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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

Dear Secretary Burwell:

On behalf of its low-income clients, Southeastern Ohio Legal Services submits these comments in opposition to the Ohio Department of Medicaid's 1115 Demonstration Wavier application.

I. Introduction

Southeastern Ohio Legal Services provides free legal services to low-income individuals and seniors in thirty counties in Southeastern Ohio. SEOLS's mission is to obtain equal access to justice for its clients through advocacy, education, and empowerment. Twenty-five of SEOLS's thirty counties are in Appalachian Ohio, and SEOLS's service area covers all but seven of Ohio's Appalachian counties. As the main provider of legal services for low-income individuals in Appalachian Ohio, which is the poorest region of the state, SEOLS has a unique understanding into how programs such as Medicaid affect Ohioans.

Ohio has implemented several initiatives over the past five years to reduce healthcare costs, as well as improve health outcomes, and coordinate care for Ohioans. An important part of these improvements was extending Medicaid coverage to more low-income Ohioans by amending the State Plan to cover adults up to 138 percent of the federal poverty level. Because of the expansion, Ohio cut its uninsured rate in half and 650,000 previously uninsured people now have healthcare coverage. These people include an estimated 400,000 with behavioral health needs and 38,000 veterans and family members.¹ Ohio also successfully reduced Medicaid spending; for the 2016 fiscal year, Ohio's total Medicaid spending was nearly \$1.3 billion below

¹ Ohio Governor's Office of Health Transformation, *Extend Medicaid Coverage to More Low-Income Ohioans*, <http://www.healthtransformation.ohio.gov/Budget/ExtendMedicaidServices.aspx> (accessed July 12, 2016).

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estimates.² Yet, the proposed Ohio Medicaid waiver plan would create significant barriers to healthcare for low-income Ohioans. The proposed plan, called the Healthy Ohio Program, imposes premiums, cost sharing, and penalties for nonpayment – all of which have been demonstrated to reduce enrollment, affordability, and access to healthcare.

SEOLS submits these comments to describe the harm that would fall upon Ohioans and how the Ohio Department of Medicaid's 1115 Medicaid waiver plan would create deeper poverty and reduce public health as people lose their healthcare coverage or are not able to get care because of unaffordable premiums or the plan's bureaucratic complexity. 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, the Health Ohio Program, if approved, will place untenable financial hardship on Ohio's poorest citizens and cause large numbers of people to go without needed medical care. Therefore, we urge CMS to reject Ohio's plan and save Ohio from taking a huge step backward.

II. Ohio failed to provide a meaningful level of public input as required by 42 C.F.R. 431.412.

On July 7, 2016, the Centers for Medicare and Medicaid Services notified Ohio Department of Medicaid Director John McCarthy that Ohio's 1115 demonstration waiver application met the requirements for a complete application as specified under section 42 C.F.R. 431.412(a). We disagree. A completed application must include both written evidence of compliance with the public notice requirements set forth in 42 C.F.R. 431.408 and an explanation of how the state considered the comments received during the comment period. The notice requirements were written to ensure a meaningful level of public input at both the state and federal levels. 42 U.S.C. 1315(d)(2)(A). Because it failed to address the public's concerns expressed at public hearings and in written comments, Ohio failed to ensure that the public had any meaningful level of input. The Healthy Ohio Program proposal was submitted to CMS without any meaningful modifications, despite the clear and reasoned voices of Ohio's citizens.

As reported to CMS, the Ohio Department of Medicaid received 956 unduplicated comments during its thirty-day comment period. An overwhelming ninety-nine percent of the commenters opposed Ohio's proposal. ODM summarized and categorized the responses. The top concern, raised in eighty-four percent of the comments, is that the Healthy Ohio Program would be unaffordable for Medicaid recipients; sixty-three percent were concerned that Medicaid recipients would forego medical care in order to meet other expenses. These and other concerns relate directly to two of the four criteria CMS uses to evaluate waiver requests: (1) will the demonstration increase and strengthen overall coverage of low-income individuals; (2) will the demonstration improve health outcomes for Medicaid and other low-income populations. Multiple organizations participating in the public comments cited studies documenting these

² Jim Siegel, *Lower Medicaid Spending Helped Ohio's Budget Amid Revenue Shortfall*, Columbus Dispatch (July 7, 2016), <http://www.dispatch.com/content/stories/local/2016/07/07/lower-medicaid-spending-helps-state-budget-land-on-solid-ground.html> (accessed July 12, 2016).

very real concerns, which give CMS the basis to reject Ohio's application. In spite of the volume, relevance, and seriousness of these concerns, Ohio's cursory response was that ODM is unable to modify the Health Ohio Program absent a statutory change. Without a more thoughtful response acknowledging, answering, or refuting those concerns, Ohio has not complied with the statutory requirement to include public input in designing and submitting its waiver program. The state statute creating the Health Ohio Program should not be allowed to trump the federal law mandating public input in Medicaid administrative policy-making.

