SENATE FINANCE SUBCOMMITTEE ON HEALTH AND MEDICAID
Chair Hackett
Ranking Member Thomas

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Chair Hackett, Ranking Member Thomas and members of the Senate Finance Subcommittee on Health and Medicaid, 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 thinktank 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.

First, we are encouraged that the eligibility financing which underpins the program is continued. With 1 in 4 Ohioans relying on Ohio Medicaid as a source of coverage, it is important that coverage continuity remains predictable especially as the Department goes through its federally mandated Corrective Action Plan regarding eligibility.

Transparency

As one of CCS' budget priorities[1], data reporting in public assistance programs is a focus. There are provisions which require online reporting of Ohio managed care's (MCOs) contractual performance as well as financial health. Both of these measures are worthwhile and should be maintained. However, as with the new provision regarding children's hospitals public reporting, all hospitals should have their performance published in an online, public, user-friendly format, especially as increased resources are being allocated through the Upper Payment Limit program and as they garner the ability to vertically integrate MCO insurance products through corresponding amendments. Also, while the price transparency provisions outlined represent a laudable goal, research suggests the design of those tools is critical and should be combined with quality data.[2] Iterative scientific research has shown two things: 1) price is not associated with quality[3] and 2) price transparency tools do not decrease patient spending[4]. The "out-of-

[1] https://www.communitysolutions.com/community-solutions-budget-priorities/
[2] https://www.commonwealthfund.org/blog/2019/hospital-price-transparency-making-it-useful-patients
[3] https://www.ncbi.nlm.nih.gov/pubmed/23277898
[4] https://jamanetwork.com/journals/jama/fullarticle/2518264

network" provisions, however, seem to appropriately address the issue of surprise billing and should be maintained.

Waivers

At first glance, it appears as though there is some redundancy regarding the coverage of non-medical services and a social determinants of health waiver. We have conducted research which suggests that issues of transportation[5], food insecurity[6], housing[7], trauma[8] and education[9] all have an impact on Medicaid spending and enrollment in the Medicaid program. In this way, the provisions are savvy policy *concepts* which should be explored in and outside of waivers. The social determinant waiver language currently is open and should remain flexible for the Ohio Department of Medicaid in seeking something with the Centers for Medicare and Medicaid Services (CMS). Any proposal, however, should mandate that there is continuity between community-based providers and the traditional medical system and should allow ODM, explicitly, to permissively exclude managed care in its design.

More importantly, given the reimbursement restrictions of Medicaid, the budget should invest resources in non-Medicaid programs which expand safe, affordable housing through the trust fund, increase funding for public transit, decrease food insecurity, and promote the use of screening tools which can address medically-derived toxic stress, such as the Adverse Childhood Events or (ACEs) screening tool. These policies will financially benefit the Ohio Medicaid program, decrease dependence of its beneficiaries and improve outcomes.

Managed Care & Value

Legally, provisions around the value-based arrangements in managed care must be achievable. We are encouraged, then, that the policy concepts dealing with managed care allow for some flexibility for the Ohio Department of Medicaid in contracting and focus on value. The language regarding value should ensure that provisions be constructed in a way that complies with federal standards around network adequacy and actuarial soundness.

There is also a provision which allows hospitals to band together to offer an insurance product as an MCO. This allows for new market entrants into Ohio's managed care landscape and could lead to lower prices and better efficiency. With that said, these arrangements should be subject to the same transparency and medical loss ratio standards as other managed care organizations and very strong price and access controls should be in place. Lastly, the market basket update having been restored will increase Medicaid costs and is tied to no quality measures for skilled nursing facilities. What's more, a number of provisions addressing NF oversight were removed in the House. If the General Assembly is going to increase resources for NFs, these resources

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[5] https://www.communitysolutions.com/download.php?mediaID=9436
[6] https://www.communitysolutions.com/download.php?mediaID=7603
[7] https://www.communitysolutions.com/download.php?mediaID=2177
[8] https://www.communitysolutions.com/research/trauma-toxic-stress-impact-defining-adverse-childhood-experiences/
[9] https://www.communitysolutions.com/download.php?mediaID=8103

should reflect the importance of the constituency who rely on their services by tying those dollars into quality and improving Ohio's currently substandard long term care landscape.

Chair Hackett, Ranking Member West, members of the Committee, thank you for the opportunity to weigh in on Am Sub HB 166. I would be happy to answer any questions you may have.