LSC Greenbook

Analysis of the Enacted Budget

Department of Medicaid

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Legislative Service Commission

September 2015

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Budget Spreadsheet By Line Item

Department of Medicaid

- Funding of $26.86 billion in FY 2016 and $27.53 billion in FY 2017 for Medicaid for all agencies
- Ohio Medicaid provides health care coverage to over 2.9 million Ohioans

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 2.9 million low-income adults, children, pregnant women, seniors, and individuals with disabilities each year. Ohio Medicaid is the largest health insurer in the state. It is also the largest single state program with annual spending of about $25 billion in combined federal and state dollars. Medicaid accounts for 4% of Ohio's economy. Medicaid services are an entitlement for those who meet eligibility requirements. 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:

- 1.4 million children, from birth to age 18;
- 51% of all Ohio children under age five;
- 200,000 senior citizens;
- 51,000 individuals residing in nursing facilities; and
- 95,000 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 is administered by the Department of Medicaid (ODM) 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.

The federal government requires each state to designate a "single state agency" to administer its Medicaid Program. ODM is the single state agency for Ohio under the federal regulation. As Ohio's single state agency ODM must retain oversight and administrative control of the Ohio Medicaid Program and assure the federal Centers for Medicare and Medicaid Services (CMS) that federally set standards are maintained. Federal law allows 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).

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

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

ODMHAS works with local boards to ensure the provision of mental health services. Ohio has community behavioral health boards, which serve all 88 counties. The boards are responsible for planning, monitoring, and evaluating the service delivery system within their geographic areas. The local boards contract with local service providers to deliver mental health services in the community.

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

ODM contracts with county departments of job and family services (CDJFSs) to perform eligibility determination and enrollment. Some of these activities are done utilizing the new integrated eligibility system: Ohio Benefits, starting October 1, 2013. Ohio Benefits will ultimately replace the eligibility system known as the Client Registry Information System-Enhanced (CRIS-E). ODM provides technical assistance to counties and assists them to implement eligibility policy.

The budget provides a total appropriation for the Medicaid Program of $26.86 billion in FY 2016, a 14.5% increase over FY 2015's spending of $23.47 billion, and $27.53 billion in FY 2017, a 2.5% increase over FY 2016. Table 1 below first shows the total Medicaid appropriation by agency. Table 2 then shows the appropriations for Medicaid by expense type.

Table 1. Medicaid Appropriations
All Funds by Agency

Ohio Department	FY 2016	FY 2017
Medicaid*	$24,012,101,965	$24,403,331,085
Developmental Disabilities	$2,605,019,417	$2,874,185,877
Job and Family Services	$195,628,960	$201,228,960
Health	$25,692,094	$25,692,094
Mental Health and Addiction Services	$13,736,600	$13,736,600
Aging	$6,770,114	$6,770,114
Office of Health Transformation	$860,000	$877,446
TOTAL	**$26,859,809,150**	**$27,525,822,176**

*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. Medicaid Appropriations
All Funds by Expense Type

Expense Type	FY 2016	FY 2017
Services	$25,583,779,065	$26,273,326,557
Administrative	$1,276,030,085	$1,252,495,619
TOTAL	**$26,859,809,150**	**$27,525,822,176**
Percent of Medicaid's budget for administration	**5%**	**5%**

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

The tables above show that the appropriations for Medicaid service expenditures make up a majority of the funding for the Medicaid Program, at 95%, while approximately 5% of Medicaid's budget is for the Medicaid-related administrative activities.

Table 3 below shows the appropriations for Medicaid funding for all agencies by fund group.

Table 3. Appropriations for the Medicaid Program by Fund Group		
Fund Group	**FY 2016**	**FY 2017**
General Revenue Fund	$18,097,944,373	$19,027,513,717
Federal Share	*$12,270,971,080*	*$12,943,334,622*
State Share	*$5,826,973,293*	*$6,084,179,095*
Dedicated Purpose Fund	$2,626,052,454	$2,500,967,799
Federal Fund	$6,123,812,323	$5,985,340,660
Internal Service Activity Fund	$11,000,000	$11,000,000
Holding Account Fund	$1,000,000	$1,000,000
TOTAL	**$26,859,809,150**	**$27,525,822,176**

Note: ODM will pass through the federal reimbursement to local providers under the Medicaid School Program.

General Revenue Fund (GRF) appropriations account for the largest portion (68%) of the funding for the Medicaid Program. About 68% of the GRF funding for Medicaid is federal Medicaid reimbursement. Federal funds account for the next largest share of recommended funding for Medicaid at 22%. Federal funds include the federal reimbursement for Medicaid services and administrative activities that are spent out of GRF or non-GRF line items.

The Dedicated Purpose Fund Group accounts for 9% of the recommended funding. Sources of 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 ICFs/IID franchise permit fee;
- Prescription drug rebate revenue; and
- Recoveries from the third-party liability.

Table 4 below provides estimates of the revenue that the state is expected to collect for the various provider types.

Table 4. Estimated Franchise Fee Revenue (Dollars in millions)		
Provider Type	**FY 2016**	**FY 2017**
Hospital	$583	$613
Nursing Facility	$400	$400
ICF/IID	$45	$44
TOTAL	**$1,028**	**$1,057**

Table 5 below shows the budget for using the various franchise fee revenue and the estimated 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.

Table 5. Franchise Fee Revenue and the Estimated Corresponding Federal Share by ALIs (Dollars in millions)				
Fund	**ALIs**	**State or Federal Share**	**FY 2016**	**FY 2017**
5GF0	651656	State	$583	$613
3F00	651623	Federal	$972	$1,016
	Hospital Total		**$1,555**	**$1,629**
5R20	651608	State	$400	$400
3F00	651623	Federal	$667	$663
	NF Total		**$1,067**	**$1,063**
5GE0	320606	State	$6	$6
5GE1	653606	State	$39	$39
3G60	653639	Federal	$18	$18
3A40	653653	Federal	$46	$46
	ICF/IID Total		**$110**	**$108**
	TOTAL		**$2,732**	**$2,801**
	Assumed FMAP		**62.51%**	**62.38%**

Agency Overview

ODM is the single state agency for Ohio under the federal regulation to administer Ohio's Medicaid Program. Ohio's Medicaid Program provides health care coverage to children, pregnant women, families, adults, 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 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

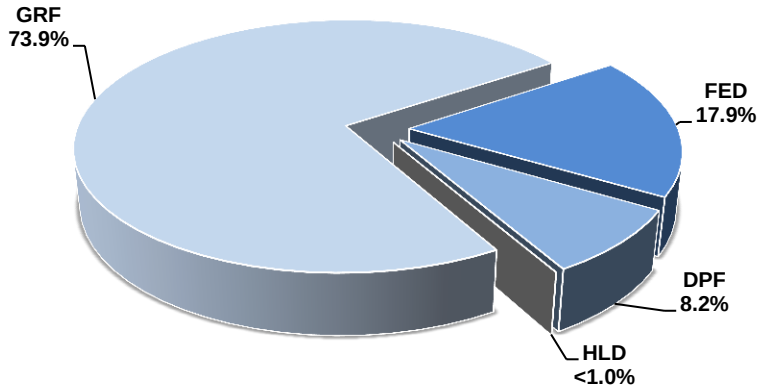
The budget provides a total appropriation for ODM of $24.10 billion in FY 2016 and $24.49 billion in FY 2017. Table 6 shows the appropriations by fund group.

