00	$0.00	-$1.11	-$3.00	-$1.11	-$3.00
11	Reduce Holzer Payment	-$0.37	-$1.00	-$0.74	-$2.00	-$1.11	-$3.00
12	Specialty Pharmacy	$0.06	$0.20	-$1.85	-$5.00	-$1.79	-$4.80
13	Improved Utilization through E-Prescribing	$0.11	$0.30	-$0.92	-$2.50	-$0.81	-$2.20
14	Pricing Reduction for Radiology	-$0.62	-$1.68	-$1.24	-$3.36	-$1.86	-$5.04
15	Facility/Non-Facility Pricing for Physician Services	-$1.50	-$4.08	-$3.02	-$8.16	-$4.52	-$12.23
16	Part B Service Reduced to Medicaid Maximum	-$17.16	-$46.59	-$18.72	-$50.62	-$35.88	-$97.21
17	Part B Dialysis Clinics at Medicaid Maximum	-$6.32	-$17.15	-$8.46	-$22.87	-$14.78	-$40.02
18	On-Site Audits	-$0.18	-$0.50	-$0.37	-$1.00	-$0.55	-$1.50
19	Permedion Cost Avoidance Activities	-$0.74	-$2.00	-$1.48	-$4.00	-$2.22	-$6.00
20	Recovery Audit Contractor CGI	-$8.47	-$23.00	-$9.27	-$25.06	-$17.74	-$48.07
21	Permedion Hospital Payment Review	-$2.76	-$7.50	-$4.16	-$11.25	-$6.92	-$18.75

[1] Much of the information regarding the budget initiatives comes from the Office of Health Transformation's document, titled "SFY 2014-2015 Budget Initiatives."

1. MCP Rx 5% Adjustment

The FY 2014-FY 2015 biennium budget includes an initiative to provide Medicaid managed care plans with greater flexibility to manage pharmacy costs. The budget makes a 5% adjustment in the component of the managed care capitation rate that is driven by projected prescription drug costs. This initiative is expected to save $136 million ($50 million state share) over the biennium.

2. MCP Cap Growth at 3%

The budget includes a plan to hold the overall growth in capitation rate at 3% per year. This initiative is estimated to save $370 million ($137 million state share) over the biennium.

Generally, the managed care plan (MCP) capitation rates are set at the beginning of each calendar year. However, as a result of a lawsuit challenging the selection of plans for the new Medicaid managed care program, OMA contracted with Mercer to develop actuarially sound capitation rates for the January through June 2013 period. For the first half of 2013, the statewide capitation rate is $263.44 for covered families and children (CFC) and $1,457.57 for the aged, blind, and disabled (ABD).

3. Reduce Hospital Readmissions by 25%

The budget includes a plan to limit Medicaid payments to hospitals for readmissions within 30 days by establishing percentage-based benchmarks for readmission reductions. These readmission reductions will be 25% of total readmissions based on stays for all nonpsychiatric hospitals per fiscal year. Hospitals will be provided with a report that tracks their readmission rates over a seven-year period and will have the responsibility to implement hospital-developed approaches to reducing their readmission rates by 25%. Failure to achieve this will result in the state recovering 25% of the value of Medicaid payments to the hospital for readmissions from the base year. The base year will be the prior year's readmissions and payments for readmissions. If hospitals meet the benchmark each year, readmissions will be reduced by 44% in total and result in substantially fewer program payments for readmissions. This initiative is expected to save $103 million ($38 million state share) over the biennium.

ODM plans to incorporate "potentially preventable readmissions" and "potentially preventable complications" into the Diagnosis-Related Group (DRG) system in the future. These groupers use clinical information from historical claims to determine the appropriateness of paying a current claim if it is related to a readmission.

4. DRG Exempt Hospitals at 90%, No FFS Settlement

Ohio Medicaid currently reimburses hospital services provided by DRG exempt hospitals at 100% of cost, which is higher than what Medicaid pays for other inpatient hospital services through the DRG system. The budget includes a reduction of

reimbursement for DRG exempt hospitals to pay 90% of cost. The budget also includes the elimination of the fee-for-service cost settlement. This initiative is estimated to save $12 million ($5 million state share) over the biennium.

5. NF Peer Group Change

H.B. 59 for the purpose of determining the Medicaid payment rates for nursing facilities located in Mahoning and Stark counties for services provided during the period beginning October 1, 2013, and ending on the first day of the first rebasing of the rates, provides for the nursing facilities to be treated as if they were in the peer group that includes such urban counties as Cuyahoga, Franklin, and Montgomery. H.B. 59 also provides for nursing facilities located in Mahoning and Stark counties to be placed in the peer groups that include such urban counties as Cuyahoga, Franklin, and Montgomery when ODM first rebases nursing facilities' Medicaid payment rates.

In addition to the above peer group changes, the budget shifts the determination of the facility-specific leave day pricing percentage to a fiscal year to eliminate the need for retroactive adjustments; and extend the 5% rate boost to "critical access" nursing facilities in federally designated empowerment zones that meet minimum occupancy and Medicaid utilization requirements, but with an additional requirement that they earn the maximum quality incentive payment and at least one clinical quality point to qualify for the critical access rate add-on.

The budget maintains the current nursing facility rate structure and continues flat pricing for low-acuity individuals. The peer group change costs $40 million ($15 million state share) over the biennium and generates $4 million in franchise fee revenue.

6. Adjust Rates for Aide and Nursing Services

The budget increases aggregate spending for Medicaid aide and nursing services by 3% in FY 2015. The increase will take into account labor market data, education and licensure status of providers, whether providers are independent or home health agencies, and the length of time of service visits. This policy is estimated to cost $23.0 million ($8.5 million state share) over the biennium.

7. Adult Day Care Rate Adjustment

The budget increases the rate for adult day services by 20% for the PASSPORT and Choices programs. This rate increase will bring the rate to $49.47 for an enhanced full day and $64.94 for an intensive full day, which is the same rate provided under the Ohio Home Care Waiver. According to the OHT, Assisted Living rates are also increasing by 3% – $49.93 for the first tier, $59.95 for the second tier, and $69.96 for the third tier. The tiers correspond with the level of services an individual requires. The vast majority of Assisted Living participants are in the third tier. OHT anticipates these provisions to cost $5.4 million ($2.0 million state share) in each fiscal year.

8. Increase in Personal Needs Allowance

H.B. 59 increases the amount of the monthly Personal Needs Allowance (PNA) for Medicaid recipients residing in nursing facilities as follows:

1. For 2014, increases the amount to not less than $45 (from $40) for an individual and not less than $90 (from $80) for a married couple; and
2. For 2015 and each calendar year thereafter, increases the amount to not less than $50 for an individual and not less than $100 for a married couple.

A PNA is the amount of income nursing home residents with Medicaid coverage are allowed to keep for their own use for items not covered by Medicaid, such as clothing, personal items, and newspapers. The PNA has not been increased or adjusted since 1997.

The executive estimates that this provision will cost $6.4 million ($2.4 million state share) over the biennium.

9. Daily Rate for Caregiver Living with Consumer

H.B. 59 provides that a Medicaid recipient's spouse or, regarding a minor, the recipient's parent, foster caregiver, stepparent, guardian, legal custodian, or any other person who stands in loco parentis, is not eligible for Medicaid payments for providing the following services to the Medicaid recipient unless conditions specified by the ODM Director are met:

1. Nursing or home health aide services provided under the home health services benefit; and
2. Private duty nursing services.

The executive estimates that this provision will save $1.0 million ($370,000 state share) over the biennium.

10. Shared Savings Initiative for Home Health

H.B. 59 permits ODM to implement, for FY 2014 and FY 2015, a quality incentive program to reduce the use of emergency department services, as well as hospital and nursing facility admissions, by certain Medicaid recipients, when admissions and utilizations are avoidable.

The quality incentive program is to apply to individuals enrolled in a home and community-based services Medicaid waiver component administered by ODM, individuals receiving nursing or home health aide services available under the federal Medicaid home health services benefit, and individuals receiving private duty nursing services.

If ODM implements the quality incentive program, H.B. 59 requires that ODM establish methods to determine the program's actual savings to Medicaid. Moreover, if

the program is implemented, ODM must distribute not more than 50% of the savings to participating Medicaid providers.

