

Ohio Medicaid Basics 2013

March 2013

HISTORY

Congress created Medicare and Medicaid in 1965 through the Social Security Act. At the time of passage, the programs were heralded as opening “another frontier, that of health security,”¹ following the original Social Security Act of 1935 which focused on income security for older Americans.

Medicare focused on health security for older Americans, while Medicaid, known as Title XIX of the Social Security Act, was created to provide health care to certain categories of people who have low incomes and cannot afford health services or health insurance on their own. Over the years, Medicaid coverage has focused on children, parents, and pregnant women, as well as the blind, aged, and disabled.

Medicaid is funded and administered jointly by the state and federal governments. Under broad federal guidelines, states establish their own standards for Medicaid eligibility, benefits, and provider payment rates,

although states must meet certain minimum standards. The federal Centers for Medicare & Medicaid Services (CMS), located within the Department of Health and Human Services (HHS), oversees the Medicaid program.

Medicaid is voluntary for states, but every state participates and administers its own program. Ohio's Medicaid program started in 1968 and is administered currently by the Ohio Department of Job and Family Services (ODJFS).

Medicaid is an entitlement program, meaning that states cannot limit the number of eligible persons enrolled in Medicaid or deny access to medically necessary services to control costs.

In state fiscal year (SFY) 2012, the total expenditure for Ohio's Medicaid program was \$17 billion,² including both state and federal funds. This accounts for about 3.5% of Ohio's economy.³ State funds were \$6.1 billion of the \$17 billion total Medicaid expenditure.

At a glance

Medicaid...

- Combines federal and state funds to cover vulnerable populations
- Is Ohio's single largest payer of health care services
- Is the largest payer of long-term care in the state
- Covers over one-half of Ohio's youngest children, ages 0 – 4, and 40% of Ohio's children ages 0-19
- Covers more than 2.2 million Ohioans with low incomes every month, including children, parents, pregnant women, seniors and certain people with disabilities
- Contracts with private managed care plans to provide health care to over 1.64 million clients
- Helps fund hospital care for Ohio's uninsured
- Supplements Medicare for certain low-income seniors and people with disabilities
- Is administered in Ohio by the Ohio Department of Job and Family Services/Office of Medical Assistance

The difference between Medicaid and Medicare

Medicaid

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

Medicare

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

INSIDE

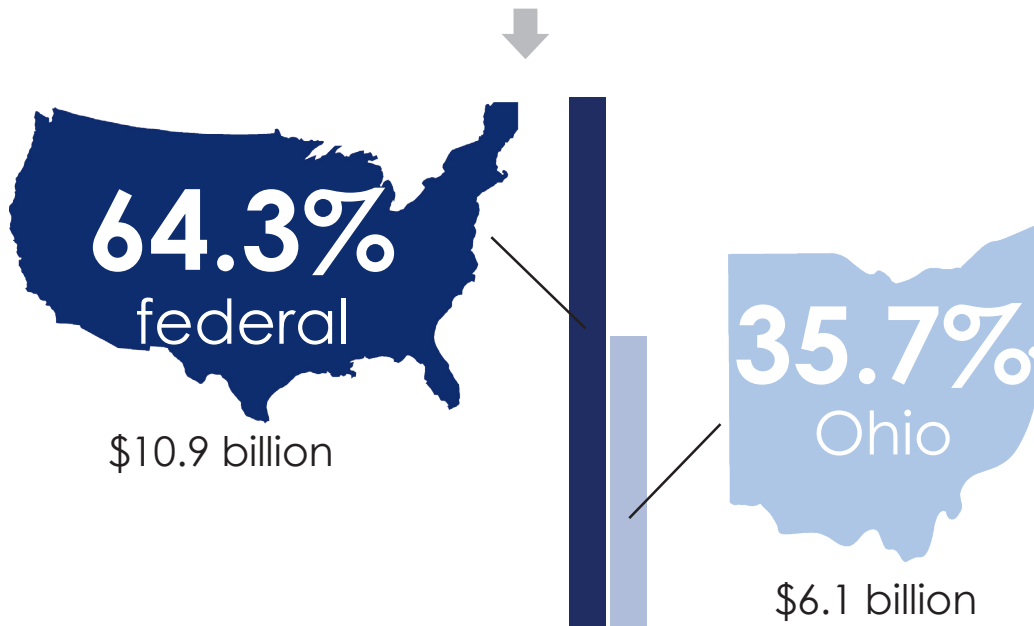
History.....	1
Financing.....	2
Enrollment.....	3
Eligibility.....	4
Benefit groups.....	4
Long-term care.....	8
Administration.....	9
Mandated and optional services.....	10

Medicaid copayments.....	10
Delivery system.....	11
Controlling costs in Medicaid.....	14
Current and proposed state initiatives.....	15
Acknowledgements.....	17
General data notes.....	17
Glossary.....	18
Notes.....	20

Who pays for Medicaid?

Total annual Medicaid spending, SFY 2012

\$17.01 billion
(across all Ohio agencies)



Source: CMS-64 Spending across all agencies, SFY 2012; ODJFS Data Run, 1/24/2013. Additional calculations by HPIO.

How much of the state budget does Medicaid represent?

The answer to this question varies depending on which funds are counted. In SFY 2013, Medicaid represents about 25% of the state share General Revenue Fund (GRF) budget. However, because Ohio follows the practice of counting the federal match on Medicaid spending as part of the state GRF—a practice not done with other federal funds—when the federal Medicaid reimbursement is added, Medicaid represents about 45% of the total GRF.⁴

Federal Medical Assistance Percentage (FMAP)

State Medicaid programs receive matching funds from the federal government to help pay for Medicaid services and administration. The Secretary of the Department of Health and Human Services (HHS) calculates these matching funds each year using the Federal Medical Assistance Percentage (FMAP). FMAP is calculated according to a formula contained within the Social Security Act, which takes into account a state's average per capita income relative to the national average. By statute, the FMAP for a state cannot be lower than 50% or more than 83%. FMAP runs according to the federal fiscal year; the 2012 FMAP was effective from October 1, 2011 through September 30, 2012. Ohio's 2012 FMAP was 64.15%,⁵ meaning that for every \$1.00 of state expenditure, the federal government contributed \$1.79.

A higher FMAP, known as "enhanced FMAP" (eFMAP), is used in the Children's Health Insurance Program (CHIP). Ohio's 2012 eFMAP for CHIP was 74.91%,⁶ meaning that for every dollar of state expenditure, the federal government contributed \$2.99. These FMAPs apply to health care costs. Medicaid administrative expenses are shared equally between the federal and state governments (50/50 rate). Medicaid administrative costs were 3.2% of the total Medicaid budget (\$544 million) in SFY 2012.⁷

total 2012 Ohio population
(11.54 million)



19%

(2.21 million)
Average monthly enrollment of Ohioans



Covered families and children (CFC)
1.66 million

Aged, blind or disabled (ABD)
421,000

Other
130,000



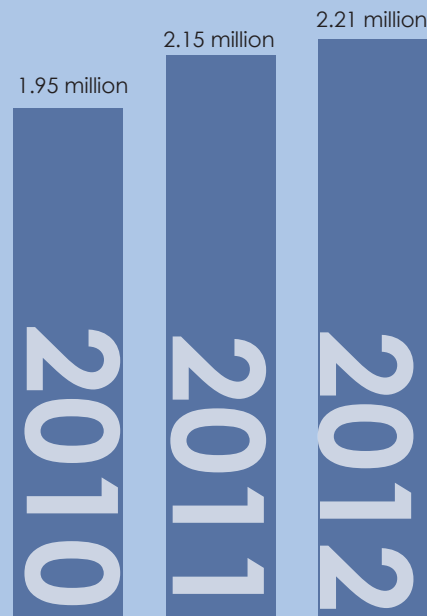
Sources: ODJFS Data Run, 1/16/2013. Ohio population from US Census Bureau. Additional calculations by HPIO.

In SFY 2012, a total of 2.64 million Ohioans were enrolled in Medicaid at some point during the year.⁸ However, because people enter and exit the program throughout the year, Medicaid's SFY 2012 average monthly enrollment was 2.21 million Ohioans.*⁹

Because Medicaid eligibility is based on income, changes in the economy have a direct impact on enrollment, especially for children, pregnant women and parents. In addition to the economy, other factors that impact enrollment include:

- Changes in the overall population (demographic changes are driving a steady increase in enrollment for seniors and people with disabilities)
- Policy changes (Ohio's adoption of the family planning option has added new people to the Limited Benefit Medicaid category)
- Rising cost of health insurance in the individual and employer-sponsored market
- Continuing decline in employer-sponsored health insurance

Ohio Medicaid enrollment trend



Source: 2010 data from 2011 *Ohio Medicaid Basics*. 2011 and 2012 data from ODJFS Data Run, 1/16/2013. Additional calculations by HPIO.

* Compared to the annual unduplicated count, average monthly enrollment is a more accurate reflection of Medicaid enrollment at any given time. In this publication, HPIO uses average monthly enrollment unless otherwise noted.

ELIGIBILITY

In order to qualify for Medicaid coverage, a person must be a U.S. citizen¹⁰ and an Ohio resident, have or obtain a Social Security number, and meet certain income and categorical requirements.

Ohio Medicaid covers low-income children, parents of dependent children, pregnant women, seniors, and people with disabilities. The income level for each category varies, as outlined in the table below.

