Greenbook

LSC Analysis of Enacted Budget

Department of Medicaid

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Legislative Service Commission

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OVERVIEW

Medicaid Program Overview

Medicaid is a publicly funded health insurance program for low-income individuals. It is a federal-state joint program: administered by the states and funded with federal, state, and, in some states like Ohio, local revenues. The federal government establishes and monitors certain requirements concerning funding, eligibility standards, and quality and scope of medical services. In Ohio, Medicaid covers over 3.0 million low-income adults, children, pregnant women, seniors, and individuals with disabilities each year.

The federal government requires each state to designate a "single state agency" to administer its Medicaid Program. The Ohio Department of Medicaid (ODM) is the single state agency for Ohio under the federal regulation. As Ohio's single state agency ODM must retain oversight and administrative control of the Ohio Medicaid Program and assure the federal Centers for Medicare and Medicaid Services (CMS) that federally set standards are maintained. ODM administers the program with the assistance of other state agencies that receive administrative funding in their budgets as can be seen in Table 1.

Table 1. Appropriations for the Medicaid Program All Funds by Agency

Ohio Department	FY 2018	FY 2019
Medicaid*	$24,002,473,387	$25,094,404,730
Developmental Disabilities	$2,755,921,749	$2,826,824,654
Job and Family Services	$265,119,931	$216,611,836
Health	$27,130,029	$27,840,949
Mental Health and Addiction Services	$12,250,367	$12,250,367
Aging	$7,115,584	$7,115,584
Pharmacy Board	$1,875,000	$2,310,000
Education	$1,045,500	$1,045,500
TOTAL	**$27,072,931,547**	**$28,188,403,620**

*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 vs. Administration		
Expense Type	**FY 2018**	**FY 2019**
Services	$25,730,310,119	$26,810,598,300
Administration	$1,342,621,428	$1,377,805,320
TOTAL	**$27,072,931,547**	**$28,188,403,620**
Percent 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 budget provides a total appropriation for the Medicaid Program of $27.07 billion in FY 2018, a 6.0% increase over FY 2017's spending of $25.55 billion, and $28.19 billion in FY 2019, a 4.1% increase over FY 2018. Table 1 shows the funding for the total Medicaid appropriation by agency. Table 2 shows the appropriations for Medicaid broken down by service versus administrative costs.

Table 2 shows that the appropriations for Medicaid service expenditures make up a majority of the funding for the Medicaid Program, at about 95% for the biennium, while approximately 5% of Medicaid's budget for the biennium is for Medicaid-related administrative activities.

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

Table 3. Appropriations for the Medicaid Program by Fund Group		
Fund Group	**FY 2018**	**FY 2019**
General Revenue Fund	$14,824,145,875	$15,672,858,193
Federal Share	$9,735,053,357	$10,311,479,657
State Share	$5,089,092,518	$5,361,378,536
Dedicated Purpose Fund	$3,203,052,727	$3,249,355,371
Federal Fund	$9,027,732,945	$9,256,190,056
Internal Service Activity Fund	$17,000,000	$9,000,000
Holding Account Fund	$1,000,000	$1,000,000
TOTAL	**$27,072,931,547**	**$28,188,403,620**

General Revenue Fund (GRF) appropriations account for the largest portion (55.2%) of the funding for the Medicaid Program. About 65.7% of the GRF funding is federal Medicaid reimbursement. The GRF's share of Medicaid spending is significantly smaller than its share in FY 2017 (68.2%). This shift out of the GRF and into non-GRF funds is largely due to the policy of replacing the sales tax on Medicaid managed care organizations with a franchise fee on all health insuring corporation (HIC) plans. The sales tax is deposited into the GRF whereas the HIC tax is deposited into a non-GRF fund.

Federal funds account for the next largest share of recommended funding at 33.1%. Federal funds include primarily federal reimbursements for Medicaid services and administrative activities that are not deposited into the GRF.

Dedicated Purpose Fund appropriations account for 11.7% of the recommended funding. Sources of these funds mainly include the following:

- Revenue generated from the new HIC franchise fee;
- Revenue generated from hospital assessments;
- Revenue generated from nursing home and hospital long-term care unit franchise permit fees;
- Revenue generated from the intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) franchise permit fee;
- Prescription drug rebate revenue; and
- Recoveries from third-party liabilities.

The revenues from provider taxes (also referred to as franchise fees) are appropriated in ODM and the Ohio Department of Developmental Disabilities (ODODD's) budgets. The budget replaces the sales and use tax on Medicaid managed care plans with a broad-based franchise fee on all HIC plans as approved by the federal Centers for Medicare and Medicaid Services (CMS). Table 4 provides estimates of the revenue that the state is expected to collect from the various provider types.[1]

Table 4. Estimated Franchise Fee Revenue ($ in millions)

Provider Type	FY 2018	FY 2019
HIC Class*	$854	$868
Hospital	$619	$648
Nursing Facility	$406	$406
ICF/IID	$42	$40
TOTAL	**$1,921**	**$1,961**

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

[1] These revenue estimates include Group VIII population.

Table 5 shows the budget for using the various franchise fee revenues and the corresponding estimated federal share by appropriation line item.[2] If the state spends the franchise fee revenue on Medicaid-related services or activities, the state can draw down federal reimbursement. The federal medical assistance percentage (FMAP) represents the portion of total qualified Medicaid spending that is reimbursed by the federal government.

