Ohio Medicaid provides a broad range of health services each year to 2.2 million low-income working families, children, seniors, and people with disabilities.

Introduction

Medicaid is Ohio’s largest health and long-term care program. It combines state and federal funds to purchase health care coverage for low-income and medically vulnerable citizens. In reality, Medicaid is not one program but many:

- An insurance program for children, parents, pregnant women, elders, and people with disabilities who meet certain low-income requirements;
- A program of chronic and long-term care for people with disabilities, including people with mental illness, and low-income elderly;
- A supplement to Medicare for low-income elderly and people with disabilities; and
- A source of funding for uncompensated care in hospitals.

2006 Ohio Medicaid Enrollees and Spending

State Fiscal Year (SFY) 2006

<table>
<thead>
<tr>
<th>Group</th>
<th>Federal Share (60%)</th>
<th>Ohio’s Share (40%)</th>
<th>Elderly and Disabled Expenditures (71.5%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elderly and Disabled Enrollees (24%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children and Parent Expenditures (28.5%)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Ohio Department of Job and Family Services. Enrollment based on SFY 2006 average monthly enrollment; incurred expenditures for SFY 2006 claims paid through September 2006; does not include DSH payments, hospital UPL, or Medicare Part A, B or D.
Overview of Medicaid

Congress created Medicaid in 1965 as Title XIX of the Social Security Act. Each state administers its own Medicaid program. The federal Centers for Medicare and Medicaid Services (CMS) monitor state-run programs and establish requirements for service delivery, quality, funding, and eligibility standards. Medicaid is voluntary for states but every state participates. Ohio Medicaid began in 1968.

In Ohio, Medicaid is administered by the Ohio Department of Job and Family Services (ODJFS) through six state agencies, 88 county departments of job and family services, 88 county boards of mental retardation and developmental disabilities (MR/DD), 56 behavioral health boards, eight managed care organizations, and 46,800 health care providers. Medicaid accounts for 3.0% of Ohio’s economy and 26.8% of total state government spending. Ohio spends more on Medicaid ($13.3 billion in 2006) than any other program, including primary, secondary and higher education combined ($12.2 billion).

Medicaid is not only Ohio’s largest governmental program, it is growing faster than most other state programs. As a result, Medicaid policy receives considerable attention when the Governor and Ohio General Assembly put together the State’s two-year operating budget. The next two budgets are due in June 2007 and June 2009.

Eligibility and Benefit Packages

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

For each eligibility group there are numerous ways to establish eligibility within specific income and resource requirements, which are determined by the state within federal guidelines. Once an individual is determined eligible for Medicaid, he or she is “entitled” to coverage for the services that are available to everyone in his or her eligibility group.

Since 1996, Medicaid eligibility has been separate from eligibility for welfare cash assistance. Twenty years ago, most persons on Medicaid—well over three-fourths—received welfare.

Percentage of Children Ages 0-4 Receiving Medicaid, By County of Residence

Source: Ohio Department of Job and Family Services.
Today, the reverse is true. Now, the vast majority of all persons enrolled in Medicaid (90%) are not receiving any welfare cash assistance.

Ohio Medicaid covered 2.2 million Ohioans in 2006 (total annual non-duplicated enrollment). However, because people enter and exit the program throughout the year, Medicaid covered 1.7 million Ohioans on average each month. Some low-income areas of the state depend on Medicaid more than others. In Ohio’s urban centers, 20-30% of the population is covered by Medicaid. Along the Ohio River, there are ten counties where more than 30% of the population is covered by Medicaid—and 21 counties where Medicaid covers more than 65% of all children under age five.

**Children and Parents**

Children up to age 19, parents, and pregnant women can qualify for Medicaid based on low family income. In 2006, Ohio Medicaid covered 941,000 children, 348,000 parents, and 23,000 pregnant women on average each month. Ohio Medicaid calls this eligibility group “covered families and children” (CFC). More than half of all Medicaid-eligible Ohioans (54%) are non-disabled children.

Most Medicaid-eligible children and parents are healthy and need access to the same primary and acute health care services as the general population (doctor visits, hospital care, prescription drugs, vision services, etc.). Children and parents are significantly less expensive than Medicaid-eligible seniors and people with disabilities who have more complex health care needs. Children and families make up 75.8% of the Ohio Medicaid population but consume only 28.5% of Medicaid spending.

**Healthy Start and Healthy Families**

Ohio Medicaid’s health coverage for children and pregnant women is called Healthy Start. Children and pregnant women in families with income at or below 150% of poverty are eligible for Healthy Start regardless of whether or not they have other health insurance (Medicaid is the payer of last resort). Pregnant women are eligible for coverage during their pregnancy, including 60 days postpartum, and their newborns are eligible for Medicaid for one year regardless of family income. Children in families with income between 151-200% of poverty are eligible for Healthy Start but only if they have no other health coverage.

If a child’s parent is also eligible for Medicaid, then the child is enrolled with the parent in Healthy Families. Healthy Families provides health coverage for families with at least one child age 19 or younger and income up to 90% of poverty. Ohio’s income test for parents was revised downward in 2006 from 100% of poverty, where it had been since 1999 (in other states, the income tests for parents range from 12% to 277% of poverty).  