How does Ohio's eligibility compare to other states?

Population	Ohio income eligibility	National median	Notes
Children 0-18	200% FPL	235% FPL	25 states cover kids > 250% FPL; 17 states cover kids > 300% FPL
Pregnant Women	200% FPL	185% FPL	39 states cover pregnant women > 185% FPL; 16 states cover pregnant women >200%)
Parents of dependent children	90% FPL	61% FPL	33 states cover parents < 100% FPL; 16 states cover parents < 50% FPL
Adults without dependent children	Does not cover	N/A	9 states offer full Medicaid coverage; 16 states offer limited coverage; 2 states offer both; enrollment is closed in 10 states

Source: "Getting into Gear for 2014: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal, and cost-Sharing Policies in Medicaid and CHIP, 2012-2013," Kaiser Commission on Medicaid and the Uninsured, January 2013. Data is current as of January 2013.

What is FPL? How is it determined?

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

2013 Federal Poverty Level (FPL) Guidelines

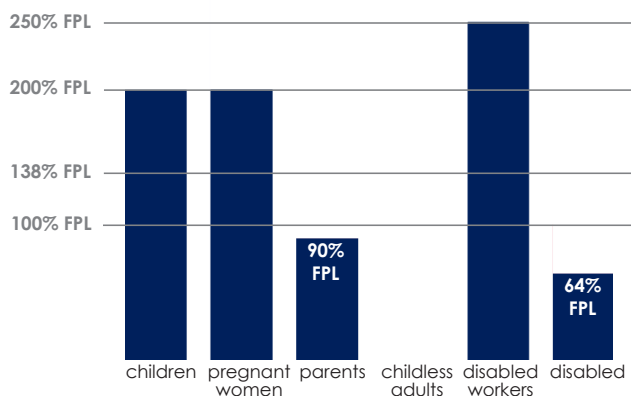
(by household size)

	64%	90%	100%	138%	200%	250%	400%
1	\$7,354	\$10,341	\$11,490	\$15,856	\$22,980	\$28,725	\$45,960
2	\$9,926	\$13,959	\$15,510	\$21,404	\$31,020	\$38,775	\$62,040
3	\$12,499	\$17,577	\$19,530	\$26,951	\$39,060	\$48,825	\$78,120
4	\$15,072	\$21,195	\$23,550	\$32,499	\$47,100	\$58,875	\$94,200

Source: Federal Register, January 24, 2013

Note: Annual guidelines for all states except Alaska, Hawaii and DC. For each additional person, add \$4,020

Current Medicaid eligibility



BENEFIT GROUPS

There are three broad benefit groups in Medicaid, based on eligibility standards: Covered Families and Children (CFC), Aged, Blind and Disabled (ABD) and "other Medicaid."

Covered Families and Children (CFC)

Children up to age 19, parents of dependent children, and pregnant women can qualify for Medicaid based on family income. Families who participate in the Ohio Works First (OWF) cash assistance program are automatically covered by Medicaid. In addition, CFC includes certain youth who may continue receiving Medicaid coverage until age 21, and Transitional Medicaid.¹¹ Children, parents, and pregnant women are generally healthier and less expensive to cover than seniors and people with disabilities. Accordingly, the CFC category represents 75% of Medicaid enrollment and 36% of total Medicaid health care spending.¹²

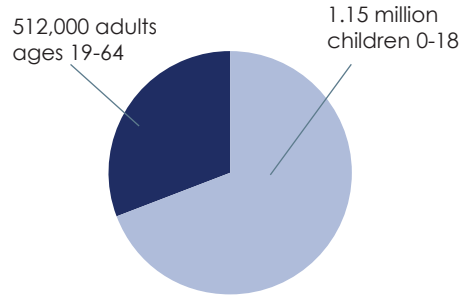
Within CFC, Ohio has several names for the Medicaid program, targeted to two populations:

Healthy Start covers children (up to 200% FPL), youth aging out of foster care (no income limit), and pregnant women (up to 200% FPL). Pregnant women are eligible for Healthy Start coverage during their entire pregnancy and up to 60 days after the baby is born. Babies born to mothers on Healthy Start are automatically eligible for health coverage for one full year from the date of birth, regardless of changes in family income.

Children in families whose income is between 150% - 200% FPL must be uninsured to be eligible for Healthy Start Medicaid. Children in families with incomes under 150% FPL can have other health insurance and still qualify for Medicaid coverage; in those cases, Medicaid acts as the payer of last resort.

Healthy Families covers parents/caregivers and their dependent children who have income up to 90% FPL. These families can have other health insurance and still qualify for Medicaid coverage; in those cases, Medicaid acts as the payer of last resort.

In SFY 2012, 1.66 million people were covered under CFC each month:



Source: ODJFS Data Run, 1/16/2013. Additional calculations by HPIO.

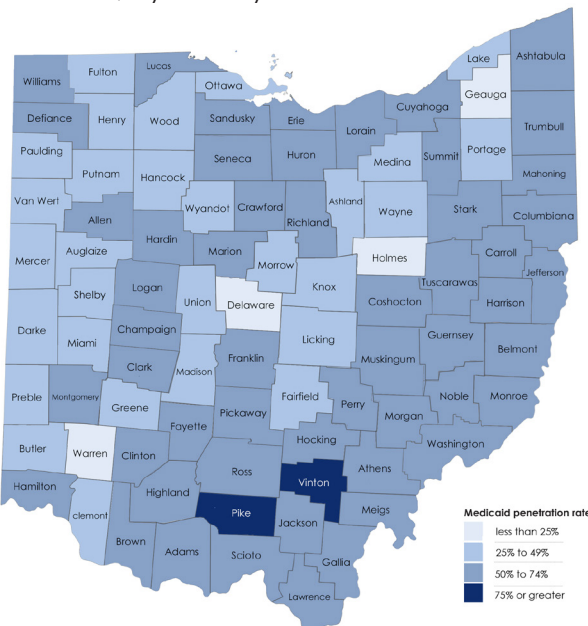
Children and Medicaid

As the largest health insurer of Ohio's children, Medicaid plays a critical role for Ohio's children and families. Consider the following:

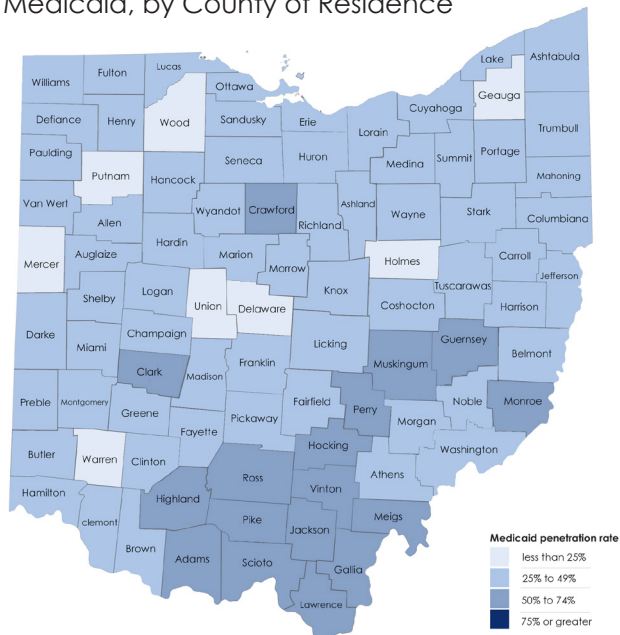
- 45% of Ohio births are paid for by Medicaid¹³
- 40% of Ohio's children ages 0-19 are covered by Medicaid¹⁴
- 53% of Ohio's youngest children, ages 0-4 are covered by Medicaid¹⁵
- Children ages 0-18 represent 54% of total Medicaid enrollment and about 23% of total Medicaid costs¹⁶
- Largely as a result of Medicaid coverage, fewer Ohio children are uninsured relative to adults; 9% of Ohio's children are uninsured, compared to 19% of adults ages 19-64¹⁷

Children enrolled in Medicaid, SFY 2011

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



Percent of Children **Ages 0-19** Enrolled in Medicaid, by County of Residence



Source: ODJFS Data Run, 1/15/2013. Additional calculations by HPIO.

Note: Because these maps use Census data for resident population estimates, the age range is 0-19. Medicaid eligibility for many children is for ages 0-18.