Table 6. Appropriations for ODM by Fund Group

Fund Group	FY 2016	FY 2017
General Revenue Fund (GRF)	$17,527,420,257	$18,392,850,348
Federal Share	*$12,270,971,080*	*$12,943,334,622*
State Share	*$5,256,449,177*	*$5,449,515,726*
Dedicated Purpose Fund (DPF)	$2,072,972,789	$1,892,602,715
Federal (FED) Fund	$4,502,108,919	$4,208,284,022
Holding Account (HLD) Fund	$1,000,000	$1,000,000
TOTAL	**$24,103,501,965**	**$24,494,737,085**

Chart 1 presents the appropriations by fund group as well.

Chart 1: Appropriations for ODM by Fund Group, FY 2016-FY 2017



Note: Percentages may not total 100 due to rounding.

As shown in the chart above, appropriations from the GRF make up a majority of the recommended funding for ODM for the biennium at 73.9%. The GRF appropriations include the Medicare Part D clawback payments, and the state share for Medicaid service expenditures. The GRF appropriations also include the federal grant amounts (federal reimbursement) for Medicaid service expenditures.

The Federal Fund Group accounts for the next largest portion of recommended funding for ODM at 17.9%, which includes federal reimbursement from Medicaid payments for both service and administrative expenditures. The Dedicated Purpose Fund Group accounts for 8.2%, and the Holding Account Fund accounts for less than 1.0%.

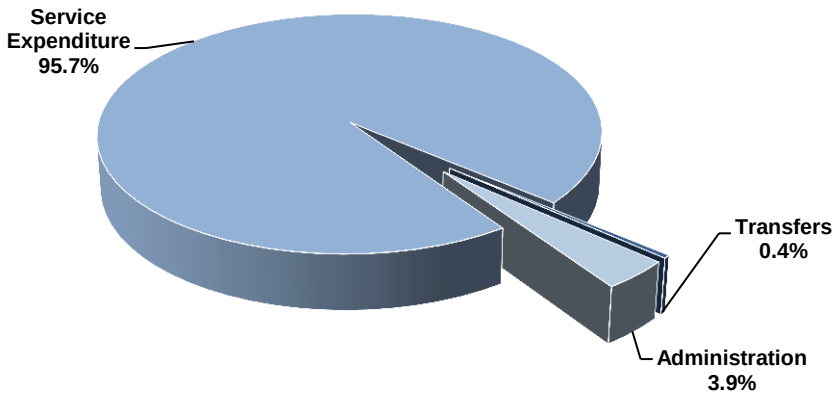
Appropriations by Expense Type

Table 7 shows the appropriations by expense type.

Table 7. Appropriations for ODM by Expense Type		
Expense Type	**FY 2016**	**FY 2017**
Services	$23,053,281,145	$23,474,362,025
Transfers to Other Agencies	$91,400,000	$91,406,000
Administrative	$958,820,820	$928,969,060
TOTAL	**$24,103,501,965**	**$24,494,737,085**

Chart 2 shows the appropriations by expense type as well. Approximately 95.7% of ODM's budget is paid out as subsidies to persons receiving Medicaid services.

Chart 2: Appropriations for ODM by Expense Type, FY 2016-FY 2017 Biennium



ODM will spend approximately $1.89 billion (3.9%) of its budget for the biennium for operating expenses including personal services, purchased services, maintenance, and equipment. ODM will pass through approximately $182.8 million of federal reimbursement over the biennium to other agencies for their Medicaid administration and services.

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
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
DD – Developmental Disabilities
DRG – Diagnosis-Related Group
DSH – Disproportionate Share Hospital
DVS – Department of Veterans Services
eFMAP – Enhanced Federal Medical Assistance Percentage
FFS – Fee-for-Service
FMAP – Federal Medical Assistance Percentage
FPL – Federal Poverty Lines
GME – Graduate Medical Education
HCAP – Hospital Care Assurance Program
HCBS – Home and Community-Based Services
HIC – Health Insuring Corporation
ICF – Intermediate Care Facility
ICF/IID – Intermediate Care Facility for Individuals with Intellectual Disabilities
JMOC – Joint Medicaid Oversight Committee
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
MITS – Medicaid Information Technology System
NF – Nursing Facility
OARRS – Ohio Automated Rx Reporting System
ODA – Ohio Department of Aging
ODE – Ohio Department of Education
ODH – Ohio Department of Health
ODJFS – Ohio Department of Job and Family Services
ODMHAS – Ohio Department of Mental Health and Addiction Services
ODODD – Ohio Department of Developmental Disabilities
OHT – Office of Health Transformation
PACE – Program of All-Inclusive Care for Elders
RAC – Recovery Audit Contractor
SCHIP – State Children's Health Insurance Program
SELF – Self-Empowered Life Funding
SPA – State Plan Amendment

Vetoed Provisions

The provisions relating to Medicaid that were vetoed, or partially vetoed, are discussed below.

Medicaid Coverage of Optional Eligibility Groups

H.B. 64 revised the law governing Medicaid coverage of optional eligibility groups as follows: (1) prohibited Medicaid from covering optional eligibility groups that state statutes do not address whether Medicaid may cover, (2) permitted Medicaid to continue covering an optional eligibility group that it covered on the effective date of this provision unless state statutes expressly prohibit Medicaid from covering the group, and (3) specified that the income eligibility threshold for an optional eligibility group is the percentage of the federal poverty line specified in state statute for the group or if the income eligibility threshold for the group is not specified in state statute, a percentage of the federal poverty line not exceeding the percentage that, on the effective date of this provision, is the group's income eligibility threshold. The Governor vetoed these provisions.

Medicaid Revocable Trusts

H.B. 64 specified that when a Medicaid applicant's or recipient's home is held in a revocable self-settled trust, all of the following are the case for purposes of determining that individual's Medicaid eligibility: (1) the home is not an available resource and, to the extent the home is in the corpus of the trust, that portion of the corpus is not to be considered an available resource, (2) to the extent the home constitutes payments from the trust to or for the applicant's or recipient's benefit, such payments are not to be considered unearned income, (3) to the extent the home constitutes any other payments from the trust, such payments are not to be considered an improper disposition of assets, and (4) the home must be excluded from the computation of spousal share determined under federal law. Additionally, the bill specified that a transfer of an applicant's or recipient's home from a revocable self-settled trust to the applicant or recipient or that individual's spouse is not to be considered an improper disposition of assets or a disposal of assets for less than fair market value for which a period of Medicaid ineligibility may be imposed under federal law. The Governor vetoed these provisions.

Medicaid Rate for Medical Transportation Providers' Fuel Costs

The budget bill required that the Medicaid payment rate for medical transportation services include a component paying for providers' fuel costs and that the rate for the fuel component be at least 5% higher than the national average for fuel prices. The Governor vetoed this provision.

Claims for Medical Transportation Services

H.B. 64 permitted a medical transportation provider to submit a claim to Medicaid for a service provided to a participant of the Integrated Care Delivery System without Medicare first denying the claim if Medicaid is responsible for paying the claim. The Governor vetoed this provision.

Nursing Facilities Medicaid Payment Rates

The budget bill eliminated requirements that beginning July 1, 2016: (1) a nursing facility must have been awarded at least five points for meeting certain accountability measures to qualify as a critical access nursing facility and (2) that ODM use the grouper methodology designated by the federal government as the resource utilization group (RUG)-IV, 48 group model when determining nursing facilities case-mix scores. The Governor vetoed these provisions.

Medicaid Waiver for Married Couple to Retain Eligibility

H.B. 64 required ODM to establish a Medicaid waiver program under which Medicaid recipients who are married to each other retain, under certain circumstances, Medicaid eligibility despite employment earnings that exceed the applicable threshold. The Governor vetoed this provision.

