Issue Brief

Looking for a New Direction:
Ohio Medicaid at a Crossroads

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The Center for Health Affairs is the leading advocate for Northeast Ohio hospitals, serving those organizations and others through a variety of advocacy and business management services. The Center also works to inform the public about issues that affect the delivery of healthcare. Formed by a visionary group of hospital leaders 94 years ago, The Center continues to operate on the principle that by working together hospitals can ensure the availability and accessibility of healthcare services. For more on The Center and to download additional copies of this brief, go to www.chanet.org.

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State policymakers across the country — and Ohio is no exception — are finding themselves facing the unenviable task of getting and keeping their state budgets out of the weeds at a time when, thanks to the recession, growing demands have been heaped upon them. Within the next couple of months, the governor of Ohio and the state General Assembly will be making some tough choices aimed at creating a balanced budget. And Medicaid is square in the crosshairs. But policymakers must bear in mind that their current actions have reactions and they must ensure future budgets don’t suffer the consequences of policy decisions being made presently.

Today, nearly 15 percent of Ohio’s population relies on Medicaid for healthcare coverage. For these 1.7 million Ohioans, Medicaid is an invaluable safety net, providing access to necessary services in a healthcare system that can otherwise present significant financial obstacles for those living at or near the poverty level. Medicaid also provides long-term care coverage for people with disabilities and the low-income elderly. And while there is no denying how important Medicaid is to the vulnerable populations it serves, it is also consuming a growing portion of the state and federal budget. As a result, there has been growing uncertainty about what the future will hold for Ohio’s Medicaid program.

The current environment makes the situation all the more troubling. In the last few years Ohio’s unemployment rate has soared, leaving more and more individuals without the employer-sponsored health insurance that often accompanies full-
time employment. Many of these individuals have turned to Medicaid, causing enrollment to spike. By June of 2009, shortly after the recession began, Ohio’s Medicaid rolls had increased 9 percent over the previous year — and it doesn’t take an economist to realize that growing Medicaid rolls equate to growing cost.\footnote{At the same time, the state is grappling with how to fill an alarming $8 billion budget hole projected for the next two years.}

Considering these factors, the trick for policymakers is ensuring that the safety net is not disrupted for those who really need it while at the same time preventing the state from continuing along an unsustainable financial course. What’s more, many other factors play into Medicaid policy decisions, making the work of policymakers all the more challenging. The way in which Medicaid is funded is one such factor. Because the Medicaid funding stream includes a federal match, cuts to Medicaid, which may seem on the surface like a logical method for trimming the state budget, may actually end up hurting the state as it loses the federal match that would have been attached to those dollars.

At the same time, both the American Reinvestment and Recovery Act and the Affordable Care Act included provisions precluding states from reducing their Medicaid eligibility requirements. These provisions are important because they ensure that vulnerable populations have access to the healthcare they need; however, they also remove a lever that states have used in the past to reduce their Medicaid costs.

Needless to say, striking the right Medicaid balance will be a challenge for policymakers and is likely to be a major part of policy discussions for many years to come. Just where Medicaid stands under new legislative mandates and in the midst of the state’s economic turmoil is uncertain but understanding the many factors that play into Medicaid policy decisions can be useful in appreciating the policy changes that are surely down the road. This issue brief aims to highlight some of these factors and to provide a roadmap for understanding the rocky Medicaid terrain on which the state now finds itself.

How Does Medicaid Work?

Established in 1965, Medicaid provides insurance to eligible low-income and medically vulnerable people and is administered at the state level under broad federal regulations. That means that Medicaid programs differ from state to state, though all state programs are based on the same federal framework. Taking some time to understand the basics of the Ohio Medicaid program, how it works and who it serves, is a good starting point for understanding what the future may hold for this program.
Who is Covered?

In Ohio, Medicaid is administered by the Ohio Department of Job and Family Services (ODJFS) and includes a number of different programs. Healthy Start covers children up to age 19 and pregnant women. Healthy Families covers parents or guardians of children who are 19 or younger. Together, Healthy Start and Healthy Families comprise what is known as the Covered Families and Children (CFC) program. To qualify for Medicaid Healthy Start and Healthy Families, a recipient must be an American citizen, live in Ohio and meet certain income guidelines, generally defined as a percentage of federal poverty level (FPL).