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program

The EPSDT program is the federally-mandated package of Medicaid benefits for children. Under EPSDT, states must provide comprehensive health and developmental assessments, as well as vision, dental and hearing services to children and youth up to age 21. The goal of these preventive services is the early identification of conditions that may compromise a child's growth and development. If a potential health problem is found, Medicaid covers the cost of further diagnosis and any necessary treatment. Ohio calls its EPSDT program HEALTHCHEK. A HEALTHCHEK coordinator is available in each county's office of job and family services to help consumers get these services.¹⁸

Children's Health Insurance Program (CHIP)

CHIP was originally established by Congress in 1997 to provide coverage for children living in families with incomes too high to qualify for Medicaid, but who cannot afford private coverage. Ohio is one of seven states to implement CHIP as a Medicaid expansion, rather than as a separate CHIP program or a combination of the two approaches. It did so by expanding coverage to children living in families with incomes up to 150% FPL in 1998 and then to children living in families with incomes up to 200% FPL in 2000. In SFY2012, 14% of all Ohio children ages 0-18 covered by Medicaid were covered by CHIP-- an average of nearly 162,000 children per month.¹⁹ CHIP provides an enhanced federal matching assistance percentage (eFMAP) rate for states to cover more children; Ohio's SFY 2012 eFMAP for CHIP was 74.91% (as opposed to the regular FMAP of 64.15%).²⁰

CHIPRA Performance Bonus Grants

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) established a system of bonus payments for states that do an outstanding job enrolling and retaining children in Medicaid. To secure the CHIPRA bonus, a state's enrollment for children in Medicaid must exceed a baseline target and the state must have implemented at least five of eight "simplification" policies that are known to boost enrollment and retention of children. Ohio has received three CHIPRA bonus awards--in 2010, 2011, and 2012-- for a total of \$51.8 million. As of December 2012, Ohio has invested \$15.5 million of these award funds in various initiatives to improve care for all Ohioans.²¹

Aged, Blind and Disabled (ABD)

Ohioans age 65 and older, and people of any age (including children), with a major disabling condition may qualify for Medicaid coverage if they meet certain financial requirements. ABD enrollees have more complex health care needs and are more expensive to cover than the CFC population. Accordingly, the ABD category represents 19% of Medicaid enrollment and 61% of total Medicaid health care spending.²²

When determining eligibility for ABD Medicaid, Ohio counts certain assets including an individual's income, cash, bank accounts, stocks and other assets. Regulations are in place to prevent individuals from improperly transferring assets in order to qualify for Medicaid.²³

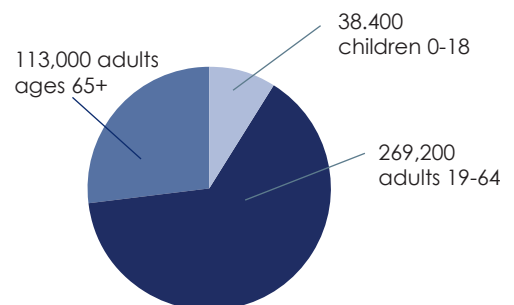
People who qualify for ABD Medicaid are covered for the same comprehensive benefit package that is available to children and parents. In addition, those in ABD Medicaid can qualify for Medicaid long-term care services, which include a broad range of medical, personal care, and support services that are provided in home, community, and facility-based settings.

ABD

Among categories within ABD are:
Medicaid Buy-In for Workers with Disabilities (MBIWD): MBIWD was created to encourage Ohioans with disabilities to work by enabling them to keep their Medicaid coverage. Disabled workers ages 19-64 with incomes up to 250% FPL qualify. Those with incomes over 150% FPL are required to pay modest premiums for the coverage.

Medicaid Spend-down: Ohioans with disabilities whose income exceeds the eligibility limit may become eligible on a month-to-month basis through a Medicaid "spend-down." The spend-down allows individuals to deduct medical expenses from their income until they meet financial eligibility guidelines. Once the spend-down is reached, consumers are eligible for Medicaid for the rest of the month.

In SFY 2012, 420,600 people were covered under ABD each month:



Source: ODJFS Data Run, 1/16/2013. Additional calculations by HPIO.

Other Medicaid

Six percent of the Medicaid caseload and 3% of total Medicaid health care spending is in categories other than CFC or ABD, in what this publication refers to as "Other Medicaid." Examples of categories within this subset include Alien Emergency Medical Assistance, Breast and Cervical Cancer Project, certain people who are leaving public institutions (including mental health, youth services, and corrections), presumptively eligible children and pregnant women and deemed newborns.²⁴

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

- **(Medicare) Premium Assistance:** Medicaid pays Medicare premiums and, in some categories, cost-sharing for certain consumers covered by Medicaid. An average of 106,000 Ohioans monthly received Medicare premium assistance through this program in SFY 2012.²⁵
- **Family Planning:** Medicaid provides a limited set of benefits for men and women with incomes up to 200% FPL, to help prevent or delay pregnancy. Since full implementation in February 2012, this program has seen significant enrollment, increasing by over 15,000 individuals each month from February through June 2012.²⁶

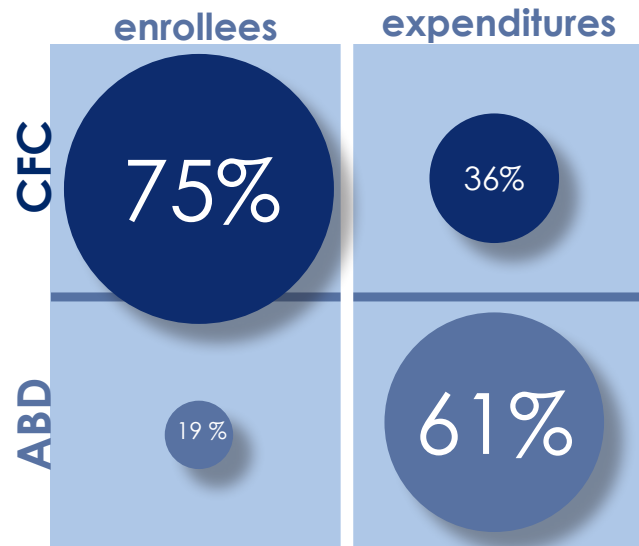
Benefit categories vary widely

Ohio Medicaid serves a wide variety of people with low and modest incomes. Clients range from newborns to elderly nursing home residents, from healthy children to workers with disabilities, from working parents to children with chronic diseases. Because of this, costs for different populations vary widely.

Breast and Cervical Cancer Project (BCCP)

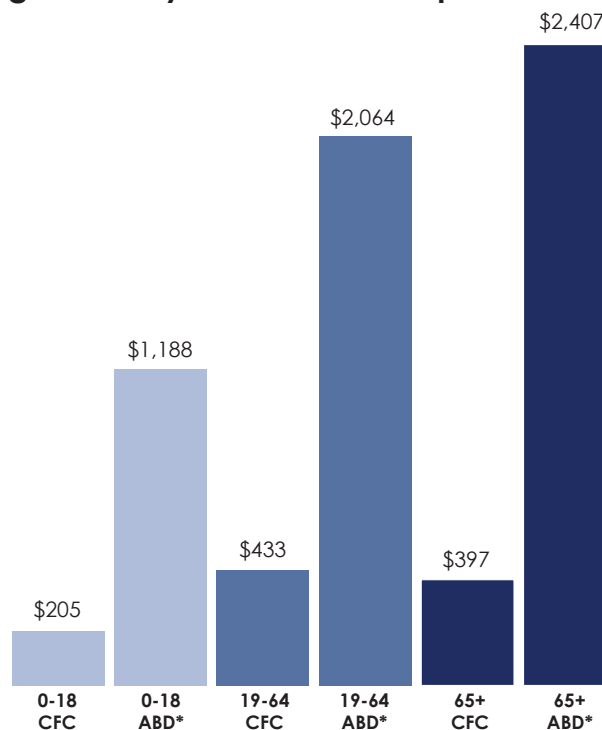
Medicaid provides health care coverage to eligible women screened through the Ohio Department of Health's Breast and Cervical Cancer Project. To qualify, women must have income below 200% FPL, and be between the ages of 40-65 and uninsured. Once screened and diagnosed as having breast or cervical cancer, BCCP Medicaid may be available to women who are in need of treatment services. Women who are covered by BCCP Medicaid have access to the full Medicaid benefit package in addition to their cancer treatment.²⁷

Cost differences between types of enrollees, SFY 2012



Source: ODJFS Data Run, 1/16/2013. Additional calculations by HPIO. **Note:** Payment data for SFY 2012 is not complete. Services for sister agencies (those outside ODJFS) are included, but due to data issues, only the federal portion of the payment is reflected in the data.

Average monthly Medicaid costs per enrollees, SFY 2012



Source: ODJFS Data Run, 1/16/2013. Additional calculations by HPIO. **Notes:** Because many Medicaid consumers are not enrolled for a full 12 months, these numbers should not be used to estimate annual costs per person. These costs are shared by the federal and state government. Services from Sister State Agencies are included, but due to data issues, only the federal portion of the payment is reflected in this data.

*ABD in this analysis includes MBIWD and excludes dual eligibles

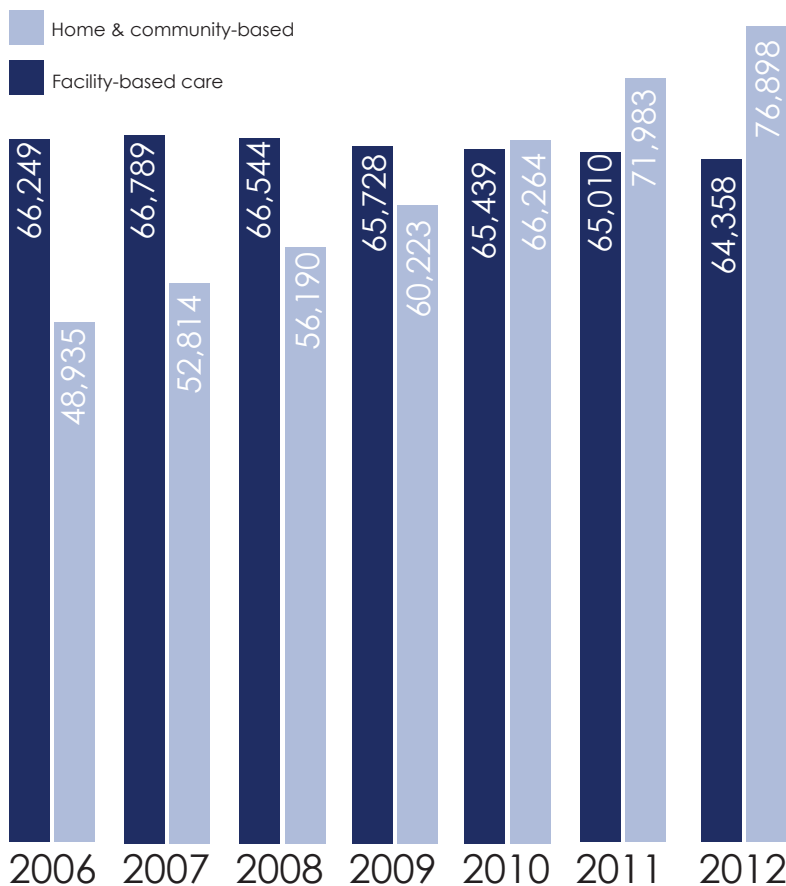
Within Ohio Medicaid, long-term care services can be either facility-based, or home and community-based.

