



Ohio Association of Health Plans

Representing Ohio's Health Insurers

Testimony

On

H.B. 1 – Medicaid Provisions

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Chairman Carey and members of the committee, thank you for giving me the opportunity to testify on the Medicaid provisions of H.B. 1. The Ohio Association of Health Plans is the statewide trade association representing companies providing health insurance benefits to more than six million Ohioans. This includes commercial insurers as well as insurers that specialize in serving the Medicaid and Medicare population.

Our mission at the Ohio Association of Health Plans is to promote and advocate quality health care and access to a variety of affordable benefits for all Ohioans. By promoting the use of best medical practices and improving the delivery of appropriate care each year, Ohio's health plans are constantly working toward the goal of a more healthy Ohio – both **physically** - with better health outcomes and health management for enrollees - and **fiscally** by controlling costs and contributing substantially to Ohio's economy.

A few years ago, many of you on this committee lead the efforts to expand the Medicaid Care Coordination Program statewide. You recognized that Ohio needed a sustainable Medicaid program that contained costs, had predictability, improved health outcomes, and ensured access to services and had the foresight to know that the only program that could deliver all of this was Medicaid Care Coordination. Today, Ohio's seven Medicaid Care Coordination Plans (CCPs) currently provide health care benefits to 1.5 million of Ohio's most vulnerable citizens.

Just as you, we believe results matter. Medicaid Care Management has been a success story for the state in a number of ways:

<i>Physical Health</i>	<i>Fiscal Health</i>	<i>Economic Support</i>
20% decrease - low birth weight babies	\$350 million - savings 08-09	3,500 - Ohio jobs (Direct and Indirect)
57% increase - primary care and outpatient venues	\$862 million – support for HB 1 initiatives	\$145 million - wages
27% decrease - inpatient services	\$820 million - franchise fee fiscal benefit	\$4.3 million - direct payroll taxes
23 % increase – annual dental visits	\$1.6 billion – total SFY 10-11 fiscal benefit	\$8.3 billion - economic output

One of the most important measures of a successful program is its impact on consumers. In addition to guaranteeing access to needed health care, CCPs serve as a “health care home” for Medicaid enrollees by coordinating all aspects of the care needed to help people stay healthier, get better faster, and take control of their own well being. For example, the Health Care Home helps coordinate ancillary services such as transportation to appointments, coordination with social services and behavioral health services. This has resulted in better health outcomes for Medicaid enrollees. In less than two years, CCPs have had an impact of reducing the number of low birth-weight babies by 20% and 50% for very low birth-weight babies.

Additionally, CCPs use the administrative portion of their reimbursement to fund programs that focus on prevention, wellness and getting chronic diseases under control – all to improve the quality of life for Medicaid consumers. Many consumers have multiple conditions which require extensive care management. The coordination of services has the added benefit of reducing more costly emergency room care and inpatient hospital stays while encouraging the use of primary care for primary and preventative care. This has resulted in a 57% increase in the use of primary care and outpatient venues and a 27% decrease in use of costly inpatient services.

Finally, CCPs provide a level of accountability through performance measures developed by ODJFS in the areas of financial solvency and provider and consumer satisfaction that is unparalleled. The outcomes of these measures demonstrate improvement in the quality of care Medicaid consumers receive as a result of CCPs.

While measurements and statistics are important, we believe that consumer stories speak for themselves. Therefore, I have brought with me today a series of consumer success stories for you to review, because they tell the story from the consumer’s vantage point.

We are pleased that H.B. 1, As Introduced and the House Passed versions, continue a commitment to Medicaid Care Coordination and focuses on some areas to enhance its value. There are several areas of interest being discussed during the budget process which are of interest and which I will focus on today.

