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PUBLIC COMMENT TO THE OHIO DEPARTMENT OF MEDICAID

"GROUP VIII WORK REQUIREMENT AND COMMUNITY ENGAGEMENT 1115 DEMONSTRATION WAIVER"

March 12, 2018

INTRODUCTION

Pursuant to Ohio Revised Code §5166.37,[1] the Ohio General Assembly has mandated the Ohio Department of Medicaid seek federal approval for an 1115 Demonstration Waiver imposing work requirements on individuals covered through Medicaid via the Group VIII expansion. Pursuant to law established in the Patient Protection and Affordable Care Act, and further articulated in federal rule,[2] the state and federal governments must collect and respond to public comment. The following document represents the public comment from the Center for Community Solutions in regards to the state's proposal before submission to the Department of Health and Human Services and the Centers for Medicare and Medicaid Services.

Ohio's proposal, known as the "Group VIII Work Requirement and Community Engagement 1115 Demonstration Waiver," represents an unfunded, legally questionable, mandate that fails to meet the essential purpose of Medicaid to provide medical assistance. As such, the Center for Community Solutions opposes the proposal.

WAIVER DESIGN

BACKGROUND

In June 2017, the Ohio General Assembly created state law which requires the Medicaid Director to establish a waiver under which an individual made eligible through expansion be required to meet at least one of the following requirements:

(A) Be at least fifty-five years of age
(B) Be employed
(C) Be enrolled in school or an occupational training program
(D) Be participating in an alcohol and drug addiction treatment program
(E) Have intensive physical health care needs or serious mental illness

In December of 2017, the Centers for Medicare and Medicaid Services (CMS) released information revising the 1115 Waiver Application and Approval guidelines. This revision was without public comment or input. The revision included transitioning the standards of evaluation from four principles to six as denoted in the following table:

1115 Demonstration Waiver Evaluation Process	
Previous Guidelines	Current Guidelines
Increase and strengthen overall coverage of low-income individuals	Improve access to high-quality, person-centered services that produce positive health outcomes for individuals
Increase access to, stabilize and strengthen providers and provider networks that serve Medicaid and low-income populations	Promote efficiencies that ensure Medicaid's sustainability for beneficiaries over the long term
Improve health outcomes for Medicaid and other low-income populations	Support coordinated strategies to address certain health determinants that promote upward mobility, greater independence, and improved quality of life among individuals

[1] http://codes.ohio.gov/orc/5166.37v1
[2] https://www.medicaid.gov/medicaid/section-1115-demo/transparency/index.html

Increase efficiency and quality of care of Medicaid and other low-income populations through initiatives to transform service delivery networks	Strengthen beneficiary engagement in their personal healthcare plan, including incentive structures that promote responsible decision-making
	Enhance alignment between Medicaid policies and commercial health insurance products to facilitate smoother beneficiary transition
	Advance innovative delivery system and payment models to strengthen provider network capacity and drive greater value for Medicaid

In January of 2018, CMS issued a State Medicaid Director letter SMD: 18-002 which provided guidance to states on how to implement 1115 Waivers that could incentivize Medicaid beneficiaries to participate in work and community engagement activities.[3] In this guidance, CMS takes the unprecedented position that requiring work and volunteering as an element of eligibility correlates to better health outcomes and is, therefore, consistent with federal law established in the Social Security Act. This guidance goes on to outline what would be required of states, including eligibility alignment with other entitlement programs such as Temporary Assistance for Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP). Notably, this alignment highlights the consideration of exemptions for certain populations, protections for the disabled, as well as the qualifications for, and variability and availability of, work and community engagement activities. CMS also recognizes that many who will be asked to adhere to this new eligibility requirement may require supports to achieve the mandate and, what's more, that economic considerations beyond the individual's control must be contemplated in the state's application. It should be noted that funding for these activities is prohibited.

Beyond this specific guidance, CMS continues many of the aspects of traditional waiver oversight, including the need for evaluation and assurances of compliance with other standards in law, including the Americans with Disabilities Act (ADA) and transparency. Explicitly, CMS requires states test hypotheses that include assessments of process, outcome measures and track information regarding lapses in eligibility.

OHIO'S PROPOSAL

On February 16th, the state of Ohio released its proposed waiver, holding two public hearings on February 21st and March 1st, with the comment period closing March 18th.[4] To comply with the state and federal guidance, the state is proposing that all individuals who are eligible for Medicaid under the expansion be included in the waiver.

