

Modernizing Medicaid Eligibility

A review of Ohio's proposal

Introduction

The Office of Health Transformation (OHT) released a proposed Section 1115 Demonstration Waiver request, "Medicaid Eligibility Modernization Project," on June 6, 2012. This proposed waiver request follows the March 2012 release of a concept paper, "How to Modernize Medicaid Eligibility in the State of Ohio," and incorporates public feedback on the concept paper.

The proposed waiver request provides important information about the overall goals and direction of Ohio's modernization project and how Ohio Medicaid eligibility could look starting in January 2014, pending federal approval.

Ohio's overall proposal to modernize Medicaid eligibility has several components:

- Simplify Medicaid eligibility categories, from the current 150+ categories to three eligibility groups
- Procure and implement a new eligibility and enrollment system to replace the 30-year old Client Registry Information System-Enhanced (CRIS-E). (This system will handle eligibility, enrollment and renewals for Medicaid and other primary public assistance programs.)
- Streamline state and local responsibility for eligibility determination

This proposal is to be implemented by January 1, 2014. This aggressive time line is driven primarily by the requirements of the Affordable Care Act and will require substantial leadership, partnership and resources to accomplish.

The proposed waiver and this paper deal with the first two components, simplification of Medicaid eligibility categories, and procurement and implementation of a new eligibility and enrollment system.

Ohio is proposing sweeping changes to simplify Medicaid eligibility and modernize the enrollment and renewal processes. While much of the change is driven by requirements of the Affordable Care Act (ACA), Ohio's proposal advances the concept of simplification to a wider group of Medicaid clients — namely, those with disabilities — than the ACA requires. According to national experts who track waiver proposals, this is precedent setting, and if approved, Ohio would set a national benchmark for simplification.

What is a Section 1115 waiver?

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services (HHS) authority to waive provisions of major health and welfare programs authorized under the Act, including certain Medicaid requirements, and to allow a state to use federal Medicaid funds in ways that are not otherwise allowed under federal rules. The authority is provided at the Secretary's discretion for demonstration projects that the Secretary determines promote Medicaid program objectives. A waiver agreement is negotiated between a state and the Centers for Medicare & Medicaid Services (CMS) within HHS and is generally approved for a five-year period with an opportunity for renewal.

Ohio's proposed Section 1115 Demonstration Medicaid Eligibility Modernization Project seeks authority to waive eleven state plan requirements, including providing benchmark coverage to all Community Adults, and to not provide EPSDT coverage to 19- and 20-year old individuals in the Community Adult group.¹

View the waiver request and submit feedback

www.healthtransformation.ohio.gov

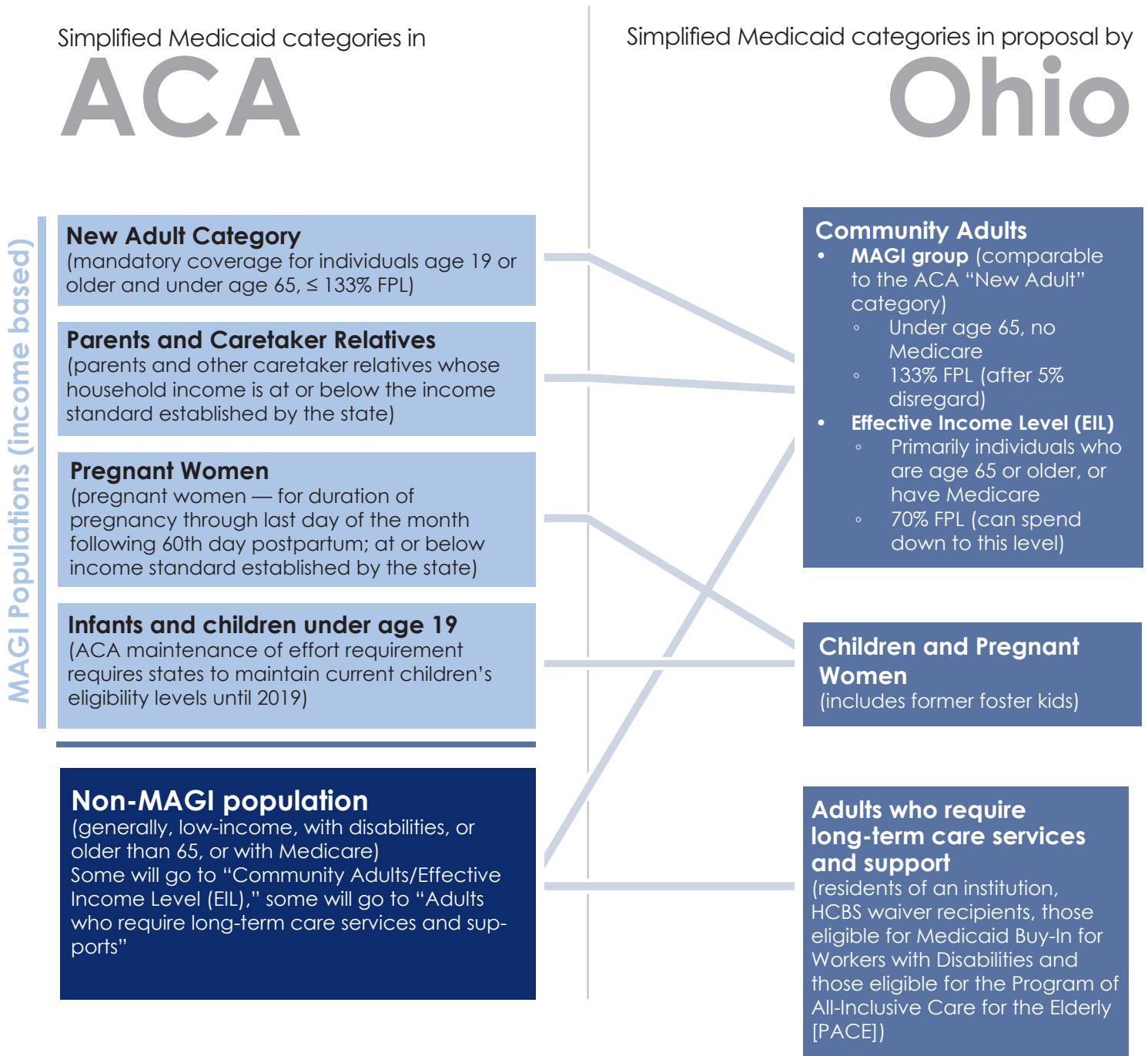
Federal rules require a period of at least 30 days before submission to allow for public comment, and at least two public hearings. **Public comments on the proposed waiver are due by 5:00 p.m. July 6.** Two public hearings have already been held (June 8 and June 11, 2012) and a third is scheduled for **June 26.**

