

State Budgeting Matters

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Highlights

- *Twenty years and innumerable health care reforms later, Ohio still has over one million uninsured, and the hospital industry still complains that funding for uncompensated care is inadequate even as HCAP continues to be earmarked for their benefit.*
- *Increased taxes at some point are necessary and inevitable. Similarly, Medicaid cost containment—indeed, health care cost containment in general—is an absolute necessity.*
- *...public policy, like liberty, demands eternal vigilance. In this case that vigilance might be provided by a standing, bi-partisan health policy council to advise the governor, General Assembly, and director of the new state department...*

Medicaid and the Impending Train Wreck in Ohio Government

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The evolution of Ohio's Medicaid program through the decades is exemplary proof of George Santayana's well-worn admonition: "Those who fail to learn from history are doomed to repeat it." Consuming four of every 10 dollars in Ohio's biennial budget, the state's (and country's) largest health program is again at the center of controversy, fiddling around the edges of meaningful health reform, and unconstructive political gamesmanship.

As the budget bill makes its way through the General Assembly, the precedents of two long-standing "reforms"—one enacted 30, and the other 20, years ago—are again at the center of the hurricane's eye. And if the Medicaid provisions in the substitute bill passed by the House are adopted, the long-range impact could be catastrophic for taxpayers, Medicaid beneficiaries, and, ultimately, health care providers.

In 1979, the goal of ending scandalously dreadful conditions in Ohio nursing homes was the subject of a bipartisan Ohio Nursing Home Commission investigation and report. A nursing home patients' bill of rights was enacted, along with a prohibition of nursing home discrimination against Medicaid and Medicare beneficiaries and a formula for paying nursing homes in state law. The details of the payment formula were a quid pro quo between lawmakers and the already powerful nursing home lobby: the state would guarantee adequate payments, the widespread discrimination would end.

As years passed and memories faded, the details of the payment formula, snatched from the Executive Branch by the General Assembly, became the equivalent of a biennial poker game between legislative leaders of both parties and the increasingly powerful nursing home industry. Campaign cash, most of it traceable right back to Medicaid, flooded the coffers of both legislative caucuses. Gradually, biennium by biennium, major provisions of the formula were fine-tuned to the benefit of the industry. In order to help finance the state's share of steadily-rising costs, a new quid pro quo was adopted—a bed tax on nursing homes, the proceeds of which are used to match federal dollars, the combined proceeds being spent on assuring biennial increases in Medicaid rates.

In the end, the cost of cleaning up the sordid conditions of the 1970s itself became a problem of enormous proportions. Today, even as patients vote with



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their feet, leaving vacant thousands of nursing home beds, Ohio spends a larger share of its budget on nursing homes than all but one or two other states. Meanwhile, access to community-based alternatives and assisted living is strictly limited.

Fast-forward to 1989 and another arena in the burgeoning health care economy. State lawmakers found themselves confronting escalating health care costs, even as the number of Ohioans without health insurance exceeded one million—over 10 percent of the population. Ohio hospitals were clamoring for financial relief from the burden of providing services to the uninsured. Expanding health care benefits through Medicaid or employer mandates did not appear to be politically viable in the face of health provider and business opposition. However, news reached Columbus that a number of states had been experimenting with a creative way of indirectly addressing the access issues of the uninsured, and revenue issues of hospitals, through a relatively obscure provision in federal law and regulation called the Disproportionate Share Hospital program (DSH).

Basically, the DSH program allows states to draw down additional federal Medicaid dollars by taxing hospitals (euphemistically called a “fee” in this case), to raise the non-federal state matching funds. The combined dollars are then returned to hospitals according to a formula roughly based on the proportion of care to the poor and uninsured that they provide. Depending on how much indigent care hospitals provide (or fail to provide), the additional federal dollars make it probable, but not certain, that most hospitals come out ahead in this transaction.

