Taking Stock of Medicaid Changes in the Final 2016-2017 State Budget

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State Budgeting Matters
Volume 11, Number 10
July, 2015
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July 16, 2015

Highlights:

- Ohio continues to invest in programs that seek to reduce its abysmal infant mortality rate. A key proposal will target areas in the state identified to have high infant mortality rates and use Medicaid managed care to provide enhanced care management to pregnant women and women of child-bearing age. In addition, more money will be invested in efforts to reduce smoking among pregnant women.

- The final budget restores Medicaid coverage to pregnant women and women in the breast and cervical cancer program up to 200 percent of the federal poverty level. This is a move in the right direction given that providing timely prenatal care can help to reduce the infant mortality rate.

- This is the first state budget in which the state must fund a portion of the Medicaid expansion. The finalized budget attaches some strings to accessing the funding for the state share of expansion. This funding, in the newly established Health and Human Services Fund, is only accessible via Controlling Board request. The governor did veto a provision that would have limited the amount of money that could be requested of the Controlling Board.

- The Senate added a provision that remained in the final budget that requires the Ohio Department of Insurance (ODI) to apply for a waiver from the federal government. Through a State Innovation Waiver, which is allowed under Section 1332 of the Affordable Care Act (ACA), ODI would need to develop a system that provides access to affordable health coverage for Ohioans. The budget language also requires ODI to include in the application, a request to waive the employer and individuals mandates required by the ACA.

- The final budget requires the Ohio Department of Medicaid (ODM) to apply for a waiver that requires all adults on Medicaid who currently qualify under the covered families and children (CFC) or Medicaid Extension category, between 0 and 138 percent of the FPL, to pay premiums into a modified health savings account (HSA). This would apply to over 1 million Ohioans who are currently enrolled under these eligibility categories. While some changes were made to the waiver proposal from the more stringent House-passed version, there are still multiple components of this program that would limit the ability of low-income individuals to access coverage and care.

- The state is authorized to move forward with a new unified disability determination system but the implementation is delayed until July 1, 2016. Medicaid disability income and asset limits will be the same as Supplemental Security Income. Individuals who are using the “spend-down” process to qualify for Medicaid must either obtain coverage through the health insurance exchange or establish a Miller trust for income above the allowable threshold. ODM intends to create a special
waiver for individuals with severe and persistent mental illness who are currently using spend-down.

- The nursing home quality payment formula is revised to focus on five indicators: pressure ulcers, utilization of anti-psychotic medicines, avoidable hospital readmissions, nursing facility staff retention, and use of the Preferences for Everyday Living Survey Instrument. Facilities that can achieve most or all of the indicators will receive a higher bonus. Ohio is one of 11 states with at least 40 percent of all its nursing homes rated at the lowest levels (one or two stars) by CMS.

- Medicaid home health aides will receive a five percent rate increase in a long-overdue acknowledgement of the low pay and poor benefits of this service.

**Addressing Infant Mortality**

The governor vetoed a Senate-added provision that codified a program that uses community health workers in areas identified to have high infant mortality rates to reach out and work with women who are pregnant or who may become pregnant. This program, known as a community hub model, is aimed at reducing infant mortality. The governor’s veto message says that this provision is too prescriptive and that Medicaid managed care plans are already required to provide “enhanced maternal health coordinated care” and that dollars should not be spent to duplicate work that plans “should already be doing.” Providing enhanced maternal health coordinated care through the managed care plans was included in the governor’s original budget proposal.

The budget contains other initiatives to address infant mortality. The Ohio Department of Health (ODH) director, in coordination with the Ohio Department of Medicaid (ODM), must identify the areas of the state with the highest infant mortality rates (referred to as infant mortality “hot spots”). Under the ODM plan, these are the areas that will be targeted for enhanced care management, under Medicaid managed care, of pregnant women and women of child-bearing age to reduce infant mortality.

