Ohio
Department of Medicaid
John R. Kasich, Governor
John B. McCarthy, Director

June 15, 2016

The Honorable Secretary Sylvia Burwell
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Burwell,

I respectfully submit the Healthy Ohio Program Section 1115 demonstration request. This request complies with the Healthy Ohio Program, as passed by the Ohio General Assembly in the State operating budget, House Bill 64, and signed into law on June 30, 2015.

Consistent with the enabling legislation, the Healthy Ohio Program seeks to build upon Ohio's successful history with innovative managed care programs and introduces new consumer driven healthcare features to not only incentivize members to take responsibility for their health, but to also introduce them to commercial market features to ease the transition out of public assistance. In addition, the Healthy Ohio Program establishes innovative program design aimed at supporting employment, encouraging private market coverage, and easing the impact of the 'subsidy cliff' when individuals eventually transition from public assistance.

Thank you for your consideration.

Sincerely,

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Ohio Department of Medicaid

Healthy Ohio Program 1115 Demonstration Waiver

Submitted
6/30/2016

Contents

Section 1: Program Overview

This Section 1115 waiver request complies with the Healthy Ohio Program, as passed by the Ohio General Assembly in the State operating budget, House Bill 64, and signed into law by Governor John Kasich on June 30, 2015. The Healthy Ohio Program builds upon Ohio's successful history with innovative managed care programs and introduces new consumer-driven healthcare features to not only incentivize members to take responsibility for their health, but to also introduce them to commercial market features to ease the transition out of public assistance. In addition, the Healthy Ohio Program establishes an innovative program design aimed at supporting employment, encouraging private market coverage, and easing the impact of the 'subsidy cliff' when individuals eventually transition from public assistance to the commercial market.

Under the leadership of Governor John Kasich, Ohio has consistently been on the forefront of leading-edge Medicaid programs aimed at improving quality of care and program efficiency, and has recently leveraged several opportunities offered by the Centers for Medicare and Medicaid Services (CMS) to initiate payment and delivery system reform. For example, Ohio was one of a targeted number of states to launch a managed care demonstration option for individuals dually eligible for Medicare and Medicaid with the purpose of fully coordinating the payment delivery of covered services through a capitated model. This effort further enhanced Ohio's leadership on managed care, as the State has over 2.3 million lives enrolled in managed care. With its years of experience, Ohio is a model to other states in the management and oversight of its managed care programs. For example, the Ohio Department of Medicaid recently released a new Medicaid Managed Care Consumer Report Card that rates Ohio's five contracted health plans with the goal of providing greater transparency around Medicaid care and services, helping Medicaid beneficiaries learn more about the managed care plans available to them, and fostering competition among the five health plans.

In recent years, the State has also implemented an unprecedented package of reforms to improve overall health system performance for pregnant women and infants and reduce infant mortality. Efforts have led to the lowest number of infant deaths in at least 75 years, and a decrease in the State's overall infant mortality rate from 7.4 deaths per 1,000 births in 2013 to 6.8 in 2014. Despite these improvements, racial disparities remain; therefore, Governor Kasich has instructed the Ohio Departments of Health (ODH) and Medicaid to direct resources into neighborhoods most at risk for poor birth outcomes.

Ohio is also on the forefront of comprehensive payment and service delivery reform. In 2013, Ohio was one of only 16 states to receive State Innovation Model (SIM) grant funding. The SIM grant has allowed the State to design and undertake implementation of system wide patient-

centered medical homes and value-based episode payment models across various payer types, including Medicaid, state employee, and commercial health plans.

Ohio has also successfully partnered with CMS to prioritize home and community based services (HCBS), allowing more seniors and people with disabilities to live with dignity at home, instead of a higher-cost nursing home. Specifically, Ohio Medicaid's HOME Choice program, the State's Money Follows the Person program, completed its 7,000th community transition in 2015, far exceeding the original goal set in 2008 of transitioning 2,000 individuals out of institutional settings and into home and community based alternatives. Further, the Governor's 2015 budget creates more choices for Ohioans with disabilities to live and work in the community by funding an additional 3,000 HCBS waiver slots, downsizing institutions to reflect increased demand for community services, and supporting community employment for anyone who wants to work. These initiatives represent one of the most significant new investments in the State's entire budget, totaling $286 million over two years.

Following passage of the Patient Protection and Affordable Care Act (ACA), Ohio was one of the first states to take advantage of the new opportunity to expand Medicaid to the new adult group. In 2013, a year prior to the official start of the Medicaid expansion opportunity, Ohio received a Section 1115 Medicaid demonstration waiver to conduct a limited test of the expansion population, and expanded coverage to adults residing in Cuyahoga County with annual household income up to 133 percent of the federal poverty level. The same year, Ohio Governor John Kasich, with the support of the State's bipartisan Controlling Board, made the decision to expand the State's Medicaid program to all newly eligible adults with household income under 133 percent of the federal poverty level, which began January 1, 2014. To date, total monthly Medicaid expansion enrollment has reached nearly 600,000 Ohioans.

In July 2015, the Ohio General Assembly created a new program within the State budget, the Healthy Ohio Program, to provide coverage to the expansion population and other non-disabled Medicaid-eligible adults. The Healthy Ohio Program moves away from traditional Medicaid and builds upon Ohio's history as a delivery system innovator by introducing consumerism concepts and incentives for healthy behaviors to the Medicaid population, as well as supporting individuals as they transition from public assistance to the commercial market. The Healthy Ohio Program not only ensures the long-term stability of the Medicaid expansion in the State, but also introduces several key enhancements that will empower members to become active participants in their healthcare.

1.1 Summary

The Healthy Ohio Program implements a new program design that builds upon the State's managed care model while incorporating requirements intended to encourage personal and financial responsibility. In addition, the program design includes features to support individuals

during their transition from public assistance to commercial market coverage. The Healthy Ohio Program targets all non-disabled, Medicaid-eligible adults age 18 and older. Adults eligible under the expansion population, as well as adults currently enrolled in the Ohio Covered Families and Children program, will be transitioned to Healthy Ohio Program.

The centerpiece of new Healthy Ohio Program features the "Buckeye Account," which is modeled after a health savings account. Both the State and the member contribute to the account and the account is used to pay for the plan's deductible and copayments. The Buckeye Account will also be used to collect incentive dollars earned by the member for completion of specified healthy behaviors. The Buckeye Account is designed to actively engage members in managing their healthcare expenses while exposing the individual to the costs of their care. This exercise not only encourages appropriate use of the healthcare delivery system but also prepares the individuals to transition from the program and enter the commercial market. In addition, members can earn financial awards to enhance their Buckeye Account, encouraging them to improve their health by completing specified healthy behaviors. Through active participation in the management of the Buckeye Account, the Healthy Ohio Program aims to transform members into active and informed consumers of healthcare services.

The State contributes $1,000 per year to each member's Buckeye Account. However, members are also required to financially contribute to the account. An essential element of the program, the member contributions give them "skin-in-the game," and create value and ownership in the program. To enroll in and maintain eligibility for the Healthy Ohio Program, all members, with the exception of pregnant women, are required to contribute monthly installment payments equal to the lesser of two percent (2%) of their annual household income or ninety nine dollars ($99) per year towards their Buckeye Account. Member contributions are held in the "core" portion of the Buckeye Account, and are accounted for separately from any State funds contributed to the account. The core portion of the Buckeye Account may be utilized by the member to pay required member copayments for covered Healthy Ohio Program services, as well as qualifying medically necessary services not otherwise included in the member's benefit package.

