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The Center for Health Affairs
The Leading Advocate for Northeast Ohio Hospitals

Established in 1965, Medicaid is funded jointly by the state and federal governments and provides health insurance to eligible low-income and medically vulnerable people. It is administered at the state level under broad federal regulations.

Medicaid

In the past, the Medicaid program in Ohio was administered by the Department of Job and Family Services. Starting in July 2013, a new cabinet-level Ohio Department of Medicaid was created to administer the state's Medicaid program.

A number of programs are associated with Medicaid in Ohio, including Healthy Start and Healthy Families. Healthy Start covers children, youth aging out of foster care and pregnant women. Healthy Families covers parents or caregivers and their dependent children.

Together, Healthy Start and Healthy Families comprise what is referred to as the Covered Families and Children (CFC) program. To be eligible for these programs, certain income guidelines apply.

Medicaid also provides coverage for the Aged, Blind and Disabled (ABD) population. The ABD program covers persons with disabilities or persons age 65 or older who meet certain income guidelines.

Ohio Eligibility Overview

Covered Populations	Income Guidelines
Children (up to 19)	≤ 200% FPL*
Pregnant Women	≤ 200% FPL
Parents & Childless Adults	≤ 138% FPL
Disabled	≤ 138% FPL**
Disabled Workers	≤ 250% FPL

** In 2015, the federal poverty level (FPL) is $20,090 for a family of three.*
*** Approximate; deductions & exceptions apply.*

Federal regulations stipulate which services Medicaid must cover at a minimum. States can choose to broaden coverage. In Ohio, Medicaid covers a variety of medically necessary services such as doctor visits, hospital care, immunizations, prescriptions and dental care. Some services are limited by the dollar amount, the number of visits per year, or the setting in which they can be provided.

While states can broaden coverage, they cannot reduce eligibility. The Affordable Care Act (ACA) included maintenance of effort (MOE) provisions designed to preserve existing Medicaid coverage until the law is fully implemented. For children under 19, MOE provisions extend until Sept. 30, 2019.

CHIP

The State Children's Health Insurance Program, often referred to as CHIP, is a federal program created in 1997 to expand health insurance coverage for children. States were permitted the flexibility to design their CHIP programs as stand-alone programs separate from Medicaid, use CHIP funds to expand existing Medicaid eligibility, or combine both approaches. Ohio chose to expand coverage through its existing Healthy Start program.

Prior to health reform, states participating in the Medicaid program were required to cover children ages 6 to 18 in households up to 100 percent of the FPL. Under the ACA's MOE provisions, states are required – at a minimum – to maintain current eligibility levels for CHIP through federal fiscal year 2019. Though a Supreme Court ruling has made it optional in each state, the legislative language in the health reform law also expanded the minimum eligibility requirement to 138 percent of the FPL effective Jan. 1, 2014.

The CHIP program is only funded through federal fiscal year 2015. Congress will need to authorize additional funding for the CHIP program this year to ensure that funding remains available for this vital program.

Federal Medical Assistance Percentage

The responsibility for funding Medicaid is shared by the state and federal governments. The federally funded portion is determined by a Federal Medical Assistance Percentage (FMAP), which is calculated by the U.S. Department of Health and Human Services. The Medicaid FMAP is determined for each state individually and can change annually. Essentially, the FMAP is the percentage of Medicaid expenditures paid by the federal government, with the remainder paid by the state. In Ohio, FMAP for federal fiscal year 2015 is 62.64 percent.

To encourage states to expand coverage for children, Congress approved enhanced funding to pay for the federal portion for CHIP that is roughly 15 percent higher than the traditional Medicaid rate. Ohio's enhanced FMAP for federal fiscal year 2015 is 73.85 percent. The ACA increases the enhanced FMAP for states by 23 percentage points beginning in federal fiscal year 2016 through 2019.

Managed Care

Medicaid services can be paid for based on either the traditional fee-for-service model or through managed care. Most Ohio Medicaid beneficiaries must join a managed care plan to access benefits. Managed care plans (MCPs) are private health insurance companies that provide the standard Medicaid benefit package to Medicaid enrollees in exchange for a set fee per enrollee per month. Used as a strategy to improve quality and control costs, MCPs cover both the CFC population and ABD population (with some exceptions). Governor John Kasich's three year proposal to further integrate Medicare and Medicaid systems to managed care, which began in 2014, affects about 114,000 dual-eligible Ohioans and is commonly referred to as MyCare Ohio.

More on Medicaid @ chanet.org

Waivers

Under the federal Social Security Act, the U.S. Secretary of Health and Human Services has the authority to grant waivers to states, which allow them to opt out of federal Medicaid requirements and afford them flexibility in operating their programs. There are four primary types of waivers, each with a distinct purpose and requirements.