<i>Non-Contracting</i>	<i>Franchise Fee</i>	<i>Pharmacy Carve Out</i>	<i>ECM</i>
No requirements for hospitals to participate; plans required to contract	Current fee expires October 1, 2009	Best Medicaid Care Coordination Program is through an integrated model	Model doesn't compare to Care Coordination—not the same playing field
Some hospitals demanding payments taxpayers cannot afford	Health Insurance Industry suggested replacement fee	Full Impacts unknown and consumers likely too loose. A comprehensive analysis should be completed first	No independently documented savings, no predictability, State assumes risk
Will increase access for consumers; remove barriers for contracting	Includes Medicaid Care Coordination under the sales tax	Continue to work with ODJFS; premature to commit to such a policy change	No extra benefits for consumers; doesn't pay for uncovered services such as transportation
Will save taxpayer dollars	Includes Medicaid Care Coordination under the premium tax	DRE at the Federal level is real solution	Limited care management

Non-Contracting

One of the major changes made in the House Passed Version of HB 1 removed a provision which would have addressed a long standing public policy issue concerning reimbursement of hospitals that are not contracting with an MCP. We believe that it is vital this provision be restored as it will ensure hospitals would be paid at the same rate by CCPs as they would have received if the state had been paying them directly. Currently, CCPs are required to contract with certain hospitals, yet there is no requirement for hospitals to participate with a MCP. Unfortunately, to date, the result in some areas has been that it is very difficult to find hospitals willing to participate at terms taxpayers can afford. Current requirements have resulted in paying higher costs for hospital services provided to Medicaid Care Management consumers than those consumers who are not in the care management program. The language as originally proposed, could have resulted in a savings to the budget of \$140 million. This is the amount the state's actuary, Milliman, has estimated would be reduced from the payments to CCPs as a result of the change.

We ask that the original language from H.B. 1 be restored to allow for more reasoned payments for hospital services.

Franchise Fee

Due to federal law changes, the current fee charged to CCPs, as it is currently structured, will expire on October 1, 2009. In order to replace this loss of funds, Ohio's CCPs stepped up to the plate and proposed broadening the base of existing assessments to include CCPs. This is accomplished by including CCPs as taxable entities under the sales and use tax and removing the exemption for CCPs from the existing premium tax on health insuring corporations. It is not often that an industry actually suggests a fee on itself, but this was clearly the right thing to do to make sure our program continues to generate the cost savings and quality outcomes that taxpayers expect.

Pharmacy Carve Out

While we are pleased to have been a partner in developing the best opportunity for continued improvement in the health of Medicaid recipients at the best possible cost, we do have some concerns we are discussing with the administration. The current budget assumptions contemplate carving out the pharmacy benefits from the Medicaid Care Coordination Program. OAH and our member health plans remain steadfast in our belief that the best program for consumers and the state is a program that is fully integrated with a comprehensive benefit package that provides coordination of all the needs of the individual, not just medical.

The major impetus for the change hinges on the Medicaid drug rebate program that was created by the federal Omnibus Budget Reconciliation Act (OBRA) of 1990. This act requires drug manufacturers that participate in a state's Medicaid program to enter into a rebate agreement with the Secretary of Health and Human Services in order for states to receive federal funding for outpatient drugs dispensed to Medicaid patients.

These rebates are available only for fee-for-service Medicaid drug expenditures, and not for Medicaid Care Coordination. Unfortunately, the quest for greater rebates from drug manufacturers has compelled a few states to sacrifice coordinated care and consumer safety by "carving out" the pharmacy benefit. While this is certainly one approach, most other states have decided to keep the benefits integrated because of the potential for higher medical costs and the negative impact on consumers. We are working with ODJFS on this issue to fully discuss the impact that carving out the pharmacy benefit from Medicaid Care Coordination would have and what that means to the state, consumers, providers and the CCPs.

While we understand the growing cost of pharmaceuticals and an interest in potentially trying to gain higher rebates from pharmaceutical companies, we believe it is critical for a full analysis to be undertaken to identify any potentially negative fiscal impacts that would be realized by carving out the prescription drug program. For example, we believe it is important for there to be an understanding of the impact a drug carve out would have on tax revenue to be collected from Medicaid Care Coordination Plans, the ability of the CCPs to manage pharmacy costs to the extent they do now, and the impact of major brand-name drugs going off patent, which will diminish the rebate dollars collected by the state. Additionally, we believe there needs to be a greater discussion around the impact these changes would have on consumers such as new co-pays. These are some of the factors that need to be weighed before the state commits to a drug carve out program in Medicaid.

