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Overview of the Recently Passed Medicaid Budget

by William Hayes, President, Health Policy Institute of Ohio

Ohio's SFY 2006-07 budget significantly limited the projected increase in Medicaid spending. Initially, the Administration calculated baseline projections indicating that Medicaid General Revenue Fund (GRF) spending would have to increase by over 12% in 2006 and almost 10% in 2007 to maintain the existing program. Instead of these percentage increases, the recently passed budget increased baseline GRF spending by only 2.1% for 2006 and 3.75% for 2007. This reduces total Medicaid spending over the baseline projections for spending by almost \$2.1 billion all funds (meaning both state and federal funds) or almost \$900 million in state funds.

The Ohio General Assembly and Taft Administration achieved this lower growth in spending through several policy changes that would produce one-time savings and several changes aimed at lowering the rate of growth in spending over time. The one-time savings initiatives will lower the base for future spending growth, assuming that policymakers do not restore any of these reductions in the future.

The one time savings actions place burdens on both consumers and providers. Consumers face three significant changes that affect their access to care. First, the budget bill eliminates coverage for parents with incomes between 90 and 100% of poverty (100% of poverty in 2004 was \$18,850 for a family of four). The Ohio Department of Job and Family Services (ODJFS) estimates that 27,000 parents will lose coverage through this policy action.

Second, the budget reduces the total amount of money for the adult dental benefit by around 50%. As a result, ODJFS must restructure its adult dental benefit into a smaller package of covered services, affecting around 800,000 adults.



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Overview of the New Medicaid Budget

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Finally, the budget cut spending for the Disability Medical Assistance (DMA) program by \$80 million over the two years of the budget, reducing it from \$140 million to \$60 million. ODJFS, along with a legislatively created DMA Council, must figure out how to reconfigure this program to live within its restricted budget. DMA provides primarily prescription medication coverage to a people with very low incomes (\$115 a month) who have an ongoing medical condition that requires prescription medication. This is done to prevent this group of people from facing a high risk of an emergency medical situation.

Providers experience two significant changes in this budget. First, all providers, except for children's hospitals and pharmacies, will have their payment rates frozen at the SFY 2005 level. Children's hospitals will get a rate increase while pharmacies will receive a rate cut.

Second, the reduction in coverage places an additional pressure on providers regarding whether or not to continue to provide care. They may choose to stop seeing their patients who have lost coverage or had their benefits reduced. Or, they may increase their amount of uncompensated care. Or, they may treat the consumers, seeking payment directly from the consumer. Certain providers, especially hospitals and clinics, worry that these changes will result in an appreciable increase in demand for care, from a population with no ready money to pay for that care.

Outside of the actual budget bill, hospitals will experience two other actions that will reduce their payments from Medicaid. First, ODJFS is in the process of recalibrating the payment rates for all hospital services. This process seeks to make sure that payments reflect changes in the practice of medicine, many of which result in the payment needing to be lower for a given service. Second, ODJFS is changing its policy for paying cost sharing payments for people on Medicare (known as crossover payments). This change will make sure that Medicaid pays no more than the maximum amount it would pay if the consumer did not have Medicare coverage. The hospital, or nursing home, will have to seek the rest of the money it is owed from Medicare.

The budget bill also contains four policies aimed at reducing the growth in spending over time. These policies are the expansion of managed care, restructuring of the payment for institutional long-term care services, experiments around community-based long-term care services, and increased use of consumer cost sharing.

The managed care expansion focuses on both the Covered, Families, and Children (CFC) population and, for the first time in a major way, a portion of the Blind and Disabled population. The bill requires Medicaid to expand full risk managed care to the entire CFC population in all 88 counties. It also demands the adoption of full risk managed care for adult blind and disabled consumers who are not in a waiver program or not also receiving Medicare. The use of managed care is to reduce the growth in per-member-per-month costs compared to its rate of growth if these people continued to get their care through the fee-for-service system.

