

# State Budgeting Matters

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## Highlights

- *The Executive Budget contains proposals that reduce costs or raise additional revenues to support the Medicaid program in FY 2010-2011.*
- *Nationally, the Medicaid program is expected to grow by 7.8 percent per year in the FY 2012-2013 biennium.*
- *Enhanced match for the Medicaid program under the federal stimulus bill will expire before the end of FY 2011.*
- *Given the projected loss of federal stimulus and the expected growth rate, Ohio's Medicaid program will need an additional \$1.4 billion in new GRF in the FY 2012-2013 biennium, increasing the current estimate of the "structural deficit."*
- *It is highly unlikely that cost containment will be able to achieve this level of savings and that additional revenues or reductions in eligibility and covered services will be required.*

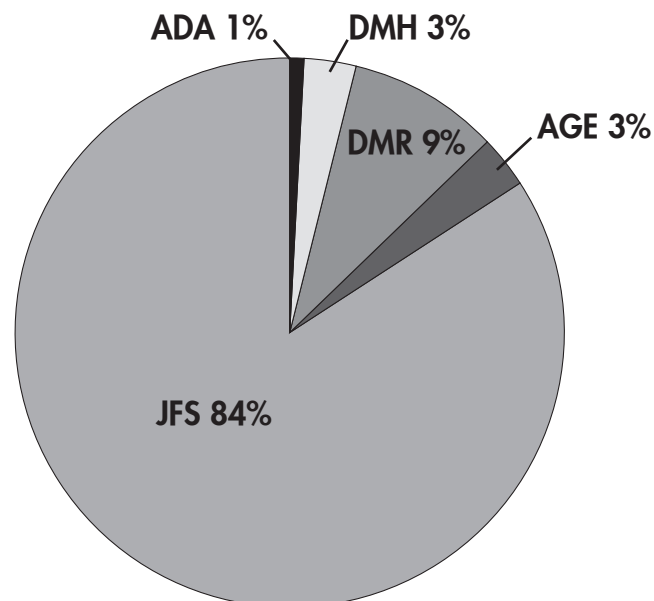
## FY 2010-2011 Medicaid Budget

After the first round of testimony in the House, members have heard from multiple groups about the inadequacies of the Medicaid budget. There is no doubt that the economy is presenting major challenges for all. Even though the federal government is providing an unprecedented amount of additional revenues, one must remember that these revenues are temporary. Ohio would be wise to use these revenues to cover increasing caseloads, maintain current levels of services, and invest in short term solutions that will save money in the long run. This issue of *State Budgeting Matters* provides an overview of the FY 2010-2011 Executive Budget proposal for the Department of Jobs and Family Services' (JFS) Medicaid program and an estimate of JFS Medicaid spending for the FY 2012-2013 biennium.

### Ohio's Medicaid Budget

By FY 2011, Ohio will spend more than \$16 billion dollars through five state agencies on the Medicaid program. The Departments of Job and Family Services (JFS), Aging (AGE), Mental Retardation and Developmental Disabilities (DMR), Mental Health (DMH), and Alcohol and Drug Addiction Services (ADA) are each responsible for a budget and the provision of a set of services through Ohio's Medicaid plan. The chart below shows the portion of the Medicaid budget that is administered by each agency.

Share of Ohio's Medicaid Budget by Administering Agency



The lion's share, or 84 percent, of Ohio's Medicaid budget is contained in JFS. Due to the size of the JFS Medicaid budget, it makes sense to look at its expenditures and cost drivers in greater detail.

