health policy institute of ohio

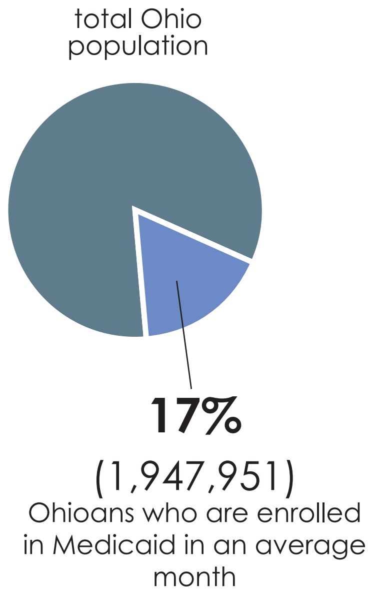
ohiomedicaidbasics2011

May, 2011

at a glance

Medicaid...

- Is Ohio's single largest payer of health care services
- Is the largest payer of long-term care in the state
- Paid for a range of health services to more than 2.3 million low-income families, children, seniors, and certain people with disabilities in 2010
- Covered 38% of Ohio children, including nearly 38,000 children with disabilities in 2010
- Combines state and federal funds to cover vulnerable populations
- Supplements Medicare for certain low-income seniors and people with disabilities
- Funds hospital care for Ohio's uninsured
- Is administered in Ohio by the Ohio Department of Job and Family Services/Office of Ohio Health Plans



17%

(1,947,951)

Ohioans who are enrolled in Medicaid in an average month

Aged, blind or disabled (ABD) **392,099**

Covered families and children (CFC) **1,555,852**

Source: DSS average monthly enrollment across all agencies SFY2010; ODJFS

Cost differences between types of enrollees

Although nearly 8 in 10 Medicaid enrollees is a child or parent, their care accounts for less than a third of all Medicaid expenditures.

2,371,701 total yearly Medicaid enrollment

	enrollees	expenditures
ABD	20.1% of all Medicaid **enrollees**	67.5% Medicaid **expenditures**
CFC	79.9% of all Medicaid **enrollees**	32.5% Medicaid **expenditures**

Source: DSS Spending across all agencies, SFY2010; ODJFS

Note on enrollment figures

In general, average monthly enrollment is preferable because it is a better reflection of what the Medicaid population looks like at any given time. Over the course of the year, there are some people enrolled in Medicaid for short periods of time; these additional beneficiaries are reflected in the yearly enrollment figure. In this publication, HPIO will typically refer to average monthly enrollment.

Overview

History

Congress created Medicaid in 1965 as Title XIX of the Social Security Act. The federal Centers for Medicare & Medicaid Services (CMS) monitor state-run programs and establish requirements for service delivery, quality, funding, and eligibility standards.

Medicaid is voluntary for states, but every state participates and administers its own program. Ohio Medicaid began in 1968.

In state fiscal year 2010, Ohio's state share of Medicaid was $4.3 billion[1]. Including federal matching funds, Medicaid accounted for 3.2% of Ohio's economy[2] and a greater proportion of state expenditures than any other single program (more than 30% of all state government spending).

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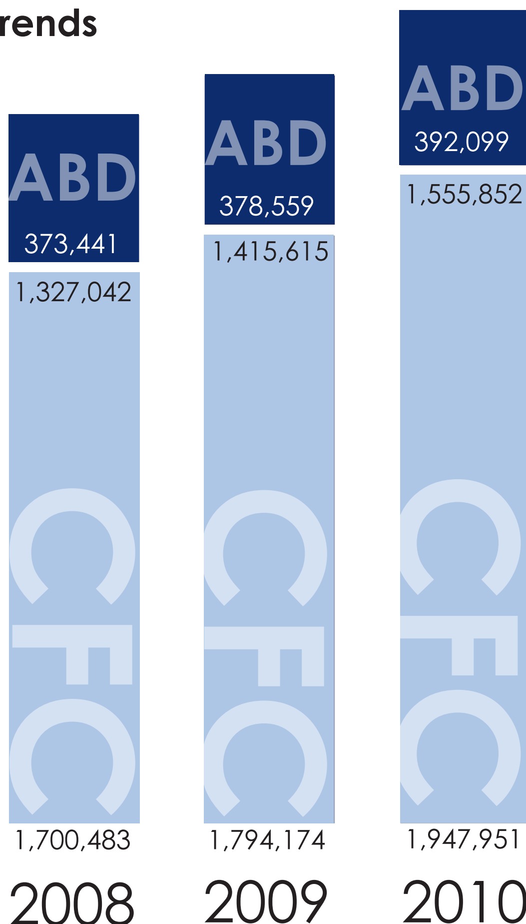
1 CMS-64 Spending across all agencies, SFY2010; ODJFS

2 Economy as represented by the Gross State Product. US Bureau of Economic Analysis, 2010.

Ohio Medicaid enrollment trends



Source: DSS average monthly enrollment across all agencies, SFY2010; ODJFS.

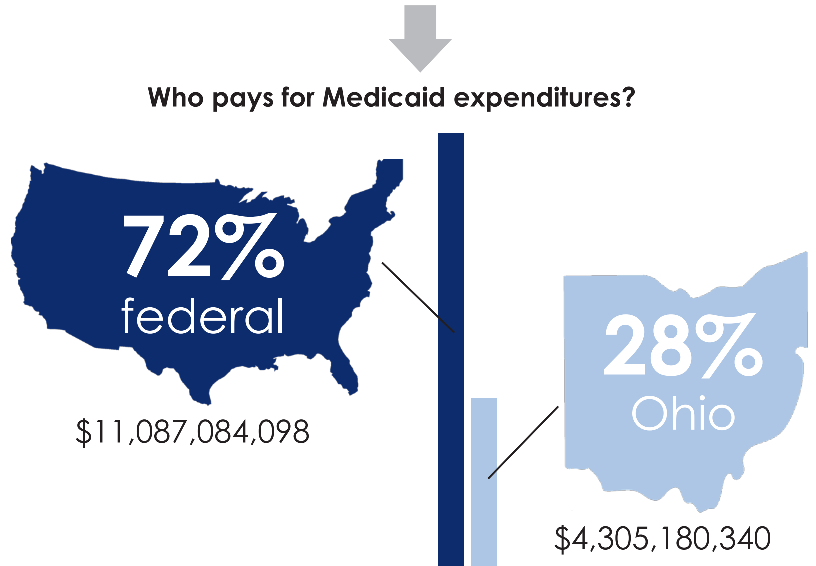
Financing

total annual Medicaid spending:

$15,392,264,438

(across all Ohio agencies)

Who pays for Medicaid expenditures?



Source: CMS-64 Spending across all agencies, SFY2010; ODJFS

FMAP and eFMAP

State Medicaid programs receive matching funds from the federal government to help pay for Medicaid services and administration. The Secretary of the Department of Health and Human Services (HHS) calculates these matching funds each year using the Federal Medical Assistance Percentage (FMAP). The standard FMAP for Ohio for fiscal year 2010 would have been 63.42%, meaning that for every dollar of state expenditure, the federal government would contribute $1.73.

However, in 2009, the American Recovery and Reinvestment Act authorized an enhanced FMAP (eFMAP) for use in the State Children's Health Insurance Program and state Medicaid. The eFMAP for Ohio in fiscal year 2010 was 74.39%, meaning that for every dollar of state expenditure, the federal government contributed $2.91. Overall, the federal share of Ohio Medicaid spending in 2010 came out to 72.03%.

