Testimony of
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Senate Finance Health and Medicaid Subcommittee

Mr. Chairman and members of the Health and Medicaid Subcommittee, thank you for allowing me to testify today. My name is Miranda Motter and I am the President and CEO of the Ohio Association of Health Plans. OAHP is the statewide trade association representing 16 health insurance companies that provide coverage to more than nine million Ohioans.

I would like to take this opportunity to discuss OAHP's budget priorities and provide comments to changes made by the House.

Managed Long Term Services and Supports. Ohio has prided itself in being a leader in Medicaid reform. However, it is clear that Ohio has fallen behind in the area of long-term care. Today 19 states are already utilizing a managed care model to care for this vulnerable population, with two more - Virginia and Pennsylvania - scheduled to "go live" within the next eight months, and four more states in the planning stage, the time has come for Ohio to join the many states who are experiencing increased member satisfaction, additional opportunities for home and community based services, improved quality, and cost savings through MLTSS.

With more than 10,000 Ohioans turning age 65 each month and the "baby boomers" beginning to turn 80 years old within a decade, Ohio must act now to ensure quality and value-based care options for this population. Ohio's health insurance industry has experience administering MLTSS programs in several states, and Ohio is well-positioned to leverage the best practices and experiences of private sector health plans to improve care and quality for more than 100,000 Ohioans.

OAHP opposes the House amendment that delays the integration of long-term services and supports into managed care until at least 2021. We urge the Senate to delete this language and allow more than 100,000 Ohioans the opportunity to experience coordinated, quality and accountable care that comes with a managed care model.

Medicaid Eligibility and Controlling Board. OAHP is opposed to changes made by the House that significantly alter the state's current Medicaid program both in terms of eligibility and operability. In terms of eligibility, the House changed the current eligibility requirements for the Group VIII population. We believe this change will affect the continuity of care, as well as the overall access to health care coverage and services. OAHP is opposed to any House change that would limit access and threaten the continuity of care for those Ohioans who are insured through this eligibility category.

In addition, the House's rewrite would require the Ohio Department of Medicaid to seek Controlling Board approval of all Medicaid expenditures every six months. This is both unworkable and unwieldy given the multitude of programs contained in Medicaid. With this language, nursing homes, addiction programs, developmental disability programs and mental health services are in jeopardy of losing funding twice a year.

While we understand the desire of the House to closely monitor Medicaid spending, we believe these changes, separately and together, will create more chaos and confusion within the Medicaid system. At a time when our state continues to move toward value over volume, and high quality care at a more reasonable cost, we believe these changes put that work in jeopardy.

Behavioral Health Redesign. Over the last two years, a collaborative and comprehensive effort has been underway to improve the capacity of Ohio's behavioral health system and integrate behavioral health into Medicaid managed care. This work will not only provide access to a more robust array of behavioral health services, but will allow individuals receiving Medicaid benefits to have all of their physical and behavioral health needs provided in a coordinated model. Health plans have worked closely with stakeholders, providers, and policymakers to position the state for a smooth and efficient roll-out of this initiative.

OAHP opposes the House's provision to delay the behavioral health redesign and carve-in to January 1, 2018 and July 1, 2018, and we urge the Senate to restore the original implementation dates included in the as introduced version of the bill. Pushing back the implementation date will only further delay individuals with complex health care need from receiving enhanced and coordinated care.

Medicaid Managed Care Sales Tax Replacement. OAHP continues to believe that the Administration's proposed sales tax replacement is a reasonable solution to fill the gap left by the elimination of the current MCO sales tax. OAHP recognizes the Administration's effort to limit the impact the proposed tax would have on Ohio's private health insurance market; however, OAHP would be concerned with any changes to the current proposal that would add additional costs in the health insurance market. OAHP will continue to lend its expertise as policymakers consider this issue and work to understand how health insurance taxes impact health insurance costs for Ohioans.

Transparency. OAHP supports public policy efforts to equip Ohio's health care consumers with the needed information to make informed decisions about their health care. We were pleased to see the House restore the transparency provisions that were passed as part of HB 52 in the last General Assembly. In fact, OAHP would recommend the Ohio Senate go one step further and provide consumers with important disclosures and notices about any "surprise" bills they may receive during an episode of care.

