

Office of Health Transformation **Overall Medicaid Budget Impact**

Governor Kasich's Budget:

- *Holds Department of Medicaid per member cost growth below one percent*
- *Reduces the state share of Medicaid spending*
- *Invests in primary care and home and community based services*
- *Replaces the Medicaid managed care sales tax with a stable alternative*

Background:

Medicaid is funded and administered jointly by the federal and state governments. Under broad federal guidelines, states establish their own standards for Medicaid eligibility, benefits, and provider payment rates, although states must meet certain minimum standards. Ohio's current program covers three million Ohioans – including more than half of all births in the state, almost half of all children, many low-income working families, and the oldest, sickest, frailest and most medically complex patients in Ohio. The bulk of Medicaid's costs come from its dominant role in delivering mental health benefits, a variety of services for individuals with physical, developmental and intellectual disabilities, and long term care services.

Transformation Strategy:

In January 2011, Governor John Kasich created the Office of Health Transformation (OHT) to improve health outcomes and control Medicaid spending. OHT organized Ohio's health and human services agencies – Aging, Developmental Disabilities, Health, Job and Family Services, Mental Health and Addiction Services, Opportunities for Ohioans with Disabilities – to design and implement an aggressive package of Medicaid reforms to improve overall health system performance. By most accounts, Ohio now leads the nation in the scope and impact of its reforms, and in the state's ability to control Medicaid spending.

Governor Kasich's first Medicaid budget (enacted in 2011) proposed spending \$500 million less than the original trend in 2012 and \$942 million less in 2013. At the same time, the budget introduced new tools to improve care coordination, integrate behavioral and physical health care, rebalance long-term care spending, and modernize reimbursement to reward value instead of volume. Ohio Medicaid used these tools to drive program innovation and deliver additional savings, actually spending \$1.9 billion less than budgeted over two years (2012-2013) and saving taxpayers \$2.9 billion over that period compared to the original trend (Figure 1).

Governor Kasich's second budget (enacted in 2013) introduced new initiatives to fight fraud and abuse, improve care coordination for the most at-risk populations, consolidate mental

health and addiction services into one department, make Medicaid more accountable as a stand-alone department, and extend coverage to more very low-income Ohioans. The Medicaid expansion took effect in January 2014 and resulted in a one-time upward shift in all-funds Medicaid spending. The budget included this upward shift and then, from that level, actual spending was a remarkable \$3.8 billion below budget over two years (2014-2015).

Governor Kasich's third budget (enacted in 2015) moved additional populations into managed care, made the single largest state investment in services for individuals with developmental disabilities in the history of that program, initiated a complete system redesign for Medicaid behavioral health services, and replaced Ohio's two disability determination systems with one. As enacted, the Medicaid budget was expected to grow \$4.1 billion over two years but actual spending was \$2.8 billion below budget – cutting the expected growth by a third (Figure 1).

Over the past six years, a combination of conservative budgeting and sound program management has resulted in stable and sustainable growth in Ohio's Medicaid program. Ohio spends the same amount per Medicaid enrollee today that it spent six years ago (about \$690 per month). State general revenue fund (GRF) spending on Medicaid has come in under budget every year of the Kasich Administration, saving Ohio taxpayers \$1.9 billion over five years (2012-2016) compared to original appropriations (Figure 2).

Executive Budget Proposal and Impact:

Medicaid Baseline. The total Medicaid “baseline” – what the Medicaid program would cost in the upcoming biennium assuming current eligibility, benefit, and payment policies remain unchanged – is projected to grow 6.3 percent to \$28.6 billion in 2018 and 3.8 percent to \$29.7 billion in 2019 (Table 1). **Most of the Medicaid baseline growth (62 percent) is related to enrollment growth in the aged, blind and disabled (ABD) eligibility category.**

Over the past two years, ABD individuals were able to gain Medicaid coverage through the expansion group based on income, without needing a disability determination. As a result, enrollment in the expansion group was higher than expected and enrollment in the ABD group was lower. In 2016, Ohio implemented a new disability determination process that automatically enrolls ABD individuals into the proper eligibility category, which will shift some of the current expansion group into ABD. Because the state pays a greater share of the cost for the ABD group (37 percent) than it does for the expansion group (currently 95 percent), the enrollment shift into ABD will drive up the baseline.

