Office of Health Transformation

Extend Medicaid Coverage and Automate Enrollment

Background:

Eligibility determination for health and human services programs in Ohio are fragmented, overly complex, and reliant on outdated technology. For example, Ohio has more than 150 categories of eligibility just for Medicaid. Variation in Medicaid income eligibility creates gaps in coverage that result in unnecessary costs for local government, uncompensated costs for hospitals, and cost-shifting to private sector insurance premiums, all of which are paid for by taxpayers and businesses. Eligibility reforms in the budget have the potential to significantly improve care for vulnerable Ohioans, increase program efficiencies, and reduce costs for Ohio's taxpayers.

Applying for Medicaid is confusing and time consuming. More than 2.3 million Ohioans were enrolled in Medicaid in December 2012. Many families came through the front door of one of the 88 local County Department of Job and Family Services (CDJFS) service centers and had to physically meet with a caseworker to get through the application process, providing information whenever it was determined more was needed, and often requiring multiple repeat visits to the county office. These families qualified through a myriad of requirements, computations, and verifications. Income disregards or special income treatment was used as needed with each family or, in some cases, different individuals in the same family.

Current Medicaid eligibility policies leave gaps in coverage. An estimated 1.5 million Ohioans do not have health insurance, most of them from working families, and some of them very poor (Appendix C shows the number of low-income uninsured Ohioans by county).[1] Medicaid plays a critical role in protecting the health of low-income Ohioans, but it leaves out many people (see Figure 1). Like many states, Ohio does not extend Medicaid coverage to adults unless they have children or are disabled. Beginning in January 2014, the federal government will establish a Health Insurance Exchange to offer tax credits for insurance premiums to Ohioans with incomes between 100 percent and 400 percent FPL, but no credits will be provided below 100 percent FPL. As a result, parents between 90 percent and 100 percent FPL and childless adults with income below 100 percent FPL will be caught in a "coverage gap" without access to Medicaid or tax credits on the Exchange (Figure 1).

Federal funding is available to eliminate the coverage gap. In June 2012, a U.S. Supreme Court ruling gave states the option to increase Medicaid eligibility for all adults to 138 percent FPL,[2] with the federal government paying 100 percent of the costs for the newly eligible population during the first three years, decreasing to 90 percent by 2020. States have flexibility to decide

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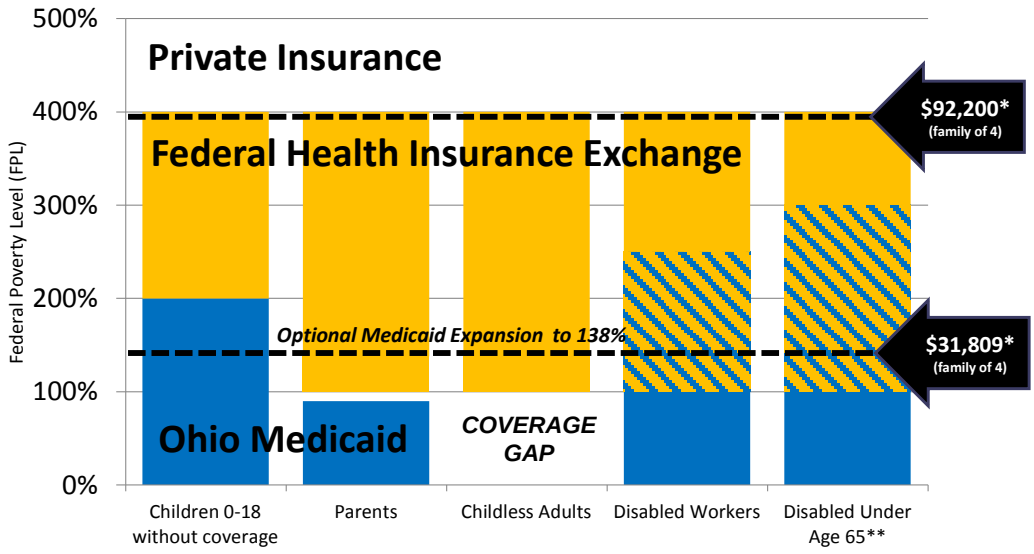
[1] US Census Bureau, *Health Insurance Coverage Status by State for All People* (2011).

