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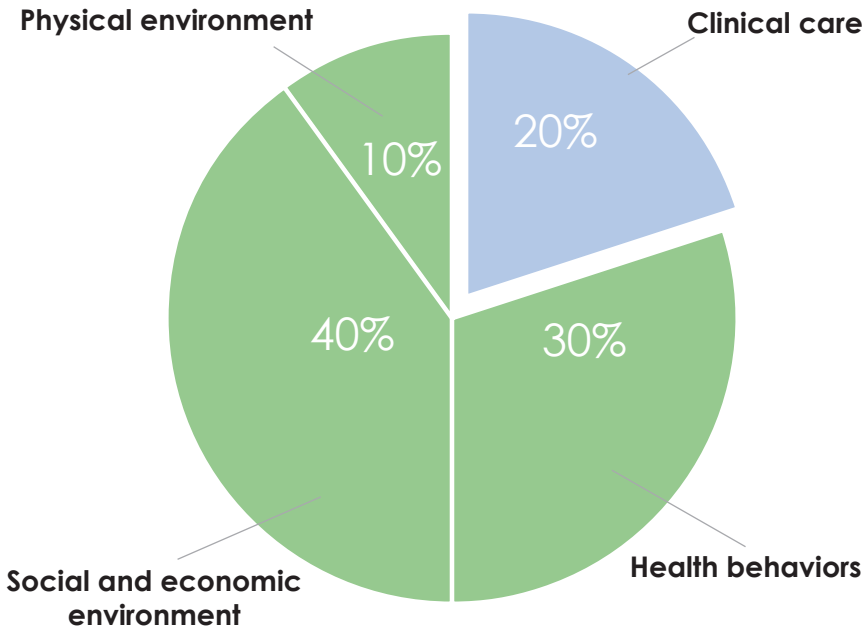
# Ohio**Medicaid**Basics**2017**

## Introduction

Medicaid pays for medically necessary healthcare services for over three million Ohioans and is the primary source of coverage for low-income Ohioans who generally do not have access to or cannot afford other health insurance coverage. The program also pays for services for people who are elderly and disabled, including long term services and supports that are not covered by Medicare and most private health insurance coverage.[1] As a healthcare payer for one in four Ohioans, Medicaid enables improved access to care[2], as well as treatment of chronic health conditions (including mental health conditions), injuries, illnesses and addictions. Medicaid also pays for preventive care, prescription drugs and screenings.

While there is evidence that Medicaid coverage improves access to care[3], it is important to note that overall health is influenced by a number of other factors. Research estimates that of the modifiable factors that influence overall health outcomes, 80 percent is attributed to non-clinical factors including our social, economic and physical environments, as well as our health behaviors, and only 20 percent is attributed to clinical care (see figure 1).[4] This indicates that access to quality clinical care is necessary, but not sufficient, to improving overall health.

Figure 1. **Modifiable factors that influence health**




**Source:** County Health Rankings and Roadmaps population health model

### Medicaid and the U.S. healthcare system

Medicaid is financed jointly by the federal government and states, including some local-level funding to support the state share.

Medicaid accounted for 17 percent of U.S. total healthcare expenditures in 2015, making the program the second-largest payer of healthcare services in terms of total expenditures.[5] Through Medicare, Medicaid and the Federal Employees Health Benefit Plan, the federal government is the largest payer for healthcare services in the country, and because of this, often drives change and industry innovation, particularly through new payment rates and models.[6]

At the state level, the Ohio Department of Medicaid (ODM) and the managed care plans under contract with ODM are important partners in payment reform initiatives led by the Governor's Office of Health Transformation (OHT) (see "Paying for value in Medicaid" beginning on page 10 of this publication).

Figure 2. **Federal poverty level (FPL) guidelines by household size, 2017**

| | 100% | 133% | 200% | 206% | 250% | 400% |
|---|---|---|---|---|---|---|
| 1 | $12,060 | $16,040 | $24,120 | $24,844 | $30,150 | $48,240 |
| 2 | $16,240 | $21,599 | $32,480 | $33,454 | $40,600 | $64,960 |
| 3 | $20,420 | $27,159 | $40,840 | $42,065 | $51,050 | $81,680 |
| 4 | $24,600 | $32,718 | $49,200 | $50,676 | $61,500 | $98,400 |

**Source**: Assistant Secretary for Planning and Evaluation, U.S. Department of Health & Human Services (2017)
**Note**: Annual guidelines for all states except Alaska, Hawaii and D.C.

## Who is eligible for Medicaid coverage?

Ohio Medicaid pays for healthcare services for children, pregnant women, parents, childless adults and people with disabilities, all of whom must have incomes below a specific amount (see figure 2). These income levels are usually set as a percentage of the federal poverty level. Income for most Medicaid beneficiaries is counted using the Modified Adjusted Gross Income (MAGI) counting methodology. However, some populations, including those applying for Medicaid on the basis of age, blindness or disability, are subject to different income counting rules and resource limits.

In order to qualify for Medicaid coverage, a person must be a U.S. citizen or meet Medicaid non-citizen requirements.[7] Medicaid enrollees must also have a Social Security number, be an Ohio resident and meet financial requirements.[8]

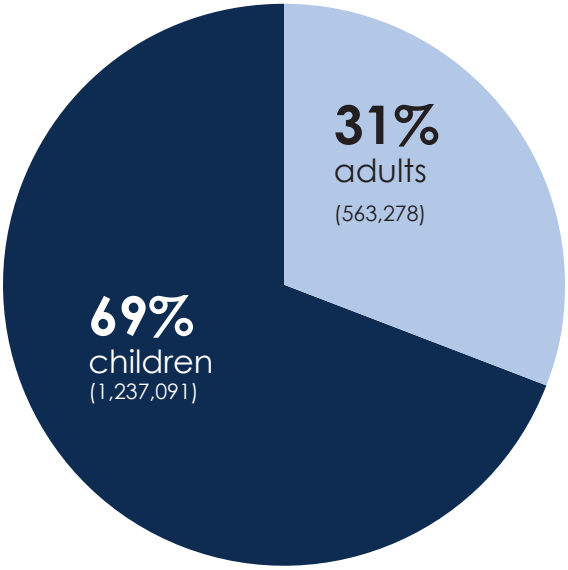
### Medicaid eligibility categories

People who are eligible for Medicaid are separated into categories based on age, household composition and medical need. Medicaid eligibility categories include Covered Families and Children (CFC), Aged, Blind and Disabled (ABD), Medicaid Expansion (also known as "Group VIII") and other Medicaid. With some exceptions, most notably children with incomes over 156 percent FPL, seniors and people with disabilities who are enrolled in Medicare, Medicaid recipients may have other insurance in addition to Medicaid. In these cases, Medicaid is the payer of last resort and must be the last coverage source to receive and process a claim.[9]

#### Covered Families and Children (CFC)

The CFC eligibility group includes families, children and pregnant women. Of the 1.8 million Ohioans enrolled in the CFC category of Medicaid during state fiscal year 2016, more than two-thirds were children (see figure 3).[10] MAGI income counting applies to CFC categories of Medicaid and therefore, a five percent income disregard is applied during the eligibility determination process. The disregard effectively raises the income eligibility limits by 5 percentage points (see figure 4).