The eFMAP rate was set to expire at the end of 2010, but was extended by Congress through June 30, 2011. After that date, the standard 2011 FMAP rate of 63.69% will go into effect through the end of the federal fiscal year (Sept. 30, 2011).

Medicaid income eligibility

Covered Population	Income Guidelines
Children up to age 19	200% FPL or less
Parents	90% FPL or less
Pregnant Women	200% FPL or less
Workers with Disabilities	250% FPL or less
Non-workers with Disabilities	64% FPL or less
Seniors 65 and older	64% FPL or less
Institutional Level of Care	Income less than the cost of care

NOTE: Some eligibility categories consider resources other than income. For seniors and people with disabilities, deductions and exceptions may apply. At the time of publication, income eligibility is slated to change with implementation in 2014 of the Affordable Care Act; ODJFS

Medicaid covers several categories of low-income Americans, including children, parents, pregnant women, seniors and people with disabilities. In general, to qualify for Ohio Medicaid a person must be a US citizen and Ohio resident, have or get a Social Security number, and meet certain financial requirements.

Ohio Medicaid covered more than 2.3 million Ohioans in 2010 (total annual non-duplicated enrollment for state fiscal year 2010). However, because people enter and exit the program throughout the year, Medicaid covered, on average, 1.95 million Ohioans each month.

There are two primary benefit groups in Ohio Medicaid, based on eligibility standards:

- Children up to age 19, parents and pregnant women can qualify for Medicaid based on low family income. Ohio Medicaid calls this benefit group "**covered families and children**" (CFC).

- Adults 65 and older and people of any age, including children, with a major disabling condition can qualify for Medicaid if they meet certain financial requirements. Ohio Medicaid calls this benefit group "**aged, blind, or disabled**" (ABD).

What is FPL? How is it determined?

Federal poverty level guidelines were originally calculated in 1963 by the Social Security Administration. The formula was set as three times the cost of food using the USDA economy food plan. FPL is now updated using the change in the Consumer Price Index for the previous calendar year.

2009 guidelines in effect until August 2011

	64%	90%	200%	250%	300%
1	$6,656	$9,360	$20,800	$26,000	$31,200
2	$8,960	$12,600	$28,000	$35,000	$42,000
3	$11,264	$15,840	$35,200	$44,000	$52,800
4	$13,568	$19,080	$42,400	$53,000	$63,600

Note: Add $3,740 for each additional person beyond 4

source:Federal Registrar, Effective July 1, 2008 to July 31, 2011

The difference between Medicaid and Medicare

Medicaid

- Aid for some poor Ohioans
- Must have low income
- Children, parents, disabled and age 65+
- Primary, acute and long-term care
- State and federal funding
- Not funded by payroll deduction

Medicare

- Care for nearly all Ohio seniors
- No income limit
- Age 65+ and some people with disabilities
- Primary and acute care only
- Federal funding (with some premium payments from Part B beneficiaries)
- Funded by payroll deduction

Benefit groups

Covered families and children (CFC)

Children up to age 19, parents, and pregnant women can qualify for Medicaid based on low family income. In 2010, Medicaid covered 1,093,724 children, 435,742 parents, 191 seniors and 26,195 pregnant women, on average, each month through the "covered families and children" (CFC) benefit group. More than half of all Medicaid-eligible Ohioans (56%) are non-disabled children.

Most Medicaid-eligible children and parents are healthy and need access to the same primary and acute health care services as the general population — doctor visits, hospital care, prescription drugs, vision services, etc. Children and parents are significantly less expensive than Medicaid-eligible seniors and people with disabilities who have more complex health care needs. CFC enrollees make up 79.9% of the Ohio Medicaid population but consume only 32.5% of Medicaid spending.

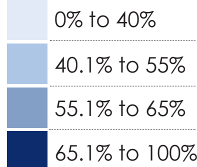
Healthy Start
Ohio Medicaid's health coverage for children and pregnant women is called Healthy Start. Children and pregnant women in families with income at or below 200% of poverty are eligible for Healthy Start. Pregnant women are eligible for coverage during their pregnancy, including 60 days postpartum, and their newborns are eligible for Medicaid for one year, regardless of family income.

Healthy Families
If a child's parent is also eligible for Medicaid, then the child is enrolled with the parent in Healthy Families. Healthy Families provides health coverage for families with at least one child age 19 or younger and income up to 90% of poverty.

Children enrolled in Medicaid

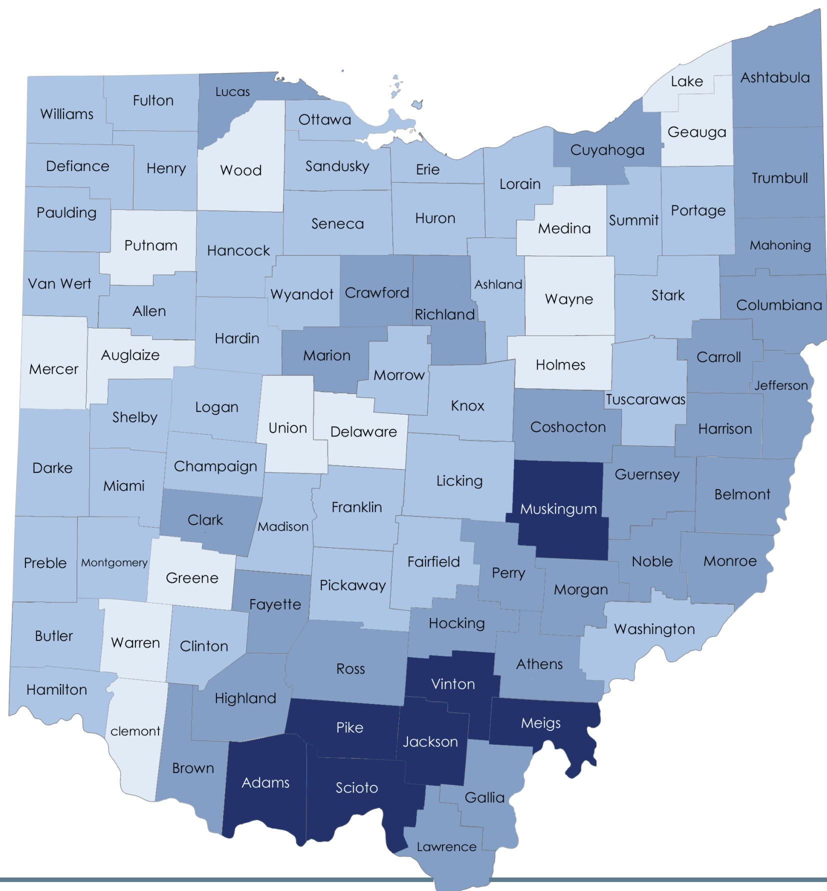
Percentage of Children Ages 0-4 Enrolled in Medicaid, by County of Residence

Medicaid penetration rate



0% to 40%
40.1% to 55%
55.1% to 65%
65.1% to 100%

Lowest Delaware Co. (15.6%)
State Average (49.6%)
Highest Vinton Co. (73.9%)



source: JFS only, SFY2010 enrollment data by county; ODJFS; penetration rate is calculated using monthly member average (JFS 2010) and resident population under 5 years of age (Census July 1, 2009 estimate)

