Proposed Section 1115 Demonstration
Medicaid Eligibility Modernization Project

STATE OF OHIO

Department of Job & Family Services

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SECTION 1: DESCRIPTION OF DEMONSTRATION

The State of Ohio (Ohio) Governor's Office of Health Transformation (OHT) and the Ohio Department of Job and Family Services (ODJFS), Ohio's Single State Medicaid Agency, are seeking Section 1115 waiver 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.

Overview

As the Centers for Medicare & Medicaid Services (CMS) has recognized in recent rulemakings, 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 methodologies 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 Ohio's eligibility processes are fragmented, overly complex, and rely on outdated technology.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 the nearly one million Ohioans who will be newly eligible 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.

As set forth in this application, Ohio's demonstration proposal has the following major features:

1. ***Consolidation into Three Basic Eligibility Groups.*** As a first step, Ohio would map 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.

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. Ohio does not have and does not intend to have a resource test for other Community Adults. 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. 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 that group.

   Individuals requiring LTSS will be able to move to the LTSS eligibility group if they meet the eligibility standards for enrollment in the LTSS group. Individuals receiving LTSS would be considered to be enrolled in the LTSS group instead of the Community Adult 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 level 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 enrolled in full Medicaid coverage 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) would remain eligible until the end of their transitional period. However, individuals who do not meet the demonstration income standards and who were eligible only for the limited-benefit Family Planning Group would not be enrolled in this protected group.

In the following sections of this waiver proposal, Ohio provides additional information. Section 1 describes the project outcomes, environment for reform, a summary of the proposed concepts for reform, and the demonstration hypotheses. Section 2 describes Ohio's current Medicaid eligibility determination process, the changes required under ACA, and Ohio's proposal for modernizing and simplifying Medicaid eligibility. Section 3 describes Ohio's current Medicaid application process and IT infrastructure and its proposal for streamlining that process and updating that infrastructure. Section 4 sets out the requested waiver authorities; Section 5 provides Ohio's approach to evaluation; and Section 6 describes the public notice process that Ohio conducted prior to the submission of this application.

Ohio's demonstration will test changes to simplify and streamline eligibility policies and replace complicated, cumbersome requirements with simpler processes and modernized information technology. Through the streamlining, Ohio intends to cover approximately the same number of Community Adults as would otherwise have been covered in the absence of the demonstration waiver, before the ACA mandatory expansion of eligibility to childless adults under age 65 (called "Group VIII" in reference to the subsection in the ACA that mandates the expansion). For this reason, Ohio has not included a demonstration of budget neutrality. However, Section 2 includes projected enrollment and expenditures for Community Adults during each year of the five-year demonstration period.

Project Outcomes

Starting January 1, 2014, eligibility for many Medicaid applicants, including the new adult group (Group VIII), will be determined using methodologies that are based on MAGI as defined in the Internal Revenue Code. The use of MAGI-based income standards and Ohio's EIL standard for remaining individuals in the Community Adult group simplifies and streamlines the Medicaid eligibility process for both applicants and the State and allows for real-time eligibility determination for many applicants. CMS made additional changes to Medicaid eligibility in the rule implementing the ACA's changes to Medicaid eligibility. In particular, the rule governs Medicaid eligibility for children, pregnant women, and parents/caretaker relatives whose financial eligibility, beginning in CY 2014, will be based on MAGI. Ohio will take state-specific steps to simplify and streamline eligibility for all non-pregnant adults in the community who do not need LTSS.

The demonstration will:

- Cover approximately the same number of individuals who would otherwise have been covered by Medicaid if there was no demonstration;
- Keep eligibility as it is today for children, pregnant women, and adults needing LTSS;
- Use simplified income standards to determine eligibility for Community Adults (non-pregnant adults who do not need LTSS);
- Eliminate the resource test for Community Adults;
- Eliminate the need for a determination of disability from Ohio Medicaid in order to qualify for Medicaid as a Community Adult;
- Simplify what is required for a non-pregnant adult not needing LTSS to be eligible for Medicaid; and
- Create a protected group for individuals found eligible for Medicaid before the effective date of this waiver and enrolled in full Medicaid coverage on the effective date of this waiver who might otherwise be disadvantaged (for example, women in the Breast and Cervical Cancer Project category with household income at or above 134% FPL, individuals on Transitional Medical Assistance (TMA) above MAGI or EIL, pending run out of their TMA covered period, etc.).

This demonstration application is submitted concurrently with work underway to use E-APD financing for planning and implementing a replacement for Ohio's Eligibility Legacy System, Client Registry Information System – Enhanced (CRISE) prior to the federally-mandated Medicaid expansion in January 2014. The new eligibility determination system will, at a minimum:

- Give individuals and families a way to apply online, when it is convenient for them, without the need to report to a local office;
- Include automated data matching with Federal and State partners;
- Allow for submission of any support documents via fax, email, or portal;
- Provide real-time, online determination for most people who apply; and
- Include Medicaid and, where possible, other health and human service programs that use income as the basis for eligibility.

Environment for Reform

The federal Affordable Care Act (ACA) is projected to expand Ohio Medicaid coverage almost 50 percent, from over two million in July 2011 to over three million in January 2014. In addition, the ACA substantially changes the way Medicaid programs cover individuals, creating a new national income

standard. To meet these demands, Ohio will need to make substantial investments in its eligibility system infrastructure. Several recent state and federal initiatives provide new authority and resources to modernize Ohio's eligibility systems, and include deadlines that create an imperative for Ohio to act now to transform both policy and infrastructure.

Ohio law requires eligibility simplification. Governor Kasich's Jobs Budget (HB 153) enacted in June 2011 requires Ohio Medicaid "to reduce the complexity of the eligibility determination processes for the Medicaid program caused by different income and resource standards for the numerous Medicaid eligibility categories" and "obtain to the extent necessary the approval of the United States Secretary of Health and Human Services in the form of a federal Medicaid waiver, Medicaid state plan amendment, or demonstration grant." (ORC 5111.0123)

Eligibility simplification is part of a broader effort to streamline health and human services in Ohio. The Governor's Office of Health Transformation (OHT), Office of Budget and Management, and Department of Administrative Services jointly established a new Health and Human Services Cabinet to optimize public resources across HHS jurisdictions. The HHS Cabinet is focused on restructuring and consolidating HHS operations and right-sizing state and local service capacity to be more efficient. The current priority is to align interconnected, technology-dependent projects: modernize eligibility systems, share information across state and local data systems, integrate claims payment systems, and accelerate electronic health information exchange. The ultimate goal is to improve customer service, increase program efficiencies, and reduce costs for Ohio's taxpayers.

Summary of Proposed Concepts for Reform

The purpose of Ohio's eligibility modernization project is to transform Medicaid eligibility to a family friendly, understandable, administratively streamlined and simple process. The two key features of the plan are simplification of eligibility policy and simplification of eligibility processes through modernization of Medicaid technology. The focus for simplification of eligibility policy through this demonstration will be the Community Adult group. Eligibility for children, for pregnant women, and for adults needing long-term services and supports (LTSS) would continue as is and not be impacted by the demonstration. However, Ohio expects all Medicaid applicants and eligibles to benefit from modernization of Medicaid technology.

Simplify Eligibility Policy

The State of Ohio is proposing to simplify the criteria for Medicaid eligibility. Current Ohio Medicaid income eligibility levels are summarized below in Figure 1 and Ohio Medicaid enrollment as of July 2011 is shown in Table 1.