Figure 3. **Medicaid Covered Families and Children enrollment for adults and children, SFY 2016**




**Source:** Ohio Department of Medicaid caseload report (2017). Additional analysis by HPIO.

***Children:*** Medicaid covers children (up to age 19) in families with incomes up to 206 percent FPL. Children in families with incomes between 156 percent and 206 percent FPL who have no other source of health insurance coverage are covered in the CFC group.

***Parents:*** Medicaid covers parents or caretaker relatives[11] in households with incomes up to 90

percent FPL and at least one child younger than 19 in the household. Parents with incomes between 90 percent and 133 percent FPL may qualify for Medicaid coverage under the Group VIII category (see page 4).

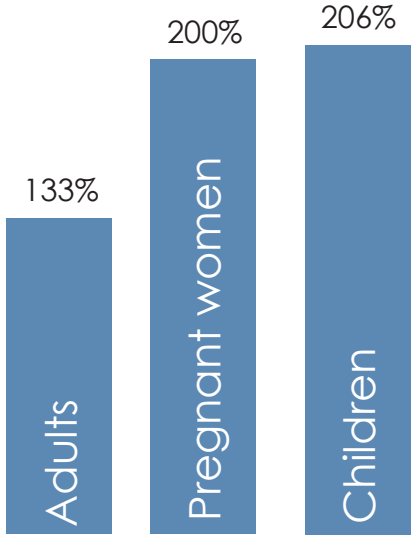
***Pregnant women:*** Medicaid covers pregnant women with incomes up to 200 percent FPL. Once determined eligible, a pregnant woman is covered during her entire pregnancy and up to 60 days after the baby is born, regardless of changes that could have affected the woman's eligibility during that time frame. Babies born to mothers covered by Medicaid are deemed eligible to continue receiving services for one full year from the date of birth, even if the mother becomes ineligible. After one year, the child may be eligible for continued Medicaid coverage, depending on household income and other eligibility criteria.

**Aged, Blind, and Disabled (ABD)**
Medicaid covers people with low incomes who are age 65 or older (aged), blind or disabled. ABD applicants must meet both income and resource criteria to qualify. The resource criterion sets limits on the amount of resources or assets an individual may have when eligibility is determined, including cash, stocks, bonds, bank accounts and property. Some resources, including the applicant's primary home, are exempt from consideration. Certain ABD applicants must also comply with transfer-of-resource criteria designed to limit the sale of assets for less than fair market value during the five-year period before applying.[14]

## Children's Health Insurance Program (CHIP)

CHIP was created by Congress as a part of the Balanced Budget Act of 1997 and it expanded coverage to low-income children not eligible for Medicaid.[12] Ohio chose to expand eligibility to current levels rather than create a separate program. In April 2015, CHIP funding was reauthorized through federal fiscal year 2017, and it is currently set to expire on October 1, 2017. Without reauthorization of CHIP funding in 2017, states like Ohio that implemented a Medicaid expansion CHIP program will be required by the Affordable Care Act (ACA) maintenance of effort provision to maintain CHIP eligibility levels until 2019 regardless of federal funding of the CHIP program.[13]

Figure 4. **Income limits, by percent of FPL, for MAGI-eligible categories, 2017**




**Source:** Ohio Department of Medicaid
**Note:** Most people that apply for these categories are eligible for a 5 percent income disregard and children with other qualifying coverage are only eligible up to 156 percent FPL.

Income and resource limits for ABD Medicaid are the same as limits for the federal Supplemental Security Income (SSI) program.[15] The income limit for 2017 is $735 per month for an individual and $1,103 for a couple[16] and the resource limit is $2,000 for an individual and $3,000 for a couple.[17]

In July 2016, Ohio changed the way that people are determined eligible for the ABD category of Medicaid. Effective August 1, 2016, a person determined eligible for SSI by the U.S. Social Security Administration is automatically enrolled in Medicaid. Enrollment in the ABD group has grown by about 63,000 since implementation of this policy change.[18] Nationally, and in Ohio, enrollment in the ABD category is also expected to grow due to changing demographics. In addition, per capita spending nationally for the ABD category is expected to increase over the next decade.[19] These factors together could result in total Medicaid spending increases.[20] For more information, see page 13.

***Medicaid Buy-in for Workers with Disabilities (MBIWD):*** MBIWD provides full Medicaid benefits to people with a disability, incomes below 250 percent FPL and resources valued

Figure 5. **Differences between Medicaid and Medicare**

| Medicaid | Medicare |
|---|---|
| • Pays for care for most Ohioans with low incomes | • Pays for care for nearly all Ohio seniors |
| • Eligibility based on income and other factors | • Eligibility based on age or disability status and work history |
| • Primary, acute and long-term services and support | • Primary and acute care only |
| • Federal and state funding, with local contributions | • Federal funding |
| • Not funded by payroll deduction | • Funded by payroll deduction |

at less than $11,473. People with incomes above 150 percent FPL must pay a monthly premium.

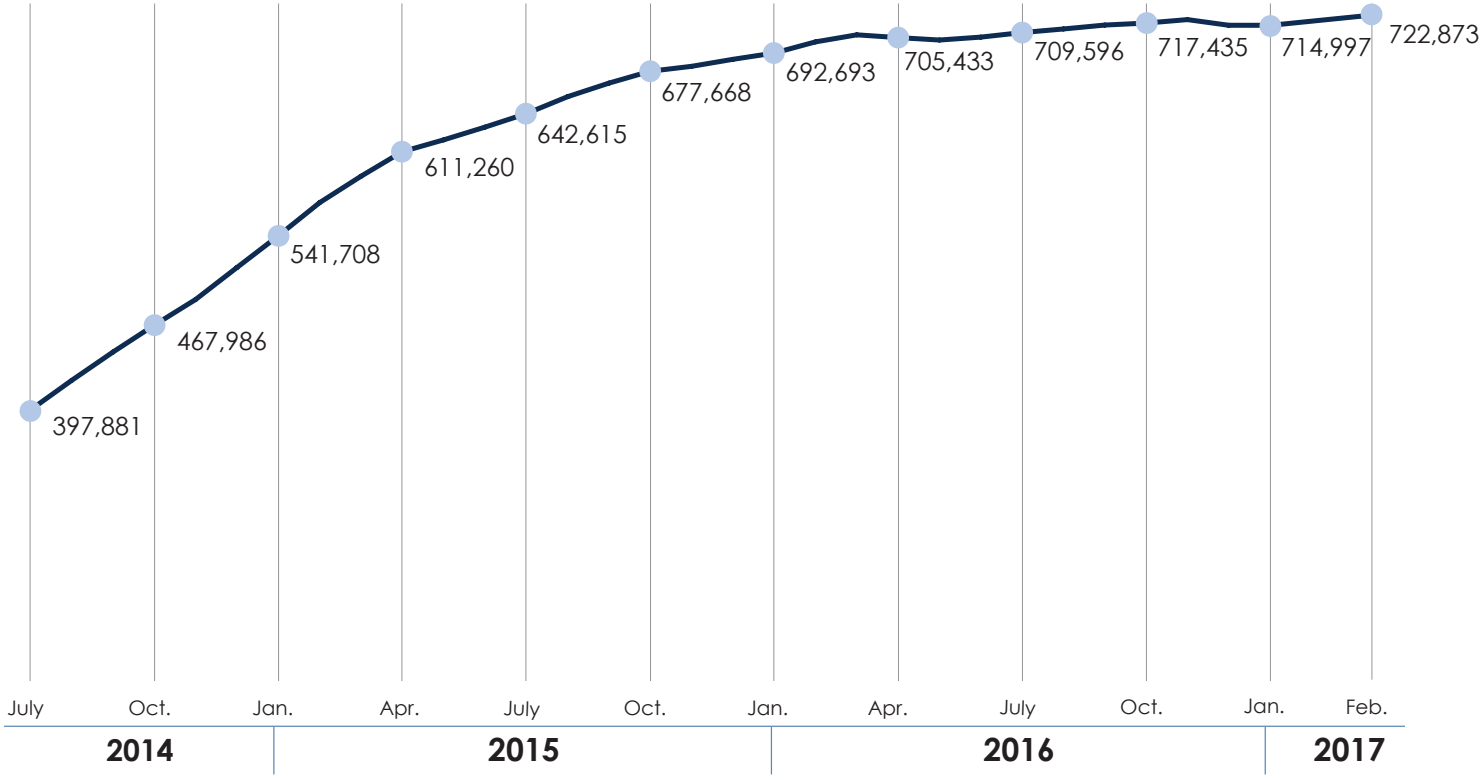
***Dual Eligibles:*** People who are eligible for both Medicaid and Medicare are referred to as "dual eligibles." For these individuals, Medicaid fills in some of the gaps in Medicare coverage by paying for services that are not part of the Medicare benefit package, most notably, long-term care services and supports (see figure 5). Depending on income, people who are dually eligible for Medicaid and Medicare may qualify for full Medicaid benefits through ABD Medicaid or Medicaid Buy-in for Workers with Disabilities, or limited benefits through the Medicare Premium Assistance Program.

