State Budgeting Matters

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Introduction

In the first biennial budget of the DeWine administration, the Ohio Department of Medicaid (ODM) figured prominently in the Governor's policy efforts to focus on children as a central tenant of his platform. Programmatically, the enrolled Medicaid budget included significant investments in home visitation, curbing custody relinquishment of multi-system youth, increasing lead poisoning remediation for Medicaid-eligible families and providing additional resources to improve maternal and infant mortality outcomes. And while there was consistent support for many of these provisions, other policy issues regarding provider rates, managed care and waivers dominated much of the Medicaid budget deliberation, with nearly half of the Governor's vetoes tied to Medicaid.

While ODM's budget does include a number of discrete policy initiatives, it is important to understand that the central objective of Medicaid is, in terms of law, to finance medical services for Medicaid eligible individuals.[1] As such, the overwhelming majority of the expenditures are tied to medical coverage since Medicaid is, by design, publicly financed health insurance. In this way, unlike other activities of the state, or other aspects of the state budget process, reimbursement is the primary framework for Medicaid resources, the majority of which come from the federal government. To aid in understanding this relationship between function, purpose and design, the following State Budgeting Matters will structure the analysis of the enrolled budget by looking at the major cost centers in Medicaid (hospitals, nursing facilities and pharmacy), the programmatic efforts of ODM and the concurrent policy issues that affect the Department.

Key Takeaways

- Most policy efforts in Medicaid centered on children and families
- The largest shifts in dollars were tied to major cost centers, including hospitals and managed care
- The legislature continued its efforts to wrestle control away from the executive in the management of the program, despite establishing an appropriations target before executive submission

Hospitals

Hospitals are reimbursed based on a fee schedule developed by the state through administrative code. These rates are paid once a service is performed which is why it is called fee for service (FFS). Managed Care Organizations (MCOs), which are responsible for adjudicating the majority of these payments, have the ability to privately negotiate payment rates higher or lower than FFS, though FFS typically serves as the foundation for those rates. These rates finance services and also finance the capital and educational expenses of providers and are adjusted by severity of illness and risk of mortality.[2] Rates are also adjusted based on the type of hospital (teaching vs. rural, for example). According to data from the

[1] 42 U.S. Code § 1396

[2] McCarthy, John. "Hospital Payments and Quality Initiatives." Joint Medicaid Oversight Committee, December 2014. http://jmoc.state.oh.us/assets/meetings/McCarthy JMOC December 2014 _ Final.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC), a federal legislative branch agency, Ohio Medicaid rates to hospitals are higher than the national average.[3]

Rates, however, are not the only form of reimbursement hospitals receive through Medicaid. In addition to payments made for services, hospitals also receive reimbursement through two "supplemental" payment programs known as the Upper Payment Limit (UPL) and the Hospital Care Assurance Program (HCAP, also known as the Disproportionate Share Hospital program or DSH), both of which were significantly altered during the budget process.

DSH is a program that seeks to provide funding to hospitals to offset their uninsured costs and their "shortfall," which is the difference between a hospital's Medicaid payments and its costs of providing services to Medicaid-enrolled patients. Nationally, according to additional research from MACPAC, when looking at Medicaid rates for hospitals which receive DSH, Medicaid rates often pay 107 percent of costs for Medicaid patients.[4] Seventy-six percent of Ohio hospitals receive DSH, (national average is 45 percent) but only 7 percent are "deemed DSH" hospitals, which, as defined by § 1923(b) of the Social Security Act, includes hospitals that have a Medicaid inpatient utilization rate of at least one standard deviation above the mean for hospitals in the state. Nationally, the average is 14 percent, meaning Ohio's DSH program before the biennial budget was disproportionately giving Medicaid dollars to hospitals that served fewer Medicaid patients than to those hospitals who served more Medicaid patients.

Generally, MACPAC has found "no meaningful relationship between states' DSH allotments and the number of uninsured individuals, the amount and sources of hospitals' uncompensated care costs, and the number of hospitals with high uncompensated care costs that also provide essential community services for low-income, uninsured and vulnerable populations."[5] Importantly, an Affordable Care Act policy, which had faced a number of delays on the federal level, will trigger cuts to these payments as an outcome of increased coverage through Medicaid expansion starting 2021.

UPL is a bit different than DSH in that its payments are intended to comprise the difference between Medicaid rates (including DSH) and Medicare rates, with Medicare acting as the threshold, hence the term "Upper Payment Limit." UPL payments to individual hospitals can exceed their costs as long as their peer group is below the limit in aggregate. However, data indicates UPL payments exceed what is allowable under law in 28 states, though information on Ohio is not currently available. There are technically a few different UPL programs in Ohio, including special carve-outs for an Ohio State University "Physician UPL" and other public hospitals under the "Care Innovation and Community

[3] "Medicaid Hospital Payment: A Comparison across States and to Medicare." Medicaid and CHIP Payment and Access Commission, April 2017. https://www.macpac.gov/wp-content/uploads/2017/04/Medicaid-Hospital-Payment-A-Comparison-across-States-and-to-Medicare.pdf.

