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State Budget Update: Medicaid Budget In HB 49 (Smith) Operating Budget FY 18-19

July 6, 2017

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This post is part of a series of blog posts that explore the Ohio Budget Update. The Medicaid budget is always the most challenging and controversial portion of the budget, which makes up over 30 percent of the state budget. The need to reduce the state share of the General Revenue Fund was challenging enough in Medicaid because every dollar you reduce in the state share has a larger impact on the federal match for Medicaid, which in Ohio is a 60 percent match. In this budget process, it was even a greater challenge with the added political debate over Medicaid expansion playing out at the federal level over the repeal and replace of the Affordable Care Act; the budget debate focused on the impact that would have on expansion states such as Ohio. Since the Gov. John Kasich expanded Medicaid in Ohio for the working poor in 2014 without the support of the legislature, it has been an ongoing point of contention. The legislature contends that the numbers the administration estimated that would enroll in the Group VIII expansion population would not be greater than 447,000. However, the current number of enrollees is over 700,000. With the federal match being reduced in 2020 from 100 percent to 90 percent, legislators are worried that the state cannot afford their growing share to maintain that population going forward. In particular, there is an amendment that was included in the final version of the bill that would prohibit any new eligible expansion enrollee from entering the program beginning in January 1, 2018. With the governor's belief in expansion to ensure Ohio's working poor can have access to health care as an opportunity to be lifted out of poverty, this provision was vetoed. In addition, there were several provisions included in the legislature that asserts more legislative control over the Medicaid budget, which were also vetoed. The administration asserts that the Medicaid budget is under-appropriated by $600 million. This has been a dispute throughout the budget process, with the legislature trying to better understand the administration's numbers and need to cut providers based on the administration's caseload assumptions for the upcoming biennium. Provider groups have been advocating for more conservative caseload projections based on historic spending trends. Prior to the Conference Committee process, Medicaid stakeholders were informed by the administration of their concerns the Medicaid appropriations were underfunded. However, the Conference Committee did not accept the administration's numbers during their final deliberations. As such, the Ohio House is working to override this veto during a veto override session on July 6 and the Senate is planning to return on July 12. Following is a list of Medicaid issues passed by the General Assembly. Items that were vetoed by the governor are indicated.

Reimbursement rates for Hospitals: Vetoed

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- Freezes hospital reimbursement rates effective January 1, 2017, (except for any changes for rebasing or recalibration scheduled for July 1, 2017) for FYs 2018 and 2019
- The governor vetoed this provision, which will return the rate setting for the biennium to the Administration with likely cuts to hospitals
- For additional information, click here

Reimbursement rates for Nursing Homes: (Portions vetoed)

- Removes the 7 percent cut to direct care rates and appropriates $100 million (appropriation vetoed)
- Adopts rate formula changes (vetoed)
- Essentially flat funds nursing home reimbursement for FY 2018 and 2019
- For additional information, click here

Medicaid Health Insuring Corporation Waiver: Vetoed

- Requires the Director of Medicaid to request an additional $207 million for local entities for their portion of the previous sales tax on managed care that was determined unlawful by the federal government and required the state to create a new tax on health insuring corporations (HIC) to replace it. The new waiver was approved in December by CMS and provides $600 million for the Medicaid budget.

Managed Care for Long Term Support Services (MLTSS): Vetoed

- Adopts the Senate version with some changes that does removes the date certain for a report to the legislature or for a vote on legislation to include LTSS in managed care
- Includes the House provision that requires a review of the MyCare program to be included in the study committee.

Assisted Living Waiver:

- Adopted the House version, which creates a workgroup
- Requires the workgroup to (1) identify potential barriers to enrollment in the Program and providers' participation in the Program and (2) consider making community-based services that are similar to assisted living services available under other programs that ODA currently administers or under a new program.
- Requires that the workgroup complete a report of its review by July 1, 2018.

Behavioral Health Redesign (Managed Care delay vetoed)

- Prohibits alcohol, drug addiction, and mental health services from being included in managed care before July 1, 2018. (This provision was vetoed by the governor, returns the carve-in to January 1, 2017.)
- Prohibits other elements of redesign to be implemented before January 1, 2018, or the later of that date and requires a beta test of

more than 50% participating providers submit clean claims and they are successfully adjudicated within 30 days

- Requires Directors of Medicaid and ODMHAS to adopt no later than October 1, 2017 and provide training materials, manuals.

Institutes of Mental Disease Waiver: Vetoed

- Requires ODM to create and administer Medicaid waiver component to provide services to eligible individuals between the ages of 21-64 at IMDs
- This was vetoed by the governor due to BH services being carved-in to managed care in six months.

Medicaid Expansion Freeze: Vetoed

- Prohibits any new enrollees beginning July 1, 2018
- Exempts those with serious mental illness and drug addiction
- Requires the Medicaid Director to seek a waiver from CMS.

Medicaid Reimbursement Rate Oversight: Vetoed

- Prohibits any Medicaid rate increases if the Department of Medicaid (or any other responsible agency) fails to submit the Medicaid payment rate proposal to the Joint Medicaid Oversight Committee (JMOC), or if JMOC votes to prohibit the proposal within 30 days, or if legislature votes to prohibit the proposal within 90 days.

Controlling Board Changes Impacting Medicaid: Vetoed

- Requires the Medicaid Director to request the Controlling Board to authorize expenditure from the fund in an amount necessary to pay for the costs of the Medicaid program
- Provides for the Health and Human Services fund to continue to exist during the 2018-2019 fiscal year
- The Controlling Board may authorize the expenditure if U.S. Congress does not enact a lowering of the federal match for the expansion group.

Work requirements for Medicaid Expansion group

- Requires ODM to establish a waiver program under which an individual must satisfy one of the following to be eligible:
    - At least 55 years of age
    - Be employed
    - Be enrolled in school or an occupational training program
    - Be participating in an alcohol and drug addiction treatment group or
    - Have intensive health care needs

Healthy Ohio Program and Waiver

- Requires Medicaid Director to submit the healthy Ohio waiver to CMS no later than January 31, 2018
- States the General Assembly's intent to use the Health Ohio Program as a model if the U.S. Congress decides to block grant the Medicaid program.