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August 4, 2016

Sylvia Matthews Burwell
Secretary
Health and Human Services
200 Independence Avenue. S. W.
Washington, D.C. 20201

Submitted online at Medicaid.gov

RE: Comments in Opposition to 1115 Demonstration Waiver

I. Introduction

As advocates for Central Ohio's low-income individuals and families, we have deep concerns about the Ohio Department of Medicaid's (ODM) intent to roll back its current Medicaid system by implementing the Healthy Ohio Program. Imposing premiums and penalties on the most economically fragile Ohioans is not the way to make our state healthier; it is simply a way for ODM to cut people from the current Medicaid program through what is essentially a cost-shifting program. Under the guise of personal responsibility, Ohio's waiver, if granted, will place untenable financial hardship on Ohio's poorest citizens and cause large numbers of people, particularly minorities, to go without needed medical care.

II. The Healthy Ohio Waiver Does Not Promote the Objectives of the Medicaid Act

In order for ODM to create and implement Healthy Ohio, it requests waivers of six fundamental precepts of Medicaid. The Center for Medicare and Medicaid Services (CMS) is permitted to grant these requests only if they are for experimental, pilot, or demonstration projects which assist in promoting the objectives of the Medicaid Act. 42 USC 1315(a) requires that the Secretary find that the request:

(1) will test a unique and previously untested use of

copayments, (2) is limited to a period of not more than two years, (3) will provide benefits to recipients of medical assistance which can reasonably be expected to be equivalent to the risks to the recipients, (4) is based on a reasonable hypothesis which the demonstration is designed to test in a methodologically sound manner, including the use of control groups of similar recipients of medical assistance in the area, and (5) is voluntary, or makes provision for assumption of liability for preventable damage to the health of recipients of medical assistance resulting from involuntary participation. 42 U.S.C.A. § 1396o (West)

In addition, there are general criteria CMS uses to determine whether Medicaid/CHIP program objectives are met. These criteria include whether the demonstration will:

- Increase and strengthen overall coverage of low-income individuals in the state; and
- Improve health outcomes for Medicaid and other low-income populations in the state.

Ohio's application, as described in the Healthy Ohio Program 1115 Demonstration Waiver released April 15, 2016, fails to meet any of these criteria and should not be granted by CMS.

A. Healthy Ohio is Not Unique and has No Demonstrative Value

1. Co-Payments and Health Reimbursement Accounts Have Already Been Unsuccessfully Tried in Other Medicaid Programs.

CMS has already granted waivers to other states – including but not limited to Arizona, Iowa, Indiana, Michigan, Montana, and Pennsylvania – to implement similar premium/cost sharing requirements for Medicaid beneficiaries. There is no demonstrated experimental value in adding another state to that list. The only thing that makes the ODM waiver request unique is that it extends the mandatory premium/cost-sharing requirement to individuals and households living below 50% of the federal poverty level (FPL). Indeed, under the ODM plan, persons with incomes as low as 1% of the FPL (near-zero income) and living in extreme poverty would have to pay a monthly or annual premium. Ohio does not need an experiment to show that individuals living in extreme poverty simply do not have the resources to meaningfully engage in Medicaid cost sharing.

The centerpiece of ODM's proposal, the Buckeye Account, is modeled upon Indiana's POWER Accounts, which are a central feature of HIP Plus. Ohio proposes elements of an HSA-like

account that are more complicated than Indiana's project. Independent analyses of Indiana's available data and reporting raise serious questions about the experiences for the consumers in Indiana. In addition, CMS has commissioned its own study of Indiana's HIP 2.0, which should be completed by the end of 2016. Other states besides Indiana – including Arizona, Arkansas, Iowa, Kentucky, Michigan, and Montana – have implemented or plan to implement similar health savings account schemes. CMS should not approve any further HSA-like proposals until the existing demonstration projects have been thoroughly evaluated.

