Public Notice of
Ohio's Proposed 1115 Waiver Application for the
Medicaid Eligibility Modernization Project

The State of Ohio (Ohio) Governor's Office of Health Transformation (OHT) and Department of Job and Family Services (ODJFS), Ohio's Single State Medicaid Agency, are seeking Section 1115 waiver authority to simplify and improve Medicaid eligibility in Ohio. Ohio's goal is to develop a simplified, streamlined, and modernized Medicaid eligibility process and to implement it January 1, 2014. Under this new simplified approach, most individuals will be able to apply for Medicaid online, and have their eligibility determined real-time.

The purpose of Ohio's eligibility modernization project is to transform Medicaid eligibility to a family friendly, understandable, administratively streamlined simple process. This project simplifies Medicaid eligibility in two key ways. First, it eliminates many bureaucratic requirements by simplifying the rules that govern who can be eligible and how. Second, it invests in the information technology that supports determining eligibility so that people can access the services they need. Today, Medicaid covers many people in a variety of service settings. The primary focus of this simplification demonstration project is on Adults in the Community (Community Adult group). Eligibility for children, for pregnant women and for adults needing long-term services and supports (LTSS) is not part of this demonstration waiver and will continue as it is today, though Ohio expects all Medicaid applicants and eligibles to benefit from modernization of Medicaid technology.

Overview

Ohio's Medicaid program will help over 2 million people in Ohio get health care services this year. Medicaid health care coverage is vital for many children, families, older adults and people with disabilities, but the program is so complicated that it can be hard for people to know if they might be eligible for Medicaid. Ohio wants to make changes to the Medicaid program so it will be easier for people who need health care coverage to know if they are eligible and make it more efficient to operate the program.

The Medicaid program is financed by both federal and state dollars and both the federal and state governments have a say in how the program works. Federal rules require certain groups of people be offered Medicaid. These groups of people are called "mandatory eligibility groups." A state can also decide to offer Medicaid to groups in addition to those required by the federal government. These groups are called "optional eligibility groups." There are many eligibility groups in the Medicaid program. Each eligibility group has its own set of rules about who is eligible for that group.

Generally eligibility rules are about how much and what kind of money a person or family can earn to get Medicaid. Some eligibility groups may also have rules about the age of an individual, or about other aspects of a person's situation that may make a difference in whether someone is eligible for Medicaid. For example, to be eligible for Medicaid through one group you might have to have children living in the home. To get on Medicaid through another group, you may have to have a disability. It's important to

get Medicaid through the group that best fits your situation because the services you receive can depend on to which eligibility group you belong.

While there are many ways a person can be eligible for Medicaid, the rules can be complicated and hard to understand. Case workers have to know the rules for the eligibility groups and help people find the right group. All of these different and complicated rules make it difficult to quickly know who is eligible for Medicaid and who is not. It also makes it very difficult for the public to understand how people can get on Medicaid.

Today Ohio has over 150 different "eligibility groups" for Medicaid. And in Ohio, unlike many states, if you are a person with a disability and need both Medicaid and Social Security disability payments, you have to apply at two different agencies to prove you have a disability and need assistance. Another problem in Ohio is that the State's computer system for the Medicaid program is very old. In 2014, the Affordable Care Act (ACA) will require Ohio to bring approximately a million more people onto Medicaid. There is concern that Ohio's computer system may not be able to handle all the changes that come with these new requirements.

The ACA is the new federal law that makes many changes to how our nation's health care system works today. Some people refer to it as the health care reform law. One of the changes made by the ACA is that, in 2014, the limit of how much a person or family can earn and still be eligible for Medicaid goes up. The law also says you do not have to be a parent, pregnant, elderly or have a disability to be an adult on Medicaid, which is generally the case now. For Ohio that means that almost one million people in the State may come onto Medicaid in 2014. This new group of people who will be eligible for Medicaid are called "Group VIII" in this public notice. They are called "Group VIII" because of the section of the Social Security Act created by the ACA to cover this new group of eligible adults.

The Centers for Medicare & Medicaid Services (CMS) is the part of the federal government that is responsible for the Medicaid program. CMS is working to change the Medicaid program so that it follows the ACA and makes it easier to understand who can get Medicaid. Ohio is asking for approval from CMS to let the State do even more to simplify the Medicaid program. It is important to do that now before the new Group VIII begins in 2014 so there will not be another set of rules to make the Medicaid program even more complicated. Ohio wants people to be able to understand and easily apply for Medicaid. Having clear and easy to understand rules will also make it easier for the State to run the program.

