2014 Medicaid Expansion

What does it mean for Direct Support Professionals?

A guide book for your agency on how to educate and inform DSPs

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Introduction to the 2014 Medicaid Expansion

On October 21st the Ohio Controlling Board voted to approve the expansion of health care benefits to an estimated 275,000 Ohioans, representing good government in action. These means if you are an adult and earn less than the 138% Federal Poverty Level (FPL), you are eligible for Medicaid health insurance.

This decision to allow federal funds to be used to provide health care to many low-wage Ohioans strengthens Ohio's workforce, brings $13 billion into the state, and will create over 30,000 jobs in Ohio over the next ten years.

Medicaid expansion is of high importance to our provider organizations and their workers. Many of our members' direct support professionals earn incomes under 138% of the federal poverty level and live without health care benefits. They live and work every day, being one serious illness or injury away from financial ruin.

A large number of them almost certainly will qualify to receive life-altering Medicaid coverage. In addition, extension will bring relief to our providers, who were facing an Affordable Care Act mandate for employer-sponsored health care that had been estimated to cost members $20 million annually.

On November 13th, the Governor's Office of Health Transformation announced that low-income families will be able to apply for Medicaid benefits online beginning December 9, nearly one month ahead of schedule.

Individuals who will qualify for Medicaid under recent eligibility changes also may begin applying on December 9.

Who is newly eligible for Medicaid coverage?

- Beginning January 1, 2014, an additional group of residents will become eligible for Medicaid coverage in Ohio.
- This group includes adults between the ages of 19 to 64, who are between 0 – 138% FPL and are not eligible under another category of Medicaid. **NEW**: Parents 91-138% are now eligible.
- Parents: Parents living with their minor children between 0 – 90% of the Federal Poverty level are currently eligible for Medicaid coverage.

What does 138% FPL look like for an individual or household?

HOUSEHOLD SIZE	138% FPL
1	$15,856
2	$21,406
3	$26,952
4	$32,499
5	$38,047
6	$43,594
7	$49,142
8	$54,689
For each additional individual in the household add $5,347.	

How can I apply for Medicaid?

To see if you are eligible for Medicaid benefits, complete an application online at [www.benefits.Ohio.gov.](http://www.benefits.Ohio.gov)

If you cannot complete an application online, you can go to your local JFS office and complete an application with a case worker, or call the **Ohio Medicaid Consumer Hotline at (800) 324-8680.**

I think I am in the newly covered Medicaid population, when do I sign up?

Beginning on December 9, newly eligible adults will be able to submit applications through Benefits.Ohio.Gov for **coverage starting on January 1, 2014**.

This video, "How to Use Ohio Benefits," may be helpful:
http://www.youtube.com/watch?v=ALd74KnfcsU&feature=c4-overview&list=UUTs1QQe0HR4vBe6LzdFdRow

What happens after I apply?

Step 1: Case Review

After you apply, you may get a letter asking for more information if needed. If you need help getting the information, ask your case worker. After the county office has everything, it may take up to 30 days to make a decision. If you are applying for disability benefits, it can take longer.

Your case will be reviewed every 12 months. If there are any changes in your household that might affect your eligibility in between your review times, you need to let your case worker know within 10 days.

Step 2: Approval

When you are first approved for Medicaid you are automatically enrolled in the Fee-For-Service coverage. You will get a letter in the mail with your Medicaid card and can start using services right away. If you stay on the Fee-For-Service plan, you will get a new card every month.

Ohio Medicaid has a statewide network of providers including hospitals, family practice doctors, pharmacies and durable medical equipment companies. Under the Fee-For-Service plan these providers bill Medicaid directly for health care services they provide to you. You should ask the provider if they accept Medicaid before you schedule an appointment.

Step 3: Managed Care

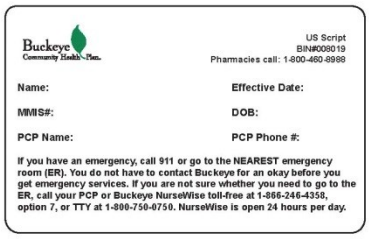
Most people are automatically approved for Medicaid Managed Care coverage. Shortly after you get on Medicaid you will get a letter asking you to choose a Medicaid Managed Care plan (MCP). Visit or call the Consumer Hotline (800-324-8680) to find out which plans are available in your area. Below are the five managed care plans for more information. If you don't choose a plan, Ohio Medicaid will choose one for you.

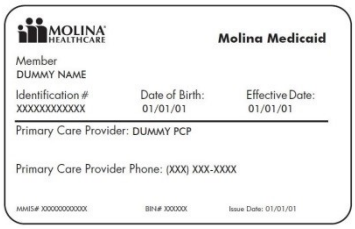
http://www.bchpohio.com www.caresource.com www.molinahealthcare.com www.uhcommunityplan.com www.paramounthealthcare.com

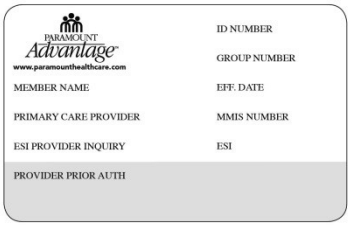
The best way to enroll in Managed Care is online with the Consumer Hotline – www.ohiomh.com.

