



August 2017

Budget

Shifting sands in Ohio's Medicaid budget: Veto, overrides and fiscal disputes

Wendy Patton

Introduction

Medicaid, the state's largest program with the most federal dollars, was the primary point of contention as Ohio's lawmakers crafted the 2018-19 budget this past spring. Struggles over Medicaid structure and funding in Congress added uncertainty to historical rancor over the Medicaid expansion in Ohio. The governor signed the budget bill into law more than a month ago, but it's not over yet: 11 of the Governor's 47 vetoes have been overridden by Ohio's House of Representatives. The Senate has sessions scheduled in August, to take action on the House overrides.

Medicaid policy is front and center. Nine of the 11 vetoes had to do with Medicaid, and of the two that pertained to other issues, one involved a Medicaid provider tax. In this issue brief, we review some of the most contentious Medicaid issues in the budget, with a focus on vetoes and overrides.

Overview of the Medicaid budget

Medicaid is the largest single health insurer in Ohio, covering more than a quarter of all Ohioans, around 3 million people.

The Medicaid all-funds budget, including state and federal General Revenue Funds (GRF), other federal funds, and state dedicated and special purpose funds, totals \$55.5 billion in the fiscal years (FY) 2018-19 budget (\$27.07 billion in FY 2018 and \$28.19 billion in FY 2019). The FY 2018-19 budget contains \$4.4 billion more than the prior budget, an increase of 8.6 percent. About two-thirds of that total is federal funds.

Analysis of budget decisions typically concern the GRF, because that is where most taxpayer dollars go. Funds in the GRF used for Medicaid total \$14.82 billion in FY 2018 (\$5.09 billion state share) and \$15.67 billion in FY 2019 (\$5.36 billion state share). Medicaid represents 23 percent of the biennial total in terms of *state* dollars in the GRF in the 2018-19 budget.

In total state funds, both GRF and non-GRF, Medicaid funding rises by about \$1.2 billion. This increment in state funding draws down matching federal funds of \$3.2 billion. Overall, this represents an increase of 8.6 percent in total Medicaid spending in the current budget relative to the prior budget.

Unhealthy proposals

1. Work requirements: The House and Senate want to seek a waiver from federal Medicaid rules and create work requirements for Ohioans who get coverage through Medicaid expansion, which covers adults earning up to 138 percent of the federal poverty line, whether they have children or not. Under the House and Senate plan, Ohioans covered by expansion would have to work, be enrolled in training or be in school. People over 55, those participating in drug or alcohol treatment and people with physical or mental disabilities would be exempt from the requirement.

The Medicaid expansion covers people who are working, but earning very low incomes – too low to afford health insurance. Most enrollees were uninsured prior to enrolling in Medicaid coverage: 75 percent had no prior insurance at all and another 14 percent had lost employer-based insurance.

An assessment of Medicaid expansion enrollees in its first year in Ohio found most were white (71.5 percent), male (55.8 percent), with a high school degree or less (58.1 percent). About 43 percent were working. Three-quarters of the rest were looking for work. Just under half were older than 45; more than a quarter were found to have an undiagnosed chronic condition – like diabetes or heart disease – and a third suffered from a behavioral health issue, like anxiety or depression. Most of those who were unemployed but looking for work reported that Medicaid enrollment made it easier to seek employment. For those who were currently employed, the majority reported Medicaid enrollment made it easier to continue working.¹ Employed enrollees would remain covered under legislature’s proposed Medicaid expansion freeze, but those between jobs or not fitting into the specified exemptions would lose of health care.

Policymakers created Medicaid to extend health care to low-income Americans. The program never mandated work because that wouldn’t promote Medicaid’s original goals. Moreover, research has shown that work requirements do not move people out of poverty. Employment among those *not* subject to a work requirement in various social service programs was found to be the same or higher after five years than among those who were subject to the work requirement. Earnings associated with short-term employment gains were generally not enough to escape poverty.²

Administering the work requirement could be costly to Ohio’s counties, the administrative arm for health and human services. Many have struggled with existing work requirements in other health and human service programs.³ Adding a new requirement, with 700,000 enrollees is an expensive proposition. There is also no funding to evaluate whether an applicant has an intensive physical health care need or serious mental illness.

The House of Representatives added the work requirement to the 2018-2019 budget bill and the Senate concurred. The Governor did not veto this provision.

