CHAPTER 12:

Medicaid Funding and Policy

This chapter was authored by Loren Anthes
Policy Fellow, the Center for Medicaid Policy, The Center for Community Solutions

> "Now, when you die and get to the meeting with St. Peter, he's probably not going to ask you much about what you did about keeping government small. But he is going to ask you what you did for the poor. You better have a good answer."
>
> *—Governor John R. Kasich, June 18, 2013*

On July 30, 1965, President Lyndon Johnson signed into law a bill that led to the creation of Medicare and Medicaid through amendments to the Social Security Act (SSA). In his speech, while sitting alongside former President Harry Truman, President Johnson quoted another President, Franklin Delano Roosevelt, who signed the original SSA legislation, stating the bill represented "a cornerstone in a structure which is being built but is by no means complete."[1] And, where the initial cost of the Medicaid program was just a little over $1 billion, costs now amount to almost $500 billion annually,[2] covering nearly one in four Americans[3] and one out of every two births.[4]

A partnership between states and the federal government, Medicaid does not make state participation mandatory. In fact, it was not until 1982, when Arizona decided to implement Medicaid, that all states had a program. Since then, there have been a number of federal level policy changes, most notably the Patient Protection and Affordable Care Act (ACA) in 2010, as well as myriad state regulatory developments that make up the current Medicaid policy context in Ohio. This state and federal partnership is both legal and financial, which often leads to the common adage "if you've seen one state's Medicaid program, you've seen one state's Medicaid program."

In the 50 years since its inception, Medicaid has served a dual role as a source of insurance coverage and as a conduit for health policy reform. An anti-poverty program initially designed to cover children, the disabled, and the elderly, Medicaid is a diverse amalgam of incremental enhancements or cutbacks, often financing state government activities as they seek to enhance their human services delivery systems or offset state spending. In recent years, because of its large role in state and federal budgets, Medicaid has become subject to the politics of health reform in Ohio and nationally, acting as a platform for ideological battles surrounding health access.

Medicaid is also a public health and payment transformation tool. Medicaid plays an outsized role

in some of Ohio's most pressing public health issues, including the opioid crisis and infant mortality. It is the predominant source of health coverage in areas of concentrated poverty, namely Appalachia and urban centers, which also means it is a major source of economic input for rural counties grappling with the impact of a globalizing economy. Beyond this, Medicaid's purchasing power has been leveraged by the state to enact reforms both in the program and in the private market, allowing the state to execute its strategy to improve quality and lower costs as it pursues value-based reform.

In Ohio, Medicaid, both in terms of a program and an executive function of state government, has changed significantly over the course of the Kasich Administration. Since Kasich's election to office, Medicaid has become a stand-alone department, covered nearly 700,000 more Ohioans than it had previously, moved further toward privatization, and renegotiated many essential elements of payment. This chapter later describes many of these changes in detail, but first it delves into a basic explanation of the program and its policy underpinnings in Ohio.

Basic Program Design

The federal government requires Medicaid beneficiaries to be either United States citizens or permanent residents and live in the state in which they receive benefits. Eligibility is also the byproduct of federal minimums and state policy decisions in regards to income and categorical definition of need. Being a means-tested program for low-income individuals, Medicaid requires the consideration of income thresholds when determining eligibility. Since the enactment of the Affordable Care Act, most income eligibility is determined through the Modified Adjusted Gross Income (MAGI) standard, which is based on taxable income and tax filing relationships,[5] using the federal poverty line to make the final determination. Table 12-1 provides the poverty thresholds for varying sized households for 2018.

Table 12-1: Annual Poverty Guidelines for the 48 Contiguous States and D.C. for 2018

	POVERTY LEVELS*					
PERSONS IN HOUSEHOLD	**100%**	**133%**	**138%**	**150%**	**200%**	**250%**
1	$12,140	$16,146	$16,753	$18,210	$24,280	$30,350
2	$16,460	$21,892	$22,715	$24,690	$32,920	$41,150
3	$20,780	$27,637	$28,676	$31,170	$41,560	$51,950
4	$25,100	$33,383	$34,638	$37,650	$50,200	$62,750
5	$29,420	$39,129	$40,600	$44,130	$58,840	$73,550
6	$33,740	$44,874	$46,561	$50,610	$67,480	$84,350
7	$38,060	$50,620	$52,523	$57,090	$76,120	$95,150
8*	$42,380	$56,365	$58,484	$63,570	$84,760	$105,950

** Updated annually. ** Add $4,320 for each additional person in household.*
Source: Office of the Assistant Secretary for Planning and Evaluation, the U.S. Department of Health and Human Services.

Eligibility

Initially, Medicaid's definition of categorical eligibility was defined within one of a few assistance groups including the aged, blind, disabled (ABD) and families with dependent children.[6] The program also closely linked to Aid to Families with Dependent Children (AFDC, or cash assistance)

and Supplemental Social Security Income (SSI). During the 1980s and 1990s, there were expansions for pregnant women and children, including the creation of the State Children's Health Insurance Program, or CHIP, and the connection to AFDC was severed though welfare reform. States have always had additional flexibility in designing eligibility, something which was increased during these decades to include coverage for adults over the age of 65, people with disabilities, and a number of other mandatory or optional coverage groups.[7]

In Ohio, depending on a combination of your income, expressed as a percentage of the Federal Poverty Level (FPL), and your categorical eligibility, you may qualify for coverage in any of several ways with different associated benefits as listed in Table 12-2.