HEALTHCHEK: Early and Periodic Screening, Diagnosis and Treatment Program

HEALTHCHEK is the core benefit package for children with disabilities and those in Healthy Start and Healthy Families. The program focuses on prevention and early detection of health problems by covering eight comprehensive check-ups in the first two years of life and annual check-ups thereafter. If a potential health problem is found, further diagnosis and all treatment is covered. A HEALTHCHEK coordinator is available in each county DJFS office to assist Medicaid consumers in getting those services.[1]

2 Beginning in April 2008, the Children's Buy-In Program (CBI) provided another option for Ohio's uninsured children in families with income above 300% FPL. However, the program is set to be eliminated with the start of state fiscal year 2012, with the children who are currently enrolled to be grandfathered in. For more information about the CBI, visit http://jfs.ohio.gov/ohp/cbi/info.stm

Aged, blind and disabled (ABD)

Adults age 65 and older and people of any age, including children, with a major disabling condition can qualify for Medicaid, if they meet certain financial requirements. In 2010, Ohio Medicaid covered 112,019 seniors, 242,091 adults with disabilities, and 37,989 children with disabilities (these children are not counted in the CFC category)through the "aged, blind, or disabled" (ABD) benefit group. ABD enrollees have more complex health care needs than non-disabled children and parents – they represent 20.1% of Medicaid enrollment and consume 67.5% of total Medicaid spending.

In Ohio, an individual's income, cash, bank accounts, stocks, and other assets are all considered to determine Medicaid ABD eligibility. There are different standards for different services, but in general, eligibility is set at 64% FPL, or 250% FPL for people with disabilities who work. Also, the applicant must meet transfer-of-resources (see glossary) provisions that are in place to prevent a person from impoverishing himself by giving away money so he can qualify for Medicaid. Those who have too much income to qualify may become eligible on a month-to-month basis through a Medicaid "spend down," (see glossary) where proof of certain medical expenses may reduce income until it falls within the financial guidelines for Medicaid eligibility.

People who qualify for ABD Medicaid are covered for primary and acute care services – the same comprehensive benefit package that is available to children and parents. In addition, seniors and people with disabilities can qualify for Medicaid long-term care services. Long-term care services include a broad range of medical, personal care, and supportive services that are provided in home, community, and facility-based settings.

Long-term care services

Facility-based long-term care services includes services provided in nursing facilities, intermediate care facilities for the mentally retarded (ICF-MR), and state-run developmental centers for the mentally retarded (MR/DD).

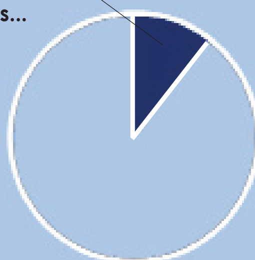
Home and community-based services (HCBS) are available for individuals who wish to stay in their home but otherwise qualify for facility-based services. Examples of HCBS include personal care and homemaking, adult day care, nursing, home delivered meals, transportation, supported employment, respite care, and emergency response systems.

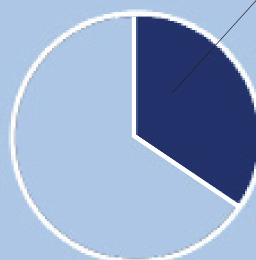
Ohio Medicaid administers a number of waiver programs. All waiver (see glossary) recipients have a level of care that qualifies them for Medicaid long-term care (see glossary) in an institution and many of them, without access to waiver services, would have no choice but to enter an institution.

In addition to HCBS waivers, Ohio Medicaid covers hospice benefits for the terminally ill and the Program for All-Inclusive Care for the Elderly (PACE), which provides acute and long-term care services in an adult day care model for frail, older adults.

Dual Eligibles

Congress created Medicare in 1965 to cover the medical needs of seniors and expanded the program later to cover some people with disabilities. However, Medicare's coverage is limited and does not cover long-term-care services, therefore Medicaid picks up most of the cost for nursing homes, home and community-based long-term care, and other medical services for low-income people on Medicare. In addition, Medicaid is required to cover the cost of Medicare premiums, coinsurance, and deductibles for low-income seniors, and a share of the cost of Part D pharmacy coverage.

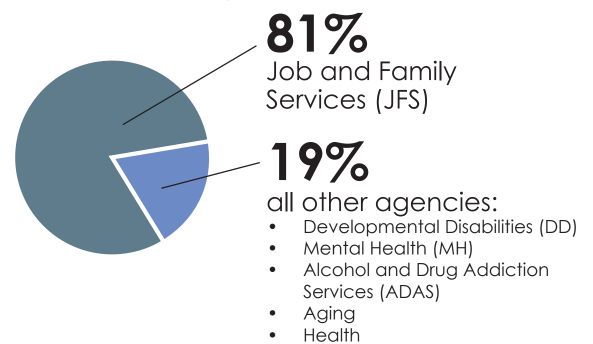




source: Yearly totals of enrollment and spending, SFY2010; ODJFS

Administration

Medicaid is jointly administered by the federal government and states. States administer the program within broad federal guidelines set by the Centers for Medicare & Medicaid Services (CMS), a division of the US Department of Health and Human Services (HHS). State participation in Medicaid is voluntary, but all states participate. The federal government supports state administration by providing matching funds and establishing general programmatic guidelines.



Medicaid is administered by the Ohio Department of Job and Family Services through six state agencies, 88 county boards of mental retardation and developmental disabilities, 50 combined behavioral health boards, 12 area agencies on aging, 135 county JFS offices, and 127 local health districts, and 70,542 providers (ODJFS provider claims, SFY2010).

The federal government requires each state to designate a "single state agency" to administer its Medicaid program. The Ohio Department of Job and Family Services (ODJFS) is Ohio's single state agency. The Office of Ohio Health Plans (OHP) within ODJFS is responsible for the day-to-day administration of Ohio Medicaid.

ODJFS delegates authority to five state agencies to administer specialized Medicaid programs. Medicaid represents a sizable share of budgets in the Ohio Department of Health (ODH), Alcohol and Drug Addiction Services (ADAS), Mental Health (MH), Aging, and Mental Retardation and Developmental Disabilities (DD). However, the vast majority of Medicaid financing (81%) is handled through ODJFS.

Mandated and Optional Services

Ohio's Medicaid program includes services mandated by the federal government plus optional services the state chooses to provide. Ohio has some discretion to vary the services it covers but, in all cases, the services must be "sufficient in amount, duration, and scope to reasonably achieve its purpose," according to federal regulations (42 C.F.R. § 440.230). Some services are limited by dollar amount, the number of visits per year, or the setting in which they can be provided, and some services now require the consumer to share in the cost.