The long-term care payment change is the most significant development in this budget bill. The Ohio General Assembly discarded the old payment formula for a new one that is price-based. Moreover, while formula decisions remain in statute, future payment rate increases are not statutorily guaranteed. Each budget session, the long-term care industry will need to gain agreement for a payment rate increase. The Administration will initially propose payment rates through the Governor's budget proposal to the General Assembly.

This new long-term care language underscores a dramatic shift in influence of the industry, at least through this budget cycle. This loss began during the past two budget cycles. However, in this budget cycle the General Assembly adopted policy changes that were more severe than what the Administration had proposed, not less.

The budget bill also included a series of small initiatives designed to promote home and community-based long-term care. These changes include an 1,800 person Assisted Living Medicaid Waiver Program, a 200-person Medicaid Voucher Pilot Program, and a 200-person Intermediate Care Facility for Persons with Mental Retardation Conversion Pilot Program. All of these programs seek to help people continue to live in their homes and the community rather than stay in institutional long-term care facilities. These efforts reflect an expectation that it is less expensive for these people to live in the community.

Finally, the budget bill requires ODJFS to increase the use of consumer cost sharing. The rules for cost sharing are currently in the clearance review process and open for public comment. The hope is that this cost sharing will cause consumers to be more careful in their use of health services. If effective,

this cost sharing would lower the growth in future spending through reduced use of services.

Studies from other states show that even a small amount of cost sharing will reduce use of services. Advocates and providers have expressed concern that this reduction will occur around needed services, perhaps leading to people becoming sicker and ending up needing more expensive services.

The bill attempts to include some protections for providers related to cost sharing. Currently, providers cannot force consumers to pay any cost sharing obligation and must continue to see consumers who have refused to pay it. The bill prohibits providers from waiving the cost sharing amount and allows them to refuse to serve a Medicaid consumer who has an outstanding debt with them. These provisions may not pass federal muster, however.

The budget bill also contains many other reforms. For example, the bill affirms the program's goal of replacing its current Medicaid information technology system with one that should enhance the capacity to purchase value. However, the bill also complicates this effort, by creating study groups and adding responsibilities for Medicaid technology decisions to other agencies. The budget bill also includes policy actions around fraud detection and review, as well as toughening asset requirements for gaining Medicaid eligibility. All of these changes attempt to reduce inappropriate Medicaid spending and lower the future growth in spending.

The budget bill has produced perhaps the largest number of simultaneous program changes ever. Implementing policy changes is often an overlooked and under-appreciated part of the budget process. These changes cannot take place without a host of administrative and computer system actions by ODJFS. Also, many of these changes can only commence after a prescribed time frame for review, comment, and public notice. As a result, ODJFS staff face an intense amount of work in a relatively short time frame.

Given the implementation challenges, ODJFS plans to roll out the consumer-focused changes over a six month period. The DMA policy change is to take place around October 2005. The parent coverage, adult dental, and cost sharing changes are to take place by January 2006. The proposed cost sharing rules are currently going through the rules review process.

Moreover, ODJFS staff cannot make these changes alone. Some of the changes require federal review and support. Many of these changes must go through state review through the rules review process. It is also possible that some of these changes will face court review if opponents of the changes sue the state. One long-term care association has already sued the state over the changes to institutional long-term care payments.

Medicare Part D Benefits Are Coming

This coming January, individuals receiving Medicare will be eligible to enroll for prescription drug benefits. On October 15, 2005, Ohio's two million Medicare consumers will be mailed their *Medicare Handbook*. And contained in that handbook for the first time will be a list of prescription drug plans into which they can enroll. Moreover, there are an estimated 340,000 Ohio Medicare consumers who may be eligible for "Extra Help" to pay for the premiums and cost-sharing associated with the new drug benefit.

These two million Medicare consumers must make decisions regarding whether or not to sign up for the benefit and, if signing up, to select which vendor to receive those benefits from.

There is a growing concern that people will not be ready to make the decisions they need to make about signing up for the benefit. The cost of the premium, the limitations of the benefit, and the penalties for not enrolling by May 15, 2006, make it important that every Medicare consumer understands what is best for him or her.

