

What's in Store for Ohio's Medicaid?

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Health Policy and Clinical Effectiveness

Pediatric Grand Rounds
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change the outcome®



Some of the Issues

OHIO

- 1.3 million people in Ohio are uninsured
 - about 1 in 8 state residents
 - many people underinsured as well
- About \$62 billion spent on health care for non-institutionalized population in Ohio

US

- About 46 million uninsured in US
- \$2.3 trillion health care system.

Overview of Talk

- Why Medicaid is important to children's hospitals and pediatricians (even if they see few Medicaid patients)
- Present background on Medicaid/SCHIP
 - Overview
 - Quality
 - Financing
- Describe new directions for Medicaid/SCHIP in Ohio
 - How Ohio fits with other State and National initiatives
- Say what may be in store for the future

Why Medicaid is Important

- Medicaid is the nation's largest payer of health care for children
- It pays for health care for 28 million children
 - SCHIP pays for over 6 million children
- Covers
 - 1 in every 4 children
 - Nearly 1 in 3 children with special needs
 - 1 in 3 infants

Note: Enrollment figures are for FY 2006.

Source: Kaiser Family Foundation IMPACTS OF MEDICAID AND SCHIP ON LOW-INCOME CHILDREN'S HEALTH. May 2007

Why Medicaid is Important for Children's Hospitals

- Medicaid is the single largest payer of care provided by children's hospitals
- Nationally, accounted for
 - 50% of revenue (whereas, 12% in general hospitals)
 - 59% of ED visits
 - 48% of all outpatient visitsIn free standing children's hospitals (FY2005)

Medicaid Policies Affect All Children

- Because it is so large, Medicaid policies/politics affect a children's hospital's ability to serve ALL children
- When Medicaid funding is cut, hospital cannot absorb losses by reducing services for Medicaid children
- It must curtail services that *all* children use

“...Medicaid has become the financial backbone of children’s health care in the U.S., but Congress and state legislators seldom understand the implications of their policy making for middle-income and wealthy families’ children, not just children of low-income....”

Peters Wilson, NACH Vice President for Public Policy.
Why Medicaid Matters to Children’s Hospitals. Interview with Peters Wilson
N.A.C.H. www.nach.org. Accessed June 2007.

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Medicaid is..

- A joint federal-state program of health care coverage for the nation's most vulnerable
 - Low-income children and pregnant women
 - People with disabilities
 - Elderly who are poor and require nursing home care
- Each state runs its own Medicaid program within the federal framework
- Uses federal dollars to match state
 - Ohio gets \$1.49 federal dollars for every Ohio dollar it spends
 - Average nationally is \$1.75 federal dollars for every state dollar
- Typically covers children up to 100% FPL (\$17,170 for a family of 3)

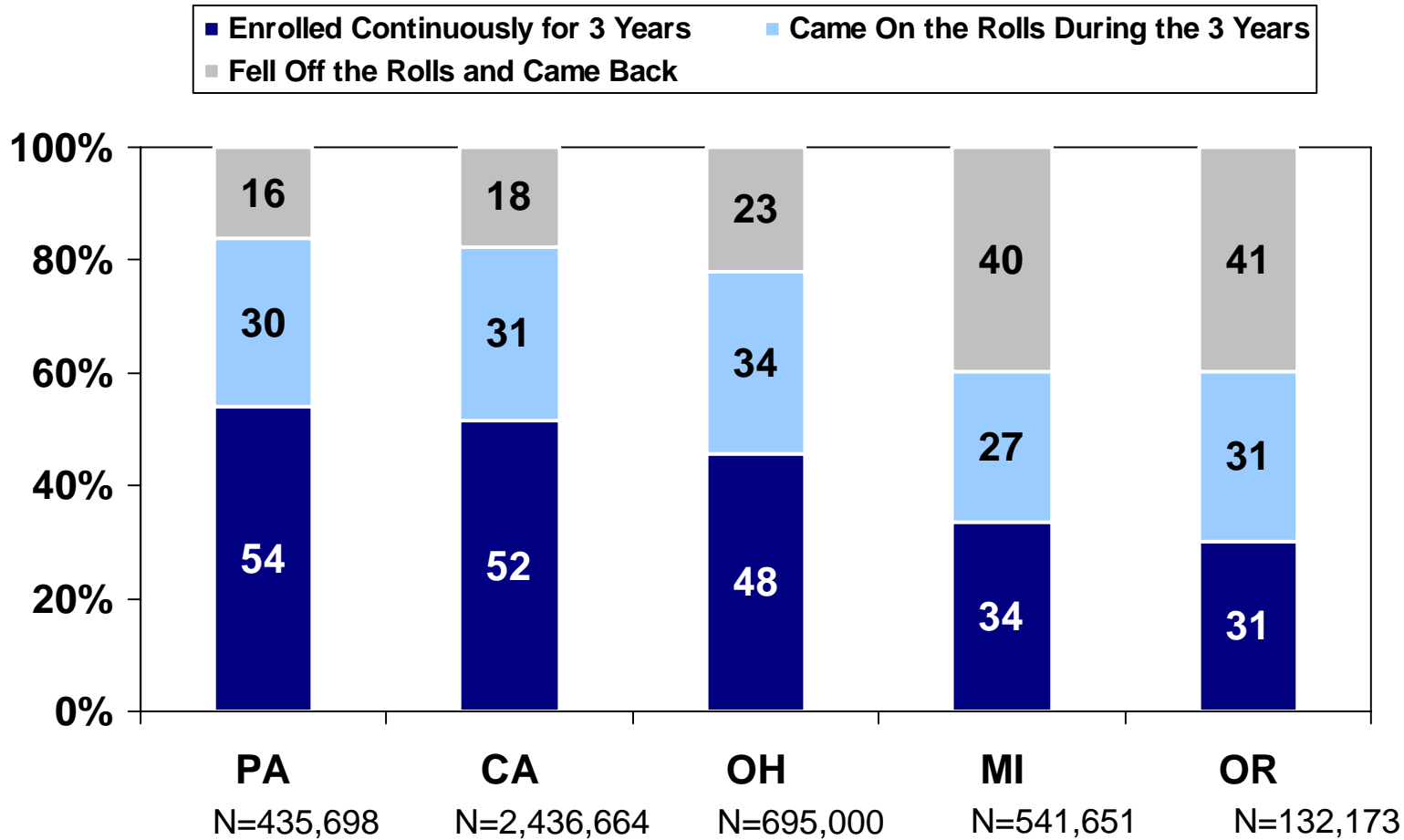
SCHIP is....

- State Children's Health Insurance Program (SCHIP)
- Is a program for children in families who earn too much to be eligible for Medicaid, but too little to afford private coverage
- Typically covers children to 200% FPL (\$34,340 for family of 3)
- Current legislation expires September 30, 2007
 - Reauthorization is occurring now
- Opportunity to introduce provisions related to quality
 - CCHMC is deeply involved in this opportunity

Medicaid/SCHIP

- Most states (36) have separate SCHIP programs
 - To take advantage of flexibility in regulations
 - To expand coverage without entitlement
 - KY has separate SCHIP
- Ohio, like 14 other states, used its SCHIP funds to expand Medicaid
- Medicaid/SCHIP are means tested
 - Coverage granted for at most 12 months, then must be renewed
 - Beneficiaries need to prove they meet the income and other requirements at renewal

Renewal Problems make Medicaid a Revolving Door for Many Children: From 18% to 44% of Children Have Gaps in Coverage



Data Source: State Medicaid Enrollment Files, CY 2001-2003.
Data includes children ages 3-17.