Table 5. ALI Appropriations by Franchise Fee Type and the Estimated Corresponding Federal Share ($ in Millions)

Fund	ALIs	State or Federal Share	FY 2018	FY 2019
5TN0	651684	State	$593	$661
3F00	651623	Federal	$996	$1,109
	HIC Class Total		**$1,589**	**$1,770**
5GF0	651656	State	$619	$648
3F00	651623	Federal	$1,039	$1,087
	Hospital Total		**$1,658**	**$1,734**
5R20	651608	State	$406	$406
3F00	651623	Federal	$681	$681
	Nursing Facilities Total		**$1,087**	**$1,086**
5GE0	653606	State	$37	$36
3A40	653654	Federal	$32	$30
	ICF/IID Total		**$69**	**$66**
	Total		**$4,403**	**$4,656**
	Assumed FMAP		**62.67%**	**62.66%**

Agency Overview

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

[2] Appropriation line item 651684 excludes the franchise fee revenue generated from Group VIII population.

Appropriations Overview

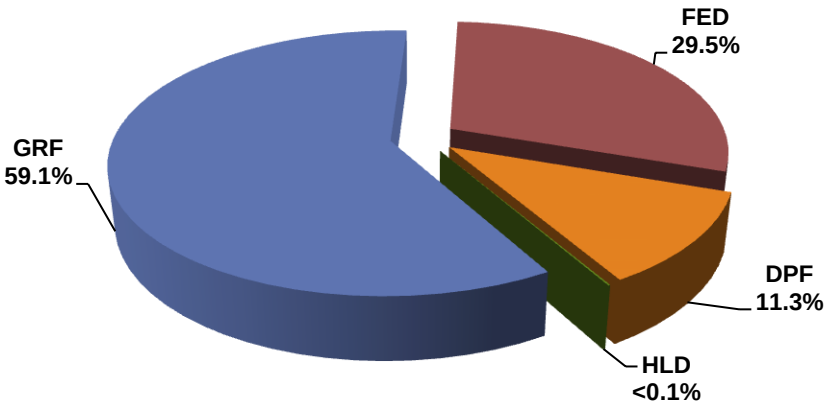
Appropriations by Fund Group

The budget provides a total appropriation for ODM of $24.13 billion in FY 2018 and $25.22 billion in FY 2019. Table 6 shows the appropriations by fund group.

Table 6. Appropriations for ODM by Fund Group		
Fund Group	**FY 2018**	**FY 2019**
General Revenue Fund (GRF)	$14,147,408,844	$15,029,621,162
Federal Share	$9,735,053,357	$10,311,479,657
State Share	$4,412,355,487	$4,718,141,505
Dedicated Purpose Fund (DPF)	$2,791,690,650	$2,802,233,832
Federal Fund (FED)	$7,188,025,490	$7,387,251,333
Holding Account Fund (HLD)	$1,000,000	$1,000,000
TOTAL	**$24,128,124,984**	**$25,220,106,327**

Chart 1 presents the appropriations by fund group as well.

Chart 1: Appropriations for ODM by Fund Group, FY 2018-FY 2019



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 funding for ODM for the biennium at 59.1%. The GRF appropriations include the Medicare Part D clawback payments, and the state share for Medicaid expenditures. The GRF appropriations also include federal grant amounts (federal reimbursement) for Medicaid service expenditures.

The Federal Fund Group accounts for the next largest portion of recommended funding for ODM at 29.5%, which includes federal reimbursement for Medicaid payments for both service and administrative expenditures. The Dedicated Purpose

Fund Group accounts for 11.3% and the Holding Account Fund Group accounts for less than 0.1%.

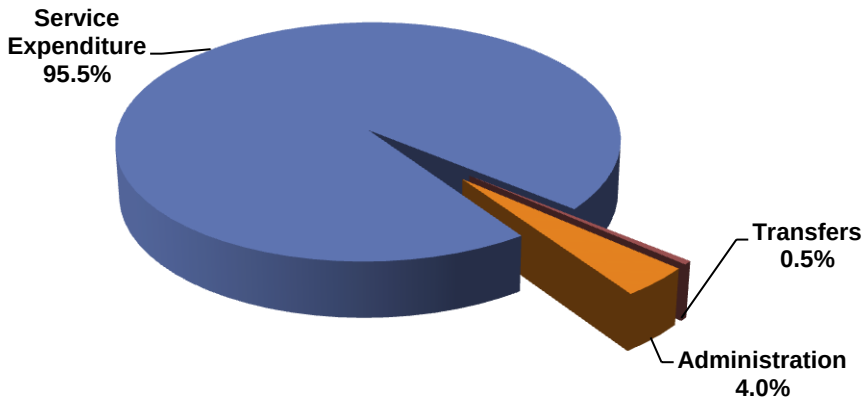
Appropriations by Expense Type

Table 7 shows the appropriations by expense type.

Table 7. Appropriations for ODM by Expense Type		
Expense Type	**FY 2018**	**FY 2019**
Services	$23,058,920,524	$24,069,305,800
Transfers to Other Agencies	$125,651,597	$125,701,597
Administration	$943,552,863	$1,025,098,930
TOTAL	**$24,128,124,984**	**$25,220,106,327**

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

Chart 2: Appropriations for ODM by Expense Type, FY 2018-FY 2019 Biennium



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

Vetoed Provisions

The Governor vetoed 15 budget bill provisions related to the Medicaid Program. On July 6, 2017, the House voted to override ten of the Governor's Medicaid-related vetoes and on August 22, 2017, the Senate voted to override six of those ten. These six provisions, therefore, will become law. All Medicaid-related vetoed provisions are described below.

Vetoed Provisions Overridden by Both the House and Senate

Controlling Board Authority

H.B. 49 prohibits the Controlling Board from authorizing expenditure of unanticipated revenue received by the state if the revenue exceeds 0.5% of the GRF appropriations for that fiscal year. As a result, if the federal government expands Medicaid, the state would need General Assembly approval to expend new federal revenues above the 0.5% limitation.

