**Introduction**

Medicaid was established as a federal-state program in 1965 (at the same time as Medicare) through Title XIX of the Social Security Act. Medicaid is the largest of the federal-state partnerships for low-income Americans. Medicaid provides federal matching funds to states for certain health care services for eligible parents, children, seniors, and people with disabilities.

Each state administers its own Medicaid program. The federal Centers for Medicare and Medicaid Services (CMS) monitors state-run programs and establishes requirements for service delivery, quality, funding, and eligibility standards. State participation is voluntary and all states have participated since 1982. Ohio Medicaid began in 1968.

**Overview of Ohio Medicaid**

Ohio Medicaid is administered by the Office of Ohio Health Plans (OHP) of the Ohio Department of Job and Family Services (ODJFS). Local offices in each of the state’s 88 counties also play an important role in Ohio Medicaid.

Medicaid represents almost 24% of Ohio’s total federal-state expenditures, making it and education the two largest items in the state budget. As a result, an increase in program costs can have a serious impact on the overall fiscal condition of the state.

Ohio Medicaid provides a broad range of health services to 2 million low-income working families, children, aged, blind, and disabled Ohioans.

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Ohio Medicaid Basics
February 2005

Ohio Medicaid:
- covers 1 out of every 3 births
- covers 1 out of every 4 children
- covers 1 out of every 4 seniors over age 85
- spends a smaller portion on administrative costs than 47 states
- pays for 70% of all nursing home care in the state
- covers children in families up to 200% of the Federal Poverty Level (FPL)
- covers working parents in families earning up to 100% FPL
- covers Medicare premiums for eligible seniors and people with disabilities
- represents almost 24% of the entire state budget
- as a health plan, is larger than the top 5 Ohio commercial insurers combined

Although the majority of people enrolled in Ohio Medicaid are families and children, the majority of expenditures pay for services to aged, blind, and disabled Ohioans.
Eligibility

Medicaid provides health care coverage to a number of different groups of people who meet certain financial requirements. These coverage groups include low-income children, some parents, pregnant women, and aged, blind, or disabled individuals. Income criteria are largely based on poverty guidelines established by the federal government. Resource criteria (assets) are considered for aged, blind, and disabled individuals applying for Medicaid and are based on cash, bank accounts, stocks, and other assets.

Parents, Children, and Pregnant Women

The Ohio Medicaid program covers over 1.1 million low-income children and 500,000 low-income parents. The majority of eligible adults in families with children are women. Children represent the largest demographic group served by Ohio Medicaid, with just over half of all eligible Ohioans being age 18 or younger. Pregnant women who meet certain income criteria are eligible for coverage during their pregnancy, including 60 days postpartum.

Aged, Blind, and Disabled (ABD)

ABD is an eligibility category of Medicaid for aged, blind, and disabled individuals whose income and assets meet established program requirements. ABD Medicaid assists with some or all medical expenses for Ohioans who are aged (65 years or older), blind, or disabled (an individual with a physical or mental impairment that prohibits work and that has lasted or will last 12 months or longer). In State Fiscal Year (SFY) 2002, over 400,000 Ohioans qualified for Medicaid in the ABD eligibility category.

ABD recipients must meet established financial guidelines. Supplemental Security Income (SSI) is not counted in the calculation. Those who have too much income to qualify may become eligible through a Medicaid “spenddown,” where proof of certain medical expenses may reduce income until it falls within the financial guidelines.

In Ohio, individuals who receive SSI do not “automatically” qualify for Medicaid. Unlike most states, Ohio has more restrictive income and asset requirements.

In the SFY 04–05 biennium, ODJFS introduced an Enhanced Care Management initiative for certain high-cost aged, blind, or disabled Ohioans to improve their health outcomes and manage costs (see box on page 6). Additionally, people eligible for Medicare who have limited income and assets receive Medicaid assistance through the Medicare Premium Assistance Program to help with their Medicare premiums, Medicare deductibles, and Medicare coinsurance (see page 4).

<table>
<thead>
<tr>
<th>Ohio Medicaid Eligibility</th>
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<tbody>
<tr>
<td><strong>Covered Populations</strong></td>
</tr>
<tr>
<td>Children (up to age 19)</td>
</tr>
<tr>
<td>Parents</td>
</tr>
<tr>
<td>Pregnant Women</td>
</tr>
<tr>
<td>Individuals with Disabilities</td>
</tr>
<tr>
<td>Ohioans age 65 and over</td>
</tr>
</tbody>
</table>

Medicare Premium Assistance Program Varies

Institutional Level of Care Income less than cost of care

Individuals on Waivers Varies

*Assets and other factors affect eligibility, which is determined at the county level.