Most Gaps in Coverage Last Only a Few Months – from 2 to 4

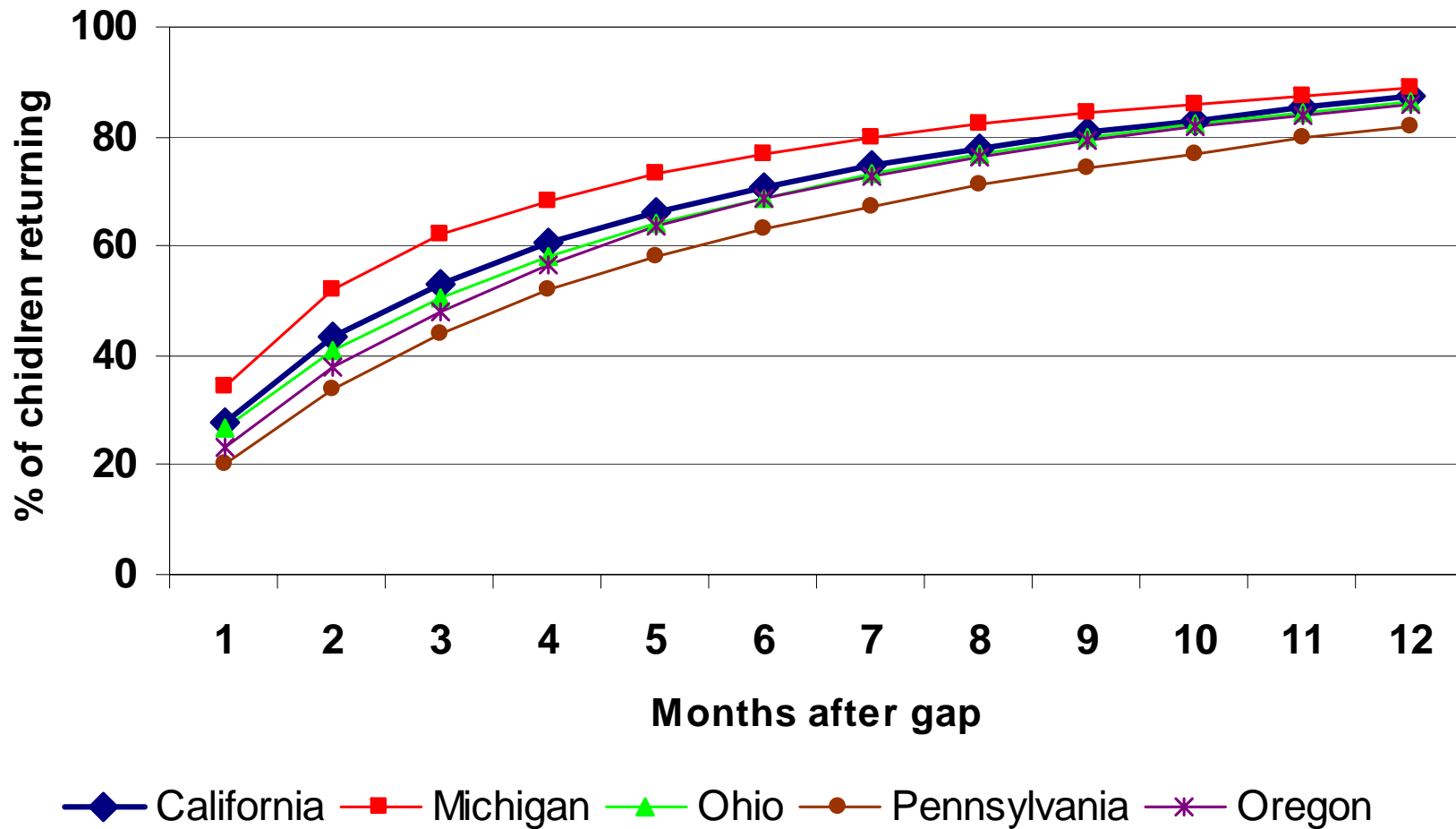
	PA	CA	OH	MI	OR
Proportion of Children with at Least One Gap in Enrollment in the Last 3 Years	16%	18%	23%	40%	41%
Mean Number of Gaps in Coverage*	1.09	1.14	1.14	1.30	1.32
Median Length of Gap (Months)	3	3	3	2	4

*Includes only those who were in Medicaid in Dec 03 and had at least 1 break during the 3 years.

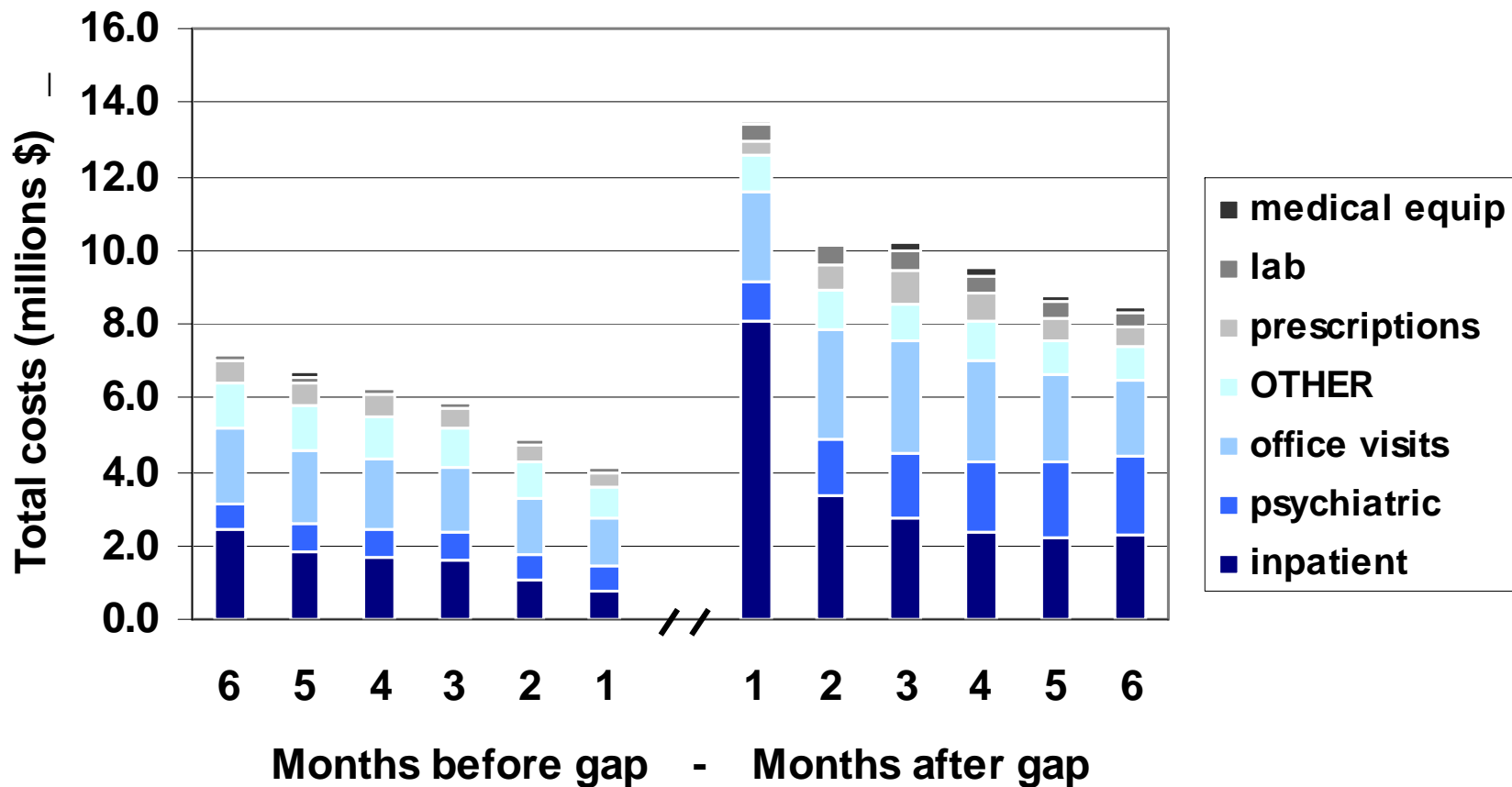
Data Source: State Medicaid Enrollment Files.

Data includes children ages 3-17 (PA data includes children 5-17).

