

Ohio Medicaid Basics 2015

HISTORY

The Medicare and Medicaid programs were founded on July 30, 1965, as part of the Social Security Amendments of 1965. President Johnson signed the bill into law, but seeds had been planted by former presidents and policymakers decades before. Upon signing the bill, Johnson awarded the first two Medicare cards to President and Mrs. Truman and declared, “[this bill] will improve a wide range of health and medical services for Americans of all ages.”¹

Medicare (Title XVIII of the Social Security Act) was created to provide health insurance coverage for people age 65 or older and people younger than 65 with certain disabilities or conditions. Medicare is financed by a portion of the payroll taxes paid by workers and their employers, along with monthly premiums, usually deducted from Social Security checks.

Medicaid (Title XIX of the Social Security Act) was designed to provide health insurance coverage for certain categories of people with low incomes. Over the years, Medicaid coverage has also been provided for children, parents, and pregnant women, as well as the blind, aged, and disabled. Medicaid is an entitlement program, meaning that people who are eligible are guaranteed benefits and the state is obligated to pay for them.

Medicaid is a federal-state partnership program, in which participating states

receive funding for eligible residents to access a defined set of medical and long-term care services. Although participation is voluntary, more than half of states implemented a Medicaid program within the first year federal funding became available (1965), and nearly all states were participating within four years.² Ohio Medicaid began in 1968.

The federal Centers for Medicare & Medicaid Services (CMS), located within the U.S. Department of Health and Human Services, oversees the Medicaid program. The federal government establishes general guidelines and sets minimum standards. In turn, states have the flexibility to establish their own criteria for Medicaid eligibility, benefits, and provider payment rates.

In Ohio, the Department of Medicaid is the single state agency responsible for administering the program, although other state agencies, county departments of job and family services, county boards of developmental disabilities, community behavioral health boards, and area agencies on aging also play important roles.

Funding for Medicaid comes from both the federal and state governments. In state fiscal year (SFY) 2014, total expenditures for Ohio’s Medicaid program were \$20.9 billion, including both state and federal funds.³ State funds were about \$7.3 billion and federal funds were about \$13.5 billion.⁴

At a glance

Medicaid...

- Is funded by both federal and state dollars
- Accounts for about 4% of Ohio’s total economy
- Is the largest payer of health care in the state and the largest payer of long-term care services
- Covers more than 2.6 million low-income adults, children, pregnant women, seniors, and individuals with disabilities each month
- Covers about 45% of Ohio’s children age 0-19⁵
- Funds hospital care for Ohio’s uninsured
- Contracts with five private managed care plans to provide health care to about 1.8 million Ohioans monthly⁶
- Pays for more than half of births in the state
- Is administered by the Ohio Department of Medicaid

The difference between Medicaid and Medicare

Medicaid

- Aid for some low-income and disabled Ohioans
- Eligibility based on 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

Overview of Ohio's Medicaid expansion decision

The Patient Protection and Affordable Care Act (ACA), enacted in March 2010, required states to expand Medicaid coverage to individuals with incomes up to 138 percent of the federal poverty level (FPL). In June 2012, the U.S. Supreme Court made expansion of Medicaid optional, rather than required.

In his 2014-2015 budget proposal to the Ohio General Assembly in early 2013, Governor Kasich included language to expand Medicaid eligibility to 138 percent of FPL as permitted in the ACA. During budget deliberations, the Ohio House eliminated provisions expanding Medicaid and added language prohibiting an expansion of Medicaid eligibility. The Ohio Senate never publicly debated the issue. On June 30, 2013, Governor Kasich signed the final biennial budget bill, using a line-item veto to remove the House language that would have prevented Medicaid expansion.

In September 2013, Ohio's Medicaid Director submitted a State Plan Amendment (SPA) to the federal government requesting extension of Medicaid coverage. The Centers for Medicare and Medicaid Services (CMS) approved Ohio's plan the next month. The Ohio Controlling Board voted in October 2013 to authorize Medicaid's spending of federal funds for newly eligible Ohioans. As a result, Medicaid expansion coverage began on Jan. 1, 2014.

Since the initial appropriation authority was only authorized through the biennium ending June 30, 2015, funding for extended Medicaid coverage was a key issue during budget deliberations for SFYs 2016 – 2017. The state budget bill signed by the Governor included funding for expansion, with some changes. See "New State Initiatives" on page 18 for more details. Since Ohio's existing SPA does not expire, unless the Medicaid director takes action to change Ohio's policy, the current Medicaid eligibility levels remain in effect.

MetroHealth Care Plus Program

In February 2013, the State of Ohio received a demonstration waiver from the federal government that enabled an early expansion of Medicaid eligibility to a targeted population of patients affiliated with The MetroHealth System in Cuyahoga County. This waiver had an enrollment cap of 30,000 and a budget neutrality requirement. MetroHealth Care Plus members were offered primary care medical homes through The MetroHealth System and two Federally Qualified Health Centers (Care Alliance and Neighborhood Family Practice). The waiver approval was scheduled to end in December 2013, but was extended through April 2014 to allow for a transition period to the state's Medicaid program. The Ohio Department of Medicaid will submit a final evaluation to the federal government.

Outcomes included⁷:

- Many enrollees had earned income
 - Up to 40% of enrollees were employed and reported income, but had no coverage.
- The cost of the program was below the budget neutrality cap
 - Average costs for the demonstration were nearly 30% below budget estimates – roughly \$42 million under the projected cost of the program
- Demand for behavioral health services was high
 - Nearly 1 in 4 enrollees were screened for a behavioral health issue and utilization of BH services increased over the course of the program. Dental and inpatient utilization increased early in the program, indicating many persons may have been foregoing important medical procedures.
- Performance on selected health outcomes was improved
 - Fully enrolled individuals exceeded their benchmarks for diabetes, blood pressure, and hypertension, and significantly improved their utilization of regular preventative care such as flu vaccination and breast cancer screening.
- Electronic health records and medical homes are critical tools
 - After implementing an electronic prescription system, it was discovered that half of the prescriptions written for uninsured adults by The MetroHealth System had never been filled because patients could not afford even the most modest of pharmacy fees. Care Plus integrated this system and care coordination based in clinical settings to increase patient adherence to treatment plans.
- Sustaining eligibility leads to better utilization
 - When enrollees were able to maintain their eligibility ('fully enrolled'), their outcomes were better, their costs were lower, and ED utilization went down. In fact 4 out of 5 fully enrolled Care Plus patients were in a medical home, actively choosing a Primary Care Provider.

FINANCING

Medicaid is jointly funded by the federal government and states. The federal government pays states for a specified percentage of program expenditures, called the Federal Medical Assistance Percentage (FMAP). The percentage varies based on per-capita income in a state relative to the national average. By statute, the FMAP for a state cannot be lower than 50% or more than 83%.

In state fiscal year (SFY) 2014, Ohio's FMAP was 63.16%. The general method for how this cost-sharing mechanism works is that for every one dollar Ohio spends on Medicaid, the federal government gives Ohio about 63 cents.⁸