The incentive program is estimated to save $6 million over the biennium. With 50% of the savings distributing back to providers participating in the incentive program, the net savings is estimated to be $3.0 million ($1.1 million state share) over the biennium.

11. Reduce Holzer Payment

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, with every new site receiving enhanced reimbursement.

H.B. 59 requires the Medicaid payment rates for certain services provided by physician practice groups meeting requirements regarding hospital outpatient clinic services to be determined in accordance with an existing Medicaid rule. The Governor vetoed this provision.

The budget thus includes elimination of the enhanced reimbursement rate for the Holzer Clinic Network and reverts payment to the standard Medicaid physician fee schedule beginning January 1, 2014. This initiative is estimated to save $3.0 million ($1.1 million state share) over the biennium.

12. Specialty Pharmacy

The budget includes a plan to add a pharmacist to Ohio Medicaid to monitor utilization and implement cost-containment strategies related to specialty pharmaceuticals, which include high-cost biological medications for serious chronic conditions such as hemophilia, cancer, and rheumatoid arthritis. The budget allows contracting with a limited number of pharmacies to ensure high-quality service and clinical support or implementing minimum standards that current participating specialty pharmacies must follow. This initiative is estimated to save $4.8 million ($1.8 million state share) over the biennium.

13. Improved Utilization through E-Prescribing

H.B. 59 replaces a provision authorizing establishment of an e-prescribing system for Medicaid with a provision authorizing the ODM Director to acquire or specify technologies to provide information regarding Medicaid recipient eligibility, claims history, and drug coverage to Medicaid providers through electronic health record and e-prescribing applications. It requires the following if the Director acquires or specifies

the technologies: (1) that the e-prescribing applications enable a Medicaid provider who is a prescriber to use an electronic system to prescribe a drug for a Medicaid recipient, and (2) that the technologies provide Medicaid providers with an up-to-date, clinically relevant drug information database and a system of electronically monitoring Medicaid recipients' medical history, drug regimen compliance, and fraud and abuse.

H.B. 59 also eliminates provisions requiring the following actions to be taken if a Medicaid e-prescribing system is established: (1) determine before the beginning of each fiscal year the ten Medicaid providers that issued the most prescriptions for Medicaid recipients receiving hospital services during the preceding calendar year and make certain notifications to those providers, and (2) seek the most federal financial participation available for the development and implementation of the system.

The executive estimates that these provisions will save $2.2 million ($814,000 million state share) over the biennium. The executive plans to contract with a private sector vendor to update connections between the Medicaid pharmacy claims system and eligibility files to e-prescribing applications.

14. Pricing Reduction for Radiology

H.B. 59 requires that the ODM Director, not earlier than January 1, 2014, reduce the Medicaid payment rate for a repeat radiological service provided in a physician's office or an independent diagnostic testing facility by specifying that the reduction is to be made when the service is provided more than once by the same provider for the same Medicaid recipient during the same session. The executive estimates that this provision will save $5.0 million ($1.9 million state share) over the biennium.

According to OHT, Ohio Medicaid currently reimburses imaging services the same amount, regardless of whether single or multiple procedures are performed at the same session. The cost of providing multiple procedures to the same patient at the same time is less than the cost of providing these same procedures individually at different times to different patients.

15. Facility/Non-Facility Pricing for Physician Services

H.B. 59 requires that the ODM Director, not earlier than January 1, 2014, establish varying payment rates for physician services based on the location of the services. The executive estimates that this provision will save $12.2 million ($4.5 million state share) over the biennium.

According to OHT, currently, Medicaid reimburses physicians, advanced practice nurses, and physician assistants the same amount for some services, regardless of where the service is delivered. The expenses actually incurred by the provider, however, vary depending on the site of the service. The provider bears the full practice expense for services performed in the office setting, but not in hospitals, ambulatory surgery centers, and nursing facilities – these facilities bill the practice expense

separately. Medicaid currently enforces "site differential payments" when some services are performed in a hospital. The executive plans to extend site differential pricing to a greater number of settings and a broader array of covered services, consistent with federal Medicare policy.

16. Part B Service Reduced to Medicaid Maximum

H.B. 59 requires that a Medicaid payment for noninstitutional services, excluding physician services and including freestanding dialysis center services, provided during the period beginning January 1, 2014, and ending July 1, 2015, to a Medicaid recipient who is a dual eligible individual enrolled for benefits under Medicare Part B, shall equal the lesser of the following:

1. The sum of the Medicare Part B deductible, coinsurance, and copayment for the services that are applicable to the individual;
2. The greater of the following:
   a. The maximum allowable Medicaid payment for the services when the services are provided to other Medicaid recipients, less the total Medicaid payment (if any) most recently paid on the Medicaid recipient's behalf for such services; and
   b. Zero.

The executive estimates that this provision will save $97.2 million ($35.9 million state share) from noninstitutional services and $40.0 million ($14.8 million state share) from dialysis clinics over the biennium.

For consumers enrolled in Medicaid and Medicare, states have the option to pay the patient's Medicare cost sharing amount (typically 20%) or reimburse up to the Medicaid maximum amount. Ohio has elected to reimburse up to the Medicaid maximum for institutional categories of services and for services paid by a Medicare Advantage plan. However, there is an exemption for dialysis clinics and noninstitutional providers. These providers are paid the full Medicare cost sharing, which can result in the provider being paid more than the Medicaid maximum amount. The executive plans to reimburse only up to the Medicaid maximum for all remaining Medicare Part B categories of service, not including physician services.

17. Part B Dialysis Clinics at Medicaid Maximum

As stated in the "Part B Service Reduced to Medicaid Maximum" initiative above, the state will save $40.0 million ($14.8 million state share) from dialysis clinics.

18. On-Site Audits

The budget includes a plan to add five full-time positions to the Medicaid audit team to perform additional on-site monitoring reviews and to ensure the state's new recovery audit contract is properly monitored and provider appeals are completed in a

timely manner. According to OHT, additional on-site monitoring of Medicaid providers will increase the amount of overpayments that Ohio Medicaid can recover, and is projected to save $1.5 million ($554,000 million state share) over the biennium.

19. Permedion Cost Avoidance Activities

Ohio Medicaid has contracted with Permedion to perform both pre- and post-payment review of hospital services, and provide technical advice to the Ohio Medicaid Program regarding coverage and utilization management policies. The executive is expecting to save an additional $19 million ($7 million state share) over the biennium under the hospital payment review. In addition to the hospital project, Permedion has identified other program integrity and cost-avoidance activities that are estimated to save an additional $6 million ($2.2 million state share) over the biennium.

Since 1985, Ohio Medicaid has contracted with Permedion to review, improve, and assure quality of care and appropriateness of services delivered to Ohio's Medicaid recipients. The contracted services include: precertification of inpatient and outpatient elective procedures, retrospective medical necessity review of hospital services, and focused quality and utilization improvement studies. These studies incorporate data collection and analysis, feedback sessions with providers, and development of strategies to improve care.

20. Recovery Audit Contractor CGI

The federal government requires states to contract with a recovery audit contractor (RAC) in order to identify overpayments and underpayments by the state Medicaid Program, and recoup overpayments. Ohio selected CGI in May 2011 to serve as Ohio's RAC. Based on projections provided by CGI, Medicaid expects to save $48 million ($18 million state share) over the biennium.

As required by the federal law, Ohio Medicaid has established a Surveillance and Utilization Review Section (SURS) to safeguard against unnecessary or inappropriate utilization of care and services and against excess payments. SURS identifies and collects overpayments made to Ohio Medicaid providers. SURS accomplishes this through data mining, medical record review, and provider audits. Ohio Medicaid also contracts for the regular review of a small percentage of inpatient hospital claims for a fixed fee. The federal Affordable Care Act (ACA) allows states to reimburse contractors who assist in the identification and recovery of improper payments on a contingency fee basis and mandates that states execute a contract with an RAC vendor for this program by April 1, 2011.

CGI, as the selected contractor, will augment work with Ohio Medicaid to detect and recover funds for improper Medicaid payments for the following:

- Hospital Inpatient;
- Hospital Outpatient;
- Federally Qualified Health Centers;
- Professional Providers;
- Ambulance Providers;
- Medical Suppliers/Durable Medical Equipment;
- Ambulatory Surgery Centers;
- Skilled Nursing Facilities/Inpatient Rehabilitation Facilities;
- Intermediate Care Facilities;
- Inpatient Psychiatric Services;
- End Stage Renal Disease; and
- Pharmacy.

