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A Comparison of Plans: Ohio and Arizona Medicaid Reform

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I. INTRODUCTION

For over a decade, Medicare and Medicaid have been extensively debated in the American political scene. Specifically, much of the discussion has focused on ways to extend coverage to the maximum number of Americans in the most economically viable way. Lately, Medicaid has been a particularly important topic of discussion nationwide, especially since state and federal governments have less funding to appropriate for publicly funded programs. With the passage of the Patient Protection and Affordable Care Act (PPACA), referred to in the pejorative sense as "Obamacare,"[1] states have created different solutions for how to reform their Medicare and Medicaid systems. In particular, Ohio and Arizona have implemented interesting approaches to reform the administration of Medicaid in their respective states.

In short, Medicaid is a national health program that focuses on helping

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1. Marilyn Serafini, *Does the Patient Protection and Affordable Care Act Need Title Reform?*, THE WASH. POST Dec. 26, 2010, http://www.washingtonpost.com/wp-dyn/content/article/2010/12/26/AR2010122602374.html.

low-income individuals or families obtain access to health care.[2] It also helps individuals with disabilities to gain access to health care.[3] Medicaid is both a federal and state program, giving states flexibility to participate.[4] The Centers for Medicare and Medicaid Services (CMS) sets guidelines for the states to follow.[5] This article discusses the Medicaid reform plans of both Ohio and Arizona and demonstrates how Ohio's plan focuses more on administrative and structural changes, while Arizona's plan focuses on cutting spending.

II. OHIO

In Ohio, Medicaid is administered by numerous state and local agencies, whose administrative authority derives from the Ohio Department of Job and Family Services (ODJFS).[6] Furthermore, more than 2.3 million Ohioans are enrolled in Medicaid.[7] According to Greg Moody, Director Ohio's Office of Health Transformation (OHT), if the current system remains unchanged, then Medicaid spending will increase by 30% over the next three years.[8] It has already increased more than 16% over the past two years.[9] In January 2011, Governor John Kasich established the OHT to increase efficiency and economy within Ohio's Medicaid program, and all of Ohio's state and local agencies administering Medicaid will now report to the newly created office.[10]

Governor Kasich is trying to tackle Medicaid reform through initiatives

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2. CENTERS FOR MEDICAID & MEDICARE SERVICES, https://www.cms.gov/MedicaidGen Info (last visited Sept. 20, 2011).
3. *Id.*
4. *Id.*
5. HEALTH POLICY INST. OF OHIO, OHIO MEDICAID BASICS 2011 1 (2011) [hereinafter OHIO MEDICAID BASICS].
6. *Id.*
7. *Id.*
8. Reginald Fields, *Medicaid Reforms Are a Key Piece of Gov. John Kasich's Budget Proposal*, THE PLAIN DEALER, Mar. 15, 2011, http://www.cleveland.com/open/index .ssf/2011/03/medicaid_reforms_are_a_key_pie.html, [hereinafter Fields, *Medicaid Reforms*].
9. Sarah Jane Tribble, *Ohio Aims to Transform Medicaid Coordination, Accountability are Key Components*, THE PLAIN DEALER, Apr. 10, 2011, at B1, [hereinafter Tribble, *Transform*].
10. OHIO MEDICAID BASICS, *supra* note 5.

such as coordinating services, implementing principals espoused by the federal health reform act, and giving elderly and disabled patients greater options to live at home instead of in a nursing facility.[11] While the federal government is currently paying for the expanded coverage, the burden will soon shift to the states, many of which are already low on funding.[12]

To understand Ohio's Medicaid reform plan, it is important to understand a few basics of the current state of the program. Of the 2.3 million Ohioans covered by Medicaid, about 79.9% of those are covered families and children (CFC) while the remaining 20.1% are patients who are aged, blind, or have disabilities (ABD).[13]