All Healthy Ohio Program members will receive services through a managed care delivery system. The "non-core" portion, or State funded portion of the Buckeye Account, will be utilized by the member's health plan to pay for initial covered healthcare expenses, similar to a deductible, as detailed in Section 4. Once the non-core portion of the Buckeye Account is depleted, the managed care entity will provide comprehensive benefits, equivalent to the Ohio State Plan, up to $300,000 per year and $1,000,000 per lifetime. Members that hit either the annual or lifetime Healthy Ohio Program benefit thresholds are no longer eligible for the Healthy Ohio Program, and will be transferred to coverage under the traditional fee-for-service

Medicaid program or the State's traditional managed care program established in accordance with section 5167.03 of the Revised Code. Whether the individual moves to fee-for-service or the traditional managed care program will depend on the individual's eligibility in accordance with the State Plan.

The Healthy Ohio Program incentivizes members to engage in healthy behaviors and achieve improved health outcomes through the health incentive points system. The health incentive points system provides opportunities for members to earn incentive points to their Buckeye Account. Each incentive point is equivalent to one dollar, and may be applied to the member's core portion of the Buckeye Account and used to pay for copayments and qualified medically necessary services not otherwise included in the member's benefit package. Healthy incentive points may be awarded to members by both the Ohio Department of Medicaid for the achievement of specified healthcare goals and the member's primary care physician for the satisfaction of specific healthcare benchmarks established by the physician.

In addition to the health incentive point system, the Healthy Ohio Program also encourages members to obtain recommended preventive care services. Members that achieve pre-determined preventive service goals during the year can carry forward the entire remaining balance of their Buckeye Account, including State contributions and any dollars earned through the incentive program to be utilized for out-of-pocket expenses incurred during the following year's enrollment. Members who do not receive recommended preventive care services during the benefit year will only be permitted to carry forward member contributions.

Regardless of continued enrollment, member contributions to the Buckeye Account are unlike premiums and belong to the member. These contributions will either be carried forward to a subsequent enrollment year or refunded to a member who otherwise does not continue in or renew participation in the plan.

The Healthy Ohio Program design, which promotes personal and financial responsibility, prepares members to actively participate in commercial market health plans. However, the Healthy Ohio Program is unique as it also actively assists members to obtain and maintain private market coverage. A critical component of the Healthy Ohio Program connects individuals with job training and employment opportunities, as well as financially supports members as they transition from public assistance to the commercial market and eases the effects of the coverage cliff. All Healthy Ohio Program members working fewer than 20 hours a week will be offered a referral to a workforce development agency.

In addition, members who successfully transition from the program to commercial market coverage through either the individual market or employer sponsored insurance will be provided a Bridge Account, which will contain the entire balance of the member's Buckeye

Account. The Bridge Account may be used to cover the costs of premiums associated with the purchase of individual market commercial insurance, as well as out-of-pocket cost sharing expenses, such as copayments, deductibles and coinsurance associated with the individual market or employer sponsored health insurance plan. The Bridge Account benefit rewards members for the prudent management of their Buckeye Account, and continues to support individuals in their transition from public assistance to the commercial market with the ultimate goal of helping these individuals maintain their commercial coverage, thereby reducing churn.

The Healthy Ohio Program will introduce consumer-driven features to the Medicaid program, which currently provides no incentives for members to be cost-conscious consumers of healthcare or to improve their health. By leveraging the principles of consumerism and providing incentives for members to seek cost-effective, quality healthcare, the Healthy Ohio Program design is expected to increase enrollee engagement, thereby improving health outcomes for members and reducing overall program costs.

1.2 Demonstration Purpose and Goals

This Healthy Ohio Program demonstration waiver is submitted in accordance with the enabling legislation enacted by the Ohio General Assembly. The program will introduce non-disabled adult Medicaid enrollees to a consumer directed healthcare model, in which members will be incentivized to utilize the healthcare delivery system in a cost-conscious manner and have the opportunity to earn rewards for completion of preventive care and targeted healthy behaviors. In addition, the demonstration will implement a variety of initiatives aimed at encouraging members to seek employment and supporting former members as they transition to private market coverage.

The Ohio Department of Medicaid goals for the operation of the Healthy Ohio Program include:

1. Promoting member engagement in health and personal responsibility, including the appropriate use of healthcare services.
    - Under this goal, the State will develop objectives targeting member contribution rates, member engagement and taking responsibility for their health, and member use of core account dollars to receive qualified services.
2. Increase the use of preventive services by members.
    - Under this goal, the State will develop objectives targeting preventive services, the percent of members qualifying for the carry forward incentive, and the awarding of the incentive debit points from the State.
3. Increasing provider engagement in member healthy behaviors.
    - In the Healthy Ohio Program, providers can award up to 100 points (each equivalent to one dollar) to a member's core account, which the member can use to pay for non-covered services and copayments. Under this goal, the State

will develop objectives targeting increasing provider engagement in member healthy behaviors through the reward of incentive points to the member's core portion of the account.

4. Increase the number of commercially insured Ohioans.
    - Under this goal, the State will develop objectives targeting increasing the proportion of the commercially insured and ensuring maintenance of coverage when leaving Medicaid programs through the Bridge Account.

1.3 Demonstration Hypotheses

To track the progress toward program goals, the State has identified the following areas for its research and evaluation efforts. The tables below present a preliminary plan for how the State may evaluate its efforts, with possible future adjustments.

Table 1.3: Healthy Ohio Program Evaluation

#	Hypothesis	Methodology	Data Sources and Metrics
Goal 1: Promote member engagement in health and personal responsibility, including the appropriate use of health care services.			
1.1	**Healthy Ohio Program policies will promote member compliance with required contributions and provide incentives to monitor and manage Buckeye Account funds.**	Track Healthy Ohio Program members making initial and subsequent Buckeye Account contributions. • Overall; • Annual family income above $4,950 (approximately 42% FPL for an individual based on 2016 poverty level); and • Annual family income at or below $4,950.	Health plan contribution and enrollment data: • Number and percentage making initial Buckeye Account contribution; • Number and percentage making subsequent Buckeye Account contributions within allowed time; and • Number and percentage dis-enrolled from Healthy Ohio Program due to non-contribution.

		Track and compare average remaining Buckeye Account balances at the end of a benefit period.	Administrative data: • Percentage of Buckeye Accounts that have a balance at the end of a benefit period; and • Average Buckeye Account balance amount at the end of the benefit period.
		Track member pro-rata share of Buckeye Account balances carried forward and the average amount by which contributions are reduced in the next benefit period for: • Members receiving preventive services (100% of Buckeye Account, including core + non-core amounts); and • Members not receiving preventive services (member contributions to Buckeye Account only).	Administrative data: • Percentage of total Buckeye Accounts eligible to carry forward the full account balance; • Percentage of Buckeye Accounts with a balance remaining at the end of the benefit period; and • Average amount by which member contributions are reduced in the next benefit period.
		Track the copayment application rate for Healthy Ohio Program members.	Administrative data: • Percentage of members who exhaust core funds and are not subject to copayments.