The need for modernization

The need for modernizing Medicaid eligibility is driven by several factors, including:

Ohio's current eligibility system and processes are "fragmented, overly complex, and rely on outdated technology."² The system is burdensome for both consumers who apply for and renew Medicaid coverage, and for county job and family service agencies who determine eligibility.

Ohio Medicaid enrollment is projected to grow by over 900,000³ as a result of the Affordable Care Act (ACA) Medicaid expansion, which establishes a new income eligibility for non-disabled adults ages 19 – 65 at 133% FPL (after 5% disregard). This growth likely would put an unbearable strain on the current eligibility and enrollment system.



The Affordable Care Act includes additional, significant requirements related to Medicaid eligibility, including:

- Moves to a new, standard income definition, Modified Adjusted Gross Income (MAGI), based on the Internal Revenue Code
- Simplifies income-based Medicaid eligibility categories
- Modernizes eligibility verification rules, requiring states to rely primarily on electronic data sources
- Requires that individuals must be able to apply via the web, by phone, mail, or in-person
- Coordinates eligibility across Medicaid, CHIP, and the Health Insurance Exchange (including access to advanced tax credits)

The climate for change in Ohio

Ohio has a strong foundation to build upon, including:

- **A recent history of simplification efforts**, including adopting telephone renewals, 12-month continuous eligibility for children, and presumptive eligibility for children and pregnant women. These last two initiatives led to annual CHIPRA performance bonus awards in 2010 and 2011.
- **Impetus** for these policy changes came from HB 153, the 2012-2013 biennial budget, which requires Ohio Medicaid “to reduce the complexity of eligibility determination.”⁴ In addition, the Administration’s newly formed Health and Human Services Cabinet is leading broader efforts to streamline health and human services.
- **Consensus** exists among a wide range of stakeholders that Ohio’s current eligibility system needs an overhaul. Among others, many county job and family service agencies, county officials, health care providers, consumer advocates, state policymakers, and Medicaid managed care plans have already been working to improve the system and have examined best practices from other states.
- **Federal financial support** at a matching rate of 90/10 (federal/state), is available for development costs for eligibility and enrollment systems for Medicaid and CHIP. In March 2012, Ohio received CMS approval for federal funding to support planning of the new Medicaid eligibility system. On a time-limited basis (through December 31, 2015), this federal financial support is available to integrate eligibility systems.⁵ In addition, federal Exchange establishment grants are available through 2014, and can fund development of eligibility systems for the Exchange.⁶

How would eligibility change?

Eligibility will remain the same for some categories and change for others:

Children under age 19 and pregnant women: Income eligibility will remain at 200% FPL;⁷

Former foster kids: Eligibility will remain the same; the age limit for this category will be extended from 21 to 26.