The following exemptions are proposed:

- 50 years of age or older
- Physically or mentally unfit for employment
- Participant in the Specialized Recovery Services Program
- Caring for a disabled/incapacitated household member
- Pregnant women
- Parent/caretaker/residing in same house with minor child

[3] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf

[4] http://medicaid.ohio.gov/Portals/0/Resources/PublicNotices/GroupVIII/Detail-GroupVIII-021618.pdf?ver=2018-02-16-092910-683

- Applied for or receiving Unemployment Compensation
- In school at least half-time
- Participating in drug or alcohol treatment;
- An assistance group member subject to and complying with any work requirement under the Ohio Works First
- (OWF) program
- Applicant for or recipient of Supplemental Security Income (SSI)
- Limit to counties that have an unemployment rate of more than 10% or do not have a sufficient number of jobs to provide employment for the individual

Further, the state will enforce the work and community engagement requirements by aligning with SNAP in the following ways:

- Work or participate in a community engagement activity (or combination of the two) for a minimum of 20 hours per week (80 hours averaged monthly)
- Community engagement activities include:
    - SNAP education and training activities
    - Job search/job readiness programs (for no more than 30 days)
    - Work Experience Program (WEP)

Failure to satisfy either the exemption or work activity results in a termination of coverage.

The state is establishing three hypotheses:

- Hypothesis 1: Group VIII population will have improved health outcomes as a result of complying with the Work and Community Engagement Requirement
- Hypothesis 2: Supporting and encouraging member community engagement will result in transition to employer based coverage
- Hypothesis 3: Employment requirements will result in broader sustained employment over time

IMPACT ON ACCESS

CMS, in its guidance and through comments provided by Administrator Seema Verma, has stated that coverage is not the primary focus of demonstration waivers and makes reference to the "hollow victory of coverage."[5] It is important, however, to consider the impact of coverage on some of the most pressing health needs in Ohio and also compare those to the newly stated objectives of CMS.

According to the most recent data from the United States Census, Ohio's uninsured rate is 5.6 percent – the lowest it's ever been. Our research indicates that this is in large part due to the Medicaid expansion,[6] which reduced the uninsured rate by nearly 18 percent for Ohioans Age 19-64 with family income at or below 138 percent of the Federal Poverty Level.[7] This increase in access will be compromised by the waiver. When looking at Ohio's implementation of work requirements for individuals receiving SNAP, where the state had initially estimated 134 thousand would lose eligibility,

[5] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-11-07.html
[6] https://www.communitysolutions.com/census-update-ohios-uninsured/
[7] http://medicaid.ohio.gov/portals/0/resources/reports/annual/group-viii-assessment.pdf

nearly 400 thousand have disenrolled.[8] Some of this is attributable to the improving economy, but does not explain the broad loss of benefits.

Ohio's overdose rate is nearly three times that of the national average.[9] Ohio spends $1 billion on addiction services annually, nearly $280 million coming from expansion,[10] making it a key resource in the fight against the opiate epidemic.[11] While Ohio's proposal does exempt individuals in treatment, this downstream approach may interrupt the normal continuity of care and perpetuate the public health crisis of addiction. This is due to the proposal's requirement to first access treatment in advance of coverage, which inverts the current eligibility process. Additionally, CMS has encouraged the use of 1115 waivers to increase access for individuals in need of inpatient substance use disorder services. The focus of this work centers on the Institutions for Mental Diseases (IMD) exclusion, as it is known, which is existing federal law prohibiting Medicaid reimbursement for inpatient behavioral health treatment. [12] As CMS has stated, they see IMD waivers as tools in the fight against opiate addiction as long as there are appropriate connections to community behavioral health.[13] As many of the individuals who would receive services in an IMD and subsequent community settings are eligible through expansion, it would appear that work requirements harm Ohio's efforts and run counter to stated CMS addiction policy.

EXEMPTIONS

According to the Office of Health Transformation, 58 percent of the individuals enrolled through expansion earned income in the previous year and 44 percent currently meet the work requirement.[14] This is consistent with national data which suggests that only 7 percent of the total Medicaid expansion population would be subject to the requirements as the remainder is either working, in school, has a major health issue, or serves as a caregiver.[15] In the proposal, the state attempts to accommodate these individual circumstances which may prevent them from meeting the requirement by creating a series of exemptions. According to the state, this leaves roughly 5 percent of the population who would be disenrolled as a result of the state's changes. However, despite these efforts to limit the impact of these policies on enrollees, the process of eligibility is fundamentally changed and made more complex.

