July 22, 2016

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

To Whom It May Concern:

The Center for Community Solutions (CCS) is a nonpartisan think tank focused on solutions to health, social and economic issues. Our mission is to provide strategic leadership and organize community resources to improve health, social, and economic conditions through applied demographic research, nonpartisan policy analysis and advocacy, and communication. We are hoping that the following comments help the Department of Health and Human Services (HHS) in their review of the 1115 Waiver Demonstration application submitted by the Ohio Department of Medicaid (Healthy Ohio).

Over the last few years, Ohio, led by Governor John Kasich, has engaged in a number of efforts to expand access, lower costs and achieve better outcomes. This has included participation in the Center for Medicare & Medicaid Innovation (CMMI) Comprehensive Primary Care Initiative (CPCi), the State Innovation Model (SIM), as well as the extension of Medicaid benefits to able-bodied, low-income adults (Group VIII). CCS supports many of ODM's initiatives to develop sound, cost-effective Medicaid policies, including the decision to extend Medicaid benefits to Group VIII. With that said, we have significant concerns with the Healthy Ohio proposal.

Before exploring the specific policy concerns we have, we want to highlight the fact that Healthy Ohio as submitted to HHS is exactly the same as what has been publicly available before federal submission. Even after the required state comment process, ODM did not substantively change the policy in their proposal. This does not mean that ODM did not consider public comment before submitting its application. In fact, in the opinion of the CCS, ODM should be congratulated for their thorough and transparent comment process. Rather, the lack of policy adjustment reflects the narrowness of the statute that mandated ODM to submit this Waiver as written. As a result of that statutory restrictiveness, there are a couple of effects we want to highlight before submitting our concerns with the policy, generally.

First, what you find in our comments will mirror what we submitted to ODM. This is due to the fact that the policy proposals contained within the application are identical to what was initially published and ODM is unable to change much of what was submitted. Second, we would ask HHS, upon review, to not only consider our comments, which in essence recommend rejection of this application, but also to issue guidance as to make clear to the Ohio legislature that prescriptive statutory mandates regarding any such future proposals will likely lead to rejection. If, as is suggested by federal regulation, such Waivers are intended to experiment with ideas that promote the objectives of CHIP and Medicaid, then legislative bodies should be aware of what is and is not allowable in terms of Waiver submission. As a joint state and federal program, prescriptiveness on the part of legislative bodies to HHS seem only to hinder the necessary policy flexibility inherent in such experiments and, as such, should be explicitly discouraged in future responses from HHS to Medicaid agencies.

With this background on process, the comments provided are organized in a manner that seeks to address the requirements and objectives of the U.S. Center for Medicare and Medicaid Services' (CMS) oversight of 1115 Demonstration Waivers by focusing on how this proposal affects eligibility, services, care, cost, and efficiency.

Eligibility

Healthy Ohio would dismantle what is an already successful extension of Medicaid benefits to the Group VIII population and harm the ability of the general Medicaid population to retain benefits. Healthy Ohio as constructed would likely result in the broad disenrollment of currently covered beneficiaries through a set of complicated, punitive and errantly applied cost-sharing policies focused on a population largely unable to meet the financial and logistical requirements of the proposal, including vulnerable populations such as foster children and women with cancer.

As of January 2016,[i] nearly 625 thousand Ohioans were eligible for Medicaid through the extension of benefits to the Group VIII population. 94 percent of this population is enrolled, resulting in nearly a 50% reduction in the uninsured in Ohio.[ii] The proposal would require participants, which include all non-disabled adults, not just Group VIII, to contribute the lesser of 2 percent of their annual family income or $99 annually. This includes several eligibility categories such as the transitional Medicaid, foster care, breast and cervical cancer, and Ribicoff children populations.

