

OHIO DEPARTMENT OF MEDICAID  
BEFORE THE OHIO MEDICAL CARE ADVISORY COMMITTEE  
PUBLIC HEARING  
HEALTHY OHIO PROGRAM SECTION 1115 WAIVER PROPOSAL

Thursday, April 21, 2016

2:00 p.m.

DEPARTMENT OF MEDICAID  
50 West Town Street  
Columbus, Ohio

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BEFORE:

James B. McCarthy, Director,  
Ohio Department of Medicaid  
James G. Tassie, Assistant Director,  
Ohio Department of Medicaid  
Mary Butler, Ohio Statewide Independent  
Living Council  
Holly Saelens, Molina Healthcare of Ohio  
Donald Wharton, MD, CareSource  
Craig Cairns, MD, MHP, Licking Memorial  
Health System  
Hubert Wirtz, Executive Director, Ohio  
Council of Behavioral Health and Family  
Services Providers  
Randy Runyon, Executive Director, Ohio  
Association of Community Health Centers  
Nicholas Lashutka, Cochair, Ohio Children's  
Hospital Association  
Mary Applegate, Cochair, Medical Director,  
Ohio Department of Medicaid

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## P R O C E E D I N G S

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MR. TASSIE: Good afternoon. My name is Jim Tassie, and I'm the Assistant Director and Head of Policy for the Ohio Department of Medicaid.

On April 15th, 2016, the Department published for public comment a draft Section 1115 Demonstration Waiver commonly known as the Healthy Ohio Waiver. In accordance with 42 CFR 431.408, we will present at today's meeting of the Medical Care Advisory Committee a summary of the contents of the waiver. The committee will have the opportunity to ask clarifying questions of Director McCarthy immediately following that presentation.

After we have fielded any questions from the committee, we will accept public comment on the contents of the draft waiver. Anyone wishing to offer comments shall have signed the signup sheet at the door when they came in. If you haven't signed the sheet, please do so now. Because of the number of people who are expected to give comment today, we are respectfully limiting comment to two minutes per person. While sharing with us a written copy of your comments is not required, we will gladly accept any written comments that reiterate, are supplemental to,

1 or in lieu of actual oral comments.

2 Finally, please note that we are only  
3 able to have about 100 people in this room. Thus, in  
4 order to facilitate comments from as many people as  
5 possible, we ask that you consider leaving the  
6 hearing at the conclusion of your comments.

7 Thank you for being with us today, and  
8 we hope that you find this presentation informative.  
9 I am now going to turn over the podium here to  
10 Director McCarthy.

11 MR. McCARTHY: Good afternoon, everyone.  
12 For the MCAC members, you probably never thought it  
13 would be so exciting to be at an MCAC meeting.  
14 Normally it's us and a group of about 10 other  
15 people, and another five who come and go while we're  
16 discussing Medicaid policy.

17 And in general terms in our normal MCAC  
18 meetings, for people who aren't here, we talk about  
19 things like State plan amendments, our 1915(C)  
20 waivers, changes to benefit packages, you know,  
21 robust discussions around dental benefits, how should  
22 we report, and things like that. So those are our  
23 normal kind of discussions, they're not as exciting  
24 as this one.

25 So for the MCAC members, thank you.

1 This is a requirement under the federal rules around  
2 1115 Waivers, that we have to present them at the  
3 MCAC meeting. They have to be public meetings, and  
4 then we get public comments from those.

5 So one of the things that we did want to  
6 do is before we get to public comments, right, we  
7 wanted to ask the MCAC members -- I know Jim had  
8 talked about we're going to get the comments from  
9 people in the audience. And for those individuals  
10 we're just going to take comments, but for the MCAC  
11 members hopefully you've had a chance to look at the  
12 waiver, and if MCAC members had any questions I would  
13 be more than willing to try to answer those  
14 questions.

15 We also have here with us some of  
16 our ones that helped us write the waiver, and we'd be  
17 willing to call on their expertise if there is a need  
18 for that, but I'll try to answer as many as possible.  
19 So with that, from any of the members, is there any  
20 question that you have?

21 MR. RUNYON: I have a question.

22 THE COURT REPORTER: I'm sorry, your  
23 name?

24 MR. RUNYON: Randy Runyon. The  
25 inpatient copay of \$75, is inpatient defined as an

1 overnight stay, or could it be -- I ask that because,  
2 you know, sometimes on private insurance plans you  
3 think that you're avoiding a hospital stay by going  
4 to what looks not like a hospital, but, in fact, is  
5 the same sort of facility.

6 THE COURT REPORTER: I'm sorry, I can't  
7 hear you.

8 MR. RUNYON: So that's pretty far out of  
9 the weeds, but that's the one that came up to me.

10 MR. McCARTHY: So the question is  
11 inpatient stay, what would an inpatient stay be  
12 classified. So it would be anything that we would  
13 pay to a provider who would charge us as an inpatient  
14 stay; so it would be a hospital, and it would be, I  
15 guess, an overnight, our inpatient overnights, so it  
16 would be an overnight stay in a hospital.

17 Other questions from MCAC members at  
18 this time?

19 (No response.)

20 MR. McCARTHY: Okay. So we are going to  
21 go through a PowerPoint real quick here on the  
22 proposal. So, Seema, you're doing that.

23 MS. VERMA: Good afternoon. My name is  
24 Seema Verma. I'm a consultant with the State. I'm  
25 just going to give an overview of the program.

1           So just starting with a brief history of  
2 the program, as many of you know, Medicaid expansion  
3 started in 2014 after Governor John Kasich expanded  
4 it to the adult population below 138 percent of  
5 poverty. In 2015, the Ohio General Assembly  
6 developed the Healthy Ohio Program for this group,  
7 and so this is an overview of that program.

8           So the Healthy Ohio Program has three  
9 main tracks. The first piece is transitioning all  
10 nondisabled adults in Ohio from the traditional  
11 Medicaid program into the Healthy Ohio Program;  
12 secondly, it introduces consumerism concepts and  
13 incentives for healthy behaviors to the Medicaid  
14 population; and then finally, it supports individuals  
15 if they're transitioning off the Medicaid program as  
16 they seek private healthcare coverage.

17           Starting with the eligibility and who  
18 will be in the Healthy Ohio Program, this is the  
19 nondisabled, Medicaid-eligible adults age 18 or  
20 older. So this not only includes the expansion  
21 population, but according to the legislation it's all  
22 nondisabled adults, so that also includes the  
23 expansion population, but low-income caretakers and  
24 parents, the transitional medical assistants or the  
25 TMS group, low-income 19 and 20 year olds, pregnant

1 women, Title-4-eligible children, foster youth to age  
2 26, and the breast and cervical cancer women in that  
3 program.

4 In terms of the benefits, the benefits  
5 are maintained; so the benefits that are in the  
6 Medicaid program would be maintained in the Healthy  
7 Ohio Program. It would also be a managed care  
8 delivery system. But what is different, and this is  
9 per the legislation, the program introduces an annual  
10 and a lifetime benefit limit. So on an annual basis,  
11 that's 300,000; and on a lifetime, that's \$1 million.  
12 So when an individual hits that limit, they are then  
13 transferred to the traditional Medicaid programs,  
14 they don't lose coverage, they just get transferred  
15 to the Medicaid program, and that would either be in  
16 a fee for service or managed care delivery system.