**Medicaid Expansion ("Group VIII")**
Beginning January 1, 2014, Medicaid coverage was expanded to adults between ages 19 and 64 who have incomes less than 133 percent FPL and who are not eligible under other categories. The Group VIII category is eligible for MAGI income counting and the five percent income disregard, effectively making the income limit 138 percent FPL.

As of February 2017, about 723,000 Ohioans were enrolled in Group VIII (see figure 6). Notably, enrollment in this category grew by 9.2 percent between February 2016 and February 2017 compared to 29.6 percent growth the previous year.[21]

**Other Medicaid**
About 8.5 percent of Medicaid enrollees in SFY 2016 were in categories other than CFC, ABD or Group VIII.[22] People enrolled in groups within the "other Medicaid" category have access to a limited set of services or are enrolled for only a limited time. Groups within this category include:

Figure 6. **Group VIII enrollment by month, July 2014-February 2017**




**Source:** Ohio Department of Medicaid, caseload reports
**Note:** To the extent possible, this graphic reports back-dated and retroactive eligibility.

***Medicare Premium Assistance Program (MPAP):*** MPAP provides a limited Medicaid benefit that helps cover certain costs associated with Medicare. Depending on income, beneficiaries are split into four groups: Qualified Medicare Beneficiaries (QMB), Special Low-Income Medicare Beneficiaries (SLMB), Qualified Individuals (QI-1) and Qualified Disabled and Working Individuals (QDWI). For people in the QMB group, Medicaid pays Medicare Part A & B premiums, deductibles and co-payments. For people in the SLMB and QI-1 groups, Medicaid pays Medicare Part B premiums and for people in the QDWI group Medicaid pays Medicare Part A premiums.

***Breast and Cervical Cancer Project (BCCP):*** BCCP provides full Medicaid benefits to uninsured women, ages 40 to 65, who were screened for breast or cervical cancer by the Ohio Department of Health and are in need of treatment for breast or cervical cancer or for a pre-cancerous condition.

***Alien Emergency Medical Assistance (AEMA):*** AEMA provides treatment for emergency medical conditions for non-U.S. citizens who are not eligible for Medicaid.

***Presumptive eligibility:*** Presumptive eligibility allows children and their parents or qualifying caretaker relatives, pregnant women and Group VIII adults to temporarily enroll in full Medicaid benefits prior to completion and review of their application for continuing Medicaid coverage.

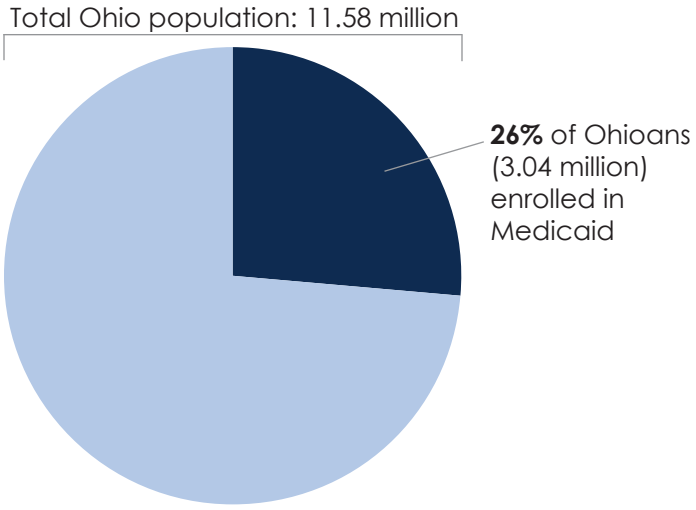
## Who is currently enrolled in Medicaid coverage?

In SFY 2016, Ohio Medicaid's average monthly enrollment was 3.04 million Ohioans, about 26 percent of the total population (see figure 7).[23] In SFY 2016, Medicaid enrollment increased 2.4 percent from the previous fiscal year (see figure 8).

### What impacts Medicaid enrollment?

Medicaid enrollment in Ohio is impacted by a number of factors. Figure 8 shows that enrollment in Ohio increased during the Great Recession (December 2007 – June 2009). Ohio's experience reflects research indicating that during periods of economic downturn unemployment rises, incomes stagnate and some employers trim benefits, such as employer-sponsored health insurance,[24] contributing to increased Medicaid eligibility and enrollment.

Figure 7. **Estimated percent of Ohioans enrolled in Medicaid, SFY 2016**




**Sources:** Ohio Department of Medicaid caseload report (February 2017); HPIO analysis based on American Community Survey 5-year population estimate (2015).

Policy changes at the state and federal levels also impact Medicaid enrollment. As seen in Figure 8, Medicaid eligibility expansion in Ohio also resulted in a significant Medicaid enrollment increase. Most Medicaid enrollment growth since 2014 can be attributed to the expansion of Medicaid eligibility levels.

