FINANCE SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES
Chairman Romanchuk
Ranking Member West

April 8, 2019

Loren Anthes, Policy Fellow, Center for Medicaid Policy

Chairman Romanchuk, Ranking Member West, and members of the House Finance Health and Human Services Subcommittee, thank you for hearing my testimony today. My name is Loren Anthes and I am a Policy Fellow at The Center for Community Solutions, a nonprofit, nonpartisan think tank that aims to improve health, social and economic conditions through research, policy analysis and communication. I work in our Center for Medicaid Policy, the mission of which is to promote the development of sound, cost-effective Medicaid policies through research, analysis, capacity building and advocacy. I am here today to offer testimony on proposals in the budget regarding Ohio's Medicaid Program.

Background

Over the last several years, the Ohio Department of Medicaid has made a number of structural reforms to orient itself toward value based reimbursement. This has included making Medicaid a stand-alone department, the creation of a new claims system, the creation of a new eligibility system, investments in coverage expansions, innovative models of reimbursement, proliferating managed care as the predominant model of delivery and the utilization of waivers to increase access to community based alternatives to institutions, increase access to behavioral health services and encourage community engagement. I will be focusing on a few items today to offer my thoughts about the current strategic direction of ODM, the policy concepts in the executive proposal and considerations this Committee should have in developing sound, cost-effective policies with the executive branch.

Moving to Value

From a reimbursement perspective, major cost centers in Ohio's Medicaid program lie with the hospitals, nursing facilities and pharmacy. From a population perspective, this cost is disproportionately borne by the Aged, Blind and Disabled (ABD) category and individuals with chronic disease and/or behavioral health issues. To effectuate value in Ohio's Medicaid program, reimbursement must be aligned to incent cost centers to move from a system built on fixed cost reimbursement to one of variable cost control. This means that dollars need to move away from simple reimbursement for services, which incent higher priced utilization, to population management – i.e. paying for outcomes.

Ohio has relied on a combination of leveraging managed care and innovative policies in episodes and primary care to facilitate this transition. Indeed, looking at the performance of Ohio's Pay for Performance (P4P) program, a number of outcomes associated with managed care have improved as the program has rolled out, though overall achievement is pedestrian (See appendix 1). Data regarding episodes of care and the comprehensive primary care initiative, while not robust in terms of public access of data, seems to indicate some momentum toward overall improvement according to independently conducted research.[1]

The state's desire to build on the existing work in value with increasing the withhold arrangement and developing a pediatric CPC model is sound. While it may not be appropriate to enact expectations for MCOs through legislation and statute, ODM should consider ways to improve how these programs are effectuated, including, but not limited to, requiring plans to provide incentives to providers who screen for non-medical problems, allowing non-traditional services to count toward the medical loss ratio under the "in lieu of" standard, developing metrics built on transitions of care across clinical and non-clinical settings. The state could also consider including social determinants to count towards risk stratification in the context of rate development and leveraging the use of "z-codes" in ICD-10 as has been done by ProMedica in Toledo to address food insecurity.

[1] https://www.urban.org/sites/default/files/publication/98727/state_innovation_models_sim_round2test_2.pdf

Maternal, Infant and Child Health Measures

In addition to CPC, the efforts around home visitation, dyad care, multi-system youth, telehealth in schools and continued post-partum coverage have a tremendous potential to improve outcomes related to children, infant/maternal mortality and behavioral health. This includes ODM's reconfiguration of behavioral health services through Behavioral Health Care Coordination (BHCC). Consideration could be paid, however, to requiring more from the professionals engaged in delivering the services in the community and aligning with health systems and managed care where possible.

For example, there could be more intentionality in what is expected when addressing issues of lead exposure. If there are dollars for home visitation, could those professionals be required to do a visual inspection of the home or arrange for a venous blood test to determine exposure levels? If those levels are high, could it require some sort of conveyance of information to the primary care provider through managed care who is then also responsible for coordinating with the Part C Early Intervention provider for coordinated services? Could they also be expected to work with families on finding secure, safe housing? Regardless of issue, dollars which flow to the local level should be allocated in a manner that employs a systems-level approach with medical providers and MCOs at significant financial risk for failure.