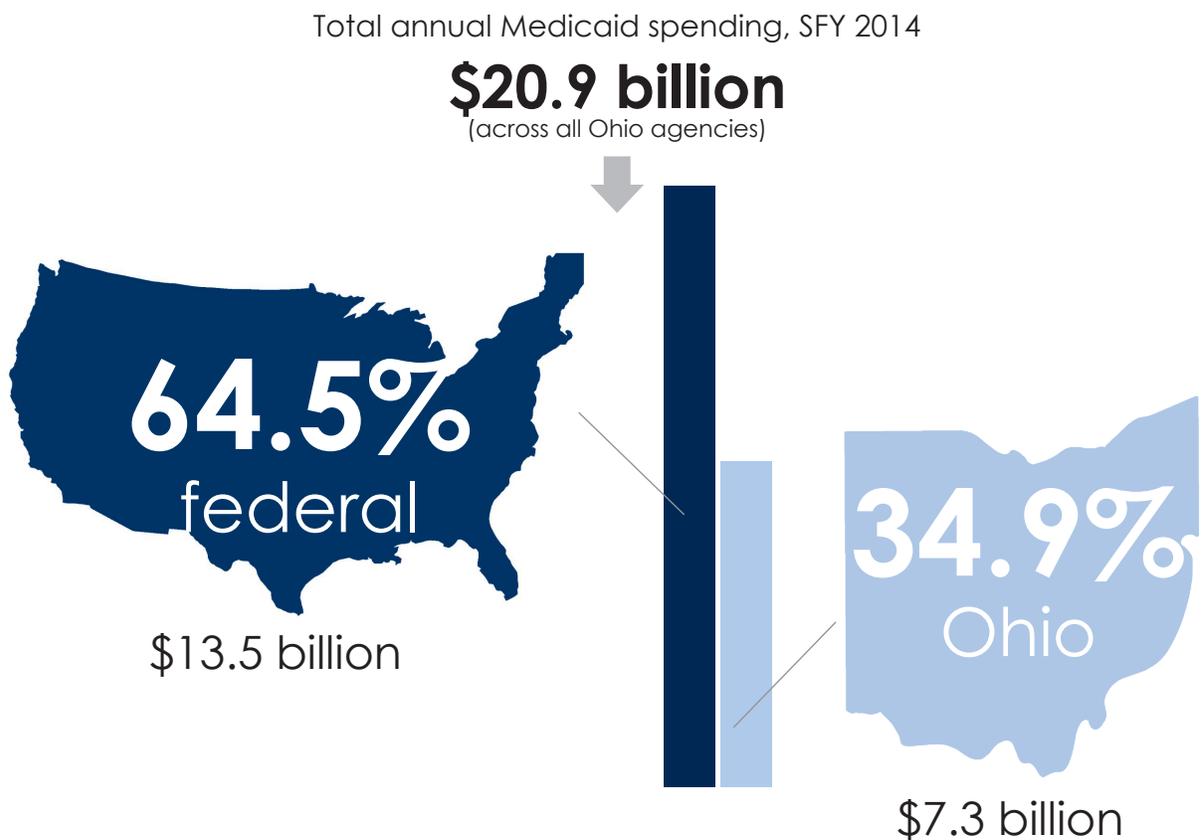
There are exceptions to the FMAP formula for certain services and certain populations. For example, family planning services and supplies

are matched at 90%. Notably, a higher FMAP, known as an "enhanced FMAP" (eFMAP) is used in the Children's Health Insurance Program (the Healthy Start program in Ohio). Ohio's eFMAP for SFY 2014 was 71.55%.⁹

The federal government also provides a different match rate for those made newly eligible for Medicaid under the ACA. Full federal funding is provided through 2016. The match rate falls to 95% in 2017, 94% in 2018, 93% in 2019, and to 90% in 2020 and beyond.¹⁰

Another major exception is the cost of administration. These expenses, in general, are matched at 50%.¹¹ Medicaid administrative costs were 3.7% (\$775.7 million) of the total Medicaid budget in SFY 2014.¹²

Figure 1. **Medicaid financing**



Source: ODM Executive Budget Medicaid Services Forecast Book, "Summary of Total Medicaid Spending," p. 136

ENROLLMENT

In SFY 2014, Ohio Medicaid's average monthly enrollment was 2.63 million Ohioans.¹³

There are many factors that affect Medicaid enrollment. Historically, changes in the economy have been a major driver of enrollment trends. As unemployment rises, workers and their children may lose access to employer sponsored insurance. When economic conditions improve, enrollment often slows.

Policy initiatives at both the state and federal level also play significant roles. For example, the ACA required most individuals to have health insurance, created new awareness about coverage options, and established new mechanisms for enrollment. At the state level, Medicaid expansion increased eligibility levels and expanded coverage to a new group.

Figure 2. Ohio Medicaid enrollment, SFY 2014

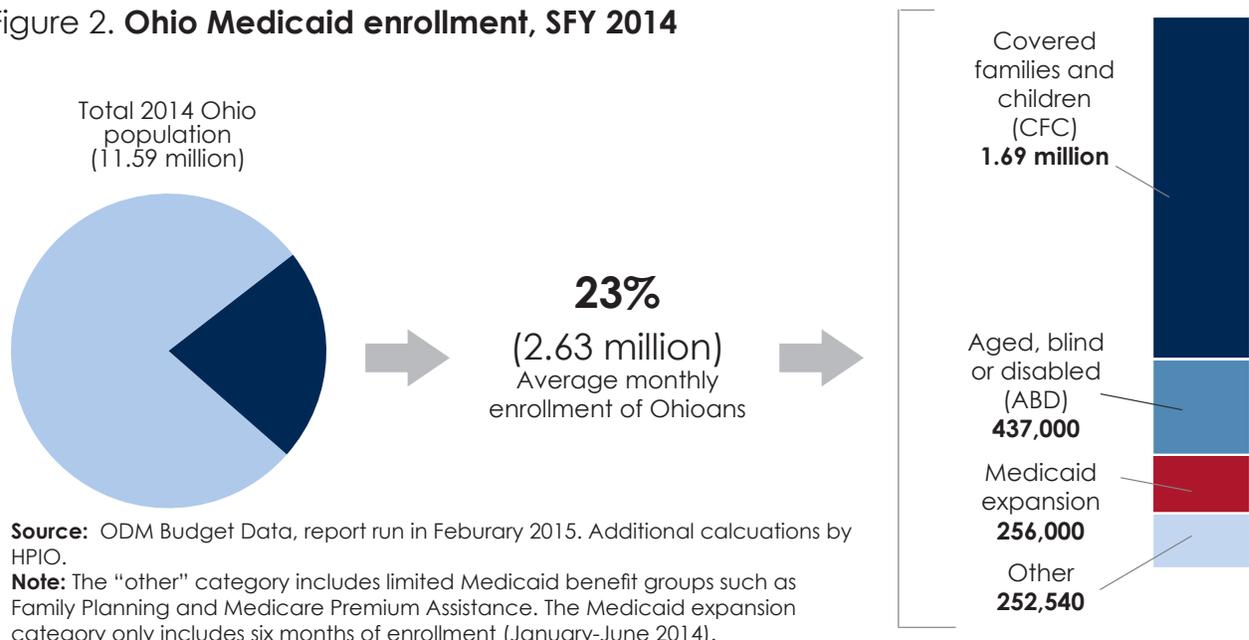
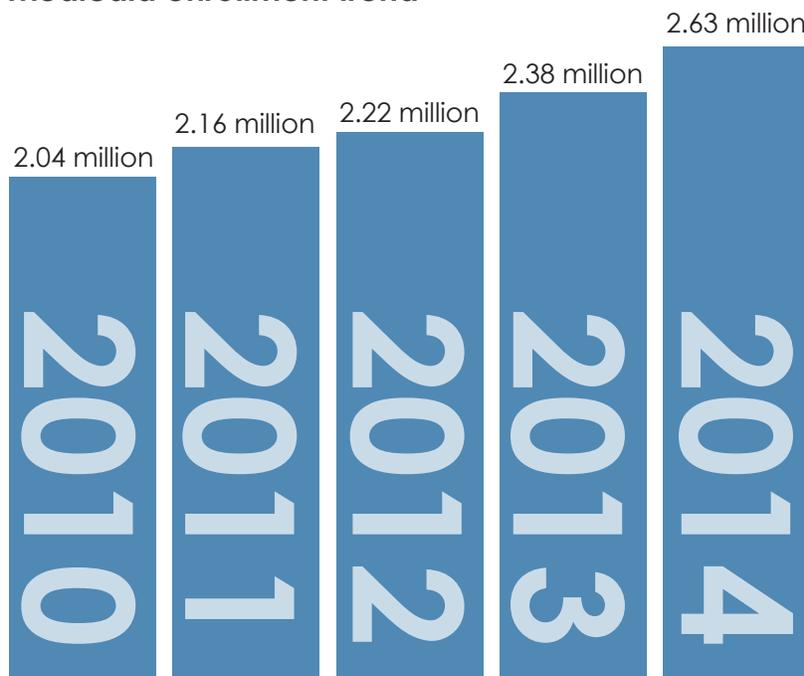


Figure 3. Ohio Medicaid enrollment trend



Source: HPIO Medicaid Basics 2013, ODM Executive Budget Medicaid Services Forecast Book and ODM Caseload Report, January 2015

Expansion enrollment

Average monthly enrollment in the expansion category (people between the ages of 19-64 with incomes below 138% FPL) during SFY 2014 was about 256,000 Ohioans. However, this only includes enrollment during the first six months of Medicaid expansion (January through June 2014). During calendar year 2014, total enrollment in Medicaid Expansion was 485,462 Ohioans.¹⁴

