

Comparison Between Ohio and Michigan Medicaid Programs

In July, the Health Policy Institute of Ohio provided the Ohio Commission to Reform Medicaid with several tables that compared Medicaid programs in 14 states. One of these tables showed that Michigan's program had the lowest per person spending overall for each of four categories of covered Medicaid populations—aged, blind/disabled, adult, and child. This data produced a request from the Commission for further analysis to explain why per person spending is less in Michigan than in Ohio.

This analysis of Ohio and Michigan Medicaid data seeks to account for these differences in per person spending. To complete this analysis, HPIO analyzed federal fiscal year (FFY) 2001 Medicaid Statistical Information System (MSIS) data for Michigan and Ohio, incorporated an analysis of FFY 2002 data on dual eligible enrollment and expenditures for all states, reviewed reports on Michigan's program, and talked with staff in Ohio's and Michigan's respective Medicaid programs.

To perform this analysis, HPIO compiled three new tables of data, which are in the Appendix.

- Table 1 compares Michigan and Ohio Medicaid populations and costs for FFY 2001 for all groups and by the eligibility categories of aged, blind/disabled, adult, children, and unknown. This table gives the number of people covered, the number who used services, the percent of users to eligibles (a utilization rate), expenditures, cost per user, and cost per eligible for each eligibility category.
- Table 2 lists the dual eligibles and expenditures consumed by the dual eligibles for each state. Table 2 also adds a section that compares population information for total population, population less than age 18, population between 18 and 65, and population over age 65. In addition, the table bolds the names of those states that are known as 209-states.
- Table 3 breaks the total spending and use of services into seven major service categories: inpatient hospital, ICF/MR, nursing facility, physician, outpatient hospital, pharmacy, and capitated payment. This table contains four separate tables within it. One table provides total expenditures, the second table total number of users, the third table an average per person cost, and the fourth table a utilization rate (number of users as a percent of total users).

continued on page 2

continued from page 1

According to the FFY 2001 MSIS data, Ohio spent on average \$5,498 of services per Medicaid user compared to \$3,931 in Michigan. Ohio's average per Medicaid user spending was higher for each category of eligibility—child, adult, blind/disabled, and aged.

2001	OHIO	MICHIGAN
Aged	\$ 20,139	\$ 13,296
B/D	13,915	6,298
Child	1,393	979
Adult	2,263	1,948
Unknown	72,340	21,504
Average	\$ 5,498	\$ 3,931

The Urban Institute/Kaiser Commission analysis of FFY 2002 MSIS data for the dual eligible population (people who get both Medicaid and Medicare coverage) shows the same results. According to this study, Ohio spends \$20,111 per dual eligible, while Michigan spends \$8,739 per dual eligible. Ohio ranks sixth and Michigan 46th in spending per dual eligible, out of the 50 states and Washington, D.C. (Bruen, 2003).

2

Possible explanations for the differences in spending

One or more of the following most likely account for Michigan's lower per person spending:

- **Proportion of people using institutional services** (see page 3);
- **Proportion of aged and blind/disabled population in poor health** (see page 4);
- **Price per unit of service** (see page 6);
- **Proportion of people in managed care** (see page 7);
- **Differences in benefits covered** (see page 8);
- **Differences in number of and assistance to the uninsured** (see page 8).

All of these possible explanations are covered on their respected pages. In addition, **Michigan's current budget situation related to Medicaid** is explored (see page 9), along with an overall **conclusion** (see page 10) and **references** (see page 11).

Proportion of people using institutional services

Institutional services tend to be more expensive than community-based services. Therefore, a state with a higher proportion of people using institutional services should experience a higher cost per person. Medicaid programs pay for two different types of institutional services—long term care facilities and inpatient hospitalization.

Long-term care facilities

Long-term care services can fall into two types—nursing homes and ICF/MRs (intermediate care facilities for the mentally retarded).

The 2001 MSIS data indicate that a much larger proportion of Ohio Medicaid consumers receive services in nursing homes and ICF/MRs than in Michigan. Over 5.4% of Ohio's total Medicaid consumers who used services in FFY 2001 received services in nursing homes compared to 3.3% in Michigan. Just over half a percent (.52%) of Ohio's total Medicaid consumers who used services received services in ICF/MRs compared to .02% in Michigan.

Among the Blind and Disabled eligibility group, 5.2% of Ohio's population received services in nursing homes compared to 2.3% in Michigan, more than twice the rate. For the Aged group, 48.5% received nursing home services in Ohio compared to 41.1% in Michigan.

