



May 3, 2019

The Honorable Scott Oelslager, Chair  
Ohio House Finance Committee  
Ohio House of Representatives  
77 South High Street, 13<sup>th</sup> Floor  
Columbus, OH 43215

Dear Chairman Oelslager,

Thank you for accepting the following as written testimony. My name is Loren Anthes and I am a Policy Fellow at The Center for Community Solutions (Community Solutions), a nonprofit, nonpartisan think tank 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. This testimony is intended to provide comment on the current version of Sub House Bill 166 (Sub HB 166), and those provisions specifically related to 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. With that said, there are many proposed policy concepts offered in Sub HB 166 for which we have initial comments and thoughts.

### **Transparency**

As one of Community Solutions' budget priorities,<sup>1</sup> 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 will be allocated through the Upper Payment Limit program and as they garner the ability to vertically integrate MCO insurance products through corresponding amendments.

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<sup>1</sup> <https://www.communitysolutions.com/community-solutions-budget-priorities/>



As agents of the state, managed care has the ability to contract with providers in ways that achieve value. However, that achievement is dependent not only on their work but on the work of the large systems with which they contract. Hospitals should have their performance on the contractual elements of Ohio’s value-based program published and searchable in a user-friendly format at a high frequency. Also, while price transparency is a laudable goal, research suggests the design of those tools is critical and should be combined with quality data.<sup>2</sup> With that said, iterative scientific research has shown two things: 1) price is not associated with quality<sup>3</sup> and 2) price transparency tools do not decrease patient spending.<sup>4</sup>

These transparency tools may be best seen as policy levers that allow the state to appropriately address the issues of cost and quality as opposed to consumer tools that affect behavior directly. To that end, one only need to look to the Pharmacy Benefit Manager issue, and the current, laudable suggested amendment to tie in the international pricing index model, as an example. The reality is, while hospitals and other providers have consolidated and increased market share, the traditional benefit of economies of scale has not lead to price reductions – in fact the opposite has occurred.<sup>5</sup> The state should endeavor to better mandate the exchange of meaningful data and collaboration between payers and providers and enable measurement therein to bolster the activities of the Department to achieve quality outcomes.

Lastly, while the implementation of site neutrality in Medicaid would significantly reduce expense, the exemption of trauma centers may have a negative impact if not appropriately regulated. According to the American College of Surgeons, a best practice is to ensure trauma centers collaborate regionally.<sup>6</sup> When this has not occurred, the number of centers increases as does overall governmental expense and, unfortunately, mortality. If site neutrality is implemented, the state should consider some limiting licensing measure, either through the creation of a “trauma board” or a certificate of need, to prevent this phenomenon from occurring.

Finally, an amendment where hospitals with Federally Qualified Health Centers (FQHC) are barred from enhanced rates if the FQHC on hospital campus is proposed. This restriction should be lifted if a hospital deploys a mobile unit to conduct venous lead testing in a high risk ZIP code consistent with the abatement program proposed through the State Children’s Health Insurance Program (SCHIP).

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<sup>2</sup> <https://www.commonwealthfund.org/blog/2019/hospital-price-transparency-making-it-useful-patients>

<sup>3</sup> <https://www.ncbi.nlm.nih.gov/pubmed/23277898>

<sup>4</sup> <https://jamanetwork.com/journals/jama/fullarticle/2518264>

<sup>5</sup> [https://www.ncci.com/Articles/Pages/II\\_Insights\\_QEB\\_Impact-of-Hospital-Consolidation-on-Medical-Costs.aspx](https://www.ncci.com/Articles/Pages/II_Insights_QEB_Impact-of-Hospital-Consolidation-on-Medical-Costs.aspx)

<sup>6</sup> <https://www.facs.org/about-ac/s/statements/76-trauma-center>



## Waivers

Waivers are expensive, time-consuming projects which require significant federal oversight but also carry the potential to enable tremendous, positive reform if implemented correctly, such as the aforementioned pharmacy waiver.

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,<sup>7</sup> food insecurity,<sup>8</sup> housing,<sup>9</sup> trauma<sup>10</sup> and education<sup>11</sup> 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 to seek 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. Simply put, while a hospital may be better able to manage someone's diabetes if housing is secure, the hospital is not a housing provider and neither is the insurer which manages benefits. Rather, providers who work in housing should be meaningfully connected to those systems in ways that are useful for the person receiving services and financially viable for the housing provider. It is also important to remember, however, that Medicaid cannot pay for non-medical services.

Given the reimbursement restrictions of Medicaid, the budget should invest resources in non-Medicaid programs which expand safe, affordable housing, increase funding for public transit, decrease food insecurity and promote the use of screening tools which can address medically-derived toxic stress. These policies will financially benefit the Ohio Medicaid program, decrease dependence of its beneficiaries and improve outcomes.

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<sup>7</sup> <https://www.communitysolutions.com/download.php?mediaID=9436>

<sup>8</sup> <https://www.communitysolutions.com/download.php?mediaID=7603>

<sup>9</sup> <https://www.communitysolutions.com/download.php?mediaID=2177>

<sup>10</sup> <https://www.communitysolutions.com/research/trauma-toxic-stress-impact-defining-adverse-childhood-experiences/>

<sup>11</sup> <https://www.communitysolutions.com/download.php?mediaID=8103>



## Managed Care

Legally, provisions around the value-based arrangements in managed care must be achievable. We are encouraged, then, that the policy concepts that deal with managed care allow for some flexibility for the Ohio Department of Medicaid in contracting and focusing on value.

We are supportive of the provisions which require more of MCOs in regards to rates beyond tying fee-for-service (FFS) into risk. The language should ensure that this provision be constructed in a way that complies with federal standards around network adequacy and actuarial soundness. We are also supportive of the provisions around the employment connection incentive program. The state should ensure there is continuity between JobsOhio data regarding available jobs and the managed care organizations. Enrollment in such a program by a Medicaid expansion beneficiary should qualify for an exemption to Ohio's pending 1115 work requirement waiver.

There is also a provision that 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. This provision should allow for third party administrators to be involved in these products to assist in the adjudication of claims and a preference should be given to arrangements which are designed to have full risk, global payments.

Thank you for the opportunity to weigh in on Sub HB 166. We remain committed to working with the General Assembly as members deliberate the budget.

Sincerely,

Loren Anthes, MBA  
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The Center for Community Solutions