Another provision requires the ODH director to review every government-funded program that seeks to reduce infant mortality and negative birth outcomes or seeks to address disparities that exist between pregnant women or women of child-bearing age who belong to a racial or ethnic minority. The administrator of each of the programs that the director identifies is then required to report to the director on the performance of their program. The director must then put together a report with an assessment of the programs’ performances and a review of medical and health records from individuals served by the programs who were born within the preceding year.

The Senate-added Moms Quit for Two Grant Program funds eligible public or nonprofit entities that provide tobacco cessation services to pregnant women or women living with children in the identified hot spots. Maternal smoking is a known risk factor for pre-term or complicated births which can lead to infant death. ODH will administer this program. The earmark for this
program is $1 million in each fiscal year from the Tobacco Prevention Cessation and Enforcement line item.

The Senate added another provision aiming to keep mothers healthy. Medicaid managed care companies are now required to provide certain services to anyone who is pregnant or the mother of a child under age 3 who is also enrolled in Help Me Grow. These services include home visits (must include depression screenings) and medically-necessary cognitive behavioral therapy.

**Department of Medicaid and Other Insurance Provisions**

**Medicaid Optional Eligibility Categories**

The final version of the budget retains the restoration of Medicaid coverage for pregnant women between 138 and 200 percent of the federal poverty level (FPL). The administration proposed to eliminate this coverage and the House agreed. In a move that will help women access prenatal care, the Senate added coverage back. The Center for Community Solutions, along with other organizations, strongly advocated to restore this funding. The Senate also restored funding for Medicaid coverage of the breast and cervical cancer program (BCCP) for women between 138 and 200 percent of FPL. Maintaining coverage for pregnant women and women in the BCCP will cost $15 million ($7.4 million state share) in FY 2016 and $30.4 million ($15.3 million state share) in FY 2017. The original proposal would have allowed anyone enrolled under these categories to continue to receive services, but would not allow anyone new to enroll, which would have yielded more savings in the second year. This explains the difference in costs for restoring coverage between 2016 and 2017. The final budget does not restore funding for Medicaid family planning services for people between 138 and 200 percent of FPL, which was originally eliminated by the as-introduced budget.

**Funding for Medicaid Extension**

The House and Senate agreed to keep the Senate-created Health and Human Services Fund and it was included in the final version of the budget. The funds for the state share of Medicaid extension are isolated in this fund. In 2017, the state must provide 5 percent of this funding; this percentage increases each year through 2020, until the state share reaches 10 percent of the costs of extension. *This state budget is the first in which the state will be funding part of the Medicaid extension.* The fund will receive up to $50 million from the FY 2015 General Revenue Fund (GRF) carry-over balance. Subsequently, the Office of Budget and Management (OBM) is required on July 1, 2016 to transfer $150 million to this fund. Any unobligated balance in this fund as of June 30, 2017, must be transferred to the Rainy Day Fund. In the original budget proposal, the administration said the state share of costs for the Medicaid expansion would be $126 million for the second half of FY 2017.1 These funds will not automatically be released to the ODM to fund the extension, and will require Controlling Board approval. By statute the funds can be used to “pay any costs associated with programs or services provided by the state to enhance the public health and overall health care quality of Ohio citizens.”
The governor vetoed a provision limiting the powers of the Controlling Board’s authority to transfer unanticipated funds that exceed $10 million, or 10 percent of the initial appropriation, and to create new funds. This would have limited the ability of ODM, to fund the state share of the Medicaid extension, which is required in the second half of FY 2017. This also could have had an unforeseen impact on funding other critical needs of the state.

**Value-Based Payments in Medicaid**

The final budget retains a Senate-added provision that requires Medicaid managed care organizations to “implement strategies that base payments to providers on the value received from the providers’ services, including their success in reducing waste in the provision of the services.” This must be achieved by July 1, 2018, and by July 1, 2020, managed care organizations must ensure that at least 50 percent of aggregate net payments made to providers are based on the value received from the services. Value-based purchasing is not defined within the legislation, but the concept is to “link provider payments to improved performance by health care providers.”