III. The Healthy Ohio Program will be especially harmful to Ohio's Appalachian population.

Thirty-two of Ohio's eighty-eight counties are part of the Appalachian Regional Commission. All of these counties have the economic classification of Distressed, At-Risk, or Transitional by the Appalachian Regional Commission; none are at the higher levels of Competitive or Attainment.³ As explained in detail below, Ohio's Appalachian population is significantly less healthy than the other regions of the state and more likely to qualify for Medicaid. Thus, the Healthy Ohio Program will disproportionately affect and harm these residents.

A. Ohio's Appalachian population qualifies for and uses Medicaid at a higher rate than other regions of the state, so any changes to Ohio's Medicaid program will disproportionately affect that region.

People in Ohio's Appalachian counties are more likely to qualify for and use Medicaid.⁴ Of the thirty Ohio counties with the highest percentage of Medicaid-eligible residents, twenty-two are in the Appalachian region. Residents of Ohio's Appalachian counties are thirteen percent more likely to be eligible for Medicaid than residents in other regions of the state. Further, residents in Ohio's Appalachian counties enroll at a higher amount than those in other regions of the state. Twenty of the twenty-eight Ohio counties with the highest per capita Medicaid enrollment are in the Appalachian region. Thus, Ohio's Appalachian region is the most concentrated region of Medicaid enrollees and Medicaid-eligible individuals in the state.

B. Ohio's Appalachian population is already much less healthy than the rest of the state. If granted, the Health Ohio Program will make Ohio's Appalachian population even less healthy.

Ohio's Appalachian counties are also the least healthy counties in the state. Using data from the Community Health Rankings from the University of Wisconsin's Population Health Institute,⁵

³ Appalachian Regional Commission, *County Economic Status in Appalachia, FY 2016*, http://www.arc.gov/research/MapsofAppalachia.asp?MAP_ID=105 (accessed on July 26, 2016).

⁴ All data for this paragraph is the Ohio Department of Medicaid's June 2016 enrollment data, which is available online at <http://medicaid.ohio.gov/RESOURCES/ReportsandResearch/MedicaidManagedCarePlanEnrollmentReports.aspx>.

⁵ Available online at <http://www.countyhealthrankings.org/app/ohio/2016/overview> (accessed July 25, 2016). Unless otherwise stated, all data in this section is from this website.

Ohio's Appalachian counties are significantly worse in the Health Factors ranking, with twenty-seven of the Appalachian counties in the lowest thirty spots.⁶ Similarly, twenty-six Appalachian counties occupy the bottom thirty-nine spots in the Health Outcomes rankings.⁷ In fact, the Health Factors ranking and the Health Outcomes ranking each have only one Appalachian county in the top thirty of Ohio counties.

A review of the data used by the Population Health Institute shows how poor the health disparities are in Ohio's Appalachian counties. The Population Health Institute uses fifty-six metrics to measure each county's health; Ohio's Appalachian counties are worse than the other regions of the state in forty-eight of those metrics. Several of the largest disparities are directly related to the Health Ohio Program. For example, adults in Appalachian counties are seven percent more likely to be uninsured than adults in the other regions of Ohio. For children, the difference is even more striking: children in Appalachian Ohio are fifteen percent more likely to be uninsured than children in other regions of Ohio.

The significant health issues facing Appalachian Ohio are not limited to whether someone has health insurance. Those with health insurance have a much more difficult time accessing appropriate medical care. In non-Appalachian Ohio, there is one primary care physician for every 1,227 people; in Appalachian Ohio, there is one primary care physician for every 1,765 people. The disparity for mental health providers is even worse: in non-Appalachian Ohio, there is one mental health provider for every 598 people; in Appalachian Ohio, there is one mental health provider for every 1,019 people. This disparity also exists with dental care. Throughout the state, there is one dentist for every 1,875 people.⁸ However, in the Appalachian counties, there is only one dentist for every 3,138 people. In addition, dental specialists are less common, with twelve Appalachian counties not having any dental specialists.⁹

Thus, the Healthy Ohio Program, which the state admits will decrease the number of insured individuals, will only add to the poor health of Ohio's Appalachian counties.

⁶ According to the University of Wisconsin's Population Health Institute's website, the Health Factors rankings "represent what influences the health of a county. They are an estimate of the future health of counties as compared to other counties within a state. The ranks are based on four types of measures: health behaviors, clinical care, social and economic, and physical environment factors."

⁷ According to the University of Wisconsin's Population Health Institute's website, the Health Outcomes rankings "represent how healthy counties are within the state. * * * The ranks are based on two types of measures: how long people live and how healthy people feel while alive."