### Healthy Start & Healthy Families

<table>
<thead>
<tr>
<th>Who is Covered?</th>
<th>Income Eligibility Guidelines</th>
<th>Gross Monthly Income</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Family Size</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Children (up to 19)</td>
<td>200% FPL</td>
<td>$1,805</td>
</tr>
<tr>
<td>Pregnant Women</td>
<td>200% FPL</td>
<td>$1,805</td>
</tr>
<tr>
<td>Families</td>
<td>90 % FPL</td>
<td>$813</td>
</tr>
</tbody>
</table>

Source: Ohio Department of Job & Family Services, Ohio Medicaid Eligibility Guidelines.

In addition to children and families, Medicaid also provides coverage for older adults and people with disabilities, also known as the Aged, Blind and Disabled (ABD) population. The ABD program covers people who are age 65 or older, those who are legally blind, and those with disabilities. To qualify for Medicaid, the ABD recipient must be an American citizen, live in Ohio and meet income eligibility requirements.
**Older Adults and People with Disabilities**

<table>
<thead>
<tr>
<th>Who is Covered?</th>
<th>Income Eligibility Guidelines</th>
<th>Income</th>
<th>Resources*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older Adults (age 65 or older) &amp; Disabled People (of any age)</td>
<td>64% FPL</td>
<td>$589</td>
<td>$1,500</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$1,011</td>
<td>$2,250</td>
</tr>
</tbody>
</table>

*Resources refer to certain assets such as cash, stocks, bonds, house, real property, life insurance, policies, annuities and trusts.*

Source: Ohio Department of Job & Family Services, Ohio Medicaid Eligibility Guidelines.

Ohio’s Medicaid program also includes a supplement to Medicare for low-income elderly through its Medicare Premium Assistance Program (MPAP). For people with disabilities who are able to work, Medicaid in Ohio is available as a buy-in program for those with incomes up to 250 percent of the poverty level.4

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**State Children’s Health Insurance Program (SCHIP)**

The State Children’s Health Insurance Program, or SCHIP, is a federal program created in 1997 to expand insurance coverage for children who did not qualify for traditional Medicaid. States were permitted flexibility to design their SCHIP programs as stand-alone programs separate from Medicaid, use SCHIP funds to expand existing Medicaid, or combine both approaches. SCHIP, and the federal matching funds that accompany it, have encouraged states to expand coverage. Though Medicaid is only required to cover children at or below 133 percent of poverty, all but four states cover children to at least 200 percent of the federal poverty level. Half of states cover children to 250 percent of the federal poverty rate.6 Ohio covers children at or below 200 percent of the federal poverty level.

In 2010, Ohio joined the Connecting Kids to Coverage Challenge, a national forum for sharing effective strategies used by states to increase the number of eligible children enrolled in Medicaid and SCHIP. Ohio approached this challenge by simplifying the enrollment process. Specifically, Ohio instituted presumptive eligibility and 12-month continuous eligibility.7 Presumptive eligibility is a simplified means of obtaining Medicaid coverage for children that does not require a face-to-face meeting. To become “presumptively eligible” for Medicaid coverage, a child’s parent must self declare that the child is under 19, a resident of Ohio, a U.S. citizen with a gross family income of no more than 200 percent of the federal poverty level. Continuous eligibility assumes that, once qualified, children will remain eligible for Medicaid for at least a year, and as such, do not need to continue to reapply during that one year.8 As a result of its efforts, Ohio was awarded a $12 million bonus by the federal government in 2010.9

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Each month, Medicaid covers around 992,000 children, 340,000 parents, 108,000 seniors and 259,000 people with disabilities.5
What are Mandatory and Optional Services?

The broad federal regulations that govern the Medicaid program mandate that states provide certain services. States can also choose to offer additional optional services. There are some limits for some services such as number of visits per year, the setting in which they can be provided and cost-sharing arrangements.30