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**Eligibility Determination**

County Departments of Job and Family Services (CDJFS) process Medicaid applications. Seniors and people with disabilities who want to apply for Medicaid should contact their local office (go to www.jfs.ohio.gov/county/ctydir.htm or call 1-800-324-8680 or TDD 1-800-292-3572 to find a local office). Families applying for Healthy Start or Healthy Families can take the following steps to apply:

1. Fill out an application form, which is available at your local CDJFS office or on-line: www.odjfs.state.oh.us/forms/file.asp?id=46422.
2. Provide your Social Security number or proof that an application for a Social Security number has been submitted.
3. Attach proof of income from work or wages, proof of pregnancy (if that applies), proof of U.S. citizenship, and information about other medical coverage (if any).
4. Mail the application to your local CDJFS office.
5. Call 1-800-324-8680 or TDD 1-800-292-3572 if you have any questions.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

EPSDT (called HEALTHCHEK in Ohio) is the core benefit package for children in Healthy Start and Healthy Families, and for children with a disability. EPSDT is designed to discover and treat health problems early and provide comprehensive, medically necessary treatment services. It covers eight comprehensive check-ups in the first two years of life and annual check-ups thereafter. If a potential health problem is found, further diagnosis and all medically necessary treatment is covered (even if those services are not covered for adults). A HEALTHCHEK coordinator is available in each county department of job and family services to assist Medicaid consumers in getting these services.

### Ohio Medicaid Income Eligibility

<table>
<thead>
<tr>
<th>Covered Populations</th>
<th>Income Guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children up to age 19</td>
<td>≤ 200% Federal Poverty Level (FPL)</td>
</tr>
<tr>
<td>Parents</td>
<td>≤ 90% FPL</td>
</tr>
<tr>
<td>Pregnant women</td>
<td>≤ 150% FPL</td>
</tr>
<tr>
<td>Ohioans with disabilities</td>
<td>≤ 64% FPL</td>
</tr>
<tr>
<td>Ohioans age 65 and over</td>
<td>≤ 64% FPL</td>
</tr>
<tr>
<td>Institutional level of care</td>
<td>Income less than the cost of care</td>
</tr>
</tbody>
</table>

Source: Ohio Department of Job and Family Services; some eligibility categories consider resources other than income; for seniors and people with disabilities, deductions and exceptions may apply.

### Seniors and People with Disabilities

Adults 65 and older and people of any age, including children, with a major disabling condition can qualify for Medicaid if they meet certain financial requirements. In 2006, Ohio Medicaid covered 136,000 seniors, 249,000 adults with disabilities, and 33,000 children with disabilities (these children are not counted in the “covered families and children” category). Ohio Medicaid calls this eligibility group “aged, blind, or disabled” (ABD). ABD enrollees have more complex health care needs than non-disabled children and parents—they represent 24.2% of Medicaid enrollment but consume 71.5% of total Medicaid spending.

Most states use Supplemental Security Income (SSI) to automatically qualify people for Medicaid, but Ohio has more restrictive income requirements. An individual’s income, cash, bank accounts, stocks, and other assets are all considered to determine Medicaid ABD eligibility (there are different standards for different services). Also, the applicant must meet transfer of resources provisions that are in place to prevent a person from impoverishing himself by giving away money so he can qualify for Medicaid. Those who have too much income to qualify may become eligible on a month-to-month basis through a Medicaid “spenddown,” where proof of certain medical expenses may reduce income until it falls within the financial guidelines for Medicaid eligibility.

People who qualify for ABD Medicaid are covered for primary and acute care services—the same comprehensive benefit package that is available to children and parents. In addition, seniors and people with disabilities who have a certain “level of care”
need can qualify for Medicaid long-term care services. Long-term care services include a broad range of medical, personal care, and supportive services that are provided in home, community, and institutional settings. Medicare does not cover the costs of long-term care, and very few Ohioans have long-term care insurance.

**Facility-Based Long-Term Care Services**

Facility-based long-term care includes services provided in nursing facilities, intermediate care facilities for the mentally retarded (ICF-MR), and state-run developmental centers for the mentally retarded. In 2006, on average each month Ohio Medicaid covered 57,500 residents in nursing facilities, 6,000 residents in ICFs-MR, and 1,500 residents in MR/DD developmental centers. Residents in these facilities consumed 29% of the total Medicaid budget in 2006.

**Home and Community-Based Long-Term Care Services**

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

**Reviews and Assessments for Long-Term Care Services**

People seeking long-term care services may receive both pre-admission counseling and screening to determine the need for services and to receive information on alternatives. Ohio’s Area Agencies on Aging provide the initial determinations of need and information about options to prevent unnecessary or inappropriate institutionalization. There are several processes to determine appropriate placements.

The Pre-Admission Screening and Resident Review (PASRR) is provided for everyone seeking treatment for over 30 days in a Medicaid Certified Nursing Facility. PASRR is a federally mandated screening process to prevent people with mental illness and/or mental retardation from being inappropriately admitted to a nursing facility.

Level of care determinations are done for persons seeking Medicaid payment for institutional care or enrollment on a Medicaid Home and Community Based Services (HCBS) waiver. Medicaid uses level of care standards to assure medical necessity for long-term care services. Level of care determinations are based on whether an individual:

- Needs assistance in performing activities of daily life (eating, bathing, etc.);
- Requires supervision for some extended period of time;
- Requires hands-on administration of prescription medication;
- Requires nursing or other skilled medical care.