Currently, eligibility is primarily a byproduct of income. With work requirements, all 700 thousand expansion enrollees would have to go through some level of adjudication on the state, local and/or provider levels. This may include, but is not limited to, segregation of populations within the state's Ohio Integrated Eligibility System (OIES), self-attestation on the part of the enrollee, certification of "unfitness" by a medical professional and the appraisal, good cause justification, or modification by a county case worker.

Complexity will be a natural byproduct of anyone who may be eligible for, or seeking, an exemption. This can include, but is not limited to, individuals living with HIV/AIDS, persons with behavioral health issues, including addiction, caretakers who may not live in the home of the person for whom they are

[8] https://www.communitysolutions.com/research/medicaid-experiments-overview-potential-waivers-ohio/
[9] http://www.dispatch.com/news/20180212/ohio-drug-overdose-deaths-up-39----nearly-triple-us-average
[10] https://www.cincinnati.com/story/news/politics/2017/06/28/john-kasich-veto-medicaid/428799001/
[11] http://www.dispatch.com/news/20180212/ohio-drug-overdose-deaths-up-39----nearly-triple-us-average
[12] https://www.macpac.gov/publication/the-medicaid-institution-for-mental-diseases-imd-exclusion/
[13] https://www.thenationalcouncil.org/wp-content/uploads/2017/11/smd-17-003.pdf
[14] http://healthtransformation.ohio.gov/Portals/0/Ohio%20Medicaid%20Work%20Requirements%20FINAL%202-16-2018.pdf
[15] https://www.kff.org/medicaid/issue-brief/medicaid-and-work-requirements-new-guidance-state-waiver-details-and-key-issues/

caring, and individuals who may have a disability. With the new eligibility system, individuals will need to garner some level of certification from a provider to validate their "unfitness" with the county. It remains to be seen how the state will ensure that information gathered by the individual and certified by a clinician will be protected and secured, let alone achieved, without coverage in place. In looking at state-based data, in fact, expansion served as a front door for nearly 40 thousand individuals who were initially determined to be able-bodied, only later having the medical needs requalify them for the aged, blind, and disabled (ABD) category.[16]

Beyond Cuyahoga, counties will face administrative challenges, especially in a time of dwindling state support.[17] Although the state will exempt 26 counties with high unemployment, as is the case with the SNAP program's Able Bodies Adults Without Dependents (ABAWDs) work requirement, many other communities, notably cities, will face the same issues of lack of access to sustainable employment for their clients. On average, the population in those exempted counties is 95 percent white. Meanwhile, numerous Ohio communities have unemployment rates equally as high, or higher, as the 26 exempted counties, but residents outside of the selected counties are not entitled to the same work requirement and/or community engagement exemptions. Most of these non-exempted Ohio communities have either majority or significant African-American populations, meaning the state could be potentially creating a racially discriminatory eligibility process through policy. Given Ohio's track record in disparities between African-American and white populations in terms of infant mortality outcomes,[18]and the connection between coverage and reductions in mortality,[19] the policy, as authored, may only increase the potential of infant death due to inadequate access to care prior to and between pregnancies.

COST

The reality of this and other work requirement proposals is that it will increase the cost of the program as it will increase the size and operational requirements of government. Data from Virginia,[20] Kentucky,[21] and Pennsylvania[22] demonstrates this, with governments in those states reporting that the operational costs for implementation would number in the hundreds of millions. To meet the requirements of budget neutrality, the state of Ohio essentially identifies the reduction of enrollment as a cause of underspending. The total reduction in spending over the five year waiver is $571.6M, which represents a reduction of about 2% of program cost during that timeframe. The state is requesting match for supportive services which, as previously noted, may conflict with federal guidance and law. The state also estimates that the program will only experience a disenrollment of 18,018 by the time the proposal matures, representing 2.5% of the Medicaid expansion population.

