Greenbook

LBO Analysis of Enacted Budget

Ohio Department of Medicaid

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September 2019

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Appropriation Spreadsheet

LBO Greenbook

Ohio Department of Medicaid

Quick look...

- Medicaid is a joint federal-state program that provides health insurance coverage to about 3.0 million low-income Ohioans, including 1.2 million children.
- As an entitlement program, Medicaid services are guaranteed to those who are eligible.
- At an annual spending of $26.76 billion in combined federal and state dollars in FY 2019, Medicaid is the largest single state program and accounts for about 4% of Ohio's economy.
  - Medicaid is the largest spending area of the combined state and federal GRF budget and the second largest area (behind K-12 education) in the state-only GRF budget.
- The Ohio Department of Medicaid (ODM) administers Ohio Medicaid with the assistance of the Ohio Department of Developmental Disabilities (ODODD), six other state agencies, and various local partners.
  - About 99% of all-funds expenditures for Ohio Medicaid are disbursed by ODM and ODODD.
  - 100% of all-funds Medicaid service expenditures are disbursed by ODM and ODODD. The other six agencies incur only administrative spending.
- Affordable Care Act (ACA) coverage began in January 2014 in Ohio. The state share for these individuals started in the second half of FY 2017 at 5% and gradually increases to 10% beginning in the second half of FY 2020.

All-funds Medicaid*	FY 2018 Actual	FY 2019 Actual	FY 2020 Appropriation	FY 2021 Appropriation
Agency				
ODM	$23,396,146,057	$23,695,800,237	$25,101,763,224	$26,980,864,854
ODODD	$2,652,175,048	$2,756,948,985	$3,209,217,295	$3,432,649,905
Job and Family Services	$255,370,678	$267,883,667	$268,514,029	$268,890,719
Health	$26,799,977	$28,878,359	$32,389,148	$32,787,199
Mental Health and Addiction Services	$4,258,248	$5,381,814	$12,091,876	$12,251,713
Aging	$5,892,897	$6,391,066	$10,734,899	$11,123,013
Pharmacy Board	$1,709,531	$2,221,467	$2,616,847	$2,639,000
Education	$276,354	$477,933	$593,478	$593,478
Grand Total	**$26,342,628,789**	**$26,763,983,529**	**$28,637,920,796**	**$30,741,799,881**
ODM Share	88.8%	88.5%	87.7%	87.8%
ODODD Share	10.1%	10.3%	11.2%	11.2%
Expense Type				
Services	$25,375,193,270	$25,719,311,171	$27,424,936,838	$29,501,469,913
Administration	$967,435,519	$1,044,672,358	$1,212,983,958	$1,240,329,968
Grand Total	**$26,342,628,789**	**$26,763,983,529**	**$28,637,920,796**	**$30,741,799,881**
Services Share	96.3%	96.1%	95.8%	96.0%
Administration Share	3.7%	3.9%	4.3%	4.0%

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

All Agency All-Funds*	FY 2014 Actual	FY 2015 Actual	FY 2016 Actual	FY 2017 Actual	FY 2018 Actual	FY 2019 Actual	FY 2020 Appropriation	FY 2021 Appropriation
	Amount ($ in millions)							
GRF – State	$5,349.1	$5,509.6	$5,328.4	$5,644.2	$5,003.4	$5,208.6	$5,590.7	$6,236.1
GRF – Federal	$8,221.4	$9,353.6	$11,667.5	$11,793.2	$9,479.1	$9,844.3	$9,959.2	$11,152.5
GRF – Total	**$13,570.5**	**$14,863.2**	**$16,995.9**	**$17,437.4**	**$14,482.5**	**$15,052.8**	**$15,549.9**	**$17,388.6**
Non-GRF – State	$1,999.5	$1,873.8	$2,397.4	$2,284.1	$3,357.1	$3,284.3	$3,639.5	$3,735.9
Non-GRF – Federal	$5,289.1	$6,730.1	$5,900.6	$5,828.7	$8,503.0	$8,246.9	$9,448.5	$9,617.3
Grand Total	**$20,859.1**	**$23,467.1**	**$25,293.8**	**$25,550.1**	**$26,342.7**	**$26,764.0**	**$28,637.9**	**$30,741.8**
Annual % Change	**--**	**12.5%**	**7.8%**	**1.0%**	**3.1%**	**1.7%**	**7.0%**	**7.3%**
	Share							
GRF – State	25.6%	23.5%	21.1%	22.1%	19.0%	19.5%	19.5%	20.3%
GRF – Federal	39.4%	39.9%	46.1%	46.2%	36.0%	36.8%	34.8%	36.3%
Non-GRF – State	9.6%	8.0%	9.5%	8.9%	12.7%	12.3%	12.7%	12.2%
Non-GRF – Federal	25.4%	28.7%	23.3%	22.8%	32.3%	31.5%	33.0%	31.3%
Grand Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Total GRF Share	**65.1%**	**63.3%**	**67.2%**	**68.2%**	**55.0%**	**56.2%**	**54.3%**	**56.6%**
Total Federal Share	**64.8%**	**68.5%**	**69.5%**	**69.0%**	**68.3%**	**68.3%**	**67.8%**	**67.6%**

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

Medicaid Program overview

Medicaid is a publicly funded health insurance program for low-income individuals. It is a federal-state joint program administered by the states and funded with federal, state, and, in some states like Ohio, local revenues. The federal government establishes and monitors certain requirements concerning funding, eligibility standards, and quality and scope of medical services. In Ohio, Medicaid covers 3.0 million low-income adults, children, pregnant women, seniors, and individuals with disabilities each year. Ohio Medicaid is the largest health insurer in the state. It is also the largest single state program with annual spending of about $27 billion in combined federal and state dollars. Medicaid accounts for 4% of Ohio's economy. Medicaid services are an entitlement for those who meet eligibility requirements, meaning that if an individual is eligible for the program then they are guaranteed the benefits and the state is obligated to pay for them.

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

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

- 1.2 million children, from birth to age 18;
- 51% of all Ohio children under age five;
- 200,000 senior citizens;
- 50,000 individuals residing in nursing facilities; and
- 100,000 individuals on home and community-based waivers.

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

- Ohio Department of Developmental Disabilities (ODODD);
- Ohio Department of Job and Family Services (ODJFS);
- Ohio Department of Health (ODH);
- Ohio Department of Mental Health and Addiction Services (OhioMHAS);
- Ohio Department of Aging (ODA);

- Ohio Department of Education (ODE); and
- Ohio Board of Pharmacy.

ODODD provides services to disabled individuals through home and community-based Medicaid waiver programs. ODODD also provides services to severely disabled individuals at eight regional developmental centers throughout the state and pays private intermediate care facilities for Medicaid services provided to individuals with intellectual or other developmental disabilities. In addition, ODODD provides subsidies to, and oversight of, Ohio's 88 county developmental disabilities (DD) boards. County boards arrange for more than 90,000 adults and children to receive comprehensive services, which include residential support, early intervention, and family support.

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

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

OhioMHAS works with local boards to ensure the provision of mental health services. Ohio has 51 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.

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).

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

The State Board of Pharmacy uses Medicaid funds for the Ohio Automated Rx Reporting System (OARRS) Integration Initiative, an effort under the State Medicaid Health Information Technology Plan to integrate OARRS directly into electronic medical records and pharmacy dispensing systems across the state. The goal of this initiative is to provide health care providers with information regarding a patient's controlled substance prescription history, support clinician interventions for patients with high-risk behaviors, and reduce the number of patients who present at multiple prescriber sites to obtain controlled substances.

ODM contracts with CDJFSs to perform eligibility determination and enrollment. Most of these activities are done utilizing the new integrated eligibility system, Ohio Benefits, which was implemented on October 1, 2013. Ohio Benefits replaced the old eligibility system known as the Client Registry Information System-Enhanced (CRIS-E). ODM provides technical assistance to counties and assists them to implement eligibility policy.

The enacted budget provides a total appropriation for the Medicaid Program of $28.64 billion in FY 2020, a 7.0% increase over FY 2019's actual spending of $26.8 billion, and $30.74 billion in FY 2021, a 7.3% increase over FY 2020. The breakdowns of the total Medicaid appropriations by agency and by service versus administrative cost can be found on page 1 of this publication. Table 1 below shows the enacted appropriations for Medicaid funding for all agencies by fund group.

