Chairman Oelslager, Vice Chair Manning, Ranking Member Skindell, and members of the Senate Finance Committee, thank you for the opportunity to submit written testimony today to express our view on some issues included in HB 49.

My name is Adam Miller and I am the new Chief Executive Officer of Human Arc, a Centauri Health Solutions Company. Mike Baird, Vice Chairman Advisory Board and former Chief Executive Office started Human Arc in 1984 with the sole purpose of bridging the gap between available government programs and their intended beneficiaries. Human Arc has expanded over the past 33 years to help hospitals and health plans connect their patients and members to governmental programs and community services. We have helped well over a million people in unfortunate circumstances enroll in Medicaid and have helped many millions find food, clothing, shelter, prescriptions and more. Human Arc has over 600 associates serving the low-income, disabled and elderly population for customers across 40+ states. We are a for-profit organization financed by the value received by our customers. We believe our long history of working with the low income population gives our voice credibility.

Our greatest concerns with Ohio H.B.49 are 1) any type of future waiver or language that would eliminate retroactive coverage, 2) lack of clarity on Medicaid guardrails and 3) Controlling Board authorization.

1) <u>Elimination of retroactive coverage</u>

Waiving the 90-day retroactive coverage period for Ohio Medicaid will substantially impact the low-income expansion population of the state, particularly those that are uninsured, eligible for Medicaid and in need of health care services. It will also adversely impact the medical providers and health plans trying to serve them. Every day we experience situations where uninsured individuals present at a hospital requiring emergency medical treatment and many times are unable to manage an application process due to mental health issues, lack of capability, illness and a myriad of other reasons. In many cases they are unaware of their eligibility for a Medicaid program. Here is just one example:

> In December my client was admitted to the hospital because of a major stroke. He was then life-flighted to a Main Campus Hospital in the Cleveland area due to severity of his condition. This client does not have any relatives or Next of Kin to make decisions or sign any paperwork. In late January this client's condition improved and was medically cleared to make decisions and sign paperwork. Human Arc was asked to assist because this client did not have any health insurance and would need to apply for Medicaid.
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> This client was self-employed and even worked during December prior to the stroke. Human Arc was able to obtain a signed authorization form to submit a Medicaid application on his behalf in late January for MAGI Medicaid Adult only program with a

request for retroactive coverage for December. In February the hospital realized this client had to go to a Nursing Home because his condition was not severe enough to stay in the hospital but he could not be discharged home since he lived alone. A Nursing Home Application was submitted in February.

The county that this client lives in is about 8 months behind on processing their Medicaid applications. Human Arc had provided the county with all verifications to process the original application with ongoing coverage. A state hearing was called in August because the county only approved his Nursing home stay and nothing prior. Human Arc won the stated hearing and the county was ordered to open my client's Medicaid effective December through present. I had to have the state hearing compliance department get involved for a few months before the county finally opened my client's Medicaid for coverage from December through present. This client has returned back to work part-time but still has issues from his stroke and still needs physical therapy. Because Ohio Medicaid permits their residents 3 months retro coverage Medicaid was able to cover all of my client medical bills starting from December through present.

Retroactive eligibility was first enacted in 1972 to protect persons who are eligible for Medicaid but do not apply for assistance until after they have received care, either because they did not know about the Medicaid eligibility requirements, or because the sudden nature of their illness prevented their applying. The provision was amended in 1973 to provide retroactive coverage for persons who died before eligibility could be claimed.[i] This is codified at 42 U.S.C. §1396(a)(34). The Social Security Program Operations Manual System (POMS) states that "Retroactivity is very important.[ii]" We believe it is important, even critical, for **all** Medicaid applicants to have access to retroactive Medicaid coverage both for the reasons stated by Congress when it was legislated as well as those we have outlined below.

