Redbook

LBO Analysis of Executive Budget Proposal

Ohio Department of Medicaid

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LBO Redbook

Ohio Department of Medicaid

Quick look…

- Medicaid is a joint federal-state program that provides health insurance coverage to 3 million low-income Ohioans, including 1.2 million children.
- As an entitlement program, Medicaid services are guaranteed to those who are eligible.
- At an annual spending of $26.34 billion in combined federal and state dollars in FY 2018, Medicaid is the largest single state program and accounts for about 4% of Ohio's economy.
  - Medicaid is the largest spending area of the combined state and federal GRF budget and the second largest area (behind K-12 education) in the state-only GRF budget.
- The Ohio Department of Medicaid (ODM) administers Ohio Medicaid with the assistance of the Ohio Department of Developmental Disabilities (ODODD), six other state agencies, and various local partners.
  - About 99% of all-funds expenditures for Ohio Medicaid are disbursed by ODM and ODODD.
  - 100% of all-funds Medicaid service expenditures are disbursed by ODM and ODODD. The other six agencies incur only administrative spending.
- Affordable Care Act (ACA) coverage began in January 2014 in Ohio. The state share for these individuals started in the second half of FY 2017 at 5% and gradually increases to 10% beginning in the second half of FY 2020.

All-funds Medicaid*	FY 2018 Actual	FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
Agency				
ODM	$23,396,146,057	$23,956,322,705	$24,664,503,844	$25,779,189,960
ODODD	$2,652,175,048	$2,789,253,827	$3,160,101,036	$3,333,516,058
Job and Family Services	$255,370,678	$262,869,931	$269,072,887	$269,454,085
Health	$26,799,977	$27,961,668	$32,389,148	$32,787,199
Mental Health and Addiction Services	$4,258,248	$12,251,639	$12,091,876	$12,251,713
Aging	$5,892,897	$7,165,937	$10,734,899	$11,123,013
Pharmacy Board	$1,709,531	$2,325,400	$2,616,847	$2,639,000
Education	$276,354	$595,956	$593,478	$593,478
Grand Total	**$26,342,628,789**	**$27,058,747,063**	**$28,152,104,015**	**$29,441,554,506**
ODM Share	88.8%	88.5%	87.6%	87.6%
ODODD Share	10.1%	10.3%	11.2%	11.3%
Expense Type				
Services	$25,375,193,270	$25,626,697,912	$26,918,005,410	$28,180,478,055
Administration	$967,435,519	$1,432,049,151	$1,234,098,605	$1,261,076,451
Grand Total	**$26,342,628,789**	**$27,058,747,063**	**$28,152,104,015**	**$29,441,554,506**
Services Share	96.3%	94.7%	95.6%	95.7%
Administration Share	3.7%	5.3%	4.4%	4.3%

*To avoid double counting, the appropriation for line item 651655, Medicaid Interagency Pass-Through, is not included in the Department of Medicaid total. Item 651655 is used to disburse federal reimbursements to other agencies for Medicaid expenditures that they have made.

All-Agency All-Funds*	FY 2014 Actual	FY 2015 Actual	FY 2016 Actual	FY 2017 Actual	FY 2018 Actual	FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
	Amount ($ in millions)							
GRF – State	$5,349.1	$5,509.6	$5,328.4	$5,644.2	$5,003.4	$5,192.7	$5,517.5	$6,113.2
GRF – Federal	$8,221.4	$9,353.6	$11,667.5	$11,793.2	$9,479.1	$9,632.9	$9,696.0	$10,456.0
GRF – Total	**$13,570.5**	**$14,863.2**	**$16,995.9**	**$17,437.4**	**$14,482.5**	**$14,825.6**	**$15,213.5**	**$16,569.3**
Non-GRF – State	$1,999.5	$1,873.8	$2,397.4	$2,284.1	$3,357.1	$3,368.0	$3,625.0	$3,647.2
Non-GRF – Federal	$5,289.1	$6,730.1	$5,900.6	$5,828.7	$8,503.0	$8,865.1	$9,313.6	$9,225.1
Grand Total	**$20,859.1**	**$23,467.1**	**$25,293.8**	**$25,550.1**	**$26,342.7**	**$27,058.7**	**$28,152.1**	**$29,441.6**
Annual % Change	**--**	**12.5%**	**7.8%**	**1.0%**	**3.1%**	**2.7%**	**4.0%**	**4.6%**
	Share							
GRF – State	25.6%	23.5%	21.1%	22.1%	19.0%	19.2%	19.6%	20.8%
GRF – Federal	39.4%	39.9%	46.1%	46.2%	36.0%	35.6%	34.4%	35.5%
Non-GRF – State	9.6%	8.0%	9.5%	8.9%	12.7%	12.4%	12.9%	12.4%
Non-GRF – Federal	25.4%	28.7%	23.3%	22.8%	32.3%	32.8%	33.1%	31.3%
Grand Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Total GRF Share	**65.1%**	**63.3%**	**67.2%**	**68.2%**	**55.0%**	**54.8%**	**54.0%**	**56.3%**
Total Federal Share	**64.8%**	**68.5%**	**69.5%**	**69.0%**	**68.3%**	**68.4%**	**67.5%**	**66.8%**

*To avoid double counting, the appropriation for line item 651655, Medicaid Interagency Pass-Through, is not included.

Medicaid program overview

Medicaid is a publicly funded health insurance program for low-income individuals. It is a federal-state joint program: administered by the states and funded with federal, state, and, in some states like Ohio, local revenues. The federal government establishes and monitors certain requirements concerning funding, eligibility standards, and quality and scope of medical services. In Ohio, Medicaid covers 3.0 million low-income adults, children, pregnant women, seniors, and individuals with disabilities each year. Ohio Medicaid is the largest health insurer in the state. It is also the largest single state program with annual spending of about $27 billion in combined federal and state dollars. Medicaid accounts for 4% of Ohio's economy. Medicaid services are an entitlement for those who meet eligibility requirements, meaning that if an individual is eligible for the program then they are guaranteed the benefits and the state is obligated to pay for them.

Another federal-state joint health care program, which has been implemented as a Medicaid expansion in Ohio, is the State Children's Health Insurance Program (SCHIP). This program provides health care coverage for children in low- and moderate-income families who are ineligible for Medicaid but cannot afford private insurance.

Ohio's Medicaid Program is among the largest in the nation. It includes coverage for the following:

- 1.2 million children, from birth to age 18;
- 51% of all Ohio children under age five;
- 200,000 senior citizens;
- 50,000 individuals residing in nursing facilities; and
- 100,000 individuals on home and community-based waivers.

The federal government requires each state to designate a "single state agency" to administer its Medicaid Program. The Ohio Department of Medicaid (ODM) is the single state agency for Ohio under the federal regulation. As Ohio's single state agency, ODM must retain oversight and administrative control of the Ohio Medicaid Program and assure the federal Centers for Medicare and Medicaid Services (CMS) that federally set standards are maintained. Federal law allows a state's single agency to contract with other public and private entities to manage aspects of the program. ODM administers the program with the assistance of other state agencies, county departments of job and family services, county boards of developmental disabilities, and area agencies on aging. ODM contracts with the following state agencies to administer various Ohio Medicaid programs through interagency agreements:

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

- Ohio Board of Pharmacy.

ODODD provides services to disabled individuals through home and community-based Medicaid waiver programs. ODODD also provides services to severely disabled individuals at eight regional developmental centers throughout the state and pays private intermediate care facilities for Medicaid services provided to individuals with intellectual or other developmental disabilities. In addition, ODODD provides subsidies to, and oversight of, Ohio's 88 county developmental disabilities (DD) boards. County boards arrange for more than 90,000 adults and children to receive comprehensive services, which include residential support, early intervention, and family support.

ODJFS provides funding to county departments of job and family services (CDJFSs) to administer Medicaid at the local level and to provide certain transportation services to Medicaid enrollees. Local administrative activities mainly include caseworkers processing eligibility determinations. CDJFSs arrange for various transportation services to be provided to Medicaid enrollees.

ODH works with CMS and functions as Ohio's state survey agency for the certification of Medicare and Medicaid health care providers. In this role, ODH, among other things, surveys and certifies facilities, such as long-term care and residential care facilities and hospitals, participating in the Medicaid Program to ensure compliance with state and federal rules and regulations. ODODD certifies intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) beds. Certification is required for a provider to receive reimbursement from Medicaid.

OhioMHAS works with local boards to ensure the provision of mental health services. Ohio has 51 community behavioral health boards, which serve all 88 counties. The boards are responsible for planning, monitoring, and evaluating the service delivery system within their geographic areas. The local boards contract with local service providers to deliver mental health services in the community.

ODA administers Medicaid programs such as the Pre-Admission Screening System Providing Options and Resources Today (PASSPORT) Medicaid waiver, the Assisted Living Medicaid waiver, and the Program for All-Inclusive Care (PACE).

ODE administers the Medicaid Schools Program, which provides districts with reimbursement for services provided to Medicaid-eligible students and reimburses ODE for the cost of administering the program. These costs include technical assistance and program monitoring to verify federal program mandates and assure program compliance and accountability.

The State Board of Pharmacy uses Medicaid funds for the Ohio Automated Rx Reporting System (OARRS) Integration Initiative, an effort under the State Medicaid Health Information Technology Plan to integrate OARRS directly into electronic medical records and pharmacy dispensing systems across the state. The goal of this initiative is to provide healthcare providers with information regarding a patient's controlled substance prescription history, support clinician interventions for patients with high-risk behaviors, and reduce the number of patients who present at multiple prescriber sites to obtain controlled substances.

ODM contracts with CDJFSs to perform eligibility determination and enrollment. Most of these activities are done utilizing the new integrated eligibility system, Ohio Benefits, which was implemented on October 1, 2013. Ohio Benefits replaced the old eligibility system known as the Client Registry Information System-Enhanced (CRIS-E). ODM provides technical assistance to counties and assists them to implement eligibility policy.

The executive budget provides a total appropriation for the Medicaid Program of $28.15 billion in FY 2020, a 4.0% increase over FY 2019's estimated spending of $27.06 billion, and $29.44 billion in FY 2021, a 4.6% increase over FY 2020. The breakdowns of the executive's total Medicaid recommendations by agency and by service versus administrative cost can be found on page 1 of the publication. Table 1 below shows the executive recommended appropriations for Medicaid funding for all agencies by fund group.

Table 1. Executive Medicaid Budget Sources by Fund Group*

Fund Group	FY 2019	FY 2020	FY 2021
General Revenue Fund	$14,825,579,515	$15,213,525,105	$16,569,270,776
Federal Share	*$9,632,895,893*	*$9,695,975,237*	*$10,456,031,296*
State Share	*$5,192,683,622*	*$5,517,549,868*	*$6,113,239,480*
Dedicated Purpose Fund	$3,359,025,592	$3,615,308,943	$3,637,155,224
Federal Fund	$8,865,141,956	$9,313,550,620	$9,225,128,506
Internal Service Activity Fund	$8,000,000	$8,719,347	$9,000,000
Holding Account Fund	$1,000,000	$1,000,000	$1,000,000
Total	**$27,058,747,063**	**$28,152,104,015**	**$29,441,554,506**

*To avoid double counting, the appropriation for line item 651655, Medicaid Interagency Pass-Through, is not included.

For the FY 2020-FY 2021 biennium, GRF appropriations account for the largest portion (55.2%) of the executive recommended funding for the Medicaid Program. About 63.4% of the GRF funding is federal Medicaid reimbursement. Federal funds account for the next largest share of recommended funding at 32.2%. Federal funds include primarily federal reimbursements for Medicaid services and administrative activities that are not deposited into the GRF.