<table>
<thead>
<tr>
<th>Federally Mandated Services</th>
<th>Ohio’s Optional Services</th>
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</thead>
<tbody>
<tr>
<td>Early &amp; periodic screening, diagnosis, and treatment for children</td>
<td>Prescription drugs</td>
</tr>
<tr>
<td>Inpatient hospital</td>
<td>Vision, including eyeglasses</td>
</tr>
<tr>
<td>Physician</td>
<td>Dental</td>
</tr>
<tr>
<td>Lab and x-ray</td>
<td>Physical therapy</td>
</tr>
<tr>
<td>Outpatient, including services provided by hospitals, rural health clinics, and Federally Qualified Health Centers</td>
<td>Occupational therapy</td>
</tr>
<tr>
<td>Medical and surgical vision</td>
<td>Speech therapy</td>
</tr>
<tr>
<td>Medical and surgical dental</td>
<td>Podiatry</td>
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<tr>
<td>Transportation to Medicaid services</td>
<td>Ambulance/ambulette</td>
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<tr>
<td>Nurse midwife, certified family nurse practitioner, and certified pediatric nurse practitioner</td>
<td>Home- and community-based alternatives to facility-based care</td>
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<tr>
<td>Family planning services and supplies</td>
<td>Community alcohol and drug addiction treatment</td>
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<tr>
<td>Home health</td>
<td>Intermediate care facilities for people with developmental disabilities</td>
</tr>
<tr>
<td>Nursing Facility</td>
<td>Hospice</td>
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<tr>
<td>Medicare premium assistance</td>
<td>Community mental health services</td>
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<td></td>
<td>Chiropractic services for children</td>
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<tr>
<td></td>
<td>Durable medical equipment and supplies</td>
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<td></td>
<td>Independent psychological services for children</td>
</tr>
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<td></td>
<td>Private duty nursing</td>
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Source: Health Policy Institute of Ohio, Ohio Medicaid Basics 2009.
How is Medicaid Funded?

Medicaid, which is funded jointly through the state and federal governments, spends $13 billion and accounts for 3 percent of the Ohio economy annually. Medicaid accounts for 28 percent of hospital and 47 percent of all nursing home spending in the state.11

The Federal Portion

The federally funded portion is a percentage referred to as the Federal Medical Assistant Percentage (FMAP), which is calculated by the U.S. Department of Health and Human Services. Each state has its own FMAP based on a three-year average of per capita personal income in comparison to the national average.12 The FMAP reflects the portion of Medicaid costs that the federal government will cover and is often referred to as the federal “match.” States are responsible for covering the remaining Medicaid costs.

Across the United States the federal match can range from 50 percent to 83 percent.13 In federal fiscal year (FY) 2009, which runs from October 1, 2008 to September 30, 2009, Ohio’s FMAP was 62.14 percent, close to what it had been for a number of years before that. Essentially, what that means is that for every $1.00 that Ohio spends on Medicaid, the federal government will reimburse the state 62.14 cents.

Though the federal match is adjusted every year, passage of the American Recovery and Reinvestment Act in 2009 brought about significant, temporary changes. As part of an attempt to stabilize a floundering economy, Congress included a significant increase in the Medicaid FMAP as part of the economic stimulus package. This enhanced FMAP, known as e-FMAP, increased the FY 2009 federal match in Ohio to 73.50 percent. Legislation authorizing an extension of e-FMAP until June 30, 2011, passed in August 2010. As a result, Ohio’s e-FMAP for FY 2011 is 74.58. In June 2011, enhanced FMAP will end and Ohio’s federal match will drop to 63.69 percent.14

The State Portion

Ohio funds its portion of Medicaid through several sources, including federal funds, state-generated general revenue funds (GRF), local levy dollars, pharmacy rebates and healthcare provider taxes. Over the last several years, provider taxes, known as franchise fees, have been assessed on hospitals, nursing facilities and managed care organizations to cover some of the state’s portion of the Medicaid budget.15 These fees are then matched with federal funds to bring additional dollars into the state’s Medicaid program.
Medicaid: the Providers’ Perspective

Underpayment

When a Medicaid beneficiary receives healthcare services from a hospital or other healthcare provider, the cost of providing those services is reimbursed by Medicaid. And while the reimbursement received from Medicaid is crucial to hospitals and the patients they serve, it also notoriously underpays providers for their services. In fact, in aggregate, Medicaid and Medicare payments to hospitals are actually less than the cost of care and have been for years. From 2000 to 2009, aggregate underpayment rose from $3.8 billion to $36 billion.17

Disproportionate Share Hospitals

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.20 Recognizing that safety net hospitals often provide services for which they are not reimbursed and that Medicaid, which has historically low reimbursement rates, is often a major payer, Congress authorized additional Medicaid funding to assist states in financing these hospitals. This funding, aimed at alleviating the financial pressure on hospitals that serve a disproportionate share of those in poverty, is aptly termed the Medicaid Disproportionate Share Hospital program. Ohio’s DSH program is called the Hospital Care Assurance Program, or HCAP.
Like the traditional Medicaid program, Medicaid DSH funding is also split by the state and federal governments. Ohio secures its portion of DSH funding by assessing an HCAP fee on all of its hospitals. This money is then pooled with its match from the federal government and redistributed to hospitals based on a formula determined by the Ohio Hospital Association under the oversight of the Ohio Department of Job and Family Services. While a valuable source of funding to hospitals, it must be remembered that HCAP does not fully cover the costs of charity care. In Northeast Ohio, even after receiving funds through HCAP, hospitals still provide an additional $200 million in charity care, care for which they receive no compensation.