Medicaid Managed Care – Community Health Worker Services

H.B. 64 required a Medicaid managed care organization to cover community health worker services and similar services for enrollees who are pregnant or capable of becoming pregnant, who live in a community identified by ODH, in consultation with the Medicaid Director, as having a high rate of infant mortality, and who meet other criteria. The bill specified that if such an enrollee resided in a region served by certain community hubs, then the community hub was to provide the services. The bill earmarked $13.4 million in each fiscal year in GRF appropriation item 651525, Medicaid/Health Care Services, to provide community health worker and similar services. The Governor vetoed these provisions.

Home Care Services Contracts

The budget bill added ODM to the list of departments required to include a monitoring system for home care services contracts. The Governor vetoed this provision.

Dental Provider Rates and Pilot Project

H.B. 64 established a demonstration pilot project that would pay Medicaid dental providers in Adams, Athens, Brown, Gallia, Hocking, Jackson, Lawrence, Meigs, Monroe, Morgan, Noble, Perry, Pike, Scioto, Vinton, and Washington counties at 65% of the American Dental Association survey of fees for dental services. The bill earmarked $8,002,000 in FY 2016 and $7,974,000 in FY 2017 in GRF appropriation item 651525, Medicaid/Health Care Services, for the pilot project. The Governor vetoed these provisions.

People Working Cooperatively

H.B. 64 earmarked $250,000 in each fiscal year in appropriation item 651631, Money Follows the Person, for People Working Cooperatively to perform home modification/repair services to low-income, frail, or cognitively impaired persons 60 years of age and older to achieve independent living in their private residence and to avoid institutional placement. The Governor vetoed this provision.

Holzer Clinic Payment

The budget bill earmarked $1.0 million in FY 2016 and $500,000 in FY 2017 in GRF appropriation item 651525, Medicaid/Health Care Services, for Medicaid payments under an existing ODM rule (i.e. the Holzer rule) regarding rates for physician, pregnancy-related, evaluation, and management services provided by physician groups that meet the criteria described in the rule. The Governor vetoed this provision.

Medicaid Rates for Ambulette Services

The budget bill required the Medicaid rates for ambulette services provided during FY 2016 and FY 2017 to be at least 10% higher than the rates in effect on June 30, 2015. The Governor vetoed this provision.

FY 2016-FY 2017 Biennium Major Medicaid Initiatives

- Across all funds in six agencies, Medicaid funding totals $26.86 billion in FY 2016 and $27.53 billion in FY 2017, increases of $3.34 billion and $0.67 billion, respectively. The majority of the Medicaid budget is funded by state and federal GRF appropriations – $18.10 billion in FY 2016 and $19.03 billion in FY 2017. The state share of the GRF is $5.83 billion in FY 2016 and $6.08 billion in FY 2017.
- From calendar year (CY) 2014 through CY 2016, Group VIII is fully funded by the federal government. For CY 2017, the state is required to pay 5% of the total costs, which is estimated to be about $135 million for the second half of FY 2017. The budget transfers a total of $200 million cash from the GRF in FY 2017 to the newly created Health and Human Services Fund.
- The budget includes $15.0 million ($7.4 million state share) in FY 2016 and $30.4 million ($15.3 million state share) in FY 2017 to maintain Medicaid coverage for pregnant women at 200% of the FPL and women in need of treatment for breast or cervical cancer.
- The budget maintains the current hospital assessment rate of about 2.65% in FY 2016 and FY 2017. This policy will result in estimated revenue of $582.9 million in FY 2016 and $613.4 million in FY 2017.

- The budget requires a Medicaid managed care organization to cover home visits and cognitive behavioral therapy for enrollees who also participate in the Help Me Grow Program and are pregnant or the birth mother of a child under three. It also requires a Medicaid managed care organization to provide enhanced care management services to pregnant women or women capable of becoming pregnant in communities with high infant mortality rates.

FY 2016-FY 2017 Biennium Initiatives with Budget Impact

Table 8 below provides a summary of the FY 2016-FY 2017 biennial budget initiatives assumed or included in H.B. 64 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, "Eliminate coverage for Family Planning group," can be found under Initiative Number 1 below.

Table 8. FY 2016-FY 2017 Biennium Initiatives with Budget Impact (Dollars in Millions)

		FY 2016		FY 2017		Biennium*	
Initiative Number	Initiatives	State Share	All Funds	State Share	All Funds	State Share	All Funds
1	Eliminate coverage for Family Planning group	-$0.03	-$0.3	-$0.05	-$0.5	-$0.08	-$0.8
2	Reduce TMA Plan to six months	-$1.5	-$4.2	-$15.0	-$39.9	-$16.6	-$44.1
3	Set managed care rates at the lower bound	-$9.4	-$34.0	-$28.0	-$104.3	-$37.4	-$138.3
4	Use one-time unearned managed care quality incentive funds	-$19.3	-$51.4	-$89.1	-$236.9	-$108.4	-$288.3
5	Reform payment methodology for detail-coded drugs	-$8.3	-$22.2	-$16.7	-$44.3	-$25.0	-$66.5
6	Consolidate outpatient charges within 72 hours of an inpatient visit	-$2.1	-$5.6	-$4.2	-$11.1	-$6.3	-$16.7
7	Eliminate 5% rate add-on for outpatient services	-$12.5	-$50.8	-$26.7	-$107.5	-$39.2	-$158.3
8	Reduce potentially preventable hospital readmissions	-$5.5	-$18.0	-$11.6	-$38.1	-$17.1	-$56.1
9	Implement correct coding standards for hospital claims processing	-$2.0	-$5.4	-$3.6	-$9.6	-$5.6	-$15.0
10	Revenue collected by maintaining Hospital Franchise Fee at current rate	$68.8	$68.8	$99.3	$99.3	$168.2	$168.2
11	Reduce NF reimbursements for low-acuity individuals	$0	$0	-$3.5	-$9.2	-$3.5	-$9.2

[1] Much of the information regarding the budget initiatives comes from the Office of Health Transformation's document, titled "SFY 2016-2017 Budget Initiatives."

Table 8. FY 2016-FY 2017 Biennium Initiatives with Budget Impact (Dollars in Millions)							
		FY 2016		FY 2017		Biennium*	
Initiative Number	Initiatives	State Share	All Funds	State Share	All Funds	State Share	All Funds
12	Implement an EVV system for home health	$0	$0	-$1.9	-$9.5	-$1.9	-$9.5
13	Redesign home health and private duty nursing benefits	$0	$0	-$3.6	-$9.6	-$3.6	-$9.6
14	Recoup certain physician payments	-$0.01	-$0.03	-$0.02	-$0.05	-$0.03	-$0.08
15	Support payment innovation	$0.4	$1.0	-$1.9	-$5.0	-$1.5	-$4.0
16	Increase Medicaid primary care and dental rates**	$0	$0	$0	$0	$0	$0
17	Expand the Medicaid in Schools Program	$0	$22.2	$0	$24.3	$0	$46.5
18	Rebase nursing facility rates with a different grouper update	$0	$0	$31.7	$84.1	$31.7	$84.1
19	Change nursing facility peer group	$0	$0	-$3.0	-$8.0	-$3.0	-$8.0
20	Medicaid Program integrity initiatives	$1.6	$9.0	-$1.3	$0	$0.36	$9.0
21	Streamline Medicaid disability eligibility and eliminate spend down	$0	$0	-$1.7	-$2.0	-$1.7	-$2.0
22	Create a special benefits program for adults with severe and persistent mental illness	$12.9	$34.4	$16.4	$43.5	$29.3	$78.0
23	Improve behavioral health care and outcomes through managed care	$0	$0	$25.9	$68.9	$25.9	$68.9
24	DDD optional managed care	$0	$0	$1.3	$3.6	$1.3	$3.6
25	Enroll adopted and foster children in managed care	$0	$0	$12.1	$32.2	$12.1	$32.2
26	Give individuals access to better care coordination sooner	$0	$0	$13.0	$38.2	$13.0	$38.2
27	Engage at-risk women through community health workers	$5.0	$13.4	$5.0	$13.4	$10.1	$26.8
28	Premiums for certain Medicaid recipients	-$1.6	-$1.6	-$3.2	-$3.2	-$4.7	-$4.7

*Biennium totals may not add due to rounding.
**These numbers represent the net effect of the provision described under item 16 below.