¹ Ohio Department of Medicaid, Ohio Medicaid Group VIII Assessment, December 2016 at <http://medicaid.ohio.gov/portals/O/resources/reports/annual/group-viii-assessment.pdf>

² LaDonna Pavetti, “Work Requirements Don’t Cut Poverty, Evidence Shows” Center on Budget and Policy Priorities, June 7, 2016 at <http://bit.ly/2tH7Vpy>

³ Wendy Patton, Shrinking Aid for Ohio’s Poorest Families, November 2015 at <https://www.policymattersohio.org/research-policy/pathways-out-of-poverty/basic-needs-unemployment-compensation/basic-needs/shrinking-aid-for-ohios-poorest-families>

2. Medicaid expansion freeze: The Senate added a provision to the budget bill that would halt enrollment in the Medicaid expansion group as of July 1, 2018. In conference committee, legislators added an exemption for those with mental illness or drug addiction and required the Governor to seek a waiver of Medicaid rules to implement these provisions.

Medicaid expansion has been excellent for Ohioans and for Ohio. It has allowed 723,000 Ohioans to gain health care coverage, many for the first time. Unemployed participants interviewed for the Kasich administration's assessment of the Medicaid expansion overwhelmingly reported that having access to health care made it easier for them to seek employment. The majority of workers enrolled through the expansion said participation made it easier to maintain their jobs. Enrollees reported gains in physical and mental health status, as well as an increase in financial security and health security.⁴

Ohio is in the middle of a drug epidemic, with more than 4,000 dead of overdoses last year.⁵ National projections also show overdose deaths spiking in 2017.⁶ Medicaid expansion has been the most important element in the fight against the disease of addiction. It has helped 500,000 Ohioans gain access to substance abuse treatment and mental health services.⁷ Two-thirds of the \$1 billion Ohio spent last year to reduce drug use and overdose fatalities were funded by Medicaid.⁸

Yet, the legislature voted to freeze enrollment in Medicaid. Because jobs in the low-wage labor market are not stable, people of low-income churn on and off the program, so the freeze will quickly eliminate participation. The governor's Office of Health Transformation estimated that 500,000 could lose coverage within the first 18 months after these provisions were implemented.⁹

The governor vetoed the entire enrollment freeze. The House did not override the veto, so the Senate cannot vote on an override. Speaker Clifford A. Rosenberger said the House could take up an override later – and they can, up until the end of the 132nd General Assembly at the end of 2017. As of now, freeze supporters have lacked the votes to do so.

3. Healthy Ohio: The so-called “Healthy Ohio” plan for Medicaid became law in the 2016-2017 budget bill. This plan would charge able-bodied, non-elderly Medicaid enrollees premiums and lock them out if they fell behind in paying by more than two months. The program had other components including incentives, health care “accounts,” and monthly statements about the use of health care services.¹⁰ The administration submitted an application for a

⁴ Ohio Department of Medicaid, Ohio Medicaid Group VIII Assessment, December 2016 at <http://medicaid.ohio.gov/portals/O/resources/reports/annual/group-viii-assessment.pdf>

⁵ Alan Johnson and Cathy Candisky, Overdose Deaths Continue to Soar in Ohio, May 28, 2017 at <http://www.dispatch.com/news/20170528/overdose-deaths-continue-to-soar-in-ohio>

⁶ Josh Katz, Drug Deaths in America are rising faster than ever, The New York Times, June 5, 2018 at https://www.nytimes.com/interactive/2017/06/05/upshot/opioid-epidemic-drug-overdose-deaths-are-rising-faster-than-ever.html?_r=0

⁷ *Columbus Dispatch*. “GOP Plan to Kill Ohio Medicaid Expansion May Fuel Drug Crisis.” [Catherine Candisky](#) & [Jim Siegel](#). April 28, 2017 & *New York Times*. “Drug Deaths in America Are Rising Faster Than Ever.” Josh Katz. June 5, 2017.

⁸ Ohio Department of Medicaid. OBM analysis of FY 2016 expenditures.

⁹ Medicaid Expansion Enrollment Freeze, Ohio Office of Health Transformation at <http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=IWbICDiBEGs%3d&tabid=136>

¹⁰ Wendy Patton, “Healthy Ohio plan is bad medicine,” Policy Matters Ohio, January 2016 at <https://www.policymattersohio.org/research-policy/quality-ohio/revenue-budget/budget-policy/healthy-ohio-plan-is-bad-medicine>

waiver of Medicaid rules to implement Healthy Ohio in 2016, was rejected by the federal government.