Aged, Blind and Disabled adults who require long-term care services and support: Eligibility (both income level and qualifying criteria) for those in the Aged, Blind and Disabled eligibility category who use long-term care services and support (residents of institutions, recipients of Home and Community-Based Services waivers, those eligible for the Medicaid Buy-In Program for Workers with Disabilities, and those eligible for the Program of All-Inclusive Care for the Elderly (PACE)) will remain the same.

Parents of dependent children: Eligibility will increase from 90% FPL to 133% FPL (plus 5% income disregard).

Adults without dependent children: Formerly not eligible for Medicaid, will be eligible up to 133% FPL (plus 5% income disregard).

Breast and cervical cancer program: This eligibility category will no longer exist after January 1, 2014; those currently enrolled as of 1/1/2014 with incomes between 134% - 200% FPL can go into the Protected Category.

Transitional Medical Assistance (TMA): This eligibility category will no longer exist after January 1, 2014; those currently enrolled as of 1/1/2014 with incomes between 134% - 200% FPL can go into the Protected Category “through the pendency of TMA eligibility only.”⁸

Family Planning Group: This eligibility category will no longer exist after January 1, 2014; those currently enrolled as of 1/1/2014 with incomes between 134% - 200% FPL will not have the option of going into the Protected Category.

Aged, Blind and Disabled adults who do not use long term care services and support: If under age 65 and no Medicare, income eligibility is increased from 64% FPL to 133% FPL (plus 5% income disregard—the MAGI standard). This equates to the New Adult category outlined in the ACA. If over 65 or with Medicare, the income standard will increase from 64% FPL to 70% FPL; these clients have the option to spend down to this category, known as effective income level (EIL).

Simplified Medicaid Eligibility

Ohio's proposal simplifies Medicaid eligibility categories beyond those outlined in the ACA. The chart on page 2 compares the Medicaid categories outlined in the ACA and those in Ohio's proposal. Ohio's proposal further collapses the simplified ACA categories and notably, includes some adult clients currently in the Aged, Blind, and Disabled (ABD) category in the new simplified category, Community Adults.

Most current enrollees who would lose Medicaid coverage will be held harmless. Ohio plans to create a "protected category" for consumers already on Medicaid who would not be eligible under the proposed eligibility criteria for Community Adults. Consumers who do not meet the new eligibility standard but who are enrolled in Medicaid as of January 1, 2014 would be allowed to continue their Medicaid coverage until they "no longer meet their previous qualifying criteria, obtain other creditable coverage, or withdraw from the program."⁹

The primary clients in the protected category will be those with incomes between 134-200% FPL in the Breast and Cervical Cancer Program and the Transitional Medical Assistance category (only through the end of their transitional period). Those in the Family Planning group will not be eligible for the protected category.

A closer look at the proposed Community Adult eligibility category

The proposed waiver deals primarily with simplification and streamlining of eligibility determinations for a new eligibility category called Community Adults, made up of non-pregnant adults who do not need long-term care services and supports.

Subgroups and income standards: This category will include two subgroups, with two different income standards:

- MAGI Subgroup:** For adults under age 65 and who do not have Medicare, there will be a MAGI-based income standard of 133% FPL (after 5% disregard). This is the New Adult category outlined in the ACA.
- Effective Income Level Subgroup (EIL):** For individuals age 65 or older or who have Medicare, there will be an income standard of 70% FPL, calculated using current Section 209(b) income exemptions/exclusions but no income disregards. This is an increase from Ohio's current Section 209(b) income standard of 64% FPL. Some individuals who must currently spend down to qualify for Medicaid coverage will no longer need to spend down.

Disability determination: Consistent with the ACA, no disability determination will be required to qualify for coverage up to 133% FPL (after 5% disregard) --the MAGI subgroup.

Ohio will no longer conduct disability determinations for Community Adults seeking eligibility through the EIL subgroup. Instead, Ohio will rely upon Social Security Administration (SSA) disability determinations.

Those above 133% FPL and with an SSA disability determination will have the option to spend down to 70% and qualify for Medicaid coverage through the EIL subgroup, or to purchase private insurance on the Exchange (premium subsidies available to 400% FPL; cost-sharing subsidies available to 250% FPL).

Benchmark coverage: Ohio proposes to provide benchmark Medicaid coverage to all Community Adults, not just the New Adult category as required in the ACA. Ohio's benchmark Medicaid coverage will include all items and services in Ohio's Medicaid program except long-term care services and supports (LTSS), and Early Periodic Screening, Diagnosis, and Treatment (EPSDT):

Medicaid and the Exchange

People with incomes over the Medicaid eligibility limit and who do not have access to affordable employer-sponsored coverage will be able to purchase coverage through the Exchange.¹⁰ Advanced tax credit premium subsidies will be available for families with incomes up to 400% FPL, and cost-sharing subsidies will be available for families with incomes up to 250% FPL.