17 The cornerstone of the program is the  
18 Buckeye Account. So all individuals that participate  
19 in the Healthy Ohio Program would have a Buckeye  
20 Account, which is very similar to a health savings  
21 account. The concept here is to familiarize  
22 individuals with how commercial health insurance  
23 works and also familiarizing them with the healthcare  
24 delivery system and the costs associated with the  
25 care that they're receiving.

1           So essentially this Buckeye Account has  
2 two components; one is the core portion, and the  
3 second is the noncore portion. The core portion  
4 includes the contributions that the individual is  
5 making into the account, and it also includes dollars  
6 that they earned into the account. Together, the  
7 core and the noncore will not exceed \$10,000.

8           So for a member who has this account,  
9 for them to access their account, they would have a  
10 debit card. So when they go to a provider and  
11 they're trying to access their account, they would  
12 have a debit card, and also they would receive  
13 monthly statements describing the activity in their  
14 account.

15           So if we look at the uses of the Buckeye  
16 Account in the core portion, which is the member  
17 portion, that includes -- the uses for that is they  
18 would use that to pay for copayments that are  
19 required in the program, and they only have to pay  
20 copayments if there's money in that core portion of  
21 the account. So if there is -- they haven't accrued  
22 dollars or once they've used the money that they've  
23 contributed to the account, then the copayments do  
24 not apply.

25           On the noncore portion of the account is

1 the State's contribution, and this essentially goes  
2 towards the program's deductible, and that's going to  
3 be \$1,000. So every year the State will contribute  
4 \$1,000 to the noncore portion of the account to cover  
5 the deductible. On the non- -- on the core side, so  
6 it's paying for copayments, but on the core side it's  
7 also paying for additional benefits that are not  
8 covered in the basic benefit plan. Those haven't  
9 been determined yet, but some type -- an example of  
10 what those services might be could be  
11 over-the-counter medications. So as they're earning  
12 money into that account, they're making  
13 contributions, and we'll talk a little bit more about  
14 how they earn dollars into the account, but it's  
15 going to go towards services that are not covered in  
16 the base benefit account.

17 Let me just go back to the deductible  
18 again. So they're going to be paying that  
19 deductible, and once they hit the deductible, which  
20 is \$1,000, then the health plan would take over any  
21 additional costs.

22 In terms of cost sharing, this is going  
23 to connect to the Buckeye Account, individuals are  
24 required to make a contribution into the Buckeye  
25 Account. Their contribution goes into the core

1 portion, and they own that contribution. So unlike a  
2 premium, this is something that they retain. Usually  
3 with a premium, you pay it, you never -- you know, it  
4 doesn't come back to you, but here there's a  
5 potential because they still own that contribution  
6 that they're making into the account.

7 The account is a required 2 percent of  
8 income up to \$99 per year as a maximum as a condition  
9 of eligibility. There are exceptions for pregnant  
10 women, and individuals with no income obviously would  
11 not be required to make a contribution. Third  
12 parties can also help individuals with these  
13 contributions, not-for-profits can pay up to 75  
14 percent, employers can pay up to 50 percent. And if  
15 both of them are making contributions there's still a  
16 minimum for the individual to be making at least a 25  
17 percent contribution towards their 2 percent income  
18 requirement.

19 As we said before, there are copayments.  
20 So in terms of overall cost sharing, an individual's  
21 making that 2 percent contribution and then they're  
22 also responsible for copayments. Again, this is only  
23 the -- the copayments only apply if they have money  
24 in their core account that they can use towards the  
25 copayments. The copayments are listed on the slide

1 and they range for inpatient services at 75;  
2 outpatient, \$4; medications are \$4; and so on and so  
3 forth; and the nonemergency use of the emergency room  
4 is \$8. These are consistent with the CMS cost  
5 sharing for copayments.

6 In terms of that monthly contribution,  
7 this just gives you a chart to get a sense of how  
8 much individuals would be paying towards their  
9 coverage. Obviously individuals with no income are  
10 not making contributions, and then individuals from  
11 50 to about 138 percent of poverty -- depends on  
12 their family size, because when we're looking at  
13 federal poverty level and 2 percent of income we're  
14 also including your family size, so that's going to  
15 vary, you can be anywhere from \$8 a month all the way  
16 up to \$100 per month.

17 So for individuals that elect not to pay  
18 their required contribution, they have a 60-day  
19 period, so there is a grace period that's included in  
20 there as well, and then those individuals can reapply  
21 if they are discontinued from the program. But in  
22 order to do that, they have to pay back their  
23 contribution that they've met, so they have to go  
24 back and pay the two months that they've missed in  
25 order to re-enroll, but they can do that at any time.

1           So in terms of the healthy incentive  
2 point system, so kind of going back to that core  
3 portion of the member account, individuals can earn  
4 points into this account that they can use to cover  
5 for their copayments, and they can also use to  
6 purchase services that are not included in the base  
7 benefit plan. These points are accruing on that core  
8 side. So the types of things that individuals can do  
9 to accrue points, it's up to \$320 per year. The  
10 State can give up to -- it's 200 points and every  
11 point equates to a dollar, so that's 200 points, and  
12 also providers can do that as well. So if an  
13 individual is participating in a smoking cessation  
14 program or a weight management program, they can also  
15 earn points into the program.

16           There is also 20 points that can be  
17 earned just by making your contribution on an  
18 electronic basis, and that's 20 points. Individuals  
19 that cancel that would also lose 20 points into the  
20 program. So that's how the individual is accruing,  
21 they're making contributions into the account, and  
22 then they're also earning points by participating in  
23 certain types of behaviors or other incentives that  
24 the State has set up so that they can earn money into  
25 that account.

1           So the way the program is centered,  
2 they've got their earn -- they're earning money into  
3 this account, they're making contributions into the  
4 account, and they also have the State's contribution  
5 into the account, which is \$1,000. So individuals  
6 have an incentive to manage this account, they're  
7 responsible for reviewing the types of services that  
8 they're using.

9           And the individuals that re-enroll into  
10 the program, so the reason why they have this  
11 incentive to manage the account is that in the second  
12 year if there's money left over in the account,  
13 that's going to offset what they owe in the following  
14 year. So they have that 2 percent required  
15 contribution, but if there's money left in the  
16 account, they have the ability to roll that over and  
17 to offset their required contribution; so it gives  
18 them an incentive to manage the account prudently.

19           So they can carry forward the money in  
20 the account, and the amount that gets rolled over  
21 depends on whether the individual has completed their  
22 preventative services or not. So if an individual  
23 completes their preventative services, all of the  
24 money in the account rolls over. So any money that  
25 was left over from the deductible, the \$1,000 that

1 the State contributed, their contributions, plus  
2 anything that they earned or an employer or  
3 not-for-profit made those contributions, all of that  
4 money rolls over.

5 In the second scenario, if they haven't  
6 completed their preventative services, as I said in  
7 the beginning, their contribution, they own that  
8 contribution. So if there's any money left and it's  
9 on a prorated basis, their contribution would roll  
10 over. The third-party contributions that were made  
11 on their behalf, all of those roll over. But they  
12 are -- they do not have access then to the State's  
13 contribution towards the deductible or the healthy  
14 incentive points that they may have earned, so those  
15 pieces don't roll over.