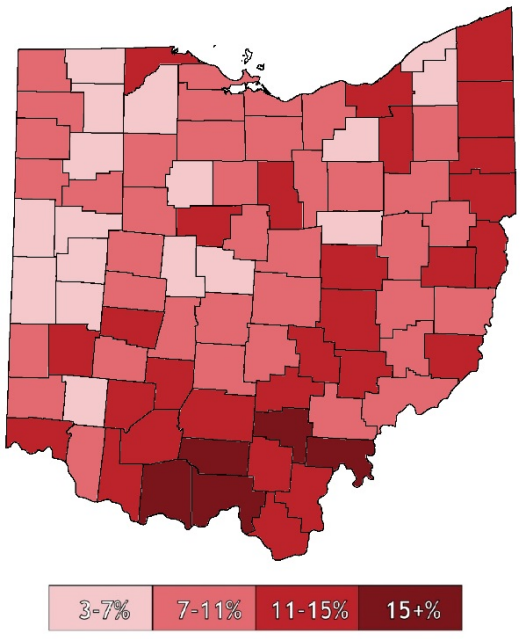
ODM estimates that Healthy Ohio will affect 1.66 million Ohioans by 2018.[iii] According to ODM, this would lead to a reduction of 126,000 individuals, in the first year, as a result of people electing not to enroll[iv]. However, CCS believes the disenrollment number would not only be higher, but that the reasons for disenrollment are much more complicated. The following is a table estimating the potential disenrollment by category of eligibility utilizing the 15 percent as projected by ODM as well as an estimate based on every 1 percent of disenrollment for the purposes of showing impact by population:

	Total Population: 1198909	
Eligibility Category	15%	For Every 1% Disenrollment
Parents	67,538	4,503
Transitional Medicaid	7,757	517
Foster Care	89	6
Ribicoff Children	4,538	303
Medicaid Extension	99,820	6,655
Breast & Cervical Cancer (BCCP)	95	6
TOTAL	179,836	11,989

Source: Ohio Department of Medicaid, February Estimates

It should be noted that these estimates are based on publicly available enrollment reports from ODM, but do not contemplate the entire population deemed eligible by Medicaid in the detailed application. As such, these numbers are actually lower than what has been stated in the detail document but higher than what is portended by the summary document. Regardless of how many may disenroll, coverage would still be threatened for nearly 1.2 million of the 3 million Ohioans enrolled in Ohio's program based on our estimates. While it is unlikely the entire population would lose coverage, evidence from multiple states shows new premiums often serve as a barrier to maintaining or gaining coverage. States, such as Oregon and Vermont, saw between a 30 percent and 77 percent drop in coverage.[v] This potential disenrollment, which runs contrary to CMS' stated goal of coverage integrity, is only complicated by what can already be a cumbersome redetermination process.

In addition to these numbers, CCS recently reviewed how this disenrollment may affect specific counties in Ohio. To do this, CCS used its estimates and compared the potential disenrollment as a proportional share of overall population. In other words, the following choropleth map shows what 1 percent disenrollment would look like if equally distributed over the entire state of Ohio:



While urban counties such as Cuyahoga and Hamilton are disproportionately affected in terms of total volume, it is rural and Appalachian counties which would see the greatest share of coverage disruption relative to total population with some counties having over 1 in 6 residents being mandated to participate. This is particularly problematic given the already resource-stressed conditions in many of these communities.

In 2015, ODM had to settle a lawsuit after 150 thousand Ohioans lost coverage due to the ineffective outreach associated with the federally mandated redetermination process.[vi] As the plaintiffs stated, ODM did not perform sufficient outreach to participants, failing to inform them of the reason for the drop in coverage or their right to appeal. While ODM should be congratulated for working with the plaintiffs on

solutions, including the creation of a number of tools to assist participants, it does cause concern when compared to what will be a much more administratively intricate system of determination as outlined in Healthy Ohio. ODM has outlined the need to reach out to beneficiaries to explain this new system but this effort is not very detailed nor does it describe any potential costs to ODM, payers, providers, or anyone else who may have a material connection to this new program of eligibility.

In regards to the intersection of eligibility determination and providers, there are outstanding questions about if and how presumptive screening would be applied and if hospitals could meet the requirement of 85 percent success rate with approvals. Additionally, if hospitals could contribute to an individual's Core Funds, could they do that all at once or would it have to be contributed on a monthly basis? If annually, this could mean that a person's eligibility for up to 75 percent of the time could be financed by a nonprofit health entity, potentially incentivizing partial coverage based on the financial needs of providers. Similarly, if the assistance must be provided monthly, you could face a situation where the contribution serves as a de-facto determination process, with providers evaluating the value of developing operational plans to address eligibility versus accepting shortfalls, bad debt and uncompensated care pools.