Dedicated Purpose Funds account for 12.6% of the recommended funding. Sources of these funds mainly include the following:

- Revenue generated from the managed care franchise fee;
- Revenue generated from hospital assessments;
- Revenue generated from nursing home and hospital long-term care unit franchise permit fees;
- Revenue generated from the ICFs/IID franchise permit fee;
- Prescription drug rebate revenue; and
- Recoveries from third-party liabilities.

The revenues from provider taxes (also referred to as franchise fees) are appropriated in ODM and ODODD's budgets. Table 2 below provides revenue that the state collects from the various provider types.

Table 2. Franchise Fee Revenue ($ in millions)				
Provider Type	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Managed Care	$779	$802	$805	$791
Hospital	$642	$657	$822	$887
Nursing Facility	$410	$409	$409	$409
ICF/IID	$51	$41	$40	$40
Total	**$1,882**	**$1,909**	**$2,076**	**$2,127**

Table 3 below shows the actuals as well as the executive's recommended budget for using the various franchise fee revenues and the corresponding estimated federal share by appropriation line item. If the state spends the franchise fee revenue on Medicaid-related services or activities, the state can draw down federal reimbursement. The federal medical assistance percentage (FMAP) represents the portion of total qualified Medicaid spending that is reimbursed by the federal government.

Table 3. ALI Appropriations by Franchise Fee Type and the Corresponding Federal Share ($ in millions*)						
Fund	**ALIs**	**State or Federal Share**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
5TN0	651684	State	$593	$661	$821	$791
5SA4**	651689	State	$196	$227	$0	$0
3F00	651623	Federal	$1,325	$1,513	$1,400	$1,354
	Managed Care Total		**$2,114**	**$2,401**	**$2,221**	**$2,145**
5GF0	651656	State	$619	$647	$822	$887
3F00	651623	Federal	$1,039	$1,102	$1,401	$1,519
	Hospital Total		**$1,658**	**$1,749**	**$2,223**	**$2,406**
5R20	651608	State	$406	$406	$416	$416
3F00	651623	Federal	$682	$692	$709	$712
	Nursing Facilities Total		**$1,088**	**$1,098**	**$1,125**	**$1,128**
5GE0	653606	State	$37	$36	$40	$40
3A40	653654	Federal	$32	$30	$25	$25
	ICF/IID Total		**$69**	**$65**	**$65**	**$65**
	Grand Total		**$4,929**	**$5,314**	**$5,634**	**$5,744**
	Assumed FMAP		**62.67%**	**63.01%**	**63.03%**	**63.13%**

*Figures related to the ICF/IID franchise fee were provided by ODODD. The remaining figures are from ODM.

**A portion of the managed care franchise fee revenue was transferred from Fund 5TN0 into Fund 5SA4 during the FY 2018-FY 2019 biennium. For the upcoming biennium, all such revenue will be retained in Fund 5TN0.

Federal reimbursement

Table 4 below shows the FMAP received or anticipated to be received by quarter for state FY 2015 through FY 2021. The regular FMAP is the amount each state typically receives for providing Medicaid services. It is calculated each year for each state and is based on the state's per capita income. States with higher per capita incomes will have lower FMAPs and vice versa. An enhanced FMAP (eFMAP) is provided for certain services, including services provided under SCHIP. Under SCHIP, each state is given an allotment of federal funds. Subject to the availability of funds from the state's allotment, the eFMAP is used to determine the federal share of the cost of SCHIP. Each state's eFMAP is calculated by reducing the state's share under the regular FMAP by 30%. However, under the ACA, each state's eFMAP for most SCHIP expenditures was increased by 23 percentage points for federal fiscal year (FFY) 2016 through FFY 2019. In federal fiscal year 2019, Ohio's eFMAP for SCHIP is 97.16% The Healthy Kids Act modifies the eFMAP for FFY 2020 by specifying an increase of 11.5 percentage points. As such, Ohio's eFMAP will be 85.61%. This increase will be eliminated in FFY 2021. States receive a higher FMAP for services provided to the Group VIII population. The FMAP was the following for each calendar year: 100% from 2014 through 2016, 95% in 2017, 94% in 2018, 93% in 2019, and 90% in 2020 and each year thereafter.

Table 4. Federal Match Rates, SFY 2015 Quarter 1-SFY 2021 Quarter 1

State Fiscal Year (SFY)	SFY Qtr.	Regular FMAP	SCHIP	Group VIII
2015	1	63.02%	74.11%	100.00%
2015	2	62.64%	73.85%	100.00%
2015	3	62.64%	73.85%	100.00%
2015	4	62.64%	73.85%	100.00%
2016	1	62.64%	73.85%	100.00%
2016	2	62.47%	96.73%	100.00%
2016	3	62.47%	96.73%	100.00%
2016	4	62.47%	96.73%	100.00%
2017	1	62.47%	96.73%	100.00%
2017	2	62.32%	96.62%	100.00%
2017	3	62.32%	96.62%	95.00%
2017	4	62.32%	96.62%	95.00%
2018	1	62.32%	96.62%	95.00%
2018	2	62.78%	96.95%	95.00%
2018	3	62.78%	96.95%	94.00%
2018	4	62.78%	96.95%	94.00%
2019	1	62.78%	96.95%	94.00%
2019	2	63.09%	97.16%	94.00%
2019	3	63.09%	97.16%	93.00%
2019	4	63.09%	97.16%	93.00%

Table 4. Federal Match Rates, SFY 2015 Quarter 1-SFY 2021 Quarter 1				
State Fiscal Year (SFY)	SFY Qtr.	Regular FMAP	SCHIP	Group VIII
2020	1	63.09%	97.16%	93.00%
2020	2	63.02%	85.61%	93.00%
2020	3	63.02%	85.61%	90.00%
2020	4	63.02%	85.61%	90.00%
2021	1	63.02%	85.61%	90.00%

ODM budget recommendation summary

Staffing levels

According to the Ohio Department of Administrative Services, as of January 2019, ODM had 580 full-time permanent employees and 18 temporary or intermittent employees.

Appropriations

Appropriations by fund group

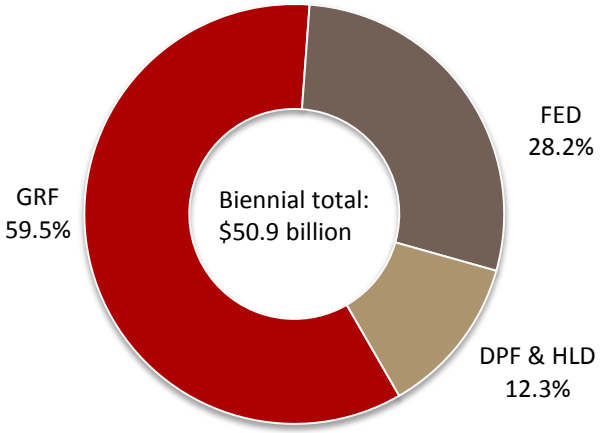
The executive budget provides a total appropriation for ODM of $24.89 billion in FY 2020 and $26.00 billion in FY 2021. Table 5 and Chart 1 show the executive recommended appropriations by fund group.

Table 5. Executive Appropriations by Fund Group*

Fund Group	FY 2018 Actual	FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
General Revenue Fund (GRF)	$13,806,565,296	$14,142,519,498	$14,451,399,003	$15,805,747,194
Federal Share	*$9,479,085,299*	*$9,632,895,893*	*$9,695,975,237*	*$10,456,031,296*
State Share	*$4,327,479,997*	*$4,509,623,605*	*$4,755,423,766*	*$5,349,715,898*
Dedicated Purpose Fund (DPF)	$2,980,517,664	$2,946,906,481	$3,176,085,023	$3,117,923,903
Federal Fund (FED)	$6,727,041,654	$7,091,598,323	$7,261,721,415	$7,080,220,460
Holding Account Fund (HLD)	$148,673	$1,000,000	$1,000,000	$1,000,000
Total	$23,514,273,287	$24,182,024,302	$24,890,205,401	$26,004,891,557
% Change	--	*2.8%*	*2.9%*	*4.5%*
GRF % Change	--	*2.4%*	*2.2%*	*9.4%*

*The appropriation for line item 651655, Medicaid Interagency Pass-Through, is included in the Department of Medicaid's total. Again, item 651655 is used to disburse federal reimbursements to other agencies for Medicaid expenditures that they have made. In the "**Overview**" section, which details all agency Medicaid spending, this is not included to avoid double counting.

Chart 1: ODM Budget Sources by Fund Group
FY 2020-FY 2021



As shown in the chart above, appropriations from the GRF make up a majority of the recommended funding for ODM for the biennium at 59.5%. The GRF appropriations include the Medicare Part D clawback payments,[1] and the state share for Medicaid expenditures. The GRF appropriations also include federal grant amounts (federal reimbursement) for Medicaid service expenditures.

The Federal Fund Group accounts for the next largest portion of recommended funding for ODM at 28.2%, which includes federal reimbursement for Medicaid payments for both service and administrative expenditures. The Dedicated Purpose Fund Group accounts for 12.3% and the Holding Account Fund Group accounts for less than 1.0%.

[1] The clawback is a monthly payment made by each state to the federal Medicare Program. The amount of each state's payment roughly reflects the expenditures of its own funds that the state would have made if it continued to pay for outpatient prescription drugs through Medicaid on behalf of dual-eligibles.

Major initiatives for the FY 2020 and FY 2021 biennium

Table 6 below provides a list of the FY 2020-FY 2021 biennial budget initiatives proposed by the executive, the start date, and the overall fiscal impact on Ohio's Medicaid Program for each. Following the table is a brief description of each initiative. Along with the description is the impact on the GRF, which includes both overall and state share GRF.

Table 6. FY 2020-FY 2021 Biennium New Initiatives ($ in millions)

Initiative Number	Initiatives	Start Date	FY 2020	FY 2021
1	Home Visiting	1-Jan-20	$13.4	$33.7
2	Linking Pregnant Moms to Services	1-Jul-20	--	$10.0
3	12-Month Enhanced Postpartum Care	1-Jul-20	--	$15.0
4	Mother/Baby Dyad Care for Women with OUD	1-Jan-20	$5.2	$10.4
5	Behavioral Health in Schools	1-Jan-20	$5.0	$10.0
6	Expand Telehealth	1-Jan-20	$5.0	$10.0
7	Establish Multi-System Youth and Innovation Support Fund	1-Jul-19	$10.0	$10.0
8	Access to Autism Services	1-Jul-20	--	$28.1
9	Wellness for Kids: Pediatric CPC	1-Jan-20	$4.0	$8.0
10	Lead Testing and Hazard Control	1-Jul-19	$5.0	$5.0
11	1115 SUD Waiver Authorization/Evaluation	1-Jan-20	$2.5	$5.0
12	Add Behavioral Health Care Coordination	1-Jan-20	$204.9	$133.1
13	Procuring Managed Care Value	1-Jul-19	$3.5	$3.5
14	Modernizing Pharmacy Program	1-Jul-20	--	$35.0
15	Work Requirement	1-Jul-19	$15.5	$12.5
16	Eliminate Automatic NF Rate Inflator	1-Jul-19	-$74.8	-$164.8
17	Ensuring Access to Community Support – Ambulance and Wheelchair Van	1-Jul-19	$10.2	$20.4
18	ODODD Waiver	1-Jan-20	$58.7	$138.8
19	Increase Managed Care Performance Withhold	1-Jan-20	-$67.1	-$141.3
20	Managed Care Lower Bound Trend Assumption	1-Jan-20	-$80.4	-$251.0
21	Billing of Retroactive Member Months	1-Jul-19	--	--
22	Program Integrity	1-Jan-20	-$5.0	-$10.0
23	Hospital Franchise Fee Alignment	1-Jul-19	$383.3	$502.8

1. Home visiting

H.B. 166 provides $13.4 million in GRF ($4.0 million state share) in FY 2020 and another $33.7 million in GRF ($10.1 million state share) in FY 2021 for home visiting services provided under the Medicaid Program. Home visiting services support individuals by assisting them in accessing services and learning the necessary skills to raise children who are physically, socially, and emotionally healthy and ready to learn. Typical components of a home visiting program include: (1) screening services to help prevent and identify potential physical, mental, development, and other problems, (2) case management services such as conducting assessments, developing a care plan, providing referrals, and scheduling treatment, and (3) family support, counseling, and skills training to help parents address specific infant and young child needs.

