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CMS's Denial of Proposed Changes to Medicaid Expansion in Ohio

In January, 2014, Ohio implemented a traditional Medicaid expansion, according to the terms set out in the Affordable Care Act. Subsequently, the operating budget passed by the state legislature in June, 2015 required Ohio to seek specific changes to its existing expansion by applying for a Section 1115 demonstration waiver. On June 15, 2016, the state submitted its waiver proposal, called the Healthy Ohio Program, to the Centers for Medicare and Medicaid Services (CMS), and on September 9, 2016, CMS denied the waiver application.

This is the first time that CMS considered a waiver application in a state that already had implemented a traditional expansion and the first time that CMS has denied a Medicaid expansion waiver application. Waiver applications in other states that already have implemented traditional expansions (Arizona and Kentucky) remain pending with CMS. CMS's decision about Ohio's waiver application may offer insights into how the agency might respond to similar requests from other states.

Ohio's proposed waiver asked for authority to implement a number of changes that would have altered the terms of coverage for Medicaid expansion adults as well as some traditional Medicaid adults, such as non-expansion parents and pregnant women. Specifically, Ohio's proposal would have:

- Created health savings accounts, which would have been used to pay a $1,000 annual deductible (funded by the state) and copayments at maximum state plan amounts (funded by beneficiary contributions);
- Imposed monthly premiums, equal to the lesser of 2 percent of annual income or $99 per year, as a condition of eligibility for all beneficiaries except pregnant women and those with zero income;
- Conditioned the start of coverage on payment of the first monthly premium;
- Disenrolled beneficiaries from coverage for failing to pay monthly premiums or for failing to provide requested renewal documentation after 60 days;
- Established a healthy behavior program; and
- Referred all beneficiaries working fewer than 20 hours per week to a workforce development agency.

Ohio also sought to waive the statutory obligation to provide a fair hearing to people who were never enrolled in coverage due to non-payment of their initial monthly premium or who were disenrolled from coverage due to non-payment of subsequent premiums. The fair hearing provision has never been waived by CMS. Additionally, fair hearings are required by the Due Process Clause of the U.S. Constitution, which is outside the Secretary's Section 1115 waiver authority.

Ohio also proposed to increase copayments for expansion and traditional adults affected by the waiver to the maximum amounts allowable under federal law; such increases do not require waiver authority to implement.

CMS's denial of Ohio's waiver application cited several areas of concern. In response to the state's proposal to charge monthly premiums for all expansion adults as well as traditional Medicaid populations, CMS stated that it was "concerned that these premiums would undermine access to coverage and the affordability of care, and do not support the objectives of the Medicaid program." CMS also concluded that the state's proposal to exclude individuals from coverage indefinitely until all arrears were paid "would not support the objectives of the Medicaid program, because it could lead to a substantial population without access to affordable coverage."

CMS noted that Ohio's existing traditional expansion has been successful and that the state's waiver application estimated that policy changes under the proposal "would lead to over 125,000 people losing coverage each year" compared to the current expansion. Since affordable coverage options became available through the Medicaid expansion and the Marketplace, Ohio's nonelderly adult uninsured rate fell from 16.3% in 2013 to 9.3% in 2015, and over 607,000 adults in Ohio have obtained coverage through the Medicaid expansion as of December 2015.

While Section 1115 waivers typically involve negotiation between CMS and the state, Ohio's waiver application indicated that it was unable to modify its terms due to the state law that required it to seek the waiver. Similarly, the state indicated that it could not change the proposal in response to public comments. The state reported that 84% of the public comments it received indicated that the waiver would be unaffordable for beneficiaries, and 72% indicated that the waiver would result in decreased enrollment. State level public comment also noted the program's complexity, with 65% indicating that the program would be too complex for beneficiaries, 55% indicating that the program would be administratively complex for the state and health plans, and 53% indicating that the program would be administratively burdensome for providers. The waiver application indicated that only 1% of state level public comments received supported the proposal.

Table 1 describes the major elements of Ohio's proposed Section 1115 demonstration as submitted to and denied by CMS.