Table 1. Medicaid Budget Sources by Fund Group*			
Fund Group	**FY 2019**	**FY 2020**	**FY 2021**
General Revenue Fund	$15,052,848,475	$15,549,862,218	$17,388,605,393
Federal Share	*$9,844,264,931*	*$9,959,169,340*	*$11,152,542,781*
State Share	*$5,208,583,544*	*$5,590,692,878*	*$6,236,062,612*
Dedicated Purpose Fund	$3,275,423,625	$3,629,796,943	$3,725,943,224
Federal Fund	$8,426,872,506	$9,448,542,288	$9,617,251,264
Internal Service Activity Fund	$8,246,354	$8,719,347	$9,000,000
Holding Account Fund	$592,567	$1,000,000	$1,000,000
Total	**$26,763,983,528**	**$28,637,920,796**	**$30,741,799,881**

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

For the FY 2020-FY 2021 biennium, GRF appropriations account for the largest portion (55.5%) of the appropriated funding for the Medicaid Program. About 64.1% of the GRF funding is federal Medicaid reimbursement. Federal funds account for the next largest share of funding at 32.1%. Federal funds include primarily federal reimbursements for Medicaid services and administrative activities that are not deposited into the GRF.

Dedicated Purpose Funds account for 12.4% of the funding. Sources of these funds mainly include the following:

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

The revenues from provider taxes (also referred to as franchise fees) are appropriated in ODM and ODODD's budgets. Table 2 below provides revenue that the state collects from the various provider types.

Table 2. Franchise Fee Revenue ($ in millions)				
Provider Type	FY 2018	FY 2019	FY 2020	FY 2021
Managed Care	$779	$802	$835	$806
Hospital	$642	$657	$822	$887
Nursing Facility	$410	$409	$420	$426
ICF/IID	$51	$41	$40	$40
Total	**$1,882**	**$1,909**	**$2,117**	**$2,159**

Table 3 below shows the actuals as well as the enacted budget for using the various franchise fee revenues and the corresponding federal share by appropriation line item. If the state spends the franchise fee revenue on Medicaid-related services or activities, the state can draw down federal reimbursement. The federal medical assistance percentage (FMAP) represents the portion of total qualified Medicaid spending that is reimbursed by the federal government.

Table 3. ALI Appropriations by Franchise Fee Type and the Corresponding Federal Share ($ in millions*)						
Fund	ALIs	State or Federal Share	FY 2018	FY 2019	FY 2020	FY 2021
5TN0	651684	State	$581	$551	$835	$806
5SA4**	651689	State	$196	$227	$0	$0
3F00	651623	Federal	$1,305	$1,325	$1,423	$1,380
	Managed Care Total		**$2,082**	**$2,103**	**$2,258**	**$2,186**
5GF0	651656	State	$679	$672	$822	$887
3F00	651623	Federal	$1,140	$1,145	$1,401	$1,519
	Hospital Total		**$1,819**	**$1,817**	**$2,223**	**$2,405**
5R20	651608	State	$406	$406	$420	$426
3F00	651623	Federal	$681	$692	$716	$729
	Nursing Facilities Total		**$1,086**	**$1,098**	**$1,136**	**$1,154**
5GE0	653606	State	$37	$36	$40	$40
3A40	653654	Federal	$32	$30	$25	$25
	ICF/IID Total		**$69**	**$66**	**$65**	**$65**
	Grand Total		**$5,056**	**$5,082**	**$5,682**	**$5,812**
	Assumed FMAP		**62.67%**	**63.01%**	**63.03%**	**63.13%**

*Figures related to the ICF/IID franchise fee were provided by ODODD. The remaining figures are from ODM.

**A portion of the managed care franchise fee revenue was transferred from Fund 5TN0 into Fund 5SA4 during the FY 2018-FY 2019 biennium. For the upcoming biennium, all such revenue will be retained in Fund 5TN0.

Federal reimbursement

Table 4 below shows the FMAP received or anticipated to be received by quarter for state fiscal year (SFY) 2015 through SFY 2021. The regular FMAP is the amount each state typically receives for providing Medicaid services. It is calculated each year for each state and is based on the state's per capita income. States with higher per capita incomes will have lower FMAPs and vice versa. An enhanced FMAP (eFMAP) is provided for certain services, including services provided under SCHIP. Under SCHIP, each state is given an allotment of federal funds. Subject to the availability of funds from the state's allotment, the eFMAP is used to determine the federal share of the cost of SCHIP. Each state's eFMAP is calculated by reducing the state's share under the regular FMAP by 30%. However, under the ACA, each state's eFMAP for most SCHIP expenditures was increased by 23 percentage points for federal fiscal year (FFY) 2016 through FFY 2019. In FFY 2019, Ohio's eFMAP for SCHIP is 97.16%. The Healthy Kids Act modifies the eFMAP for FFY 2020 by specifying an increase of 11.5 percentage points. As such, Ohio's eFMAP will be 85.61%. This increase will be eliminated in FFY 2021. States receive a higher FMAP for services provided to the Group VIII population. The FMAP was the following for each calendar year: 100% from 2014 through 2016, 95% in 2017, 94% in 2018, 93% in 2019, and 90% in 2020 and each year thereafter.

Table 4. Federal Match Rates, SFY 2015 Quarter 1-SFY 2021 Quarter 1				
SFY	SFY Qtr.	Regular FMAP	SCHIP	Group VIII
2015	1	63.02%	74.11%	100.00%
2015	2	62.64%	73.85%	100.00%
2015	3	62.64%	73.85%	100.00%
2015	4	62.64%	73.85%	100.00%
2016	1	62.64%	73.85%	100.00%
2016	2	62.47%	96.73%	100.00%
2016	3	62.47%	96.73%	100.00%
2016	4	62.47%	96.73%	100.00%
2017	1	62.47%	96.73%	100.00%
2017	2	62.32%	96.62%	100.00%
2017	3	62.32%	96.62%	95.00%
2017	4	62.32%	96.62%	95.00%
2018	1	62.32%	96.62%	95.00%
2018	2	62.78%	96.95%	95.00%
2018	3	62.78%	96.95%	94.00%
2018	4	62.78%	96.95%	94.00%
2019	1	62.78%	96.95%	94.00%
2019	2	63.09%	97.16%	94.00%
2019	3	63.09%	97.16%	93.00%
2019	4	63.09%	97.16%	93.00%

Table 4. Federal Match Rates, SFY 2015 Quarter 1-SFY 2021 Quarter 1				
SFY	SFY Qtr.	Regular FMAP	SCHIP	Group VIII
2020	1	63.09%	97.16%	93.00%
2020	2	63.02%	85.61%	93.00%
2020	3	63.02%	85.61%	90.00%
2020	4	63.02%	85.61%	90.00%
2021	1	63.02%	85.61%	90.00%

ODM budget summary

Appropriations

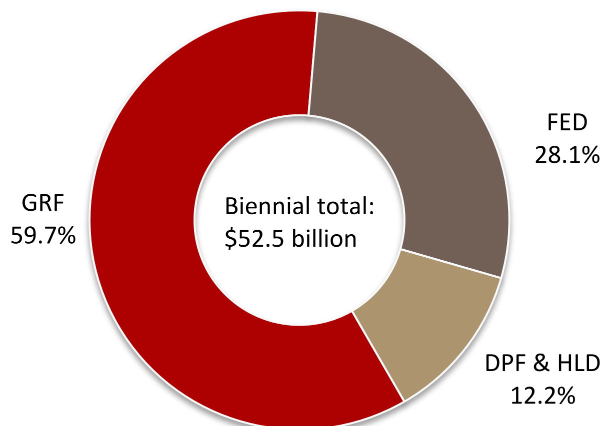
Appropriations by fund group

The enacted budget provides a total appropriation for ODM of $25.33 billion in FY 2020 and $27.21 billion in FY 2021. Table 5 and the chart below show the enacted appropriations by fund group.