Figure 1: Current Ohio Medicaid Income Eligibility Levels

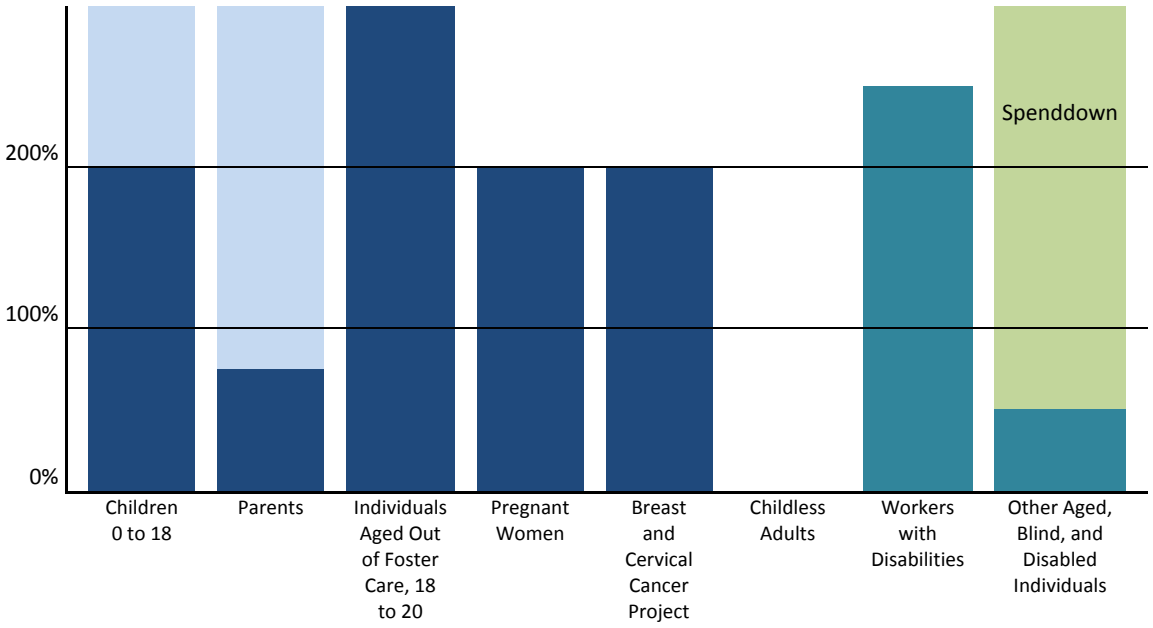

Table 1: Ohio Medicaid Enrollment, July 2011

Medicaid Eligibility Category	2011 Enrollment
Children 0 through 18	1,182,000
Parents	483,000
Individuals Aged Out of Foster Care 18 to 20	200
Pregnant Women	27,000
Breast and Cervical Cancer Project	700
Workers with Disabilities	6,600
Other Aged, Blind, and Disabled Adults	359,000
Total	2,058,500

Note: Numbers Reflect Individuals with Full Medicaid Benefits Only

The State of Ohio is proposing to simplify the criteria for Medicaid eligibility by mapping the multiple current eligibility categories described above into three simplified groups: (1) children and pregnant women, (2) individuals using long-term services and supports (LTSS), and (3) community adults. The eligibility criteria and standards for the first two simplified groups will not change as a result of the demonstration. Only the third group, community adults, is included in Ohio's Demonstration Waiver. The simplified categories are described below and enrollment in each category is summarized in Table 2.

Children and Pregnant Women

Ohio will maintain existing eligibility standards for children, including children needing LTSS, as well as for pregnant women, and these groups will not be included in the demonstration. The new mandatory

group for individuals under age 26 who have aged out of foster care will be mapped to this group and will not be included in the demonstration.

Adults who need LTSS

Ohio will maintain existing eligibility standards for individuals who need LTSS, for example, residents of long-term care facilities and individuals enrolled in 1915(c) home and community based waivers. This group also includes consumers enrolled in the Program of All-Inclusive Care for the Elderly (PACE) and individuals enrolled in Medicaid Buy-In for Workers with Disabilities (MBIWD). These categories will be included in the LTSS group and will be maintained as they are today, outside of the demonstration.

Community Adults

Ohio's demonstration focuses on this third group, Community Adults. This group includes new adults (Group VIII) as well as individuals who currently qualify for Medicaid but who are not eligible for groups one and two described above. The Community Adult group includes, for example, parents with income up to 90% FPL, community (non-institutional/non-waiver) ABD , cash and deemed cash recipients, and individuals who qualify under Section 1619 of the Social Security Act.

For Community Adults, Ohio proposes, through this demonstration, to:

1. Simplify the income standards for Community Adults.
2. Eliminate Ohio's resource test for Community Adults.
3. Provide benchmark coverage to Community Adults that consists of all Medicaid services except LTSS and EPSDT.
4. Eliminate the need for a state disability determination in order to qualify for Medicaid as a Community Adult.
5. Require Community Adults, including consumers in Group VIII, to pay copayments as specified in Ohio's Medicaid State plan.
6. Create a protected category for consumers already on Ohio Medicaid who might be disadvantaged by implementation of demonstration eligibility criteria for Community Adults.

Table 2: Ohio Medicaid Enrollment if Proposed Criteria Applied in July 2011

Medicaid Eligibility Category		Enrollment
1. Children 0 through 18, Pregnant Women, and Individuals Aged Out of Foster Care 18 through 20		1,209,000
2. Long Term Services and Supports		141,000
3. Community Adults		714,000
MAGI-based Community Adult Enrollment		
• *Adults enrolled in family Medicaid*	*406,000*	
• *Individuals enrolled in ABD Medicaid, under age 65, without Medicare, with income between 70% and 133% FPL*	*8,000*	
• *Breast and Cervical Cancer Project*	*570*	
• *Transitional Medical Assistance*	*47,000*	
Effective Income Level (EIL) Enrollment		
• *Individuals currently enrolled who are under age 65 and enrolled in Medicare*	*58,000*	
• *Individuals currently enrolled who are under age 65 and not enrolled in Medicare*	*128,000*	
• *Individuals currently enrolled who are over age 65 and enrolled in Medicare*	*25,000*	
• *Individuals currently enrolled who are over age 65 and not enrolled in Medicare*	*6,000*	
• *Individuals enrolled in premium assistance only (QMB, SLMB, and QI-1)**	*4,800*	
• *Individuals newly enrolling due to EIL/change in spenddown policy**	*300*	
Protected Group Enrollment		
• *Transitional Medical Assistance*	*23,000*	
• *Breast and Cervical Cancer Project*	*130*	
• *Other*	*7,000*	
TOTAL		**2,064,000**
**Newly eligible individuals: Individuals currently enrolled in premium assistance only (QMB, SLMB, and QI-1) and individuals newly enrolling due to EIL/change in spenddown policy*		*5,100*

Note: Numbers Reflect Individuals with Full Medicaid Benefits Only

Simplify Eligibility Processes through Modernization of Infrastructure

Current Eligibility Processes

The current processes by which individuals are determined eligible are extremely complicated, duplicative and painstaking. The processes were designed for a world of paper processing that was already out of date before the turn of the century. The potential consumer is faced with a kaleidoscope of complicated choices and requirements. There are over 150 categories of eligibility in Ohio and it is difficult to know which one an individual might qualify for and how he or she should apply. Ohio's 88 counties often set their own requirements for creating and submitting applications for Medicaid and other entitlement programs. For example, some counties have set days when an individual can walk in to apply, other counties only take applications over the telephone, some counties require the use of kiosks to fill out applications, and in some counties only certain workers are permitted to do certain processes and tasks and those workers are not always available. Often the same information must be filled out multiple times in order to satisfy different program requirements.

Once an application is filled out, the county worker must work through over 50 computer screens and must have a vast knowledge of eligibility requirements in order to help the applicant. Applicants may be required to return to the county offices multiple times in order to present all the needed documentation. Travel to and from the county office can sometimes be 20-30 miles from the individual's home.

