



The leading advocate for Northeast Ohio hospitals

August 5, 2016

Department of Health and Human Services  
Centers for Medicare and Medicaid Services  
7500 Security Boulevard, Mail Stop S2-01-16  
Baltimore, Maryland 21244-1850

**Re: Healthy Ohio Program 1115 Demonstration Waiver**

Dear Secretary Burwell:

The Center for Health Affairs is a nonprofit hospital association representing 36 providers across Northeast Ohio. This year marks The Center's century-long commitment to its work advocating for policies to eliminate barriers to healthcare, improve the quality of services delivered and reduce the costs associated with delivery of such services. While located in Cleveland, OH, The Center has long supported policies to improve healthcare delivery across the region, state and nation. The Center appreciates the opportunity to submit comments to the State of Ohio Department of Medicaid (ODM) on the Healthy Ohio 1115 Demonstration Waiver (Healthy Ohio) on behalf of our hospital members.

It is undeniable that the Ohio Department of Medicaid, under the direction of Governor Kasich, has made tremendous strides in transforming the Department and streamlining services, and for that, The Center commends the Department's work. Chief among its accomplishments is successfully implementing Medicaid extension in Ohio, which resulted in healthcare coverage for over 625,000 low-income residents. Additionally, the Governor's Office of Health Transformation has made momentous changes to healthcare delivery in the state in its efforts to modernize the Medicaid program, rebalance home and community-based services and innovate payment to incentivize value over volume.

It is our belief that Healthy Ohio endangers the long-term success of these laudable reforms. We understand, of course, that the Department is satisfying their legal obligation to the legislature by adequately responding to the prescriptive language included in H.B. 64. With that in mind, the following recommendations should be taken as cautionary advice – to both the Administration and the Ohio General Assembly – as to how to avoid damaging the integrity of one of Ohio's most crucial programs.

The following comments will examine the core tenants of the Healthy Ohio waiver in contrast to the 1115 Demonstration Waiver criteria set forth by the U.S. Center for Medicare and Medicaid Services (CMS). Careful examination makes clear that components of the Healthy Ohio waiver violate most, if not



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all, of the core objectives specified as part of Section 1115 Demonstration Waiver Criteria, especially as they relate to access, coverage, outcomes and quality of healthcare delivered to Medicaid recipients.

### ***Section 1115 Demonstration Waiver Criteria***

- I. Increase and strengthen overall coverage of low-income individuals in the state;
- II. Increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income populations in the state;
- III. Improve health outcomes for Medicaid and other low-income populations in the state;
- IV. Increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks;
- V. Remain “budget neutral” to the Federal government

### ***Healthy Ohio Goals and Objectives***

- I. Promote member engagement in health and personal responsibility, including the appropriate use of healthcare services;
- II. Increase the use of preventive services by members;
- III. Increase provider engagement in member healthy behaviors;
- IV. Increase the number of commercially insured individuals

### **Access**

The current version of the Healthy Ohio proposal has many admirable concepts ostensibly designed to improve healthcare in the state. For example, creating a Health Savings Account (HSA), known as the “Buckeye Account,” to encourage greater personal responsibility by allowing patients to manage their own healthcare dollars is, on its face, a sound concept. However, using a Buckeye Account as a mechanism to deprive patients of coverage will, in fact, undermine the progress and improvements Ohio has made in its Medicaid program.

### ***Premiums & Cost-Sharing***

In Section 1916A of Title XIX, the Social Security Administration provides clear guidance with regard to the use of enrollment fees, premiums, deductions and cost sharing agreements for states’ Medicaid plans.<sup>1</sup> As noted by the Center on Budget and Policy Priorities and others, the statute limits the extent to which states can charge premiums and cost-sharing to beneficiaries with incomes below 150 percent of the Federal Poverty Limit (FPL), presumably because beneficiaries with low incomes cannot afford to pay for care.<sup>2</sup>



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Research has shown that charging Medicaid recipients premiums to access care actually decreases enrollment. According to ODM's own estimates, of the over 1.5 million Ohioans who will be affected by Healthy Ohio, 125,875 are expected to lose access to healthcare coverage during the program's first year.<sup>3</sup> As the demonstration continues, ODM expects the percentage of Medicaid-eligible people that choose not to enroll in Medicaid to increase to nearly 140,000 by 2022.

ODM's projections reflect what years of research already tell us: premiums and enrollment fees act as barriers to healthcare coverage for low-income groups.<sup>4</sup> In fact, the U.S. Department of Health and Human Services just last year released a report highlighting the implications for medical cost sharing among low-income populations.<sup>5</sup> Their results concluded:

- i. Low-income individuals are especially sensitive to even nominal increases in medical out-of-pocket costs, and modest copayments can have the effect of reducing access to necessary medical care.
- ii. Medical fees, premiums, and copayments could contribute to the financial burden on poor adults who need to visit medical providers.