Most children get back on coverage, but not soon enough



Medical costs are nearly doubled after a gap in coverage of at least 3 months



Source: California claims data: 1999-2001

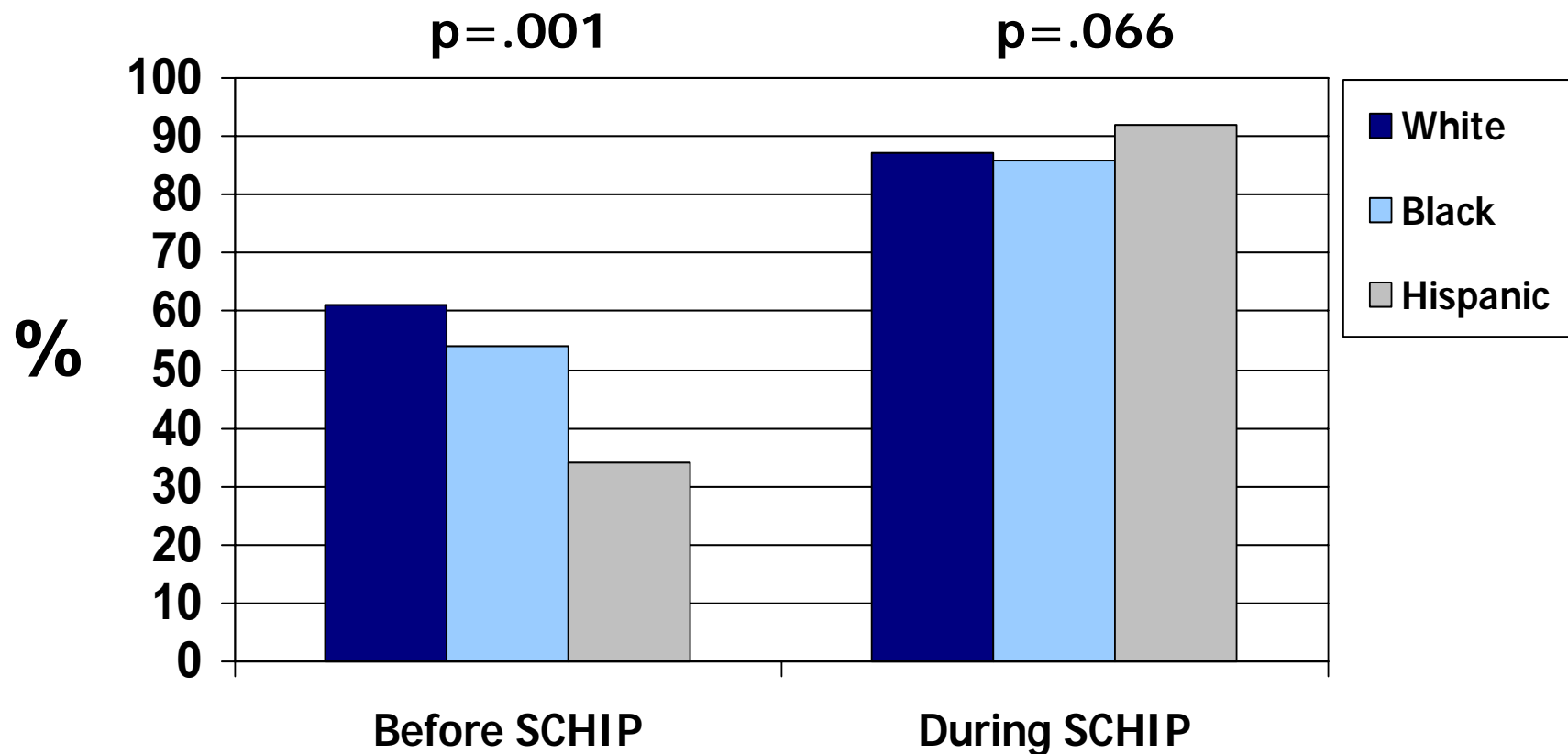
Insurance..... Changes the Outcome

- Improves access and use
- Improves “health-related quality of life” (HRQL)
- Reduces racial disparities
- Results shown in a national, 10-state evaluation of SCHIP and in individual state-specific evaluations

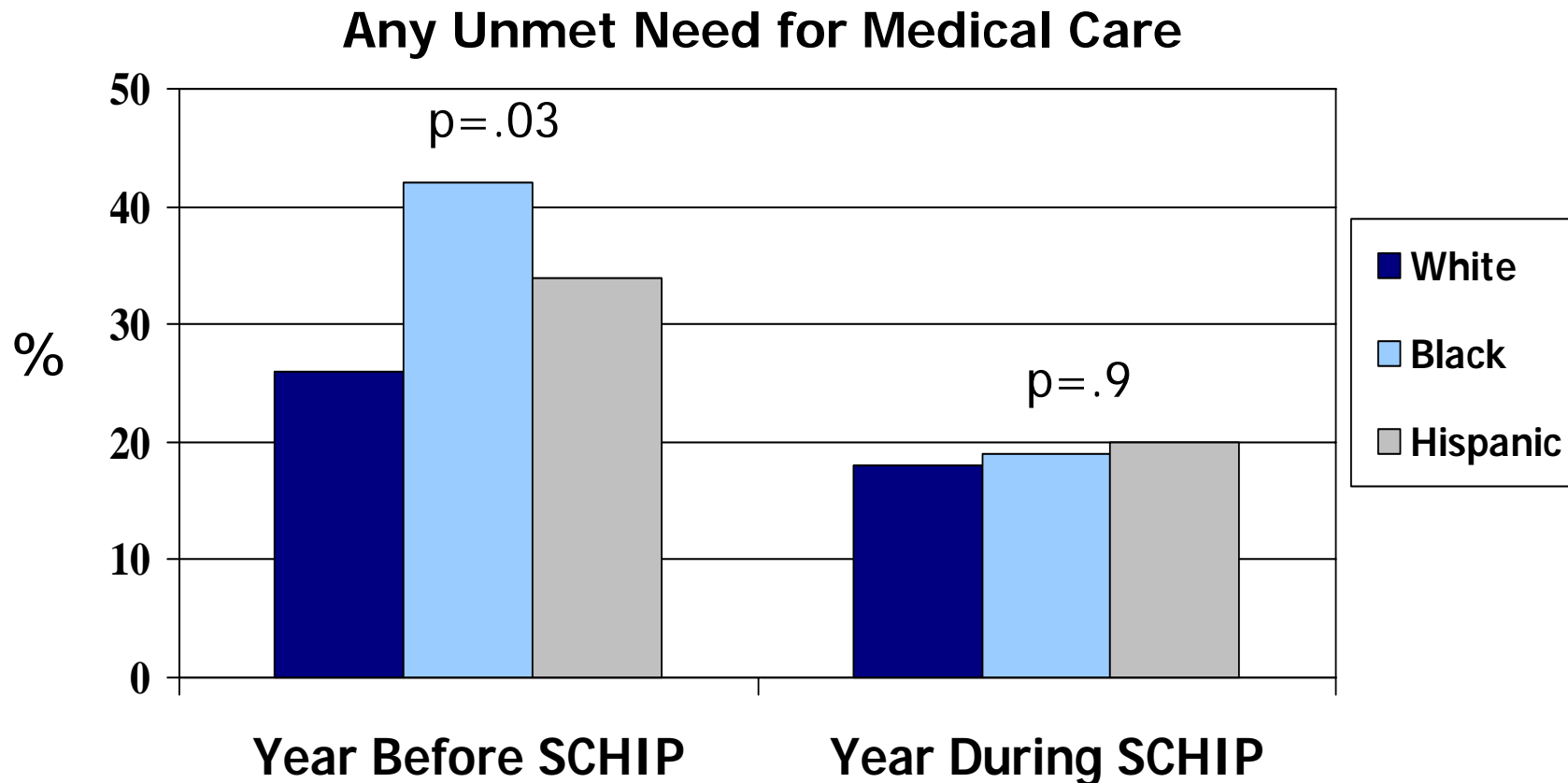
SCHIP in New York Improves Access and Continuity

	Year Before SCHIP	Year During SCHIP
Had Usual Source of Care (USC)	86%	97%
Used USC for All or Most Care	47%	89%