Table 5. Enacted Appropriations by Fund Group*				
Fund Group	FY 2018 Actual	FY 2019 Actual	FY 2020 Appropriation	FY 2021 Appropriation
General Revenue Fund (GRF)	$13,806,565,296	$14,368,377,136	$14,770,121,958	$16,593,035,654
Federal Share	*$9,479,085,299*	*$9,844,264,931*	*$9,959,196,340*	*$11,152,542,781*
State Share	*$4,327,479,997*	*$4,524,112,205*	*$4,810,925,618*	*$5,440,492,873*
Dedicated Purpose Fund (DPF)	$2,980,517,664	$2,875,597,775	$3,190,573,023	$3,202,611,903
Federal Fund (FED)	$6,727,041,654	$6,659,506,687	$7,365,769,840	$7,409,918,894
Holding Account Fund (HLD)	$148,673	$592,568	$1,000,000	$1,000,000
Total	$23,514,273,287	$23,904,074,167	$25,327,464,821	$27,206,566,451
% Change	--	1.7%	6.0%	7.4%
GRF % Change	--	*4.1%*	*2.8%*	*12.3%*

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

ODM Budget Sources by Fund Group
FY 2020-FY 2021



As shown in the chart above, appropriations from the GRF make up a majority of the funding for ODM for the biennium at 59.7%. The GRF appropriations include the Medicare Part D clawback payments,[1] 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 funding for ODM at 28.1%, which includes federal reimbursement for Medicaid payments for both service and administrative expenditures. The Dedicated Purpose Fund Group accounts for 12.2% and the Holding Account Fund Group accounts for less than 1.0%.

[1] The clawback is a monthly payment made by each state to the federal Medicare Program. The amount of each state's payment roughly reflects the expenditures of its own funds that the state would have made if it continued to pay for outpatient prescription drugs through Medicaid on behalf of dual-eligibles.

Major initiatives for the FY 2020-FY 2021 biennium

Table 6 below provides a list of the FY 2020-FY 2021 budget initiatives, the start date, and the overall fiscal impact on Ohio's Medicaid Program for each. Following the table is a brief description of each initiative. Along with the description is the impact on the GRF, which includes both overall and state share GRF.

Table 6. FY 2020-FY 2021 Biennium New Initiatives ($ in millions)				
Initiative Number	Initiatives	Start Date	FY 2020	FY 2021
1	Home Visiting	1-Jan-20	$13.4	$33.7
2	Linking Pregnant Moms to Services	1-Jul-20	--	$10.0
3	12-Month Enhanced Postpartum Care	1-Jul-20	--	$15.0
4	Mother/Baby Dyad Care for Women with OUD	1-Jan-20	$5.2	$10.4
5	Behavioral Health in Schools	1-Jan-20	$5.0	$10.0
6	Expand Telehealth	1-Jan-20	$5.0	$10.0
7	Multi-System Youth Custody Relinquishment	1-Jul-19	$6.0	$12.0
8	Access to Autism Services	1-Jul-20	--	$28.1
9	Wellness for Kids: Pediatric CPC	1-Jan-20	$4.0	$8.0
10	Lead Testing and Hazard Control	1-Jul-19	$5.0	$5.0
11	1115 SUD Waiver Authorization/Evaluation	1-Jan-20	$2.5	$5.0
12	Add Behavioral Health Care Coordination	1-Jul-20	--	$250.0
13	Procuring Managed Care Value	1-Jul-19	$3.5	$3.5
14	Modernizing Pharmacy Program	1-Jul-20	$101.9	$203.7
15	Work Requirement	1-Jul-19	$15.5	$12.5
16	Nursing Facility Rate Changes	1-Jul-19*	-$37.4	-$0
17	Ensuring Access to Community Support – Ambulance and Wheelchair Van	1-Jan-20	$10.2	$20.4
18	Increase Managed Care Performance Withhold	1-Jan-20	-$67.1	-$141.3
19	Managed Care Lower Bound Trend Assumption	1-Jan-20	-$80.4	-$251.0
20	Billing of Retroactive Member Months	1-Jul-19	--	--
21	Program Integrity	1-Jan-20	-$5.0	-$10.0
22	Hospital Franchise Fee Alignment	1-Jul-19	$383.3	$502.8
23	Behavioral Health Rate Adjustment/Redesign Fix	1-Aug-19	$50.0	$50.0

*Some provisions will not be implemented until January 1, 2020.

1. Home visiting

H.B. 166 provides $13.4 million in GRF ($4.0 million state share) in FY 2020 and another $33.7 million in GRF ($10.1 million state share) in FY 2021 for home visiting services provided under the Medicaid Program. Home visiting services support individuals by assisting them in accessing services and learning the necessary skills to raise children who are physically, socially, and emotionally healthy and ready to learn. Typical components of a home visiting program include: (1) screening services to help prevent and identify potential physical, mental, development, and other problems, (2) case management services such as conducting assessments, developing a care plan, providing referrals, and scheduling treatment, and (3) family support, counseling, and skills training to help parents address specific infant and young child needs.

2. Linking pregnant mothers to services

H.B. 166 provides $10.0 million in FY 2021 in non-GRF funds to identify women early in their pregnancies in order to link them to services that will allow for healthier deliveries. An example of a service that may be provided are progesterone shots. Progesterone shots increase a woman's chances of having a full-term baby by helping prevent contractions.

3. 12-Month enhanced postpartum care

H.B. 166 provides $15.0 million in GRF ($5.4 million state share) in FY 2021 for a 12-month enhanced postpartum care initiative. Currently, pregnant women may qualify for Medicaid if they reside in a household with an income at or below 200% federal poverty level (FPL). This FPL is higher than traditional Medicaid eligibility. Pregnant women who are enrolled under the higher FPL are provided care for the duration of their pregnancy and up to 60 days after the baby is born. Under this initiative, the postpartum period of coverage would be extended to cover a 12-month period instead. While this would cover all eligible pregnant women, ODM hopes to target women with substance use disorder. ODM estimates that approximately 14,000 women would receive this extended coverage.

ODM will need to obtain CMS approval to provide this enhanced coverage.

4. Mother/baby dyad care for women with opioid use disorder

H.B. 166 provides $5.2 million in GRF ($1.6 million state share) in FY 2020, and $10.4 million ($3.1 million state share) in FY 2021 to provide support for mothers and babies born with opioid addiction by providing treatment and support to co-located mother and child rather than separation during treatment. Babies born with neonatal abstinence syndrome develop a wide range of neurologic and other issues associated with opioid withdrawal. Some studies have indicated that a mother/baby dyad approach could reduce the length of hospital stays, which could ultimately decrease neonatal intensive care unit (NICU) costs. ODM anticipates that over 2,000 mothers/babies could utilize these services and expects treatment length to be approximately 18 days.

5. Behavioral health in schools

H.B. 166 provides $5.0 million in GRF ($1.5 million state share) in FY 2020, and $10.0 million ($3.0 million state share) in FY 2021 to increase access to behavioral health services within schools. The intention of this initiative is to provide students with access to behavioral health services on their school campus through the use of telehealth services. Currently, students need to leave their school campus to receive these services. ODM expects that regular access to behavioral health services could prevent the need for costly stabilization and treatment in an emergency room.

6. Expand telehealth

H.B. 166 provides $5.0 million in GRF ($1.5 million state share) in FY 2020 and $10.0 million ($3.0 million state share) in FY 2021 to support telehealth coverage.

7. Multi-system youth custody relinquishment

H.B. 166 provides $6.0 million in FY 2020 and $12.0 million in FY 2021 in non-GRF funds to establish a Multi-System Youth and Innovation Support Fund. This fund would be used to prevent custody relinquishment of multi-system children and youth and to obtain services consistent with the plan developed under section 121.374 of the Revised Code. Funds for this purpose will be provided through the Health Care/Medicaid Support and Recoveries Fund (Fund 5DL0). Currently, the fund is used to pay for Medicaid services and costs associated with the administration of the Medicaid Program. H.B. 166 allows for two additional uses of the fund: (1) programs that serve youth involved with multiple government agencies, and (2) identify strategies to assist with reducing custody relinquishment for the sole purpose of gaining access to services for multi-system children and youth.

8. Access to autism

H.B. 166 provides $28.1 million in GRF funds ($10.4 million state share) in FY 2021 to combine autism services under new autism-specific coverage codes. While most services for autism are currently covered under Medicaid, practitioners bill for these services by utilizing a variety of current procedural terminology (CPT) codes. When insurers receive these bills, the CPT codes are used to help determine the amount of reimbursement that a practitioner will receive for rendering services. ODM anticipates that by establishing new autism-specific codes, utilization of services could increase. This initiative is aimed at providing access to children with an autism diagnosis who are not eligible for a waiver through ODODD.