In both Oregon and Utah, states approved by CMS to raise premium payments, Medicaid enrollment decreased after implementation. In 2003, nearly half of Oregon's Medicaid beneficiaries stopped using the program after premiums were collected.<sup>6</sup> As for the "Healthy Indian Plan (HIP) 2.0," in many ways the model for Healthy Ohio, early reports have noted several problems with regard to premium collection; specifically how the state calculates payments for those making little or no income.<sup>7</sup>

#### *Enrollment & Benefit Management*

In addition to the financial worries created by premium payments, the issue of eligibility determination and HSA management needs attention as well. As beneficiaries are required to adapt to a new system of determination – one contingent on their monthly contribution – some type of formal education ought to be offered to patients, providers and case management organizations. As pointed out by the Center for Community Solutions, ODM just last year was forced to settle a lawsuit after 150,000 Ohioans lost Medicaid coverage due to the failure to communicate changes in the redetermination process.<sup>8</sup> The Center for Health Affairs echoes this concern and views extensive outreach and education as crucial if ODM expects a new premium to be understood and paid by beneficiaries.

Finally, with regard to eligibility determination, the Healthy Ohio proposal mandates if an enrollee fails to make a required monthly payment within 60 days of its due date, it will result in disenrollment. If increasing the use of preventive services and encouraging healthy behavior are fundamental objectives of Healthy Ohio, then denying access to a primary care physician (PCP) due to a failure to submit a monthly contribution seems counterintuitive. Additionally, the administrative burden of, and costs



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associated with, reenrolling a beneficiary have yet to be clearly outlined. Presumably, State and County Job and Family Services Departments will be tasked with reinstating Medicaid coverage and ensuring a patient's Buckeye Account is up-to-date. Regardless of the entity tasked with the administrative responsibility of managing the account, verifying contributions, as well as managing the funds, is likely to dissuade beneficiaries from accessing care.

While CMS continues to allow certain states to charge their Medicaid beneficiaries premiums to access services, doing so in Ohio would be a mistake. Since the implementation of Medicaid extension in 2014, more than 625,000 Ohioans have gained access to healthcare coverage.<sup>9</sup> Additionally, due in large part to the Patient Protection and Affordable Care Act (PPACA), Ohio's uninsured rate is at an all-time low. Creating an additional barrier to access for low-income populations by way of a monthly premium contribution nullifies the progress of so many monumental reforms in healthcare. The Center strongly urges ODM to reconsider requiring premiums as a prerequisite to accessing care.

## **Delivery**

Healthy Ohio, as proposed, creates serious impediments in the delivery of healthcare services to low-income populations. As it pertains to CMS' criteria for 1115 Demonstration Projects, Healthy Ohio does not meet the requirements to "increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income population in the state," nor does it "increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks." Healthy Ohio would bring tremendous instability to an often delicate provider-patient relationship and, furthermore, would do more to dismantle existing service delivery networks than it would to strengthen them.

### *Continuity of Care*

Providers in Northeast Ohio have a long history of working collaboratively to manage patient populations and improve the health status of their citizens. Acute care hospitals, social service agencies, Federally Qualified Health Centers (FQHCs) and many other institutions contribute to this region's robust healthcare delivery network. Healthy Ohio threatens the very existence of this network by removing a crucial component of delivery: coverage. Sustaining Medicaid coverage should not be bogged down by bureaucratic barriers. For patients, withholding benefits is likely to deter them from seeking care at all and, once care is sought, it is even more likely to take place in an uncoordinated, high-cost setting. For providers, caring for patients whose insurance status is unpredictable makes it particularly difficult to manage a patients' health.



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The uncoordinated healthcare delivery promoted by Healthy Ohio will damage the quality of care patients receive and negatively impact their own personal health. For many years, hospitals have stressed the importance of maintaining the continuity of care in order to manage a patient's health. Research has shown that churning between different types of coverage precipitates discontinuity of care.<sup>10</sup> If approved, Healthy Ohio is likely to worsen the quality of care delivered over time, since care teams will no longer have the ability to manage the quality and costs of services delivered if the patient is no longer engaged in his or her own healthcare.