Ohio must ask for approval from CMS to "waive," certain federal rules about the Medicaid program. "Waiving" means asking permission to do certain activities to determine eligibility in a different way. Asking permission is done through an "1115 waiver" or "demonstration" application. Ohio's waiver application is called the "Medicaid Eligibility Modernization Project." It's called an "1115 waiver" because Section 1115 of the Social Security Act allows states to request permission to waive certain Medicaid rules. To learn more about 1115 waivers, you can visit the CMS website at this link: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html?filterBy=1115#waivers

Public Input

The State posted the proposed 1115 waiver, or demonstration, application on the Governor's Office of Health Transformation (OHT) website so all Ohioans can read the waiver application. The State would like to hear your comments about the changes the State is proposing to simplify the Medicaid program. After hearing the public's ideas and comments about the proposed changes, the State will make final decisions about what changes to make to the proposed 1115 waiver application and then submit it to CMS. You can find the proposed 1115 waiver application at this website: http://www.healthtransformation.ohio.gov/CurrentInitiatives/ModernizeEligibilityDeterminationSystems.aspx

The public comment period for Ohio's proposed 1115 waiver application is from June 6 until July 6, 2012 at 5 p.m. There are several ways to give your comments to the State on the proposed Medicaid changes. One way is to attend public hearings that the State will hold on the proposed 1115 waiver application. At the public hearing, you can give verbal or written comments to the State about the proposed changes. Two public hearings will be held at the dates/locations noted below.

Public Hearings

Three public hearings on the proposed 1115 waiver have been scheduled to solicit input on the proposed changes to the Medicaid program. The State will accept verbal and/or written comments at the public hearings. The dates for the public hearings are Friday, June 8, 2012, Monday, June 11, 2012 and Tuesday, June 26, 2012. The detailed information for each public hearing is shown below.

Friday, June 8, 2012

Medical Care Advisory Committee

Open to the Public

1:00 p.m. to 3:00 p.m.
Ohio Department of Job and Family Services
Office of Ohio Health Plans
6th Floor, Room C621A/B
50 W. Town Street
Columbus, Ohio 43215

If you are unable to attend the public hearing in person, you may participate by teleconference or webinar. To participate via teleconference (on the date and time of the public hearing) call 1-877-381-2706 and enter passcode 9987610.

To participate via webinar during the public hearing, please use the following URL https://mmc.webex.com/mmc/onstage/g.php?t=a&d=719301497 and follow the instructions posted at this link.

Monday, June 11, 2012

Public Forum
1:00 p.m. to 3:00 p.m.
State Library of Ohio
Large Board Room
274 E. First Avenue
Columbus, Ohio 43201

If you are unable to attend the public hearing in person, you may participate by teleconference or webinar. To participate via teleconference (on the date and time of the public hearing) call 1-877-381-2706 and enter passcode 9987610.

To participate via webinar during the public hearing, please use the following URL https://mmc.webex.com/mmc/onstage/g.php?t=a&d=715808603 and follow the instructions posted at this link.

Tuesday, June 26, 2012

Public Forum
1:00 p.m. to 3:00 p.m.
Rhodes State Office Tower
Lobby Hearing Room
30 E. Broad Street
Columbus, OH 43215

The public comment period for the proposed 1115 waiver application is from **June 6, 2012 through July 6, 2012**. **All comments must be received by 5 p.m. on July 6, 2012.** Requests for a copy of the proposed 1115 Waiver or comments on the proposed 1115 Waiver should be submitted by mail to:

Ohio Department of Job and Family Services
Office of Ohio Health Plans
Attn: ***Medicaid Eligibility Modernization 1115 Waiver***
P. O. Box 182709
Columbus, Ohio 43218-2709

Another way to provide your comments is by emailing comments to **eligibility@jfs.ohio.gov** or mailing written comments to the P.O. Box address above.