**ACA Section 1332 Waiver aka “Super Waiver”**

A Senate-added provision that requires the Ohio Department of Insurance (ODI) to apply for a waiver remains in the final budget. ODI is required to apply for a State Innovation Waiver that is allowed under Section 1332 of the Affordable Care Act to develop a system that provides access to affordable health coverage for Ohioans. A new system must cover a comparable number of people and be priced at least as affordable as marketplace coverage. The coverage available must also be comprehensive, covering the ten essential health benefits. Within the waiver application, the budget requires the superintendent of ODI to request to waive the employer and individual mandates for insurance coverage that are currently in place as a result of the ACA. This would cause significant disruptions to the insurance market. This waiver does not extend to Medicaid.

**Transparency in Health Services Prices**

Various proposals were made to increase transparency around health services prices and quality including an all-payer claims database, the requirement to advertise charges for medical procedures, and a hospital report card. All of these provisions were removed before the budget was finalized. The Health Services Price Disclosure Study Committee, under the Office of Health Transformation (OHT), was established in the enacted version of the Bureau of Workers’ Compensation (BWC) budget (H.B. 52). This committee will examine the feasibility of medical services providers disclosing prices of medical services and must provide a report to the governor and legislature by December 31, 2015. The study committee must also provide recommendations on how health insurers can provide information on how to compare prices of health services. Although this was passed in the BWC budget, the committee is tasked with examining health services across all payers and providers. This provision also requires, by January 1, 2017, that health services providers be able to give an estimate for all non-emergency services to anyone who requests an estimate.
Healthy Ohio Medicaid Waiver

Despite having removed the Healthy Ohio waiver program from the Senate-passed budget, changes were made to the House’s Healthy Ohio Medicaid waiver and the conference committee added the program back into the final budget. Read *State Budgeting Matters Volume 11, Number 5: Ohio House Medicaid Plan Markedly Different than Indiana Plan; Thousands of Ohio Children and Adults Would Lose Access to Health Care Coverage* to learn more about the House version of this proposal.

**Who Has to Enroll in Healthy Ohio?**

In the enacted version of the budget, ODM is required to apply for a waiver that requires all adults on Medicaid who currently qualify under the covered families and children (CFC) or Medicaid Extension category, between 0 and 138 percent of the FPL, to pay premiums into a modified health savings account (HSA). Anyone who falls into these categories must enroll in a health plan offered by a managed care organization. Based on June, 2015 Medicaid enrollment figures, approximately 1.09 million people, or just over 36 percent of all Medicaid enrollees, fall into the eligibility categories that will be required to pay into the HSA, displayed by the two red pieces in Figure 1. This version of the waiver does not require children to pay a premium, unlike the House-passed plan. Adults in the CFC and Medicaid Extension categories are required to enroll in Healthy Ohio. The budget language explicitly prohibits these populations from receiving services through the traditional Medicaid fee-for-service (FFS) or Medicaid managed care.

![Figure 1: Ohio Medicaid Enrollment by Eligibility Category, June, 2015](source: Ohio Department of Medicaid, ODM Eligible Clients, June 2015)
**Payment Rates to Providers through Healthy Ohio**

A significant difference between the proposed and enacted versions of Healthy Ohio is the reimbursement rate for services. The House-passed plan had proposed to pay Medicare rates to providers for all services to Healthy Ohio participants. Ohio Medicaid, according to The Henry J. Kaiser Family Foundation’s 2012 Medicaid to Medicare Fee Index, on average paid 61 percent of what Medicare typically paid. This would have substantially increased the cost of care for these individuals. The enacted version of Healthy Ohio does not include the requirement to pay Medicare rates.

**Premiums and Buckeye Accounts**

Total premium payments from Healthy Ohio participants will be equal to the lesser of 2 percent of annual family income or $99. The premium in the House plan for Healthy Ohio was the greater of 2 percent of monthly family income or $1. These premiums would be deposited in the HSA, also known as the Buckeye account. Medicaid is required to deposit $1,000 per person into the Buckeye account each year, but cannot make the deposit until an initial monthly payment is made by the participant. An account may not have more than $10,000 in it at one time.