Medicaid: the State’s Perspective

Though there’s no denying the value of Medicaid to the vulnerable populations it serves, this safety net does not come without a cost. Medicaid is a very expensive program, often the largest program in a state’s budget. And not only is Medicaid expensive, in most states, its cost is growing at an unsustainable rate, threatening to crowd out other essential state-funded services. Making this situation even more troubling is that in the wake of the recent recession, many states are facing budget holes that leave them few options for funding state programs without instituting serious cuts.

Unfortunately, this is just the situation that Ohio Governor John Kasich and the state General Assembly are currently facing. Medicaid is the largest item in the state budget, accounting for 26 percent of total state spending. Medicaid spending over the last ten years has grown more than 8 percent each year, two times the rate of growth for the entire state budget. Left unchanged, taxpayers will need to pay an additional $1.6 billion in 2011 to fund the Medicaid program, perhaps at the cost of other state-funded programs such as education. Add to this Ohio’s estimated $8 billion budget hole for the next two-year budget and it’s clear that something must be done to curb Medicaid costs.
In an effort to address Medicaid cost concerns, one of Kasich’s first moves as governor was to reveal plans to overhaul Ohio’s Medicaid program. He began by signing an executive order on January 13, 2011, creating the Governor’s Office of Health Transformation, with the stated intention to “carry out the immediate need to address Medicaid spending issues, plan for the long-term efficient administration of the Ohio Medicaid program, and act to improve overall health system performance in Ohio.”

Greg Moody, a longtime healthcare consultant, was appointed by Kasich to head this office that will now oversee six state agencies including Medicaid, Developmental Disabilities, Mental Health, Alcohol and Drug Addiction Services, Aging and Health. Now, rather than splitting Medicaid policy, spending and administration issues among agencies, as had been the case in the past, the Office of Health Transformation will serve as the ultimate point of accountability for the entire Medicaid program. Governor Kasich, clearly committed to reining in Medicaid spending, created the Office of Health Transformation to serve as his main vehicle for accomplishing this goal.

Commentary from Bill Ryan, President & CEO, The Center for Health Affairs

Those in health policy circles often debate the reasons behind the growth in Medicaid spending. And while there are certainly dozens of factors playing into this equation, the political pressure to expand Medicaid eligibility to ever-increasing constituency groups cannot be minimized. This pressure exists for several reasons. First, commercial insurance, with its lifetime caps and refusal to fully cover certain vital services is not held truly accountable for covering certain populations, such as those with mental illness, disabilities or those in need of care in a nursing facility.

As a result, these individuals, whose healthcare costs are undeniably expensive, are pushed out of the private market. Second, the federal government, which could reasonably be expected to cover at least a portion of this population under the Medicare program, also chooses not to do so. With no where left to go, advocates push policymakers to include these various constituencies under the Medicaid umbrella.

Some advocates argue that it is the job of policymakers to decide what the Medicaid program truly should be. Is it a healthcare program for those living in poverty or is it a political construction aimed at correcting market failure in the private insurance market? While the answer to this question is still up in the air, one thing is certain: commercial insurance market failure coupled with the federal government’s reliance on the state to care for high-cost individuals is putting states – who must work under a balanced budget – in a nearly impossible situation.
Strategies for Stemming Medicaid Spending

Traditionally, there are essentially three “levers” for accomplishing cuts in Medicaid spending: cutting enrollment, cutting services and cutting provider payments. Though each of these strategies seems straightforward, they are each more complicated than they initially appear.

Lever One: Cut Enrollment

Perhaps the first strategy to come to mind when conversation turns to cutting Medicaid costs is tightening up eligibility requirements to reduce enrollment. After all, if a person does not qualify for Medicaid, the state doesn’t have to pay for his or her healthcare. It seems to be a straightforward matter of basic math: fewer people to pay for means the state spends less money. But there are a number of reasons why this lever is not a realistic strategy in Ohio.