21. Permedion Hospital Payment Review

As stated in the "Permedion Cost Avoidance Activities" initiatives above, the state will save an additional $18.8 million ($7.0 million state share) over the biennium under the Permedion's hospital payment review.

FY 2014-FY 2015 Biennium New Initiatives – Budget Neutral

The FY 2014-FY 2015 biennial budget includes the following initiatives that are considered as budget neutral:

1. Create a Children's Hospital Quality Improvement Program

H.B. 59 permits the ODM Director to implement, during FY 2014 and FY 2015, a children's hospitals quality outcomes program that encourages children's hospitals to develop (1) infrastructures that are needed to care for patients in the least restrictive setting and promote the care of patients and their families, (2) programs designed to improve birth outcomes and measurably reduce neonatal intensive care admissions, (3) patient-centered methods to measurably reduce utilization of emergency department services for primary care needs and nonemergency health conditions, and (4) other reforms the Director identifies.

H.B. 59 requires that up to $6 million state share and the corresponding federal share in each fiscal year be used to support payments made to children's hospitals for developing programs that achieve quality outcomes and any other measures the ODM Director deems appropriate.

Since FY 2006, supplemental payments to children's hospitals have been included in the budget. Funding of $6 million per year (state funds) plus federal matching funds were provided. In FY 2009, a line item and an earmark of $4.4 million in FY 2010 and $4.0 million in FY 2011 from the hospital franchise fee provided additional payments to children's hospitals. The FY 2012-FY 2013 biennial budget also provided $6 million and the corresponding federal share in each fiscal year for the supplemental payments to children's hospitals.

2. Graduate Medical Education Payments

H.B. 59 modifies, beginning January 1, 2014, provisions governing Medicaid payments for graduate medical education (GME) costs as follows: (1) requires the ODM Director to adopt rules that govern the allocation of payments for GME costs and (2) eliminates provisions specifying how payments for GME costs are made under the Medicaid managed care system.

The budget does not change the current level of Medicaid direct GME funding, which is about $200 million over the biennium. Medicaid direct GME payments are currently made as an add-on to inpatient hospital claims. The executive plans to, beginning July 1, 2014, allocate Medicaid-direct GME payments based on rules that will be developed to support: a workforce trained in comprehensive primary care with a commitment to serve all Ohioans, dollars following residents into community practices, primary care placements in recognized patient-centered medical homes, a residency mix that recognizes and supports the needs of Ohio, and strategies that mitigate underserved areas in Ohio.

3. Remove Custom Wheelchairs, Oxygen (Other Than Emergency Oxygen) and Resident Transportation Costs from the Nursing Facility Rate

H.B. 1 of the 128th General Assembly (the main operating appropriations act for 2009-2011) included the costs of wheelchairs, oxygen, and resident transportation services among the costs included in nursing facilities' Medicaid-allowable costs. The inclusion of wheelchair, oxygen, and resident transportation costs in nursing facilities' costs is part of what has been called "bundling." Other costs that are part of bundling include over-the-counter pharmacy products, physical therapy, occupational therapy, speech therapy, and audiology. Bundling affects nursing facilities' Medicaid payments.

H.B. 59 removes custom wheelchairs from nursing facilities' Medicaid-allowable costs, as well as repairs to and replacements of custom wheelchairs and parts that are made in accordance with the instructions of the physician of the individual who uses the custom wheelchair. The bill also removes oxygen (other than emergency oxygen) and resident transportation services from nursing facilities' Medicaid-allowable costs. All of the removals take effect January 1, 2014.

Continuing law provides for a portion of nursing facilities' Medicaid payment rates for direct care costs to be based on their costs for bundled services. Under current law, this is reflected with a $1.88 per Medicaid day payment rate increase for nursing facilities' costs per case-mix unit, a factor in determining their Medicaid payment rates for direct care costs. With the removal of custom wheelchair, oxygen (other than emergency oxygen), and resident transportation costs, this amount is reduced to 86 cents beginning January 1, 2014.

H.B. 59 requires furthermore the ODM Director to implement, for the period beginning January 1, 2014, and ending June 30, 2015, strategies for purchasing custom wheelchairs, oxygen (other than emergency oxygen), and resident transportation services for Medicaid recipients residing in nursing facilities. In implementing the purchasing strategies, the Director is to seek to achieve a more efficient allocation of resources and price and quality competition among providers of the goods and services. The Director must consider one or more of the following when determining the purchasing strategies:

1. Establishing competitive bidding;

2. Establishing manufacturers rebate programs;

3. Another purchasing strategy that saves the Medicaid Program an amount equivalent to the savings that would be realized from one or both of the purchasing strategies specified above.

4. Update the Nursing Facility Quality Incentive Rate Component

H.B. 59 revises the accountability measures that are used in determining nursing facilities' quality incentive payments under the Medicaid Program for FY 2015 and thereafter. H.B. 59 also specifies a lower maximum quality incentive payment ($13.16 rather than $16.44 per Medicaid day) starting in FY 2015 for nursing facilities that fail to meet at least one of the accountability measures regarding pain, pressure ulcers, physical restraints, urinary tract infections, hospital admission tracking, and vaccinations.

H.B. 153 of the 129th General Assembly increased Medicaid quality incentive payments for nursing facilities from 1.7% of the average Medicaid nursing facility rate in 2011 to 9.7% in 2013. S.B. 264 of the 129th General Assembly specified 20 accountability measures for receiving quality incentive payments.

5. Link More Health Plan Payments to Performance

The budget authorizes Ohio Medicaid to increase up to 2% the amount of health plan payments it withholds, pending the plan's ability to demonstrate that certain performance outcomes are met.

H.B. 153 of the 129th General Assembly required ODJFS to establish a Managed Care Performance Payment Program under which ODJFS was permitted to provide payments to managed care organizations that meet performance standards established by ODJFS. The Department was permitted to specify in the contract with the managed care organization the standards that must be met to receive the payments. When an organization meets the performance standards, ODJFS was required to make payments to the organization.

FY 2014-FY 2015 Biennium New Initiatives – Potential Savings

In addition to all the initiatives mentioned above, H.B. 59 includes the following initiatives for which potential savings are difficult to quantify.

1. Provide Post-Acute Rehabilitation in Nursing Facilities

H.B. 59 permits the ODM Director to establish a Medicaid waiver component, an alternative purchasing model for nursing facility services, provided during the period beginning July 1, 2013, and ending July 1, 2015, to Medicaid recipients with specialized health care needs, including recipients dependent on ventilators and recipients who have traumatic brain injury.

According to OHT, some nursing facilities in Ohio could serve a population that is otherwise served in more expensive rehabilitation hospitals and long-term, acute-care hospitals (LTACHs), including some individuals with traumatic brain injury, some individuals on ventilators who could be weaned, and some individuals in need of intensive rehabilitation services. The average cost to serve these individuals in an LTACH is $1,388 per patient day compared to $740 per patient day at the highest rate Medicare pays in nursing facilities for "ultra-high rehabilitation services."

The budget includes payment changes that prioritize post-acute rehabilitation in nursing facilities, not hospitals. ODM plans to create a specialty nursing facility service category in Ohio for individuals who would otherwise be served in rehabilitation hospitals and LTACHs, and to authorize a new ventilator weaning program. In addition, ODM plans to reduce payments for LTACHs and rehabilitation hospitals from 100% of costs to 90%.

2. Seeking Federal Benefits for Veterans in Nursing Facilities

H.B. 59 authorizes ODM to collaborate with the Department of Veterans Services (DVS) regarding the coordination of veterans' services. It authorizes ODM and DVS to implement, during FY 2014 and FY 2015, certain initiatives that they determine will maximize the efficiency of the services and ensure that veterans' needs are met.

The budget includes identifying veterans who currently reside in nursing homes on Medicaid and connecting them to federal veterans' benefits without uprooting them from their current residences. On January 29, 2013, OHT approved $260,000 for a pilot project to identify veterans on Medicaid and connect them to veterans' benefits.

3. Automatically Update the Nursing Facility Franchise Fee

H.B. 59 replaces the specific dollar amounts used for the franchise permit fee on nursing homes and hospital long-term care units with a formula for determining the amount of the franchise permit fee rate.

