OHIO SENATE HEALTH COMMITTEE
HEARINGS ON BEHALF OF OHIO SENATE FINANCE, HOUSE BILL 110
CHAIRMAN S. HUFFMAN

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Chairman Huffman, Vice Chairman Antani, Ranking Member Antonio and members of the Senate Health Committee, thank you for the opportunity to provide interested party testimony on House Bill 110, specifically as it relates to the Ohio Department of Health, the Ohio Department of Medicaid and the Ohio Department of Job and Family Services. 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 Tara Britton, Director of Public Policy and Advocacy, Loren Anthes, Policy Fellow and Chair for Health Planning and Hope Lane-Gavin 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 available data on pregnancy-related deaths in Ohio is from 2016. This data is outdated and more recent data needs to be taken into consideration to enhance infant and maternal health. 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. 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.[1]

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 as of the last state budget, 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 that insurance coverage policies are aligned to support a tailored approach to "fourth trimester" care. Medicaid currently covers pregnant individuals with incomes up to 200 percent of the federal poverty level through 60 days postpartum. We know that postpartum complications and deaths are not limited to those first 60 days. In West Virginia, for example, 62 percent of all maternal deaths from 2007-2013 occurred more than 60 days after delivery. 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.[2] 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

[1] PNAS September 1, 2020 117 (35) 21194-21200; first published August 17, 2020; https://doi.org/10.1073/pnas.1913405117

[2] Aaron Bloschichak, Katie Martin. Most Postpartum Spending Occurs Beyond 60 Days After Delivery. https://healthcostinstitute.org/hcci-research/most-postpartum-spending-occurs-beyond-60-days-after-delivery

Medicaid were recovering from a cesarean section, and over a quarter reported experiencing depression in the months following birth.

The American Rescue Plan Act of 2021 gives states a new option to extend Medicaid postpartum coverage from 60 days to 12 months by filing a State Plan Amendment to their Medicaid program. With 10 states already offering this coverage, we encourage the Ohio Department of Medicaid to take advantage of this option which would allow coverage through 2027 and encourage the Senate to provide an appropriation as well as consider working with ODH and ODM to create a permanent pregnancy pathway for pregnant women that includes the extended postpartum period.

Data from the Centers for Disease Control and Prevention[3] tell us that Black women are dying at roughly 3 times the rate of white women in birth-related deaths. That statistic gets more dire 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, blood loss from a ruptured blood vessel, 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 as the most effective way to increase use of this evidence-based service would be to eliminate cost barriers

MEDICAID

We believe the executive proposal's approach, approved by the House, in 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 to 70 percent of the program.

[3] Emily E. Petersen, MD; Nicole L. Davis, PhD; David Goodman, PhD; Shanna Cox, MSPH; Carla Syverson, MSN; Kristi Seed; Carrie Shapiro-Mendoza, PhD; William M. Callaghan, MD; Wanda Barfield, MD. Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016, Weekly / September 6, 2019 / 68(35);762–765

Importantly, this additional federal support has relieved pressure on the state's direct spending into 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 are numerous. First, the last time the state went through a process which quickly resumed determinations during a period of suspension (2015), the state was sued and an injunction was imposed to restore coverage.[4] As such, a more deliberate process mitigates legal hazard for Ohio. 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. It is for these reasons the Senate should not create additional regulations on the eligibility data activities of the Department through budget policies which artificially accelerate determinations while also hindering some of the most effective tools for making such determinations, like those policy concepts represented in Senate Bill 17.

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

[4] Catherine Candisky. Judge Orders Ohio to Restore Medicaid Benefits to Some But Not All Who Lost Them. https://www.governing.com/archive/tns-ohio-medicaid-ruling.html

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.[5] And while the House budget removed this provision and increased funding for the industry, the quality improvement policies were delayed and sanction levels for poor quality facilities was reduced. With the creation of a committee to investigate quality incentives for the industry, we recommend adding language that would include consumers as a part of the review process, alongside experts in the field to provide a more robust report to the General Assembly.

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, which would support the initial recommendation made in this testimony.[6]

ADULT PROTECTIVE SERVICES (APS)

The Center for Community Solutions has a long history of advocating for a strong adult protective services system in Ohio. In recent research we covered the rollout of statewide APS changes across the state, enacted legislation that increases the categories of mandatory reporters of suspected APS cases, as well as examined senior levies that are in place across Ohio. Even before the pandemic, older Ohioans could face the prospect of unjust circumstances such as financial exploitation from scam artists, friends or family and physical, sexual or emotional abuse. Older adults may find themselves in situations of neglect, or self-neglect, which can result in deterioration of physical and mental health. Individuals who experience these situations are four times more likely to be admitted to a nursing home and three times more likely to be admitted to a hospital.[7] In light of the pandemic and social distancing required for all our safety, older adults, like all of us, have had less interaction with society, reducing the