2. Healthy Ohio Will Not Increase the “Cost-Conscious” Use of Medicaid

ODM's stated purpose for the Healthy Ohio Program is to introduce non-disabled Medicaid recipients to a consumer-driven healthcare model where they will be incentivized to use their insurance in a “cost-conscious manner.” However, the model makes no mention as to how Ohio Medicaid recipients will be able to comparison shop, and actually make conscious decisions on choosing more cost-effective health care. NHeLP, in its analysis of Health Expense Accounts in Medicaid, found that comparison shopping was nearly impossible for Medicaid recipients because of a lack of price transparency.¹ Studies have found that when faced with co-payments and deductibles, individuals tend to reduce as much on essential care as less necessary care, which can lead to more expensive health interventions like hospital stays and emergency room visits.²

In addition to a lack of price transparency, Medicaid recipients face additional hurdles to comparative health care shopping. Many Medicaid beneficiaries lack transportation to allow them to go across town for a cheaper test; they must depend on health care that is close to home, regardless of how the cost compares elsewhere. Many have limited telephone minutes and cannot use them on hold with a variety of doctor offices to comparison shop, do not have internet access to comparison shop online, and do not have child care to utilize while they obtain second opinions on health care decisions. The state's transition to managed care itself remains a huge learning curve for Medicaid beneficiaries who commonly do not understand the concept. A movement to health reimbursement accounts, a switch confusing to professionals in employer-based plans, would be overwhelming and often unusable for this population.

Current, successful, health care movements are going in the opposite direction of the Healthy Ohio waiver. Instead of requiring individuals to take additional steps to receive needed care, models have moved toward patient-centered medical homes, coordinated care, and addressing

¹ NHeLP, Q&A: Health Expense Accounts in Medicaid, David Machledt & Jane Perkins, March 4, 2015.

² Emmett B. Keeler, *Effects of Cost Sharing on Use of Medical Services and Health*, 8 MED. PRACTICE MANAGEMENT 317 (1992), <http://www.rand.org/pubs/reprints/RP1114.html>. For a broader discussion of the relationship between health care utilization and deductibles, see Katherine Swartz, Robert W. Johnson Found., *Cost-Sharing: Effects on Spending and Outcomes*, 4 (2010), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2010/rwjf402103/subassets/rwjf402103_1.

social determinants of health to truly treat and improve population health. Over the last decade, ODM has funded programs aimed at payment reform focused on quality over quantity, has implemented MyCare Ohio which aims to coordinate Medicaid and Medicare services in part through a care team, and has instituted continuous coverage for children to avoid churn and gaps in health coverage. The Healthy Ohio waiver is a step backward from those efforts.

B. Healthy Ohio Does not Provide Benefits to Recipients Which Can Reasonably Be Expected to Outweigh the Harm

The only possible benefit to Medicaid recipients of the Healthy Ohio waiver is that an extremely small percentage of recipients who obtain employment, and who do not use all of the funds in their Buckeye Account, can then roll over those funds to assist with cost sharing in an employer-sponsored plan. The suggestion, however, that a Healthy Ohio Bridge Account will decrease churn back into Medicaid from private health insurance coverage, and increase the proportion of Ohio residents covered by employer-sponsored insurance or market coverage, shows a lack of understanding of Ohio's current labor market and ignores information from the 2016 Ohio Medicaid Assessment Survey.

The Ohio Medicaid Assessment Survey, a study of the movement between public and private insurance, found that, of the new Medicaid enrollees working in 2015, only 5.7% were eligible for an employer-sponsored program. Most Ohio enrollees, who previously had private insurance, lost coverage when they became unemployed.³ Over 80% of the Medicaid enrolled adults are either working or disabled.⁴ In 2015, eleven of Ohio's top twelve occupations did not pay enough to raise a family of three above 200% of the federal poverty level and eight of the twelve left a working family of three below 133% FPL.⁵ Unless and until Ohio's labor market and wage scales improve, many responsible working individuals and families will depend on Medicaid to support their ability to work. Erecting barriers to Medicaid harms not only the individuals and families locked out of health care, but also Ohio's economy.