The expenditures between the CFCs and ABDs are not proportional. ABDs account for 67.5% of Medicaid expenditures, while CFCs account for only 32.5%.[14] The CFC group consists of parents, pregnant women, and children up to nineteen years of age.[15] The ABDs consist of elderly patients sixty-five years and older, the blind, and also individuals with disabilities.[16] The general category of individuals with disabilities also consists of children who have severe disabilities.[17] Eligibility for Medicaid assistance depends on whether a patient falls into the CFC or ABD group, both of which are stratified.[18] The CFCs are separated such that children nineteen years of age and under are considered separately from pregnant women, who are then considered separately from parents.[19] Similarly, the ABD group is stratified such that workers with disabilities are separated from the non-working disabled, who are separated from the elderly, who in turn are

11. Tribble, *Transform*, *supra* note 9.
12. Phillip Klein, *The Legal Case Against Obamacare's Medicaid Expansion*, The Washington Examiner, June 9, 2011, http://washingtonexaminer.com/blogs/beltway-confidential/2011/06/constitutionality-obamacares-medicaid-expansion-0.
13. *Id.*
14. *Id.*
15. *Id.*
16. *Id.*
17. *Id.*
18. *Id.*
19. *Id.*

separated from those who are institutionalized.[20] Each category has different eligibility requirements for Medicaid based on a percentage of the Federal Poverty Level (FPL).[21]

The PPACA has forbidden states from taking this approach and has mandated that they maintain their current adult eligibility standards until January 1, 2014, as well as their current child eligibility standards until September 30, 2019.[22] Further, states may not make it more difficult for people to enroll in Medicaid.[23] Failure to comply could result in states' loss of federal funds.[24] In Ohio's case, failure to comply could mean loss of federal funding for the state's single largest expense, a consequence that would be very damaging to the state.[25] Due to this mandated expansion, independent organizations and the state government estimate that between 667,000 and 936,000 more people will enroll in Medicaid in 2014.[26]

Ohio's situation underscores the importance of the need to reform how Medicaid is administered in the state, and that is exactly what Governor Kasich has set out to accomplish in Ohio. In addition to reorganizing the Ohio Medicaid system by centralizing it under the OHT, Kasich's plan seeks to coordinate care for those enrolled in both Medicare and Medicaid.[27] This means that health homes will be promoted by calling for

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20. OHIO MEDICAID BASICS, *supra* note 5.

21. *Id.* (FPL guidelines were set in 2009 and were in effect until August of 2011. FPL for this period was $10,400. For Children and Pregnant Women, the limit for Medicaid eligibility was 200% FPL; for parents 90% FPL; for Workers with Disailities 250% FPL; Non-workers with Disabilities and Seniors 65 and older 64% FPL; and the institutionalized have an income less than the cost of care, so it is assumed that the state would cover all of their costs).

22. THE KAISER COMM'N ON MEDICAID & THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., UNDERSTANDING THE MEDICAID & CHIP MAINT. OF ELIGIBILITY REQUIREMENTS 1 (2011) [hereinafter REQUIREMENTS].

23. GEORGETOWN HEALTH POLICY INST. CTR. FOR CHILDREN & FAMILIES, CTR. ON BUDGET & POLICY PRIORITIES, HOLDING THE LINE ON MEDICAID & CHIP: KEY QUESTIONS AND ANSWERS ABOUT HEALTH CARE REFORM'S MAINT.-OF-EFFORT REQUIREMENTS 1 (2010) [hereinafter HOLDING THE LINE].

24. REQUIREMENTS, *supra* note 22, at 1.

25. Fields, *Medicaid Reforms, supra* note 8.

26. OHIO MEDICAID BASICS, *supra* note 5.

27. *Id*.

greater coordination of physical and mental medical care.[28] It would also reduce administrative costs by combining departments to eliminate duplicative billing.[29] Instead of separate entities operating independently, their operations would become coordinated, thus resulting in diminished administrative confusion.