Federally mandated services

- Early and periodic screening, diagnosis, and treatment for children (HEALTH-CHEK)
- Inpatient hospital
- Physician
- Lab and X-ray
- Outpatient, including services provided by hospitals, rural health clinics, and Federally Qualified Health Centers
- Medical and surgical vision
- Medical and surgical dental
- Transportation to Medicaid services
- Nurse midwife, certified family nurse practitioner, and certified pediatric nurse practitioner
- Family planning services and supplies
- Home health
- Nursing facility
- Medicare premium assistance

Ohio's optional services

- Prescription drugs
- Speech therapy
- Podiatry
- Physical therapy
- Occupational therapy
- Vision, including eyeglasses
- Dental
- Ambulance/ambulette
- Community alcohol and drug addiction treatment
- Home and community-based alternative to facility-based care
- Intermediate care facilities for people with mental retardation
- Hospice
- Community mental health services
- Chiropractic services for children
- Durable medical equipment and supplies
- Independent psychological services for children
- Private duty nursing

Office of Health Transformation

In January 2011, Governor Kasich issued Executive Order 2011-02K, creating the **Governor's Office of Health Transformation** (OHT). All state agencies that have a hand in administering Medicaid in Ohio now directly report to OHT.

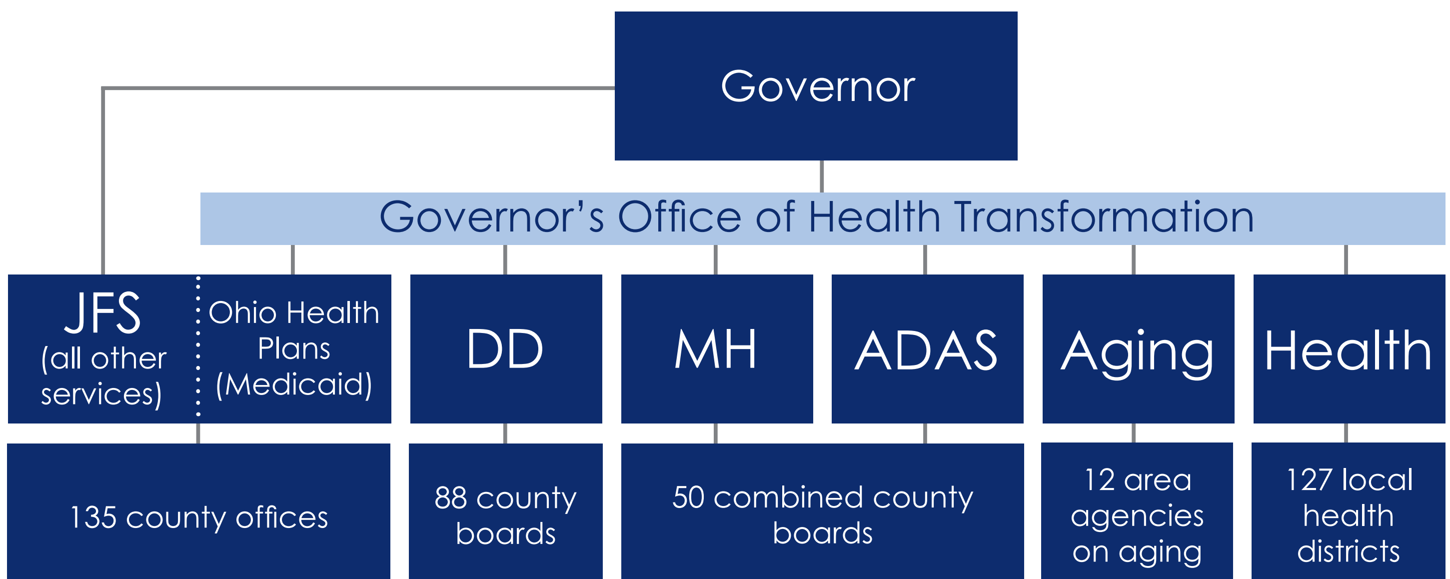
The Office of Health Transformation identifies its top priorities as increasing administrative efficiency and financial sustainability within Ohio's Medicaid program. This includes addressing long-term care, behavioral health integration, care coordination, payment reform, and short-term spending strategies.

Language from Executive Order 2011-02K:
"All Cabinet Agencies, Boards and Commissions shall comply with requests or directives issued by OHT, subject to supervision of their respective directors."

"To plan for the long-term efficient administration of the Ohio Medicaid Program, act to improve overall health system performance, and in the next six months (by middle of 2011):

- *Advance the Administration's Medicaid modernization and cost-containment priorities in the operating budget;*
- *Initiate and guide insurance market exchange planning (*[Ohio Department of Insurance]* in the lead with OHT supporting Medicaid connections);*
- *Engage private sectors partners to set clear expectations for overall health system performance; and*
- *Recommend a permanent HHS organization structure and oversee transition to that permanent structure."*

New Ohio Medicaid organization



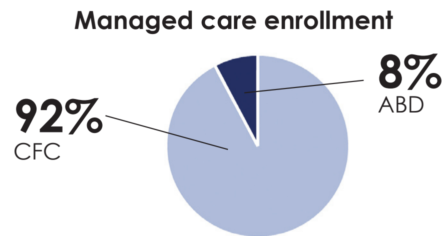
Delivery System

Ohio Medicaid provides primary and acute care services through managed care plans and a fee-for-service system. Both delivery systems provide medically necessary primary care, specialty and emergency care services and preventive services. Ohio Medicaid also provides home and community-based and facility-based long-term care services, exclusively through the fee-for-service system.

Managed Care

Ohio's Medicaid managed care program was created in 1978 and continues today as a strategy to ensure access to services, provide quality care and manage Medicaid costs. Almost all Medicaid-eligible children and parents – nearly 1.4 million people in 2010 – receive Medicaid services through a managed care organization (MCO). In addition, 114,578 people with disabilities are enrolled in managed care.

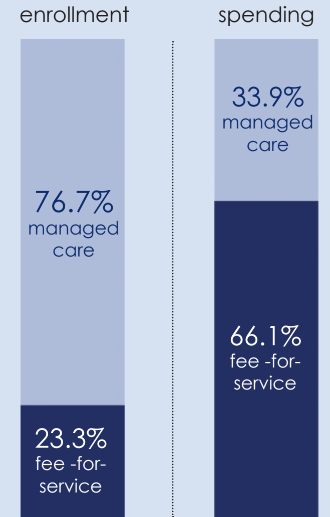
Managed care enrollment



source: ODJFS analysis of MCP average monthly members, SFY2010; ODJFS

A managed care organization (MCO) is a private health insurance company that provides — or arranges for someone to provide — the standard Medicaid benefit package to Medicaid enrollees. MCOs contract with ODJFS to manage care for Ohio Medicaid enrollees in exchange for a capitation payment (see glossary), or a set amount of money per member per month, paid one month in advance by ODJFS. The MCO (not the state) is at full risk for covering any costs that exceed the capitation payment it receives from Medicaid. MCOs attempt to control costs and quality by coordinating care through a network of providers selected by the MCO. MCOs also provide services in addition to the traditional Medicaid benefit package as a strategy to emphasize prevention and ensure that medical services are provided in the most appropriate settings.

Ohio Medicaid Managed Care and Fee-for-Service Enrollment and Spending



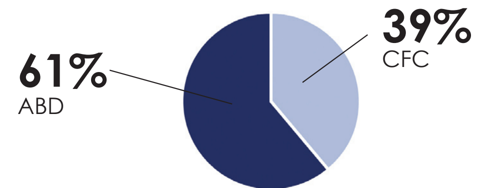
source: ODJFS analysis of FFS and MCP average monthly members and total cost of coverage, SFY2010; ODJFS

Fee-for-Service (FFS)

Most Medicaid-eligible seniors and people with disabilities (71%) are prohibited by Ohio law from enrolling in Medicaid managed care, including children under age 21 with disabilities, residents of institutions, recipients of Medicaid waiver services, and persons eligible for Medicare or who spend down their assets in order to qualify for Medicaid.