Ohio envisions a solution that simplifies eligibility processes, making them understandable to all. This vision includes standardization of the process for enrollment, removing duplicative processes where possible, allowing self service capability for those individuals capable and desirous of self service, and modernizing applicable technology.

Current Eligibility System

The current eligibility and enrollment system used by the State of Ohio is the CRISE, the State of Ohio's response to the Federal mandate from the 1980s that all states develop automated systems for processing of Aid to Families with Dependent Children (AFDC), Food Stamp, and Medicaid benefits. CRISE was written in the seventies, installed in the eighties, and expanded in the nineties as a statewide, automated solution for county caseworkers as they determine OWF/cash, Food Stamp, and Medicaid eligibility.

Originally, CRISE was able to fulfill 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 application to do more, but all the additions were built upon the original foundation. The foundation could only extend so far and the limit was reached some time ago. The foundational problem is so severe that Ohio Medicaid has concluded that over sixty percent of cases are manually adjusted to ensure that system insufficiencies do not result in eligibility denials when applicants are, in fact, eligible. Ohio proposes that, rather than building more on an aging foundation, a new foundation be put down that will accommodate any number and type of change that will serve the citizens of Ohio. Ohio Medicaid consumers will be able to enroll or re-enroll themselves if they choose, empowering them and reducing the cost to both the state and federal governments.

Demonstration Hypotheses

Under this demonstration, the State proposes to test the impact of simplifying and streamlining Medicaid eligibility for all non-pregnant adults not needing LTSS. The State expects that simplifying and

streamlining eligibility for this group will promote the objectives of the Medicaid program by improving the eligibility determination/re-determination process for applicants/Medicaid consumers while reducing the administrative costs associated with eligibility determination/re-determination.

SECTION 2: ELIGIBILITY POLICY SIMPLIFICATION DETAIL

Ohio's Demonstration Proposal – Summary

Ohio seeks waiver authority to simplify eligibility for Community Adults (non-pregnant adults who do not need LTSS), while leaving eligibility standards unchanged for children, pregnant women and adults needing LTSS.

Ohio proposes a simplified "Community Adults" group in place of the array of family-based or disability-based groups for non-pregnant adults who do not need LTSS:

Current or ACA Category	New Community Adult Category
Individuals who are not pregnant, are under age 65, are not entitled to or enrolled in Medicare, are not enrolled in a mandatory eligibility group, and have household income not exceeding 133% FPL	MAGI Subgroup (Community Adults underage 65 without Medicare) Effective Income Level (EIL) Subgroup (primarily Community Adults age 65 or older or with Medicare)
Families who are receiving cash assistance	
Families deemed eligible for cash assistance	
Parents in families with countable income not exceeding 90% FPL	
Women eligible under Breast and Cervical Cancer Project (BCCP)	
Individuals eligible for family planning services	
Individuals who meet 209(b) criteria with or without a spenddown	
1619 Individuals	

Current Ohio Medicaid Eligibility Categories and Complications

Eligibility for adults in Ohio today is highly complex, with a significant number of eligibility categories. The eligibility category an individual is being evaluated for affects:

- Whether certain eligibility criteria apply. For example, resource limits apply to disability-based coverage groups but not family-based coverage.
- The specific limits that apply. For example, the resource limit is higher for applicants for the Medicaid Buy-In for Workers with Disabilities group than for Ohio's 209(b) spenddown group
- How the criteria is judged. For example, income is calculated differently for family-based coverage compared to disability-based coverage.
- Who judges the criteria. For most eligibility groups, income is calculated by the local County Departments of Job and Family Services. However, the Breast and Cervical Cancer Project (BCCP) category does not have a Medicaid income limit. Instead, the Department of Health determines an individual's income eligibility for the BCCP screening program.

Much of this complexity arises from the way the Medicaid program has been expanded in small pieces, one eligibility category at a time. Coverage of non-pregnant adults not needing LTSS could be significantly simplified and improved by reconsidering the way Medicaid defines and processes eligibility.

A listing of all of Ohio's current Medicaid eligibility groups with federal citations is attached as Appendix A. Ohio's current Medicaid eligibility groups (mandatory groups plus Ohio's selected optional groups) affected by Ohio's proposed demonstration can be summarized as the following:

Current Group	Specific Category
"Family" Adult Groups	Families who are receiving cash assistance
	Families deemed eligible for cash assistance
	Families with countable income not exceeding 90% FPL
Special Groups	Women eligible under Breast and Cervical Cancer Project (BCCP)
	Individuals eligible for family planning services
"ABD" Groups	Individuals who meet 209(b) criteria with or without a spenddown
	1619 Individuals

When an individual or family applies for Medicaid, how income is calculated depends on whether the category of coverage for which an individual is potentially eligible is considered "family", "ABD", or "long-term care" (LTC) coverage. Additionally, how the family and relevant family members are defined and counted depends on the type of Medicaid being considered.

Differences in eligibility criteria between family, disability, and LTC coverage means that some individuals will go through the determination process for family coverage, be found ineligible, and then go through the more complicated determination process for coverage as an aged, blind, or disabled individual.

ACA Changes

The ACA's primary changes to the pre-ACA eligibility groups are the new "adult group", which is defined to exclude many individuals assumed to be otherwise covered (individuals who are pregnant, disabled, or elderly), and the expansion of coverage (and a change from optional to mandatory coverage) for individuals who have aged out of foster care. The impact of the ACA and the related regulations on Ohio's current eligibility groups is shown in Appendix B.

The new adult group (Group VIII) will be considered part of the proposed Community Adult group and included in the demonstration. The eligibility category for individuals who have aged out of foster care will be mapped to the children and pregnant women group and will not be included in the demonstration.

Ohio's Demonstration Proposal for Community Adults: Detailed

Ohio proposes to simplify eligibility criteria for non-pregnant adults who do not need LTSS, while leaving eligibility criteria unchanged for children, pregnant women, and adults needing LTSS.

Simplified Income Standards

Ohio will establish two simplified income eligibility standards for Community Adults. One income standard is a MAGI-based standard of 133% FPL for Community Adults under age 65 without Medicare. The second income standard is an EIL for Community Adults not eligible for the MAGI subgroup, primarily Community Adults age 65 or older or with Medicare.

Implementation of the MAGI standard combined with improved systems functionality will facilitate the application process for individuals who qualify for Community Medicaid. It will also cause some

members of two groups of individuals who can currently qualify for full Medicaid coverage to move to the protected group and, in the future, for individuals in similar circumstances to not qualify for Medicaid. (Individuals eligible only for coverage under the limited-benefit Family Planning Group will not be moved to the protected group.) Individuals who currently qualify for the Breast and Cervical Cancer Project (BCCP) can have countable income up to 200% FPL. Those individuals with income up to 133% FPL (plus an additional 5% general disregard) will instead qualify for the Community Adult MAGI group. Individuals currently on BCCP with income between 134% and 200% FPL will be moved to the protected group on the effective date of this waiver.

Individuals in the Community Adult group who currently qualify for Medicaid under Transitional Medical Assistance (TMA) whose income is above the MAGI standard will also be moved to the protected group. Since TMA is a time limited program, coverage under the protected group will continue for this group through the pendency of TMA eligibility only.

Ohio will set its new EIL at 70% FPL. This EIL will be compared to countable income, which will be calculated using current Section 209(b) income exemptions/exclusions but without any income disregards. Similar to the process used today, Community Adults in the EIL subgroup will have the option of spending down to the EIL, which will move to 70% FPL, up from about 64% FPL.