⁸ Ohio Department of Health, *Hills and Valleys: The Challenge of Improving Oral Health in Appalachian Ohio 2012*, at 17, <http://www.odh.ohio.gov/~media/ODH/ASSETS/Files/%20ohs/oral%20health/Appalachian%20Report%20FINAL.ashx>.

⁹ *Id.*

C. If approved, the Healthy Ohio Program will disproportionately harm Ohioans in rural areas – including Appalachia – because of the lack of affordable transportation for low-income people.

Under the Healthy Ohio Program, Medicaid enrollees in Appalachian Ohio will also face significant transportation issues. By definition, low-income individuals and families have a limited budget and, thus, a limited transportation budget. For low-income people in rural areas, transportation is unaffordable and unavailable.¹⁰ The average cost of owning and operating a used car or truck in the United States is \$6,016.¹¹ For those who cannot afford to own a car, public transportation usually is not an option. Many counties in Appalachian Ohio do not have a public transportation system. In those counties with public transportation, service is available only in a few populated areas.¹²

With its monthly payment requirement and increased paperwork, the Health Ohio program will require an increase in face-to-face interaction with county government agencies. Without reliable transportation, low-income Ohioans in rural parts of the state cannot go to appointments with their caseworker or their doctors.¹³ Adding additional trips to the county's Job and Family Services office to complete paperwork or make payments for the Healthy Ohio Program will further stretch budgets.

Finally, the lack of affordable transportation for low-income people in rural Ohio is problematic simply because medical providers are far away. In non-Appalachian Ohio, there is one primary care physician every three square miles; in Appalachian Ohio, there is one primary care physician every fourteen square miles.¹⁴ In non-Appalachian Ohio, there is one mental health provider every two miles; in Appalachian Ohio, there is one mental health provider every eight miles. In non-Appalachian Ohio, there is one dentist every four miles; in Appalachian Ohio, there is one dentist every nineteen miles.

The Healthy Ohio Program will force low-income Ohioans to make difficult – if not impossible – choices. In a best-case scenario, a Medicaid enrollee will be forced to choose between going to the county Job and Family Services office and running other errands. For some people, that will involve deciding whether to travel to fill out the necessary paperwork for the Healthy Ohio Program and travelling to a medical appointment. In a worst-case scenario, a Medicaid enrollee will lose Medicaid coverage because he or she cannot afford to go to the Job and Family

¹⁰ Athens County Job and Family Services & Hocking-Athens-Perry Community Action Program, *Lack of Transportation: A Symptom of Poverty and a Cause of Poverty*, (April 2013) at 2, <http://jfs.athensoh.org/documents/TransportationReport2013.pdf>.

¹¹ *Id.* at 3.

¹² *Id.* at 9. Even in a relatively populated county like Athens County (64,757 residents in the 2010 census), which has a major university (Ohio University, with 20,215 students in the Spring 2016 semester), public transportation is limited to one city and two small neighboring villages.

¹³ *Id.* at 7-8.

¹⁴ All data in this paragraph is from the University of Wisconsin's Population Health Institute's website.

Services office when expenses related to travelling to work,¹⁵ the grocery store,¹⁶ and a child's medical appointments¹⁷ are necessary and costly. Issues involving transportation are already difficult choices for low-income people to make. There simply is no reason for the Healthy Ohio Program to create additional barriers for Ohioans to obtain and use medical insurance.

IV. The Healthy Ohio Program does not promote the objectives of the Medicaid Act.

To create and implement the Healthy Ohio Program, ODM requests waivers of six fundamental precepts of Medicaid. 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. Federal law 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. § 1396o(f).

In addition, there are general criteria CMS uses to determine whether Medicaid 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.

The Healthy Ohio Program fails to meet these criteria and should not be approved by CMS.

¹⁵ Athens County Job and Family Services & Hocking-Athens-Perry Community Action Program at 8.

¹⁶ Nearly 500,000 rural Ohio households live outside a ten-minute drive to any grocery store; more than 1.1 million rural Ohio households live outside a ten-minute drive of a large supermarket. Francis Muamba, Jill K. Clark, and Nathaniel Betz, *Food Access Gaps in Rural Ohio* (May 24, 2010) at 3, http://glenn.osu.edu/farmland-policy/papers/2010_5.pdf.

¹⁷ Access to transportation is a significant barrier to children's health in Appalachian Ohio. Ohio Children's Defense Fund, *Ohio's Appalachian Children at a Crossroads: A Roadmap for Action* (May 4, 2016) at 16, <http://www.cdfohio.org/research-library/2016/OH-appalachian-children-crossroads.pdf>

A. The Healthy Ohio Program is not unique and has no demonstrative value.

The Health Ohio Program does not provide any unique characteristics that will allow ODM and CMS to study its effectiveness. Instead, it relies on ideas that are currently being tested elsewhere or have proven to be ineffective at reducing healthcare costs for enrollees. As a result, the Health Ohio Program application should be denied.