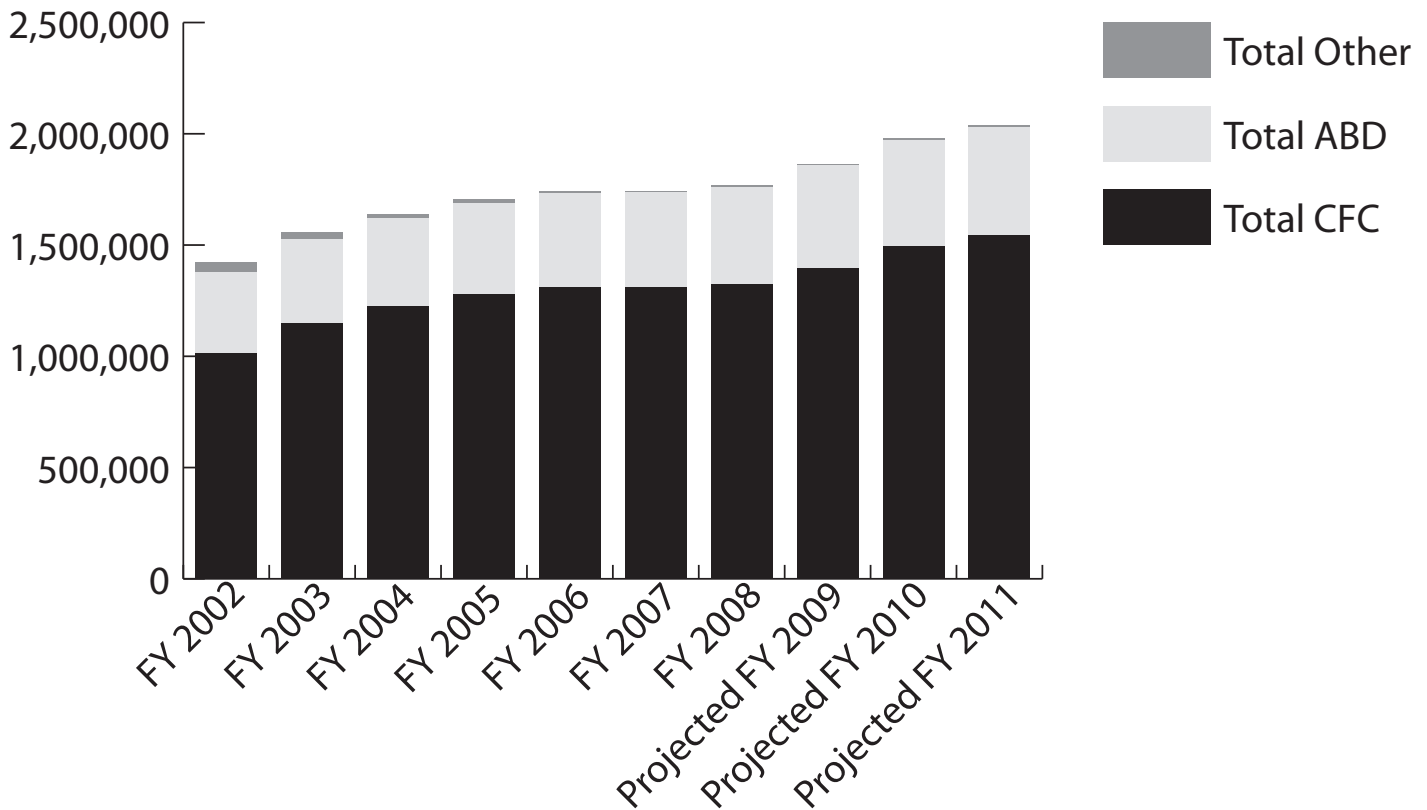


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### Summary of JFS Medicaid Caseloads



The chart above shows Medicaid caseloads by major eligibility group.<sup>1</sup> The Covered Children and Families (CFC) category includes low income parents and children. The recent economic downturn has led to large caseload increases in this category. Employment, or the lack of employment, is a major driver for this eligibility group. The CFC group represents 75 percent of the total Medicaid caseload, but only about 33 percent of the total spending. The per member per month cost in this category is expected to average about \$240 for the FY 2010-2011 biennium. The JFS forecast shows the CFC caseload growth rate beginning to slow after FY 2010.

The Aged, Blind, and Disabled (ABD) category includes income eligible adults and adults with disabilities. Caseloads are much smaller in this category, about 25 percent of overall Medicaid caseloads; however, the category represents about

67 percent of total program spending. The per member per month cost in this category is expected to average about \$1,375 for the FY 2010-2011 biennium. Caseload estimates show this category continuing to grow at a steady pace. ABD caseloads are less affected by changes in the economy.