While the EIL subgroup is primarily for Community Adults age 65 or older or with Medicare, some Community Adults who have been found disabled by the SSA but who are not enrolled in or entitled to Medicare (particularly those with income over the 133% MAGI-based standard), may choose to enroll in the EIL subgroup. If these Community Adults choose to have their eligibility determined using the EIL and their income is above the EIL, they will need to spend down to that standard. As this would not lead to any difference in Medicaid coverage, Ohio believes that these individuals will prefer to enroll in the MAGI subgroup, unless they have income above the 133% FPL limit. Individuals with a disability determination from SSA (but no Medicare coverage) and income over 133% FPL could choose to spend down and enroll in the EIL subgroup.

When an individual in the MAGI group turns age 65, becomes entitled to/enrolled in Medicare, or has an SSA disability determination and income over 133% FPL, his/her eligibility would be determined based on the EIL standard. Ohio proposes that any changes between the MAGI and EIL subgroup become effective with the enrollee's next redetermination/renewal period.

Beginning January 1, 2014, new Community Adult applicants under age 65 without Medicare will qualify with MAGI-based income up to 133% FPL. Individuals in this subgroup with income over 133% of FPL will not be eligible for Medicaid. (Individuals with income over 133% with an SSA disability determination would have the option to enroll through the EIL subgroup and spend down to the EIL.)

Community Adult applicants not eligible for the MAGI subgroup (e.g., those with Medicare and those age 65 or older) could qualify by having income below the EIL or by spending down to the EIL. Thus, current Medicaid enrollees in this subgroup would be able to spend down to the EIL.

No Resource Test

In addition to using simplified income standards for certain Community Adults, Community Adults will not be subject to a resource limit (Ohio currently has a resource limit for Section 209(b) coverage groups).

Benchmark Coverage

Ohio intends to provide benchmark coverage to all Community Adults, not just those in 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 requiring LTSS could move to the LTSS eligibility group if they meet the eligibility standards for enrollment in that group.

Copayments

The copayment amounts for Community Adults, including Group VIII, will be the same as required for other adults under Ohio's Medicaid state plan.

No Disability Determination

No state or federal disability determination will be necessary to qualify for the MAGI subgroup of Community Adult coverage. In addition, the State will no longer conduct disability determinations for Community Adults seeking eligibility through the EIL subgroup. Instead, the State will use disability (and blindness) determinations made by the SSA.

Protected Groups

Ohio will create a protected category for consumers already on Ohio Medicaid who might otherwise be disadvantaged by implementation of demonstration eligibility criteria for Community Adults. Individuals who do not meet the MAGI-based income standard but who were enrolled in full Medicaid coverage on January 1, 2014 would be allowed to continue participation in the Medicaid program under applicable criteria until they no longer meet their previous qualifying criteria, obtain other creditable coverage, or withdraw from the program.

Individuals receiving transitional medical assistance (TMA) would remain eligible until the end of their transitional period. Individuals eligible only for coverage under the limited-benefit Family Planning Group will not be moved to the protected group.

Projected Enrollment and Fiscal Impacts

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
Impact of ACA Enrollment		**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.

SECTION 3: ELIGIBILITY PROCESS AND INFRASTRUCTURE SIMPLIFICATION AND MODERNIZATION

Existing Ohio Application and Redetermination Processes

Initial Application

Medicaid's administrative complexity means that individuals who seek health care coverage must navigate a complicated, confusing, and sometimes burdensome application process. As an example, consider one hypothetical family – Mom Jones-Smith and Dad Smith have two children. At the time of their initial application, Mom works for a small business. Dad used to work for a large company that provided health insurance, but he was recently laid off. A serious chronic medical condition has prevented him from getting a new job. Dad goes to Ohio Medicaid's website and fills out an application online, indicating that he is interested only in medical coverage for the family.

The application is electronically submitted to the local CDJFS by Ohio's system. Though not every county's workflow is the same, the following is an example of an eligibility determination process for this situation. The application is assigned to a county worker, who reviews the information in eGateway. The worker then "clears" the application through the Statewide Clearance process to determine whether anyone in the family is already in Ohio's electronic eligibility determination system, CRISE. In this case, no one in the family has ever applied for or received assistance in Ohio, and no one shows up in CRISE.

Based on the income, age, and citizenship information provided in the application, the children are determined to be presumptively eligible for Medicaid. The worker runs two separate CRISE cases (one for each child) and authorizes presumptive eligibility coverage. Then the worker copies the application information from eGateway to CRISE and runs the eligibility "driver" for the family, noting the required verifications. Citizenship verification is obtained electronically through a batch file. For family-based Medicaid, the family will need to provide verification of income. As Dad may be ineligible for family-based Medicaid but eligible for disability Medicaid, requested verifications would include any medical documentation of Dad's claimed disability, and completed Release of Information forms for any doctors or hospitals that the agency will need to contact. Additionally, Dad has to provide information regarding the family's resources in order for the worker to assess his possible eligibility for disability-based Medicaid.

The worker completes a JFS 07105, in Word or hard copy, and mails it to the family, informing them of needed verifications and a due date. An informational packet of materials is also sent to the family. The worker also informs Dad that he must apply for Social Security Disability benefits. Finally, the worker documents the status of the case and actions taken so far on the CLRC screen in CRISE. The case pends in CRISE until the verifications are received.

The family gathers the requested information, including employer statements and medical information from providers or signed releases for the agency to collect medical information from the providers. Dad mails, faxes, or personally drops off all of the needed verification documents. A county worker creates and sends a document receipt for each piece of verification received, and adds a copy to the consumer's file. The worker then accesses the case in CRISE and reruns the eligibility driver, noting whether all of the needed verifications have been provided. If not, the worker will send Dad another JFS 07105 to request the still-needed verifications.

Using the system, the worker determines that the family's countable income equals 140% FPL for a family of 4. The worker examines retroactive coverage, and determines there were no qualifying medical expenses in the three months before the application. The worker therefore opens Medicaid coverage for the two children beginning on the first day of the month of the application, and denies coverage for Mom. In order for Dad to receive Medicaid on the basis of a disability, he will have to be found disabled by Ohio's Disability Determination Area (DDA) or the SSA.

Disability Determination Process

ODJFS receives approximately 675 disability determination cases per week, or 35,000 medical or psychological disability determination applications per year. Cases are separated into the following categories:

- New Case (87.5% of 2010 cases): requires case development for evidence within the previous 18 months from the general Medicaid application date;
- Continuing Disability Review (CDR) (6.4% of 2010 cases): current Medicaid consumer whose disabling condition requires case development for evidence since last approved date;
- Alien Emergency Medical Assistance (AEMA) (4.7% of 2010 cases): requires emergency room documentation that supports an acute and emergent episode;
- Death (1.3% of 2010 cases): requires either discharge summary documenting death or death certificate documenting date of death with period to be covered; and
- Hearing Compliance (approximately 6% of total cases): may require contact with county and/or disability determination unit to determine the need for additional medical evidence.

The disability determination process begins at the CDJFS, which is responsible for:

- Completing the initial general Medicaid application;
- Determining whether the individual meets the relevant eligibility criteria other than disability;
- Completing the initial disability application form, medical releases, and authorized representative form;
- Gathering medical documentation to support the individual’s disability;
- Obtaining medical and psychological examinations and testing; and
- Electronically uploading medical information into Ohio’s electronic disability processing system (eQuIL).

The county process (gathering medical documentation, completing the disability packet, etc.) can take longer than expected, especially if there are delays in obtaining the necessary medical documentation to be added to an individual's case packet. If an individual does not currently have health care coverage, it is unlikely the individual has medical documentation of a disability. In that case, the county must arrange for the medical exam. It can take weeks just to see the doctor, who may then need to order various tests.