The budget includes a modification of the method that is used to calculate the nursing facility franchise permit fee assessment rate. In place of actual fee amounts, which have to be recalculated based on projected net patient revenue each biennium and amended to statute to reflect revised rates, the budget requires the franchise fee per bed per day assessment amount to be calculated each year at the maximum percentage allowed by federal law (not to exceed 6%), eliminating the need for routine biennial budget amendments.

4. Streamline the Claims Review Process

H.B. 59 permits ODM to conduct post-payment reviews of nursing facilities' Medicaid claims to determine whether overpayments have been made. It requires nursing facilities to refund overpayments discovered by post-payment reviews.

5. Terminate Special Focus Facilities

H.B. 59 requires ODM to terminate a nursing facility's Medicaid participation if the nursing facility is placed in the federal Special Facility Focus Program and fails to make improvements or graduate from the program within certain periods of time.

The federal government operates a Special Focus Facility Program that identifies facilities with more deficiencies than most facilities, more serious deficiencies, and a pattern of serious deficiencies. They publish a list monthly identifying those facilities newly added to the list, those that remain on the list without improving, those that remain on the list but are improving, and those that recently graduated from the list. The executive plans to terminate the provider agreement of a facility that either fails to improve within 12 months of being placed on the list or fails to graduate from the list within 24 months of being placed on the list.

6. Involve Providers in Third-Party Recoveries

H.B. 59 requires a public assistance recipient or participant and the person's attorney, if any, to cooperate with each medical provider of the recipient or participant by disclosing third-party payer information to such providers. It specifies that if the required disclosure is not made, the recipient or participant and the person's attorney, if any, are liable to reimburse ODM or a county department of job and family services for the amount that would have been paid by the third party had the third party been disclosed. After initiating informal recovery activity or filing a legal recovery action against a third party, H.B. 59 authorizes a public assistance recipient or participant and the person's attorney, if any, to provide written notice of the activity or action to the relevant county department of job and family services as an alternative to providing such notice to ODM.

In addition, H.B. 59 authorizes ODM to assign its right of recovery against a third party for a Medicaid claim to a Medicaid provider if ODM notifies the provider that it intends to recoup ODM's prior payment for the claim. H.B. 59 requires a third party, if

ODM makes such an assignment, to do both of the following: (1) treat the provider as if the provider was ODM and (2) pay the provider the greater of the amount ODM intends to recoup from the provider for the claim, or if the third party and the provider have an agreement that requires the third party to pay the provider at the time the provider presents the claim to the third party, the amount that is to be paid under that agreement.

Ohio Medicaid is the payer of last resort and contracts with a vendor to recover Medicaid payments when the beneficiary has other insurance coverage that should cover all or part of the medical expenses.

7. Revalidate Providers Every Five Years

H.B. 59 revises the law governing time-limited Medicaid provider agreements as follows:

1. Requires all provider agreements to be time limited.
2. Provides that provider agreements expire after a maximum of five (rather than seven) years.
3. Eliminates the phase-in period for subjecting provider agreements to time limits.
4. Requires that rules regarding time-limited provider agreements be consistent with federal regulations governing provider screening and enrollment and include a process for revalidating providers' continued enrollment as providers rather than a process for re-enrolling providers.
5. Requires ODM to refuse to revalidate a provider agreement if the provider fails to file a complete application for revalidation within the time and in the manner required by the revalidation process or to provide required supporting documentation not later than 30 days after the date the provider timely applies for revalidation.

The five-year revalidation is a new federal requirement that is intended to identify and eliminate fraudulent providers.

8. Track Trusts as Part of Recovery

H.B. 59 requires a Medicaid applicant or recipient who is a beneficiary of a trust to submit a complete copy of the trust instrument to the county department of job and family services and ODM. It specifies that the copies are confidential and not subject to disclosure under Ohio's Public Records Law (R.C. 149.43).

Ohio Medicaid currently does not have any mechanism for tracking trusts, and recoveries from trusts are missed. This provision will enable Ohio Medicaid to identify when a trust is involved and improve collection of payments when a Medicaid beneficiary dies.

9. Medicaid Access to Ohio's Prescription Monitoring Program

H.B. 59 requires, rather than permits, the State Board of Pharmacy to provide information in the Ohio Automated Rx Reporting System (OARRS) to both of the following:

1. The medical director of a Medicaid managed care organization, if the information relates to a Medicaid recipient enrolled in the managed care organization, including information related to prescriptions for the recipient not covered or reimbursed under the Medicaid Program.
2. The ODM Director, if the information relates to a recipient of a program administered by ODM, including information related to prescriptions for the recipient not covered or reimbursed under a program administered by the Department.

H.B. 59 requires the Board of Pharmacy to notify the ODM Director if the Board determines from a review of OARRS information that a violation of law may have been committed by a provider of services under a program administered by ODM.

Access to OARRS will allow Medicaid to confirm that, if a consumer is assigned to a specific provider through the coordinated services program to curtail prescription drug abuse, the provider is not allowing the recipient to receive controlled substances outside the Medicaid Program.

ANALYSIS OF ENACTED BUDGET

Introduction

This section provides an analysis of the enacted budget's funding for each line item in ODM's budget.

Table 11. Appropriations for the Department of Medicaid				
Fund	**ALI and Name**		**FY 2014**	**FY 2015**
General Revenue Fund				
GRF	651425	Medicaid Program Support – State	$177,071,199	$180,446,636
GRF	651525	Medicaid/Health Care Services	$13,701,114,114	$14,599,795,041
GRF	651526	Medicare Part D	$309,349,142	$313,020,518
		General Revenue Fund Subtotal	***$14,187,534,455***	***$15,093,262,195***
General Services Fund Group				
5DL0	651639	Medicaid Services – Recoveries	$462,900,000	$514,700,000
5FX0	651638	Medicaid Services – Payment Withholding	$6,000,000	$6,000,000
		General Services Fund Group Subtotal	***$468,900,000***	***$520,700,000***
Federal Special Revenue Fund Group				
3ER0	651603	Medicaid Health Information Technology	$123,074,778	$123,089,606
3F00	651623	Medicaid Services – Federal	$2,965,609,943	$3,196,808,545
3F00	651624	Medicaid Program Support – Federal	$565,046,401	$454,423,399
3FA0	651680	Health Care Grants – Federal	$45,400,000	$44,500,000
3G50	651655	Medicaid Interagency Pass-Through	$1,712,881,658	$1,895,403,348
		Federal Special Revenue Fund Group Subtotal	***$5,412,012,780***	***$5,714,224,898***
State Special Revenue Fund Group				
4E30	651605	Resident Protection Fund	$2,878,319	$2,878,319
5AJ0	651631	Money Follows the Person	$5,555,000	$4,517,500
5GF0	651656	Medicaid Services – Hospitals/UPL	$531,273,601	$531,273,601
5KC0	651682	Health Care Grants – State	$10,000,000	$10,000,000
5R20	651608	Medicaid Services – Long Term Care	$398,000,000	$398,000,000
5U30	651654	Medicaid Program Support	$54,305,843	$37,903,126
6510	651649	Medicaid Services – HCAP	$215,527,947	$215,314,482
		State Special Revenue Fund Group Subtotal	***$1,217,540,710***	***$1,199,887,028***
Holding Account Redistribution Fund Group				
R055	651644	Refunds and Reconciliations	$1,000,000	$1,000,000
		Holding Account Redistribution Fund Group Subtotal	***$1,000,000***	***$1,000,000***
Total Funding: Department of Medicaid			***$21,286,987,945***	***$22,529,074,121***

The budget includes a restructuring of the Medicaid line items. The prefixes for Medicaid ALIs that have been brought over from ODJFS to ODM are changed from 600 to 651. Table 12 below shows the previous names and numbers alongside the new names and numbers. The table also lists the newly created line items and the line items that are discontinued without new line items replacing them.