1. The Lock Out Provisions Will Stop Individuals From Re-Enrolling in Medicaid Leaving Individuals Without Access To Coverage

The "churn" that would significantly increase under Healthy Ohio is the movement of individuals and families in and out of Medicaid, as family finances are strained and recipients are unable to afford premiums and maintain coverage. People who miss two premium payments will be locked out of the program until they pay what they owe and re-enroll. This lack of continuous

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<https://osuwmcdigital.osu.edu/sitetool/sites/omaspublic/documents/OMASBriefPublicPrivateSub031416FINAL.pdf>.

⁴ [https://osuwmcdigital.osu.edu/sitetool/sites/omaspublic/documents/OMASSLIDEDECK_FINAL\(1\).pdf](https://osuwmcdigital.osu.edu/sitetool/sites/omaspublic/documents/OMASSLIDEDECK_FINAL(1).pdf).

⁵ <http://www.policymattersohio.org/sowo-aug2015>.

coverage will lead to discontinuity of care. The Health Policy Institute of Ohio reported that sustained eligibility – like that fostered under Ohio’s current Medicaid expansion and Covered Families and Children program- leads to better utilization of health care and better health outcomes for Medicaid enrollees. When enrollees were able to maintain their eligibility (‘fully enrolled’), their outcomes were better, their costs were lower, and ED utilization went down.⁶ According to a 2013 study in the Journal of Health Economics, any premium - from virtually zero to \$10 - will cause churning of between 12 - 15 percent of the population at any given time.⁷ Given that more than a million Ohioans would be subject to the “Healthy Ohio” plan, it may be assumed that up to 150,000 enrollees will drop in and out of enrollment. The lock-out will make it harder to re-enroll and the increased churning will be detrimental to the health of recipients.

2. The Healthy Ohio Waiver Does Not Adequately Propose Any Real Benefit to Medicaid Recipients

The proposed Healthy Incentive Point System allows members to earn “points” by completing healthy behaviors. In addition to the complexity of the proposed incentive point system, the ODM proposal provides little or no information as to what healthy behaviors would be covered by the incentive points system and there are no proposed wellness targets or standards. The proposed demonstration waiver merely provides that “standards for the awarding of points by the State and by providers will be further detailed prior to waiver implementation.” There is no timeline for developing those standards and they are not part of the State’s waiver request proposal.

It is unclear how many persons would benefit from the proposed incentive scheme, what healthy behaviors would be promoted, or how the program would be explained to participants. Indeed, the sheer complexity of the proposed “points” system and the low likelihood that Medicaid beneficiaries will understand the program would seriously impede any meaningful participation in this demonstration project.

Moreover, based on the very limited information in the proposed Ohio waiver and the underlying statutory language in the Ohio budget bill, certain activities that could generate incentive points clearly discriminate against low-income families. Lack of transportation, living in neighborhoods with few “healthy food” outlets, volatile and erratic work schedules, and lack of bank accounts would greatly impede the ability of many low-income Ohioans to implement the incentive measures and thereby gain incentive points. The Ohio waiver plan proposes no steps to address those barriers.

⁶ Health Policy Institute of Ohio, “Medicaid Basics 2015 at http://www.healthpolicyohio.org/wp-content/uploads/2016/03/MedicaidBasics_2015_Final.pdf.

⁷ Laura Dague, “The effect of Medicaid premiums on enrollment: A regression discontinuity approach,” *Journal of Health Economics* 37 (2014) 1-12.

Finally, research on the effectiveness of incentives to encourage changes in consumer behaviors has produced mixed results.⁸ Ohio's convoluted proposal of earning and using incentive points will add nothing unique to the existing rubric of ideas already under scrutiny. The ten-state Medicaid Incentives for the Prevention of Chronic Diseases (MIPCD) program, currently underway, will provide a broader base from which to design and evaluate incentive programs. No additional healthy incentive programs should be approved until the final results of the MIPCD program have been evaluated.

3. Eliminating The 3-Month Retroactive Coverage Period Will Lead To Large Amounts Of Medical Debt And Uncompensated Care.