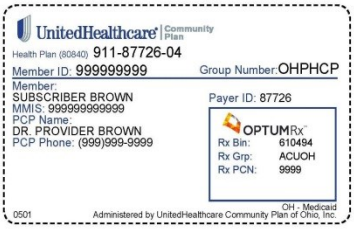
Step 4: Getting Health Care

Managed Care acts just like regular private health insurance. Once you are enrolled in a Managed Care plan, you will get a new card in the mail. Here's what they look like:









Managed Care plans send one permanent card when you enroll. Keep this card for as long as you are on the plan. The plan will also send you information on your doctors, health services and scope of coverage from your plan.

What Managed Care Does

- Links members to the Medical Home best able to serve them
- Ensures that Medicaid recipients get the care in the most appropriate setting (similar to coverage offered by employers)
    - Outpatient vs. Inpatient care when possible
    - Increases primary care visits
    - Reduces unnecessary Emergency Room visits
- Significantly increases immunizations, cancer screenings, maintenance medications and prenatal/postpartum care.
- Improves the quality of life
    - Identifies and facilitates treatment for secondary conditions
    - Coordinates care to reduce duplication and waste
    - Reduces socio-economic barriers to care
    - Implements physician driven strategies that support a Medical Home
- High Risk Care Management is a face-to-face, highly interactive model for extremely fragile members.

Ohio Medicaid Covered Services

Visit http://medicaid.ohio.gov/FOROHIOANS/CoveredServices.aspx#61656-checkups-and-cleanings for a complete list of services covered by Medicaid, including:

- Alcohol & Drug Addiction
- Dental
- Emergency
- Family Planning
- Healthchek
- Hospital
- Medical Equipment
- Mental Health
- Pregnancy
- Prescriptions
- Preventive Health
- Professional Medical Services
- Transportation
- Vision

Information for Employers

Medicaid Expansion and Employer Health Coverage

Frequently Asked Questions

1. **As an employer, can I educate my employees about Medicaid expansion?**

Yes, employers can provide information to employees (including those enrolled in an employer-sponsored health plan) regarding their health coverage options, including Medicaid. However, as an employer, you should not make benefits choices for your employee, make recommendations regarding which benefits choices are right for your employee, or otherwise promise that any program will provide any specific benefit to your employee. Benefits choices are very fact-specific and will vary from employee-to-employee. External resources are available to assist employees with Medicaid enrollment.

2. **Can I incentivize employees to drop or waive coverage under my employer-sponsored health plan and instead enroll in Medicaid?**

No, based on existing guidance, employers should not incentivize employees (or their dependents), through monetary payments or otherwise, to drop or waive employer-sponsored health coverage in favor of Medicaid. Likewise, employers should not treat employees (or their dependents) eligible for Medicaid as ineligible for any employer-sponsored health plan on that basis.

Historically, compliance issues have been raised under Medicare (you have likely heard of Medicare Secondary Payer requirements), and authorities are very clear that employers cannot incentivize (through a bonus, opt-out payment or other item or service of value) active employees and their dependents enrolled in employer-sponsored health coverage and Medicare to drop or waive employer coverage in favor of Medicare. Such tactics are illegal and viewed as shifting the financial burden of coverage to the government (because an active employee with both coverages who drops employer-sponsored health coverage makes Medicare the primary payer when it would have otherwise paid secondary to the employer-sponsored health plan). This issue has existed to a lesser degree under Medicaid because there have been significantly less employees working sufficient hours to be eligible for employer-sponsored health coverage while, at the same time, still meeting Medicaid eligibility criteria. However, post-expansion, significantly more employees may fall into this population.

3. **If an employee is currently enrolled in my employer-sponsored health plan, but then becomes eligible for Medicaid, can my employee drop coverage mid-year under my employer plan?**

Yes, such an employee (or dependent) should be permitted to drop employer-sponsored health coverage mid-year without having to wait until renewal/annual open enrollment for the employer-sponsored health plan.

4. **If an employee becomes eligible for Medicaid, can my employee enroll in Medicaid at any time or only during an annual open enrollment period or similar enrollment window?**

As of January 1, 2014, if/when an employee (or dependent) becomes eligible for Medicaid, that employee (or dependent) can enroll in Medicaid at any time. Individuals can actually apply now for Medicaid eligibility/benefits commencing on January 1, 2014.

5. **If an employee is currently enrolled in Medicaid, but loses eligibility, can that employee enroll in my employer health plan mid-year or only during renewal/annual open enrollment?**

If an employee (or dependent) loses Medicaid eligibility (due, for example, to changed financial circumstances) and is otherwise eligible for your employer-sponsored health coverage, the loss of Medicaid should allow for mid-year enrollment.

This document is compiled in part of information provided by the Ohio Department of Medicaid and the Ohio Office of Health Transformation.

This document is provided for general information purposes only and should not be construed as legal advice. Specific questions regarding individual employees or plan terms should be directed to your legal counsel or insurer/third party administrator, as applicable.