The federal government and others are working to reduce confusion among the elderly and their support systems regarding this benefit. It is well documented that the elderly are more likely to take action when they get information from a source they trust. To reduce confusion, many organizations in Ohio, such as the Access the Benefits Coalitions, are holding training and information sessions to help describe Medicare Part D and answer questions.

The Medicare Part D benefit has already had an impact on Ohio's state budget. This law changed how Ohio pays for prescription benefits to Medicaid consumers who also have Medicare (dual eligibles). Starting January 2006, Ohio will send money to the federal government to cover the state's share prescription obligation for these dual eligible consumers. The new budget created a separate line item to reflect this specific expenditure, a line item that will substantively reduce the calculation of the percent of Medicaid spending in the state budget.

The coming Medicare Part D benefit implementation warrants close attention to its effect for Ohio's Medicare consumers, providers, and communities. HPIO is exploring the value and opportunity to organize a well designed evaluation on the effects of Medicare Part D in Ohio.

Two Federal Government-Sponsored Health Reform Workgroups

by William Hayes, President, Health Policy Institute of Ohio

The federal government is sponsoring two separate workgroups, each focusing on health care reform: the Medicaid Commission and the Citizens Health Care Working Group. Policymakers, health professionals, advocates, and other people interested in or affected by federal health policy actions should pay attention to, and possibly participate in, the work of both groups.

Medicaid Commission

In July, Health and Human Services Secretary Mike Leavitt announced the members of the Bush Administration's Medicaid Commission. The Medicaid Commission has 13 voting and 15 non-voting members.

The charge to these members is twofold. First, by September 1st of this year the Commission is to issue a report that provides recommendations on how to reduce Medicaid spending growth by \$10 billion over the next five years. The Commission is holding two public hearings to obtain information and comments regarding this set of recommendations.

This report will contain proposals to reduce federal Medicaid money that comes to Ohio. Possible ways to reduce spending include limitations on the use of provider taxes, limitations in the amount of Medicaid administrative dollars for states, and changes in the counting of assets for Medicaid eligibility. The provider tax policy proposals could affect Ohio's existing provider taxes around long-term care, as well as the proposed provider tax that is to fund the managed care expansion.

Second, by December 31, 2006, the Commission is to issue a report that includes recommendations on how to create a sustainable Medicaid program over the long term. The Federal Charter authorizing the Commission requires it to develop proposals that address the following issues:

- Eligibility, benefit design, and delivery;
- Expanding the number of people covered with quality care while recognizing benefit constraints;
- Long-term care;
- Quality of care, choice, and beneficiary satisfaction;
- Program administration;
- Additional topics submitted by the Health and Human Services Secretary.

The chair of the Commission is former Tennessee Governor Don Sundquist. The vice chair is Angus King, former governor of Maine. The other members are:

- Nancy Atkins, commissioner of West Virginia's Medicaid program;

- Melanie Bella, for Medicaid director from Indiana and vice president for policy at the Center for Health Care Strategies;
- Gail Christopher, vice president at the Joint Center for Political and Economic Studies;
- Gwen Gillenwater, director for advocacy and public policy at the National Council on Independent Living;
- Robert Helms, director of health policy studies at the American Enterprise Institute;
- Kay James, former director of the Office of Personnel Management;
- Troy Justesen, deputy assistant secretary for the office of special education and rehabilitative services at the Department of Education;
- Tony McCann, secretary of the Maryland Department of Health and Mental Hygiene;
- Mike O'Grady, assistant secretary for planning and evaluation at HHS;
- Bill Shiebler, former president of Deutsche Bank;
- Grace-Marie Turner, president of the Galen Institute.

The 15 nonvoting members, who are to provide advice to the voting members, are James Anderson, Julianne Beckett, Carol Berkowitz, Maggie Brooks, Mark de Bruin, Valerie Davidson, John Kemp, John Monahan, Joseph Marshall, John Nelson, Joseph Piccione, John Ruggie, Douglas Struyk, Howard Weitz, and Joy Johnson Wilson. James Anderson, who is president and CEO, of Cincinnati Children's Hospital Medical Center, is the only member of the Commission from Ohio.