Overall Budget Picture

While the federal share is decreasing for both the Children's Health Insurance Program and Expansion, federal funding is secure and this budget contemplates the Joint Medicaid Oversight rate in an explicit fashion. As such, any single change to major proposals, like restoring the market basket cut or eliminating the UPL increase, has implications for this target. The good news is that the majority of the smaller dollar, upstream policy innovations are of a scale that make their inclusion more desirable than not, meaning any enhancement or cutback, globally, is best tied to one of the major cost centers and not the general structural approach to value outlined in this executive proposal.

With that said, there are long term issues which require focus. First, Ohio's population is aging and with that aging population comes additional cost. For whatever value there may be in work requirements or other measures focused on parents and the Medicaid expansion, they have very little structural value, financially. Second, while PBMs have been an appropriate focus of the legislature, it is important to understand that the issue of unregulated price is a definitional aspect of US healthcare, especially in the diversity inherent in the pharmacy supply chain. According to data comparing price in the US versus that of other industrialized nations, the costs in United States for most hospital, long term care and pharmacy services are much higher than peer nations.[2] This is due to high administrative costs, high wages, and regulatory capture. Medicaid, uniquely, is able to flexibly establish rates in most areas of delivery with limited authority in pharmacy and long term care, all with a very efficient overhead of less than 4 percent, so it is an overall very efficient program. That said, as providers continue to escalate price in commercial coverage, it sets the expectation for higher rates in Medicaid, which will create long term pressure on public resources.

Third, the General Assembly would be very wise to look at the balancing measures which influence costs in our delivery system. Going back to the aforementioned data, the United States has the lowest level of investment in social services when compared to counties spending less on healthcare. Termed social determinants, factors like food, housing and transportation play an outsized role in predicting expense for services, particularly in Medicaid, which does have stronger price control ability. For those reasons, I would strongly encourage this body to look beyond ODM's budget and into other parts of the budget to lower Medicaid costs. Yes, MCOs and providers should have their reimbursement aligned with these principles, which does and should continue to happen. However, if cost, in part, is a function of need over availability, growing the denominator is a worthwhile, savvy endeavor.

For example, while lead exposure is a critical issue with long term systemic effects on the lives of children and the associated costs to the medical and educational systems, the problem starts

[2] International Federation of Health Plans, 2013 Comparative Price Report.

with unsafe housing and housing insecurity. In the same way it is less expensive to get a flu shot than it is to be admitted for the flu, housing can be a both a health-related and state budget vaccine for lead poisoned children. In other words, if we had more affordable housing, we would have less need to expensively rehabilitate dangerous housing.

Chairman Romanchuk, Ranking Member West, members of the Committee, thank you for your time today. I would be happy to answer any questions you may have.

Appendix 1: Managed Care Performance

OHIO'S PAY FOR PERFORMANCE PROGRAM
2013 - 2018

Award | Millions of Dollars	2013	2014	2015	2016	2017	2018	TRENDS
Buckeye Community Health Plan	$ 3.4	$ 1.6	$ 2.1	$ 4.7	$ 8.5	$ 13.2	
CareSource	$ 17.0	$ 7.4	$ 13.4	$ 25.1	$ 20.8	$ 29.0	
Molina Healthcare of Ohio	$ 4.9	$ 4.0	$ 9.8	$ 7.5	$ 6.2	$ 9.1	
Paramount Advantage	$ 2.1	$ 1.8	$ 3.1	$ 7.2	$ 6.2	$ 8.8	
United Healthcare Community Plan of Ohio	$ 1.8	$ 0.6	$ 1.7	$ 4.1	$ 5.5	$ 5.8	
TOTALS	**$ 29.2**	**$ 15.4**	**$ 30.1**	**$ 48.6**	**$ 47.2**	**$ 65.9**	

Award | Percentage of Total Possible	2013	2014	2015	2016	2017	2018	TRENDS
Buckeye Community Health Plan	42%	22%	16%	27%	48%	70%	
CareSource	39%	18%	22%	34%	27%	35%	
Molina Healthcare of Ohio	36%	32%	53%	36%	32%	46%	
Paramount Advantage	62%	45%	33%	55%	48%	62%	
United Healthcare Community Plan of Ohio	30%	10%	13%	24%	32%	32%	
AVERAGE	**42%**	**25%**	**27%**	**35%**	**37%**	**49%**	

All data from Ohio Department of Medicaid P4P Reports for State Fiscal Years 2013 – 2018.