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 Healthy Ohio Program unique is that it extends the mandatory premium and cost-sharing requirement to individuals and households living below fifty percent of the federal poverty level. Indeed, under the Healthy Ohio Program, persons with incomes as low as one percent of the federal poverty level 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 the Healthy Ohio Program, the Buckeye Account, is modeled upon Indiana's POWER Accounts, which are a central feature of that state's HIP Plus program. Ohio proposes elements of an HSA-like account that are more complicated and drastic than Indiana's project. Independent analyses of Indiana's available data and reporting raise serious questions about the experiences for the consumers in Indiana.¹⁸ 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 programs. CMS should not approve any further HSA-like proposals until the existing demonstration projects have been thoroughly evaluated and identified problems are resolved.

In fact, other states have found that the administrative costs in collecting premiums are more expensive than the amount of premiums actually collected.¹⁹ For example, Virginia ended a premium program for families with income between 150 and 200 percent of the federal poverty

¹⁸ E.g., Judith Solomon and Jesse Cross-Call, Center on the Budget and Policy Priorities, *Evaluation Needed Before Allowing Replication of Indiana's Medicaid Waiver* (April 14, 2016) at 1, <http://www.cbpp.org/sites/default/files/atoms/files/4-14-16health.pdf>.

¹⁹ Jessica Schubel and Judith Solomon, Center on the Budget and Policy Priorities, *States Can Improve Health Outcomes and Lower Costs in Medicaid Using Existing Flexibility* (April 9, 2015) at 4, <http://www.cbpp.org/sites/default/files/atoms/files/4-9-15health.pdf>.

level when they found it cost the state \$1.39 to collect \$1.00 in premiums.²⁰ Similarly, Arkansas estimated that eliminating health savings accounts for individuals between fifty and ninety-nine percent of the federal poverty level would cut administrative costs in half.²¹ There is no need for Ohio to repeat other states' mistakes.

2. The Healthy Ohio Program 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 healthcare. In a recent analysis of health expense accounts in Medicaid programs, the National Health Law Program (NHeLP) found that comparison shopping was nearly impossible for Medicaid recipients because of a lack of price transparency.²² 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.²³

In addition to a lack of price transparency, Medicaid recipients face additional hurdles to comparative healthcare shopping. As mentioned above, many Medicaid beneficiaries – particularly those in rural areas such as Appalachian Ohio – lack transportation to allow them to go across town for a cheaper test; they must depend on healthcare 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 healthcare decisions. Ohio's transition to managed care itself still presents a huge learning curve for Medicaid beneficiaries who commonly do not understand the concept. A

²⁰ Trisha Brooks, Georgetown University Health Policy Institute, *Handle with Care: How Premiums Are Administered in Medicaid, CHIP and the Marketplace Matters* (December 2013) at 2, <http://www.healthreformgps.org/wp-content/uploads/Handle-with-Care-How-Premiums-Are-Administered.pdf>.

²¹ Marquita Little, Georgetown University Health Policy Institute, *Arkansas Approves Private Option Improving Security for Families, Hospitals & State Budget*, <http://ccf.georgetown.edu/all/arkansas-governor-hutchison-takes-pragmatic-approach-medicaid-private-option> (accessed August 5, 2016).

²² David Machledt and Jane Perkins, NHeLP, Q&A: Health Expense Accounts in Medicaid (March 4, 2015), <http://www.healthlaw.org/about/staff/david-machledt/all-publications/qa-health-expense-accounts-in-medicaid>.

²³ Emmett B. Keeler, *Effects of Cost Sharing on Use of Medical Services and Health*, (1992), <http://www.rand.org/pubs/reprints/RP1114.html>. For a broader discussion of the relationship between healthcare utilization and deductibles, see Katherine Swartz, Robert W. Johnson Foundation, *Cost-Sharing: Effects on Spending and Outcomes* (December 2010) at 4, http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2010/rwjf402103/subassets/rwjf402103_1.

movement to health reimbursement accounts, a switch confusing to professionals in employer-based plans, would be overwhelming and often unusable for this population.

The fallacy of the Healthy Ohio Program's cost-conscious objective is particularly evident in Appalachian Ohio. As noted above, primary care physicians, mental health providers, and dentists are rarer in Appalachian Ohio on both per capita and per mile bases. This scarcity of medical providers makes comparison shopping and cost-conscious decisions nearly impossible. For example, in Vinton County, all three primary care physicians and both dentists who accept Medicaid patients work in the same office.²⁴ It is hard for a consumer to comparison shop when there is only one game in town.²⁵

Successful healthcare movements are going in the opposite direction of the Healthy Ohio Program. Instead of requiring individuals to take additional steps to receive needed care, models have moved toward patient-centered medical homes, coordinated care, and addressing social determinants of health to truly treat and improve population health.²⁶ 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 Program is a step backward from those efforts.