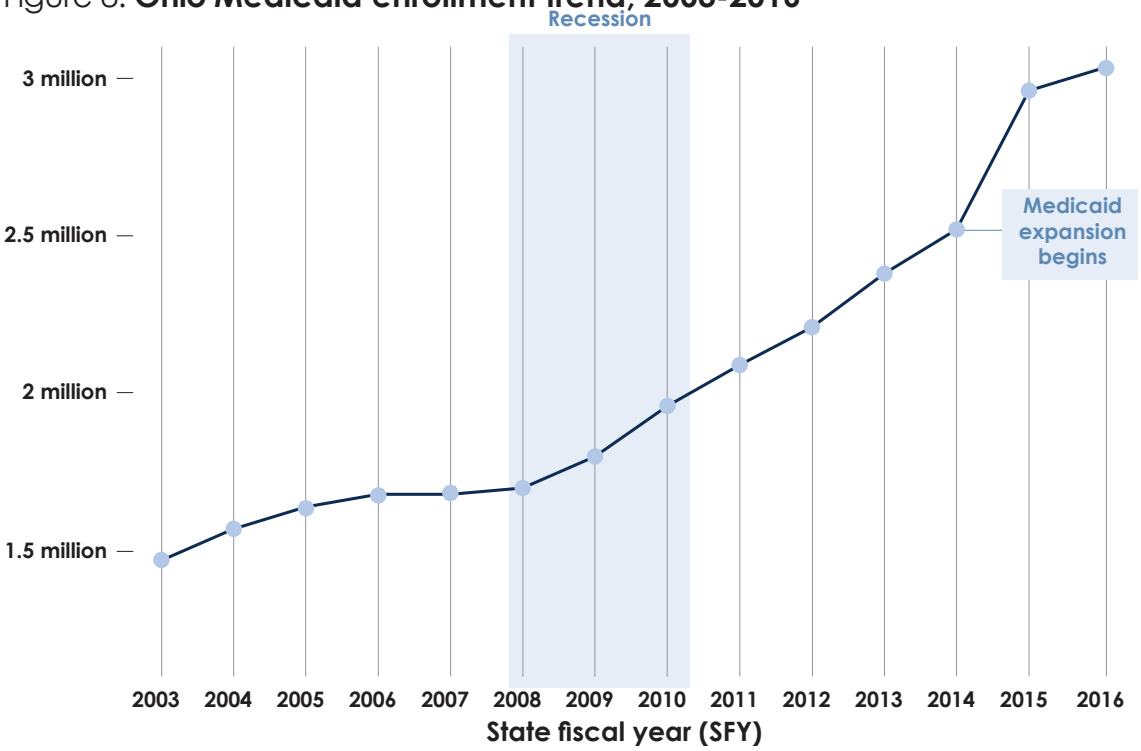
## What services does Medicaid cover?

States are required to provide federally-mandated benefits, including essential health benefits as defined by the Affordable Care Act (ACA) and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for children. Ohio provides additional services including vision and dental care and prescription drug coverage (see figure 9). Certain services are limited in duration and scope, and other services require a determination of medical necessity, prior authorization or a co-payment.[25]

## Why do people enroll in Medicaid?

Medicaid is often the most financially feasible health coverage option for people with

Figure 8. **Ohio Medicaid enrollment trend, 2003-2016**




**Sources:** 2003-2011Ohio Department of Job and Family Services, Public Assistance Monthly Statistics reports; 2012-2016 Ohio Department of Medicaid (ODM), caseload reports.
**Note:** ODM caseload reports update each month to reflect retroactive and back-dated eligibility. SFY averages for 2012-2016 were retrieved from the January report following the end of the fiscal year.

Figure 9. **Ohio Medicaid covered services**

### Federally mandated services

- Ambulatory surgical centers
- Certified nurse practitioners
- Dental (medical and surgical)
- Family planning and supplies
- Home health
- Inpatient hospital
- Lab and x-ray
- Nonemergency transportation to Medicaid services
- Nursing facility care
- Nurse midwife
- Outpatient hospital
- Physical services
- Vision (medical and surgical)

### Ohio's optional services

- Ambulance/ambulette
- Chiropractic services
- Community alcohol and drug addiction treatment
- Community behavioral mental health
- Dental
- Durable medical equipment and supplies
- Home and community based service waivers
- Hospice care
- Independent psychology
- Intermediate care facility
- Occupational therapy
- Physical therapy
- Podiatry
- Prescription drugs
- Private duty nursing
- Speech therapy
- Targeted case management
- Vision care

**Source:** Adapted from medicaid.ohio.gov

low incomes. While some people with low incomes are able to obtain private health insurance coverage, many Ohioans face barriers to obtaining private coverage.

## Low employer-sponsored health insurance offer rates

The most common way for low-income, working-age adults to access private health insurance coverage is through an employer. However, a national analysis found that fewer than 60 percent of working parents with an income below 200 percent FPL were offered employer-sponsored health insurance (ESI).[26]

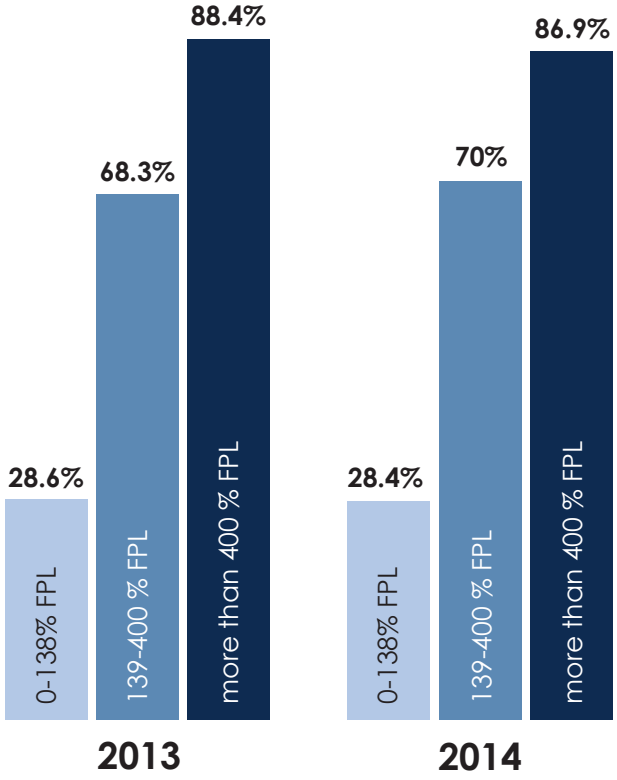
**Low-wage jobs:** According to the Kaiser Family Foundation's 2016 Employer Health Benefit Survey, high-wage workers are more likely to be eligible for ESI coverage than low-wage workers.[27] In Ohio, the percent of workers with ESI coverage increases with income level (see figure 10). Nearly 90 percent of workers with incomes above 400 percent FPL had ESI coverage in 2014, compared to less than 30 percent of workers with incomes below 138 percent FPL.[28]

**Full-time vs. part-time workers:** ESI offer rates can also vary greatly by a worker's full-time or part-time status. In the U.S., only 21 percent of part-time workers (less than 30 hours a week) were offered ESI coverage, compared to 72 percent of full-time workers (30 hours or more a week) in 2014.[29]

## Unemployment and other changes in life circumstances that impact coverage

Planned and unexpected changes in life circumstances can reduce income or restrict access to private health insurance coverage. These circumstances include, but are not limited to, unemployment, availability of jobs with access to affordable health insurance coverage, death of a partner, divorce, illness, addiction, caregiving for family or friends, attending school or vocational training and transitioning between careers or employers. Under these circumstances, people may not have adequate savings to purchase private health insurance, and as a result, may rely on Medicaid as a source of coverage.