Figure 4. Medicaid expansion enrollment, calendar year 2014



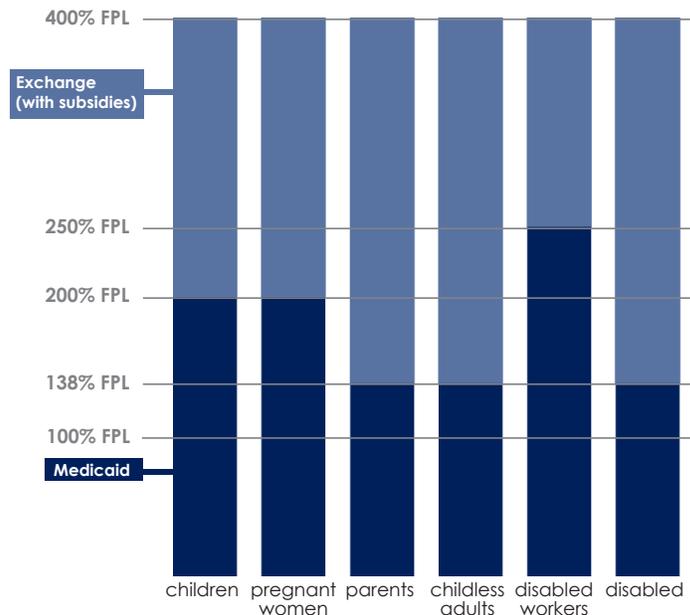
Source: Ohio Department of Medicaid monthly caseload report, January 2015

ELIGIBILITY

Ohio Medicaid provides health coverage to children, pregnant women, parents, childless adults, and people with disabilities with limited income. The income level for each category varies.

In order to qualify for Medicaid coverage, a person must be a U.S. citizen or meet Medicaid citizenship requirements, have or obtain a Social Security number, be an Ohio resident, and meet certain financial requirements.¹⁵

Figure 5. Subsidized health coverage eligibility in Ohio



What is FPL? How is it determined?

The federal poverty level (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 certain programs and benefits, including Medicaid.

FPL guidelines were originally calculated in 1963 by the Social Security Administration. The formula was set at three times the cost of food using the United States Department of Agriculture economy food plan. FPL is now updated using the change in the Consumer Price Index for the previous calendar year.

2015 FPL guidelines

Based on annual income

household size	64%	90%	100%	138%	200%	250%	400%
1	\$7,533	\$10,593	\$11,770	\$16,243	\$23,540	\$29,425	\$47,080
2	\$10,195	\$14,337	\$15,930	\$21,983	\$31,860	\$39,825	\$63,720
3	\$12,868	\$18,081	\$20,090	\$27,724	\$40,180	\$50,225	\$80,360
4	\$15,520	\$21,825	\$24,250	\$33,465	\$48,500	\$60,625	\$97,000

Source: Federal Register, January 22, 2015

Note: Annual guidelines for all states except Alaska, Hawaii and DC. For each additional person, add \$4,160

How does Ohio's eligibility compare to other states?¹⁶

Population	Ohio income eligibility	National median	Notes
Children 0-18	211% FPL	255% FPL	In Ohio, children with no other "credible source of coverage" are eligible up to 206% FPL. Children with other sources of coverage are eligible up to 156% FPL. A 5% income disregard applies.
Pregnant Women	200% FPL	200% FPL	As of January 2015, 33 states cover pregnant women at or above 200% FPL. Eleven states cover pregnant women at or above 250% FPL.
Parents of dependent children	138% FPL	138% FPL for states expanding Medicaid 44% FPL for states not expanding Medicaid	As of April 2015, 28 states and D.C. have adopted Medicaid expansion. Medicaid expansion raises eligibility to 133% FPL with a 5% income disregard.
Adults without dependent children	138% FPL	138% FPL for states expanding Medicaid No coverage for states not expanding Medicaid	Two expansion states extend Medicaid eligibility for parents and/or other adults above the ACA minimum levels (District of Columbia at 221% FPL and 215% for other adults and Connecticut at 201% FPL for parents). Wisconsin is the only non-expansion state to provide full Medicaid coverage (at 100% FPL) to childless adults.

Note: The Affordable Care Act established an income disregard equal to 5% of the FPL for the purpose of determining income eligibility for Medicaid and CHIP for individuals whose eligibility is based on Modified Adjusted Gross Income (MAGI).

BENEFIT GROUPS

There are various benefit groups covered by Ohio Medicaid, based on eligibility standards: Covered Families and Children (CFC), Aged, Blind and Disabled (ABD), Medicaid Expansion (also known as “Group 8”), and “other Medicaid,” which includes the Medicare Premium Assistance Program and Family Planning, among others. These groups are described in more detail below.

Covered Families and Children (CFC)

The Covered Families and Children (CFC) eligibility group includes families, children, and pregnant women. Within CFC there are several categories, including Healthy Start and Healthy Families.

Healthy Start: Healthy Start is Ohio's children's health insurance program (CHIP). It covers children (up to age 19) in families with income up to 206% FPL and pregnant women in families with income up to 200% FPL. Children in families with income between 150% and 200% FPL must be uninsured to be eligible for Healthy Start.

Pregnant women are eligible for Healthy Start coverage during their entire pregnancy. Coverage concludes at the end of the month following a 60-day coverage window that begins the day the baby is born. Babies born to mothers on Healthy Start are deemed eligible for health coverage for one full year from the date of birth.

Healthy Families: Healthy Families covers families with income up to 90% FPL and a child younger than 19. These families can have other health insurance and still qualify for Medicaid coverage. In those cases, Medicaid acts as the payer of last resort.

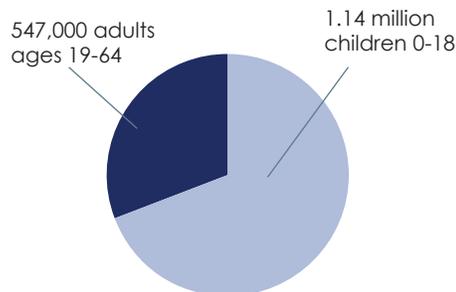
Children enrolled in Medicaid, SFY 2014

Medicaid is the largest payer of health care for Ohio children. In 2013, more than 1.2 million Ohio children (0-19) relied on Medicaid for health care coverage, representing about 45% of all Ohio children.

The Children's Health Insurance Program (CHIP) provides an enhanced federal

CFC

In SFY 2014, an average of 1.69 million people were covered under CFC each month:



Source: ODM Budget Data, Report Run February 2015. Additional calculations by HPIO.

Children's Health Insurance Program (CHIP)

The Children's Health Insurance Program (CHIP) was created by Congress as a part of the Balanced Budget Act of 1997 and is designed to expand coverage to low-income children not eligible for Medicaid.¹⁷ The legislation gave states the flexibility on how to implement the program: to either use an expansion of Medicaid, create a separate CHIP program, or a combination of both. Ohio is one of seven states that opted to operate a Medicaid expansion CHIP program.

matching assistance percentage (eFMAP) rate for states. Ohio's eFMAP for CHIP is 73.92% in SFY15 and 91.01% in SFY16.¹⁸

In SFY 2014, 11.5% of all Ohio children (ages 0-19) with Medicaid coverage were enrolled in CHIP— an average of almost 145,000 children per month.¹⁹

The ACA extended CHIP funding through the 2015 federal fiscal year. Without reauthorization, federal funding was set to expire on September 30, 2015. However, Congress voted to pass legislation extending funding for CHIP for two years. The bill was signed into law by President Obama on April 16, 2015. The legislation extends CHIP for two years.²⁰

Aged, Blind, and Disabled (ABD)

Medicaid covers certain low-income individuals who are aged (65 years or older), blind, or disabled. ABD applicants must meet both income and resource criteria to qualify for Medicaid. Assets and resources are items such as cash, stocks, bonds, bank accounts and property and are considered when determining eligibility. Some resources, including the applicant's home, are exempt from consideration. ABD applicants must also meet transfer-of-resource criteria that are in place to prevent a person from impoverishing themselves in order to qualify for Medicaid.