The Other category includes the Disability Medical Assistance program, the Breast and Cervical Cancer Project, and the Children's Buy-In program for families over 300 percent of poverty. The Disability Medical Assistance program is a state-funded program that provides a limited benefit package to childless individuals with incomes at or below 33 percent of poverty. This program was closed to new enrollment in FY 2004 and caseloads have dropped from 22,589 in FY 2004 to an expected 972 individuals by FY 2012. Caseloads in the Breast and Cervical Cancer program are expected to continue to increase to 645 individuals by FY 2012 due to increased investment in screenings at the Department

<sup>1</sup> Ohio Department of Job and Family Services Projected Medicaid Expenditures FY 2009-2011, Executive Submission, February, 2009.

**JFS Medicaid Program Growth by Category of Spending (\$ in millions)**

Category of Service	Adjusted Estimate FY 2009	Exec Budget FY 2010	Year-Over-Year Increase	Growth Rate	Exec Budget FY 2011	Year-Over-Year Increase	Growth Rate
Nursing Facilities	\$ 2,575	\$2,590	\$15	0.6%	\$2,587	(\$3)	-0.1%
ICF/MR	\$542	\$547	\$5	0.9%	\$547	\$1	0.1%
Inpatient Hospital	\$1,123	\$1,198	\$76	6.7%	\$1,250	\$52	4.4%
Outpatient Hospital	\$401	\$420	\$19	4.8%	\$441	\$21	5.0%
Physician	\$354	\$357	\$4	1.1%	\$362	\$4	1.2%
Prescribed Drugs	\$560	\$1,097	\$536	95.7%	\$1,940	\$843	76.9%
Home Care Waiver	\$333	\$379	\$46	13.8%	\$417	\$38	9.9%
Managed Care - ABD & CFC	\$4,413	\$4,486	\$73	1.7%	\$4,714	\$228	5.1%
All Other	\$1,055	\$1,165	\$110	10.4%	\$1,247	\$81	7.0%
Medicare Buy-In	\$314	\$344	\$31	9.7%	\$380	\$36	10.4%
Disability Medical Assistance	\$11	\$8	(\$3)	-23.0%	\$2	(\$6)	-73.3%
Medicare Part D	\$255	\$272	\$17	6.5%	\$287	\$15	5.7%
<b>Total</b>	<b>\$11,935</b>	<b>\$12,863</b>	<b>\$928</b>	<b>7.8%</b>	<b>\$14,175</b>	<b>\$1,311</b>	<b>10.2%</b>

of Health beginning in FY 2008. The Children’s Buy-In program, which began in the last biennium, is expected to cover 718 individuals by FY 2012.

The chart above shows total JFS Medicaid program spending<sup>2</sup> by major category of service, along with the year over year growth rate and increase in spending. To provide an apple to apples comparison, managed care spending in FY 2009 has been reduced by \$434 million, the amount of the FY 2008 final premium payment that was made in FY 2009.<sup>3</sup> With this adjustment total program spending for Medicaid grows by \$928 million, or 7.8 percent, from FY 2009 to FY 2010 and by \$1,311 million, or 10.2 percent, from FY 2010 to FY 2011.

Notable spending drivers in the FY 2010-2011 biennium include:

2 Ohio Department of Job and Family Services Projected Medicaid Expenditures FY 2009-2011, Executive Submission, February, 2009. Figures include spending for Medicare Part D premiums.

3 OBM Monthly Financial Report, July 10, 2008, p. 18.

**Caseloads.** Due to the economic downturn, caseload increases explain a significant portion of the overall increase in program expenditures. Holding per member per month costs constant at FY 2009 rates (\$231.07 for CFC, \$1,336.77 for ABD) and using monthly caseload estimates, caseload growth explains \$175 million, or 19 percent, of the increase from FY 2009 to FY 2010 and \$587 million, or 45 percent, from FY 2010 to FY 2011. The remainder is due to rate increases for hospitals and managed care premiums as well as increases in utilization.

**Inpatient and outpatient hospitals.** The new hospital franchise fee raises \$259 million per year. The Executive Budget proposes to increase hospital rates by 5 percent beginning in January, 2010, to offset some of the sting of the franchise fee increase. Medicaid spending increases by \$87.9 million in FY 2010 and by \$178.5 million in FY 2011 due to this rate increase.

**Prescription Drugs.** The double-digit growth in this

category is the result of the carve out of the pharmacy benefit from Medicaid managed care (see next section for a more detailed explanation).

**Home Care Waiver.** The budget includes funding for a total of 600 new waiver slots per year. These waivers are separate and distinct from those offered through the PASSPORT and MR/DD programs.

