



OHIO SENATE DEMOCRATIC CAUCUS

Director John McCarthy
Bureau of Health Plan Policy
Ohio Department of Medicaid
50 W. Town St. 5th Floor
Columbus, Ohio 43218

May 16, 2016

RE: Healthy Ohio Program 1115 Demonstration Waiver

Dear Director McCarthy,

We, the Ohio Senate Democratic Caucus, write in strong opposition to the “Healthy Ohio Program” 1115 Demonstration Waiver and to the underlying statutory language enacted through H.B. 64, the most recent state operating budget. Requiring premiums, Health Savings Account (HSA) style funding, and various administrative hoops will move the Medicaid program in the wrong direction by decreasing healthcare access while increasing financial burdens placed upon the program.

Both Ohio and the nation have seen great change in the delivery of healthcare since the passage of the Patient Protection and Affordable Care Act. In Ohio, that change has included expanding the Medicaid program to cover those in the so-called group VIII, those Ohioans earning no more than 138% of the federal poverty level. The growth and reform of the program has also come with increased legislative oversight, primarily through the passage of S.B. 206 of the 130th General Assembly which established the Joint Medicaid Oversight Committee. The creation of the committee established specific goals for the Medicaid program including cost containment, value and result in services provided, and “[improving] the physical and mental health of [M]edicaid recipients[.]”¹

Unfortunately, this work has not succeeded in sufficiently informing members of the General Assembly of the challenges facing the covered population or how proposals like the “Healthy Ohio Program” will roll back prior progress and undermine ongoing efforts for reform. It is ironic that the first several pages of the waiver discuss the progress made to date on patient

¹ Ohio Rev. Code § 5162.70(B).

choice, comprehensive primary care, and rewarding quality over quantity, all while providing healthcare access to hundreds of thousands of Ohioans for the first time—while subsequent pages propose a program which will undermine that progress.

This comment will review: first, the burden of premiums and cost sharing and second, unrealistic and harmful administrative burdens from the plan.

We support the valuable and well-informed opposing comments already submitted on this matter and want to add our voice to theirs, particularly regarding the barriers of premium contributions and the problems with the Buckeye Accounts as an HSA-style of financing.

Burden of Premiums and Cost Sharing

Requiring premium payments through HSA contributions, including those with no income, is counter to the mission of the Medicaid program and will impede access to care. The plan requires participants to pay \$99 or 2% of their income, whichever is less. Though this is a small monthly amount, there is simply no room in the average budget of an individual or family near or below the poverty line. The stress of daily living at or especially below the poverty level is exceedingly difficult. The premiums required under the waiver are callous to this reality and will “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” harm the Medicaid population.² The budget neutrality of the plan relies upon individuals falling off Medicaid rolls and state officials recognize that approximately 130,000 individuals will lose coverage under the plan.³ If these individuals are dropped, it could be a direct conflict with the intent of Senate Bill 206.

Styled as “Buckeye Accounts” in the proposal, the plan establishes a \$1,000 state contribution along with the required individual contribution described above. While participants can use their own contributions for non-covered services such as over-the-counter medication, the state share will be used to pay for covered expenses similar to a deductible. They can also earn contributions through a point system by the Medicaid system or by a primary care provider. This is described as a means for participants to have “skin-in-the-game,” but there is insufficient

² The Center for Community Solutions, headed by former Ohio Medicaid director John Corlett, quoted in the Dayton Daily News, “Low Income Ohioans On Medicaid May Face Premiums” Bischoff, Laura, April 26, 2016.

<http://www.daytondailynews.com/news/news/low-income-ohioans-on-medicaid-may-face-premiums-a/nrBcc/>

³ State officials project about 15 percent of Medicaid enrollees would lose coverage through failure or refusal to shoulder some of their health care costs, making Ohio the first state in the nation to remove people at or below 100 percent of the federal poverty level from Medicaid for failing to pay premiums. “Tens of Thousands of Ohioans could lose Medicaid coverage under fee proposal,” The Columbus Dispatch Candisky, Candace, April 7, 2016.