Once the medical records have been received and a county worker has submitted a disability application packet through eQuIL, the DDA:

- Requests additional information from the county when the medical information in the initial application packet is insufficient;
- Performs a highly specialized clinical review of medical information in eQuIL according to the Social Security disability guidelines in 20 CFR 416 Subpart I to determine whether the individual is disabled; and

- Enters the disability determination decision into eQuIL, where it can be accessed by county staff.

Upon receipt of the DDA's decision, the county worker will access the individual's case in CRISE and approve or deny Medicaid based on the DDA's determination. If the individual is found disabled but has income above the Medicaid need standard, a spenddown is calculated.

Initial Application Continued

In our example family, after receiving and reviewing Dad's medical records, the DDA finds that he is disabled. The worker enters the DDA decision into CRISE and runs the eligibility driver to determine Dad's eligibility. The worker determines that Dad is eligible for Medicaid with a spenddown, approves the coverage in CRISE, and mails Dad a spenddown brochure. As always, the worker documents the status of the case on the CLRC screen in CRISE.

Because all benefits are explored every time the eligibility driver is run, CRISE doesn't just generate a Notice of Approval of Dad's coverage. Instead, approvals and denials of all the other coverage (or potential coverage) groups are issued. This understandably causes confusion, and Dad calls the worker to ask what's going on.

It is important to note that in this example, the family composition and the verification process was intentionally kept simple. There are no non-custodial parents. Neither child has income (earned income, child support, etc.) that could render one child ineligible while the other is eligible. The family has no countable resources. Also, the family was able to promptly provide all requested verifications, the family stayed together at one address during the entire period, and the county worker had no difficulty contacting them when needed.

This description of the process was further simplified by arbitrarily declaring that the family is not seeking other forms of public assistance. In reality, a family like the one described would likely be seeking cash and/or food assistance, with the additional complications caused by different rules regarding what verification is acceptable and sufficient for which program. Families often have complicated relationships - adults move in and out of the home, or custody arrangements change. This can require that individuals be added to or removed from existing Medicaid cases, requiring re-examination of the eligibility of each individual in the family. In addition, families with individuals seeking disability-based Medicaid or LTC services may have sufficient resources or income to cause complications.

Proposed New Ohio Application and Redetermination Processes

Ohio Medicaid first will simplify the eligibility categories and criteria for Medicaid so that individuals can easily understand what they are eligible for and what they need to do to become eligible. The current array of eligibility categories and criteria is confusing even to the seasoned eligibility worker.

After the new eligibility processes are implemented, an individual who seeks health care coverage will most often go to a website or call a help desk. The applicant will be asked for enough information to identify him or her, and will be asked for approval to verify eligibility criteria.

Whether the individual is applying for coverage at the Ohio Medicaid website or through a call center will make little difference to the initial set of questions. When simplified eligibility categories and criteria are combined with modernized eligibility processes and technology, an applicant will be asked for only key information or for clarification when data is inconsistent. An individual who applies for Medicaid

will be better able to understand whether he or she is likely to be Medicaid-eligible, what information or verifications are required to determine eligibility, and why he or she was found eligible or ineligible for Medicaid coverage.

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.

New Eligibility System

Ohio and CMS share a vision of a modernized eligibility determination system that is easy to use, fast, simple, and highly reliable. The new system will improve the process for consumers to apply for and be determined eligible for Medicaid, TANF, SNAP or private insurance. Ohio believes a new system is paramount for improvement of access to health coverage, the reduction of administrative and program costs, and improving health outcomes. The system is envisioned to be highly agile, provide real-time determinations, and allow for no wrong doors for applicants.

Ohio will partner with CMS to replace the current outdated legacy eligibility system CRISE with an extensible, scalable, adaptable and flexible system and accompanying architecture. Ohio will avoid proprietary technologies and implement a solution that leverages the Medicaid Information Technology Architecture (MITA). Ohio is well aware that planning is the key to any successful IT implementation. Ohio and CMS will work together to ensure that our shared vision for a new system is realized. Ohio and CMS have already engaged in gate reviews and expedited APDs for a new system. Many project documents have already been shared and approved. With the assistance of CMS, Ohio will publish a request for purchase (RFP) this summer.

Ohio will work with CMS to take a staged approach to moving from the old CRISE system to the new eligibility system. The approach would be a migration program by program starting with Medicaid (beginning with populations that will be new to Medicaid in 2014, and therefore not in the current CRISE system) and then following with SNAP and TANF. It is also likely that certain populations within the Medicaid program will be migrated to the new system first, avoiding a “big bang” approach. Ohio believes a program migration approach is the only viable way to move program functionality off the monolithic CRISE solution. Ohio will ensure that the staged approach does not impact its ability to implement the new Community Adult group on January 1, 2014.

The new eligibility determination system will at a minimum provide:

- 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, email, and portal;
- Transition to a paperless environment;
- Improved data quality, program integrity, and quality control;
- Dynamic rules based engine; and
- Leverage Service Oriented Architecture (SOA)/MITA architecture.

Ohio Medicaid values qualities that improve the consumer experience and make the enrollment process easy to understand. Consumer interaction with the system will be simple and straightforward. Determinations will be accurate and quick. The system will be available anytime and anywhere. Consumers will be presented with a reliable and accurate system where the processes are consistent and repeatable. The consumer experience is critical to the successful launch and subsequent continued use of the self-service portion of the solution.

Applicants

In order to perform real-time, online, automated eligibility determinations, Ohio's modernized eligibility determination system will need to have specific business rules addressing when an individual is allowed to apply on behalf of another individual. These rules, to be worked out as the system requirements are being drafted, will address not only the obvious situations (married couples, parents of children) but also some of the more complicated questions. For example, who has authority to apply for health care coverage on behalf of abandoned babies, or on behalf of children who have run away from home or who are alleged to be in abusive situations but who are "not yet adjudicated" and are not yet legally in the custody of a state agency?

Verification Rules

The verification process will be simplified, especially from the applicant's perspective. Many eligibility criteria will be based on the applicant's statement, unless the modernized eligibility determination system has conflicting information. Where possible, eligibility verification will be done electronically, asking the individual for verification documents only when electronic verification is unavailable or incompatible with other information.

If additional information is required from the individual, the system will generate a request for verification with information about methods of providing the verification. The individual will be able to scan and upload documents or to provide verification through alternate means. A worker will review provided verifications and determine whether inconsistencies are resolved or whether a conflict still exists or additional verification is needed.

A detailed verification plan for Ohio's eligibility determination processes will be drafted as Ohio receives more information about the federal data hub and learns more about what other electronic verifications sources are available and reliable. This detailed verification plan will address the obvious and logical issues (like how to verify income when an individual reports he or she expects to start a job on a future date) but also more complicated issues. For example, what verifications are waived or simplified for:

- Homeless individuals;
- Abandoned babies or other children who are in need but who are "not yet adjudicated",
- victims of trafficking; or
- Individuals who are unable to provide verifications due to natural or personal disasters (such as a tornado or a house fire)?

Eligibility Determination

Once sufficient information is gathered to determine if an individual is eligible for coverage in a child/pregnant woman or Community Adult group, the system will either offer Medicaid coverage or refer the individual to other options (passing along all information gathered so far).

At some point in the application, verification, and determination process, the individual will be asked to set up an electronic account, so that he or she can return later to review or edit data, report a change, or provide information for a redetermination of eligibility.

If our hypothetical family had first applied for Medicaid after eligibility categories have been simplified and a modernized computer system has been implemented, the experience of applying would be very different.