**Deductions and exceptions apply.

2004 Federal Poverty Guidelines*

<table>
<thead>
<tr>
<th>Annual Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Size</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
</tbody>
</table>

* These apply to the 48 contiguous states and Washington, D.C.

Source: United States Department of Health and Human Services (HHS),
Key Programs

Once an individual is determined eligible for Medicaid, there are a variety of programs and services available. Major programs include:

- Healthy Start/SCHIP
- Healthy Families
- Aged, Blind, or Disabled
- Medicare Premium Assistance Program
- Breast and Cervical Cancer Project (BCCP) Medicaid

Healthy Start/SCHIP

The Healthy Start program has been available to children and pregnant women since 1989. In 1997, the State Children’s Health Insurance Program (SCHIP) was also created to address the growing problem of children without health insurance. SCHIP is the single largest expansion of health insurance coverage for children since the inception of Medicaid in the mid-1960s.

States may design their SCHIP program as a stand-alone program that is separate from Medicaid, use SCHIP funds to expand existing Medicaid eligibility, or combine both approaches. Ohio expanded its existing program and offers coverage through Healthy Start. In Ohio, children from birth through age 18 in families with incomes up to 200% of the federal poverty guidelines are eligible. Children in families with incomes from 151–200% are eligible if they do not have other health coverage. Children in families with incomes at or below 150% are eligible regardless of other health coverage.

A report released in July, 2004, by the Kaiser Commission on Medicaid and the Uninsured noted that national enrollment in SCHIP declined slightly during the second half of 2003, marking the first time in the program's six-year history that the number of children covered by SCHIP has decreased nationally. In Ohio, SCHIP enrollment increased by 3% from June, 2003 (125,026) to December, 2003 (128,602).

Healthy Families

Healthy Families provides health coverage for the entire family—parents and children. A family’s size and income determines if the family is eligible for Healthy Start or Healthy Families. In Ohio, working families with incomes up to 100% of federal poverty guidelines are eligible for coverage. To be eligible, families must include a child under the age of 18.

Some of the services available include doctor visits, prescriptions, dental care, immunizations, vision care, and mental health. Studies show that families who get these needed health care services have kids who miss less school and parents who miss less work.

Healthy Families allows up to twelve months of coverage for families who would lose coverage because of an increase in income. Congress mandated this benefit called “Transitional Medicaid” to encourage parents to work or obtain higher paying jobs. Also, coverage is available for 19- and 20-year-olds who meet certain income and asset tests (known as Ribicoff children).
Aged, Blind, or Disabled (ABD)

Ohioans who are age 65 and older, who are blind, or who have a major disabling condition may be covered under the ABD program. For Ohio Medicaid, disabled means having a disability as classified by the Social Security Administration. People of all ages with a wide variety of disabilities, including blindness, mental retardation, and severe mental illness, may qualify if their disability, income, and assets meet certain criteria.

In addition to services found in other Medicaid programs (e.g., doctor visits, hospital care, prescription drugs, vision services, etc.), individuals who have disabling conditions may also be eligible for long-term care services. The ABD program provides these services in a variety of settings, including nursing facilities, intermediate care facilities for the mentally retarded (ICF/MR), and at home. Eligibility requirements vary, and many of these services are offered through waiver programs.

Medicare Premium Assistance Program

Ohioans who are enrolled in Medicare may be eligible to receive Medicaid assistance to pay for some of their Medicare Parts A or B premiums, coinsurance, or deductibles. Three types of assistance are offered and individuals must meet the general eligibility requirements for Medicaid, as well as the asset limit requirements. Income limits for each type of assistance vary. In certain cases, an individual may be enrolled in the Medicare Premium Assistance Program and other Medicaid programs at the same time.

Breast and Cervical Cancer Project (BCCP) Medicaid

Women with breast or cervical cancer (including precancerous conditions) are eligible for full Medicaid coverage during the course of their treatment if their cancer was diagnosed through the Ohio Department of Health's Breast and Cervical Cancer Project (BCCP). To obtain services through BCCP, women must live in households with incomes less than 200% of poverty, be uninsured or underserved, and be at least 40 years of age. In addition, to qualify for Medicaid coverage these women must meet basic Medicaid program requirements related to Ohio residency and citizenship status.

Disability Medical Assistance (DMA) Program

DMA is managed by OHP, but it is not a federal Medicaid program—it is funded solely through state appropriations. DMA is designed to provide medical assistance to very low-income Ohioans who are medication dependent and not otherwise eligible for Medicaid. Medication dependent means that a licensed physician has certified the individual has a chronic medical condition that requires continuous medication for a long-term, indefinite period of time. Additionally, there are income, resource, residency, and citizenship requirements.