2. Linking pregnant mothers to services

H.B. 166 provides $10.0 million in FY 2021 in non-GRF funds to identify women early in their pregnancies in order to link them to services that will allow for healthier deliveries. An example of a service that may be provided are progesterone shots. Progesterone shots increase a woman's chances of having a full-term baby by helping prevent contractions.

3. 12-Month enhanced postpartum care

H.B. 166 provides $15.0 million in GRF ($5.4 million state share) in FY 2021 for a 12-month enhanced postpartum care initiative. Currently, pregnant women may qualify for Medicaid if they reside in a household with an income at or below 200% federal poverty level (FPL). This FPL is higher than traditional Medicaid eligibility. Pregnant women who are enrolled under the higher FPL are provided care for the duration of their pregnancy and up to 60 days after the baby is born. Under this initiative, the postpartum period of coverage would be extended to cover a 12-month period instead. While this would cover all eligible pregnant women, ODM hopes to target women with substance use disorder. ODM estimates that approximately 14,000 women would receive this extended coverage.

ODM will need to obtain CMS approval to provide this enhanced coverage.

4. Mother/baby dyad care for women with opioid use disorder

H.B. 166 provides $5.2 million in GRF ($1.6 million state share) in FY 2020, and $10.4 million ($3.1 million state share) in FY 2021 to provide support for mothers and babies born with opioid addiction by providing treatment and support to co-located mother and child rather than separation during treatment. Babies born with neonatal abstinence syndrome develop a wide range of neurologic and other issues associated with opioid withdrawal. Some studies have indicated that a mother/baby dyad approach could reduce the length of hospital stays, which could ultimately decrease neonatal intensive care unit (NICU) costs. ODM anticipates that over 2,000 mothers/babies could utilize these services and expects treatment length to be approximately 18 days.

5. Behavioral health in schools

H.B. 166 provides $5.0 million in GRF ($1.5 million state share) in FY 2020, and $10.0 million ($3.0 million state share) in FY 2021 to increase access to behavioral health services within schools. The intention of this initiative is to provide students with access to behavioral health services on their school campus through the use of telehealth services. Currently, students need to leave their school campus to receive these services. ODM expects that regular access to behavioral health services could prevent the need for costly stabilization and treatment in an emergency room.

6. Expand telehealth

H.B. 166 provides $5.0 million in GRF ($1.5 million state share) in FY 2020 and $10.0 million ($3.0 million state share) in FY 2021 to support telehealth coverage.

7. Establish Multi-System Youth and Innovation Support Fund

H.B. 166 provides $10.0 million in FY 2020 and $10.0 million in FY 2021 in non-GRF funds to establish a Multi-System Youth and Innovation Support Fund. This fund would provide enhanced services to children with complex and multi-system needs. Funds for this purpose will be provided through the Health Care/Medicaid Support and Recoveries Fund (Fund 5DL0). Currently, the fund is used to pay for Medicaid services and costs associated with the administration of the Medicaid Program. H.B. 166 allows for two additional uses of the fund: (1) programs that serve youth involved with multiple government agencies, and (2) innovative programs that ODM has the statutory authority to implement and that promote access to health care or help achieve long-term cost savings to the state.

8. Access to autism

H.B. 166 provides $28.1 million in GRF funds ($10.4 state share) in FY 2021 to combine autism services under new autism-specific coverage codes. While most services for autism are currently covered under Medicaid, practitioners bill for these services by utilizing a variety of current procedural terminology (CPT) codes. When insurers receive these bills, the CPT codes are used to help determine the amount of reimbursement that a practitioner will receive for rendering services. ODM anticipates that by establishing new autism-specific codes, utilization of services could increase. This initiative is aimed at providing access to children with an autism diagnosis who are not eligible for a waiver through ODODD.

9. Wellness for kids

H.B. 166 provides $4.0 million in GRF funds ($1.2 million state share) in FY 2020 and $8.0 million ($2.4 million state share) in FY 2021 to increase wellness promotion efforts under the Comprehensive Primary Care Program for Children. ODM anticipates increasing the per member per month rate for children receiving services under the program by $1. ODM estimates that 1.2 million children will receive additional wellness services.

10. Lead testing and hazard control

H.B. 166 provides $5.0 million in GRF funds ($0.6 million state share) in FY 2020 and $5.0 million ($1.2 million state share) in FY 2021 for lead testing and other lead-related activities.

11. 1115 Substance Use Disorder (SUD) Waiver – design and implementation

H.B. 166 provides $2.5 million in all funds ($0.6 million GRF state share) in FY 2020 and $5.0 million in all funds ($1.3 million GRF state share) in FY 2021 to support the design and evaluation of the 1115 SUD Demonstration Waiver. ODM is currently working with OhioMHAS to design the 1115 waiver application. 1115 waivers require additional evaluation. CMS recently stated that the process has become more involved and for each approved 1115 demonstration, states must provide numerous metrics on a regular interval, conduct evaluations by partnering with an independent evaluator, and submit monitoring and evaluation tools.[2]

Section 1115 provides the U.S. Department of Health and Human Services Secretary with broad authority to approve experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. Flexibility under Section 1115 is broad to allow states to test the merit of new ideas of policy. These projects are intended to demonstrate and evaluate a policy or approach that has not been demonstrated on a widespread basis. Section 1115 waivers typically are approved for five years and may be extended for a set length of time.

ODM's requested waiver is for SUD inpatient and residential treatment in managed care and fee-for-service populations for both adults and children. The request is to ensure that a complete array of care is available for enrollees with opioid or other SUD. It will allow the Ohio Medicaid Program to maintain access to necessary SUD services in the most appropriate setting regardless of length of stay.[3]

12. Behavioral health care coordination

H.B. 166 also provides $204.9 million in GRF funds ($22.3 million state share) in FY 2020 and $133.1 million ($28.3 million state share) in FY 2021 to implement behavioral health care coordination (BHCC). BHCC will target enrollees with the most intensive behavioral health needs. These individuals will receive intensive care coordination from a community provider.

13. Procuring managed care value

H.B. 166 provides $3.5 million in all funds ($1.8 million in state share GRF) in FY 2020 and in FY 2021 to support renegotiation of managed care contracts. This money will be used to solicit information from other states and experts, hire outside counsel, support regional forums, and establish a website to generate public feedback.

[2] https://www.cms.gov/newsroom/press-releases/cms-strengthens-monitoring-and-evaluation-expectations-medicaid-1115-demonstrations.

[3] https://public.medicaid.gov/connect.ti/public.comments/viewQuestionnaire?qid=1899843.

14. Modernizing Medicaid's pharmacy program

ODM plans to require managed care plans to implement a single preferred drug list. According to ODM, this will simplify the process of providing care to Medicaid enrollees and possibly result in a reduction in medication errors. ODM maintains that the "single preferred drug list is expected to harness the state's purchasing power, which could offset expenses by $10.5 million in state GRF over the biennium."[4]

15. Work Requirement and Community Engagement 1115 Waiver Demonstration

On March 19, 2019, ODM received notification from CMS that Ohio's 1115 waiver application for a work and community engagement demonstration for the Group VIII population had been approved. H.B. 166 provides $15.5 million in all funds ($5.1 million GRF state share) in FY 2020, and $12.5 million in all funds ($4.4 million GRF state share) in FY 2021 to cover expenditures related to the implementation of this program. Approximately 109,000 individuals are estimated to require additional assessment to determine whether they meet any of the exemptions to these requirements. These funds will be used to cover increased assessment and medical evaluation costs, administrative requirements, and information technology system upgrades. ODM has not included any cost reductions for the upcoming biennium since the start date of the demonstration is uncertain. Cost reductions could occur if enrollees failed to meet the work and community engagement requirements and were disenrolled.

To date, 15 states, including Ohio, have submitted a request to CMS to implement work requirements as part of their Medicaid programs. Both Arkansas and Kentucky have received 1115 waivers to institute work requirements for Group VIII Medicaid recipients. However, in late March 2019, a federal judge has blocked these work requirements. Other states which have approved waivers are Arizona, Indiana, Michigan, New Hampshire, and Wisconsin. Alabama, Mississippi, Oklahoma, South Dakota, Tennessee, Utah, and Virginia all have waivers pending.[5]

16. Elimination of Automatic Nursing Facility Rate Inflator

H.B. 166 will eliminate the Medicare market-basket index from the calculation of nursing facility per diem rates. This will decrease GRF spending by $74.8 million ($27.7 million state share) in FY 2020 and by $164.8 million ($61.0 million state share) in FY 2021.

H.B. 166 revises the formula used to determine Medicaid payment rates for nursing facility services by removing an adjustment to the rates that was set to take effect beginning in FY 2020. The formula has several components and includes specific dollar amounts that are added and subtracted to the sum of the amounts determined for the different components.

[4] Testimony provided by ODM for the House Finance Committee on March 20, 2019.

[5] https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/#Table2.

For FY 2018 and FY 2019, the formula contains a $16.44 add-on, which became part of the formula on July 1, 2016. H.B. 166 extends this add-on amount to fiscal years beginning in FY 2020 and removes a requirement that, beginning with FY 2020 (other than the first fiscal year in a rebasing cycle), the add-on instead be the sum of the following:

1. The amount of the add-on for the preceding fiscal year;
2. The difference between (a) the Medicare skilled nursing facility market basket index determined for the federal fiscal year that began during the state fiscal year preceding the one for which the rate is being determined and (b) the budget reduction adjustment factor for the fiscal year for which the rate is being determined.

Beginning with FY 2020 (other than the first fiscal year in a rebasing cycle), the formula includes the difference between the Medicare skilled nursing facility market basket index and the budget reduction adjustment factor as part of the manner in which the rates for the four cost centers (ancillary and support costs, capital costs, direct care costs, and tax costs) are determined. H.B. 166 removes that amount as part of the rate calculation.

H.B. 166 also repeals a provision of law stating the General Assembly's intent to specify in statute the factor to be used for a fiscal year as the budget reduction adjustment factor. That factor cannot exceed the Medicare skilled nursing facility market basket index determined for the federal fiscal year that begins during the state fiscal year preceding the fiscal year for which the factor is being determined. If the General Assembly fails to specify the factor in statute, the budget reduction adjustment factor is zero.

17. Ensuring access to community support – ambulance and wheelchair van

H.B. 166 will provide $10.2 million in GRF funds ($3.1 million state share) in FY 2020 and $20.4 million ($6.1 million state share) in FY 2021 to ensure access to transportation. This represents a 15% rate increase for certain transportation services.

18. ODODD waiver

H.B. 166 will provide $58.7 million in all funds ($18.5 million GRF state share) in FY 2020 and $138.8 million ($12.9 million GRF state share) in FY 2021 to ensure access to community waiver supports.

19. Increase managed care performance withhold

H.B. 166 will increase the amount withheld from the Medicaid managed care capitation payments from 2% to 3%. ODM withholds these amounts to provide incentive payments to organizations that meet performance standards. This could result in unspent funds in the amount of $67.1 million in GRF funds ($20.1 million state share) in FY 2020 and $141.3 million in GRF funds ($42.4 million state share) in FY 2021. This assumes that not all performance measures would be met. MyCare is exempted from this increase.