Additionally, the Ohio plan calls for payment reform for medical treatment under Medicaid.[30] Currently, the system allows for reimbursement to caregivers for treatments given to patients who suffer from hospital-acquired infections.[31] Under the new plan, Medicaid would refuse to pay hospitals and other caregivers for such treatment under the theory that because such illnesses are preventable, the state should not be burdened.[32] Furthermore, the plan calls for cutting about 15% in administrative funding for aging agencies, such as nursing homes, while also increasing the number of people who can obtain waivers that allow them to live at home instead of in nursing homes.[33] Governor Kasich's hope is that by giving the elderly the option to live at home, the cost of care will be reduced.[34] Further, the option would reduce the administrative costs incurred by nursing home facilities.[35]

The plan also intends to integrate physical and behavioral care in such a way that it has centralized administration, thereby alleviating the financial burden of caring for those with physical and behavioral needs.[36] The Ohio Department of Jobs and Family Services manages the physical healthcare for Ohioans with mental illnesses.[37] The Department of Mental Health and Alcohol and Drug Addiction Services independently administers the

28. *Id.*
29. Tribble, *Transform*, *supra* note 9.
30. *Id.*
31. Tribble, *Transform, supra* note 9.
32. *Id.*
33. *Id.*
34. *Id.*
35. *Id.*
36. OHIO MEDICAID BASICS, *supra* note 5.
37. *Id.*

behavioral health services for Ohioans with mental illnesses.[38] The plan would achieve this integration and reduce the cost of administration by shifting the financial burden to the state from the localities.[39] Of course, this also implies that localities would have to cut their spending on the care of the behaviorally and mentally disabled, which may include the reduction of community counseling and psychiatric treatment.[40] The reform also sets out a plan to unify the long-term care budget by combining the Medicaid funds with that of ODJFS in order to create a single long-term care budget.[41]

Ultimately, Governor Kasich's Medicaid reform plan asserts that it will save Ohio $1.4 billion in spending, "without reducing eligibility for the 2.1 million low-income children, families, older adults, and Ohioans with disabilities."[42] Not including the projected new enrollees, estimates indicate that Ohio's Medicaid spending will increase by $2 billion in 2013.[43] However, the new enrollees from 2014 to 2016 will be fully covered by the federal government and subject to gradual payment decreases in subsequent years, which would help the state save money.[44] However, Jennifer Tolbert, an expert at the Kaiser Family Foundation, estimates that the PPACA is expected to save about $1.1 trillion in the long term, while costing approximately $940 million, leaving the federal government with a surplus.[45]

Not all Ohioans are optimistic about the new healthcare plan.[46] Parts of the plan, such as cuts in funding to nursing homes, will result in fewer jobs

38. *Id.*
39. *Id.*
40. Tribble, *Transform*, *supra* note 9.
41. OHIO MEDICAID BASICS, *supra* note 5.
42. Aaron Marshall, *Gov. John Kasich Says His 'Jobs Budget' is the Most Reform-Minded in Ohio History*, THE PLAIN DEALER, Mar. 15, 2011, http://www.Cleveland.com /open/index.ssf/2011/03/gov_john_kasich_says_his_jobs.html.
43. Diane Suchetka, *Health Care Reform Will Move Millions More to Medicaid*, THE PLAIN DEALER, June 21, 2011, http://www.cleveland.com/consumer-health/index.ssf/2011 /06/health_care_reform_will_move_millions_more_people_to_medicaid.html.
44. *Id.*
45. *Id.*

throughout the state.[47] According to Peter Van Runkle, Executive Director of the Ohio Health Care Association, the Medicaid reforms will cut about 7,000 jobs in the nursing home sector alone.[48] Others say that healthcare providers can be more efficient about the way they offer care to their patients.[49]

III. ARIZONA

Arizona's Medicaid reform plan differs greatly from Ohio's plan. Under Governor Jan Brewer's reform plan, there are not only cutbacks, but also pure eliminations in order to control Medicaid spending.[50] Much like Ohio's system of classifying users of Medicaid, Arizona Medicaid recipients are divided into either the ABD or the CFC-like categories.[51] There is no CFC category as such. Instead there are separate categories for Children, Families and Women.[52] However, the Arizona system is more stratified than Ohio's because they also have a category for young adults aged nineteen to twenty-one.[53] Additionally, the coverage provided for women is only stratified into three areas, namely pregnant women, family planning services for women, and women in need of breast and/or cervical treatment.[54]

Furthermore, there is a category that falls under the CFC that is not included in Ohio's administrative setup – coverage for non-ABD adults under the age of sixty-five.[55] The ABD category covers precisely those in its namesake – the aged, blind or disabled.[56] To qualify for the ABD

