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CHAIRMAN ROEMER

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Chairman Roemer, Ranking Member West and members of the House Finance Subcommittee on Health and Human Services, thank you for the opportunity to provide interested party testimony on House Bill 110, specifically as it relates to the Ohio Department of Health and the Ohio Department of Medicaid. The Center for Community Solutions is a nonprofit, nonpartisan think tank that aims to improve health, social and economic conditions through research, policy analysis and communication. Members of our policy team are collectively submitting written testimony for your consideration. The team includes Loren Anthes, Policy Fellow and Chair for Health Planning and Hope Lane and Natasha Takyi-Micah both Public Policy and External Affairs Associates.

MATERNAL AND INFANT HEALTH

For the past several years, Community Solutions has been committed to examining and improving maternal and infant health for families in our state. By analyzing disaggregated maternal mortality data, infant mortality reports and other critical statistics such as birth records, we've developed policy solutions to help combat an escalating maternal and infant health crisis and continue to advocate for rule changes and administrative waivers state departments can pursue to improve outcomes.

In the previous state budget, we were pleased to see that data collection in the maternal health space was prioritized with the strengthening of the Pregnancy Associated Mortality Review (PAMR) Board, however, we maintain that data collection and oversight remain a concern. The latest data on pregnancy-related deaths in Ohio was in 2016, which was five years ago. This data is outdated and more recent data needs to be taken in consideration to enhance infant and maternal health. In order for other areas in the maternal and infant health space to improve, such as coverage and benefits and care delivery transformation, data collection including reporting requirements must progress. In addition to advocating for more frequent public reporting on

maternal deaths in the state, from biannually to annually, we also believe that public annual disaggregated reporting of maternal morbidity data is crucial to identifying gaps in care and services, studying the racial disparities gap between black and white mothers and determining evidence based-solutions for both the community and organizational levels throughout Ohio.

Additionally, we believe in establishing continuing education requirements that address implicit bias in the healthcare system for all medical professionals and contractors who interact with pregnant and postpartum women and their families including birthing facility, maternity ward and emergency department personnel. Recently, a peer-reviewed study from the National Academy of Sciences looked at the issue of physician concordance in regards to infant mortality outcomes. To explain, physician concordance involves receiving care from a physician who shares the same race or gender as the patient. In looking at data between 1992 to 2015, researchers discovered, Black newborns are twice as likely to die if looked after by white doctors.[i]

The reasons for these disparities are complex, but are not impossible to remediate. Indeed, the authors concluded that the patient encounter, the institutional climate and the associated clinical training needed, are central to improving outcomes, regardless of physician background. By providing education to obstetrics staff on peripartum racial and ethnic disparities, and their root causes, cultural competency and best practices, Ohio families of color can avoid tragic outcomes that manifest for no other reason than the color of their skin. Since the Pregnancy-Associated Mortality Review Board (PAMR) is codified and in place, medical professionals such as those with the Ohio Perinatal Quality Collaborative and The Ohio Equity Institute as well as medical schools can tailor their curriculum around complications identified by the Board to ensure the continuing education provided is relevant and data-informed.

The American College of Obstetrics and Gynecologists (ACOG) has continuously recommended insurance coverage policies are aligned to support a tailored approach to “fourth trimester” care. While Medicaid is required to cover pregnant individuals with incomes up to 133 percent of the federal poverty level through 60 days postpartum, in West Virginia, for example, 62 percent of all maternal deaths from 2007-2013 occurred more than 60 days postpartum. For this reason, we recommend all individuals whose pregnancies are covered by Medicaid be able to maintain their Medicaid coverage for at least one year postpartum including coverage for services like case management and outreach, substance use disorder treatment and mental health screening and treatment. Research has shown that extending Medicaid coverage does help to eliminate preventable maternal deaths. We know that most postpartum spending occurs beyond 60 days after delivery, with more than 70 percent of postpartum spending occurring after 90 days. [ii] Research from the Urban Institute found that approximately half of all uninsured new mothers reported that losing Medicaid after pregnancy was the reason they were uninsured. It’s important to note here that about one-third of new moms who lost Medicaid were recovering from a cesarean section, and over a quarter reported experiencing depression in the months following birth.

According to the Centers for Disease Control and Prevention (CDC), black women are dying at roughly 3 times the rate of white women in birth-related deaths. That statistic gets direr

with age. Black women over age 30, are 4 to 5 times more likely to die in childbirth than white women. Women who experience hemorrhage at hospitals predominantly serving Black patients face a higher risk of severe complications than those who receive care at hospitals with whiter clientele. It is important to note that most pregnancy-related deaths are preventable. The inclusion of doulas into the normal course of care before, during and after child birth has been shown to improve outcomes for mothers and infants, while reducing costs associated with care. Evidence demonstrates expectant mothers matched with a doula had better birth outcomes than did mothers who gave birth without involvement of a doula. Because of this, and the Cochrane Systemic Review of Random Control Studies Regarding Continuous Labor Support we support insurance reimbursement of doula services and ask that the budget consider state mandated private insurance coverage in addition to Medicaid.