As opposed to other states that have provisions protecting individuals from losing coverage due to domestic violence, a disaster declaration, or medical frailty, Ohio would offer no such protections, except in the case of pregnant women. While this specific protection is important, mothers are still not exempted after delivery, potentially creating an interruption in coverage during the critical first year of life and increasing the potential for another risky birth without the appropriate post-natal care or planning. This deficiency in the proposed policy is particularly problematic for Ohio where the infant mortality rate is 23 percent higher than the national average.[vii] This lockout provision will also interrupt the continuity of care for all participants, not just recent mothers, thus decreasing access to coordinated care. This provision has the effect of destabilizing and weakening provider networks available to serve the Medicaid population who rely on predictable, care-coordinated coverage.

CMS has previously denied a number of provisions in 1115 Waivers including a requirement of premium payment for individuals with incomes below 100 percent of the Federal Poverty Level (FPL). The current proposal offers this requirement, establishing a standard that not only would contradict previous CMS decisions on 1115 Waivers, but would exacerbate the likelihood of disenrollment, particularly among lower income populations. Lack of access through disenrollment puts individuals at risk for negative health outcomes including lower birth weight for babies of new mothers,[viii] delay or non-receipt of needed medical care due to cost,[ix] poor mental

health,[x] and preventable hospitalization.[xi] Furthermore, Medicaid coverage has been shown to increase the financial security of beneficiaries, meaning any interruption in current coverage is likely to cause more economic insecurity rather than strengthen it.

Recommendation

CCS praises ODM from protecting individuals with no income from the requirement to contribute to the Buckeye Account. With that said, this proposed eligibility system would contradict the federal government's objectives for Medicaid by likely decreasing enrollment overall. Disenrollment would negatively impact health outcomes and the financial security for unprotected low-income populations, particularly the medically frail, persons with serious and persistent mental illness, victims of domestic abuse, foster children, women with breast and/or cervical cancer and individuals living in disaster areas.

ODM should do a number of things before submitting its proposal. First, ODM should abandon its efforts to require premiums as an element of eligibility, particularly for those individuals most at risk. Second, ODM should outline its outreach process for determinations for providers and participants. To assist in this process, CCS would recommend that all hypotheses of the demonstration be more detailed demographically and categorically. While there is some measurement based on utilization rates in terms of age and gender, race and categorical eligibility are absent. In order to secure a more targeted outreach process throughout Healthy Ohio, ODM should adopt these measurements in all relevant hypotheses and utilize them to inform a more comprehensive public outreach strategy and demonstration evaluation.
Ideally, ODM should consider revising the populations included in the proposal. This is not only due to the potential issues with enrollment, but also due to the lack of a comparable, current population from which to base an experiment as the remainder of people in Medicaid will be children and members in the ABD categories. But, as it is a statutory requirement of submission, this may be impossible.

Services & Care

CCS believes that Healthy Ohio will increase churn in the Medicaid population, significantly disrupting the continuity of care for patients, providers and delivery networks. This is mainly due to the required payment of monthly premiums and the lack of information that could help providers and patients to understand this new, complex system.

As outlined previously, it is currently unclear as to how ODM would educate patients, providers, and case management organizations, (such as Job and Family Service Departments and navigators), on the tenets of the program and their respective, related

responsibilities. For providers, the mandatory collection of co-pays, while previously allowed though not often pursued, will serve as an administrative burden and will likely not be cost effective. [xii, xiii] For clinicians, the interruption of coverage may be confusing and difficult to manage, especially for individuals with chronic diseases and co-morbid conditions, perpetuating downstream costs and ineffective care. And, even when coverage is not interrupted, the economic incentive to avoid care during the moment of service not only contests the medical judgment of clinicians, but could seriously compromise the revenue integrity of providers participating in Medicaid by creating new uncertainties in billable services and collection cycles. In a similar vein, there may be significant legal questions as to how the application of financial incentives in the context of service delivery may violate Anti-kickback and Stark laws, creating the potential for fraud and abuse. This is especially true given the ambiguity around whether or not moneys that could be directly received by patients through Buckeye Accounts would include federal matching funds.

A previously accepted 1115 Waiver, MetroHealth Care Plus, was implemented in 2013 as a precursor to expansion in Ohio. During this demonstration, over 36 thousand individuals in Cuyahoga County were granted access to coverage in a fashion similar to the subsequent statewide Group VIII expansion, providing the benefits of coordinated primary care facilitated through electronic health records. In the nine months the demonstration was active, costs were 29 percent ($41 million) below budget neutrality estimates and research has shown significant improvements in diabetes care and utilization of critical services such as screening, vaccinations, behavioral health and dental care. [xiv] This demonstration, built on extending eligibility, shows that costs can be contained and utilization patterns can improve as long as there is a patient-centered, coordinated approach to the delivery system. If, however, similarly situated systems face the confounding factors of co-pays, eligibility interruption, and the creation of multiple "point" systems on the governmental, health plan, and provider levels, results such as these are likely not achievable.