[2] The Affordable Care Act requires eligibility for adults to be set at 133 percent FPL but also establishes a 5 percent income disregard, so the effective eligibility level is up to 138 percent FPL.

whether or not and when to extend coverage, but the years of federal funding are fixed[3] and enhanced federal funding is not available for a partial expansion.[4]

Figure 1.

Federal Income Eligibility Levels, January 2014



Ohio Governor's Office of Health Transformation

* 2012 poverty level is $11,170 for an individual and $23,050 for a family of 4
**Over age 65 coverage is provided through Medicare, not the Exchange.

Federal funding also is available to simplify and automate eligibility systems. In August 2011, the federal government announced a time-limited opportunity for states to use enhanced (90 percent) federal matching funds to integrate eligibility determination functions across programs based on income eligibility.[5] The new policy allows health and human services programs – including Temporary Assistance for Needy Families, Supplemental Nutrition Assistance Program and Child Care and Development Fund – to utilize systems designed for determining a person's Medicaid eligibility without sharing in the common system development costs, so long as those costs would have been incurred to develop systems for Medicaid. States may access the 90-percent enhanced federal funding up to but not after December 31, 2015.

Ohio law requires eligibility modernization. Governor Kasich's Jobs Budget (HB 153), enacted June 2011, directed Ohio Medicaid "to reduce the complexity of the eligibility determination processes for the Medicaid program caused by different income and resource standards for the

[3] The Federal Medical Assistance Percentage (FMAP) for the expansion is fixed at 100 percent in 2014, 2015 and 2016, and then decreases to 95 percent in 2015, 94 in 2018, 93 in 2019, and 90 percent in 2020 and beyond.
[4] CMS, *Frequently asked questions on Exchanges, market reforms, and Medicaid* (December 10, 2012), page 12.
[5] Joint USDA, CMS, ACF *Guidance on developing integrated eligibility determination systems* (August 11, 2011).

numerous Medicaid eligibility categories" and "obtain to the extent necessary the approval of the United States Secretary of Health and Human Services."[6] The Governor's Office of Health Transformation prepared an application to modernize Ohio's eligibility systems, but put the waiver on hold pending a decision about whether or not to change Medicaid eligibility levels.[7]

Executive Budget Proposal and Impact:

The Executive Budget includes a comprehensive package of reforms to simplify eligibility based on income, streamline state and local responsibility for eligibility determination, and update eligibility systems technology. The goal is for most enrollees to become eligible for Medicaid and other programs based on income tax information without needing to undergo any additional eligibility tests. The two major features of the plan are to simplify eligibility policy and to automate eligibility determination systems.

SIMPLIFY ELIGIBILITY POLICY

Consolidate Medicaid eligibility into three basic groups. As a first step, Ohio will map the state's current 150+ Medicaid eligibility categories into three groups: (1) children and pregnant women, (2) individuals who are age 65 or older, who have Medicare coverage, or who need long-term services and supports, and (3) community adults (non-pregnant adults who do not need long-term services and supports), including individuals eligible as parents or caretaker relatives.[8] The eligibility criteria and standards for the first two simplified groups will not change (income, resources, spend-down, disability determination, and other creditable coverage will be treated the same). Only the third group, community adults, will see significant changes in eligibility standards for Medicaid. All three groups will benefit from simplified processes, including for most applicants conversion to a new federally mandated modified adjusted gross income (MAGI) standard that will allow for real-time eligibility determination.[9]

Simplify eligibility standards and increase coverage for community adults. Beginning January 1, 2014, community adult applicants will qualify for Medicaid with MAGI at or below 138 percent FPL. There will be no application of spend-down processes, no resource test, and no state or federal disability determination requirement, although there will be other qualifying criteria such as legal residency. The new policy is expected to impact the following populations:

- Newly eligible. Community adults with MAGI below 138 percent FPL, including parents with MAGI between 90 percent and 138 percent FPL, will be newly eligible to enroll in Medicaid. Ohio Medicaid estimates 366,000 individuals will enroll, including 270,000 previously uninsured Ohioans (Figure 2). The total cost of services for this group is

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[6] ORC 5111.0123

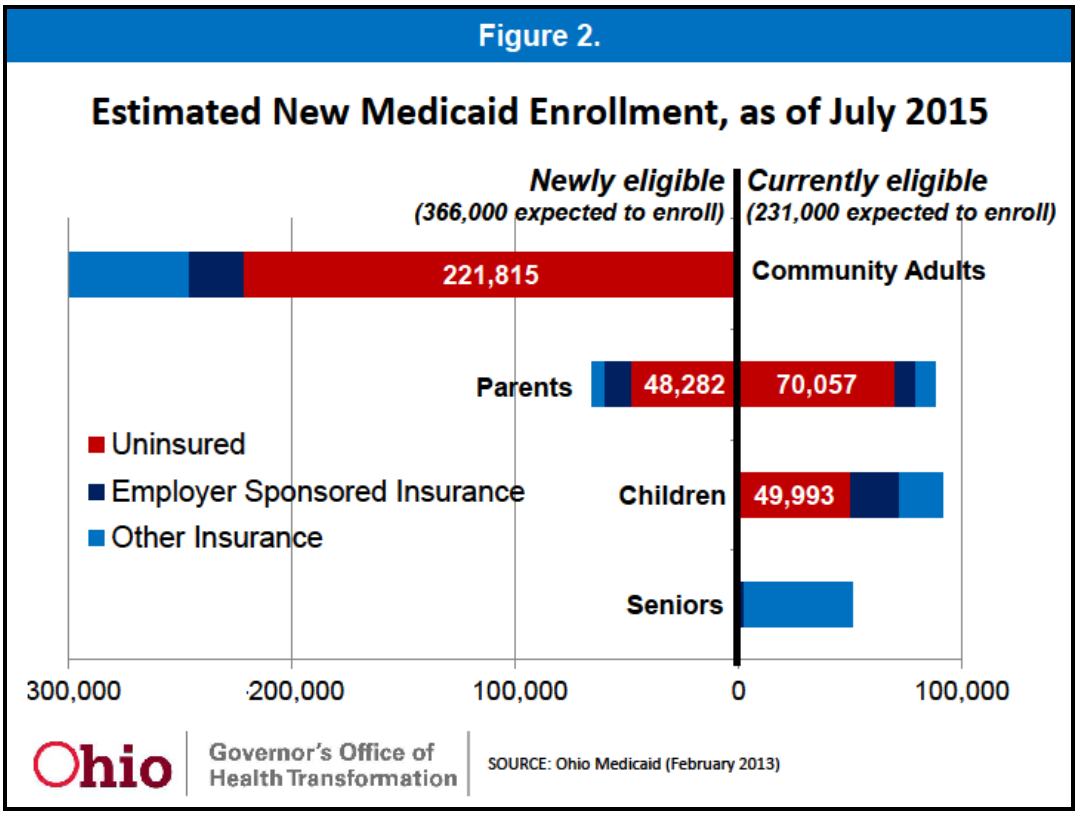
[7] Office of Health Transformation, *Proposed Section 1115 Demonstration: Eligibility Modernization* (June 2012).

[8] Community adults include the expansion population called "Group VIII" by the federal government based on the section of law that defines the group; CMS, *New option for coverage of individuals under Medicaid* (April 9, 2010).

[9] CMS, *Conversion of net income standards to MAGI equivalent income standards* (December 28, 2012).

estimated to be $2.6 billion over the biennium, all of which will be paid by the federal government. In some cases, state and local government will see savings result when Ohioans who are covered by other programs move onto Medicaid. For example, the Ohio Department of Rehabilitation and Correction estimates it will save $27 million over the biennium on inpatient hospital costs for prisoners, and the county community mental health and addiction services system is expected to save $105 million over the biennium on services that shift to Medicaid, primarily for adults who do not currently have access to coverage. (Appendix B summarizes the newly eligible impact on federal, state and local resources.)