Figure 10. **Employer-sponsored health insurance trend by federal poverty level (FPL) for Ohio, 2013 to 2014**



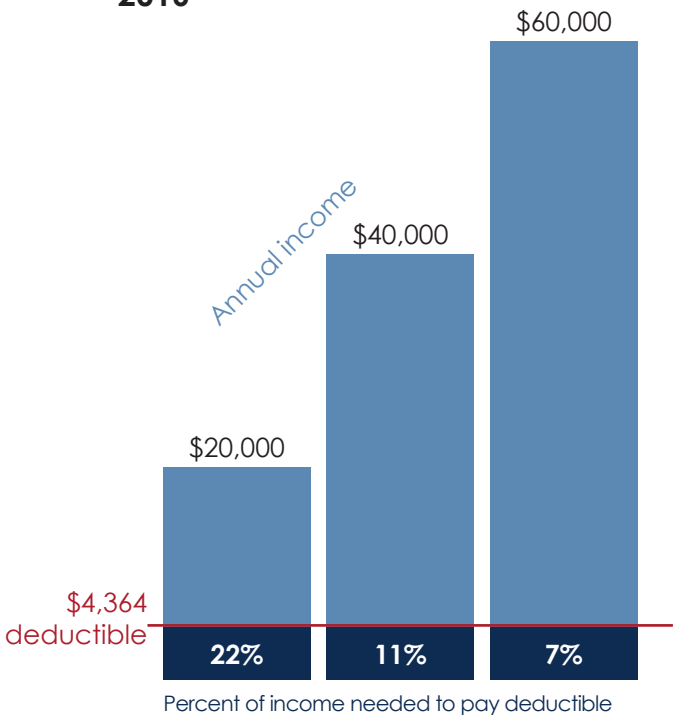

**Source:** Data from the Medical Expenditure Panel Survey – Insurance Component, as compiled by the State Health Access Data Center

## Unaffordability of private individual (non-group) health insurance coverage

Under current federal law, people with incomes below 100 percent FPL and those who are eligible for Medicaid are not eligible for subsidies to purchase individual health insurance coverage on the ACA marketplace. Therefore, most Ohio adults with incomes below 138 percent FPL are ineligible for marketplace subsidies. Unsubsidized coverage is typically too expensive for people with low incomes to purchase.

For example, the average unsubsidized premium for a single person in Ohio on the ACA individual marketplace for plan year 2016 was $405 per month[30], which is nearly one-third of a single person's income at 138 percent FPL.[31] Even if subsidies were available to people with very low incomes, it would

Figure 11. **Percent of income needed to pay an average deductible for family coverage on an HSA-qualified HDHP, 2016**




**Sources:** Adapted from Abdus et al., *The Financial Burdens of High-Deductible Health Plans* (2016); Kaiser Family Foundation, *2016 Employer Health Benefits Survey* (2016)

be difficult, if not impossible, to balance a budget that included monthly premiums and cost sharing after paying for other necessities such as shelter, food, childcare, payroll taxes, clothing and utilities.

## Inability to pay cost sharing

Private health insurance plans with lower premiums typically have higher cost-sharing requirements such as deductibles, co-payments and co-insurance. Research shows that people with incomes below 250 percent FPL are more likely to be financially burdened by costs associated with high deductible health plans (HDHPs) than people with middle to high incomes (see figure 11).[32] The disproportionate impact of HDHPs on low-income households leads to higher levels of delayed or forgone medical care due to cost.[33]

## Limited ability to work due to disabling conditions

Disabilities that temporarily or permanently limit ability to work also reduce income and lifetime earnings[34], making it more difficult to afford ESI or other private coverage. Depending on the severity and duration of the disabling condition, people with disabilities may qualify for federal Social Security Disability Insurance (SSDI) and Medicare. However, Medicare is only available to SSDI recipients after a 24-month waiting period that begins on the first month of SSDI eligibility.[35] During the waiting period, people may qualify for Medicaid depending on their income and other factors.

## Coverage for long term services and supports (LTSS)

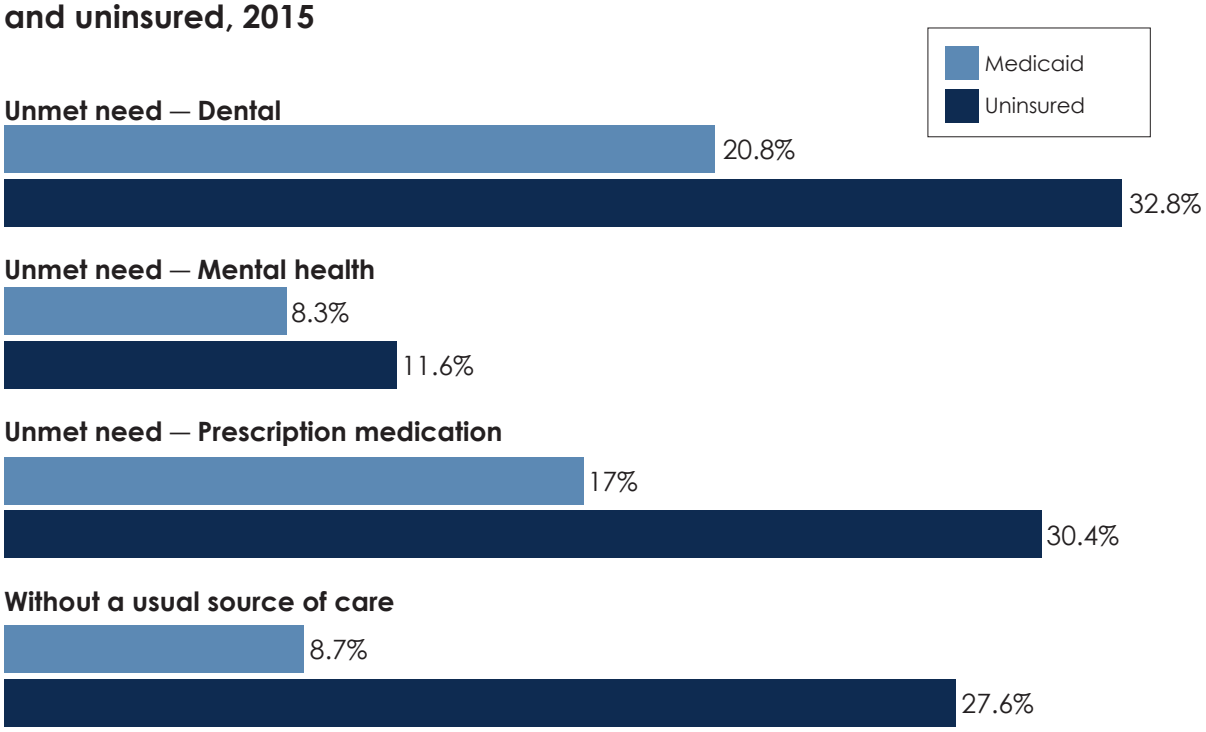
With some specific, short-term exceptions, Medicare generally does not cover LTSS provided in a nursing home. Those without adequate income, assets or long term care insurance may apply for Medicaid in order to access services such as home care, nursing home care and assisted living. Because of this, Medicaid is the largest payer for LTSS nationally[36] and in Ohio.[37]

### What does it mean to be uninsured?

People who are uninsured have no health insurance coverage and are responsible for paying for the healthcare services they receive. This puts people who are uninsured at greater risk for medical bankruptcy than those who are insured.[38] As a result, people who are uninsured may delay or forgo needed care (see figure 12), get care at hospital emergency departments or rely on safety-net providers including free clinics and Federally Qualified Health Centers for primary care and other limited services.