**Managed Care.** Due to the pharmacy carve out; growth in per member per month costs in this category is much lower than recent trends. As managed care is mandatory for the CFC eligibility category, much of the increase is the result of caseload increases.

**Other.** The largest areas of spending in this category are home health services and private duty nursing (about \$400 million per year), hospice (\$192 million per year), medical supplies and equipment (about \$155 million per year), ambulance and ambulette services (about \$96 million per year), and dental (about \$55 million per year). Growth in this category is the result of increases in caseloads and utilization.

## Policy Changes Included in the Executive Budget

### *Nursing home reimbursement*

For many years, the nursing home industry benefitted from a statutory formula with guaranteed annual rate increases that was put in place in the late 1970s to address quality issues that were rampant at the time. Due to the decline in state revenues following the 2001 recession, the nursing home formula was frozen for two biennia. Once the freeze was lifted, the statutory formula would have increased spending in the program's largest category of services by double-digit increases, which was unaffordable and effectively undermined the viability of the formula. Needing to find a new formula, in H.B. 66, the FY 2006-2007 budget bill, the legislature moved the statutory formula from the cost-based reimbursement system to a price-based system. This change anticipated a four-year phase-in with stop loss/stop gain provisions to allow providers time to adjust their

business model. The reimbursement formula and its phase-in have been heavily debated in the state legislature since H.B. 66, and many changes have been made.

As the anticipated four-year phase-in to the new formula ends this fiscal year, the Executive Budget proposes to fully phase-in the price based formula. As State Medicaid Director John Corlett pointed out in his testimony before the Health and Human Services Subcommittee, this change will reduce Medicaid spending (all funds) in the nursing facility category by \$55.9 million in FY 2010 and by \$56.3 million in FY 2011, or approximately 2 percent. Data provided by the Skilled Nursing Care Coalition in their testimony before the Health and Human Services Subcommittee showed that 499 nursing facilities, or 54 percent, are at or below the price. Less than half of the facilities will be negatively impacted by this change and 342 facilities, or 37 percent, will actually see their rates increase.

### *Hospital policy changes*

The Executive Budget calls for a new hospital franchise fee coupled with a 5 percent rate increase for hospitals. Currently, hospitals are assessed a fee to provide non-federal dollars for the Disproportionate Share Hospital (DSH) program, known as the Hospital Care Assurance Program (HCAP) in Ohio. Program assessments are used to leverage federal matching dollars. Both the fee and the federal dollars are then distributed back to hospitals by formula to reimburse them for the cost of providing uncompensated care to medically indigent populations. While a few hospitals that do not provide much uncompensated care lose money under HCAP, because of the addition of the federal match, most come out ahead. The federal stimulus bill increases Ohio's federal allocation for DSH by a total of \$20.15 million. Unlike HCAP, the proposed hospital fee increase, which is expected to raise a total of \$964.5 million in FY 2010 and \$818.1 million in FY 2011, would be used to fund the non-federal share of the Medicaid program and would not be set aside exclusively for hospital expenses.

In addition, the Executive Budget adds a statutory “noncontracting” provision that requires hospitals who participate in the Medicaid program to accept the reimbursement from Medicaid managed care plans at fee-for-service rates. As plans are required to have a certain number of providers and provider types on their panels in order to do business in a county, the limited availability of providers has created monopolies in some areas. While the terms of these contracts are confidential, given the reported savings over the biennium of \$145.6 million, it is reasonable to assume that, in some cases, plans are paying in excess of 100 percent of Medicaid fee-for-service rates. At the state level, these agreements increase overall managed care costs determined through the program’s actuarial process by as much as 2 percent.

### *Managed Care*

In response to recommendations from the Ohio Commission to Reform Medicaid (OCRM), H.B. 66, the FY 2006-2007 budget bill, expanded the Medicaid managed care program to include all CFC recipients and a portion of the ABD population. Since that time, spending for managed care premiums, which bundle together a wide variety of medical, hospital, and other health care services, has overtaken spending for nursing facility care to become the largest category of spending in the Medicaid program – an estimated total of \$4.7 billion in FY 2010.