<http://www.dispatch.com/content/stories/local/2016/04/07/proposed-medicaid-requirements-could-mean-650000-will-lose-health-coverage.html>

evidence that onerous payment requirements or incentive points will influence behavior or health in a way that is at all worth the hardship to the program and individuals.

Health Savings Accounts generally have been shown to be problematic for lower income individuals. “These increased out-of-pocket costs are particularly burdensome for lower-income families because they have less disposable income. If a medical condition or illness goes untreated because individuals are unable to pay for appropriate care out-of-pocket, their health could decline further, forcing them to make greater use of expensive services like hospitalization in the future.”⁴ The structure further discourages use of care by allowing individuals to roll-over unused portions to future years. Someone highly concerned about accessing care in an emergency or for a severe condition may be incentivized to delay or ignore more routine care.

The nature of income for those within the covered population increases the likelihood of churn and periods of ineligibility. Approximately 55% of those covered by Medicaid are employed, but do not earn enough to be above the eligibility level.⁵ Those with fluctuating incomes would need to seek frequent redeterminations for the payment to be accurate or risk losing coverage when income wanes and payments become difficult. Many covered by Medicaid depend on their healthcare to keep working.⁶ Churn is bad for costs, bad for health, and bad for the job readiness of the Medicaid-eligible population.

The lack of details on how the incentive points will be awarded is also concerning. How will equal access to these much needed supplemental funds be guaranteed to both those who are relatively healthy and needing to engage in few new healthy behaviors, and those with many circumstances that require such intervention? Is there sufficient access throughout the state to the types of programs that will be rewarded? For providers, will there be supplemental reimbursement for the time spent determining points awards? How will the program be structured to mitigate against biases among providers?⁷

⁴ Center on Budget and Policy Priorities, “A brief overview of the major flaws with health savings accounts,” April 5, 2006. <http://www.cbpp.org/sites/default/files/atoms/files/hsa-overview.pdf> Higher income tax filers were also more likely to report HSA activity. U.S. GAO “Health Savings Accounts: Participation Increased and Was More Common Among Individuals with Higher Incomes GAO-08-474R, April 1, 2008.

<http://www.gao.gov/products/GAO-08-474R>

⁵ Joel Potts, JMOC Testimony, October 15, 2015.

http://www.jmoc.state.oh.us/Assets/documents/Potts_Presentation_Oct15_2015.pdf

⁶ See for example, Cheri L. Walter *Testimony before the Senate Finance Medicaid Sub-Committee*, pg. 2 (May 2, 2013) discussing how those with mental illness suffer disproportionately when loss of medical care affects overall stability including ability to maintain or seek employment.

⁷ See for example: “Could Doctor Bias Be Affecting Your Treatment?” Hayes, Ashley Jan. 13, 2016.

<http://www.webmd.com/news/20160113/doctor-bias-treatment> And “Medscape Lifestyle Report 2016: Bias and Burnout” Peckham, Carol Starting at Slide 6, January 13, 2016.

<http://www.medscape.com/features/slideshow/lifestyle/2016/public/overview>

Unrealistic and harmful administrative burdens

The implementation of the program and operation of the debit card/eligibility system poses additional burdens. Recent experiences in Ohio, detailed below, support the conclusion that implementing this system will be difficult and that the hardship will likely be felt by patients and front-line staffers often at the county level.