It is also during this process that individuals seeking Medicaid coverage for their institutional care or enrollment on an HCBS waiver complete a Medicaid application and submit it to their county department of job and family services.
employment, respite care, and emergency response systems.

Historically, long-term care services were delivered in institutional settings. Nursing facility coverage is a mandatory benefit and, given the high cost of facility-based care, it is generally easier to meet Medicaid financial eligibility standards when seeking institutional care than in a community setting. With the growth in consumer demand for home-based services and the passage of the Americans with Disabilities Act, states have increasingly asked the federal government to “waive” federal requirements to allow more long-term care service options in the community.

Ohio Medicaid administers waiver programs that serve more than 58,000 individuals on average each month, including 33,000 seniors age 60 and older, 7,700 children and adults up to age 60, and 17,400 people with mental retardation or a developmental disability. All of these waiver recipients have a level of care that qualifies them for Medicaid long-term care in an institution and many of them, without access to waiver services, would have no choice but to enter an institution.

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

### The Difference Between Medicaid and Medicare

<table>
<thead>
<tr>
<th>Medicaid</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aid for some poor Ohioans</td>
<td>Care for nearly all Ohio seniors</td>
</tr>
<tr>
<td>Must have low income</td>
<td>No income limit</td>
</tr>
<tr>
<td>Children, parents, disabled, and age 65+</td>
<td>Age 65+ and some people with disabilities</td>
</tr>
<tr>
<td>Primary, acute and long-term care</td>
<td>Primary and acute care only</td>
</tr>
<tr>
<td>State and Federal funding</td>
<td>Federal funding</td>
</tr>
<tr>
<td>No payroll deduction</td>
<td>Payroll deduction</td>
</tr>
</tbody>
</table>

### Medicare and Medicaid “Dual Eligibles”

Congress created Medicare in 1965 to cover the medical needs of seniors and expanded the program later to cover some people with disabilities. However, Medicare’s coverage is limited and Medicaid picks up most of the cost for nursing homes, home and community-based long-term care, and other medical services for low-income people on Medicare. In addition, Medicaid is required to cover the cost of Medicare premiums, coinsurance, and deductibles for low-income seniors, and a share of the cost of Part D pharmacy coverage. Dual eligibles represent a small portion of the Ohio Medicaid population (10%) but consume nearly half (44%) of total Medicaid spending.
Mandatory and Optional Benefits

Ohio’s Medicaid program includes services mandated by the federal government plus optional services the State chooses to provide. Ohio has discretion to vary the services it covers but, in all cases, the service must be “sufficient in amount, duration, and scope to reasonably achieve its purpose.” Some services are limited by dollar amount, the number of visits per year, or the setting in which they can be provided, and some services now require the consumer to share in the cost.

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

Federally Mandated Services

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

Ohio’s Optional Services

- Prescription drugs
- Vision, including eyeglasses
- Dental
- Physical therapy
- Occupational therapy
- Speech therapy
- Podiatry
- Ambulance/ambulette
- Community alcohol and drug addiction treatment
- Home and community based alternatives to facility-based care
- Intermediate care facilities for people with mental retardation
- Hospice
- Community mental health services

Medicaid Part D Prescription Drugs

As of January 1, 2006, federal law requires Medicaid consumers who also have Medicare to receive prescription drug coverage through a Medicare prescription drug plan (PDP), not Medicaid. These consumers can enroll in a PDP themselves or, if they do not enroll, a PDP is selected for them by Medicare (they can change plans at any time). All consumers who were dually eligible for Medicare and Medicaid at least one month between July 2006 and December 2006 are automatically eligible for Medicare prescription drug coverage. They also qualify for extra financial help, including zero premiums, zero deductibles, and smaller co-payments. For more information or assistance selecting a PDP, contact the Ohio Senior Health Insurance Information Program at 1-800-686-1578 or 1-800-MEDICARE.
Administration

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

Single State Agency

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

As the single state agency, ODJFS must retain oversight and administrative control of the Ohio Medicaid program and may not “delegate authority to issue final policies, rules, and regulations.” However, federal law does give ODJFS authority to contract with other public and private entities to manage aspects of the program. For example, county departments of job and family services administer the Medicaid eligibility process, and Area Agencies on Aging conduct level of care assessments.

Other State Agencies

ODJFS contracts with five state agencies to administer Medicaid programs. Medicaid

Federal Requirements for Medicaid Services

- Statewideness—states cannot limit health care services available under the state plan to a specific geographic location or fail to provide a covered service in a particular area, with exceptions for home and community-based waiver services.
- Reasonable promptness—states must furnish Medicaid promptly to recipients without delay caused by the agency’s administrative procedures.
- Any willing provider—states may not restrict Medicaid beneficiaries’ access to qualified providers, with exceptions under managed care.
- Equal access to care—states must set payment rates that are adequate to assure Medicaid clients reasonable access to services of adequate quality.
- Comparability of services—states must ensure that the medical assistance available to any eligible individual is not less in amount, duration, or scope than what’s available to any other individual.
- Reasonableness standard—states cannot exclude medically necessary services from coverage when this exclusion would result in a denial of all treatment for a particular medical condition.