In July, 2003, over 28,000 consumers were enrolled in DMA. Because of funding limits, Ohio's targeted enrollment is now 15,000. ODJFS manages enrollment by selectively opening and closing application periods.
Optional Medicaid Services

States may opt to cover additional services, which also qualify for federal matching funds. Ohio covers the following optional services for adults:

- prescription drugs;
- vision services, including eyeglasses;
- dental services;
- physical therapy;
- occupational therapy;
- speech therapy;
- podiatry;
- ambulance and ambulette services;
- intermediate care facilities for people with mental retardation (ICF/MR);
- hospice care;
- community alcohol and drug addiction treatment;
- home and community-based service waivers.

Despite a slowed economy and its considerable impact on Ohio’s state budget, the General Assembly maintained most health care services and covered populations under Ohio’s Medicaid program for the SFY 04–05 biennium. Am. Sub. H.B. 95 continued dental, vision, and podiatry services for all Medicaid consumers, but eliminated independent psychology and chiropractic services for adults. However, Medicaid still covers psychology services provided through community mental health programs.

Ohio Access Initiative


The vision for Ohio Access is to ensure that:

- Ohio’s seniors and people with disabilities live with dignity in settings they prefer;
- They are able to maximize their employment, self-care, interpersonal relationships, and community participation; and
- Government programs honor and support the role of families and friends who provide care.

The April 2004 report identifies a number of action steps that the task force is poised to pursue, including seeking legislative support for Ohio Access principles, planning for the SFY 06–07 budget, engaging stakeholders to refine Ohio Access strategies, and ensuring that Ohio Access 2004 is the primary planning blueprint used for long-term care services and supports in Ohio.
Delivery Systems

Medicaid provides primary and acute care services through a fee-for-service (FFS) system, or, for consumers in some areas, a managed care system. Additionally, Ohio Medicaid provides long-term care benefits for eligible consumers through facility-based services or home health care.

Primary and Acute Health Care

Individuals may access primary and acute care services through either the fee-for-service or managed care system. Both systems provide all medically necessary primary care, specialty and emergency care, and preventive services.

In the Fee-for-Service system, Medicaid beneficiaries present a Medicaid card when they access health care. The Ohio Medicaid program has a network of approximately 36,000 providers that includes hospitals, family practice doctors, pharmacies, durable medical equipment companies, and others. A Medicaid consumer may go to any Ohio Medicaid provider; however, provider participation in the Medicaid program is voluntary.

Ohio’s Managed Care system started in 1978 when ODJFS first contracted with managed care plans (MCPs) to ensure access to services, provide quality care, and manage Medicaid costs. As of July, 2004, approximately 510,000 Ohioans were enrolled in one of six licensed Medicaid MCPs. About 42% of Healthy Families and Healthy Start consumers are enrolled in MCPs operating in 15 counties. Managed care helps assure access to a primary care provider, emphasizes preventive care, and encourages the appropriate use of services in the most cost-effective settings. MCPs provide services beyond those required in the Fee-for-Service system, including provider directories and call centers for member services.

Hospital Care Assurance Program (HCAP)

The Hospital Care Assurance Program (HCAP) ensures that health care is available for a wide range of medically underserved populations. Through HCAP, Ohio meets the federal requirement to provide additional payments to hospitals that provide a disproportionate share of uncompensated care to indigent individuals.

In exchange for receiving HCAP funds, hospitals provide basic, medically necessary hospital services free of charge to people whose incomes are at or below 100% of the federal poverty guidelines. Funding for HCAP comes from an assessment on Ohio hospitals and federal matching funds. The FFY 2003 HCAP program distributed $477.5 million to Medicaid hospitals.

Enhanced Care Management (ECM)

During the SFY 04–05 biennium, ODJFS is phasing in a new initiative to expand care management for eligible aged, blind, or disabled (ABD) Medicaid consumers who are not already enrolled in waiver programs. The Enhanced Care Management (ECM) program targets adults with diagnoses of diabetes, asthma, congestive heart failure (and related conditions), chronic obstructive pulmonary disease, and children under age 21 with asthma. The initial targeted counties are Cuyahoga, Coshocton, Franklin, Guernsey, Hamilton, Lucas, Montgomery, Morgan, Muskingum, Noble, Perry, Stark, and Summit. It is anticipated that the new initiative will provide a medical home for ABD consumers, prevent and manage chronic conditions, improve health outcomes, help manage Medicaid program costs, and provide a 24/7 health advice line. The target date for the program to begin is the first quarter of SFY 2005. State and community level advisory groups will be formed as the program phase-in continues throughout the biennium.
Long-Term Care

Many low-income elderly and individuals with disabilities of all ages need long-term care, which includes a broad range of medical, social, personal care, and supportive services. That segment of Ohio's population most likely to need long-term care (those over age 85) has increased by 50,000 (34%) over the last ten years. By 2050, there will be one million Ohioans over age 85.5

Medicare does not cover the costs of long-term care and few Ohioans have long-term care insurance. Ohio Medicaid pays for services delivered in institutional, home, and community settings for individuals who meet certain “level of care” criteria. Only 14 states spend more for their elderly than Ohio.