Table 12. Changes to Medicaid Appropriation Line Items

Fund	Previous ALIs and Names		New ALIs and Names	
GRF	600425	Health Care Programs	651425	Medicaid Program Support – State
GRF	600525	Health Care/Medicaid	651525	Medicaid/Health Care Services
GRF	600526	Medicare Part D	651526	Medicare Part D
5DL0	600639	Health Care/Medicaid Support – Recoveries	651639	Medicaid Services – Recoveries
5FX0	600638	Medicaid Payment Withholding	651638	Medicaid Services – Payment Withholding
3ER0	600603	Health Information Technology	651603	Medicaid Health Information Technology
3F00	600623	Health Care Federal	651623	Medicaid Services – Federal
3FA0	600680	Health Care Grants – Federal	651680	Health Care Grants – Federal
3G50	600655	Interagency Reimbursement	651655	Medicaid Interagency Pass-Through
4E30	600605	Resident Protection Fund	651605	Resident Protection Fund
5AJ0	600631	Money Follows the Person	651631	Money Follows the Person
5GF0	600656	Health Care/Medicaid Support – Hospital/UPL	651656	Medicaid Services – Hospital/UPL
5KC0	600682	Health Care Grants – State	651682	Health Care Grants – State
5R20	600608	Long-Term Care Support	651608	Medicaid Services – Long Term Care
5U30	600654	Health Care Program Support	651654	Medicaid Program Support
6510	600649	Hospital Care Assurance Program Fund	651649	Medicaid Services – HCAP
5KW0		-	651612	Managed Care Performance Payments
3F00		-	651624	Medicaid Program Support – Federal
R055		-	651644	Refunds and Reconciliations
4K10	600621	DDD Support – Franchise Fee	Discontinued, expenditures moved to ODODD	
4Z10	600625	HealthCare Compliance	Discontinued, expenditures is now included in 651654	
GRF	600537	Children's Hospital	Discontinued, expenditures is now included in 651525	
GRF	600321	Program Support	Discontinued, expenditures is now included in 651425	
GRF	600416	Information Technology Projects	Discontinued, expenditures is now included in 651425	
GRF	600417	Medicaid Provider Audits	Discontinued, expenditures is now included in 651425	
5P50	600692	Health Care/Medicaid Support – Drug Rebates	Discontinued, expenditures is now included in 651639	
3F00	600650	Hospital Care Assurance – Federal	Discontinued, expenditures is now included in 651623	
5S30	600629	Health Care Program and DDD Support	Discontinued, expenditures moved to ODODD	

The prefix of "65" designates the line item as a Medicaid line item. Line items in other state agencies also have the prefix 65 to denote a Medicaid line item. The number "1" (in 651) indicates that it is a Medicaid line item in ODM's budget. In general, most of the new line items retain the same uses and will be supported by the same funds, but have a different number and name. However, some line items have significant changes.

Medicaid/Health Care Services (651525)

This new GRF line item is used to reimburse health care providers for covered services to Medicaid recipients. This new line item replaces line item 600525, Health Care/Medicaid, and is used for the same purpose except that the costs of administrative activities and health care-related contracts such as eyeglass purchases, inpatient hospital peer review, enrollment information centers, and contracted case management is now no longer funded through this new line item.

The federal earnings on the payments that are made entirely from this line item is now 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), Inpatient and Outpatient Hospital Services, Prescription Drugs, Physician Services, Medicare Buy-In, Ohio Home Care Waiver, 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%, although family planning expenditures earn an enhanced 90% federal participation rate, and a portion of the buy-in premium payments are state funds only. Expenditures for the State Children's Health Insurance Program (SCHIP) from this line item earn an enhanced federal participation rate of approximately 74%.

The budget provides $13.70 billion in FY 2014, a 17% increase over FY 2013 expenditures (in line item 600525) and $14.6 billion in FY 2015, a 7% increase over FY 2014. The funding levels are a result of Medicaid line item restructuring. In addition, the appropriations are based on the executive's baseline Medicaid spending forecast/assumptions and the various budget initiatives in H.B. 59 mentioned above. The following lists the baseline budget assumption:

ACA Woodwork Effect

Whether or not a state implements the Medicaid expansion, states will see increased enrollment among currently eligible people, most of whom were previously uninsured. States will be required to pay their standard share of Medicaid costs to cover this population. This is sometimes called the "woodwork" effect.

The woodwork effect could be a result of the new requirement under the ACA that most individuals must have health care coverage. Many people who are currently eligible for Medicaid but not enrolled in Medicaid may think they are subject to the mandate and thus come forward applying for Medicaid. However, according to a report of the Congressional Budget Office (CBO), first, many of the people who will not become eligible for Medicaid if their state does not choose to implement the expansion will have income that falls below the mandatory tax-filing threshold (projected by CBO and the Joint Committee on Taxation to be about $10,000 for a single filer and about $19,000 for a married couple in 2016) and will therefore be exempt from penalties

associated with the mandate.[2] Second, the ACA exempts individuals who would have to pay more than 8% of their income for health insurance. Third, people who will not be exempt under those criteria may receive a hardship exemption as provided in the ACA.

The woodwork effect could also be a result of other provisions of the ACA including the outreach through the no wrong door interface for Exchange and Medicaid/SCHIP coverage, eligibility simplification, new subsidies in the Exchange, and other aspects of the ACA.

Mercer estimates that the woodwork effect will have a cost of $531.3 million in FY 2014 and $995.6 million in FY 2015. The state will be responsible for its share of these costs.

ACA Physician Rate Increase

The ACA requires states to raise their Medicaid physician fees to at least Medicare levels, for family physicians, internists, and pediatricians for many primary care services. Physicians in both FFS and managed care environments get the enhanced rates. The primary care fee increase, which applies in 2013 and 2014, is fully federally funded up to the difference between a state's Medicaid fees in effect on July 1, 2009, and Medicare fees in 2013 and 2014.

Mercer estimates that this rate increase will have additional costs of $398.1 million in FY 2014, and $261.9 million in FY 2015.

Health Homes

H.B. 153 authorized Ohio Medicaid to implement a system under which Medicaid recipients with chronic conditions are provided with coordinated care through health homes. Beginning in October 2012, Ohio Medicaid received federal approval for enhanced federal match to pay for care coordination in serious and persistent mental illness (SPMI)-focused health homes. Under the new system, care managers in Patient-Centered Medical Homes provide intensive care coordination and develop an individualized care plan for each consumer to address both medical and nonmedical needs.

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

[2] Congressional Budget Office, "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision," July 2012.

Mercer estimates that the net cost of health homes is $4.0 million in FY 2013, $168.6 million in FY 2014 and $314.5 million in FY 2015.

Pediatric Accountable Care Organizations

H.B. 153 required Ohio Medicaid, not later than July 1, 2012, to establish a pediatric accountable care organization (ACO) recognition system for children under age 21 who are blind or disabled. The standards of recognition are to be the same as, or not conflict with, those adopted under the ACA. Assuming a start date of July 1, 2012, Milliman, the state's former contracted actuary, estimated that this program would have a net cost of $87.0 million for the FY 2012-FY 2013 biennium. ODM anticipates establishing a pediatric accountable care organization in the FY 2014-FY 2015 biennium. It is estimated that a pediatric accountable care organization will have a net cost of $87.1 million in FY 2014 and $40.9 million in FY 2015.

Integrated Care Delivery System

On December 12, 2012, the U.S. Department of Health and Human Services announced that Ohio will partner with the Centers for Medicare and Medicaid Services (CMS) in the Financial Alignment Demonstration to test a new model for providing dual enrollees with a more coordinated, person-centered care experience.

Under the demonstration, Ohio and CMS will contract with Integrated Care Delivery System (ICDS) plans that will coordinate the delivery of and be accountable for all covered Medicare and Medicaid services for participating dual enrollees. ICDS plans will be responsible for conducting a comprehensive assessment of dual enrollees' medical, behavioral health, long-term services and supports, and social needs in seven regions (29 counties) of the state for about 114,000 dual enrollees. Dual enrollees and their caregivers will work with a care management team to develop person-centered, individualized care plans.

The demonstration will be available to individuals who meet all of the following criteria:

- Age 18 and older at the time of enrollment;
- Eligible for full Medicare Parts A, B, and D and full Medicaid; and
- Reside in an ICDS demonstration county.

Mercer estimates that the net cost of ICDS is $357.5 million in FY 2014 and $449.3 million in FY 2015.

Family Planning Services

The ACA adds a new Medicaid eligibility option for states to improve access to family planning care without applying for waivers from the federal government. States can amend their Medicaid plans to create a new eligibility group of low-income individuals through a state plan amendment. On January 8, 2012, Ohio Medicaid

implemented a new eligibility category that allows men and women of childbearing age who are under 200% FPG to receive family planning services.