Table 12-2: Medicaid Coverage Categories

	CATEGORY	DESCRIPTION	FPL LEVEL
Covered Families and Children (CFC)	Children	This group includes children, including those receiving subsidies for adoption or foster care.	Up to 156%
	State Children's Health Insurance Program (SCHIP)	Same as children.	Between 156% and 206%
	Pregnant Women	Receive expedited eligibility processing and have coverage beyond 60 days of delivery.	Up to 200%
	Families	Parents and children receiving cash assistance.	Up to 90%
Aged, Blind and Disabled (ABD)	Aged, Blind and Disabled (ABD)	Must be 65 or older, significantly visually impaired, or have a disabling condition that meets SSI requirements, including an asset limit of $2,000. Some individuals may also qualify for Medicare.	Up to 75%
	Medicaid Buy-In for Workers with Disabilities (MBIWD)	Employed individuals between 16 and 65 who have a disability. Also, must not have assets totaling more than $11,473 and must pay an annual premium if income is above 150% of FPL.	Up to 250%
Medicare Premium Assistance	Qualified Medicare Beneficiary (QMB)	Medicare beneficiary who received Medicaid for Medicare Part A and B premiums.	Up to 100%
	Specified Low-Income Medicare Beneficiary (SLMB)	Medicare beneficiary who received Medicaid for Medicare Part B premiums.	Between 100-120%
	Qualified Individual (QI)	Medicare beneficiary who received Medicaid for Medicare Part B premiums, subject to annual cap.	Between 120%-135%
	Qualified Disabled and Working Individual (QDWI)	Must have lost Medicare Part A coverage after losing disability coverage but is able to purchase Part A coverage through premiums. Must also not have assets that exceed the SSI asset limit.	Up to 200%
Other	Breast and Cervical Cancer Project (BCCP)	Uninsured women between 21 and 64 (depending on condition and physician involvement).	Up to 250%
	Medicaid Expansion (Group VIII)	Non-disabled, childless adults under 65 years of age.	Up to 138%

Source: The Ohio Legislative Service Commission.

The ABD group, however, does not use the MAGI standard for eligibility. Instead, this group is subject to asset tests and income limits established in the eligibility process for SSI.

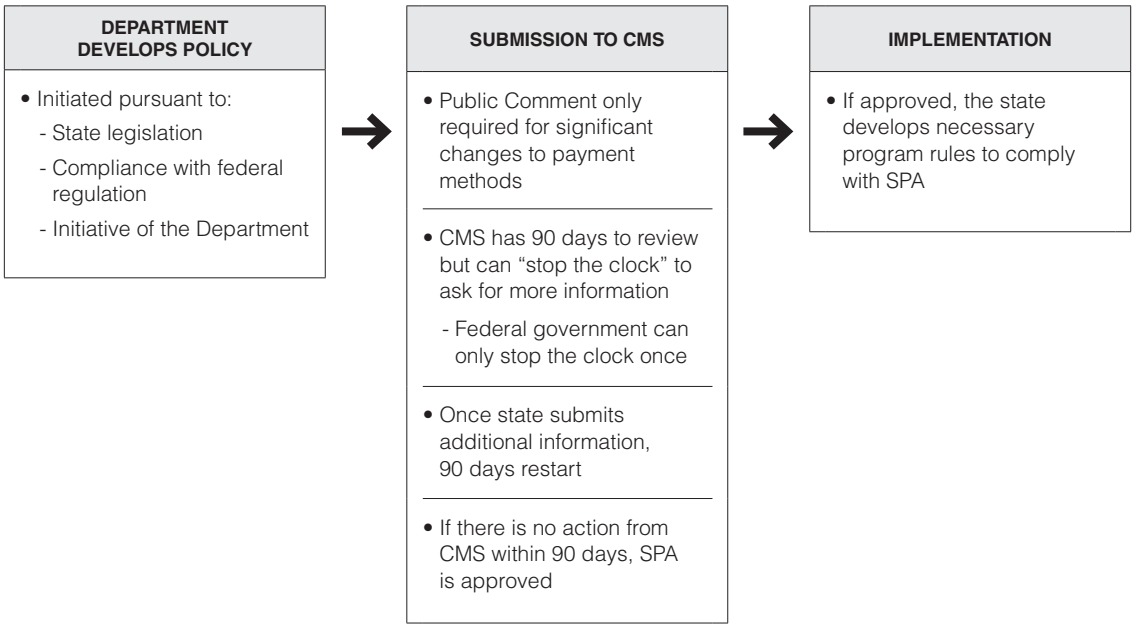
Benefits

As a joint federal and state partnership, the federal government has baseline standards, and states have the flexibility to design their programs in a number of ways. To ensure the operational fidelity to federal regulation, and to provide the partnership clarity around the scope of the Medicaid benefit in any given state, each state develops a "state plan." This document is a formal, written agreement between the state and federal government that must be submitted by a single state agency, and ensures that the state will abide by federal rules in terms of receiving dollars, outline which optional groups and services are being offered, as well as the standards being used to determine eligibility.[8] This document is not a static contract and is often changed with State Plan Amendments (SPAs) which, like the state plan generally, are subject to approval by the Centers for Medicare and Medicaid Services (CMS). The basic requirements for a state in maintaining a Medicaid program include reasonable promptness, or the ability to access care without delay as a result of agency procedures, ensuring payments are adequate to ensure equal access to services, freedom of choice, statewide coverage, and the coverage of mandatory benefits. The process for amending a state plan is outlined in Figure 12-1.

Figure 12-1: State Plan Amendment Process

Must meet federal standards

1. Statewideness: Throughout the whole state
2. Comparability: Services must be available to everyone regardless of eligibility category
3. Choice of Providers: Enrollees must be able to choose among providers



Source: Medicaid and CHIP Payment and Access Commission.

As with eligibility, there are mandatory benefits and optional benefits. These benefits must be outlined in amount, duration, and scope. Benefits offered in Ohio are listed in Table 12-3:

Table 12-3: Mandatory and Optional Medicaid Benefits

MANDATORY SERVICES	OPTIONAL SERVICES
- Early and Periodic screening, diagnosis, and treatment (EPSDT) for children - Inpatient hospital - Physician - Lab and X-ray - Outpatient, including services provided by hospitals, rural health clinics, and Federally Qualified Health Centers - Medical and surgical vision - Medical and surgical dental - Transportation of Medicaid services - Nurse midwife, certified family nurse, and pediatric nurse practitioner - Home Health - Nursing facility - Medicare premium assistance - Family planning	- Prescription drugs - Durable medical equipment and supplies - Vision, including eyeglasses - Home and community-based alternatives - Dental - Physical therapy - Occupational therapy - Speech therapy - Podiatry - Chiropractic services - Mental health services - Alcohol and drug addiction services - Intermediate Care Facilities (ICF)/IID - Hospice - Ambulance/ambulette transportation

Source: Health Policy Institute of Ohio.