Currently in Ohio, Medicaid applicants with medical bills incurred in any of the three months prior to application, may request retroactive coverage for those months. This "look-back" period allows those who have incurred medical bills while uninsured, to get Medicaid coverage if they meet eligibility requirements for the months in question. This means that uninsured people, who were eligible for but not receiving Medicaid at the time of a catastrophic accident, illness or criminal assault, can get their medical bills covered. This retroactive coverage is eliminated in the Healthy Ohio waiver. The waiver will not allow Medicaid coverage to begin until the first premium payment is made. Thus, since premium payments cannot be paid retroactively, there can be no retroactive coverage.

The implementation of Healthy Ohio would mean that someone who enters the hospital, extremely ill and unable to actively engage in a Medicaid application, will be left with the bills for all of her hospital stay prior to the payment of her first premium. This will be true even if, at the time she entered the hospital, she met all of the Medicaid eligibility requirements and was too ill to complete the enrollment process and pay her premium. This individual is immediately saddled with potentially life-altering medical debt, even though she was Medicaid eligible at the time those debts were incurred. Since it is extremely unlikely that low-income people in this situation will be able to pay off this medical debt, hospitals will see a rise in uncompensated care. Both the individual and the health care provider are much worse off under the Healthy Ohio program than they are under current Medicaid rules.

C. Healthy Ohio is Projected to Substantially Decrease the Overall Number of People on Medicaid

ODM is asking CMS to allow it to change eligibility not only in the Medicaid expansion category, but also for all other non-disabled adults. This includes many of Ohio's most vulnerable populations: parents with income below 90% FLP, low-income 18, 19 and 20-year-

⁸ <http://kff.org/medicaid/issue-brief/an-overview-of-medicaid-incentives-for-the-prevention-of-chronic-diseases-mipcd-grants/>

olds, children aging out of foster care, and women with breast and cervical cancer. All of these groups will be subject to premiums, a lock out if those premiums are missed, and no retroactive coverage to reduce medical debt.

According to ODM, Healthy Ohio will lead to a reduction of 126,000 individuals in the first year following its implementation.⁹ Independent researchers estimate an even greater decline in that first year.¹⁰ For each successive year of the proposed waiver, ODM projects ever larger decreases in enrollment. Because ODM's projections are based only on the assumption of an 85% penetration rate (i.e., 15% of the eligible population will simply choose not to enroll), the estimated declines fail to account for the inevitable drops in enrollment caused by lock out for failure to pay premiums. This is simply unacceptable. A project that predicts, and indeed relies upon for budget neutrality, the loss of hundreds of thousands of participants over a four year span, will do significant harm to Ohio. None of the supposed benefits listed by ODM can outweigh this devastating harm.

While minorities make up 20 percent of Ohio's non-elderly population, significantly larger percentages of Blacks and Hispanics live below the poverty line than Whites.¹¹ In 2012, fifteen percent of those who identified as White were living in poverty, compared to 42% of those who identified as Hispanic and 40% of those who identified as Black.¹² Even though the majority of Hispanics, Blacks, and American Indians/Alaska Natives have at least one full-time worker in the family, they are more than twice as likely to be poor than Whites.¹³

According to the Kaiser Family Foundation's analysis of Current Population Survey data, "people of color face longstanding and persistent disparities in accessing health coverage that contribute to greater barriers to care and poorer health outcomes."¹⁴ Ohio's decision to expand Medicaid coverage was an important step toward "significantly diminishing the level of health

⁹ Ohio Department of Medicaid, Healthy Ohio Section 1115 Demonstration Waiver Detail." Public Notice and Request for Comment, April 5, 2016, <http://medicaid.ohio.gov/PORTALS/0/Resources/PublicNotices/HealthyOhio-Deatial.pdf>.

¹⁰ Comments by Center for Community Solutions on Healthy Ohio 1115 Demonstration Waiver, filed with the Ohio Department of Medicaid on April 21, 2016, http://www.communitysolutions.com/assets/docs/Health_Policy/2016/healthy%20ohio%20comments%20for%20the%20ohio%20department%20of%20medicaid%20_04212016.pdf.