Note: New authority granted by the Deficit Reduction Act of 2005 allows states to offer alternative benefit packages and impose new cost-sharing requirements on certain non-disabled, non-elderly populations. For these non-exempt groups, states are no longer tied to the statewideness and comparability rules. For more on the Deficit Reduction Act, see page 18.
represents a large and growing share of budgets in the Ohio Departments of Alcohol and Drug Addiction Services (42%), Mental Health (46%), Aging (79%), and Mental Retardation and Developmental Disabilities (84%). The Ohio Department of Health certifies long-term care and hospital providers—ODH certification is required for a provider to receive reimbursement from Medicaid.

The Medicaid budget in Ohio is typically reported as ODJFS only, which understates Medicaid’s statewide impact. ODJFS-only Medicaid spending on health services accounts for 21% of the State’s budget, but total Medicaid spending (all funds across all agencies) is actually 27% of Ohio’s budget.

Financing

Medicaid is jointly financed by federal and state governments. The federal government “matches” Ohio’s spending on Medicaid-covered services using a calculation called the Federal Medical Assistance Percentage (FMAP). The federal government calculates Ohio’s FMAP annually based on a three-year average of per capita personal income compared to the national average.

### 2007 Federal Medicaid Matching Rates for Ohio Medicaid

- Medical services for most enrollees: 59.66%
- Enhanced match for uninsured children in families with income greater than 133% of poverty: 71.76%
- Family planning services: 90%
- Medicaid Administration: 50%
- New information technology systems: 75% to 90%


![2006 Ohio Health and Human Services Department Budgets](image-url)
Ohio’s current (federal fiscal year 2007) FMAP is 59.66%, which means the federal government will reimburse the state 59.66 cents for every dollar it spends on most Medicaid-covered services (Ohio is responsible for 40.34 cents). Or said another way, every dollar that the State of Ohio spends on Medicaid generates nearly $2.50 in total spending for health care in Ohio. Nationally, FMAP rates range from 50% to 76%.

Ohio’s FMAP is expected to increase to 60.79% in federal fiscal year 2008 because the State’s per capita income is lagging the national average. The increased rate would result in Ohio picking up an estimated $213 million in additional federal Medicaid revenue during the 2008-2009 budget.

**Ohio Medicaid Funding**

Ohio Medicaid is funded from several sources, including federal funds, state-generated general revenue funds (GRF), local levy dollars, pharmacy rebates, and health care provider taxes. State GRF is generated primarily from income and sales tax revenue. Health care provider taxes (called franchise fees) are assessed on hospitals, nursing facilities, and managed care organizations to cover some of the state share of Medicaid.

More than most states, Ohio depends on county-generated funds to cover some of the State’s share of Medicaid spending, particularly for community-based services. Local levies are approved by county voters to provide health

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**2006 Ohio Medicaid Spending by Category**

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals</td>
<td>26.3¢</td>
</tr>
<tr>
<td>Nursing Facilities</td>
<td>19.6¢</td>
</tr>
<tr>
<td>ICF-MR</td>
<td>5.5¢</td>
</tr>
<tr>
<td>Prescribed Drugs</td>
<td>14.2¢</td>
</tr>
<tr>
<td>HCBS Waivers</td>
<td>9.1¢</td>
</tr>
<tr>
<td>Plan Admin.</td>
<td>3.1¢</td>
</tr>
<tr>
<td>All Other</td>
<td>14.7¢</td>
</tr>
</tbody>
</table>

Source: Ohio Dept. of Job and Family Services; SFY 2006 actual expenditures claims paid through September 2006; managed care spending is divided by category of service. Note: Managed care spending estimates are divided by category of service and based on SFY 2006 capitation payments and managed care cost reports from SFY 2005; “Hospitals” includes Disproportionate Share Hospital (DSH) payments and hospital Upper Payment Limit (UPL); “Prescribed Drugs” includes Medicare Part D state share; “Plan Administration” includes ODJFS, county administration, contracts, and other state agencies; “All other” includes managed care administration (0.8% of total) dental, hospice, home health therapies, durable medical equipment, and Medicare premium assistance.
and human services (including Medicaid match) for specific populations, including people with mental illness, drug addiction, mental retardation, or a developmental disability.

**Ohio Medicaid Spending**

1982 was the first year that Ohio Medicaid spent more than $1 billion. Now it spends more than $1 billion every month. In SFY 2006, Ohio Medicaid spent $13.3 billion. Two-thirds of that amount was spent on hospitals ($3.5 billion), long-term care facilities ($3.3 billion), and prescribed drugs ($1.9 billion). In addition to provider categories, there are other ways to “slice” the Medicaid budget, including:

- Eligibility group—children and parents (28.5% of total Medicaid spending) and seniors and people with disabilities (71.5%);
- Medicare eligibility—Medicare and Medicaid “dual eligibles” (44%) and people eligible for Medicaid but not Medicare (56%);
- Delivery system (after the managed care expansion is fully implemented)—managed care (40%) and fee-for-service (60%); and
- Ohio Department—ODJFS (88%) and all other state departments (12%).