First, cutting enrollment may reduce the Medicaid rolls but it doesn’t erase the healthcare needs of those who are no longer eligible. For these people, paying for healthcare out of pocket is generally a financial burden that is difficult or even impossible to overcome. Without the resources to get the care they need, these individuals may wait to seek care until their healthcare needs have escalated, turning to the emergency room with much more expensive healthcare problems than would have been seen had they had access to primary care.

Another reason that this strategy may not be as effective as it initially appears is that the population it generally targets, children and parents in the Covered Families and Children program, have the least expensive healthcare needs. Children and parents, who represent 78 percent of enrollees, account for only 30 percent of Medicaid expenditures in Ohio. Conversely, elderly and disabled individuals only account for 22 percent of the population and yet represent 70 percent of total Medicaid expenditures in the state.26 As a result, cutting enrollment in the CFC population may have only a minimal impact on overall Medicaid spending.

Governor Kasich, along with 32 other Republican governors, pursued this cost-savings approach by asking the Obama administration to allow them to cut enrollment without losing the federal match, as is stipulated in the Accountable Care Act. The administration denied this request and instead offered alternatives to help states reduce Medicaid spending such as cutting optional services and increasing the use of managed care.

![Medicaid Enrollment & Expenditures, 2008](image)

*Source: Health Policy Institute of Ohio, Ohio Medicaid Basics 2009.*
But even beyond these drawbacks, cutting enrollment is not realistic because of new federal laws that impose drastic financial penalties for doing so. The American Recovery and Reinvestment Act (ARRA) authorized an enhanced FMAP for states; however, in order to receive this increase in the federal match, states had to maintain their Medicaid eligibility rules and enrollment procedures in place as of July 1, 2008. The Affordable Care Act (ACA) extended and strengthened this maintenance-of-effort requirement. Under this provision, states have to maintain their eligibility rules and enrollment procedure in place as of March 23, 2010, in order to receive any federal funding for their Medicaid programs.\textsuperscript{27}

In addition to the maintenance-of-effort requirements spelled out in the ACA, one of the primary objectives of the law was to expand health coverage to a significant portion of uninsured Americans. To ensure health coverage is accessible to those with low incomes, the ACA expands Medicaid eligibility to 133 percent of the federal poverty level. It also expands eligibility to a population that has traditionally not been eligible for Medicaid at all: childless adults. As a result of these changes to Medicaid, the program is expected to cover an additional 16 million Americans by 2019.\textsuperscript{29} Though these requirements do not take effect until 2014, it’s clear that cutting enrollment now only to increase it within a few years is not the most efficient approach.

**Lever Two: Cut Services**

Like cutting enrollment, cutting services seems on the surface to be a matter of basic math: reducing the number of services covered means reducing the amount of money spent on healthcare services altogether. Yet, this strategy is also not so straightforward.

First, certain services must be maintained because they are part of the mandatory service set defined by the federal government. Of course, states can still cut optional services; however, cutting services does not make the healthcare needs associated with them simply disappear. Individuals that need dental services, for example, still need dental services when they are not a part of the Medicaid service offerings. When dental services are not included, a dental problem that may have been handled appropriately in a dentist’s office eventually escalates to an emergency. Clearly, the emergency room is not the ideal setting for such care and is much more expensive than what would have been needed had there been coverage for dental care. One study determined the cost to manage symptoms related to dental caries on an inpatient basis is about 10 times that of providing care to these patients in a dentist’s office.\textsuperscript{30} Dental care is a good example but the same is true of other optional services. Providing care in the most appropriate setting such as a primary care office or dental office is more efficient and costs less than waiting to treat problems until they are emergencies.

Similarly, many optional Medicaid services help patients maintain their health status and avoid the need for any additional healthcare. In other words, optional services can actually help to lower costs. Prescription drugs are a good example. Someone with a health condition that requires regular prescriptions,
such as someone with diabetes, may have no additional healthcare concerns if they manage their disease well and have access to medication. However, without access to their prescription drugs, someone with diabetes can develop an array of serious (and expensive) health problems. Then, the cost savings accrued from not paying for the drugs are lost (many times over) in treating the covered services required as a result of the complications.