16 Another component in terms of the  
17 Healthy Ohio Program is promoting self-sufficiency,  
18 and there's a component here to support employment  
19 and individuals transitioning off of public  
20 assistance. So to this end, there is a voluntary  
21 referral to workforce development agency for  
22 unemployed members or members that are working less  
23 than 20 hours a week. This is completely voluntary,  
24 it's not tied to eligibility, but it gives  
25 individuals that are interested the opportunity to

1 participate in the State's workforce development  
2 program, so that's job training or job search  
3 activities.

4           Then the other component in terms of  
5 supporting work and self-sufficiency is that as  
6 individuals, if they gain income or change jobs and  
7 they're able to transition off the program, we  
8 essentially create the Bridge Account to help  
9 individuals purchase commercial health insurance when  
10 they're no longer eligible for the program. So this  
11 helps ease that transition off of Medicaid coverage  
12 into private health insurance, and this is done  
13 through the creation of the Bridge Account.

14           So we talked about the Buckeye Account,  
15 and those are for individuals that are active in the  
16 Medicaid program and the Healthy Ohio Program, but  
17 when an individual transitions off the program the  
18 money in their account transfers over to the Bridge  
19 Account. The Bridge Account allows the individuals  
20 to essentially use the money that they have earned,  
21 that they have perhaps saved by using the program  
22 prudently, and to use that service to pay for  
23 premiums for their commercial health insurance or to  
24 pay with any out-of-pocket expenses or cost sharing.  
25 So, again, the program introduces a concept of

1 consumerism and encourages and incentivizes the  
2 individual to manage their account well, because  
3 there is an incentive to actually maintain that  
4 balance even when they leave the program.

5           So in summary, I think you've got, you  
6 know, three components. You've got the Buckeye  
7 Account, which is for individuals enrolled in the  
8 Medicaid program. That's very consistent with a  
9 consumer-directed model, it's allowing individuals to  
10 manage both accounts and help pay for services that  
11 are not covered as well as their copayments. And the  
12 incentive structure encourages individuals to use  
13 that account, and then -- and have it transition into  
14 the Bridge Account that really rewards members that  
15 transition off of public assistance.

16           The other component of this is that --  
17 or purpose of this Bridge Account is it reduces  
18 churn. As we know, individuals move back and forth  
19 from Medicaid to private health insurance or this  
20 could be the exchange, and this -- the Bridge Account  
21 sort of helps them make that transition.

22           So this program does require permission  
23 from the federal government, and the vehicle for that  
24 is what we call a Section 1115 Waiver. So the State  
25 is seeking a five-year waiver. 1115 Waivers are

1 demonstration waivers. So essentially what that  
2 means is that the State is, you know, introducing  
3 some new concepts and then evaluating those concepts  
4 through the waiver program.

5 So for the Healthy Ohio Program, there  
6 are four components or four goals that will be  
7 evaluated. The first one is promoting member  
8 engagement and personal responsibility, including  
9 appropriate use of healthcare services. So by having  
10 the account, does it encourage individuals to seek  
11 care in more appropriate settings? Does it  
12 discourage people from going to the emergency room or  
13 seeking primary care instead of going to the  
14 emergency room, using generic drugs over specialty  
15 drugs? So there's a lot that goes into that member  
16 engagement. Is the member more involved? Are they  
17 more involved in their healthcare?

18 No. 2 is because of the incentive around  
19 preventative care. Remember that if the individual  
20 has completed their preventative services and that  
21 account rolls over or higher amount of the dollars in  
22 the account rolls over, so we'll evaluate whether  
23 this incentivizes individuals to increase their use  
24 of preventative care.

25 Then No. 3, does it increase provider

1 engagement in member behavior? So as you'll recall,  
2 providers have the ability to assign points to an  
3 individual based on their -- you know, potentially  
4 their treatment adherence or a number of situations  
5 which will be identified in the future, but it  
6 also -- does that also engage the provider more  
7 closely?

8           Then No. 4, does it increase the number  
9 of the commercially insured? So with the  
10 introduction of the Bridge Account, do we actually  
11 see an uptake in the number of commercial insurance?  
12 So those are the four components of the waiver  
13 evaluation.

14           So in terms of the waiver costs and  
15 budget neutrality, so the State is required through  
16 the 1115 Waiver to demonstrate budget neutrality,  
17 that the program would not cost any more than it  
18 would under the traditional program. So the  
19 estimates indicate that the program will save both  
20 the State and federal government nearly \$1 billion  
21 over the five-year waiver period. The savings are  
22 derived from a couple of different areas; one is the  
23 program and the benefit design. So by having the  
24 account and having the incentives set up for  
25 individuals to use the healthcare system more

1 appropriately and seek preventative healthcare, that  
2 can have an impact on healthcare costs, and then  
3 secondly member attrition. So there's new incentives  
4 for individuals to seek private health insurance, and  
5 so you may see more individuals off of this program  
6 onto private health insurance.

7 In terms of next steps, with the 1115  
8 process, we've posted the waiver, the State has  
9 posted the waiver. This is part of the public  
10 comment period. There will be two hearings that are  
11 going to be held, and the waiver obviously is posted  
12 for comment as well. The waiver will be finalized  
13 and submitted to CMS in June of 2016; so that allows  
14 the State to consider the public comments, finalize  
15 the waiver and submit that. And then there's also a  
16 federal public comment period as well, and then  
17 negotiations will take place with CMS, and the time  
18 line that's been estimated is January 2018 for the  
19 implementation.

20 That concludes the presentation. Thank  
21 you.

22 MR. McCARTHY: Thank you, Seema.

23 MCAC members, do you have any questions,  
24 either members here or members on the phone?

25 MR. CAIRNS: Craig Cairns with Licking

1 Memorial, Newark, Ohio.

2                   What was the coverage for substance  
3 abuse treatment? Does it cover medication-assisted  
4 therapy and partial hospitalization, or does it  
5 mention those?

6                   MR. McCARTHY: Yeah. So the question is  
7 what is the coverage for substance abuse.

8                   The coverage under the waiver is the  
9 exact same that we have currently in the Medicaid  
10 program. So the service, whatever a person is  
11 getting is being transferred over to the waiver,  
12 there is no benefit changes.

13                   So what does that mean? We're going  
14 through redesigns, all the things that we're  
15 redesigning there rolls right over into the waiver.

16                   No other questions here, on the phone?  
17 MCAC members, any questions?

18                   (No response.)

19                   MR. McCARTHY: Hearing none, we can move  
20 over to the public comment period. We have a list  
21 here hopefully of everyone that is going to be  
22 commenting.

23                   The first person we have here with both  
24 written and oral testimony is Patrick Beatty. Please  
25 step forward to the microphone, speak clearly into

1 the microphone, yes, so that everyone can hear,  
2 especially our court reporter.

3 MR. BEATTY: Thank you. On behalf of  
4 Equitas Health and the Ohio AIDS Coalition and the  
5 citizens of Ohio affected by HIV and AIDS, we are  
6 writing to comment in opposition to the proposed  
7 Healthy Ohio Waiver.