[4] Cunningham, Peter, Robin Rudowitz, Katherine Young, Rachel Garfield, and Julia Foutz. "Understanding Medicaid Hospital Payments and the Impact of Recent Policy Changes - Appendix." The Henry J. Kaiser Family Foundation, June 9, 2016. https://www.kff.org/report-section/understanding-medicaid-hospital-payments-and-the-impact-of-recent-policy-changes-appendix/.

[5] "Report to Congress on Medicaid and CHIP March 2019." Medicaid and CHIP Payment and Access Commission, March 2019. https://www.macpac.gov/wp-content/uploads/2019/03/Annual-Analysis-of-Disproportionate-Share-Hospital-Allotments-to-States.pdf.

Improvement Program" (CICIP), but those were not a part of the budget's "Hospital Franchise Fee Alignment."

In total, through these rates and supplemental payments, Ohio Medicaid covers 98 percent of costs for Medicaid enrollees and 90 percent of costs when factoring in the uninsured (a rate which has been cut in half since expansion).[6] To finance these supplemental payments, Ohio relies on franchise fees to generate the state match for federal draw down. These fees vary by hospital and depend on patient make-up and peer group. To account for the HCAP cuts coming in State Fiscal Year (SFY) 2021, and to "account for ongoing health care industry changes" as stated by ODM, the franchise fee rate was raised from 2.66 percent of hospital costs to 3.24 percent of hospital costs. Since these payments are made in intervals and are dependent on a hospital's experience, the payments are made through Dedicated Purpose Fund 3F00 (line item 651623), meaning the exact dollars are not distinct from general reimbursement, drug rebates or research dollars. However, looking at the revenue and drawdown estimates from the Legislative Service Commission, the overall impact of the fees and the resultant revenue is listed in Table 1.

Table 1: Supplemental Payments to Hospitals (Millions $)

	SFY 2019	SFY 2020	Δ SFY 19-20		SFY 2021	Δ SFY 20-21	
UPL Fees	$ 657	$ 822	*25.1%*	*$ 165*	$ 887	*7.9%*	*$ 65.00*
UPL Draw Down	$ 1,145	$ 1,401	*22.4%*	*$ 256*	$ 1,519	*8.4%*	*$ 118.00*
DSH Fees	$ 236	$ 249	*5.5%*	*$ 13*	$ 168	*-32.5%*	*$ (81.00)*
DSH Draw Down*	$ 404	$ 426	*5.5%*	*$ 22*	$ 287	*-32.5%*	*$ (138.51)*
Total Fees	$ 893	$ 1,071	*19.9%*	*$ 178*	$ 1,055	*-1.5%*	*$ (16)*
Total Drawdown	$ 1,549	$ 1,827	*18.0%*	*$ 278*	$ 1,806	*-1.1%*	*$ (21)*
Net	$ 656	$ 756	*15.3%*	*$ 100*	$ 751	*-0.6%*	*$ (5)*

**Draw down was calculated using fee and expenditure data from the Legislative Service Commission and the totals represent estimates.*

Notably, because these programs rely on federal funding that is primarily managed through dedicated purpose funds, the General Revenue Fund (GRF) expenditures go down by about $107.6M ($32.3M state share) over the biennium. It also remains to be seen how these payments will function in the future. The Centers for Medicare and Medicaid Services (CMS) issued a rule that prohibited these payments, initially designed for fee-for-service, to go through a managed care system. According to this rule, arrangements deemed as pass-through must be phased out over a 10-year period (terminating 2027) unless they are restructured as a value-based purchasing program, delivery system reform, or via state directed fee schedules. These three options, deemed "438.6(c) preprints" do not exist in Ohio outside of CICIP.[7]

[6] Ibid.

[7] Gaffner, Andrew, and Christine M. Mytelka. "Proposed Updates to Pass-through Payment Guidance." Milliman, December 6, 2018. http://us.milliman.com/insight/2018/Proposed-updates-to-pass-through-payment-guidance/.

Managed Care

Ohio's managed care program represents the majority of benefit administration for Ohio Medicaid, 1 in every 3 dollars appropriated in the state budget flows through these private companies.[8] As we have written about before, managed care is the main conduit through which ODM tries to effectuate its policies in value-based reimbursement, including state innovation model (SIM) payment programs and pay for performance (P4P). The state is also going through a process to reprocure these contracts, providing $7 million over the biennium to facilitate information gathering, hire outside counsel and conduct regional forums. And while procurement may be the state's most impactful activity regarding managed care, a number of budget provisions have affected its operation.