Facility-Based Care covers services provided in certain residential settings and accounts for the largest portion of Ohio Medicaid costs. Ohio Medicaid is the leading payer of nursing facilities in the state and covers 70% of all nursing home care in Ohio. In SFY 2003, Ohio nursing home expenditures were $2.6 billion, or 5.5% of Ohio’s total all-funds state spending.

Medicaid also covers care in residential facilities for individuals with developmental disabilities, including mental retardation (ICF/MRs). In SFY 2003, Ohio ICF/MR expenditures were $429 million.

Public demand is increasing for Community-Based Care as an alternative to facility-based care. By enrolling in waiver programs, thousands of Ohio Medicaid consumers avoid or delay institutionalization. Waivers provide an opportunity for eligible Medicaid consumers to remain in the community with supportive services—including their own homes—rather than move to an institution to receive needed care. On an average monthly basis, more than 43,000 individuals are expected to receive waiver services in SFY 2005.

Ohio has federal authority to operate a number of Home and Community-Based Services (HCBS) waiver programs. Ohio Medicaid administers the Ohio Home Care program. The Ohio Department of Aging and the Ohio Department of Mental Retardation and Developmental Disabilities administer additional waiver programs (see box on page 8, “Sister Agencies Working Together”) through interagency agreements with ODJFS. Some of the services offered through a Medicaid waiver include adult day care, nursing, home-delivered meals, transportation, adaptive/assistance devices, homemaker/personal care, supported employment services, respite care, environmental modifications, and emergency response systems.

The Ohio Home Care program offers a Core benefit package (including up to 14 hours of nursing and/or daily living services per week); the Core Plus package (more than 14 hours of nursing and/or daily living services per week); the Ohio Home Care Waiver (an alternative to nursing home or hospital care); and the Transitions Waiver (for consumers originally enrolled in the Ohio Home Care Waiver who now require services in the home or community as an alternative to care in an ICF/MR).
In addition to waivers, Ohio Medicaid offers other alternatives to institutional care. The Medicaid Hospice program provides benefits to the terminally ill; the Program for All-Inclusive Care for the Elderly (PACE) integrates acute and long-term care services across settings for frail, older adults; and Ohio Access Success assists Medicaid nursing home residents return to the community.

Medicaid Pharmacy Program

The pharmacy program is the single largest item of new Medicaid spending, even though Ohio has the 5th lowest Medicaid pharmacy cost in the nation (measured by average cost per prescription). Ohio Medicaid spending on prescribed drugs totaled $1.5 billion in SFY 2003, and it is estimated that spending on prescribed drugs in SFY 2005 will be $2 billion.

Ohio Medicaid covers over 25,000 prescription drugs from nearly 300 different therapeutic categories. Pharmacy claims are processed by a pharmacy benefit manager in an on-line, real-time environment that allows the pharmacist access to the terms of coverage. In the event a particular drug is not approved, the pharmacist can notify the prescribing physician of possible alternatives in a timely fashion. The physician may choose an alternative product or may call a toll-free number to request prior authorization for the product originally prescribed.

ODJFS maintains a preferred drug list (PDL) that was first implemented in 2003. The Ohio Medicaid PDL includes both generic and trade-name drugs that do not require prior authorization; this has resulted in substantial savings within Ohio Medicaid’s pharmacy benefit program. In addition to other cost-saving initiatives like manufacturer supplemental rebates, Ohio Medicaid has implemented pharmacy benefit strategies and best practices that ensure quality patient care and reduce pharmacy spending growth.

As the result of the state budget bill, Am. Sub. H.B. 95, Ohio Medicaid implemented a co-payment program, effective January 1, 2004. A $3 co-payment is now charged for prescription medications that require prior authorization for individuals 21 years of age and older. This program is expected to encourage the use of less costly drugs.