Information on the workings of the Medicaid Commission can be found on the Centers for Medicare and Medicaid Services website at <http://www.cms.hhs.gov/faca/mc/details.asp>.

Citizens' Health Care Working Group

The Medicare Modernization Act (MMA), which gave us the Medicare prescription drug benefit, authorized the second health reform effort. Section 1014 of the MMA called for the creation of the Citizen's Health Care Working Group. The sponsors of this section of the MMA were Senator Orrin Hatch (R-Utah) and Senator Ron Wyden (D-Oregon).

They pushed for this Working Group to create a vehicle for an informed national public debate about improving the health care system to provide every American with the ability to obtain quality, affordable health care coverage. Per the statute, Congress authorized this effort because:

- the American public must engage in an informed public debate to make choices about the services they want covered, what health care coverage they want, and how

- they are willing to pay for that coverage;
- even with all the money being spent there remain a large number of uninsured, the insured do not always have access to essential effective services, and employers are having a difficult time providing coverage;
- even with increases in health spending there has not been a commensurate improvement in our health status as a nation;
- health care costs can result in medical bills that potentially harm the economic stability of the entire family;
- common life occurrences can jeopardize the ability of a family to retain private coverage or access public coverage;
- there is need for more creative policies to tap the potential for state, local, and private sector innovations in health care access, coverage, and quality;
- Despite our nation's wealth, the health care system does not provide coverage to all Americans who want it.

The Working Group is to begin its work by holding public hearings in various parts of the country. These hearings will help the Working Group create a report entitled "The Health Report to the American People," to be released within 90 days of the completion of these hearings. The Working Group will then conduct a series of community meetings around the country to solicit comment and reaction to the report. At a minimum these community meetings are to address the following questions:

- What health care benefits and services should be provided?
- How does the American public want health care delivered?
- How should health care coverage be financed?
- What trade-offs are the American public willing to make in either benefits or financing to ensure access to affordable, high quality health care coverage and services?

Upon completion of the community meetings, the Working Group has 120 days to issue an interim set of recommendations on health care coverage and ways to improve and strengthen the health care system. After a period for public comment, the Working Group will finalize these recommendations and submit them to Congress and the President. The law calls for the President to review the recommendations and submit a report to Congress that contains additional views and comments on the recommendations and recommendations for legislative and administrative actions. Key Congressional committees are then to hold at least one hearing on the report within 45 days of its submission from the President to Congress.

The Working Group has a daunting task. It was formed in March 2005, holding its first meeting in May. It has two years to complete its work and has begun to hold the initial public hearings.

The Working Group consists of 15 members, including the Secretary of Health and Human Services and 14 individuals from across the United States. According to the authorizing legislation, these 14 people are to come from either consumers of health services, or a close associate or family member, who

Upcoming Publications in HPIO's *Why's of Health* Series

Two new publications in the *Why's of Health* series from the Health Policy Institute of Ohio will be released in early September: *Does Health Matter?* and *Does Mental Health Matter?*

Does Health Matter? closely examines the value of health, which is at the very core of all health care debates,

health care policymaking, and health care evaluation. *Does Mental Health Matter?* assesses how mental health affects individuals, families, employers, and society.

The *Why's of Health* series explores some of the complex systems issues surrounding individual and community health. Each paper will include leading national research on the topic, explain and explore the compelling arguments that comprise the current debate, and integrate Ohio-specific data and research findings, where available. These papers should contribute to a deeper understanding of the basic facets of health, health care coverage, health care financing, and health care delivery, particularly as they intersect with policymaking to impact the health of Ohioans.

The first paper in the series, *Does Oral Health Matter?*, was published in May and assessed how oral health issues affect individuals, families, employers, and society.

Among the upcoming papers are *Does Health Care Coverage Matter?*, *Why Health Care Coverage Is Not Enough*, *Why Are Health Care Costs Increasing*, *Why Health Care Quality Matters*.