Instead, all seniors and most people with disabilities, including children, receive Medicaid services through a fee-for-service (FFS) program. Under FFS, Medicaid providers are paid for particular services based on a pre-set schedule of payment. The FFS system operates statewide so a Medicaid beneficiary may go to any of the 70,542 Ohio Medicaid providers, including hospitals, family practice doctors, pharmacies and durable medical equipment companies. These providers are permitted to provide health care services to Medicaid consumers and to bill Medicaid for those services. However, a provider's participation in the Medicaid program is voluntary, so beneficiaries are advised to ask the provider if they accept Medicaid before scheduling an appointment.

Fee-for-service enrollment



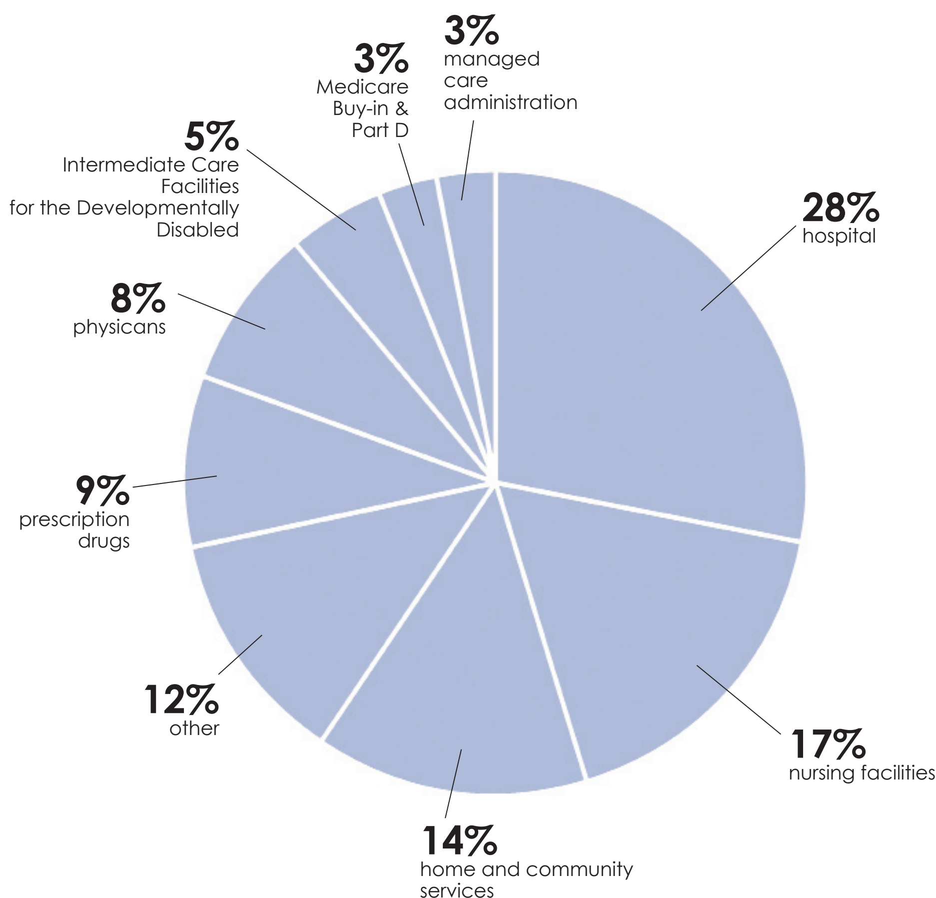
source: ODJFS analysis of FFS average monthly members, SFY2010; ODJFS

FFS enrollees are more expensive per person than individuals enrolled in managed care, primarily because they require high-cost, long-term-care services such as facility-based care and home- and community-based waiver services, which are excluded from managed care. As such, the FFS population represents only 23.35% of total Medicaid enrollment, but accounts for 66.13% of total Medicaid spending.

Medicaid spending is influenced by economic conditions and other factors. As is the case with health spending in general, the health services for a small group of high-need, high-cost individuals are responsible for much of the growth in the Ohio Medicaid program.

Ohio Medicaid cost drivers include increasing enrollment, price increases in medical and long-term care services and increased utilization of services by enrollees and providers.

2010 Ohio Medicaid spending



Source: Governors Office of Health Transformation analysis of ODJFS SFY 2010 data. Managed care expenditures are distributed to providers according to information from Milliman. Hospitals include inpatient and outpatient expenditures as well as HCAP Home and community services include waivers as well as home health and private duty nursing.

Enrollment

Medicaid eligibility is based on income, so changes in the economy have a direct impact on caseload, particularly for children and parents. The uninsured rate for Ohio children declined from 9.8% in 1998 to 4.1% in 2008 due in large part to a Medicaid eligibility expansion for children in 2000 (OFHS, 1998 and 2008). Enrollment is expected to grow in 2014 when the program is slated to expand to cover adults up to 138% of poverty under the Affordable Care Act.

Other factors that impact caseload include changes in the overall population (demographic changes are driving a steady increase in enrollment for seniors and people with disabilities), policy changes (the decision to cut parent eligibility from 100% to 90% of poverty in 2005 resulted in 25,000 fewer parents enrolled in Medicaid), and recent declines in employer-sponsored health insurance, which results in more low-income families dependent on public insurance.

Price

Medicaid spending is tied to the medical market, where annual cost growth continues to exceed growth in wages and general price inflation. State revenues are tied to tax bases that reflect growth rates for income and sales, which have lagged significantly behind the growth in medical costs.

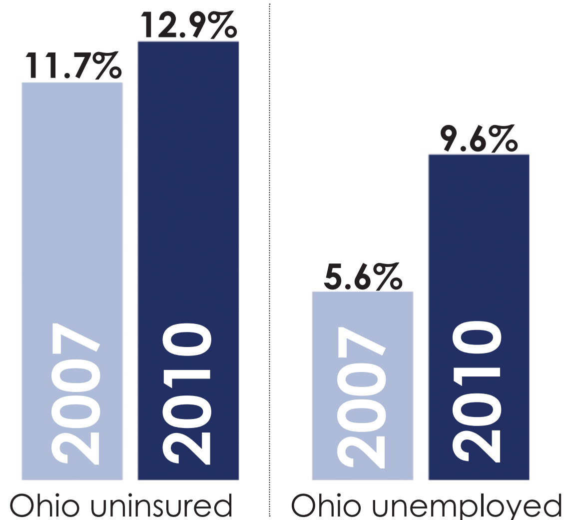
Utilization

Changes in utilization (consumers using certain services more frequently) result from changes in how consumers and providers make decisions about care, changes in the overall population (aging enrollees consume more services), new technologies and pharmaceuticals, and the availability of services and access to those services.

Current issues

Note: The following section of *Medicaid Basics* was written after Gov. Kasich released his biennium budget proposal, but before the 2012-2013 budget was approved.

In the coming years, Ohio Medicaid policy will be driven by federal policy changes, as well as the need to balance the state budget. As is the case with other public services, the recent national economic downturn has driven up the demand for Medicaid coverage and services, while at the same time choking off the money governments use to pay Medicaid bills. The state has experienced an increase in uninsured rates among adults, a decrease in employer-sponsored coverage, and an increase in unemployment, all of which have led to increased Medicaid caseloads. While the economy is showing signs of recovery, the challenge of long term fiscal sustainability within the Medicaid program remains.