The premise of managed care is that quality can be increased and costs can be contained by focusing on prevention and wellness and by improving the coordination of health care services for those who are already sick. In response to the collapse of many managed care companies due to insolvency in the early 1990s, federal regulations require that states pay “actuarially sound” rates for managed care to ensure reimbursement is sufficient for the care needed for the population served. This provision, aimed at assuring the adequacy of payments to HMOs, limits the state’s ability to arbitrarily manage costs through rate setting.

In order to control costs of managed care the Executive Budget proposes three strategies. The

first limits reimbursement to “noncontracting” hospitals, as described in the section above. The second moves premium payment from prospective to retrospective, which results in a one-time savings of \$270.4 million in FY 2010. The final strategy carves out the pharmacy benefit so that the state can leverage more lucrative drug rebate agreements that are only available to state Medicaid plans. The Executive Budget assumes that the total rebate percentage will be 40 percent.

### *Increased franchise fees*

Federal law allows states to tax specified classes of health care providers and reimburse providers for these taxes, also known as franchise fees, through increased payments for Medicaid services. States may then claim federal reimbursement for these payments, which raises new revenue that can be used to finance other parts of the Medicaid program. Ohio currently levies franchise fees on nursing facilities, intermediate care facilities (ICF/MRs), and Medicaid managed care plans. In recent years, these fees have been hotly debated by Congress over concern that some states have been using these fees to circumvent their share of the responsibility for financing the Medicaid program. The Deficit Reduction Act of 2005 and the Tax Relief and Health Care Act of 2006 add a number of restrictions to the use of these taxes; however, the American Recovery and Reinvestment Act of 2009, extends the moratorium on final implementation through the end of state fiscal year 2009. One exception is Ohio’s provider tax for Medicaid managed care; this tax will expire on October 1, 2009.

The Executive Budget takes an aggressive approach to franchise fees by increasing fees to the federally allowable limit for nursing facilities and ICF/MRs and leverages a new franchise fee on hospitals. As described above, the amount of revenues raised by this proposal is substantial – over \$2.6 billion in the FY 2010-2011 biennium<sup>4</sup> (of which \$760 million represents new state share revenue). Opposition from the Ohio Hospital Association and the Skilled Nursing Coalition has raised a question: How would Medicaid and other state programs or state taxes

4 Ohio Department of Job and Family Services Projected Medicaid Expenditures FY 2009-2011, Executive Submission, February, 2009.

have to change if these fees were removed from the biennial budget?

## The Potential Size of the Medicaid Budget in the Next Biennium

The overall growth of health care expenditures, the loss of federal stimulus funds, and the policy decisions made during this budget will drive the need for new GRF dollars to fund the Medicaid program in the next biennium.

The Office of the Actuary at the Centers for Medicare and Medicaid recently published estimates on the growth of health care expenditures. The office estimates that, nationally, Medicaid will grow by 7.8 percent per year for calendar years 2012 and 2013.<sup>5</sup> In addition, the office notes that Medicaid growth rates will accelerate over the next decade as the nation's aging population makes up a larger share of Medicaid enrollment.

Under the federal stimulus bill, the federal match for Medicaid spending through the recession adjustment period (October 1, 2008 to December 31, 2010) will vary by quarter but is expected to top 73.47 percent. When the stimulus provisions expire, federal match rates will drop by almost 10 percentage points.

<sup>5</sup> National Health Expenditure (NHE) Amounts by Type of Expenditure and Source of Funds: Calendar Years 1965-2018, February, 2009.

Preliminary estimates put Ohio's federal match rate at 64.02 percent for federal fiscal year 2011.<sup>6</sup> The loss of enhanced federal match will cause substantial growth in the state share of GRF spending on Medicaid in FY 2012.

The following chart shows the budget impact to JFS Medicaid spending using the projected national Medicaid growth rates and federal Medicaid match rates for FY 2012 and FY 2013 based on the FY 2011 spending levels proposed in the Executive Budget.

The share of the Medicaid program supported by non-GRF revenues will decline from a high of 30 percent in FY 2010 to 17 percent in FY 2013. Due to the loss of federal stimulus, non-GRF federal revenues will decline by an estimated \$383 million from FY 2011 to FY 2012. In addition, non-GRF, non-federal revenue sources will likely remain flat over the next biennium. These sources include third party liability, prescription drug rebates, and franchise fees for nursing facilities, ICF/MRs, and hospitals. Because of the overall decline in non-GRF revenues, additional spending must be shifted to the GRF. So while All Funds Medicaid spending increases by only 7.8 percent, the growth rate in Total GRF is much higher, 13.7 percent from FY 2011 to FY 2012.