Medicaid Coverage of Optional Eligibility Groups

H.B. 49 eliminates the Medicaid Program's authority to cover an optional eligibility group if state statutes do not address whether the program may cover the group. It permits the Medicaid Program to cover an optional eligibility group currently covered by the program. However, it prohibits the Medicaid Program from covering an optional eligibility group that the program does not currently cover unless state statutes either require the group to be covered or expressly permit the group to be covered.

Medicaid Rates for Neonatal and Newborn Services

H.B. 49 requires that the Medicaid rates for certain neonatal and newborn services equal 75% of the Medicare rates for the services. It also requires that the Medicaid rates for other services selected by the ODM Director be reduced to avoid an increase in Medicaid expenditures.

Medicaid Rates for Nursing Facility Services

H.B. 49 makes revisions to the formula used to determine Medicaid payment rates for nursing facility services, provides that the total amount of payments for nursing facility services provided under Medicaid fee-for-service and the Integrated Care Delivery System (i.e., MyCare Ohio) cannot exceed $2,659,167,368 for FY 2018 and $2,664,485,703 for FY 2019 and requires that nursing facilities' rates be decreased as necessary to ensure that the total amount of payments equal those amounts.[3]

Behavioral Health Redesign

H.B. 49 prohibits alcohol, drug addiction, and mental health services from being included in Medicaid managed care before July 1, 2018.

Controlling Board Authorization Regarding Medicaid Expenditures

H.B. 49 gives the Controlling Board authorization regarding Medicaid expenditures as follows:

[3] The Governor vetoed all of this provision, except for the limits on total payments.

1. Permits the ODM Director during the 2018-2019 fiscal biennium to request that the Controlling Board authorize expenditure from the Health and Human Services Fund in an amount necessary to pay for the costs of the Medicaid Program;
2. Permits the Controlling Board to authorize the expenditure if the U.S. Congress does not amend the law to lower the federal medical assistance percentage for the expansion eligibility group (Group VIII);
3. Permits the OBM Director, if the Controlling Board authorizes the expenditures, to transfer up to $26,309,868 in FY 2018 and $34,667,668 in FY 2019 from Fund 5DL0 and up to $196,226,296 in FY 2018 and $226,841,369 in FY 2019 from Fund 5TN0 to the Health and Human Services Fund.

Vetoed Provisions Overridden by the House Only

Legislative Oversight of Rules Increasing Medicaid Rates

The Governor vetoed a provision of H.B. 49 prohibiting the implementation of a proposal to increase a Medicaid payment rate if any of the following occurs:

1. ODM or other responsible state agency fails to submit the proposal to the Joint Medicaid Oversight Committee (JMOC);
2. JMOC votes, not later than 30 days after receiving the proposal, to prohibit the proposal's implementation;
3. The General Assembly, not later than 90 days after JMOC's deadline, adopts a concurrent resolution prohibiting the proposal's implementation.

Long-Term Services Added to Medicaid Managed Care

The Governor vetoed a provision of H.B. 49 prohibiting nursing facility services and home and community-based waiver services from being added to Medicaid managed care and requiring the General Assembly to consider and vote on legislation that would authorize the inclusion of nursing facility services and home and community-based waiver services in the Medicaid managed care system.

The vetoed provision also provided for an ongoing committee called the Patient-Centered Medicaid Long-Term Care Delivery System Advisory Committee to be established if the General Assembly enacted legislation authorizing the inclusion of nursing facility services and home and community-based waiver services in the Medicaid managed care system. JMOC was to provide the committee administrative assistance and ODM was to provide it updates about the inclusion of nursing facility services and home and community-based waiver services in the Medicaid managed care system.

Health Insuring Corporation Franchise Fee

The Governor vetoed a provision of H.B. 49 requiring the ODM Director to seek federal approval to increase the health insuring corporation franchise fee in a manner that would provide for the franchise fee to raise up to an additional $207 million each fiscal year beginning not sooner than FY 2019 and ending by the close of FY 2024. The provision specified that the additional funds be distributed to each county and transit authority that experiences reduced sales tax revenues due to the cessation of the sales tax on Medicaid health insuring corporations.

Waiver Regarding Healthy Ohio Program

The Governor vetoed a provision of H.B. 49 requiring the Medicaid Director to resubmit a request for a federal Medicaid waiver needed to implement the Healthy Ohio Program not later than January 31, 2018.

Vetoed Provisions Not Overridden by Either Chamber

Medicaid Eligibility Requirements for Expansion Group

The Governor vetoed a provision of H.B. 49 prohibiting the Medicaid Program from newly enrolling individuals as part of the expansion eligibility group beginning July 1, 2018. The provision exempted individuals who have a mental illness or drug addiction from the freeze and required the ODM Director to seek a federal Medicaid waiver to implement the freeze.

Recovery of Medicaid Overpayments

The Governor vetoed a provision of H.B. 49 reducing the number of years ODM has to notify a nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID) of a Medicaid overpayment from five to three.

Medicaid Waiver to Provide Services at Institutions for Mental Diseases

The Governor vetoed a provision of H.B. 49 requiring ODM to create and administer a Medicaid waiver component to provide services to eligible individuals between the ages of 21 and 64 at institutions for mental diseases, which are hospitals and other facilities of more than 16 beds primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases.

Managed Care Premium Payment Withholdings

The Governor vetoed a provision of H.B. 49 limiting the percentage of managed care organization (MCO) premium payments that may be withheld by ODM for purposes of the managed care performance payment program to 1% for FY 2019.