20. Managed care lower bound trend assumption

H.B. 166 will assume a lower growth rate trend for healthcare inflation for the upcoming biennium than the trend that was used for forecasting projections. ODM contracted with Milliman to estimate high, medium, and low trends and traditionally has set its baseline forecast to match the medium estimate. By assuming a lower trend in all forecasts of projected costs, H.B. 166 will save $80.4 million in GRF funds ($24.1 million state share) in FY 2020 and $251.0 million in GRF funds ($75.5 million state share) in FY 2021.

21. Billing of retroactive member months

H.B. 166 will implement a new reconciliation process regarding the billing of retroactive member months. This new process is estimated to reduce expenditures from the GRF by $74.7 million ($22.4 million state share) in FY 2020 and $38.3 million ($11.5 million state share) in FY 2021.

22. Program integrity

H.B. 166 makes the terms and procedures for suspending a Medicaid provider agreement because of certain types of indictments generally the same as those for suspending a provider agreement because of a credible allegation of fraud. This change effectively combines two rules regarding provider suspension. Such changes will reduce internal legal and administrative costs. ODM anticipates reductions of $5.0 million in GRF funds ($1.5 million state share) in FY 2020 and $10.0 million in GRF funds ($3.0 million state share) in FY 2021.

23. Hospital franchise fee alignment

H.B. 166 will increase the hospital franchise fee from 2.66% to 3.24% in FY 2020 and to 3.35% in FY 2021. ODM charges hospitals an annual franchise fee equal to a percentage of the hospital's total facility costs. A hospital's total facility costs are the hospital's total costs for all care provided to all patients, including the direct, indirect, and overhead costs to the hospital of all services, supplies, equipment, and capital related to the care of patients, regardless of whether patients are enrolled in a health insuring corporation. However, total facility costs exclude all of the following costs: Medicare costs, skilled nursing services provided in distinct-part nursing facility units, home health services, hospice services, ambulance services, renting durable medical equipment, and selling durable medical equipment.

According to ODM, this realignment is expected to cost $383.3 million in FY 2020 and $502.8 million in FY 2021. However, there will be subsequent reductions in GRF expenditures by $53.4 million ($16.0 million state share) in FY 2020 and $54.2 million ($16.3 million state share in FY 2021).

Highlights of policy initiatives in the current biennium: FY 2018-FY 2019

Some of the policy initiatives of the current biennium are briefly discussed below.

1. Eliminate the Medicaid sales tax

H.B. 49 of the 132nd General Assembly repealed the Medicaid managed care sales tax on July 1, 2017. Since 2009, Ohio had imposed a 5.75% state sales and use tax on payments to Medicaid managed care plans. The sales and use tax was determined by CMS to be an impermissible taxing method for drawing down Medicaid matching funds from the federal government, since non-Medicaid health insuring corporations were not subject to it. The previous tax generated over $900 million in state taxes and $200 million in local taxes. The sales and use tax was replaced with a tax on all health insuring corporation (HIC) plans. The tax rate paid ranges from $26 to $56 per Medicaid member month, and $1 to $2 per non-Medicaid member month.

2. Care Innovation and Community Improvement Program

H.B. 49 of the 132nd General Assembly required the Medicaid Director to establish the Care Innovation and Community Improvement Program. Any nonprofit hospital agency affiliated with a state university and any public hospital agency may volunteer to participate in the program if it operates a hospital that has a Medicaid provider agreement. Nonprofit and public hospital agencies that participate in the program are responsible for the state share of the program's costs and must make or request the appropriate government entity to make intergovernmental transfers to pay for the costs. The Director is required to establish a schedule for making the transfers.

Each nonprofit and public hospital agency participating in the program is to receive supplemental payments under the Medicaid Program for physician and other professional services that are covered by the Medicaid Program and provided to Medicaid recipients. The amount of the payments is to equal the difference between the Medicaid rate for the services and average commercial rates for the services. The Director is permitted to terminate, or adjust the amount of, the payments if the amount of the funds for the program is inadequate.

3. Transportation brokerage

H.B. 49 of the 132nd General Assembly transferred the responsibility of funding the nonemergency medical transportation (NEMT) system from ODJFS to ODM effective July 1, 2018. However, this transfer did not occur and ODJFS retains responsibility for administering NEMT.

ODM had planned on making system changes when it obtained responsibility for the program. Under ODM, the system would have become a statewide brokerage system. Since the transfer did not occur, the system remains unchanged and services continue to be provided through a county-based transportation system.

4. Behavioral Health Redesign

Over the last several years, ODM and OhioMHAS have taken efforts to redesign the behavioral healthcare system in Ohio. The redesign seeks to enhance the quality and delivery of care for mental health and SUD treatment. The design has been implemented in stages. During the current biennium, the final two stages were completed.

On January 1, 2018, an updated benefit package for community behavioral health services was implemented. This phase of the redesign did the following: updated Medicaid behavioral health billing codes to align with national standards, developed a single fee schedule for mental health and substance use disorder services, tied rates to the qualifications of the provider, and expanded services for individuals with the most intensive needs. The changes implemented on this date only impacted fee-for-service claims and claims for individuals enrolled onto MyCare Ohio.

The last phase of the redesign, which occurred on July 1, 2018, integrated behavioral health into Medicaid managed care. Thus, as of July 1, behavioral health services are now covered by Medicaid managed care plans instead of paid for directly by ODM. To assist with this integration, ODM included a number of safeguards to help both service providers and Medicaid recipients. These safeguards include: a grace period that required Medicaid managed care plans to allow Medicaid recipients to continue receiving services through out-of-network providers through December 31, 2018, a requirement that Medicaid managed care plans maintain minimum reimbursement rates equivalent to fee-for-service rates for behavioral health services through June 30, 2019, and the establishment of a task force devoted to post-implementation concerns. The task force consists of ODM, OhioMHAS, MCPs, and various other involved entities.

5. Pharmacy benefit manager

In response to a state-commissioned report, ODM required all five Medicaid managed care plans to terminate their contracts with pharmacy benefit managers (PBMs) by the end of calendar year 2018. In addition, effective January 1, 2019, PBM contracts were required to be based on a "pass-through" pricing model instead of a "spread pricing" model. Under a pass-through pricing model, PBMs would charge Medicaid the same price that was paid to the pharmacy for the medication and would receive an administrative fee for doing so.

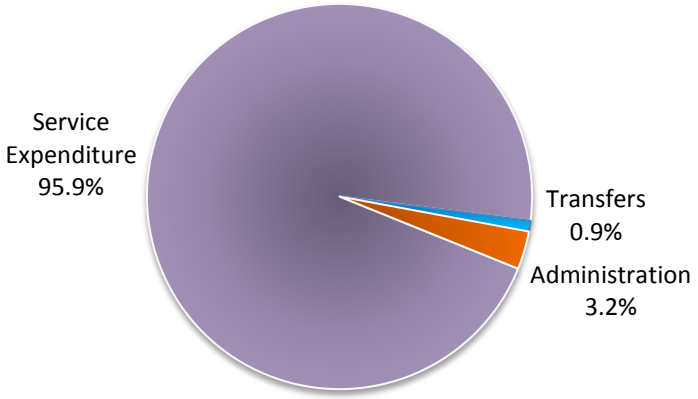
Appropriations by expense type

Table 7 and Chart 2 show the executive recommended appropriations by expense type. Approximately 95.9% of ODM's budget is for payments to providers of Medicaid services.

Table 7. ODM Budget Uses by Expense Type*		
Expense Type	**FY 2020**	**FY 2021**
Services	$23,858,866,907	$24,952,685,837
Administrative	$805,636,937	$826,504,123
Transfers to Other Agencies	$225,701,597	$225,701,597
Total	**$24,890,205,441**	**$26,004,891,557**

*The appropriation for line item 651655, Medicaid Interagency Pass-Through, is included in the Department of Medicaid total appropriation.

Chart 2: ODM Budget Uses by Expense Type
FY 2020-FY 2021



ODM will spend approximately 3.2% of its recommended budget for the biennium for administration including personal services, purchased services, maintenance, and equipment. Approximately 0.9% of ODM's budget is federal reimbursement that will be passed through to other agencies for their Medicaid administrative costs.

Analysis of FY 2020-FY 2021 budget proposal

This section provides an analysis of the Governor's recommended funding for each appropriation line item (ALI) in ODM's budget. For organizational purposes, these ALIs are grouped into three major categories based on their funding purposes. The analysis for an ALI with a lower category or subcategory designation will appear before that for an ALI with a higher category or subcategory designation. That is, the analysis for an ALI with a category designation of C1:8 will appear before the analysis for an ALI with a category designation of C2:1 and the analysis for an ALI with a category designation of C1:3 will appear before the analysis for an ALI with a category designation of C1:8.

To aid the reader in locating each ALI in the analysis, the following table shows the category in which each ALI has been placed, listing the ALIs in order within their respective fund groups and funds. This is the same order the ALIs appear in the MCD section of the budget bill.

In the analysis, each appropriation item's estimated expenditures for FY 2019 and recommended appropriations for FY 2020 and FY 2021 are listed in a table. Following the table, a narrative describes how the appropriation is used and any changes affecting the appropriation that are proposed by the Governor. If the appropriation is earmarked, the earmarks are listed and described.

Categorization of ODM's Appropriation Line Items for Analysis of FY 2020-FY 2021 Budget Proposal

Fund	ALI	ALI Name	Category	
General Revenue Fund Group				
GRF	651425	Medicaid Program Support – State	2	Medicaid Administration
GRF	651525	Medicaid Health Care Services	1	Medicaid Services
GRF	651526	Medicare Part D	1	Medicaid Services
Dedicated Purpose Fund Group				
4E30	651605	Resident Protection Fund	2	Medicaid Administration
5AN0	651686	Care Innovation and Community Improvement Program	1	Medicaid Services
5DL0	651639	Medicaid Services – Recoveries	1	Medicaid Services
5DL0	651685	Medicaid Recoveries – Program Support	2	Medicaid Administration
5DL0	651690	Multi-system Youth Innovation and Support	1	Medicaid Services
5FX0	651638	Medicaid Services – Payment Withholding	1	Medicaid Services
5GF0	651656	Medicaid Services – Hospital Upper Payment Limit	1	Medicaid Services
5R20	651608	Medicaid Services – Long Term	1	Medicaid Services
5SC0	651683	Medicaid Services – Physician UPL	1	Medicaid Services
5TN0	651684	Medicaid Services – HIC Fee	1	Medicaid Services
6510	651649	Medicaid Services – Hospital Care Assurance Program	1	Medicaid Services

Categorization of ODM's Appropriation Line Items for Analysis of FY 2020-FY 2021 Budget Proposal				
Fund	**ALI**	**ALI Name**		**Category**
Holding Account Fund Group				
R055	651644	Refunds and Reconciliation	1	Medicaid Services
Federal Fund Group				
3ER0	651603	Medicaid Health and Transformation Technology	2	Medicaid Administration
3F00	651623	Medicaid Services – Federal	1	Medicaid Services
3F00	651624	Medicaid Program Support – Federal	2	Medicaid Administration
3FA0	651680	Health Care Grants – Federal	2	Medicaid Administration
3G50	651655	Medicaid Interagency Pass Through	3	Transfers

Category 1: Medicaid Services

This category of appropriation provides funds for all Medicaid services, including payments for Medicaid providers, prescription drugs, long-term care services, as well as managed care capitation payments.

C1:1: Medicaid Health Care Services (ALI 651525)

Fund/ALI		FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
GRF ALI 651525, Medicaid Health Care Services		$13,502,619,362	$13,766,385,226	$15,061,125,767
	% change	--	2.0%	9.4%

This GRF line item is used to reimburse health care providers for covered services to Medicaid recipients and to make managed care capitation payments. The federal earnings on the payments made from this line item are deposited as revenue into the GRF. Spending within this line item generally can be placed into one of several major service categories: managed care plans, nursing facilities (NFs), hospital services, behavioral health, aging waivers, prescription drugs, physician services, Home Care waivers, and all other care.