Sister Agencies Working Together

The federal government requires that each state designate a “single state agency” to administer its Medicaid program. ODJFS is the single state agency in Ohio. However, ODJFS has federal authority to contract with other state “sister” agencies through interagency agreements to manage aspects of the Medicaid program—provided that ODJFS maintains oversight and administrative control. Some of these agreements for specialized services include:

- Ohio Department of Mental Health manages psychiatric inpatient admissions and the community mental health program;
- Ohio Department of Alcohol & Drug Addiction Services manages community alcohol and drug addiction treatment services;
- Ohio Department of Mental Retardation and Developmental Disabilities manages state-run ICF/MRs, the Community Alternative Funding System (CAFS), and the Medicaid Individual Options and Residential Facilities waivers;
- Ohio Department of Aging administers the Medicaid PASSPORT and CHOICES waivers;
- Ohio Department of Education participates in a contract to allow reimbursement of Medicaid administrative costs to certain school districts; and
- Ohio Department of Health is developing a program that will allow reimbursement of certain administrative costs for providing health care services at the local/county level.
Financing and Expenditures

Medicaid is funded by a combination of federal, state, and local dollars allocated through a matching structure. The federal government matches state spending using a calculation called the Federal Medical Assistance Percentage (FMAP). This percentage is primarily based on a state’s average per capita income level compared to the national average income level and is determined annually. The dollars flow to the states through matching funds for expenditures on Medicaid-covered services. These funds are known as federal financial participation (FFP). 7 Every dollar of state Medicaid spending becomes $2.40 in total spending for health care in Ohio.

The Congressional Budget Office estimates that the federal government spent $161 billion on Medicaid in federal fiscal year (FFY) 2003, making the Medicaid program larger than Medicare. Even though Medicaid is the largest source of federal grant support for states and the joint financing structure allows each state opportunities to maximize state spending, Medicaid expenditures continue to strain state budgets. 8

Recently, the joint financing structure has been a point of contention between the states and the federal government. Over the years, states have freely used the mechanisms available to them under the statute to maximize federal matching funds. Increased federal scrutiny of these strategies has led to statutorily-imposed payment limits and other restrictions on program financing arrangements.

Ohio Medicaid Financing

Ohio Medicaid is funded, for the most part, through Ohio General Revenue Funds (GRF) and federal matching funds based on the Federal Medicaid Assistance Percentage (FMAP). Ohio’s FMAP for FFY 2004 is 50% for Medicaid administrative activities, 59.23% for services to Medicaid enrollees, and 71.46% for SCHIP. Of total state spending (GRF and non-GRF), Medicaid accounted for $10.8 billion, or 23.2%, of the state budget in SFY 2003. $997 million was distributed to sister state agencies to provide specialized Medicaid services (see box on page 8 for more on sister agencies).

The Jobs and Growth Tax Relief Reconciliation Act of 2003 temporarily raised the FMAP to states through June, 2004. Additionally, the legislation provided $10 billion for FFYs 2003 and 2004 that states could use for broader budgetary relief. 9 This act provided Ohio with about $365 million for the state’s Federal Fiscal Relief Fund. Of that amount, the Ohio General Assembly authorized $109 million to be transferred into the Medicaid Reserve Fund, with a significant portion of this amount used to maintain coverage for low-income parents.
Medicaid Expenditures

In 2003, Ohio Medicaid spent $5.9 billion of its budget on:

- nursing facilities ($2.6 billion),
- hospitals ($1.8 billion), and
- prescription medications ($1.5 billion).

Because Medicaid is an entitlement program, predicting and managing spending can be more challenging than it is for other state programs. Medicaid expenditures are heavily influenced by economic conditions and other factors beyond the control of administrators and legislators.

Families and children constitute the largest segment of the Ohio Medicaid population (76% of covered Ohioans) but account for only 26% of all Ohio Medicaid costs. In fact, state data suggest that a significant portion of overall Medicaid costs are associated with a relatively small number of consumers. According to data from ODJFS, in SFY 2003, 8,143 Medicaid consumers accounted for just over $1.1 billion in total Medicaid spending. Basically, 0.5% (one half of one percent) of all Medicaid consumers accounted for approximately 10.1% of total Medicaid spending.

In the coming years, revenue growth for states is likely to be nowhere near as strong as the growth states experienced in the late 1990s. State revenues grow at about 4% in a good year. The growth of Medicaid spending in Ohio continues to outpace revenue growth, and the Ohio Medicaid program expects this to be an ongoing challenge.

Medicaid Caseload/Enrollment Trends

Nationally, Medicaid enrolls over 52.4 million people, ranging from low-income women and children to the elderly and disabled. In Ohio, total Medicaid caseload, on a monthly basis, grew by 5.9% in SFY 2004. This growth is in part because of expansions in coverage, but primarily it’s due to weakness in the economy (causing people to lose their jobs or have a lower level of income).