Medicaid Payment Rates for Hospital Services

The Governor vetoed a provision of H.B. 49 setting the Medicaid payment rate for a hospital service provided from July 1, 2017, through June 30, 2019, to an amount

that is equal to the amount that was paid for the same service on January 1, 2017, except for any change resulting from the rebasing or recalibration of hospital rates on July 1, 2017.

FY 2018-FY 2019 Biennium Initiatives with Budget Impact

Table 8 below provides a list of the FY 2018-FY 2019 biennial budget initiatives assumed or included in H.B. 49 and the overall fiscal impact on Ohio's Medicaid Program of each.[4] Following the table is a brief description of each initiative. The last three initiatives in the table do not have an overall budget impact, but do have an impact on the state share of GRF spending for the program. This impact is described in the narrative.

Table 8. FY 2018-FY 2019 Biennium Initiatives with Budget Impact ($ in Millions)

Initiative Number	Initiatives	FY 2018	FY 2019
1	Eliminate the Medicaid sales tax	-$1,123.1	-$1,209.5
2	Replace sales tax with member month fee	$853.9	$867.8
3	Premiums for certain Medicaid recipients	-$52.6	-$184.7
4	Managed care CMS requirements implementation	$6.0	$6.7
5	Enroll everyone in managed care	$0.0	$493.7
6	Timing changes member month tax for MLTSS	$0.0	-$447.7
7	Helping Ohioans Move, Expanding Choice Program	-$4.5	-$5.4
8	Support self-directed waiver brokerage services	$0.0	$2.9
9	Comprehensive Primary Care continuation and expansion	$51.6	$72.0
10	Alternative purchasing model for nursing facility services	$17.3	$17.3
11	Care Innovation and Community Improvement Program	$200.0	$200.0
12	Noninstitutional laboratory, radiology and pathology services	$7.6	$15.3
13	Lead funding partnership	$5.0	$5.0
14	Program integrity	-$5.0	-$10.0
15	ODM & ODJFS business simplification	-$19.8	-$18.1
16	Fund elimination and reform	$0.0	$0.0
17	Single preferred drug list for FFS and managed care	$0.0	$0.0
18	Transportation brokerage	$0.0	$0.0

[4] Much of the information regarding the budget initiatives comes from the Office of Health Transformation's white papers.

1. Eliminate the Medicaid Sales Tax

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

2. Replace Sales Tax with Member Month Fee

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

3. Premiums for Certain Medicaid Recipients

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

4. Managed Care CMS Requirements Implementation

The budget makes changes to comply with new requirements issued by CMS for managed care plans beginning July 1, 2017. In May 2016, CMS issued a final rule (42 C.F.R. Part 438) to implement the first significant changes to Medicaid managed care regulations in over a decade. The rule contains provisions to support health care

delivery system reforms, strengthen the consumer experience and consumer protections, and strengthen program integrity by improving accountability and transparency. Ohio Medicaid will implement the rule over the next biennium, and in doing so will need to make a number of changes to the Ohio Administrative Code, information technology systems, and managed care provider agreements. Making these changes will cost $6.0 million in FY 2018 and $6.7 million in FY 2019.

5. Enroll Everyone in Managed Care

The budget requires nearly all Medicaid enrollees to be in a managed care plan by July 1, 2018. The new populations enrolled in managed care will include individuals receiving community and facility based long-term services and supports, participants in the Medicaid Buy-in Program for workers with disabilities, individuals dually eligible for Medicaid and Medicare who are not participating in MyCare, and eligible individuals receiving refugee medical assistance. ODM will implement a new Managed Medicaid Long-Term Services and Supports (MLTSS) Program through a competitive procurement, ideally selecting at least three plans to participate. Exceptions to the new requirement will include individuals served through ODODD; individuals enrolled on ODODD waiver programs will continue to receive long-term care through fee-for-service (FFS), but will have the option to enroll in a health plan for acute care services. This initiative will cost $493.7 million in FY 2019. Most of this cost is due to timing as ODM will need to pay outstanding claims under the FFS system for this population at the same time ODM is paying their managed care capitated amounts. The cost will largely be offset by changes to the timing of member month payments (described in Initiative 6).

6. Timing Changes Member Month Tax for MLTSS

The budget adjusts the timing of managed care payments to minimize any one-time costs related to converting FFS payments to managed care for the MLTSS Program. The current schedule of three payments monthly will be converted into four payments monthly and the last payment in each fiscal year will carry over into the next fiscal year beginning in FY 2019. This timing adjustment will offset $447.7 million of the costs of Initiative 5 in FY 2019.

7. Helping Ohioans Move, Expanding Choice Program

The budget eliminates the Ohio Access Success Project on January 1, 2019, and requires ODM to transfer its enrollees into the Helping Ohioans Move, Expanding (HOME) Choice Program or, if that program is integrated into a Medicaid waiver program, the same or another Medicaid waiver program. This change could potentially save $4.5 million ($2.3 million state share) in FY 2018 and $5.4 million ($2.8 million state share) in FY 2019.

8. Support Self-Directed Waiver Brokerage Services

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

9. Comprehensive Primary Care Continuation and Expansion

H.B. 49 eliminates the authority of the ODM Director to implement as part of the Medicaid program a system under which individuals with chronic conditions receive health home services and the Director's authority to implement a similar system for individuals with developmental disabilities. H.B. 49 also abolishes ODM's patient-centered medical home program. (The program is often called the Comprehensive Primary Care Program.) This change could potentially avoid Medicaid cost of $51.6 million ($13.6 million state share) in FY 2018 and $72 million ($19.1 million state share) in FY 2019.