Facility-based long-term care services are provided in nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICF-IID, formerly known as ICF-MR, intermediate care facilities for the mentally retarded (ICF-MR)), and state-run developmental centers for the developmentally disabled.

Home and community-based services (HCBS) allow people with disabilities and chronic conditions to receive care in their homes and communities instead of in long-term care facilities, hospitals or intermediate care facilities. Home and community-based services are waiver programs because under current federal law, eligible people with disabilities and chronic conditions are entitled to facility-based care, but home and community-based care are considered optional. Therefore states must apply for a waiver from the federal government in order for Medicaid to provide home and community-based services.

Compared to other states, Ohio Medicaid typically has delivered a higher proportion of long-term care through facility-based services, leading to greater expense and less consumer satisfaction. For many years Ohio has worked to rebalance the mix of long-term care and encourage Medicaid consumers to choose more cost-effective home and community-based services.

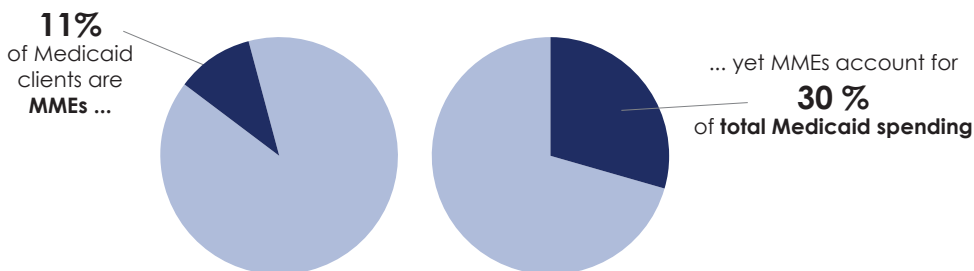
People Served in Long-Term Care Institutions Compared to Home and Community-Based Waivers



Source: ODJFS Data Run, 1/15/2013.
Note: Average monthly numbers of residents and waiver recipients

Medicare-Medicaid Enrollees (MMEs) (dual eligibles)

Formerly known as "dual eligibles," Medicare-Medicaid enrollees (MMEs) are enrolled in both Medicaid and Medicare. Medicare was created in 1965 to cover the medical needs of senior citizens and later was expanded to cover some people with disabilities. However, Medicare's coverage is limited and does not cover long-term care services. Medicaid pays for most of the cost of nursing homes, home and community-based long-term care, and other medical services for low-income people enrolled in Medicare. In addition, Medicaid pays for Medicare premiums, coinsurance, and deductibles for some low-income consumers, and a share of the cost of Medicare Part D pharmacy coverage.



Source: ODJFS Data Run, 1/15/2013. Additional calculations by HPIO. Note: These data include Medicaid costs only, and exclude costs paid for by Medicare and/or other third party liability carriers. Therefore, these do not represent the total cost for Medicare-Medicaid Enrollees.

Coordinating care for MMEs

In December 2012, Ohio reached agreement with the Centers for Medicare and Medicaid Services (CMS) on a new initiative to better coordinate care for MMEs. Known as the Integrated Care Delivery System (ICDS), the project will comprehensively manage the full continuum of benefits for MMEs, including long-term care services and supports, behavioral health services, and physical health services.²⁸

Designed as a three-year demonstration project that will eventually reach 114,000 MMEs, Ohio plans to launch the ICDS program in 29 counties on September 1, 2013. Five managed care plans have been selected to help manage and coordinate the care of MMEs in the project. (For more information, see materials posted at <http://1.usa.gov/ZfRNWx>)

ADMINISTRATION

Medicaid is funded and administered jointly by the state and federal governments. Under broad federal guidelines, states establish their own standards for Medicaid eligibility, benefits, and provider payment rates, although states must meet certain minimum standards. The federal Centers for Medicare & Medicaid Services (CMS), located within the Department of Health and Human Services (HHS), oversees the Medicaid program.

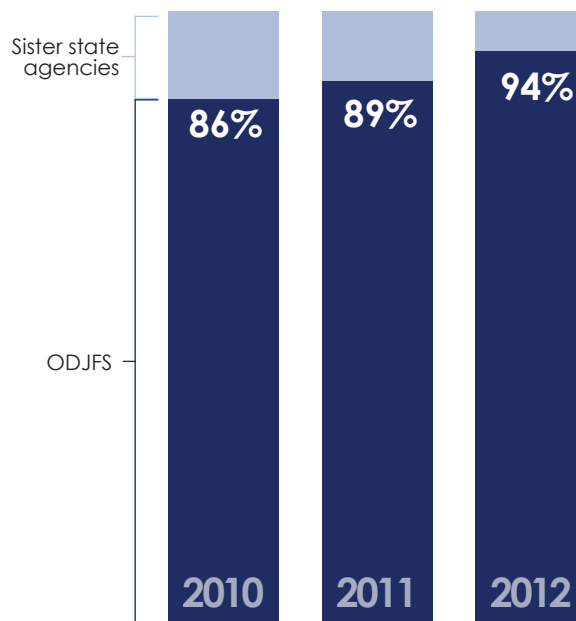
The federal government requires each state to designate a "single state agency" to administer its Medicaid program. Ohio's single state agency is the Ohio Department of Job and Family Services (ODJFS). Within ODJFS, the Office of Medical Assistance (OMA) (formerly known as the Office of Ohio Health Plans) is responsible for day-to-day management of Medicaid. Ohio plans to elevate Medicaid to a cabinet-level agency effective July 1, 2013.

In January 2011, Governor Kasich created the Governor's Office of Health Transformation (OHT). All state agencies that have a role in administering the Ohio Medicaid program directly report to OHT. More information about OHT can be found at www.healthtransformation.ohio.gov.

ODJFS delegates authority to five state agencies (known as "sister state agencies") to administer some Medicaid programs. As a result, Medicaid is included in the budgets of Ohio Departments of Aging (ODA), Alcohol and Drug Addiction Services (ODADAS), Developmental Disabilities (ODODD), Health (ODH), and Mental Health (ODMH). Ohio's 2012-2013 biennial budget transitioned some Medicaid budget line items between ODJFS and sister agencies; most notably, the Department of Aging Medicaid budget moved to ODJFS in SFY 2012. As a result, the majority of Medicaid financing continues to be handled through ODJFS, but the proportion is changing.

Beginning in SFY 2012, the financial responsibility for the non-federal share of Medicaid funds for alcohol and drug treatment and mental health carve-out benefits²⁹ transitioned from community behavioral health boards to the state. Full integration occurred in SFY 2013. This transition is known as "elevation" of Medicaid behavioral health financing to the state level.

Percent of state spending on Medicaid paid by ODJFS



Source: ODJFS Data Run, 1/15/2013. Additional calculations by HPIO.

Note: The Aging budget moved to JFS in SFY12. Remainder of expenses paid by Ohio Departments of Developmental Disabilities, Mental Health, Alcohol and Drug Addiction Services, Aging and Health. Amounts exclude transfers (i.e., sister agency spending), administration, and Department of Aging for SFY10/11. The amounts for SFY 2012 also include HCAP and Supplemental payments not included in previous years.

MANDATED AND OPTIONAL SERVICES

Ohio's Medicaid program includes services mandated by the federal government plus optional services the state chooses to provide. Ohio has some discretion to vary the covered services but by federal law, in all cases, a service must be "sufficient in amount, duration, and scope to reasonably achieve its purpose."³⁰ Some services are limited by dollar amount, the number of visits per year, or the setting in which they can be provided. Some services require the consumer to share in the cost.