Benefit administration is complex and involves tens of thousands of billing codes. Depending on the service and the individual in question, the state acts as a fiscal agent, ensuring eligible individuals are receiving the services for which they are entitled and that payment is made to eligible providers in a timely fashion. For the majority of the Medicaid population, these benefits are overseen by private insurance companies contracted by the state. These companies, referred to as managed care, are responsible for administering the benefit to Medicaid-eligible individuals and much of their operation and design will be covered in a later section of this chapter.

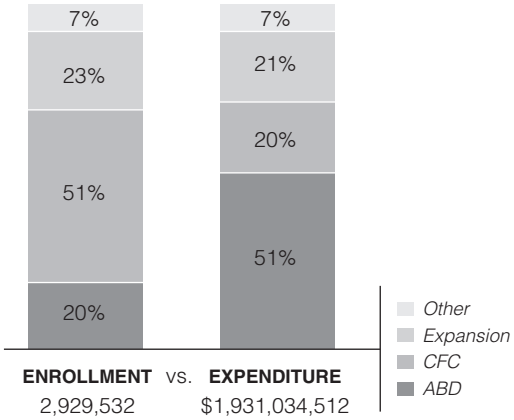
Typically, benefit construction regarding optional services is a combination of policy choice made by the Ohio Department of Medicaid and that which is required through an action by the General Assembly. For the department, many of the benefit expansions are for items that may increase the value of service being delivered, such as home- and community-based care, which is often preferred by the long-term care population and can be delivered at lower cost than the mandatorily required nursing facility benefit.[9]

Financing

Although Ohio has a number of categories of individuals eligible for Medicaid, their needs and the costs associated with delivering the benefit are not distributed evenly. What's more, depending on the program in question, Medicaid dollars may flow through the Ohio Department of Medicaid (ODM),

the Ohio Department of Mental Health and Addiction Services, the Ohio Department of Developmental Disabilities, the Department of Aging, the Ohio Department of Health, or the Ohio Department of Job and Family Services. Individuals with more complex needs like the aged, blind, and disabled tend to require the most in terms of resources. Often, you see these high-cost populations as areas of focus for ODM in terms of policy development. Table 12-4 depicts the number of Medicaid recipients and the varying costs associated for each major program component as of December 2017.

Table 12-4: Medicaid Program Enrollments and Associated Costs



Source: Ohio Department of Medicaid, "Eligibles and Expenditures Report, December 2017," January 2018.

ABD: Aged, Blind and Disabled; CFC: Covered Families and Children; Expansion: Medicaid Expansion

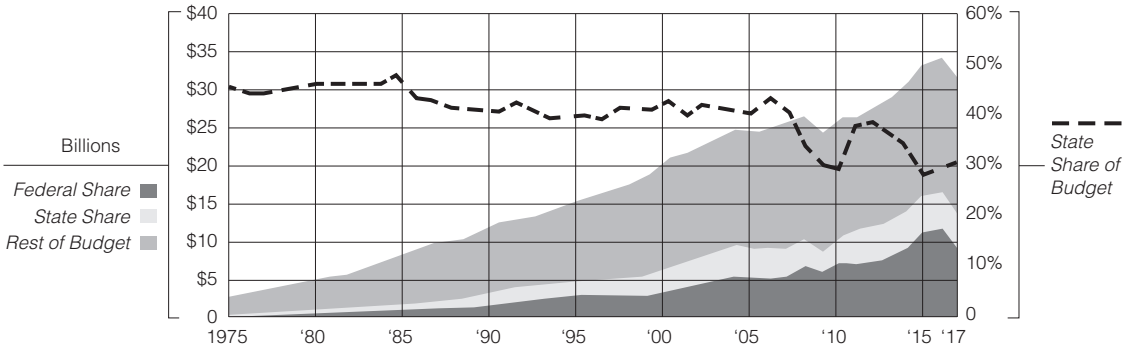
For example, in the first biennial budget of the Kasich Administration, the state submitted an SPA to the CMS to create "health homes" for individuals with a severe and persistent mental illness, or SPMI. This population, while a small minority in total numbers (10 percent) of Medicaid recipients represented a high area of cost to the program (26 percent).[10] To understand how reforms like these are financed, it is important to understand the financial relationship between Ohio and the federal government, and the Federal Medical Assistance Percentage (FMAP).

FMAP is the calculation that represents how much money is split between the state and the federal government. First, the state must spend its own dollars for the Medicaid program. Then, the amount the state spends is "matched" by the federal government at a percentage that is driven by a formula that takes into account the average per capita income for each state relative to the national average. Given this formula design, the decennial census plays a significant role in the final attribution of the dollars the state receives from the federal government. This means Ohio, which has not gained in population relative to other states nationally, will continue to see reductions in this source of federal funding.[11]

The Social Security Administration limits this "regular FMAP" match to be not less than 50 percent nor more than 83 percent. The calculation of FMAP changes every year, although it can vary depending on the program being implemented, sometimes with the added benefit of a higher federal match.[12] FMAP rates also tend to lag the economy, meaning the adjustment of these rates often does not keep pace with major economic events, which can make the fiscal administration of the program more difficult. As of Federal FY 2019, Ohio's regular FMAP is 22nd nationally, at 63.09 percent, meaning moneys for Ohio's regular Medicaid benefits are funded 63.09 percent by the federal government, and 36.91 percent by the state.[13]

It is important to understand FMAP in order to understand Medicaid's long-term influence on Ohio's budget. Where Ohio Medicaid had once represented a small portion of Ohio's all-funds budget in 1975, that amount has increased considerably. That said, the state share of that funding has decreased significantly over time:

Figure 12-2: Medicaid as a Share of Ohio's Budget

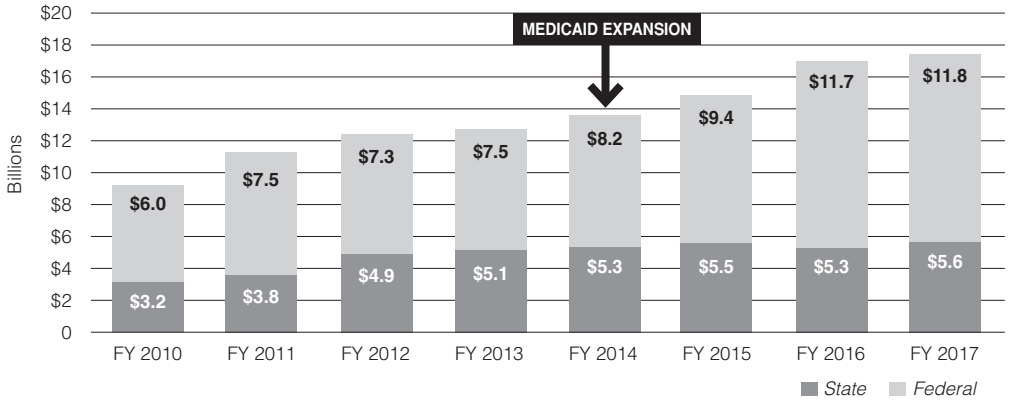


Source: Ohio Legislative Service Commission.

Ohio is unique as a state in that it counts the majority of the funding it receives from the federal government as General Revenue Funds (GRF). This means that the percentage of program growth, while significant in terms of all funds, is mostly due to the increase of federal financing associated with programmatic changes and expansions.

This trend is particularly notable of the Kasich Administration, which has taken advantage of a number of Affordable Care Act initiatives that included enhanced FMAP. The most recent drops of state share were due to, in large part, enhanced funding associated with the Medicaid expansion population.

Figure 12-3: Kasich Administration - GRF Medicaid Financing



Source: Ohio Legislative Service Commission.

Often, policy choices to leverage higher FMAP rates for specific Medicaid groups plays out in the state budget. For example, the Kasich Administration used the state budget to move individuals previously covered by the "family planning" eligibility group — which received a 90 percent FMAP — into the new expansion coverage eligibility category — which has an FMAP above 90 percent until 2020 — thereby allowing the state to access a higher federal match and commit fewer state resources to that population while enhanced funding is available. Conversely, if the state developed policies that removed coverage under the expansion for this group, that match would be lost, not only preventing the state from accessing the economic benefit of more dollars coming into Ohio, but also that of a

decreased state obligation.

Medicaid can also be used to offset state dollars in other health-related programs. In the budget bill for the FY 2012–2013 biennium, "Help Me Grow," a home visitation case management program for pregnant women, leveraged Medicaid in this way. Where the program had previously relied on state and federal funding under the auspices of the Ohio Department of Health (ODH) singularly, the bill required ODH to work with the Ohio Department of Job and Family Services on an SPA so that Medicaid funds, which include the federal funding from FMAP, could be used to pay for services.[14] That change allowed state GRF appropriations to be allocated elsewhere, and for additional federal moneys to come into state coffers.

Managed Care

Under Title 42 of United States Code §1396-1, the purpose of Medicaid is to furnish medical assistance to populations whose income and resources are insufficient to meet the costs of necessary medical services.[15] The Ohio Department of Medicaid, in fulfilling this duty, acts as a publicly subsidized insurer and does not provide any medical services directly. Instead, it is responsible for ensuring reimbursement is made to medical providers delivering services to beneficiaries.

To furnish services, there are two basic modalities of delivery. First, and historically the most common, is the fee for service system (FFS). In FFS, the rates are developed by the agency and providers are reimbursed based on a fee schedule. Simply put, when an eligible provider renders a qualifying service to a legal Medicaid recipient, the provider charges a fee for that service, and they are reimbursed directly by the Ohio Department of Medicaid. The second modality is managed care. Managed care organizations (MCOs), are private insurance companies which act as a contracted fiscal agent on the part of the state. Managed care is made possible through the use of State Plan 1932(a) authority, though is also made available to special populations through a 1915(b) waiver, which is explained in more detail in the subsequent section of this chapter. For MCOs, per-member-per-month payment rates are developed by an actuary. Providers must contract directly with the MCOs, and the rates are bound by a principal known as actuarial soundness. Actuarial soundness essentially ensures the same beneficiary protections as those in the state plan by requiring that all rates paid to the MCO be "reasonable, appropriate, and attainable" in order to cover the population in question.[16] These rates are built from encounter data and may differ depending on the region in which an MCO is operating.

MCOs are a tool for the state to control costs and increase desired outcomes through a contract. As private entities, MCOs have incentives and tools available to them that a traditional FFS arrangement does not. MCOs have utilization management powers which allow them to deny a service or review a claim they think may be high cost or unnecessary. An example of this is prior authorization, where the plan requires a provider to seek permission before the delivery of a service. In additional to utilization control powers, MCOs are also operating in competition with one another, with the state applying market share and other financial incentives as a reward for accomplishing identified metrics, typically based on standardized measures related to care and service. Last, and perhaps most critically, the MCOs have the ability to work with providers and hire staff in ways that coordinate care and, in some cases, finance non-traditional benefits (like transportation, for example) to control costs. This case management function of MCOs is the primary argument in favor of this model of delivery.

Waivers

Beyond the state plan, the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that "promote the objectives of Medicaid." "Waivers," as they are called, literally remove federal requirements of the program as long as certain standards are met. Nationally, waivers have been used in a number of contexts to develop experimental programs or advance policy priorities of the state and federal governments. Ohio has several waivers in place, including a 1915(b) Freedom of Choice waiver which enables the state to implement managed care for specific populations, and 1915(c) Home and Community-based Services waivers. There are also 1115 waivers that have garnered more attention in recent years as mechanisms for advancing or rebuking policies associated with the Affordable Care Act. In all cases, waivers have to be approved and monitored by the federal government and often have more specific requirements in terms of reporting and financing than the traditional program.

