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Proposed Changes to Medicaid Expansion in Ohio

Ohio implemented a traditional Medicaid expansion, according to the terms set out in the Affordable Care Act, in January 2014, after the state's Controlling Board approved the appropriation of federal matching funds. 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 have obtained coverage through the Medicaid expansion as of December 2015.

On June 15, 2016, Ohio submitted the a Section 1115 demonstration waiver application, called the Healthy Ohio Program, to the Centers for Medicare and Medicaid Services (CMS) as required by the operating budget passed by the state legislature in June 2015. The proposal includes a number of changes that would affect Medicaid expansion adults as well as traditional Medicaid adults in Ohio. The state requests that the demonstration last for five years from January 2018 to December 2022. Ohio seeks Section 1115 waiver authority to modify the state's existing Medicaid expansion and to change coverage for non-expansion parents, pregnant women, and other traditional Medicaid adults by:

- Creating health savings accounts, which would be used to pay a $1,000 annual deductible (funded by the state) and copayments at maximum state plan amounts (funded by beneficiary contributions);
- Imposing monthly contributions, 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;
- Conditioning the start of coverage on payment of the first monthly contribution;
- Disenrolling beneficiaries from coverage for failing to pay 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; beneficiaries also could carry forward any remaining healthy behavior incentive and deductible funds if certain preventive services are received;
- Allowing beneficiaries who lose eligibility due to increased income to transfer any remaining health savings account funds into a separate account to pay private health insurance costs; and
- Referring all beneficiaries working fewer than 20 hours per week to a workforce development agency.

Ohio differs from other states that have Section 1115 Medicaid expansion waivers approved to date in that Ohio already implemented a traditional Medicaid expansion without a waiver. Ohio estimates that the number of beneficiaries covered under its proposed waiver would decline (fewer eligible member months) compared to continuing current coverage without the waiver. As a result, the state anticipates $995 million in savings from

the waiver, even though the per member per month costs are estimated to be higher under the waiver, due to program features such as healthy behavior incentive dollars and account rollover funds.

Among other waiver requests, Ohio seeks to waive the statutory obligation to provide a fair hearing to beneficiaries who are never enrolled in coverage due to non-payment of their initial monthly contribution or who are disenrolled from coverage due to non-payment of monthly contributions. This 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's proposal also would increase existing copayments for expansion and traditional adults affected by the waiver. Current copayments in Ohio include $3.00 for dental services, certain prescription drugs, and non-emergency use of the emergency room; $2.00 for vision services and certain prescription drugs; and $1.00 for eyeglasses, although some managed care plans may not charge copayments. Ohio's proposal would require copayments for all beneficiaries covered by the waiver at the maximum amounts allowable under federal law: $75 for inpatient services, $4 for outpatient services and preferred drugs, and $8 for non-preferred drugs and non-emergency use of the emergency room. Ohio does not need waiver authority to implement these increased copayments.

CMS will review Ohio's waiver after the federal public comment period closes on August 7, 2016. While not commenting specifically on whether Ohio's waiver will be approved, the HHS Secretary has said that, "If we're taking steps that reduce affordability or reduce access[,] those aren't things that we will approve." While Section 1115 waivers typically involve negotiation between CMS and the state, Ohio's waiver application indicates that it is unable to modify its terms due to the state law that required it to seek the waiver. Although no changes were made to the proposal in response to state level 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. Only 1% of state level public comments received supported the proposal. Table 1 describes the major elements of Ohio's proposed Section 1115 demonstration.

Table 1: Ohio's Proposed Section 1115 Medicaid Expansion Demonstration Waiver	
Element	**Ohio Waiver Proposal**
Overview:	Modifies 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:	Requests 5 year approval from January 1, 2018 to December 31, 2022.
Coverage Groups Required to Enroll in Waiver:	Would include 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 enroll in Healthy Ohio even if they also qualify for home and community-based waiver services.
Monthly Contributions:	Would impose 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 accrue debt for any months in which they received coverage but failed to make a monthly contribution. Employers could contribute up to 50% of a beneficiary's required contributions, and not-for-profit organizations could contribute up to 75%; however, beneficiaries must pay at least 25% of the total required contribution.

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Effective Coverage Date:	Would condition 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 begin on the first day of the month in which their application was approved. Also would waive 3 months retroactive coverage for most adults (except pregnant women).
Disenrollment for Failure to Provide Renewal Documents:	Would disenroll beneficiaries who do not submit requested documentation to renew coverage within 61 days. Individuals could re-enroll if they do not have outstanding debt from unpaid monthly contributions.
Disenrollment for Failure to Make Monthly Contributions:	Monthly health savings account contributions are a condition of eligibility, and beneficiaries who do not pay within 60 days will be dis-enrolled. Individuals can re-enroll only after paying debt owed.
Health Savings Accounts:	Beneficiary/core portion of account: Beneficiaries' required monthly contributions (described above) would go into the core portion of the account and would be used for copays and medically necessary services not included in the Medicaid benefit package. These contributions belong to the beneficiary and would be 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 go into the core portion of the account. State/non-core portion of account: The state would contribute $1000 annually to the non-core portion of the account to fund initial healthcare expenses, similar to a deductible, until these funds are depleted. MCO account contributions: MCOs could contribute 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 receive monthly account statements showing their account activity, balances, and contributions. Account roll-over funds to reduce future monthly contributions: Beneficiaries could carry forward any remaining funds from beneficiary or third party monthly contributions in the core portion of their account to the next year, which could be 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 be at maximum state plan amounts and would be paid at the point of service from the core portion of the health savings account via an MCO-issued debit card. Pregnant women are exempt from copayments. Copayments would be waived once funds in the core portion of the beneficiary's health savings account (from monthly contributions and healthy behavior incentives) is exhausted.

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

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Annual and Lifetime Limit:	After the non-core health savings account funds ($1,000 state-funded annual deductible) are depleted, MCOs are responsible for covered benefits up to $300,000 per year and $1,000,000 per lifetime. Beneficiaries who exceed these limits would be transferred to the state's fee-for-service or traditional Medicaid managed care delivery systems.
Work Referral:	Would refer all beneficiaries who work less than 20 hours per week to a workforce development agency; however, work is not required as a condition of Medicaid eligibility.
Financing:	The state anticipates that the waiver would meet budget neutrality requirements and save $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 be greater, but there would be fewer eligible member months.
Next Steps:	The federal comment period closed on August 7, 2016. The waiver is under review with CMS.