Due to the loss of the federal stimulus, the year-over-year increase in state share of spending from FY

<sup>6</sup> FFIS Issue Brief 09-10, FY 2011 FMAP Projections.

### Projected FY 2012-2013 JFS Medicaid Spending (\$ in millions)\*

Projection: Assumes 7.8% program growth, federal match rate of 64.02%

	FY 2011	FY 2012 Estimate	GRF Impact	%	FY 2013 Estimate	GRF Impact	%
<b>Total GRF 525</b>	<b>\$10,694</b>	<b>\$12,160</b>	<b>\$1,466</b>	<b>13.7%</b>	<b>\$13,328</b>	<b>\$1,168</b>	<b>9.6%</b>
• State Share 525	\$3,379	\$4,375	\$996	29.5%	\$4,795	\$420	9.6%
• Federal Share	\$7,314	\$7,785	\$470	6.4%	\$8,532	\$748	9.6%
<b>Total Non-GRF</b>	<b>\$3,194</b>	<b>\$2,811</b>	<b>(\$383)</b>	<b>-12%</b>	<b>\$2,811</b>	<b>-</b>	<b>0.0%</b>
• Non-GRF/Non-Federal	\$1,1011	\$1,1011	-	0.0%	\$1,1011	-	0.0%
• Federal	\$2,182	\$1,799	(\$383)	-17.6%	\$1,799	-	0.0%
<b>Total All Funds Cost</b>	<b>\$13,887</b>	<b>\$14,971</b>	<b>\$1,083</b>	<b>7.8%</b>	<b>\$16,138</b>	<b>\$1,168</b>	<b>7.8%</b>

\*Spending estimates for FY 2009-2011 are from the Ohio Department of Job and Family Services, Projected Medicaid Expenditures FY 2009-2011, Executive Submission, February, 2009. Revenue estimates are from the OBM Blue Book. Note that estimates do not include spending from prior year encumbrances or Medicare Part D.

2011 to FY 2012 increases by \$996 million while the federal share increases by only \$420 million. This is due to the reduction in the federal share of spending by almost 5 percentage points.<sup>7</sup> In FY 2013, the year-over-year increases follow the more typical state/federal split patterns.

## What Does this Mean for Ohio?

Absent the adoption of additional cost containment measures, declines in enrollment, or extension of a higher federal matching rate beyond current projections, it is estimated that the state will need an additional \$1.4 billion<sup>8</sup> in state share resources in order to fund the JFS Medicaid program in the FY 2012-2013 biennium without significant changes to eligibility, services, or rates. Using OBM's estimated revenue for FY 2011 for GRF tax receipts of \$17,277.9 million, tax revenues would have to increase by 5.8 percent in FY 2012 and by another 2.3 percent in FY 2013 in order to fund this program alone.

## What Options Does the State Legislature Have to Control Medicaid Costs?

Controlling the growth of Medicaid expenses has been a hot topic at both the state and federal level for much of the past decade. During this time, Ohio has created a number of commissions to look at reform and cost savings opportunities in different parts of the Medicaid program. The Center for Community Solutions recently completed a review of the recommendations for two of these commissions, the Ohio Commission to Reform Medicaid (OCRM) and the Ohio Medicaid Administrative Study Council (OMASC). These reviews found that the state had implemented, or was in the process of implementing, many of the recommendations. While it is encouraging that so much progress has been made, it is also clear that more progress is needed.

<sup>7</sup> Enhanced federal match is available from October 1, 2008 through December 31, 2010, or the second quarter of state FY 2009 through the first half of state FY 2011.

<sup>8</sup> This total is the sum of GRF state share spending in FY 2010 and FY 2011. The federal share of spending is supported by federal reimbursement for Medicaid spending that is deposited in the GRF.

Recommendations include the following items:

### *Establish firm budget targets.*

Adopt and manage to rolling five-year health care spending targets for Medicaid and public employees, aimed at bringing changes in health care costs into line with changes in the overall economy, including personal income and state revenues.