Initially opposed by the Ohio Hospital Association, Ohio’s Hospital Care Assurance Program (or HCAP

as Ohio’s DSH program is called) eventually gained the lobby’s assent, the quid pro quo being that the number of “losers,” and the amount of their losses, would be minimized. Originally amounting to about \$80 million, the program was expanded during the early 1990s to an annual cost of over \$600 million. Once established, it became a health care provider entitlement, much like the nursing home payment formula. When Governor George Voinovich floated the idea of diverting the hospital tax revenue to provide health insurance for some of Ohio’s uninsured, the hospital industry balked, and

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the proposal quickly and quietly died. Twenty years and innumerable health care reforms later, Ohio still has over one million uninsured, and the hospital industry still complains that funding for uncompensated care is inadequate even as HCAP continues to be earmarked for their benefit.

Fast-forward to this year. Ohio is in the midst of an economic crisis, and state government faces declining tax revenues, growing numbers of uninsured, and a structural budget deficit (tax revenues are not keeping up with costs). Governor Ted Strickland, facing a re-election campaign next year, proposed a biennial budget with “no new taxes.” However, faced with the recurrent nightmare of escalating Medicaid costs, he proposed increases in “fees” for hospitals, nursing homes, and Health Maintenance Organizations (HMOs) to help cover the non-federal costs of Medicaid.

Breaking from tradition, however, the Governor did not abide by the time-honored quid pro quos that through the decades amassed many millions in campaign cash for candidates of both political parties. Indeed, to the chagrin of the hospital lobby, their members would pay in more than they would directly get out. Further, still chaffing from a mid-decade

round of bi-partisan Medicaid reforms, Ohio's nursing home industry would actually have several hundred facilities experience a decline in payment rates as the Governor completes the phase-in of a new formula adopted with strong bi-partisan support in 2005.

Not unexpectedly, the hospital industry responded with a statewide full-court press, threatening massive job losses in an already struggling economy. Meanwhile, the nursing home industry quietly played their usual "card" as they have done so effectively since the inception of Medicaid. In making their cases, neither lobby has opposed the idea of paying the taxes per se. Rather, they have pressed for a "fair return" on their "investments."

Ohioans, like other Americans, have become accustomed to the hardball politics of the "caring professions." Indeed, most of us take some comfort in seemingly continual improvement in the quality of health care, even as we rail about ever-increasing costs, the unconscionable reality of 45 million uninsured, and the paradox of our relatively poor health status among industrialized democracies, even as our health care spending far outstrips that of any other country. It would be easy to shrug off this latest round of health care politics-as-usual except for several very new, unprecedented realities.

- First, we are about to enter the third consecutive biennium with a structural deficit. Left unchanged, tax revenues will be less than projected spending, the difference being made-up with temporary and one-time revenue, including a significant amount of federal "stimulus funds."
- Second, the amount of the structural deficit is growing—projected to be well in excess of 10 percent, reaching as much as \$4 billion per year by the end of the 2011 Fiscal Year.

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- Third, Medicaid costs are projected to continue growing at the rate of several percent per year, even after several years of major initiatives to contain costs, and even as the economy contracts and state revenues fall. Total annual Medicaid spending will reach \$16 billion by the end of the new biennium.
- Fourth, the largest single component of federal stimulus dollars for the states is a temporary, two-year increase in the federal matching rate for Medicaid. The increase in state dollars that will be needed to offset the loss of this federal assistance during the next biennium will be about \$1.6 billion. That revenue will have to be found through increased taxes just to keep Medicaid going at current caseloads and payment rates.

To sum the situation up, the state's fiscal crisis, already enormous, will be worse in two years unless actions are taken now to address them. Increased taxes at some point are necessary and inevitable. Similarly, Medicaid cost containment—indeed,

health care cost containment in general—is an absolute necessity.

With this problem in full view, recent developments with the House version of the biennial budget are consistent with the pattern of ignoring history. After two months of hearings, House Democratic leaders yielded to the temptations of another round of business-as-usual Medicaid politics. Their substitute budget bill proposes to one-up the Governor on provider "fees," making enormous concessions to hospital and nursing home interests through a baffling array of payment gimmicks. Along with other proposed House changes, the net effect on Department of Job and Family Services (DJFS) Medicaid spending would be about \$1.6 billion over the biennium.