¹¹ <http://kff.org/medicaid/fact-sheet/the-ohio-health-care-landscape/>

¹² Id.

¹³ <http://kff.org/disparities-policy/issue-brief/health-coverage-by-race-and-ethnicity-the-potential-impact-of-the-affordable-care-act/>

¹⁴ <http://kff.org/disparities-policy/issue-brief/the-impact-of-the-coverage-gap-in-states-not-expanding-medicare-by-race-and-ethnicity/>

insurance disparities for the country's racial and ethnic minorities,"¹⁵ but rolling back coverage in the ways that Healthy Ohio proposes will chip away at that improvement.

D. The Cost-Sharing Provisions Will Decrease Access to Care and Will Cause Individuals to Forego Needed Care.

Ohio's plan will charge recipients a monthly fee of 2% of their monthly income, or \$99 a year, whichever is less. This calculation means that Ohio's poorest families and individuals will pay a higher percentage of their monthly income than those at the higher end of the scale. For example, a single person living at 10%FPL, or with gross income of \$99 a month, will pay a monthly premium of \$1.98 or exactly 2% of her income. While another single person, living at 138% of poverty, with income of \$1367 per month, will pay \$8.25 per month – or about 0.6% of her monthly income.

1. Premiums Imposed on Beneficiaries With All Levels of Income Would Be Devastating

Imposing these premiums on Ohio's lowest income, and most vulnerable citizens makes their ability to maintain the most basic standard of living even more tenuous. A person living at 50% of the poverty rate, or \$495 in gross monthly income, must pay \$8.25 a month if he wants Medicaid. If he is lucky enough to live in subsidized housing, he will pay about \$150 for rent and utilities. Otherwise, market rent could take up the remainder of his income. If this person has children, there will be child care premiums or school costs, as well as higher food and transportation costs. Even if this person/family gets Food Assistance to help supplement their food costs, this will not pay for all of their food, or cover necessary items like clothing, toilet paper or, diapers. Ohio will now be asking a new group of people to decide between paying for health care and paying for food and other necessities.

A large body of research over the years also shows that cost-sharing for services outside of the ER reduces healthcare used by poor families, results in discontinuous use, or forces families to choose between gas, food, rent, and other necessities. For example, the Rand Corporation's Health Insurance Experiment study – a long-term, experimental study of cost-sharing – found that low-income individuals who were subject to cost-sharing were significantly less likely to receive effective acute care than those not subject to cost-sharing.¹⁶ By contrast, the study found that the provision of healthcare without cost improved hypertension, dental health, vision, and selected serious symptoms among the sickest and poorest patients.¹⁷ Here in Ohio, Metrohealth

¹⁵ Hoag Levins, "The ACA's Impact On Minority Health Insurance Disparities," at <http://ldihealtheconomist.com/he0000107.shtml>

¹⁶ Robert H. Brook, et al., The Health Insurance Experiment: A Classic Rand Study Speaks to the Current Health Care Reform Debate," http://rand.org/pubs/research_briefs/RB9174.html.

¹⁷ Id.

Hospital's early experiment with Medicaid expansion found that the expansion of readily accessible care, without cost, enhanced health.¹⁸

2. Administrative Hurdles Will Add Cost and Present Further Barriers to Coverage

In addition, there is no discussion in the waiver as to how people will actually pay their premiums, and how the physical act of paying these premiums will impose extra burdens on low-income households. Those lucky enough to have a bank account and steady employment, can set up an Electronic Funds Transfer (EFT), easily pay their premiums electronically and earn extra incentives from the State. However, many low-income people do not use or have access to traditional bank accounts. Do they have to travel to their county JFS office to make a payment in person? Or to the offices of their Managed Care Plan? The waiver offers no answers to these questions.