Figure 2.



- Currently eligible but not enrolled. Some people who are currently eligible but not yet enrolled in Medicaid are expected to enroll in January 2014, regardless of whether or not eligibility expands. This "woodwork effect" results from the new federal requirement to have health insurance, easier access to insurance through the federal Health Insurance Exchange, and increased awareness about the availability of health coverage. Ohio Medicaid estimates an additional 92,000 children, 88,000 parents, and 51,000 seniors will enroll in Medicaid as a result of the woodwork effect (Figure 2). Ohio will receive the regular federal match rate for this population, resulting in higher state Medicaid costs. Ohio Medicaid estimates the cost of these individuals will be $1.5 billion

($521 million state share) over the biennium.[10] (Appendix B summarizes the impact of woodwork on federal, state and local resources; the woodwork effect is *not included* in the estimated cost of eligibility simplification and automation because it is expected to occur with or without changes in Medicaid income eligibility policy).

- Previously eligible. Some community adults qualify for Medicaid today at income levels above 138 percent FPL as a result of income disregards, transitional medical assistance, and other exceptions. Ohio Medicaid estimates that 90,863 individuals who would have qualified for Medicaid under current policies will not under the new MAGI policy (Figure 3). However, these individuals will have access to tax credits on the Health Insurance Exchange, up to 400 percent FPL. Ohio Medicaid estimates the savings from not covering this group on Medicaid will be $246 million over the biennium, and because the state would have paid the regular match for this population, the state will save $91 million over the biennium. (Appendix B summarizes the impact of this group on federal, state and local resources.)

Figure 3.
Estimated Medicaid Enrollment from Eligibility Simplification

Newly Eligible Population	Estimated Gain/(Loss) as of June 2015
Previously uninsured	270,097
Previously had other insurance	95,519
Subtotal new enrollment	***365,616***
Previously had Medicaid	(90,863)
Total change in enrollment	**274,753**
Source: Appendix A provides more detail about estimated enrollment.	

Eligibility simplification will result in some Ohioans becoming newly eligible for Medicaid, and some who would have been eligible under the old rules not being eligible in the future. The federal, state and local financial impact of these changes is summarized in Figure 4.

[10] Ohio Medicaid's earlier estimates of woodwork were higher than current estimates because: (1) the earlier estimate counted eight quarters of expanded enrollment and spending beginning January 2014 when the Medicaid expansion takes effect, but the budget estimate is for the period beginning July 2013, which begins six months prior to the expansion, so the budget estimate counts six quarters of expanded enrollment and spending not eight; and (2) the earlier estimate was based on the 2010 Family Health Survey (FHS) and the current estimate is based on the 2012 FHS.

Figure 4.
Estimated Financial Impact Resulting from Eligibility Simplification

Source of Funds	SFY14-15 Costs/(Savings)
Federal	
Newly eligible enrollment cost	$2.6 billion
Previously eligible enrollment savings	($155 million)
Total	$2.4 billion
State	
Newly eligible enrollment cost	$0
Previously eligible enrollment savings	($91 million)
State inpatient hospital for prisoners	($27 million)
Net HIC and sales tax revenue	($117 million)
Total	($235 million)
County	
Service costs that shift to Medicaid	($105 million)
Net sales tax revenue	($25 million)
Total	($130 million)
Source: Appendix B provides more detail about estimated enrollment.	

Expect personal responsibility from Ohioans who benefit from Medicaid. In order to ensure individuals in the Medicaid program take personal responsibility for their health care services and also become ready to move off of Medicaid and into private insurance, Medicaid is proposing new cost sharing requirements for every adult above 100 percent of poverty. This proposal is in line with proposed federal regulations on cost sharing. Ohio will require an $8 co-payment for use of an emergency room for non-emergency conditions, $8 co-pays for non-preferred drugs, and $3 co-pays for preferred drugs. Certain long-term maintenance drugs (such as insulin) will have no co-pay. Also, under new federal rule changes, a provider can deny a service if the person does not pay the co-pay. For example, a pharmacist could deny the person the non-preferred drug for not paying the $8 co-pay but instead offer the preferred drug at the $3 co-pay.