As described in the legislation, the functions of the Buckeye account are complex. There are two parts of the account, core and non-core. The participant’s contributions, and any contributions made on behalf of the participant, make up the core portion of the account, while the deposits from ODM comprise the non-core portion. An individual participant must make at least 25 percent of the total required contribution on his/her own, while an employer or not-for-profit organization can make contributions up to a certain amount as well. The managed care plan that the participant is enrolled in must require participants to pay copayments for services out of his/her Buckeye account, unless the amount in the core portion of the account is zero. The managed care plan will not pay for services until the non-core, Medicaid-funded portion is zero.

This system is set up so that participants pay copayments for services, while the Medicaid-funded portion of the account pays for services. A participant only has to pay copayments if there are funds available in the core portion of the account. Once the Medicaid funds are depleted in the non-core portion of the account, the managed care plan begins paying for services. ODM must make monthly statements available to participants that show the current amounts in each portion of their account.

There is a point system attached to each Buckeye account and participants can earn points for certain activities and meeting goals. One point is equal to one dollar. Points are awarded for setting up electronic funds transfers to pay monthly premiums (20 points), achieving health goals (up to 200 points), and satisfying health benchmarks (up to 100 points). It should be noted that 7.2 percent of Ohio households are unbanked, meaning they do not have an account at an insured institution.² Nationally, more people in low income households were unbanked than in middle/high income households.³ For those Medicaid enrollees in Ohio who are unbanked, setting up an electronic funds transfer to pay Medicaid premiums would not be feasible.
Debit Cards for Buckeye Account
In order for participants to pay copayments, among other things, each Buckeye account will be linked to a debit card. This debit card will be issued by the managed care organization in which the participant is enrolled and will be used to pay for both copayments, out of the core portion, and services, out of the non-core portion, of the Buckeye account. The debit card must be able to verify a participant’s eligibility in Healthy Ohio, determine whether a service is covered under the health plan, determine if the provider from whom the participant is seeking treatment is participating in the health plan, and provide balances of both the core and non-core portions of the Buckeye account.

What Happens if Someone Can’t Afford to Pay Premiums?
This waiver adds barriers to accessing care through Medicaid and it is expected that enrollment in these categories of the program will decline as a result. Likely some people who are struggling to make ends meet will not be able to contribute premiums on a monthly basis. Should a participant go 60 days without paying a premium, he/she will be disenrolled from the program. The exception to being disenrolled is if a participant is pregnant. A participant will also be disenrolled if he/she does not submit documentation to recertify for the program within 60 days of receiving a notice. A Healthy Ohio participant who is disenrolled is not allowed to access Medicaid through fee-for-service or managed care, meaning he/she will have no coverage options. Unlike the House plan that disenrolled someone for a year for failure to pay, the enacted version of Healthy Ohio allows a person to pay the full amount of the missing payment and then re-enroll.

Leaving the Healthy Ohio Program
Healthy Ohio enrollees who cease to participate in the program because they have increased income and have moved to an employer-sponsored health plan or purchased health insurance on their own will have their Buckeye account funds transferred to a bridge account. Funds in these bridge accounts may only be used to pay for costs related to obtaining health care coverage or out-of-pocket expenses for health care services and prescription drugs, similar to the requirements around spending from a traditional HSA in the private insurance market.

Accommodations for Participants with Significant Health Expenses
The requirements for developing the Healthy Ohio waiver include annual and lifetime limits on health expenses. The legality of this is questionable, because the ACA prohibits insurers from implementing annual or lifetime caps on payments. Nonetheless, the Healthy Ohio proposal includes a provision that would implement a $300,000 annual payout limit and a $1 million lifetime payout limit. Should a participant in the program exceed these limits, he/she would be transferred to coverage through the Medicaid fee-for-service or managed care system. This replaces the House plan to require the creation of a catastrophic health plan for these individuals.
Approving the Healthy Ohio Waiver

There is a lengthy process to approve any Medicaid waiver. A waiver must first be written by ODM after negotiations with the Center for Medicare and Medicaid Services (CMS). There are multiple public comment periods on the waiver, as well as required approval from other federal entities. It is likely to take over a year before this program could be implemented, and approval of this waiver is not guaranteed. There are several components in this proposed waiver that have more severe restrictions in place than in any other approved Medicaid waivers nationwide. In addition, CMS approved waivers in other states in order to extend Medicaid, but since Ohio has already extended Medicaid, it is yet to be determined if CMS will approve adding Healthy Ohio-like requirements to the CFC-adult population.