In general, ABD populations with annual incomes up to 64% FPL are eligible for Medicaid in Ohio. Previously, ABD applicants whose income exceeded the Medicaid limit may have qualified for Medicaid on a month-to-month basis after they "spent down" some of their income on health expenses. The Medicaid spend down program was eliminated after July 2016 in the state budget for SFYs 2016-2017.

The budget bill for SFYs 2016-2017 makes changes to Ohio's disability determination systems that affect eligibility for Medicaid. The Ohio Department of Medicaid will seek a State Plan Amendment under Section 1634 of the Social Security Act to allow a single disability determination to be used for both Medicaid and Supplemental Security Income (SSI). The Medicaid eligibility income standard will be raised from 64% FPL to 75% FPL and the asset test will be raised. People on SSI will become automatically eligible for Medicaid. The Ohio Department of Medicaid estimates that 9,500 to 14,500 Ohioans currently on SSI but not yet enrolled in Medicaid will be automatically enrolled. Most of this group is eligible, but not yet enrolled.²¹

The Medicaid spend down program will also be eliminated. Ohio will seek a State Plan Amendment under Section 1915(i) of the Social Security Act to create a special program to continue benefits for people in this group with severe and persistent mental illness (SPMI). The Ohio Department of Medicaid estimates 4,000 to 6,000 Ohioans will be eligible for this benefit program.²²

Medicaid Expansion ("Group 8")

Beginning January 1, 2014, Medicaid coverage was extended to childless adults between 19 and 64 who have incomes less than 138% FPL (133% FPL with a 5% income disregard) and who are not eligible under other categories of Medicaid.

Note that the expansion category is often called "Group 8" because The Affordable Care Act amended the Social Security Act to add a new Medicaid

Medicaid Expansion demographics and health care utilization

With only a year of information, limited data is available for the expansion population in Ohio. Data from January and February 2014 show that enrollment was closely split between men and women, with slightly more men enrolling (52%). The largest age group to enroll was those ages 19 to 34 (42%).

Notably, 42% of Group 8 was employed during the same time frame.

Preliminary utilization data from January and February 2014 shows a pent-up demand for behavioral health services among the expansion population, with significantly more behavioral health related claims than the CFC or ABD populations. Group 8 initially had a higher number of inpatient and emergency department claims, but by June 2014 had more medical, outpatient, dental and pharmacy claims, showing a shift from uncoordinated to coordinated care services and alleviation of pent-up demand.²³

Costs of covering Group 8

During biennial budget deliberations, some state policymakers have expressed concern about the costs of covering the Medicaid expansion population. Under the ACA, the federal government pays 100% of the cost of covering Group 8 enrollees through 2016. After 2016, enhanced federal funding gradually decreases to a minimum of a 90% match.

In SFY 2014, all funds expenditures for Group 8 totaled \$686.5 million, which was fully reimbursed by the federal government.²⁴ In SFY 2017, the executive budget proposed an appropriation of \$5 billion. The state share in 2017 is 5% and the administration's estimated cost of covering the population is \$120 million.²⁵

The state budget for SFYs 2016-2017 directs the Office of Budget and Management (OBM) to transfer \$200 million to the newly-created Health and Human Services Fund. This is intended to be the source of the state share for the Medicaid expansion population in SFY 2017.

eligibility group. Specifically, the ACA added section 1902(a)(10)(A)(i)(viii) to the Act. Section 1902(a)(10)(A)(i) is the section of the federal law that lists the Medicaid eligibility categories that states must cover.

Other Medicaid

Ten percent of the Medicaid caseload in SFY 2014 was in categories other than CFC or ABD, in what this publication refers to as “Other Medicaid.” Examples of categories within this subset include the Breast and Cervical Cancer Project, Alien Emergency Medical Assistance (AEMA), Family Planning, presumptively eligible children and pregnant women and deemed newborns (infants born to women receiving Medicaid on the date of delivery).

The largest “Other” category is known as “Limited Benefits” and includes:

- **The Medicare Premium Assistance Program** is Ohio’s program that pays Medicare premiums, deductibles and coinsurance for individuals with low incomes enrolled in Medicare who do not qualify for full Medicaid benefits. This program is sometimes referred to as the Medicare Buy-In Program and is considered to be a part of the larger Medicaid program. An average of 117,689 Ohioans monthly received assistance through this program in SFY 2014.²⁶
- The ACA added a new Medicaid eligibility option for states to improve access to **Family Planning** services without applying for a waiver from the federal government. In January 2012, Ohio Medicaid implemented a new eligibility category to allow men and women of childbearing age under 200% FPL to receive a limited set of benefits to help prevent or delay pregnancy. An average of 128,522 Ohioans per month received assistance through this program in SFY2014.²⁸ The

Breast and Cervical Cancer Project (BCCP)

Ohio’s Breast and Cervical Cancer Project (BCCP) is a program that provides breast and cervical cancer screening, diagnostic testing, and case management services at no cost to eligible women in Ohio.

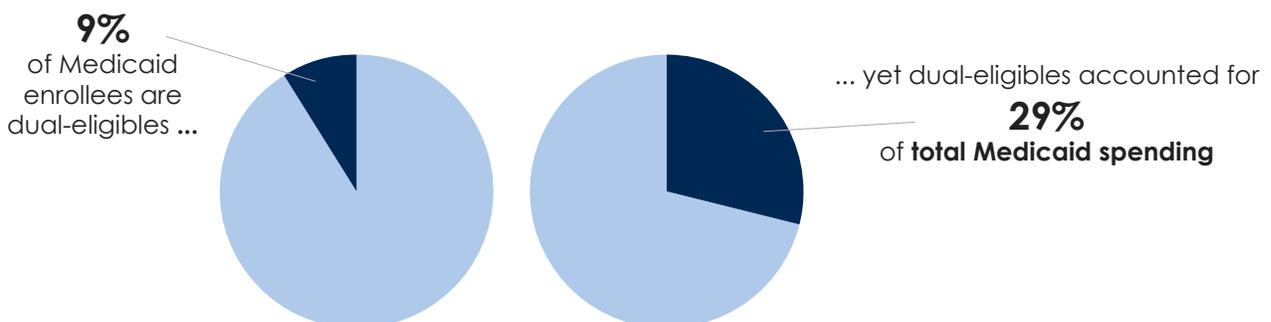
The program was implemented in Ohio in 1994 using federal funds from the Centers for Disease Control and Prevention. The state began to contribute additional funds in 2007. In general, women are eligible for BCCP if they have low-incomes (below 200% FPL), do not have health insurance, and are between ages 40-65 (covered services vary by age).²⁷

state budget for FY2016-2017 eliminates coverage for this limited benefit program, given the availability of these services for people in Group 8.

Dual Eligibles

People who are eligible for both Medicaid and Medicare simultaneously are called “dual eligibles.” For these individuals, Medicaid helps fill in some of the gaps in Medicare coverage by paying for services that are not part of the standard Medicaid benefit package, such as long-term care services. Individuals receiving long-term care services account for most of the costs to Medicare for dual eligibles. For people who are other dually eligible and do not qualify for full Medicaid benefits, Medicaid makes Medicare more affordable by providing assistance with Medicare premiums, deductibles, and other coinsurance requirements (see Medicare Premium Assistance Program). Whether they qualify for full benefits or more limited assistance, most dual-eligible beneficiaries are very low-income individuals, typically with incomes below \$10,000 a year and face serious health challenges such as diabetes, heart disease, dementia or a severe mental illness.²⁹

Figure 6. Average monthly Medicaid costs per enrollee, SFY 2014



Source: ODM Budget Data, report run in February 2015. Additional calculations by HPIO.

Medicaid redetermination and renewal

Federal law requires state Medicaid programs to review whether an individual continues to meet all the necessary eligibility requirements ("redetermine" eligibility) every twelve months. In 2014, federal law temporarily prohibited states from performing Medicaid eligibility redeterminations for the first three months of the year as new methodology for calculating eligibility was implemented. Additionally, Ohio Medicaid requested and was granted a nine month waiver of redetermination while it implemented the Ohio Benefits eligibility system.

Annual eligibility reviews resumed in 2015, and consumer advocates identified challenges to Ohio's process, including technological barriers related to the consumer portal Ohio Benefits, lack of a return envelope, additional postage requirements and confusion about the form and instructions for its return.