Generally speaking, Healthy Ohio would reverse a trajectory of cost containment achieved by the Ohio Department of Medicaid via a traditional expansion in Ohio and instead embrace an expensive and cumbersome Waiver model rejected by other states for a population much broader than Group VIII. After the traditional expansion to Group VIII, Ohio was $2 billion below original estimates in overall spending. [xv] In fact, for the first time since expansion, the Group VIII population has come in under budget, reflecting national data which suggests that the Group VIII populations trend healthier and lower-cost after continued enrollment.[xvi] Higher matching rates from traditional expansion also served as an offset to General Revenue Funds typically allocated to the Medicaid program. This assisted the ODM in pursuing other policies which maintained

benefits and coverage options in the Medicaid program as well as the flexibility to advance their work in value-based payment. Furthermore, as many participants are already working,[xvii] the requirement to establish a workforce referral seems to be an unnecessary, administratively burdensome task for County Departments of Job and Family Services (through which TANF benefits are coordinated), and tacitly implies that Medicaid is a welfare program as opposed to a publicly-subsidized insurance provider.

Recommendation

Ohio has already shown, through previous Demonstrations, that coverage, including coverage for Group VIII, can improve outcomes, increase access, and lower costs. As written, the proposal would likely result in the interruption of the continuity of care and the stabilization of provider networks which include, but are not limited to, the mandatory collection of co-pays, the lack of clarity around nonprofit hospitals' ability to qualify as a contributing entity for premium assistance (which excludes major public hospitals), and complex, unfunded processes which would de-value the provider-patient relationship through a complicated system of incentives. CCS believes that Healthy Ohio will interrupt the continuity of care for participants and likely result in churn and poorer outcomes. CCS would ask ODM to provide some clarity to providers and payers as to how they are able to manage the eligibility of these populations and the potential variability in coverage and coverage options. CCS would ask ODM to work with its contracted actuaries to help identify the potential effects of these changes for doctors, hospitals, Managed Care Plans, categorical eligibility groups, as well as the effect on supplemental payment programs such as the Upper Payment Limit (UPL) program and the Hospital Care Assurance Program (HCAP). This analysis should be conducted before implementation with a "circuit-breaker" function that would nullify implementation of Healthy Ohio if the analysis would violate budget neutrality requirements, precipitate churn, or lead to interruption in delivery networks.

EFFICIENCY & COST

The Healthy Ohio proposal requires ODM to develop a complex, flexible infrastructure so it can process a diversity of transactions via Health Savings Accounts (HSAs) known as "Buckeye Accounts". ODM and Managed Care Plans will be responsible for maintaining the system administratively, including the issuance of monthly statements to consumers, the provision of annual financial contributions, and the monitoring and development of a point system based on healthy behaviors that have financial rewards in two, disparate accounts. As seen in other states, programs such as these are not only difficult for patients and providers to navigate, but they are also very expensive. In fact, Arkansas recently eliminated the imposition of HSAs and cost-sharing requirements, cutting the administrative costs roughly in half.[xviii] There also does not seem to be any

description of the cost to the State nor any estimate as to how this system of debits may affect the rate construction of Managed Care Plans as they re-procure to have this large caseload shifted into a new program.

The points, with certain limitations, are to be allocated through the enacted 1115 Waiver statute by the Medicaid Director and by the Primary Care Physician(s) of the patient. As written in law, participants must "achieve goals" around their health in order to be eligible for some of these points. This could set a dangerous standard that eligibility is a function of overall health outcomes as opposed to participation in certain activities (i.e. the individual quits smoking versus the individual's participation in a smoking cessation class). Obviously, many factors, including some chronic conditions, genetics, environment, and other social determinants of health, are beyond the direct control of the individual.[xix] Economic incentives, then, may disproportionately benefit populations with existing means as opposed to those who may be more vulnerable, particularly those with lower incomes or pre-existing chronic disease issues. Likewise, policy attitudes change as Medicaid Directors change and, as such, the broad and potential variability of administrative discretion to affect millions of Ohioans' personal economics and health behavior should be approached with thoughtful caution.

