Office of Health Transformation

Modernize Medicaid Eligibility

Governor Kasich's Budget:

- *Requires premium payments for adults over 100 percent of poverty.*
- *Speeds up the transition off of Medicaid.*
- *Standardizes Medicaid coverage for adults above 138 percent of poverty.*
- *Saves $100 million ($47 million state share) over two years.*

Background:

Medicaid is funded jointly by the federal and state governments. The federal government sets some basic requirements concerning eligibility levels that must be covered in every state. While Ohio has some control over the income limit for each eligibility category, federal law requires Medicaid coverage to be provided to individuals who meet specific categorical requirements. Categorical and eligibility requirements are specified in a particular state's Medicaid state plan. Altering eligibility levels requires approval of a state plan amendment by the Center for Medicare and Medicaid Services (CMS). Ohio's current state plan covers the following groups:

- ***Modified Adjusted Gross Income (MAGI) coverage.*** Some individuals are eligible for Medicaid based on their household income, including:
  - *Children under age 19 below 206 percent of the federal poverty level (FPL);*
  - *Young adults aging out of foster care (no income limit);*
  - *Pregnant women below 200 percent FPL; and*
  - *Adults age 19 to 64 years, not covered by Medicare, below 138 percent FPL (133 percent plus a five percent income disregard).*

- ***Aged, Blind, and Disabled (ABD) coverage.*** Medicaid benefits are afforded to Ohioans who are age 65 or older, or who are living with blindness or a disability, using income calculations based on Social Security Income methodologies. Individuals are eligible for ABD coverage below 64 percent of poverty but can "spend down" from a higher income level on health care costs and, if they hit the 64 percent level, become eligible.

- ***Other categories of eligibility***. In some cases, Ohioans at higher income levels who would not qualify for Medicaid based on MAGI or ABD criteria instead qualify because of other special circumstances. These groups include persons with long-term care needs (up to 225 percent FPL) and enrollees who came into the program through presumptive eligibility, or the Breast and Cervical Cancer Program (BCCP). There are also several "limited coverage" programs that are time-limited or offer limited services, including

Refugee Medical Assistance, Alien Emergency Medical Assistance, Family Planning Services, and the Medicare Premium Assistance Program.

In 2014, Ohio Medicaid provided health care coverage for 2.8 million low-income Ohioans, including 1.2 million children, 430,000 seniors and people with disabilities, and 1.1 million other adults. About half of the Medicaid eligible adults work (42 percent have earned income) and, for those without earned income, about half (46 percent) have a behavioral health diagnosis or using behavioral health services.

Executive Budget Proposal and Impact:

The Executive Budget makes eligibility changes that acknowledge the availability of subsidized coverage on the federal marketplace exchange and promote personal responsibility. In total, these changes save $100 million ($47 million state share) over two years.

- ***Assess premiums for adults above 100 percent of poverty.*** Ohio Medicaid currently requires cost sharing in the form of co-pays for everyone except children, pregnant women, and persons who are aged, blind or disabled (ABD). There are no premiums in the current Medicaid program. The Executive Budget requires childless, non-pregnant adults who have income between 100-138 percent MAGI to pay a monthly premium to the Medicaid program. Under Section 1115 of the Social Security Act, CMS may grant Ohio the authority to charge premiums for this population. After three consecutive months of premium payment delinquency, an individual may experience a disruption in coverage. Monthly premium amounts will be calculated using a similar methodology as used in the federal marketplace exchange and capped to not exceed two percent of household income. The average monthly premium charge is expected to be approximately $20. This provision will take effect January 1, 2016 and save $1.6 million in 2016 and $3.2 million in 2017 (state share).

- ***Eliminate Medicaid coverage for non-aged or disabled adults above 138 percent of poverty.*** Because subsidized health insurance is now available on the federal marketplace exchange, the Executive Budget will eliminate Medicaid coverage above 138 percent MAGI for pregnant women, BCCP, and the Family Planning Group. Currently, individuals in these groups are eligible for Medicaid up to 200 percent of poverty, but those levels were set when the federal exchange did not exist and the only alternative to Medicaid was to be uninsured. Ohioans enrolled through the pregnant women and BCCP eligibility groups at the time of the change will be allowed to continue to receive services through Medicaid until their eligibility expires under current rules. Individuals with eligibility in the Family Planning Group with income below 138 percent MAGI can obtain full Medicaid coverage instead of the limited benefit, and those above 138 percent MAGI can obtain subsidized coverage through the federal marketplace. This provision saves $15.3 million ($7.4 million state share) in 2016 and $31.4 million ($15.4 million state share) in 2017. This provision does not apply to persons at higher incomes

who qualify for Medicaid through Medicaid Buy-In for Workers with Disabilities (MBIWD) or because they need long-term care services; these groups require services available through Medicaid but not necessarily covered by plans on the exchange.

- ***Speed up the transition off Medicaid.*** Currently in Ohio, when a parent or caretaker relative's earned income increases above the eligibility threshold for the group (206 percent of poverty for children and 90 percent of poverty for parents and caretakers), a 12-month Transitional Medical Assistance (TMA) span is approved without requiring individuals to complete quarterly reporting of their income. The Executive Budget will return this eligibility policy to the pre-recession policy which will provide six months of continued Medicaid eligibility in addition to quarterly reporting. As long as the person's income remains below 185 percent of poverty and he or she reports quarterly, six additional months of eligibility will be granted. This provision saves $4.1 million ($1.5 million state share) in 2016 and $39.9 million ($15.0 million state share) in 2017.