1. Eliminate Medicaid Coverage for Family Planning Group

The budget, beginning January 1, 2016, assumes the elimination of Medicaid coverage for individuals who have modified adjusted gross income (MAGI) above 138% FPL in the Family Planning group. This population is currently covered at MAGI levels up to 200% FPL. Individuals with incomes above 138% FPL are eligible for federal subsidies through the health insurance exchange. This policy is estimated to save $274,000 ($27,400 state share) in FY 2016 and $512,094 ($51,209 state share) in FY 2017 in GRF appropriation item 651525, Medicaid/Health Care Services.

2. Reduce the Transitional Medical Assistance Plan to Six Months

The budget reduces the duration of the Transitional Medical Assistance (TMA) period from 12 months to six months. The TMA takes effect when a parent or caretaker relative's earned income increases above the eligibility threshold for the group. The TMA provides temporary continued eligibility in order to ease an individual's transition from Medicaid due to an improved financial situation. This proposal also institutes a quarterly income reporting requirement. If an individual's income remains below 185% FPL and they fulfill the quarterly reporting requirement, the individual will be granted six additional months of eligibility. This provision is estimated to save $4.1 million ($1.5 million state share) in FY 2016 and $39.9 million ($15.0 million state share) in FY 2017 in GRF appropriation item 651525, Medicaid/Health Care Services.

3. Set Managed Care Rates at the Lower Bound

The budget assumes managed care capitation rates will be set at the lower bound beginning January 1, 2016. ODM contracts with an actuarial firm, which annually determines a range of actuarially sound capitation rates for different populations (e.g., ABD Adult) for use by Ohio's MCPs. Setting the capitation rate at the lower bound is anticipated to reinforce efficient operations by the Medicaid MCPs and to streamline internal processes at the state level. This policy is estimated to save $34.0 million ($9.4 million state share) in FY 2016 and $104.3 million ($28.0 million state share) in FY 2017 in GRF appropriation item 651525, Medicaid/Health Care Services.

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

The budget includes the use of unspent funds from the Medicaid Managed Care Incentive Fund (Fund 5KW0) beginning on July 1, 2016 to offset one-time GRF costs associated with transitioning current FFS populations into managed care. This policy is estimated to save $51.4 million ($19.3 million state share) in FY 2016 and $236.9 million ($89.1 million state share) in FY 2017 in GRF appropriation item 651525, Medicaid/Health Care Services.

5. Reform Payment Methodology for Detail-Coded Drugs

The budget assumes payment for drugs based on the Medicaid physician fee schedule instead of on hospital costs when these drugs are administered by hospitals in an outpatient setting or independently billed by hospitals. Currently, in some cases hospitals are reimbursed at 60% of their hospital-specific costs for administering drugs under the above conditions. Any drug not listed on the Medicaid physician fee schedule, however, will still be reimbursed at 60% of cost. This policy is estimated to save $22.2 million ($8.3 million state share) in FY 2016 and $44.3 million ($16.7 million state share) in FY 2017 in GRF appropriation item 651525, Medicaid/Health Care Services.

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

The budget assumes hospitals to include any outpatient charges that occur 72 hours before or after an inpatient stay to be included on that inpatient claim. Hospitals are currently required to include only those outpatient charges which occur 24 hours before or after an inpatient visit. This policy also works in tandem with episodes of care programs, such as the State Innovation Model. This policy is estimated to save $5.6 million ($2.1 million state share) in FY 2016 and $11.1 million ($4.2 million state share) in FY 2017 in GRF appropriation item 651525, Medicaid/Health Care Services.

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

The budget assumes the elimination of the temporary 5% rate increase for outpatient hospital services for all but children's hospitals. The executive maintains that this rate add-on is unnecessary due to Medicaid expansion, as hospital uncompensated care costs are decreasing. This temporary rate increase is set to expire in December 2015. This policy is estimated to save $50.8 million ($12.5 million state share) in FY 2016 and $107.5 million ($26.7 million state share) in FY 2017 in GRF appropriation item 651525, Medicaid/Health Care Services.

8. Reduce Potentially Preventable Hospital Re-admissions

The budget assumes implementation of potentially preventable readmissions (PPR) software that analyzes clinically related readmissions across hospital providers. Ohio Medicaid currently targets PPR claims at the same hospital within 30 days, but does not target PPR claims across providers. Ohio's current average inpatient hospital PPR rate is 9.2%; Ohio Medicaid anticipates this rate declining by 1% annually with the implementation of this software. In addition, ODM will implement a PPR benchmark and will assess a 1% penalty on hospitals that exceed this benchmark. Together, these policies are estimated to save $18.0 million ($5.5 million state share) in FY 2016 and $38.1 million ($11.6 million state share) in FY 2017 in GRF appropriation item 651525, Medicaid/Health Care Services.

9. Implement Correct Coding Standards to Hospital Claims Processing

The budget assumes implementation of, by January 1, 2016, National Correct Coding Initiative (NCCI) methodologies and edits into the MITS to properly process outpatient Medicaid claims in accordance with federal regulations. This policy is estimated to save $5.4 million ($2.0 million state share) in FY 2016 and $9.6 million ($3.6 million state share) in FY 2017 in GRF appropriation item 651525, Medicaid/Health Care Services.

10. Maintain Current Hospital Franchise Fee

The budget allows ODM to maintain the hospital franchise fee at the current rate of about 2.65%. It also allows ODM to work with the hospital industry to create a collection schedule that takes into account the cash flow needs of hospitals. Currently, the assessment rate must be established each program year by amending the Ohio Administrative Code; this causes delays in the assessment and collection of fees and places an undue burden on hospitals. ODM collected the hospital franchise fee revenue of about $514 million in FY 2015. It is estimated that the state will collect about $582.9 million in FY 2016 and $613.3 million in FY 2017, respectively, an additional $68.9 million in FY 2016 and $99.3 million in FY 2017.

11. Reduce NF Reimbursement for Low-Acuity Individuals

The budget reduces reimbursement payments to nursing facilities for the lowest acuity individuals from $130 per resident day to (1) $115 per Medicaid day if ODM is satisfied that the nursing facility is cooperating with the Long-Term Care Ombudsman Program in efforts to help the nursing facility's low resource utilization residents receive the services that are most appropriate for their level of care, or (2) $91.70 per Medicaid day if ODM is not satisfied.

This provision is estimated to save $9.2 million ($3.5 million state share) in FY 2017.

12. Implement an Electronic Visit Verification System for Home Health

The budget assumes implementation of an Electronic Visit Verification (EVV) system for home health providers to validate service delivery to eligible individuals by authorized service providers. An EVV system reduces fraudulent activity by using technologic solutions, including telephony, GPS tracking, and biometrics, to authenticate the presence of service and by allowing the recipient of care to confirm that they are receiving care at the time of service delivery. This policy is estimated to save $9.5 million ($1.9 million state share) in FY 2017 in GRF appropriation item 651525, Medicaid/Health Care Services.[2]

13. Redesign the Home Health and Private Duty Nursing Benefit

The budget assumes the redesign of the home health and private duty nursing benefit toward a short-term acute care benefit for those individuals who are not part of a managed care plan or HCBS waiver, and toward managed care or an HCBS waiver for those individuals who receive long-term care. This policy is estimated to save

[2] The appropriation items 651425 and 651624 experience investment costs as a result of this provision; the numbers described here represent the net effect of this provision.