9. Wellness for kids

H.B. 166 provides $4.0 million in GRF funds ($1.2 million state share) in FY 2020 and $8.0 million ($2.4 million state share) in FY 2021 to increase wellness promotion efforts under the Comprehensive Primary Care Program for Children. ODM anticipates increasing the per member per month rate for children receiving services under the program by $1. ODM estimates that 1.2 million children will receive additional wellness services.

10. Lead testing and hazard control

H.B. 166 provides $5.0 million in GRF funds ($0.6 million state share) in FY 2020 and $5.0 million ($1.2 million state share) in FY 2021 for lead testing and other lead-related activities.

11. 1115 Substance use disorder (SUD) waiver – design and implementation

H.B. 166 provides $2.5 million in all funds ($0.6 million GRF state share) in FY 2020 and $5.0 million in all funds ($1.3 million GRF state share) in FY 2021 to support the design and evaluation of the Section 1115 SUD Demonstration Waiver. ODM is currently working with OhioMHAS to design the Section 1115 waiver application. Section 1115 waivers require additional evaluation. CMS recently stated that the process has become more involved and for each approved Section 1115 demonstration, states must provide numerous metrics on a regular interval, conduct evaluations by partnering with an independent evaluator, and submit monitoring and evaluation tools.[2]

Section 1115 provides the U.S. Department of Health and Human Services Secretary with broad authority to approve experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. Flexibility under Section 1115 is broad to allow states to test the merit of new ideas of policy. These projects are intended to demonstrate and evaluate a policy or approach that has not been demonstrated on a widespread basis. Section 1115 waivers typically are approved for five years and may be extended for a set length of time.

ODM's requested waiver is for SUD inpatient and residential treatment in managed care and fee-for-service populations for both adults and children. The request is to ensure that a complete array of care is available for enrollees with opioid or other SUD. It will allow the Ohio Medicaid Program to maintain access to necessary SUD services in the most appropriate setting regardless of length of stay.[3]

12. Behavioral health care coordination

H.B. 166 also provides $250.0 million in GRF funds ($45.3 million state share) in FY 2021 to implement behavioral health care coordination (BHCC). BHCC will target enrollees with the most intensive behavioral health needs. These individuals will receive intensive care coordination from a community provider.

13. Procuring managed care value

H.B. 166 provides $3.5 million in all funds ($1.8 million in state share GRF) in FY 2020 and in FY 2021 to support renegotiation of managed care contracts. This money will be used to solicit information from other states and experts, hire outside counsel, support regional forums, and establish a website to generate public feedback.

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[2] https://www.cms.gov/newsroom/press-releases/cms-strengthens-monitoring-and-evaluation-expectations-medicaid-1115-demonstrations.

[3] https://public.medicaid.gov/connect.ti/public.comments/viewQuestionnaire?qid=1899843.

14. Modernizing Medicaid's pharmacy program

H.B. 166 provides $101.9 million in GRF funds ($30.6 million in state share GRF) in FY 2020 and $168.7 in all funds in FY 2021 to support modernization of the Medicaid pharmacy program. ODM plans to require managed care plans to implement a single preferred drug list. According to ODM, this will simplify the process of providing care to Medicaid enrollees and possibly result in a reduction in medication errors.

15. Work requirement and community engagement 1115 waiver demonstration

On March 19, 2019, ODM received notification from CMS that Ohio's 1115 waiver application for a work and community engagement demonstration for the Group VIII population had been approved. H.B. 166 provides $15.5 million in all funds ($5.1 million state share GRF) in FY 2020 and $12.5 million in all funds ($4.4 million state share GRF) in FY 2021 to cover expenditures related to the implementation of this program. Approximately 109,000 individuals are estimated to require additional assessment to determine whether they meet any of the exemptions to these requirements. These funds will be used to cover increased assessment and medical evaluation costs, administrative requirements, and information technology system upgrades. ODM has not included any cost reductions for the biennium since the start date of the demonstration is uncertain. Cost reductions could occur if enrollees failed to meet the work and community engagement requirements and were disenrolled.

As of August 2019, 16 states, including Ohio, have submitted a request to CMS to implement work requirements as part of their Medicaid programs. Arkansas, New Hampshire, and Kentucky have received 1115 waivers to institute work requirements for Group VIII Medicaid recipients. However, these three states have had those waivers set aside by courts. Other states which have approved waivers are Arizona, Indiana, Michigan, Ohio, Utah, and Wisconsin. Alabama, Mississippi, Oklahoma, South Carolina, South Dakota, Tennessee, and Virginia all have waivers pending.[4]

16. Nursing facility rate changes

H.B. 166 makes a number of changes to the nursing facility Medicaid rates. The primary changes are highlighted. The first is that the bill repeals a provision that would have adjusted nursing facilities' rates for tax costs and a $16.44 add-on by an amount equal to the difference between the Medicare skilled nursing facility market basket index and a budget reduction adjustment factor. Another is that the bill provides for nursing facilities to earn a quality incentive payment under Medicaid beginning with the second half of FY 2020. The bill also provides for a nursing facility's Medicaid payment rate to be $115 per day for services provided to low resource utilization residents regardless of whether the nursing facility cooperates with the Long-Term Care Ombudsman Program. Some of these changes increase expenditures, while some decrease expenditures. However, the overall net effect will be a reduction in expenditures of $37.4 million in FY 2020.

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[4] https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/#Table2.

17. Ensuring access to community support – ambulance and wheelchair van

H.B. 166 will provide $10.2 million in GRF funds ($3.1 million state share) in FY 2020 and $20.4 million ($6.1 million state share) in FY 2021 to ensure access to transportation. This represents a 15% rate increase for certain transportation services.

18. Increase managed care performance withhold

H.B. 166 will increase the amount withheld from the Medicaid managed care capitation payments from 2% to 3%. ODM withholds these amounts to provide incentive payments to organizations that meet performance standards. This could result in unspent funds in the amount of $67.1 million in GRF funds ($20.1 million state share) in FY 2020 and $141.3 million in GRF funds ($42.4 million state share) in FY 2021. This assumes that not all performance measures would be met. MyCare is exempted from this increase.

19. Managed care lower bound trend assumption

H.B. 166 assumed a lower growth rate trend for health care inflation for the upcoming biennium than the trend that was used for forecasting projections. ODM contracted with Milliman to estimate high, medium, and low trends and traditionally has set its baseline forecast to match the medium estimate. By assuming a lower trend in all forecasts of projected costs, H.B. 166 will save $80.3 million in GRF funds ($24.1 million state share) in FY 2020 and $251.0 million in GRF funds ($75.5 million state share) in FY 2021.

20. Billing of retroactive member months

H.B. 166 will implement a new reconciliation process regarding the billing of retroactive member months. This new process is estimated to reduce expenditures from the GRF by $74.7 million ($22.4 million state share) in FY 2020 and $38.3 million ($11.5 million state share) in FY 2021.

21. Program integrity

H.B. 166 makes the terms and procedures for suspending a Medicaid provider agreement because of certain types of indictments generally the same as those for suspending a provider agreement because of a credible allegation of fraud. This change effectively combines two rules regarding provider suspension. Such changes will reduce internal legal and administrative costs. ODM anticipates reductions of $5.0 million in GRF funds ($1.5 million state share) in FY 2020 and $10.0 million in GRF funds ($3.0 million state share) in FY 2021.

22. Hospital franchise fee alignment

H.B. 166 increased the hospital franchise fee from 2.66% to 3.24% in FY 2020 and to 3.35% in FY 2021. ODM charges hospitals an annual franchise fee equal to a percentage of the hospital's total facility costs. A hospital's total facility costs are the hospital's total costs for all care provided to all patients, including the direct, indirect, and overhead costs to the hospital of all services, supplies, equipment, and capital related to the care of patients, regardless of whether patients are enrolled in a health insuring corporation. However, total facility costs exclude all of the following costs: Medicare costs, skilled nursing services provided in distinct-part nursing

facility units, home health services, hospice services, ambulance services, renting durable medical equipment, and selling durable medical equipment.

According to ODM, this realignment is expected to cost $383.3 million in FY 2020 and $502.8 million in FY 2021. However, there will be subsequent reductions in GRF expenditures by $53.4 million ($16.0 million state share) in FY 2020 and $54.2 million ($16.3 million state share) in FY 2021.

23. Behavioral health rate adjustment/redesign fix

H.B. 166 provides $50.0 million in GRF funds ($15.0 million in state share GRF) in each fiscal year to support the behavioral health redesign implemented a few years ago.