The state is exploring options to improve the process and decrease gaps in coverage. For example, Ohio Medicaid implemented passive renewals for consumers scheduled for redetermination in April and May. Passive renewal means that the eligibility system automatically reviews information on file for a beneficiary and if all criteria can be confirmed by the system, coverage is renewed automatically without requiring additional documentation from the individual.

As a result of resuming the redetermination and renewal process, some Ohioans lost Medicaid coverage in early 2015. As of March, about 204,000 Ohioans had been disenrolled.

Plaintiffs reached a settlement agreement with the Ohio Department of Medicaid on May 11, 2015. The deal restores Medicaid coverage to more than 150,000 individuals who lost coverage between January and March when the state was not conducting passive redeterminations. Under the agreement, state officials will also implement new strategies to make the annual redetermination process more user-friendly and efficient. Requirements for the Department of Medicaid include creating a statewide telephone renewal option, improving the online process, providing renewal packets in Somali and Spanish, and ensuring that termination notices include the reason for discontinuing coverage and information about appealing the decision.

MyCare Ohio

MyCare Ohio is a system of managed care plans selected to coordinate the physical, behavioral, and long-term care services for individuals over age 18 who are eligible for both Medicaid and Medicare ("dual eligible"), including people with disabilities, older adults, and individuals who receive behavioral health services.

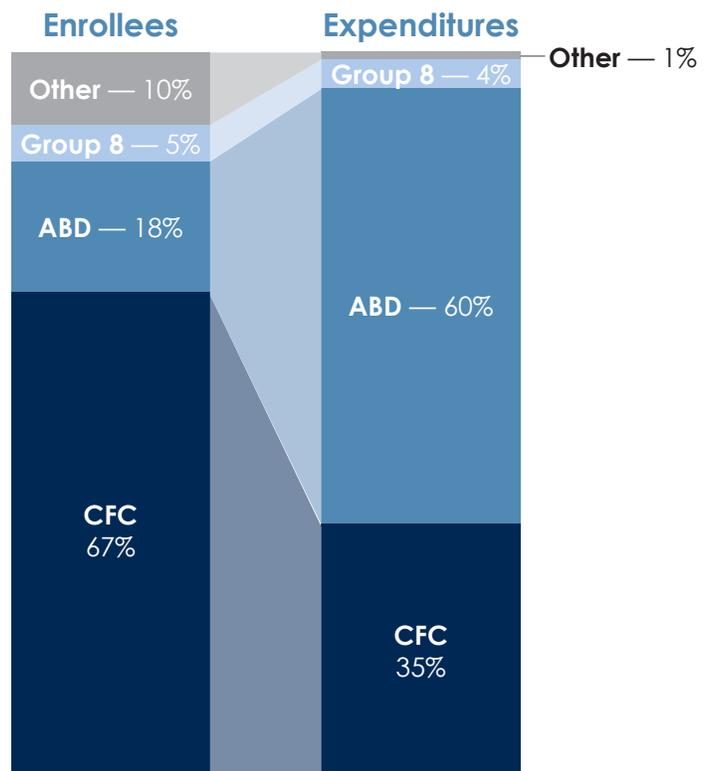
Implementation of this three-year demonstration began on May 1, 2014 in some counties around the state. As of December 31, 2014, MyCare Ohio plans enrolled 100,366 Ohioans in twenty-nine counties.³⁰

The Department of Medicaid is required to submit a report to the General Assembly annually. For more information about the demonstration project and programmatic activity through June 2015, see <http://jmoc.state.oh.us/Assets/documents/reports/mycare-ohio-SFY2015.pdf>.

Coverage costs by benefit category

Ohio Medicaid serves a wide variety of people with low and modest incomes. Beneficiaries include families, children, pregnant women and the elderly, blind and disabled. Because of the range of recipients and their needs, costs vary widely. In general, ABD enrollees have more complex healthcare needs and are more expensive to cover than the CFC population.

Figure 6. Cost Differences between types of enrollees, SFY 2014



Note: This figure only includes 6 months of Medicaid expansion in SFY 2014 (January – June).

Source: ODM Budget Data, report run in February 2015. Additional calculations by HPIO.

Ohio Department of Medicaid (ODM)

The federal government requires each state to designate a “single state agency” to administer its Medicaid program. The Ohio Department of Medicaid has been Ohio’s single state agency since July 1, 2013. Previously, the Ohio Department of Job and Family Services (ODJFS) was the designated single state agency and the Office of Medical Assistance was the department responsible for the day-to-day management of the program.

Federal law allows states’ single agency to contract with other public and private entities to administer various Ohio Medicaid programs through interagency agreements. Ohio delegates authority to five state agencies (known as “sister state agencies”) to administer some Medicaid programs:

- Department of Aging (ODA)
- Department of Developmental Disabilities (ODODD)
- Department of Health (ODH)
- Department of Education (ODE)
- Ohio Department of Mental Health and Addiction Services (OhioMHAS)

Additionally, county departments of job and family services, county boards of developmental disabilities, community behavioral health boards, and area agencies on aging all play important roles in providing Medicaid services.

The creation of the Ohio Department of Medicaid restructured Medicaid-related appropriations line items to capture all Medicaid spending across all agencies. It removed non-Medicaid spending from Medicaid lines. It also split services from administration and support.

The “elevation” of Medicaid behavioral health financing occurred throughout state fiscal years 2012 and 2014. Beginning July 1, 2011, the financial responsibility for the state share of Medicaid funds for alcohol and drug treatment and mental health carve-out benefits transitioned from community behavioral health boards to the state. Full integration occurred by July 1, 2013.

The state budget for SFYs 2016-2017 “carves in” behavioral health services into managed care. See “New state initiatives” on page 18 for more information.

Governor’s Office of Health Transformation (OHT)

In January 2011, Governor Kasich created the Governor’s Office of Health Transformation (OHT) through executive order with the objectives to modernize Medicaid, streamline health and human services, and pay for value. OHT coordinates the state agencies that administer federal health care programs and initiatives. For more information about OHT, see www.healthtransformation.ohio.gov.

Office of Human Services Innovation (OHSI)

Governor Kasich established the Office of Human Services Innovation in August 2014 to work with state and local agencies and stakeholders to pursue a better-coordinated, person-centered human services system that will help Ohioans become employed, succeed at work, and break the cycle of poverty. For more information about OHSI, see www.humanservices.ohio.gov.

Joint Medicaid Oversight Committee (JMOC)

The Joint Medicaid Oversight Committee (JMOC) was established by Senate Bill 206 in 2014 and is responsible for overseeing reforms to Ohio’s Medicaid program. The committee is comprised of five members appointed by the Senate President (three from the majority party and two from the minority party) and five members appointed by the Speaker of the House (three from the majority party and two from the minority party). A majority member from the House serves as chairperson in odd-numbered years and a majority member from the Senate serves as chairperson in even-numbered years.

The committee oversees Medicaid compliance with legislative intent, evaluates legislation for long-term impact on Medicaid, and assists in limiting the rate of spending growth, while improving quality of care and health outcomes for individuals enrolled in Ohio’s Medicaid program.

MANDATED AND OPTIONAL SERVICES

To address the various healthcare needs of Medicaid beneficiaries, states are required to cover a comprehensive range of services ("mandatory benefits") and may cover additional "optional benefits." Some services are limited by dollar amount, number of visits per year, or setting in which they can be provided. Some services require the consumer to share in the cost.³¹

Copays and premiums

Many of the people served by Medicaid obtain medical care at no cost; however, certain medical services require a copayment, including non-emergency services obtained in a hospital or emergency room, dental services, eye examinations, eyeglasses, most brand-name medications and medications that require prior authorization. Copayments generally range from \$1 to \$3.

Medicaid consumers are exempt from copayments if they meet one of the following requirements:

- Younger than age 21
- Pregnant or pregnancy ended up 90 days ago (there are copayments for routine eye examinations and eyeglasses fittings)
- Living in a nursing home or an intermediate care facility for individuals with intellectual disabilities (ICF/IID)
- Receiving emergency services in a hospital, clinic, office or other facility
- Receiving family planning-related services
- Receiving hospice care
- Enrolled in a managed care plan that does not charge copayments³²

Medicaid 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

There are two delivery systems for Ohio Medicaid: fee for service (FFS) and managed care. "Delivery system" refers to the way the state provides financial reimbursement to health care professionals and facilities for providing approved services and benefits. Both systems provide medically necessary primary care, specialty and emergency care services, and preventive services. Ohio Medicaid also provides long-term care services exclusively through the FFS system for non-dual-eligible beneficiaries (See "Dual Eligibles" on page 9 for more information about this population).

