



## **Representative Barbara R. Sears**

Majority Floor Leader

District 47

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### **Sponsor Testimony – Medicaid – Working for Ohioans**

June 18, 2013

Thank you Chairman Amstutz, Vice-Chair McClain, Ranking Member Sykes and members of the Finance and Appropriations Committee for giving me the opportunity to present HB 176 – Medicaid – Working for Ohioans. This legislation was drafted incorporating many ideas from members since the budget process began, although truly Ohioans have been talking about and debating this issue since the passage of the Patient Protection and Affordable Care Act (PPACA) in 2010.

The incredible over reach of the Federal Government through the passage and implementation of the PPACA is nothing short of breathtaking.

To set the stage for this conversation, I would first like to take a moment to look under the umbrella of the PPACA through its components:

1. Medicaid Expansion
2. Marketplace reforms ( Carrier mandates and rules, fees, fines, taxes and penalties)
3. Exchanges (the Marketplace)

**The first silo** – reforming the eligibility guidelines in our Medicaid program; the true conversation for today and the legislation that I am introducing.

**The second silo** – the marketplace reforms; I have included with my testimony a copy of the Deloitte May 2013 Progress Report on The Affordable Care Act (ACA) of 2010. This document looks at most of the Marketplace reforms items and summarizes them by key elements and provides an implementation status update. I have also included an overview of the penalties our citizens and businesses have the potential of paying and an overview of the fees and taxes included in the PPACA.

**The last silo** – the Exchanges (the Marketplace); as you know the State of Ohio has rightly pushed the responsibility of the development of the Exchange to the Federal Government. It is at this point well documented, that any notion of true State flexibility was just a notion, and in fact the “exchange” is little more than the marketing controlling arm of the PPACA and the vehicle for processing the subsidies and tax credits.

The silos are just that – silos although they were designed to work in tandem with the first and third supported by the second, can and will work independently if required. It is the marketplace reforms, rules, fees, fines, taxes and penalties, along with the subsidies, that are the most offensive to so many Americans.

Today, I would like to speak specifically about what I call the first silo, Medicaid expansion. We all know there are two times that you truly have the ability to reform just about anything, the first born out of necessity – a fiscal crisis and the second born from strength – advantage. This is the opportunity that has been presented to us in Ohio. This “once-in-a-lifetime” opportunity to refocus our eligibility guidelines in our Medicaid program allow us to look at Ohio’s working poor and provide hope for a healthier and more successful Ohio.

To be clear and honest in this conversation, a change in our definition of eligibility as contemplated under the PPACA is a very big change for Ohio. However, I believe we are more than ready for the challenge. I believe Ohio has an excellent team in place that can drive us to our goal of improving the health of Ohioans.

So let’s dig in...I will attempt to:

1. Review of the bill language in specific term of what we are looking for from the Administration and from the Federal Government as it relates to our Medicaid partnership.
2. Why it is important to expand our Medicaid eligibility?

### **Overview of the HB 176 Medicaid – working for Ohioans**

Currently we have two working committees that oversee Medicaid: (1) Joint Legislative Committee on Medicaid Technology and Reform (formed in 2005); and (2) Joint Legislative Committee on Health Care Oversight (formed in 2000). Although this may surprise you, I have served on both committees.

The Joint Legislative Committee on Medicaid Technology and Reform is tasked with the responsibility to review or study any matter that it considers relevant to the operation of the Medicaid program established under Chapter 5111 of the Ohio Revised Code, with priority given to the study or review of mechanisms to enhance the program’s effectiveness through improved technology systems and program reforms. HB 176 (L-13 to 61) details an additional priority for this committee to review and study the reforms to be implemented under section 5111.80 of the Revised Code. HB 176 also modifies the membership of the committee, requiring at a minimum quarterly meeting and provides for LSC and staffing as needed.