Dad would still start at Ohio Medicaid's website by filling out an application indicating that he is interested only in medical coverage. The system would verify Dad's identity, check to determine whether there is already an on-line account for the family, and ask Dad for authorization to electronically verify eligibility criteria where possible. The system will be able to electronically verify family members' citizenship, residence, ages, and MAGI-based income of 190% FPL for a family of 4.

SECTION 4: WAIVER AUTHORITIES

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.

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.

SECTION 5: APPROACH TO EVALUATION

Ohio will develop an evaluation design plan to measure the impact and success of this demonstration. The plan will include the demonstration hypotheses, the data that will be used, and the methodology for data collection. The focus of the design will be measuring the impact of simplifying and streamlining Medicaid eligibility for Community Adults on both applicants and the State.

Potential research hypotheses include:

- Eligibility for Community Adults will be determined more quickly and reduce barriers to enrollment.
- The revised eligibility process will reduce churning for individuals in the Community Adult group.
- Community Adult applicants will be satisfied with the new eligibility determination process.
- The revised eligibility process will help Ohio meet timeliness and performance standards for eligibility determination.
- The revised eligibility process will enhance program efficiency and integrity.
- The simplified and streamlined eligibility process will support the federally-mandated expansion.
- Current pre-ACA enrollment will be maintained through thoughtful eligibility criteria and continued eligibility for individuals with income over the income standards for the Community Adult group.

Ohio's plan for testing these hypotheses includes:

- Analyzing eligibility determination statistics for a period prior to the changes to a period post implementation to compare the number of applications processed and the average processing times for Community Adult applications.
- Analyzing enrollment spans to evaluate churning both before and after the streamlining.
- Conducting a survey of new applicants for the Community Adult group to determine their satisfaction with the application process. This could be done for the online application automatically after the application is submitted.
- Conducting a survey of current enrollees in the Community Adult group to identify any process issues or negative effects of changes.
- Analyzing Ohio's eligibility error rates (PERM and MEQC).
- Analyzing eligibility date to determine the number of individuals who attained/lost eligibility because of the eligibility changes.

SECTION 6: PUBLIC NOTICE

Compliance with Federal Public Notice Requirements

Ohio implemented a process, in compliance with the regulations specified in 42 CFR 431.308, to assure transparency of Ohio's proposed 1115 waiver and the content therein, and to solicit meaningful public input in the development of the 1115 Waiver Application.

In March 2012, the Governor's Office of Health Transformation (OHT) posted a copy of the Concept Paper entitled "How to Modernize Medicaid Eligibility in the State of Ohio." This concept paper served as a starting point for considerations and discussions with stakeholders including, but not limited to, county policy groups, consumer and provider advocacy groups and associations, Sister State Agencies, internal staff, etc., about how to modernize Medicaid eligibility in Ohio. The concept paper provided information about how Ohio's current system is fragmented and overly complex, outlined concepts for reform, and described the potential impact on current Medicaid enrollees.

Ohio maintained the posting of the Concept Paper, seeking public comment until the 1115 Waiver application was posted for public comment. Ohio is now seeking public comment on its proposed 1115 waiver and is providing a 30-day comment period for stakeholder input regarding the demonstration application.

Public Notice

A Public Notice document, the public input process, planned hearings, the demonstration application, and a link to the to the relevant Medicaid demonstration page on the CMS website is posted on Ohio's website. Throughout the entire public comment and review period, Ohio will maintain and keep current the public website at this website:
http://www.healthtransformation.ohio.gov/CurrentInitiatives/ModernizeEligibilityDeterminationSystems.aspx

Specifically, the Public Notice document includes the following information:

a) The program description, goals and objectives to be implemented under the demonstration project, including a description of the current or new beneficiaries who will be affected by the demonstration.
b) To the extent applicable, the proposed health care delivery system and the eligibility requirements, benefit coverage and cost sharing (premiums, co-payments and deductibles) required of individuals that will be modified by the demonstration, and how such provisions vary from the State's current program features.
c) The hypothesis and evaluation parameters of the demonstration.
d) The specific waiver and expenditure authorities that the State think are necessary to authorize the demonstration
e) The locations and Internet address where copies of the demonstration application are available for public review and comment.
f) Postal and Internet email addresses where written comments may be sent and reviewed by the public, and the minimum 30-day time period in which comments will be accepted.
g) The location, date and time of at least two public hearings convened by the State to seek public input on the demonstration application.

An abbreviated public notice, including a summary description of the demonstration, the location and times of the public hearings, and an active link to the full public notice document on Ohio's website was published in the Register of Ohio. In addition, email notification has been provided to all those who requested updates through OHT's website listserv, as well as to other interested parties. The email provides a direct link to the proposed 1115 waiver.

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

Public Comments

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.***

APPENDIX A

Existing Ohio Medicaid Eligibility Groups

Mandatory Groups

Medicaid due to eligibility for other assistance

SSA and/or CFR Citation	Group name	Who is this? (Criteria)
1902(a)(10)(A)(i)(I)	Receiving assistance under Title I, X, XIV, or IV-E	Receive assistance from the state under grants to states for the aged, blind, or disabled individuals, or receiving assistance as a foster child through IV-E
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 435.131, .132, .133, .134	Grandfathered individuals	Multiple groups who met Medicaid eligibility criteria and were enrolled in or met criteria for another program on specific dates ranging from 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

Continuing Medicaid due to specific forms of increased income

SSA and/or CFR Citation	Group name	Who is this? (Criteria)
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

Medicaid for Children

SSA and/or CFR Citation	Group name	Who is this? (Criteria)
1902(e)(4); 42 CFR 435.117	Deemed newborns	Deemed newborns
1902(a)(10)(A)(i)(III); 1905(n)(2)	Qualified Children	Children under age 19 with income/resources below cash limits
1902(a)(10)(A)(i)(IV); 1902(l)(1)(B)	Poverty Level Infants	Infants under age 1, with family income up to 133% FPL (disregard of 133% to 150% FPL)
1902(a)(10)(A)(i)(VI); 1902(l)(1)(C)	Poverty Level Children 1 to 6	Children 1 to 6 with income not exceeding 133% FPL (disregard of 133% to 150% FPL)
1902(a)(10)(A)(i)(VII); 1902(l)(1)(D)	Children 6 to 19	Children 6 to 19 with income not exceeding 100%

Medicaid for Pregnant Women

SSA and/or CFR Citation	Group name	Who is this? (Criteria)
1902(a)(10)(A)(i)(III); 1905(n); 42 CFR 435.116	Qualified Pregnant Women	A (medically verified) pregnant woman with income/resources below cash limits
1902(a)(10)(A)(i)(IV); 1902(l)(1)(A)	Poverty-Level Pregnant Women	Pregnant (and postpartum) women, with family income up to 133% FPL
1902(e)(5)	Postpartum women	Postpartum women

Medicaid for Aged, Blind, or Disabled Individuals

SSA and/or CFR Citation	Group name	Who is this? (Criteria)
1902(f); Pub. L. 92-603	209(b)	Aged, Blind, or Disabled Individuals

Specialty Programs

SSA and/or CFR Citation	Group name	Who is this? (Criteria)
1902(a)(10)(E)(i); 1905(p)(1)	QMB	
1902(a)(10)(E)(iii)	SLMB	
1902(a)(10)(E)(ii); 1905(s)	QDWI	(Currently unavailable – anyone eligible for this would be MBIWD-eligible, and this has a "not otherwise eligible" clause)
1902(a)(10)(E)(iv)	QI-1	
42 CFR 440.255	AEMA	Alien Emergency Medical Assistance