Table 1: Comparing Approved Healthy Indiana Waiver to Ohio Proposals

<table>
<thead>
<tr>
<th>KEY PLAN ELEMENTS</th>
<th>INDIANA-Approved waiver</th>
<th>OHIO-House-passed</th>
<th>OHIO- Final Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decreases the number of uninsured, and increases the number of individuals with Medicaid coverage</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>Limited to individuals who are over the age of 21</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Individuals with incomes at or below 100% of FPL are charged premiums as a condition of eligibility</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Total family contributions</td>
<td></td>
<td>Monthly premiums are the greater of 2% of income or $1.00</td>
<td>Monthly premiums are the greater of 2% of income or $1.00</td>
</tr>
<tr>
<td>Limits on what charities, employers, or health care providers can contribute to a participant HSA</td>
<td></td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Assumes higher payments to providers</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Length of time a participant is locked out of Medicaid if premiums or documentation are 60+ days late</td>
<td>Adults between 101-138% FPL are locked out for 6 months</td>
<td>12 months</td>
<td>Until premiums are paid</td>
</tr>
<tr>
<td>Includes provisions preventing a participant from losing coverage if they were unable to pay premium due to domestic violence, living in a county with a disaster declaration, being medically frail, and other exceptions deemed necessary</td>
<td>YES</td>
<td>NO</td>
<td>No, but does not disenroll pregnant women for failure to pay</td>
</tr>
<tr>
<td>Participants provided with basic Medicaid coverage if they fail to provide premiums</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
</tr>
</tbody>
</table>
Voluntary referral to workforce services | YES | YES | YES
--- | --- | --- | ---
Requires 90 days of retroactive coverage requirement from the date of application. | NO | NO | NO
Allows for expanded Medicaid presumptive eligibility determination by community mental health centers and health departments | YES | NO | NO
Requires coverage of all essential health benefits designated by the ACA | YES | NO | NO
Yearly and lifetime limit on benefit payouts | NO | YES | YES
State Medicaid agency required to establish a catastrophic health care plan for those exceeding the annual or lifetime payout limits of $300,000 and $1 million. | NO | YES | NO
Participants who exceed annual or lifetime payout limit are moved to traditional Medicaid fee-for-service or managed care | NO | NO | YES

Source: Amended Substitute House Bill Number 64, 131st Ohio General Assembly and Kaiser Family Foundation, Medicaid Expansion in Indiana

**Unified Disability Determination System**

The executive budget proposed the implementation of a new unified disability determination system. The budget delays the implementation of this change until July 1, 2016. The new system will eliminate spend-down eligibility for Medicaid.

Ohio is currently a “209(b) option” state in which the income eligibility limit for the Medicaid aged, blind, and disabled program is more restrictive than Supplemental Security Income (SSI). The Medicaid disability determination system is administered by county job and family service departments separately from the Opportunities for Ohioans Department (OOD) process used to qualify for SSI. The administration’s plan is to convert Ohio to a “1634 state” that will make Medicaid income eligibility consistent with SSI and allow the state to create a single, merged disability determination system for both Medicaid and SSI. The income limit will increase from 64 percent of FPL to 75 percent of FPL, and the asset limit increases from $1,500 to $2,000. Approximately 12,000 individuals who are not on Medicaid will become eligible.

This option eliminates spend-down for about 22,000 individuals with higher incomes. This includes approximately 4,000 to 6,000 Ohioans with severe and persistent mental illness. A special waiver will be created to continue Medicaid coverage for these individuals, but details of the waiver have not been worked out.