Vetoed provisions

The Governor vetoed or partially vetoed several provisions impacting ODM. The provisions are discussed below.

Automatic designation of authorized representatives

The Governor vetoed a provision that specified that, for an applicant for medical assistance who resides in a nursing facility or residential care facility that participates in the Assisted Living Program, the facility will be automatically designated as the individual's primary authorized representative at the time of the application for medical assistance.

Health care price transparency

The Governor vetoed a provision that would have required ODM to comply with the Health Care Price Transparency Law.

MyCare Ohio and standardized claims forms

The Governor partially vetoed a provision that requires the Medicaid Director to select a standardized claim form for each provider type from among universally accepted claim forms used in the United States and requires that a provider that renders a medically necessary health care service under MyCare Ohio use the form. The language vetoed would have provided that any claim for a medically necessary, allowable service that is properly submitted using the standardized claim form and claim codes was to be considered a clean claim and was to be paid within 30 calendar days. Additionally, language was vetoed that would have required ODM, if it failed to pay such a claim within 35 calendar days, to pay interest equal to 1% per month calculated from the expiration of the 35-day period.

Medicaid rates for nursing facility services

The Governor partially vetoed provisions that impacted Medicaid rates for nursing facility services. In particular, provisions that provide for a nursing facility to earn a quality incentive payment under Medicaid beginning with the second half of FY 2020 were impacted. Under H.B. 166, a nursing facility is not to receive a quality incentive payment for a fiscal year, other than the second half of FY 2020, if the nursing facility's licensed occupancy percentage is less than 80%. However, this disqualification does not apply to a nursing facility for a fiscal year if the nursing facility has a score for meeting the quality metrics for the fiscal year of at least

15 points. The Governor vetoed a second exception that would have allowed a nursing facility to be exempt for a fiscal year if, less than four years before the first day of the fiscal year, it had undergone a renovation during which it temporarily removed one or more of its licensed beds from service. The Governor also vetoed part of a third exception that would have exempted a nursing facility for a fiscal year if it had been initially certified for participation in Medicaid less than four years before the first day of the fiscal year. As a result of the partial veto, a nursing facility is exempt for a fiscal year if it was initially certified for participation in Medicaid. The Governor also partially vetoed language that specified the total amount that is to be spent on quality incentive payments for FY 2021 and each fiscal year thereafter. Lastly, the Governor partially vetoed a provision that impacted the budget reduction adjustment factor. Specifically, the Governor vetoed a provision that would have delayed the elimination of the adjustment until FY 2022.

Home-delivered meals under Medicaid waivers

The Governor vetoed a provision that established payment rates for home-delivered meals provided under MyCare Ohio and Ohio Home Care waiver programs during FY 2020 and FY 2021. The rates would have been as follows: $7.19 per meal delivered on a daily basis by a volunteer or employee of the provider, $6.99 per meal (chilled or frozen) delivered weekly by the provider or volunteer, and $6.50 per meal (chilled or frozen) delivered weekly by a common carrier. In addition, language was vetoed that required each home and community-based services Medicaid waiver program that covered home-delivered meals to provide for the meals to be delivered in a format and frequency consistent with individuals' needs and that the individual delivering such meals meet face to face with the recipient.

Medicaid rates for personal care services

The Governor vetoed a provision that required Medicaid rates for personal care services that are provided under a Medicaid waiver and are an alternative to nursing facility services be increased annually beginning with FY 2022. The increase would be the difference between the Medicare skilled nursing facility market basket index and the same budget reduction adjustment factor used to determine nursing facilities' Medicaid rates.

Medicaid managed care – shared savings, quality incentive programs, and other

The Governor vetoed several provisions that impacted Medicaid managed care. The provisions vetoed:

- Required ODM to do the following if the U.S. Secretary of Health and Human Services agreed to enter into an enforceable agreement that safeguarded the state's receipt of federal Medicaid funds: (1) establish a Shared Savings Bonus Program, (2) establish a Quality Incentive Program, and (3) permit regional networks of hospitals to become Medicaid MCOs if they accepted a capitated payment that was not more than 90% of the lowest capitated payment made to a Medicaid MCO that was a health insuring corporation.
- Required each Medicaid MCO to establish a program that incentivized enrollees to obtain covered health care from high quality and efficient providers.

- Required the Medicaid Director to establish a Medicaid waiver program under which Medicaid MCOs could cover any service or product that would have a beneficial effect on enrollees' health and was likely to reduce costs under the plan within three years.
- Required a Medicaid MCO, if it established a rate for a service that was greater than the fee-for-service rate for the service, to require providers of the service to enter into value-based contracts as a condition of joining the MCO's provider panel.
- Prohibited a Medicaid MCO from permitting a provider to be a part of the MCO's provider panel unless the provider assured the MCO that it will comply with a requirement regarding cost estimates.
- Required, with certain exceptions, a hospital to accept as payment in full from a Medicaid MCO an amount equal to 90% of the fee-for-service rate for a nonemergency service provided to a Medicaid recipient if the hospital does not have a contract with the MCO and the MCO refers the recipient to the hospital.
- Allowed a Medicaid MCO to submit a bulk request to the State Board of Pharmacy for information about all Medicaid recipients enrolled in the organization's Medicaid MCO plan and required the Board to provide the requested information in a single electronic file or format.

Adjustments in Medicaid managed care capitation rates

The Governor vetoed a provision that required ODM to obtain Joint Medicaid Oversight Committee (JMOC) approval and then the Controlling Board's approval for necessary appropriations before adjusting any previously set capitation rates paid to Medicaid MCOs. The approval would have been necessary if the total cost to the Medicaid Program would have exceeded $50.0 million.

State pharmacy benefit managers

The Governor partially vetoed or vetoed several provisions regarding state pharmacy benefit managers (PBMs). H.B. 166 establishes a PBM under the Medicaid care management system. The Governor vetoed a provision that would have required the Medicaid Director to re-procure the state PBM contract every four years and to review the state PBM contract every six months and make recommended changes. The Governor partially vetoed language dealing with disclosures during the procurement process. In particular, language was vetoed that would have required the state PBM to list separately the fees and assessments charged to Ohio pharmacies that operate 11 or fewer locations and those charged to Ohio pharmacies that operate fewer than 11 locations. Additionally, a provision that would have permitted the affiliated companies of the state PBM to conduct PBM business in their own names with Medicaid MCOs was vetoed. In addition, language that would have required the state PBM be responsible for processing all pharmacy claims under the care management system and permitted a Medicaid MCO to contract directly with a pharmacy regarding the practice of pharmacy was also vetoed. The Governor also vetoed language that would have required the Medicaid Director to determine the rate the state PBM is paid for its services and to establish a dispensing fee to be paid to the state PBM for each drug it dispenses under the care management system. The Governor vetoed language that would have required the state PBM,

in consultation with the Medicaid Director, to develop a Medicaid prescribed drug formulary for the care management system. Lastly, the Governor vetoed a provision that would have required the Medicaid Director to make quarterly reports, as well as a provision regarding rulemaking authority.

PASSPORT enhanced community living services

The Governor vetoed a provision that earmarked $27,027 in each fiscal year from GRF line item 651525, Medicaid Health Care Services, to increase the payment rates for enhanced community living services covered by the PASSPORT Program.

Medicaid managed care organization financial health

The Governor vetoed a provision that required ODM, no later than January 1, 2020, to evaluate and benchmark the financial health of Medicaid MCOs, submit findings to JMOC, and adopt rules addressing the organizations' financial health as evaluated.

Medicaid payment rates for inpatient hospital services

The Governor vetoed a provision that required that an urban hospital's Medicaid base rate for inpatient services provided during FY 2020 be at least the average of the base rate for hospitals in the same peer group region if the urban hospital's FY 2019 base rate is less than $4,000.

Medicaid rate for Vagus Nerve Stimulation

The Governor vetoed a provision that required that the Medicaid rate for the Vagus Nerve Stimulation service provided under the outpatient hospital benefit equal 75% of the Medicare rate for the service during the period beginning July 1, 2019, and ending July 1, 2021. The provision also required that the Medicaid rates for other select services be reduced to avoid an increase in Medicaid expenditures.