8 There are general criteria that CMS uses  
9 to determine whether Medicaid program objectives are  
10 met under 1115 Waivers. These criteria include  
11 whether the demonstration will increase and  
12 strengthen overall coverage of low-income individuals  
13 in the state, increase access to stabilize and  
14 strengthen providers and provider networks available  
15 to serve Medicaid and low-income populations in the  
16 state, improve health outcomes for Medicaid and other  
17 low-income populations in the state, or increase the  
18 efficiency and quality of care for Medicaid and other  
19 low-income populations through initiatives to  
20 transform service delivery networks. Demonstrations  
21 must also be budget neutral to federal government,  
22 which means that during the course of the project  
23 federal Medicaid expenditures will not be more than  
24 federal spending without the waiver.

25 Each of those standards is violated by

1 the proposed waiver. The source of those violations  
2 are the statutes underlying the waiver and  
3 authorizing its structure. It will, if implemented,  
4 disrupt coverage for HIV-positive Ohioans and  
5 increase rates of HIV transmission in the state.

6 It unlawfully will deny access to  
7 benefits authorized under the Ryan White Care Act to  
8 individuals who are HIV positive. It will unlawfully  
9 deny access to other benefits authorized under other  
10 state laws. It will violate the antidiscrimination  
11 provisions of the ACA and the ADA. It will violate  
12 multiple provisions of the Social Security Act, none  
13 of which can be waived even under authority of 1115.  
14 It will expose charitable organizations and  
15 healthcare providers to civil and criminal penalties.  
16 It violates rights granted under the IDEA, the  
17 Individuals with Disabilities Education Act. It  
18 violates the Internal Revenue Code, and it will  
19 unlawfully interfere with the mandatory entitlement  
20 guaranteed by federal law.

21 In the coming weeks, the Ohio AIDS  
22 Coalition will be submitting a comprehensive  
23 explanation of each of these fatal flaws in the  
24 statutes as noted above. Because the terms of the  
25 statutes are non-negotiable, we will be urging the

1 Center for Medicare and Medicaid services to reject  
2 the waiver. Thank you.

3 MR. McCARTHY: Next up we have Amber  
4 Donovan.

5 I forgot with Patrick, although we know  
6 Patrick, if all of the speakers would come up to give  
7 their comments, the first thing if you could state  
8 your name and the organization that you're with, even  
9 though I've said it, just to make sure we get it on  
10 record.

11 MS. DONOVAN: My name's Amber Donovan,  
12 and I'm with Metro Health Hospital in Cleveland,  
13 Ohio.

14 Good afternoon. The Healthy Ohio Waiver  
15 as proposed would negatively impact young adults  
16 transitioning from foster care and the providers who  
17 serve them. My name is Amber Donovan, and I am the  
18 social work coordinator for the Foster Care Program  
19 at Metro Health.

20 In Ohio approximately 1,000 young adults  
21 leave foster care per year. Cuyahoga County Children  
22 and Family Services and Metro Health Hospital work  
23 together to coordinate healthcare services for this  
24 population. Annually we have 120 to 150 young adults  
25 that transition from foster care in Cuyahoga County.

1 Compared to their peers who are still connected to  
2 their families, individuals who age out of foster  
3 care have a greater risk of homelessness, early  
4 pregnancy, poor health outcomes, food and security,  
5 mental health needs, and educational attainment.

6 Currently these young adults in Ohio  
7 qualify for Medicaid until the age of 26. The  
8 Healthy Ohio Waiver would disrupt their lives in the  
9 following way: The waiver premium requirement would  
10 become another stress factor in their already chaotic  
11 lives. The average aged-out youth struggles with  
12 poverty.

13 According to the 2007 Shape and Health  
14 Study, young adults who come out of foster care  
15 typically earn an average of \$8,000 a year by the age  
16 of 24. The premium requirement creates an undue  
17 burden on these individuals. The likelihood of them  
18 paying the premium or having the ability to pay the  
19 fee would be very low, because they're already making  
20 tough choices with limited resources.

21 Additionally, the waiver would impact  
22 their status credit -- their credit status as these  
23 young adults are turned over to collections. Sending  
24 a young person to the collections to pay the health  
25 care debt would only keep them in poverty.

1           The Healthy Ohio Waiver would also  
2 present challenges to the provider system.  
3 Specifically, if young adults lose health coverage  
4 because they are unable to pay the premium, they will  
5 not maintain a regular relationship with their  
6 providers, they will disconnect from the healthcare  
7 system, they will delay or avoid care until they're  
8 in a crisis state. When they get to this point, they  
9 will likely access care in the emergency room, which  
10 will be more costly.

11           Healthcare coverage matters. And in  
12 2016 in January, Metro launched a clinic to meet the  
13 needs of young adults transitioning from foster care.  
14 Within three months, we've witnessed young people  
15 setting up and following through on appointments on  
16 their own. Receiving care in a primary care setting  
17 rather than going to the emergency room saves them  
18 from missing work and losing their jobs due to  
19 illness. This prevents early pregnancy and increases  
20 reproductive health. The clinic helps young adults  
21 better manage their complex medical needs.

22           Metro Health and the State of Ohio have  
23 worked hard to promote primary and preventative care  
24 and coordinated services in an effort to improve  
25 individual and community health for the protection

1 and stability of the young adults connected to foster  
2 care.

3 I humbly request that the Ohio  
4 Department of Medicaid not advance the Healthy Ohio  
5 Waiver Proposal with the Centers for Medicare and  
6 Medicaid services. Thank you.

7 MR. McCARTHY: It's a little dark up  
8 here, so I'm going to flip this light switch, and I'm  
9 not sure which one it is. If the lights go out, I'll  
10 turn it back on.

11 Next on our list we have Loren Anthes.

12 MR. ANTHERS: Thank you. My name is  
13 Loren Anthes, and I am a Public Policy Fellow in the  
14 Center for Medicaid Policy with the Center for  
15 Community Solutions. We have submitted our  
16 comments and they are available at  
17 [www.communitysolutions.com/Medicaid](http://www.communitysolutions.com/Medicaid).

18 As an element of its mission, CCS  
19 supports the development of cost-effective Medicaid  
20 policies. Simply put, we believe Healthy Ohio,  
21 created by the Ohio legislature, is an incomplete set  
22 of policy concepts that are wasteful, complex, and  
23 ultimately harmful for Ohioans.

24 In its current form, the costs and  
25 fiscal administration of this program are not fully

1 articulated, which could result in higher  
2 reimbursement rates, as well as the potential for  
3 widespread fraud and abuse. The proposal does not  
4 contemplate the costs associated with an  
5 administratively complex system. This proposal also  
6 does not describe how managed care rates may be  
7 affected as it remains to be seen if the  
8 administration of the debit system would be  
9 considered an allowable cost. One only need to look  
10 to Arkansas which recently dropped the premium  
11 requirement for their waiver due to cost, or Virginia  
12 which saw \$1.39 spent for every dollar collected in  
13 premiums.

14 In addition, there is also the potential  
15 for tens of millions of dollars of fraud by allowing  
16 providers to, in effect, deposit money into a  
17 person's Buckeye Account for obtaining services  
18 either through premium subsidization or the point  
19 system.