Federally mandated services

- Ambulatory surgery centers
- Certified family nurse practitioner services
- Certified pediatric nurse practitioner services
- Family planning services and supplies
- Healthchek (EPSDT) program services
- Home health services
- Inpatient hospital
- Lab and x-ray
- Medical and surgical dental services
- Medical and surgical vision services
- Medicare premium assistance
- Non-emergency transportation to Medicaid services
- Nursing Facility care
- Outpatient services, including those provided by Rural Health Clinics and Federally Qualified Health Centers
- Physician services

Ohio's optional services

- Ambulance/ambulette
- Chiropractic services
- Community alcohol and drug addiction treatment
- Community mental health services
- Dental services
- Durable medical equipment and supplies
- Home and Community-Based Services Waivers
- Hospice care
- Independent psychological services
- Intermediate Care Facility services for Individuals with Intellectual Disabilities (ICFIID)
- Occupational therapy
- Physical therapy
- Podiatry
- Prescription drugs
- Pregnancy related services
- Private duty nursing
- Speech therapy
- Vision care, including eyeglasses

Source: ODJFS, "Covered Services." <http://jfs.ohio.gov/OHP/consumers/benefits.stm>

MEDICAID COPAYMENTS

Certain medical services require a copayment, including visits for non-emergency services obtained in a hospital, dental services, routine eye examinations, eyeglasses, most brand-name medications, and medications that require prior authorization.³¹

Not all Medicaid consumers are subject to copayments. Consumers are exempt if they meet at least one of these conditions³²:

- Younger than age 21
- Pregnant, or pregnancy ended within the previous 90 days
- Living in a nursing home or intermediate care facility for the mentally retarded
- Receiving emergency services
- Receiving family planning-related services
- In a managed care plan that does not charge copayments

Ohio Medicaid provides primary and acute care services through managed care plans and a fee-for-service system. Both delivery systems provide preventive services as well as medically necessary primary care, specialty and emergency care services. Historically, Ohio has provided long-term care services exclusively through the fee-for-service system; however, that is changing with the establishment of the Integrated Care Delivery System for Medicare-Medicaid enrollees, which will be administered through managed care plans.

Managed care

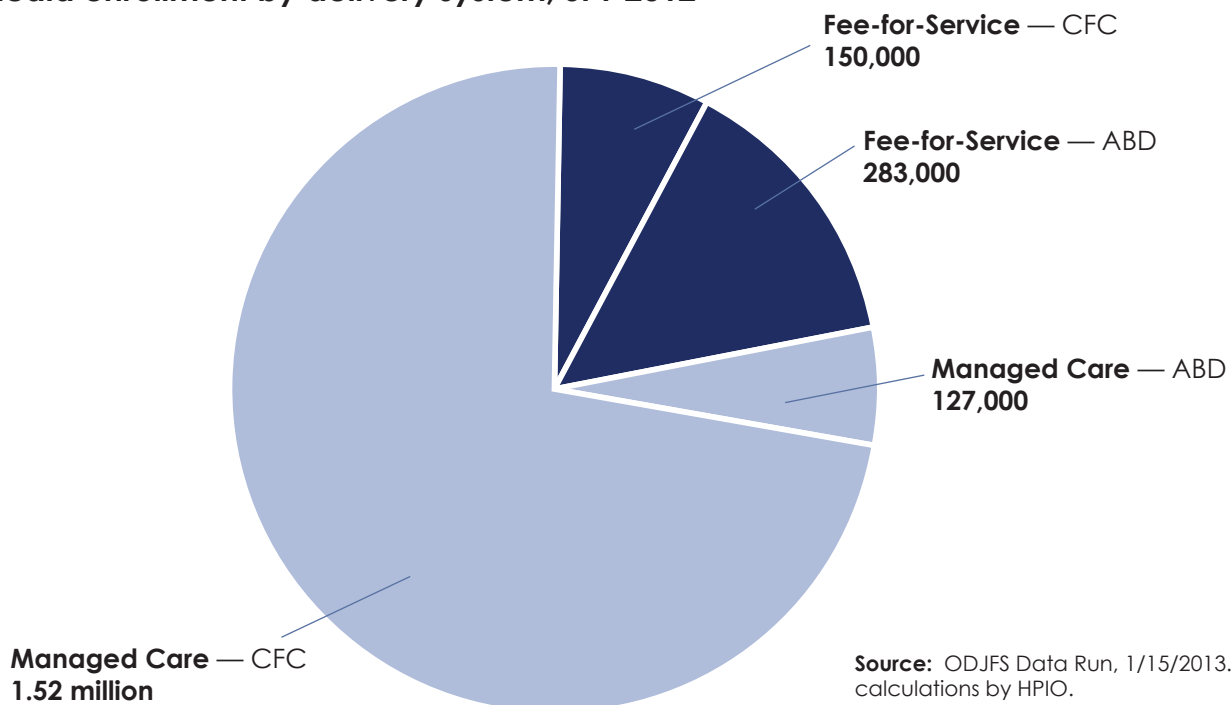
Ohio's Medicaid managed care program was created in 1978 and continues today as a strategy to ensure access to services, provide quality care and manage Medicaid costs. A managed care plan (MCP) is a private health insurance company that provides, or arranges for someone to provide, the standard Medicaid benefit package to Medicaid enrollees. ODJFS contracts with a selected set of managed care plans to coordinate care for Ohio Medicaid enrollees in exchange for a capitation payment – a set amount of money per member per month. The MCP, not the state, is then at full risk for covering any costs that exceed the capitation payment it receives from Medicaid. MCPs control quality and cost by coordinating care through a network of providers selected by the plan. MCPs 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.

Almost all children, pregnant women, and parents enrolled in the Covered Families and Children (CFC) category are required to enroll in a managed care plan. In SFY 2012, 1.5 million CFC clients were enrolled in an MCP, representing 91% of the total CFC population.³³ By contrast, not all those enrolled in ABD Medicaid are required to enroll in a MCP; in SFY 2012, 127,100 ABD clients, were enrolled in an MCP, representing 31% of the total ABD population.³⁴

For a list of consumers who are excluded from, or not required to enroll in, Medicaid managed care, see <http://1.usa.gov/ZuCs2S>

Ohio is moving to place more ABD consumers into Medicaid managed care. As noted earlier, the Integrated Care Delivery System (ICDS) project will use Medicaid managed care plans to manage and coordinate care for 114,000 MMEs (dual eligible), starting in September 2013. Effective July 2013, Ohio will transition the 38,000 children currently enrolled in ABD Medicaid into Medicaid managed care plans.

Medicaid enrollment by delivery system, SFY 2012



Source: ODJFS Data Run, 1/15/2013. Additional calculations by HPIO.

Ohio Medicaid has gone through a process of re-procuring Medicaid managed care contracts, intended to improve quality and health outcomes for consumers. The new contracting period, effective July 1, 2013, reduces the number of managed care service regions from eight to three and combines coverage for ABD and CFC in each region. Five Medicaid managed care plans will provide health services to Ohio Medicaid consumers. New health plan contract language, based on model health plan contract language created by Catalyst for Payment Reform,³⁵ is intended to move the Medicaid managed care plans from paying for volume to paying for value. (For more information about Ohio Medicaid managed care, see <http://jfs.ohio.gov/ohp/bmhc/index.stm>)

Fee-for-Service (FFS)

Consumers who are excluded from, or not required to enroll in Medicaid managed care receive Medicaid services through the fee-for-service system (FFS). Under FFS, Medicaid providers are paid for particular services based on a pre-set schedule of payment. The FFS system operates statewide so a Medicaid enrollee can go to any of the more than 84,000 Ohio Medicaid providers, including hospitals, doctor offices, pharmacies, dentists, and durable medical equipment companies. These providers are authorized to provide health care services to Medicaid enrollees and to bill Medicaid for these services. However, a provider's participation in the Medicaid program is voluntary, and many providers limit the number of Medicaid clients they serve, so enrollees are advised to ask the provider if they accept Medicaid before scheduling an appointment.

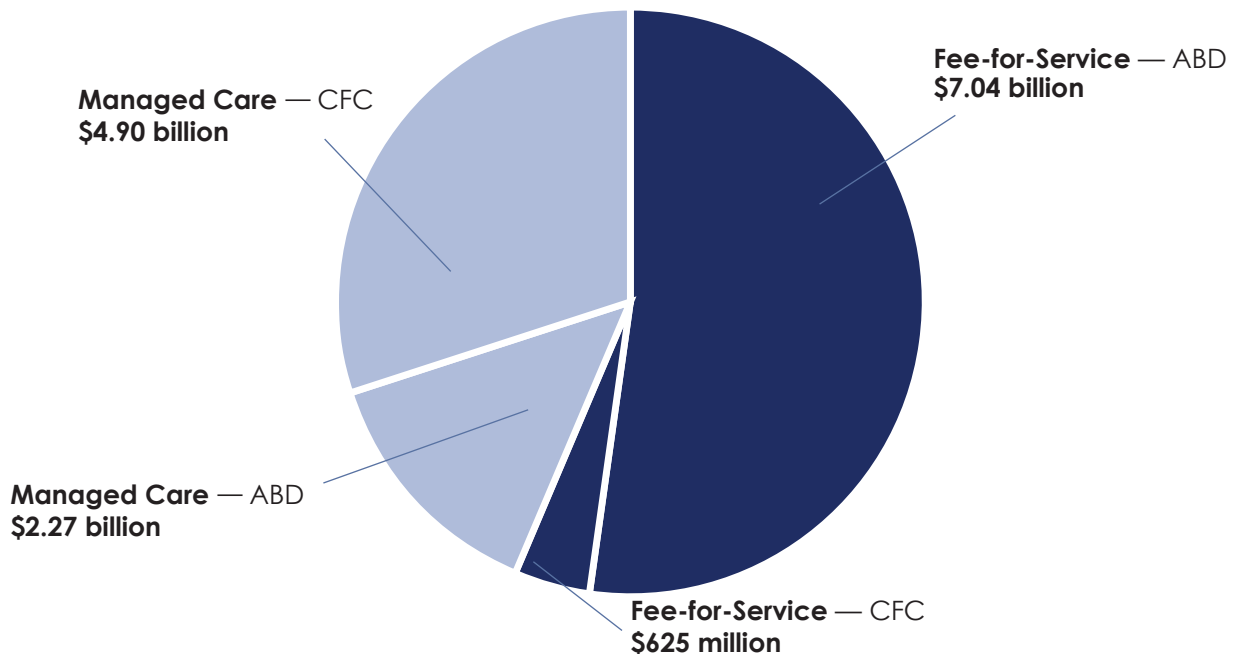
Generally, FFS enrollees are more expensive per person than individuals enrolled in managed care, because many require high-cost, long-term care services, which are excluded from managed care. As a result, the FFS population represents 21% of total Medicaid enrollment and 52% of total Medicaid health care spending.³⁶

