Authority to Extend Medicaid Coverage

- The Affordable Care Act (ACA) amended Section 1902 of the Social Security Act to require each state to provide Medicaid coverage for a specific expansion population – primarily poor adults under 138 percent of poverty who do not have either a disability or children at home.[1]

- The 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]

- Ohio law (R.C. 5163.03) provides that "the Medicaid program shall cover all mandatory eligibility groups" and "may cover any of the optional eligibility groups."[3] Ohio Medicaid may not cover an optional group that state statutes prohibit, but no such prohibition exists for the ACA group in Ohio law.

- The most direct method for extending Medicaid coverage is via a Medicaid State Plan Amendment (SPA). Ohio law (R.C. 5162.07) gives the Medicaid director express authority to seek a SPA without additional legislation.[4]

- On September 26, 2013, the Ohio Medicaid director submitted a SPA seeking to extend Medicaid coverage. On October 10, 2013, the Centers for Medicare and Medicaid Services (CMS) approved Ohio's SPA. As a result, federal funds are available to extend Medicaid coverage in Ohio beginning January 1, 2014.

- Ohio law (R.C. 131.35) authorizes a state agency to spend federal funds pursuant to an appropriation of the General Assembly or authorization by the Controlling Board.[5] On October 11, 2013, the Ohio Medicaid director submitted a Controlling Board request seeking authorization to spend federal-only funds to extend Medicaid coverage in Ohio beginning January 1, 2014.

- **The only action required to extend Medicaid coverage is Controlling Board approval on October 21, 2013.[6]**

Notes

[1] 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 of the Social Security Act. The ACA added division (a)(10)(A)(i)(VIII) to Section 1902 to require 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, …."

[2] The Court concluded that the inclusion of the new coverage group was a fundamental change to the Medicaid program because it was a change from requiring states to cover medical services for particular categories of vulnerable individuals to a requirement that the state cover all individuals under 133 percent of the federal poverty level. Looking at the issue via a Commerce Clause analysis, the Court concluded that the States did not bargain for such an expansive alteration in the purposes of the Medicaid program, and thus, the ACA expansion was more properly considered a new program. Because of this shift in policy, the Court concluded that applying Section 1903's financial penalty to states that didn't expand coverage would be unconstitutional. "In light of the Court's holding," the Chief Justice states, "the Secretary cannot apply Section [1903] to withdraw existing Medicaid funds for failure to comply with the requirements set out in the expansion."

[3] 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."

[4] 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."

[5] R.C. 131.35 specifically provides, "Controlling board authorization for a state agency to make an expenditure of federal funds constitutes authority for the agency to participate in the federal program providing the funds."

[6] Medicaid administrative rules 5160:1-1-58(B)(8) and 5160:1-1-51(I)(3)(c)(iii) govern the administration of the expansion group, and Medicaid claims payment and eligibility vendors are on track to update state systems as needed to extend coverage beginning January 1, 2014.