B. The Healthy Ohio Program does not provide benefits to recipients that can reasonably be expected to outweigh the harm to those recipients.

The only possible benefit to Medicaid recipients of the Healthy Ohio Program is that an extremely small percentage of recipients who obtain employment *and* do not use all of the funds in their Buckeye Account can 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, thus, 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 only 5.7 percent of new Medicaid enrollees in 2015 were eligible for an

²⁴ Ohio Department of Medicaid's Provider Search Directory, <https://portal.ohmits.com/Public/Public%20Information/search%20provider%20directory/tabId/61/Default.aspx> (accessed August 1, 2016).

²⁵ In fact, in some places, is no game in town at all for dental health. For example, no dentists in Monroe and Noble Counties accept Medicaid patients. *Id.*

²⁶ *E.g.* Institute of Medicine of the National Academies, Committee on the Learning Health Care System in America, *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America*, 189-217 (2013).

employer-sponsored program.²⁷ Most Ohio enrollees, who previously had private insurance, lost coverage when they became unemployed.²⁸ More than eighty percent of adults enrolled in Ohio's Medicaid program are either working or disabled.²⁹ In 2015, eleven of Ohio's top twelve occupations did not pay enough to raise a family of three above 200 percent of the federal poverty level and eight of the twelve occupations left a working family of three below 133 percent of the federal poverty level.³⁰ Unless 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 healthcare, but also Ohio's economy.

1. The lockout provisions will stop individuals from reenrolling in Medicaid, leaving low-income individuals without access to coverage.

The Health Ohio Program will increase “churn” – the movement of individuals and families in and out of Medicaid as 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 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 healthcare and better health outcomes for Medicaid enrollees.³¹ When enrollees are able to maintain their eligibility (“fully enrolled”), outcomes are better, costs are lower, and emergency room utilization decreases.³² According to a 2013 study in the *Journal of Health Economics*, any premium – from virtually zero to \$10 – will cause churning of between twelve and fifteen percent of the population at any given time.³³ Given that more than one million Ohioans would be subject to the Healthy Ohio Program, it may be assumed that between 120,000 and 150,000 enrollees will drop in and out of enrollment. The lockout will make it harder to re-

²⁷ Eric Seiber and Tim Sahr, *Ohio Medicaid Assessment Survey, 2015 Update on Public-Private Substitution among Adults in Ohio Medicaid* (February 2016), http://grc.osu.edu/sites/default/files/inline-files/OMASBriefPublicPrivateSub031416FINAL_0.pdf.

²⁸ *Id.*

²⁹ Teresa C. Long, *The Changing Landscape of Healthcare Coverage Across Ohio: Debut of the 2015 Ohio Medicaid Assessment Survey Statewide Findings* (August 19, 2015) at 17, [http://grc.osu.edu/sites/default/files/inline-files/OMASLIDEDECK_FINAL\(1\).pdf](http://grc.osu.edu/sites/default/files/inline-files/OMASLIDEDECK_FINAL(1).pdf).

³⁰ Policy Matters Ohio, *Left Behind: State of Working Ohio 2015* (August 2015) at 17 <http://www.policymattersohio.org/wp-content/uploads/2015/09/SOWO-2015-final-2.pdf>.

³¹ Health Policy Institute of Ohio, *Ohio Medicaid Basics 2015* (June 2015) at 2-10, http://www.healthpolicyohio.org/wp-content/uploads/2016/03/MedicaidBasics_2015_Final.pdf.

³² *Id.* at 2.

³³ Laura Dague, *The Effect of Medicaid Premiums on Enrollment: A Regression Discontinuity Approach*, *Journal of Health Economics*, Vol. 37, 1-12 (2014).

enroll and the increased churning will be detrimental – and sometimes dangerous – to the health of recipients.

As CMS said in a recent letter to Indiana’s Insurance and Healthcare Policy Director, “Exclusions from coverage, such as lockouts, are not permitted under Medicaid law.”³⁴ The letter continued, “Authorizing a lockout for individuals at any income level who do not complete their annual eligibility redetermination is not consistent with the objectives of the Medicaid program, which include ensuring access to affordable coverage.”³⁵ The same objectives and reasoning apply to the Health Ohio Program.

2. Other states’ experiences with premiums already show that premiums are directly related to a decrease in access to healthcare.