An unknown number of individuals who are currently relying on spend-down in institutions or on Medicaid HCBS waivers will need to use a legal mechanism known as a Miller Trust. The trust will hold excess income above the special income limit ($2,200 monthly) and can be used to pay the provider. The trust is subject to estate recovery. Individuals who do not use a
Miller Trust will have to gain health insurance through the health insurance marketplace. There are serious concerns among advocates for seniors and the disabled about how this vulnerable population will be able to establish and manage this complex legal arrangement.

**Nursing Facility Payment Rates**

The executive budget proposed a major change in the way nursing facilities are reimbursed and evaluated. At present, the nursing facility reimbursement formula is in statute, except for participants in the MyCare “dual-eligible” demonstration project. The statutory formula is complex, with a daily payment rate determined by individual components for direct care costs, capital costs, ancillary and support costs, tax costs, and quality indicators. A few facilities that are designated as “critical access facilities” also receive a 5 percent boost to their daily rate.³

The average daily Medicaid reimbursement rate for each resident is $169, well below Medicare and private insurance rates. Tax costs include state business taxes and local property taxes using a base year of 2003. Payroll taxes are included in the direct care cost component. With the exception of the quality component, facilities are categorized into peer groups according to the counties in which they are located. The standard rate is based on the 25th percentile of each peer group’s costs for the 2003 base year. Adjustments are then made from this base, including an annual cost escalator, but the department is not required to conduct a rebasing more than once every ten years. OHT has indicated that it will undertake the rebasing in FY 2017 using 2013 costs. For direct care costs, the largest component of reimbursements, a facility’s payment is adjusted according to a “case-mix score” that takes into account the costs of serving residents with different levels of needs, with the exception of the reimbursement rate for “low resource utilization residents,” which is set at a flat $130 per day.

The executive version of the bill proposed to remove the basic payment formula from statute and replace the current quality measurement system with five new standards. Presently, nursing homes must meet five of 20 quality measures in order to receive a bonus, and most facilities are able to do this. The quality component accounts for nearly 10 percent of the average nursing home payment.⁶ The executive also proposed updating the method of determining case mix scores by using a resource utilization group (RUG) model with 66 categories, allowing for greater differentiation. ODM projected that rebasing the formula to 2013 would increase All Funds costs by $154 million, but updating to a new RUG model would lower costs by $70 million, leaving a net cost of $84 million that would be applied to the quality component.⁷

As in previous budgets, the legislature refused to take the payment formula out of statute. The existing components were left in place except for the quality payment, which was changed but with important modifications to the executive proposal. The legislature also attempted to rein in the updated “grouper” methodology for determining residents’ case-mix scores by specifying that only 48 categories could be used rather than the proposed 66 categories. The governor vetoed this restriction on administrative discretion, however, and the department will move forward with the case-mix update.
To create the new quality structure, the budget bill adds $16.44 per day to the existing formula components. Instead of using the entire amount for quality payments, the new formula holds back $1.79 per day to create a quality incentive pool. This implies that most of the increases from rebasing will not be subject to quality incentives. Facilities that meet at least one of the five quality standards will receive a bonus; those that meet all five would receive the highest bonus. The five new components are:

- Maximum target percentages of pressure ulcers among long- and short-stay residents;
- Maximum target percentages for utilization of anti-psychotic medicines by long- and short-stay residents;
- A maximum target rate for avoidable resident hospital readmissions;
- A minimum percentage target rate for employee retention;
- Utilization of the nursing home version of the Preferences for Everyday Living Survey Instrument.

The first three components are similar to the executive budget proposal. The employee retention standard is a substitute for executive proposals to require the measurement of nurse staffing levels and the consistent assignment of individual staff members to individual residents. The survey instrument, which is a process measure, was not part of the executive proposal. It is a 72-question form that guides an interviewer in asking residents how they want to be cared for in their basic activities of daily living. The new measurement does not require that the facility actually change its operations in response to findings, or that the instrument be administered by a neutral third party. The language only requires that the survey be conducted.