46. Tribble, *Transform, supra* note 9.
47. *Id.*
48. *Id*.
49. *Id.*
50. *See generally* MRP, *infra* note 59.
51. *See generally* DIVISION OF MEMBER SERVICES, ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM HEALTH INSURANCE (2010) [hereinafter HEALTH INSURANCE].
52. *See generally* HEALTH INSURANCE.
53. *Id.* at 8.
54. *Id.* at 11.
55. *Id.* at 15.
56. *Id.*

category in Arizona, one must be sixty-five or older, or disabled, or blind.[57], Like Ohio, some disabled children may fall into this category.[58]

The Arizona plan calls for several outright eliminations in order to reduce state spending on Medicaid.[59] The reform plan is divided into five categories: Eligibility Reform, Personal Responsibility, Benefit Reform, Long-Term Reform, and an "Other" category.[60]

The Eligibility Reform category includes five major eliminations that will restrict eligibility of those seeking Medicaid coverage.[61] The first, effective July 1, 2011, is the elimination of enrollment of childless adults.[62] Although it allows childless adults who have been enrolled as of June 30, 2011 to continue their coverage, no new childless adults may enroll under this category for Medicaid benefits.[63] Furthermore, those childless adults who lose Medicaid benefits will not be permitted to re-enroll.[64] The apparent goal is to completely eliminate individuals enrolling under the childless adult category.

The next major elimination is the removal of the "spend down" program.[65] Previously, this program extended Medicaid coverage to those Arizonans who bore medical expenses that lowered their income to below forty percent of the FPL and who would not have originally qualified for Medicaid coverage.[66] On May 1, 2011, the program was frozen and was totally shut down on October 1, 2011.[67] The next elimination is that of the Medicaid coverage offered to patients earning between seventy-five percent and one hundred percent of the FPL, which took effect on October 1,

57. *Id.* at 17.
58. OHIO MEDICAID BASICS, *supra* note 5.
59. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM, STATE OF ARIZONA PROPOSED MEDICAID REFORM PLAN (2011) [hereinafter MRP], *available at azgovernor.gov/dms/Upload/PR_031511_AHCCCSSummary.pdf.*
60. *Id.*
61. *Id.* at 1-2.
62. *Id.* at 1
63. *Id.*
64. *Id.*
65. *Id.*
66. *Id.*

2011.[68]

Since Arizona is also home to a large number of aliens, residents and illegal aliens, the plan proposes to cut Medicaid funding of Federal Emergency Services (federal approval pending) to non-qualified aliens.[69] The plan also calls for childless adults and parents to have their eligibility evaluated every six months, rather than every year.[70]

The Personal Responsibility category includes three changes.[71] The state proposes to expand mandatory co-payments for parents and children, along with penalizing patients for missing scheduled appointments.[72].

The Benefit Reform category contains two measures that limit how much patients can recover from Medicaid.[73] The first would limit Medicaid coverage of inpatient care to twenty-five days.[74] The second reform would completely eliminate Medicaid coverage of non-emergency transportation, such as non-emergency transportation to the doctor for appointments.[75] In actuality, the transportation reform only seeks to eliminate coverage in urban areas Phoenix and Tucson, while imposing co-payment rates on non-emergency transport in rural areas.[76]

In the Long-Term Reforms section, the Arizona plan seeks to integrate care of physically and behaviorally ill patients, similar to Ohio's plan.[77] Like Ohio's plan[78], it also proposes to pay for quality of care, not quantity

67. *Id.*
68. *Id.* at 2.
69. Id. at 2; *see generally* CENTERS FOR MEDICARE & MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES, WHO IS A QUALIFIED ALIEN? (discussing what constitutes a qualified alien), *available at* https://www.cms.gov/MedicaidEligibility/downloads/alien1.pdf.
70. MRP, *supra* note 59, at 2.
71. *Id.* at 3.
72. *Id.*
73. *Id.* at 3-4.
74. *Id.* at 3.
75. *Id.* at 4.
76. *Id.*
77. *Id.* at 5.
78. Tribble, *Transform*, *supra* note 9.

of care.[79] By implementing this principle, the plan appears to create an incentive for healthcare providers to ensure the patient actually benefits from the received care. However, an interesting addition to the Long-Term Reform is the proposed financial penalties on patients seeking Medicaid coverage who engage in unhealthy habits such as smoking and obesity.[80] From this, the state hopes to put some responsibility on the patients to live a healthier lifestyle, thereby reducing the amount of Medicaid dollars spent on illnesses created by their own poor lifestyle choices.