**Ohio Medicaid Cost Drivers**

Medicaid spending is influenced by economic conditions and other factors, many of which are beyond the control of legislators and public administrators. Ohio Medicaid cost drivers include:

- Hospital Care Assurance Program

The Ohio Hospital Care Assurance Program (HCAP) provides payments for hospitals that provide care for people who do not have insurance and cannot pay. These payments are in addition to the regular payments these hospitals receive for providing inpatient care to Medicaid beneficiaries. To receive HCAP funds, Ohio law requires hospitals to provide basic, medically necessary hospital services free of charge to anyone whose income is at or below 100% of poverty. Funding for HCAP comes from an assessment on all Ohio hospitals plus federal matching funds from the federal disproportionate share hospital (DSH) program. In federal fiscal year 2006, the HCAP program collected $219.2 million from all Ohio hospitals, matched it with federal dollars, and redistributed $545.6 million back to hospitals based on Medicaid shortfalls and uncompensated care costs.
drivers include increasing enrollment, price increases in medical and long-term care services, and increased utilization of services by enrollees. A small group of very high-cost individuals are driving much of the growth in the Ohio Medicaid program.

**Enrollment**

Medicaid eligibility is based on income, so changes in the economy have a direct impact on caseload, particularly for children and parents. During the most recent economic downturn (2000 to 2006), Ohio’s Medicaid enrollment increased 56%. Medicaid fully offset recent declines in employer-sponsored insurance for children. The uninsured rate for Ohio children actually declined from 9.8% in 1998 to 5.4% in 2004, due in large part to a Medicaid eligibility expansion for children in 2000.10

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

**Price**

Medicaid spending is tied to the medical market, where annual cost growth has far exceeded

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**How Much of the State Budget Does Medicaid Consume?**

Depending on how funds are counted, the answer to this question can vary. Because Ohio counts the federal match on Medicaid spending as part of the General Revenue Fund—something not done with any other federal funds (and something that other states do not do)—a simple calculation done on the basis of total GRF shows Medicaid as 38% of the total.11 However, if federal Medicaid funds are excluded, the total amount of state-generated GRF devoted to Medicaid spending is about 20%.12

The other way to calculate this proportion is to consider all Medicaid spending from all funding sources as a portion of all state spending. When considering all federal and state dollars across all Ohio agencies, Medicaid accounted for $13.3 billion (27%) of the total state spending in state fiscal year 2006. Sometimes this calculation is reported as ODJFS-only Medicaid spending for health services ($10.5 billion in 2006 or 21% of total state spending), and this results in an understatement of the total impact of Medicaid statewide.
growth in wages and general price inflation. State revenues are tied to tax bases that reflect growth rates for income and sales, which have lagged significantly behind the growth in medical costs. All signs suggest this trend will continue and Medicaid will continue to consume a greater share of the Ohio budget and crowd out other spending priorities.

Utilization

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

High-Cost Individuals

A small proportion of Medicaid beneficiaries (5%) account for half of total Medicaid spending, while most beneficiaries (50%) have few or no health care expenses (less than 5% of total). Compared to the commercially insured population, Medicaid enrollees are more likely to have several high-cost conditions, including asthma, bipolar disorder, congestive heart failure, chronic obstructive pulmonary disease, and diabetes.

Many of Medicaid’s most expensive beneficiaries are also enrolled in Medicare, but Medicare doesn’t pay for all the health care services they need, like long-term care. Only 10% of the Medicaid population is also eligible for Medicare, but they account for (44%) of total Medicaid spending. Trends in caseload, price, and utilization indicate that Medicaid’s highest-cost beneficiaries, particularly the dual eligibles, will continue to be the primary drivers of Medicaid cost increases.

Trend

All forecasts are for continued growth in Medicaid enrollment and costs. The federal budget projection is for Medicaid spending to increase about 8.4% every year for the next decade. Most of the growth is accounted for by projected increases in enrollment, medical prices, and greater use of services by seniors and people with disabilities. Spending and enrollment for children and parents, which are driven more by economic factors than demographics, are projected to be relatively flat over the next decade.

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**Ohio Medicaid Per Member Per Month Spending Trends**

*This decrease in 2006 reflects pharmacy coverage moving to Medicare for dual eligibles.*
Reform

Ohio lawmakers enacted a broad package of Medicaid reforms in June 2005. At the time, the Ohio Medicaid program was growing twice as fast as State revenues and crowding out other spending priorities. In response, lawmakers enacted multiple policy changes to slow Medicaid program growth immediately and over time. As a result, total Ohio Medicaid spending increased 2.7% from 2005 to 2006—the lowest rate of growth in a decade.

Contain Costs

Ohio Medicaid would have spent $700 million more in 2006 if lawmakers had not increased provider taxes to offset state-generated general revenue funds (GRF) and enacted significant cost containment measures. The legislature increased the franchise fee for nursing facilities (offsetting $80.9 million GRF in 2006) and created a new franchise fee for Medicaid managed care organizations (offsetting $8.9 million in GRF in 2006). In addition, the legislature enacted the following cost containment measures (2006 savings are shown in parentheses):

- Hold provider rates flat for nursing facilities ($438.6 million), ICFs-MR ($37.4 million), and hospital inpatient services ($20.8 million);

- Cap Medicaid payments for Medicare wrap-around services for nursing facilities ($28.3 million) and hospital inpatient ($22.5 million);

- Reform home and community-based waiver services to reduce costs ($8.2 million);

- Reduce adult dental benefits ($18.3 million), reduce parent eligibility from 100% to 90% of poverty ($8.4 million), and require some copayments ($3.9 million);

- Restrict the price paid for trade-name drugs ($15.5 million), allow pharmacy tablet splitting ($9.9 million), and create a supplemental rebate program for behavioral health drugs (savings come after 2006).