1.2	**Healthy Ohio Program policies will improve member access to services not traditionally covered under the State Plan (such as over-the-counter medications).**	Track and compare the core portion of Buckeye Account expenditures on qualified additional health-related benefits.	Administrative data: • Percentage of Buckeye Accounts that have expenditures for qualified additional health-related services at the end of a benefit period; • Average Buckeye Account expenditures for qualified additional health-related services at the end of the benefit period; and • Percent of the Buckeye Account core portion funds on average used to purchase qualified additional health-related services.
1.3	**Healthy Ohio Program will promote member engagement in a healthy lifestyle through the healthy incentives point system.**	Track and compare member achievement of healthy incentive point goals.	Administrative data: • Number of members receiving any Healthy Incentive points; • Average number of healthy incentive points earned; • Number of healthy incentive points earned from State; and • Number of healthy incentive points earned from providers .

Goal 2: Increase the use preventive services by members			
2.1	**Healthy Ohio Program will promote member use of preventive services and primary care.**	Track and compare health service utilization rates between the Healthy Ohio Program and Medicaid members in the State's fee-for-service and traditional managed care program. Compare to reported rates of preventive service utilization in contiguous states' Medicaid and commercial market populations where available.	Claims data: • Primary care encounters; • Specialist care encounters; • Emergency Department visits; • Preventive care codes; and • Chronic disease management codes. Public reports: • Preventive service utilization in contiguous state Medicaid programs; and • Commercial market.
		Track and compare Buckeye Account amounts carried forward and contribution discount rates.	Administrative data: • Percentage of total Buckeye Accounts eligible to carry forward the full account balance.
		Track preventive care utilization rates and trends among different age and gender groups.	Claims data: • Number, type, and frequency of preventive care services used; and • Gender- and age-specific rates of pre-determined preventive service utilization.
Goal 3: Increase provider engagement in member healthy behaviors			
3.1	**Healthy Ohio Program policies will encourage provider engagement in**	Track and compare incentive reward points awarded to a member's	Administrative data: • Percent of providers who

	healthy member behavior by allowing incentive payments.	Buckeye Account by providers.	award incentive points; and • Average number of incentive points awarded by provider type.
Goal 4: Increase the number of commercially insured			
4.1	**Healthy Ohio Program's Bridge Account will increase the proportion of Ohio residents covered by employer-sponsored insurance (ESI) or individual market coverage.**	Track Ohio residents covered by ESI and individual market coverage over the demonstration.	Current Population Survey & American Community Survey: • ESI coverage percent estimates, all ages.
		Track Ohio residents covered by ESI and individual market coverage with Bridge Accounts.	Healthy Ohio Program enrollment and Bridge Account records: • Number and percentage of Healthy Ohio Program members with Bridge Accounts covered by ESI and individual market coverage.
4.2	**Healthy Ohio Program's Bridge Account will decrease churn back into Medicaid program.**	Track Ohio residents awarded a Bridge Account who reenter the Healthy Ohio Program. Compare to data on previous rates of program reentry and national or other state data on number of individuals that churn in and out of Medicaid.	Administrative Data: • Number with Bridge Accounts that reenter program. Public reports: • Rates of Medicaid program reentry

1.4 Demonstration Area

The Healthy Ohio Program will operate statewide.

1.5 Demonstration Timeframe

The demonstration is requested for a five year approval period from January 1, 2018 to December 31, 2022.

1.6 Demonstration impact to Medicaid and CHIP

The Healthy Ohio Program modifies eligibility, cost sharing, and the delivery system for several eligibility groups currently covered by the Covered Families and Children program. In addition to these modifications, the Healthy Ohio Program will also provide an additional benefit in the form of the Bridge Account to members transitioning to private market coverage due to an increase in family income. The State will transition such an individual's Buckeye Account to a new Bridge Account, which can be utilized to assist the individual in obtaining and maintaining coverage through the individual market or employer-sponsored insurance.

Section 2: Demonstration Eligibility

Eligibility for the Healthy Ohio Program is established in State statute. Pursuant to Ohio Revised Code §5166.40(B), each adult Medicaid recipient, other than a ward of the State, must be enrolled in the Healthy Ohio Program if the individual is eligible for Medicaid either on the basis of being included in the category identified by the Ohio Department of Medicaid as Covered Families and Children or on the basis of being included in the new adult group category, as described in Section 1902(a)(10)(i)(VIII) of the Social Security Act (the Act). The statute further defines "adult" as an individual at least eighteen years of age. Therefore, consistent with the Ohio Revised Code, the Healthy Ohio Program will target all Medicaid-eligible individuals age 18 and older that qualify for Medicaid under any of the following eligibility categories:

- Individuals eligible in the new adult group pursuant to Section 1902(a)(10)(i)(VIII) of the Act;
- Low-income parents and caretaker relatives pursuant to Section 1931 of the Act;
- Individuals eligible for Transitional Medical Assistance pursuant to Section 1925 of the Act;
- Medicaid for low-income 19 and 20 year olds;
- Women eligible in the pregnant women category;
- Medicaid-eligible children age 18;
- Title IV-E eligible children age 18;
- Foster youth ages 18-26; and
- Individuals eligible for the Breast and Cervical Cancer project.

Any individual who is eligible under one of these groups will be required to be enrolled in the Healthy Ohio Program, even if the individual also qualifies for additional home and community based waiver services. All home and community based services will continue to be provided to

eligible individuals in accordance with the current service delivery system, and will be carved out of the managed care delivery system in the Healthy Ohio Program. However, Healthy Ohio Program participants needing home and community based waiver services continue to be subject to the program's cost sharing requirements as well as have the benefit of utilizing the Buckeye Account to pay for covered services.

The broad scope of the Healthy Ohio Program empowers all adults currently eligible for the Covered Families and Children program to become more accountable for their healthcare decisions by participating in their health coverage through required monthly contributions and new healthcare incentives. In addition, all Healthy Ohio Program participants will be eligible to potentially take advantage of the Bridge Account available to assist members transitioning to individual health insurance or employer-sponsored insurance plans.

2.1 Eligibility Groups

Table 2.1: Healthy Ohio Program Eligibility

Eligibility Group Name	Social Security Act and CFR Citations	Income Level
New Adult Population: Individuals with household income at or below 133% FPL, age 19 through 64	1902(a)(10)(A)(i) (VIII)	0-133% FPL
Low Income Families	1931	0-90% FPL
Transitional Medical Assistance	408(a)(11)(A) 1931(c)(2) 1925 1902(a)(52)	No limit first 6 months. 0-185% FPL for second six months.
Individuals age 19 & 20 who meet the income and resource requirements of AFDC	1902(a)(10)(A)(ii)(I) – (IV) 1905(a)(i) 42 CFR 435.222	0-44% FPL
Pregnant women	42 CFR 435.116	0-200% FPL
Children age 18	1902(a)(10)(A)(i)(VII) 1902(l)(1)(D)	0-206% FPL
Children age 18 with Title IV-E Adoption Assistance, Foster Care, or Guardianship Care	1902(a)(10)(A)(i)(I) 473(b)(3) 42 CFR 435.145	No Upper Income Limit
Children aging out of foster care, ages 18 to age 26	1902(a)(10)(A)(i)(IX)	No Upper Income Limit
Certain women needing treatment for breast or cervical cancer	1902(a)(10)(A)(ii)(XVIII) 1902(aa)	200% FPL

2.2 Eligibility Standards and Methods

This demonstration does not modify any eligibility standards or methods from what is present in the State Plan. While individuals age 18 and over currently eligible for the Covered Families and Children program will have coverage under the Healthy Ohio Program moving forward, the underlying eligibility standards and methodologies will not differ from the State Plan.

