

Comments Opposing Group VIII Work Requirements and Community Engagement 1115 Wavier

Submitted to:

Bureau of Health Plan Policy
Ohio Department of Medicaid
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By

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Ohio's Section 1115 Request for a Waiver to Impose Work-Related Requirements as Eligibility Criteria for Medicaid Must Be Rejected

As proposed, the waiver request is contrary to federal law, undermines the very purpose of Medicaid and fails completely to comply with the criteria for approving Medicaid waivers set forth in Section 1115(A) of the Social Security Act. In summary,

Point 1. The proposed work requirements in Ohio's Section 1115 waiver request are completely contrary the federal law. Section 1115(A) of the Social Security Act sets forth criteria for approving Medicaid waivers designed to develop cost effective five-year demonstration models for enhancing health care services for the poor. There are no provisions in Section 1115(A) encouraging states to save health care costs by kicking poor Ohioans off Medicaid. There is nothing that mentions the imposition of work-related eligibility requirements as a possible means of enhancing health care coverage for poor adults. Ohio's waiver request does not even propose an innovative model for enhancing health care or explain how work-related requirements have much to do with either the quantity of quality of health care.

Ohio's waiver request estimates that 18,018 poor Ohioans, currently eligible for Medicaid, would be denied coverage in State Fiscal 2019 alone, a result diametrically opposed to purpose of waivers in Section 1115(A). Projected over a five-year demonstration period, 90,090 Ohioans who meet the current eligibility standards for Medicaid would be shut out of health care coverage. As we will discuss below, the difficulty of meeting compliance requirements would cause substantially more adults to lose eligibility for health care coverage.

Point 2. Ohio's Section 1115 waiver request, contrary to federal law, would essentially replace Medicaid Expansion, a program that provides health care coverage for poor adult Ohioans with the creation of a new federal welfare program. The waiver request provides no explanation of how work-related eligibility requirements would improve health care. In fact, there is no discussion

of innovative health care models at all. The Secretary of HHS has no legal authority to approve a waiver that establishes a new program by imposing arbitrary requirements as a condition for health care.

Point 3. The inevitable confusion, miscommunication and misunderstanding over compliance with work-related requirements emerges as a blueprint for denying Medicaid coverage to a substantial portion of poor Ohioans who meet the eligibility requirements for Medicaid under current law. Compliance with the work-related requirements and the numerous exemption categories in Ohio's 1115 waiver request has nothing to do with improving health care habits or health care services to poor Ohioans.

Ohio's waiver request is a reflection of fierce, longstanding opposition of the Expansion program by the majority party in the Ohio General Assembly. The waiver request is clearly not based on any tangible results of Medicaid Expansion in Ohio. (See the following summary point).

Point 4. Ohio's 1115 waiver request is contrary to the results of a study commissioned by the Ohio General Assembly and conducted by the Ohio Department of Medicaid. The study assessed the effects of Medicaid Expansion on the state's 709,000 enrollees. Its findings confirmed the consensus opinions of the medical community, namely that Medicaid Expansion improved the health care for poor Ohioans, and reduced the financial burden on rural clinics hospitals and cut the number emergency room visits.

The Imposition of work related requirements would clearly threaten the improvements in health care delivery for poor Ohioans, which is completely contrary to the purpose of Medicaid and to Section 1115(A) of the Social Security Act. According to its own estimate, as noted, approval of the waiver request could cause as many as 90,090 poor Ohioans to be denied Medicaid coverage over the course of the five-year demonstration. The difficulty of keeping up with

compliance requirements would cost substantially more Ohioans to lose their health care coverage.

Detailed Argument

Point 1. The proposed work requirements in Ohio's Section 1115 waiver request are completely contrary the federal law. Section 1115(A) of the Social Security Act sets forth criteria for approving Medicaid waivers designed to develop cost effective five-year demonstration models for enhancing health care services for the poor. There are no provisions in Section 1115(A) encouraging states to save health care costs by kicking poor Ohioans off Medicaid. There is nothing that mentions the imposition of work-related eligibility requirements as a possible means of enhancing health care coverage for poor adults. Ohio's waiver request does not even propose an innovative model for enhancing health care or explain how work-related requirements have much to do with either the quantity of quality of health care.