Changes ahead for the Hospital Care Assurance Program (HCAP)

Current federal law requires states to operate a Disproportionate Share Hospital (DSH) program that partially reimburses hospitals for uncompensated or free care provided to low-income and uninsured patients, including patients covered by Medicaid.³⁷ Ohio's DSH program, called the Hospital Care Assurance Program (HCAP), is funded by a tax on hospitals, which is used to draw down federal Medicaid matching funds. In exchange for this funding, HCAP requires Ohio hospitals to give free necessary medical care to people who are uninsured with incomes up to 100% FPL.³⁸ Many Ohio hospitals also provide charity care to low income individuals above 100% FPL.³⁹

Due to the expected decrease in the number of uninsured people as a result of health reform, the Affordable Care Act (ACA) reduces DSH payments to hospitals by \$18.1 billion over six years. From 2014 through 2020, payments are reduced to 75% of their current level with funds added back depending on a state's overall uninsured rate decrease.⁴⁰

Medicaid spending by delivery system, SFY 2012



Source: ODJFS Data Run, 1/15/2013. Additional calculations by HPIO.

Medicaid provider rates

Historically, Medicaid pays providers at rates lower than both private insurance and Medicare. Low payment rates are a primary barrier to provider participation in Medicaid.⁴¹ In 2011, 72% of office-based physicians in Ohio accepted new Medicaid patients.⁴² As of 2012, Ohio Medicaid's payment rate for fee-for-service was 61% of Medicare rates for all services.⁴³ The rates that Medicaid managed care plans pay most providers are negotiated between the plan and the provider and can vary from fee-for-service rates. Medicaid managed care plans are required to maintain a "sufficient number, mix and geographic distribution of providers and services."⁴⁴

The Affordable Care Act (ACA) provides a fully federally-funded Medicaid payment rate increase for primary care services to 100% of Medicare payment levels in 2013 and 2014.⁴⁵ This increases payments for primary care services in Ohio by more than 70% in 2013.⁴⁶ The rate increase is meant to encourage greater physician participation in Medicaid and give additional support to those currently providing primary care services to Medicaid patients.

The rate increase applies only to certain providers who deliver primary care services⁴⁷ and is only for 2013 and 2014. States have the option to continue the rate increase beyond 2014 with state funds.⁴⁸

Ohio Medicaid Quality Strategy⁴⁹

The Ohio Medicaid quality strategy is driven by three goals:

- **Better Care:** Improve overall quality by making health care more patient-centered, reliable, accessible and safe.
- **Healthy People/Healthy Communities:** Improve the health of the Ohio Medicaid population by supporting proven interventions to address behavioral, social and environmental determinants of health.
- **Best Evidence Medicine:** Facilitate the implementation of best clinical practices to Medicaid providers through collaboration and quality improvement science approaches.

Ohio Medicaid has identified the seven most costly and prevalent conditions⁵⁰ among the Medicaid population. These clinical focus areas drive the overall quality strategy. For example, a portion of Medicaid payments to managed care plans are linked to improved outcomes for the clinical focus areas. In addition, there are specific initiatives in place to address each of the clinical focus areas, which use quality improvement science to promote the adoption of best clinical practices more widely.

Medicaid and Health Outcomes

Evidence regarding the impact of Medicaid coverage on health outcomes is varied and emerging. Some studies show that patients on Medicaid fare worse than those with private insurance^{51,52,53} and, in some cases, worse than those with no insurance⁵⁴. Other studies have demonstrated positive health outcomes related to Medicaid coverage.^{55,56,57} When reviewing available research, it is important to assess the following:

- **What is the comparison?** Is the study comparing Medicaid coverage vs. no coverage, or Medicaid coverage vs. private insurance, or both?
- **For what variables does the study control?** Comparisons between people with Medicaid and other populations are difficult because it is challenging to fully control for differences between groups (e.g., income, baseline health status, community/family supports, access to care, etc.) that directly affect the use of health care and health outcomes. As a result, it can be difficult to differentiate between causation and correlation. More rigorous study designs help to isolate the impact of Medicaid coverage versus other factors.
- **Limitations to generalizing findings.** Medicaid is a large national program, with wide variation among state plans. Variations in geography, local health care environments, features of state plans, and eligibility categories within Medicaid make it difficult to generalize specific study results to other locations or populations.

Because of the inherent challenges of research involving human beings, the research design of Medicaid outcome studies to date have typically been observational or quasi-experimental, rather than randomized controlled trials — the gold standard of medical and scientific research.

That is changing with the advent of the Oregon Health Study,⁵⁸ an ongoing randomized controlled study that compares adults who received Medicaid coverage as a result of a lottery, with those who did not. After the first year, researchers found that relative to uninsured adults with low incomes, new Medicaid recipients had less medical debt, used more health care, and reported better physical and mental health. To date, the only objective health measure is mortality, on which researchers were unable to detect an effect. Data from the second year will include physical health measures such as blood pressure, obesity, cholesterol, and blood sugar control. The results of the Oregon Health Study are specific to the study's population, plan, and health care environment.

CONTROLLING COSTS IN MEDICAID

Reducing provider reimbursement rates and benefit packages are often cited as the only options for reducing Medicaid costs. While states do have the flexibility to use those methods, it is becoming increasingly difficult to do so without compromising the quality and sustainability of the Medicaid program as cuts accumulate.

Many states are implementing initiatives to reduce Medicaid costs and maintain access to quality care for consumers. The table below outlines key strategies identified by the National Governor's Association⁵⁹ and Ohio's efforts.

Strategy	Components	Ohio
Implement managed care contracting policies	<ul style="list-style-type: none"> Deliver care through managed care plans Develop performance-based contracts Competitive bidding contracts Shared savings models 	<ul style="list-style-type: none"> In 2012, 91% of CFC and 31% of ABD populations received care through managed care plans New contract language, based on model health plan contract language created by Catalyst for Payment Reform, is intended to move plans from paying for volume to paying for value Partners for Kids is a pediatric accountable care organization that serves children covered by Ohio Medicaid and includes a shared savings component⁶⁰
Manage chronic care for complex cases	<ul style="list-style-type: none"> Identify and address the needs of high-risk, high-cost, and vulnerable populations 	<ul style="list-style-type: none"> Ohio Medicaid has identified seven high-cost and prevalent conditions which drive the quality strategy (see page 13) The Medicaid Health Homes project, focusing on individuals with severe and persistent mental illness, integrates physical and behavioral health (see page 15) The Integrated Care Delivery System will comprehensively manage the full continuum of care for Medicare-Medicaid enrollees (see page 9)
Develop capacity to deliver effective long-term care services	<ul style="list-style-type: none"> Deliver more long-term care services and supports in home and community-based settings and less in institutions 	<ul style="list-style-type: none"> Ohio continues to rebalance the mix of long-term care and encourage Medicaid consumers to choose more cost-effective home and community-based services (see page 8) The 2014-2015 Executive Budget includes plans for Ohio to join the Balancing Incentives Payment Program which will further the rebalance towards home and community-based care and earn higher reimbursement
Prevent pre-term births	<ul style="list-style-type: none"> Improve medical interventions to avoid and arrest spontaneous preterm labor Better management of conditions that lead to medically necessary preterm deliveries 	<ul style="list-style-type: none"> High-risk pregnancy and premature births are one of the clinical focus areas in the Ohio Medicaid quality strategy. Current strategies include: <ul style="list-style-type: none"> Elimination of scheduled deliveries prior to 39 weeks Clinical intervention (antenatal steroids) for high-risk mothers
Manage pharmacy costs	<ul style="list-style-type: none"> Cost savings and control policies, while continuing to provide adequate access to prescription drugs 	<ul style="list-style-type: none"> The 2014-2015 Executive Budget includes: <ul style="list-style-type: none"> New cost-sharing requirements for prescription drugs for certain adults A new initiative to monitor and implement cost containment strategies for specialty pharmaceuticals
Build capacity to administer program integrity functions	<ul style="list-style-type: none"> Strengthen the Medicaid Integrity Program by assessing interagency and federal-state coordination and collaboration Fraud and abuse prevention 	<ul style="list-style-type: none"> Ohio's Surveillance and Utilization Review Section (SURS) reviews provider paid claims and identifies potential abuse. The 2014-2015 Executive Budget includes: <ul style="list-style-type: none"> Adding staff to the Medicaid audit team to boost monitoring and recovery capabilities Stronger efforts to identify overpayments and underpayments Strengthening pre- and post-payment review of hospital services to inform coverage and utilization management
Payment innovation*		<ul style="list-style-type: none"> Ohio Medicaid has specific initiatives with key providers including managed care plans, hospitals, and nursing homes to drive paying for value⁶¹ In January 2012, Ohio Medicaid became the first state Medicaid program to join Catalyst for Payment Reform In February 2013, Ohio Medicaid was awarded a State Innovation Model (SIM) grant that will be used to develop a comprehensive plan to expand patient-centered medical homes and episode-based payments for acute medical events for most Ohioans on Medicaid, Medicare, and commercial plans

*Payment innovation is not included in the National Governors Association list of strategies, but is known to be an effective strategy for controlling costs.