When mailing or emailing please specify the ***Medicaid Eligibility Modernization 1115 Waiver.***

A hard copy of the proposed 1115 waiver application can also be picked up at ODJFS, which is located at:

Ohio Department of Job and Family Services
Office of Ohio Health Plans

50 West Town Street
Columbus, Ohio 43215

Ohio has included in this public notice a summary of the proposed application's main points and the changes the State wants to make to simplify the Medicaid program. The summary includes:

- A description of the State's goals for revising the Medicaid program
- How the State plans to simplify the Medicaid program
- What groups of people will be affected by the changes and how it will impact them
- How the changes will affect the people who are on the Medicaid program each year and how much it will cost
- How the State will determine whether these changes are successful in simplifying and transforming the Medicaid program
- What specific federal rules the State is asking permission to waive

SUMMARY OF OHIO'S PROPOSED1115 WAIVER APPLICATION

Program Description, Goals and Objectives

The State of Ohio (Ohio) Governor's Office of Health Transformation (OHT) and Department of Job and Family Services (ODJFS), Ohio's Single State Medicaid Agency, are asking for Section 1115 waiver federal authority to simplify and improve Ohio's Medicaid eligibility process. Ohio's goal is to develop a simplified, streamlined, and modernized Medicaid eligibility process to be implemented January 1, 2014, when the federally-mandated Medicaid eligibility expansion is scheduled to take place. Under this simplified, streamlined approach, most individuals will be able to apply for Medicaid online, answer a limited number of questions, and have their eligibility determined real-time.

How the State Plans to Simplify the Medicaid Program

As the Centers for Medicare & Medicaid Services (CMS) has recognized in recent rulemaking, the current federal legal framework for determining Medicaid eligibility is extremely complex. There are multiple mandatory and optional eligibility groups for different "categorical populations," and the determination of financial eligibility uses methods based on other programs, primarily the former Aid to Families with Dependent Children (AFDC) and Social Security Income (SSI) programs. CMS has acknowledged that the eligibility rules are burdensome for states and difficult for the public to understand.

Medicaid eligibility is particularly complicated in Ohio because it is a Section 209(b) State. Ohio has over 150 categories of Medicaid eligibility, and two separate processes to determine Medicaid eligibility based on disability. Ohio's eligibility processes are fragmented, overly complex, and rely on outdated technology. Ohio's current technology does not have the capacity to process applications and enrollment for the nearly one million Ohioans who will be newly eligible (Group VIII) for Medicaid in 2014 as a result of the Affordable Care Act (ACA).

Although CMS is undertaking efforts intended to simplify Medicaid eligibility and enrollment, these efforts will not fully address the problems with Ohio's current system. Ohio therefore has developed, based on careful study and stakeholder input, a comprehensive eligibility modernization plan to simplify eligibility based on income, streamline state and local responsibility for eligibility determination, and update eligibility systems technology. These initiatives build on, and are consistent with, CMS efforts to simplify Medicaid eligibility, but some of them will require Section 1115 waiver authority.

These changes will impact county eligibility operations. The state is engaged in a process with county policy staff to identify the impact of self-service and other modernization changes on county operations. The operative assumption is that there will be a significant continuing role of counties, but that there will be opportunities for streamlining and focusing resources on challenging cases.

Ohio's proposed waiver application has the following major features:

1. ***Consolidation into Three Basic Eligibility Groups.*** As a first step, Ohio would group the State's Medicaid eligibility categories into three groups: (1) children and pregnant women; (2) adults who require long-term services and supports (LTSS), including adults who reside in a long-term care facility or receive Section 1915(c) home- and community-based services and adults eligible for Medicaid Buy-In for Workers with Disabilities (MBIWD); and (3) non-pregnant adults who do not need LTSS (referred to as Community Adults).

   Eligibility for children, pregnant women, and adults requiring LTSS would continue to be governed by existing standards and processes but using modern technology. The demonstration would focus on simplification and streamlining of eligibility determinations for Community Adults, as set forth below.

2. ***Simplification of Income Eligibility for Community Adults.*** Ohio is requesting waiver authority to simplify income eligibility for all Community Adults (non-pregnant adults who do not need LTSS). Ohio proposes to have two income standards for Community Adults. One income standard is for Community Adults who are under age 65 and do not have Medicare. The income standard for this subgroup is the MAGI-based income standard of 133% (after a standard 5% disregard) for the new adult group. Some individuals who must currently spend down to qualify for Medicaid coverage will become eligible for coverage under this group without a spenddown.

   The second income standard is for Community Adults who do not meet the criteria for the first subgroup: primarily individuals who are age 65 or older or who have Medicare. The income standard for this subgroup (referred to as the EIL subgroup) is an "effective income level (EIL)" based on Ohio's current Section 209(b) income standard (approximately 64% FPL). This income standard is calculated using current Section 209(b) income exemptions/exclusions but no income disregards. Ohio will set its new EIL at 70% FPL. Some individuals who must currently spend down to qualify for Medicaid coverage will no longer need to spend down because Ohio would be moving its FPL for qualifying for Medicaid for this group from 64% FPL to 70% FPL.