Managed care

A managed care plan (MCP) is a private health insurance company that provides, or arranges for someone to provide, the standard benefit package to Medicaid enrollees. The Ohio Department of Medicaid contracts with five managed care plans to coordinate care for Ohio Medicaid enrollees in exchange for a capitation payment — a set amount of money per member per month (PMPM) regardless of the amount of services actually used. The MCP is then at full risk for covering any costs that exceed the capitation payment it receives from Medicaid. The MCP reimbursement structure is designed to reduce costs and create incentives for improved quality and continuity of care.

The five managed care plans awarded state contracts to serve Ohio's Medicaid population are:

- Buckeye Community Health Plan
- CareSource
- Molina Healthcare of Ohio
- Paramount Advantage
- UnitedHealthcare Community Plan of Ohio

Ohio Medicaid began to use managed care in 1978. Over the next few decades, the state experimented with incorporating the use of MCPs in different regions and populations around the state. The structure of the program evolved from voluntary enrollment (eligible consumers had a choice between enrolling in a MCP or using FFS) to mandatory enrollment (eligible consumers must enroll in one of the participating MCPs to receive health services).³³ The state budget bill for SFYs 2006-2007 required that the CFC population

and certain ABD populations be enrolled in managed care plans.

Most Medicaid consumers are eligible for membership in an Ohio Medicaid MCP. However, certain consumers are excluded or are not required to enroll. Consumers who are excluded from Medicaid managed care membership include: Medicaid-eligible individuals who are on a waiver or institutionalized and dual-eligibles (individuals eligible for both Medicaid and Medicare simultaneously), and certain other groups.³⁴ See "MyCare Ohio" box on page 10 for details about Ohio's demonstration program enrolling dual-eligibles in managed care in some counties.

Almost all children, pregnant women, and parents enrolled in the Covered Families and Children (CFC) category are required to enroll in a managed care plan. The transition of ABD children into managed care began on July 1, 2013, and more than 37,000 children with special needs, previously receiving services through FFS Medicaid, were enrolled.

In SFY 2014, 1.54 million CFC enrollees were enrolled in a MCP, representing 91% of the total CFC population.³⁵ Although not all those enrolled in ABD Medicaid are required to enroll in an MCP, the state of Ohio has moved more of the ABD population into managed care. In SFY 2014, 171,279 ABD clients were enrolled in an MCP, representing 77% of the total ABD population eligible to enroll.

As a result of the state budget for SFYs 2016-2017, children in foster care and those who are adopted will be enrolled in managed care.

Fee for service (FFS)

Consumers who are excluded from or not required to enroll in Medicaid managed care receive Medicaid services through the fee-for-service system (FFS). Under FFS, Medicaid pays most service providers a set fee for the specific type of service rendered (such as an office visit, test, or procedure). Payments are based on whichever is lowest on the state's fee schedule, the actual charge, or federal Medicare allowances.

Long-term care

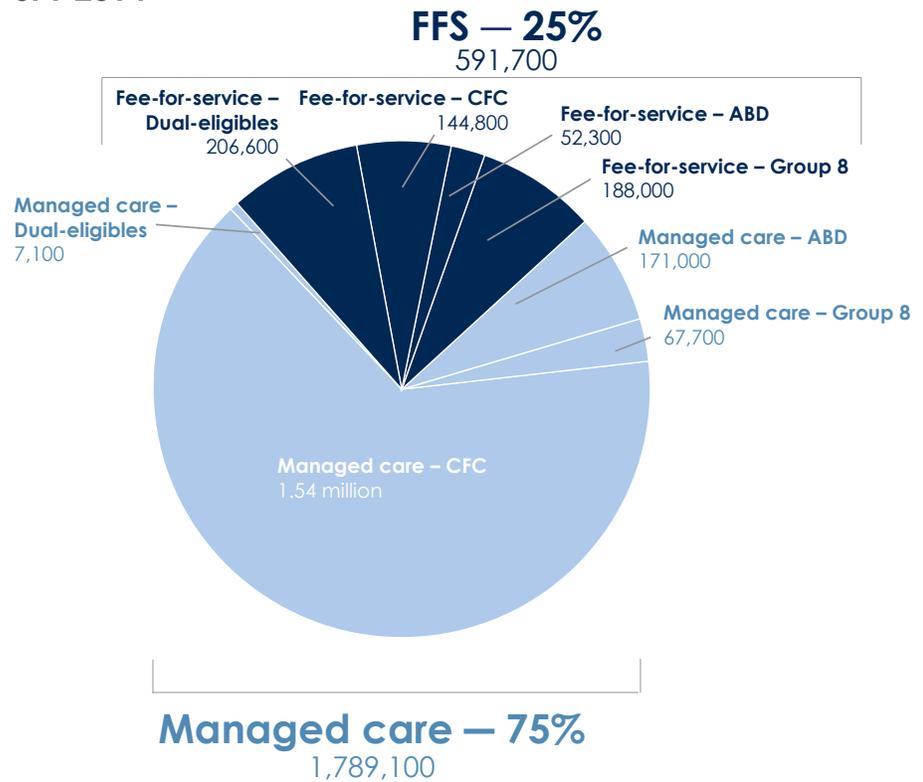
There are several types of long-term care services provided by Ohio Medicaid: facility-based, home and community-based (HCBS), and locally funded services.

Facility-based long-term care services include services provided in nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICF-IID), and state-run developmental centers for the developmentally disabled. Medicaid is the largest payer of nursing home care in Ohio. Across all funds, Medicaid nursing facility expenditures were \$2.41 billion in SFY 2014.³⁶

Home and community-based services (HCBS) allow people with disabilities and chronic conditions to receive care in their homes and communities instead of long-term care facilities, hospitals, or intermediate care facilities.

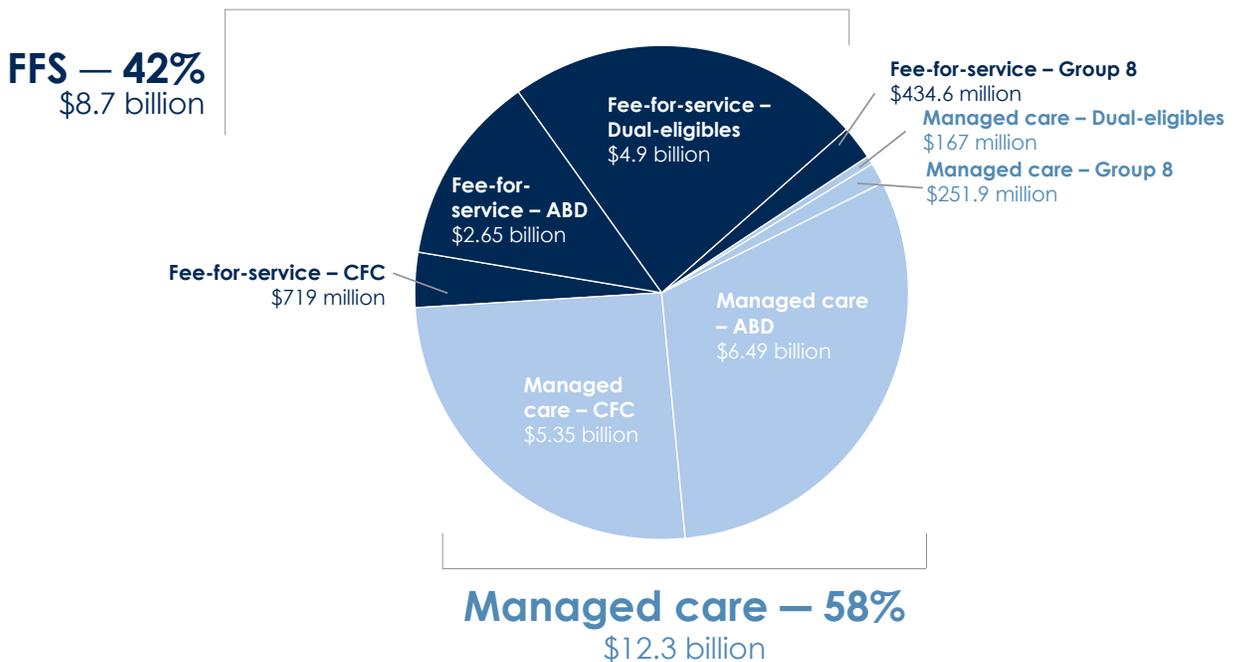
The Ohio Department of Medicaid administers two waiver programs: Ohio Home Care Waiver (OHCW)