Health Homes: Integrating behavioral and physical health

In October 2012, Ohio Medicaid implemented a new person-centered system of care, called a “health home,” to improve care coordination for Medicaid clients with serious and persistent mental illness (SPMI). Because individuals with mental illness commonly have serious medical conditions, this model is intended to break down the traditional silos between behavioral health and physical health care. Case managers, located at community behavioral health providers, will coordinate mental health services and assist individuals with obtaining the physical health care they need as well. In addition, they will link clients to supports such as transportation and child care.

Ohio received federal approval for this program (an option included in the Affordable Care Act) in 2012, and the enhanced federal matching assistance percentage (FMAP) of 90%. The first phase includes five Ohio counties (Adams, Butler, Lawrence, Lucas and Scioto); by the end of SFY 2013, the program will be statewide. (For more information on Medicaid Health Homes, see <http://1.usa.gov/Y5hv1p>)

Consolidate mental health and addiction services

Two Sister State agencies, the Ohio Department of Alcohol and Drug Addiction Services and the Ohio Department of Mental Health, will consolidate into the Ohio Department of Mental Health and Addiction Services, effective July 1, 2013. The new department will promote a combined system of care centered on the individual.

A new eligibility and enrollment system

A number of provisions in the Affordable Care Act require states to design and operate coordinated, technology-supported enrollment processes to assist those who lack access to affordable employer-based coverage in obtaining health coverage through Medicaid, CHIP, or the Exchanges.⁶²

New enrollment systems must be in place by October 1, 2013, for coverage that begins January 1, 2014. States must meet these provisions whether or not they expand Medicaid.

The law requires states to develop enrollment systems that are⁶³:

- **Consumer-friendly:** The systems must ensure that applicants are screened for all available health subsidy programs and enrolled in the appropriate program, with minimal collection of information and documentation from applicants.
- **Coordinated:** Programs must be coordinated and there must be seamless transition between all health coverage programs.
- **Simplified:** States must operate a streamlined enrollment process and foster administrative simplification, using uniform income rules and forms as well as paperless verification procedures.
- **Technology-enabled:** States must use Web portals and securely exchange and utilize data to support the eligibility determination.

Designing and implementing a new system by October 1, 2013 will be challenging, but is critically necessary. Ohio's Enhanced Client Registry Information System (CRIS-E), which supports eligibility determination for Medicaid and other public assistance programs, is more than 30 years old. CRIS-E is a patchwork system that prevents automation and can barely meet the needs of Ohio's current Medicaid and human service programs, resulting in duplication, inefficiency and excessive cost for state and local governments to administer Medicaid and other health and human service eligibility processes.⁶⁴ A new system will automate many administrative tasks that currently are handled manually.

Recognizing the information technology (IT) challenges faced by many states, the federal government has provided a time-limited 90 percent federal matching rate for systems development. In March 2012, Ohio received federal approval for the 90% matching funds to build the new system, which will initially be used for Medicaid eligibility then expanded to support eligibility for other public assistance programs.

For more information on Ohio's efforts to modernize eligibility determination systems, see <http://1.usa.gov/ZuJxk7>

Statewide implementation of presumptive eligibility

Presumptive eligibility refers to the process in which certain qualified providers are empowered to perform a simplified eligibility review and grant immediate medical assistance to people applying for Medicaid (currently limited to children and pregnant women). Those determined presumptively eligible must complete the full application process within 60 days to continue Medicaid coverage. Ohio first implemented presumptive eligibility for children in April 2010, relying on county job and family service (JFS) agencies as the qualified provider. In 2012, Ohio expanded presumptive eligibility to pregnant women and added federally qualified health centers and children's hospitals as qualified providers. Statewide implementation is planned for 2013, at which time other entities may be added as qualified providers.⁶⁵

PROPOSED INITIATIVES

Medicaid expansion

Ohio policymakers face a significant policy decision in 2013: whether to expand Ohio's Medicaid program to people with incomes up to 138% of the Federal Poverty Level (FPL),⁶⁶ (\$26,951 annually for a family of three, in 2013).

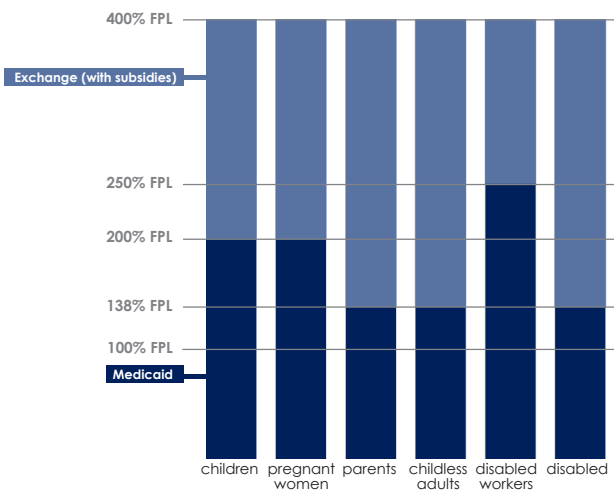
The Patient Protection and Affordable Care Act (ACA), enacted in March 2010, required states to expand Medicaid coverage to individuals with incomes up to 138% FPL. The federal government will pay 100% of the cost for people who are newly eligible for Medicaid from 2014 to 2016, gradually decreasing to 90% in 2020 and beyond. However, in June 2012, the U.S. Supreme Court made expansion of Medicaid optional, rather than required.

Governor Kasich included the Medicaid expansion in 2014-2015 Executive budget, introduced on February 4, 2013. (For an overview of the Governor's proposal, see <http://1.usa.gov/ZBiiYw>) The Executive budget includes an automatic "opt out" trigger that would shut down the program for newly eligible groups if, for any reason, federal funding for expanded coverage is reduced. It is now up to the legislature to debate and decide if Ohio will adopt the expansion.

The graphs below illustrate Ohio Medicaid eligibility with and without the expansion.

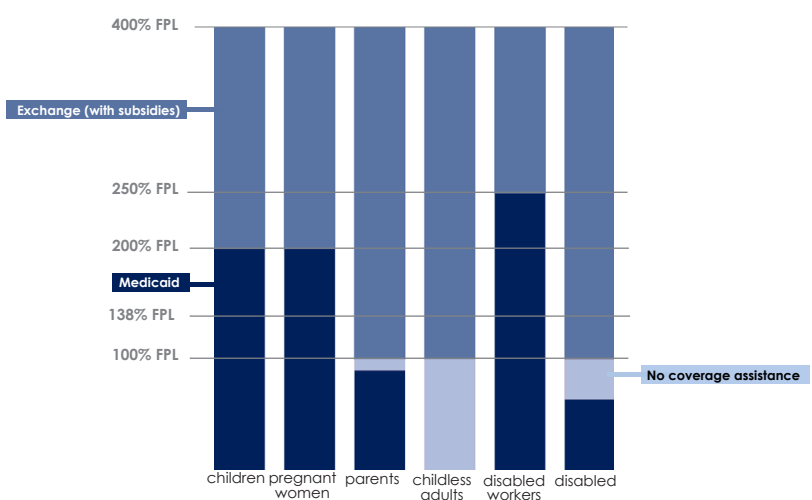
Subsidized health coverage eligibility for Ohioans in 2014

with ACA Medicaid expansion



Subsidized health coverage eligibility for Ohioans in 2014

without ACA Medicaid expansion



The Health Policy Institute of Ohio (HPIO), The Ohio State University (OSU), Regional Economic Models, Inc. (REMI), and the Urban Institute, have partnered on a research study, "Expanding Medicaid in Ohio: Analysis of Likely Effects," to analyze the fiscal impact of a Medicaid expansion on Ohio. (For the expansion study brief, see <http://bit.ly/ZLGk5p> and for HPIO policy brief "Policy Considerations for Medicaid Expansion in Ohio," see <http://bit.ly/13k4O4X>)

Simplify Medicaid eligibility policy

Ohio Medicaid currently has over 150 eligibility categories. The Executive Budget proposes “mapping” those categories into three groups:

1. Children and pregnant women
2. Individuals who are age 65 or older, who have Medicare coverage, or who need long-term care services and supports
3. Community adults — non-pregnant adults who do not need long-term care services and supports, including individuals eligible as parents or caretaker relatives. This category includes those who would be newly eligible for Medicaid, if the proposed Medicaid expansion is adopted.