If Ohio had the same proportion of Medicaid users receiving nursing home services as Michigan, Ohio would have had 30,268 fewer consumers using nursing home services in FFY 2001.

Michigan's lower percent of people in institutional settings could reflect policy actions that encourage community-based care. It could also reflect a difference in the relative health of the overall aged and blind/disabled populations in both states.

Either way Michigan has fewer people using institutional long-term care services. In FFY 2001 Ohio had 76,928 people who received services paid by Medicaid in nursing homes compared to 44,747 in Michigan. Ohio also had 7,412 consumers receiving Medicaid paid services in ICF/MR facilities compared to 318 in Michigan.

Inpatient hospitalization

Comparing inpatient hospitalization rates between Ohio and Michigan is difficult because of differences in the use of Medicaid managed care. In FFY 2001, 73.6% of Michigan's Medicaid consumers received services through capitated payments—including 57.7% of Michigan's ABD consumers—compared to 28.4% in Ohio.

The MSIS data indicates how many Ohio and Michigan Medicaid consumers used inpatient hospital services in FFY 2001 and what those services cost. Michigan's higher rate of managed care means that it will have a lower rate of overall fee-for-service hospital use. Therefore, it is not surprising to see a higher proportion of Ohio Medicaid consumers using inpatient, fee-for-service hospital services.

Proportion of Medicaid ABD population in poor health

Per person spending reflects, in part, each person's demand for services. People who are sicker have a higher demand for services, and potentially a need for more intense services. This results in a higher average per-person cost for Medicaid. Therefore, the relative health of Medicaid consumers in Michigan and Ohio could explain some of the difference in per capita expenditures.

Even though Michigan's population has 1.4 million fewer people than Ohio, according to the Urban Institute's analysis the two states have almost the same number of dual eligible consumers—216,000 for Michigan and 219,000 for Ohio (Bruen, 2003). This larger dual eligible population suggests that Michigan has more liberal eligibility policies that allow coverage to more people.

Overall, aged and blind/disabled populations are the most expensive portion of the Medicaid population. The chronic conditions that exist among the ABD population cause the population to have a higher need for services (and a higher per-person cost for these services). When these facts are combined with Ohio having more restrictive eligibility requirements for ABD than Michigan, the result is that on an average per-person basis, Ohio has a sicker ABD population than Michigan. (One way of looking at this is that Ohio does the reverse of cherry-picking. Because the state covers a smaller percentage of the ABD population than Michigan, those people Ohio covers tend to be sicker and therefore cost more per person.)

Moreover, Ohio's ABD population has a higher proportion of eligible consumers who use services (91% to 88% for the aged and 93% to 92% for the blind/disabled, according to FFY 2001 data). Ohio's higher utilization rate indicates that more of its covered ABD population have health needs that require services. In addition Ohio, which is a 209-b state, has a lower income threshold for eligibility (64% of poverty compared to 74%) and a lower asset level (\$1,500 to \$2,000) than Michigan.

The Ohio ABD situation does not appear to be unique. In fact, five of the top seven states in spending per dual eligible are 209-b states, four of which have income standards below the SSI level of 74% of poverty. A review of the number of SSI recipients in Ohio and Michigan further underscores the restrictive effect of 209-b status. As of December 2000 (part of FFY 2001), Ohio had more SSI recipients than Michigan (240,002 to 209,539), including more blind and disabled SSI recipients (222,449 to 190,136). Despite this, Michigan has more blind and disabled Medicaid consumers than Ohio (Social Security Administration, 2000).

Ohio's tendency for covering a sicker ABD population is intensified through what is called spenddown (where Ohioans who find themselves over income for eligibility through ABD Medicaid can still qualify for ABD Medicaid coverage). The spenddown amount is the difference between a person's income and the ABD income eligibility standard. If a person incurs medical bills greater than this difference, then they can qualify for Medicaid coverage in that month should they meet all other eligibility requirements. Because each of these people only qualified for ABD coverage because they had current bills from using health care services, they are more likely to be sicker than Michigan ABD consumers of a similar income level, especially for those with family incomes between 64 and 74% of poverty. According to Ohio Medicaid information for July 2003, 54.1% of the aged consumers and 26.6% of the blind/disabled consumers obtained their coverage through spenddown. A similar proportion of consumers were likely to have obtained their coverage through spenddown in FFY 2001.