In Cuyahoga County alone, it is estimated that nearly 30 percent of the expansion population will have to go through some level of appraisal by a county case worker before eligibility is granted. This new

[16] https://www.obm.ohio.gov/Budget/monthlyfinancial/doc/2017-07_mfr.pdf
[17] http://www.cleveland.com/metro/index.ssf/2017/01/ohio_communities_counties_have.html
[18] https://www.communitysolutions.com/the-commission-on-infant-morta/
[19] https://www.kff.org/womens-health-policy/report/medicaid-coverage-of-pregnancy-and-perinatal-benefits-results-from-a-state-survey/
[20] http://www.richmond.com/news/virginia/government-politics/general-assembly/bill-gets-bigger-in-revised-analysis-of-medicaid-work-requirement/article_882a5762-d57d-5edb-b6e4-ff079ace7b38.html
[21] https://www.rollcall.com/news/politics/medicaid-kentuckyv
[22] http://www.philly.com/philly/business/pa-human-services-head-cites-expense-of-forcing-medicaid-recipients-to-get-jobs-20180306.html

process, which subverts the efficiency of the current, data-driven system to one that is more dependent on human activity, will increase the variable costs of the state and county governments as well as the providers who rely on eligibility to ensure predictable revenue cycles. Cuyahoga County, in fact, has testified that this activity of appraisal and adjudication will increase their costs in the millions. In its calculations, Ohio does not contemplate the cost of administration on the state or local level. The state also foregoes including how the increase in uncompensated care may increase disproportionate share payments to hospitals, which is also a Medicaid expense. This information is critical to develop a complete understanding of the cost of the new eligibility system for the purposes of calculating budget neutrality, a legal requirement of 1115 Demonstration Waivers.

Beyond budget neutrality, the state should explain how this mandate complies with current Ohio Revised Code §5162.70(B)(1) which mandates the Director to "implement reforms… that limit the growth in per recipient per month cost of the Medicaid program."[23] As noted by the Joint Medicaid Oversight Committee's independent actuary, Medicaid expansion has a deflationary impact on all populations who are considered in this calculation.[24] With the state's estimates showing that the per member cost of the population increasing with the implementation of the waiver, this will likely increase the overall per member cost of the program, thus creating a conflict in Ohio law.

OUTCOMES

In 2017, the Health Policy Institute of Ohio (HPIO) developed a Health Value Dashboard,[25] a document that compares Ohio against other states in terms of outcomes and spending to arrive at a score denoting the "value" of Ohio's healthcare delivery system. Overall, Ohio ranks near the bottom in outcomes and is below average in terms of spending, leaving the state 46 out of 50. While Ohio is ranked high in terms of access (17), mainly due to the expansion of Medicaid, it ranks lower in a number of metrics on the clinical, social and physical levels.

This proposal, in total, will diminish Ohio's achievement in value. First, access will be diminished, pushing Ohio's ranking lower. Beyond that, as noted throughout the HPIO document, many of the social determinants of health, such as access to housing and food, will be harmed. As noted in Ohio's independently developed review of the expansion, enrollees were better able to access food, afford housing and saw their medical debt reduced significantly.[26] If coverage is compromised in any way, or requires individuals to more actively validate their need through governmental process, it will increase the likelihood of disenrollment by enrollees who would then have the economic freedom to address other, basic needs. With the loss of coverage for primary care, individuals who had transitioned their utilization patterns to primary care settings will revert to relying on emergency departments for their routine needs. This will not only mean that issues will be addressed in a fragmented and emergent way, but that spending on these services will increase as former enrollees transition to high-cost settings.

[23] http://codes.ohio.gov/orc/5162.70
[24] http://www.jmoc.state.oh.us/assets/meetings/Ohio%20JMOC%20SFY%202018-2019%20Biennial%20Projection%20Report_2016.10.12.pdf
[25] http://www.healthpolicyohio.org/wp-content/uploads/2017/07/2017Dashboard_FullWithAppendix.pdf
[26] http://medicaid.ohio.gov/portals/0/resources/reports/annual/group-viii-assessment.pdf

ECONOMIC MOBILITY

The new direction of CMS towards waivers stresses the importance of the link between employment and overall health. Indeed, CMS is correct that access to employment has a strong correlation to good health.[27] However, the hypothesis put forward by the state inverts the traditional relationship of coverage and economic mobility.