C1:2: Medicare Part D (ALI 651526)

Fund/ALI		FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
GRF ALI 651526, Medicare Part D		$458,645,939	$500,325,646	$554,214,667
	% change	--	9.1%	10.8%

This GRF line item is used for the phased-down state contribution, otherwise known as the clawback payment, under the Medicare Part D requirements contained in the federal Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. The clawback is a monthly payment made by each state to the federal Medicare Program. The

amount of each state's payment roughly reflects the expenditures of its own funds that the state would have made if it continued to pay for outpatient prescription drugs through Medicaid on behalf of dual-eligibles (individuals eligible for both Medicare and Medicaid).

Recommended funding levels are based on the projected increases in the clawback payment rates to the Medicare Part D Program. The executive budget projects that the dual-eligible caseload covered under this program will increase during the FY 2020-FY 2021 biennium. The combination of an increasing caseload and higher clawback payment rates from drug trend drive continued growth during the biennium.

H.B. 166 allows the Director of Budget and Management to transfer the state share of appropriations between GRF line item 651525 and this item.

C1:3: Care Innovation and Community Improvement Program (ALI 651686)

Fund/ALI	FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
5AN0 ALI 651686, Care Innovation and Community Improvement Program	$51,680,120	$53,435,797	$53,406,291
% change	--	3.4%	-0.1%

This line item is used to provide funding for the state share of the Care Innovation and Community Improvement Program. Funding for this line item comes from the Care Innovation and Community Improvement Program Fund (Fund 5AN0). Any nonprofit hospital affiliated with a state university or public hospital agency may participate in the program if the agency operates a hospital that has a Medicaid provider agreement. Under the program, each participating agency receives supplemental payments under the Medicaid Program for physician and other professional services that are covered by Medicaid. However, the participating agency is responsible for the state share of costs. Recommended funding levels are based on the executive's projected revenue and expenditures.

C1:4: Medicaid Services – Recoveries (ALI 651639)

Fund/ALI	FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
5DL0 ALI 651639, Medicaid Services – Recoveries	$612,202,457	$741,454,299	$724,170,233
% change	--	21.1%	-2.3%

This line item is used by ODM to pay for Medicaid services and support. The Health Care/Medicaid Support and Recoveries Fund (Fund 5DL0) provides funding for this line item. The major revenue sources for Fund 5DL0 are prescription drug rebates, Institutions for Mental Diseases Disproportionate Share (IMD DSH), third-party liability, hospital settlements, and other recoveries.

The executive recommends an increase in funding for FY 2020 and FY 2021 to support home and community waiver services. Funds for this increased activity will be transferred from the cash balance remaining in the Money Follows the Person Fund (Fund 5AJ0), which is being abolished. The Money Follows the Person Program is a demonstration program that provides funds to transition eligible Ohioans out of nursing facilities and into home and community-based settings. Federal reimbursement for the Money Follows the Person Program is no longer available. Line item 651639 will be used to support transition services in the future.

C1:5: Multi-System Youth Innovation and Support (ALI 651690)

Fund/ALI		FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
5DL0 ALI 651690, Multi-System Youth Innovation and Support		$0	$10,000,000	$10,000,000
	% change	--	N/A	0.0%

The executive budget creates this new line item, which will be used to fund programs that serve youth involved with multiple governmental agencies and other innovative approaches that support healthcare access or result in long-term savings to the state. H.B. 166, expands the use of the Health Care/Medicaid Support and Recoveries Fund (Fund 5DL0), to include these two activities. Money to support Fund 5DL0 comes from a variety of sources including, prescription drug rebates, IMD DSH, third-party liability, hospital settlements, and other recoveries.

C1:6: Medicaid Services – Payment Withholding (ALI 651638)

Fund/ALI		FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
5FX0 ALI 651638, Medicaid Services – Payment Withholding		$27,000,000	$12,000,000	$12,000,000
	% change	--	-55.6%	0.0%

This line item is used for provider payments that are withheld from providers that change ownership. It is used to transfer the withheld funds to the appropriate fund used by ODM at final resolution. The funds are withheld and temporarily deposited into the Exiting Operator Fund (Fund 5FX0) until all potential amounts due to ODM or the provider reach final resolution. Recommended funding levels are based on the executive's projected revenues and expenditures.

C1:7: Medicaid Services – Hospital Upper Payment Limit (ALI 651656)

Fund/ALI		FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
5GF0 ALI 651656, Medicaid Services – Hospital Upper Payment Limit		$671,505,583	$822,016,219	$887,150,856
	% change	--	22.4%	7.9%

This line item is used to support Hospital Upper Payment Limit (UPL) programs and provides offsets to Medicaid GRF spending. The source of funds for this line item is the revenue generated from a hospital assessment. Assessment revenue is deposited into the Hospital Assessment Fund (Fund 5GF0). The assessment is based on a percentage of total facility costs, and is collected over the course of three payments during each year. The federal match for expenditures from this line item is made from line item 651623, Medicaid Services – Federal.

The increases in the appropriation reflect the additional revenue that will be generated as a result of the executive's proposal to increase the hospital franchise fee rate. The current assessment rate is about 2.66% of hospital costs. The executive budget recommends increasing the assessment rate to 3.24% in FY 2020 and to 3.35% in FY 2021.

C1:8: Medicaid Services – Long Term (ALI 651608)

Fund/ALI		FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
5R20 ALI 651608, Medicaid Services – Long Term		$405,666,000	$415,666,000	$415,666,000
	% change	--	2.5%	0.0%

This line item is used to make Medicaid payments to nursing facilities. The source of funds for this line item is the franchise fee payments from nursing facilities and long-term care units in hospitals. Ohio Medicaid is required to assess an annual franchise permit fee on each long-term care bed in a nursing home or hospital. The assessment amount is calculated each year at the maximum percentage allowed by federal law (not to exceed 6% of the total estimated net patient revenue). The franchise fee payments are deposited into the Nursing Home Franchise Permit Fee Fund (Fund 5R20).

C1:9: Medicaid Services – Physician UPL (ALI 651683)

Fund/ALI		FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
5SC0 ALI 651683, Medicaid Services – Physician UPL		$7,004,616	$7,520,000	$7,645,000
	% change	--	7.4%	1.7%

This line item is used by ODM to spend intergovernmental transfers for a Supplemental Upper Payment Limit (UPL) Program for physicians of the Ohio State University's Wexner Medical Center. The funding arrangement is similar to the Hospital UPL Program in that they both close the gap between Medicaid and Medicare payment rates for the given subset of providers. The source of funds for this line item is from intergovernmental transfers. The revenue is deposited into Medicaid Services – Physician UPL Fund (Fund 5SC0). The appropriation levels are based on the executive's projection of the revenue.

C1:10: Medicaid Services – HIC Fee (ALI 651684)

Fund/ALI		FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
5TN0 ALI 651684, Medicaid Services – HIC Fee		$561,000,000	$820,564,060	$791,187,400
	% change	--	46.3%	-3.6%

This line item is used to reimburse health care providers for covered services to Medicaid recipients. Funding for line item 651684 comes from the Health Insuring Corporation Class Franchise Fee Fund (Fund 5TN0). Revenues are collected from the tax on all health insuring corporation (HIC) plans. The tax rate ranges from $26 to $56 per Medicaid member month, and $1 to $2 per non-Medicaid member month. Revenue assumptions are based on projected member months. The federal match for expenditures from this line item is made from line item 651623, Medicaid Services – Federal.

Recommended funding is based on the executive's projected revenue, as well as policy changes. In H.B. 49 of the 132nd General Assembly, $196.2 million in FY 2018 and $226.8 million in FY 2019 was transferred to the Health and Human Services Fund (Fund 5SA4) and expended out of line item 651689. This transfer is not projected to occur in the upcoming biennium. Thus, the funds will be retained in Fund 5TN0 and expended from line item 651684; hence, the increase in this line item in FY 2020.

C1:11: Medicaid Services – Hospital Care Assurance Program (ALI 651649)

Fund/ALI		FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
6510 ALI 651649, Medicaid Services – Hospital Care Assurance Program		$235,938,312	$249,167,065	$168,310,123
	% change	--	5.6%	-32.5%

This line item is to fund the state share of the Hospital Care Assurance Program (HCAP). The source of revenue for Fund 6510 is HCAP assessments from Ohio hospitals. Shortly after assessment revenue is received, it is disbursed back to hospitals using the HCAP formula. The federal share of HCAP expenditures is funded through federal line item 651623, Medicaid Services – Federal.

The decline in the recommended funding level in FY 2021 is due to reduced payments for HCAP. Under the ACA and other federal legislation, payments for HCAP are reduced starting in FFY 2021. Thus, the line item is decreased in response.

C1:12: Refunds and Reconciliation (ALI 651644)

Fund/ALI	FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
R055 ALI 651644, Refunds and Reconciliation	$1,000,000	$1,000,000	$1,000,000
% change	--	0.0%	0.0%

Revenue to the Refunds and Reconciliation Fund (Fund R055) is from checks received by ODM whose disposition cannot be determined at the time of receipt. Upon determination of the appropriate fund into which the check should have been deposited, a disbursement is made from this line item to the appropriate fund.

C1:13: Medicaid Services – Federal (ALI 651623)

Fund/ALI	FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
3F00 ALI 651623, Medicaid Services – Federal	$6,083,132,010	$6,459,332,595	$6,266,809,500
% change	--	6.2%	-3.0%

This line item provides the federal share for certain Medicaid expenditures. Major activities in this line item include the federal share of nursing facility, hospital, prescription drug expenditures, and general Medicaid services. The primary source of revenue for Fund 3F00 is federal Medicaid reimbursement; however, it also includes Health Care Financing Research, Demonstrations, and Evaluations grants, as well as the federal share of drug rebates. In addition, the federal share of both the Hospital Franchise Fee Program and the Hospital Care Assurance Program (HCAP) is expended through this line item.

The executive budget recommends an increase in appropriation for this line item in FY 2020 due to a policy proposal for realigning the Hospital Franchise Fee Program, which is discussed under the "**Major initiatives for the FY 2020-FY 2021 biennium**" section. The realigning will take place in both FY 2020 and FY 2021.

The decline in the recommended funding level in FY 2021 is due to reduced payments for HCAP. HCAP helps individuals below 100% FPL that are not enrolled on Medicaid with unpaid hospital bills. Under the ACA and other federal legislation, payments for HCAP are reduced starting in FFY 2021. Thus, the line item is decreased in response.

Category 2: Medicaid Administration

This category of appropriations provides funds for the administration of Medicaid programs.

C2:1: Medicaid Program Support – State (ALI 651425)

Fund/ALI		FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
GRF ALI 651425, Medicaid Program Support – State		$178,754,197	$184,688,131	$190,406,760
	% change	--	3.3%	3.1%

This GRF line item is used to fund ODM's operating expenses. This line item provides the state share GRF for payroll, purchased personal services, conference fees, maintenance, and equipment, etc. The associated federal match is appropriated in line item 651624, Medicaid Program Support – Federal.

The recommended funding level will be used to support administrative costs associated with the implementation of the work requirement, managed care re-procurement, 1115 SUD waiver authorization and evaluation, among others.

C2:2: Resident Protection Fund (ALI 651605)

Fund/ALI		FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
4E30 ALI 651605, Resident Protection Fund		$4,878,000	$3,910,338	$4,013,000
	% change	--	-19.8%	2.6%

This line item is used to pay the costs of relocating residents to other facilities, maintaining or operating a facility pending correction of deficiencies or closure, and reimbursing residents for the loss of money managed by a facility. The source of funding for this line item is from fine revenues collected from facilities in which the Ohio Department of Health finds deficiencies. The fines collected are deposited into the Resident Protection Fund (Fund 4E30). Some of the funds deposited into this fund are transferred to the Department of Aging and used for ombudsmen-related activities. Ombudsmen advocate for people receiving home care, assisted living, and nursing home care and help resolve complaints about services.