Opt out if federal funding is reduced. The federal government has made it clear that states may opt in and out of covering newly eligible populations at any time.[11] The Executive Budget codifies an automatic opt out trigger so that if for any reason the federal government reduces its financial participation for expanded coverage, then the program for newly eligible groups shuts down, and Ohio taxpayers are not stuck holding the bill. In addition, Ohio Medicaid may

[11] CMS, Frequently asked questions on exchanges, market reforms and Medicaid (December 2012), question 24

turn off eligibility for newly eligible populations if the state is required as a result of federal action to reduce or eliminate any tax that provides financial support for the Medicaid program.

AUTOMATE ELIGIBILITY DETERMINATION SYSTEMS

Replace Ohio's 34-year-old eligibility determination system. Ohio's Enhanced Client Registry Information System (CRIS-E) provides intake and eligibility determination support for several of Ohio's health and human services programs and provides some case management functions for several Ohio Department of Job and Family Services programs. When CRIS-E was implemented in 1978, it was able to meet the needs of the counties by allowing for 18,000 users to manually enter cases for Ohio citizens. As time went by, many processes were added to allow the original system to do more, but all of the additions were built on the original foundation, which could only extend so far and long ago reached its limit of new applications. The problem is so severe that Ohio Medicaid estimates 60 percent of CRIS-E's eligibility determinations for Medicaid need to be manually overridden to prevent eligible applicants from being denied coverage. CRIS-E is so fragile and technically obsolete that it is no longer practical or cost effective to invest in enhancing the system.

Replace CRIS-E with a new integrated eligibility system. The Ohio Department of Administrative Services is contracting with a vendor to replace CRIS-E with a new, integrated, enterprise solution that supports both state and county operations.[12] The new system will provide the technology necessary for integrating eligibility across Ohio's health and human services agencies. The project will focus first on Medicaid eligibility, then expand to other programs that currently depend on CRIS-E (this phase will retire CRIS-E), and finally expand to support other health and human services programs. The new system will give individuals and families seeking Medicaid coverage an option to apply online and provide real-time determination for most people who apply. The budget includes $230 million for this system ($26 million state share) over the biennium.

Change eligibility processes and workflow to be more efficient. In addition to the CRIS-E replacement, the Ohio Department of Administrative Services will release a second request for proposals (RFP) in February 2013 to acquire an organizational change management (OCM) vendor to coordinate the transition from the current business environment to a new, more efficient and effective business environment. Combined with the simplification of eligibility policy, the new integrated eligibility system provides the opportunity to improve the business processes involved with enrolling Ohio citizens in HHS programs. The state is working with county agencies to improve the processes at both the county and state levels. The Executive Budget includes funding for this project and leverages 90 percent federal funds.

Updated January 31, 2013

[12] DAS, *Integrated eligibility and HHS business intelligence procurement*

Appendix A.
Projected Medicaid ENROLLMENT for Newly Eligible, Currently Eligible but not Enrolled, and Previously Eligible Medicaid Populations