Sec 5111.0126 (L 62 to 84) covers three important topics:

It declares that should the Federal government reduce the partnership percentage as indicated in the PPACA law, the newly covered group will cease to be covered and automatic disenrollment will occur without the ability to appeal the disenrollment. It also declares that the programs structured for this newly covered group will be structured in a manner that will cause the per recipient Medicaid expenditures once established to be reduced.

Sec 5111.80 (L 85 to 140) provides the pillars of the mission statement for Ohio's success in Medicaid. This truly highlights and documents the guiding principles (included with this testimony) under the Office of Health Transformation, with legislative influence within the committee and legislative process.

This section challenges us to:

1. Improve the health of Medicaid recipients while reducing costs, including uncompensated care costs; control Medicaid costs and reduce the rate of increase in expenditures;
2. Enroll at least 80% of Medicaid recipients in private sector health plans;
3. Require Medicaid recipients to assume greater personal responsibility through cost sharing and by incorporating the objectives of health savings accounts through value-based insurance design;
4. Ensure that Medicaid recipients who abuse narcotics received proper treatment and are unable to access the narcotics they abuse through the health care systems;
5. Promote employment-related services and job training linkage available under Medicaid Managed Care Programs and other programs to lower Medicaid caseloads by assisting able-bodied, adult Medicaid recipients into the workforce; and,
6. Make the administration of the Medicaid program more efficient and establish the state as a national leader in preventing Medicaid fraud and abuse; and support health care payment innovations in the private sector by assisting other purchasers of health care services and health care providers by leveraging the Medicaid program's purchasing power.

Sec 5111.801 (L 141 to 165) simply states that the medical assistance director shall request a state plan amendment, shall not implement until federal approval is received, may begin the implementation process and shall cease if the approval request is denied.

Sec 5111.802 (L 166 to 172) requires the medical assistance director to submit a report to the General Assembly on the progress of the reforms and may include recommendations for additional reforms.

Lastly Sec 5111.947 (L 173 to 179) allows the state to deposit the Federal share for the purposes of the Medicaid expenditures.

## **Policy reasons for supporting Medicaid Expansion**

A policy analyst for the conservative policy group, The Buckeye Institute, stated the solution clearly in an updated May 21, 2013 *The Plain Dealer* article by Sarah Jane Tribble entitled, "Could Medicaid expansion decrease drug court costs, save local taxpayer dollars? Cleveland judge says yes". In that article the analyst stated "...there needs to be 'overarching systematic reform that will offer assistance to these people...there are more ways to deal with this issue than to simply say we have to expand this one program' ". It imperative that we take an overarching systemic approach to this system so we may effectively address the needs of Ohio's most vulnerable.

## Ohio's overarching systematic approach

It is appropriate at this point to refer you to a slide (included with this testimony) we have seen from the Office of Health Transformation (OHT) and the Department of Medical Assistance summarizing the Ohio Health and Human Services Innovation Plan. I would encourage everyone to take some time and review the depth of what is indicated in this plan. The plan reviews the identification of the problem, policy priorities, initiatives, governance and current work teams. If you look at the plan in the third column, "Improve Health System Performance", it specifically outlines the problem attempting to be solved; in this case Ohio's ranking in health outcomes. It looks at policy priorities to improve that ranking and phases in the initiatives to reach the policy priorities, while also determining who will be responsible for the process. The administration is transparent in progress with its 2011 and 2012 Accomplishments Reports (included with this testimony) which tell the story of how we have been "Renewing – Reforming – Reviving" Ohio Medicaid programs. In fact, ODH was recognized in 2012 with the Vision Award from the Association of State and Territorial Health Officials for a "39-week" project to reduce the incidence of low-weight babies. It is clearly working; we have had an 8 percent increase in full-term deliveries. These brief reports summarize a great deal of work and highlight efforts from the legislative branch, the executive branch, private individuals, business and our universities.

So if Ohio needs not just a systematic approach, but an overarching systemic approach, what are we really saying needs to be done?