- ### Section 1115 Research & Demonstration Projects

  This section provides the Secretary of Health and Human Services broad authority to approve projects that test policy innovations likely to further the objectives of the Medicaid program.

- ### Section 1915(b) Managed Care Waivers

  This section provides the Secretary authority to grant waivers that allow states to implement managed care delivery systems, or otherwise limit individuals' choice of provider under Medicaid.

- ### Section 1915(c) Home and Community-Based Services Waivers

  This section provides the Secretary authority to waive Medicaid provisions in order to allow long-term care services to be delivered in community settings. This program is the Medicaid alternative to providing comprehensive long-term services in institutional settings.

- ### Concurrent Section 1915(b) and 1915(c) Waivers

  This section allows states to simultaneously implement two types of waivers to provide a continuum of services to people with disabilities and the elderly, as long as all federal requirements for both programs are met.

Enrollment & Spending

More than 2.8 million Ohioans receive coverage through Medicaid. The Aged, Blind and Disabled component of the program accounts for 19 percent of the enrollees, and 61 percent of total Medicaid healthcare spending. Approximately 75 percent of enrollees and 36 percent of expenditures are associated with Covered Families and Children. The remaining six percent of the Medicaid caseload and the final three percent of Medicaid expenditures are accounted for by other Medicaid recipients and programs. Altogether, about $17 billion is spent in Ohio on Medicaid, with roughly $11 billion covered by the federal government and $6 billion covered by Ohio. At the state level, 28 percent of Medicaid payments go to hospitals annually; 17 percent goes to nursing facilities; and 14 percent on home and community services.

Hospital Care Assurance Program

In 1981, the Medicaid disproportionate share hospital (DSH) program was established by Congress to help ensure states provide adequate financial support to hospitals that serve a significant number of low-income patients. Recognizing that safety net hospitals typically incur higher uncompensated care costs than other hospitals and rely heavily on Medicaid, which historically has low reimbursement rates, Congress authorized DSH payments to assist states in financing the programs.

Like the traditional Medicaid program, Medicaid DSH funding was also designed to be split by state and federal governments and is subject to FMAP. The federal agency involved in the administration of Medicaid determined in 1985 that states could use hospital taxes and donations to fund the nonfederal share of Medicaid DSH payments. Ohio makes use of this practice.

Under HCAP, hospitals are taxed and those funds are used as the state's share to draw matching federal Medicaid DSH funds. The total pool is then redistributed to hospitals based on a formula determined by the Ohio Hospital Association under the oversight of the Ohio Department of Medicaid.

Ohio law also requires all hospitals that receive DSH funds to provide basic, medically necessary hospital-level services free of charge to persons below the poverty line. In the years following the authorization of DSH funding, Congress passed additional legislation that added some restrictions to the program. The "hold harmless prohibition," passed in 1991, means that a hospital cannot be guaranteed it would at least receive its tax dollars back. In 1993 the Omnibus Budget Reconciliation Act added a DSH payment ceiling that prohibits each hospital from receiving an HCAP payment that is more than its losses in treating Medicaid patients and the uninsured.

Passage of the Affordable Care Act in 2010 marks the next phase in the evolution of the DSH program. Because the ACA is expected to significantly reduce the number of people without health insurance, hospitals are expected to experience lower uncompensated care costs. As a result, the ACA included provisions that would have reduced DSH payments each quarter starting in 2014 and continuing through 2020. However, Congress has delayed the start of Medicaid DSH cuts until 2017.

Medicaid Expansion

In addition to the changes to the DSH program mentioned above, passage of national health reform brought numerous changes for the Medicaid program. Among the most significant changes included in the law was the expansion of Medicaid eligibility to all individuals under age 65 with incomes up to 138 percent of the federal poverty level beginning in 2014. This provision was expected to lead to a significant reduction in the uninsured population and was one of the primary drivers behind the decision to reduce the DSH allotments used to help hospitals care for this population.

While this provision was initially mandated as part of the ACA for all states, the Supreme Court's ruling on June 28, 2012 deemed state expansion optional. For states that choose to go forward, expansion will be paid for entirely at the federal level from 2014 through 2016, at which point federal funding will gradually decline until beginning in 2020 and through subsequent years the expansion will be paid for at 90 percent by the federal government, with the states picking up the remaining 10 percent of the cost. The expansion also guarantees a basic package of benefits for all newly eligible adults.

In October 2013, Ohio's Controlling Board voted by a 5-to-2 majority to authorize the state to accept federal funds to expand Medicaid to all adults earning up to 138 percent of the federal poverty level. The Controlling Board's decision allows the state to accept federal funding starting Jan. 1, 2014 through the end of the current biennium on June 30, 2015. For the expansion population to continue to receive Medicaid benefits, state lawmakers will need to reauthorize the Medicaid program for the expansion population by June 30, 2015. Reauthorization of the Medicaid program for the expansion population is essential for both consumers and healthcare providers.