"Job lock" is a policy concept built on the premise that the design of entitlements, including Medicaid, provide a disincentive for people to work or find employment that may compromise their eligibility. In other words, if a benefit is lost as income grows, what is the incentive to grow income? While this argument is logical, evidence suggests this concept is inaccurate. Specifically, as recent data from the National Bureau of Economic Research (NBER) shows, Medicaid expansion incentivizes individuals to pursue additional economic opportunities.[28] What's more, longitudinal statistics show that access to coverage, even from the inception of the Medicaid program in 1965, has been one of the most influential factors in creating economic mobility for individuals in poverty, with children seeing tremendous, sustainable gains in income and educational achievement, long term.[29]

Beyond this research, it may be important to understand the role that the expansion has played in Ohio as a driver of economic growth. Ohio's history in terms of gross domestic product is traditionally defined by its connections to agriculture and manufacturing. However, in recent years, more and more growth in employment and economic output has been tied to the healthcare industry, with the sector accounting for largest job growth of any industry according to the Ohio Department of Development.[30] Beyond healthcare, nearly 40 percent of individuals who work in agriculture receive their regular source of coverage through Medicaid, Medicare or the Children's Health Insurance Program.[31] As Medicaid expansion represents nearly $6 billion each year in economic activity, the potential loss of coverage translates to an artificial depression of the direct and indirect economic activity, potentially leading to job loss in the healthcare sector (and beyond) leading to higher costs for employer sponsored insurance due to likely cross-subsidization from increases in uncompensated care.

CONCLUSION

In every facet of waiver evaluation put forward by CMS, the state's proposal fails. Importantly, beyond the merits of testing the connections between eligibility and work, it is unlikely that there will be sufficient supports to connect enrollees to community engagement opportunities to remain compliant. The proposal also severely lacks detail in regards to administrative process and cost. While the state has created a number of exemptions they feel accommodate the realities of the expansion group, it does not provide the mechanics of their calculations nor does it contemplate the cost to local governments in that administration. There are also a number of legal considerations that have not been fully explored, including the potential to implement policy inconsistent with the Civil Rights and Social Security Acts. In sum, this proposal will diminish access, increase the costs to government, and will do nothing to promote the health of enrollees.

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[27] https://www.rwjf.org/en/library/research/2012/12/how-does-employment--or-unemployment--affect-health-.html

[28] http://www.nber.org/papers/w22540

[29] https://www.irp.wisc.edu/publications/focus/pdfs/foc332f3.pdf

[30] https://development.ohio.gov/files/research/E1001.pdf

[31] http://www.choicesmagazine.org/choices-magazine/submitted-articles/health-insurance-and-national-farm-policy

COMPARING OHIO'S PROPOSAL TO CMS WAIVER EVALUATION CRTIERIA

1115 Demonstration Waiver Evaluation Process	
Current CMS Guidelines	Proposal Impact
Improve access to high-quality, person-centered services that produce positive health outcomes for individuals	The proposal will decrease access, particularly for minority populations and those with Substance Use Disorders.
Promote efficiencies that ensure Medicaid's sustainability for beneficiaries over the long term	The increase in per member costs indicates healthier enrollees will self-select out of the program, increasing the risk pool of the population and creating a potential contradiction in state law.
Support coordinated strategies to address certain health determinants that promote upward mobility, greater independence, and improved quality of life among individuals	While the state is asking for supports to assist with community engagement, federal match is unlikely to be available. Evidence nationally and in Ohio shows coverage creates more economic mobility and less dependence on governmental supports.
Strengthen beneficiary engagement in their personal healthcare plan, including incentive structures that promote responsible decision-making	This policy does not address this at all, but does require some level of engagement with providers and county case managers who have connections to work and community engagement supports. The requirement, however, is designed more as a disincentive, as opposed to an incentive, as coverage is currently more available when compared to the proposal.
Enhance alignment between Medicaid policies and commercial health insurance products to facilitate smoother beneficiary transition	There is nothing in this outline other than encouraging employment for members, though it is likely many are in low-income and/or seasonal positions without access to employer sponsored insurance.

RECOMMENDATIONS & QUESTIONS

Pursuant to federal law, we would like to have responses from the Ohio Department of Medicaid to the following questions and recommendations included in their submission to the Department of Health and Human Services:

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

QUESTIONS

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 individuals on 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?

Comments and questions about this edition may be sent to lanthes@communitysolutions.com
1501 Euclid Ave., Ste. 310, Cleveland, OH 44115
101 E. Town St., Ste. 520, Columbus, OH 43215
P: 216-781-2944 // F: 216-781-2988 // www.CommunitySolutions.com