In 2016, nearly 1,000 Ohioans protested to the Centers for Medicare in opposition to the many harmful aspects of the so-called “Healthy Ohio” plan.¹¹ The Kasich Administration itself projected the waiver proposal would reduce enrollment by 125,000 to 140,000 people in each of the five years of the demonstration project.¹² “Healthy Ohio” did the opposite of what demonstration projects under which Medicaid rules are waived are supposed to do, which is to help low-income populations gain access to health care. The federal government rejected the plan in 2016 under existing law which has not, to date, changed.

The new budget bill included a provision to re-submit the so-called “Healthy Ohio” waiver. The governor vetoed it. The House overrode the veto (66-31). The Senate has not yet voted.

4. Premiums: The Healthy Ohio plan would charge premiums for people earning less than the poverty level. Governor Kasich has a slightly less harmful, but still ill-advised plan of his own. According to the Ohio Legislative Service Commission’s “Budget in Brief,” the governor wants to require childless, non-pregnant adults with income between 100 percent and 138 percent of the federal poverty guideline to pay a monthly premium of about \$20 beginning January 2018 (subject to the federal government’s approval). This is a smaller group than would be affected by Healthy Ohio, which would also charge premiums on Medicaid expansion enrollees with earnings below the federal poverty line.

For people on very limited incomes – like those on Medicaid – premiums decrease use of health care services. Low-income individuals are especially sensitive to increases in medical costs. Modest co-payments can reduce access to necessary medical care. The Rand Corporation’s Health Insurance Experiment, a long-term, experimental study of cost sharing, found that health care barriers like cost hurt the sickest and poorest patients.¹³ Here in Ohio, MetroHealth Hospital’s early experiment with Medicaid expansion found that access to care without cost enhanced health among the poor.¹⁴ A study in the Journal of Health Economics found that among those earning less than 150 percent of the federal poverty level, a monthly premium of up to \$10 causes 12 to 15 percent of enrollees to drop out within the first few months of coverage.¹⁵

If the Senate joins the House in override of the Healthy Ohio plan, the Kasich administration will probably put the work requirements and the Kasich plan for charging premiums into a new waiver proposal and seek approval from the federal government.

¹¹ *Id.*

¹² Ohio Department of Medicaid, Healthy Ohio Plan summary at <http://www.medicaid.ohio.gov/Portals/0/Resources/PublicNotices/HealthyOhioHSA/HealthyOhio-Summary.pdf>

¹³ 2 Robert H. Brook et.al., “The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate,” http://www.rand.org/pubs/research_briefs/RB9174.html

¹⁴ Randall D. Cebul, Thomas E. Love, Douglas Einstadter, Alice S. Petrusis and John R. Corlett, “MetroHealth Care Plus: Effects Of A Prepared Safety Net On Quality Of Care In A Medicaid Expansion Population,” *Health Affairs*, July 2015 vol. 34 no. 7 pp. 1121-1130 at <http://content.healthaffairs.org/content/34/7/1121.abstract>

¹⁵ Laura Dague, “The effect of Medicaid premiums on enrollment: A regression discontinuity approach,” *Journal of Health Economics* 37 (2014) 1-12.

Medicaid turf wars

5. Medicaid coverage of optional eligibility groups: The legislature included a measure in the budget bill that would give the General Assembly control over any new groups to be covered by Ohio's Medicaid program.

The federal government requires Medicaid cover certain low-income groups, including children and their parents, pregnant women, people with disabilities, and certain services, like long-term care for people age 65 and older. However, a state can choose to cover other groups. Ohio law lists a number of other or 'optional' groups that can be covered, including adopted children, foster care adolescents who live on their own, women in treatment for breast and cervical cancer and several others. The only optional group covered by Ohio's Medicaid program but not covered by Ohio law is low-income adults who gained coverage through the expansion.

The budget as passed by the legislature extends Ohio law include Medicaid expansion enrollees, but would eliminate the right of the executive (the Ohio Department of Medicaid) to expand eligibility to new groups.

The governor vetoed this provision. The House over-rode it (65-30). The Senate has not yet acted.

Ohio accepted federal funds to expand Medicaid to low-income workers under the Affordable Care Act (ACA) in 2013, and implemented Medicaid expansion in 2014, serving adults earning less than 138 percent of poverty, whether they had custody of children or not. The ACA as originally passed made the Medicaid expansion population a required, or "mandatory" group (it is important to note that the federal government pays for this group almost entirely). A subsequent Supreme Court decision made this group optional and Medicaid expansion, a state choice.