Current Source of Coverage	Ultimate Take-Up Rates	Best Estimate of Participation SFY 2015	SFY 2020
NEWLY ELIGIBLE			
Parents (19-64 years)			
Uninsured	70%	48,282	58,981
Individual	70%	3,459	4,225
Employer	20%	11,994	14,658
Other/unknown	20%	2,076	2,538
Newly eligible parents		***65,811***	***80,402***
Childless Adults (19-64 years)			
Uninsured	55%	221,815	271,082
Individual	55%	36,986	45,200
Employer	15%	25,025	30,583
Other/unknown	15%	15,979	19,527
Newly eligible childless adults		***299,805***	***366,392***
NEWLY ELIGIBLE TOTAL ENROLLMENT		**365,616**	**446,794**
CURRENTLY ELIGIBLE NOT ENROLLED (WOODWORK)			
Children (up to age 19)			
Uninsured	80%	49,993	83,134
Individual	80%	13,057	21,721
Employer	15%	22,141	36,833
Medicare Only	15%	914	1,521
Other/unknown	15%	5,469	9,098
Woodwork children		***91,574***	***152,307***
Parents (19-64 years)			
Uninsured	65%	70,057	116,549
Individual	65%	3,239	5,389
Employer	20%	9,112	15,153
Medicare Only	20%	2,376	3,953
Other/unknown	20%	3,535	5,879
Woodwork parents		***88,319***	***146,923***
Aged (65 and over)			
Uninsured	20%	1,189	1,999
Individual	20%	1,149	1,932
Employer	20%	1,506	2,531
Medicare Only	20%	45,190	75,933
Other/unknown	20%	1,865	3,133
Woodwork aged		***50,899***	***85,528***
WOODWORK TOTAL ENROLLMENT		**230,792**	**384,758**
PREVIOUSLY ELIGIBLE			
Breast and cervical cancer		6	8
Family planning		26,378	27,516
Transitional Medicaid to six months		54,123	55,419
Parent coverage		10,356	10,671
PREVIOUSLY ELIGIBLE TOTAL ENROLLMENT		**90,863**	**93,614**

2020 number based on June 2015 participation estimate (caseload trend information is not available)

2015 is average monthly enrollment

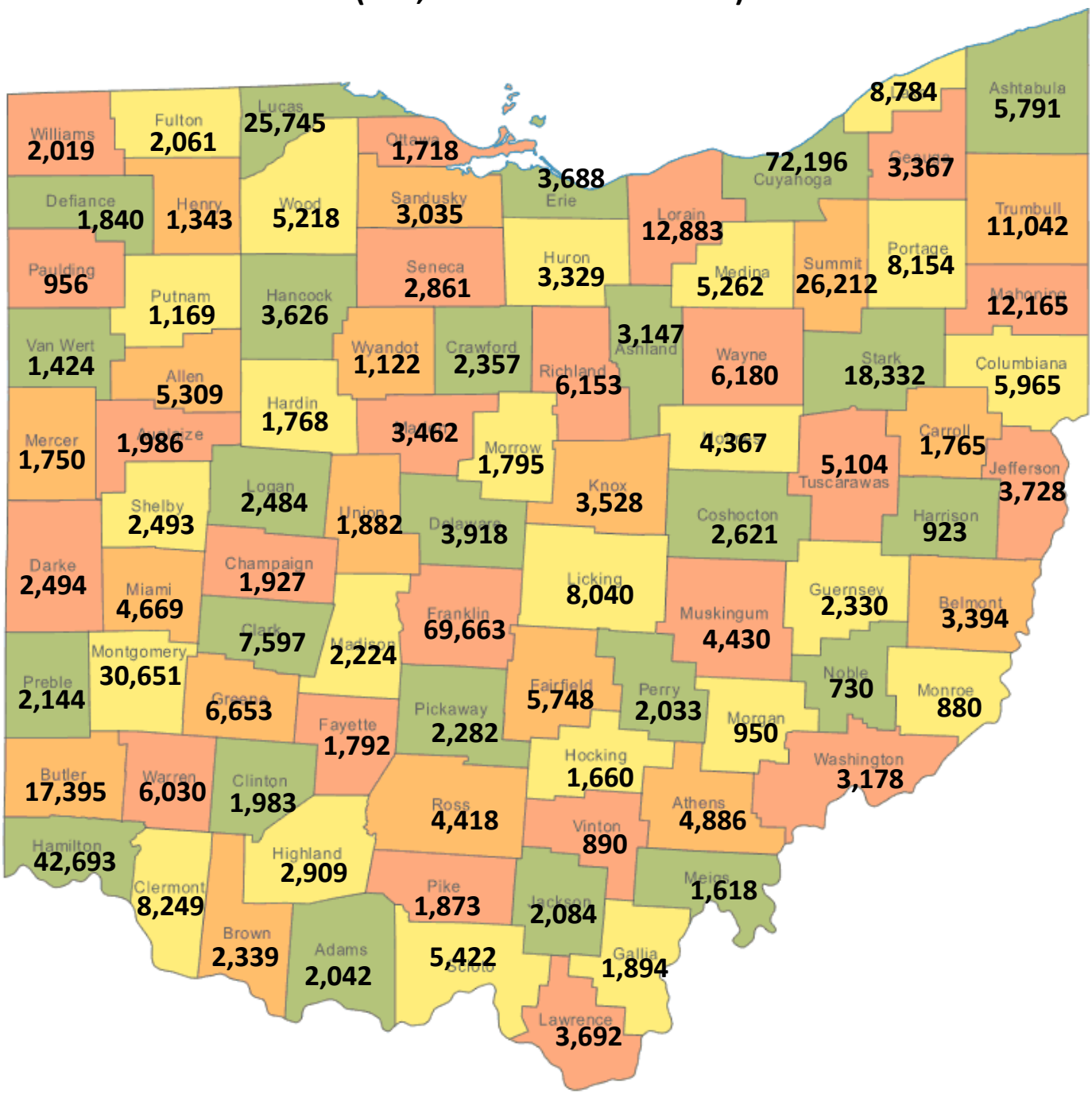
Appendix B.