3. ***Express Lane Eligibility for Community Adults.*** Ohio requests waiver authority to streamline eligibility by strengthening linkages between Medicaid and programs such as Temporary Assistance for Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP) to use information and findings from those programs to simplify, streamline, and expedite the Medicaid eligibility process (Express Lane Eligibility for Community Adults).

4. ***Elimination of Resource Test for Community Adults.*** Ohio currently has a resource (asset) test for adults age 65 and older and people with disabilities who qualify under Section 209(b). In order to further simplify and streamline eligibility, Ohio eliminates the current resource test for Community Adults who become eligible based on the EIL. This means Ohio will not have a resource test for any Community Adults.

5. ***Benchmark Coverage for Community Adults.*** Ohio requests waiver authority to provide benchmark coverage to all Community Adults, not just those in the new adult group (referred to as Group VIII). Benchmark coverage will consist of all items and services in Ohio's Medicaid program except LTSS and Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services. Individuals who need LTSS will need to meet additional requirements and would be considered to be in the LTSS group instead of the Community Adult group. This benchmark coverage will enable the State to provide coverage that meets the needs of all Community Adults without having to administer different benefit packages to different consumers in the same group.

6. ***Elimination of State Disability Determination for Community Adults.*** Ohio requests waiver authority to eliminate the need for the State to conduct disability determinations for Community Adults under 133% FPL (using the MAGI determination).

   Because Ohio intends to provide benchmark coverage that consists of all Medicaid services except LTSS and EPSDT, all Community Adults will receive the same coverage regardless of whether they fall within a disability eligibility group or the new adult group. Therefore a disability determination will not be necessary to establish eligibility for most adults.
   Since the MAGI standard is simpler and does not require spend down for those with income up to 133% FPL, Ohio expects that applicants with disabilities will enroll based on eligibility for the MAGI subgroup. Individuals at any income l***e***vel with a disability determination from the SSA may also elect to have their eligibility determined using the EIL.

   Individuals who need LTSS could enroll in the LTSS eligibility group if they meet the income criteria and other eligibility standards for one of the categories in that group.

7. ***Maximum Income Standards for Community Adults.*** Ohio is requesting waiver authority to establish a maximum income standard of 133% FPL for the MAGI subgroup of Community Adults (non-pregnant adults not needing LTSS who are under age 65 and do not have Medicare). The income standard for the EIL subgroup of Community Adults (those who are over age 65 or have Medicare) will be the EIL (70% FPL) with the option to spend down to that standard. As part of this approach, Ohio will no longer offer transitional medical assistance (TMA) since most individuals in this category will now qualify under MAGI or EIL.

8. ***Protections for Current Community Adults.*** Ohio will create a protected category for individuals found eligible for Medicaid before the effective date of this waiver and enrolled in Medicaid on the effective date of this waiver who might otherwise be disadvantaged by the changes to Medicaid eligibility implemented through this demonstration. Community Adults who do not meet the demonstration income standards but who are on Medicaid as of January 1, 2014 would be allowed to continue participation in the Medicaid program under applicable criteria until they no longer meet qualifying criteria, obtain other creditable coverage, or withdraw from

the program. Individuals receiving transitional medical assistance (TMA) who do not meet the demonstration income standards would remain eligible until the end of their transitional period.

List of Eligibility Groups Impacted by Ohio's Proposed Waiver Application

Mandatory & Optional Categories Impacted By Waiver
(only non-pregnant adults in these categories)

SSA and/or CFR Citation	Group name	Who is this? (Criteria)
1902(f)	209(b)	Aged, Blind, or Disabled Individuals
42 CFR 435.110	Medicaid for Parents and Caretaker Relatives	Parents and caretaker relatives (and if applicable the spouse of the parent or relative) with household income at or below a limit selected by the state (between 1988 AFDC limits and 2010 limit for SSA §1931 families)
1902(a)(10)(A)(i)(VIII); 42 CFR 435.119	Individuals age 19 or older and under age 65 at or below 133 percent FPL	Individuals age 19 through 64; not pregnant; not entitled to or enrolled for Medicare benefits under Medicare Part A or B; not otherwise eligible and enrolled for mandatory Medicaid coverage; with household income at or below 133% FPL. Exclusion if individual resides with his or her dependent child not covered by minimum essential benefits.
1931(b)(2)(C)	Low Income Families above cash standard	Families (less restrictive income/resource standards)
1902(a)(10)(A)(i)(I)	Receiving assistance under Title I, X, XIV	Receive assistance from the state under grants to states for the aged, blind, or disabled individuals
1902(a)(10)(A)(i)(II); 1619; 1905(q)	1619 Individuals	Individuals found by SSA to meet 1619 criteria; met Medicaid criteria before meeting 1619 criteria
1902(a)(10)(A)(i)(II); 1905(q); 1634; 42 CFR	Grandfathered individuals	Multiple groups who met Medicaid eligibility criteria and were enrolled in or met criteria for another program on specific dates ranging from