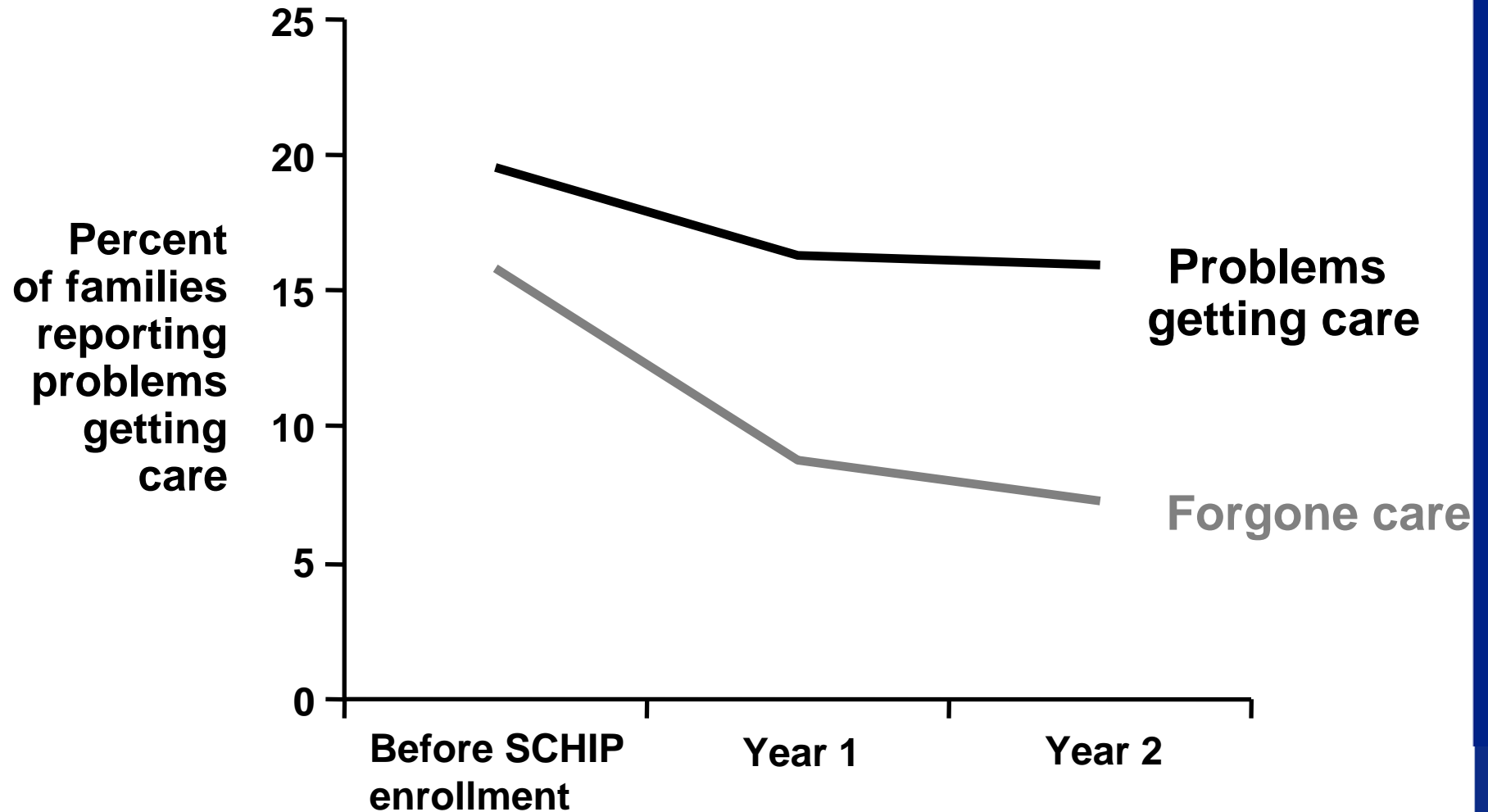
Used USC for All / Most Care: Outcome and Disparities Affected



SCHIP Reduced Racial/Ethnic Disparities



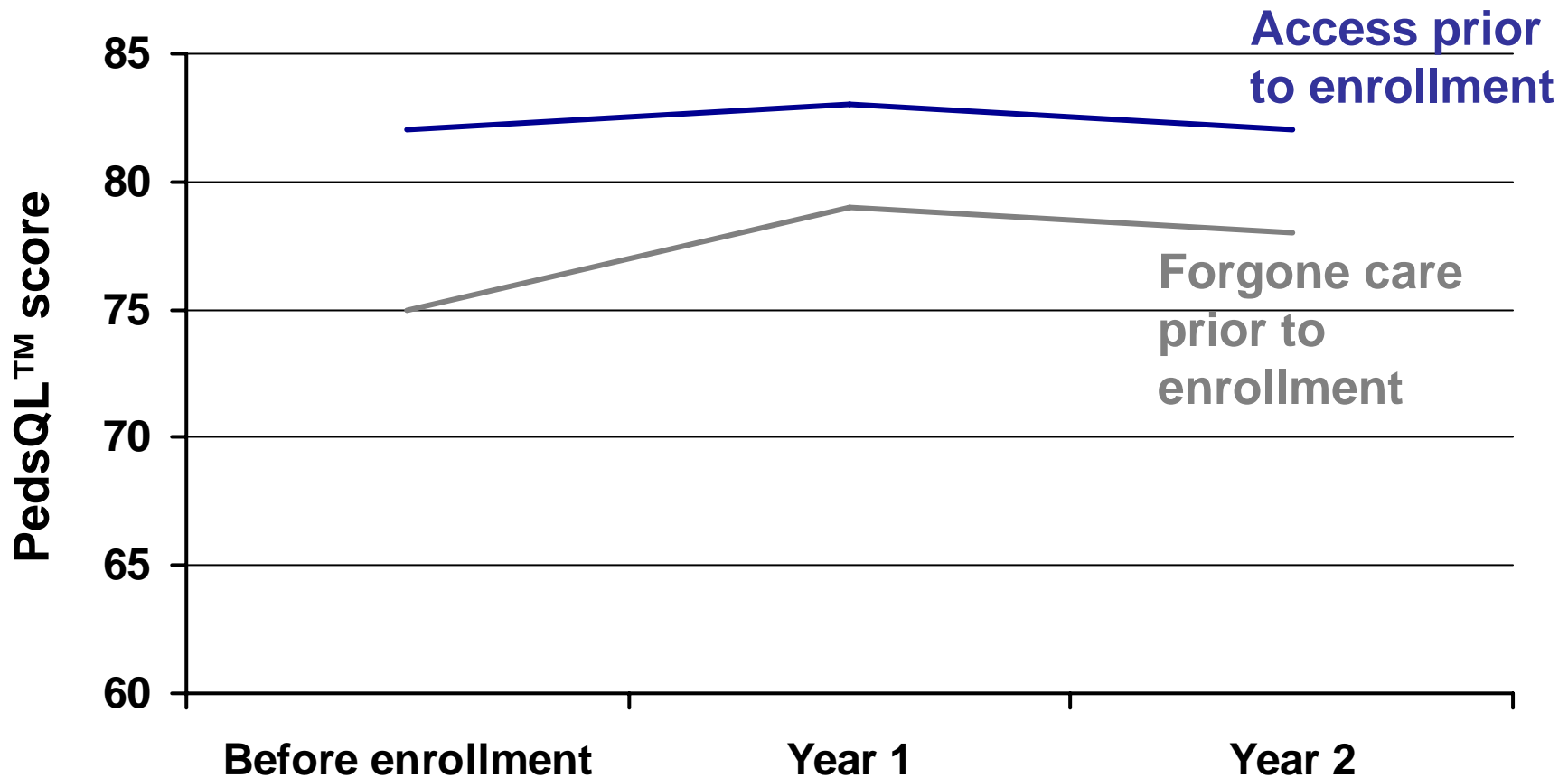
Fewer Families Reported Problems Getting Care After Enrollment in SCHIP



Source: Seid, M, Varni, JW, Cummings, L, Schonlau, M. (2006). Access to Care and Health-Related Quality of Life for Children in the California State Children's Health Insurance Program: A Two-Year Prospective Cohort Study. Journal of Pediatrics 149(3), 354-361