10. Alternative Purchasing Model for Nursing Facility Services

H.B. 49 modifies the determination of the Medicaid payment rate to be paid under the alternative purchasing model for nursing facility services provided by designated discrete units of nursing facilities to Medicaid recipients with specialized health care needs. ODM must set the payment rate at either a certain percentage of the statewide average of the Medicaid payment rate for long-term acute care hospital services or another amount determined in accordance with a methodology that includes improved health outcomes as a factor. Prior law set the percentage at 60%. H.B. 49 lowers the percentage to 34%. This change could potentially reduce Medicaid cost by $17.3 million ($6.5 million state share) in FY 2018 and FY 2019.

11. Care Innovation and Community Improvement Program

H.B. 49 requires the Medicaid Director to establish the Care Innovation and Community Improvement Program for the 2018-2019 fiscal biennium. Any nonprofit hospital agency affiliated with a state university and any public hospital agency may volunteer to participate in the program if it operates a hospital that has a Medicaid provider agreement. Nonprofit and public hospital agencies that participate in the program are responsible for the state share of the program's costs and must make or request the appropriate government entity to make intergovernmental transfers to pay for the costs. The Director is required to establish a schedule for making the transfers.

Each nonprofit and public hospital agency participating in the program must do at least one of the tasks in accordance with strategies, and for the purpose of meeting goals designed to benefit Medicaid recipients. Regardless of the task chosen, a nonprofit and public hospital agency must submit annual reports to JMOC summarizing its work on the task and progress in meeting the program's goals.

Each nonprofit and public hospital agency participating in the program is to receive supplemental payments under the Medicaid program for physician and other professional services that are covered by the Medicaid Program and provided to Medicaid recipients. The amount of the payments is to equal the difference between the Medicaid rate for the services and average commercial rates for the services. The Director is permitted to terminate, or adjust the amount of, the payments if the amount of the funds for the program is inadequate.

The Director is required to establish a process to evaluate the work done under the program by nonprofit and public hospital agencies and their progress in meeting the program's goals. The process must be established not later than January 1, 2018. The Director is authorized to terminate a nonprofit or public hospital agency's participation in the program if the Director determines that an agency is not doing at least one of the tasks discussed above or making progress in meeting the program's goals.

The budget includes funding of $200 million ($60 million state share) each year in FY 2018 and FY 2019 for this program.

12. Noninstitutional Laboratory, Radiology, and Pathology Services

The budget reduces the Medicaid rates for noninstitutional laboratory, radiology, and pathology services by 5% for the period beginning January 1, 2018, and ending July 1, 2019. It is estimated that this policy would potentially reduce Medicaid costs by $7.6 million ($2.3 million state share) in FY 2018 and $15.3 million ($4.6 million state share) in FY 2019.

13. Lead Funding Partnership

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

14. Program Integrity

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

15. ODM & ODJFS Business Simplification

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

16. Fund Elimination and Reform

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

17. Single Preferred Drug List for FFS and Managed Care

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

18. Transportation Brokerage

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

ANALYSIS OF ENACTED BUDGET

Appropriations for the Department of Medicaid				
Fund		**ALI and Name**	**FY 2018**	**FY 2019**
General Revenue Fund				
GRF	651425	Medicaid Program Support – State	$176,312,968	$178,754,197
GRF	651525	Medicaid/Health Care Services	$13,492,852,269	$14,372,535,691
GRF	651526	Medicare Part D	$478,243,607	$478,331,274
		General Revenue Fund Subtotal	***$14,147,408,844***	***$15,029,621,162***
Dedicated Purpose Fund Group				
4E30	651605	Resident Protection Fund	$4,878,000	$4,878,000
5AJ0	651631	Money Follows the Person	$12,760,900	$12,373,500
5AN0	651686	Care Innovation and Community Improvement Program	$60,000,000	$60,000,000
5DL0	651639	Medicaid Services – Recoveries	$774,381,570	$722,709,203
5DL0	651685	Medicaid Recoveries – Program Support	$36,146,571	$41,328,516
5FX0	651638	Medicaid Services – Payment Withholding	$12,000,000	$12,000,000
5GF0	651656	Medicaid Services – Hospital Upper Payment Limit	$619,104,791	$647,635,236
5KC0	651682	Health Care Grants – State	$5,000,000	$5,000,000
5R20	651608	Medicaid Services – Long Term	$405,666,000	$405,666,000
5SC0	651683	Medicaid Services – Physician UPL	$30,000,000	$30,000,000
5TN0	651684	Medicaid Services – HIC Fee	$593,195,389	$660,893,005
5TZ0	651600	Brigid's Path Program	$500,000	$500,000
6510	651649	Medicaid Services – Hospital Care Assurance Program	$238,057,429	$199,250,372
		Dedicated Purpose Fund Group Subtotal	***$2,791,690,650***	***$2,802,233,832***
Federal Fund Group				
3ER0	651603	Medicaid Health and Transformation Technology	$61,896,000	$61,896,000
3F00	651623	Medicaid Services – Federal	$6,353,919,469	$6,478,785,019
3F00	651624	Medicaid Program Support – Federal	$607,899,720	$682,203,750
3FA0	651680	Health Care Grants – Federal	$38,658,704	$38,664,967
3G50	651655	Medicaid Interagency Pass-Through	$125,651,597	$125,701,597
		Federal Fund Group Subtotal	***$7,188,025,490***	***$7,387,251,333***
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			**$24,128,124,984**	**$25,220,106,327**

Medicaid/Health Care Services (651525)

This GRF line item is used to reimburse health care providers for covered services to Medicaid recipients. The federal earnings on the payments that are made entirely from this line item are deposited as revenue into the GRF. Spending within this line item generally can be placed into one of several major service categories: Managed Care Plans, Nursing Facilities (NFs), Hospital Services, Behavioral Health, Aging Waivers, Prescription Drugs, Physician Services, Home Care Waivers, Group VIII (i.e., those individuals who become eligible for Medicaid through the ACA), and All Other Care. The majority of expenditures from this line item earn the regular Federal Medical Assistance Percentage (FMAP) reimbursement rate at approximately 63%. However, Group VIII receives 95% federal matching in 2017, 94% in 2018, 93% in 2019, and 90% in 2020 and thereafter. Expenditures for the State Children's Health Insurance Program (SCHIP) from this line item earn an enhanced federal participation rate of approximately 74%. The Affordable Care Act (ACA) further increases the already enhanced SCHIP federal matching rate by 23 percentage points beginning October 1, 2015 until September 30, 2019.