While most of Ohio’s caseload growth was among low-income children and families, there has been a marked rise in the number of new ABD enrollees. This increase in ABD caseload is significant because medical care for this group makes up 74% of all Medicaid spending, even though they represent only 26% of the total Medicaid caseload. ABD Medicaid recipients have a much higher per member/per month (PM/PM) cost than families and children. Between fiscal years 1995 and 2003, the average monthly Medicaid spending per person increased 33% for covered

Ohio Medicaid Spending by Provider Category

Medicaid as a Portion of All Ohio State Spending (SFY 2003)

Source: Office of Ohio Health Plans, Ohio Department of Job and Family Services.
families and children and 76.5% for the aged, blind, and disabled. The ABD population not only costs more per person, but this cost is increasing much faster than the cost of the CFC population.

Trends indicate that Medicaid enrollment has slowed. Ohio’s challenge (and that of other states) is that even 3% or 4% growth is still growth—and revenues are not keeping up.

The Impact of Medicare Policy on Medicaid Spending

Federal Medicare policy creates spending obligations for the Medicaid program. In SFY 2002, Ohio Medicaid spent approximately $1.7 billion state dollars—or 46% of total spending on services—for consumers with both Medicare and Medicaid coverage. This population, referred to as “dual eligibles,” accounted for 13.1% of all Ohio Medicaid consumers for that year. Although Medicare is the primary payer for hospital stays for this population, it does not cover institutional long-term care or prescription drugs. Medicaid is the primary payer for these services. Because trends reflect shorter hospital stays and greater reliance on outpatient pharmaceutical drug therapies, costs have shifted from the federal Medicare program to the federal-state Medicaid program.

This financing structure changes significantly on January 1, 2006. As the result of the Medicare Prescription Drug Improvement and Modernization Act of 2003, Medicare Part D—not Medicaid—will offer outpatient prescription drug coverage to dual eligibles. This law requires that states continue to help pay for the prescription drug costs of people who receive Medicare and get a Medicaid card. The law also requires, for the first time, that states send money to the federal government to administer a Medicare benefit. National estimates project that prescription drug payments to the federal government for Medicaid consumers in all states will increase from $6 billion in FY 2006 to $15 billion in FY 2013.

Additionally, federal Medicare Part B premium increases pass directly to Ohio Medicaid. The premium increase for federal fiscal year 2005 of 17.5% ($11.60 per month) will cost Ohio approximately $10.2 million in state funds. This projection is based on an estimate of 219,000 dual eligible consumers.
Controlling Medicaid Expenditures

States have increasingly focused on Medicaid as a key component of their efforts to balance their budgets. Every state and the District of Columbia began FY 2004 with new plans to reduce their Medicaid spending growth. A survey of state Medicaid officials conducted by Health Management Associates in December, 2003, identified states’ cost containment initiatives that have taken place since the beginning of FY 2004. These initiatives, as well as Ohio’s efforts, include the following:

Provider Rate Reductions or Freezes

A number of states have reduced provider rates or reduced plan rate increases to make payments to providers lower than they would have been otherwise. Rate reductions affected providers of all types, including those that provide behavioral health, managed care, hospital, transportation, and personal care services. Ohio limited rate increases to long-term care facilities and general hospitals.

Prescription Drugs

For prescription drugs, states are requiring prior authorization for more drug classes, imposing limits on number of prescriptions per month, implementing or expanding preferred drug lists, contracting with pharmacy benefit managers, initiating supplemental rebates from manufacturers, and implementing long-term care pharmacy initiatives. Ohio efforts include revising the preferred drug list, as well as negotiating supplemental rebate contracts.

Co-payments

Several states implemented new or higher beneficiary co-payments. Services targeted for co-payments include emergency room visits, prescription drugs, inpatient hospital care, durable medical equipment, and optometry. Ohio implemented co-payments of up to $3 for non-pregnant adults on all prescriptions requiring prior authorization.

Benefit Limits or Eliminations

Several states reduced or eliminated benefits, including dental, vision, orthotics, in-home therapies, dialysis, transportation, and behavioral health services. Ohio eliminated independent psychology and chiropractic services for adults.

Managed Care and Disease Management

Some states are expanding managed care arrangements. Actions have included increasing the number of mandatory enrollees in risk-based managed care and implementing new programs that emphasize care management or disease management programs that target specific chronic conditions like diabetes, asthma, or hypertension. Ohio introduced the Enhanced Care Management (ECM) Initiative to help manage the chronic conditions of ABD consumers.
Long-Term Care

States are increasingly looking to strategies that relocate nursing home residents into community settings. Some states are placing caps on services offered by waiver programs. Ohio redesigned its Ohio Home Care Program into separate waivers and implemented Ohio Access Success—a program that assists Medicaid nursing home residents return to the community.