Optional Medicaid Groups

Medicaid for Families, Pregnant Women, and Individuals Under 21

SSA and/or CFR Citation	Group name	Who is this? (Criteria)
1931(b)(2)(C)	Low Income Families above cash standard	Families (less restrictive income/resource standards)
1920A	Presumptive Eligibility for Children	Presumptive eligibility from date of application (for children meeting certain criteria) until date of eligibility determination
	Presumptive Eligibility for Pregnant Women	Presumptive eligibility from date of application (for pregnant women meeting certain criteria) until date of eligibility determination
1902(a)(10)(A)(ii)(IX)	Poverty-Related Pregnant Women & Infants	Pregnant women and children under 1, with income from 150% - 200% FPL
1902(a)(10)(A)(ii); 1905(a)(i); 42 CFR 435.222	Under 21 with income & resources below cash standards	includes many subgroups, including: Rib kids, foster or adoptive kids, kids in NFs, inpatient psych kids, etc.
1902(a)(10)(A)(ii)(VIII)	Adoption Assistance	Specific kids getting adoption assistance who could not be placed without medical assistance
1902(a)(10)(A)(ii)(VIII)	non-IV-E adoption assistance	Kids under 21 who can't be placed for adoption without Medicaid, meet specific standards, but not IV-E placement

1902(a)(10)(A)(ii)(XVII)	independent foster care adolescents (Chafee group)	Under 21, was in foster care on 18th birthday

Medicaid for Individuals with Long-Term Care Needs

SSA and/or CFR Citation	Group name	Who is this? (Criteria)
1902(a)(10)(A)(ii)(V)	SIL	in a medical institution for not less than 30 consecutive days (eligibility begins on the first day), who meet the resource requirements, with income not above 300% of the Federal Benefit Rate
1902(a)(10)(A)(ii)(VI); 42 CFR 435.217	HCBS-via-SIL	Individuals who would be eligible for Medicaid LTC/institutional payments if in a medical institution, and who require HCBS to keep them out of that hospital, NF or ICF-MR
42 CFR 435.211	Institutionalized individuals	Individuals who would be eligible for TANF, SSI, or optional state supplement if not in a medical institution

Specialty Programs

SSA and/or CFR Citation	Group name	Who is this? (Criteria)
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)(XI); 42 CFR 435.230, 435.121	RSS	Individuals who receive an optional state supplement
1902(a)(10)(A)(ii)(XV)	MBIWD	16 to 65, would be eligible for SSI if not for excess income, income below a standard set by state, working. May have to pay premium.
1902(a)(10)(A)(ii)(XVI)	Medically Improved	MBIWD medically improved
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

CHIP

SSA and/or CFR Citation	Group name	Who is this? (Criteria)
1902(a)(10)(A)(ii)(XIV); 1905(u)(2)(B)	Optional Targeted Low-Income Children	Kids with income between 150% and 200% FPL, with no creditable coverage
1902(a)(10)(A)(ii)(IX)	Poverty-Related Pregnant Women & Infants	Pregnant women and children under 1, with income from 150% - 200% FPL

APPENDIX B

ACA Medicaid Regulation's Changes to Ohio's Medicaid Eligibility Groups

Effective 1/1/2014

Mandatory Groups

Medicaid due to eligibility for other assistance

SSA and/or CFR Citation	Group name	Who is this? (Criteria)
1902(a)(10)(A)(i)(I)	Receiving assistance under Title I, X, XIV, or IV-E	Receive assistance from the state under grants to states for the aged, blind, or disabled individuals, or receiving assistance as a foster child through IV-E
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 435.131, .132, .133, .134	Grandfathered individuals	Multiple groups who met Medicaid eligibility criteria and were enrolled in or met criteria for another program on specific dates ranging from 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 435.113, .114, .115	Cash Assistance	Individuals receiving TANF, deemed cash recipients, grandfathered cash-based recipients, and multiple specific cash-related groups

Continuing Medicaid due to specific forms of increased income

SSA and/or CFR Citation	Group name	Who is this? (Criteria)
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

Medicaid for Children

SSA and/or CFR Citation	Group name	Who is this? (Criteria)
1902(e)(4); 42 CFR 435.117	Deemed newborns	Deemed newborns
1902(a)(10)(A)(i)(III); 1905(n)(2)	Qualified Children	Children under age 19 with income/resources below cash limits
1902(a)(10)(A)(i)(IV); 1902(l)(1)(B)	Poverty Level Infants	Infants under age 1, with family income up to 133% FPL (disregard of 133% to 150% FPL)
1902(a)(10)(A)(i)(VI); 1902(l)(1)(C)	Poverty Level Children 1 to 6	Children 1 to 6 with income not exceeding 133% FPL (disregard of 133% to 150% FPL)
1902(a)(10)(A)(i)(VII); 1902(l)(1)(D)	Children 6 to 19	Children 6 to 19 with income not exceeding 100%
42 CFR 435.118; 1902(a)(10)(A)(i)(III), (IV),	Infants and children under age 19	Children under age 19 with household income below the upper limit (chosen by the state within

(VI), and (VII); 1902(a)(10)(A)(ii)(IV) and (IX); and 1931(b) and (d)		specified limits) for the appropriate age range: under 1, 1 through 5, or 6 through 18.
1902(a)(10)(A)(i)(IX)	Former Foster Children*	Individuals under 26; not described in or enrolled under 1902(a)(10)(A)(i)(I) through (VII) groups (or have income above the standard for the group*); were in foster care under State responsibility on the individual's 18th birthday; and were enrolled in Medicaid while in foster care

* Individuals will not fall into this group unless they have income too high for the adult expansion 1902(a)(10)(A)(i)(VIII) group.

Medicaid for Pregnant Women

SSA and/or CFR Citation	Group name	Who is this? (Criteria)
1902(a)(10)(A)(i)(III); 1905(n); 42 CFR 435.116	Qualified Pregnant Women*	A pregnant woman with income below an upper limit, chosen by the state, between (higher of 133% FPL or 1989 limits) and the highest 2009 limit for pregnant women
1902(a)(10)(A)(i)(IV); 1902(l)(1)(A)	Poverty-Level Pregnant Women	Pregnant (and postpartum) women, with family income up to 133% FPL
1902(e)(5)	Postpartum women	Postpartum women

* 42 CFR 435.4 defines "pregnant woman" as including the postpartum period.

Medicaid for Adults

SSA and/or CFR Citation	Group name	Who is this? (Criteria)
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)
42 CFR 435.119; 1902(a)(10)(A)(i)(VIII)	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.

Medicaid for Aged, Blind, or Disabled Individuals

SSA and/or CFR Citation	Group name	Who is this? (Criteria)
1902(f); Pub. L. 92-603	209(b)	Aged, Blind, or Disabled Individuals with resources below $1,500/person, $2,250/couple who have income below the need standard (about 65% FPL) or incur a spenddown to the standard.

Specialty Programs

SSA and/or CFR Citation	Group name	Who is this? (Criteria)
1902(a)(10)(E)(i); 1905(p)(1)	QMB	
1902(a)(10)(E)(iii)	SLMB	
1902(a)(10)(E)(ii); 1905(s)	QDWI	
1902(a)(10)(E)(iv)	QI-1	
42 CFR 440.255	AEMA	Alien Emergency Medical Assistance*

* AEMA itself is not directly amended by the ACA. However, to be eligible for AEMA coverage an individual must receive emergency care and meet the eligibility criteria (other than citizenship or qualified alien status) for some category of Medicaid. The expansion of Medicaid eligibility means that AEMA eligibility is expanded as well.