Better Access Improves Children's HRQOL

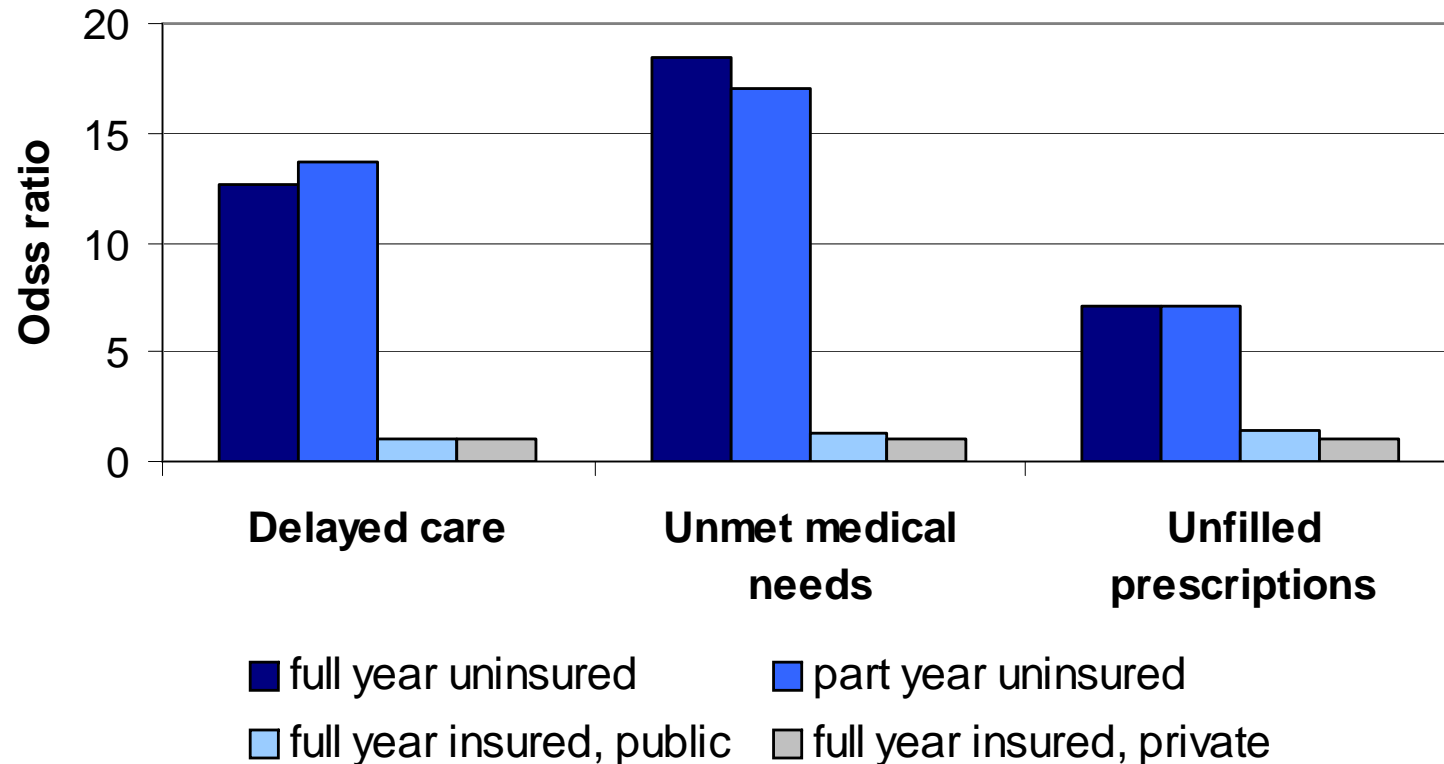
No forgone care during SCHIP enrollment



Source: Seid, M, Varni, JW, Cummings, L, Schonlau, M. (2006). Access to Care and Health-Related Quality of Life for Children in the California State Children's Health Insurance Program: A Two-Year Prospective Cohort Study. *Journal of Pediatrics* 149(3), 354-361

But... Children need to be covered for a year (or more)

Association between insurance and unaddressed health needs (Odds ratios)

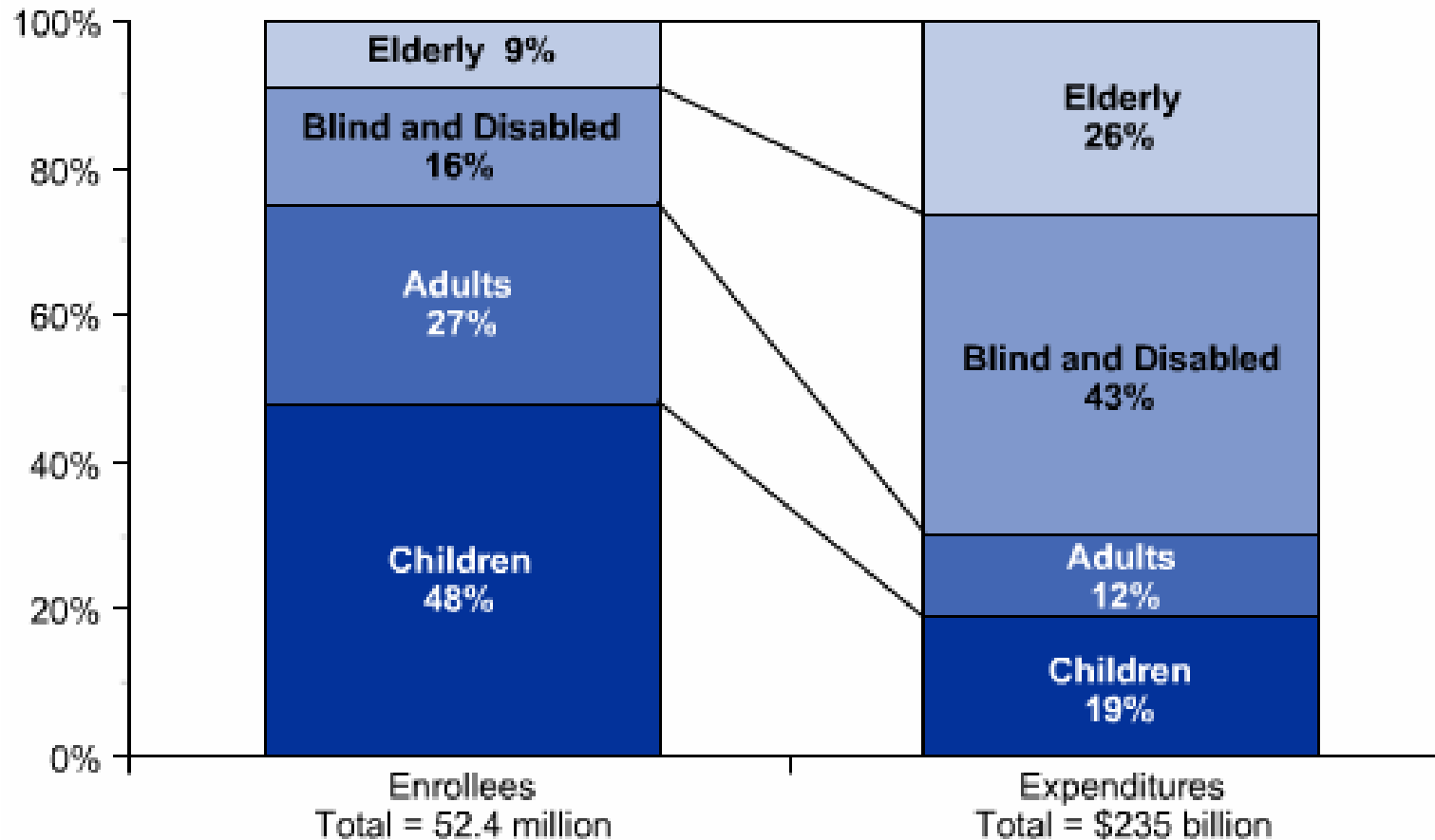


Note: full year privately insured is referent group for odds ratios
Source: Olson, Tang, Newacheck. NEJM 2005