$9.6 million ($3.6 million state share) in FY 2017 in GRF appropriation item 651525, Medicaid/Health Care Services.

14. Recoup Certain Physician Payments

ODM will extend Ohio Medicaid's retrospective review and technical denial policy to any physician claim associated with a technical denial received by a hospital. This policy is currently only applied toward hospitals themselves. This policy is estimated to save $26,000 ($10,000 state share) in FY 2016 and $51,000 ($19,000 state share) in FY 2017 in GRF appropriation item 651525, Medicaid/Health Care Services.

15. Support Payment Innovation

ODM will implement innovative payment models, including paying for better coordinated care and improved outcomes through patient-centered medical homes. Such payment innovations were developed as a result of the convention in 2013 of Governor Kasich's Advisory Group on Health Care Payment Innovation to align public and private health care purchasing power to reward the value of services, not the volume. This policy is estimated to cost $1.0 million ($375,000 state share) in FY 2016 and save $5.0 million ($1.9 million state share) in FY 2017 in GRF appropriation item 651525, Medicaid/Health Care Services.

16. Increase Medicaid Primary Care and Dental Rates

The budget assumes an increase in payments to eligible Medicaid providers that bill for office or outpatient services codes, and preventative services codes. Ohio Medicaid will provide an enhanced payment amount to any practitioner (e.g., physicians, advanced practice nurses, physician assistants, and clinics) who bills for the specified primary care codes through both FFS and managed care delivery systems. ODM will also increase dental provider rates by 1%. Neither physician services nor dental provider rates have received an increase since 2000. The primary care rate increase is projected to cost $42.1 million ($15.8 million state share) in FY 2016 and $109.2 million ($41.1 million state share) in FY 2017, while the dental provider rate increase is projected to cost $1.5 million ($562,000 state share) in FY 2016 and $3.0 million ($1.1 million state share) in FY 2017, for a total cost of $43.6 million ($16.3 million state share) in FY 2016 and $112.2 million ($42.2 million state share) in FY 2017 out of GRF appropriation item 651525, Medicaid/Health Care Services. This cost, however, is to be offset entirely by savings achieved through the following policies:

- **Apply the Medicaid maximum payment to Medicare crossover claims**: reimburse up to the Medicaid maximum for all Part B categories of service, including physician services. For dual eligible individuals, states have the option to pay either the patient's Medicare cost-sharing amount (typically 20%) or reimburse up to the Medicaid maximum amount. Ohio

currently reimburses up to the Medicaid maximum for all services except physician services. This policy is estimated to save $43.1 million ($16.2 million state share) in FY 2016 and $86.2 million ($32.4 million state share) in FY 2017 in GRF appropriation item 651525, Medicaid/Health Care Services.

- **Convert subsidies for medical education into a primary care rate increase**: transfers $25 million ($9.4 million state share) from GME to teaching hospitals to support a primary care rate increase in FY 2017.
- **Eliminate enhanced payment to Holzer Clinic**: eliminates the enhanced reimbursement rate for the Holzer Clinic Network and reverts payment to the standard Medicaid physician fee schedule beginning January 1, 2016. According to OHT, since 1992, the Holzer Clinic has been reimbursed at 140% of the Medicaid physician fee schedule. The enhanced rate was set because the Holzer Hospital did not provide outpatient hospital services, and the enhanced payment approximated what the total payment amount would have been had claims for service been billed by both the hospital and the physician group practice. The enhanced rate supported one rural clinic. However, the Holzer Clinic expanded to ten new delivery sites and expansion continues, with every new site receiving enhanced reimbursement. This policy is estimated to save $500,000 ($187,000 state share) in FY 2016 and $1.0 million ($376,000 state share) in FY 2017 in GRF appropriation item 651525, Medicaid/Health Care Services.

17. Expand the Medicaid in Schools Program

The budget will expand the Medicaid in Schools Program (MSP) to include intensive behavioral services provided by a Certified Ohio Behavioral Analyst (COBA), services provided by an aide under the direction of a registered nurse or COBA, and specialized transportation from a child's home to school as services that may be included in a student's Individualized Education Plan (IEP). Services currently allowable under an IEP include behavioral, nursing, occupational therapy, targeted case management, and specialized transportation. Ohio Medicaid reimburses schools through MSP for services provided to children with an IEP. The school is responsible for providing services, but can draw federal funds through MSP to reimburse 63% of the cost. There are currently 580 school systems enrolled in MSP serving 61,000 Medicaid-eligible students with an IEP. This provision is projected to allow school districts to claim federal funds totaling $22.2 million in FY 2016 and $24.3 million in FY 2017 for services that the school districts otherwise would have had to provide with their own funds. This provision will have no impact on the state GRF, as school districts provide the local match, through expenditures tied to eligible IEP services, to draw federal Medicaid funds.

18. Rebase Nursing Facility Rates with a Different Grouper Update

The budget will update rates beginning in FY 2017 using calendar year 2013 costs as a basis. The update is required by current law and will result in rates more reflective of current health care costs and Ohio nursing facility service delivery. Rebasing also allows for the opportunity to update the resource utilization groups (RUGS) methodology used to measure resident acuity in the state's nursing facilities, from RUGS III to RUGS IV to coincide with the calculation of new rate components during the rebasing process. Rebasing and implementing a new grouper is estimated to cost $84.1 million ($31.7 million state share) in FY 2017 out of GRF appropriation item 651525, Medicaid/Health Care Services.[3]

19. Change Peer Group

The budget requires ODM, with the first rebasing of Medicaid payment rates for nursing facilities, to place nursing facilities in Allen and Trumbull counties in the peer groups used to determine the Medicaid payment rates for nursing facilities in Mahoning County or Stark County. This provision is estimated to save $8.0 million ($3.0 million state share) in FY 2017 in GRF appropriation item 651525, Medicaid/Health Care Services.

20. Program Integrity Initiatives

The budget assumes procurement of an advanced data analytics system for pre- and post-payment review. This system intends to use Ohio Medicaid's access to enormous amounts of data in order to enhance program integrity efforts and detect billing patterns tied to potential fraud, waste, or abuse. This policy is estimated to cost $9.0 million ($1.6 million state share) in FY 2016 and cost $0 ($1.3 million state share savings) in FY 2017. This system is projected to pay for itself and begin to produce savings by FY 2017.

21. Streamline Medicaid Disability Eligibility and Eliminate Spend Down

The budget, no earlier than July 1, 2016, will transition from what is known as a 209(b) state under Title XIX of the federal Social Security Act (SSA) to what is known as a 1634 state under Title XVI of the SSA. As a 209(b) state, Ohio currently places more restrictive qualifications on Medicaid disability eligibility than do states with 1634 status. The following changes (and their projected budget impacts) will occur as a result of this transition:

[3] These numbers represent the net impact of the two proposals. Rebasing nursing facilities is estimated to cost $153.8 million ($57.9 million state share) in FY 2017, while updating to RUGS IV is estimated to save $69.7 million ($26.2 million state share) in FY 2017, both out of appropriation line item 651525.

- Possibly replace Ohio's two duplicative disability eligibility determination systems with one system administered by Opportunities for Ohioans with Disabilities (OOD) that will determine eligibility for both Medicaid and Supplemental Security Income (SSI). This is estimated to save $7.4 million ($3.7 million state share) in FY 2017 in GRF appropriation item 651425, Medicaid Program Support – State, and in FED Fund 3F00 appropriation item 651624, Medicaid Program Support – Federal.4
- Raise the income standard for Medicaid from 64% FPL to 75% FPL (to match SSI) and raise the asset test from $1,500 to $2,000, which would result in approximately 7,110 additional Ohioans qualifying for Medicaid. This is expected to cost $65.0 million ($24.4 million state share) in FY 2017 out of GRF appropriation item 651525, Medicaid/Health Care Services.
- Eliminate the Medicaid spend down provision, which allows individuals to spend down their assets on medical expenses in order to qualify for Medicaid. This would result in approximately 4,500 Ohioans no longer being eligible for Medicaid. This is estimated to save $59.6 million ($22.4 million state share) in FY 2017 in GRF appropriation item 651525, Medicaid/Health Care Services.