Balancing Incentive Program

The Balancing Incentive Program provides federal grants to states that make structural reforms to increase nursing home diversions and access to noninstitutional long-term services and supports. To qualify, states must implement structural changes – including a "no wrong door" single entry point, standardized assessment instruments, and conflict-free case management – and commit to spend at least 50% of the state's Medicaid long-term care budget on noninstitutional services by 2015. States that make this commitment are eligible immediately for enhanced FMAP for noninstitutional Medicaid long-term care. Ohio is eligible to receive 2% enhanced FMAP based on its current mix of spending.

Medicaid Program Support – State (651425)

This new GRF line item replaces line item 600425, Health Care Programs, and is used to fund ODM's operating expenses.

Beginning in FY 2014 and continuing in FY 2015, the state share of administrative funding previously appropriated in ODJFS's GRF line items 600321, Program Support; 600416, Information Technology Projects; 600417, Medicaid Provider Audits; 600425, Health Care Programs; and 600525, Health Care/Medicaid, is now appropriated in this new line item. Additionally, the state share of administrative funding from ODJFS's non-GRF line items 600639, Health Care/Medicaid Support – Recoveries; 600629, Health Care Program and DDD Support; and 600608, Long-Term Care Support, is also consolidated into this new line item. As a result, 651425 exists as a purely administrative, purely state share GRF line item. The associated federal match is now appropriated in line item 651624, Medicaid Program Support – Federal, along with the federal match for administrative activities previously funded from 600623, Health Care Federal.

ODM plans to replace the Client Registry Information System – Enhanced (CRIS-E) with a new integrated eligibility system. The design and development costs will be provided through line item 651654, Medicaid Program Support, the operational costs will be provided through line item 651425, Medicaid Program Support – State.

CRIS-E provides intake and eligibility determination support for several of Ohio's health and human services programs and provides some case management functions for several ODJFS programs. CRIS-E was implemented in 1978. The executive estimates 60% of CRIS-E's eligibility determinations for Medicaid need to be manually overridden to prevent eligible applicants from being denied coverage. The Ohio Department of Administrative Services (DAS) is contracting with a vendor to replace CRIS-E with a new, integrated, enterprise solution that supports both state and county

operations. The new system will provide the technology necessary for integrating eligibility across Ohio's health and human services agencies. The project will focus first on Medicaid eligibility, then expand to other programs that currently depend on CRIS-E, and finally expand to support other health and human services programs. The new system will give individuals and families seeking Medicaid coverage an option to apply online and provide real-time determination for most people who apply. The budget includes $230 million for this system ($26 million state share) over the biennium.

In addition to the CRIS-E replacement, DAS released a second request for proposals (RFP) in February 2013 to acquire an organizational change management (OCM) vendor to coordinate the transition from the current business environment to a new, more efficient and effective business environment. Combined with the simplification of eligibility policy, the new integrated eligibility system provides the opportunity to improve the business processes involved with enrolling Ohio citizens in health and human services programs. The state is working with county agencies to improve the processes at both the county and state levels. The budget includes funding for this project and leverages 90% federal funds.

The budget provides funding of $177.1 million for FY 2014 and $180.4 million in FY 2015. In addition, certain service contracts previously categorized as subsidy expenditures have now been reclassified as an administrative expenditure in accordance with the definition used by CMS.

Medicare Part D (651526)

This new GRF line item replaces line item 600526, Medicare Part D, and is used for the same purpose: 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 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 eligible for both Medicare and Medicaid.

The budget provides funding of $309.3 million for FY 2014, a 6% increase over FY 2013 expenditures (in line item 600526), and $313.0 million in FY 2015, a 1% increase over FY 2014. The funding levels are based on the executive's projected spending for the clawback payments. During FY 2012, Ohio Medicaid made over $260 million in clawback payments for approximately 190,000 dual eligibles. The executive projects that the number of dual eligibles for Medicare Part D will increase and thus increase the clawback payments to the federal government.

H.B. 59, as was also included in H.B. 153, allows the Ohio Department of Budget and Management (OBM) Director to increase the state share of appropriations in either GRF line item 651525, or this GRF line item 651526, with a corresponding decrease in the state share of the other line item to allow ODM to implement the Medicare Part D requirements for FY 2014 and FY 2015.

Medicaid Services – Recoveries (651639)

This new line item replaces line item, Health Care/Medicaid Support – Recoveries, and is 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.

H.B. 59 requires that all of the following be 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.

H.B. 59 abolishes the Prescription Drug Rebates Fund (Fund 5P50) and provides for the money that would otherwise be credited to the Prescription Drug Rebates Fund to be credited instead to the Health Care/Medicaid Support and Recoveries Fund.

Previously, the Prescription Drug Rebates Fund was in the state treasury and both of the following were credited to it:

1. The nonfederal share of all rebates paid by drug manufacturers to ODM in accordance with rebate agreements required by federal law; and

2. 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.

The budget provides funding of $462.9 million in FY 2014, a 210% increase over FY 2013 expenditures (in line item 600639) and $514.7 million in FY 2015. The increases in appropriations for this line item are due to restructuring and the increased rebates expected.

Medicaid Services – Payment Withholding (651638)

This new line item replaces line item 600638, Medicaid Payment Withholding, and is used for the same purposes: to release to providers 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. The budget provides funding of $6.0 million in each fiscal year.

Medicaid Health Information Technology (651603)

This new line item replaces line item 600603, Health Information Technology, and is used for the same purpose: provider electronic health record (EHR) incentives and administrative costs related to the Health Information Technology (HIT) grant.

Health Information Technology (600603) was created by the Controlling Board in September 2010. The Controlling Board also established a new fund, Fund 3ER0, and appropriated $402,291,950 in FY 2011 to line item 600603, Health Information Technology. The American Reinvestment and Recovery Act of 2009 provided funding for payments to Medicaid providers and for state administrative expenses related to adoption of EHR technology. ODJFS issued the EHR incentive payments to Medicaid providers to encourage the adoption and use of certified EHR technology. The incentive payment to eligible providers is 100% federally funded.

The budget provides funding of $123.1 million in each fiscal year, which represents an increase of 18% over FY 2013 expenditures (in line item 600603). The increase in appropriations for this line item is because there were several technology projects launched in FY 2013.

H.B. 153 authorized ODJFS to establish an incentive payment program to encourage the use of EHR technology by Medicaid providers who are physicians, dentists, nurse practitioners, nurse-midwives, and physician assistants. ODJFS may adopt rules to implement the program. H.B. 153 required ODJFS to notify the provider of its determination regarding the amount or denial of an incentive payment. Not later than 15 days after receiving the notification, the provider may make a written request that ODJFS reconsider its determination. After receiving the request, ODJFS is required

to reconsider its determination and may uphold, reverse, or modify its original determination. ODJFS must then mail by certified mail a written notice of the reconsideration decision. Not later than 15 days after the decision is mailed, the provider may appeal the reconsideration decision to the Court of Common Pleas of Franklin County.

H.B. 153 also required certain Medicaid providers to use only an electronic claims submission process to submit Medicaid reimbursement claims to ODJFS. The providers were also required to arrange to receive Medicaid reimbursement from ODJFS by means of electronic funds transfer. ODJFS was not to process a Medicaid claim submitted on or after January 1, 2013, unless the claim was submitted through an electronic claims submission process. H.B. 153 permitted the ODJFS Director to adopt rules under the Administrative Procedure Act to implement the process.

The electronic claims submission process and the requirement to be reimbursed by means of electronic funds transfer do not apply to the following:

1. Nursing facilities;

2. ICFs/IID;

3. Medicaid managed care organizations; and

4. Any other provider or type of provider designated by the Medicaid Director.

Health Care Grants – Federal (651680)

This new line item replaces line item 600680, Health Care Grants – Federal, and is used for the same purpose: Medicaid/SCHIP and non-Medicaid/SCHIP Program initiatives stemming from the ACA.

Line item 600680, Health Care Grants – Federal, was created by the Controlling Board in November 2010. The Controlling Board also established a new fund, Fund 3FA0 and appropriated $325,000 in FY 2011 to line item 600680, Health Care Grants – Federal. In February 2011, the Controlling Board increased the appropriation to $13,701,346 in FY 2011. The budget provides funding of $45.4 million for FY 2014, a 302% increase over FY 2013 expenditures (in line item 600680), and $44.5 million in FY 2015, a 2% decrease from FY 2014. The appropriation levels for this line item are based on the federal grants that Ohio received.