Even if participants made every effort to change their behavior to understand and achieve the goals outlined, nearly 46 percent of Ohioans earning less than $15 thousand remain unbanked or underbanked,[xx] meaning they would likely need a significant amount of financial literacy education to understand how to use traditional banking services. Specifically, as Electronic Fund Transfers are incented through the proposed point system, participants would need to monitor their new accounts closely to ensure they do not subject themselves to fees for over drafting and insufficient balances, potentially compromising eligibility and even creditworthiness. It also isn't clear from the Waiver proposal where these accounts would be held and whether participants would have to pay fees to maintain or access these accounts. These problems would be complicated by the fact that 17 percent of Ohio households do not have a computer at home and that Ohioans use smartphones at a rate significantly lower than the national average, making it difficult to regularly monitor transactions.[xxi] ODM would need to outline the ways in which they would help facilitate individuals' understanding of how to make contributions and monitor their accounts along with a strong customer service function that can help participants understand how to resolve any issues.

Recommendation

HSAs have demonstrated their increased cost and decreased efficiency in Medicaid programs. This is especially true when compared to Ohio's current successful system of benefit administration. As designed, the incentive system disproportionately harms

individuals with more complex needs and promotes a system of incentives based in part on factors beyond a participant's control.

REMAINING QUESTIONS

The following list is intended to assist the State in developing a more robust application to CMS and assist the general public in understanding key design elements of Healthy Ohio. CCS recommends these be answered directly before final submission to CMS:

1) How does the incentive system avoid violating Fraud and Abuse Laws[xxii]?
2) If an individual is able to access the entirety of their Buckeye Account after terminating participation in Healthy Ohio, for whatever reason, are they able to access dollars provided by Medicaid that include federal matching funds?
3) What are the costs associated with operationalizing the transaction system? Will these costs built into the capitated payments made to Ohio's Medicaid Managed Care Plans?
4) How do individuals contribute their portion if they do not have regular access to banking services or have other challenges (non-English speaking, limited literacy, etc.)?
5) If these accounts are held by banks, will they be prohibited from charging fees to participants?
6) Why is there a difference in the population estimates between the Summary document and the Detail document?
7) Have the business requirements for implementing Healthy Ohio in MITS been developed? If not, what is the expected time frame for developing those requirements and how long would it take to implement those requirements? Will providers be able to utilize MITS in real time to determine whether an individual is eligible for Healthy Ohio?
8) Can other government programs contribute toward a participant's contribution i.e a public hospital, or a State university hospital, or the Ryan White HIV/AIDS Program?
9) Why does the "deductible" change based on how much is in the participant's non-core Buckeye account?

[i] "Medicaid Managed Care Plan Enrollment Reports - January 2016." Medicaid Managed Care Plan Enrollment Reports. January 4, 2016. Accessed March 2016. http://medicaid.ohio.gov/RESOURCES/ReportsandResearch/MedicaidManagedCarePlanEnrollmentReports.aspx#1465550-2016-monthly-enrollment.

[ii] Candisky, Catherine. "Uninsured Ohioans down to 8.7 Percent, Survey Shows." The Columbus Dispatch, August 19, 2015. Accessed March 2016. http://www.dispatch.com/content/stories/local/2015/08/19/medicaid-insurance-survey.html.

[iii] "Healthy Ohio Section 1115 Demonstration Waiver Detail." Public Notice and Request for Comment. April 5, 2016. Accessed April 15, 2016. http://medicaid.ohio.gov/Portals/0/Resources/PublicNotices/HealthyOhio-Detail.pdf.

[iv] "Healthy Ohio Section 1115 Demonstration Waiver Summary." Public Notice and Request for Comment. April 5, 2016. Accessed April 6, 2016. http://medicaid.ohio.gov/RESOURCES/PublicNotices/HealthyOhioHSA.aspx.

[v] Artiga, Samantha, and Molly O'Malley. "Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences." Www.kff.org. May 2005. Accessed March 2016. https://kaiserfamilyfoundation.files.wordpress.com/2013/01/increasing-premiums-and-cost-sharing-in-medicaid-and-schip-recent-state-experiences-issue-paper.pdf.

[vi] Candisky, Catherine. "More than 150,000 Ohioans to Get Medicaid Again after Settlement." The Columbus Dispatch, May 12, 2016. Accessed March 2016. http://www.dispatch.com/content/stories/local/2015/05/12/medicaid-settlement-details.html.