- **Care Gap "Unconscionable"**
- **Universal Coverage AAP Aim**

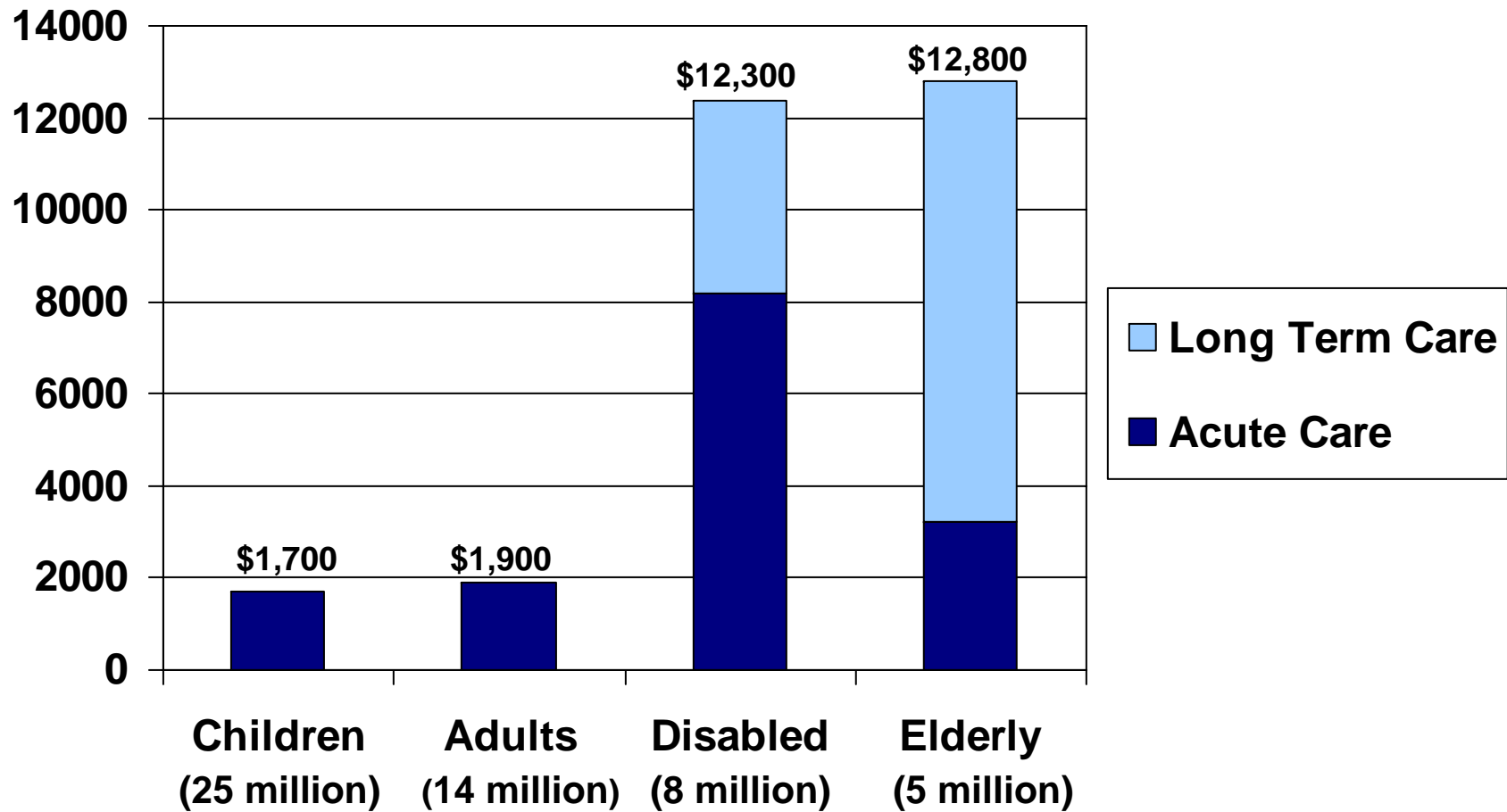
(*JAMA*. 1999;281:2076-2077)

25% of Medicaid Beneficiaries Account for 69% of Costs



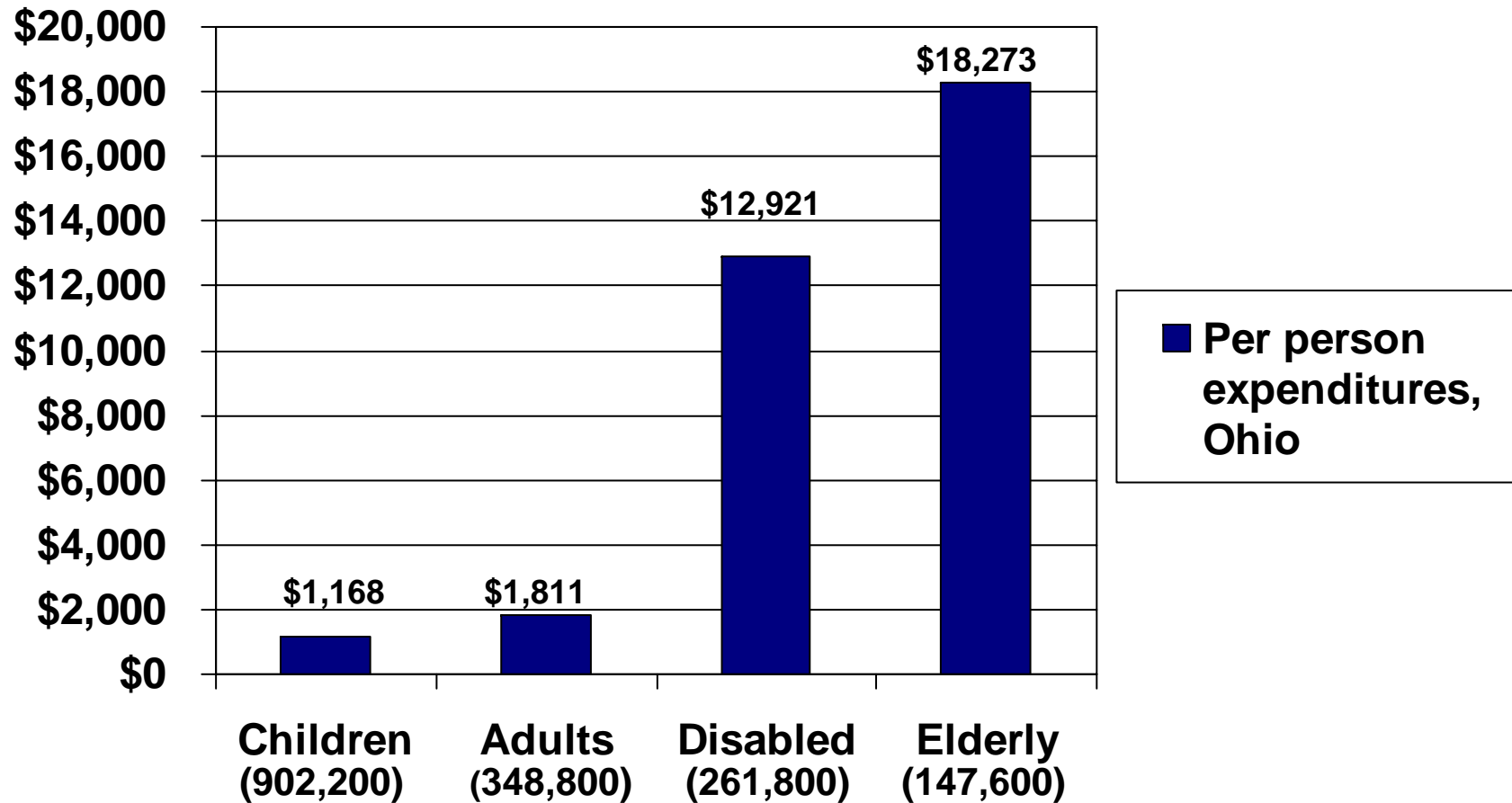
Source: Kaiser Commission estimates, based on CBO and OMB data, 2003 data. Expenditure distribution based on CBO data that includes only federal spending on services. Total expenditures assume a state share of 43% of total program spending.