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Section 1115(A) of the Social Security Act states:

There is created within the Centers for Medicare & Medicaid Services a Center for Medicare and Medicaid Innovation (in this section referred to as the "CMI") to carry out the duties described in this section. The purpose of the CMI is to test innovative payment and service delivery models to reduce program expenditures under

the applicable titles while preserving or enhancing the quality of care furnished to individuals under such titles. In selecting such models, the Secretary shall give preference to models that also improve the coordination, quality, and efficiency of health care services furnished to applicable individuals defined in paragraph (4)(A).

Under “Selection of Models to be Tested,” the law stipulates that the Secretary of Health and Human Services “shall select models to be tested from models where the Secretary determines that there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures.” The numerous examples that follow cite such models as:

- Expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible;
- Providing services not typically covered by Medicaid; or
- Using innovative service delivery systems that improve care, increase efficiency, and reduce costs.

There is absolutely no suggestion that a waiver request that would save health care costs by kicking thousands of poor Ohioans out of the Medicaid Expansion program would come close to meeting the criteria approval under Section 1115(A) of the Social Security Act. Clearly, Ohio’s request for a waiver to impose work requirements as a condition for Medicaid eligibility violates Section 1115(A) of the Social Security Act. because **it would result in the denial of Medicaid coverage for thousands of poor Ohioans who are currently eligible for health care coverage under Medicaid.**

How do we know that? The text of the waiver request says so. Ohio’s 1115 waiver request estimates that the imposition of Work requirements will cost 18,018 poor adults their Medicaid eligibility in SFY 2019 alone. The estimated loss of Medicaid for thousands of Ohio’s in year one of the program provides sufficient grounds for rejecting Ohio’s waiver request as contrary to federal law. Using the state’s own projections,

90,090 poor Ohioans would be denied health care through Medicaid over the five-year life of the proposed demonstration.

Opponents of the waiver will show that the estimated number of poor Ohioans shut out of Medicaid will be substantially higher. At the same time there is no discussion of how the waiver would enhance health care or make health care more cost effective without reducing the quality of health care services. Ohio's 1115 waiver request fails completely to meet the basic purpose of Medicaid, which is to provide "medical assistance" to individuals "whose income and resources are insufficient to meet the costs of necessary medical services."

Point 2. Ohio's Section 1115 waiver request, contrary to federal law, would essentially replace Medicaid Expansion, a program that provides health care coverage for poor adult Ohioans with the creation of a new federal welfare program. The waiver request provides no explanation of how work-related eligibility requirements would improve health care. In fact, there is no discussion of innovative health care models at all. The Secretary of HHS has no legal authority to approve a waiver that establishes a new program by imposing arbitrary requirements as a condition for health care.

The imposition of work requirements completely transforms Medicaid Expansion from a health care coverage program for poor adults into a new type of welfare program. Medicaid, unlike SNAP and TANF and other federal assistance programs does not provide a defined monthly benefit. Medicaid functions as a form of health insurance, allowing participants to receive medical services when the need arises.

The Secretary of HHS has the authority to approve Medicaid waiver requests under Section 1115(A) but does not have the authority to approve eligibility requirements that create a new type of welfare program that is essentially different from Medicaid Expansion. The demonstration project outlined in Ohio's 1115 waiver request

would do just that and must be rejected as contrary to federal law. The waiver request, explicitly proposes to “align” Medicaid work requirements with work requirements attached to its SNAP and “ABAWD” (Able Bodied Adults without Dependents) policies. The waiver request thereby announces its intention to transform Medicaid Expansion from a vehicle for providing health care coverage to poor adults into a welfare program.