While it is argued (and must be conceded) that this increased spending will stimulate the economy, health care is the precisely wrong part of the economy to be stimulating. These costs are not sustainable by Ohio's taxpayers—not even close. Based on historical rates of state tax revenue and Medicaid growth, Medicaid will increase from 40 percent to 75 percent of all state spending by 2020; these changes will only accelerate the move in that direction. Beyond this, fueling the ever-escalating upward spiral of health care spending without major reforms will add to the already unsustainable health care cost burden born by employers in other sectors of the economy.

From 2004 through 2006, two bi-partisan commissions recommended a series of reforms to Ohio Medicaid. Some recommendations have been adopted, but others have not. Among the latter are those that zeroed-in on fundamentally changing the bases for spending decisions—using the state's purchasing power to get a better deal for taxpayers and beneficiaries alike, forcing efficiencies on a bloated and under-producing health care system whose current prosperity comes at too steep a price, and taming, if not ending, the culture of pay-to-play health care politics.

Building upon the unfinished business of those reform commissions, here are some alternatives to the current priorities of leaders in the House that might be better suited to Ohio's needs, addressing health care costs on the scale required by the times.

- Coordinate the enormous purchasing power of state government to stabilize health care costs on behalf of Ohio taxpayers and businesses. Create a cabinet-level Ohio Department of Health Plans to (1) implement the recommendation of the Ohio Commission to Reform Medicaid (OCRM)

and the Ohio Medicaid Administrative Study Council (OMASC) to manage Medicaid through a single cabinet level agency beginning July 1, 2010; (2) purchase health services on behalf of state employees; and (3) make provision for collaborative health purchasing opportunities for local governments, school boards, and public retirement systems.

- Pursuant to the OMASC recommendations, establish a physician-led medical division within the new department that is 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.
- 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 incomes and state revenues. Factors used in establishing spending targets might include (1) Medicaid per member/per month (PMPM) costs for each category of consumers, (2) the Consumer Price Index – All Urban Consumers, and (3) projected changes in state revenues.
- Beginning in FY 2010, move state and federal Medicaid appropriations into a single set of line-items within ODJFS, including unified appropriations for long-term care services to various populations. Interagency agreements

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should govern management of Medicaid funds flowing to partner agencies and systems. The unified long-term care budget should be accompanied by December 31, 2010, sunset provisions of statutes governing nursing home and other provider payments, as well as Certificate of Need (CON) provisions for long-term care facilities.

- Adopt competitive purchasing procedures to become effective no later than July 1, 2011, including (1) direct contracting with integrated health systems as well as managed care organizations; and (2) selective contracting with providers based upon quality and price (which will require repealing any-willing-provider provisions for behavioral health services).
- Start implementing the recommendations of the Ohio Health Quality Improvement Team that were released last week, especially those aimed at aligning payments with medical homes.
- Create an Ohio Public Health Reform Commission, modeled on the OCRM, to recommend policy and funding priorities aimed at aligning the work of Ohio's public health departments and programs with evidence-based preventive medical services.

In considering these ideas, it begs reflection that few, if any, public policies can stand for all times, and that what appears to be a solution to a problem today may come back as a problem itself as the years pass. It was a striving second-term state legislator who, back in 1979, sponsored the nursing home reimbursement and anti-discrimination statutes with the conviction and certainty of all reformers, thinking that "good politics and good policy" could be spun into an alchemical brew that would stand the test of time. Within a few of years, those good intentions were turned into a publicly financed cash cow for both caucuses in the General Assembly, and the emergence of alternatives to institutional services was stifled for decades.

Among the lessons I would share from that experience (*mea culpa*) is this: public policy, like liberty, demands eternal vigilance. In this case that vigilance might be provided by a standing, bi-partisan health policy council to advise the governor, General Assembly, and director of the new state department proposed above. It should specifically exclude the usual suspects—the various provider lobbies and professional advocates. Charged only with representing the interests of the common women and men of Ohio, the members of such a body might help restore public purpose to the mix of special interests (necessary though they may be) that control the levers of health policy in the Statehouse.

Comments regarding this special edition of State Budgeting Matters may be sent to John Begala at jbegala@CommunitySolutions.com.