C2:3: Medicaid Recoveries – Program Support (ALI 651685)

Fund/ALI		FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
5DL0 ALI 651685, Medicaid Recoveries – Program Support		$41,328,516	$40,351,245	$44,375,000
	% change	--	-2.4%	10.0%

This line item is used to pay costs associated with the administration of Medicaid. Revenues from a variety of sources including, prescription drug rebates, Institutions for Mental Diseases Disproportionate Share (IMD DSH), third-party liability, hospital settlements, and other recoveries are deposited into the Health Care/Medicaid Support and Recoveries Fund (Fund 5DL0) to support this line item.

C2:4: Medicaid Health and Transformation (ALI 651603)

Fund/ALI	FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
3ER0 ALI 651603, Medicaid Health and Transformation	$61,895,999	$48,031,056	$48,340,000
% change	--	-22.4%	0.6%

This line item is used for provider electronic health record (EHR) incentives and administrative costs related to the Health Information Technology (HIT) grant. EHR incentives are provided by CMS to healthcare providers to encourage their use of EHR technology in ways that can improve patient care. HIT grants are provided by the U.S. Department of Health and Human Services and are used to conduct projects that contribute to health information technology improvements.

The EHR incentive payments are anticipated to end in FY 2022. As the program winds down, the payments are anticipated to decrease. This is the reason for the decrease in appropriation to line item 651603.

C2:5: Medicaid Program Support – Federal (ALI 651624)

Fund/ALI	FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
3F00 ALI 651624, Medicaid Program Support – Federal	$682,203,750	$516,667,497	$527,369,363
% change	--	-24.3%	2.1%

This line item is used for the Medicaid federal share of administrative costs. This line item may also be used to support various contracts. The state share for these activities is primarily provided from GRF line item 651425, Medicaid Program Support – State.

C2:6: Health Care Grants – Federal (ALI 651680)

Fund/ALI	FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
3FA0 ALI 651680, Health Care Grants – Federal	$38,664,967	$11,988,670	$12,000,000
% change	--	-69.0%	0.1%

This line item funds Medicaid Program initiatives stemming from the ACA. The spending level is based on the revenue received for various federal grants.

Category 3: Transfers

C3:1: Medicaid Interagency Pass Through (ALI 651655)

Fund/ALI	FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
3G50 ALI 651655, Medicaid Interagency Pass Through	$225,701,597	$225,701,597	$225,701,597
% change	--	0.0%	0.0%

This line item is used to disburse federal reimbursement to other agencies for Medicaid-related expenditures they have made. Funding for this line item is through the Interagency Reimbursement Fund (Fund 3G50). The departments of Aging, Developmental Disabilities, Education, Health, Job and Family Services, and Mental Health and Addiction Services, and the State Board of Pharmacy assist ODM in administering certain Medicaid programs/services and receive federal reimbursements for doing so.

MCD/lb

General Revenue Fund

GRF 651425 Medicaid Program Support-State

FY 2016 Actual	FY 2017 Actual	FY 2018 Actual	FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
$137,428,170	$156,769,355	$139,987,073	$178,754,197	$184,688,131	$190,406,760
% change	14.1%	-10.7%	27.7%	3.3%	3.1%

Source: General Revenue Fund

Legal Basis: Section 333.10 of H.B. 49 of the 132nd G.A. (originally established by Section 323.10 of H.B. 59 of the 130th G.A.)

Purpose: This line item funds the Ohio Department of Medicaid's (ODM) operating expenses. The associated federal match is appropriated in line item 651624, Medicaid Program Support - Federal.

GRF 651426 Positive Education Program Connections

FY 2016 Actual	FY 2017 Actual	FY 2018 Actual	FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
$0	$0	$0	$2,500,000	$0	$0
% change	N/A	N/A	N/A	-100%	N/A

Source: General Revenue Fund

Legal Basis: Section 2 of H.B. 332 of the 132nd GA

Purpose: This line item provides funding for the Positive Education Program Connections in Cuyahoga County.

GRF 651525 Medicaid Health Care Services

FY 2016 Actual	FY 2017 Actual	FY 2018 Actual	FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
$15,979,052,611	$16,227,246,835	$13,204,693,889	$13,502,619,362	$13,766,385,226	$15,061,125,767
% change	1.6%	-18.6%	2.3%	2.0%	9.4%

Source: General Revenue Fund

Legal Basis: Section 333.10 of H.B. 49 of the 132nd G.A. (originally established by Section 323.10 of H.B. 59 of the 130th G.A.)

Purpose: This line item reimburses health care providers for covered services to Medicaid recipients. The federal earnings on the payments that are made from this line item are deposited as revenue into the GRF. The majority of expenditures from this line item earn the regular Federal Medical Assistance Percentage (FMAP) reimbursement rate at approximately 63%; however, expenditures for the State Children's Health Insurance Program (SCHIP) and for covering the Medicaid expansion population through the federal Affordable Care Act (ACA) earn an enhanced federal participation rate.

Beginning in FY 2018, the expenditures for the ACA expansion population are supported by this line item but are also supplemented by Fund 5TN0 appropriation item 651684, Medicaid Services-HIC Fee. The federal match for the ACA expansion population is 94% in calendar year (CY) 2018, and will be 93% in CY 2019, and 90% in CY 2020 and thereafter. In addition, beginning in FY 2018, managed care performance payments are made out of line item 651525. Such payments were previously made out of Fund 5KW0 line item 651612, Managed Care Performance Payment.

In FY 2016 and FY 2017, the expenditures for the ACA expansion population were fully funded out of line item 651525. In FY 2014 and FY 2015, Fund 3F00 line item 651623, Medicaid Services - Federal, was used to fund expenditures related to the ACA expansion population. Prior to the second half of FY 2017, federal funds provided 100% of the expenditures associated with the ACA expansion population. During the second half of FY 2017, federal funds provided 95% of these expenditures and the state provided the remaining 5%.

GRF 651526 Medicare Part D

FY 2016 Actual	FY 2017 Actual	FY 2018 Actual	FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
$305,634,132	$418,595,274	$461,884,333	$458,645,939	$500,325,646	$554,214,667
% change	37.0%	10.3%	-0.7%	9.1%	10.8%

Source: General Revenue Fund

Legal Basis: Sections 333.10 and 331.80 of H.B. 49 of the 132nd G.A. (originally established by Section 323.10 of H.B. 59 of the 130th G.A.)

Purpose: This line item is used for the phased-down state contribution, otherwise known as the clawback payment, under the Medicare Part D requirements contained in the federal Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. The clawback is a monthly payment made by each state to the federal Medicare Program. The amount of each state's payment roughly reflects the expenditures of its own funds that the state would have made if it continued to pay for outpatient prescription drugs through Medicaid on behalf of dual eligibles (individuals eligible for both Medicare and Medicaid).

Dedicated Purpose Fund Group

4E30 651605 Resident Protection Fund

FY 2016 Actual	FY 2017 Actual	FY 2018 Actual	FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
$0	$1,315,640	$1,770,786	$4,878,000	$3,910,338	$4,013,000
% change	N/A	34.6%	175.5%	-19.8%	2.6%

Source: Dedicated Purpose Fund Group: Assessments against nursing facilities for deficiencies

Legal Basis: ORC 5162.66; Section 333.10 of H.B. 49 of the 132nd G.A. (originally established by Section 323.10 of H.B. 59 of the 130th G.A.)

Purpose: This line item pays the costs of relocating residents to other facilities, maintaining or operating a facility pending correction of deficiencies or closure, and reimbursing residents for the loss of money managed by the facility.

5AJ0 651631 Money Follows the Person

FY 2016 Actual	FY 2017 Actual	FY 2018 Actual	FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
$1,689,928	$7,280,036	$4,295,197	$12,373,500	$0	$0
% change	330.8%	-41.0%	188.1%	-100%	N/A

Source: Dedicated Purpose Fund Group: CFDA 93.791, earned reimbursement from the Money Follows the Person Grant

Legal Basis: Section 333.10 of H.B. 49 of the 132nd G.A. (originally established by Section 323.10 of H.B. 59 of the 130th G.A.)

Purpose: This line item supports the federal Money Follows the Person Grant initiative. The initiative provides federal reimbursement for the costs of transitioning eligible Medicaid individuals out of institutional settings and into home or community-based care.

5AN0 651686 Care Innovation and Community Improvement Program

FY 2016 Actual	FY 2017 Actual	FY 2018 Actual	FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
$0	$0	$0	$51,680,120	$53,435,797	$53,406,291
% change	N/A	N/A	N/A	3.4%	-0.1%

Source: Dedicated Purpose Fund Group: Intergovernmental transfers made by nonprofit or public hospital agencies participating in the Care Innovation and Community Improvement Program

Legal Basis: Sections 333.10 and 333.320 of H.B. 49 of the 132nd G.A.

Purpose: This line item is used to provide funding for the Care Innovation and Community Improvement Program. Any nonprofit hospital affiliated with a state university or public hospital agency may participate in the program if the agency operates a hospital that has a Medicaid provider agreement. Under the program, each participating agency will receive supplemental payments under the Medicaid Program for physician and other professional services that are covered by Medicaid. However, the participating agency is responsible for the state share of costs.

5DL0 651639 Medicaid Services-Recoveries

FY 2016 Actual	FY 2017 Actual	FY 2018 Actual	FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
$537,876,341	$518,048,211	$774,001,996	$612,202,457	$741,454,299	$724,170,233
% change	-3.7%	49.4%	-20.9%	21.1%	-2.3%

Source: Dedicated Purpose Fund Group: (1) The nonfederal share of all Medicaid-related revenues, collections, and recoveries; (2) Federal reimbursement received for payment adjustments made under the Medicaid Program to state mental health hospitals maintained and operated by the Department of Mental Health and Addiction Services; (3) Revenues ODM receives from another state agency for Medicaid services pursuant to an interagency agreement, other than such revenues required to be deposited into the Health Care Services Administration Fund; (4) Certain funds ODM receives in a fiscal year for performing eligibility verification services necessary for compliance with the independent, certified audit requirement of the federal law (42 C.F.R. 455.304); (5) The nonfederal share of all rebates paid by drug manufacturers to ODM in accordance with rebate agreements required by federal law; (6) The nonfederal share of all supplemental rebates paid by drug manufacturers to ODM in accordance with the Supplemental Drug Rebate Program established by continuing state law.

Legal Basis: ORC 5162.52; Section 333.10 of H.B. 49 of the 132nd G.A. (originally established by Section 323.10 of H.B. 59 of the 130th G.A.)

Purpose: This line item provides offsets to Medicaid GRF spending and pays for costs associated with the administration of the Medicaid Program.

5DL0 651685 Medicaid Recoveries-Program Support

FY 2016 Actual	FY 2017 Actual	FY 2018 Actual	FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
$0	$0	$14,540,841	$41,328,516	$40,351,245	$44,375,000
% change	N/A	N/A	184.2%	-2.4%	10.0%

Source: Dedicated Purpose Fund Group: (1) The nonfederal share of all Medicaid-related revenues, collections, and recoveries; (2) Federal reimbursement received for payment adjustments made under the Medicaid Program to state mental health hospitals maintained and operated by the Department of Mental Health and Addiction Services; (3) Revenues ODM receives from another state agency for Medicaid services pursuant to an interagency agreement, other than such revenues required to be deposited into the Health Care Services Administration Fund; (4) Certain funds ODM receives in a fiscal year for performing eligibility verification services necessary for compliance with the independent, certified audit requirement of the federal law (42 C.F.R. 455.304); (5) The nonfederal share of all rebates paid by drug manufacturers to ODM in accordance with rebate agreements required by federal law; (6) The nonfederal share of all supplemental rebates paid by drug manufacturers to ODM in accordance with the Supplemental Drug Rebate Program established by continuing state law.