Strategic Direction of Medicaid during the Kasich Administration

MEDICAID MILESTONES OF THE KASICH ADMINISTRATION

2011	2013	2014	2018
• Office of Health Transformation created • Medicaid Information Technology System (MITS)	• State Innovation Model initiated • Medicaid program restructured; Ohio Department of Medicaid created • Medicaid expansion under the Affordable Care Act	• MyCare Ohio	• Behavioral Health Redesign

The Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (ACA) is the most recent federal legislation to have a significant impact on Medicaid. This impact can be measured in terms of reforms in regards to eligibility, financing, and experimentation. Prior to the passage of the ACA in 2010, nearly one in five Americans were historically uninsured, which is why one of the major planks of the ACA was expanded coverage.[17] To accomplish this, Congress enacted two key policies that were designed to reduce the number of uninsured in the United States. First, Congress established the Health Insurance Exchanges, later called "Marketplaces," which would provide subsidized private insurance on a sliding scale between 100 and 400 percent of the FPL. It would ensure that this coverage was attained, in part, by creating an "Individual Mandate" that required people to maintain a minimum level of insurance coverage by 2014. Second, it mandated the expansion of coverage to a newly created group in the Social Security Act called "Group VIII," which is a reference to its *Federal Register* definition in Title 42, commonly referred to as the "Medicaid expansion." In June 2012, however, the U.S. Supreme Court ruled that, while the Individual Mandate was constitutional, the Medicaid expansion requirement was unconstitutionally coercive of states and thus optional for states to implement.[18]

The ACA also created a number of other changes in regards to the operation of state Medicaid programs, including significant investments in information technology systems, electronic health record development, and value-based care.[19] As mentioned previously, the new standard of MAGI was one

example of the way in which the ACA impacted Ohio's Medicaid program, but in many ways, the Kasich Administration has been defined by its acceptance and embracement of ACA policies, which will be described in the next and terminal section of this chapter.

Governor Kasich came into office in the midst of a slow economic recovery and less than one year after the passage of the ACA. His administration would be defined by a structural reorganization of Medicaid, a greater reliance on privatization through managed care, the Medicaid expansion, and experiments with value-based design. As a result of these endeavors, and the political landscape associated with the ACA, the political environment surrounding Medicaid policymaking has also been made more acutely ideological. This included a number of initiatives by the General Assembly that, despite sharing a party affiliation with Governor Kasich, created formal oversight of the program and advanced policy positions that sought to degrade the authority of the executive branch's control over Medicaid.

Restructuring Medicaid

At the beginning of his first term, Governor Kasich created the Office of Health Transformation. This cabinet-level agency served a role as the lead strategic organization for the rest of health and human services in the executive branch. Structurally, this strategic direction included the consolidation of the Mental Health and Addiction departments into a single agency, now called the Ohio Department of Mental Health and Addiction Services,[20] as well as transitioning Medicaid from an agency within the Ohio Department of Job and Family Services to a stand-alone department, amove which had been previously recommended and allowed for the Medicaid director's greater control of the program.[21] Additionally, in the FY 2012–2013 budget, the Kasich Administration realigned the appropriations line items across all agencies that receive Medicaid funding, making clearer the financing obligations by department, as well as reducing the number of appropriations line items in total.[22]

Significant investments have been made by the Ohio Department of Medicaid over this time, including two of its most important benefit management systems that manage claims payment, the Medicaid Information Technology System, or MITS, and eligibility determination, the Ohio Integrated Eligibility System called OIES, or "Ohio Benefits." It is important to note that Ohio Benefits is still under development, and while it had been the system for Medicaid, it does not yet integrate other programs. The intent behind the new system, as outlined by the Office of Health Transformation, is to ultimately integrate the eligibility systems for Medicaid, the Supplemental Nutrition Assistance Program, and the Temporary Assistance for Needy Families program, and to ensure a more efficient, simplistic system of determination across all programs for the benefit of enrollees and the county governments largely responsible for managing the eligibility across all systems. For both of these efforts, the state received a temporary increase in the FMAP for the design, development, and installation of these systems, having 9 out of every 10 dollars of investment shouldered by the federal government.

A Move towards Privatization

The Kasich Administration has relied heavily on managed care to implement many of its policy initiatives, with the Ohio Department of Medicaid issuing a request for proposals outlining a new contract for which the plans would have to bid in 2011. After the resolution of a lawsuit regarding the awarded contracts, the state shifted from a regional model to a statewide model of MCO delivery, requiring all five MCOs to operate across Ohio, covering both the Covered Families and Children (CFC) and ABD categories, and operating in regions that had been consolidated from five to three. Beyond the

geographic and operational footprint, Ohio's Medicaid program also included additional populations, such as foster children, in managed care through a process known as "carve in." Since 2008, the total Medicaid population enrolled in a plan has increased from about 70 percent to more than 80 percent.[23]

When looking at the populations historically covered by managed care, many of the more complex, costly, and needy populations have been left out. The Kasich Administration has shown a preference for managed care as a tool in controlling costs and increasing outcomes by including these populations as a part of the MCO benefit. Included in these efforts are the privatization of benefits for individuals simultaneously enrolled in Medicaid and Medicare, individuals with behavioral health diagnoses, and the long-term care population.