Other states have experienced significant drops in Medicaid enrollment after they implemented premiums. In Indiana, thirty percent of participants did not make their premium payments.³⁶ In Maryland, premiums were applied at relatively high income levels, yet twenty-five percent of families unenrolled from Medicaid.³⁷ In Oregon, a program with premiums experienced a nearly fifty percent drop in enrollment and the largest declines were experienced by those with no income.³⁸

Notably, Ohio’s plan will hurt the health outcomes and financial security of the medically frail, persons with serious and persistent mental illness, victims of domestic violence, foster children, women with breast and/or cervical cancer, and individuals living with HIV/AIDS. This enrollment could put other individuals at risk of long-lasting harm including lower birth weights for babies and higher HIV transmission rates among individuals not accessing essential HIV/AIDS case management services. As Ohio cuts its residents from the Medicaid program for not being able to make monthly payments and navigate a bureaucratic system, they will still get sick and need healthcare. However, they will be forced to use hospital emergency departments without insurance or the ability to pay.

³⁴ Letter from Vikki Wachino to Tyler Ann McGuffee (July 29, 2016) at 1, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-lockouts-redetermination-07292016.pdf>.

³⁵ *Id.*

³⁶ Maureen Groppe and Shari Rudavsky, *Do Indiana’s Poor Medicaid Recipients Really Have Skin in the Game?*, Indianapolis Star (February 1, 2016), <http://www.indystar.com/story/news/2016/02/01/indiana-tests-charging-medicaid-patients-monthly-contribution/79520120>.

³⁷ Maryland Department of Health and Mental Hygiene, *Assessment of the Impact of Premiums* (April 2004), <https://mmcp.dhmh.maryland.gov/docs/MCHPSurvey-FINAL042604.pdf>.

³⁸ John McConnell and Neal Wallace, Office for Oregon Health Policy and Research, *Impact of Premium Changes on the Oregon Health Plan* (February 2004) at 7-8, <http://www.statecoverage.org/files/Impact%20of%20Premium%20Changes%20in%20the%20Oregon%20Health%20Plan.pdf>.

3. The Healthy Ohio Program 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 Healthy Ohio Program.

Similarly, ODM has not identified how many Ohioans 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 small likelihood that Medicaid beneficiaries will understand the program will seriously impede any meaningful participation in this demonstration project.

Moreover, based on the very limited information in Ohio’s proposal 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. Low literacy, language barriers, high rates of mental illness, and addiction disorders pose additional barriers to navigating this highly complex and confusing incentive points scheme. The Healthy Ohio Program proposes no steps to address those barriers.

The complexity of changing dollars to “points,” keeping the core and non-core portions of the Buckeye Account separate for certain services while combined for others, and tracking incentive points alongside monthly payments will cause serious problems for both system administrators and Medicaid participants.

Finally, research on the effectiveness of incentives to encourage changes in consumer behaviors has produced mixed results.³⁹ 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. It does not make sense to approve an additional healthy incentive program before the results of the MIPCD program have been evaluated, especially when Ohio’s proposal lacks necessary details.

³⁹ Amanda Van Fleet and Robin Rudowitz, The Henry J. Kaiser Family Foundation, *An Overview of Medicaid Incentives for the Prevention of Chronic Diseases (MIPCD) Grants* (September 16, 2014), <http://kff.org/medicaid/issue-brief/an-overview-of-medicaid-incentives-for-the-prevention-of-chronic-diseases-mipcd-grants> (accessed on August 1, 2016).

4. Eliminating the three-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 a successful 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. The Healthy Ohio Program eliminates this retroactive coverage by disallowing Medicaid coverage – despite meeting all eligibility requirements – until the first premium payment is made.

The Healthy Ohio Program means that a very ill person who is unable to actively engage in a Medicaid application will be left with the bills for all of her hospital stay or other treatment prior to the payment of her first premium to the Ohio Medicaid system. The person will incur personal medical debt despite having been eligible for Medicaid to pay the needed expenses. Because any person eligible for Medicaid, by definition, is unable to pay for medical expenses, hospitals and other healthcare providers will undoubtedly see a rise in uncompensated care.

In evaluating other states’ waiver proposals, CMS has agreed that eliminating retroactive eligibility from the Medicaid program is an untenable policy decision. In an April 5, 2016 letter to Arkansas Governor Asa Hutchinson, whose state made a similar proposal to CMS, you wrote, “Retroactive coverage is an important Medicaid provision that protects people who need medical care, and who may not know they are eligible for coverage. Retroactive coverage is especially important when issues with a state’s eligibility and enrollment systems lead to unnecessary gaps in coverage.” There is no reason for CMS to take a different position with the Healthy Ohio Program.