Figure 7. Medicaid enrollment by delivery system, SFY 2014



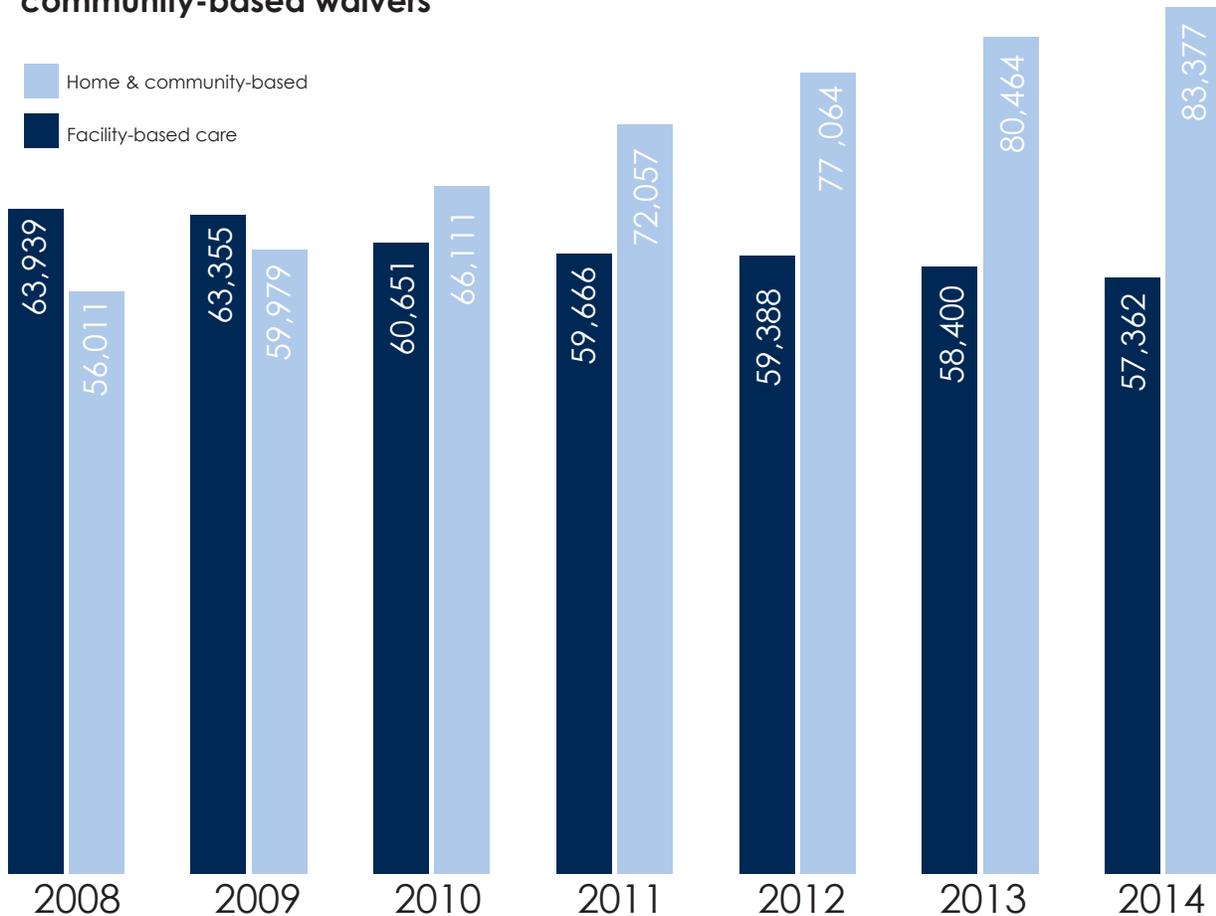
Source: ODM Budget Data, report run in February 2015. Additional calculations by HPIO

Figure 8. Medicaid spending by delivery system, SFY 2014



Source: ODM Budget Data, report run in February 2015. Additional calculations by HPIO

Figure 9. People served in long-term care institutions compared to home and community-based waivers



Source: ODM Executive Budget Medicaid Services Forecast Book.

Note: Average monthly numbers of residents of institutions and waiver recipients

and the Transitions Carve-Out Waiver (T2). The T2 waiver was phased out at the end of SFY 2015 and those individuals will be enrolled in PASSPORT beginning in February.

The Ohio Department of Developmental Disabilities administers four home and community-based Medicaid waivers: Individual Options (IO), Level One (L1), Self-Empowerment Life Funding (SELF), and Transitions Developmental Disabilities (DD). The primary goal of these waivers is to enable people with developmental disabilities to remain in their homes or in community-based settings of their choice. Funding and services are based on each individual and determined by a standard assessment tool.³⁷

The Ohio Department of Aging administers the following Medicaid waiver programs: PASSPORT (Pre-Admission Screening System Providing Options and Resources Today) and the Assisted Living Medicaid waiver.

Together, these waivers provided access to long-term care for almost 70,000 individuals in SFY 2014.

Pay for Performance (P4P)

To incentivize Ohio Medicaid managed care plans to improve health outcomes, the Ohio Department of Medicaid implemented a pay-for-performance (P4P) program based on key program areas: access, clinical quality, and consumer satisfaction. For SFY 2014, plans were held accountable for 24 measures, six of which are also P4P metrics. Ohio set the minimum performance standard at the national 25th percentile. Plans face financial penalties for failing to meet minimum standards. MCPs are also eligible for bonus payments based on performance on the P4P metrics. To receive the full bonus payment, plan performance scores must be in the 90th percentile for each of the six measures.³⁸ In 2014, \$15 million of a possible \$70 million was awarded to Medicaid MCPs through the P4P program.³⁹

The six P4P metrics for SFY 2014 and Ohio plan performance compared to the national average are shown in Figure 10 on page 16.

Figure 10. Pay for performance metrics and Ohio, national performance

Measures	Ohio plans			National average	
	FY2013	FY2014	Trend	Medicaid	Commercial PPO
Timeliness of prenatal care	87.5%	86%	▼	81.9%	82.2%
Comprehensive diabetes care – LDL-C screening	71.2%	70.3%	▼	76%	81.3%
Controlling high blood pressure	51.6%	48.4%	▼	56.3%	57.6%
Use of appropriate medications for people with asthma – total	81.9%	83.1%	▲	84.1%	90.5%
Appropriate treatment for children with upper respiratory infections	80.4%	81.9%	▲	85.2%	83.2%
Follow-up after hospitalization for mental illness – 7-day follow-up	44.1%	51.8%	▲	42%	49.8%

Source: Ohio Department of Medicaid. "Medicaid Managed Care Quality Performance Metrics and Results." Testimony in the Joint Medicaid Oversight Committee. March 19, 2015

Ohio Medicaid Quality Strategy

The Ohio Medicaid quality strategy is driven by three goals: delivering better care, contributing to healthy people and healthy communities, and practicing best-evidence medicine across the care continuum.

The focus areas of the strategy are: High risk pregnancy/premature births, behavioral health, cardiovascular disease, diabetes, asthma, upper respiratory infections, access, and consumer satisfaction.

The Department has identified specific initiatives in place to address these goals. See the full list here: <http://medicaid.ohio.gov/MEDICAID101/QualityStrategy.aspx>.

ONGOING STATE INITIATIVES

A new eligibility and enrollment system

In March 2012, the Governor's Office of Health Transformation (OHT) initiated an eligibility modernization project to simplify eligibility determinations based on income, streamline state and local responsibilities, and modernize eligibility technology. With funding from the federal government, Ohio designed and built a new integrated eligibility system for all of the state's health and human services programs.

A key component of the system is the Ohio Benefits website (benefits.ohio.gov), which went live in October 2013. Ohio Benefits is an online citizen self-service portal that allows Ohio residents to check eligibility and apply for benefits.