Even though the administration did not get everything it wanted, the new quality standards are a step in the right direction. Ohio nursing homes as a group do not fare well on national rankings. According to a Kaiser Family Foundation analysis of CMS quality data, Ohio is one of 11 states with at least 40 percent of all its nursing homes rated at the lowest levels (one or two stars). Ohio is also one of nine states to have more than 20 percent of its nursing homes rated in the lowest one-star category. Clearly, there is room for improvement in quality. Part of the industry’s struggle with quality is due to the low wages and high turnover of direct care staff. A report by the Scripps Gerontology Center at Miami University found an average annual turnover rate of 33 percent for state-tested nursing assistants. The report also found “significant” variation in turnover within the same labor markets, however, which would seem to indicate that facilities have viable options to control turnover rates.

Another area in which the legislature partially accepted a change in the formula was the executive budget proposed to lower the per diem rate for low-acuity residents from $130 per day to $91.70 per day. The executive proposal would have lowered costs by $24 million (All Funds). The bill modified this proposal to provide an intermediate rate of $115 per day if the department is satisfied that the facility is working with the ombudsman to ensure appropriate services. The new flat rate cannot begin until FY 2017. Whether it will be enough to induce facilities move low-resource residents to community settings remains to be seen.
The bill also creates a new pilot program that requires ODM to request a federal waiver to transfer patients to nursing facilities in lieu of freestanding long-term care hospitals. The waiver directs ODM to select four nursing facilities to participate in the waiver who already routinely transfer patients to long-term care hospitals. These facilities would be located in Cuyahoga, Franklin, Hamilton, and Lucas counties. The language specifies that the payment rates for these services cannot exceed rates paid to hospitals.

**Medicaid Home Health Aides**

The House had included a 10 percent rate increase for home health aides outside of the DD system, and a $29 million per year earmark in the main ODM line item to pay for it. The rate increase does not apply to independent providers. The Senate modified the increase to 5 percent and reduced the earmark to $14.5 million per year. The final budget delays the increase until January 1, 2016, and removes the earmark.

**Conclusion**

The 2016-2017 budget makes big changes in the Medicaid program, especially as it relates to how adults will be covered by the program. While the restoration of Medicaid coverage for women who are pregnant or in the BCCP up to 200 percent of FPL was a positive move, the Healthy Ohio waiver will make the Medicaid program more complex and less accessible for thousands of Ohioans. Should the Healthy Ohio waiver be implemented, adults on the Medicaid program will experience a different program and barriers to coverage that are unprecedented in Ohio. This budget makes additional proposals to reduce infant mortality in Ohio. This is important work that will address a critical issue in Ohio and it is imperative to track these programs and measure the improvements these programs make. As these and other changes to the Medicaid program are implemented it will be important to make sure that these changes move the state in the right direction.

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1 Office of Health Transformation. Overall Medicaid Budget Impact.  
http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=amxyk8dEZ8Q%3d&tabid=252

2 2013 FDIC National Survey of Unbanked and Underbanked Households. October, 2014.  

3 2013 FDIC National Survey of Unbanked and Underbanked Households. October, 2014.  

4 The data in this section rely on updates provided by the Office of Health Transformation as of April, 2015, and available at:  
http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=hSAAEHhkLjA%3d&tabid=252

5 Critical access facilities are located in a federally-designated empowerment zone and have at least 65 percent of their residents using Medicaid. See R.C. 5165.23. Certain facilities can also be designated as “outlier facilities” because of residents’ special direct care needs, and have their rates determined through a special formula. See R.C. 5165.153.


7 Director John McCarthy, Ohio Department of Medicaid, Testimony to the Senate Medicaid Committee, May 5, 2015, page 55. Available at:  

8 R.C. 5165.25, As Enacted by H.B. 64.


11 Ibid.

12 ODM Director John McCarthy, Senate Medicaid testimony, op. cit.