Ohio Revised Code

Section 126.021 Medicaid caseload and expenditure forecast report.

Effective: October 3, 2023
Legislation: House Bill 33 - 135th General Assembly

The director of budget and management, as part of the submission to the governor under section 126.02 of the Revised Code, shall prepare and submit to the governor not later than the first day of January preceding the convening of the general assembly a medicaid caseload and expenditure forecast report, prepared in consultation with the department of medicaid. For each component identified in divisions (A) to (Q) of this section, the report shall include proposed, actual, or estimated medicaid program data for each fiscal year of the proposed budget biennium and for each fiscal year of the current budget biennium. If determined useful, the directors of budget and management and medicaid may choose to include additional years of data for components of the report.

The report shall include all of the following:

(A) A complete budget for the medicaid program delineated by the agency administering each component of the program, fund, appropriation item, and whether the spending is for services or administration;

(B) A summary of medicaid service spending by eligibility group and subgroup and service delivery system;

(C) A detailed mapping of the summary spending provided in division (B) of this section into individual appropriation items and including state and federal shares of each appropriation item;

(D) A complete description of each policy proposal, including assumed start date and cost projection delineated by fiscal year, appropriation item, state and federal shares, eligibility group and subgroup, and service delivery system;

(E) The medicaid caseload delineated by eligibility group and subgroup and service delivery system;

(F) The percentage of total medicaid enrollment that is comprised of medicaid recipients enrolled under the care management system established under section 5167.03 of the Revised Code and the percentage of total medicaid spending that the care management system comprises;

(G) A detailed accounting of the care management system component of the medicaid budget by eligibility group and subgroup, including spending, member months, and per member per month capitation rates;

(H) A detailed accounting of the fee-for-service component of the medicaid budget by eligibility group and subgroup, including spending, member months, and per member per month costs;

(I) Historical spending data by service delivery system, medicaid provider and program, including at least the following provider categories: hospital, pharmacy, waiver, nursing, home health care, professional medical and clinic, nursing facility, behavioral health care, and intermediate care facility for individuals with intellectual disabilities;

(J) A detailed accounting of the medicare buy-in and medicare Part D components of the medicaid budget by eligibility group and subgroup, including spending, average monthly premiums, and average rates;

(K) A summary of projected spending for each fiscal year delineated by forecast component and by baseline and policy proposals;

(L) A detailed calculation demonstrating the effect of a hypothetical one-dollar increase in medicaid home and community-based services wages for direct care providers for each fiscal year, delineated by provider, appropriation item, and state and federal shares;

(M) A detailed calculation demonstrating the effect of a hypothetical one percentage point increase in provider franchise fee revenue for each fiscal year, for each of the fees imposed under sections 5168.21, 5168.41, and 5168.76 of the Revised Code;

(N) A detailed calculation demonstrating the effect of a hypothetical one-dollar increase in nursing facility and intermediate care facility for individuals with intellectual disabilities per medicaid day

payment rates;

(O) A detailed explanation of how the governor's medicaid budget recommendations satisfy the requirements of section 5162.70 of the Revised Code;

(P) The most recent report required under section 5162.70 of the Revised Code;

(Q) Any other information the director of budget and management or the medicaid director deems to be useful to facilitate a better understanding of the governor's medicaid budget recommendations.