20 The Healthy Ohio proposal is also  
21 exceedingly complex, forcing providers and patients  
22 into a system of red tape that could compromise  
23 health outcomes and healthcare industry jobs. How  
24 will providers and patients know the current status  
25 of eligibility? Will there be a change in MITS?

1 What is the financial exposure for hospitals, nursing  
2 homes, and other providers who utilize retroactive  
3 eligibility? As health care is a major economic  
4 force in Ohio, with health systems comprising eight  
5 of the top 20 largest employers in the State, such  
6 instability may result in difficult choices regarding  
7 services, which will effect overall care, and  
8 staffing, which will effect Ohio's economy.

9           Additionally, nearly half of this  
10 population is unbanked or underbanked, and nearly one  
11 in five lack access to a computer at home. How will  
12 they be able to monitor their Buckeye Account, and  
13 gain the necessary literacy to make the changes  
14 expected of them by this proposal?

15           Also, as you may remember, in 2015 Ohio  
16 was ordered to restore the eligibility of 150,000  
17 Ohioans after a challenging public notification  
18 process regarding redetermination. While the State  
19 should be congratulated for their efforts to rectify  
20 the situation, Healthy Ohio will be immensely more  
21 complex and will require a more multifaceted  
22 communications process. To that end, CCS would ask  
23 for more detail regarding outreach for this  
24 population, as well as the inclusion of more specific  
25 demographics, such as race and categorical

1 eligibility, into the hypotheses being tested. Doing  
2 so would help the targeting of outreach, particularly  
3 for case managers with payers, providers, and JFS  
4 offices who may face increased burden from what would  
5 become a defacto monthly eligibility process.

6           Mostly importantly, CCS believes that  
7 this proposal is harmful, leading millions of Ohioans  
8 to have their coverage compromised resulting in worse  
9 health outcomes for a vulnerable population. The  
10 Department estimates that 1.66 million Ohioans would  
11 be eligible for this program. This includes parents,  
12 women with cancer, and children aging out of the  
13 foster care system, or those with special needs.

14           In many states where similar reforms  
15 have been implemented, disenrollment has typically  
16 followed, such as that with Oregon who saw a decline  
17 of about 77 percent. Some have pointed to Indiana as  
18 a successful model, but to do so would be erroneous  
19 at best. First, individuals are not excluded from  
20 coverage for nonpayment, a key difference with Ohio's  
21 plan. Additionally, as the Center on Budget and  
22 Policy Priorities has recently highlighted in  
23 research, premiums may not be charged based on  
24 people's actual incomes, the role of third-party  
25 payers is unclear and oftentimes the payment is,

1 quote, off the grid, and that system of prepayment  
2 known as fast-tracking may be underutilized and  
3 creating access issues.

4 Finally, CCS would like the Department  
5 to answer the following questions in its required  
6 report on this comment process, either through its  
7 formal submission or through the final application  
8 language itself.

9 No. 1, how does the incentive system  
10 avoid violating fraud and abuse laws?

11 No. 2, if an individual is able to  
12 access the entirety of their Buckeye Account after  
13 terminating participation in Healthy Ohio, for  
14 whatever reason, are they able to access dollars  
15 provided by Medicaid that include federal funding?

16 What are the costs -- No. 3, what are  
17 the costs associated with operationalizing the  
18 transaction system? Will these costs be built into  
19 the capitated payments made to Ohio's Medicaid  
20 managed care plans?

21 No. 4, how do individuals contribute  
22 their portion if they do not have regular access to  
23 banking services or have other challenges, such as  
24 not being able to speak English or having limited  
25 literacy?

1           No. 5, if these accounts are held by  
2 banks, will they be prohibited from charging fees to  
3 participants?

4           No. 6, why is there a difference in the  
5 population estimates between the summary document and  
6 the detail document?

7           No. 7, have the business requirements  
8 for implementing Healthy Ohio in MITS been developed?  
9 If not, what is the expected timeframe for developing  
10 those requirements and how long would it take to  
11 implement? Will providers be able to utilize MITS in  
12 real-time to determine whether an individual is  
13 eligible for Healthy Ohio?

14           No. 8, can other governmental programs  
15 contribute toward a participant's contribution, i.e.  
16 a public hospital, or a State university hospital, or  
17 the Ryan White HIV/AIDS Program?

18           No. 9, why does the deductible change  
19 based on how much is in the participant's noncore  
20 Buckeye Account?

21           Thank you.

22           MR. McCARTHY: Our next speaker is Kelly  
23 Smith.

24           MS. SMITH: Hi. My name is Kelly Smith.  
25 I'm the Program and Policy Director at the Mental

1 Health and Addiction Advocacy Coalition. We're a  
2 statewide coalition made up of over 100 organizations  
3 that have a common interest in behavioral health.  
4 And I'm going to be brief and skip around in my  
5 testimony to touch on this from a behavioral health  
6 perspective.

7           Individuals in the Healthy Ohio Program  
8 will begin to fall off Medicaid rules or be locked  
9 out of the program for failure to pay premiums. More  
10 uncompensated care will begin to burden providers.  
11 The Healthy Ohio Program will take us back to the  
12 time before Medicaid expansion was enacted, when  
13 people did not receive care, when the uninsured  
14 visited the emergency room frequently for their care,  
15 when providers were responsible for services they  
16 provided to people without coverage, and when some  
17 local alcohol, drug addiction and mental health  
18 service ADAHM Boards were able to budget and pay for  
19 indigent care.

20           ADAHM Boards, again, may have to  
21 compensate for a lack of coverage, a problem that  
22 Medicaid expansion has begun to rectify. In our last  
23 state operating budget, the ADAHMs Boards received a  
24 cut in state dollars because Medicaid expansion  
25 supposedly would be used by people to pay for

1 services without coverage. Should the Healthy Ohio  
2 Program be implemented, we will have to request more  
3 funding for our local ADAHMs boards to again cover  
4 these costs.

5 According to ODM, Medicaid members  
6 needing treatment for mental health or substance  
7 abuse disorders represent 27 percent of Ohio Medicaid  
8 enrollment, but account for 47 percent of Medicaid  
9 spending. Only half of the behavioral health  
10 population on Medicaid is seen through the community  
11 behavioral health system. The most expensive 5  
12 percent account for over half of the behavioral  
13 health expenditures.

14 The Office of Health Transformation  
15 compared the top 100 in 2014 total behavioral health  
16 users by using certain diagnostic codes who were  
17 connected to community mental health centers versus  
18 no connection to community mental health centers who  
19 were receiving behavioral health services through  
20 Medicaid. Of those not connected, the cost for one  
21 person reaches over \$682,000 in services, while those  
22 connected to community mental health centers reaches  
23 for less in costs and for one person is just over  
24 \$106,000 in services for one year.

25 Those not connected to care often

1 default to receiving care in nursing homes and  
2 hospitals or lack a connection to treatment due to  
3 chronic homelessness, criminal justice involvement,  
4 or social isolation. Uncoordinated healthcare for  
5 people with chronic illness is dangerous for them and  
6 burdens other systems.