MyCare Ohio

The MyCare Ohio demonstration project, implemented in 2014, sought to consolidate the benefit administration of individuals covered by Medicaid and Medicare, otherwise known as "dual eligibles." Currently, this program, which is a 1915(c) waiver, is set to expire in February 2019.[24] When looking at national data, dual eligibles account for just 15 percent of Medicaid beneficiaries but 36 percent of the cost. This disproportionate share of the cost is driven by a number of factors including the duplicative nature of the two sources of coverage and the complexity of care for these individuals who tend to have higher needs.[25] This program, which has its own independently contracted plans, is operated in geographically limited regions across the state and provides coverage to more than 107,000 Ohioans. Ultimately, the intent behind this demonstration is to provide a single source of care management to individuals enrolled in the plans, with the hope that better coordination can lead to better outcomes and greater efficiency. While the state has made claims of cost and quality benefits through its regular reporting on the project,[26] some in the long-term care industry, notably nursing homes, have pushed back against this narrative, citing billing problems and a lack of evidence to support the Kasich Administration's claims.[27]

Regarding long-term care, another target of Kasich's managed care reform has been the long-term care benefit. This includes, but is not limited to, services provided to individuals with developmental disabilities and to low-income seniors. While people with developmental disabilities may now choose to enroll in an MCO product, individuals receiving services in a nursing home or through a home and community-based services waiver (HCBS) do not currently have regular access to an MCO. Through budget policy, the Kasich Administration has pushed to remove the special protection nursing facilities have in Ohio Revised Code, especially given the reported low quality of service provision in many Ohio facilities[28] and the fact that nursing facilities account for more than one out of every six FFS dollars spent.[29] Despite this effort, they have been routinely unsuccessful and managed Long-term Services and Supports, or MLTSS, has not yet been implemented.

In June 2013, the Ohio Department of Medicaid applied for, and was awarded, $169 million in additional FMAP for its efforts to direct half of all Medicaid long-term care funding to HCBS waiver programs by 2015. This program, known as the Balancing Incentive Program, or BIP, is a national initiative established under the ACA. As a part of this effort, the state was required to make sure that eligibility and enrollment was accessible, that the case management system was free of conflicts, and that there was a core standardized assessment in place. By September 2014, a year before the deadline, Ohio had surpassed its 50 percent spending target.[30]

In addition to long-term care, behavioral health is also an area of benefits the state has sought to privatize. Nearly one out of every eight dollars spent in FFS[31] is related to behavioral health. Additionally, persons with severe mental illness have a life-span that is 25 years shorter than the general population[32] and opioid-related overdoses have become Ohio's number one cause of accidental death.[33] Given this combination of high cost and poor outcomes, the Kasich Administration grappled with reforming the behavioral health delivery system since its inauguration. In its primary incarnation, reform included the development of a "health home" service, wherein behavioral health providers would have established medical homes for individuals with SPMI. Medical homes, also known as Patient Centered Medical Homes, or PCMH, are models of care which align specific populations around a model of care to be managed by a central case manager, typically represented by a certain clinical position. Ohio's effort would have provided a capitated payment to the primary community behavioral health provider of the medical home for managing the totality of the person's care. Unfortunately, the scale and scope of the project led to wide cost and capacity variability amongst the providers who would deliver this benefit, and after some efforts to launch the project, the state decided to unwind the effort and seek a managed care model.[34]

Behavioral Health Redesign

As noted earlier, persons with serious mental illness make up 10 percent of the eligible in Medicaid, but they account for 26 percent of the total program cost. In 2011, the Ohio Department of Medicaid submitted an SPA to create "health homes" for this population as a way to address this issue. Health homes are a model of care delivery where case management is organized around a specific disease, population, and/or a health condition.[35] These models were enabled by Section 2703 of the ACA and are intended to drive down costs while improving outcomes. While the state did receive approval, enhanced FMAP, and made significant efforts to roll out the health homes, the project was formally discontinued in 2015 because of a lack of financial sustainability, though some payments were still being made as late as July 2018.[36]

In 2015, the Office of Health Transformation announced it would re-launch its efforts in behavioral health reform, this time through managed care privatization. Labeled "Behavioral Health Redesign," the administration sought to implement a two-fold effort of reform focusing on a restructuring of the coding methodologies and services for community behavioral health providers as well as the carving-in of the benefit into managed care. Over the course of the subsequent years, some providers, their trade associations, the General Assembly, and the administration have publicly debated the implementation of redesign, including multiple hearings, rate negotiations, and program delays.[37] While some providers were concerned with the potential harm this may cause in terms of resources long term, other providers were welcoming of the changes. Regardless of the perspective, it will remain to be seen how these changes will affect the continuity of care for the portion of the population diagnosed with a behavioral health issue.

Value-Based Design

Another hallmark of the Kasich Administration has been its focus on developing value-based reimbursement. These efforts, however, are not limited to Medicaid, but they often rely on Medicaid as an economic force by which reform is made possible. Included in this work are two main areas of focus

in advancing the State Innovation Model and increasing the expectations of performance in regards to Ohio Medicaid managed care programs.

The State Innovation Model

The State Innovation Model (SIM) initiative was made possible through the ACA and is governed by an ACA-created governmental agency called the Center for Medicare and Medicaid Innovation (CMMI). According to law, the mission of CMMI is to test "innovative payment and service delivery models to reduce program expenditures."[38] The SIM project has been one of the ways in which the federal government has partnered with states to develop models of transformation, with dollars flowing from two rounds of funding in 2013 and 2014, respectively. In Ohio, SIM is represented by two main policy initiatives: 1) Comprehensive Primary Care (CPC) and 2) Episode-based Payments.

In CPC, payment encourages primary care at the center of the delivery model through the utilization of a patient-centered medical home. Conceptually, the state is trying to incentivize primary care to encourage better health and improve population health outcomes. To do this, practices that enroll in the program become eligible for a monthly fee to support activities required by CPC, and they become eligible for shared savings. Given the potential to reduce the overall cost of care, the latter policy lever is intended to incent better coordination by making the provider a shareholder in the state's success. In order to become eligible for this program, providers must meet requirements in regards to clinical activity, quality, and efficiency. Additionally, through regular reporting by the state and its contracted MCOs, providers can see how they rank relative to their peers in regards to their performance in a number of areas including pediatric and women's health, chronic conditions, and average spending.[39] CPC has evolved to align with the national CPC+ program, which is operationally very similar to CPC and also seeks to engage private payers in driving toward quality and efficiency through primary care.