We can identify the problems and I realize that I am stating very simplistically:

1. A population that is without access and resources to health care;
2. A population that is unprepared or unable to join the workforce; and
3. A population that is unable to be as independent in life as they could be with some guidance.

Although Medicaid expansion is the foundation for the solution, it is the structure built on the foundation that works to the solution.

It is intriguing to think about mapping out an overarching systemic approach that provides linkage from one department of government to another. We have some modeling on which we can build. If you look at relationship of a parent, mentor, counselor, or "life coach", you begin to see how Ohio can reach this goal in a meaningful way.

Never before have we extended health care coverage to those without a unique common issue; currently we have parents, children, disabled and aged. In fact, we have an almost perverse approach with our parent group. We design, educate and train this group so that if health care coverage is vitally important, one does **not** improve their financial position as it is easier and more beneficial to remain stagnant in the system if you have young children and are not married. It does not encourage the family values and the quality of life most Ohioans dream of for themselves and their children.

We could adopt very specific legislation regarding the population that could be served under an expanded Medicaid; the reality is we have been spending months looking at the "faces" the working poor, uninsured, childless adult population. We have heard stories that have made many of us cry and shake our heads. We have heard stories that make us want to be punitive to the few abusers of our programs and systems. We have heard stories that point to monumental success with treatment and opportunity.

We know some things about those whom we might see in an expanded population; we could see underemployed, undereducated, addicted. We could also see disabled, veterans and those living with behavior or mental health issues. We could see those living with very easily treated conditions or those with very complex conditions.

If we don't know the needs of the population other than the faces we have seen in testimony and the faces we see in our communities prior to structuring the approach to promote employment-related services and other programs to lower Medicaid caseloads, we could find ourselves structuring programs with no one to enroll in them.

### **So start at the beginning with the end goal in mind!**

First, we must determine who is actually enrolling; what their needs are and link to (just to name a few) programs that are currently in place or to be developed based on realized needs within the new population to be served:

1. Housing
  - a. Supportive
  - b. Temporary
2. Educational programming
  - a. GED programs
  - b. Certificate
  - c. Higher Education
  - d. Financial
  - e. Nutritional
  - f. Parenting
  - g. Wellness and Health Care Management
3. Workforce Development
  - a. Example: Ohio Works First; learning, earning and parenting program - LEAP (included with this testimony) could be reformed to provide opportunities for childless adults. I referenced a section from Bulter County's JFS website on their program for your review. This program is briefly discussed in the book Learning from Leaders – Welfare Reform Politics and Policy in Five Midwestern States by Carol S. Weissert, which was discussed in former Ohio Representative Joan Lawrence's testimony recently.
4. Corrections
5. Community and Faith Based Initiatives

I gave just one example – however, I am sure that we each could come of with ideas that would add greatly to this short list.

Thinking in terms of Maslow's hierarchy of needs, you can build a pathway to linking programs and people.

### **So who do we put in charge?**

Every State department should have as part of its mission, improving the lives of Ohioans. We're here doing the peoples work to make Ohio the State that is best to work, live and raise a family. On this issue, I believe

the place to start is health care and the best access point is our Medicaid Managed Care partners. They already are performing individual health assessments for those Ohioans that they work with, adding to what they currently measure. I believe, however, that they could be in the best position to identify the resources someone may need in order to begin more independent.

An additional choice could be our partners at ONE stop shops (OhioMeansJobs) using our work force development tools. However, in preparing for this testimony, I revisited the JFS Redbook and the JFS Annual Report. Currently 99 percent of our Work Force Development dollars are Federal WIA dollars with 85 percent required to fund Local programs; 10 percent Special Federal Grants and 5 percent State dollars. The State contributes additional 1 percent (\$2 million) which funds the Military Injury Relief Subsidies. Our flexibility at the state level is very limited, leaving the most flexible partner our Medicaid Manage Care Partners. I have included with testimony a documents regarding Work Force Development.