In total, these provisions are estimated to save $2.0 million ($1.7 million state share) in FY 2017 in the aforementioned line items.

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

The budget requires ODM to begin to include alcohol, drug addiction, and mental health services in the care management system not later than January 1, 2018. The executive proposes to create a special benefit program for adults with severe and persistent mental illness (SPMI) who lose coverage as a result of the spend down changes detailed above. The majority of those who lose coverage due to these changes are adults with SPMI. While these individuals have access to services through Medicare and private insurance, neither option pays for the types of community support activities and care coordination provided under Medicaid. As such, Ohio Medicaid will seek a state plan amendment under section 1915(i) of the SSA to provide for eligibility for adults with SPMI with income up to 225% FPL who are not eligible under another Medicaid category and who meet diagnostic and needs assessment criteria established by the state and validated by a third-party entity. Ohio Medicaid will also identify HCBS services needed by this population to be covered as services under the 1915(i) authority. These services will be developed in conjunction with a broader benefit

[4] The appropriation items 651425 and 651624 experience investment costs and savings as a result of this provision; the numbers described here represent the net effect of this provision.

redesign, and ODMHAS staff will conduct outreach efforts with behavioral health providers and consumer and family organizations to ensure support for the targeted population. If these plans were implemented prior to January 1, 2018, it is projected to cost $34.4 million ($12.9 million state share) in FY 2016 and $43.5 million ($16.4 million state share) in FY 2017 out of GRF appropriation item 651525, Medicaid/Health Care Services.

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

The budget assumes restructuring of all Medicaid-reimbursed behavioral health services under some form of managed care in order to improve care coordination and overall outcomes for people with mental health and addiction service needs. ODM and ODMHAS will coordinate this effort, beginning with structured processes for stakeholder input to occur in March 2015. This policy is estimated to cost $68.9 million ($25.9 million state share) in FY 2017 out of GRF appropriation item 651525, Medicaid/Health Care Services.

24. Give Individuals with Developmental Disabilities an Option to Enroll in Managed Care

The budget allows giving the approximately 40,000 individuals who receive home and community-based services or who reside in developmental centers, and who are currently excluded from managed care, the option to enroll in a health plan, which in some cases may improve their access to primary care physicians, specialists, and dental services. This provision is projected to cost $3.6 million ($1.3 million state share) in FY 2017 out of GRF appropriation item 651525, Medicaid/Health Care Services.

25. Enroll Adopted and Foster Children in Managed Care

The budget allows transitioning the 28,000 children in Ohio's child welfare system from the FFS program to managed care, beginning on January 1, 2017. This transition will be monitored to ensure consistent coverage, better care coordination, and improved access to services. This provision is projected to cost $32.2 million ($12.1 million state share) in FY 2017 out of GRF appropriation item 651525, Medicaid/Health Care Services.

26. Give Individuals Access to Better Care Coordination Sooner

ODM will change the managed care enrollment process so that an individual is able to enroll in a Medicaid MCP of their choosing upon enrollment, allowing for faster access to care management and better access to services. It currently takes an average of 45 days for an individual who qualifies for Medicaid to be enrolled into one of the five MCPs. This policy is projected to cost $38.2 million ($13.0 million state share) in FY 2017 out of GRF appropriation item 651525, Medicaid/Health Care Services.

27. Engage At-Risk Women Through Community Health Workers

Managed care plans will be directed to use community health workers who live in the most high-risk neighborhoods to assist with the outreach to and identification of women, particularly pregnant women, to ensure their connection to ideal health care and community supports. The community health worker is expected to remove barriers to care for these women by connecting them with community services outside the health plan that support healthy living and work. Health plans are required to coordinate with local health districts to ensure that all health care and community supports are aligned toward decreasing infant mortality and improving the health of families. This policy is projected to cost $13.4 million ($5.0 million state share) in FY 2016 and $13.4 million ($5.0 million state share) in FY 2017 out of GRF appropriation item 651525, Medicaid/Health Care Services.

28. Premiums for Certain Medicaid Recipients

Pending CMS approval, childless, nonpregnant adults with income between 100% FPL and 138% FPL will be required to pay a monthly premium to the Medicaid Program. Monthly premiums will be capped so as not to exceed 2% of an individual's household income and are expected to be roughly $20. If an individual is delinquent on premiums for three consecutive months, that individual may experience a disruption in coverage.

Ohio expanded its Medicaid Program to cover the Group VIII population through Controlling Board action on October 21, 2013. Section 1115 of the Social Security Act permits CMS to grant states the authority to charge premiums for the Group VIII population. Premiums will be calculated using a similar methodology as premiums charged in the federal marketplace exchange. This policy is estimated to save $1.6 million in FY 2016 and $3.2 million in FY 2017 (all state share) in GRF appropriation item 651525, Medicaid/Health Care Services.

ANALYSIS OF ENACTED BUDGET

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

Table 9. Appropriations for the Department of Medicaid

Fund	ALI and Name		FY 2016	FY 2017
General Revenue Fund				
GRF	651425	Medicaid Program Support – State	$192,082,820	$196,608,060
GRF	651525	Medicaid/Health Care Services	$17,027,059,783	$17,854,625,106
GRF	651526	Medicare Part D	$308,277,654	$341,617,182
		General Revenue Fund Subtotal	***$17,527,420,257***	***$18,392,850,348***
Dedicated Purpose Fund Group				
4E30	651605	Resident Protection Fund	$2,878,000	$2,878,000
5AJ0	651631	Money Follows the Person	$5,161,000	$4,910,000
5DL0	651639	Medicaid Services – Recoveries	$551,125,000	$561,317,000
5FX0	651638	Medicaid Services – Payment Withholding	$6,000,000	$6,000,000
5GF0	651656	Medicaid Services – Hospitals/UPL	$582,887,931	$613,303,715
5KC0	651682	Health Care Grants – State	$10,000,000	$10,000,000
5SA0	651628	Maternal and Child Health	$500,000	$0
5R20	651608	Medicaid Services – Long Term Care	$400,000,000	$400,000,000
5U30	651654	Medicaid Program Support	$62,885,000	$53,834,000
6510	651649	Medicaid Services – HCAP	$451,535,858	$237,049,000
		Dedicated Purpose Fund Group Subtotal	***$2,072,972,789***	***$1,892,602,715***
Federal Fund Group				
3ER0	651603	Medicaid Health Information Technology	$71,764,000	$61,896,000
3F00	651623	Medicaid Services – Federal	$3,725,394,919	$3,456,139,022
3F00	651624	Medicaid Program Support – Federal	$567,832,000	$562,547,000
3FA0	651680	Health Care Grants – Federal	$45,718,000	$36,296,000
3G50	651655	Medicaid Interagency Pass-Through	$91,400,000	$91,406,000
		Federal Fund Group Subtotal	***$4,502,108,919***	***$4,208,284,022***
Holding Account Fund Group				
R055	651644	Refunds and Reconciliations	$1,000,000	$1,000,000
		Holding Account Fund Group Subtotal	***$1,000,000***	***$1,000,000***
Total Funding: Department of Medicaid			**$24,103,501,965**	**$24,494,737,085**

Medicaid/Health Care Services (651525)

This GRF line item is used to reimburse health care providers for covered services to Medicaid recipients. The federal earnings on the payments that are made entirely from this line item are deposited as revenue into the GRF. Spending within this line item generally can be placed into one of several major service categories: Managed Care Plans, Nursing Facilities (NFs), Hospital Services, Behavioral Health, Aging Waivers, Prescription Drugs, Physician Services, Home Care Waivers, Group VIII (i.e., those individuals who become eligible for Medicaid through the ACA), and All Other Care. The majority of expenditures from this line item earn the regular Federal Medical Assistance Percentage (FMAP) reimbursement rate at approximately 63%, 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 ACA extends SCHIP through most of 2015 and beginning October 1, 2015 the already enhanced SCHIP federal matching rate will increase by 23 percentage points.