SSA and/or CFR Citation	Group name	Who is this? (Criteria)
435.131, .132, .133, .134		1972 to 1987
1902(a)(10)(A)(i)(II); 42 CFR 435.130	RSS	Individuals receiving mandatory state supplements
1902(a)(10)(A)(i)(I); 1931; 42 CFR 435.110, .113, .114, .115	Cash Assistance	Individuals receiving TANF, deemed cash recipients, grandfathered cash-based recipients, and multiple specific cash-related groups
1902(a)(10)(A)(ii)(XI); 42 CFR 435.230, 435.121	RSS	Individuals who receive an optional state supplement
1902(a)(10)(A)(i)(I); 1902(a)(52); 1925; 1931	Transitional Medical Assistance	Families received cash assistance or LIF Medicaid in 3 of prior 6 months; lost eligibility due solely to increased earnings
1902(a)(10)(A)(i)(I); 1931(c)	4-month extended	4-month extended due to spousal or child support
1902(a)(10)(A)(ii)(XVIII)	BCCP	Under 65, not in a mandatory group, no other creditable coverage, diagnosed under CDC's program
1902(a)(10)(A)(ii)(XXI)	Family Planning Option	Not pregnant, with income no higher than the state's highest eligibility limit for pregnant women

Estimates of Impact on Enrollment in the Medicaid Program and Costs

The following tables summarize the expected impact of this waiver by displaying the number of affected individuals and the expected costs or savings. Table 3 projects waiver enrollment and expenditures for Community Adults. Table 4 isolates the changes to eligibility, including costs, to more clearly show the impact of the waiver on enrollment and expenditures. Each of these tables identifies whether eligibility groups and associated costs are existing or new. Table 5 shows Ohio's projected enrollment and expenditures for the entire population with full Medicaid benefits, including the expected impact of the expansions required in 2014 by federal legislation.

Table 3 shows the projected enrollment and expenditures associated with the Community Adult population described in this waiver, except for the expected impact of the expansions required in 2014 by federal legislation. In the first section ("Ohio MAGI Waiver Proposal"), there is a new cost associated with this group because no spenddown will be required for them on and after the effective date of this waiver. The second section ("Ohio EIL Waiver Proposal") projects enrollment and costs for two new groups – some individuals previously enrolled only in the Medicare Premium Assistance Programs (with the existing state costs identified separately), and some individuals enrolling due to the change in spenddown policy. Some individuals eligible under the EIL will no longer have a spenddown; these new costs to the state are also projected. The "Ohio Waiver Protected Groups" section projects enrollment and costs for Community Adults who are eligible and enrolled in Medicaid on January 1, 2014, but who do not meet the requirements for coverage under either the MAGI group or the EIL group. Costs here are associated with three groups: Those receiving Transitional Medical Assistance (which will continue until the end of their transitional period, meaning these costs will end during CY 2014); those receiving Breast and Cervical Cancer Project coverage; and other adult Medicaid enrollees, not receiving LTSS, with income above 138% FPL and who are not eligible for coverage in the EIL group.

Note: The projections in Table 3 reflect only individuals eligible for full Medicaid coverage as Community Adults. This estimate does not include children, pregnant women, individuals eligible for LTSS, mandatory federal Medicaid expansions, or individuals eligible only for premium assistance.

Table 3.