Optional Groups

Medicaid for Families, Pregnant Women, and Individuals Under 21

SSA and/or CFR Citation	Group name	Who is this? (Criteria)
1931(b)(2)(C)	Low Income Families above cash standard	Families (less restrictive income/resource standards)
1920A	Presumptive Eligibility for Children	Presumptive eligibility from date of application (for children meeting certain criteria) until date of eligibility determination
	Presumptive Eligibility for Pregnant Women	Presumptive eligibility from date of application (for pregnant women meeting certain criteria) until date of eligibility determination
1902(a)(10)(A)(ii)(IX)	Poverty-Related Pregnant Women & Infants	Pregnant women and children under 1, with income from 150% - 200% FPL
1902(a)(10)(A)(ii); 1905(a)(i); 42 CFR 435.222	Under 21 with income & resources below cash standards	includes many subgroups, including: Rib kids, foster or adoptive kids, kids in NFs, inpatient psych kids, etc.
1902(a)(10)(A)(ii)(VIII)	Adoption Assistance	Specific kids getting adoption assistance who could not be placed without medical assistance
1902(a)(10)(A)(ii)(VIII)	non-IV-E adoption assistance	Kids under 21 who can't be placed for adoption without Medicaid, meet specific standards, but not IV-E placement
1902(a)(10)(A)(ii)(XVII)	independent foster care adolescents (Chafee group)	Under 21, was in foster care on 18th birthday*

* This optional category is still in the Social Security Act, but has been superseded by the new mandatory category.

Medicaid for Individuals with Long-Term Care Needs

SSA and/or CFR Citation	Group name	Who is this? (Criteria)
1902(a)(10)(A)(ii)(V)	SIL	in a medical institution for not less than 30 consecutive days (eligibility begins on the first day), who meet the resource requirements, with income

		not above 300% of the Federal Benefit Rate
1902(a)(10)(A)(ii)(VI); 42 CFR 435.217	HCBS-via-SIL	Individuals who would be eligible for Medicaid LTC/institutional payments if in a medical institution, and who require HCBS to keep them out of that hospital, NF or ICF-MR
42 CFR 435.211	Institutionalized individuals	Individuals who would be eligible for TANF, SSI, or optional state supplement if not in a medical institution

Specialty Programs

SSA and/or CFR Citation	Group name	Who is this? (Criteria)
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)(XI); 42 CFR 435.230, 435.121	RSS	Individuals who receive an optional state supplement
1902(a)(10)(A)(ii)(XV)	MBIWD	16 to 65, would be eligible for SSI if not for excess income, income below a standard set by state, working. May have to pay premium.
1902(a)(10)(A)(ii)(XVI)	Medically Improved	MBIWD medically improved
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

CHIP

SSA and/or CFR Citation	Group name	Who is this? (Criteria)
1902(a)(10)(A)(ii)(XIV); 1905(u)(2)(B)	Optional Targeted Low-Income Children	Kids with income between 150% and 200% FPL, with no creditable coverage

APPENDIX C

Impact of Proposed Waiver Changes on Community Adults

Mandatory & Optional Coverage Groups Impacted By Waiver

Federal Citations	Affected Groups	Extent of Waiver
1902(f); Pub. L. 92-603	209(b)	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); * necessary for the State to establish 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); * necessary to eliminate the resource test for Community Adults in the EIL subgroup (primarily individuals who are age 65 or older or have Medicare)
42 CFR 435.110	Medicaid for Parents and Caretaker Relatives	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
1902(a)(10)(A)(i)(VIII)	Individuals age 19 or older and under age 65 at or below 133 percent FPL	
1931(b)(2)(C)	Low Income Families above cash standard	
1902(a)(10)(A)(i)(I)	Receiving assistance under Title I, X, XIV, or IV-E	
1619	1619 Individuals	
1905(q); 1634	Grandfathered Individuals	
1902(a)(10)(A)(i)(II); 42 CFR 435.130	RSS	
1902(a)(10)(A)(i)(I); 1931	Cash Assistance	
1902(a)(10)(A)(ii)(XVIII)	BCCP	
1902(a)(10)(A)(ii)(XXI)	Family Planning Option	

Mandatory & Optional Coverage Groups Not Impacted By Waiver

Medicaid for Children

SSA and/or CFR Citation	Group name	Who is this? (Criteria)
1902(e)(4); 42 CFR 435.117	Deemed newborns	Deemed newborns
42 CFR 435.118; 1902(a)(10)(A)(i)(III), (IV), (VI), and (VII); 1902(a)(10)(A)(ii)(IV) and (IX); and 1931(b) and (d)	Infants and children under age 19	Children under age 19 with household income below the upper limit (chosen by the state within specified limits) for the appropriate age range: under 1, 1 through 5, or 6 through 18.
1902(a)(10)(A)(i)(IX)	Former Foster Children	Individuals under 26; not described in or enrolled under 1902(a)(10)(A)(i)(I) through (VII) groups (or have income above the standard for the group*); were in foster care under State responsibility on the individual's 18th birthday; and were enrolled in Medicaid while in foster care
1920A	Presumptive Eligibility for Children	Presumptive eligibility from date of application (for children meeting certain criteria) until date of eligibility determination
	Presumptive Eligibility for Pregnant Women	Presumptive eligibility from date of application (for pregnant women meeting certain criteria) until date of eligibility determination
1902(a)(10)(A)(ii)(IX)	Poverty-Related Pregnant Women & Infants	Pregnant women and children under 1, with income from 150% - 200% FPL
1902(a)(10)(A)(ii); 1905(a)(i); 42 CFR 435.222	Under 21 with income & resources below cash standards	includes many subgroups, including: Rib kids, foster or adoptive kids, kids in NFs, inpatient psych kids, etc.
1902(a)(10)(A)(ii)(VIII)	Adoption Assistance	Specific kids getting adoption assistance who could not be placed without medical assistance
1902(a)(10)(A)(ii)(VIII)	non-IV-E adoption assistance	Kids under 21 who can't be placed for adoption without Medicaid, meet specific standards, but not IV-E placement
1902(a)(10)(A)(ii)(XIV); 1905(u)(2)(B)	Optional Targeted Low-Income Children	Kids with income between 150% and 200% FPL, with no creditable coverage

Medicaid for Pregnant Women

SSA and/or CFR Citation	Group name	Who is this? (Criteria)
1902(a)(10)(A)(i)(III); 1905(n); 42 CFR 435.116	Pregnant Women	A pregnant woman with income below an upper limit, chosen by the state, between (higher of 133% FPL or 1989 limits) and the highest 2009 limit for pregnant women

Medicaid for Individuals with Long-Term Care Needs

SSA and/or CFR Citation	Group name	Who is this? (Criteria)
1902(a)(10)(A)(ii)(V)	SIL	in a medical institution for not less than 30 consecutive days (eligibility begins on the first day), who meet the resource requirements, with income not above 300% of the Federal Benefit Rate
1902(a)(10)(A)(ii)(VI); 42 CFR 435.217	HCBS-via-SIL	Individuals who would be eligible for Medicaid LTC/institutional payments if in a medical institution, and who require HCBS to keep them out of that hospital, NF or ICF-MR
42 CFR 435.211	Institutionalized individuals	Individuals who would be eligible for TANF, SSI, or optional state supplement if not in a medical institution
1902(a)(10)(A)(ii)(XV)	MBIWD	16 to 65, would be eligible for SSI if not for excess income, income below a standard set by state, working. May have to pay premium.
1902(a)(10)(A)(ii)(XVI)	Medically Improved	MBIWD medically improved

Specialty Programs

SSA and/or CFR Citation	Group name	Who is this? (Criteria)
1902(a)(10)(E)(i); 1905(p)(1)	QMB	
1902(a)(10)(E)(iii)	SLMB	
1902(a)(10)(E)(ii); 1905(s)	QDWI	
1902(a)(10)(E)(iv)	QI-1	
42 CFR 440.255	AEMA	Alien Emergency Medical Assistance