The budget provides GRF funding in this line item of $17,027,059,783 for FY 2016, a 22.4% increase over the FY 2015 expenditures of $13,916,554,641, and $17,854,625,106 for FY 2017, a 4.9% increase over FY 2016. The appropriation levels are based on the executive's forecast of Medicaid spending, the policies assumed or included in the budget (most of which are discussed in the "**FY 2016-FY 2017 Biennium Initiatives with Budget Impact**" section), the movement of the payments for Group VIII to this line item, and other eligibility changes.

Medicaid Program Support – State (651425)

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

The budget provides funding of $192,082,820 for FY 2016, a 40.8% increase over FY 2015 expenditures, and $196,608,060 for FY 2017, a 2.4% increase over FY 2016. The increases in the appropriation levels are due to policies such as investing in the electronic visit verification for home health providers to verify billing accuracy, investing in the program Integrity System, and supporting single Disability Determination, as discussed in the "**FY 2016-FY 2017 Biennium Initiatives with Budget Impact**" section of this Greenbook.

Medicare Part D (651526)

This GRF line item is used for the phased-down state contribution, otherwise known as the clawback payment, under the Medicare Part D requirements contained in the federal Medicare Prescription Drug, Improvement, and Modernization Act (MMA)

of 2003. The clawback is a monthly payment made by each state to the federal Medicare Program 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 $308,277,654 for FY 2016, a 6.3% increase over FY 2015 expenditures, and $341,617,182 for FY 2017, a 10.8% increase over FY 2016. The funding levels are based on the executive's projected spending for the clawback payments. During FY 2014, Ohio Medicaid made over $295 million in clawback payments for approximately 206,000 dual eligibles. The executive projects that the number of dual eligibles will continue to rise to 211,000 in FY 2017 and thus increase the clawback payments to the federal government.

The budget, as was also included in H.B. 59 of the 130th General Assembly, 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 2016 and FY 2017.

Medicaid Services – Recoveries (651639)

This line item 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.

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

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

6. The nonfederal share of all supplemental rebates paid by drug manufacturers to ODM in accordance with the Supplemental Drug Rebate Program established by continuing state law.

The budget provides funding of $551,125,000 for FY 2016, a 7.1% increase over FY 2015 expenditures, and $561,317,000 for FY 2017, a 1.8% increase over FY 2016. The increase in appropriations for this line item is due to the increased rebates expected. ODM estimates drug rebates based on a historical ratio of rebates to projected pharmacy spending.

Medicaid Services – Payment Withholding (651638)

This line item is used for provider payments that are withheld from providers that change ownership. It is used to transfer the withheld funds to the appropriate fund used by ODM at final resolution. The funds are withheld and temporarily deposited into the Exiting Operator Fund (Fund 5FX0) until all potential amounts due to ODM or the provider reach final resolution. The budget provides flat funding at of $6.0 million for FY 2016 and FY 2017.

Medicaid Health Information Technology (651603)

This line item is used for 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 fund, Fund 3ER0, and appropriated $402,291,950 in FY 2011 to line item 600603, Health Information Technology. The American Recovery and Reinvestment 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 $71,764,000 for FY 2016, a 4.4% decrease from FY 2015 expenditures, and $61,896,000 for FY 2017, a 13.8% decrease from FY 2016. The decrease in appropriations for this line item is based on projected spending.

Health Care Grants – Federal (651680)

This line item is used for 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 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 $45,718,000 for FY 2016, a 92.8% increase over

FY 2015 expenditures, and $36,296,000 for FY 2017, a 20.6% decrease from FY 2016. The spending level is based on the available revenue received.

Among the funding that supports this line item are the performance bonuses that Ohio received due to its efforts to enroll and retain children onto Medicaid. The performance bonuses were established under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and have been awarded annually since federal fiscal year (FFY) 2009. Ohio received its last performance bonuses award of $10.8 million in FFY 2014. Ohio also received performance bonuses in previous years – $19.0 million in FFY 2012, $20.8 million in FFY 2011, and $13.1 million in FFY 2010. Bonus awards have previously 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, expanding access to patient-centered medical homes, and providing research funds for childhood asthma and neonatal abstinence syndrome.

In addition to the CHIPRA performance bonuses, the State Innovation Model Award grant is also used to support this line item. Ohio received $75 million in December 2014 for the second phase of the State Innovation Model Award grant from CMS. The grant will be used over the next four years to support the testing and evaluation of a multi-payer health system transformation model that was developed under phase one of the grant. Specifically, Ohio will use the grant to accelerate the use of patient-centered medical homes (PCMH) and episode-based models. The PCMH model increases the coordination between patients and their physicians and pays providers for improving patient health through measurable outcomes. It is anticipated that the PCMH model will be utilized statewide by 2018. Under the episode-based model, providers receive payments based on a specific condition or medical event (e.g., asthma acute exacerbation, joint replacement) rather than for a variety of services related to that event. By the end of the phase two grant period, 50 episodes of care should be established. While the health system transformation model will be used by the Medicaid Program, OHT also anticipates that some or all aspects of the model might be adopted by commercial insurance companies since they collaborated on the model design.

CMS awarded a total of more than $622 million to 11 states, including Ohio, to implement the model testing phase of the grant program. In February 2013, Ohio received a $3 million State Innovation Model Design Award grant from CMS for the first phase of the grant. The money, along with approximately $4 million in state and private funding and in-kind resources, was used to design a comprehensive statewide health transformation plan.

Medicaid Services – Federal (651623)

This federally funded line item is used for the Medicaid federal share when the state share is provided from a source other than GRF line item 651525, Medicaid/Health Care Services, or GRF line item 651425, Medicaid Program Support – State, or line item 651682, Health Care Grants – State. Major activities in this line item include the federal share of nursing facility, hospital, prescription drug expenditures, and general Medicaid services. The primary source of the funds is federal Medicaid reimbursement; however, it also includes Health Care Financing Research, Demonstrations, and Evaluations grants and the federal share of drug rebates. These moneys are deposited into the Health Care Federal Fund (Fund 3F00).

The budget provides funding of $3,725,394,919 for FY 2016, a 21.5% decrease from FY 2015 expenditures, and $3,456,139,022 for FY 2017, a 7.2% decrease from FY 2016. The decreases in the appropriation levels are mainly due to the movement of Group VIII service payments from this line item to GRF line item 651525, Health Care/Medicaid, and other policies discussed in the "**FY 2016-FY 2017 Biennium Initiatives with Budget Impact**" section of this Greenbook.

Medicaid Program Support – Federal (651624)

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

The budget provides funding of $567,832,000 for FY 2016, a 93.5% increase over FY 2015, and $562,547,000 for FY 2017, a 0.9% decrease from FY 2016. The fluctuation in the appropriation levels are mainly due to policies such as investing in the electronic visit verification for home health providers to verify billing accuracy, investing in the program Integrity System, and supporting single Disability Determination, as discussed in the "**FY 2016-FY 2017 Biennium Initiatives with Budget Impact**" section of this Greenbook.