7           The behavioral health redesign has a  
8 goal to lessen the cost of the highest spenders of  
9 those utilizing behavioral health service by ensuring  
10 people receive coordinated care by connecting them to  
11 community mental health centers and enrolling them  
12 into managed care.

13           The Healthy Ohio Program would cap  
14 expenses and place lifetime limits on healthcare  
15 coverage. Once an individual reaches the cap or  
16 limit, they are not disenrolled, but they are moved  
17 back into a form of traditional Medicaid. If our  
18 goal is to provide a better care for our nation  
19 through the behavioral health redesign process and  
20 ultimately move this population to managed care, the  
21 Healthy Ohio Program will not achieve this outcome  
22 for the highest service users with caps and limits  
23 and moving between Medicaid plans.

24           Access to care is the number one reason  
25 the MHAAC is here today to provide public comment,

1 which is why I would like to touch on at least we  
2 know that those we represent will be burdened with  
3 sharing the cost and understanding how to navigate  
4 the requirements of a modified health savings  
5 account. Why are we targeting the poorest and  
6 sickest, those with mental illness and/or addiction  
7 standards, and many other Ohioans, to teach them  
8 personal and financial responsibility?

9 The population we represent who are on  
10 Medicaid are not just in poverty, rather they are  
11 trying to get well and are in the recovery process or  
12 stay well by receiving behavioral healthcare. Many  
13 are in poverty because of their illness, and this is  
14 an unfair demonstration to put them through.

15 If people are no longer able to receive  
16 treatment through the existing Medicaid system, Ohio  
17 will see an increase in costs to other systems,  
18 including criminal justice, hospitals, schools, and  
19 the courts, and it will witness unintentional  
20 consequences that will increase the rates of suicide,  
21 overdose deaths, and overburdened families. It will  
22 create a weakened community behavioral health system  
23 in our state.

24 We appreciate your consideration of our  
25 analysis of the Healthy Ohio Program 1115

1 Demonstration Waiver request. Thank you.

2 MR. McCARTHY: Next we have Nita Clark.

3 MS. CLARK: Good afternoon. My name is  
4 Nita Clark, and I'm with UHCAN Ohio. UHCAN Ohio is a  
5 statewide health advocacy organization and consumer  
6 voice on health policy for the State of Ohio.

7 We believe that this waiver is not  
8 healthy for Ohioans. As UHCAN Ohio's health equity  
9 director and project director for our statewide  
10 outreach enrollment and health literacy project, I  
11 see many people who are enrolled in Medicaid on a  
12 daily basis. They are waitresses, substitute  
13 teachers, caregivers, the young man who graduated  
14 college and can't find a job, the self-employed, like  
15 the person who takes care of your lawn, or the person  
16 who cleans your office, they are my fellow church  
17 members, my neighbors and my family. I bet if we  
18 stop, we can all call to mind someone who is on  
19 Medicaid or should be.

20 Many of those we see have had no health  
21 insurance before the Medicaid expansion and are  
22 living from paycheck to paycheck. These Ohioans  
23 don't have extra income, and any premiums would be  
24 difficult for them to pay.

25 For example, Ms. Worley from Cleveland

1 says she uses a \$25 incentive that she receives every  
2 six months to help her purchase her over-the-counter  
3 vitamins and other medicines that she needs daily or  
4 often. And one young man we saw finally found a job,  
5 but is over 25 miles from where he lives, and he is  
6 struggling to pay for gas to get there. Where is the  
7 extra \$10 per month going to come from for them?

8 Those we see are grateful to have health  
9 coverage, and many are just learning how to use their  
10 coverage, find a primary care doctor, get annual  
11 checkups, and use their prescription benefits.

12 For example, one of our enrollees,  
13 Jackie, is a retail worker and single mom of four  
14 children. She told us that before enrolling in  
15 Medicaid, she used the emergency room for her care,  
16 but now that she has coverage through Medicaid she  
17 can get the care she needs. She has been able to see  
18 a doctor and is now receiving treatment for a back  
19 problem that she had from long ago that has gone  
20 untreated.

21 The goal of Ohio's Medicaid program is  
22 to cover Ohio's low-income families and improve their  
23 health. This proposal would hurt Ohio families. Our  
24 Medicaid expansion has helped us to move in the  
25 direction of covering more people, over 600,000 new

1 adults.

2 Premiums have been shown to cause a  
3 decrease in Medicaid enrollment. For example, Morgan  
4 experienced a 77 percent drop in Medicaid enrollment  
5 after it instituted premiums for adults below 100  
6 percent of poverty. Adding premiums would defeat the  
7 gains Ohio has made through its Medicaid expansion.  
8 This waiver is not healthy for Ohioans, and we  
9 strongly oppose it.

10 MR. McCARTHY: Thank you. Our next  
11 presenter is Wendy Fatton.

12 MS. FATTON: Good afternoon. I am Wendy  
13 Fatton with Policy Matters Ohio. I have submitted  
14 more extensive written comments with citations to the  
15 research I'll reference in my comments today. These  
16 are also available on our website.

17 Demonstration projects like the Healthy  
18 Ohio plan that we've heard about today are supposed  
19 to promote the objectives of the Medicaid programs.  
20 The proposed waiver does not further these key  
21 Medicaid objectives.

22 Number one, it would not increase and  
23 strengthen overall coverage of low-income  
24 individuals. The Department of Medicaid's own  
25 analysis for the proposal forecasts a decline in

1 enrollment if the Healthy Ohio Waiver is in place  
2 compared to similar assumptions without the proposed  
3 waiver.

4           Number two, the Healthy Ohio plan does  
5 not increase access to healthcare and threatens  
6 providers of Medicaid services. The proposal  
7 forecasts that up to 140,000 adults would not enroll  
8 in or would lose Medicaid coverage in each of the  
9 five years of the demonstration period.

10           In our written comments, we outline  
11 research that has found that boosting costs on  
12 low-income populations like the premiums imposed  
13 under the waiver proposal reduces access to necessary  
14 medical care while making healthcare readily  
15 available without boosting costs enhances health  
16 outcomes.

17           The proposed lockout provision compounds  
18 the threat. If someone misses two monthly payments  
19 or a paperwork deadline, she loses coverage. If she  
20 lost coverage because of nonpayment, she must make  
21 that debt up before regaining care. Providers who  
22 serve the Medicaid population will bear increased  
23 financial risks for Medicaid as a result of this.

24           If someone eligible for, but not  
25 enrolled in Medicaid suffers a heart attack, the

1 person will be treated, but Medicaid coverage will  
2 not start until the initial premium is paid or for  
3 those locked out of the system until back payment is  
4 also made. This undermines an Ohio healthcare system  
5 that has been strengthened by insurance coverage  
6 afforded by the Medicaid expansion.

7 The waiver proposal will not result in  
8 improved health outcomes. The low-income population  
9 has especially pressing needs for continuous access  
10 to healthcare. As poverty increases, the likelihood  
11 of chronic diseases like diabetes, hypertension, and  
12 depression, barriers that interrupt consistent,  
13 ongoing disease management result in poor health  
14 outcomes.

15 The RAND Corporation's review of studies  
16 on the effect of certain health plans that include  
17 health savings account, which is the model used for  
18 this waiver, concluded while evidence suggests that  
19 the health of the overall population may not change  
20 with increased cost sharing, the health of  
21 individuals with low incomes and greater healthcare  
22 needs may decline.