For more information see **Private Health Insurance Basics fact sheet 1**.

Figure 12. **Healthcare access indicators for adult Ohioans (19+) on Medicaid and uninsured, 2015**




**Source:** Ohio Medicaid Assessment Survey adult dashboard (2015)

## How do people on Medicaid access healthcare services?

Medicaid coverage pays for healthcare services including primary care, preventive services, emergency services and specialty care needed to manage chronic conditions. Enrollees use their Medicaid coverage through one of two delivery systems: managed care or fee-for-service.

### Managed care plans (MCPs)

MCPs are privately-operated health insurance companies that contract with providers, such as physicians and hospitals, to deliver Medicaid-covered services to enrollees. MCPs may also offer enhanced services to enrollees, like incentives for using preventive services and health education programs.[39] Over the past decade, Ohio has moved toward requiring MCP enrollment for most Medicaid participants. As of February 2017, about 83 percent of people on Ohio Medicaid were enrolled in an MCP.[40]

MCPs pay for care for Ohio Medicaid enrollees in exchange for a capitation payment, which is a set per member per month (PMPM) payment from the Medicaid program. The MCP covers any costs incurred by members, including expenses above the capitation payment.[41] If costs are less than the capitation payment, the MCP retains the difference. Federal rules regulate the actuarial soundness of the capitation payment to ensure that provider rates on which the payment is based are sufficient to cover healthcare services provided.[42] The MCP reimbursement structure is intended to reduce costs and create incentives for improved quality, coordination and continuity of care.

To ensure access to care, MCPs contract with providers at negotiated rates. MCPs must allow consumers access to services that "are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are furnished."[43] In the event that an enrollee cannot access services from a provider in an MCP's network, the MCP must work with the enrollee to ensure that he or she can receive covered services from another provider. Unlike FFS Medicaid, MCPs are not required to contract with any willing provider.

Figure 13. **Ohio pay for performance (P4P) clinical quality measures, minimum performance standards (MPS) for SFYs 2016 and 2017 and actual performance for CY 2015**

| P4P clinical quality measure | SFY 2016 MPS (percent of applicable enrollees) | SFY 2017 MPS (percent of applicable enrollees) | Actual Ohio average plan performance (CY 2015) |
|---|---|---|---|
| Follow-up after hospitalization for mental illness | 31.7% | 32% | 50.8% |
| Prenatal and postpartum care: timeliness of prenatal care | 77.8% | 77.4% | 83.9% |
| Prenatal and postpartum care: postpartum care | 56.2% | 55.5% | 62.8% |
| Controlling high blood pressure (patients with hypertension) | 48.6% | 49.9% | 45.8% |
| Adolescent well-care visits | 41.7% | 41.8% | 43% |
| Appropriate treatment for children with upper respiratory infection | 81.6% | 84.2% | 90% |
| Comprehensive diabetes care: HbA1c Control (<8.0%) | 38.2% | 40% | 38.5% |

**Source:** Data from Ohio Department of Medicaid (ODM) Medical Assistance Provider Agreement for Managed Care Plans and ODM "Medicaid Managed Care P4P Summary and Plan Ranking"

MCPs currently under contract with the state are: Buckeye Health Plan, CareSource, Molina Healthcare, Paramount Advantage, UnitedHealthcare and Aetna (MyCare only).

### Fee-for-service (FFS)

Individuals who are excluded from or not required to enroll in Medicaid managed care receive services through the FFS system. Populations currently served through the FFS system include people with developmental disabilities and others living in an institution or with a Medicaid waiver, some dually eligible adults and those recently enrolled who have not yet selected or been automatically enrolled in an MCP.

Under FFS, Medicaid providers are paid directly for each covered service (such as an office visit, test or procedure) at rates outlined in an appendix to the Ohio Administrative Code.[44]

## Paying for value in Medicaid

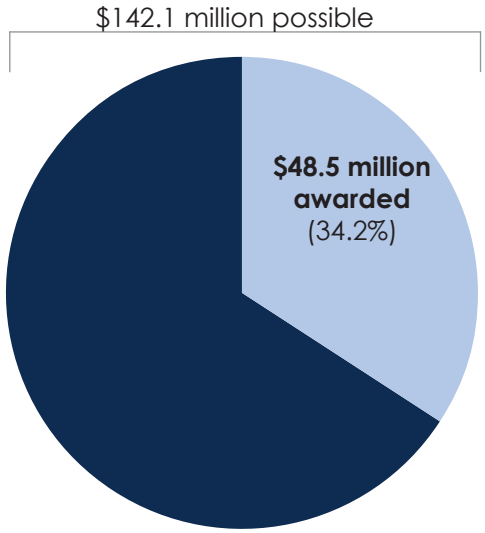
ODM evaluates the performance of MCPs across key program areas through a set of quality measures and standards.[45] MCPs are evaluated based on metrics aligned with the Department's Quality Strategy. The Quality Strategy promotes initiatives that the department believes will improve service quality and reduce costs to the greatest extent possible. As part of this Quality Strategy, ODM is also focused on "paying for value." Several of ODM's initiatives around paying for value are outlined in this section.

### Pay for performance (P4P)

ODM established a pay for performance (P4P) incentive system to financially reward MCPs that achieve set levels of performance around Medicaid's program priority areas.[46] There are seven clinical quality measures on which MCP performance is evaluated as part of P4P for SFYs 2016 and 2017.[47]

To qualify for a financial reward, the MCP must exceed a minimum performance standard, which is set at the 25th national Medicaid percentiles (see figure 13). Higher

Figure 14. **Percent of pay for performance (P4P) incentives awarded to Medicaid managed care plans, SFY 2016**




**Source:** Data from Ohio Department of Medicaid "Medicaid Managed Care 2016 P4P Summary and Plan ranking"

performance can lead to a larger financial reward. Conversely, failure to meet set minimum performance standards can result in a noncompliance penalty.[48] MCPs are required to develop and implement improvement initiatives in areas of low performance.[49]

In SFY 2016, MCPs were awarded a total of $48.5 million (34 percent) of a possible $142 million through the P4P program (see figure 14). Performance across plans on the P4P measures varied greatly.[50]

### Federal State Innovation Model (SIM) initiative

Ohio Medicaid also participates in the federal SIM initiative, led by the Governor's Office of Health Transformation (OHT). The federal government awarded Ohio a 48-month, $75 million implementation grant that began in 2015 to align healthcare payments with desired health outcomes. SIM funds have been used to develop a Comprehensive Primary Care program for Ohio, as well as episode-based payment models for various clinical conditions, working in partnership with Medicaid MCPs, private health insurers, providers and other public and private health stakeholders.

#### Ohio's Comprehensive Primary Care program (CPC)

A patient-centered medical home (PCMH) is a team-based model for care delivery that includes comprehensive management of a patient's health needs through improved care coordination. Ohio's CPC program is designed to increase access to PCMHs and pay for value by financially rewarding primary care practices that keep people healthy and hold down the total cost of care. In Ohio, to qualify for incentive payments, participating providers must meet activity, efficiency, clinical quality and total cost of care measures.