- ***Raise the income level at which individuals with disabilities qualify for Medicaid and eliminate spend down.*** The Executive Budget requires Ohio Medicaid and Opportunities for Ohioans with Disabilities (OOD) to replace Ohio's two duplicative disability determination systems with one system that will determine eligibility for both Medicaid and Supplemental Security Income (see *Simplify Eligibility Determination*). Under the new system, the income standard for Medicaid will be raised from 64 percent FPL to 75 percent FPL to match eligibility for Supplemental Security Income, and the asset test will be raised from $1,500 to $2,000. As a result, an estimated 7,110 additional Ohioans will qualify for Medicaid at a cost of $51.4 million ($19.3 million state share) in 2016 and $65.0 million ($24.4 million state share) in 2017. At the same time, spend down will be eliminated, which will result in approximately 4,500 Ohioans no longer qualifying for Medicaid because their income is too high, resulting in savings of $47.1 million ($17.7 million state share) in 2016 and $59.6 million ($22.4 million state share) in 2017. The reduced cost of administering one system instead of two will generate additional savings of $6.0 million ($3.0 million state share) and $7.4 million ($3.7 million state share) in 2017. The net impact of these changes costs $1.7 million ($1.4 million state share) in 2016 and $2.0 million ($1.7 million state share) in 2017.

- ***Why the Budget otherwise remains silent on Medicaid coverage levels.*** Current Medicaid eligibility levels were approved on October 10, 2013 and went into effect on January 1, 2014. The Kasich Administration supports the current levels, so the budget bill is silent on this issue. The authority to set and keep Medicaid eligibility at current levels results from a combination of the following federal and state laws:

  - Federal law requires state Medicaid programs to cover a specified set of *mandatory* eligibility groups and permits them to cover *optional* groups.[1]

- Ohio law requires Medicaid to cover "all mandatory eligibility groups" and permits the program to cover "any of the optional eligibility groups" unless otherwise prohibited by state law (Ohio Revised Code section 5163.03 enacted June 2013).[2]

- The most direct method to set Medicaid eligibility levels is via a State Plan Amendment (SPA). Ohio law permits the Medicaid director to seek a SPA without additional legislation (Ohio Revised Code section 5162.07 enacted June 2013)

- On September 26, 2013, the Ohio Medicaid director submitted a SPA to seek federal approval to extend coverage to Ohioans with income below 138 percent of poverty. (Ohio law does not prohibit covering this group.)

- On October 10, 2013, the Centers for Medicare and Medicaid Services (CMS) approved Ohio's SPA request and made federal funds available to extend Medicaid coverage in Ohio beginning January 1, 2014.[3]

The existing state plan authority does not expire. Therefore, unless the Medicaid director submits another SPA to change Ohio's policy, the current Medicaid eligibility levels – including the expansion group – remain in effect.

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[1] The Affordable Care Act (ACA) amended Section 1902 of the Social Security Act to require each state to provide Medicaid coverage for poor adults under 138 percent of poverty even if they do not have either a disability or children at home. Section 1903 of the Social Security Act provides that a state can lose federal financial assistance if the state plan, or the state's administration of the state plan, fails to comply with Section 1902. Specifically, division (a)(10)(A)(i)(VIII) of Section 1902 requires that, as a condition of receiving federal Medicaid dollars, a state's Medicaid state plan "must … provide [for] making medical assistance available … to all individuals … beginning January 1, 2014, who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under [Medicare Part A], or enrolled for benefits under [Medicare Part B], and are not described in a previous subclause of this clause, and whose income … does not exceed 133 percent of the poverty line [with a 5-percent disregard that increases the limit to 138 percent of the poverty line] … applicable to a family of the size involved, …." The United States Supreme Court upheld the ACA requirement on states to extend Medicaid coverage but restricted the federal government's enforcement authority for that provision, making it expressly mandatory but effectively optional for states to comply.

[2] R.C. 5163.03: "(A) Subject to section 5163.05 of the Revised Code [which allows eligibility requirements for aged, blind, and disabled individuals to be more restrictive than the eligibility requirements for the supplemental security income program], the Medicaid program shall cover all mandatory eligibility groups. (B) The Medicaid program shall cover all of the optional eligibility groups that state statutes require the Medicaid program to cover. (C) The Medicaid program may cover any of the optional eligibility groups [that] state statutes expressly permit the Medicaid program to cover the optional eligibility group [or] state statutes do not address whether the Medicaid program may cover the optional eligibility group. (D) The Medicaid program shall not cover any eligibility group that state statutes prohibit the Medicaid program from covering."

[3] Ohio Medicaid routinely seeks and the federal government approves State Plan Amendments that set specific eligibility and benefit requirements for Ohio's program. Since January 2011, Ohio Medicaid submitted 117 SPAs and CMS approved 80, disapproved one (now pending appeal), and 36 are pending consideration (January 2015).