Nationally, Covering Children is Cheap Most Costs are for Disabled and Elderly



Source: Kaiser Commission for Medicaid and Uninsured estimates.
based on CBO and Urban Institute data, 2004

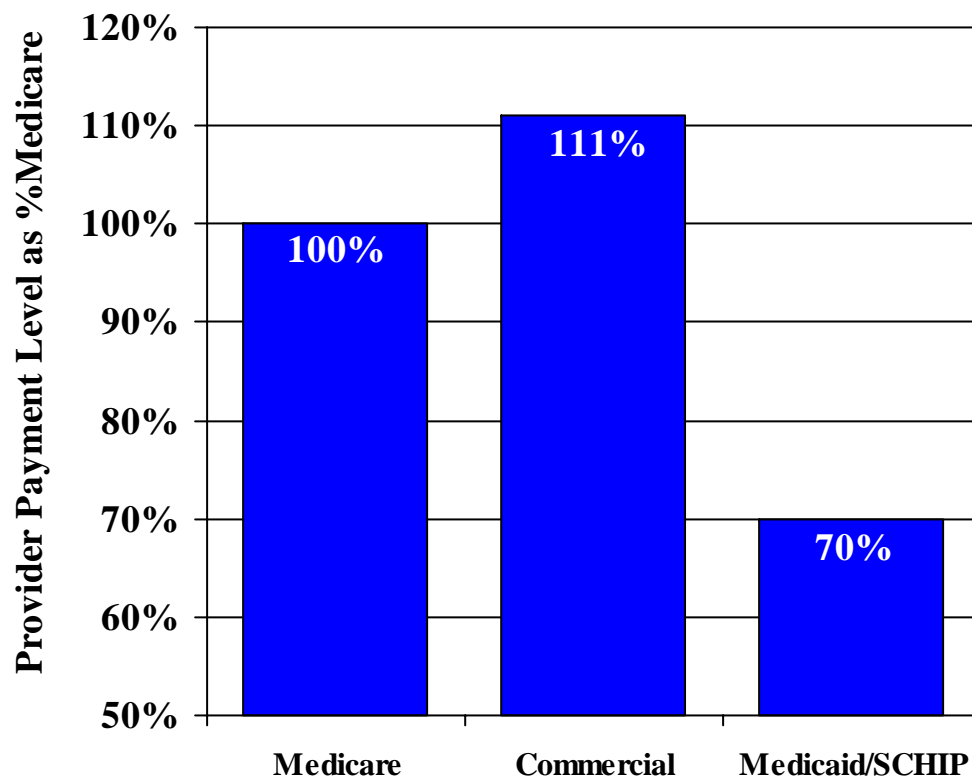
Ohio Per Person Expenditures are Similar to National Ones



Source: Medicaid: A Primer Kaiser Commission for Medicaid and Uninsured. July 2005.
Based on based on data from MSIS, 2005; Covers FFY 2001

Medicaid/SCHIP Typically do not Cover Costs

Commercial and Medicaid/SCHIP Medical Health Plan Provider Payment for Pediatric Services as a Percentage of Medicare



Source: 2006 Pediatric Medical Cost Model: an actuarial study comparing utilization and cost of services provided in commercial and Medicaid/SCHIP health plans for children in 2004, commissioned by the American Academy of Pediatrics and completed by Reden & Anders, Inc. (Available at URL: <http://www.aap.org/research/pedmedcostmodel.cfm>)

How do hospitals and providers cover the shortfall?

- Cross-subsidies
- Supplements
 - Medicaid DSH payments partially cover the shortfall in hospitals
 - In Ohio, there has been a state supplement in the budget
 - In FQHC's BPHC funding is supplemental

In Private Practice---

- There are no supplemental funding streams
- Private office-based physicians typically see few (or no) Medicaid patients
 - 35% of solo or 2-physician practices were not taking new Medicaid patients
- Medicaid children concentrated in safety net providers (public clinics, hospitals, CHCs)
 - one-quarter of physicians nationwide provide over one-half the care for Medicaid patients
- Access to dental care, mental health and specialty services even greater problem

Some provider groups are challenging reimbursement

- Provider groups have successfully sued state under the “equal opportunity” clause in Medicaid to increase reimbursement
 - In FL, OK, IL

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Ohio Medicaid

- Governor proposed for 2008-2009 budget:
 - Expanding coverage from 200% to 300% FPL (34,340 to 51,510 for family of 3)
 - Expanding beyond 300%, with cost-sharing according to income
 - Restoring coverage for parents to 100% FPL from 90%
 - (28,000 parents; \$75M)
- House and Senate voted and.....

Ohio House and Senate

- Voted unanimously on their respective budgets
- Speaker agreed to concur with Senate version
- House votes today, expected to concur
- This means
 - no conference committee
 - Senate version is what will go to the Gov

Budget that goes to the Governor

- Expand Coverage from 200% to 300% FPL
 - 20,000 children; \$20M state dollars
- Establish a Commission to study eligibility
 - Eligibility expansions
 - Crowd-out
 - Expansions of parental coverage
 - Enrolling more of the currently eligible
- Supplement for children's hospitals (\$30M)
- Inflationary increase for inpatient Medicaid (2.9% in FY08; 3.3% in FY09)
- Inflationary increase for physicians of 3%
 - Last 2 at the discretion of the Medicaid dept

If there is a conference committee

- Governor and advocates will try to:
 - Secure coverage for children >300% FPL
 - Compromise worked out that
 - Covered children who were very ill or for whom coverage was unaffordable
 - Secure parental coverage from 90% to 100%

Ohio's expansion in perspective

- As of July, 2006
 - 21 states, including Ohio, covered through 200% FPL
 - 8 states covered between 200% and 300%
- Currently
 - 9 states are proposing expansions to 300% FPL (including Ohio)
 - Other states implementing even more extensive expansions
 - Illinois, Pennsylvania, New York

Silow-Carroll S and Alteras T, States in Action: A bimonthly look at innovation, May/June, 2007. Commonwealth Fund.
www.commonwealthfund.org. accessed June 2007

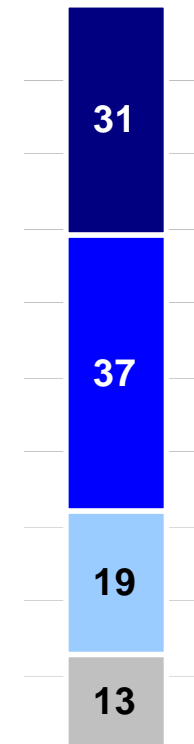
- Two state proposed or implementing universal coverage (MA and CA)

Cohen Ross D and Cox L. Resuming the path to health coverage for children and families: Kaiser Commission on Medicaid and the Uninsured, January 2007.

Most of Ohio's Uninsured Children are Eligible NOW

Poverty Level	Uninsured Children	Income
< 100%	48,000	Under \$17,170
101-200%	58,000	\$17,170-\$34,340
201-300%	30,000	\$34,341-\$51,510
> 300%	20,000	Over \$51,510
	156,000	