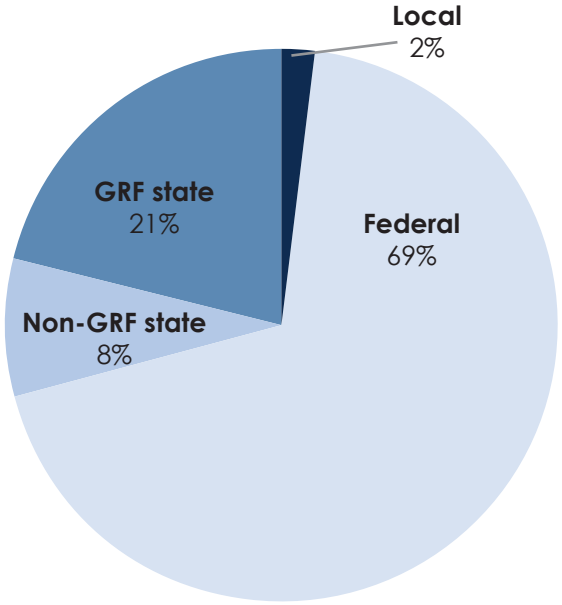
#### Ohio's episode-based payment models

Ohio has developed a series of episode-based payment models designed to pay for value in outcomes and cost across an episode of care, including total joint replacement, perinatal and asthma acute exacerbation episodes. Episodes of care include all care related to a defined medical event. In Ohio, certain providers may share in savings if their average costs for an episode of care are below a set benchmark and quality targets are met. Providers with average costs above an acceptable level may be penalized. More information on Ohio's SIM initiatives can be found on the **Governor's Office of Health Transformation Engage Partners to Align Payment Innovation** page on their website.

## Medicaid financing and spending

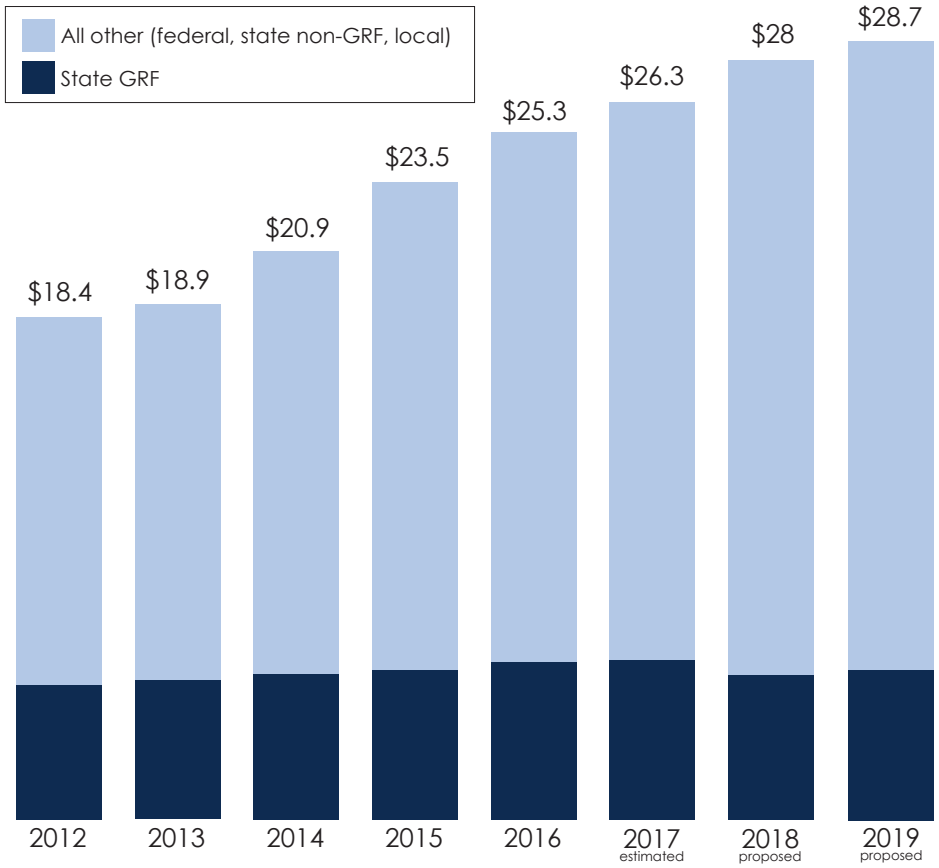
Medicaid is a federal-state partnership program in which the federal government and states share the cost of providing coverage to Medicaid enrollees for a defined set of medical and long-term care services and supports. Including both state and federal funding, Ohio's Medicaid program cost over $25.5 billion in SFY 2016, representing 37.8 percent of the state's total budget.[51] The federal share of Ohio's Medicaid program was 69 percent, or about $17.6 billion. Ohio's General Revenue Fund (GRF) contributed $5.8 billion, or about 21 percent (see figure 15).[52] The remainder came from state non-GRF sources including fees assessed on insurers, hospitals and other medical providers and local funding[53] including developmental disabilities levies. During recent years, total

Figure 15. **Ohio Medicaid spending by funding sources, SFY 2016**




**Source:** Ohio Department of Medicaid, Annual Report (2016)

Figure 16. **Ohio Medicaid spending, in billions, SFY 2012-2019**




**Source:** Data from Ohio Legislative Services Commission, *Historical Revenues and Expenditures* table 4 and SFY 2018-2019 executive budget proposal.

Medicaid program spending has grown substantially, but most growth has been in federal share, with the state GRF share growing at a slower rate (see figure 16).

Medicaid is financed through a federal-state reimbursement arrangement based on the Federal Medical Assistance Percentage (FMAP). Through this arrangement, states receive partial reimbursement from the federal government for healthcare services provided to Medicaid enrollees at a rate that varies between 50 and 83 percent.[54]

FMAP varies across states and Medicaid eligibility categories, with certain categories of Medicaid enrollees eligible for enhanced FMAP rates. Ohio's regular FMAP for Federal Fiscal Year 2017 is 62.3 percent, but the state is reimbursed 96.6 percent for children covered by CHIP and 95 percent for Group VIII adults.[55] In the past, the federal government has used enhanced FMAPs to help states balance budgets during economic downturns[56], to incentivize coverage expansions and to encourage the adoption of administrative or program changes.

## Medicaid history and administration

The Medicare and Medicaid programs were founded on July 30, 1965 as part of the Social Security Amendments of 1965. Medicare provides health insurance coverage to people age 65 or older and people with qualifying disabling conditions. Medicaid provides health insurance coverage for people with low incomes.

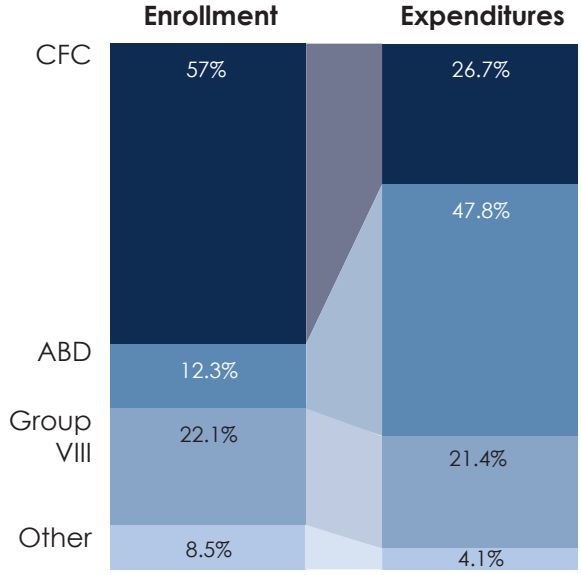
The federal Centers for Medicare & Medicaid Services (CMS) oversees the Medicaid program at the federal level and the Ohio Department of Medicaid (ODM) administers the program in Ohio. The Joint Medicaid Oversight Committee (JMOC) was created in 2014 to provide ongoing legislative oversight of the Ohio Medicaid program. The bi-cameral, bi-partisan committee establishes cost containment benchmarks for the program.

