Why the Budget is Silent on Medicaid Expansion

Current Medicaid eligibility levels went into effect on October 10, 2013. The authority to set and keep Medicaid eligibility at current levels results from a combination of the following federal and state laws:

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

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

- The most direct method to set Medicaid eligibility levels is via a State Plan Amendment (SPA). Ohio law permits the Medicaid director to seek a SPA without additional legislation (5162.07 enacted June 2013).[3]

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

- On October 10, 2013, the Centers for Medicare and Medicaid Services (CMS) approved Ohio's SPA request and made federal funds available to extend Medicaid coverage in Ohio beginning January 1, 2014.[4]

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

Notes:

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

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

[3] R.C. 5162.07: "The Medicaid director shall seek federal approval for all components, and aspects of components, of the Medicaid program for which federal approval is needed, except that the director is permitted rather than required to seek federal approval for components, and aspects of components, that state statutes permit rather than require be implemented. Federal approval shall be sought in the following forms as appropriate: (A) the Medicaid state plan, (B) amendments to the Medicaid state plan, (C) federal Medicaid waivers, (D) amendments to federal Medicaid waivers, (E) other types of federal approval, including demonstration grants."

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