Most (71%) of the cost savings achieved in 2006 resulted from provider rate freezes, which are difficult to sustain over time. So, in addition to short-term cost containment, lawmakers also expanded managed care and enacted long-term care reforms to control Medicaid spending growth over time.
Expand Managed Care

Ohio’s Medicaid managed care program was created in 1978 and continues today as a strategy to ensure access to services, provide quality care, and manage Medicaid costs. The 2006-2007 budget more than doubled the size of Ohio’s program, from 529,000 enrollees in 15 counties in June 2005 to an estimated 1.3 million enrollees in all 88 counties by July 2007. Medicaid managed care enrollees are expected to have a choice of three health plans in every county. The number of Medicaid managed care organizations in Ohio is expected to increase from six in June 2005 to eight in July 2007.

As a result of the managed care expansion, almost all Medicaid-eligible children and parents—an estimated 1.2 million people every month—will receive Medicaid services through a managed care organization. In addition, some seniors and people with disabilities—an estimated 126,000 people every month—will be enrolled in managed care. Most Medicaid-eligible seniors and people with disabilities (72%) are excluded from the managed care expansion and will continue to receive Medicaid services through the fee-for-service program, including children under age 21 with disabilities, residents of institutions, recipients of Medicaid waiver services, and persons eligible for Medicaid spenddown or Medicare.

Medicaid Managed Care Organizations

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

- Case management and disease management
- 24-hour hotline for medical advice and direction
- Member services
- Provider directory
- Member handbook
- Grievance resolution system
- Provider network management
- Preventive care reminders
- Health education materials and activities
- Extended office hours (varies among MCOs)
- Expanded benefits, including transportation, vision, and prenatal care incentives (varies among MCOs)
Impact on the State Budget

The Medicaid managed care expansion required a short-term investment to achieve long-term savings. ODJFS estimates that the Medicaid managed care expansion will increase Medicaid spending $209 million during the first two years of implementation (2006 and 2007), most of which the State will recover ($153 million) from a new tax on Medicaid Managed Care Organizations (MCOs) (4.5% of revenues).

Lawmakers considered the net cost of the expansion—$56 million over two years—a down payment on future savings, and expect managed care to control growth over time compared to fee-for-service. Spending growth will be determined by changes in enrollment and the amount Medicaid pays MCOs. Early estimates indicate Medicaid MCO payments could grow 7% in the second year of the expansion, more than initially predicted and faster than Ohio Medicaid growth overall. Federal law requires Medicaid payments to MCOs to be "actuarially sound," and the process of determining actuarial soundness is what will determine how much MCO payments will grow over time.

Rebalance Long-Term Care

Medicaid was originally designed to provide long-term care services in institutions, rather than in home or community-based settings, which most people prefer. In 1981, Congress gave states the option to ask the federal government to “waive” certain Medicaid requirements in order to cover long-term care services in home and community settings. Since then, all states, at varying rates, have been “rebalancing” the way that Medicaid long-term care services are financed to allocate a higher proportion of dollars to home and community-based services (HCBS).

Ohio has been slower than most states to rebalance long-term care services—the State spends a greater share of its Medicaid long-term care budget on institutions than all but two other states (Georgia and Mississippi). As a consequence, Ohio has too many nursing facility beds (13% are empty) and too few home and community-based services (for example, an estimated 22,000 Ohioans with MRDD are waiting for HCBS waivers).

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

Source: Ohio Department of Job and Family Services.
In 2005, largely as a result of pressure from Medicaid consumers and a combination of stagnant state revenues and escalating institutional costs, Ohio lawmakers enacted several reforms to control spending growth in long-term care facilities, expand access to home and community-based services and, ultimately, give Ohio’s seniors and people with disabilities better choices to live in settings they prefer.

**Control Spending Growth in Long-Term Care Facilities**

Even as the demand for nursing facilities has declined (the number of nursing facility residents decreased 7% from 1998 to 2004), nursing facility spending has consumed a greater share of Ohio Medicaid and crowded out spending on other priorities like home and community-based services.

In 2004, as a strategy to contain costs, lawmakers suspended the nursing facility reimbursement formula and slowed the State’s share of spending growth to 4.5% in 2004 and 0.7% in 2005. The 2006-2007 budget froze the State’s share of nursing facility spending at 2005 levels in 2006 and 2007—and saved the Ohio Medicaid program more than $1 billion over two years.

The 2006-2007 budget also replaced the cost-based payment system for nursing facilities with a price-based model. The old formula resulted in some facilities being paid 30% more than other facilities for residents with similar health care needs. The new formula sets a price that is based on the experience of cost-efficient providers, adjusted to reflect resident case mix. Facilities can earn additional amounts based on a variety of performance measures. The new formula provides policymakers greater control over reimbursement, rewards efficiency and quality, and is expected to hold down Medicaid costs overall.

