

TESTIMONY

MEDICAID AND HEALTH CARE PROPOSALS

IN HB 153

HOUSE FINANCE COMMITTEE  
SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES

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CHAIRMAN BURKE, Ranking Member Goyal, and Representatives Sears, Adams and Weddington. My name is Cathy Levine. I am the Executive Director of UHCAN Ohio, a statewide, nonprofit consumer health advocacy organization. Along with Col Owens, I co-chair Ohio Consumers for Health Coverage, on whose behalf I speak today. Our coalition is focused on making sure that health reform addresses the diverse needs of consumers.

Consumers are extremely concerned about skyrocketing health care costs and poor quality of care, especially vulnerable populations including older adults with multiple chronic conditions and people with disabilities. That's why we were delighted by the policy goals announced by the Governor's Office of Health Transformation (OHT). Their four transformation priorities – improve care coordination, integrate behavioral and physical health, balance long term care, and modernize reimbursement – are exactly right. We agree, as well, with the approach of focusing on the 4% of Medicaid beneficiaries who account for 50% of spending – the so-called “Hot Spotters” approach - as well as the over-arching goal of driving spending from high-cost settings to lower-cost settings. That's why we applaud OHT for leaving the so-called “optional” services in place, because cutting services such as dental care leads people to seek care in more expensive settings.

That's also why we are puzzled by some budget choices that seem to undercut stated priorities.

Briefly, “health homes” or “patient centered medical homes” are proven models for reducing costs for people with chronic health conditions. That's why we are puzzled by the administration's proposal to zero out funding for federally qualified health centers, which provide culturally competent “health homes” in medically underserved areas in Ohio. Federal funding for expansion is in jeopardy and the need in Ohio is so great that the federal funding does not supplant the need for state funding.

Next, OHT's stated goal of “balancing long term care to enable seniors and people with disabilities to live with dignity in the settings they prefer” has long been a priority of consumer advocates. You have heard a great deal of testimony already on proposed cuts to the Area Agencies on Aging, which administer the Passport program. We have reviewed the administration's arguments about regional variation (which is true of nursing homes and indeed of all health care). But, if our goal is to move people from seeking care in higher-cost settings to lower-cost settings, proposed cuts to Passport make no sense. The services coordinated by the Area Agencies and Aging keep many older adults and people with disabilities in their homes and out of nursing homes. If proposed per member per month service cuts are enacted, personal care assistance will be reduced and people who could remain at home will be driven into nursing homes.

More fragile patients who are prone to incur the highest costs need “high touch” care – individualized, in-person coordination to overcome challenges and improve health to a sufficient degree to avoid expensive treatments and settings. That's why provider rate cuts to caregivers who earn \$8 to \$15 an hour for God's work seems risky. It is also why I urge the legislature not to sign off on any wholesale transfers of Medicaid patients who require long term care into Medicaid managed care plans. We were pleased that OHT's proposal to the Center for Medicaid and Medicare Innovation called for a planning process to determine the best models of care for people who are dually eligible for Medicaid and Medicare. Around the country, a small number of initiatives have shown significant savings by high-touch, personalized, coordinated care delivery models. Successful initiatives determine what high-need

patients require to keep them from needing more costly care, and then build the payment formulas and administrative structure to support the delivery model – and not vice versa. This process needs to take place *before* deciding on the role of the Medicaid managed care plans. It will be unfortunate if the General Assembly shortcuts the proposed planning process which enables stakeholders to participate in designing and implementing effective delivery systems.

Finally, I would like to address the priority of “Modernizing Reimbursement.” Bi-partisan stakeholders across the country have long recognized that the way we pay for health care today – fee for service – encourages a high volume of procedures, rather than the right care at the right time and setting. Reforming how we pay for care is essential to creating delivery systems that focus on improving patient experience and outcomes, while lowering costs. Experts around the country have identified the “low hanging fruit” of payment reform: Changing how hospitals are reimbursed for Potentially Preventable Events (PPEs), including preventable infections, complications, and readmissions. Hospitals that have higher rates of preventable patient harm should be paid less. New York’s Medicaid program saved \$400 million in three years after instituting new hospital payment policies. Texas has introduced legislation to impact all payers. Medicare will institute some reforms later in 2012.

This budget should propose changes in Medicaid payment formulas based on rates of PPEs. We recognize that ODJFS needs to update obsolete Diagnostic Related Groups (DRG) first. However, even so, experts suggest that Ohio Medicaid should be able to start saving significant money with new payment methodologies in the upcoming biennium. Why is this so important? An average of 195,000 Americans died in each of the years 2000-2002 from medical errors. Improvements since then have been uneven. A reported 913,215 patient safety errors occurred among Medicare beneficiaries between 2005 and 2007, resulting in \$6.9 billion in wasted payments. An estimated 20% of Medicare beneficiaries face post-hospitalization readmissions, many of which are preventable. Many hospitals have undertaken voluntary safety initiatives around specific procedures and have reported dramatic reductions in complications. But we can’t wait for voluntary action to stop wasting money and lives. We should align payments with the outcomes we want to see.

I want to thank you very much for your genuine concern coupled with your tireless efforts to listen, read, and research to determine how to transform Medicaid and, by extension, Ohio’s entire health care sector, into a system that provides **better care at lower costs** for all of us, but especially our most vulnerable residents.

I’m happy to answer any questions you may have.