Table 1: Ohio's Proposed Section 1115 Medicaid Expansion Demonstration Waiver (Denied by CMS)	
Element	**Ohio Waiver Proposal**
Overview:	Would have modified the state's existing Medicaid program for both expansion adults and traditional adults by: • Creating health savings accounts with 2 components: (1) core funds comprised of monthly beneficiary contributions and incentive dollars earned by completing healthy behaviors, which would be used to fund copayments and additional services not covered by Medicaid; and (2) non-core funds consisting of a state-funded annual deductible, which would be used to pay the first $1,000 of Medicaid-covered services; • Imposing monthly contributions equal to the lesser of 2 percent of income or $99 per year as a condition of eligibility for all beneficiaries except pregnant women and those with zero income; • Conditioning the start of coverage on payment of the first monthly contribution; • Disenrolling beneficiaries from coverage for non-payment of monthly contributions or failing to provide requested renewal documentation after 60 days; • Establishing a healthy behavior program that would allow beneficiaries to earn health savings account dollars to fund copayments or medically necessary services that are not covered by Medicaid; • Allowing beneficiaries to carry forward any monthly contributions remaining in their health savings account to reduce the next year's required contributions, and any remaining healthy behavior rewards and deductible funds if certain preventive services are received; • Allowing beneficiaries who lose eligibility due to increased income to transfer remaining health savings account funds into another account to pay private health insurance premiums and cost-sharing; and • Referring all beneficiaries working fewer than 20 hours per week to a workforce development agency.
Duration:	Requested 5 year approval from January 1, 2018 to December 31, 2022.
Coverage Groups Required to Enroll in Waiver:	Would have included all adult Medicaid beneficiaries age 18 and older who qualify for the ACA's Medicaid expansion and those who qualify through other poverty-related pathways, including Section 1931 parent/caretakers; Transitional Medical Assistance; 18, 19 and 20 year olds; pregnant women; Title IV-E 18 year olds; former foster care youth ages 18 to 26; and breast/cervical cancer beneficiaries. These beneficiaries must have enrolled in Healthy Ohio even if they also qualify for home and community-based waiver services.
Monthly Contributions:	Would have imposed monthly contributions for all beneficiaries (except pregnant women and those with zero income) equal to the lesser of 2 percent of annual household income or $99 per year (up to $8.25 per month). Beneficiaries would have accrued debt for any months in which they received coverage but failed to make a monthly contribution. Employers could have contributed up to 50% of a beneficiary's required contributions, and not-for-profit organizations could have contributed up to 75%; however, beneficiaries must have paid at least 25% of the total required contribution.

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Element	**Ohio Waiver Proposal**
Effective Coverage Date:	Would have conditioned the start of coverage on payment of the initial monthly contribution, with coverage effective the first day of the month in which the payment is made instead of the application date. Coverage for pregnant women and individuals with no income would have begun on the first day of the month in which their application was approved. Also would have waived 3 months retroactive coverage for most adults (except pregnant women).
Disenrollment for Failure to Provide Renewal Documents:	Would have disenrolled beneficiaries who did not submit requested documentation to renew coverage within 61 days. Individuals could have re-enrolled if they did not have outstanding debt from unpaid monthly contributions.
Disenrollment for Failure to Make Monthly Contributions:	Monthly health savings account contributions would have been a condition of eligibility, and beneficiaries who did not pay within 60 days will be dis-enrolled. Individuals could have re-enrolled only after paying debt owed.
Health Savings Accounts:	Beneficiary/core portion of account: Beneficiaries' required monthly contributions (described above) would have gone into the core portion of the account and would have been used for copays and medically necessary services not included in the Medicaid benefit package. These contributions would have belonged to the beneficiary and would have been refunded upon termination from waiver coverage (or if eligible, transferred to a Bridge Account, as described below). Any dollars earned from healthy behavior incentives (described below) also would have gone into the core portion of the account. State/non-core portion of account: The state would have contributed $1000 annually to the non-core portion of the account to fund initial healthcare expenses, similar to a deductible, until these funds were depleted. MCO account contributions: MCOs could have contributed to beneficiary health savings accounts to pay the cost of participation in health-related incentive programs, such as smoking cessation or weight loss. Account statements: Beneficiaries would have received monthly account statements showing their account activity, balances, and contributions. Account roll-over funds to reduce future monthly contributions: Beneficiaries could have carried forward any remaining funds from beneficiary or third party monthly contributions in the core portion of their account to the next year, which could have been used to reduce or eliminate future monthly contributions. The total account value, including any roll-over funds, is limited to $10,000.
Co-Payments:	Copayments would have been at maximum state plan amounts and would have been paid at the point of service from the core portion of the health savings account via an MCO-issued debit card. Pregnant women were exempt from copayments. Copayments would have been waived once funds in the core portion of the beneficiary's health savings account (from monthly contributions and healthy behavior incentives) was exhausted.