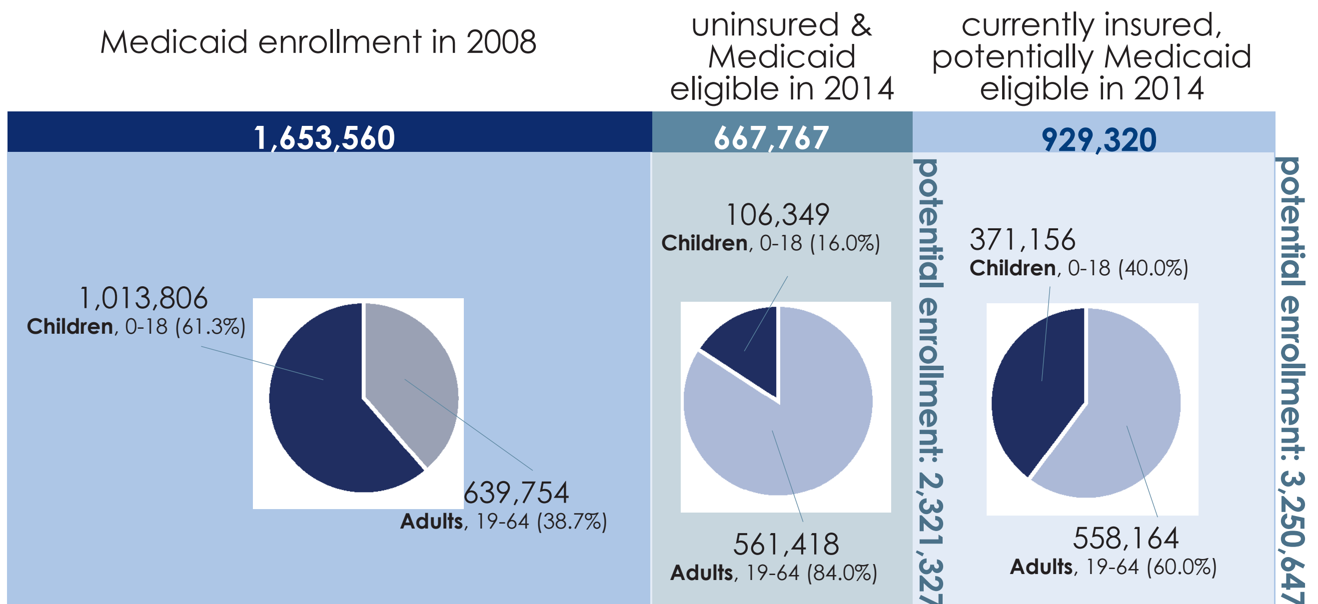
sources: CPS, Annual Social and Economic Supplement; all population uninsured percentage (March 2007, 2010) US Bureau of Labor Statistics; Ohio unemployment rate (Dec 2007, 2010)

Federal policy changes to Medicaid

The federal Affordable Care Act (ACA) includes "maintenance of effort" (MOE) provisions that limit states' ability to control costs by tightening eligibility requirements or reducing covered benefits. The ACA requires that states maintain their current eligibility standards for Medicaid until January 1, 2014 for adults and the Children's Health Insurance Program (CHIP) until September 30, 2019. During the MOE periods, states also are barred from imposing new paperwork and other barriers that would make it harder for people to enroll in Medicaid or CHIP. These MOE requirements are designed to assure that people do not lose coverage as health reform is being implemented. If the state forgoes the MOE, it would risk losing the federal match for Medicaid.

In addition, under the ACA, Medicaid eligibility will be expanded to include adults with incomes up to 138% of poverty. Because of the uncertainty of changes in the economy and employer-sponsored insurance coverage by 2014, it is difficult to determine how much this could add to Ohio's Medicaid caseload (The Kaiser Commission on Medicaid and the Uninsured estimated last year that the ACA could increase Ohio Medicaid enrollment by about 667,000, while the Office of Health Transformation recently estimated, using 2010 Ohio Family Health Survey data, that the number of Ohioans enrolled in Medicaid would grow by 936,000 in 2014).

Potential increases in Medicaid enrollment under reform

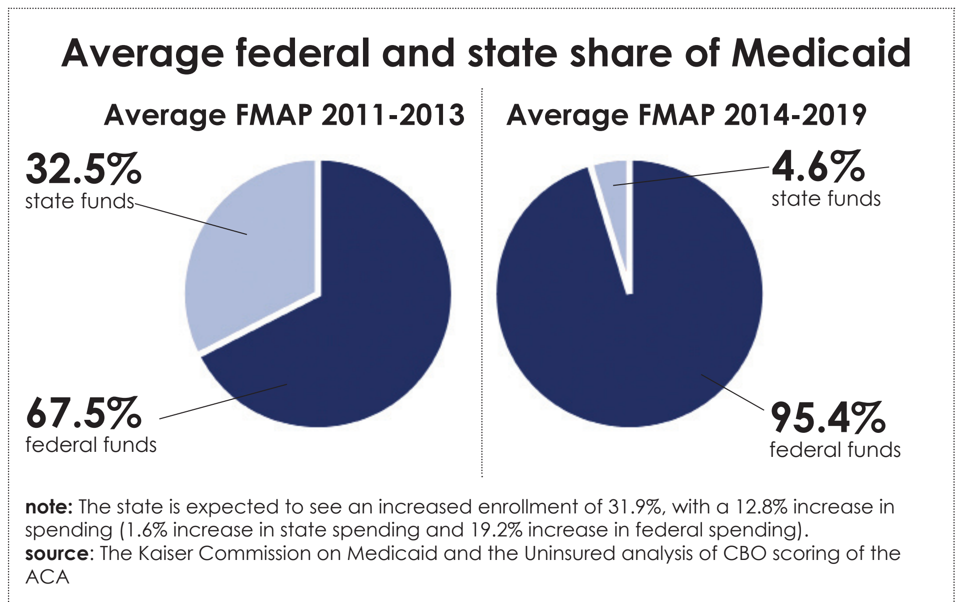


NOTE: The data from this chart is from July 2010 HPIO analysis of 2008 OFHS data, rather than SFY2010 data found throughout the rest of this document.

Future funding and budget implications

Facing an estimated $8 billion deficit, newly elected Governor John Kasich presented his first biennium budget in February. Given that the Medicaid program accounts for a substantial portion of the state budget, the Kasich Administration has made the program a priority, with an eye toward improving quality of care and containing costs to ensure long-term financial stability.

For SFY2012, the projected Medicaid budget for ODJFS is $15.3 billion, an 11.4% increase over SFY2011.



note: The state is expected to see an increased enrollment of 31.9%, with a 12.8% increase in spending (1.6% increase in state spending and 19.2% increase in federal spending).
source: The Kaiser Commission on Medicaid and the Uninsured analysis of CBO scoring of the ACA

The ACA will provide the state with some increased FMAP funding, starting in 2014. In fact, the first five years of Medicaid expansion, from 2014 to 2019, the state will receive 100% federal match for newly eligible enrollees. That match is expected to result in a total cost to Ohio Medicaid of about $17.13 billion in federal funds and $830 million in state funds during that time period. However, the state will receive the standard FMAP rate for those who had been previously eligible but may be more likely to now enroll given the individual mandate. Therefore, long term financial sustainability of the program will depend on state efforts to transform and modernize the system in a way that contains costs and preserves quality of care (OBM – Executive Budget SFY2012-2013).