Legal Basis: ORC 5162.52; Section 333.10 of H.B. 49 of the 132nd G.A.

Purpose: This line item is used to pay costs associated with the administration of Medicaid. H.B. 49 of the 132nd G.A. merged Fund 5U30 with Fund 5DL0, and created this line item to replace line item 651654, Medicaid Program Support.

5DL0 651690 Multi-System Youth Innovation and Support

FY 2016 Actual	FY 2017 Actual	FY 2018 Actual	FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
$0	$0	$0	$0	$10,000,000	$10,000,000
% change	N/A	N/A	N/A	N/A	0.0%

Source: Dedicated Purpose Fund Group: (1) The nonfederal share of all Medicaid-related revenues, collections, and recoveries; (2) Federal reimbursement received for payment adjustments made under the Medicaid Program to state mental health hospitals maintained and operated by the Department of Mental Health and Addiction Services; (3) Revenues ODM receives from another state agency for Medicaid services pursuant to an interagency agreement, other than such revenues required to be deposited into the Health Care Services Administration Fund; (4) Certain funds ODM receives in a fiscal year for performing eligibility verification services necessary for compliance with the independent, certified audit requirement of the federal law (42 C.F.R. 455.304); (5) The nonfederal share of all rebates paid by drug manufacturers to ODM in accordance with rebate agreements required by federal law; (6) The nonfederal share of all supplemental rebates paid by drug manufacturers to ODM in accordance with the Supplemental Drug Rebate Program established by continuing state law.

Legal Basis: ORC 5162.52; Section 333.95 of H.B. 166, As Proposed

Purpose: This line item will be used to fund programs that serve youth involved with multiple government agencies and innovative programs that the Department of Medicaid has the statutory authority to implement and that promote access to health care or help achieve long-term cost savings to the state.

5FX0 651638 Medicaid Services-Payment Withholding

FY 2016 Actual	FY 2017 Actual	FY 2018 Actual	FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
$6,383,192	$12,399,558	$12,226,619	$27,000,000	$12,000,000	$12,000,000
% change	94.3%	-1.4%	120.8%	-55.6%	0.0%

Source: Dedicated Purpose Fund Group: Withheld funds from providers that change ownership

Legal Basis: Section 333.10 of H.B. 49 of the 132nd G.A. (originally established by Section 323.10 of H.B. 59 of the 130th G.A.)

Purpose: This line item is used to release payments that are withheld from providers that change ownership and to transfer the withheld funds to the appropriate fund used by ODM at final resolution. The funds are withheld and temporarily deposited into the Exiting Operator Fund (Fund 5FX0) until all potential amounts due to ODM or the provider reach final resolution.

5GF0 651656 Medicaid Services - Hospital Upper Payment Limit

FY 2016 Actual	FY 2017 Actual	FY 2018 Actual	FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
$568,275,051	$557,450,602	$679,066,108	$671,505,583	$822,016,219	$887,150,856
% change	-1.9%	21.8%	-1.1%	22.4%	7.9%

Source: Dedicated Purpose Fund Group: Money generated by assessment on hospital total facility costs

Legal Basis: ORC 5168.25; Section 333.10 of H.B. 49 of the 132nd G.A. (originally established by Section 323.10 of H.B. 59 of the 130th G.A.)

Purpose: This line item supports hospital upper payment limit programs and provides offsets to Medicaid GRF spending. The federal match for expenditures from this line item is made from line item 651623, Medicaid Services - Federal.

5KC0 651682 Health Care Grants-State

FY 2016 Actual	FY 2017 Actual	FY 2018 Actual	FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
$1,263,823	$313,250	$0	$5,000,000	$0	$0
% change	-75.2%	-100%	N/A	-100%	N/A

Source: Dedicated Purpose Fund Group: All non-federal funds and grants received pursuant to the administration of the Medicaid Program other than any such funds required by law to be deposited into another fund

Legal Basis: ORC 5162.56; Section 333.10 of H.B. 49 of the 132nd G.A. (originally established by Section 323.10 of H.B. 59 of the 130th G.A.)

Purpose: This line item funds expenses related to the services provided under, and the administration of, the Medicaid Program.

5KW0 651612 Managed Care Performance Payment

FY 2016 Actual	FY 2017 Actual	FY 2018 Actual	FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
$48,507,051	$168,685,514	$0	$0	$0	$0
% change	247.8%	-100%	N/A	N/A	N/A

Source: Dedicated Purpose Fund Group: Moneys withheld under the Performance Payments for Medicaid Managed Care Program

Legal Basis: Discontinued line item (originally established by Section 323.10 of H.B. 59 of the 130th G.A.)

Purpose: This line item was used to make performance payments under the Performance Payments for Medicaid Managed Care Program. H.B. 59 of the 130th G.A. authorized ODM to withhold up to two percent of health plan payments, pending the plan's ability to meet certain performance outcomes. At the beginning of each quarter, the Medicaid Director certified to the OBM Director the amount withheld. The OBM Director transferred cash in the amount certified from the GRF to the Managed Care Performance Payment Fund (Fund 5KW0) and reduced appropriation item 651525, Medicaid/Health Care Services by the same amount. Beginning in FY 2018, managed care performance payments are made out of line item 651525, Medicaid Health Care Services.

5R20 651608 Medicaid Services-Long Term

FY 2016 Actual	FY 2017 Actual	FY 2018 Actual	FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
$399,818,149	$403,248,622	$405,532,215	$405,666,000	$415,666,000	$415,666,000
% change	0.9%	0.6%	0.0%	2.5%	0.0%

Source: Dedicated Purpose Fund Group: Franchise fee assessment on nursing facilities

Legal Basis: ORC 5168.54; Section 333.10 of H.B. 49 of the 132nd G.A. (originally established by Section 323.10 of H.B. 59 of the 130th G.A.)

Purpose: This line item makes Medicaid payments to nursing facilities.

5SA0 651628 Maternal and Child Health

FY 2016 Actual	FY 2017 Actual	FY 2018 Actual	FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
$500,000	$0	$0	$0	$0	$0
% change	-100%	N/A	N/A	N/A	N/A

Source: Dedicated Purpose Fund Group: Cash transfer from the excess FY 2015 GRF ending balance

Legal Basis: Discontinued line item (originally established by Sections 327.10, 327.245, and 512.30 of H.B. 64 of the 131st G.A.)

Purpose: This line item was allocated to Integrating Professionals for Appalachian Children to improve maternal and child health outcomes in the service area comprised of Athens, Gallia, Hocking, Jackson, Meigs, Perry, Ross, Vinton, and Washington counties.

5SA4 651689 Medicaid Health & Human Services

FY 2016 Actual	FY 2017 Actual	FY 2018 Actual	FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
$0	$0	$264,376,763	$310,829,377	$0	$0
% change	N/A	N/A	17.6%	-100%	N/A

Source: Dedicated Purpose Fund Group: Transfers from the GRF, Support and Recoveries Fund (Fund 5DL0), and Health Insuring Corporation Class Franchise Fee Fund (Fund 5TN0)

Legal Basis: Section 333.33 of H.B 49 of the 132nd G.A.

Purpose: This line item pays for costs associated with the Medicaid Program. H.B. 49 of the 132nd G.A. permitted the Medicaid Director to seek Controlling Board approval to authorize expenditures from this fund if the U.S. Congress did not amend the amount of federal reimbursement received for the Group VIII population. The Medicaid Director sought and received this approval on October 30, 2017, and July 9, 2018.

5SC0 651683 Medicaid Services-Physician UPL

FY 2016 Actual	FY 2017 Actual	FY 2018 Actual	FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
$3,503,537	$14,147,003	$5,566,189	$7,004,616	$7,520,000	$7,645,000
% change	303.8%	-60.7%	25.8%	7.4%	1.7%

Source: Dedicated Purpose Fund Group: Intergovernmental transfers made by The Ohio State University's Wexner Medical Center

Legal Basis: Section 333.10 of H.B. 49 of the 132nd G.A. (originally established by Controlling Board on August 17, 2015)

Purpose: This line item is used by ODM to spend intergovernmental transfers for a Supplemental Upper Payment Limit (UPL) program for physicians of The Ohio State University's Wexner Medical Center. The funding arrangement is similar to the Hospital UPL program in that they both close the gap between Medicaid and Medicare Payment rates for the given subset of providers.

5TN0 651684 Medicaid Services-HIC Fee

FY 2016 Actual	FY 2017 Actual	FY 2018 Actual	FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
$0	$0	$581,158,191	$561,000,000	$820,564,060	$791,187,400
% change	N/A	N/A	-3.5%	46.3%	-3.6%

Source: Dedicated Purpose Fund Group: Monthly franchise fee on health insuring corporations

Legal Basis: Section 333.10 of H.B. 49 of the 132nd G.A.

Purpose: This line item is used to reimburse health care providers for covered services to Medicaid recipients. The federal match for expenditures from this line item will be made from line item 651623, Medicaid Services – Federal.

5TZ0 651600 Brigid's Path Program

FY 2016 Actual	FY 2017 Actual	FY 2018 Actual	FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
$0	$0	$500,000	$500,000	$0	$0
% change	N/A	N/A	0.0%	-100%	N/A

Source: Dedicated Purpose Fund Group: Funds that would have otherwise been distributed to municipal governments in fiscal years 2018 and 2019 under ORC 5747.50

Legal Basis: Sections 333.10, 333.63 and 757.20 of H.B. 49 of the 132nd G.A.

Purpose: This line item is used to provide funds for the development of a pilot program under which newborns who have neonatal abstinence syndrome, after being medically stabilized at a hospital, are transferred to a nonhospital, community facility that is located in Montgomery County. The program is to provide the newborns medical, pharmacological, and therapeutic services specified by the Department of Medicaid, the Department of Job and Family Services, and the Department of Health.

5U30 651654 Medicaid Program Support

FY 2016 Actual	FY 2017 Actual	FY 2018 Actual	FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
$12,994,290	$18,167,321	$3,346,012	$0	$0	$0
% change	39.8%	-81.6%	-100%	N/A	N/A

Source: Dedicated Purpose Fund Group: Variety of Medicaid financing activities

Legal Basis: Discontinued line item (originally established by ORC 5162.54 and Section 323.10 of H.B. 59 of the 130th G.A.)

Purpose: This line item paid costs associated with the administration of Medicaid. Beginning in FY 2018, this line item is replaced by line item 651685, Medicaid Recoveries - Program Support, which is supported by Fund 5DL0.

6510 651649 Medicaid Services-Hospital Care Assurance Program

FY 2016 Actual	FY 2017 Actual	FY 2018 Actual	FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
$445,516,981	$232,270,068	$234,136,746	$235,938,312	$249,167,065	$168,310,123
% change	-47.9%	0.8%	0.8%	5.6%	-32.5%

Source: Dedicated Purpose Fund Group: Hospital Care Assurance Program (HCAP) assessments on hospitals

Legal Basis: Section 333.10 of H.B. 49 of the 132nd G.A. (originally established by Section 323.10 of H.B. 59 of the 130th G.A.)

Purpose: This line item funds the Hospital Care Assurance Program (HCAP), which provides subsidy payments to hospitals that provide uncompensated, or charity, care to certain low-income and uninsured individuals. Due to a delay in receiving federal approval, the payments for FY 2015 were not made until FY 2016.

Holding Account Fund Group

R055 651644 Refunds and Reconciliation

FY 2016 Actual	FY 2017 Actual	FY 2018 Actual	FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
$264,618	$45,310	$148,673	$1,000,000	$1,000,000	$1,000,000
% change	-82.9%	228.1%	572.6%	0.0%	0.0%

Source: Holding Account Fund Group: Unidentified checks received by ODM

Legal Basis: Section 333.10 of H.B. 49 of the 132nd G.A. (originally established by Section 323.10 of H.B. 59 of the 130th G.A.)