The Medicaid State Plan is the document that outlines the details of Ohio's agreement with the federal government about operations of the Medicaid program. States may also request amendments to their state plan and temporary waivers to change Medicaid programs.

## ABD enrollment growth and total Medicaid spending

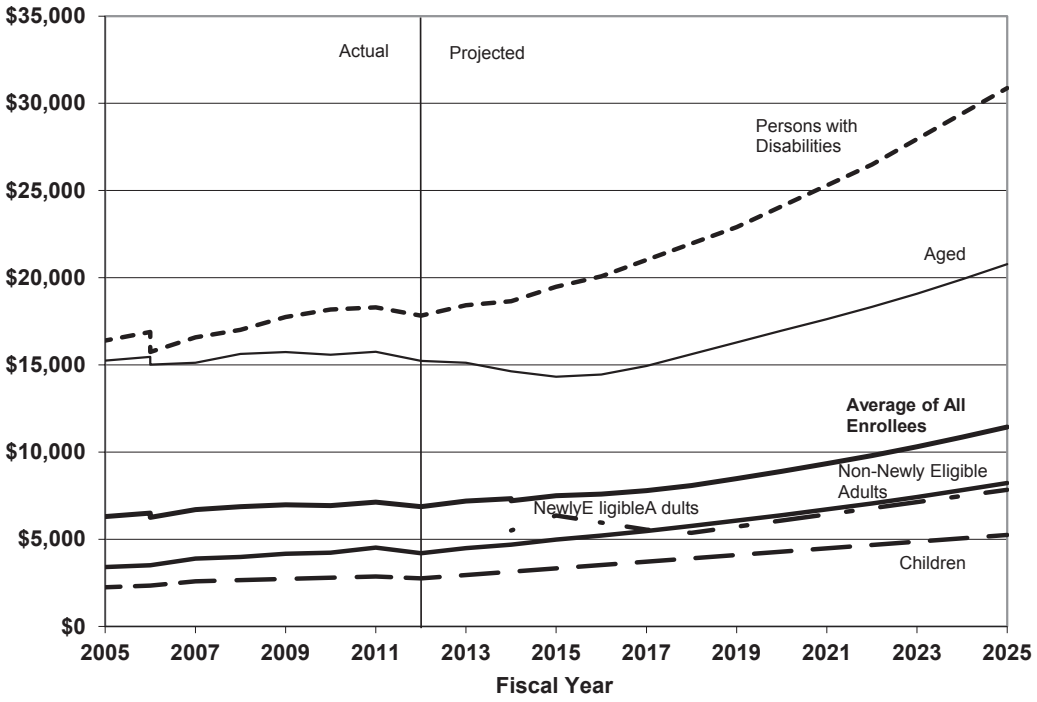
Individuals enrolled in the ABD category of Medicaid generally have health challenges that are expensive to treat and, therefore, the percentage of total Medicaid spending dedicated to serving the population is proportionally higher than other groups (see figure 17). CMS anticipates that per member per month costs for covering the ABD population will grow over the next decade, and the number of people enrolled in the category will continue to increase.[57] Over the next decade, these factors combined are likely to increase total Medicaid spending over time (see figure 18).[58]

Figure 17. **Cost differences between types of Medicaid enrollees, SFY 2016**




**Source:** Ohio Department of Medicaid, Medicaid eligibles and expenditures reports (SFY 2016). Additional analysis by HPIO.

Figure 18. **Past and projected Medicaid expenditures on medical assistance payments per enrollee, by enrollment category, fiscal years 2005–2025**




**Source:** Graphic created by Centers for Medicare and Medicaid Services, Office of the Actuary (2016)

## Conclusion

The Medicaid program pays for healthcare services for over 3 million Ohioans and is an important driver of payment reform and quality measurement initiatives within the healthcare system. Federal proposals to modify the financing structure of the program or change the program's regulatory framework could significantly impact Ohioans eligibility for Medicaid coverage and benefits and should be monitored closely.

The Ohio Department of Medicaid recently studied the impact of Medicaid expansion on health outcomes and other factors that influence health for the Group VIII population. The study found that expanded Medicaid eligibility improved access to care and also improved outcomes related to employment, food security and financial hardship for the Group VIII population.[59] Similarly, HPIO's 2017 ***Health Value Dashboard*** demonstrates that after Medicaid expansion, Ohio improved on various access-related measures. However, the *Dashboard* also indicates that Ohio continues to perform poorly on many of the other factors that impact overall health. This suggests that maintaining access to care is necessary, but not sufficient, to achieving good health.

Policymakers and other health stakeholders should ensure that policies and programs implemented within and outside of the Medicaid program are aligned to address the other drivers of overall health.

## Glossary

**Co-insurance:** A method of cost sharing in which the consumer is required to pay a defined percentage of his or her medical costs, often after the deductible has been met.

**Co-payment:** A flat rate dollar amount paid by a consumer directly to the provider at the time of receiving a covered healthcare service.

**Deductible:** A set amount that a consumer pays during a benefit period or plan year for covered services before the insurer begins to make payment toward those covered services.

**Federal Poverty Level (FPL):** FPL is a measure of income issued annually by the U.S. Department of Health and Human Services and is used to determine eligibility for many federal and state programs and benefits, including most categories of Medicaid.

**Group VIII:** Refers to the section of the Social Security Act amended by the ACA that added adults with income up to 133 percent FPL to the list of Medicaid eligibility categories.

**High deductible health plan (HDHP):** A health plan with a higher deductible which can typically be purchased for a lower monthly premium. The point at which a health plan becomes an HDHP is set by statute. The Internal Revenue Service issues an annual instruction that adjusts the deductible and HDHP annual out-of-pocket spending limits based on inflation.

**Income disregard:** Concept from the MAGI methodology that effectively reduces household income by a set percentage during the eligibility determination process. Other income counting methodologies apply deductions for specific household expenses such as rent/mortgage and utilities.

**Modified Adjusted Gross Income (MAGI):** The income counting methodology that is used to determine eligibility for most non-Aged, Blind and Disabled categories of Medicaid. MAGI combines all applicable household income and then applies a five percent income disregard determining income eligibility.

### Other Medicaid primers

**Ohio Legislative Services Commission, Medicaid Primer**
http://www.lsc.ohio.gov/publications/2017medicaid-primer.pdf

**Kaiser Family Foundation, Medicaid Pocket Primer**
http://kff.org/medicaid/fact-sheet/medicaid-pocket-primer/

**Congressional Research Service, Medicaid: a primer**
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To apply for Medicaid benefits, visit
**http://benefits.ohio.gov**

You can also apply over the phone (1-800-324-8680) or by visiting your county Department of Job and Family Services office

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