**Expand Access to Home and Community-Based Services**

Over the past decade, Ohio has more than doubled the number of people who receive Medicaid services through home and community-based waivers. The 2006-2007 budget continued this trend by expanding existing HCBS waivers to serve 3,800 more Ohioans on average per month in 2006 (a 7% increase over 2005).

The 2006-2007 budget also created several new alternatives to institutions, including an option for Home Care Waiver recipients to more directly control spending for their care, an Assisted Living Waiver to provide supervision and personal care services for up to 1,800 people in residential facilities other than nursing homes, and a Medicaid Voucher Pilot to provide money for 200 Medicaid recipients to purchase medically

**Housing**

Medicaid federal financial participation is not available to pay for expenses such as housing, food, and utilities for participants in HCBS waiver programs except in limited circumstances, such as out-of-home respite care in state-approved facilities (not private residences). Individuals are expected to use their own income and resources (for example, SSI cash assistance benefits and earnings from employment) to meet living expenses. In contrast, room and board costs are embedded in per diem nursing facility and ICF/MR rates. This federal exclusion complicates the provision of support services in the community.
necessary health care costs up to 70% of the cost of nursing facility care in lieu of admission to a nursing facility.

Ohio’s response to consumer demand for more home and community-based services has been achieved through an influx of new Medicaid dollars, not by redirecting Medicaid funding from institutions. Ohio has increased the number of people on HCBS waivers while also increasing the price Medicaid pays for institutional services. As a result, in terms of institutional versus HCBS spending, Ohio has not rebalanced its long term care spending to the extent achieved in most other states.

Federal Deficit Reduction Act

In addition to recent Ohio reforms, Congress enacted the federal Deficit Reduction Act of 2005 (DRA) to save $40 billion in federal Medicaid spending over five years and give states increased flexibility to administer their Medicaid programs. The DRA requires states to strengthen limits on asset transfers to qualify for nursing home coverage, require proof of citizenship to qualify for Medicaid, and comply with a new Medicaid integrity program to prevent, detect, and address fraud and abuse.

The DRA allows states—and Ohio Medicaid is acting on these options—to apply for federal grants to design new ways to increase quality and efficiency, implement a Long-Term Care Partnership Program to encourage people to purchase long-term care insurance, increase funding for “money follows the person” programs to encourage community alternatives to institutional care, implement “cash and counseling” programs to allow for self-direction of personal assistance services, and enforce co-payments for medical services, prescription drugs, and non-emergency care in an emergency room.

The DRA also allows states—and Ohio Medicaid is evaluating these options—to vary benefits and cost-sharing requirements across eligibility groups and geographic areas, create a “benchmark” plan instead of the standard benefit package for some populations, create a Medicaid buy-in program for children with disabilities with family incomes below 300% of poverty, create Health Opportunity Accounts (similar to health savings accounts), and redesign the non-emergency medical transportation program.
2008-2009 Budget Outlook

Ohio Medicaid has gone through significant change in the past few years. Many of the reforms that were enacted in the 2006-2007 budget are still in the process of being implemented. However, that does not prevent looking ahead to anticipate the changes and challenges that may confront the program in the future. Some of the issues that are likely to emerge early in 2007 as part of the 2008-2009 budget debate are listed below.

Eligibility
- Explore ways to use Medicaid to cover the uninsured, including employee premium subsidies and other public/private partnerships;
- Review results from other state health care reform efforts (Florida, Illinois, Maine, Massachusetts, New Mexico, Pennsylvania, Vermont, and others);
- Reconsider current eligibility levels, such as 90% of poverty for parents;
- Allow new eligibility groups to “buy-in” to Medicaid.

Benefits
- Evaluate new federal flexibility for states to alter benefits, including limited benefit plans, as an alternative to full Medicaid coverage;
- Integrate consumer-centered care, self-direction, and patient responsibility;
- Explore managed care options for long-term care, Medicaid enrollees who are also eligible for Medicare, and children with disabilities;
- Implement “Money Follows the Person” and home and community-based options;
- Examine the interaction between Medicaid and the behavioral health.

Administration
- Consider organizational issues, such as creating a new Medicaid department and recommendations from the Medicaid Administrative Council;
- Review options to improve efficiency and eliminate waste, fraud, and abuse;
- Invest in health information technology.

Financing
- Consider the implications that state revenue is rebounding, but slower than other states;
- Review provider rate strategies, including pay for performance;
- Identify new sources of cost containment (many one-time options were used up in the last budget);
- Anticipate the impact of State Appropriation Limit (SAL) restrictions;
- Evaluate federal restrictions on provider taxes as a source of local Medicaid match;
- Continue rebalancing long-term care spending;
- Develop strategies to control growth in managed care rates;
- Influence the federal State Child Health Insurance Program (SCHIP) reauthorization.
Medicaid and the Uninsured

Several states (Florida, Massachusetts, California) received federal Medicaid waivers that allow them to convert Medicaid funds—usually funds that the state was about to lose for one reason or another—into a Safety Net Pool to subsidize health insurance coverage for the uninsured.

