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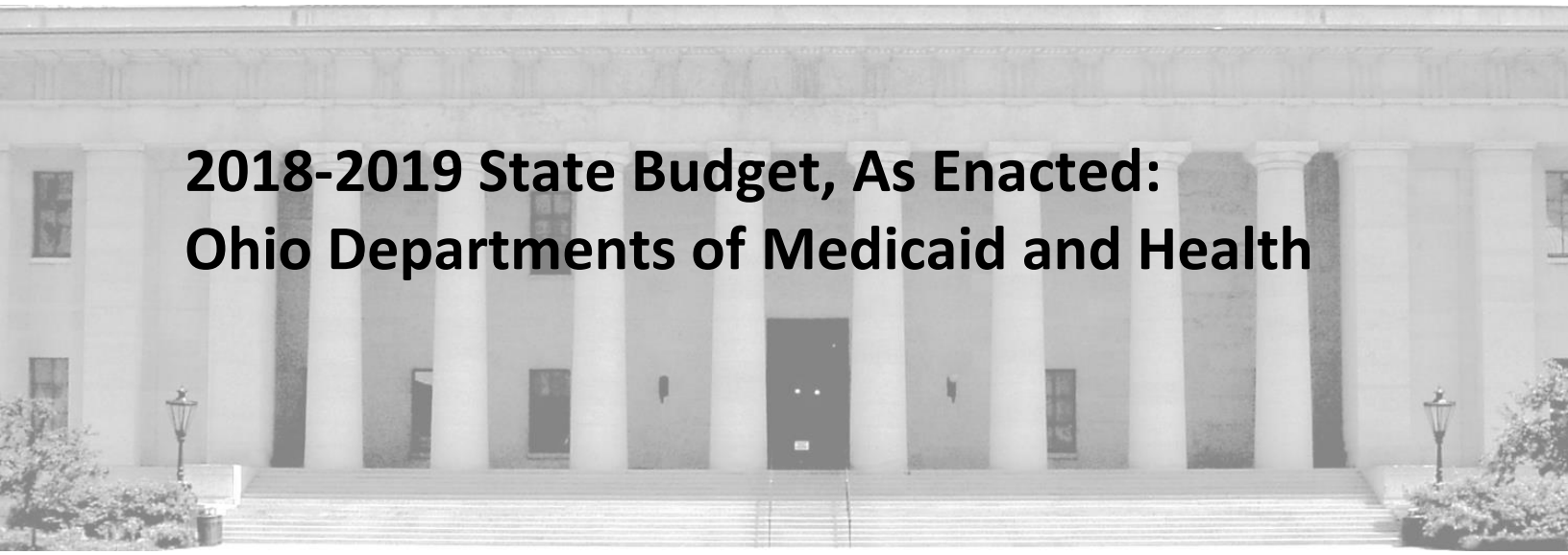

# 2018-2019 State Budget, As Enacted: Ohio Departments of Medicaid and Health

Loren Anthes, Public Policy Fellow

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## Ohio Department of Medicaid

*Introduction*

After months of debate, revised revenue estimates, and a veto process, which has not yet resolved, the Ohio budget has been enrolled and the Ohio Department of Medicaid (ODM) remained a focus for members of the General Assembly. The legislature sought more control over Ohio's program and, notably, developed several proposals that would increase the cost-sharing and eligibility requirements for individuals enrolled in the expansion group through the use of demonstration waivers. At the conclusion of the budget, the Governor vetoed 47 provisions, (the most of his tenure), a number of which dealt with the very Medicaid policies sought by policymakers in the House and Senate. The House reconvened soon thereafter and, for the first time in 40 years, overrode 11 of those vetoes, nine of which dealt directly with the Medicaid program. It is now up to the Senate to concur with the House to enact those provisions. There is also ongoing debate between the Kasich Administration and many providers over a potential gap in Medicaid funding as a result of the final budget. This gap may lead to a broad cut of 7 percent for Medicaid providers to keep the budget in balance, though nursing facilities would not be affected as they have their reimbursement established in Ohio Revised Code. With so much still taking place, this report tries to highlight some of what ODM may be facing in terms of policy and next steps as the Governor looks to the final year of his term.