A recent analysis on coverage for persons with development disabilities (Hemp 2003) reinforces HPIO's

analysis of the MSIS data that Ohio covers a sicker population and that Ohio has a greater emphasis on institutional long-term care services. Braddock's research found that Ohio has a larger percent of its blind and disabled covered population having a developmental disability in 2000 (83,928 to 80,713), even though Michigan has more people covered through its blind/disabled eligibility category. Michigan had a larger number of its consumers covered with basic health care services only (71,325 to 68,214). Ohio had a larger number of consumers needing long term care (15,714 to 9,388). Michigan had more of its long term care consumers receiving services through home and community based waivers (7,689 to 5,593) and Ohio more through institutional nursing home or public or private ICF/MR facilities.

continued on page 6

Price per unit of service

The price per unit of service is a third possible source of average cost per person differences between Medicaid consumers in Ohio and Michigan. Because of differences in the extent of managed care between Ohio and Michigan, it is difficult to compare prices, although institutional long-term care services for all population groups and capitation payments for children and adults are exceptions.

HPIO took the number of people who used a service and divided that number into the total expenditures for that service to get an average cost per user. This analysis has its limits because some people will have used a service more than once. Therefore, the average price per user most likely overstates the actual average price per user. However, this limitation resides in the data for both Ohio and Michigan, making any overstatement similar in both states and thus allowing for a comparison to still take place.

According to HPIO's analysis:

- Ohio paid more for nursing home services—\$29,283 average annual cost per user compared to \$23,727. The nursing home cost difference reflects a higher per diem rate in Ohio compared to Michigan. In 2002, Ohio paid a per diem rate of \$143.63 and Michigan paid a per diem rate of \$138.30.
- Ohio paid a higher capitation for children (\$943 to \$633) and for adults (\$1,773 to \$1,370).
- Michigan paid more for ICF/MR services (\$119,944 to \$66,010). Michigan's ICF/MR payment is more in line with Ohio's payment rate to public ICF/MR facilities. The difference, therefore, may reflect the reality that Michigan has few, high-need ICF/MR consumers still residing in public facilities.

This analysis shows that Ohio pays more for certain services than in Michigan. It can not, however, determine whether Ohio pays too much or Michigan too little.

Michigan's recent experience with its managed care capitation rates sheds some light on this question. Michigan has had to increase its capitation payments to managed care plans by \$67 million (Michigan, 2004). This increase occurred because the new actuarial soundness test of rates found that Michigan was not paying enough to the plans in its rates. The need for this increase, which Ohio did not encounter, suggests that part of the difference in spending between Ohio and Michigan came about because Michigan was paying its health plans too little.

Proportion of people in managed care

During the 1990s, most states pursued using managed care plans as a way to help manage their Medicaid budgets. Paying a managed care plan a fixed per member per month (PMPM) payment makes budget planning more predictable, especially as more people and more services come under such payment arrangements. In addition, states used managed care plans as a mechanism to contain costs. This mechanism worked when states established capitation rates with an assumed savings discount from predicted fee-for-service costs for the same consumers and same set of services.

Michigan has pursued a more intense full-risk managed care strategy than Ohio. As a result, in FFY 2001 73.6% of all Michigan's Medicaid consumers received acute care services through capitated payments to a managed care plan, compared to 28.4% in Ohio. (Note: Consumers residing in nursing homes, or in community-based care programs as an alternative to residing in a nursing home, and people eligible for both Medicaid and Medicare cannot be enrolled in a Medicaid managed care plan.)

Percent of Medicaid Users in Capitation FFY 2001

Eligibility Category	Ohio	Michigan
Aged	0.0%	1.1%
Blind/Disabled	2.7%	57.7%
Adult	40.7%	93.0%
Child	35.2%	78.0%
Foster Care		
Child	1.2%	64.0%
Unknown	21.8%	22.5%
TOTAL	28.4%	73.6%

In addition, Michigan provides mental health, substance abuse, and developmental disability specialty services and supports under a managed behavioral health program. Michigan spent almost \$1.35 billion on these services for approximately 100,000 consumers in SFY 2003 (Michigan Dept. of Community Health, 2003).

Michigan has had to raise its capitation payments for physical health services by \$67 million this past year. Its previous rates failed to meet the test of actuarial soundness.

Differences in benefits covered

Benefit differences between Michigan and Ohio are another possible explanation for the differences in per person spending. The Kaiser Foundation's current comparison of Medicaid benefit plans between states indicates that Michigan reportedly does not cover seven services, compared to four that Ohio did not cover (Kaiser, 2003). However, some of these services may be covered under the waiver programs. More importantly, these services do not consume a large amount of the Medicaid budget.

The Kaiser Foundations benefit comparison has its limits. For example, their information reports that Michigan covers ICF/MR services, even though Michigan has reportedly eliminated ICF/MR as an entitlement service.