Point 3. The inevitable confusion, miscommunication and misunderstanding over compliance with work-related requirements emerges as a blueprint for denying Medicaid coverage to a substantial portion of poor Ohioans who meet the eligibility requirements for Medicaid under current law. Compliance with the work-related requirements and the numerous exemption categories in Ohio’s 1115 waiver request has nothing to do with improving health care habits or health care services to poor Ohioans.

Ohio’s waiver request is a reflection of fierce, longstanding opposition of the Expansion program by the majority party in the Ohio General Assembly. The waiver request is clearly not based on any tangible results of Medicaid Expansion in Ohio. (See Point 4).

It is telling that Ohio’s waiver request only discusses the impact of its proposed demonstration on Medicaid enrollees in the first year of the five-year demonstration. It is already clear that a projected loss of Medicaid coverage for some 18,018 poor adults is contrary to the legal criteria for granting state waivers in Section 1115(A) of the Social Security Act. By focusing entirely on SFY 2019, the waiver request fails to reveal the full extent of the demonstration project’s non-compliance with federal Medicaid law and its potential for dismantling Ohio’s successful expansion of health care coverage for poor adults.

Ohio’s waiver request projects that 709,927 Ohioans enrolled in Medicaid Expansion, will “either meet the work requirements or be exempt from them” in SFY 2019. Of the remaining 36,036 “subject to work requirements as a condition of

eligibility,” 18,018 people are projected to lose their Medicaid eligibility through failure to comply.

At first blush, one asks, why would a state go to such lengths to punish two and one-half percent of Medicaid Expansion participants for failure to meet work requirements? The waiver request implicitly acknowledges well-established facts, namely that most adults who received Medicaid through the Affordable Care Act are working, looking for work or are caretakers of family members in a household in which one or more members work.

The full scope of the demonstration project as a blueprint for reducing participation in the Medicaid Expansion program only emerges when one considers:

- The difficulty of documenting compliance for existing Medicaid participants over the five-year life of the demonstration, which is not considered in Ohio’s waiver request, and
- The impact of documenting compliance in the case of future Medicaid applicants over the five-year life of the program.

At present, submitting an application for Medicaid Expansion is a relatively easy process, requiring a minimum of verification. Medical clinics and other health care institutions, recognizing the benefits of health care coverage for poor adults have taken an active role in helping their patients apply. Every six months, the enrollee is asked to affirm that he or she meets the income standards for continued eligibility.

The work requirements and exemption categories seem clear enough, until one considers how implementation would actually work. Here are the means of satisfying the work requirements presented in the waiver request.

- 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); or
- Work Experience Program (WEP).

Exemptions from work requirements would include:

- 50 years of age or older
- Physically or mentally unfit for employment; How is this determined and for how long?
- 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;
- Applied for or receiving Unemployment Compensation;
- In school at least half-time;
- Participating in drug or alcohol treatment;
- Applicant for or recipient of Supplemental Security Income (SSI).

According to the waiver request, “individuals will be required to report any changes to their exemption status or their failure to meet the Work and Community Engagement Requirement to a County Department of Job and Family Services (CDJFS) office.”

The Implementation of the “Work and Community Engagement Requirements,” set forth in the waiver request, however, is not discussed in Ohio’s waiver request. This

omission conceals the fact that the demonstration offers a formula for administrative chaos and, as such, would function as an engine for denying or terminating health care coverage for a substantial portion of Ohio's adult poor. Why would this be the case?

First, the burdens of daily life make it difficult for poor Ohioans to keep up with compliance requirements and associated deadlines. In relative terms, they move more frequently, have less stable employment, have less access to transportation and less experience in communicating by email with county officials or providers who could document that they met one of the "work and community engagement requirements" required for Medicaid coverage. The monthly challenge of providing food, housing and paying regular expenses makes their lives subject to constant changes and adjustments.

Second, state support for county governments has declined in recent years. County job and family services (CDJFS) agencies, will not be given much, if anything, in the way of additional resources to keep up with the enormous expansion of their responsibilities, necessitated by the monitoring of work-related compliance standards for Medicaid eligibility, along with numerous exemption categories.