Rural Healthcare Workforce Training and Retention Program

The Governor vetoed a provision that required the Medicaid Director to establish a Rural Healthcare Workforce Training and Retention Program for FY 2020 and FY 2021. Under this program, nonprofit hospital agencies and public hospital agencies could earn supplemental Medicaid payments for graduate medical education costs. Participating agencies would have been responsible for the state share of the program's costs.

Re-procurement of Medicaid managed care organizations

The Governor vetoed a provision that required the Medicaid Director to re-procure its contracts with Medicaid MCOs by July 1, 2020.

Retail pharmacy supplemental dispensing fee

The Governor partially vetoed a provision that required ODM to adopt rules to provide pharmacies a supplemental dispensing fee under the care management system. The Governor vetoed language establishing a deadline of January 1, 2020, to adopt rules providing for this fee. In addition, language that required the three payment levels for this fee be based on (1) the ratio of Medicaid prescriptions to total prescriptions a pharmacy location fills and (2) the

number of pharmacy locations participating in the care management system in that geographic area was also vetoed.

Analysis of FY 2020-FY 2021 budget

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

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

In the analysis, each appropriation item's actual expenditures for FY 2019 and appropriations for FY 2020 and FY 2021 are listed in a table. Following the table, a narrative describes how the appropriation is used and any changes affecting the appropriation. If the appropriation is earmarked, the earmarks are listed and described.

Categorization of ODM's Appropriation Line Items for Analysis of FY 2020-FY 2021 Budget				
Fund	ALI	ALI Name	Category	
General Revenue Fund Group				
GRF	651425	Medicaid Program Support – State	2	Medicaid Administration
GRF	651426	Positive Education Program Connections	1	Medicaid Services
GRF	651525	Medicaid Health Care Services	1	Medicaid Services
GRF	651526	Medicare Part D	1	Medicaid Services
GRF	651529	Brigid's Path Pilot	1	Medicaid Services
GRF	651533	Food Farmacy Pilot Project	1	Medicaid Services
Dedicated Purpose Fund Group				
4E30	651605	Resident Protection Fund	2	Medicaid Administration
5AN0	651686	Care Innovation and Community Improvement Program	1	Medicaid Services
5DL0	651639	Medicaid Services – Recoveries	1	Medicaid Services
5DL0	651685	Medicaid Recoveries – Program Support	2	Medicaid Administration
5DL0	651690	Multi-System Youth Custody Relinquishment	1	Medicaid Services
5FX0	651638	Medicaid Services – Payment Withholding	1	Medicaid Services
5GF0	651656	Medicaid Services – Hospital Upper Payment Limit	1	Medicaid Services
5R20	651608	Medicaid Services – Long Term	1	Medicaid Services

Fund	ALI	ALI Name		Category
5SC0	651683	Medicaid Services – Physician UPL	1	Medicaid Services
5TN0	651684	Medicaid Services – HIC Fee	1	Medicaid Services
6510	651649	Medicaid Services – Hospital Care Assurance Program	1	Medicaid Services
Holding Account Fund Group				
R055	651644	Refunds and Reconciliation	1	Medicaid Services
Federal Fund Group				
3ER0	651603	Medicaid Health and Transformation Technology	2	Medicaid Administration
3F00	651623	Medicaid Services – Federal	1	Medicaid Services
3F00	651624	Medicaid Program Support – Federal	2	Medicaid Administration
3FA0	651680	Health Care Grants – Federal	2	Medicaid Administration
3G50	651655	Medicaid Interagency Pass Through	3	Transfers

Category 1: Medicaid Services

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

C1:1: Positive Education Program Connections (ALI 651426)

Fund/ALI	FY 2019 Actual	FY 2020 Appropriations	FY 2021 Appropriations
GRF ALI 651426, Positive Education Program Connections	$2,500,000	$2,500,000	$2,500,000
% change	--	0.0%	0.0%

This GRF line item is used for the Positive Education Program Connections in Cuyahoga County. The program helps support young people whose mental health issues impact their daily life.

C1:2: Medicaid Health Care Services (ALI 651525)

Fund/ALI	FY 2019 Actual	FY 2020 Appropriations	FY 2021 Appropriations
GRF ALI 651525, Medicaid Health Care Services	$13,754,057,822	$14,112,337,514	$15,886,271,485
% change	--	2.6%	12.6%

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

C1:3: Medicare Part D (ALI 651526)

Fund/ALI		FY 2019 Actual	FY 2020 Appropriations	FY 2021 Appropriations
GRF ALI 651526, Medicare Part D		$456,570,668	$490,402,102	$533,290,526
	% change	--	7.4%	8.8%

This GRF line item is used for the phased-down state contribution, otherwise known as the clawback payment, under the Medicare Part D requirements contained in the federal Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. The clawback is a monthly payment made by each state to the federal Medicare Program. The amount of each state's payment roughly reflects the expenditures of its own funds that the state would have made if it continued to pay for outpatient prescription drugs through Medicaid on behalf of dual-eligibles (individuals eligible for both Medicare and Medicaid).

Funding levels are based on the projected increases in the clawback payment rates to the Medicare Part D Program. The budget projects that the dual-eligible caseload covered under this program will increase during the FY 2020-FY 2021 biennium.

H.B. 166 allows the Director of Budget and Management to transfer the state share of appropriations between GRF line item 651525 and this item.

C1:4: Brigid's Path Pilot (ALI 651529)

Fund/ALI		FY 2019 Actual	FY 2020 Appropriations	FY 2021 Appropriations
GRF ALI 651529, Brigid's Path Pilot		$0	$500,000	$500,000
	% change	--	N/A	0.0%

This line item is used by ODM to distribute funds to the Brigid's Path Program in Montgomery County. The program provides inpatient medical care for drug-exposed newborns.

C1:5: Food Farmacy Pilot Project (ALI 651533)

Fund/ALI		FY 2019 Actual	FY 2020 Appropriations	FY 2021 Appropriations
GRF ALI 651533, Food Farmacy Pilot Project		$0	$250,000	$250,000
	% change	--	N/A	0.0%

This line item is used by ODM to distribute funds to provide comprehensive medical, nutrition, and lifestyle support for food-insecure patients with type 2 diabetes and their families served by a hospital system in a county with a charter form of government and with a total population between 500,000 persons and one million persons.

C1:6: Care Innovation and Community Improvement Program (ALI 651686)

Fund/ALI	FY 2019 Actual	FY 2020 Appropriations	FY 2021 Appropriations
5AN0 ALI 651686, Care Innovation and Community Improvement Program	$52,706,563	$53,435,797	$53,406,291
% change	--	1.4%	-0.1%

This line item is used to provide funding for the state share of the Care Innovation and Community Improvement Program. Funding for this line item comes from the Care Innovation and Community Improvement Program Fund (Fund 5AN0). Any nonprofit hospital affiliated with a state university or public hospital agency may participate in the program if the agency operates a hospital that has a Medicaid provider agreement. Under the program, each participating agency receives supplemental payments under the Medicaid Program for physician and other professional services that are covered by Medicaid. However, the participating agency is responsible for the state share of costs.

C1:7: Medicaid Services – Recoveries (ALI 651639)

Fund/ALI	FY 2019 Actual	FY 2020 Appropriations	FY 2021 Appropriations
5DL0 ALI 651639, Medicaid Services – Recoveries	$589,080,563	$741,454,299	$781,970,233
% change	--	25.9%	5.5%

This line item is used by ODM to pay for Medicaid services and support. The Health Care/Medicaid Support and Recoveries Fund (Fund 5DL0) provides funding for this line item. The major revenue sources for Fund 5DL0 are prescription drug rebates, Institutions for Mental Diseases Disproportionate Share (IMD DSH), third-party liability, hospital settlements, and other recoveries.

C1:8: Multi-System Youth Custody Relinquishment (ALI 651690)

Fund/ALI	FY 2019 Actual	FY 2020 Appropriations	FY 2021 Appropriations
5DL0 ALI 651690, Multi-System Youth Custody Relinquishment	$0	$6,000,000	$12,000,000
% change	--	N/A	100.0%

This line item is used to prevent custody relinquishment of multi-system children and youth and to help these children obtain appropriate services. H.B. 166 expands the use of the Health Care/Medicaid Support and Recoveries Fund (Fund 5DL0), to include programs that serve multi-system youth as well as innovative programs that promote access to health care or help achieve long-term cost savings to the state. Money to support Fund 5DL0 comes from a variety of sources including prescription drug rebates, IMD DSH, third-party liability, hospital settlements, and other recoveries.