Eligibility Cuts

In Fiscal Year 2004, 18 states reported implementing eligibility restrictions. Ohio is one of the states that has not implemented cuts to Medicaid program eligibility.

Other Strategies

Some states have focused on increasing fraud and abuse control for providers and recipients. Other strategies include identification and coordination of insurance benefits of noncustodial parents and implementing volume purchasing for hearing aids and batteries. Ohio increased its capacity to coordinate benefits and identify fraud. Additionally, Ohio implemented a decision support system (DSS) to enhances the state’s ability to measure provider performance, identify fraud and abuse, and benchmark quality and cost indicators.

The Impact of Cost Containment

Cost containment strategies like the ones mentioned above can be very complex. Often, a policy change that appears reasonable can produce an unintended consequence that undermines the intent of the Medicaid program or that causes increased spending on other Medicaid services. Reducing or freezing provider rates can have a serious impact on access to services and could cause increases in emergency room use or hospitalizations.

For example, a cost containment proposal to eliminate dental services for adults might result in significant negative health and economic consequences for individuals and communities, such as increased and costly use of emergency rooms (for pain, abscesses, and other dental problems), hospitalization for severe infection, increased risk of addiction to pain medications, and prolonged absence from work.

Ohio policymakers have these and other difficult issues to consider as they work to sustain Ohio Medicaid, a program important for the health of the state. Ultimately, many believe that significant federal changes are also necessary for the long-term health of the Medicaid program.

Value Purchasing and Quality

State Medicaid programs, including Ohio’s, are striving to become value purchasers. This means they adopt purchasing strategies that reduce or slow costs while maintaining or improving access and quality. The goal of these efforts is to get more health for the health care dollar. Ohio Medicaid pursues a variety of quality initiatives as part of its value purchasing efforts. Among these efforts are:

- Collecting and analyzing data to ensure that consumers have access to a regular source of primary care in its fee-for-service and managed care systems;
- Conducting quality studies that evaluate programs and services, such as reviewing the number, type, and reasons for unused medications in nursing facilities;
- Investing in information technology tools that will increase Ohio Medicaid’s ability to measure health outcomes and provider performance.

Medicaid’s Role in the Economy

By 2011, health care spending is projected to constitute 17% of the Gross Domestic Product (GDP). Medicaid makes up a significant portion of the total national spending on major health concerns.

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<thead>
<tr>
<th>Service</th>
<th>Total national spending in 2001 (billions)</th>
<th>Portion paid by Medicaid</th>
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<tbody>
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<td>Professional services</td>
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<tr>
<td>Hospital care</td>
<td>$451</td>
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<tr>
<td>Prescription drugs</td>
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<tr>
<td>Nursing home care</td>
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<td>48%</td>
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Ohio Commission to Reform Medicaid

Am. Sub. H.B. 95 of the 125th General Assembly mandated the formation of the Ohio Commission to Reform Medicaid. The commission was created to undertake a complete review of Ohio's Medicaid program and make recommendations regarding fundamental structural reform and cost containment. Members with national and state reputations were appointed by the Governor, President of the Senate, and Speaker of the House and charged with producing a report of its findings and recommendations. Extensive testimony from a wide array of stakeholders was heard before the commission and its subcommittees from late 2003 through 2004.

In December 2004, the commission released a draft set of recommendations that identified both “early impact” and “later impact” strategies to restrain spending and set the stage for long-term structural change in Medicaid. Information concerning the commission, including initial recommendations, is available online at http://www.ohiomedicalreform.com.

Ohio Nursing Facility Reimbursement Study Council

Am. Sub. H.B. 95 of the 125th General Assembly required the Ohio Nursing Facility Reimbursement Study Council to recommend changes to how nursing facilities are paid by the Ohio Medicaid Program. The council is comprised of Ohio stakeholders who include representatives of the nursing home associations, state policymakers and regulators, consumers, the Governor’s Office, and the General Assembly. Although the council issued its report in June 2004, significant issues remained on the table for discussion, including certificate of need, quality issues, transition, and capital reimbursement.

Why Changing Medicaid Isn’t Easy

Ohio Medicaid is not a single program, but rather a collection of programs, services, and funding mechanisms that is part of the increasingly complex health and human services system. In many cases, an adjustment to one element of this system will have unintended effects or consequences on other elements. For example, every dollar of Medicaid spending for services is a dollar of income for a provider, so cutting spending or services will lower income for these providers.