Third, a number of the exemptions and "community engagement" activities are temporary. A substantial number of Medicaid applicants and recipients will move in and out of work-related activities and exemption categories, potentially affecting their Medicaid eligibility. How do they keep up with "work and community engagement requirements" as they experience frequently changes in their life circumstances? How do already overburdened CDJFS agencies monitor compliance?

The daily burdens on the lives of the poor, the temporary nature of work-related eligibility standards for Medicaid eligibility and CDJFS agencies with insufficient resources to effectively manage compliance guarantees confusion, misunderstanding, miscommunication and inconsistency, which will inevitably lead to substantial declines in Medicaid coverage. For example:

A woman has an irregular work schedule. She doesn't know ahead of time what her hours will be. Sometimes she works 80 hours a month, others 75 or even 50. She relies on medication and weekly treatment in order to work at all. The treatment is covered by Medicaid. Will she be ineligible for Medicaid some months when her work hours fall short of the required 80? If so, how will she pay for the treatment and medication that enables her to work at all? How will she document compliance standards for Medicaid eligibility?

Or, after suffering a bout of undiagnosed depression, a man drops a course, making him less than a half-time student. Does he remain eligible for Medicaid to treat his depression? How does he know what to do to remain eligible?

There are thousands of possible situations facing Medicaid applicants and enrollees that could impact their Medicaid eligibility. Policy brochures and administrative rules are inadequate to cover specific individual circumstances. Case workers at county agencies are difficult to reach. The demonstration project described in the waiver request would place Medicaid coverage at risk for thousands of Ohioans because of sheer difficulty in understanding or meeting compliance standards,

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Act. According to its own estimate, as noted, approval of the waiver request could cause as many as 90,090 poor Ohioans to be denied Medicaid coverage over the course of the five-year demonstration. The difficulty of keeping up with compliance requirements would cost substantially more Ohioans to lose their health care coverage.

The Ohio Department of Medicaid published a recent report to the General Assembly, entitled *Ohio Medicaid Group VIII Assessment*. Group VIII refers to the 709,000 adults who qualified for Medicaid Expansion, by virtue of their low incomes. The Ohio Department of Medicaid report indicated that Medicaid Expansion provided much greater access to health care for previously uninsured Ohioans, (including treatment for drug addiction and mental illness); a decline in unmet health care needs; more effective use of the health care system; improved health care outcomes and improved financial situations for participants as indicated by the following results:

Health System Access and Utilization (Section III of the Report)

6. Group VIII enrollees overwhelmingly reported that access to medical care had become easier since enrolling in Medicaid—these gains were largest for those who were previously uninsured.
7. For many Group VIII enrollees, improved access to care was associated with a reduction in unmet medical needs. Nearly half of Group VIII enrollees (43.3%) reported a decline in unmet health care needs, while only 8.3% reported an increase, with the remainder reporting no unmet needs or no change in the level of unmet needs.
8. Emergency department use, which is often a very costly form of care, decreased for Group VIII enrollees. Survey results and medical records analyses showed that Group VIII participants

were better integrated into the health care system, increasingly connecting to a usual and appropriate source of health care.

Physical Health (Section IV of the Report)

9. Nearly half of Group VIII enrollees (47.7%) reported improvement in their overall health status since enrolling in Medicaid, compared to 3.5% who said their health had worsened.
10. After obtaining Medicaid coverage, 27.0% of Group VIII enrollees were diagnosed with at least one chronic health condition. These new diagnoses, alongside widespread reports of improved health access, suggest that Group VIII enrollees have become more likely to receive needed appropriate care.
11. According to the medical records case study, the individuals studied had lower levels of high blood pressure or high cholesterol since enrolling in Medicaid.