In the City of Cincinnati, it will cost an adult a minimum of \$3.50 for a round-trip bus fare to travel to JFS or their MCP to pay a premium. Add that \$3.50 on to the \$8.25 premium, and the person living at 50% FPL is now paying \$11.75 per month, or 2.4% of her monthly income for Medicaid. Reliable mass transportation is unavailable to most outside of major metro areas. For those in the more rural part of Ohio, without access to public transportation, the options to pay are even more limited. These hidden fees mean that many people will pay more than 2% of their income for Medicaid, and will be unable to afford to maintain coverage.

3. The Healthy Ohio Waiver Will Have an Adverse effect on Access to Health Care for Children and Pregnant Women.

While the proposal would not technically apply to the children in the household, studies have shown that kids are less likely to visit the doctor if their parent does not have coverage. When Mom drops off coverage after being unable to pay the premium for two months, it's easy to see how the children are likely to also stop getting medical care. This will increase the use of emergency rooms and decrease preventive care – two results that will threaten the health of Ohio children.

If the Healthy Ohio Program is implemented, pregnant women will get coverage the month their Medicaid application is approved. Under existing regulations, Medicaid is approved as of the first day of the month of application, regardless of when the County Job and Family Services (JFS) approves the application. Over the last two years, since Medicaid expansion, we have seen delays at counties of 90+ days for Medicaid application processing. At a recent community

¹⁸ Randall D. Cebul, Thomas E. Love, Douglas Einstadtler, Alice E. Petrusis, and John R. Corlett, "MetroHealth Care Plus: Effects of a Prepared Safety Net on Quality of Care in a Medicaid Expansion Population," *Health Affairs*, July 2015, Vol. 34 No. 7, 1121-1130, at <http://content.healthaffairs.org/content/34/7/1121.abstract>.

meeting, we heard multiple stakeholders describe wait times of six to nine months. This proposed change means that pregnant women must either pay out-of-pocket for care while they wait for their Medicaid application to be approved, or they forego care. Based on our experience, and national studies, we know what will happen – they will forego care, because they cannot afford to pay. Despite Ohio’s terrible infant mortality rate—Ohio ranks 44th nationally, with Black babies dying at a rate more than twice as high as White babies¹⁹--and an alleged commitment by the state government to reduce the rate, the proposed Healthy Ohio Program would seriously jeopardize the ability of poor pregnant women to access prenatal care, thereby placing our youngest and most vulnerable citizens at even higher risk.

E. Healthy Ohio is Not Voluntary

There is no voluntary aspect to the Healthy Ohio waiver. Instead, all non-disabled adults regardless of income or family status would be required to enroll.

III. Conclusion

The Secretary may only approve an 1115 demonstration waiver project which is likely to assist in promoting the objectives of Title XIX 42 U.S.C. 1315(a).²⁰ Section 1315(a) was not enacted to enable states to save money or to evade federal requirements but to “test out new ideas and ways of dealing with the problems of public welfare recipients.” S.Rep. No. 1589, 87th Cong., 2d Sess. 20, *reprinted in* 1962 U.S.C.C.A.N. 1943, 1961. The Secretary must consider the impact of the proposed demonstration project on those the Medicaid Act was enacted to protect. *Newton-Nations v. Betlach*, 660 F.3d 370,380 (9th Cir. 2011).

Medicaid is designed to enhance, not limit, access to health care. Ohio’s proposal, which forecasts a significant decrease in enrollment, and locks all members out of coverage regardless of income level for failure to pay premiums, defeats the objectives of the Medicaid program by creating unnecessary barriers to enrollment and access to care. As a result, we urge CMS to reject the waiver request.

¹⁹ 2014 Ohio Infant Mortality Data: General Findings” at <http://www.odh.ohio.gov/odhprograms/cfhs/octpim/latestoimd.aspx>

²⁰ The statutory cite for 1115 waivers is found at 42 U.S.C. 1315.

Thank you for the opportunity to comment on Ohio's Healthy Ohio 1115 Waiver Proposal.

Sincerely,

/s/ Ashley B. Saltzman

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