**Lever Three: Cut Provider Payments**

The third strategy for reducing Medicaid spending, cutting payments to providers, like the first two strategies, is not as simplistic as it may initially seem. Paying less for services may indeed lead to lower overall spending; however, as with other options, cutting provider payments may have other negative unintended consequences.

As mentioned above, Medicaid already significantly underpays providers for their services. Though hospitals and providers do all they can to absorb these losses by increasing efficiency and reducing costs, the Medicaid (and Medicare) underpayment gap — also known as Medicare or Medicaid shortfall — is often simply too large to overcome with operational efficiencies. As a result, hospitals are often forced to rely on the private insurance market to make up these reimbursement losses. Cost shifting, as this practice is known, is defined as “systematically higher prices (above cost) paid by one payer group to offset lower prices (below cost) paid by another,” and has been an effective strategy for making up Medicaid reimbursement losses for hospitals. And while this strategy has allowed hospitals and other providers to manage in a difficult reimbursement environment, it should not be seen as a long-term solution.

Raising reimbursement rates for the private insurance market can drive up costs, pricing some employers and individuals out of the private insurance market altogether. As a result, the number of people without private insurance rises, increasing the number of people who must rely on Medicaid and those without any health coverage. An increase in the proportion of Medicaid patients means an increasing proportion of Medicaid reimbursement (which historically provides low reimbursement rates) for hospitals. An increase in the number of uninsured patients generally means an increase in uncompensated care. To address the reimbursement gap that results, hospitals turn again to the private insurance market to make up the difference. The private insurance market reacts to these changes by raising rates, and the cycle begins again.
Clearly, the cost shifting that occurs as a result of Medicare and Medicaid shortfall is only likely to get worse if the state cuts provider payments. With the cost of private insurance rising ever higher as a result, and more and more people joining the Medicaid rolls or those without insurance, it’s clear that cutting provider payments does not ultimately save Medicaid costs and actually contributes to the unintended consequence of driving up the cost of private insurance.

In addition to cost shifting, cutting provider payments can lead to other unfortunate consequences. Unable to absorb the losses from Medicaid underpayment, some providers simply choose not to accept Medicaid patients. While all Northeast Ohio hospitals accept Medicaid and have charity care policies in place to ensure that those with low incomes have access to the care they need, this is not the case with all providers. As a result, cutting provider payments can make it harder for Medicaid beneficiaries to find providers that accept Medicaid, a situation that can compromise enrollees’ access to care.

What are Ohio Hospitals Doing?

Unfortunately, Medicaid spending is so high and the hole in the state budget is so large no one strategy will be sufficient to solve the state’s funding problem. Recognizing the daunting task faced by the state, hospitals have not been sitting on the sidelines during state budget discussions. In fact, through the Ohio Hospital Association, Ohio’s hospitals have proposed a variety of cost saving measures and initiatives that could serve to make a significant improvement in the state’s current fiscal situation.

Franchise Fee Model

Through the franchise fee, hospitals raised an additional $580 million for the state over the last two years. Now, after a year of analysis, Ohio’s hospitals have proposed a redesigned franchise fee that would garner even more dollars for the state if included in the budget. This proposal would extend the franchise fee—which is slated to sunset — for an additional two years and would require an increased assessment on hospitals. The new franchise fee structure would yield $925 million for the state share, with $434 million specifically designated to support the Medicaid program and the remaining $491 million to make payments back to hospitals. Overall, the new franchise fee model, including the federal match, would yield an additional $1.2 billion for the state.
Quality Initiatives

Quality initiatives are another avenue that Ohio hospitals have pursued in an effort to ease the state’s Medicaid burden by improving care and reducing costs. Improving quality not only means patients are getting better care and experiencing better outcomes but also that additional costs associated with poor outcomes are avoided.

Preventable hospital-acquired infections are only one type of quality concern and yet they provide a salient example of the interplay of cost and quality. Each year, the U.S. spends $30 billion treating these infections, which could have been avoided altogether with the right interventions including diligent hand hygiene. Many Ohio hospitals are working as part of a collaborative effort to reduce certain hospital-acquired infections such as Clostridium Difficile (C. Diff), Methicillin-resistant Staphylococcus aureus (MRSA), and Central Line Associated Blood Stream Infection (CLABSI). This initiative alone is expected to save the state almost $30 million over the biennium.

As significant as the work on preventable infections is, it is only one of many collaborative quality initiatives poised to yield significant cost savings for the state. Other initiatives focus on a variety of quality areas such as reducing heart attack mortality, improving the process and outcomes related to pneumonia care, and reducing hospital readmissions.