Among the funding that supports this line item is the performance bonus that Ohio received due to its efforts to enroll and retain children on Medicaid. The performance bonuses were established under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). Ohio has implemented several measures to increase enrollment and retention, including eliminating in-person interviews and establishing presumptive eligibility for children. Thus far Ohio has received three performance bonuses – $17.9 million in 2012, $20.8 million in 2011, and $13.1 million in 2010. Moneys the state receives have been used to fund a variety of health initiatives

such as increasing early identification and intervention efforts for autism, providing additional community addiction treatment services, and expanding access to patient-centered medical homes.

Medicaid Services – Federal (651623)

This new line item replaces line item 6000623, Health Care Federal. 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 Hospital Care Assurance Match Fund (Fund 3F00).

The budget provides funding of $2.97 billion for FY 2014, a 24% increase over FY 2013 expenditures (in line item 600623), and $3.20 billion in FY 2015, an 8% increase over FY 2014. The increases in the appropriation levels are due to the line item restructuring and projected increase in Medicaid expenditures.

Medicaid Program Support – Federal (651624)

This new line item is used for the Medicaid federal share when the state share is provided for Medicaid administrative expenditures.

This new federally funded line item is used for the Medicaid federal share when the state share is provided mostly from line item 651425, Medicaid Program Support – State. This line item also includes contracts previously funded through line item 600525, Health Care/Medicaid, the federal share of other administrative spending previously funded through line items 600623, Health Care Federal; 600321, Program Support; and 600416, Information Technology Projects.

The budget provides funding of $565.0 million in FY 2014 and $454.4 million in FY 2015.

Medicaid Interagency Pass-Through (651655)

This new line item replaces line item 600655, Interagency Reimbursement, and is used for the same purpose: to disburse federal reimbursement to other agencies for Medicaid expenditures they have made.

The budget provides funding of $1.71 billion for FY 2014, a 38% increase over FY 2013 expenditures (in line item 600655), and $1.90 billion in FY 2015, an 11% increase over FY 2014. The increases in the appropriation levels are due to increased transfers to

other agencies, including the new transfers to ODJFS, which were not necessary before FY 2014 due to Medicaid being contained within ODJFS.

Resident Protection Fund (651605)

This new line item replaces line item 600605, Resident Protection Fund, and is used for the same purposes: 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.

Funds in the line item are transferred to the Department of Aging and the Department of Health. 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 Nursing Home Assessments Fund (Fund 4E30).

The budget provides funding of $2,878,319 each year for FY 2014 and FY 2015.

Money Follows the Person (651631)

This new line item replaces line item 600631, Money Follows the Person, and is used for the same purpose: to support the federal Money Follows the Person Grant initiative.

The budget provides funding of $5.6 million for FY 2014, a 248% increase over FY 2013 expenditures (in line item 600631), and $4.5 million in FY 2015, a 19% decrease from FY 2014. The funding levels are the executive's projected spending.

Ohio is one of 34 states that were awarded federal funding for the Money Follows the Person demonstration projects, which were enacted by Congress as part of the Federal Deficit Reduction Act of 2005. The total grant amount is $100 million over a five-year period. The funding will allow Ohio to relocate about 2,200 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 will be reimbursed at the regular federal Medicaid reimbursement. After the 12-month period, Ohio Medicaid draws down the regular federal reimbursement for each transitioned Medicaid member.

H.B. 119 of the 127th General Assembly provided funding of $3.5 million in FY 2008 and $30.5 million in FY 2009 to support the Money Follows the Person Grant initiative. H.B. 562 created the Money Follows the Person Enhanced Reimbursement

Fund (Fund 5AJ0) into which the Director of Budget and Management is to transfer the enhanced portion of the federal grant the state receives under the Money Follows the Person demonstration project. Since the deposits made into this fund are earned reimbursement, the cash in the fund may be expended as state funds.

Medicaid Services – Hospital/UPL (651656)

This new line item replaces line item 600656, Health Care/Medicaid Support – Hospital/UPL, and is used for the same purpose: 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 budget provides funding of $531.3 million in each fiscal year, which represents an increase of 4% over FY 2013 expenditures (in line item 600656). The increase in the appropriation is attributable to the projected increase in the hospital total facility cost. The hospital assessment will be about 2.64% of the total facility cost in FY 2014, and 2.51% in FY 2015.

H.B. 1 of the 128th General Assembly created this hospital assessment and required it to be terminated on October 1, 2011. H.B. 153 of the 129th General Assembly continued the assessments for two additional years, ending October 1, 2013, rather than October 1, 2011. H.B. 153 increased the hospital assessment to about 2.5% of the total facility cost in each year and required ODJFS to adopt rules specifying the percentage of hospitals' total facility costs that hospitals are to be assessed.

H.B. 59 continues the assessments imposed on hospitals for two additional years, ending October 1, 2015, rather than October 1, 2013. The assessments are in addition to the Hospital Care Assurance Program (HCAP), but like HCAP, they raise money to help pay for the Medicaid Program. H.B. 59 provides for a portion of the hospital assessments to be used during FY 2014 and FY 2015 to continue the Hospital Inpatient and Outpatient Supplemental Upper Payment Limit Program and the Medicaid Managed Care Hospital Incentive Payment Program. Under the first program, supplemental payments are made to hospitals for Medicaid-covered inpatient and outpatient services. Under the second program, additional funds are provided to Medicaid managed care organizations to be used by the organizations to increase payments to hospitals for providing services to Medicaid recipients who are enrolled in the Medicaid managed care organizations.

Health Care Grants – State (651682)

This new line item replaces line item 600682, Health Care Grants – State, and is used for the same purpose: to fund planning and implementation grants related to the ACA. The budget provides funding of $10 million each year in FY 2014 and FY 2015 for this new line item.

H.B. 153 of the 129th General Assembly created the Health Care Special Activities Fund (Fund 5KC0), and appropriated $10 million each year in FY 2012 and FY 2013 in line item 600682, Health Care Grants – State. 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. Ohio Medicaid uses the money in the fund to pay for expenses related to the services provided under, and the administration of, the Medicaid Program.

Medicaid Services – Long Term Care (651608)

This new line item replaces line item 600608, Long-Term Care Support, and is used for the same purpose: to make Medicaid payments to nursing facilities. The source of funds for this line item is the franchise fee payments from nursing facilities. 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).

H.B. 153 of the 129th General Assembly discontinued line item 600613, Nursing Facility Bed Assessments, and consolidated its funding into line item 600608, Long-Term Care Support. The corresponding Fund 4J50 was abolished and Fund 5R20 was renamed from the Nursing Facility Stabilization Fund to the Nursing Home Franchise Permit Fee Fund.

The budget provides funding of $398 million in each fiscal year, which represents an increase of 2% over FY 2013 expenditures (in line item 600608). The increase in appropriations is due to the estimated increase in the assessment amount.

H.B. 59 revises the law governing the amount of the franchise permit fee that nursing homes and hospital long-term care units are assessed for each fiscal year. The fees are a source of revenue for nursing facility and home and community-based services covered by the Medicaid Program and the Residential State Supplement Program.

Under prior law, the franchise permit fee rate was $11.67 per bed per day. H.B. 59 replaces 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 to be 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[3] or (b) 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.

H.B. 153 kept the nursing facility franchise fee at about $11.38 in FY 2012 and $11.60 in FY 2013 in order to maximize federal reimbursement for nursing facility services. Under the federal law, the percentage for the provider tax increased from 5.5% to 6% of the total net patient revenue starting October 1, 2011. The $11.38 in FY 2012 and $11.60 in FY 2013 is at the maximum allowed by federal law. Medicaid rates for nursing facilities were adjusted to recognize the change of the fee.