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[5] Rebecca Laes-Kushner, MA, MPA. Skilled Nursing Facilities: Too many beds. https://commed.umassmed.edu/blog/2018/03/27/skilled-nursing-facilities-too-many-beds

[6] Tara Britton. Putting the "Mother" Back into Maternal and Infant Health. https://www.communitysolutions.com/putting-mother-back-maternal-infant-health/

[7] The Elder Justice Roadmap. U.S. Department of Justice. https://www.justice.gov/file/852856/download

likelihood for mandatory reporters of elder abuse to recognize and report it. For these and many other reasons, Community Solutions is asking that the Ohio Senate maintain the House passed funding increase for APS in the ODJFS budget (line item 600534) from $4.23 million each year of the biennium to $5.72 million each year of the biennium. At current budget levels, each county receives around $48,000 for APS. The House increase would provide $65,000 per county per year in Ohio, enough to fund one full time APS caseworker.

MULTI-SYSTEM YOUTH (MSY)

The Center for Community Solutions supports the recommendations of the Multi-System Youth (MSY) Action Plan and current state efforts to develop a program that can provide more comprehensive care for children with complex needs through OhioRISE (Resilience through Integrated Systems and Excellence). As these programs are fully developed, the state must ensure support continues to be available to work toward eliminating forced custody relinquishment for families and connecting Ohio's children in need through dedicated funding for MSY in the budgets of the Departments of Medicaid, Developmental Disabilities and Job and Family Services. These funding sources were established in the last state budget and have shown that with dedicated resources and a cross-agency/cross-systems effort, children and families can access needed services, often closer to home, and with more support from communities. As of mid- February 2021, over 430 children across the state have been supported through the funding that sits within the Department of Medicaid, alone. Undoubtedly, many of these children and families would have been forced into custody relinquishment had it not been for this funding. We are grateful to Governor DeWine and his administration and the many champions for multi-system youth in this committee and across the legislature who have made this progress possible.

SAFETY-NET SERVICES

We want to ensure safety-net services are as responsive as possible to the needs of Ohio families – something that is essential in the midst of the current public health and economic crises. This would include supporting policies that prioritize a swift economic recovery through efficient and effective access to relief and benefit programs.

The House passed budget includes a provision allowing Ohio to participate in the Elderly & Disabled Simplified Application Project (EDSAP). This program, created by the United States Department of Agriculture and utilized by a dozen other states, seeks to improve Supplemental Nutrition Assistance Program (SNAP) retention of older adults and individuals with disabilities without any earned income by extending the certification of their SNAP eligibility to 36 months. SNAP is a benefit already underutilized by this population who notoriously struggles with food security and state data suggests that roughly 30 percent of these households experienced disruptions to their SNAP benefits at renewal even though their circumstances rarely change. Given that this population represents roughly one-third of all SNAP households in the state, participation in this project would save time for SNAP recipients and caseworkers alike. We ask that the Senate maintain this addition as it continues to hear the budget.

Additionally, counties need the capacity and resources to be able to process applications for programs such as Temporary Assistance for Needy Families (TANF) and Supplemental Nutrition Assistance Program (SNAP) to ensure families are able to meet their most immediate needs. Improving safety-net services also requires timely and accessible data to identify gaps in services. Community Solutions supports budget policies that enhance data transparency.

While we do recognize the increased attention to abuse and fraud in Ohio's public benefits system, we want to assure that the needs of low income and vulnerable Ohioans are not being sacrificed in the name of program integrity. Now more than ever we want to assure that safety net programs, namely Medicaid and SNAP, are accessible to eligible individuals and families and that additional barriers are not presented to an already complex system, limiting access. Many of the proposals already introduced in the legislature to tackle fraud would result in significant disenrollment in key programs for older adults, persons with disabilities and children. While we know that, depending on the program, this isn't the intended outcome, increasing bureaucracy decreases access. We would be happy to work alongside policymakers to truly improve access to vital safety net programs.

As a member of Advocates for Ohio's Future and its work group that focuses on a long-term plan for TANF, we thank the Department of Job and Family Services for continuing to work with us to fully understand and improve TANF in Ohio. As part of achieving overall goals for TANF, it's important that the work to improve the program focus on the immediate, emergency needs of low-income children and families by investing in the core components of the program including emergency assistance (PRC)/work supports, food, housing, income-support, and child care and ensure unspent TANF dollars are reinvested into sustainable core programs to increase the security of low-income families, expand job training and work opportunities and improve educational and health outcomes of low-income children. We look forward to working with the administration and the legislature to ensure TANF is focused on the needs of Ohio families living in deep poverty without getting pulled in too many different directions.

Thank you for the opportunity to provide 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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