For more information on the series or to receive copies of the papers as they become available, contact Jason Sanford at (614) 224-4950, ext. 302.



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Health Reform Workgroups

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have one or more of the following traits:

- are or have been recently uninsured
- have had chronic illnesses, including mental illness
- are disabled
- have coverage through Medicaid or Medicare

or, individuals with expertise in financing and paying for benefits and access to care, business and labor, and providers of health care. These members cannot be elected government officials or paid employees or representatives of associations or advocacy organizations.

The members of the working group are:

- Randall L. Johnson, chair, Director of Human Resources Strategic Initiatives at Motorola;
- Catherine G. McLaughlin, vice chair, health economist and Director of the Economic Research Initiative on the Uninsured at the University of Michigan;
- Frank J. Baumeister, Jr., physician from Oregon, specializing in gastroenterology and with experience serving Medicaid consumers;
- Dorothy A. Bazos, registered nurse and health policy consultant from New Hampshire, currently developing grants for local clinics to increase access to Medicaid eligible populations, refugees, and immigrants;
- Montye S. Conlan, advocate for the disabled from Florida
- Richard G. Frank, professor of health economics at Harvard University Medical School;
- Joseph T. Hansen, president of the United Food and Commercial Workers International Union, located in Washington, D.C.
- Therese A. Hughes, government relations and legislative analyst at the Venice Family Clinic in California;
- Brent C. James, physician and vice president of Intermountain Health Care, from Utah;
- Patricia A. Maryland, hospital administrator from Indiana
- Rosario Perez, registered nurse and the director of community outreach at CHRISTUS St. Joseph Hospital in Texas;
- Aaron Shirley, physician and associate professor of pediatrics at the University of Mississippi Medical Center
- Deborah R. Stehr, health care advocate and full-time care giver for her adult son with cerebral palsy, from Iowa;
- Christine L. Wright, registered nurse specializing in oncology from South Dakota.

You can keep track of the work of this reform effort at <http://www.citizenshealthcare.gov>. This effort creates an exciting opportunity for all to be involved in an informed, public debate on health care reform for the country as a whole and for Ohio and its communities.

OHHIT & HPIO Partner with eHealth Initiative; HIT Symposium to be Held Oct. 17

by Philip Powers, Director of Health Informatics

Several recent studies have shown that Health Information Technology can make meaningful reductions in medical errors, and gain efficiency in preventing duplicate testing, resulting in better health care and cost savings. There are other benefits that HIT can offer, such as: continuity of care, analysis and reinforcement of best practices, drug interaction cautions, formulary alerts, disease management, disease surveillance, community health improvement measurements and more.

As a result of these findings, the Health Policy Institute of Ohio sponsored the Ohio Health Information Technology (OHHIT) group, which has partnered with eHealth Initiative (eHI) to promote electronic means to improve health care in Ohio. eHI is a national effort to develop, share and disseminate knowledge, resources and tools to facilitate and support community-based health information exchange. To help accomplish this goal in Ohio, eHI is surveying the state's medical facilities, providers, payers and government to learn about HIT efforts and interest levels around the state. The survey builds upon an HIT survey completed by KePro earlier this year.

The partnership is building on the success of the OHHIT Summit held last October and is planning a new OHHIT Symposium for October 17, 2005. At the Symposium, the eHI report will be released. This will raise the awareness of local efforts and inform us all to the challenges of interconnecting them. The goal is to foster local organizations and, ultimately, build a statewide, Patient-centric Health Information Organization.

As noted in "Crossing the Quality Chasm," by National Academy Press and the Institute of Medicine (2001), "If we want safer, higher quality care, we will need to have redesigned systems of care, including the use of information technology to support clinical and administrative processes... the current care systems cannot do the job. Trying harder will not work. Changing systems of care will."

Change is never easy. But it has become clear that the time for this change in Ohio is now, and we want to help foster it.

Information on this fall's OHHIT Symposium will be available in early September on the Health Policy Institute of Ohio website at <http://www.healthpolicyohio.org>.