Federal, State and County COST AND REVENUE IMPACTS of Newly Eligible, Currently Eligible not Enrolled, and Previously Eligible Medicaid Populations

COST/(SAVINGS) in millions				
	SFY 2014	**SFY 2015**	**SFY 2014-2015**	**SFY 2014-2020**
ALL FUNDS				
Newly eligible enrollment cost*	$ 562	$ 2,000	$ 2,561	$ 14,481
Woodwork enrollment cost*	$ 529	$ 952	$ 1,481	$ 9,188
Previously eligible enrollment savings	$ (62)	$ (184)	$ (246)	$ (1,289)
Total Medicaid spend (all funds)	**$ 1,029**	**$ 2,768**	**$ 3,796**	**$ 22,380**
FEDERAL SHARE				
Newly eligible enrollment cost*	$ 562	$ 2,000	$ 2,561	$ 13,895
Woodwork enrollment cost*	$ 343	$ 617	$ 960	$ 6,171
Previously eligible enrollment savings	$ (39)	$ (116)	$ (155)	$ (812)
Total Medicaid spend (state share)	**$ 865**	**$ 2,501**	**$ 3,366**	**$ 19,253**
STATE SHARE				
Newly eligible enrollment cost*	$ -	$ -	$ -	$ 586
Woodwork enrollment cost*	$ 186	$ 335	$ 521	$ 3,018
Previously eligible enrollment savings	$ (23)	$ (68)	$ (91)	$ (477)
Total Medicaid spend (state share)	**$ 163**	**$ 267**	**$ 430**	**$ 3,127**
OTHER				
State inpatient hospital for prisoners	$ 9	$ 18	$ 27	$ 117
County behavioral health services	$ 35	$ 70	$ 105	$ 455
TAX AND FEE REVENUE in millions				
STATE SHARE				
Newly eligible (HIC + sales/use)	$ 21	$ 107	$ 129	$ 838
Woodwork (HIC + sales/use)	$ 21	$ 44	$ 65	$ 447
Previously eligible (HIC + sales/use)	$ (3)	$ (10)	$ (12)	$ (73)
Total State Tax and Fee Revenue	**$ 40**	**$ 141**	**$ 181**	**$ 1,212**
COUNTY SHARE				
Newly eligible (Sales/use)	$ 5	$ 23	$ 28	$ 176
Woodwork (Sales/use)	$ 5	$ 9	$ 14	$ 94
Previously eligible (Sales/use)	$ (1)	$ (2)	$ (3)	$ (15)
Total County Tax and Fee Revenue	**$ 9**	**$ 30**	**$ 39**	**$ 255**
* Costs include two-year primary care physician fee increase and prescription drug rebates.				

Appendix C.

Number of Ohio county residents who are uninsured with income below 138 percent of poverty (593,912 statewide in 2010)



SOURCE: U.S. Census, *Small Area Health Insurance Estimates* (2010)