First, over the last few years, Ohio has been transitioning to a new eligibility system. Launched first for Medicaid – with the intent to expand to all benefits programs – is a critical modernization of the system. The goal of the Ohio Benefits system is to unify eligibility determination for all public assistance programs, including SNAP and TANF, allow more flexible access online, and ideally reduce hands-on time caseworkers spend on basic eligibility issues to move towards productive case management. The original goal for full implementation was by December 2015; this has been pushed back to July 2017. We are thus still operating with two systems where information must be manually transferred. In testimony to the Joint Medicaid Oversight Committee, Joel Potts of the Ohio Job and Family Services Directors Association notes that 70 to 80% of people are in both systems and 98% of the cases still need hands-on casework.⁸ These delays and problems are not the fault of any one person or office and include federal, state, and local difficulties; but it is the reality into which the “Healthy Ohio Program” would add further complications.

Second, adding complications to the eligibility process will also place an additional burden on recipients. After the federally required year of no redeterminations when the process began again in early 2015, more than 200,000 individuals were removed from the Medicaid rolls, which is more than a third of those who went through the redetermination in the first quarter.⁹ Some difficulties with redetermination were expected, but ultimately more than 150,000 individuals were reinstated as part of a settlement of a suit challenging the redetermination process.¹⁰ Many of the problems were related to flaws in the computer system not allowing “passive” redeterminations wherein the state uses available records to automatically re-determine eligibility.¹¹ It is likely that the additional eligibility criteria related to the “Healthy Ohio Program” will further complicate eligibility determination and further burden the technology systems that support it.

⁸ Joel Potts, JMOC Testimony, October 15, 2015.

http://www.jmoc.state.oh.us/Assets/documents/Potts_Presentation_Oct15_2015.pdf

⁹ “State reaches settlement with some Medicaid recipients” Columbus Dispatch, Candisky, Catherine, May 7, 2015. <http://www.dispatch.com/content/stories/local/2015/05/06/state-medical-settlement.html>

¹⁰ “More than 150,000 Ohioans to get Medicaid again after settlement” Columbus Dispatch, Candisky, Catherine, May 12, 2015. <http://www.dispatch.com/content/stories/local/2015/05/12/medicaid-settlement-details.html>

¹¹ Id.

Currently, the state is also engaged in a behavioral health redesign with any aggressive timeline for including behavioral health within managed care and for improving overall access.¹² It appears that those involved in this work are the same offices and individuals who will have a role in running the “Healthy Ohio Program.” These are highly qualified and dedicated individuals, but there simply is a limit to what can be done at any one time. Both the continued overhaul of the eligibility system and the behavioral health redesign are large scale projects that can bring a concrete benefit to the Medicaid program. Their success and timing should not be jeopardized by creating further administrative burdens through authorization of the “Healthy Ohio Program.”

Important work has been done and is being done to modernize and improve the Medicaid program and public assistance eligibility system. It would be unfortunate to jeopardize those efforts by adding the unwieldy and ill-conceived requirements of the “Healthy Ohio Program.”

Conclusion

We urge the rejection of the “Healthy Ohio Program” 1115 Waiver. While we recognize that the language is largely proscribed in statute, it is important to highlight how this plan is misguided and will harm Ohioans and the program alike. Hopefully, as the continued benefits of healthcare access and modernization of payment and delivery systems occur, the legislature will no longer engage in imposing restrictions that reduce costs by reducing access. The Medicaid program should instead be able to focus on its core mission: providing essential health services to lower income Ohioans with programs that are high quality and cost-effective.

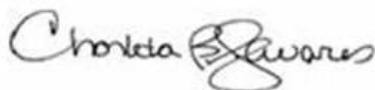
We include with this letter messages from our constituents objecting to the waiver. Thank you for your consideration.



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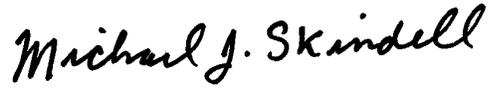


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¹² Presentation, Behavioral Health Redesign Timeline, McCarthy, John, Joint Medicaid Oversight Committee, September 17, 2015. <http://www.jmoc.state.oh.us/Assets/documents/TimelineUpdate-McCarthy.pdf>



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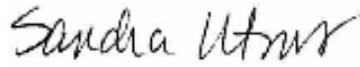
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