Beyond the individual practice level through CPC, the state has also sought to create comparative performance incentives and reporting as it relates to common conditions and procedures. Implemented in a series of three waves, Episode-based Payments seek to consolidate seemingly disparate service codes into a set of common, comparable payments.[40] Each wave involves the definition of an episode built on common code sets for any particular condition or service, such as asthma or total joint replacement. Providers submit their claims in the same way they had, though this time payers, including the FFS and MCOs, review the claims, risk adjust them, and the payment is affected positively or negatively depending on performance in cost and quality. Basically, when a provider submits their claims, they are compared to their peers for the same service and if they perform well in terms of keeping costs low and quality high, they earn an incentive. If, on the other hand, their costs are high relative to their peers and their quality is not good, they will be penalized. What is more, providers, who are able to access this information through the Medicaid Information Technology System, or MITS, will now be able to compare and align information between the two programs between the CPC and Episode programs, creating incentives for providers who connect patients to high-quality environments in both settings.

Through both of these initiatives, the state has convened providers and payers as advisors in design. Importantly, these initiatives are not limited to Medicaid and do include private insurers who operate in the individual and employer sponsored markets.[41] While the results have not yet moved the needle in terms of overall value, the foundation of these initiatives represents a major shift from traditional forms of Medicaid payment into value-based arrangements. Where Medicaid had once been mostly agnostic to the issues of quality and price on a comparative level, SIM has established a new model

of payment that puts these issues at the forefront of reimbursement.

P4P

Outside of the State Innovation Model (SIM), the Ohio Department of Medicaid has also created incentives through its contractual process with managed care to incent better quality. Under Pay for Performance, or "P4P," MCOs are subject to comparative performance on specific clinical measures established in the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS is used by more than 90 percent of the United States' health plans and compares performance across seven "domains" of care, including 94 total measures for things such as postpartum care and control for chronic diseases such as hypertension and diabetes.

In 2013, the state designed P4P as a bonus program, making a percentage of the total payment made to plans eligible as an incentive. Depending on an MCO's comparative performance in any given measure, they were able to earn this bonus payment.[42] Historically, MCOs have not achieved the total potential allowed, with only $49 million of the $142 million available being awarded in 2016.[43] As of the FY 2018–2019 budget, this program has shifted from a bonus payment to a withhold payment, meaning that a percentage of the total paid to managed care will be kept by the state until the MCO has achieved a specific outcome. This withhold amount increases over time, with a current cap of 2 percent. In addition to using HEDIS as a measurement tool, the state also added quality indices to the P4P program, focusing on cardiovascular disease, diabetes, behavioral health, and children.

As is the case with SIM, Ohio's P4P program is intended to create incentives that align quality and outcomes with payment. Where P4P had once been a bonus payment, it is now a withhold arrangement with the state, exposing MCOs to financial risk. In theory, this should motivate the MCOs to establish measures within their contracts with providers to mitigate this risk by aligning their P4P measurements with contractual expectations.

Medicaid Expansion and Greater General Assembly Oversight

Beyond these more nuanced and policy-heavy decisions, the Kasich Administration's relationship to Medicaid will most likely be tied to the decision to implement the Medicaid expansion. As has been mentioned, the Medicaid expansion became an optional choice for states after the U.S. Supreme Court's decision in 2012. Before expanding Medicaid across the state, the Ohio Department of Medicaid, Cuyahoga County and the MetroHealth System, a county-owned safety-net hospital in Cleveland, developed an early version of the expansion through an 1115 demonstration waiver in 2013. This waiver, known as "MetroHealth Care Plus." expanded coverage to nearly 28,945 poor, uninsured patients. Through this increased access and source of coverage to the hospital, patients were better able to address their chronic health needs, and notably, the program came in nearly 30 percent under budget.[44]

In the subsequent year, coalition forces across the state representing the faith community, providers, insurers, and others advocated to have Medicaid expanded as a part of the state's FY 2012-2013 budget. While not included in the final budget, the Kasich Administration asserted its ability to expand Medicaid through a SPA, even though there was no additional state appropriation authority associated. After some political back and forth, the state created the ability for the administration to accept federal funds through the Controlling Board, a seven-member executive-legislative oversight body.[45] See Chapter 7 for a description of the Controlling Board and its functions.

In the subsequent years following expansion, the politics of Medicaid as a state policy issue have grown more complex. This includes the creation of the Joint Medicaid Oversight Committee (JMOC), which acts as a legislative oversight body of the state Medicaid department. This body meets regularly to review state Medicaid policy and, notably, to establish a target growth rate for the director when they formulate the administration's budget request to the General Assembly.[46] This effort includes a review by an independently contracted actuary who gets access to Medicaid claims information for the purposes of analysis.

In addition to the creation of JMOC, the General Assembly has also sought to impose policies that put greater control over the direction of the program. These efforts have included, but are not limited to, the use of 1115 waivers and creation of laws that provide the General Assembly more input over covered populations and provider rates. Many of the waivers sought to align with efforts in other entitlements to impose greater requirements for eligibility on Medicaid recipients, particularly those enrolled through the expansion. This has included efforts to impose cost sharing and work requirements, policies that had been discouraged by the Obama Administration but have been encouraged by the Trump Administration.[47] While legally questionable, policies such as these can be seen as a political response to the ACA.[48] While Medicaid expansion has been a financial boon to the State of Ohio's finances and played a vital role during the opioid crisis as a main source of coverage for individuals with substance use disorders, conservative lawmakers in Ohio and in Congress will likely continue to look at ways to restrict the program's growth in terms of spending and enrollment long term.

Summary

The Kasich Administration has relied on a combination of structural and policy maneuvers to fundamentally change the scope of Ohio's Medicaid program. Operationally, the Medicaid program is now governed by a single state agency, and the line items associated with its operation have been consolidated and simplified amongst all the agencies that rely on its funding. Supplementary activities include the design and development of two new systems of benefit administration, including the creation of new claims and eligibility determination systems.

Beyond the operational design, Kasich has advanced policies that have expanded coverage significantly, reoriented payment towards value, and relied on privatization as the main vehicle through which reform is made possible. During this time, too, the United States has been in the midst of one of the longest periods of economic expansion it has ever had.[49] While good news, Medicaid's relatively constrained growth is in part attributable to its nature as a countercyclical program, meaning its utility has not been as challenged as it may be in times of economic downturn. Additionally, with a renewed focus by Congress to terminate Medicaid as an entitlement, policy surrounding the single largest source of coverage for Ohioans will continue to be a key lever in future state budgets.

