



Policy Brief

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Reforming Ohio Medicaid: “Open the Markets and Level the Playing Field”

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Executive Summary

Ohio’s new plan for Medicaid, laid out in the 2006-2007 biennial budget, has important implications for reforming the state’s biggest long term problem. While it is an improvement over the existing system, the plan falls short of fully employing the market-based reforms needed both to control Medicaid’s costs and to improve its quality.

With virtually nonexistent productivity growth, and Medicaid spending projected to rise 40 percent in nominal terms between 2006 and 2010, market

reforms become imperative. These reforms involve the creation of a real marketplace where subsidized buyers and providers act in their own interests.

Florida and South Carolina are moving rapidly in this direction. It is useful to contrast Ohio’s plan with what these two states are doing. If Ohio follows their example of empowering consumers and promoting competition, benefits will accrue to taxpayers, beneficiaries, and providers alike.

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The Buckeye Institute assists policymakers, scholars, entrepreneurs, the media and the public by providing objective analysis and sound solutions to state and local policy questions, particularly in the areas of taxation, government spending, regulation, and education.

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The Buckeye Institute for Public Policy Solutions neither seeks nor accepts government funding. It enjoys the support of foundations, individuals and businesses sharing a concern for Ohio's future.

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Introduction

Ohio's new plan for Medicaid, laid out in the 2006-2007 biennial budget, has important implications for reforming the state's biggest long term problem (See Figure 1). While the plan is an improvement over the existing system, it falls short of fully employing the market-based reforms needed both to control Medicaid's costs and to improve its quality. Florida and South Carolina are rapidly moving in this direction. It is useful to contrast Ohio's plan with what these two states are doing.

Acute Care

Covered Families and Children is the largest category, in terms of the number of beneficiaries, in the Medicaid program (See Figure 2). Ohio will now require managed care plans for this group. This move represents an improvement over the existing fee for service (FFS) plan that many are covered by, since FFS cannot effectively control unneeded (and therefore costly) utilization. The managed care plan's effectiveness will be determined by its structure. If Ohio selectively contracts with HMOs three major problems will arise.

First, beneficiaries will have limited or even no choices in their Medicaid-financed health care, and the low quality of that care will not improve. Second, state government will remain in the business of setting rates and specifying benefit packages: a price control scheme will continue. If the rates are set too low, providers will once again exit the Medicaid market. Third, even if the rates are high enough to retain providers, a marketplace without competition is unlikely to innovate or boost its virtually nonexistent productivity growth.

Ohio should follow Florida's lead and award risk-adjusted grants to beneficiaries, who can then purchase health coverage from competing bids from carriers, who will then cover costs above specified amounts. An additional feature of the plan is that beneficiaries can earn additional funds for their own use by exhibiting "good" health behavior such as obtaining immunizations, blood pressure screenings, and diabetes testing.

South Carolina has also proposed allowing enrollees to choose among competing providers, although its mechanism for doing so would differ from Florida's. In order to promote competition among prepaid plans, Florida will solicit over 90% of its beneficiaries in Medicaid FFS,

South Carolina plans to give people a Personal Health Account (PHA) that is linked to major medical FFS. Beneficiaries who remain in Medicaid FFS are charged co-pays, to be paid out of the PHA, for specific uneconomical practices (inpatient vs. outpa-

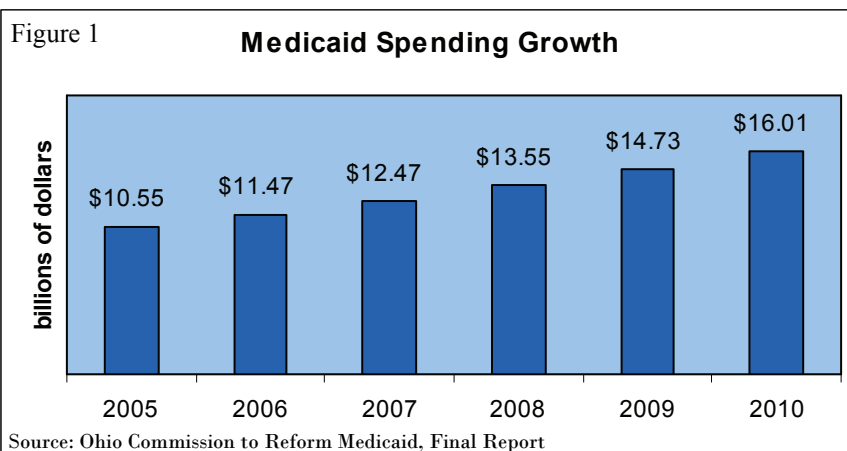
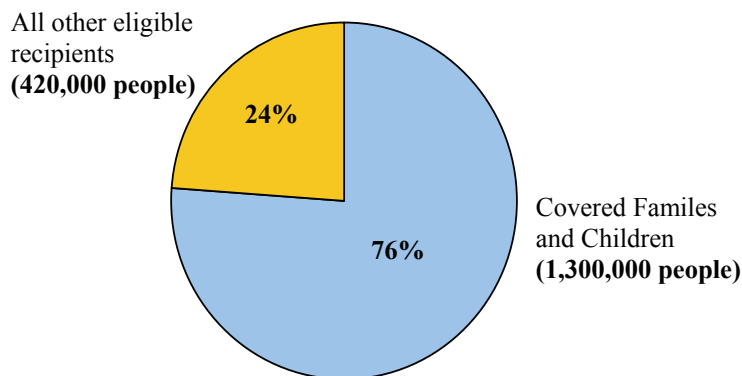


Figure 2

Who are Medicaid's Beneficiaries?