In addition, the Medicaid baseline will increase slightly as a result of the federal requirement that the state pay a larger share of the cost for the expansion population (Group VIII). Ohio's share of the expansion will increase from zero in December 2016, to five percent in January 2017, six percent in January 2018, and seven percent in January 2019. Despite this increase, **Group VIII only accounts for 25 percent of Medicaid baseline growth.** The remaining Medicaid

baseline growth is accounted for by covered families and children (3 percent) and Medicare premium assistance populations (10 percent).

Executive Budget Reforms. The Executive Budget invests in critical priorities – comprehensive primary care and home and community based services – while also seeking reimbursement changes that reduce the growth in spending on prescription drugs, hospitals, and nursing facilities. The net impact of these reforms is state general revenue fund savings of \$1.0 billion in 2018 and \$1.2 billion in 2019 compared to the baseline (Table 1). For more information about these reforms, see [OHT 2018-2019 Budget Initiatives](#).

Executive Budget	SFY 2018		SFY 2019	
	All Funds	State GRF	All Funds	State GRF
ORIGINAL MEDICAID BASELINE	\$28,562,648,375	\$ 6,343,489,075	\$29,661,214,530	\$ 6,701,698,756
Executive Budget				
Improve Care Coordination	\$ (315,866,270)	\$ (865,396,597)	\$ (464,297,238)	\$ (971,438,063)
Prioritize Home and Community Based Services*	\$ 8,711,448	\$ 4,394,746	\$ 75,017,942	\$ 29,536,064
Provide Choices in Ohio's Developmental Disabilities System*	\$ 25,153,022	\$ 9,558,148	\$ 93,042,941	\$ 35,356,317
Reform Provider Payments	\$ (209,525,000)	\$ (86,224,802)	\$ (469,868,032)	\$ (185,421,141)
Improve Program Performance	\$ (115,594,873)	\$ (97,865,121)	\$ (187,686,624)	\$ (70,929,160)
Subtotal	\$ (607,121,673)	\$ (1,035,533,626)	\$ (953,791,011)	\$ (1,162,895,983)
TOTAL MEDICAID BUDGET	\$27,955,526,702	\$ 5,307,955,449	\$28,707,423,519	\$ 5,538,802,773

* Ohio Department of Disabilities HCBS programs are included in the total for "Provide Choices" not "Prioritize HCBS"

Medicaid Managed Care Sales Tax Replacement. Since 2009, Ohio has imposed a sales tax on services purchased by Medicaid managed care plans. However, [CMS ruled in 2014](#) that, as of July 2017, it will no longer accept Ohio's Medicaid managed care sales tax as a permissible source of state funds to draw down federal matching funds for Medicaid. Ohio Medicaid requested federal permission to replace the current tax program with an alternative that keeps Ohio's budget whole. CMS approved Ohio's request in December 2016.

Effective July 1, 2017, the Executive Budget repeals the Medicaid managed care sales tax and replaces it with the CMS-approved alternative. This exchange shrinks the overall size of the Medicaid program \$269 million in 2018 and \$342 million in 2019. Ohio Medicaid will deposit revenue from the replacement tax into a special account, which is consistent with how Medicaid currently accounts for revenue generated by the hospital tax and nursing facility tax. However, because a portion of the sales tax was previously deposited in the state GRF, the resulting shift from GRF to a non-GRF account decreases the state share of Medicaid \$866 million in 2018 and \$968 million in 2019 – resulting in a \$1.8 billion reduction in Medicaid state GRF over the biennium. For more information, see [Improve Care Coordination](#).

Executive Budget Appropriations. After adjusting baseline projections for savings and cost avoidance, and to account for the Medicaid managed care sales tax repeal and replacement,

the Executive Budget increases overall Medicaid spending 6.3 percent to \$28.0 billion in 2018 and 2.7 percent to 28.7 billion in 2019 (Table 1 and Figure 1). The state share-only GRF appropriations decreases 8.5 percent to \$5.3 billion in 2018 and then grows 4.3 percent to \$5.5 billion in 2019 (Table 1 and Figure 2).