Population Group		Enrollment					Expenditures				
Ohio MAGI Waiver Proposal		**CY 2014**	**CY 2015**	**CY 2016**	**CY 2017**	**CY 2018**	**CY 2014**	**CY 2015**	**CY 2016**	**CY 2017**	**CY 2018**
Adults enrolled in Family Medicaid	Existing Category	432,298	439,421	443,815	448,253	452,736	$2,706,669,654	$2,877,825,922	$3,040,306,535	$3,211,961,167	$3,393,312,017
Individuals enrolled in ABD Medicaid, under age 65, without Medicare, with income between 70% and 133% FPL	Existing Category	8,505	8,590	8,676	8,763	8,851	$193,655,788	$204,588,403	$216,141,956	$228,351,585	$241,254,400
Individuals enrolled in Breast and Cervical Cancer Project coverage	Existing Category	610	616	622	628	634	$19,386,217	$20,477,439	$21,628,032	$22,841,149	$24,120,107
Adults enrolled in Transitional Medical Assistance	Existing Category	50,276	50,779	51,287	51,800	52,318	$314,784,069	$332,558,349	$351,336,032	$371,173,396	$392,129,846
Cost to state of spenddown offset loss	New Cost	--	--	--	--	--	$12,073,324	$13,039,190	$14,082,326	$15,208,912	$16,425,625
Total MAGI Group		**491,689**	**499,406**	**504,400**	**509,444**	**514,539**	**$3,246,569,053**	**$3,448,489,303**	**$3,643,494,880**	**$3,849,536,208**	**$4,067,241,995**
Ohio EIL Waiver Proposal											
Individuals enrolled in ABD Medicaid not eligible for MAGI-based Medicaid	Existing Category	241,004	243,414	245,848	248,306	250,790	$3,839,809,282	$4,056,610,727	$4,285,640,578	$4,527,596,588	$4,783,237,664
Individuals enrolled in premium assistance only (QMB, SLMB, and QI-1) who will become eligible	New Category	5,121	5,172	5,224	5,276	5,329	$25,070,572	$26,484,982	$27,981,823	$29,560,333	$31,230,715
Existing costs to state for individuals enrolled in premium assistance only	Existing Costs	--	--	--	--	--	$35,753,388	$37,770,491	$39,905,152	$42,156,279	$44,538,428
Individuals newly enrolling due to EIL/change in spenddown policy	New Category	323	326	329	332	335	$6,413,540	$6,770,871	$7,147,506	$7,544,464	$7,962,818
Cost to state of spenddown offset loss	New Cost	--	--	--	--	--	$5,847,859	$6,315,688	$6,820,943	$7,366,618	$7,955,948
Total EIL Group		**246,448**	**248,912**	**251,401**	**253,914**	**256,454**	**$3,912,894,642**	**$4,133,952,758**	**$4,367,496,002**	**$4,614,224,282**	**$4,874,925,574**
Ohio Waiver Protected Groups											
Adults enrolled in Transitional Medical Assistance	Existing Category	24,603	-	-	-	-	$115,531,752	$0	$0	$0	$0
Breast and Cervical Cancer Project	Existing Category	160	160	160	160	160	$5,084,909	$5,318,815	$5,563,481	$5,819,401	$6,087,093
Others	Existing Category	7,488	6,365	5,410	4,599	3,909	$46,883,267	$41,685,222	$37,060,618	$32,954,179	$29,298,436
Total Protected Group		**32,251**	**6,525**	**5,570**	**4,759**	**4,069**	**$167,499,928**	**$47,004,037**	**$42,624,099**	**$38,773,579**	**$35,385,529**
TOTAL IMPACT OF OHIO'S DEMONSTRATION WAIVER PROPOSAL		**770,388**	**754,843**	**761,371**	**768,117**	**775,062**	**$7,326,963,622**	**$7,629,446,099**	**$8,053,614,981**	**$8,502,534,069**	**$8,977,553,099**

Table 4 focuses on changes to Medicaid eligibility and expenditures as a result of the proposed demonstration. There are two groups of newly enrolling adults: some individuals previously eligible only for Medicare Premium Assistance Programs but now eligible for full Medicaid coverage, and some individuals newly enrolling due to the change in spenddown policy. These projections are shown in the first two lines of the enrollment and expenditure charts. The third line shows the combined impact of the loss of the spenddown offset for individuals who no longer have to pay a spenddown. The fourth line shows the combined impact of two groups: community adults not enrolled in Medicaid on January 1, 2014 who will not be eligible for coverage after that date as a result of policy changes; and individuals who leave the protected group. As TMA, by rule, is limited to 12 months of coverage, it is expected that all TMA recipients in the protected group will finish their TMA period and leave Medicaid coverage in CY 2014. A 15 percent per year attrition rate was assumed for most other individuals in the protected group.

Note: The projections in Table 4 reflect only individuals eligible for full Medicaid coverage as Community Adults. This estimate does not include children, pregnant women, individuals eligible for LTSS, mandatory federal Medicaid expansions, or individuals eligible only for premium assistance.

Table 4.