Purpose: This line item is used to disburse funds that are held for checks whose disposition cannot be determined at the time of receipt. Upon determination of the appropriate fund into which the check should have been deposited, a disbursement is made from this line item to the appropriate fund.

Federal Fund Group

3ER0 651603 Medicaid and Health Transformation Technology

FY 2016 Actual	FY 2017 Actual	FY 2018 Actual	FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
$55,705,287	$47,169,881	$29,128,025	$61,895,999	$48,031,056	$48,340,000
% change	-15.3%	-38.2%	112.5%	-22.4%	0.6%

Source: Federal Fund Group: CFDA 93.778 and the American Reinvestment and Recovery Act of 2009 (Public Law 111-5) Section 4201, Medicaid Provider HIT Adoption and Operation Payments Implementation

Legal Basis: ORC 5164.93; Section 333.10 of H.B. 49 of the 132nd G.A. (originally established by Section 323.10 of H.B. 59 of the 130th G.A.)

Purpose: This line item is used for provider electronic health record (EHR) incentives and administrative costs related to the Health Information Technology (HIT) grant.

3F00 651623 Medicaid Services-Federal

FY 2016 Actual	FY 2017 Actual	FY 2018 Actual	FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
$3,841,522,208	$3,655,601,110	$6,226,396,603	$6,083,132,010	$6,459,332,595	$6,266,809,500
% change	-4.8%	70.3%	-2.3%	6.2%	-3.0%

Source: Federal Fund Group: CFDA 93.778 Medical Assistance Grants (Medicaid); CFDA 93.779, Health Care Financing Research, Demonstrations and Evaluations; and the federal share of drug rebates and other Medicaid revenues

Legal Basis: ORC 5162.50; Section 333.10 of H.B. 49 of the 132nd G.A. (originally established by Section 323.10 of H.B. 59 of the 130th G.A.)

Purpose: This line item provides the Medicaid federal share when the state share is provided from a source other than GRF line item 651525, Medicaid/Health Care Services, GRF line item 651425, Medicaid Program Support – State, or line item 651682, Health Care Grants – State. Major activities in this line item include the federal share of nursing facility, hospital, prescription drug expenditures, and general Medicaid services.

In FY 2014 and FY 2015, this line item was also used to fund expenditures relating to the Medicaid expansion population through the federal Affordable Care Act (ACA). Beginning in FY 2016, the expansion population is mainly funded through GRF line item 651525, Medicaid Health Care Services.

3F00 651624 Medicaid Program Support - Federal

FY 2016 Actual	FY 2017 Actual	FY 2018 Actual	FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
$292,426,416	$339,823,842	$335,945,855	$682,203,750	$516,667,497	$527,369,363
% change	16.2%	-1.1%	103.1%	-24.3%	2.1%

Source: Federal Fund Group: CFDA 93.778 Medical Assistance Grants (Medicaid); federal share of Medicaid administrative expenses

Legal Basis: ORC 5162.50; Section 333.10 of H.B. 49 of the 132nd G.A. (originally established by Section 323.10 of H.B. 59 of the 130th G.A.)

Purpose: This line item provides for the federal share of Medicaid administrative expenses while the state share of these expenditures is provided mostly from GRF line item 651425, Medicaid Program Support – State.

3FA0 651680 Health Care Grants-Federal

FY 2016 Actual	FY 2017 Actual	FY 2018 Actual	FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
$15,377,474	$20,878,969	$17,443,941	$38,664,967	$11,988,670	$12,000,000
% change	35.8%	-16.5%	121.7%	-69.0%	0.1%

Source: Federal Fund Group: CFDA 93.525: State Planning and Establishment Grants for the Affordable Care Acts Exchanges; performance bonuses under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

Legal Basis: Section 333.10 of H.B. 49 of the 132nd G.A. (originally established by Section 323.10 of H.B. 59 of the 130th G.A.)

Purpose: This line item funds Medicaid/SCHIP and non-Medicaid/SCHIP Program initiatives stemming from the Affordable Care Act of 2010.

3G50 651655 Medicaid Interagency Pass Through

FY 2016 Actual	FY 2017 Actual	FY 2018 Actual	FY 2019 Estimate	FY 2020 Introduced	FY 2021 Introduced
$149,123,953	$114,243,712	$118,127,230	$225,701,597	$225,701,597	$225,701,597
% change	-23.4%	3.4%	91.1%	0.0%	0.0%

Source: Federal Fund Group: CFDA 93.796, State Survey and Certification of Health Care Providers and Suppliers; CFDA 93.778, Medical Assistance Program (Medicaid: Title XIX); CFDA 93.767 Children's Health Insurance Program

Legal Basis: Section 333.10 of H.B. 49 of the 132nd G.A. (originally established by Section 323.10 of H.B. 59 of the 130th G.A.)

Purpose: This line item is used to disburse federal reimbursement to other agencies for Medicaid expenditures they have made. The departments of Aging, Developmental Disabilities, Education, Health, Job and Family Services, and Mental Health and Addiction Services, and the State Board of Pharmacy assist ODM in administering certain Medicaid programs/services and receive federal reimbursements for services provided and related administration. Prior to FY 2016, federal reimbursements for services provided were appropriated to this line item and to the agency line items that received transfers from this line item. Beginning in FY 2016, federal reimbursements for services provided are appropriated to the applicable agency only. However, reimbursements related to administration remain in this line item.

Line Item Detail by Agency			FY 2018	Estimate FY 2019	Introduced FY 2020	FY 2019 to FY 2020 % Change	Introduced FY 2021	FY 2020 to FY 2021 % Change
Report For: Main Operating Appropriations Bill				**Version: As Introduced**				
MCD Department of Medicaid								
GRF	651425	Medicaid Program Support-State	$ 139,987,073	$ 178,754,197	$ 184,688,131	3.32%	$ 190,406,760	3.10%
GRF	651426	Positive Education Program Connections	$0	$ 2,500,000	$ 0	-100.00%	$ 0	N/A
		Medicaid Health Care Services-State	$ 3,725,608,590	$ 3,869,723,469	$ 4,070,409,989	5.19%	$ 4,605,094,471	13.14%
		Medicaid Health Care Services-Federal	$ 9,479,085,299	$ 9,632,895,893	$ 9,695,975,237	0.65%	$ 10,456,031,296	7.84%
GRF	651525	Medicaid Health Care Services - Total	$ 13,204,693,889	$ 13,502,619,362	$ 13,766,385,226	1.95%	$ 15,061,125,767	9.41%
GRF	651526	Medicare Part D	$ 461,884,333	$ 458,645,939	$ 500,325,646	9.09%	$ 554,214,667	10.77%
	GRF - State		$ 4,327,479,997	$ 4,509,623,605	$ 4,755,423,766	5.45%	$ 5,349,715,898	12.50%
	GRF - Federal		$ 9,479,085,299	$ 9,632,895,893	$ 9,695,975,237	0.65%	$ 10,456,031,296	7.84%
	General Revenue Fund Total		**$ 13,806,565,296**	**$ 14,142,519,498**	**$ 14,451,399,003**	**2.18%**	**$ 15,805,747,194**	**9.37%**
4E30	651605	Resident Protection Fund	$ 1,770,786	$ 4,878,000	$ 3,910,338	-19.84%	$ 4,013,000	2.63%
5AJ0	651631	Money Follows the Person	$ 4,295,197	$ 12,373,500	$ 0	-100.00%	$ 0	N/A
5AN0	651686	Care Innovation and Community Improvement Program	$0	$ 51,680,120	$ 53,435,797	3.40%	$ 53,406,291	-0.06%
5DL0	651639	Medicaid Services-Recoveries	$ 774,001,996	$ 612,202,457	$ 741,454,299	21.11%	$ 724,170,233	-2.33%
5DL0	651685	Medicaid Recoveries-Program Support	$ 14,540,841	$ 41,328,516	$ 40,351,245	-2.36%	$ 44,375,000	9.97%
5DL0	651690	Multi-System Youth Innovation and Support	$0	$ 0	$ 10,000,000	N/A	$ 10,000,000	0.00%
5FX0	651638	Medicaid Services-Payment Withholding	$ 12,226,619	$ 27,000,000	$ 12,000,000	-55.56%	$ 12,000,000	0.00%
5GF0	651656	Medicaid Services - Hospital Upper Payment Limit	$ 679,066,108	$ 671,505,583	$ 822,016,219	22.41%	$ 887,150,856	7.92%
5KC0	651682	Health Care Grants-State	$ 0	$ 5,000,000	$ 0	-100.00%	$ 0	N/A
5R20	651608	Medicaid Services-Long Term	$ 405,532,215	$ 405,666,000	$ 415,666,000	2.47%	$ 415,666,000	0.00%
5SA4	651689	Medicaid Health & Human Services	$ 264,376,763	$ 310,829,377	$ 0	-100.00%	$ 0	N/A
5SC0	651683	Medicaid Services-Physician UPL	$ 5,566,189	$ 7,004,616	$ 7,520,000	7.36%	$ 7,645,000	1.66%
5TN0	651684	Medicaid Services-HIC Fee	$ 581,158,191	$ 561,000,000	$ 820,564,060	46.27%	$ 791,187,400	-3.58%
5TZ0	651600	Brigid's Path Program	$ 500,000	$ 500,000	$ 0	-100.00%	$ 0	N/A
5U30	651654	Medicaid Program Support	$ 3,346,012	$0	$0	N/A	$0	N/A
6510	651649	Medicaid Services-Hospital Care Assurance Program	$ 234,136,746	$ 235,938,312	$ 249,167,065	5.61%	$ 168,310,123	-32.45%
	Dedicated Purpose Fund Group Total		**$ 2,980,517,664**	**$ 2,946,906,481**	**$ 3,176,085,023**	**7.78%**	**$ 3,117,923,903**	**-1.83%**
R055	651644	Refunds and Reconciliation	$ 148,673	$ 1,000,000	$ 1,000,000	0.00%	$ 1,000,000	0.00%
	Holding Account Fund Group Total		**$ 148,673**	**$ 1,000,000**	**$ 1,000,000**	**0.00%**	**$ 1,000,000**	**0.00%**

Line Item Detail by Agency			FY 2018	Estimate FY 2019	Introduced FY 2020	FY 2019 to FY 2020 % Change	Introduced FY 2021	FY 2020 to FY 2021 % Change
MCD	**Department of Medicaid**							
3ER0	651603	Medicaid and Health Transformation Technology	$ 29,128,025	$ 61,895,999	$ 48,031,056	-22.40%	$ 48,340,000	0.64%
3F00	651623	Medicaid Services-Federal	$ 6,226,396,603	$ 6,083,132,010	$ 6,459,332,595	6.18%	$ 6,266,809,500	-2.98%
3F00	651624	Medicaid Program Support - Federal	$ 335,945,855	$ 682,203,750	$ 516,667,497	-24.26%	$ 527,369,363	2.07%
3FA0	651680	Health Care Grants-Federal	$ 17,443,941	$ 38,664,967	$ 11,988,670	-68.99%	$ 12,000,000	0.09%
3G50	651655	Medicaid Interagency Pass Through	$ 118,127,230	$ 225,701,597	$ 225,701,597	0.00%	$ 225,701,597	0.00%
Federal Fund Group Total			**$ 6,727,041,654**	**$ 7,091,598,323**	**$ 7,261,721,415**	**2.40%**	**$ 7,080,220,460**	**-2.50%**
Department of Medicaid Total			**$ 23,514,273,287**	**$ 24,182,024,302**	**$ 24,890,205,441**	**2.93%**	**$ 26,004,891,557**	**4.48%**