The executive recommends $13.49 billion for FY 2018, a 16.9% decrease from the FY 2017 expenditures of $16.23 billion and $14.37 billion for FY 2019, a 6.5% increase over FY 2018. The large decrease in FY 2018 is primarily due to the replacement of the sales tax on Medicaid managed care plans with the HIC tax. Transactions associated with the sales tax were performed out of the GRF, whereas transactions associated with the HIC tax will be performed out of non-GRF Fund 5TN0.

Medicaid Program Support – State (651425)

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

The budget provides funding of $176.3 million for FY 2018, a 12.5% increase over the FY 2017 expenditures and $178.8 million for FY 2019, a 1.4% increase over FY 2018. The increases in the appropriation levels are due to the increase in caseload driven contracts, and policies such as Managed Care CMS requirements implementation.

Medicare Part D (651526)

This GRF line item is used for the phased-down state contribution, otherwise known as the clawback payments, under the Medicare Part D requirements contained in the federal Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. The clawback is a monthly payment made by each state to the federal Medicare Program that began in January 2006. The amount of each state's payment roughly reflects the expenditures of its own funds that the state would have made if it

continued to pay for outpatient prescription drugs through Medicaid on behalf of dual eligibles, those individuals eligible for both Medicare and Medicaid.

The budget provides funding of $478.2 million for FY 2018, a 14.2% increase over the FY 2017 expenditures, and $478.3 million for FY 2019. The funding levels are based on the executive's projected spending for the clawback payments. During FY 2016, Ohio Medicaid made over $305.6 million in clawback payments for approximately 200,000 dual eligibles. The executive projects increases in the clawback payments based on assumptions such as an upward trend in pharmaceutical costs.

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

Resident Protection Fund (651605)

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

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

The budget provides flat funding for this line item at $4.9 million for FY 2018 and FY 2019, which is $3.5 million more than FY 2017's spending level. The increase is due to the policy of using available non-GRF balances to reduce GRF spending.

Money Follows the Person (651631)

This line item is used to support the federal Money Follows the Person grant initiative. The budget provides funding of $12.8 million in FY 2018, a 75.3% increase over FY 2017 expenditures, and $12.4 million in FY 2019, a 3.0% decrease from FY 2018. The funding levels are the executive's projected spending. Ohio's grant is used for the Helping Ohioans Move, Expanding (HOME) Choice Program. This program assists in relocating seniors and persons with disabilities from institutions to home and community-based settings. The federal government allocates a portion of the grant each year based upon the projected enrollment numbers as estimated by Ohio Medicaid. Ohio Medicaid cannot enroll more than their estimated projected enrollment. The grant is realized by the state as federal reimbursement on expenditures for transitioning eligible Medicaid members out of institutional settings and into home or community-based care. More specifically, for qualified and demonstrated services the federal government reimburses Ohio at an enhanced federal match rate of nearly 80% for

Medicaid members for their first 12 months in home or community-based care, while other supplemental services are reimbursed at the regular federal Medicaid reimbursement rate. After the 12-month period, Ohio Medicaid draws down the regular federal reimbursement for each transitioned Medicaid member.

The budget eliminates the Ohio Access Success Project on January 1, 2019, and requires ODM to transfer its enrollees to the HOME Choice Program.

Care Innovation and Community Improvement Program (651686)

This new line item is used to fund the state share of the Care Innovation and Community Improvement Program. The budget provides $60.0 million for FY 2018 and FY 2019.

H.B. 49 establishes the Care Innovation and Community Improvement Program Fund (Fund 5AN0) and provides for all intergovernmental transfers made under the program to be deposited into it. Money in Fund 5AN0 and the corresponding federal share in Fund 3F00 will be used to make the supplemental payments to nonprofit and public hospital agencies under the program. The budget also includes funding of $140 million each year in FY 2018 and FY 2019 in the federal fund 3F00 appropriation item 651623, Medicaid Services – Federal.

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

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

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 federal law (42 C.F.R. 455.304);
5. The nonfederal share of all rebates paid by drug manufacturers to ODM in accordance with rebate agreements required by federal law; and

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

In addition, the budget abolishes the Health Care Services Administration Fund (Fund 5U30), transfers the balance in that fund to Fund 5DL0, and provides for the revenue that would otherwise be deposited into that fund to be deposited into Fund 5DL0. This revenue includes tort and audit recoveries made by Department auditors, audit contractors, and the Attorney General's Office, and the state share of vendor offsets.

The budget provides funding in line item 651639 of $774.4 million for FY 2018, a 49.5% increase over FY 2017 expenditures, and $722.7 million for FY 2019, a 6.7% decrease from FY 2018. The increase in appropriation in FY 2018 for this line item is due to (1) the policy of using available non-GRF balances to reduce GRF spending, and (2) the increased drug rebates expected. ODM estimates drug rebates based on a historical ratio of rebates to projected pharmacy spending. Line item 651685 is a new item. The budget provides funding in this new line item of $36.1 million for FY 2018 and $41.3 million for FY 2019.