C. The Healthy Ohio Program is projected to substantially decrease the overall number of people on Medicaid.

Not only is ODM asking CMS to allow it to change eligibility in the Medicaid expansion category. It is also asking CMS to allow it to change eligibility for all other non-disabled adults. This includes many of Ohio’s most vulnerable populations: parents with incomes below ninety percent of the federal poverty level, low-income individuals between ages 18 and 21, children aging out of foster care, and women with breast and cervical cancer. All of these groups will be subject to premiums, a lockout from coverage if those premiums are missed, and no retroactive coverage to reduce medical debt.

According to ODM, the Healthy Ohio Program will lead to a reduction of 125,875 individuals in the first year following its implementation.⁴⁰ Independent researchers estimate an even greater

⁴⁰ Ohio Department of Medicaid, *Healthy Ohio Section 1115 Demonstration Waiver Summary*, (April 15, 2016) at 3, <http://medicaid.ohio.gov/Portals/0/Resources/PublicNotices/HealthyOhio-Summary.pdf>.

decline in that first year.⁴¹ For each successive year of the Health Ohio Program, ODM projects ever-larger decreases in enrollment. Because ODM's projections are based only on the assumption of an eighty-five percent penetration rate (i.e., fifteen percent of the eligible population will simply chose not to enroll), the estimated declines fail to account for the inevitable drops in enrollment caused by lockout 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.

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 two percent of their monthly income, or \$99 a year, whichever is less. This calculation means that Ohio's poorest individuals and families will pay a higher percentage of their monthly income than those at the higher end of the scale. For example, a person with gross monthly income of \$99 a month will pay a monthly premium of \$1.98 – exactly two percent of her income. At the same time, a person living with gross monthly income of \$1,367 will pay \$8.25 per month – about 0.6 percent of her monthly income.

1. Premiums imposed on beneficiaries will be devastating for people at all levels of income.

Imposing these premiums on the poorest and most vulnerable Ohioans makes their ability to maintain the most basic standard of living even more tenuous. A person living at fifty percent of the poverty rate, or \$495 in gross monthly income, will pay \$8.25 a month for Medicaid coverage. An \$8.25 per month payment may not seem like a lot, but it is when other expenses are considered. Housing expenses, in particular, are very high for low-income renters. For instance, the Ohio Housing Finance Agency recently found that the average housing and transportation costs for a single renter living at the poverty line exceeds one hundred percent of that renter's income in all eighty-eight Ohio counties.⁴² Further, more than a quarter of Ohio's renters pay more than half of their monthly income for rent.⁴³ Housing is particularly expensive for low-income people in Appalachian Ohio; the eight Ohio counties with the highest percentage of gross rent to income are in Appalachian Ohio.⁴⁴

⁴¹ Comments by Center for Community Solutions on Healthy Ohio 1115 Demonstration Waiver, filed with the Ohio Department of Medicaid (April 21, 2016) at 2-3, http://www.communitysolutions.com/assets/docs/Health_Policy/2016/healthy%20ohio%20comments%20for%20the%20ohio%20department%20of%20medicaid%20_04212016.pdf.

⁴² Ohio Housing Finance Agency, *Ohio Housing Needs Assessment Technical Supplement to the Fiscal Year 2016 Annual Plan* (July 1, 2015) at 122,

<https://ohiohome.org/news/documents/2016-HousingNeedsAssessment.pdf>.

⁴³ *Id.* at 118.

⁴⁴ *Id.* at 117.

The expenses for low-income Ohioans are not limited to housing expenses. For families, there will be childcare expenses or school-related costs and higher food and transportation costs. Even if this family receives food assistance to supplement their food costs, this will not pay for all of their food, or cover necessary items like clothing, toilet paper, and diapers. Ohio will now be asking a new group of people to decide between buying food for themselves and their families and obtaining healthcare to prevent, treat, and cure their physical and mental illnesses. It makes no sense to ask people living in poverty to forgo eating so that they can go to the doctor or buy needed medications.

Last year, HHS released a report highlighting the impact of medical cost sharing on low-income populations.⁴⁵ The report made three key findings: (1) low-income individuals are especially sensitive to increases in out-of-pocket medical costs even if those increases are nominal; (2) medical fees, premiums, and co-payments contribute to the financial burden on poor adults who need to visit medical providers; and (3) fees and co-payments have a more pronounced impact on access to healthcare for the poorest families because they have no money to cover out-of-pocket medical expenses.⁴⁶

Healthcare as intended by the Medicaid program will create better health outcomes. A Rand Corporation Health Insurance Experiment study found that the provision of healthcare without cost improved hypertension, dental health, vision, and selected serious symptoms among the sickest and poorest patients.⁴⁷ Here in Ohio, Metrohealth Hospital's early experiment with Medicaid expansion found that the expansion of readily accessible care, without cost, enhanced health.⁴⁸ Ohio's attempt to move away from these positive health outcomes should be stopped.