In the context of the state budget, a couple of managed care related items were tied to $539 million in GRF reductions as highlighted in Table 2.

Table 2: Managed Care Programmatic Impact in GRF (Millions $)

	SFY 2020			SFY 2021		
	TOTAL	GRF		TOTAL	GRF	
		State	Fed		State	Fed
Increase Managed Care Performance Withhold	($67.10)	($20.10)	($47.00)	($141.30)	($42.40)	($98.90)
Managed Care Lower Bound Trend Assumption	($80.40)	($24.10)	($56.30)	($251.00)	($75.50)	($175.50)
Total Reductions	($147.50)	($44.20)	($103.30)	($392.30)	($117.90)	($274.40)

Where Ohio's P4P program was previously organized as a bonus structure, it is now in a withhold structure, meaning MCOs have to "earn" their full payments through the achievement of quality as defined by the Ohio Department of Medicaid. Given the previous performance of MCOs, and the increase of the withholding from 2 percent of the total capitation to 3 percent, the state estimates unspent funds of $208.4 million ($62.5 million state share). Additionally, the budget is assuming a lower growth rate based on estimates from the state's independent contracted actuary, Milliman. It is important to note the relationship between these estimates, P4P and rate construction as the entirety of these decisions must comply with federal standards relative to actuarial soundness.

Beyond these savings, ODM will also spend additional dollars to address the Pharmacy Benefit Manager (PBM) issue that has vexed the General Assembly over the last couple of years. While there were budget provisions more prescriptively outlining the expectations of the legislature relative to PBMs, the final budget (after vetoes) included a provision where ODM will require all plans to implement a single preferred drug list. This is in addition to ongoing efforts of the Department to prohibit the use of spread pricing by MCO contracted entities, greater reporting relative to data and fees as well as ongoing analysis regarding outcomes. In all, these efforts will total $304.6 million in expenditures though it is unclear how much is tied to GRF in SFY 2021 specifically.

Lastly, one major item which was deliberated during the last budget dealt was managed care's franchise fee arrangement. This fee, which was deemed as an inadmissible provider tax by the federal

[8] Anthes, Loren C. "Engineering Outcomes: Managed Care and Value-Based Design in Ohio Medicaid." The Center for Community Solutions, March 29, 2019. https://www.communitysolutions.com/research/engineering-outcomes-managed-care-value-based-design-ohio-medicaid/.

government, had been leveraged by local governments to finance a number of local services, notably transportation. While this local leveraging is no longer allowed, the fee was replaced by a CMS-approved tax which would affect all insurers at different rates. Where the first year of this change financed $2.08 billion in revenue for the state, the fully implemented version now generates $2.19 billion in revenue, meaning the source of funding is relatively stable when compared to prior years.

Other Programmatic Initiatives

Nursing Facilities

The market basket rate update relative to tax costs, which was the subject of Joint Medicaid Oversight Committee (JMOC) discussion when the target rate was set in 2018, was eliminated.[9] The budget did however provide for the opportunity for providers to earn an incentive payment based on the achievement of quality. All told, the rate changes represent a net reduction of $37.4 million in SFY2020.

Supporting Children & Families

The budget provided significant money for children's health, including money for home-visiting programs, lead remediation, pregnancy services, postpartum care and opioid treatment, behavioral health services in school, the creation of autism-specific billing codes, multi-system youth and incentive dollars tied to Ohio's SIM project Comprehensive Primary Care (CPC). Table 3 outlines the investments made, which total $170.8 million over the biennium. With 58 percent of the money associated with each of these initiatives are tied to federal funds, Table 3 shows how Medicaid functions as a state and federal partnership to develop programmatic solutions to some of the state's most pressing public health issues.

Table 3: Children & Family Programs (Millions $)

	SFY 2020				SFY 2021			
	TOTAL	GRF		Non-GRF	TOTAL	GRF		Non-GRF
		State	Fed			State	Fed	
Home Visiting	**$13.40**	$4.00	$9.40		**$33.70**	$10.10	$23.60	
Linking Pregnant Moms to Services					**$10.00**			$10.00
Month Enhanced Postpartum Care					**$15.00**	$5.40	$9.60	
Mother/Baby Dyad Care for Women with OUD	**$5.20**	$1.60	$3.60		**$10.40**	$3.10	$7.30	
Behavioral Health in Schools	**$5.00**	$1.50	$3.50		**$10.00**	$3.00	$7.00	
Multi-System Youth Custody Relinquishment	**$6.00**			$6.00	**$12.00**			$12.00
Access to Autism Services	**$0.00**				**$28.10**	$10.40	$17.70	
Wellness for Kids: Pediatric CPC	**$4.00**	$1.20	$2.80		**$8.00**	$2.40	$5.60	
Lead Testing and Hazard Control	**$5.00**	$0.60	$4.40		**$5.00**	$1.20	$3.80	
Totals	**$38.60**	**$8.90**	**$23.70**	**$6.00**	**$132.20**	**$35.60**	**$74.60**	**$22.00**

[9] Anthes, Loren C. "In Establishing Medicaid Target Growth Rate JMOC Misses the Target." The Center for Community Solutions, December 20, 2018. https://www.communitysolutions.com/jmoc-medicaid-target-growth-rate/.