Priorities for the new Administration — Medicaid modernization

Care coordination

In February the Kasich Administration applied for a planning grant from the federal Center for Medicare and Medicaid Innovation to begin implementation of a new Individual-Centered Integrated Care Delivery System (ICDS) that would provide coordinated care for Ohioans enrolled in Medicare and Medicaid, with a focus on dual-eligibles. Although the grant application was not approved, the Administration has indicated that it will still move forward with its plans for an ICDS program.

Among the components of the ICDS program would be:

- **Promote the use of health homes**, which expand on the medical home concept by increasing coordination of medical and behavioral health care for those with severe and/or multiple chronic conditions.
- **Encourage the creation of pediatric accountable care organizations** (ACOs) for the 37,934 Ohio children with disabilities served in the state's fee-for-service Medicaid program. The Administration plans initially to enroll children with disabilities into Medicaid managed care plans and then, over time, transition to a pediatric ACO model.

Payment reform

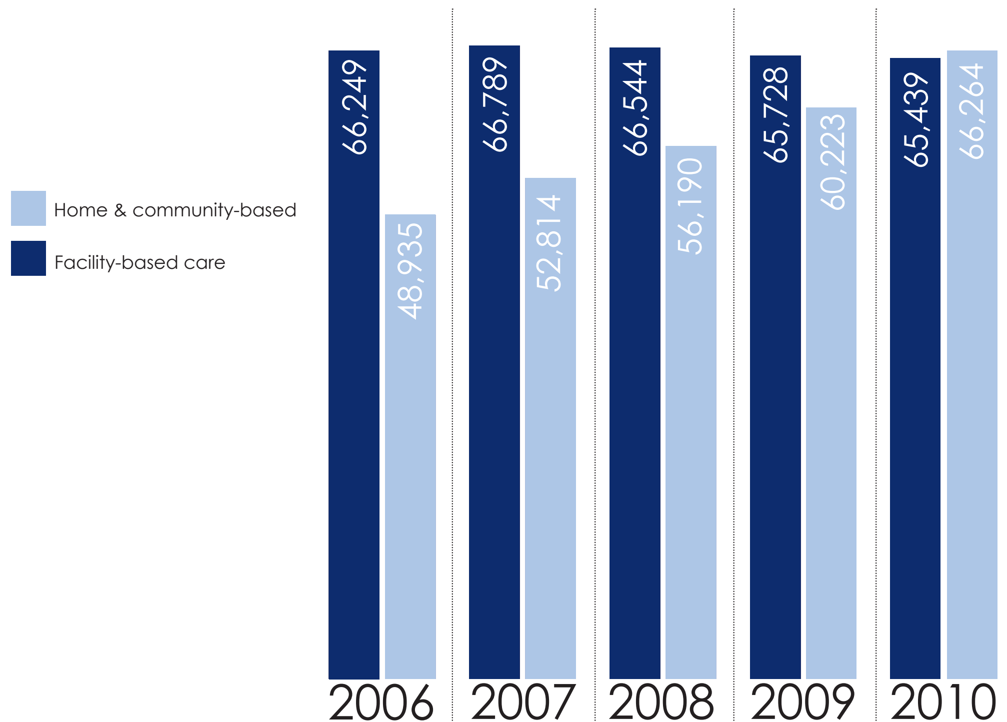
The governor's budget proposal calls for a series of changes to the way providers are paid for treating Medicaid beneficiaries. Among the proposed reforms are:

- **Change hospital payments** in an effort to incentivize improved outcomes. Among the approaches being considered are changing the reimbursement fee schedules for outpatient services and prohibiting payment for conditions that hospitals could have helped prevent.
- **Reform managed care payments**. Among these proposals are to change capitation rates (see glossary) and to require Medicaid reimbursement to default to fee-for-service rates for hospitals that will not contract with a managed care plan.
- **Adjust the nursing home payment formula** and make other changes that would enable the state to use more funds for home- and community-based services.

Rebalance long-term care

Gov. Kasich's budget proposal calls for a number of changes to the long-term care delivery system for Medicaid beneficiaries, with the goal of encouraging Medicaid beneficiaries to choose more cost-effective home- and community-based services. Since 1965, low-income Americans have been entitled to facility-based care in nursing facilities paid for by Medicaid. Long-term care services that support people in home and community settings are optional; states may ask federal permission to waive institutional level of care requirements and add these services as a Medicaid benefit.

People Served in Long-Term Care Institutions Compared to Home and Community-Based Waivers



source: Average monthly residents or recipients, SFY2010; Facility residents based on enrollment data; Waivers based on claims data; ODJFS.

Among the proposed changes are:

- **Creation of a unified long-term care budget**. The Administration plans to combine Medicaid funding for long-term services with ODJFS funding to create a single long-term care budget.
- **Creation of a single waiver for home- and community-based services**. Currently Medicaid administers a number of HCBS waivers (PASSPORT, Ohio Home Care, Ohio Home Care/Transitions Aging Carve-out, Choices and Assisted Living). The governor's budget would replace those with a single waiver. The governor's budget also calls for prioritizing waivers to encourage more Ohioans to choose less costly community-based services.
- **Reform nursing home payment rates**. The Administration is endorsing a plan to link nursing home payments to improved patient outcomes.
- **Consolidate all Medicaid programs for people with disabilities** in the Department of Developmental Disabilities.
- **Evaluate the cost-effectiveness of the Program for All-Inclusive Care for the Elderly (PACE)**.

Integrate behavioral and physical health care

Traditionally, Ohioans with serious mental illness who are on Medicaid have physical health benefits administered by ODJFS and behavioral health services overseen by county boards and administered by the Department of Mental Health and Alcohol and Drug Addiction Services. The Kasich Administration plans to change that approach. Among the steps being proposed are:

- **Move financial responsibility for community behavioral health from local boards to the state**, a move the Administration hopes will both relieve expenses for local governments and enable the state to achieve efficiencies and better care coordination.
- **Adopt utilization management controls and cost containments measures** within the community mental health Medicaid benefit

Ohio Medicaid
http://jfs.ohio.gov/Ohp/

Governor's Office of Health Transformation
http://www.healthtransformation.ohio.gov/

The Ohio Office of Budget and Management
http://obm.ohio.gov/default.aspx

Centers for Medicare & Medicaid Services
http://www.cms.gov/home/medicaid.asp

Center for Community Solutions health care resources
http://www.communitysolutions.com/key_issues/related_publications_health_care.aspx

Congressional Budget Office, Health Care page
http://www.cbo.gov/publications/collections/collections.cfm?collect=10

Center for Health Care Strategies
http://www.chcs.org/

Commonwealth Fund Ohio state scorecard
http://www.commonwealthfund.org/Maps-and-Data/State-Data-Center/State-Scorecard/DataByState/State.aspx?state=OH

Heritage Foundation health care resources
http://www.heritage.org/Initiatives/Health-Care

Kaiser Family Foundation

State Health Facts on Ohio
http://www.statehealthfacts.org/profileglance.jsp?rgn=37

The Kaiser Commission on Medicaid and the Uninsured
http://www.kff.org/about/kcmu.cfm

"Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL"
http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf

Glossary

Affordable Care Act (ACA) – The federal health care reform law enacted in March 2010. The law was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is used to refer to the final, amended version of the law.