Additionally because of all of the current checks and balances in our current rule making process, the Medicaid Manage Care Partners through contractual agreements are not only the most flexible but is also the most nimble from a timing standpoint. I have included with testimony a document that briefly outlines our rule making timeline; keep in mind that this timeline begins after any internal department requirements.

**If you cannot measure it, you should not fund it.**

Our Medicaid managed care partners and our Office of Medical Assistance measure and value virtually everything and working with the Office of Healthcare Transformation (OHT) the coordination of program linkage would be – well probably not simple to do – but certainly doable. We know this because of the coordination that has occurred with all of the departments under OHT. OHT has been able to reduce the total size of departments, move programming to more logical departments and reduce duplicate programming and services.

HB 176 requires that the medical assistance director report annual and meet quarterly to discuss the progress of reforms and to identify new needed reforms based on hot spots.

I would like to discuss just one of many areas that I was intrigued with – corrections.

**Corrections: What do we know about former inmates?**

Former inmates have higher unemployment and disproportionately higher chronic disease and mental health disabilities. Additionally, according to the study “Medicaid Coverage for Individuals in Jail Pending Disposition, Opportunities for Improved Health Care at Lower Costs” found that of the ‘largely uninsured’ former inmate population, 70 percent sought health services within 10 months of paroles, 30 percent of which visited the emergency room. Former inmates are 40 percent more likely to have a general health condition and 30 percent more likely to have multiple medical conditions than the general public, according to the study. (Information taken from Correctional News – Medicaid Expansion to Provide Health Care for Former Inmates, 5/15/2013)

The study also indicated that 50 percent of all former inmates are dependent upon some sort of addictive substance and are at risk for homelessness 7 to 11 times higher than the general population.

So if we can identify a problem with re-entry within our criminal justice system and use a overarching systematic approach, which is the correct approach, we know we have the possibility to (1) improve treatment

and education within the correctional facilities, thereby preparing inmates mentally and physically to have hope of opportunities outside of prison; (2) reduce to more appropriate levels the collateral sanction that occur upon leaving the correctional facilities, thereby providing more opportunity for inmates to seek and reach employment; and (3) identify ongoing health care and high risk of homelessness as unmet needs.

Currently, we approach these issues in a very adhoc, inconsistent, non-systematic manner which our judges and law enforcement tell us does little to protect our public, help those addicted, or reduce recidivism within Ohio. In fact, we have heard very compelling testimony from judges that are making life and death decisions out of the courtroom based on jail space, not on needs.

Although I could continue for hours – maybe even days and weeks with facts and statistics, we have heard them in Finance Committee, Health and Human Services Subcommittee and the Healthier Ohio Working Group. I have not included for your review a copy of the Health Transformation Budget Priorities – Senate Finance Committee Testimony based off of the House language dated April 18, 2013 and the Senate Finance Subcommittee on Medicaid Testimony provided by the Office of Medical Assistance dated April 24, 2013. They are detailed on the OHT website and in the budget reports.

### **Ohio Medicaid Facts**

I will provide you with a couple quick interesting points:

- (1) Medicaid spending increased 33 percent over the prior 3 year; in 2012 it was held just below 3 percent
- (2) Medicaid overspending was common, requiring budget corrections; in 2012 it was under budget by \$590 million
- (3) Ohio now leads the nation in reforms to modernize Medicaid; working with the legislature and our private partners we have the ability to not just bend the cost curve but improve the quality of life for Ohioans
- (4) Fraud and Abuse: in 2011 Ohio was selected by HHS-OIG as the #1 MFCU in the country for FFY 2010 and in FFY 2011 we were ranked #4 for gross indictments; #3 for gross convictions and for FFY 2012 Ohio ranked #1 for gross indictments and #3 for gross convictions. Certainly fraud and abuse is an area where it's important to be nimble, for every new safe guard developed, someone will learn how to get around it. Ohio has proven regardless of the states governance this has been a priority issue.
- (5) The Ash Center for Democratic Governance at Harvard University's John F. Kennedy School of Government honored the Ohio Program Integrity Group (PIG) as one of the "bright ideas" for 2012.