The impact of benefit differences matters less on what is covered than on how Michigan works to keep consumers out of institutional settings for long-term care services.

Differences in number of and assistance to the uninsured

A final possible explanation for the difference in per person spending between Michigan and Ohio relates to the uninsured. Medicaid serves as the insurer of last resort. Research shows that people who are uninsured and come into Medicaid or Medicare programs have pent up health care needs. Further, the uninsured and underinsured tend to be sicker and in need of services. One Ohio study found that 75% of the new Medicaid covered nursing home patients were not on Medicaid at the time of the health event that sent them into the nursing home (Glavin, 2003). Another Ohio study found that uninsured women detected with breast cancer were detected with late stage cancer at a much higher rate than women who were regularly on Medicaid or private insurance (Koroukian, 2004).

Michigan has a better situation related to the uninsured. Its uninsured rate is around one percent less than the rate in Ohio. Michigan has obtained this lower rate, in part, by creating primary care coverage programs in several counties for low income uninsured people. It draws federal monies to help finance these programs through use of disproportionate share hospital dollars. Ohio has no programs like those in Michigan, though a couple of Ohio communities (most notably Lucas and Franklin Counties) have brought providers together to create a sliding fee schedule access-to-care program for the uninsured in their counties (Tilly, 2002).

The Michigan programs may help reduce pent up demand when their consumers qualify for full Medicaid coverage. These programs may also help to manage chronic illness and detect severe illnesses earlier, thus reducing the total need for services and costs for serving these consumers.

Michigan's current budget situation

These spending differences have not freed Michigan's Medicaid program from budget challenges. The Administration's 2005 budget proposal in Michigan includes \$447 million in new Medicaid spending to maintain its existing program. According to the Executive Budget, the need for these new revenues results from:

- the loss of federal fiscal relief;
- the loss of federal funding for special financing transactions;
- new federal requirements regarding the actuarial soundness of the managed care programs;
- the inability to obtain statutory approval for a pharmacy provider tax;
- a significant increase in caseload and utilization.

It is also worth noting that Michigan will receive \$66 million in increased federal matching dollars thanks to a change in its FMAP rate. Without this money, the state would have needed an additional \$66 million dollars—on top of the \$447 million in new Medicaid spending—to maintain their program at current levels.

To address Michigan's \$1.3 billion structural budget shortfall in 2005, including paying for the \$447 million needed for Medicaid, the Executive Budget proposes \$494 million in spending cuts, \$391 million in revenue enhancements, a \$146 million reduction in the general fund contribution to the School Aid Fund, redirections of \$154 million in cigarette tax revenue to Medicaid instead of the Rainy Day Fund, \$64 million associated with the shift in Merit Award payment schedule, and \$40 million in other fund shifts. As part of the revenue enhancement Michigan's Governor is calling for a 75-cent per pack increase in the cigarette tax. This increase in the cigarette tax, when combined with the existing cigarette tax, would provide almost \$265 million direct, ongoing support for the Medicaid program. In addition, the Executive budget calls for \$70 million in Medicaid spending savings through increased efforts to secure reimbursements from responsible third parties, reduction in pharmacy-related costs, increases in vital records fees, and changes in the nursing home payment policy for leave days (temporary hospital stays).

Conclusion

This analysis confirms that Ohio spends more per Medicaid consumer than Michigan.

A combination of factors helps to explain this difference, including:

- Ohio has historically had and continues to have a higher portion of people receiving services through long term care institutional providers, both nursing homes and ICF/MRs;
- Ohio's Medicaid ABD population has a greater need and use of health care services;
- Ohio Medicaid pays managed care plans a higher capitation payment for serving children and adults;
- Ohio Medicaid pays a higher per diem payment to nursing homes;
- Ohio Medicaid has a smaller proportion of its consumers in full-risk managed care plans;
- Ohio full-risk managed care policy focuses only on children and their parents; it does not emphasize the blind and disabled population and children in foster care;
- Michigan has developed a full-risk managed care program for mental health, substance abuse, and developmental disability services and supports;
- Michigan has more established supports to get primary care to its uninsured population.

This analysis has several limitations. While it highlights several logical factors for the differences in spending, it cannot quantify which factors account for what portion of the differences in spending. Such an analysis would require more detailed information than the MSIS data on the CMS website provides.

Medstat, who is the decision support vendor for both Ohio and Michigan, might be able to conduct a more refined analysis of this question. Medstat might also have access to more current information than is available in the public release datasets.

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