Medicaid Interagency Pass-Through (651655)

This line item is used to disburse federal reimbursement to other agencies for Medicaid expenditures they have made. The departments of Aging, Developmental Disabilities, Health, Job and Family Services, and Mental Health and Addiction Services assist ODM in administering certain Medicaid programs/services and receive reimbursements, for services provided and related administration, out of line item 651655. Line item 651655 is appropriated so that these transfers may occur. In addition, line items within these agencies, that receive transferred funds, are also appropriated so that expenditures can occur out of these line items as well. So, in effect, appropriations for line item 651655 are double counted in ODM's budget and the receiving agency's budget. H.B. 64 of the 131st General Assembly, As Introduced, corrects this and

allocates federal reimbursements related to services to the appropriate state agency. However, reimbursements related to administration remain in this line item.

The budget provides funding of $91,400,000 for FY 2016, a 95.2% decrease from FY 2015 expenditures, and $91,406,000 for FY 2017.

Resident Protection Fund (651605)

This line item is used to pay the costs of relocating residents to other facilities, maintaining or operating a facility pending correction of deficiencies or closure, and reimbursing residents for the loss of money managed by the facility.

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

The budget provides flat funding of $2,878,000 for FY 2016 and FY 2017.

Money Follows the Person (651631)

This line item is used to support the federal Money Follows the Person grant initiative. The budget provides funding of $5,161,000 in FY 2016, a 156.5% increase over FY 2015 expenditures, and $4,910,000 in FY 2017, a 4.9% decrease from FY 2016. The funding levels are the executive's projected spending.

The funding is used to relocate seniors and persons with disabilities from institutions to home and community-based settings. The federal government allocates a portion of the grant each year based upon the projected enrollment numbers as estimated by Ohio Medicaid. Ohio Medicaid cannot enroll more than their estimated projected enrollment. The grant is realized by the state as federal reimbursement on expenditures for transitioning eligible Medicaid members out of institutional settings and into home or community-based care. More specifically, for qualified and demonstrative services the federal government reimburses Ohio at an enhanced federal match rate of nearly 80% for Medicaid members for their first 12 months in home or community-based care, while other supplemental services are reimbursed at the regular federal Medicaid reimbursement. After the 12-month period, Ohio Medicaid draws down the regular federal reimbursement for each transitioned Medicaid member.

The Affordable Care Act of 2010 (ACA) extends the MFP Program through September 30, 2016, and appropriates an additional $2.25 billion ($450 million for each year in FFY 2012 to FFY 2016). Any funds remaining at the end of each fiscal year carry over to the next fiscal year, and can be used to make grant awards to current and new grantees until FY 2016. Under ACA, grant awards are available to states for the fiscal year they got the award, and four additional fiscal years after. Any unused grant funds

awarded in 2016 can be used until 2020. ACA also expands the definition of who is eligible for the MFP Program to include people that live in an institution for more than 90 consecutive days. (Exception: days that a person was living in the institution for the sole purpose of receiving short-term rehabilitation services reimbursed by Medicare do not count toward this 90-day period).

Medicaid Services – Hospital/UPL (651656)

This line item is used to support hospital upper payment limit (UPL) programs and provides offsets to Medicaid GRF spending. The source of funds for this line item is the revenue generated from a hospital assessment. Assessment revenue is deposited into the Hospital Assessment Fund (Fund 5GF0). The assessment is based on a percentage of total facility costs, and is collected over the course of three payments during each year. The federal match for expenditures from this line item is made from line item 651623, Medicaid Services – Federal. This fee is separate from the established assessment fee currently used to support the state's Disproportionate Share Hospital (DSH) Program.

The budget provides funding of $582,887,931 in FY 2016, a 5.0% increase over FY 2015 expenditures, and $613,303,715 in FY 2017, a 5.2% increase from FY 2016. The increase in the appropriation is attributable to the projected increase in the hospital total facility costs.

Health Care Grants – State (651682)

This line item is used to fund planning and implementation grants related to the ACA. Ohio Medicaid deposits funds it receives pursuant to the administration of the Medicaid Program in Fund 5KC0, other than any such funds that are required by law to be deposited into another fund. Typically this is in the form of intrastate transfer vouchers from other agencies for specific projects associated with the Health Innovation Fund. There are currently no agreements to receive grants or moneys to Fund 5KC0. However, in anticipation of receipt, the budget provides flat funding of $10.0 million for FY 2016 and FY 2017.

Maternal and Child Health (651628)

This new line item is used to be allocated to Integrating Professionals for Appalachian Children. Funds from this line item are used to improve maternal and child health outcomes in the service area comprised of Athens, Gallia, Hocking, Jackson, and Meigs. The budget provides funding of $500,000 in FY 2016 for this line item.

Medicaid Services – Long Term Care (651608)

This line item is used to make Medicaid payments to nursing facilities. The source of funds for this line item is the franchise fee payments from nursing facilities. The assessment amount is calculated each year at the maximum percentage allowed by federal law (not to exceed 6%). The franchise fee payments are due to the state in

February, May, August, and November of each year and are deposited in the Nursing Home Franchise Permit Fee Fund (Fund 5R20).

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

H.B. 59 of the 130th General Assembly replaced the specific dollar amount of the per bed per day rate of the fee with a formula to be used to determine the per bed per day fee rate. Effective July 1, 2013, the franchise permit fee rate was 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 percentage5 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.

The franchise fee calculated from the above formula was about $12.00 for FY 2014 and $12.05 for FY 2015.

The budget provides relatively flat funding for this line item at the FY 2015 expenditure level of $400 million each year in FY 2016 and FY 2017.

Medicaid Program Support (651654)

This line item 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). A significant portion of revenue to Fund 5U30 are (1) tort and audit recoveries made by

[5] The indirect guarantee percentage is the percentage specified in federal law that is to be used to determine whether a class of providers is indirectly held harmless for any portion of the costs of a broad-based healthcare-related tax. The indirect guarantee percentage is currently 6%. (42 U.S.C. § 1396b(w)(4)(C)(ii).)

department auditors, audit contractors, and the Attorney General's Office, and (2) from the transfer of state share of vendor offsets.

The budget provides funding of $62,885,000 for FY 2016, a 355.8% increase over FY 2015 expenditures, and $53,834,000 for FY 2017, a 14.4% decrease from FY 2016.

Refunds and Reconciliations (651644)

This line item is used to disburse funds that are held for checks whose disposition cannot be determined at the time of receipt. Upon determination of the appropriate fund into which the check should have been deposited, a disbursement is made from this line item to the appropriate fund. In addition, unidentified federal reimbursement is temporarily drawn into this account until distribution can be made into the appropriate account.

The budget provides funding of $1 million for FY 2016 and FY 2017.

Medicaid Services – HCAP (651649)

This line item is to fund the state share of the Hospital Care Assurance Program (HCAP). The federal share of HCAP is funded through line item 651623, Medicaid Services – Federal.

Fund 6510 is used to support line item 651649. The only source of revenue for Fund 6510 is HCAP assessments from Ohio hospitals. Shortly after assessment revenue is received, it is disbursed back to hospitals using the HCAP formula.

The federal government requires state Medicaid programs to make subsidy payments to hospitals that provide uncompensated, or charity, care to low-income and uninsured individuals at or below 100% FPL under the 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 budget provides funding of $451,535,858 for FY 2016 and $237,049,000 for FY 2017. The executive assumes no payment in FY 2015. The funding levels for HCAP are based on the executive's projected assessment revenue and spending. The maximum amount of HCAP is capped in federal law. ODM estimated the revenue based on caps established in the Medicare Modernization Act of 2003. ACA requires annual aggregate reductions in federal funding from FFY 2014 through FFY 2020.

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