Negative impact on the overall health of this population

The gap in coverage that will be created by the elimination of retroactive coverage could be devastating to those newly enrolled Ohio recipients who received services prior to their start date. This gap could be substantial, particularly if an individual is denied, requests an appeal which is sustained and eventually overturned. The time frame for application processing could be days to weeks to months or more. Since there is not adequate coverage after a health care emergency, the likelihood of following the intended continuum of care is reduced and health outcomes will be impacted.

Increased medical debt and bankruptcies

Medical debts contribute to over half (52 percent) of debt collections actions that appear on consumer credit reports in the United States and contribute to almost half of all bankruptcies in the United States. Uninsured people are more at risk of falling into medical bankruptcy than people with insurance.[iii]

Reduced financial stability of medical providers

The Affordable Care Act has lowered the uninsured rate in the U.S., but it has not relieved the financial pressure hospitals experience from providing uncompensated care.[iv] Uncompensated care is the term hospitals use to describe both bad debt, which they define as any bill not paid in full, and charity care, which is provided to uninsured low-income consumers and doesn't even get billed.[v] The proposed elimination of retroactive Medicaid coverage will increase this financial pressure on hospitals by increasing the number of uninsured, eliminating the medical provider's opportunity to be paid retroactively for services rendered. Providers must have a margin to continue providing care. No margin, no mission.

2) <u>Lack of clarity on Medicaid guardrails</u>

We are concerned with Sec. 5166.37 and the lack of clarity as it relates to (B) Be employed and (E) Have intensive health care needs.

Be employed

According to the Kaiser Family Foundation, "An analysis of Ohio's Medicaid expansion found that most expansion enrollees who were unemployed but looking for work reported that Medicaid enrollment made it easier to seek employment. Over half of expansion enrollees who were employed reported that Medicaid enrollment made it easier to continue working. Given these data and findings, Medicaid work requirements would have a narrow reach and could negatively affect those who are not working due to disability or caregiving responsibilities if they are not exempted from the requirement."[vi]

Below are just a few examples of the challenges presented by a work requirement.

A. An Ohio resident has a chronic condition and is in and out of the hospital. When he is not in the hospital he finds handyman work to complete for neighbors and family. His yearly income is less than $10K a year.
B. An Ohio resident does not have a regular schedule with work. The job he has only allows him to work as many as hours as there is work available. His pay stubs may reflect one work week with 25 hours and then he may not work again for 2 or 3 weeks.
C. An Ohio resident is an independent contractor doing construction work. He works for a man but then splits his check between himself and his cousin because he "employs" his cousin. He could make anywhere from a couple hundred a month to over $5,000. There are gaps between when works and does not work.

Intensive health care needs

Language clarifying "intensive health care needs" is warranted. In example A. above, is a "chronic condition" considered to be an "intensive health care need?" Subjectivity in this clause would be extremely detrimental.

3) Controlling Board Authorization

We are concerned with a provision in the House passed version of the budget that requires a six month oversight review by the Controlling Board for the continued funding of the Group VIII population as this provides instability in the market place.

Thank you, Chairman Oelslager and members of the Senate Finance Committee for the opportunity to submit this written opposition testimony. If you have any questions or wish to discuss any of these issues with our organization, please do not hesitate to contact us.

Respectfully,

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[ii] SI 01715.001 Medicaid and the Aged, Blind and Disabled C. 3., Program Operations Manual System (POMS), Social Security Administration, https://secure.ssa.gov/poms.nsf/lnx/0501715001

[iii] SI 01715.001 Medicaid and the Aged, Blind and Disabled C. 3., Program Operations Manual System (POMS), Social Security Administration, https://secure.ssa.gov/poms.nsf/lnx/0501715001

[iv] http://www.beckershospitalreview.com/finance/21-statistics-on-high-deductible-health-plans.html

[v] http://www.modernhealthcare.com/article/20170328/NEWS/170329910?utm_source=modernhealthcare&utm_campaign=dose&utm_medium=email&utm_content=20170328-NEWS-170329910

[vi] http://www.kff.org/medicaid/issue-brief/medicaid-and-work-requirements/