### *Adopt competitive purchasing procedures.*

Competitive purchasing procedures should allow integrated health systems to compete with managed care organizations for capitation contracts and allow the state to selectively contract with providers based upon quality and price.

### *Push harder to contain long-term care costs.*

Ohio's nursing home industry blossomed in the 1960s and 1970s. Since that time, models for the delivery of long-term care services have changed, but Ohio's primary long-term care system has not kept up with these changes. Currently, Ohio's supply of nursing home beds exceeds demand. The Executive Budget is on the right track to reign in long-term care costs by rebalancing the long term care delivery system; however, more action is needed.

### *Invest in additional home- and community-based options.*

The state has made significant investment in home- and community-based care programs; however, most of this investment has been in the PASSPORT program, which serves adults ages 60 and over with nursing home level of care. Additional investment is needed to expand home- and community-based options, particularly for individuals between 21 and 64 who have an institutional level of care.

The Associated Press recently reported that there are more than 9,000 people under the age of 65 with mental illness currently residing in Ohio's nursing homes. In the deinstitutionalization movement in the late 1980s, state institutions were closed and mentally ill patients were released to the communities. The average daily census in the state's mental hospitals dropped from 3,147 in FY 1990 to

1,036 in FY 2008.<sup>9</sup> Looking at this data, it appears that this population is being quietly reinstitutionalized. The structure of the community-funded mental health system and the state-funded Medicaid system creates a financial incentive to shift individuals to more expensive and restrictive settings. Nursing home care is paid by the state through JFS GRF appropriations, while care through the community mental health system is paid by county boards of mental health using a combination of state subsidies, federal Medicaid reimbursement, and local levy funds. The growth in community funding has not kept pace with the growth in the Medicaid program. As a result, many of the community supports needed to prevent institutionalization have been eroded.

Phase 2 of the Unified Long-Term Care Budget plans to address the long-term care needs of those with behavioral health needs. This is a very difficult population to serve as many do not qualify for Medicaid making funding streams more difficult to piece together. There is currently no concerted strategy for meeting the needs of this population. There are certainly lessons to be learned from the aging community about home-based care, but the needs of this population are much more variable. It is of utmost importance that, health, mental health, housing providers, policymakers, and advocates come together to devise a unified system.

In addition to expanding care to younger institutionalized populations, the state should also expand home- and community-based care options. The statutory cap that limits the assisted living waiver program to 1,800 slots should be eliminated and the assisted living waiver should be expanded to include other providers such as public housing. The Residential State Supplement program, which provides a cash benefit to individuals to help pay for approved housing arrangements, should be reinvigorated and expanded particularly to meet the needs of the mentally ill moving out of nursing homes.

As proposed in the Executive Budget, follow-up visits to nursing home patients to ensure that patients are aware of their care options, and, if they choose,

<sup>9</sup> LSC Redbook, Department of Mental Health

assistance to help them move to a community-based setting, are critical supports. Investment in this biennium in home- and community-based care will help to decrease more costly institutional placements in the long-run.

#### *Establish a physician-led medical division.*

Pursuant to the OMASC recommendations, this new division should be charged with (1) adopting evidence-based protocols for prevention and disease management; (2) aligning payments with protocols; (3) providing large-scale physician, nurse, and allied health training on protocols and payment reforms; and (4) tracking results for preventive and primary care services, as well as care management for chronic conditions beginning with diabetes, COPD, and chronic heart disease.

#### *Create an Ohio Public Health Reform Commission.*

Modeled after the OCRM, this commission should be charged with recommending policy and funding priorities aimed at aligning the work of Ohio's public health departments and programs with evidence-based preventive medical services.

## Conclusion

The Medicaid program will likely continue to grow faster than state revenues in the upcoming biennium. In addition, there will be pressures to increase funding for other state programs as well, such as education and other human services. The excessive use of one-time revenues to shore up the FY 2010-2011 budget will exacerbate the budget shortfall going into the FY 2012-2013 budget.

While there are options for slowing the growth in Medicaid expenditures, the FY 2012-2013 budget will likely still require significant new revenues. Irrespective of the current economic crisis, our revenue system has been heavily damaged by five years of tax cuts. Policymakers must take action now to begin to deal with Ohio's structural deficit.

*Please note: While Dick Sheridan remains closely involved with SBM, from time to time, it will be written by other Community Solutions' Public Policy staff.*