Per Member Program Spending. In addition to total spending, the Joint Committee on Medicaid Oversight (JMOC) develops a projected medical inflation rate for the Medicaid program based on the per member per month (PMPM) cost of continuing current Medicaid policy. JMOC then sets a goal for the Medicaid director to limit program growth to the lower of the JMOC rate or the three-year average Consumer Price Index (CPI) for medical services.

In January 2017, [JMOC reported](#) that Ohio Medicaid PMPM spending has been significantly lower than was estimated at the introduction of the last budget. JMOC set a target for Medicaid PMPM to not grow more than 2.9 percent in 2016 (it actually grew 1.2 percent) and not more than 3.3 percent in 2017 (it actually grew less than 2.6 percent). ***JMOC estimates the lower-than-budgeted rate of growth produced savings of \$1.6 billion across all funds (2015-2016).***

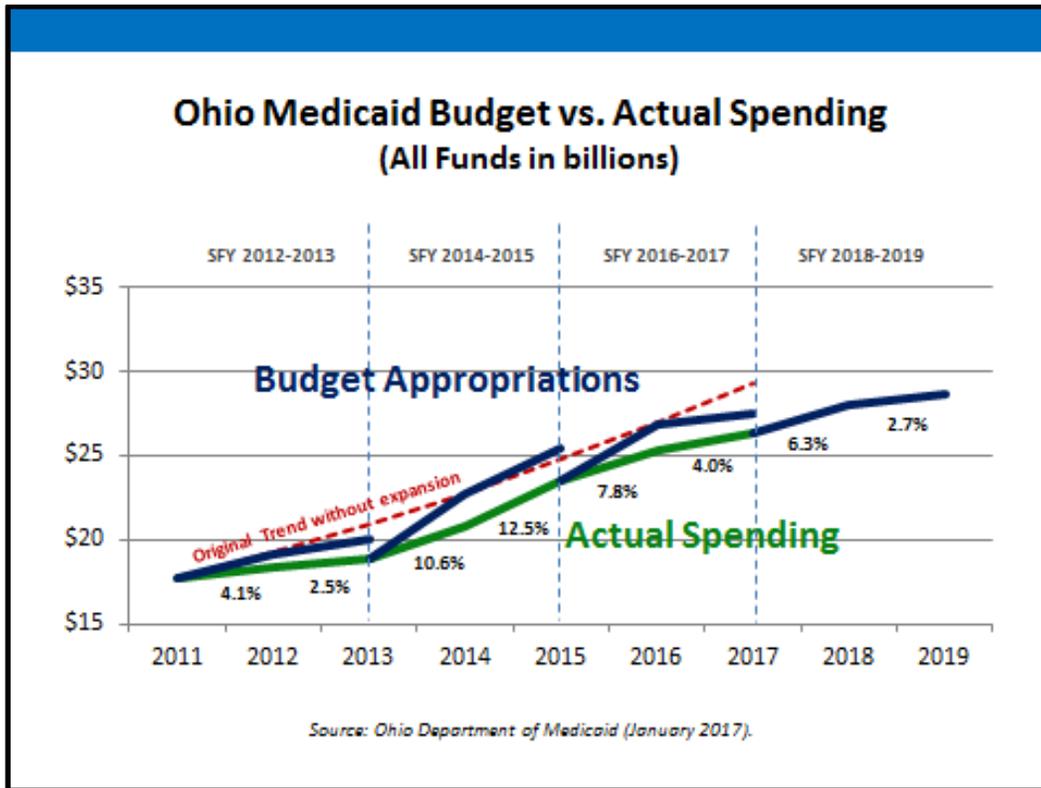
For the 2018-2019 budget, [JMOC recommends](#) limiting Medicaid PMPM growth to 3.3 percent each year (3.3 percent on average over the biennium). Ohio Medicaid currently projects 4.3 percent average Medicaid PMPM growth over the biennium, almost entirely as a result of investments in services for Ohioans with developmental disabilities. When this population is excluded, the expected PMPM growth for all other populations, including covered families and children and expansion adults, is less than one-half of one percent over the biennium (Table 2).

State Fiscal Year	JMOC Upper Bound	Medical CPI	JMOC Target	Ohio Medicaid with Policy Changes	
				(All Agencies)	(Excluding DODD)
2018	3.80%	3.30%	3.30%	2.24%	1.64%
2019	4.00%	3.30%	3.30%	6.38%	-0.83%
Average	3.90%	3.30%	3.30%	4.29%	0.39%

Source: Optumas (October 2016) and Ohio Medicaid (January 2017).

