TESTIMONY

HB 153
HEALTH CARE IN OHIO

HOUSE FINANCE COMMITTEE

APRIL 14, 2011

COL OWENS, CO-CHAIR
OHIO CONSUMERS FOR HEALTH COVERAGE

SENIOR ATTORNEY
LEGAL AID SOCIETY OF SOUTHWEST OHIO, LLC
215 E. 9TH STREET, SUITE 500
CINCINNATI, OHIO 45202
PH 513-362-2841
FAX 513-241-7871
CELL 513-300-3042
E-Mail cowens@lascinti.org
Good morning, Chairman Amstutz, Ranking Member Sykes, and members of the Finance Committee. My name is Col Owens. I am a Senior Attorney at the Legal Aid Society of Southwest Ohio, LLC, and co-chair of Ohio Consumers for Health Coverage (OCHC), a broad-based statewide consumer advocacy coalition working for quality affordable health care for all Ohioans.

The significance of the health care budget cannot be exaggerated. Ohio’s Medicaid program serves well over 2 million people, and Ohio’s uninsured adult population numbers 1.4 million. Both populations have grown substantially during the recession.¹

In testimony before this committee, Greg Moody, Director of the Office of Health Transformation (OHT), identified several major themes for Medicaid transformation and health care reform in Ohio.² The central goal is a health care system that delivers better care, with higher quality outcomes, at lower cost. Four priority strategies were identified: improve care coordination, integrate behavioral and physical health, balance long term care, and modernize reimbursement. OHT focuses on “hotspots,” or areas of high cost, such as 4% of Medicaid participants with chronic conditions accounting for 50% of Medicaid spending,³ in order to move these individuals from high-cost to lower-cost care delivery settings. Other identified strategies include effective health benefit exchanges and the electronic information exchange.

We strongly support this infrastructure of reform. It makes sense. However, several budget proposals in HB 153 do not appear to be consistent with this vision. The fiscal proposals do not reflect the sound policy choices they are implementing. I will address these briefly.

1. Community Health Centers

Patient-centered medical homes are central to the Administration’s plan, and Community Health Centers are key examples of that approach. Yet HB 153 zeroes out their state funding of $2.6 million per year. This would be on top of the substantial cut of $600 million contained in the recently-adopted federal budget deal for the remainder of FFY ’11. State funds, while not extensive, help Centers greatly to serve the non-Medicaid eligible population. These funds should be restored.

2. Passport

The Administration plan places great emphasis on moving people from high-cost institutional care settings to lower-cost home and community based care settings. The proposed cut of $100 million in service plans over the biennium seems at odds with this priority. Fewer personal care visits will threaten the ability of many seniors and persons with disabilities to remain at home and out of nursing homes.

³ This disproportionate spending occurs in the unhappy context of Ohio spending more overall for health care than most other states, while ranking 42nd among states in a battery of health outcomes. Id.
Even if the AAA’s shift billing from administration to services to obtain a higher match rate, as has been suggested, this cut will still have very damaging impacts, and will undercut the Administration’s strategy. It should be re-visited.

3. Behavioral Health

The Administration’s embrace of integration of behavioral and physical health (the natural offspring of parity) is most welcome. Elevating the responsibility for Medicaid match for mental health services to the state is also welcome. However, once again, some proposed budgetary cuts do not reflect these priorities. For example, funds to local boards for non-Medicaid services are cut 30%. More funding in the 505 Line is needed. Funds that remain should be directed to the four priority areas identified by ODMH: children with severe mental illness; housing; those leaving institutions (hospitals and prisons); and those in crisis. Caps on service utilization should be accompanied by a prior authorization mechanism to protect those requiring higher levels of service.

4. Modernize Reimbursement for Hospitals

Payment reform is based on the broadly-shared belief that fee-for-service reimbursement is out of date and counter-productive, paying for volume rather than value, quantity rather than quality. One area where this is acutely the case is payment for hospitalization resulting from adverse events such as hospital acquired infections and avoidable hospital re-admissions. It is estimated that 20% of Medicare patients face post-hospitalization re-admissions within 30 days of discharge, many of which are avoidable. Incentives and penalties to reduce the incidence of such adverse events are considered by many experts to be the “low-hanging fruit” of payment reform, yielding both higher quality care and significant savings to Medicaid and private payers. It also saves lives: an average of 200,000 Americans died in each year of 2000-2002 from medical errors.

Yet surprisingly the Administration’s plan includes only negligible savings to be derived from this area, $308,000. Ohio’s Medicaid Director testified that this strategy cannot be undertaken until MITS is on line and obsolete Diagnostic Related Groups (DRGs) are updated; and that those events cannot occur in time to achieve significant savings in the upcoming biennium. Experts in other states suggest the process need not be so time-consuming. ODJFS has announced that MITS will be on-line in August. It would seem the Administration could, with dedicated focus, achieve the necessary DRG updating in time to derive savings in the second year of the biennium. At a minimum, hospitals should be required to publish transparent data on quality measures related to preventable adverse events.

In summary: the policy structure is excellent, but budget proposals need to reflect it.

Thank you for the opportunity to testify. I am happy to answer any questions.