Under the leadership of Governor Kasich, Ohio, like 31 other states and the District of Columbia, took advantage of Medicaid expansion. To do so, the state had to appropriate billions of federal Medicaid dollars into the budget. Ohio's General Assembly did not uniformly support the expansion, so Governor Kasich accepted the federal funds through the authority of the Controlling Board, a seven-member committee primarily made up of legislators that can approve certain funding decisions in lieu of legislative action. Some legislators are still trying to close off this avenue through which action was taken - and could possibly be taken in the future.

6. Limits on Controlling Board authorization of federal funds: The General Assembly proposed restricting the state Controlling Board from approving unexpected revenue influxes of more than 0.5 percent of general revenue fund, or about \$165 million.¹⁶ This, too, related to contention over the governor's use of the Controlling Board to accept federal funds for the Medicaid expansion.

The Governor vetoed this provision. The House overrode the Governor's veto (66-31). The Senate has not acted yet. The veto should be allowed to stand.

¹⁶ Jim Segal, The Columbus Dispatch, Kasich says legislature has left budget \$1.4 billion short, July 6, 2018 at <http://www.dispatch.com/news/20170706/kasich-says-legislature-has-left-medicaid-14-billion-short>

This provision was yet another attack on the Medicaid expansion, reflecting historical rancor over how the governor obtained appropriation authority for federal matching funds for the Medicaid expansion through the Controlling Board. Some legislators viewed Kasich's strategy an end run around the General Assembly.

7. Controlling Board authorization of state match if Congress changes federal matching

rates: The 2016-17 state budget included state matching funds for the Medicaid expansion for first time¹⁷ and set up a special fund, the "Health and Human Services Fund," for this purpose. Funds were to be released by the Controlling Board. Legislators inserted this fund and approval process into the new budget, and went a step further, forbidding release of funds should the federal matching rate for the Medicaid expansion be changed.

The Governor vetoed part of this provision pertaining to the Controlling Board. The House overrode the veto (66-31). The Senate has not acted yet. The veto should not be overridden.

The Governor's veto did not disallow the continuation of the Health and Human Services Fund, but eliminated Controlling Board approval. This particular element, like other points of contention in this budget, reflect the historical battles over Medicaid expansion.

8. Legislative control of Medicaid rate structure: The General Assembly proposed to take control of payment rates to Medicaid providers, prohibiting the Ohio Department of Medicaid from raising rates without permission. This provision would give greater control over Medicaid spending to a legislature with many members who oppose Medicaid expansion.

The Governor vetoed the provision. The House overrode the veto (66-30).

Control over rates remains a flash point. The administration indicated that rates inserted in the final legislative language knock the budget out of balance. The governor's Office of Health Transformation claims: "As a result of legislative changes in the budget, the budget as passed was \$1.4 billion out of balance (\$432 million state share). Hospitals and health care providers face an immediate 6 percent rate cut."¹⁸

9. Legislative control of Medicaid rates for nursing facilities: The House introduced, and the Senate accepted, measures to change the formulas to set rates for nursing home. They also voted to change accountability and quality measurements.

The Governor largely vetoed these provisions. The House overrode the vetoes (96-1). The Senate has not yet acted.

The State Budget Director pointed out that the House veto override provides \$237 million more funding for nursing homes, and will further complicate the contested Medicaid budget.¹⁹

¹⁷ Under the ACA, the federal government required no state match until January 1 of 2017, when a 5 percent match was required for the first time (State match will rise to 10 percent by 2020 and stay there. By contrast, state match for most other Medicaid groups is about 37 percent of cost).

¹⁸ Governor's Office of Health Transformation, "Ohio Medicaid Appropriation," July 6, 2017 at <http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=JUeJSve1nio%3d&tabid=136>

¹⁹ Segal, Op.Cit.

Medicaid Services for vulnerable groups

10. Infant mortality: The legislature proposed boosting Medicaid payment rates for neonatal and newborn specialists. Ohio has high infant mortality rates; a boost in rates could encourage specialists to treat those with health coverage through Medicaid. But the measure was not funded. Money would have come out of cuts to other Medicaid provider rates.

The governor vetoed this provision. The House overrode it (96-0). The Senate has yet to act.

11. Long term services and supports for seniors: The executive budget proposed placing long-term services and supports (LTSS) — including home and community-based services and nursing facility care — under the oversight and coordination of the Medicaid managed care plans, which administer most Medicaid services in Ohio. Previously, home and community-based LTSS for individuals over 60 had been coordinated under the leadership of Ohio’s 12 Area Agencies, which coordinate Medicaid programs and services that allow people to age at home instead of in nursing homes. These programs are allowed through a waiver of Medicaid rules, and are simply referred to as “waivers.”