2.3 Enrollment Limits

There are no limits on the number of enrollees that can be covered by the Healthy Ohio Program.

2.4 Projected Eligibility and Enrollment

It is anticipated that enrollment will fluctuate over time as individuals become more familiar with the advantages of the program, such as the Bridge Account. Further fluctuations may continue over time as more people gain and maintain private insurance coverage.

Table 2.4: Healthy Ohio Program Projected Eligibility

Demonstration Year	Projected Eligibility
DY1	1,661,000
DY2	1,705,000
DY3	1,749,000
DY4	1,794,000
DY5	1,841,000

Projected eligibility during the demonstration period reflects estimated Medicaid enrollment without the demonstration and an assumed 85% composite penetration rate (15% of eligible population elects not to enroll in Medicaid).

2.5 Long-Term Services and Supports

Long-term services and supports are covered by the Healthy Ohio Program. Individuals that fall under Healthy Ohio Program eligibility receive the benefits described in the Ohio Medicaid State Plan. Therefore, Healthy Ohio Program participants eligible on the basis of being included in the new adult group category will not have a day limit imposed on long-term services and supports. Healthy Ohio Program participants eligible on the basis of being included in one of the eligibility categories identified by the Ohio Department of Medicaid as the Covered Families and Children program will receive up to 90 days of long-term services and supports through the Healthy Ohio Program, and thereafter, will be transferred to traditional fee-for-service Medicaid coverage in accordance with the existing policy and procedures. All eligibility and treatment of income for provision of long-term services and supports is in alignment with the procedures and benefits documented in the Ohio Medicaid State Plan.

2.6 Changes to eligibility procedures

The Healthy Ohio Program proposes to eliminate the 3 month retroactive eligibility period for all enrolled populations. As required by the enabling legislation, Healthy Ohio Program members must make a required contribution to their Buckeye Account prior to the start of benefits. Specifically, Ohio Revised Code §5166.402(E) prohibits a Healthy Ohio Program participant from receiving benefits under the program until after the initial contribution is made by the individual to his or her Buckeye Account. As detailed in Section 4 of this waiver proposal, this required contribution is equal to 2 percent of annual household income, prorated on a monthly basis, not to exceed $99 per year, or $8.25 per month. The contribution requirement exists for all individuals eligible for the Healthy Ohio Program, as detailed in Section 2.1 of this waiver proposal, with the exception of pregnant women. Once the initial contribution is received, individuals will begin coverage effective the first day of the month in which the payment was made. Since pregnant women are exempt from the monthly contribution requirement, pregnant women will begin coverage the first day of the month in which their application was approved. Similarly, individuals with no income, who by default will not have a contribution requirement, will begin coverage the first day of the month in which their application was approved.

Table 2.6: Eligibility Start Dates

Population	Eligibility Start Date
All Healthy Ohio Program eligible not exempt from cost sharing	1st day of month in which 2% contribution to Buckeye Account is received
Individuals with zero income	1st day of month in which application is approved
Pregnant women	1st day of month in which application is approved

Any individual that becomes eligible for another Medicaid eligibility group not listed in Section 2.1 of this waiver will be disenrolled from the Healthy Ohio Program. In addition, at redetermination an individual that does not submit requested documentation within 61 days will be disenrolled from the Healthy Ohio Program. Disenrolled individuals may reenroll in the Healthy Ohio Program provided that they do not have previous debt to the program. Debt is accrued for any months in which the individual received coverage but did not make the 2 percent of income contribution. Back payment of delinquent contributions is further discussed in Section 4.

2.7 Workforce development activity

All individuals eligible for the Healthy Ohio Program who are unemployed or who work less than 20 hours per week will be offered a referral to a workforce development agency. Program participants are not required to participate in any program as a condition of enrollment.

Section 3: Benefits

The Healthy Ohio Program will provide all enrollees with the benefits currently provided in the Ohio Medicaid State Plan. Individuals eligible in the adult group will continue to receive the benefits documented on the current Alternative Benefit Plan (ABP) that aligns with the Ohio Medicaid State Plan. When individuals hit the Healthy Ohio Program benefit threshold of three hundred thousand dollars ($300,000) per year or one million dollars ($1,000,000) per lifetime, they transition to coverage under either the State's traditional managed care program or the traditional fee-for-service Medicaid program, as applicable for the member's eligibility. Members that transfer out of the Healthy Ohio Program will have their Buckeye Account closed out and will no longer be subject to the cost sharing requirements set forth in Section 4. Instead, such individuals will be subject to the policies and requirements of the Ohio Medicaid State Plan. Provided they remain eligible, members that reach the annual benefit threshold are transferred back to the Healthy Ohio Program at the end of their current twelve month benefit period.

Members may use the core portion of the Buckeye Account, which includes individual contributions, earned healthy incentive points, or core dollars carried forward from previous benefit periods, to pay for qualifying medically necessary services that are not otherwise included in the member's benefit package, such as over-the-counter medications. The Ohio Department of Medicaid will define these qualifying services in detail on an annual basis.

3.1 Benefit Package Chart

Table 3.1: Benefit Packages

Eligibility Group	Benefit Package
New Adult Population: Individuals with household income at or below 133% FPL, age 19 through 64	ABP that is the State Plan Mental health limits in the State Plan do not apply No LTC day limits
Low Income Families	State Plan
Transitional Medical Assistance	

Individuals age 19 & 20 who meet the income and resource requirements of AFDC	Mental health limits in the State Plan apply Up to 90 days LTC limit applies.
Pregnant women	
Children age 18	
Children age 18 with Title IV-E	
Children age 18 with Adoption Assistance, Foster Care, or Guardianship Care	
Individuals under age 65 needing treatment for breast or cervical cancer	
Note: All individuals under age 21 are eligible for full EPSDT services as detailed in the Ohio Medicaid State Plan.	

3.2 Section 1937 Alternative Benefit Plans

Benefits provided under the Healthy Ohio Program are identical to the benefits documented in the Medicaid State Plan, as detailed in Section 3.1. All populations that will transition to the Healthy Ohio Program will have health benefits identical to the health benefits currently available to the applicable individuals. In addition, the Healthy Ohio Program offers eligible members the opportunity to use their accounts for some additional qualified benefits, as discussed in Section 4.1.

The benefits offered to the adult population covered on the Healthy Ohio Program are documented through an ABP State Plan amendment and authorized as Secretary Approved Coverage that aligns with the Medicaid State Plan.

3.3 Benefit Detail

Benefits provided under the Healthy Ohio Program are identical to the benefits documented in the State Plan. Members receive benefits under the Healthy Ohio Program up to a maximum value of three hundred thousand dollars ($300,000) per year, and up to one million dollars ($1,000,000) lifetime. Members that exceed these limits are transferred to either fee-for-service Medicaid or the State's traditional managed care program, as applicable based on the individual's eligibility. Members that exceed the annual or lifetime benefits thresholds continue to have access to the State Plan benefits, but will no longer have a Buckeye Account, required contributions, applicable Healthy Ohio Program copayments, or access to the healthy incentive points system.