Eligibility criteria and standards for the first two simplified groups would not change. The third group, community adults, will see significant changes in eligibility standards if the proposed Medicaid expansion is adopted, and a proposed Medicaid benchmark benefit package. (For more details, see <http://1.usa.gov/ZBiiYw>)

New cost sharing requirements

The Executive budget proposes new cost sharing requirements for every adult enrolled in Medicaid over 100% FPL, including:

- \$8 copayment for use of an emergency room for non-emergency conditions
- \$8 copayment for non-preferred drugs
- \$3 copayment for preferred drugs

(Note: certain long-term maintenance drugs, such as insulin, will have no co-pay.)

ACKNOWLEDGMENTS

HPIO thanks Dan Hecht and his colleagues in the Data Research Unit within the Office of Medical Assistance for producing much of the data for this report. Their timely assistance and insight are much appreciated.

GENERAL DATA NOTES

ODJFS data in this report comes from the Decision Support System, during the last week of December 2012. The data is based upon Paid Dates of Service.

Payment data for SFY 2012 is not complete. Services from Sister Agencies (those providing Medicaid reimbursable services which are monitored by an agency other than ODJFS) are included, but due to data issues, only the federal portion of the payment is reflected in this portion of the data.

Unless otherwise noted, enrollment data reflects average monthly enrollment.

The Health Policy Institute of Ohio is an independent organization that is not affiliated with Ohio Medicaid. For questions about the Ohio Medicaid program, please call

1-877-852-0010

or visit

<http://jfs.ohio.gov/Ohp/>



www.hprio.net

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

Aged, Blind, Disabled (ABD) – A Medicaid eligibility category that includes individuals who are low income and who are aged 65 years or older, blind or disabled (disability as classified by the Social Security Administration for an adult or child).

Alien Emergency Medical Assistance (AEMA) – A category of Medicaid that provides coverage for the treatment of an emergency medical condition for certain individuals who do not meet Medicaid citizenship requirements. Only care related to the emergency medical condition is covered; ongoing treatment is not covered.

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

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

Children’s Health Insurance Program (CHIP) – Enacted in 1997, CHIP is a federal-state program that provides health coverage for children who live in families with incomes too high to qualify for Medicaid, but who cannot afford private coverage. States have the option of administering CHIP through their Medicaid programs or through a separate program, or a combination of both. Formerly known as SCHIP, or the State Children’s Health Insurance Program, the name was changed when the program was reauthorized in 2009.

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

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

Disproportionate Share Hospital Program (DSH) – A federal program that works to increase health care access for the poor. Hospitals that treat a “disproportionate” number of Medicaid and other indigent patients qualify for higher Medicaid payments based on the hospital’s estimated uncompensated cost of services to the uninsured and underinsured. Ohio’s DSH program is called the Hospital Care Assurance Program (HCAP).

Dual Eligible – A person who is eligible for two health insurance plans, often referring to a person who is enrolled in both Medicare and Medicaid. (See also Medicare-Medicaid Enrollees.)

Federal Medical Assistance Percentage (FMAP) – The statutory term for the federal Medicaid matching rate—i.e., the share of the costs of Medicaid services or administration that the federal government bears.

Federal Poverty Level (FPL) – Annually updated guidelines established by the U.S. Department of Health and Human Services to determine eligibility for various federal and state programs. In 2013, the FPL for a family of four is \$23,550.

Federally-Qualified Health Center (FQHC) – FQHCs are community-based and patient-directed organizations that serve populations with limited access to health care. The centers are located in a medically under-served area or population. Centers must meet certain requirements and then are eligible to receive cost based Medicare and Medicaid reimbursement. FQHCs are sometimes referred to as CHCs (Community Health Centers).

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

General Revenue Fund (GRF) – Resources are allocated by the state for programs from this fund. GRF is composed of all revenues from state taxes, as well as reimbursements from the federal government for some GRF expenditures. Ohio counts the federal match on Medicaid spending as part of the state GRF.

Health Insurance Marketplace – (initially known as Health Insurance Exchanges, or Exchanges) The Health Insurance Marketplace is a competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans, starting January 1, 2014. Exchanges offer a choice of health plans that meet certain benefits and cost standards. The Exchange can set standards beyond those required by the federal government, accept bids, and negotiate contracts with insurers. Under the ACA, states have the option to establish their own marketplaces, allow the federal government to run the marketplace, or partner with the federal government to run the marketplace.

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

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

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

Medicaid – A joint federal-state program that provides health care for low-income people who meet both income and categorical requirements. Under broad federal guidelines, states establish their own standards for Medicaid eligibility, benefits, and provide payment rates.

Medicaid Health Homes – A coordinated, person-centered system of care. An individual who is eligible for health home services can obtain comprehensive medical, mental health and drug and/or alcohol addiction treatment, and social services that are coordinated by a team of health care professionals.

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

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

Medicare-Medicaid Enrollees (MMEs) – People who are enrolled in both Medicare and Medicaid. (Also known as Dual Eligibles.)

Presumptive Eligibility – The process in which certain qualified entities are empowered to perform a simplified eligibility review and grant immediate medical assistance to people applying for Medicaid (currently limited to children and pregnant women). Those determined presumptively eligible must complete the full application process within 60 days to continue Medicaid coverage.

Sister State Agencies – State agencies that provide Medicaid reimbursable services which are monitored by an agency other than the Ohio Department of Job and Family Services. Sister state agencies include the Ohio Departments of Aging (ODA), Alcohol and Drug Addiction Services (ODADAS), Developmental Disabilities (ODODD), Health (ODH), and Mental Health (ODMH).

Spend-down – Aged, blind and disabled individuals whose income is too high but who would otherwise be eligible for Medicaid may become eligible on a month-to-month basis through a Medicaid spend-down. The spend-down allows individuals to deduct medical expenses from their income until they meet financial eligibility guidelines. Once the spend-down is reached, consumers are eligible for Medicaid for the rest of the month.

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

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

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

Transitional Medicaid – A category of Medicaid in which people who lose Medicaid eligibility due to earned income may be eligible to maintain Medicaid coverage for a transition period of up to twelve months.

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

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5. Federal Register/ Vol. 75, No. 217/ Wednesday, November 10, 2010/Notices.
6. Ibid.
7. ODJFS Data Run, 1/15/2013. Additional calculations by HPIO.
8. ODJFS Data Run, 1/16/2013.
9. ODJFS Data Run, 1/15/2013. Additional calculations by HPIO.
10. Immigrants who arrived in the U.S. before August 22, 1996 may be eligible for Medicaid if they meet other eligibility guidelines. With certain exceptions, immigrants who arrived on or after August 22, 1996 are not eligible for Medicaid. For a list of exceptions, see "ODJFS Fact Sheet: Immigrant, Their Children, and Medicaid." Downloaded 1/24/2013 at http://jfs.ohio.gov/OHP/bcps/FactSheets/Immigrants_0607.pdf.
11. People who lose Medicaid eligibility due to earned income may be eligible to maintain Medicaid coverage for a transition period of up to twelve months. See Ohio Revised Code 5101:1-40-05 Medicaid: Transitional Medicaid. Downloaded 2/20/2013 at <http://codes.ohio.gov/oac/5101%3A1-40-05>
12. Payment data for SFY 2012 is not complete. Only the federal portion of services from Sister Agencies (those outside ODJFS) are included in these figures. Source: ODJFS Data Run 1/16/2013. Additional calculations by HPIO.
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22. Payment data for SFY 2012 is not complete. Only the federal portion of services from Sister Agencies (those outside ODJFS) are included in these figures. Source: ODJFS Data Run 1/16/2013. Additional calculations by HPIO.
23. For more information, see "Transfer of Assets in the Medicaid Program," January 8, 2008. CMS. Downloaded 1/30/2013 at <http://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/downloads/TOAbackgrounder.pdf>
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25. ODJFS Data Run, 1/16/2013. Additional calculations by HPIO.
26. ODJFS Data Run, 1/16/2013.
27. "ODJFS Fact Sheet: Medicaid Program Overview." Downloaded 1/17/2013 at <http://jfs.ohio.gov/ohp/bcps/FactSheets/Medicaid.pdf>.
28. December 12, 2012 news release, "Kasich Administration Announces State-Federal Agreement on Coordinated Care Delivery Program for Ohio Seniors." Downloaded 1/24/2013 at <http://governor.ohio.gov/Portals/0/12.12.12.%20Dual%20Eligibles%20Release%20FINAL.pdf>
29. Ohio contracts with managed care plans to provide a comprehensive set of benefits to Medicaid consumers. Mental health services and drug and substance abuse treatment are "carved out" of Ohio's contract with managed care plans and provided through Ohio's community behavioral health system.
30. 42 C.F.R. § 440.230
31. ODJFS "Medicaid Copayments." Downloaded 1/17/2013 at <http://jfs.ohio.gov/OHP/consumers/copay.stm>
32. Ibid.
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34. Ibid.
35. Catalyst for Payment Reform (CPR) is an independent organization led by health care purchasers, with active involvement of providers, health plans, consumers and labor groups working to improve quality and reduce costs by identifying and coordinating workable solutions to improve how we pay for health care in the U.S. Ohio Medicaid joined CPR in January 2012, becoming the first state Medicaid program to do so. For more information about CPR, see http://www.catalyzepaymentreform.org/Home_Page.html
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39. Ohio Hospital Association HCAP, Uncompensated and Charity Care Fact sheet. Downloaded 3/11/2013 at <http://www.ohanet.org/wp-content/uploads/2012/01/Charity-Care-Fact-Sheet-updated-09-2-11.pdf>
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