Population Group		Enrollment – Cumulative Across Years					Expenditures				
New Categories Proposed in Ohio's Demonstration Waiver		**CY 2014**	**CY 2015**	**CY 2016**	**CY 2017**	**CY 2018**	**CY 2014**	**CY 2015**	**CY 2016**	**CY 2017**	**CY 2018**
Individuals enrolled in premium assistance only (QMB, SLMB, and QI-1) who will become eligible	New Category	5,121	5,172	5,224	5,276	5,329	$25,070,572	$26,484,982	$27,981,823	$29,560,333	$31,230,715
Individuals newly enrolling due to EIL/change in spenddown policy	New Category	323	326	329	332	335	$6,413,540	$6,770,871	$7,147,506	$7,544,464	$7,962,818
Cost to state of spenddown offset loss	New Cost						$17,921,184	$19,354,878	$20,903,268	$22,575,530	$24,381,572
Individuals exiting protected group and new individuals not eligible due to the change in policy	New Category	-24,603	-26,049	-27,329	-28,469	-29,490	($38,510,584)	($170,651,714)	($187,332,887)	($204,177,292)	($221,290,562)
Net Impact of Ohio's Demonstration Waiver		**-19,159**	**-20,551**	**-21,776**	**-22,861**	**-23,826**	**10,894,712**	**($118,040,983)**	**($131,300,289)**	**($144,496,966)**	**($157,715,456)**

Table 5 displays Ohio's projected enrollment and total (state plus federal) expenditures for direct services, for the Medicaid population with full Medicaid coverage, including the expected impact of the expansions required in 2014 by federal legislation. In this table, the combined impact of the proposed demonstration on enrollment and expenditures is summarized. Cost and population trends are based on historical experience through 2012, with adjustments for 2015 and beyond reflecting previous post-recession experiences.

Table 5.

Population Group		Enrollment					Expenditures*				
Ohio's Proposed Eligibility Categories		**CY 2014**	**CY 2015**	**CY 2016**	**CY 2017**	**CY 2018**	**CY 2014**	**CY 2015**	**CY 2016**	**CY 2017**	**CY 2018**
Children and Pregnant Women	Current Policy	1,251,704	1,259,126	1,271,717	1,284,434	1,297,279	$4,254,574,786	$4,507,064,725	$4,743,525,203	$4,992,391,440	$5,254,314,297
Adults who need LTSS	Current Policy	158,740	164,205	171,467	179,049	186,967	$7,461,203,001	$7,815,829,298	$8,341,018,315	$8,901,497,702	$9,499,638,814
Community Adults	1115 Waiver	**770,388**	**754,843**	**761,371**	**768,117**	**775,062**	**$7,326,963,622**	**$7,629,446,099**	**$8,053,614,981**	**$8,502,534,069**	**$8,977,553,099**
Total Ohio Proposed Eligibility Categories		**2,180,832**	**2,178,174**	**2,204,555**	**2,231,601**	**2,259,308**	**$19,042,741,410**	**$19,952,340,122**	**$21,138,158,499**	**$22,396,423,211**	**$23,731,506,209**
Impact on Enrollment due to ACA**											
Children	ACA	165,500	200,000	218,000	220,000	221,500	$573,100,000	$656,500,000	$724,600,000	$760,350,000	$797,350,000
Adults	ACA	751,000	855,500	914,000	923,500	933,000	$3,801,400,000	$4,463,850,000	$4,916,150,000	$5,164,750,000	$5,425,800,000
Total ACA-induced Expansion		**916,500**	**1,055,500**	**1,132,000**	**1,143,500**	**1,154,500**	**$4,374,500,000**	**$5,120,350,000**	**$5,640,750,000**	**$5,925,100,000**	**$6,223,150,000**
TOTAL INCLUDING WAIVER CHANGES AND ACA EXPANSION		**3,097,332**	**3,233,674**	**3,336,555**	**3,375,101**	**3,413,808**	**$23,417,241,410**	**$25,072,690,122**	**$26,778,908,499**	**$28,321,523,211**	**$29,954,656,209**

* Disproportionate Share Hospital Payments, Upper Payment Limit, and other costs are not included.

** Based on Mercer June 2012 review of Milliman June 2011 impacts to Ohio Medicaid from ACA.

Evaluating Changes to the Medicaid Program

If given approval by CMS to make these changes to the Medicaid program, Ohio will study carefully whether these changes are making the Medicaid program simpler to understand and manage. It is important to the State that these changes simplify, streamline and transform Medicaid in a way that helps Ohioans. To know whether the changes to the program are successful or not, the State will determine if:

1. Eligibility for Community Adults is determined more quickly and reduces current enrollment complications
2. The improved eligibility process makes it easier for people who are eligible for Medicaid to stay enrolled in the program
3. People who are on Medicaid in the Community Adult group are more satisfied with the revised eligibility process
4. The revised process makes the Medicaid program more efficient
5. People who were enrolled in Medicaid on January 1, 2014, remained eligible and, if so, for how long.