2. The Healthy Ohio Program will have an adverse effect on access to healthcare for children and pregnant women.

While the Healthy Ohio Program would not technically apply to the children in the household, studies have shown that children are less likely to visit the doctor if their parents do not have coverage.⁴⁹ As a result, the Healthy Ohio Program will increase the use of emergency rooms and decrease preventive care – two results that will threaten the health of Ohio children.

⁴⁵ U.S. Department of Health and Human Services, *Financial Condition of Health Care Burdens of People in Deep Poverty* (July 16, 2015), https://aspe.hhs.gov/sites/default/files/pdf/108461/ib_DeepPoor.pdf.

⁴⁶ *Id.* at 1.

⁴⁷ Robert H. Brook, et al., *The Health Insurance Experiment: A Classic Rand Study Speaks to the Current Health Care Reform Debate*, http://www.rand.org/pubs/research_briefs/RB9174.html.

⁴⁸ Randall D. Cebul, Thomas E. Love, Douglas Einstadtler, Alice E. Petrulis, and John R. Corlett, *MetroHealth Care Plus: Effects of a Prepared Safety Net on Quality of Care in a Medicaid Expansion Population*, *Health Affairs*, Vol. 34, No. 7, 1121-1130 (July 2015).

⁴⁹ Leighton Ku and Matthew Broaddus, Center on Budget and Policy Priorities, *Coverage of Parents Helps Children, Too*, (October 20, 2006) at 1, <http://www.cbpp.org/sites/default/files/atoms/files/10-20-06health.pdf>; Institute of Medicine of the National Academies, Committee on the Consequences of Uninsurance, *Health Insurance Is a Family Matter*, 5-6 (2002).

If the Healthy Ohio Program is implemented, pregnant women will get coverage the same 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 office approves the application. Since Ohio expanded its Medicaid program, legal aid clients have experienced delays of more than ninety days for Medicaid application processing. Other clients have reported wait times of six to nine months. The Healthy Ohio Program would mean that pregnant women must either pay for care out-of-pocket while they wait for their Medicaid application to be approved or forego care because they cannot pay for it. Poor pregnant women will not be able to pay for prenatal care while they wait for their Medicaid application to be processed; instead, they will forego care.

Ohio's administrative and legislative officials have committed to reduce Ohio's infant mortality rate, which is among the worst in the country.⁵⁰ The Healthy Ohio Program does not support that alleged commitment. Instead, Healthy Ohio Program would seriously jeopardize the health of pregnant women and place Ohio's youngest and most vulnerable citizens at even higher risk.

3. Administrative hurdles will add cost and present further barriers to coverage.

Finally, Ohio provides no explanation about how people will actually pay their premiums and why the physical act of paying these premiums will not 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, easily pay their premiums electronically, and earn extra incentives from the state. However, as with other parts of the Healthy Ohio Program, this provision will affect people already overwhelmed by the challenges of poverty and other socioeconomic barriers. For example, low-income individuals may have difficulty making monthly premium payments if they are non-English speaking, have limited literacy, or have are cognitively challenged. People may also have problems accessing their bank accounts if they are transient, in and out of homelessness, or victims of domestic violence. Ohio should not leave these people – the most vulnerable among us – without access to Medicaid.

V. Conclusion

CMS may approve an 1115 demonstration project only if it is likely to assist in promoting the objectives of 42 U.S.C. 1315(a). 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.”⁵¹ CMS also must consider the impact of the proposed demonstration project on those the Medicaid Act is designed to protect.⁵²

⁵⁰ Brie Zeltner, *Ohio Ranks 45th Nationally in Infant Mortality, Near Bottom for Death of Black Babies*, Cleveland Plain-Dealer (August 6, 2015),

http://www.cleveland.com/healthfit/index.ssf/2015/08/ohio_ranks_45th_nationally_on.html.

⁵¹ S.Rep. No. 1589, 87th Cong., 2d Sess. 20, *reprinted in* 1962 U.S.C.C.A.N. 1943, 1961.

⁵² *Newton-Nations v. Betlach*, 660 F.3d 370, 380 (9th Cir. 2011).

Ohio's proposal fails on all levels. It will negatively affect the very people the Medicaid Act was enacted to protect. The proposal itself forecasts a significant decrease in enrollment and locks all members out of healthcare coverage when they are unable to pay premiums. Worse, it defeats the primary objectives of the Medicaid program by creating difficult and unnecessary barriers to enrollment and continued access to care. For many Ohioans, these barriers are insurmountable. Therefore, we ask CMS to reject the waiver request.

If you have questions or would like further information on the issues raised by these comments, please contact Andrew Neuhauser at aneuhauser@oslsa.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew D. Neuhauser". The signature is fluid and cursive, with a long horizontal flourish extending to the right.

Andrew D. Neuhauser
Attorney at Law

James M. Daniels
Director, Southeastern Ohio Legal Services