**Table 1: ODM, GRF and Non-GRF 2016-2019**

| | FY 2016 | FY 2017 | Appropriation FY 2018 | % Change FY17-18 | Appropriation FY 2019 | % Change FY18-19 |
|---|---|---|---|---|---|---|
| *GRF* | $16,422,114,913.83 | $16,802,611,463.77 | $14,147,408,844.00 | -15.8% | $15,029,621,162.00 | 6.24% |
| *Non-GRF* | $6,380,748,300.24 | $6,111,088,649.02 | $9,980,716,140.00 | 63.3% | $10,190,485,165.00 | 2.10% |
| *Total* | $22,802,863,214.07 | $22,913,700,112.79 | $24,128,124,984.00 | 5.3% | $25,220,106,327.00 | 4.53% |

Source: LSC Budget in Detail, As Enacted

*General Budget*

The most notable change in the appropriation levels with the budget for the Ohio Department of Medicaid come from the reduction in state contributions and the increase of non-GRF contributions. This is largely due to the influence of two specific line items dealing with the new Health Insurance Corporation (HIC) fee (651684) and the associated increase of federal matching dollars (651623). The latter line item is responsible for the bulk of the shift, roughly $2.6 billion.

*Legislative Oversight*

The budget process included several provisions, which would have increased the influence of the General Assembly in the day-to-day management of the Medicaid program. This involved proposals, which would eliminate the abilities of the ODM to cover optional eligibility groups

without statutory approval and establish a new rates for a provider groups without receiving tacit approval from the Joint Medicaid Oversight Committee (JMOC). It would also require the Medicaid Director to seek funding from the Controlling Board to pay for expenses in the program relative to the expansion group. All three of these items were vetoed by the Governor, and then all three were overridden by the House.

Given the uncertainty of these provisions before the Senate, language from the Governor's vetoes may provide some insight into the policy background of options moving forward. First, in regards to eligibility, the Governor cited that the "ceding a portion of the Director of Medicaid's authority to the legislature" violated federal law.[1] It appears this may mean that any further efforts to enact eligibility policy through law may run into legal issues in the eyes of the Kasich administration. Regarding rate oversight, the Governor highlighted the inflexibility that such a process would entail, specifically citing how it would fundamentally alter the relationship between the Department and JMOC. Last, regarding the Controlling Board approval of Medicaid funds, the veto message stated that they "do not oppose the requirement" but that it prohibits the Board from releasing funds if the federal match changes due to Congressional action. With the recent defeat of the proposal in Congress to alter Medicaid financing, this provision may return as it appears there will be more stability in federal funding during the biennium.

While it was not a part of the override process, the Governor vetoed a few other provisions regarding general eligibility and the delivery system. One provision would have frozen enrollment for the Medicaid expansion by July, 2018. Advocates had organized against this issue citing concerns about continuity of care, especially in the context of access to addiction treatment. In the Governor's veto, he highlighted the fact that this violated federal law, a sentiment echoed by advocates stating it would be a violation of the Equal Protection Clause. While the House did not override this veto, it does not prohibit them from taking up the issue at any point during the General Assembly. The Governor also vetoed the provisions delaying the transition of the long-term care and behavioral health populations into managed care. These two provisions were overridden with overwhelming support from both sides of the aisle.