Ohio will determine whether the changes to the Medicaid program have achieved the above by:

1. Analyzing eligibility determination statistics for a period prior to and after the changes to compare the number of applications processed and the average processing times for Community Adult applications.
2. Analyzing enrollment spans to evaluate turnover before and after the changes
3. Conducting a survey of new applicants for the Community Adult group to determine their satisfaction with the application process
4. Conducting a survey of current enrollees in the Community Adult group to identify any process issues or negative effects of changes
5. Analyzing Ohio's eligibility error rates
6. Analyzing eligibility data to determine the number of individuals who attained/lost eligibility because of the changes.

Details about the Approval needed by the Federal Government

Specific Waiver Approval Sought

To the extent necessary to implement the proposal, the State of Ohio requests that CMS, under the authority of Section 1115(a)(1) of the Social Security Act (the Act), waive the following State plan requirements contained in section 1902 of the Act in order to enable Ohio to implement this demonstration:

1. Section 1902(a)(4)(A) to the extent necessary to permit the State to simplify income standards for Community Adults (non-pregnant adults not needing LTSS) by creating two income standards: a MAGI-based income standard of 133% FPL for Community Adults who are under age 65 and do not have Medicare; and an effective income level (EIL) of 70% FPL for Community Adults who do not meet the criteria of the MAGI subgroup (primarily individuals age 65 or older or who have Medicare); and to protect current Medicaid enrollees negatively impacted by the new income standards.

2. Section 1902(a)(10)(A) to the extent necessary to permit the State not to collect and report data regarding the eligibility groups that comprise the Community Adult group.
3. Section 1902(e)(1)(A) to the extent necessary to permit the State to not provide transitional medical assistance (TMA) and extended medical assistance under Section 1925 and Section 1931.
4. Section 1902(e)(14)(D) to the extent necessary to permit the State to conduct Medicaid eligibility determinations using modified adjusted gross income (MAGI) for Community Adults who are under age 65 and do not have Medicare.
5. Section 1902(f) to the extent that it requires the State to conduct a disability determination, only as applied to Community Adults (non-pregnant adults not applying for LTSS).
6. Section 1902(f) to the extent necessary for the State to establish an EIL of 70% FPL for Community Adults who do not meet the criteria of the MAGI subgroup (primarily individuals age 65 or older or who have Medicare).
7. Section 1902(f) to the extent necessary to allow the state to accept blind work expenses, medically-related work expenses, and impairment-related work expenses as expenses incurred for medical or remedial services.
8. Section 1902(a)(4)(A) and Section 1902(f) to the extent necessary to eliminate the resource test for Community Adults in the EIL subgroup (primarily individuals who are age 65 or older or have Medicare) while retaining it for the LTSS group.
9. Section 1937(a)(2)(B) to the extent necessary to permit the State to provide benchmark coverage to all Community Adults (non-pregnant adults not applying for LTSS).
10. Section 1902(a)(43) to the extent necessary to enable the State to not provide coverage of early and periodic screening, diagnostic and treatment (EPSDT) services to 19- and 20-year-old individuals in the Community Adult group.
11. Section 1902(a)(10)(A), Section 1902(a)(10)(C)(i)-(iii), and Section 1902(a)(17) to the extent necessary to permit the State to use Express Lane eligibility determinations for individuals in the Community Adult group.

Additional Federal Approval Sought

In addition to the waiver authorities specified above, Ohio intends to implement additional eligibility simplification and streamlining changes through the state plan amendment (SPA) process. This will include a SPA to eliminate coverage of the BCCP group effective January 1, 2014. Individuals formerly in the BCCP group with income up to 133% FPL will be eligible through the Community Adult group.. Ohio would continue coverage of individuals in the BCCP group with income over 133% FPL as part of the protected group discussed in Section 2. Ohio also intends to submit a SPA to eliminate the new family planning group as of January 1, 2014. Some individuals formerly in the family planning group will be eligible through the Community Adult group for a comprehensive benefit package. Unlike with BCCP, Ohio does not intend to continue eligibility for individuals in the family planning group with income over 133% FPL as part of the protected group.