Because people often have jobs and incomes that fluctuate, many people will move from coverage through Medicaid to coverage through the Exchange and vice versa.

Effective, seamless coordination between Medicaid and the Exchange is critical to ensure that those transitions happen smoothly and in a timely manner.

- LTSS are available in the LTSS eligibility group for individuals who meet the eligibility standards for that category.
- EPSDT is available for children and youth up to the age of 21. As a result of the benchmark coverage design, 19- and 20-year-old individuals in the Community Adult category will not have access to EPSDT services. The impact of this policy should be examined more closely as this could be especially difficult for youth with special health needs.

No resource test for Community Adults: Ohio plans to eliminate the current resource test for Community Adults who are eligible through the EIL subcategory. Because Ohio does not have a resource test for other Community Adults, this means that no Community Adults will be subject to a resource limit, further simplifying the eligibility process. The current resource test will be retained for the LTSS group.

Express Lane Eligibility: Express Lane Eligibility (ELE) is an option that allows states to use data that families have already provided to government to make an eligibility or renewal determination. Ohio proposes to use this option for Community Adults by partnering with programs such as Temporary Assistance for Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP). Ohio should implement ELE for the Children and Pregnant Women category as well.

New Eligibility System

The proposed waiver includes some information about Ohio's plans for a new eligibility determination and enrollment system to replace the current outdated system, CRIS-E.

In line with ACA requirements, Ohio outlines the following elements¹¹:

- Robust self-service
- Integrated consumer access
- Immediate Medicaid determination for some applicants
- Automated data matching functionality with federal and state partners
- Submission of support documentation via fax, e-mail, and portal
- Transition to a paperless environment
- Improved data quality, program integrity, and quality control
- Dynamic rules based engine, and
- State of the art technology

Ohio plans to issue a request for purchase (RFP) in summer 2012. The system will be operational by January 1, 2014.

The new eligibility determination and enrollment system will be used for Medicaid, TANF, SNAP or private insurance (presumably purchased through the Exchange). The proposed waiver outlines a staggered approach in which Ohio would start with Medicaid, and then follow with SNAP and TANF.

As noted earlier, effective, seamless coordination between Medicaid and the Exchange will be critical. No matter where or how consumers apply for coverage, they should be directed to the coverage for which they are eligible and the application process should be simple, accessible, and timely.

The proposed waiver outlines a thoughtful approach to simplifying and modernizing Ohio's Medicaid eligibility and enrollment system. It is especially noteworthy for extending the concept of simplification to a wider group of Medicaid categories than required in the ACA. If approved, Medicaid eligibility will be radically different as of January 2014. Continuing stakeholder engagement through the approval process is critical.

As with any system overhaul, implementation is key. As Ohio builds the policy and information technology systems over the next eighteen months, continuing an open, transparent process must be a priority to ensure that no unintended consequences arise. All Ohioans will benefit from a simplified, consumer-centered system that ensures eligible individuals have access to quality health care coverage.

End notes

1. For a full list of requested waiver authorities, see page 27, "Proposed Section 1115 Demonstration Medicaid Eligibility Modernization Project." Downloaded at <http://bit.ly/NUVEFR>.
2. See "Concept Paper on How to Modernize Medicaid Eligibility in the State of Ohio," March 14, 2012, for a fuller discussion of the challenges of the current system. Download at <http://bit.ly/MHxFrJ>
3. Governor's Office of Health Transformation press release. April 1, 2011. Accessed September 23, 2011. <http://bit.ly/LLUqwB>
4. See ORC 5111.0123
5. The new policy allows certain other human service programs to utilize systems designed for health coverage programs without sharing in the development costs, providing certain conditions are met. See August 10, 2011 and January 23, 2012 joint HHS and USDA letters for more information.
6. Establishment grants can fund 100% of eligibility systems developed for the Exchange. In the case of a shared system, the overall costs would then be allocated 100% to the Exchange and 90% to Medicaid.
7. The ACA maintenance of effort requirement means that states cannot change eligibility standards and procedures for children through 2019.
8. "Proposed Section 1115 Demonstration Medicaid Eligibility Modernization Project," page 15. Downloaded at <http://bit.ly/NUVEFR>.
9. Ibid. Page 16.
10. States have the option to implement the Basic Health Program for consumers not eligible for Medicaid and with incomes up to 200% FPL. As of publication of this paper, Ohio has not indicated it is pursuing this option. Therefore, it is assumed that those with incomes above 138% FPL will turn to the Exchange for coverage.
11. "Proposed Section 1115 Demonstration Medicaid Eligibility Modernization Project," page 24.



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