*Waivers*

In addition to oversight regarding the operational authority of the Director, the General Assembly sought multiple demonstration waivers regarding the operation of Medicaid in Ohio. First, there was a proposal to seek an 1115 demonstration waiver so that Medicaid reimbursement of behavioral health services in inpatient settings could be expanded. As we have written about previously, this would seem to be duplicative of efforts that are currently being developed by the state in response to the federal Managed Care Rule from 2016, something which was cited in the Governor's veto message.[2] Second, there was an effort to resurrect the "Healthy Ohio" waiver from 2016 as well as a policy seeking to impose a work requirement on Medicaid expansion enrollees with a few exemptions. Interestingly, the Governor's veto on the Healthy Ohio waiver (which was overridden by the House) mentioned the fact that the budget would require the Director to submit an identical proposal to the one

which was rejected by the Centers for Medicare and Medicaid Services (CMS). The veto explains that the administration would still like to pursue a policy which increases the enrollment requirements of participants, but that the veto was necessary in order to maintain negotiation flexibility.

The work requirement language was not vetoed and remains policy. In all likelihood, it is possible that the administration, rather than seeking out two separate waivers, will seek out a single waiver with both the work requirements and the cost-sharing elements. This waiver would still be subject to the public comment process set in federal law.[3] Research also suggests work requirements may violate the Administrative Procedure Act (APA).[4] To explain, the APA allows federal courts to review 1115 demonstration waivers under the "arbitrary and capricious" standard. While this does not mean judges can substitute their opinion of policy in place of that of the Secretary, it may mean that parties opposed to a work requirement could present a legal challenge to the policies being sought by the administration. According to the Congressional Research Service, the court will look at "the waiver's research or experimental goals, the potential impact on program beneficiaries, and objections raised concerning the proposal."

*Funding Gap*

As described in earlier reports, the administration sought to implement several policies that would alter payments to nursing facilities (NFs) and hospitals. These policies included the removal of a special protection afforded to NF reimbursement in Ohio Revised Code, efforts to increase quality in those settings, rules around coding changes for hospitals, and a policy which would compel hospitals to contract with managed care at governmental rates if they could not agree to a contract with any given plan. This last item, known as "non-contracting," may have impacted the current termination of the contract between Cleveland Clinic and CareSource, Ohio's largest Medicaid plan.[5] Regardless, according to the Office of Health Transformation, the legislature counted on the appropriation levels associated with these policies but, as a result of the budget process, the policies were stricken, meaning that the administration is no longer able to achieve the savings they sought in their initial proposal.[6] This $1.4 billion shortfall is represented by $237 million in foregone NF policy and a $1.1 billion gap in hospital policy.

Because nursing facilities are protected in law, the state cannot leverage its rulemaking authority to change their rates. That means that other providers may be subject to a rate cut, which, according to the administration, is about 7 percent across the board. Advocates have made claims that they believe the budget, because of this issue, was not balanced. However, as the appropriation levels are what is established in the budget, not the guarantee of said rates, it appears the administration is well within their legal authority to pursue rate cuts. At this point, the administration is engaging provider groups to negotiate this issue, but it is worthwhile to document how the inflexibility of reimbursement associated with NFs, and the legislating of Medicaid authority over providers, generally, has impacted the final budget.

*Miscellaneous*

Beyond these major structural issues for ODM, several other policy changes survived the Governor's veto pen. One item which was overridden was the changes to the managed care tax. Initially, the legislature proposed an increase in the fees that would be collected from plans as a way to supplement the funding to counties and regional tax authorities. The policy would require the Director to work with the CMS to increase the fee percentage from 5.8 percent to 7.2 percent. In his veto, the Governor pointed to the fact that this may compromise the current waiver CMS has approved, though that was refuted by members of the General Assembly. What's more, 7.2 percent exceeds the "safe harbor" threshold on provider taxes (6 percent); a limit on a Medicaid-based provider tax revenue used for drawing down federal funds.[7]

Comprehensive Primary Care, the multi-year policy which incentivizes primary care coordination, survived the legislative process. This was initially in question after the House had eliminated it, but, through continuance, maintains one of the hallmark programs of the administration in its work on value-based reimbursement. Lastly, the Care Innovation and Community Improvement Program was created to permit a nonprofit hospital affiliated with a university and public hospital agency to provide the state money for the purposes of drawing down matching funds from the federal government. This program, which appears to be a public hospital Upper Payment Limit program,[8] allows hospitals to use their funds in an amount up to $60 million for the purposes of drawing down federal funds upwards of $140 million each fiscal year.