Medicaid Services – Payment Withholding (651638)

This line item is used for provider payments that are withheld from providers that change ownership. It is used to transfer the withheld funds to the appropriate fund used by ODM at final resolution. The funds are withheld and temporarily deposited into the Exiting Operator Fund (Fund 5FX0) until all potential amounts due to ODM or the provider reach final resolution. The budget provides flat funding at $12.0 million for FY 2018 and FY 2019. The funding level is ODM's projection, which is based on the historical trend. The actual collection arises from activities of nursing facilities that have a change of operator.

Medicaid Services – Hospital Upper Payment Limit (651656)

This line item is used to support hospital upper payment limit (UPL) programs and provide 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 assessment fee used to support the state's Disproportionate Share Hospital (DSH) Program.

The budget provides funding in this line item of $619.1 million in FY 2018, an 11.1% increase over the FY 2017 expenditures, and $647.6 million in FY 2019, a 4.6% increase over FY 2018. The increase in the appropriation is attributable to the projected

increase in the hospital total facility costs. The budget maintains the current assessment rate of 2.66% for FY 2018 and FY 2019.

Health Care Grants – State (651682)

This line item is used to fund planning and implementation grants related to the ACA. Ohio Medicaid deposits funds it receives pursuant to the administration of the Medicaid Program in Fund 5KC0, other than any such funds that are required by law to be deposited into another fund. Typically, this is in the form of intrastate transfer vouchers from other agencies for specific projects associated with the Health Innovation Fund. There are currently no agreements to receive grants or moneys to Fund 5KC0. The budget provides flat funding at $5.0 million each year for FY 2018 and FY 2019.

Medicaid Services – Long Term Care (651608)

This line item is used to make Medicaid payments to nursing facilities. The source of funds for this line item is the franchise fee payments from nursing facilities. The assessment amount is calculated each year at the maximum percentage allowed by federal law (not to exceed 6%). The franchise fee payments are due to the state in February, May, August, and November of each year and are deposited in the Nursing Home Franchise Permit Fee Fund (Fund 5R20).

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

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

1. Determine the estimated total net patient revenues for all nursing homes and hospital long-term care units for the fiscal year;
2. Multiply the amount estimated above by the lesser of (a) the indirect guarantee percentage[5] 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

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

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 budget provides funding for this line item at $405.7 million each year in FY 2018 and FY 2019. This funding level is based on FY 2017's franchise fee rates.

Medicaid Services – Physician UPL (651683)

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

The source of funds for this line item is intergovernmental transfers. The revenue is deposited into Medicaid Services – Physician UPL Fund (Fund 5SC0). The budget provides funding of $30.0 million each year for FY 2018 and FY 2019.

Medicaid Services – HIC Fee (651684)

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

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

The budget provides funding in this new line item of $593.2 million for FY 2018, and $660.9 million for FY 2019. The appropriation levels are based on the executive's projection of the franchise fee revenue excluding the revenue generated by the Group VIII population.

Brigid's Path Program (651600)

This new line item is used to fund the Brigid's Path Pilot Program for newborns with neonatal abstinence syndrome. The budget provides funding of $500,000 each year for FY 2018 and FY 2019.

Medicaid Services – HCAP (651649)

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

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

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

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

Medicaid Health Information Technology (651603)

This federal line item is used for provider electronic health record (EHR) incentives and administrative costs related to the Health Information Technology (HIT) grant. The budget provides funding of $61.9 million for FY 2018 and FY 2019.

Medicaid Services – Federal (651623)

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

The budget provides funding for this line item of $6.35 billion for FY 2018, a 73.8% increase over the FY 2017 expenditures, and $6.48 billion for FY 2019, a 2.0% increase over FY 2018. The increases in the appropriation levels are mainly due to the replacement of the sales tax on Medicaid managed care plans with the HIC tax, the policy of shifting GRF payments to non-GRF, and other policies discussed in the

"**FY 2018-FY 2019 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 for this line item of $607.9 million for FY 2018, a 78.9% increase over FY 2017 expenditures, and $682.2 million for FY 2019, a 12.2% increase over FY 2018. The increases in the appropriation levels are mainly due to policies such as Managed Care CMS requirements implementation.

Health Care Grants – Federal (651680)

This line item funds Medicaid/SCHIP and non-Medicaid/SCHIP program initiatives stemming from the ACA of 2010. The budget provides funding in this line item at $38.7 million for FY 2018 and FY 2019, a 85.2% increase over the FY 2017 expenditures. The spending level is based on the revenue received for various federal grants.

Medicaid Interagency Pass-Through (651655)

This line item is used to disburse federal reimbursements to other agencies for Medicaid expenditures they have made. The departments of Aging, Developmental Disabilities, Health, Job and Family Services, and Mental Health and Addiction Services assist ODM in administering certain Medicaid programs/services and receive reimbursements for services provided and related administration out of line item 651655. The budget provides funding for this line item at $125.7 million for FY 2018 and FY 2019, a 10.0% increase over the FY 2017 expenditures.

Refunds and Reconciliations (651644)

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

The budget provides funding for this line item at $1.0 million for FY 2018 and FY 2019.