January 30, 2017

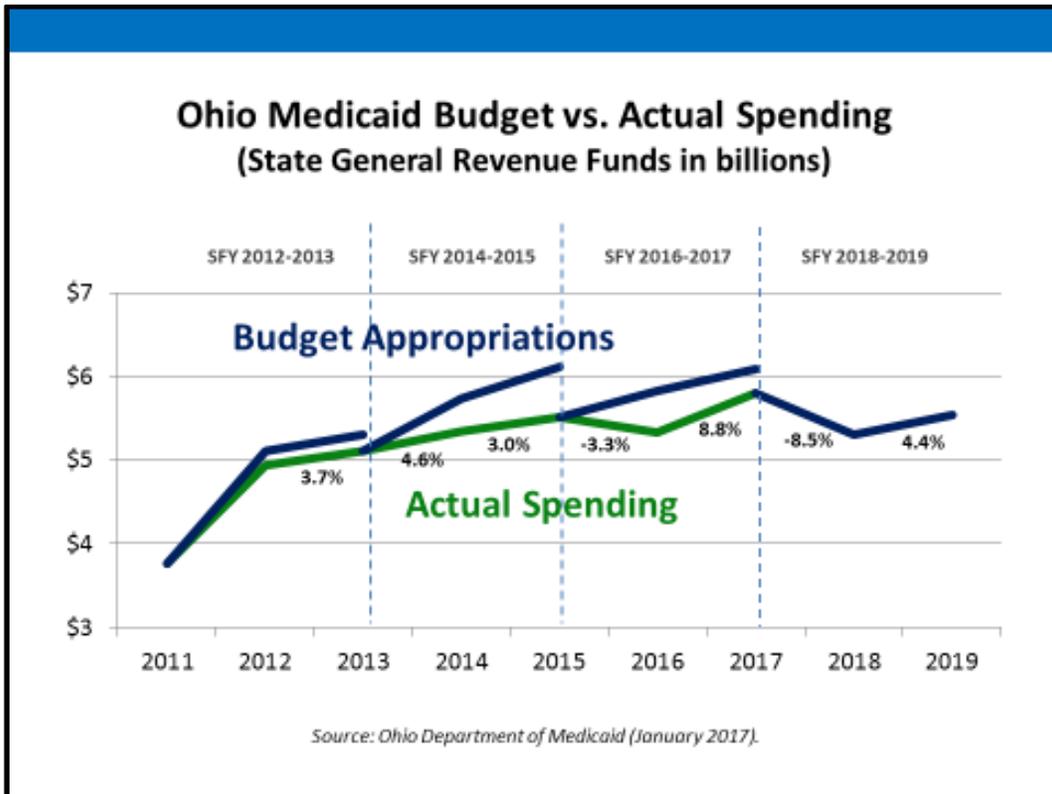
Figure 1.



Ohio Medicaid Budget vs. Actual Spending (All Funds in millions)

Year	Budget	Actual	Savings	Percent Change
2011	--	\$17,681	--	--
2012	\$19,097	\$18,401	\$696	4.1
2013	\$20,042	\$18,857	\$1,185	2.5
2014	\$22,749	\$20,859	\$1,890	10.6
2015	\$25,401	\$23,467	\$1,934	12.5
2016	\$26,858	\$25,293	\$1,565	7.8
2017	\$27,525	\$26,305	\$1,220	4.0
2018	\$27,956	--	--	6.3
2019	\$28,707	--	--	2.7

Figure 2.



Ohio Medicaid Budget vs. Actual Spending (State General Revenue Funds in millions)

Year	Budget	Actual	Savings	Percent Change
2011	--	\$3,777	--	--
2012	\$5,111	\$4,935	\$175	30.9
2013	\$5,301	\$5,116	\$185	3.7
2014	\$5,739	\$5,349	\$390	4.6
2015	\$6,112	\$5,509	\$603	3.0
2016	\$5,827	\$5,328	\$498	-3.3
2017	\$6,084	\$5,798	\$286	8.8
2018	\$5,308	--	--	-8.5
2019	\$5,539	--	--	4.4