% of uninsured



Source: Ohio Family Health Survey, 2004
 Note: Poverty level for family of 3

Expansion vs. coverage of currently eligible but not enrolled

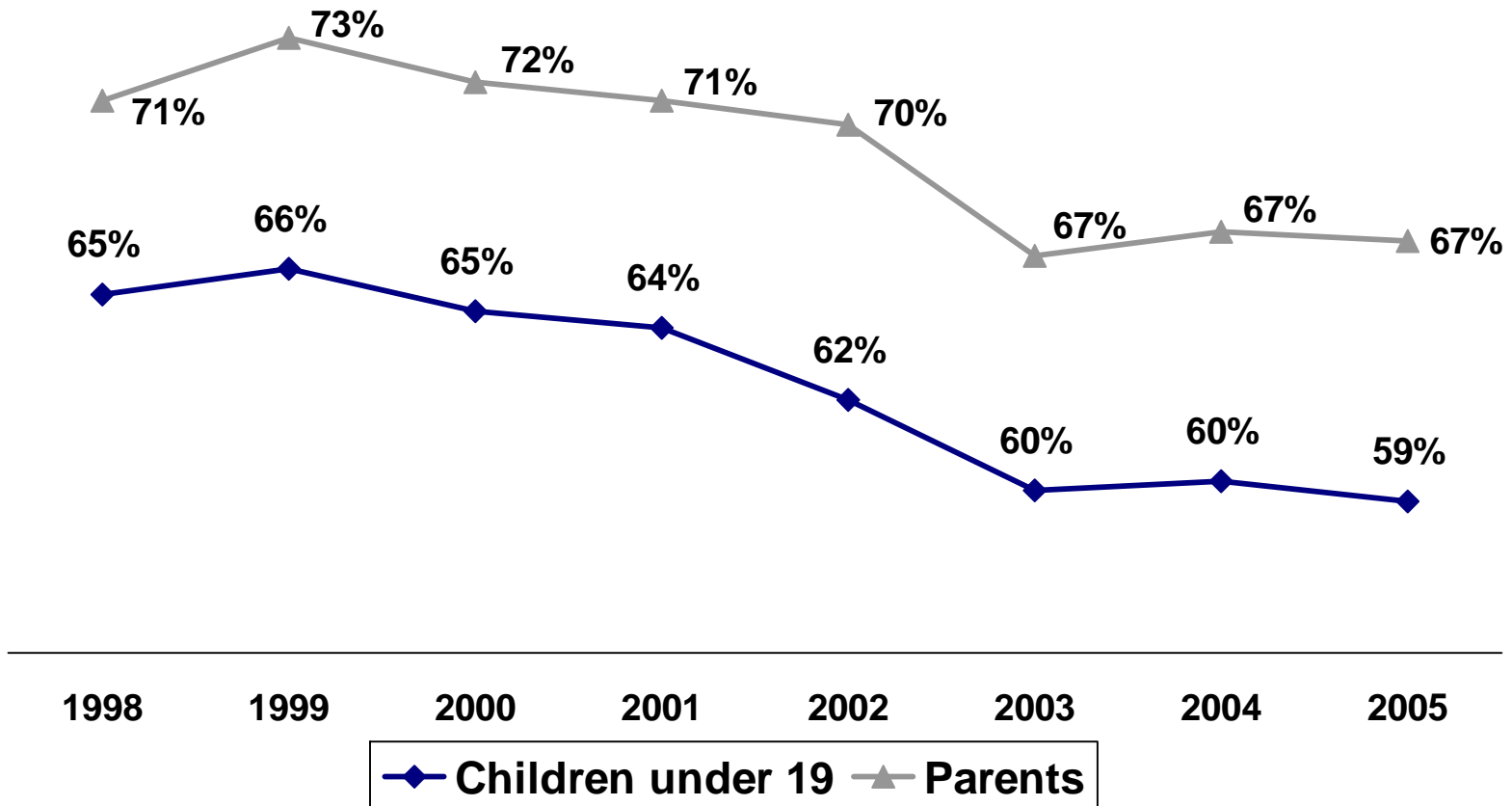
- Budget to the Governor will include funds:
 - To serve 20,000 additional children (\$20M state funds; federal match in addition)
 - These are the “expansion” children
- Budget does not include funds for children currently eligible but not insured

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Pressure is mounting and more extensive changes may be in store

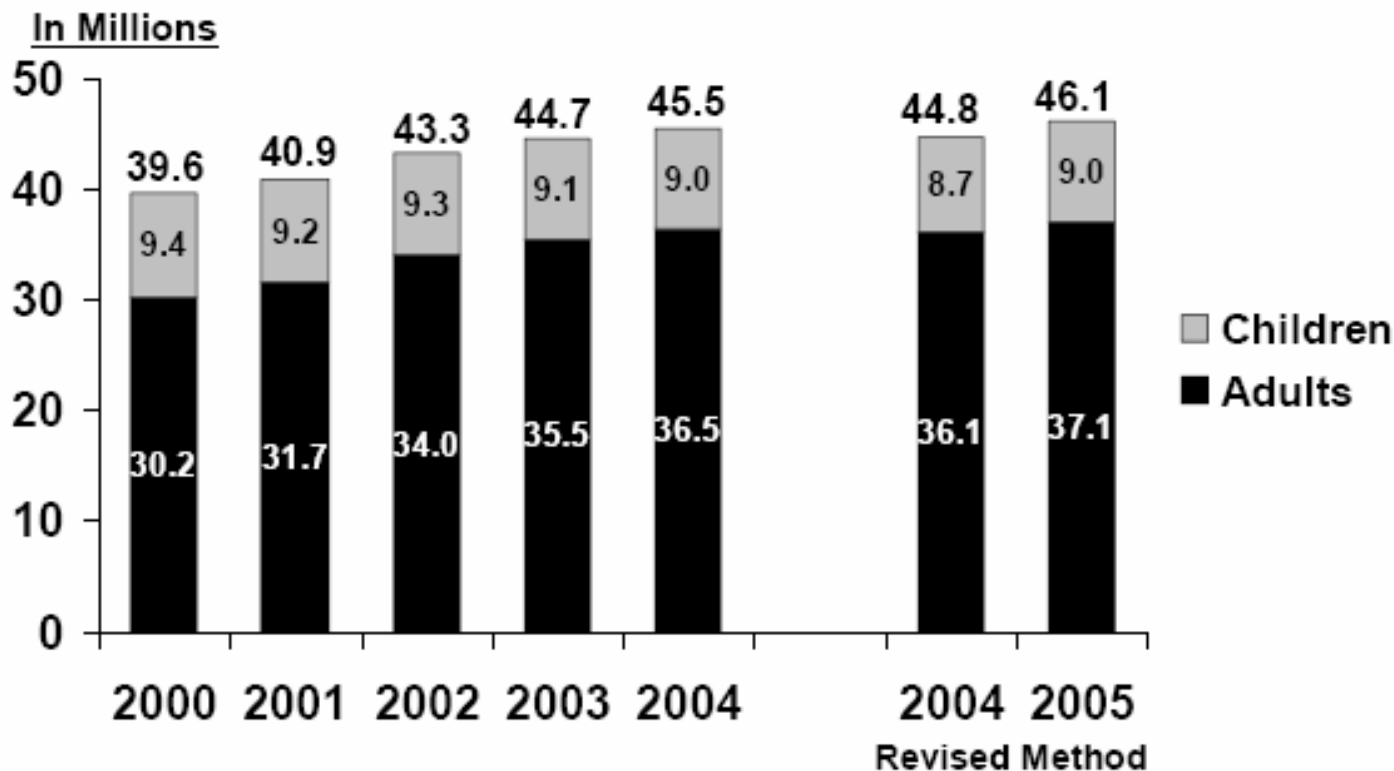
- Employer-based coverage is continuing to erode
- Pressure is building for more coherent and comprehensive coverage
 - From individuals
 - From labor
 - From businesses
- More far-reaching changes may be coming
- These could well affect hospitals and private practices

Employer-based coverage is declining



Source: CCF analysis of National Health Interview Survey.

More and More people Lack Insurance Coverage



Because of revised Census Bureau methods used for the 2005 data, 2005 estimates should be compared only to 2004 data that have been re-estimated using the new methods and not to earlier years. Sums may not equal totals due to rounding.

SOURCE: KCMU and Urban Institute estimates based on the March Current Population Surveys, 2001-2006.

Concern about uninsured is high

- Major Presidential candidates have proposals
 - Some involving universal coverage
- States are leading the way
 - With universal coverage proposals
 - With expansions beyond 200% FPL (34,340 for family of 3)

Expansions of Medicaid/SCHIP keep Medicaid/SCHIP problems

- Major Reforms like in CA, MA, or Presidential Candidates
 - “individual mandate”
 - Provide universal coverage
- Can use funds outside of Medicaid budget
- Expansions from current base Medicaid/SCHIP base
 - Do not recoup funds outside of Medicaid budget
 - Retain the low reimbursement levels
 - Retain concerns about “crowd-out”
 - Retain Medicaid/SCHIP quality oversight

Proposed Reforms around Quality Using SCHIP reauthorization

- Uniform reporting by states on core measures
- Development of appropriate measures
- Financial incentives for quality improvements
- Technical assistance for states around quality improvement
- Demonstrations on HIT, chronic care, etc.
- Monitoring coverage stability and provider capacity

Quality Pyramid