Within the Other category, the plan proposes to "[c]ut reimbursement rate[s] for health providers by 5%," in addition to modifying reimbursement of Medicare liabilities.[81]

Overall, the proposed plan for Medicaid reform in Arizona could result in saving the state over 400 million dollars in Medicaid expenses alone.[82]

Most of the cuts and expansions seem to be well received. However, in April of 2011, the Arizona Hospital and Healthcare Association (AzHHA) sent a letter to the United States Secretary of the Department of Health and Human Services opposing certain cuts to healthcare providers.[83] The AzHHA's letter, among other things, emphasized that Governor Brewer's plan would cause hospitals to lose a total of $1.3 billion.[84]

Additionally, the elimination of Medicaid coverage for childless adults was contested and brought to court.[85] In August 2011, Maricopa County Superior Court Judge Mark Brain allowed the Medicaid cuts to childless adults to be implemented, rejecting the petitioners' argument that the cuts

79. MRP, *supra* note 59, at 5.
80. *Id.*
81. *Id.* at 4.
82. *Id.* at 1-5. (totaling all the projected savings from each of the cuts and expansions within the reform plan).
83. *See generally* Letter from Laurie Liles, President and CEO, Arizona Hospital and Healthcare Association, to The Honorable Kathleen Sebelius, Secretary, United States Department of Health and Human Services (Apr. 8, 2011).
84. *Id.* (arguing in the letter to the Secretary of the US Dept. of HHS that the present cuts in addition to cuts from 2008 would total up to losses of $1.3 billion).
85. Mary K. Reinhart, *Judge Allows Cuts to Arizona's Medicaid Program*, THE ARIZ. REPUBLIC, Aug. 11, 2011,http://www.azcentral.com/news/election/azelections/articles/2011

violated Arizona state law.[86] Attorneys for Brewer and the AHCCCS argued that the judicial branch had "no business telling the Legislature how to appropriate state funds."[87] Their main argument was that there was not enough money to keep Arizona's Medicaid system operating as it had before the reform.[88]

In addition to the cuts previously mentioned, Governor Brewer's plan also eliminates financing of certain transplant operations that are normally covered by Arizona's Medicaid.[89] Such transplants include heart, liver, lung, pancreas and bone marrow procedures.[90] Arizona has also elected to eliminate a large number of non-federally required treatment provisions in order to cut as much spending as possible.[91] Such cuts include, but are not limited to, "emergency dental procedures, insulin pumps and orthotics."[92]

IV. CONCLUSION

Ohio and Arizona's reform plans seem to be in contrast with one another. Ohio has reorganized the state's Medicaid system into a more streamlined system under the OHT and is trying to maintain coverage to as many people as possible while eliminating unnecessary spending. On the other hand, Arizona's plan focuses more on budget cuts and restrictions on eligibility than on administrative reorganization.

Ultimately, while Arizona's plan certainly reduces excess spending in many areas, it cuts several life-saving procedures as well. In comparison to Ohio's Medicaid reform plan, which reorganizes the administrative structure of the state Medicaid system and makes long-term changes,

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/08/10/20110810arizona-medicaid-cuts-judge-allows.html.

86. *Id.*

87. *Id*.

88. *Id.*

89. Marc Lacey, *Arizona Cuts Financing for Transplant Patients*, THE N.Y. TIMES, Dec. 2, 2010, http://www.nytimes.com/2010/12/03/us/03transplant.html?_r=1&hpw=&page wanted=1.

90. Kevin Sack, *Arizona Medicaid Cuts Seen as a Sign of the Times*, THE N.Y. TIMES, Dec. 4, 2010, http://www.nytimes.com/2010/12/05/us/05transplant.html?ref=politics.

91. *Id.*

92. *Id*.

Arizona's plan is purely aimed at cutting costs wherever it can for short-term benefits. It fails to provide a long-term solution to effectively administer Medicaid to an increased population.