MEDICAID

Additionally, we believe the executive proposal's approach to managing the state's caseload and funding after the termination of the Public Health Emergency (PHE) to be sound. Since February of last year, the Ohio Department of Medicaid's (ODM) caseload has grown by greater than 350,000 individuals – namely parents and others who lost coverage through their employers. At the same time, the economy retracted as activity slowed, thereby creating challenges in the state's ability to manage this caseload growth. This is why Congress responded to this challenge by mandating states eliminate barriers to enrollment and providing states with additional federal dollars through enhanced federal medical assistance percentage (eFMAP), increasing the federal share of the program from roughly 64 percent to 70% of the program.

Importantly, this additional federal support has relieved pressure on the state's direct spending into the program and in other parts of the state's budget, generally. This is why, for example, the Governor was able to cut the program in early summer 2020 without the need to limit benefits, cut rates to providers or make significant cuts to other state priorities. Indeed, the average monthly benefit represents nearly $106 million per month in eFMAP.

While this fiscal flexibility provides significant benefit on its own, it's also important to highlight the direct benefit it has for key populations. Specifically, because eFMAP does not apply to the Group VIII/Medicaid expansion population, the majority of the funding benefit has gone to the Aged Blind and Disabled (ABD) category of enrollees. Looking at data between February 2020 and December 2020, the ABD caseload was relatively stable (grew 1.46 percent) The direct state spending, however, decreased by 15.5 percent – a decrease of almost $588 million when comparing the two months, month to month. Given the disproportionate impact COVID-19 has on the disabled and older adults, particularly those in congregate care settings for which Medicaid is a mandatory benefit, this enhanced funding has enabled the state to manage the needs of some of Ohio's most at risk at a time when it is most needed. This funding, however, is tied to the PHE and, as such, is not permanent.

Once the PHE expires, the state will lose additional federal dollars and must begin the process of eligibility renewals and enrollment. This shift creates a significant challenge for the state and its county partners who are responsible for managing the determination process. To simplify this

caseload obligation, the Ohio Department of Medicaid has proposed setting aside dollars in the Health and Human Services Fund to ensure a smooth transition. The benefits to this approach a numerous. First, the last time the state went through a process which quickly restarted determinations during a period of suspension (2015), the state was sued and an injunction was imposed to restore coverage.[iii] As such, a more deliberate process mitigates legal risk. Second, given the outsized role of counties in eligibility determination, taking a more measured approach will ease any potential administrative expense for local governments still grappling with budget challenges of their own. Finally, given Ohio's recent challenges with Payment Error Rate Measurement (PERM), which creates its own significant financial risk to the state, any effort which may unnecessarily accelerate renewals and determinations is likely to increase the potential for error.

Beyond eFMAP, ODM has also initiated an effort with the Ohio Department of Health and the Ohio Department of Aging to "buy back" beds from nursing facilities on a voluntary basis. Over the last couple of decades, Ohio has transformed its long-term care landscape, encouraging more home and community-based alternatives to facility-based care. Not only has this shift saved the state money, as community-based options are significantly less costly, but it has also helped Ohio achieve the mandate of Olmstead v. L.C. ("the Olmstead Decision"), which mandates public entities provide community-based options where possible. Additionally, with COVID-19, Ohio sought a number of regulatory flexibilities that encourage the use of these options as a way to prevent and contain spread. Even before this effort by the state as a response to the virus, the industry has a surplus of beds, which not only carry a cost to the provider, but also to the state which uses bed counts for the purposes of determining reimbursement. With this policy, the state follows the example of other states, which see this policy as a way to address Medicaid costs and capacity, simultaneously.[iv]

HOSPITAL LICENSURE

If there is one axiom of the pandemic upon which all policymakers should agree, it's that accurate, timely data is a necessity in policymaking and public discourse. It's one of the reasons the Center for Community Solutions is an advocate for data transparency in its budget priorities. Embedded within the executive proposal is a section regarding hospital licensure. Not only does this provision carry with it the potential to make clearer those standards we as Ohioans should expect from this critical infrastructure, which also represents the single largest cost-center in Medicaid, but it also opens the potential for better, more accessible data from these providers. In particular, Community Solutions would like to see the inclusion of severe maternal morbidity data as a required data element that must be shared with the public in a disclosable form.[v]

Thank you for the opportunity to provider testimony on this critical legislation. If you would like to discuss any of these issues, please do not hesitate to reach out.

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[i] https://www.pnas.org/content/117/35/21194
[ii] https://healthcostinstitute.org/hcci-research/most-postpartum-spending-occurs-beyond-60-days-after-delivery
[iii] https://www.governing.com/archive/tns-ohio-medicaid-ruling.html
[iv] https://commed.umassmed.edu/blog/2018/03/27/skilled-nursing-facilities-too-many-beds
[v] https://www.communitysolutions.com/putting-mother-back-maternal-infant-health/