The legislature changed the governor’s provision on managed care and LTSS. The budget bill passed by the General Assembly prohibits the Department of Medicaid from expanding managed care to nursing facilities, family services and home and community based waiver services and requires a separate General Assembly vote to authorize such a move.

The legislature also created the “Patient centered Medicaid managed care long term services and supports study committee.” In December of 2018, the committee will report on ways to ensure good outcomes for LTSS under managed care. The report will identify performance and quality measures, strategies for improving consumer education and choice, models that improve health, ways to ensure coordination, prompt pay and care authorization, key data to be reported by providers, data sharing models and managed care organization contract policies. The committee will also specify an ongoing role for the Area Agencies on Aging.

The governor vetoed the delay and the vote, but left the study committee and its task in place. The House overrode the veto (95-2). The Senate has not yet acted.

12. Mental health beds: Medicaid law prohibited the use of federal Medicaid dollars to pay for behavioral health care of most patients in hospitals or similar treatment facilities (“institutions for mental diseases”) with more than 16 mental health beds. Due to the drug epidemic, Ohio has a shortage of treatment beds.²⁰ The budget addressed the problem in several ways, including directing the administration to seek a waiver of this law. However, effective this month (July 1, 2017), Ohio acted to implement a federal regulation change that permits Medicaid managed care plans to pay for inpatient psychiatric services in institutions for mental diseases regardless of size.

The governor vetoed this provision because of the change in requirements. The House did not override it, so the Senate cannot act on it.

The average length of stay for inpatient psychiatric treatment is far below the 15 days now

²⁰ Budget Bite: Mental Health and Addiction Services, Policy Matters Ohio, March 30, 2017 at <https://www.policymattersohio.org/research-policy/quality-ohio/revenue-budget/budget-policy/budget-bite-mental-health-and-addiction-services>

permitted under federal Medicaid regulation. This includes Medicaid payments for stays in the psychiatric state hospitals. So in essence, Medicaid has already acted on this. That's why the Governor vetoed it and the House didn't act.

13: Mental health services and behavioral health redesign: The state is updating diagnosis coding and preparing to turn coordination, administration and billing for behavioral health services over to Medicaid managed care plans. The governor's budget would have required providers to start using the updated codes as of July 1, 2017. Managed care would start administering oversight and billing as of January 1, 2018.

The House feared this timeline was too fast and inserted a provision that delayed the inclusion of alcohol, drug addiction and mental health services from managed care before July 1, 2018. Implementation of the new coding system was put off to January 1, 2018.

The governor vetoed the provision delaying the movement of alcohol, drug addiction and mental health services into managed care as of July 1, 2018. The House overrode it (95-2). The Senate has not yet acted.

The Governor's veto only applied to the delay (to July 1, 2018) for managed care plan administration. It did not apply to the delay in coding, to January 1, 2018. If the Governor's veto stands, both the change in coding of claims and the move of behavioral health services to managed care would occur on January 1, 2018 (It becomes a one-step process).

If the Senate concurs with the House and the governor's veto is overridden, the two-step process is preserved: the coding protocol goes into effect January 1 and behavioral health services become part of the managed care system on July 1, 2018.

Medicaid-related issues

14. Managed Care Organization tax: The budget takes one of the state's four provider taxes, the managed care organization tax, out of the sales tax base and places it into the base of the health insuring corporation tax. With that change, the funds are moved out of the General Revenue Fund and accounted for as a dedicated purpose fund. It's a mechanical switch, but it makes Medicaid in the GRF look like it declines sharply in this budget.

There is debate over loss of local governments that piggyback sales taxes on the state base. During conference committee, the legislature put in a provision that directs state government to go back to the federal government and to reverse the tax cut in this fund and restore the rate on the restructured tax so as to replace the revenues counties and transit agencies lost.

The governor vetoed the measure that would have restored funding to counties and transit agencies through this tax. The House overrode the veto (87-10). The Senate has yet to act.

When the federal government told Ohio to bring the Medicaid Managed Care provider tax (MCO tax) into compliance by broadening its base, the state did, but also cut the tax, and left local governments and transit agencies out of the fix.