Individuals covered under the Healthy Ohio Program may utilize their individual contributions and earned healthy incentives points in their Buckeye Account to purchase additional qualifying health-related benefits not covered under the State Plan, as described in Section 4. Only members with a balance in the "core" portion of the Buckeye Account may utilize the Buckeye Account to pay for these additional qualifying services. No funds may be used for these services

from the non-core portion of the Buckeye Account. The specific additional qualifying services eligible for purchase from the core portion of the Buckeye Account will be further defined by the Ohio Department of Medicaid on an annual basis, but may include services like over-the-counter medications.

When individuals are no longer eligible for the Healthy Ohio Program due to an increase in income, they become eligible for a Bridge Account, as described in Section 4. As part of their Healthy Ohio Program benefits, individuals eligible for the Bridge Account may use funds in their Bridge Account to pay for specific costs associated with participation in a commercial health plan offered through their employer or sold on the marketplace.

3.4 Long-term services and supports

Long-term services and supports are covered under the Healthy Ohio Program as documented in the State Plan and associated 1915(c) waivers for the applicable populations. Eligibility for long-term services and supports is discussed in Section 2.5 above.

3.5 Premium Assistance

The Healthy Ohio Program does not offer a premium assistance program. However, as part of their Healthy Ohio Program benefit, individuals transitioning to commercial market health insurance plans may maintain their Bridge Account as detailed in Section 4, using the unspent funds remaining in their original Buckeye Account to help pay for premiums of individual or family insurance policies purchased from a commercial insurer.

Section 4: Cost-Sharing

The Healthy Ohio Program's cost sharing structure differs from the State Plan, which may require a minimal copayment for certain medical services, up to $3.00. The copayments established in the State Plan are not required for all beneficiaries, and the State Plan sets forth several exemptions, including, but not limited to, individuals enrolled in a managed care plan that does not charge copayments.

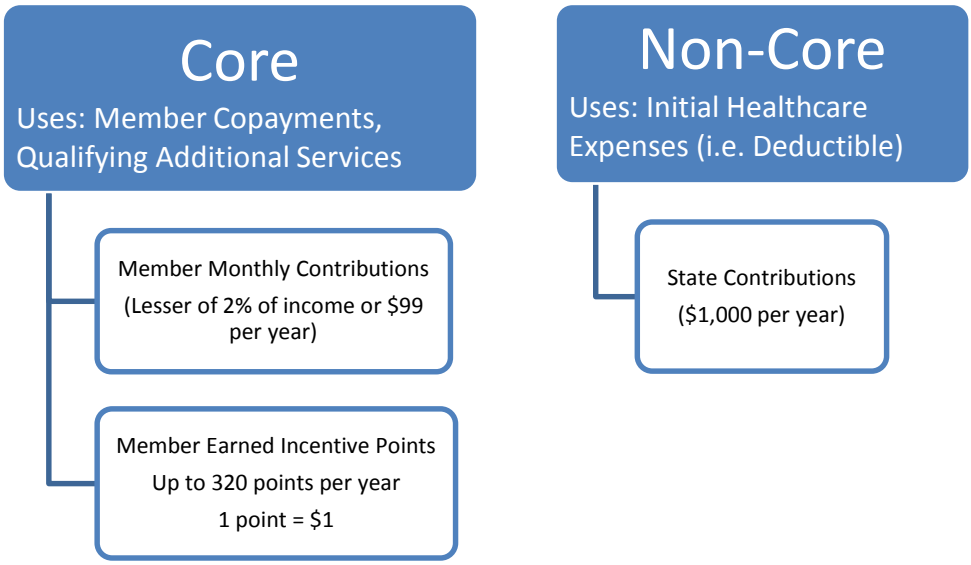
By contrast, the Healthy Ohio Program is designed to incorporate elements of personal responsibility for all members, and includes an innovative cost sharing structure in which members make monthly contributions to an account similar to a health savings account, called a Buckeye Account. Members use the contributions they make to their Buckeye Account to cover required copayments for covered services, as well as to purchase qualifying additional health-related benefits. Members have the opportunity to earn incentives that can be awarded by providers and the State. Members are also rewarded for the appropriate use of healthcare by allowing them to carry forward their contributions and earned incentives to future year's enrollment; and, if they receive preventive care, members can also retain the State's remaining contributions to the account. Unused contributions made to the account by the individual

remain member dollars, and will be refunded to the member upon termination from the Healthy Ohio Program. However, the full balance of the account (including member contributions, earned incentives, and State contributions) is eligible to transfer to a Bridge Account to follow members transitioning from the Healthy Ohio Program to commercial coverage due to increased income.

4.1 The Buckeye Account

The Buckeye Account, which promotes member completion of preventive services, is the keystone of the Healthy Ohio Program. This account is bifurcated into member and State portions: core and non-core. The core portion of the Buckeye Account is comprised of member contributions and earned incentive points, while the non-core portion is comprised of the State's annual $1,000 contribution to the member's Buckeye Account, which is made after the member has enrolled and made his or her first contribution.

Figure 4.1: Composition of the Buckeye Account



The uses for the core and non-core portions of the Buckeye Account differ. Funds in the core portion of the account are used by the member to pay for required copayments for services. Once the core portion of the Buckeye Account is exhausted, the member is no longer required to pay copayments for Healthy Ohio Program services. Members may also choose to utilize the core portion of the account to purchase qualifying additional health-related benefits. Specifically, members will be permitted to utilize the balance of any member contributions and/or earned incentive points to purchase specific qualifying and medically necessary healthcare goods and services, as established by the Ohio Department of Medicaid. The non-core portion of the Buckeye Account is used to cover the member's initial healthcare claims, similar to a deductible, until the non-core portion of the account has a zero balance.

Members have an incentive to manage the account, as any remaining funds from their contributions are carried forward to the next year to pay for additional services. Once the non-core portion of the account is exhausted, the member's managed care plan will cover all covered healthcare claims up to the three hundred thousand dollar annual or one million dollar lifetime threshold. Members that reach the Healthy Ohio Program benefit thresholds are transferred to coverage under either the State's traditional managed care program or fee-for-service Medicaid program, as applicable.

Healthy Ohio Program members will receive a monthly statement showing their Buckeye Account activity, balances, and contributions. This statement will detail the balances of the core and non-core portions of the account and may be made available electronically to members.

If the member has dollars remaining in his or her account at the end of the year, he or she may be eligible to carry forward the entire account balance to the next year if the member has completed recommended preventive services. However, the total value of the Buckeye Account for any one enrollee may never exceed $10,000, inclusive of any dollars carried forward from previous benefit periods, earned incentives, and the annual State deposit into the account.

4.2 Debit Card

Per the Healthy Ohio Program legislation, all enrolled members will be issued a debit card by their managed care plan. The member's debit card will be multi-functional and will be used by providers both to verify eligibility for the Healthy Ohio Program and confirm eligibility for the specific service the member is seeking. The debit card will also be a method of payment the member can use at the point of service to cover services paid from both the core and non-core portion of the Buckeye Account. The debit card will be restricted to providing payment for services for which the member is eligible under the Healthy Ohio Program. The card will automatically apply payment of copayments and qualifying additional health-related services to the core side of the account and will pay for claims from the non-core side of the account until the non-core side of the account is equal to zero. The member's managed care entity is responsible for issuing and administering the member's debit card.

If a member does not have his or her debit card and makes a copayment or otherwise pays out-of-pocket for a service that would have been covered by the core account, the member may submit proof of payment to receive reimbursement for the amount that would have been paid out of the Buckeye Account for the applicable service.