[vii] "2013 Ohio Infant Mortality Data: General Findings." www.odh.ohio.gov. 2013. Accessed March 2016. http://www.odh.ohio.gov/~/media/ODH/ASSETS/Files/cfhs/Infant Mortality/2013 Ohio Infant Mortality Data Report FINAL.pdf.

[viii] "Low Birth Weight and the Environment." Health Effects Low Birthweight and the Environment. June 6, 2014. Accessed March 2016. http://ephtracking.cdc.gov/showRbLBWGrowthRetardationEnv.action.

[ix] "Delay or Nonreceipt of Needed Medical Care, Nonreceipt of Needed Prescription Drugs, or Nonreceipt of Needed Dental Care during the past 12 Months Due to Cost, by Selected Characteristics: United States, Selected Years 1997–2013." 2014. Accessed March 2016. http://www.cdc.gov/nchs/data/hus/2014/069.pdf.

[x] "International Journal of Epidemiology." Http://www.oxfordjournals.org/. November 6, 2001. Accessed March 28, 2016. http://ije.oxfordjournals.org/content/31/2/359.long.

[xi] Bindman, A. B. "Preventable Hospitalizations and Access to Health Care." JAMA: The Journal of the American Medical Association 274, no. 4 (1995): 305-11.

[xii] Hubbard, Thomas. Healthy People in a Healthy Economy: A Blueprint for Action in Massachusetts. Report. June 2009. Accessed March 2016. http://www.tbf.org/tbf/56/hphe/~/media/71D60849236E470D8FED6D67FE9BEEDA.pdf.

[xiii] DeAngelo, Aly. Healthy Ohio Legislation Summary. Report. October 2015. Accessed March 2016. http://ohiohospitals.org/OHA/media/Images/Finance and Policy/Document/Hospital_Insights-October15-Healthy-Ohio-Whitepaper.pdf.

[xiv] Cebul, Randall D., Thomas E. Love, Douglas Einstadter, Alice S. Petrulis, and John R. Corlett. "Health Affairs." MetroHealth Care Plus: Effects Of A Prepared Safety Net On Quality Of Care In A Medicaid Expansion Population. July 2015. Accessed March 2016. http://content.healthaffairs.org/content/34/7/1121.short?cited-by=yes.

[xv] Candisky, Catherine. "Ohio's Medicaid Costs $2 Billion Less than Estimates." The Columbus Dispatch, August 12, 2015. Accessed March 2016. http://www.dispatch.com/content/stories/local/2015/08/12/medicaid-costs-below-estimates.html.

[xvi] Ackerman, Susan, and Gregory Craig. "Medicaid Budget Update, Review of Major Cost Drivers & Next Budget Process." Www.jmoc.state.oh.us. March 2016. Accessed March 2016. http://www.jmoc.state.oh.us/Assets/documents/FY2016JMOCBudgetUpdate.pdf.

[xvii] Ross, Casey. "Ohio's Rate of Uninsured Residents Cut in Half, State Says." The Plain Dealer, August 19, 2015. Accessed March 2016. http://www.cleveland.com/healthfit/index.ssf/2015/08/ohios_rate_of_uninsured_reside.html.

[xviii] Little, Marquita. "Arkansas Medicaid Private Option Approved by Legislature." Center For Children and Families. February 06, 2015. Accessed March 2016. http://ccf.georgetown.edu/all/arkansas-governor-hutchison-takes-pragmatic-approach-medicaid-private-option/.

[xix] Hubbard, Thomas. Healthy People in a Healthy Economy: A Blueprint for Action in Massachusetts. Report. June 2009. Accessed March 2016. http://www.tbf.org/tbf/56/hphe/~/media/71D60849236E470D8FED6D67FE9BEEDA.pdf.

[xx] "Unbanked and Underbanked for Ohio, 2013 by Selected Household Characteristics." 2013 FDIC National Survey of Unbanked and Underbanked Households, 2014. Accessed March 2016. https://www.economicinclusion.gov/surveys/2013household/documents/tabular-results/2013_banking_status_Ohio.pdf.

[xxi] File, Thom. Computer and Internet Use in the United States. Report no. P20-569. May 2013. Accessed March 2016. https://www.census.gov/prod/2013pubs/p20-569.pdf.

[xxii] United States of America. US Department of Health and Human Services. Office of Inspector General. A Roadmap for New Physicians: Fraud & Abuse Laws. Accessed April 15, 2016. http://oig.hhs.gov/compliance/physician-education/01laws.asp.