#### *Health Outcomes*

Not only will Healthy Ohio serve to increase discontinuity of care but it will also negatively impact health outcomes. It is well known that regular visits to a PCP can produce better health outcomes over time, since access to preventive healthcare is crucial to managing a patient's health. In fact, one of the stated goals of the Healthy Ohio proposal is to increase the use of preventive services by Medicaid beneficiaries. The Center argues, along with many others, that the current proposal would decrease – not increase – the utilization of preventive services, as patients would simply not visit their PCP if coverage under the Medicaid program has lapsed. This will have a negative impact on the patient's health and the provider's ability to deliver the services needed to keep beneficiaries healthy.

As was proven in MetroHealth's 1115 Demonstration Project in 2013, patients with reliable health coverage and regular access to PCPs demonstrated significantly improved health outcomes as a result of care coordination.<sup>11</sup> Additionally, the MetroHealth Care Plus program demonstrated that care coordination, in tandem with dependable coverage, significantly decreased the cost of delivering care to low-income populations.

Medicaid extension in many ways replicated the work that had already been done during MetroHealth's Care Plus program. Now, low-income childless adults have access to healthcare coverage through the Medicaid program, which provides patients with regular, coordinated care delivered in the doctor's office, not the emergency department. In addition to controlling costs, delivering healthcare in the appropriate setting has been proven to reduce hospitalizations for chronic conditions.<sup>12</sup> The Center urges the DOM to consider the implications of Healthy Ohio in regards to the patient's continuity of care and the lasting impact uncoordinated care has on a patient's overall health.

#### **Cost**

As we have mentioned previously, Healthy Ohio has implications beyond those related to quality and care delivery. It stands to cost consumers, providers and the State of Ohio millions of dollars over the proposed five-year demonstration period.



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### *Education*

Outside of the financial contributions Medicaid consumers will be required to make under Healthy Ohio, the burden of managing their required Buckeye Account has the potential to create additional problems, since 46 percent of Ohioans earning less than \$15,000 are unbanked or underbanked, meaning financial literacy is especially low in the state.<sup>13</sup> The expectation that consumers, who lack the financial literacy needed to manage a traditional bank account, possess the skills to operate a new and complex HSA is simply unrealistic.

More likely than not, individuals who do not sufficiently manage their Buckeye Accounts will fall into a financial situation that is worse off than their current status. For years it has been documented that medical debt is among the leading causes of bankruptcy in the United States.<sup>14</sup> The current Healthy Ohio proposal places financially vulnerable consumers at a greater risk of accumulating medical debt, which has a tendency to affect housing, credit card debt and the potential for bankruptcy.<sup>15</sup> Significant education and outreach would be necessary if the DOM expects Medicaid consumers to understand the complexities of the Buckeye Account. In its current proposal, the DOM does not indicate any additional costs associated with such education, which is assumed to mean none will be offered.

### *Administrative*

Outreach and enrollment is only a portion of the overall cost to implement Healthy Ohio. In order to fully operationalize the program, the DOM would have to spend significant resources to develop and train staff in order to perform the administrative tasks that would be created as a result. As pointed out in previous comment letters, the DOM and the Medicaid managed care plans would be charged with tasks such as issuing monthly statements and annual financial contributions to consumers.<sup>16</sup> Layering administrative burdens on top of what is, by most accounts, an already bureaucratic process should raise red flags for government officials attempting to streamline services. While the DOM Healthy Ohio Summary estimates a savings of nearly \$1 billion by 2022, the estimates do not take into account the costs associated with administering the program, nor do they mention the dollars Ohio receives as a result of Medicaid extension, which at its current rate brings in over \$2 billion annually.<sup>17</sup> If Healthy Ohio moves forward, it is important to accurately represent the administrative costs associated with operating a program, especially since states like Arkansas have seen their costs cut in half after eliminating the use of HSAs and cost-sharing in their Medicaid program.<sup>18</sup>

### *Premium Assistance*

Outside of states' costs, there is a general sense that healthcare providers will be expected to cover a large portion of the costs associated with implementing Healthy Ohio. Should CMS approve Ohio's



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application, hospitals and other healthcare providers in the state will likely be expected to subsidize premium payments for patients who cannot afford to keep their coverage up-to-date. The notion of a third party bearing the responsibility of subsidizing an individual's premium payment stands in direct contradiction to one of Healthy Ohio's core objectives: promoting personal responsibility. If the stated intent of levying premium payments is to motivate patients to take greater personal responsibility for their own healthcare costs, the belief that a third party ought to make premium payments on behalf of an individual undermines that notion.