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Healthy Behavior Program:	Healthy behavior incentive points and activities: Beneficiaries could have earned up to 320 points per year in the core portion of their health savings account for achieving specific healthcare goals or benchmarks. Each point would have been equivalent to one dollar. Providers could have awarded up to 100 points, and the state could have awarded up to 200 points. Standards for awarding healthy behavior points would have been further detailed prior to waiver implementation and may have included completion of a smoking cessation or weight management program, adherence to a prescription drug regimen, or other activities. In addition, beneficiaries who established an electronic funds transfer (EFT) to automatically make their monthly account contributions could have earned 20 points; however, these points would have been deducted if the beneficiary terminated the EFT. Use of healthy behavior incentive funds: Like monthly account contributions, funds earned by healthy behavior points could have been used for copayments or qualifying medically necessary services that are not covered by Medicaid, such as over-the-counter medications. Such additional services would have been defined annually by the state. Account roll-over funds for completing preventive care: Beneficiaries who obtained recommended preventive services could have carried forward all remaining health savings account funds, including any core funds from healthy incentive points and any non-core balance from the state-contributed deductible, to the following year. Carried over core funds (healthy behavior incentives) could have been used to reduce future monthly contributions. Carried over non-core (deductible) funds would have been added to the following year's deductible funds. Specific preventive services would have been determined by the state annually based on CDC recommendations. (As described above, beneficiaries could have carried forward any core account funds remaining from monthly contributions to reduce future contributions regardless of whether preventive services were completed.)
Bridge Account:	Beneficiaries who left Medicaid as a result of increased income could have transferred their entire health savings account balance (core and non-core funds) into a Bridge Account, which could have been used to pay premiums and cost-sharing for employer-sponsored or individual market private insurance. Those who regained Healthy Ohio eligibility before exhausting their Bridge Account would have had the balance transferred back to a health savings account under the waiver.
Delivery System:	Benefits would have been delivered through a statewide mandatory capitated managed care program under § 1115 authority, which would have been separate from the state's existing § 1915(b) managed care system for other coverage groups. Would have offered choice of at least 2 MCOs per region.
Benefits:	Expansion adults would have continued to receive an alternative benefit plan that contained the same benefits as the Medicaid state plan; however, expansion adults would have continued to be exempt from the state plan limits on mental health and long-term care services. Traditional adults would have continued to receive the Medicaid state plan benefit package, which includes limits on mental health services and 90 days of long-term care coverage (after which they would have transferred to fee-for-service Medicaid). Behavioral health services (which are carved out of the state's existing managed care program) would have been included in the MCO benefit package under the waiver. Home

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	and community-based waiver services would continue to have been carved out of managed care and paid fee-for-service.
Annual and Lifetime Limit:	After the non-core health savings account funds ($1,000 state-funded annual deductible) was depleted, MCOs would have been responsible for covered benefits up to $300,000 per year and $1,000,000 per lifetime. Beneficiaries who exceeded these limits would have been transferred to the state's fee-for-service or traditional Medicaid managed care delivery systems.
Work Referral:	Would have referred all beneficiaries who work less than 20 hours per week to a workforce development agency; however, work would not have been required as a condition of Medicaid eligibility.
Financing:	The state anticipated that the waiver would have met budget neutrality requirements and saved $995 million over the five year demonstration period. Compared to the without waiver estimates, the per member per month costs per coverage group under the waiver would have been greater, but there would have been fewer eligible member months.
Status:	CMS denied the waiver application on September 9, 2016.