*Conclusion*

While the budget has concluded, it still remains in question which of the override vetoes will be picked up by the Senate. Procedurally, the House can still debate any other veto of the Governor's during the General Assembly that was not addressed in the most recent set of votes. And while the federal reform efforts may have stalled, Ohio is still facing questions in terms of appropriations and revenue collections, setting up for what may be a significant budget corrections process in the near future.

**Ohio Department of Health**

*Introduction*

Outside of a largely symbolic effort to enroll Ohio in a "Health Care Compact,"[9] the Ohio Department of Health (ODH) was immune to the effects of the Governor's veto pen and that of the House override process. That said, a number of policies dealing with children with special needs, HIV/AIDS, lead abatement, and tobacco cessation were still deliberated and enacted.

**Table 2: ODH, GRF and Non-GRF 2016-2019**

| | FY 2016 | FY 2017 | Appropriation FY 2018 | % Change FY17-18 | Appropriation FY 2019 | % Change FY18-19 |
|---|---|---|---|---|---|---|
| *GRF* | $84,477,027.99 | $78,616,867.79 | $74,544,339.00 | -5.18% | $75,544,339.00 | 1.34% |
| *Non-GRF* | $480,745,388.11 | $460,145,309.71 | $549,318,309.00 | 19.38% | $550,076,449.00 | 0.14% |
| *Total* | $565,222,416.10 | $538,762,177.50 | $623,862,648.00 | 15.80% | $625,620,788.00 | 0.28% |

Source: LSC Budget in Detail, As Enacted

*BCMH*

In the Governor's proposal, the Bureau of Children with Medical Handicaps (BCMH) was supposed to be transitioned out of the Ohio Department of Health and into Ohio's Medicaid program. After pushback from advocates concerned that this would limit eligibility in the program for special needs children, the House removed the initiative. This removal was maintained throughout the budget, and BCMH remains.

*HIV/AIDS*

One provision in the budget would require that information regarding an HIV test may be disclosed to a physician who treats that patient. In the executive and House versions, the policy specified that an individual's records and information maintained by a drug-treatment program may be disclosed, without consent, to clinicians including doctors, advanced practice nurses, and physician assistants. This provision regarding disclosure was removed in the Senate.

*Lead*

In regards to lead, the administration's proposal around lead-safe residential rental units was maintained. This policy included the creation of a registry, to which homeowners could contribute, and the establishment of a training program for persons interested in conducting residential rental unit lead-safe maintenance practices. Additionally, a provision inserted by the House, would give sole and exclusive authority of ODH to regulate lead abatement. This provision was opposed by municipalities and housing advocates who were successful in having the provision removed, thus allowing cities to maintain their authority. There was also the creation of a new general revenue fund, 440527, which sets aside $150,000 per fiscal year for lead abatement.

The Lead Funding Partnership, a $5 million per fiscal year collaborative initiative between ODH and ODM, will also be pursued. This effort involves the state submitting a Medicaid State Plan amendment to the federal government to leverage Children's Health Insurance Program dollars (CHIP) to help homeowners address lead hazards in their homes.

*Conclusion*

There were no significant changes between the Senate-passed version of ODH's budget and the one enrolled through Conference and signed by the Governor. All funding associated with tobacco cessation and infant mortality, as we have detailed before, was maintained with the former being responsible for one of the largest dedicated purpose fund changes with an increase of from just under $2 million to $12.5 million each fiscal year.[10]

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Comments and questions about this edition may be sent to lanthes@CommunitySolutions.com.
1501 Euclid Ave., Ste. 310, Cleveland, OH 44115
101 E. Town St., Ste. 520, Columbus, OH 43215
P: 216-781-2944 // F: 216-781-2988 // www.CommunitySolutions.com