We urge the DOM to reexamine the true intent of third party premium assistance as we believe this aspect of the Healthy Ohio proposal opens the door to a myriad of issues for the patient-provider relationship. Specifically, when healthcare providers have the potential to be the largest single contributor to an individual's healthcare premium, patients may actually relinquish the power of their own healthcare to that entity, rather than taking a greater personal interest in managing it themselves. The DOM should further examine the provisions in the Healthy Ohio proposal that address premium assistance for Medicaid recipients. As it stands, the current provision is simply a tax on hospitals – one of the state's largest employers – under the guise of a social program designed to provide low-income citizens a ladder out of poverty.

#### *Healthcare Providers*

Beyond the expectation that providers subsidize premium payments, healthcare providers, specifically hospitals, stand to lose a tremendous amount of revenue from the elimination of the Medicaid 90-day retroactive eligibility payment. Any patient, irrespective of their insurance status, has the ability to walk through the doors of a hospital and receive treatment. However, if patients are eligible for Medicaid coverage, hospitals have a form of recourse when it comes to payment for the services rendered. If the patient is Medicaid-eligible, the hospital has the ability to begin the process of applying for Medicaid on the day the patient arrives. While approval for Medicaid coverage can take anywhere from 24 hours to several months, determination is generally expected within 90 days. If the application is approved, hospitals – under current Medicaid guidelines – have the opportunity to submit their claims to the DOM and receive reimbursement for the services rendered during the application process on a fee-for-service basis. The retroactive period, lasting 90 days from the submission of the Medicaid application, helps hospitals cover some of the costs incurred but, more importantly, avoids classifying these services as bad debt.

Oftentimes, Medicaid-eligible patients who are uninsured enter the hospital through the emergency department, since they are unlikely to have a PCP with whom to schedule an appointment. These visits are typically spurred by a major health event that is a result of foregone care, which for hospitals means a greater share of resources are required to address the patient's needs. No longer reimbursing



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hospitals for these services will not only create instability in terms of billable services, but it will also have a detrimental effect on revenue cycles.

According to Human Arc, one of Ohio's largest companies providing in-house assistance for insurance enrollment, hospitals across the state stand to lose over \$500 million dollars from the elimination of the 90-day retroactive billing period. Here in Northeast Ohio, providers across the region are likely to lose about half of that, between \$240 and \$280 million, if retroactive Medicaid billing is no longer available. This massive financial blow to healthcare providers will drastically change the way hospitals deliver care and assist uninsured patients in accessing the Medicaid program. Today, many hospitals have in-house programs designed to help Medicaid-eligible patients apply for and receive coverage. The significant amount of revenue hospitals will lose if retroactive billing is no longer an option would likely result in the elimination of these services. Should this occur, it is likely that State and County Departments of Job and Family Services would see a tremendous increase in the volume of applicants through their offices – work that was previously done by hospitals and their hired third-party contractors.

The Center and its member hospitals urge the DOM to reconsider the removal of the 90-day retroactive eligibility payment from its application to CMS. Seeing as how this change was not included in H.B. 64, the DOM has no legal obligation to pursue this modification to the program.

The Center for Health Affairs appreciates the opportunity to comment on the Healthy Ohio proposal and its potential impact on the citizens of Ohio. This proposal would diminish the hard work of the DOM in recent years to increase access to, and improve the delivery of, healthcare in Ohio. Furthermore, as home to the largest population of Medicaid enrollees in the state, we stress the importance of preserving our healthcare delivery system in Northeast Ohio to ensure low-income populations continue to receive the care they deserve.

Regards,

Bill Ryan

President & CEO



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- <sup>2</sup> Center of Budget and Policy Priorities. "Evaluation Needed Before Allowing Replication of Indiana's Medicaid Waiver." Accessed May 5, 2016 <http://www.cbpp.org/research/health/evaluation-needed-before-allowing-replication-of-indianas-medicaid-waiver>
- <sup>3</sup> Ohio Department of Medicaid. "Healthy Ohio Section 1115 Demonstration Waiver Summary." Accessed May 5, 2016 <http://medicaid.ohio.gov/Portals/0/Resources/PublicNotices/HealthyOhio-Summary.pdf>
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- <sup>7</sup> Ibid.
- <sup>8</sup> The Center for Community Solutions. "Healthy Ohio Program 1115 Demonstration Waiver Comment Letter." Accessed May 5, 2016. [http://www.communitysolutions.com/assets/docs/Health\\_Policy/2016/healthy%20ohio%20comments%20for%20the%20ohio%20department%20of%20medicaid%20\\_04212016.pdf](http://www.communitysolutions.com/assets/docs/Health_Policy/2016/healthy%20ohio%20comments%20for%20the%20ohio%20department%20of%20medicaid%20_04212016.pdf)
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<sup>16</sup> The Center for Community Solutions. “Healthy Ohio Program 1115 Demonstration Waiver Comment Letter.” Accessed May 5, 2016.

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