Translating Research into Practice

by Janet Goldberg, Policy Analyst

From July 18-20th, the Lewin Group and the Agency for Healthcare Research and Quality co-sponsored the annual Translating Research into Practice (“TRIP”) conference in Washington, D.C. The TRIP movement recognizes that too often good research results are either not communicated, or communicated ineffectively, to clinicians and policymakers who rely on science-based knowledge to make informed decisions. The challenge for conference attendees – and those of us at the Health Policy Institute of Ohio – is to find ways to narrow this gap between the knowledge producers and knowledge users.

Jacqueline Tetroe, a member of the Knowledge Translation Research Group at the Ottawa Health Research Institute, presented the results of an interesting study on the challenges of translating research into practice and policy. The study involved surveying applied researchers, policymakers and knowledge transfer experts in Canada to identify their views on the TRIP process. This research was prompted by earlier work suggesting that the lack of communication between researchers and policymakers hinders the use of applied research in decision-making:

“Both decision-makers and health services researchers behave as though health services research makes a genuine contribution to public policy. At the same time, many researchers are skeptical about the extent to which research is used and many policy makers are skeptical about the usefulness of research... In public policy making, many suppliers and users of health services research are dissatisfied, the former because they are not listened to, the latter because they do not hear much they want to listen to.” (adapted from Innvaer, et.al., Health Policy Maker’s perceptions of their use of evidence: a systemic review. *Journal of Health Services Research and Policy* 7/4 239)

Tetroe’s survey of applied researchers found a similar theme: translation of research for policymakers is neither a high priority nor an appealing process - despite the fact that they believe their research is useful. Highlights of the survey include the following:

- The four most common forms of implementation, or TRIP, performed by researchers were educational sessions with practitioners (42%), stakeholder involvement (40%), media involvement (23%) and educational sessions with policy makers (19%).
- Most researchers see TRIP, or knowledge transfer, as time and resource intensive with little reward and acknowledge a lack of skills to effectively inform policymakers.
- Researchers believe that their work is important and useful to decision makers (75%), health care practitioners (68%) and the Canadian public (49%).

The survey of policymakers found that their use of research is facilitated by personal contact with researchers, timeliness and relevance of the research, and the inclusion of research summaries with policy recommendations.

Together, these survey results suggest a real need for organizations like the Health Policy Institute of Ohio that are committed to making research relevant, understandable, and usable by policymakers. According to the knowledge transfer experts surveyed by Tetroe, the most effective knowledge transfer processes involve policymakers, include clear presentations tailored to the audience, and provide an opportunity for education, interaction, and collaboration – all seminal characteristics of HPIO’s *Talk About Health* Series.

New SPASM Helps Public Health Epidemiologists and Researchers

As a service to Ohio’s practicing public health epidemiologists and researchers, the Health Policy Institute of Ohio has once again helped sponsor a practitioner-based epidemiology course through the Summer Program in Applied Statistical Methods (SPASM) at the Ohio State University.

Last year’s course, taught by Dr. David G. Kleinbaum, Professor of Epidemiology at Emory University in Atlanta, was offered at no cost to current public health practitioners. Over 120 practicing public health epidemiologists and researchers attended the course.

This year, 222 public health epidemiologists and researchers attended the workshop. Three courses were taught: Applied Infectious Disease Epidemiology, Practice-Based Epidemiology, and the Epidemiology of Natural and Man-Made Disasters.

In addition to the Health Policy Institute of Ohio, other sponsors of the course this year were the Ohio Department of Health, the Ohio State University School of Public Health, the Center for Biostatistics at the Ohio State University, the Franklin County Board of Health, and the State Epidemiology Group.

Planning is already underway for next year’s SPASM, which will be the last phase of the three-year cycle of the workshops. Next year, new courses will tentatively be offered in Environmental Health Epidemiology, Field Epidemiology, and Geographic Information System (GIS) Epidemiology (in addition to possible repetition of courses previously offered.)



37 West Broad Street, Suite 350
Columbus, OH 43215-4198
Phone: 614.224.4950; Fax: 614.224.2205
www.healthpolicyohio.org