Recently national attention has focused on the Massachusetts Health Care Reform Plan because it provides near universal coverage to state residents. The Massachusetts plan requires individuals to purchase insurance (with “fair share” contributions from employers), provides assistance to connect individuals to affordable insurance, and subsidizes premium costs on a sliding scale up to 300% of poverty ($60,000 for a family of four). The premium subsidy is funded by taking $575 million out of the Medicaid disproportionate share hospital program and by capturing $636 million from an expiring Medicaid upper payment limit (UPL) program.\textsuperscript{21}

During the 2006 Ohio gubernatorial campaign, Ted Strickland proposed adapting elements of the Massachusetts Plan to increase the number of Ohioans with access to affordable health insurance. Governor Strickland’s proposal did not include an individual or employer mandate to purchase health insurance, but it did include assistance to connect individuals to affordable insurance and the intent to seek a federal waiver to leverage Medicaid funds to subsidize insurance premiums for the uninsured up to 150% of poverty ($30,000 for a family of four). The estimated cost was $550 million for the first two years.\textsuperscript{22}

There are two important considerations when comparing Massachusetts and Ohio. First, Ohio’s UPL program is worth about $46 million over three years\textsuperscript{23} compared to $636 million in Massachusetts, so Ohio would have to find another source of funding to accomplish what Massachusetts is proposing. Second, Ohio has a higher proportion of low-income uninsured residents than Massachusetts, in part because Massachusetts previously expanded Medicaid to higher income levels. Therefore, a larger share of Ohio’s population would need public assistance in order to afford coverage.
Online Resources

Medicaid Glossary
www.cms.hhs.gov/apps/glossary/

Federal Agencies

Ohio Departments
Aging: www.goldenbuckeye.com
Alcohol and Drug Addiction Services: www.odadas.state.oh.us
Budget and Management: www.obm.ohio.gov
Health: www.odh.state.oh.us
Job and Family Services: www.jfs.ohio.gov/ohp
Mental Health: www.mh.state.oh.us
Mental Retardation and Developmental Disabilities: www.odmrdd.state.oh.us

Government Associations
American Legislative Exchange Council: www.alec.org
National Academy of 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

Foundations and Research Institutes
The Buckeye Institute: www.buckeyeinstitute.org
The Commonwealth Fund: www.cmwf.org
Families USA: www.familiesusa.org
The Health Foundation of Greater Cincinnati: www.healthfoundation.org
Health Policy Institute of Ohio: www.healthpolicyohio.org
The Kaiser Commission on Medicaid and the Uninsured: www.kff.org/kcmu
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 its publications, presentations, website, or staff interviews.

1 Centers for Medicare and Medicaid Services (CMS), “Personal health care expenditures by type of expenditure and source of funds: calendar year 2004.”

2 2005 Ohio Gross State Product ($440.9 billion) is estimated to grow 1.9% (2002-2005 average annual rate of growth) to $449.3 billion in 2006 (U.S. Bureau of Economic Analysis); the State of Ohio main operating budget appropriated $49.6 billion for fiscal year 2006 (Ohio Office of Budget and Management).


4 Kaiser Family Foundation, “Income Eligibility for Parents Applying for Medicaid by Annual Income as a Percent of Federal Poverty Level, 2005.”

5 42 CFR Section 410.10(e)(1)(ii) and 42 CFR Section 431.10(e)(3).

6 42 U.S.C. §1396a(a)(1), (10), (17), (23), and (30).

7 Health Management Associates calculation based on the Ohio Legislative Service Commission’s “Budget in Detail: Conference Committee Report” (June 2005) and interviews with Ohio budget officers.

8 Federal Register, Volume 70, Number 229 (November 30, 2005).

9 Federal Funds Information for States, Issue Brief 06-42 FY 2008 FMAPs (September 26, 2006).

10 Ohio Department of Job and Family Services, “Health Insurance Coverage in Ohio, 2004: Results of the Ohio Family Health Survey,” (March 2005).

11 Ohio Office of Budget and Management, “Budget Highlights: Fiscal Years 2006 and 2007,” Figure 1.

12 Ohio Office of Budget and Management, “Budget Highlights: Fiscal Years 2006 and 2007,” Figure 2.

13 Over the period from 2006 to 2014, the CMS actuarial projection is for federal Medicaid spending to increase 8.4% annually and state Medicaid spending to increase 8.5% annually; the Congressional Budget Office projects annual average growth of 8.4% from 2007 to 2015.


15 Ohio Medicaid spending increased 12.9 percent on average annually from 2001 to 2004, while total revenues for the State of Ohio increased 5.8% on average over the same period (Ohio Office of Budget and Management “Comprehensive annual financial report” for revenue and “Detailed appropriation summary by fund” for Medicaid spending growth, appropriations line item 600-525).

16 Ohio Office of Budget and Management.


19 Ohio’s nursing facility occupancy rate was 87% in 2003 according to the Miami University Scripps Gerontology Center (2005).

20 White House fact sheet, “President Bush signs the Deficit Reduction Act,” (February 8, 2006).


23 Health Management Associates estimate (June 2006).
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For More Information About Medicaid, Ohio Medicaid Basics 2007, and the Health Policy Institute of Ohio

Ohio Medicaid Basics 2007 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. 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/Ohp or call 800-324-8680.

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