## Medicaid PMPM -- All Agency

	FY 2007	FY 2008	FY 2009	FY 2010
Service Cost	\$ 11,804,659,514	\$ 12,315,957,215	\$ 13,266,749,057	\$ 14,661,974,173
Member months	1,768,783	1,789,934	1,886,843	2,046,072
PMPM	\$ 556.16	\$ 573.39	\$ 585.93	\$ 597.16
% increase		3.10%	2.19%	1.92%

	FY 2011	FY 2012	FY 2013 Estimate
Service Cost	\$ 15,660,041,336	\$ 16,008,369,555	\$ 16,530,298,041
Member months	2,157,606	2,215,290	2,369,929
PMPM	\$ 604.84	\$ 602.19	\$ 581.25
% increase	1.29%	-0.44%	-3.48%

From Ohio Department of Medicaid, Projected Medicaid Service Expenditures, Executive Budget Submission (page 15)

We are tracking in the correct direction, lowering the PMPM cost. It is reasonable to assume that adding a new population will spike the PMPM as conditions are identified, treatment is initiated and health is stabilized. Once we begin to understand the new populations' needs, we can clearly identify the pathway to the programs that we will enable to be successful.

### Why now?

1. 275,000 Ohioans are uninsured, low-income and without opportunity to purchase coverage.
2. Ohioans are now and will be subject to the fees and taxes that are part of the Reform silo.
3. Ohioans are spending hundreds of millions in ad-hoc treatment programs and services that do more touching than treating the problems. These dollars could be repurposed for other state priorities.
4. Ohio businesses could be subject to millions in penalties without expansion. The penalties will begin on January 1, 2014.
5. The implementation of this level of change demands a process that has time to be thoughtful, requiring many steps and approvals. Short changing the process will allow unintended consequence to occur and subject Ohioans to significant cost.

In the closing paragraph of the Medicaid chapter of the book entitled Health Care Politics and Policy in America by Kant Patel and Mark Rushefsky, they write: " The Medicaid program, in many ways, represents the best

and the worst of American politics. It reflects the best of the American tradition of helping the poor and disadvantaged groups who cannot help themselves. It also reflects the worst of American politics – that of an incremental, patchwork approach to policymaking – influenced by the vagaries of electoral and economic cycles that often produce irrational and incomprehensible public policy.” HB 176 allows for a rational and comprehensible public policy approach that has the ability to develop into an overarching systemic approach to helping the poor and disadvantaged, while also helping those that need hope and a gentle push forward.

HB 176 recognizes a unique opportunity to reform Ohio’s Medicaid program and to reform the processes we use to link entitlement programs to insure they work for Ohioans. All of this must start with a foundation – Medicaid expansion. HB 176 adds the framework and allows the legislature, working within each of our committees, to identify and develop the interior and exterior of the program by identifying “hot spots” and legislative priorities that are used as linkage opportunities within the programs (current hot spot initiatives included with my testimony). Each legislative committee and each member has the opportunity to use their expertise to develop programs that have the ability to serve and enable success for the districts they serve.

Thank you for your time and attention to this very important issue, I fully understand that some will be opposed to this legislation simply because it is a part of the PPACA; for you, I would respectfully ask that you study the legislation and the benefits it can and will have for Ohioans. Medicaid expansion and the retraction of eligibility have occurred under both Republican and Democratic watch and in a bipartisan manner. I have faith in our legislature that we will be able to continue to responsibly manage our budget in a manner that is respectful of our citizen’s tax dollars and our state priorities. I am happy to answer any questions you may have and bring to you any additional resources you may wish as we consider this legislation.