Support for Fraud and Abuse Prevention

In addition to quality initiatives, Ohio hospitals are offering their support for initiatives that rein in cost by targeting fraud and abuse in the Medicaid program. Though the exact amount of spending on Medicaid fraud and abuse in the United States is unknown, “improper payments” — a broad government category reflecting everything from outright fraud to misdirected funds resulting from illegible handwriting — totaled $98 billion in 2009 in the Medicare and Medicaid programs. Ohio’s participation in Medicaid and fraud and abuse prevention activities could save the state as much as $160 million annually.
Rebalancing Long-Term Care

Another important strategy that stands to make a significant cost impact for the state is rebalancing long-term care. Providing care in a nursing facility for those who could be served in a less restrictive setting, such as at home or in an assisted living facility, is an inefficient use of the state’s resources. Nursing home stays generally cost at least $3,500 per month while non-institutional long-term care costs under $1,500 per month. To be sure, some of this cost disparity is due to differences in the level of need in each of these settings. In other words, the higher cost in residential nursing facilities is due to the fact that many of the residents there have higher needs. Yet, in truth, acuity only accounts for some of this cost differential. Experts estimate that between 5 and 12 percent of long-stay residents could be classified as having “low care” needs.

Progress in rebalancing Ohio’s long-term care services has been slower than other states. As it stands, Ohio spends a higher percentage of its Medicaid budget on institutional long-term care than all but eight states; however, continuing efforts on the part of the state have resulted in a recent shift. Today, there are more individuals receiving long-term care services in their home and community settings than in institutional settings. A concentrated effort to continue the progress that has been made could save the state between $25,000 and $50,000 for each beneficiary it moves out of nursing homes into home and community-based services.

Conclusion

The economic downturn and the state budget woes it has created across the United States have made it necessary for states to come up with strategies to plug the holes. With Medicaid already consuming the largest portion of most state budgets and growing every year, it is natural that it would be at the top of the list of programs targeted for cost containment. In Ohio, with its $8 billion budget gap, this is certainly the case.

Yet as important as it is for the state to trim costs, it is also imperative that the safety net that protects our state’s most vulnerable citizens be maintained. As policymakers consider how to make the Medicaid program more sustainable, it is important to realize that drastic cuts in any area may lead to additional negative unintended consequences – and unintended costs – down the line. Recognizing the challenge of the current budget environment, hospitals have done all they can to ease the state’s burden, submitting dozens of hospital-related cost containment strategies to the Office of Health Transformation. Though these strategies are important, the success of Medicaid policy changes ultimately rests with lawmakers’ ability to balance the need for spending cuts with the need to provide care for the low income and medically vulnerable.
Suggestions for Stakeholders

As the state budget process unfolds, stakeholders must be attentive to the policy changes that may be down the road for Ohio’s Medicaid program. The governor’s newly created Office of Health Transformation is a clear sign that the state is committed to cutting rising Medicaid expenditures. With these changes underway, it is essential that stakeholders stay involved in advocating for policy changes that not only cut costs but also improve quality and preserve the safety net.

• Urge policymakers to include the redesigned franchise fee in the state’s two-year budget.
• Participate in or support initiatives that improve hospital quality of care.
• Point out potential unintended consequences of cuts to enrollment, services and provider payments in discussions with policymakers.
• Support the state’s efforts to rebalance long-term care.
• Begin to ask questions of federal lawmakers about Medicaid funding for elderly and disabled recipients: Does it really makes sense for states to fund this expensive and growing population? Does the federal match even cover the cost of care for these enrollees? Is the financial burden of caring for this population straining states to the point that they must sacrifice funding for other essential programs such as education to pay for it? Would it make more sense to fund the entire elderly and disabled population through Medicare?
Endnotes

3. Ibid.
4. Ibid.
11. Ibid.
12. Ibid.
14. Ibid.
18. Ibid.


33. Rick Frank (Director, Policy and Advocacy, Ohio Hospital Association), in discussion with the author, February 2011.


35. Rick Frank (Director, Policy and Advocacy, Ohio Hospital Association), in discussion with the author, February 2011.


37. Rick Frank (Director, Policy and Advocacy, Ohio Hospital Association), in discussion with the author, February 2011.


41. Rick Frank (Director, Policy and Advocacy, Ohio Hospital Association), in discussion with the author, February 2011.