4.3 Member Required Contributions

All individuals eligible for the Healthy Ohio Program, with the exception of pregnant women, are required to make monthly contributions to their Buckeye Account equal to the lesser of two percent (2%) of annual income prorated on a monthly basis or $99 per year (or $8.25 per month). Debt is accrued for any months in which the individual received coverage but did not make the 2 percent of income contribution. Contributions to the Buckeye Account are made in monthly installments, however, members may prepay for multiple months at one time. All member contributions accrue to the core portion of the Buckeye Account.

Individuals with no income effectively have a zero dollar contribution due to the percent of income requirement. For all individuals required to make a contribution, paying the contribution is a condition of eligibility. Coverage will begin effective the first day of the month in which the first required contribution is received. For pregnant women and individuals with zero income who are not required to make a contribution, coverage will begin effective the first day of the month in which their eligibility is determined.

Table 4.3: Estimated Buckeye Account Required Contributions (Single Person)

FPL	Monthly / Annual Income	Monthly / Annual Contribution
0%	$0	$0
10%	$99 / $1,188	$1.98 / $23.76
25%	$248 / $2,970	$4.95 / $59.40
50%	$495 / $5,940	$8.25 / $99
75%	$743 / $8,910	
100%	$990 / $11,880	
138%	$1,366 / $16,394	

Once a member enrolls in the Healthy Ohio Program, continued eligibility is contingent on payment of monthly contributions. Members who do not pay their required monthly contribution within 60 days from the due date will be dis-enrolled from Healthy Ohio Program coverage. The member may reenroll in Healthy Ohio Program coverage, but, prior to restarting benefits, the former member is required to pay all debt owed from prior missed payments.

Recognizing that member income and family size may change throughout the benefit period, members may request a recalculation of the 2 percent of income required contribution amount after any qualifying event such as a change in household size, or a change in employment. All changes to contribution amounts will be effective the first day of the month following the recalculation.

4.4 Third Party Contributions

In accordance with Ohio Revised Code §5166.402(D), only employers, not-for-profit organizations, and the member's managed care organization may make a contribution to a Buckeye Account on the member's behalf. Employers of Healthy Ohio Program enrollees may contribute up to 50 percent of the member's required contribution amount, and not-for-profit organizations may contribute up to 75 percent of a member's required contribution. In cases where both employers and not-for-profit organizations contribute to a member's Buckeye Account, the contributions will be coordinated to ensure that the member always contributes at least 25 percent of the total required contribution.

In addition, managed care entities may also make contributions to the core portion of the member's Buckeye Account. However, these contributions may not be used to reduce the member's required contribution. Instead, such contributions may only be utilized to pay the cost for the member to participate in health-related incentive programs, such as participation in a smoking cessation or weight loss program.

4.5 Copayments and Deductibles

The Healthy Ohio Program contains both copayments and a deductible. All cost sharing for the Healthy Ohio Program is paid through the member's Buckeye Account and can be collected by the provider at the point of service via the Buckeye Account debit card.

Per 42 CFR §447.52, §447.53, and §447.54, copayments are indexed to the maximum allowable copayment amounts and are paid from the core portion of the member's Buckeye Account. With the exception of pregnant women, all individuals covered under the Healthy Ohio Program will have the copayments defined below. However, the member will only owe copayments if there are dollars in the core portion of the Buckeye Account to cover the copayment.

Table 4.5: Healthy Ohio Program Copayments

Service	Copayment	Note
Inpatient Services	$75	Copayments apply to all enrolled members except for pregnant women. Copayments apply provided members have funds in the core portion of their Buckeye Account. Copayments are waived for members with no funds in the core portion of their Buckeye Account.
Outpatient Services	$4	
Preferred Rx	$4	
Non-preferred Rx	$8	
Non-emergency use of the ER	$8	

In addition to copayments, the Healthy Ohio Program also includes a feature similar to a deductible. The non-core portion of the Buckeye Account, which contains the State's

contributions to the account, is utilized to pay for the member's initial healthcare expenses until the value of the non-core portion of the account is zero. Therefore, unlike a traditional deductible, which pays for initial expenses up to a specific dollar limit, the Healthy Ohio Program deductible is equal to the balance of the non-core portion of the Buckeye Account and is available to pay for initial healthcare expenses until the non-core balance is zero.

For example, if a member has $1,000 in the non-core side of the Buckeye Account during the first year, the deductible will be $1,000. However, in the second year, if the member is eligible to carry forward funds in accordance with Section 4.7, the balance in the account will be greater than $1,000 following the State's annual $1,000 Buckeye Account contribution. Therefore, deductibles will vary depending on accrued carry forward amounts.

The managed care organizations will utilize all State funds available in the non-core portion of the Buckeye Account to pay for the member's initial healthcare expenses until the non-core balance is zero. These expenses are always fully funded by the non-core side of the account, thus member contributions do not fund these costs. Once the non-core balance is zero and the deductible is met, the member's managed care plan fully covers any claims beyond the deductible up to the Healthy Ohio Program annual and lifetime benefit threshold amounts.

4.6 Healthy Incentive Points

The Healthy Ohio Program includes opportunities for members to earn dollars to the core portion of their Buckeye Account called the Healthy Incentive Point System. The Healthy Incentive Point System allows members to earn points by completing healthy behaviors. Each point earned is equivalent to one dollar and, like member contributions, accrue to the core portion of the Buckeye Account. All funds in the core portion of the account can be used to cover the cost of required copayments or to pay for additional qualifying health-related benefits, as described in Section 4, such as over-the-counter medications.

A capped amount of points may be awarded each year as specified in the Healthy Ohio Program enabling legislation. Incentive points may be awarded to members' accounts by providers and the State. As a starting point, each member who establishes an electronic funds transfer (EFT) to automatically make his or her monthly contributions to the Buckeye Account will earn 20 points; however, these points are deducted if the member terminates the EFT. Providers may award a total of 100 points to each member and the State may award a total of 200 points to each member.

Table 4.6: Healthy Incentive Points

Entity	Points per year
State	Up to 200 Points
Providers	Up to 100 Points

Member Establishing EFT	20 points
Member Canceling EFT	-20 points
Total points available:	**Up to 320 points**

Healthy behaviors that qualify for award points may include completion of a smoking cessation or weight management program, adherence to a prescription drug regimen, and other healthy behaviors. Standards for the awarding of points by the State and by providers will be further detailed prior to waiver implementation.

4.7 Preventive Care Incentive

Members with dollars remaining in their Buckeye Account at the end of the benefit period may be eligible to carry these dollars forward to the subsequent 12-month eligibility period, which may reduce or eliminate required contributions owed for the benefit period. The amount of funds the member can carry forward to the following benefit period depends on whether the funds are in the core or non-core portion of the Buckeye Account, and if the member has completed the recommended preventive services.

Members "own" their contributions, and therefore, all members are eligible to carry forward funds remaining in the Buckeye Account that were either contributed by the member or on the member's behalf in accordance with Section 4.4. By contrast, members that obtain specific recommended preventive care services are able to carry forward the *entire* value of the Buckeye Account, both the core and non-core portion, which includes all State contributions and earned incentive point dollars. Buckeye Accounts that carry forward in full will remain intact, such that remaining funds in the non-core portion of the Buckeye Account carry forward to the non-core side of the account, and remaining funds in the core portion of the Buckeye Account carry forward to the core portion of the account.

