Written Comments of Miranda Creviston Motter, President and CEO
Senate Finance Committee
Thursday, June 15, 2017

Chairman Oelslager, Vice Chair Manning, and Ranking Member Skindell, thank you for the opportunity to provide written comments on the Senate's substitute version of the Fiscal Year 2018-19 budget bill (House Bill 49). On behalf of the Ohio Association of Health Plans (OAHP) and its member plans, I would like to commend the committee for its leadership and work throughout this process.

OAHP has already provided testimony twice concerning budget items as part of the Senate Finance subcommittee process. On May 10, myself and representatives from OAHP's member plans participated in panel testimony regarding the Medicaid managed long term services and supports (MLTSS) proposal. Two weeks later, on May 24, I testified once more regarding MLTSS and a number of other key budget provisions and House changes that will potentially impact Ohio's public and private insurance markets.

Since then, subcommittee work has completed and the upper chamber has released its rewrite of substitute House Bill 49. With that said, I would like to focus my written comments to those changes made by the Senate in the substitute version of the budget bill.

Managed Long-Term Services and Supports (MLTSS). It is our understanding that the managed long-term services and supports proposal remains under review by the Senate as it nears the conclusion of its budget work. As this chamber continues to deliberate on the issue, OAHP requests that the Senate evaluate this policy on its merits.

- Today more than 100,000 Ohioans receive long-term care services under a 40-plus year-old system.
- Ohio's long-term care system is largely unmeasured in terms of quality and accountability.
- Forty-one percent of Ohio's nursing facilities receive below-average ratings of one or two stars.
- Not-for-profit facilities have more four and five star ratings (64 percent) than for-profit facilities (37 percent). It should come as no surprise that Ohio's largest for-profit nursing facility association is opposed to moving into a value-based system through MLTSS.
- In Ohio, all nursing facilities are effectively paid the same – regardless of quality and performance.
- A great deal of collaboration and dialogue has been underway since the Ohio House of Representatives amended House Bill 49, preserving the status quo by delaying the integration of long-term services and supports into managed care until at least 2021.
- Two of Ohio's three nursing facility organizations stand in support of implementing a managed long-term services and supports program, and the Ohio Association of Area Agencies on Aging also recently committed its support for moving forward. The support of these organizations is the result of their willingness to take part in a constructive, meaningful dialogue with policymakers and other stakeholders to ensure that any MLTSS program is pursued in a manner that is best for Ohio's consumers, providers, and taxpayers.

OAHP opposes the House amendment that denies more than 100,000 Ohioans coordinated, accountable, quality long-term services until at least 2021. We urge the Senate to delete this language in order to build a meaningful, quality-based system for long term care service providers.

Medicaid Eligibility and Controlling Board. OAHP opposes changes made by the House that significantly alter the state's current Medicaid program in terms of both eligibility and operability. It is our understanding that this issue also remains under review by the Senate, as it nears the conclusion of its budget work.

- The House changed 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 terms of operability, 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 House's desire to closely monitor Medicaid spending, we believe these changes - separately and together - could create chaos and confusion within the Medicaid program. At a time when our state continues to move toward value-based approaches 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.

As the General Assembly continues to review this issue, OAHP respectfully requests that integrated, comprehensive care and services are not delayed for Ohioans with behavioral health needs.

Comprehensive Primary Care (CPC) Initiative. OAHP's commercial and Medicaid managed care plans have been vested in working with the state to increase statewide access to patient centered medical homes 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.

In addition to OAHP, the following organizations have also come out in support of preserving the CPC initiative: the Ohio Hospital Association, the American Academy of Pediatrics, the Ohio Children's Hospital Association, the Ohio State Medical Association, the Ohio Association of Community Health Centers, the Ohio Academy of Family Physicians, and the Ohio Osteopathic Association.

This collaborative effort around the CPC initiative 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 very 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 restores the Administration's original proposal, which would provide $27.1 million in state share savings for FY 2018 and another $54.3 million in state share in FY 2019. 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.

Though the Senate did not make any changes to this provision in its substitute bill, we would ask that you revisit the non-contracting provision during the omnibus process and consider restoring the as-introduced proposal.

Telemedicine. OAHP applauds the Senate for removing House language that - if enacted - would create a new health insurance mandate concerning telemedicine.

While OAHP member plans believe telemedicine is an important tool to ensure access to care and potentially reduce health care system costs, the House's provision mandates: (1) all health insurers to cover telemedicine; (2) telemedicine services to be paid at the same rate as is paid when an individual receives a services in-person; and (3) cost-sharing parity between non-telemedicine services and telemedicine services.

This is a health insurance mandate and will effectively add upwards pressure to health insurance costs of those Ohioans purchasing insurance coverage. In a memo to the Ohio Senate dated June 5, the Ohio State Medical Association (OSMA) openly doubted potential savings through telemedicine and acknowledged the increases in costs that may be associated with expanding its use. OSMA wrote, "It is a misconception that it is less expensive for a physician or practice to conduct a medical consultation or other service via telemedicine rather than as an in-office service."

It is also important to understand that the House language would not only apply to the private market, but also to the state's Medicaid market and the House provided no additional appropriations to the state's Medicaid budget to cover the costs that would be associated with the mandate.

Again, OAHP thanks the Senate for taking the appropriate action in its budget rewrite, as a provision of this nature is inconsistent with the General Assembly's recent decision to refrain from implementing any new health insurance mandates for two years.

Psychiatric Exemption. OAHP would also like to thank the Senate for removing a health care mandate that would require Medicaid managed care plans to cover certain psychiatric drugs prescriptions by advance practice registered nurses without a prior authorization.

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[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.
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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. Expanding the exemption to advanced practice registered nurses would further limit that ability and has the potential to increase pharmacy costs within the Medicaid program. As was the case with the House's telemedicine provision, no additional funds were included to pay for this increase in Medicaid costs.

Again, like the telemedicine mandate, OAHP believes this provision 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 remains opposed to an accepted House 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.

Clarification on Prior Authorization for Opioids Prescribed for Chronic Pain. OAHP requests that the Senate use House Bill 49 as an opportunity to provide some operational clarity to processes enacted through Senate Bill 319 of the 131st General Assembly. SB 319, which was also known as the "Opiate MBR," was amended last December to include language requiring prior authorization requirements on opioid analgesics prescribed for chronic pain. During the discussion on SB 319, OAHP and its member plans cited administrative and operational concerns with the language, particularly the language relative to the plans being required to exempt certain conditions from the prior authorization requirements.

OAHP has been working with SB 319's sponsor, Senator Eklund, and Representative Sprague – the author of the provision - in seeking an amendment that alleviates those administrative and operational concerns by allowing plans to continue to ensure the appropriate utilization and medical necessity of these drugs and would allow plans to administer prior authorization for approval of these drugs all while staying true to the legislation's original policy.

Again, thank you for the opportunity to comment on the changes made by the Senate in the sub. House Bill 49. OAHP looks forward to its continued work with the Senate, House and Administration throughout the remainder of the FY 2018-19 budget process.

Sincerely,

Miranda C. Motter

Miranda Motter
President and CEO

CC: Senate President Larry Obhof
Members of the Senate Finance Committee