Mental Health (Section V of the Report)

12. Based on a mental health screening of survey participants, about one-third of Group VIII enrollees (31.9%) and 35.7% of pre-expansion enrollees screened positive for depression or anxiety disorders, with these conditions limiting usual routine activities, including employment.
13. Since enrollment in Medicaid, 44.0% of Group VIII enrollees reported better access to mental health services.
14. Group VIII enrollees with depression and anxiety reported greater improvement in access to care (68.5%) and prescriptions (71.2%) than those without depression or anxiety (62.4% and 62.5%, respectively).

15. For Group VIII enrollees with a clinical diagnosis of depression, most (61.7%) received pharmacotherapy treatment consistent with acute care guidelines established by the National Committee for Quality Assurance that target continuous treatment with antidepressant medication during the first 12 weeks of care.
16. Group VIII participants were as likely as pre-expansion enrollees to be diagnosed with substance abuse or dependence (32.3% versus 33.8%, respectively) and to be diagnosed for opiate abuse and dependence (3.6% for each group). However, Group VIII enrollees were less likely to receive prescriptions for medications associated with abuse and dependence, such as opioids and benzodiazepines (25.6% versus 32.0% for opioids, 10.4% versus 13.6% for benzodiazepines). This finding is consistent with prior Ohio Department of Medicaid analyses demonstrating reductions in opioid prescribing for pain conditions concurrent with opioid prescribing reform measures.
17. Group VIII enrollees with opioid use disorders reported greater improvement in their access to care than other Group VIII enrollees (75.4% versus 64.0% for overall access to care; 82.7% versus 64.8% for access to prescription medications; and 59.3% versus 32.2% for access to mental health care).

Employment and Financial Hardship (Section VI of the Report).

18. Most study participants reported that enrollment in Medicaid made it easier to work and to seek work. Three-quarters of the Group VIII enrollees (74.8%) who were unemployed but looking for work reported that Medicaid enrollment made it easier to seek employment. For those who were currently employed, 52.1% reported that Medicaid enrollment made it easier to continue working.

19. Group VIII enrollees were more than twice as likely to report improvements in their financial situation rather than declines in financial well-being. In particular, Medicaid enrollment enabled participants to meet other basic needs. More than half of Group VIII enrollees (58.6%) reported that it was now easier to buy food, 48.1% stated that it was easier to pay their rent or mortgage, and 43.6% said it was easier to pay off other debts.
20. The percentage of Group VIII enrollees with medical debt fell by nearly half since enrolling in Medicaid (55.8% had debt prior to enrollment, 30.8% had debt at the time of the study).

The Ohio Department of Medicaid report supported statements by the medical community such as: Medicaid's crucial role in preventing rural hospitals and clinics from closing under the weight of uncompensated care costs and Medicaid's contribution as the primary resource for drug treatment as Ohio suffered from an opioid epidemic. Tellingly, the report also addressed the essential role of health care in enabling Ohioans to remove medical and psychological obstacles to regular employment.

In conclusion, the report found"

- Group VIII enrollees reported increased access to usual and appropriate sources of care, better management of chronic diseases and health risk factors, and reductions in emergency department use.
- Importantly, many Group VIII enrollees were diagnosed with a previously unknown chronic health condition for which they are now able to seek care. Because they were able to obtain treatment for previously untreated conditions, several of the enrollees stated that they did not think they would be alive today if Medicaid expansion had not occurred.

- The review of medical records confirmed that many Group VIII enrollees experienced improved chronic disease and health risk factor management for conditions such as heart disease and depression resulting from appropriate access to statin prescriptions, antidepressant medications, and clinical health interventions. The medical records review also revealed an increase in the likelihood of a Group VIII enrollee visiting his or her medical provider at least twice annually.

“Finally,” the Ohio Department of Medicaid’s report to the Ohio General Assembly concluded, “despite the short time elapsed since Medicaid expansion,

Group VIII enrollees reported modest physical and mental health status gains, and most reported an increase in household, employment, and health security. Overwhelmingly, new enrollees reported being grateful for their Medicaid expansion health care coverage and valued having access to Ohio’s health care system.