We have previously written about the budget's investments in multi-system youth, infant mortality, lead abatement, adverse childhood experiences and the pediatric CPC program.[10] [11] [12] [13] And while these investments represent just 6 percent of the total ODM budget, they signify a consciously designed set of initiatives focused on family health that represents the majority of the programmatic Medicaid policy beyond pharmacy and hospital payments. As nearly 51 percent of all children in Ohio under five years of age receive their coverage through Ohio Medicaid, the impact of these programs could be significant.

Work Requirements

While the state makes investments in providers and children, able-bodied adults still remain a focus of the legislature and of ODM. In particular, the state has allocated $38 million to manage the process of implementing work requirements in the state of Ohio. While there will most likely be legal challenges to work requirements as a condition of eligibility, the expenditure associated with propping up the program is further contextualized by recent struggles ODM has had managing eligibility, generally.[14] Though it is encouraging to see the state recognize the need for resources where they previously had not, the Center for Community Solutions remains concerned that the allocation to local governments falls significantly short relative to what will be needed with our estimates quadrupling what the state provided.[15] Ultimately, it remains to be seen how these struggles, made more complex by a new eligibility determination scheme with work requirements, will affect average costs, enrollment and Ohio's economy.

Conclusion

Consistent with state law, ODM submitted a budget within the JMOC target growth rate, but the legislature still tried to flex its muscle by including a number of provisions which would increase its control over the program and its operation. This included provisions requiring new waivers, rules around price transparency, and conditions of managed care procurement, among other items. As a result, of the 26 provisions which were vetoed by the governor, 13 dealt with Medicaid.

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[10] Anthes, Loren C. "State Makes Significant Investment in Multi-System Youth." The Center for Community Solutions, July 17, 2019. https://www.communitysolutions.com/state-makes-significant-investment-multi-system-youth/.

[11] Britton, Tara. "Governor's Budget Makes Effort to Address High Infant Mortality Rate, More Work Needed on Ohio's Maternal Mortality Rate." The Center for Community Solutions, March 22, 2019. https://www.communitysolutions.com/continued-efforts-address-ohios-high-rate-infant-mortality-included-governors-budget-work-needed-understand-maternal-mortality-state/.

[12] Lusheck, Brie. "Trauma, Toxic Stress and the Impact: Defining Adverse Childhood Experiences." The Center for Community Solutions, January 4, 2019. https://www.communitysolutions.com/research/trauma-toxic-stress-impact-defining-adverse-childhood-experiences/.

[13] Anthes, Loren C. "Creating Quality for Kids: A Review of Ohio Medicaid's Focus on Value Based Reimbursement." The Center for Community Solutions, August 23, 2019. https://www.communitysolutions.com/creating-quality-kids-review-ohio-medicaids-focus-value-based-reimbursement/.

[14] Exner, Rich. "Ohio and U.S. Uninsured Rates Increase in 2018, Census Bureau Says." cleveland.com. cleveland.com, September 10, 2019. https://www.cleveland.com/datacentral/2019/09/ohio-and-us-uninsured-rates-increase-in-2018-census-bureau-says.html.

[15] Anthes, Loren. "Medicaid Work Requirement Waiver Analysis: Budget Neutrality." The Center for Community Solutions, May 22, 2018. https://www.communitysolutions.com/research/medicaid-work-requirement-waiver-analysis-budget-neutrality/.

In recent years, with super-majorities in both the House and Senate, these provisions were more likely to be overridden. However, with Democrats gaining seats in the House and a new governor, the acrimony associated with the budget, which resulted in a delay, did not focus on Medicaid provisions as much as education funding and subsidies for the nuclear energy industry. In the end, however, ODM's investments are being made at a time with significant budget stability, given the recent economic growth. As such, the flexibility of the state to implement programs is not constrained by the typical Medicaid budget mechanics of a recession, which usually drives spending upward. It remains to be seen how effective these provisions will be, long term, but they do represent a concerted effort to continue Ohio's previous efforts to drive value-based reform and concentrate on improving the outcomes of the 1.3 million Ohio children who rely on Medicaid for coverage.

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