Endnotes

1 Lyndon B. Johnson, "Remarks at the signing of the Medicare Bill with President Truman in Independence," *CMS History Project President's Speeches*, July 30, 1965.

2 "NHE Fact Sheet," Centers for Medicare and Medicaid Services, August 10, 2016.

3 Rachel Nuzum, Sara R. Collins, Melinda K. Abrams, Pamela Riley, M.D., Jordan Kiszla, and Jamie Ryan, "Why the U.S. Needs Medicaid," *The Commonwealth Fund* (blog), September 23, 2016.

4 Phil Galewitz, "Nearly Half of U.S. Births are Covered by Medicaid, Study Finds," *Kaiser Health News*, September 3, 2013.

5 "Eligibility," Medicaid.gov, Accessed May 10, 2018.

6 "Eligibility: Provider Payment and Delivery Systems," MACPAC. October 2016.

7 Ibid.

8 "State Plan: Provider Payment and Delivery Systems," MACPAC, 2018.

9 Erica L. Reaves and MaryBeth Musumeci, "Medicaid and Long-Term Services and Supports: A Primer," *The Henry J. Kaiser Family Foundation*, June 28, 2017.

10 "Create Health Homes for People with Mental Illness," Governor's Office of Health Transformation, February 6, 2012.

11 Vic Miller, "FMAPs and the Impact of Decennial Census Data" National Association of Medicaid Directors, 2013.

12 "Federal Medical Assistance Percentage (FMAP) for Medicaid And Multiplier," *The Henry J. Kaiser Family Foundation*, 2016.

13 "Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier." *The Henry J. Kaiser Family Foundation*, May 10.

14 Wendy Risner, "LSC Greenbook Analysis of the Enacted Budget: Department of Health," Ohio Legislative Service Commission, 2011.

15 Federal Register: 42, § 7-1396-1.

16 Brad Armstrong, FSA, MAAA, Chris Pettit, FSA, MAAA, and Marlene Howard, FSA, MAAA. "Actuarial Soundness in Final Medicaid Managed Care Regulations," *Milliman*, November 1, 2016.

17 "Key Facts about the Uninsured Population," *The Henry J. Kaiser Family Foundation*, December 07, 2017.

18 "A Guide to the Supreme Court's Decision on the ACA's Medicaid Expansion," *The Henry J. Kaiser Family Foundation*, May 15, 2013.

19 "Affordable Care Act," Medicaid.gov, 2018.

20 "Consolidate ODADAS and ODMH," Ohio Office of Health Transformation, 2011.

21 "Create a Cabinet Level Medicaid Department," Ohio Office of Health Transformation, 2011.

22 "Create a Unified Medicaid Budgeting and Accounting System," Ohio Office of Health Transformation, 2013.

23 "Annual Report," Ohio Department of Medicaid, August 1, 2017.

24 "State Waiver List," Medicaid.gov, 2018.

25 MaryBeth Musumeci, "Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS," *The Henry J. Kaiser Family Foundation*, December 07, 2015.

26 "MyCare Ohio Progress Report 2017," Ohio Department of Medicaid, April 25, 2017.

27 Andy Chow, "Nursing Homes Push Back Against Managed care Move Suggestions," *WKSU*, May 23 2017.

28 John Caniglia and Jo Ellen Corrigan. "Ohio Nursing Homes among the Nation's Lowest Rated in Quality of Care: A Critical Choice," *Cleveland.com*, March 20, 2017.

29 "Medicaid Primer," Ohio Legislative Service Commission, 2017.

30 "Balancing Incentive Program (BIP)," Ohio Department of Medicaid, 2014.

31 Ibid.

32 Kate Torogovnick, "Why Do the Mentally Ill Die Younger?" *Time*, December 3, 2008.

[33] Laura A. Bischoff, "Drug Overdose Deaths Jump 33% in Ohio," Dayton Daily News, August 30, 2017.

[34] "Create Health Homes," Ohio Office of Health Transformation, 2012.

[35] "Health Homes." Medicaid.gov, 2018.

[36] 'Create Health Homes.' Ohio Office of Health Transformation, 2012.

[37] Karen Kasler, "Mental Health Services Providers Say Medicaid Managed care Redesign Is Straining Their Resources," *Statenews.org*, April 19, 2018.

[38] Federal Register: 42, § 1315a.

[39] "Comprehensive Primary Care (CPC) Program," Ohio Department of Medicaid, 2018.

[40] "Episodes," Ohio Department of Medicaid, 2018.

[41] "Introduction to the Ohio Episode-Based Payment Model," Ohio Office of Health Transformation, December 2015.

[42] Jon Barley, PhD, "2016 P4P Summary and Plan Ranking," Ohio Department of Medicaid, 2017.

[43] Zach Reat, MPA, Amy Rohling McGee, MA, and Reem Aly, JD, MHA, "Ohio Medicaid Basics 2017," *The Health Policy Institute of Ohio*, April 11, 2017.

[44] "MetroHealth Care Plus Program: Transitioning from Uninsured to Medicaid Coverage," *Better Health Partnership*, April 15, 2015.

[45] Trip Gabriel, 'Medicaid Expansion Is Set for Ohioans,' *The New York Times*, October 21, 2013.

[46] Ohio Revised Code: § 103.412.

[47] Ginger Christ, "Ohio Groups, Officials Oppose Medicaid Work Requirements, as State Prepares to Submit Waiver to Federal Government," *Cleveland.com*, April 3, 2018.

[48] MaryBeth Musumeci, "A Guide to the Lawsuit Challenging CMS's Approval of the Kentucky HEALTH Medicaid Waiver," *The Henry J. Kaiser Family Foundation*, May 25, 2018.

[49] Ben Leubsdrof, "U.S. Economic Expansion Could Become Longest on Record." *The Wall Street Journal*, December 13, 2017.