Accountable Care Organization (ACO) – A group of health care providers who provide coordinated care, chronic disease management, and thereby improve the quality of care patients receive. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings.

Aged, Blind, Disabled (ABD) – A Medicaid designation that assists with medical expenses for poor individuals who are aged 65 years or older, blind or disabled (disability as classified by the Social Security Administration for an adult or child).

Capitation – A method of payment for health services in which an individual or facility-based provider is paid a fixed amount for each person served without regard to the actual number or nature of services provided to each person in a set period of time.

Categorically Needy – Medicaid's eligibility pathway for individuals who can be covered. There are more than 25 eligibility categories organized into five broad groups: children, pregnant women, adults with dependent children, individuals with disabilities and the elderly. Persons not falling into one of these groups (notably childless adults) cannot qualify for Medicaid no matter how low their income. The ACA simplifies Medicaid eligibility, expanding coverage to all adults up to 138% of FPL (133% + 5% income disregard). This will extend eligibility to an estimated 560,000 Ohioans.

Centers for Medicare & Medicaid Services (CMS) – The federal agency within the Department of Health and Human Services that directs the Medicare and Medicaid programs (Titles XVIII and XIX of the Social Security Act). Formerly the Health Care Financing Administration (HCFA). www.cms.gov

Children's Health Insurance Program (CHIP) – Enacted in 1997, CHIP is a federal-state program that provides health care coverage for uninsured low-income children who are not eligible for Medicaid. States have the option of administering CHIP through their Medicaid programs or through a separate program (or a combination of both). The federal government matches state spending for CHIP but federal CHIP funds are capped. Formerly known as **SCHIP**, or State Children's Health Insurance Program, the name was changed when the program was reauthorized in 2009.

CLASS Act – The ACA creates the Community Living Assistance Services and Support (CLASS) Act, which is a national, voluntary long-term care insurance program that will be available after October 2012 to help pay for services and supports to help maintain independence in the community. People over age 18 who are working will have the opportunity to enroll. Enrollees (after contributing to the program for five years) who the program determines have functional limitations expected to last at least 90 days and who meet other eligibility requirements will get a cash benefit to help pay for supports to stay independent. These limitations include needing help with many basic daily living activities such as eating and getting in and out of bed. The minimum average daily benefit will be $50 a day.

Department of Health and Human Services (HHS) – HHS is the U.S. government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. Many HHS-funded services, including Medicare, are provided at the local level by state or county agencies or through private sector grantees. The department's programs are administered by 11 operating divisions, including eight agencies in the U.S. Public Health Service and three human services agencies.

Dual Eligible – A person who is eligible for two health insurance plans, often referring to a Medicare beneficiary who also qualifies for Medicaid benefits.

Federal Medical Assistance Percentage (FMAP) – The statutory term for the federal Medicaid matching rate—i.e., the share of the costs of Medicaid services or administration that the federal government bears. The American Recovery and Reinvestment Act (ARRA) provided a temporary increase in the FMAP (also known as enhanced FMAP or **eFMAP**) through December 31, 2010, and additional legislation partially extends this funding through June 30, 2011.

Federal Poverty Level (FPL) – Annually updated guidelines established by the U.S. Department of Health and Human Services to determine eligibility for various federal and state programs. In 2011, the FPL for a family of four is $22,350.

Federally-Qualified Health Center (FQHC) – A health center in a medically under-served area or population that is eligible to receive cost-based Medicare and Medicaid reimbursement and provides direct reimbursement to nurse practitioners, physician assistants and certified nurse midwives. FQHCs are sometimes referred to as CHCs (Community Health Centers). A CHC is an ambulatory health care program usually serving a catchment area that has scarce or non-existent health services or a population with special needs.

Fee-for-Service – A traditional method of paying for medical services under which doctors and hospitals are paid for each service they provide. Bills are either paid by the patient, who then submits them to the insurance company, or are submitted by the provider to the patient's insurance carrier for reimbursement.

Home and Community-Based Services (HCBS) – Any care or services provided in a patient's place of residence or in a non-facility-based setting located in the immediate community.

Long-Term Care (LTC) – A set of health care, personal care and social services provided to persons who have lost, or never acquired, some degree of functional capacity (e.g., the chronically ill, aged, disabled, or retarded) in an institution or at home, on a long-term basis.

Managed Care – health care systems that integrate the financing and delivery of appropriate health care services to covered individuals. Managed care systems arrange with selected providers to furnish a comprehensive set of health care services.

Medicaid – A federally-aided, state-administered and jointly-funded health insurance program that provides medical benefits to qualified indigent or low-income persons in need of health and medical care. The program is subject to broad federal guidelines and states determine the benefits covered and methods of administration.

Medical Home – An approach to providing comprehensive primary care that facilitates partnerships between individual patients, and their personal providers, and when appropriate, the patient's family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need it in a culturally and linguistically appropriate manner.

Medicare – A federally funded health insurance plan that provides hospital, surgical and medical benefits to elderly persons over 65 and certain disabled persons. Medicare Part A provides basic hospital insurance, and Medicare Part B provides benefits for physicians' professional services. Medicare Part C (Medicare Advantage Plan) allows those covered to combine their coverage under Parts A and B but is provided by private insurance companies. Medicare Part D helps pay for medications doctors prescribe for treatment.

Transfer-of-resources – As defined by Medicaid, is a voluntary gift or change of ownership of a resource without receiving fair market value in return. If the transfer has been made during the "look-back" period prior to applying for Medicaid, it is assumed that the transfer was made in order to become Medicaid eligible. In those cases, a penalty period is assessed, during which Medicaid is denied. Transfers of resources between spouses do not generate a penalty. Transfers of resources to children may generate a penalty.

Spend down – The process of establishing eligibility for Medicaid by allowing an individual who would otherwise not be eligible for the program to spend excess net income on certain medical expenses.

Waiver – Authorization by the Secretary of the U.S. Department of Health and Human Services (HHS) to waive certain Medicaid statutory requirements, giving states more flexibility in Medicaid program operation. An example is the home and community care based (HCBC) waiver programs operated under Section 1915(c) of the Social Security Act that allow long-term care services to be delivered in community settings.

for a complete health policy glossary, visit
www.hpio.net/glossary

The Health Policy Institute of Ohio is a 501(c)3 nonprofit organization that serves as Ohio's nonpartisan, independent source for forecasting health trends, analyzing key health issues, and communicating current research to policymakers, state agencies and other decision-makers.

Since its founding in 2003, HPIO has become the state's trusted source of information and leadership on health policy issues. In the past, Ohio decision makers often had to rely on data and analysis provided by interest groups with particular perspectives and agendas. HPIO's mission is to provide nonpartisan, unbiased research, analysis and communication that enables policymakers to make the most informed decisions possible on matters that affect the health of all Ohioans.

Acknowledgment
The Health Policy Institute of Ohio would like to thank the Ohio Department of Job and Family Services for providing much of the data used in this publication.

The Health Policy Institute of Ohio is an independent organization that is not affiliated with Ohio Medicaid.
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