Table 4.7(A): Accounts Eligible to Carry Forward

Accounts Eligible for Carry Forward Benefit				
	Member Contributions (CORE)	Third Party Contributions (CORE)	Healthy Incentive Points (CORE)	State Contributions (NON-CORE)
Preventive Service Goals Met	✓	✓	✓	✓
Preventive Service Goals NOT Met	✓	✓	X	X

The specific list of qualifying preventive services that make an individual eligible to carry forward the entire Buckeye Account balance will be established by the State on an annual basis,

based on Centers for Disease Control preventive care age- and gender-based recommendations.

The member's required contribution amount is reduced by any balance present in the core side of the account carried forward. If the amount carried forward is equal to or greater than the member's required contribution then the member may eliminate his or her required monthly contribution.

Table 4.7(B): Carry Forward Example- No Preventive Care

Enrollment Year	Starting Buckeye Account Balance		Ending Buckeye Account Balance	
	Core	Non-Core	Core	Non-Core
Year 1	**$8.25 Maximum member monthly contribution**	**$1,000**	**Total: $300 Incentive Points: $250 Contributions: $50**	**$400**
Carry forward: Member did not complete preventive care so cannot carry forward the non-core portion of the account or the earned incentive points. Member can carry forward the $50 of contributions in the core portion of the account to the next benefit year. The $50 reduces the member's required contributions for the next year (maximum of $99 per year).				
Year 2	**$50**	**$1,000**	**Total: $45 Incentive Points: $40 Contributions: $5**	**$100**

Table 4.7(C): Carry Forward Example- Preventive Care

Enrollment Year	Starting Buckeye Account Balance		Ending Buckeye Account Balance	
	Core	Non-Core	Core	Non-Core
Year 1	**$8.25 Maximum member monthly contribution**	**$1,000**	**$300**	**$400**
Carry forward: Member completed preventive care so can carry forward the entire non-core portion of the account and the core portion of the account. The core portion of the account carries forward to the core side of the account for the next year and the non-core portion of the account carries forward to the non-core side of the account for the next year. This $300 carry forward to the core side of the account eliminates the member's required contributions for the next year's enrollment (maximum of $99 per year). The member starts year 2 with $1,400 in their non-core side of the account to fund the cost of covered medical services.				
Year 2	**$300**	**$1,400**	**$45**	**$100**

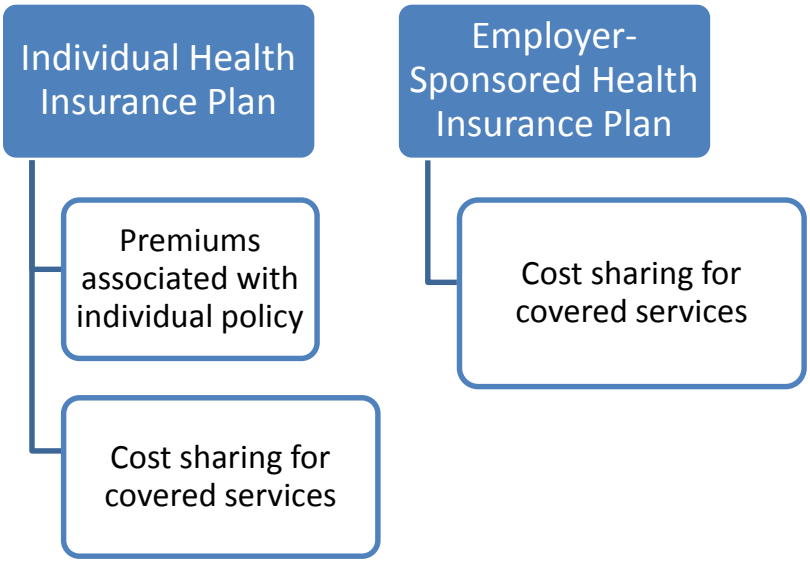
The amounts eligible to carry forward will be applied to the Buckeye Account no later than four months after the start of the member's subsequent benefit year to allow for time for claims runout. Member contributions for the remaining months will be discounted by the amount carried forward, or in some cases, eliminated depending on the amount carried forward.

4.8 Bridge Account

Income fluctuations among Medicaid beneficiaries often result in loss of coverage and frequent transitions in the source of coverage (i.e., churn). In fact, a Health Affairs study published in 2014 by Sommers, et al., estimated that "more than 40 percent of adults likely to enroll in Medicaid or subsidized Marketplace coverage would experience a change in eligibility within twelve months." To reduce the frequency and impact of coverage changes, Healthy Ohio Program members that (i) have a balance remaining in their Buckeye Account, (ii) experience an increase in income, and (iii) purchase either an individual health insurance plan or enroll in employer-sponsored insurance are eligible for a Bridge Account.

The Bridge Account is comprised of the entire balance remaining in the core and non-core portions of the member's Buckeye Account, thereby further encouraging prudent management of the Buckeye Account while the individual enrolled in the Healthy Ohio Program. For members exiting the program who are eligible for a Bridge Account, this account may be used to help pay for premiums for individual market policies as well as cost sharing requirements (including copayments, coinsurance, and deductibles) for both individual market or employer-sponsored insurance. The Bridge Account is designed to support members as they transition to commercial market coverage. By easing the transition from Medicaid to commercial insurance and providing additional support as individuals build their financial self-sufficiency, the Bridge Account aims to reduce churn and help members maintain commercial market coverage.

Figure 4.8: Uses of the Bridge Account



Dollars in the Bridge Account may be used to cover any service covered on the commercial market plan, with the exception that the Bridge Account may not be used to pay for elective

abortion procedures. Once the former member exhausts the funds in the Bridge Account, the account is closed.

Members that regain eligibility for the Healthy Ohio Program prior to exhausting their Bridge Account will have the Bridge Account closed and the balance transferred their new Buckeye Account. At the time that the original Buckeye Account is closed, the State will calculate the ratio of core and non-core dollars remaining in the account. These ratio amounts will be used to deposit the applicable amounts on a prorated basis from the Bridge Account into their new Buckeye Account. Members may only have one Buckeye Account or Bridge Account open at any time.

Table 4.8: Bridge Account and Buckeye Account transition

<table>
<tr><td rowspan="3">1. If a member loses eligibility for the Healthy Ohio Program because he or she had an income increase, the entire value of their Buckeye Account is deposited into a Bridge Account.</td><td colspan="2">Buckeye Account Ending Balance</td></tr>
<tr><td>Core</td><td>Non-Core</td></tr>
<tr><td>$200
(20% of total)</td><td>$800
(80% of total)</td></tr>
<tr><td rowspan="2">2. The member starts the Bridge Account with $1,000</td><td colspan="2">Bridge Account Opening Balance</td></tr>
<tr><td colspan="2">$1,000</td></tr>
<tr><td rowspan="2">3. The member becomes eligible for the Healthy Ohio Program before exhausting the Bridge Account.</td><td colspan="2">Bridge Account Ending Balance</td></tr>
<tr><td colspan="2">$500</td></tr>
<tr><td rowspan="3">4. Bridge Account funds are deposited on a prorated basis into the new Buckeye Account. Since the total original Buckeye Account was comprised of 20% core dollars and 80% non-core dollars, 20% of the total remaining Bridge Account dollars are deposited into the new Buckeye Account core portion, and 80% are deposited into the non-core portion.</td><td colspan="2">Buckeye Account Opening Balance</td></tr>
<tr><td>Core</td><td>Non-Core</td></tr>
<tr><td>$100
(20% of total)</td><td>$400
(80% of total)</td></tr>
</table>

4.9 Member refunds

Not all members who lose eligibility for the Healthy Ohio Program will be eligible for a Bridge Account, which is a benefit reserved solely for members no longer eligible for the program due to increased income. For example, members that lose eligibility due to moving to another state will not be eligible for a Bridge Account. Individuals not eligible for a Bridge Account who lose eligibility or otherwise leave the program will receive a refund of their individual contributions, and, if applicable, contributions made on their behalf by their employer or a non-profit organization. All non-core dollars, as well as dollars in the core account representing

healthy incentive points earned by the member will return to the State upon the member's loss of program eligibility.