23 Finally, number four, the waiver will  
24 not increase the efficiency and quality of care. The  
25 analysis indicates that per-member, per-month costs

1 increase under the proposal while enrollment drops.  
2 The proposal does not provide a nuanced analysis of  
3 this, but the effect is not one of increased  
4 efficiency.

5 The proposal contains several incentives  
6 that are supposed to improve healthy outcomes or  
7 administrative efficiency, but these incentives could  
8 be unattainable for many Medicaid enrollees for  
9 reasons outlined in our proposal or in our written  
10 comments.

11 This is very unfair, but we really don't  
12 know who is hurt or who is helped by the Healthy Ohio  
13 plan. The evaluation metrics are too broad to  
14 understand its impact on the diverse segments of the  
15 Medicaid population of Ohio.

16 Thank you for the opportunity to comment  
17 today.

18 MR. MCCARTHY: Thank you. Next we have  
19 Marsha Riley.

20 MS. RILEY: Good afternoon, everyone.  
21 My name is Marsha Riley, I'm a CAC for -- Certified  
22 Application Counselor for UHCAN Ohio.

23 I see many people on a regular basis  
24 that have come back to me with questions about their  
25 insurance, how to find a provider, simply how to use

1 their insurance card. I can only imagine what would  
2 happen if premiums, health spending accounts, annual  
3 and lifetime caps for those enrolled on Medicaid are  
4 instituted.

5 As a Certified Application Counselor, I  
6 believe that this change would have a drastic effect  
7 on those that have Medicaid. Many will lose their  
8 coverage and will go back to using the emergency room  
9 for their health needs or simply go without treatment  
10 at all.

11 I would like to leave with you one  
12 example of the many people that I see and have  
13 enrolled in Medicaid. A young man that came to me  
14 who had not had any health coverage and was  
15 struggling to pay for just his simple prescriptions  
16 and medications. He finally was able to get help  
17 with his Medicaid. We don't want to see our people  
18 going back to going to the emergency room for  
19 simple -- for their healthcare needs or simply going  
20 without in coverage or healthcare needs at all.

21 Thank you.

22 MR. McCARTHY: Thank you. Now we have  
23 Francene Travis.

24 MS. TRAVIS: Good afternoon. My name is  
25 Francene Travis. I'm not affiliated with any

1 organization, I'm just a citizen.

2           What concerns me most about this, and  
3 everybody says it quite eloquently, about people, the  
4 money they have to put in. Nobody has said that do  
5 you understand that asking a person who has a  
6 nondisposable income means they can't buy tissue,  
7 they can't buy toothpaste, they can't buy soap, they  
8 can't buy deodorant. These are things you take for  
9 granted every day, and these people won't be able to  
10 do it.

11           That's all I got to say.

12           MR. McCARTHY: Thank you. Next we have  
13 Rosetta Leeper.

14           MS. LEEPER: Good afternoon. My name is  
15 Rosetta Leeper. That was my aunt, Francene Travis,  
16 that was just up here.

17           I have been at both ends of the  
18 spectrum. I have done home healthcare, I've worked  
19 in nursing homes. I'm physically not able to do that  
20 anymore; so I chose to go in customer service where I  
21 am the face that they see when they're asking, "How  
22 am I supposed to pay for my medication? How am I  
23 supposed to buy food?" They're already losing their  
24 homes to pay for Medicare, and now we want them to  
25 pay premiums as well?

1           We're trying to bend something that's  
2 already fractured. Why are we trying to get  
3 \$1 billion off the poor for the State of Ohio?  
4 Aren't the Ohioans the State of Ohio? So is that  
5 money going to go towards them, towards their  
6 community, towards the potholes that are never fixed,  
7 but tear up the cars that they can't afford to fix?  
8 How is this good for anybody? How is it caring for  
9 anybody?

10           It's easy to sit in an office and vote  
11 and make decisions because you don't have to talk to  
12 them. I do, and I have to cry with them and pray  
13 with them and try to find other avenues of social  
14 services that may help, but most likely will not.

15           Insulin is expensive, and they have to  
16 choose whether to buy the insulin or buy food. If  
17 you're a diabetic, there are certain things you just  
18 can't eat, and that costs more money. But do we  
19 really care about that or do we care about the \$1  
20 billion? Well, I'll tell you right now, it doesn't  
21 smell right, and I'm not going to eat it.

22           MR. McCARTHY: Thank you. Next we have  
23 Lynn Buffington.

24           MS. BUFFINGTON: Lynn Buffington, and  
25 I'm also here as a citizen and also as a taxpayer.

1 I know I've had little experience with  
2 HSAs, with Medicaid, and with the healthcare system.  
3 My husband and I have had private, good insurance  
4 throughout our adult lifetime through employment, and  
5 we've had an HSA for the past 16 years.

6 I've had a lot of experience with the  
7 healthcare system because I'm a cancer survivor. And  
8 as far as Medicaid goes, the reason I'm actually here  
9 today is because I just drove -- I'm on my way back  
10 from western New York to my home in Greene County  
11 near Dayton from spending yesterday taking my  
12 85-year-old mother to the cemetery to -- on the  
13 occasion of my sister's -- what would have been her  
14 65th birthday. So she died a year ago.

15 She was on Medicaid the last few years  
16 of her life. She had a very vibrant working life.  
17 She worked for 40 years, but she had open heart  
18 surgery and was on Medicaid the last few years of her  
19 life when she could not work. So I know very well  
20 the challenges of dealing with the bureaucracy of the  
21 healthcare system and Medicaid and denial of  
22 services, and all that goes with it.

23 It's because of this bureaucracy that  
24 I'm concerned about the so-called Healthy Ohio  
25 Program. I think that this un-Healthy Ohio Program

1 is exactly why so many Ohioans are disfavored. The  
2 Ohio House and Senate, they are so unpopular across  
3 the entire political spectrum of Ohioans, and I think  
4 it's because of something like this, proposing a --  
5 new bureaucratic layers, new bureaucratic layers to  
6 this program when, as professionals before me more  
7 eloquently stated up here, there is evidence from the  
8 provisions of this program being used in other states  
9 showing it to be both costly and ineffective and  
10 damaging to people's health. So it's just we do not  
11 need this program.

12 The last thing I wanted to say is that a  
13 lot of the rationale for this program is supposed to  
14 be to encourage healthier lifestyles and more  
15 appropriate use of the healthcare system. Well,  
16 people on Medicaid are -- have to go into one of our  
17 Ohio Medicaid managed programs. Isn't that what  
18 those managed programs are for?

19 If we want to do more towards  
20 encouraging healthy lifestyles and appropriate use of  
21 the healthcare system, the Ohio Assembly I think  
22 would do better to influence those managed care  
23 programs that are set up in our state to do that job.  
24 We already have people to do that job.

25 Thank you.

1 MR. McCARTHY: Thank you. Next up we  
2 have Edward Hamilton.

3 MR. HAMILTON: It's okay.

4 MR. McCARTHY: Declined.

5 Now, the next one, I have a hard time  
6 reading this one, it looks like begins with an M,  
7 Miller Bash, B-a-s-h. Might be butchering a name.  
8 Mike, maybe it's Mike Bash. Okay.