Another potential solution for this issue does exist at the federal level and is included in President Obama's proposed budget. The Drug Rebate Equalization (DRE) Act would extend the Medicaid Drug Rebate Program to spending on drugs for those Medicaid consumers enrolled in CCPs and allow States to collect rebates on drugs provided through Medicaid care coordination plans. Because of the pending federal legislation, the lack of information on the budget savings, and the negative impact on consumers, we believe it is premature for Ohio to commit to a public policy decision of this magnitude.

Alternative Proposals

During budget deliberations we know that many proposals are presented for consideration, and we know that there are some in the healthcare arena that do not like the checks and balances in place

under a care coordination delivery system. While we can appreciate that point of view, there is no other model that delivers the access, care management, quality, outcomes and cost accountability and predictability that a Care Coordination model brings to the State. We understand there are some pushing a proposal to create a program labeled “Enhanced Care Management” to compete with the Medicaid Care Coordination Program. This experimental approach could force Medicaid consumers in six counties to change the way they obtain health care, and allow providers to charge for services without any of the oversight or cost limitations that the current Medicaid Care Coordination Program is subject to. We are very concerned that such a proposal would be disruptive to Medicaid consumers, would not produce accurate comparisons due to a lack of the same rules for participation and ultimately would cost the State money rather than realizing a savings. Comparison studies of the various models are available and I have attached a recent study by The Lewin Group which shows the results of Ohio’s existing full risk Care Coordination Program is the superior model.

Prompt Pay

Another issue that has been presented by some medical providers is a perception that CCPs do not have prompt payment requirements they must meet and therefore should be subject to Ohio’s prompt payment laws. The reality is that CCPs are required to comply with a federal prompt payment standard which in many cases is more expansive than the Ohio law and are monitored frequently by ODJFS. I have attached a comparison document that shows you the differences between the two standards. I have also included the most recent report from ODJFS that shows how quickly each of the CCPs is paying their claims. In the past, Ohio law required ODJFS to get a waiver to allow the Ohio prompt payment laws to stand in place of the federal requirement. Unfortunately, CMS rejected this request and would not allow Ohio to forgo the federal requirement in lieu of the state standard. Unfortunately, the House added a provision that will now subject CCPs to not only the federal language but also the state prompt payment standard. Our concern is not that the state standards are harder to meet – our concern is that if we are subject to two separate regulatory structures, federal vs. state, and two separate regulatory agencies, ODI vs. ODJFS, the administrative costs for compliance will increase and the results calculated using differing standards. Additionally, the substitute bill creates a prompt payment workgroup to, among other things, look at how to develop one set of standards to govern prompt payment. Perhaps this is to address the dual regulation. However, it makes no sense to have a workgroup look at the issue but go ahead and make the change in law before the workgroup does its work. We would ask that if you want to create a workgroup then the workgroup should report back to the legislature with recommendations on how to develop a single prompt payment standard and language creating dual regulation should be eliminated in 3901.382 (G) (8). Part of this report should also be whether the federal government will allow Ohio to substitute its prompt payment laws in lieu of the federal standards.

Greater Saving Opportunities

Finally – other opportunities exist to go beyond where we are today. A recent report by the Scripps Gerontology Center at Miami University estimates that the number of Ohioans of all ages that will need long-term services will increase by 14 % between now and 2020. Ohio’s aging population continues to increase with approximately 12,000 Ohioans turning sixty each month. The current strain on Ohio’s budget for long-term care services is likely to continue. These individuals represent approximately 30 percent of the Medicaid population, but account for 70 percent of Medicaid long-term expenditures. While the natural tendency in economically tough times is to focus on immediate cost containment measures, it is also important to take steps that begin to address these out-of-control costs. We encourage Ohio to follow the lead of other states that are implementing programs for dual

eligibles and other Medicaid recipients in order to bring significant, long-term cost savings to Ohio. In implementing a unified long term care budget and acknowledging the need for coordinated care. It makes sense that going forward, we should not recreate the wheel and develop new systems for this population, but capitalize on the strengths of the existing Medicaid Care Coordination Program that is in place statewide today.

Thank you for permitting me to testify today and to demonstrate to you the success stories from Ohio's health plans and their impact on our state's physical and fiscal health.