Ohio Medicaid is required to assess an annual franchise permit fee on each long-term care bed in a nursing home or hospital. Until July 1, 2001, the amount of the fee was $1.00 for each bed multiplied by the number of days in the fiscal year for which the fee is assessed. The fee is applied to: (1) nursing home beds, (2) Medicare-certified skilled nursing facility beds, (3) Medicaid-certified nursing facility beds, and (4) beds in hospitals that are registered as skilled nursing facility beds or long-term care beds, or licensed as nursing home beds. H.B. 94 raised the franchise permit fee to $3.30 for FY 2002 and FY 2003. S.B. 261 of the 124th General Assembly (the FY 2002-FY 2003 biennium corrective budget) raised the franchise permit fee to $4.30 for fiscal years 2003 through 2005. H.B. 66 increased the fee to $6.25 for FY 2006 and FY 2007. H.B. 119 of the 127th General Assembly (the FY 2008-FY 2009 biennial budget) maintained the fee at $6.25 for FY 2008 and FY 2009. H.B. 1 of the 128th General Assembly (the FY 2010-FY 2011 biennial budget) increased the fee to about $12.01 for FY 2010 and $11.95 for FY 2011.

Whereas prior law required ODJFS to use money in that fund to make Medicaid payments only to nursing facilities, H.B. 153 required ODJFS to use the money to make Medicaid payments to providers of home and community-based services as well as

[3] 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 health-care related tax. The indirect guarantee percentage is currently 6%. (42 U.S.C. 1396b(w)(4)(C)(ii).)

providers of nursing facility services. Additionally, H.B. 153 permitted money in the Nursing Home Franchise Permit Fee Fund to be used for the Residential State Supplement Program.

Prior law provided for only the first dollar of the franchise permit fee to be deposited into the Home- and Community-Based Services for the Aged Fund and for the Nursing Facility Stabilization Fund to receive the remainder. Because H.B. 153 required all of the money raised by the franchise permit fee to be deposited into the renamed Nursing Facility Stabilization Fund and provided for the money in that fund to be used for home and community-based services and the Residential State Supplement Program rather than just nursing facilities, it is possible that more of the money raised by the franchise permit fee is used for home and community-based services and the Residential State Supplement Program than under prior law.

H.B. 153 abolished the PASSPORT Fund. Money raised by horse racing-related taxes that under prior law was deposited into the PASSPORT Fund is required to be deposited into the Nursing Home Franchise Permit Fee Fund. H.B. 153 continues to require that the money be used for the PASSPORT Program.

Medicaid Program Support (651654)

This new line item replaces line item 600654, Health Care Program Support, and is used to pay costs associated with the administration of Medicaid. Funding for this line item comes from a variety of Medicaid financing activities. The money is deposited in the Health Care Services Administration Fund (Fund 5U30).

Under the executive's restructuring of the line items, in FY 2014 and FY 2015, funds previously appropriated for administrative activities in line item 600625, Healthcare Compliance, is consolidated into 651654, Medicaid Program Support. A portion of line item 600625 associated with managed care expenditures is consolidated into line item 651612, Managed Care Performance Payments.

The budget provides $54.3 million in FY 2014, a 377% increase from the FY 2013 expenditure level (in line item 600654), and $37.9 million in FY 2015, a 30% decrease from FY 2014. These changes in appropriation levels are attributable to the line item restructuring.

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.

The budget provides funding of $1.0 million in each year for FY 2014 and FY 2015.

Medicaid Services – HCAP (651649)

This new line item replaces line item 600649, Hospital Care Assurance Program Fund, and is used for the same purpose: to fund the Hospital Care Assurance Program (HCAP).

The budget provides $215.5 million for FY 2014, an 8% increase over FY 2013 expenditures (in line item 600649) and $215.3 million for FY 2015. The funding levels for HCAP are based on the executive's projected assessment revenue and spending.

Line item 600649, Hospital Care Assurance Program Fund, and line item 600650, Hospital Care Assurance – Federal, are currently used to fund HCAP. 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% FPG under the 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 state funds (assessment revenues) were currently appropriated in line item 600649, and the federal funds were appropriated in line item 600650.

Under the line item restructuring, line item 600650, Hospital Care Assurance – Federal, is discontinued. Spending through this line item is included in line item 651623, Medicaid Services – Federal.

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FY 2014 - FY 2015 Final Appropriation Amounts — All Fund Groups

Line Item Detail by Agency

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			FY 2012	FY 2013	Appropriation FY 2014	FY 2013 to FY 2014 % Change	Appropriation FY 2015	FY 2014 to FY 2015 % Change
MCD	**Department of Medicaid**							
GRF	651425	Medicaid Program Support - State	$0	$0	$ 177,071,199	N/A	$ 180,446,636	1.91%
		Medicaid/Health Care Services-State	$0	$0	$ 4,739,421,777	N/A	$ 5,097,244,293	7.55%
		Medicaid/Health Care Services-Federal	$0	$ 0	$ 8,961,692,337	N/A	$ 9,502,550,748	6.04%
GRF	651525	Medicaid/Health Care Services - Total	$0	$ 0	$ 13,701,114,114	N/A	$ 14,599,795,041	6.56%
GRF	651526	Medicare Part D	$0	$0	$ 309,349,142	N/A	$ 313,020,518	1.19%
	GRF - State		$0	$ 0	$ 5,225,842,118	N/A	$ 5,590,711,447	6.98%
	GRF - Federal		$0	$ 0	$ 8,961,692,337	N/A	$ 9,502,550,748	6.04%
	General Revenue Fund Total		**$0**	**$ 0**	**$ 14,187,534,455**	**N/A**	**$ 15,093,262,195**	**6.38%**
5DL0	651639	Medicaid Services - Recoveries	$0	$0	$ 462,900,000	N/A	$ 514,700,000	11.19%
5FX0	651638	Medicaid Services - Payment Withholding	$0	$0	$ 6,000,000	N/A	$ 6,000,000	0.00%
	General Services Fund Group Total		**$0**	**$0**	**$ 468,900,000**	**N/A**	**$ 520,700,000**	**11.05%**
3ER0	651603	Medicaid Health Information Technology	$0	$0	$ 123,074,778	N/A	$ 123,089,606	0.01%
3F00	651623	Medicaid Services - Federal	$0	$0	$ 2,965,609,943	N/A	$ 3,196,808,545	7.80%
3F00	651624	Medicaid Program Support - Federal	$0	$0	$ 565,046,401	N/A	$ 454,423,399	-19.58%
3FA0	651680	Health Care Grants - Federal	$0	$0	$ 45,400,000	N/A	$ 44,500,000	-1.98%
3G50	651655	Medicaid Interagency Pass-Through	$0	$0	$ 1,712,881,658	N/A	$ 1,895,403,348	10.66%
	Federal Special Revenue Fund Group Total		**$0**	**$0**	**$ 5,412,012,780**	**N/A**	**$ 5,714,224,898**	**5.58%**
4E30	651605	Resident Protection Fund	$0	$0	$ 2,878,319	N/A	$ 2,878,319	0.00%
5AJ0	651631	Money Follows the Person	$0	$0	$ 5,555,000	N/A	$ 4,517,500	-18.68%
5GF0	651656	Medicaid Services - Hospitals/UPL	$0	$0	$ 531,273,601	N/A	$ 531,273,601	0.00%
5KC0	651682	Health Care Grants - State	$0	$0	$ 10,000,000	N/A	$ 10,000,000	0.00%
5R20	651608	Medicaid Services - Long Term Care	$0	$0	$ 398,000,000	N/A	$ 398,000,000	0.00%
5U30	651654	Medicaid Program Support	$0	$0	$ 54,305,843	N/A	$ 37,903,126	-30.20%
6510	651649	Medicaid Services - HCAP	$0	$0	$ 215,527,947	N/A	$ 215,314,482	-0.10%

FY 2014 - FY 2015 Final Appropriation Amounts

All Fund Groups

Line Item Detail by Agency

			FY 2012	FY 2013	Appropriation FY 2014	FY 2013 to FY 2014 % Change	Appropriation FY 2015	FY 2014 to FY 2015 % Change
MCD Department of Medicaid								
State Special Revenue Fund Group Total			**$0**	**$0**	**$ 1,217,540,710**	**N/A**	**$ 1,199,887,028**	**-1.45%**
R055	651644	Refunds and Reconciliations	$0	$0	$ 1,000,000	N/A	$ 1,000,000	0.00%
Holding Account Redistribution Fund Group Total			**$0**	**$0**	**$ 1,000,000**	**N/A**	**$ 1,000,000**	**0.00%**
Department of Medicaid Total			**$0**	**$ 0**	**$ 21,286,987,945**	**N/A**	**$ 22,529,074,121**	**5.83%**