Ohio uses health care provider taxes like the MCO tax to finance Medicaid, but it also funds other programs through the state General Revenue Fund. The MCO tax also funded local government and transit agencies that piggybacked a local sales tax on the state base. With the transfer to the insurance tax, counties and transit agencies lost more than \$200 million a year, collectively.

The 2018-2019 state budget has a short-term "transition fund" to help with adjustment but for most affected counties and transit authorities, the revenue stream vanishes by 2019. This loss follows years of cuts to counties through the Local Government Fund and compounds Ohio's chronic underfunding of public transit.

Legislators proposed restoring the MHIC to its former level for six years. Analysis based on data provided by the Kasich administration shows their proposal meets the requirements of federal rules.

15. The "1332" waiver of Affordable Care Act laws on insurance: The Senate added a provision in the 2016-17 budget that required the Kasich administration to apply for a "State Innovation Waiver" allowed under Section 1332 of the ACA. The waiver would be for a state-developed system that provided better access to affordable health coverage without the employer and individual mandates required by the ACA.²¹

The Ohio Department of Insurance just recently started on this project.²² The new budget bill also includes the requirement. This provision was not vetoed.

²¹ Tara Britton and John Honeck, "Taking Stock of Medicaid Changes in the Final 2016-2017 State Budget," Center for Community Solutions, July 16, 2015 at http://www.communitysolutions.com/assets/docs/State_Budgeting_Matters/2015/sbmv11n10_taking%20stock%20of%20medicaid%20changes%2007152015.pdf

²² Jillian Froment, Director of the Ohio Department of Insurance, sent a June 1, 2017 letter to Seema Verma, Administrator of the Centers for Medicare and Medicaid Services, urging her to loosen guidance governing 1332 waiver applications. A web page has been set up on the waiver (<http://insurance.ohio.gov/Consumer/Pages/Waiver.aspx>)

Summary and conclusion

The ACA and its expansion of Medicaid have had a profoundly positive impact on Ohio, providing dependable health coverage to 723,000 people who were mostly not covered before they enrolled; boosting the rate of insured Ohioans to over 94 percent, among the best in the nation; providing the foundation for the fight to stem the drug epidemic; helping people to become healthy and productive, and creating jobs, particularly in rural counties.²³

Millions of Ohioans can breathe a sigh of relief because as of August 1, 2017, Congress failed to eliminate the ACA and Medicaid has not – yet – been dismantled. Hundreds of thousands can rest easier knowing that the Ohio House of Representatives did not – yet – freeze the Medicaid expansion for Ohioans. But plenty of danger remains in the unresolved Ohio budget. The ball is in the Senate’s court.

Ohio’s legislators should not override vetoes of items that are harmful. The House should not revisit an override of the governor’s veto of the Medicaid freeze. The Senate should not override the governor’s veto of the failed “Healthy Ohio” plan. The Senate should not override the governor’s veto of Controlling Board oversight of state funds for Medicaid expansion. Nor should they join the House in an override of the veto of limits on funds the Controlling Board can accept.

The Senate should join the House in overriding the veto of a provision to reverse the cuts to counties and transit agencies with a change to one of the state’s four provider taxes. This tax, formerly known as the Managed Care Organization” (MCO) tax and now known as the “Managed Care Health Insuring Corporation” (MHIC) tax, was taken out of the sales tax base and placed in the health insuring corporation tax base. With that change, counties and transit agencies that had a local tax levied on the state sales tax base lost a revenue stream of more than \$200 million a year, collectively, starting in 2019. Legislators directed the Kasich Administration to explore ways of restoring the provider tax to its former size and hold counties and transit agencies harmless. The governor’s veto should be overridden.

It is clear that the governor is dedicated to moving as much of the Medicaid program as possible into managed care. While not all components of Medicaid waiver programs fall under that the managed care umbrella – most notably, developmental disability waivers – the governor has signaled his commitment to the managed care model in vetoing legislative provisions related to expansion of managed care, and the House has signaled its determination to have authority by overriding vetoes.

Perhaps the Congressional retreat from a restructuring of the ACA and Medicaid will restore some certainty to the state budgeting process and allow resolution of loose ends. It is time for lawmakers and the governor to finalize the budget and move forward with policies that help Ohioans live better lives.

²³ Kate Sopko, Ohio’s Growing Health Care Sector, Policy Matters Ohio, June 2017 at <https://www.policymattersohio.org/files/research/growinghealthcaresector-sopko-may2017.pdf>

Acknowledgements

This work was made possible in part by:

Center on Budget and Policy Priorities

The Gund Foundation

The Ford Foundation