The ACA required that Medicaid and marketplace eligibility systems align. As a result, applications

of Ohioans who apply through the state's portal (benefits.ohio.gov) and are not eligible for Medicaid are transferred to the federal marketplace (HealthCare.gov) and applications of Ohioans who apply for health insurance through the federal portal but are deemed eligible for Medicaid are transferred to the state. Both systems use the same federal data hub to verify information.

The transfer process between the state and federal systems experienced technical problems in early 2014. The inability of HealthCare.gov to automatically transfer Medicaid applications to the states created confusion among Ohioans applying for coverage and a backlog of applications in many counties through summer 2014. By fall 2014, this process was improved with file transfers from the FFM to the Ohio Department of Medicaid occurring twice a week.⁴⁰

The next phase of the Ohio Integrated Eligibility Project Timeline includes determining eligibility for the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) on the new system. December 31, 2018 is the last day for the state to leverage the federal 90% matching funds for system development.

Payment reform

Ohio was awarded a \$3 million federal grant through the Centers for Medicare and Medicaid Services (CMS) to design a new payment and healthcare delivery model in February 2013 in Round One of the State Innovation Models (SIM) Initiative. Ohio used the SIM grant to develop a plan to expand the use of patient-centered medical homes (PCMH) and episode-based payments for acute medical events to most Ohioans who receive coverage under Medicaid, Medicare, and commercial health plans.⁴¹

In December 2014, Ohio was awarded a Model Test Award for Round Two of the SIM. The state received a \$75 million, four-year grant to launch episode-based payments for high-cost medical events statewide starting in November 2014 (with the goal of defining and implementing 50 or more episodes within the next four years) and to adapt Southwest Ohio's Comprehensive Primary Care Initiative (CPCI) for a statewide roll-out of PCMH beginning in 2015. The SIM test will include 80-90% of the state's population, including Ohioans receiving coverage through Medicaid (both fee-for-service and managed care).⁴²

Infant mortality

Ohio's infant mortality rate is among the worst in the nation and has been a major focus of state policymakers and stakeholders in recent years. Infant mortality is defined as the death of a baby before his or her first birthday. In 2011, Ohio's infant mortality rate was 7.88 infant deaths per 1,000 live births. This rate is higher than the U.S. rate of 6.07.⁴³ There is also a significant racial disparity, with black infants dying at more than twice the rate of white infants.

The Ohio legislature recently passed several bills addressing the leading causes of infant mortality, including legislation requiring the investigation of the sudden death of a child who is one year of age or younger and

in apparent good health⁴⁴ and legislation requiring the Ohio Department of Health to establish the Safe Sleep Education Program and certain facilities, such as some hospitals, to implement safe sleep screening procedures to assess whether an infant will have a safe crib or other suitable place to sleep once discharged.⁴⁵

Additionally, the state budget for SFYs 2016-2017 (H.B. 64 of the 131st General Assembly) includes:

- Enhanced care management services provided by Ohio Medicaid managed-care plans for both pregnant and non-pregnant women in the most high-risk neighborhoods as a strategy to improve health status and future birth outcomes
- A process to identify communities with the highest rates of infant mortality in order to prioritize resources for those areas
- Additional services in home visitation for pregnant women and newborns, including cognitive behavioral therapy and depression screenings
- Annual reporting on the effectiveness of Medicaid at meeting health care needs of pregnant women, infants, and children
- Provides funding for evidence-based tobacco cessation programs for pregnant women in areas with high infant mortality rates⁴⁶

The state's infant mortality prevention efforts are significant as they relate to the Medicaid population because Medicaid plays a large role in access to health care for pregnant women and children. In 2013, Medicaid paid for more than 52% of births in Ohio.⁴⁷

For more information on Ohio's efforts to reduce infant mortality, see the Ohio Department of Health's Ohio Collaborative to Prevent Infant Mortality: <http://www.odh.ohio.gov/odhprograms/cfhs/octpim/infantmortality.aspx>.

Presumptive eligibility

The ACA expanded states' ability to use presumptive eligibility (PE) to streamline the enrollment process for Medicaid and CHIP. PE is a program that provides immediate access to health services by giving individuals temporary health coverage through Medicaid if they are presumed to be eligible. Those determined presumptively eligible must complete the full application process

within 60 days to continue coverage. Qualified entities making PE determinations must ensure that 85% of applicants enrolled through PE must submit an application for full benefits and 85% of those applications must result in an awarding of Medicaid eligibility.

Ohio first implemented PE for children in April 2010, using county job and family service agencies as the qualified provider. PE was expanded to pregnant women in 2012 and added federally qualified health centers (FQHCs) and children's hospitals as qualified providers.⁴⁸

The Ohio Department of Medicaid launched Ohio's broader PE initiative in March 2014. Currently, children, parents/caretakers, pregnant women, and adults who meet certain other criteria are eligible and hospitals, FQHCs, and county job and family service agencies are qualified providers.

Medicaid primary care provider rates

The ACA increased Medicaid payment rates for many primary care services to Medicare fee levels

in 2013 and 2014. Goals of the rate bump included recruiting new physicians to Medicaid, increasing support for those who already participate and encouraging them to expand their Medicaid patient base. Federal funding for the fee increase expired on December 31, 2014.

The Executive Budget included a primary care rate increase to mitigate the impact of the loss of the short-term increase. The proposed rate increase was offset by savings from applying the Medicaid maximum payment methodology to Medicare crossover claims (reimbursing up to the Medicaid maximum amount for all claims, including physician services, instead of paying the higher Medicare cost sharing amount) and a reduction in graduate medical education (GME) payments. The final version of the bill includes the proposed cuts to Medicare crossover claim payments. The Department has indicated it will not cut GME funding. As a result, while some Medicaid providers will receive an enhanced payment for certain primary care billing codes, the net effect will likely be a decrease in Medicaid provider reimbursement.

NEW STATE INITIATIVES

Health savings accounts

In the Executive Budget for SFYs 2016-2017, Governor Kasich proposed assessing Medicaid premiums for Group 8, non-pregnant adults with incomes between 100-138% FPL (the population newly eligible under Medicaid expansion). During consideration of the budget, the Ohio legislature replaced this proposal with the Healthy Ohio Program.

The final budget language requires the Ohio Department of Medicaid to seek a waiver to mandate enrollment in a Health Savings Account (HSA) for every non-disabled adult enrolled in Medicaid, regardless of income. This means all Medicaid recipients in the Covered Families and Children (CFC) and Medicaid expansion eligibility groups will be required to participate, with the exception of children. Each Healthy Ohio enrollee would be required to deposit 2% of their income up to a \$99 annual limit into an HSA administered by their health plan and the Medicaid program will deposit an additional \$1,000 per year.

Notably, Medicaid coverage is terminated if a recipient fails to pay the required monthly contribution, although pregnant women are excluded from this provision. Coverage resumes once the participant pays the full amount of the monthly installment.

The Ohio Department of Medicaid has indicated that it will draft the waiver, seek public input as required

by federal regulations, and submit the waiver to the federal Centers for Medicare and Medicaid Services (CMS) during the second half of 2015.⁴⁹

Managed behavioral health care

In Ohio behavioral health services are currently "carved out" from the general Medicaid program, meaning that they are administered separately from the Medicaid managed care system. Medicaid reimbursement for services in the publicly-funded behavioral health system is paid on a fee-for-service basis.

The 2016-2017 state budget repeals the prohibition on including alcohol, drug addiction, and mental health services in the Medicaid care management system. As a result, all Medicaid-reimbursed behavioral health services will be "carved in" to Medicaid managed care. Providers in the new network will include community behavioral health organizations, inpatient hospitals, clinics, and specialty practitioners. The Ohio Department of Medicaid is required to begin the transition no later than January 1, 2018. The budget language specifies that the Department's proposal must be approved by the Joint Medicaid Oversight Committee (JMOC) before implementation. JMOC is required to consider the proposed timeline, issues related to access, adequacy of the provider network in its review and payment levels. JMOC will also provide ongoing monitoring of the restructuring.⁵⁰

Acknowledgment and general data notes

The Health Policy Institute of Ohio thanks the Ohio Department of Medicaid for providing much of the data used in this report.

The main sources of Ohio Department of Medicaid data used are a budget report run in February 2015, at the request of HPIO, and the ODM Executive Budget Medicaid Services Forecast for Fiscal Years 2016-2017, submitted February 2, 2015.

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Author

Stephanie Gilligan, HPIO Director of Access and Coverage Policy

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