9 MR. COREY: Could it be Corey by chance?

10 MR. TASSIE: No. You're next.

11 MR. COREY: Next, all right.

12 MR. McCARTHY: Why don't you go next.  
13 Next Michael Corey. We'll come back to the next  
14 person who we'll catch at the end.

15 MR. COREY: I have bad penmanship, so I  
16 thought that might be me.

17 MR. McCARTHY: Yours is very, very nice.

18 MR. COREY: Okay. My name is Michael  
19 Cory, and I am the policy analyst at the Children's  
20 Defense Fund of Ohio. We at the Children's Defense  
21 Fund Ohio oppose the proposed Healthy Ohio Medicaid  
22 Waiver because it will disrupt coverage and increase  
23 costs.

24 The CDF Ohio office was established in  
25 1981. Our mission is to ensure every child a healthy

1 start, a head start, a fair start, a safe start, and  
2 a moral start in life, and successful passage to  
3 adulthood with the help of caring families and  
4 communities. Every day we come to work with the  
5 commitment to be a strong, independent voice for all  
6 children. Today I am grateful for the opportunity to  
7 do precisely that.

8 In Ohio, 640,000 more Ohioans now have  
9 coverage as a result of Medicaid expansion, and more  
10 than 2.9 million Ohioans -- excuse me -- are enrolled  
11 in Medicaid. The waiver would create the following  
12 changes for over 1 million of Ohio's Medicaid  
13 population: Charging enrollees unaffordable  
14 premiums, premiums have led to declines in enrollment  
15 in other states; Medicaid enrollees could have their  
16 coverage terminated for nonpayment of premiums;  
17 instituting health savings accounts and debit cards,  
18 which would be costly to administer and make it more  
19 complex for people to use Medicaid; the waiver  
20 proposes annual and lifetime caps, which were ended  
21 as a result of the Affordable Care Act. Medicaid  
22 recipients should not be subject to such caps.

23 We acknowledge that these changes will  
24 not directly impact children, but children live with  
25 adults, and when adults are covered, children's

1 access to healthcare increases and health outcomes  
2 improve. The Children's Defense Fund urges the  
3 Centers for Medicare and Medicaid services to reject  
4 the waiver and not undue the progress Ohio has made  
5 on access to quality healthcare coverage for Ohio  
6 residents.

7 Thank you.

8 MR. McCARTHY: Thank you. Next we have  
9 Wilfred Franklin.

10 MR. FRANKLIN: Good afternoon, everyone.  
11 Everybody hear me okay? Okay. I'll take that as a  
12 yes.

13 My name is Wilfred Franklin, and the  
14 group that I am with is the working poor. I didn't  
15 come today and plan on saying anything, but it's  
16 really hard for me not to be offended when I keep  
17 hearing myself referred to as a lower-income  
18 individual, and then I'm told that I need to be  
19 taught how to manage my own money.

20 I am a war veteran, I am also a  
21 convicted felon, I am also a day laborer, which means  
22 I make about 50 bucks a day, okay. Now, after I pay  
23 into the federal government and pay into my state  
24 government, and depending on wherever my job is that  
25 day, pay into that local government, now you want me

1 to turn around and pay in again for health coverage.

2 Maybe you guys -- or, excuse me, maybe  
3 the people that forgot -- that wrote this forgot,  
4 we're broke. We're poor. That's all I have to say.

5 MR. McCARTHY: Thank you. Next we have  
6 Ed Glinsky.

7 MR. GLINSKY: Good afternoon.  
8 Appreciate the opportunity. I'm here as a private  
9 citizen not representing any organization other than  
10 myself and the taxpayers of Ohio.

11 I'd like to share a couple stories,  
12 actually three groups, to kind of illustrate some  
13 issues here. The first one involves the grandmother  
14 of my grandchild on the other side of the family.  
15 This is a lady who's approximately 54 years old.  
16 About five years ago, she had two bad knees. She had  
17 the first one replaced, that was fine. She had the  
18 second knee replaced, not so good. Subsequently, she  
19 had that knee replaced two additional times. She  
20 developed a subsequent infection, had to have her leg  
21 amputated. She has had two subsequent surgeries on  
22 the amputated leg, including one last week. She's  
23 been in a nursing home for the last year-and-a-half.

24 My question is: With the caps, where in  
25 the world would this lady be if her coverage was

1 capped, not to mention her sole source of income  
2 currently is Social Security Disability which hardly  
3 affords her any money for any kind of a health  
4 savings account or premium.

5           The second scenario involves my  
6 daughter. She's in her early 30s, she has two small  
7 children, and she is a waitress. She works very  
8 hard, but her income is about 20,000 a year. She's  
9 currently on Medicaid, but I can tell you that  
10 between rent, food, other expenses, she does not have  
11 extra income for a health savings account, which by  
12 the way, I've always heard referred to as healthcare  
13 for the healthy and wealthy, not the poor and sick.

14           The third group, I do advocacy work, I  
15 volunteer at Alvis, which is a prison re-entry  
16 facility. I go in once a week and teach a class for  
17 ladies and gentlemen that are being released from the  
18 penal system back into society. These folks have  
19 numerous obstacles already in front of them involving  
20 housing, job procurement, many aren't allowed to  
21 drive, many aren't allowed to re-enter into the  
22 occupation that they were in previously, numerous  
23 hurdles. We all hear about the incarceration issues  
24 in this country. To require these people now to  
25 acquire and fund a health savings account and pay a

1 premium would just be one additional burden that  
2 these people do not need.

3 Overall, I think this is a very  
4 vindictive proposal, and as a private citizen I will  
5 do everything in my power to voice my concern about  
6 these proposed changes. So thank you.

7 MR. McCARTHY: Thank you.

8 So that's everyone we have signed up.  
9 There was one person I could not read the name. You  
10 still here?

11 (No response.)

12 MR. McCARTHY: Once, twice, three times,  
13 okay.

14 So that concludes the public testimony.  
15 But I want to bring up one item, a number of people  
16 brought it up, I do want to clarify. In the waiver  
17 on the lifetime limit and the annual limit of  
18 \$300,000 and a million, once a person hits that, I  
19 want to clarify, the person is not disenrolled from  
20 Medicaid. They're disenrolled from the Healthy Ohio  
21 Program and put back onto traditional Medicaid,  
22 whether it be managed care or fee for service, so the  
23 person will maintain coverage over that period of  
24 time. I just want to make that clarification.

25 So with that, I want to thank everyone

1 for coming out today and for taking time out of your  
2 busy day to inform us of concerns, issues around the  
3 waiver. We really appreciate it. We do take into  
4 account all of the information we have. So thank you  
5 and have a good day.

6 (Thereupon, the meeting was  
7 concluded at 3:15 p.m.)

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CERTIFICATE

I do hereby certify that the foregoing is a true and correct transcript of the proceedings taken by me in this matter on Thursday, April 21, 2016, and carefully compared with my original stenographic notes.

*Carolyn D. Ross*

Carolyn D. Ross,  
Registered Professional  
Reporter and Notary  
Public in and for the  
State of Ohio.

My commission expires April 3, 2019.  
(CDR-80800)

