Public Comment: Group VIII Work Requirement and Community Engagement 1115 Demonstration Waiver

March 1, 2018 | Loren Anthes, Public Policy Fellow, Center for Medicaid Policy

As mandated by Ohio Revised Code Section 5166.37 through House Bill 49, the state's biennial budget, the Ohio Department of Medicaid is seeking federal approval for an 1115 Demonstration Waiver that will impose work requirements for enrollees granted eligibility through the extension of benefits to the Group VIII population identified in Title XIX of the Social Security Act. While the Center for Community Solutions will prepare and submit formal comments on the proposal, the following testimony represents some of our initial policy questions and concerns. We are hopeful, pursuant to federal law, the state strongly considers our thoughts before final submission to the Department of Health and Human Services. In total, we believe the proposal represents a disparaging, and legally questionable, set of eligibility reforms that will create unnecessary complexity, grow the size and cost of government, and perpetuate Ohio's status as a low-value health purchaser through disenrollment and poorer outcomes.

The complexity of the proposal has been messaged as insignificant, with the state claiming only 1 in 20 enrollees will be disenrolled. But the real question is: what happens to the other 19 and how do we get to that 1 in 20 number? Based on information from the Office of Health Transformation, the state will be able, through data, to exempt individuals of a certain age, who are a parent caretaker, who have a chronic condition, who are complying with the work requirement for the Supplemental Nutrition Assistance Program and who earn income equal to the value of 20 hours of work per week based on minimum wage. However, the project of the Ohio Integrated Eligibility System (Ohio Benefits) has not been completed and won't be fully operational by the time this waiver is implemented. How do we then deal with the individual issues of enrollees? An example: if we know that one-third of behavioral health providers have yet to submit a claim under behavioral health redesign, how do we know who is in treatment? Will waiting lists for behavioral health services be considered? What are the HIPPA considerations in sharing medical information with County Departments of Job and Family Services? With that in mind, the eligibility process will likely default into a combination of self-attestation, appraisal and county case-management. That will naturally make the process of obtaining eligibility, even with the necessary stated exemptions, much more complex than the current system based on income.

One only need to look to the examples of Kentucky and Virginia to see how such programs increase the cost of operating government. Indeed, governmental complexity often begets higher governmental cost. As the process of eligibility will invariably differentiate county to county, each with their own set of resources, processes and logistical dynamics, the expense of the operation will increase. Currently, the state's proposal only contemplates the budget neutrality effects of disenrollment, which is worth less than half a percent of the total cost of the benefit during that timeframe. The costs do not include, or at least articulate, what the state believes the expense will be to enable this new system or to deliver it on the local level. Additionally, while the state should be commended for considering the resources needed for work supports, the Centers for Medicare and Medicaid (CMS) have clearly stated this is not available – something which is reinforced by language in Title XIX. Lastly, the state's own projections show that the average per member costs for the expansion go up, denoting two important things. First, it shows that healthier people are leaving the expansion group, meaning the costs of operating the program generally go up. This both increases the risk of the total program and discourages the use of preventative care. Second, it seems to conflict with law established when Medicaid was first expanded, mandating the Director to pursue policies that decrease average member costs. As Ohio's independently contracted actuary has noted in the Joint Medicaid Oversight Committee, the expansion has a deflationary impact on the per member costs of Medicaid overall, so losing Medicaid expansion enrollment will naturally increase average member expense.

Finally, it appears this proposal is an answer in search of a problem. If we think that only 1 in 20 will be affected, why are we still making 19 people go through some level of process? It transitions coverage to its own form of work, transitioning access to care to an occupation, in and of itself. This proposal, in its very architecture, is primarily about eligibility restriction for a Social Security Act mandated population. As such, the proposal seems to conflict with the stated purpose of Medicaid to promote the health and wellbeing of its enrollees. Especially as the state grapples with the difficulties of the opiate epidemic and infant mortality, the expansion represents a key resource to provide treatment, and connect mothers and infants to critical resources.

Ultimately, we would not want to see this waiver offered. But, given the legislative mandate, we will be recommending CMS deny this waiver on the grounds it conflicts with their mission. As it is unlikely that they will deny this application, we are hopeful the state consider our recommendations and questions to better equip the public for this transition.

The Center for Community Solutions Makes the Following Recommendations

1. Change the unit of government for high unemployment exemptions from counties to cities given the racial disparities the current proposal would create
2. Engage LeanOhio and process map this new eligibility system before implementation, and distribute process information to the public and County Departments of JFS, complete with training and resources before "go-live"
3. Revise budget neutrality estimates to include state and local impact
4. Even though parents are exempt, there should be an explicit exemption for women who have delivered for at least one year, post-partum, especially given Ohio's infant mortality crisis
5. Exempt justice-involved individuals who are connected to Ohio's program of eligibility in-reach for returning populations

The Center for Community Solutions Would Like the Following Questions Answered Before HHS Submission

1. How does the process of segmenting populations for exemptions work and who would be responsible for implementation for the determination process? Is the state going to provide lists to the county or is the county responsible?
2. Does the state plan on requesting additional federal match for OIES beyond the currently scheduled termination in September?
3. How are exemptions tracked? For example, if a seasonal worker earns more income that would put them over an annual average, does the worker have to notify? Any additional information on how the 20 hours per week would be determined is needed.
4. Will waiting lists for substance use and mental health treatment qualify for an exemption?
5. If someone is retroactively determined to be ineligible during a period of service, who is liable? What happens if the state does not receive matching dollars for the work supports it is requesting? Will other funds be identified or will there be no supports?
6. If a person does not have coverage, but they are likely to be considered medically unfit, what's the process for securing a medically-backed statement indicating potential eligibility? Is this standardized across the state?