Therefore, policymakers, state administrators, and others use a systems approach when considering changes to Medicaid. Economic effects are especially considered, as Medicaid brings new funding to the state through federal matching dollars. This match means that for each dollar of reduction in Ohio’s Medicaid spending, the state’s health care system loses $2.40.

Ohio Medicaid has an obvious impact on the lives of the low-income individuals, children, and families it serves. Connections between Ohio Medicaid and other important issues, however, are not always as clear.

For example, Ohio Medicaid:

• helps maintain a healthy work force;
• helps reduce personal bankruptcies (the number one reason for bankruptcy is unpaid medical debt);
• helps kids stay healthy and succeed in school;
• supports welfare-to-work efforts; and
• supports nearly all state-funded health and human service-related agencies—including university medical schools, mental health agencies, and health departments.

Medicaid also supports the state’s entire health care infrastructure by helping to:

• reduce uncompensated care;
• promote earlier treatment in appropriate settings and reduce preventable hospitalizations;
• decrease unnecessary emergency room use; and
• support education and training in academic medical centers.

Without the Medicaid program, these infrastructure costs would be passed on to employers and their employees through higher insurance premiums. In addition, individuals, families, and society as a whole would bear the human costs of untreated illnesses.

Ohio Medicaid is an important and complex system that touches the lives of individuals and families across the state. Understanding the basics of this system is an important step toward improving the health of millions of Ohioans.
Online Resources

- Agency for Healthcare Research and Quality — www.ahrq.gov
- American Legislative Exchange Council — www.alec.org
- The Buckeye Institute — www.buckeyeinstitute.org
- Center for Health Care Strategies — www.chcs.org
- Center on Budget and Policy Priorities — www.cbpp.org
- Centers for Medicare and Medicaid Services (CMS) — www.cms.gov
- The Commonwealth Fund — www.cmwf.org
- Families USA — www.familiesusa.org
- Health Affairs — www.healthaffairs.org
- Heritage Foundation — www.heritage.org
- The Kaiser Commission on Medicaid and the Uninsured — www.kff.org/kcmu
- National Academy for State Health Policy — www.nashp.org
- National Association of State Medicaid Directors — www.nasmd.org
- National Conference of State Legislatures — www.ncsl.org
- National Governors Association — www.nga.org
- Ohio Commission to Reform Medicaid — www.ohiomedicaidreform.com
- Ohio Department of Job and Family Services — www.jfs.ohio.gov/ohp
- The Urban Institute — www.urban.org

Endnotes

Except for notations below, all program information and statistics in Ohio Medicaid Basics were provided by the Ohio Department of Job and Family Services through their publications, presentations, website, or staff interviews.

4 Ohio Access, Governor Taft’s Strategic Plan to Improve Long-Term Services and Supports for People with Disabilities (an update to the original February 2001 report). February, 2004.
14 See note 11 above.
16 Centers for Medicare and Medicaid Services, Program Information on Medicare, Medicaid, SCHIP, and Other Programs. Office of Research, Development, and Information, June, 2002.
An Ohio Parent’s View of Medicaid

The security of knowing that the kids can get what they need is so valuable to us. I’m not afraid that the next trip to the doctor or a kid falling off a bike will wipe us out financially.

And if one of the kids is running a fever, we don’t have to “play Russian roulette” wondering if it’s bad enough to call the doctor and spend $100, or should we wait, hoping it will get better on its own.

We really struggle with that, and hope we don’t make the wrong decision. I’m grateful for this program, and we don’t take advantage of it by making unnecessary trips to the doctor.

— Statement of John Reed of Salem, Ohio; taken from the Kaiser Commission on Medicaid and the Uninsured and Alliance for Health Reform briefing “Medicaid Coverage for All Children Living in Poverty,” September 30, 2002.

For More Information About Medicaid, Ohio Medicaid Basics, and the Health Policy Institute of Ohio

Ohio Medicaid Basics provides a brief overview of the Ohio Medicaid program. For more information about the federal Medicaid program, including federal eligibility requirements, benefits, financing, and administration, please refer to The Medicaid Resource Book, a publication of the Kaiser Commission on Medicaid and the Uninsured and available at www.kff.org or by calling 800.656.4533. For more information about Ohio Medicaid, please visit the website of the Office of Ohio Health Plans of the Ohio Department of Job and Family Services at www.jfs.ohio.gov.

Ohio Medicaid Basics is a project of Health Policy Institute of Ohio. The Institute is an independent, nonpartisan organization that forecasts health trends, analyzes key health issues, and communicates current research to Ohio policymakers, legislators, and other decision makers.

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