C1:9: Medicaid Services – Payment Withholding (ALI 651638)

Fund/ALI	FY 2019 Actual	FY 2020 Appropriations	FY 2021 Appropriations
5FX0 ALI 651638, Medicaid Services – Payment Withholding	$20,502,249	$12,000,000	$12,000,000
% change	--	-41.5%	0.0%

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

C1:10: Medicaid Services – Hospital Upper Payment Limit (ALI 651656)

Fund/ALI	FY 2019 Actual	FY 2020 Appropriations	FY 2021 Appropriations
5GF0 ALI 651656, Medicaid Services – Hospital Upper Payment Limit	$671,849,037	$822,016,219	$887,150,856
% change	--	22.4%	7.9%

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.

The increases in the appropriation reflect the additional revenue that will be generated as a result of the increase in the hospital franchise fee rate. The current assessment rate is about 2.66% of hospital costs. The budget increases the assessment rate to 3.24% in FY 2020 and to 3.35% in FY 2021.

C1:11: Medicaid Services – Long Term (ALI 651608)

Fund/ALI	FY 2019 Actual	FY 2020 Appropriations	FY 2021 Appropriations
5R20 ALI 651608, Medicaid Services – Long Term	$405,653,714	$420,154,000	$425,554,000
% change	--	3.6%	1.3%

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

C1:12: Medicaid Services – Physician UPL (ALI 651683)

Fund/ALI	FY 2019 Actual	FY 2020 Appropriations	FY 2021 Appropriations
5SC0 ALI 651683, Medicaid Services – Physician UPL	$3,057,547	$7,520,000	$7,645,000
% change	--	146.0%	1.7%

This line item is used by ODM to spend intergovernmental transfers for a Supplemental UPL Program for physicians of the Ohio State University's Wexner Medical Center. The funding arrangement is similar to the Hospital UPL Program in that they both close the gap between Medicaid and Medicare payment rates for the given subset of providers. The source of funds for this line item is from intergovernmental transfers. The revenue is deposited into Medicaid Services – Physician UPL Fund (Fund 5SC0).

C1:13: Medicaid Services – HIC Fee (ALI 651684)

Fund/ALI	FY 2019 Actual	FY 2020 Appropriations	FY 2021 Appropriations
5TN0 ALI 651684, Medicaid Services – HIC Fee	$551,000,000	$834,564,060	$806,187,400
% change	--	51.5%	-3.4%

This line item is used to reimburse health care providers for covered services to Medicaid recipients. Funding for line item 651684 comes from the Health Insuring Corporation Class Franchise Fee Fund (Fund 5TN0). Revenues are collected from the tax on all health insuring corporation (HIC) plans. The tax rate ranges from $26 to $56 per Medicaid member month, and $1 to $2 per non-Medicaid member month. Revenue assumptions are based on projected member months. The federal match for expenditures from this line item is made from line item 651623, Medicaid Services – Federal.

Funding is based on projected revenue, as well as policy changes. In H.B. 49 of the 132nd General Assembly, $196.2 million in FY 2018 and $226.8 million in FY 2019 was transferred to the Health and Human Services Fund (Fund 5SA4) and expended out of line item 651689. This transfer is not projected to occur in the upcoming biennium. Thus, the funds will be retained in Fund 5TN0 and expended from line item 651684; hence, the increase in this line item in FY 2020.

C1:14: Medicaid Services – Hospital Care Assurance Program (ALI 651649)

Fund/ALI	FY 2019 Actual	FY 2020 Appropriations	FY 2021 Appropriations
6510 ALI 651649, Medicaid Services – Hospital Care Assurance Program	$236,204,003	$249,167,065	$168,310,123
% change	--	5.5%	-32.5%

This line item is to fund the state share of the Hospital Care Assurance Program (HCAP). The source of revenue for Fund 6510 is HCAP assessments from Ohio hospitals. Shortly after assessment revenue is received, it is disbursed back to hospitals using the HCAP formula. The federal share of HCAP expenditures is funded through federal line item 651623, Medicaid Services – Federal.

The decline in the funding level in FY 2021 is due to reduced payments for HCAP. Under the ACA and other federal legislation, payments for HCAP are reduced starting in FFY 2021. Thus, the line item is decreased in response.

C1:15: Refunds and Reconciliation (ALI 651644)

Fund/ALI	FY 2019 Actual	FY 2020 Appropriations	FY 2021 Appropriations
R055 ALI 651644, Refunds and Reconciliation	$592,568	$1,000,000	$1,000,000
% change	--	68.6%	0.0%

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

C1:16: Medicaid Services – Federal (ALI 651623)

Fund/ALI	FY 2019 Actual	FY 2020 Appropriations	FY 2021 Appropriations
3F00 ALI 651623, Medicaid Services – Federal	$5,999,439,164	$6,563,381,020	$6,596,507,934
% change	--	9.4%	0.5%

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

The budget increases the appropriation for this line item in FY 2020 due to a realignment of the Hospital Franchise Fee Program, which is discussed under the "**Major initiatives for the FY 2020-FY 2021 biennium**" section. The realigning will take place in both FY 2020 and FY 2021.

The funding level remains stable in FY 2021 due to reduced payments for HCAP. HCAP helps individuals below 100% FPL that are not enrolled on Medicaid with unpaid hospital bills. Under the ACA and other federal legislation, payments for HCAP are reduced starting in FFY 2021. Thus, the line item is decreased in response.

Category 2: Medicaid Administration

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

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

Fund/ALI	FY 2019 Actual	FY 2020 Appropriations	FY 2021 Appropriations
GRF ALI 651425, Medicaid Program Support – State	$155,248,646	$164,132,342	$170,223,643
% change	--	5.7%	3.7%

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

The enacted funding level will be used to support administrative costs associated with the implementation of the work requirement, managed care re-procurement, 1115 SUD waiver authorization and evaluation, among others.

C2:2: Resident Protection Fund (ALI 651605)

Fund/ALI	FY 2019 Actual	FY 2020 Appropriations	FY 2021 Appropriations
4E30 ALI 651605, Resident Protection Fund	$2,668,035	$3,910,338	$4,013,000
% change	--	46.6%	2.6%

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

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

Fund/ALI	FY 2019 Actual	FY 2020 Appropriations	FY 2021 Appropriations
5DL0 ALI 651685, Medicaid Recoveries – Program Support	$23,422,054	$40,351,245	$44,375,000
% change	--	72.3%	10.0%

This line item is used to pay costs associated with the administration of Medicaid. Revenues from a variety of sources including prescription drug rebates, Institutions for Mental Diseases Disproportionate Share (IMD DSH), third-party liability, hospital settlements, and other recoveries are deposited into the Health Care/Medicaid Support and Recoveries Fund (Fund 5DL0) to support this line item.

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

Fund/ALI	FY 2019 Actual	FY 2020 Appropriations	FY 2021 Appropriations
3ER0 ALI 651603, Medicaid Health and Transformation Technology	$19,342,510	$48,031,056	$48,340,000
% change	--	148.3%	0.6%

This line item is used for provider electronic health record (EHR) incentives and administrative costs related to the Health Information Technology (HIT) grant. EHR incentives are provided by CMS to health care providers to encourage their use of EHR technology in ways that can improve patient care. HIT grants are provided by the U.S. Department of Health and Human Services and are used to conduct projects that contribute to health information technology improvements.

The EHR incentive payments are anticipated to end in FY 2022. As the program winds down, the payments are anticipated to decrease.

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

Fund/ALI	FY 2019 Actual	FY 2020 Appropriations	FY 2021 Appropriations
3F00 ALI 651624, Medicaid Program Support – Federal	$418,110,105	$516,667,497	$527,369,363
% change	--	23.6%	2.1%

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

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

Fund/ALI	FY 2019 Actual	FY 2020 Appropriations	FY 2021 Appropriations
3FA0 ALI 651680, Health Care Grants – Federal	$14,340,978	$11,988,670	$12,000,000
% change	--	-16.4%	0.1%

This line item funds Medicaid Program initiatives stemming from the ACA. The spending level is based on the revenue received for various federal grants.