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FY 2018 - FY 2019 Final Appropriation Amounts — All Fund Groups

Line Item Detail by Agency

Report For Main Operating Appropriations Bill — **Version: As Enacted**

			FY 2016	FY 2017	Appropriation FY 2018	FY 2017 to FY 2018 % Change	Appropriation FY 2019	FY 2018 to FY 2019 % Change
MCD Department of Medicaid								
GRF	651425	Medicaid Program Support-State	$ 137,428,170	$ 156,769,355	$ 176,312,968	12.47%	$ 178,754,197	1.38%
		Medicaid Health Care Services-State	$ 4,311,563,837	$ 4,434,064,762	$ 3,757,798,912	-15.25%	$ 4,061,056,034	8.07%
		Medicaid Health Care Services-Federal	$ 11,667,488,774	$ 11,793,182,073	$ 9,735,053,357	-17.45%	$ 10,311,479,657	5.92%
GRF	651525	Medicaid Health Care Services - Total	$ 15,979,052,611	$ 16,227,246,835	$ 13,492,852,269	-16.85%	$ 14,372,535,691	6.52%
GRF	651526	Medicare Part D	$ 305,634,132	$ 418,595,274	$ 478,243,607	14.25%	$ 478,331,274	0.02%
	GRF - State		$ 4,754,626,140	$ 5,009,429,391	$ 4,412,355,487	-11.92%	$ 4,718,141,505	6.93%
	GRF - Federal		$ 11,667,488,774	$ 11,793,182,073	$ 9,735,053,357	-17.45%	$ 10,311,479,657	5.92%
	General Revenue Fund Total		**$ 16,422,114,914**	**$ 16,802,611,464**	**$ 14,147,408,844**	**-15.80%**	**$ 15,029,621,162**	**6.24%**
4E30	651605	Resident Protection Fund	$ 0	$ 1,315,640	$ 4,878,000	270.77%	$ 4,878,000	0.00%
5AJ0	651631	Money Follows the Person	$ 1,689,928	$ 7,280,036	$ 12,760,900	75.29%	$ 12,373,500	-3.04%
5AN0	651686	Care Innovation and Community Improvement Program	$0	$0	$ 60,000,000	N/A	$ 60,000,000	0.00%
5DL0	651639	Medicaid Services-Recoveries	$ 537,876,341	$ 518,048,211	$ 774,381,570	49.48%	$ 722,709,203	-6.67%
5DL0	651685	Medicaid Recoveries-Program Support	$0	$0	$ 36,146,571	N/A	$ 41,328,516	14.34%
5FX0	651638	Medicaid Services-Payment Withholding	$ 6,383,192	$ 12,399,558	$ 12,000,000	-3.22%	$ 12,000,000	0.00%
5GF0	651656	Medicaid Services - Hospital Upper Payment Limit	$ 568,275,051	$ 557,450,602	$ 619,104,791	11.06%	$ 647,635,236	4.61%
5KC0	651682	Health Care Grants-State	$ 1,263,823	$ 313,250	$ 5,000,000	1,496.17%	$ 5,000,000	0.00%
5KW0	651612	Managed Care Performance Payment	$ 48,507,051	$ 168,685,514	$ 0	-100.00%	$ 0	N/A
5R20	651608	Medicaid Services-Long Term	$ 399,818,149	$ 403,248,622	$ 405,666,000	0.60%	$ 405,666,000	0.00%
5SA0	651628	Maternal and Child Health	$ 500,000	$0	$ 0	N/A	$ 0	N/A
5SC0	651683	Medicaid Services-Physician UPL	$ 3,503,537	$ 14,147,003	$ 30,000,000	112.06%	$ 30,000,000	0.00%
5TN0	651684	Medicaid Services-HIC Fee	$0	$0	$ 593,195,389	N/A	$ 660,893,005	11.41%
5TZ0	651600	Brigid's Path Program	$0	$0	$ 500,000	N/A	$ 500,000	0.00%
5U30	651654	Medicaid Program Support	$ 12,994,290	$ 18,167,321	$ 0	-100.00%	$ 0	N/A
6510	651649	Medicaid Services-Hospital Care Assurance Program	$ 445,516,981	$ 232,270,068	$ 238,057,429	2.49%	$ 199,250,372	-16.30%
	Dedicated Purpose Fund Group Total		**$ 2,026,328,344**	**$ 1,933,325,825**	**$ 2,791,690,650**	**44.40%**	**$ 2,802,233,832**	**0.38%**

FY 2018 - FY 2019 Final Appropriation Amounts

All Fund Groups

Line Item Detail by Agency

			FY 2016	FY 2017	Appropriation FY 2018	FY 2017 to FY 2018 % Change	Appropriation FY 2019	FY 2018 to FY 2019 % Change
MCD Department of Medicaid								
R055	651644	Refunds and Reconciliation	$ 264,618	$ 45,310	$ 1,000,000	2,107.03%	$ 1,000,000	0.00%
Holding Account Fund Group Total			**$ 264,618**	**$ 45,310**	**$ 1,000,000**	**2,107.03%**	**$ 1,000,000**	**0.00%**
3ER0	651603	Medicaid Health and Transformation Technology	$ 55,705,287	$ 47,169,881	$ 61,896,000	31.22%	$ 61,896,000	0.00%
3F00	651623	Medicaid Services-Federal	$ 3,841,522,208	$ 3,655,601,110	$ 6,353,919,469	73.81%	$ 6,478,785,019	1.97%
3F00	651624	Medicaid Program Support - Federal	$ 292,426,416	$ 339,823,842	$ 607,899,720	78.89%	$ 682,203,750	12.22%
3FA0	651680	Health Care Grants-Federal	$ 15,377,474	$ 20,878,969	$ 38,658,704	85.16%	$ 38,664,967	0.02%
3G50	651655	Medicaid Interagency Pass Through	$ 149,123,953	$ 114,243,712	$ 125,651,597	9.99%	$ 125,701,597	0.04%
Federal Fund Group Total			**$ 4,354,155,338**	**$ 4,177,717,514**	**$ 7,188,025,490**	**72.06%**	**$ 7,387,251,333**	**2.77%**
Department of Medicaid Total			**$ 22,802,863,214**	**$ 22,913,700,113**	**$ 24,128,124,984**	**5.30%**	**$ 25,220,106,327**	**4.53%**