Source: Ohio Commission to Reform Medicaid, Final Report

tient surgery, using emergency rooms for primary care, excessive office visits, etc). Beneficiaries, who may retain a portion of unused funds, will finally have an incentive to economize on unnecessary medical care. This plan will be limited to enrollees with no history of unstable expensive acute care.

Beneficiaries not eligible for the above, as well as all others, may take the actuarial value of their PHA-FFS coverage and enroll in alternative plans. These include Medical Home Networks (MHN), private sector network plans that share high cost risks with the state; private HMOs that assume all risk; or enrollment in private employer plans. Since beneficiaries may retain a portion of the funds in the PHA, they have an incentive to choose low cost private coverage. As is true with the Florida plan, the ability of beneficiaries in South Carolina's proposed plan to choose among competing providers will improve the quality of medical care.

Long-Term Care

Ohio's 2006-2007 budget ends the anti-

quoted "cost-based" reimbursement system for nursing homes. This major reform could lead to dramatic gains in nursing home quality and efficiency, but only if it is properly implemented. That would involve allowing the marketplace to work. Unfortunately, the legislation appears to allow Ohio Medicaid to determine payment levels to nursing homes.

Since the Medicaid system cannot possibly know what is the "right" price for nursing home services, this provision is just another price control scheme destined to fail. Once again, Ohio should consider the Florida and South Carolina approaches.

Florida's proposal involves the use of competing managed care providers for LTC beneficiaries. LTC providers would offer to beneficiaries a package of benefits including acute care, mental health services, and nursing home and community based services. Beneficiaries would receive a risk-adjusted grant from Medicaid, and they could choose from at least two competing providers. The providers would negotiate with nursing homes for services for their enrollees. Nursing homes would have an incentive to offer lower prices and better quality care, because beneficiaries could transfer from one provider to another. Providers, who are prepaid, would have incentives to give services outside nursing homes—which is often the route preferred by those needing care.

The proposed South Carolina LTC plan uses

a different framework for nursing homes and other LTC beneficiaries. Medicaid would determine the number of needed beds and then solicit sealed bids from nursing homes within each region of the state. Beds would be allocated to homes from lowest to highest bid. The auction would be phased in so that no current beneficiaries are affected. The rates would be adjusted annually based on a quality index. Nursing homes delivering better care would receive higher adjustments.

For other long-term care beneficiaries, the state would establish PHAs similar to those already used with success in “cash and counseling” demonstration projects. Beneficiaries are spending the funds out of accounts they control. Consequently, South Carolina anticipates more a cost-effective delivery of services if its proposal is approved. Ohio’s reform appears to consider this direction, with a pilot voucher program involving Intermediate Care Facilities for the mentally retarded. In addition, Ohio’s plan contains a requirement for managed care for the Aged, Blind and Disabled. This requirement, however, may lead to the same problems that plague managed acute care plans.

Conclusion

The solution to Ohio’s Medicaid problem of unsustainable cost growth and low quality care involves the creation of a real marketplace where subsidized buyers and providers act in their own interests. Ohio policy makers courageously attacked the Medicaid problem in the most recent budget. If they follow the example of Florida and South Carolina by empowering consumers and promoting competition taxpayers, beneficiaries and providers alike will benefit.

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Appendix A: State Program Comparison

| | Ohio | Florida | South Carolina (Proposed) |
|---|--|--|--|
| <i>Recipient choice</i> | None | Recipients can choose from a set of customized benefit packages tailored to meet their needs. | Recipients will have Personal Health Accounts (PHAs) that they can use to purchase health-related goods and services. Recipients will also be enrolled in catastrophic and preventative plans. |
| <i>Incentives for Healthy Lifestyles</i> | None | Recipients who participate in "healthy lifestyle" programs (e.g., weight loss, smoking cessation) will receive funds in an Enhanced Benefits Account to use for health-related expenses. | None |
| <i>Subsidies to Purchase Private Insurance</i> | None | Recipients can opt-out of Medicaid and the state will cover their portion of the cost of employer-sponsored health insurance. | Money in PHAs can be used to purchase private coverage from managed care organizations. |
| <i>Recipient Control over How Medicaid Dollars are Spent</i> | Pilot program limited to just 200 people utilizing vouchers giving them more control over their Medicaid spending. | All recipients choose benefit package. | All recipients control how funds in PHA are spent. |
| <i>Financial predictability for the state</i> | None. The state pays for as many products and services as a recipient uses. | The amount of money spent on each benefits package is a fixed amount. | The amount of money deposited in PHAs is a fixed amount. |