Category 3: Transfers

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

Fund/ALI	FY 2019 Actual	FY 2020 Appropriations	FY 2021 Appropriations
3G50 ALI 651655, Medicaid Interagency Pass Through	$208,273,930	$225,701,597	$225,701,597
% change	--	8.4%	0.0%

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

MCD/lb

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

MCD Department of Medicaid

Fund	Line Item	Line Item Detail by Agency	FY 2018	FY 2019	Appropriations FY 2020	FY 2019 to FY 2020 $ Change	FY 2019 to FY 2020 % Change	Appropriations FY 2021	FY 2020 to FY 2021 $ Change	FY 2020 to FY 2021 % Change
GRF	651425	Medicaid Program Support-State	$ 139,987,073	$ 155,248,646	$ 164,132,342	$ 8,883,696	5.72%	$ 170,223,643	$ 6,091,301	3.71%
GRF	651426	Positive Education Program Connections	$0	$ 2,500,000	$ 2,500,000	$ 0	0.00%	$ 2,500,000	$ 0	0.00%
		Medicaid Health Care Services-State	$ 3,725,608,590	$ 3,909,792,891	$ 4,153,141,174	$ 243,348,283	6.22%	$ 4,733,728,704	$ 580,587,530	13.98%
		Medicaid Health Care Services-Federal	$ 9,479,085,299	$ 9,844,264,931	$ 9,959,196,340	$ 114,931,409	1.17%	$ 11,152,542,781	$ 1,193,346,441	11.98%
GRF	651525	Medicaid Health Care Services - Total	**$ 13,204,693,889**	**$ 13,754,057,822**	**$ 14,112,337,514**	**$ 358,279,692**	**2.60%**	**$ 15,886,271,485**	**$ 1,773,933,971**	**12.57%**
GRF	651526	Medicare Part D	$ 461,884,333	$ 456,570,668	$ 490,402,102	$ 33,831,434	7.41%	$ 533,290,526	$ 42,888,424	8.75%
GRF	651529	Brigid's Path Pilot	$0	$0	$ 500,000	$ 500,000	N/A	$ 500,000	$ 0	0.00%
GRF	651533	Food Farmacy Pilot Project	$0	$0	$ 250,000	$ 250,000	N/A	$ 250,000	$ 0	0.00%
GRF - State			$ 4,327,479,997	$ 4,524,112,205	$ 4,810,925,618	$ 286,813,413	6.34%	$ 5,440,492,873	$ 629,567,255	13.09%
GRF - Federal			$ 9,479,085,299	$ 9,844,264,931	$ 9,959,196,340	$ 114,931,409	1.17%	$ 11,152,542,781	$ 1,193,346,441	11.98%
Sub-Total General Revenue Fund			**$ 13,806,565,296**	**$ 14,368,377,136**	**$ 14,770,121,958**	**$ 401,744,822**	**2.80%**	**$ 16,593,035,654**	**$ 1,822,913,696**	**12.34%**
4E30	651605	Resident Protection Fund	$ 1,770,786	$ 2,668,035	$ 3,910,338	$ 1,242,303	46.56%	$ 4,013,000	$ 102,662	2.63%
5AJ0	651631	Money Follows the Person	$ 4,295,197	$ 8,124,633	$ 0	($8,124,633)	-100.00%	$ 0	$ 0	N/A
5AN0	651686	Care Innovation and Community Improvement Program	$0	$ 52,706,563	$ 53,435,797	$ 729,234	1.38%	$ 53,406,291	($29,506)	-0.06%
5DL0	651639	Medicaid Services-Recoveries	$ 774,001,996	$ 589,080,563	$ 741,454,299	$ 152,373,736	25.87%	$ 781,970,233	$ 40,515,934	5.46%
5DL0	651685	Medicaid Recoveries-Program Support	$ 14,540,841	$ 23,422,054	$ 40,351,245	$ 16,929,191	72.28%	$ 44,375,000	$ 4,023,755	9.97%
5DL0	651690	Multi-system Youth Custody Relinquishment	$0	$0	$ 6,000,000	$ 6,000,000	N/A	$ 12,000,000	$ 6,000,000	100.00%
5FX0	651638	Medicaid Services-Payment Withholding	$ 12,226,619	$ 20,502,249	$ 12,000,000	($8,502,249)	-41.47%	$ 12,000,000	$ 0	0.00%
5GF0	651656	Medicaid Services - Hospital Upper Payment Limit	$ 679,066,108	$ 671,849,037	$ 822,016,219	$ 150,167,182	22.35%	$ 887,150,856	$ 65,134,637	7.92%
5R20	651608	Medicaid Services-Long Term	$ 405,532,215	$ 405,653,714	$ 420,154,000	$ 14,500,286	3.57%	$ 425,554,000	$ 5,400,000	1.29%
5SA4	651689	Medicaid Health & Human Services	$ 264,376,763	$ 310,829,377	$ 0	($310,829,377)	-100.00%	$ 0	$ 0	N/A
5SC0	651683	Medicaid Services-Physician UPL	$ 5,566,189	$ 3,057,547	$ 7,520,000	$ 4,462,453	145.95%	$ 7,645,000	$ 125,000	1.66%
5TN0	651684	Medicaid Services-HIC Fee	$ 581,158,191	$ 551,000,000	$ 834,564,060	$ 283,564,060	51.46%	$ 806,187,400	($28,376,660)	-3.40%
5TZ0	651600	Brigid's Path Program	$ 500,000	$ 500,000	$ 0	($500,000)	-100.00%	$ 0	$ 0	N/A
5U30	651654	Medicaid Program Support	$ 3,346,012	$0	$0	$0	N/A	$0	$0	N/A
6510	651649	Medicaid Services-Hospital Care Assurance Program	$ 234,136,746	$ 236,204,003	$ 249,167,065	$ 12,963,062	5.49%	$ 168,310,123	($80,856,942)	-32.45%
Sub-Total Dedicated Purpose Fund Group			**$ 2,980,517,664**	**$ 2,875,597,775**	**$ 3,190,573,023**	**$ 314,975,248**	**10.95%**	**$ 3,202,611,903**	**$ 12,038,880**	**0.38%**
R055	651644	Refunds and Reconciliation	$ 148,673	$ 592,568	$ 1,000,000	$ 407,432	68.76%	$ 1,000,000	$ 0	0.00%

Line Item Detail by Agency			FY 2018	FY 2019	Appropriations FY 2020	FY 2019 to FY 2020 $ Change	FY 2019 to FY 2020 % Change	Appropriations FY 2021	FY 2020 to FY 2021 $ Change	FY 2020 to FY 2021 % Change
MCD		**Department of Medicaid**								
Sub-Total Holding Account Fund Group			**$ 148,673**	**$ 592,568**	**$ 1,000,000**	**$ 407,432**	**68.76%**	**$ 1,000,000**	**$ 0**	**0.00%**
3ER0	651603	Medicaid and Health Transformation Technology	$ 29,128,025	$ 19,342,510	$ 48,031,056	$ 28,688,546	148.32%	$ 48,340,000	$ 308,944	0.64%
3F00	651623	Medicaid Services-Federal	$ 6,226,396,603	$ 5,999,439,164	$ 6,563,381,020	$ 563,941,856	9.40%	$ 6,596,507,934	$ 33,126,914	0.50%
3F00	651624	Medicaid Program Support - Federal	$ 335,945,855	$ 418,110,105	$ 516,667,497	$ 98,557,392	23.57%	$ 527,369,363	$ 10,701,866	2.07%
3FA0	651680	Health Care Grants-Federal	$ 17,443,941	$ 14,340,978	$ 11,988,670	($2,352,308)	-16.40%	$ 12,000,000	$ 11,330	0.09%
3G50	651655	Medicaid Interagency Pass Through	$ 118,127,230	$ 208,273,930	$ 225,701,597	$ 17,427,667	8.37%	$ 225,701,597	$ 0	0.00%
Sub-Total Federal Fund Group			**$ 6,727,041,654**	**$ 6,659,506,687**	**$ 7,365,769,840**	**$ 706,263,153**	**10.61%**	**$ 7,409,918,894**	**$ 44,149,054**	**0.60%**
Department of Medicaid Total			**$ 23,514,273,287**	**$ 23,904,074,167**	**$ 25,327,464,821**	**$ 1,423,390,654**	**5.95%**	**$ 27,206,566,451**	**$ 1,879,101,630**	**7.42%**
Grand Total			**$ 23,514,273,287**	**$ 23,904,074,167**	**$ 25,327,464,821**	**$ 1,423,390,654**	**5.95%**	**$ 27,206,566,451**	**$ 1,879,101,630**	**7.42%**