Comprehensive Primary Care (CPC) Initiative. OAHP's commercial and Medicaid managed care plans have been vested in working with the state to increase access to patient centered medical homes statewide through the Comprehensive Primary Care initiative. Not only will this initiative increase the quality of care Ohioans receive, but it will assist in reducing the cost of care through improved health outcomes and cost efficiency.

This effort has been underway for nearly four years and has distinguished Ohio in the movement to value based, patient centered care. OAHP requests that the Senate reinstate the language needed to continue this important initiative.

Single Preferred Drug List. OAHP is opposed to the Administration's proposal to require a single Preferred Drug List (PDL) and prior authorization policies to be used by the Medicaid managed care and fee-for-service programs beginning in SFY 2018. OAHP believes this would be a significant step backward in effectively managing the program's pharmacy benefit and would revert the pharmacy benefit back to a one-size fits all program. Ohio relies on Medicaid managed care plans to contain costs and improve quality of care through evidence-based best practices and innovation. According to an April 2016 study by the Menges Group, the four states utilizing a single PDL collectively had costs per prescription that were higher than those in states where managed care plans maintain latitude to administer their pharmacy benefits. In comparison to all states, Ohio has the 16th lowest net Medicaid costs per prescription.[1]

Currently, the State of Texas is transitioning away from the single PDL used in its Medicaid program in order to more successfully negotiate the most clinically effective and lowest-priced drugs. The Texas Health and Human Services Commission has stated that the move will result in lower net prices for prescription drugs across its Medicaid program and estimates annual savings of $100 million.[2]

Leverage with Non-Contracting Hospitals. OAHP opposes the House's removal of language that would pay hospitals that do not contract with Medicaid managed care plans the fee-for-service rate for services rendered. We ask that the Senate

[1] Assessment of Medicaid MCO Preferred Drug Policy Options in Louisiana. The Menges Group. April 2016.
[2] The Prescription for a Healthier Medicaid Rx Program. Texas Association of Health Plans. January 2017.

restores the Administration's original proposal. The as introduced proposal addresses one of the primary drivers of health care costs - inpatient and outpatient hospital costs – and will serve to mitigate the higher costs Ohio taxpayers pay today to non-contracting hospitals. Today, because health plans are required to ensure access through network adequacy standards, hospitals have the upper hand when it comes to contract negotiations. This proposal, effectively, levels the playing field in terms of those negotiations.

Telemedicine. OAHP opposes the new telemedicine health insurance mandate that was included in the House rewrite. While OAHP member plans believe that telemedicine is an important tool relative to ensuring access to care and has the potential for reducing health care system costs, we believe the mandate as drafted by the House which requires telemedicine to be covered at the same level as an in-person service, will add upwards pressure to health insurance costs to those Ohioans purchasing insurance coverage. Additionally, the language - as drafted - applies not only to the commercial market, but to the state's Medicaid market and the House did not add any additional appropriations to the state's Medicaid budget to cover the costs that will be associated with this mandate. Lastly, OAHP believes a provision of this kind is inconsistent with the General Assembly's recent decision to refrain from implementing any new health insurance mandates for two years.

Health Care Compact. OAHP opposes an accepted amendment that would enter Ohio into the Interstate Health Care Compact upon approval from Congress. Last General Assembly, OAHP testified in opposition of stand-alone legislation that requested Ohio's inclusion to the health care compact.

Psychiatric Exemption. OAHP opposes a provision added by the House that would allow some advanced practice registered nurses to prescribe certain psychiatric drugs without prior authorization as part of the Medicaid program. Psychotropic drugs are consistently one of the top classes of drugs for Medicaid managed care plans, yet their ability to manage this class is limited. Currently, Section 5167.12 limits that ability for Medicaid managed care plans from promoting the use of generics as they do with other health conditions. Expending the exemption to advanced practice registered nurses would further limit that ability and has the potential to increase pharmacy costs within the Medicaid program, additional costs which the House did not providing funds for.

Again, thank you for the opportunity to provide comments on the biennial budget. I am happy to answer any questions you may have.