For members who have made an overpayment of a required contribution, the Buckeye Account will be reconciled on an annual basis. Members with overpayments will have the option to receive a refund for an overpayment or leave their overpayment in the core portion of the Buckeye Account to offset future contributions. Notwithstanding the foregoing, members may always request consideration for a refund of an overpayment prior to the annual account reconciliation period. These requests will be addressed on a case by case basis.

4.10 Non-payment penalties

Eligibility in the Healthy Ohio Program is contingent upon the member making the required contribution to the Buckeye Account. Only members with zero income and pregnant women are exempt from this contribution requirement. All other members must make a contribution to their Buckeye Account to begin their Healthy Ohio Program benefits, and must continue to make monthly contributions to remain enrolled. Members who do not make a contribution to their Buckeye Account within 60 days from the contribution due date are disenrolled from the program. To reenter the program, these members must pay all of their missed monthly contributions for months they had coverage under the Healthy Ohio Program. In the case where a disenrolled member has funds remaining in the core side of the account representing prior contributions, these dollars can be refunded to the member, in accordance with Section 4.9, provided the member has not reenrolled by the time the Buckeye Account is closed and reconciled. Members that pay the amount of the debt and reenter the program within the same 12-month benefit period will have their Buckeye Account reactivated and will not receive a second $1,000 annual contribution from the State.

4.11 Cost sharing justification

Cost sharing detailed in this waiver submission is drafted in alignment with the Healthy Ohio Program, as established pursuant to Ohio Revised Code §5166.40 to §5166.409.

4.12 Cost sharing exemptions

All enrolled individuals have a Buckeye Account and are eligible to earn Healthy Incentive points, carry forward account balances, and establish a Bridge Account. Pregnant women are exempt from all cost sharing components of the Healthy Ohio Program, including copayments as well as the required monthly two percent of household income Buckeye Account contributions. In addition, by default, members with no income will not be required to make required monthly contributions, as the required Buckeye Account contribution amounts are calculated as a percentage of income.

The Healthy Ohio Program only applies copayments for covered services if the member has a balance remaining in the core portion of their Buckeye Account. Therefore, individuals that do not have funds in the core portion of their Buckeye Account are exempt from making copayments. However, this exemption is temporary and only applies while the core portion shows a zero balance.

Section 5: Delivery System and Payment Rates for Services

The Healthy Ohio Program builds upon Ohio's successful statewide managed care program and incorporates new innovative features, including the Buckeye Account, Bridge Account, and earned Healthy Incentive Point System. The Healthy Ohio Program will be a statewide managed care program that is distinct from the State's existing managed care program. All adults age 18 and over eligible through the Covered Families and Children program, as detailed in Section 2, will no longer be enrolled in the traditional managed care program or the fee-for-service program, but will have eligibility under the Healthy Ohio Program. Those enrolled in the Healthy Ohio Program who reach the three hundred thousand dollar annual or one million dollar lifetime benefit threshold will be disenrolled from Healthy Ohio Program and regain eligibility for coverage under the traditional managed care program or fee-for-service program, as applicable based on the individual's eligibility.

5.1 Delivery System Reforms

The Healthy Ohio Program implements a new managed care program and adds elements of consumer directed care, personal responsibility, and earned incentives for healthy behaviors as detailed in Section 4. Specific to the new Healthy Ohio managed care program, all eligible individuals will be subject to mandatory enrollment in managed care. The breast and cervical cancer population that currently does not have access to a managed care delivery system will become a managed care population under the Healthy Ohio Program. In addition, behavioral health services that are currently carved out of the existing traditional managed care program will be carved in under the Healthy Ohio Program allowing for increased care coordination for Healthy Ohio Program enrollees across the continuum of care.

5.2 Delivery System Type

The Healthy Ohio Program will utilize a managed care delivery system. The managed care system, contracts, and oversight for the Healthy Ohio Program will be separate from the existing traditional managed care program that offers managed care services through 1915(b) authority.

5.3 Delivery System Table

Table 5.3: Delivery System

Eligibility Group	Delivery System	Authority
New Adult Population	Managed Care Plans	1115
Low Income Families		
Transitional Medical Assistance		
Individuals age 19 & 20 who meet the income and resource requirements of AFDC		
Pregnant women		
Children age 18		
Children age 18 with Title IV-E Adoption Assistance, Foster Care, or Guardianship Care		
Children Assistance, Foster Care, or Ages 18 to 26		
Certain women needing treatment for breast or cervical cancer		

If an individual in any of these eligibility groups exceeds the Healthy Ohio Program benefit threshold of three hundred thousand dollars annually or one million dollars per lifetime, he or she transitions back to either fee-for-service or the traditional managed care program, as defined in the State Plan and the State's existing 1915(b) managed care waiver.

5.4 Managed Care

The new managed care program under the Healthy Ohio Program will be statewide. Enrollment in managed care plans will be mandatory for all populations with eligibility under this program. There will be no individuals exempted from mandatory managed care enrollment under the Healthy Ohio Program.

Table 5.4: Managed Care Enrollment Table

Eligibility Group	Managed Care Enrollment	Note
New Adult Population	Mandatory	Freedom of Choice Waiver requested
Low Income Families		
Transitional Medical Assistance		
Individuals age 19 & 20 who meet the income and resource requirements of AFDC		
Pregnant women		
Children age 18		
Children age 18 with Title IV-E Adoption Assistance, Foster Care or Guardianship Care		

Children aging out of foster care, ages 18 to 26		
Certain women needing treatment for breast or cervical cancer		

The State will conduct a competitive managed care procurement to select the Healthy Ohio Program managed care plans. Selection of the health plans will assure that there are at minimum two managed care plan options for enrollees in all regions of the State. Prior to implementation of the Healthy Ohio Program, all selected managed care plans will complete readiness review. This process will review each managed care plan's provider network and ability to meet access to care and provider network adequacy standards. If a plan cannot assure access and network adequacy for Healthy Ohio Program enrollees, the plan may be required to provide open networks until these standards can be met.

Ohio's long history with managed care and the fact that the majority of the populations that will be covered under the Healthy Ohio Program are currently encompassed by the traditional managed care program will serve as a strong foundation for implementing the Healthy Ohio Program. The Healthy Ohio Program implementation will not be phased in but will begin for all identified populations on January 1, 2018.

5.5 Excluded services

All services provided under the Healthy Ohio Program will be provided through managed care as long as the applicable individual remains eligible for managed care enrollment. Services are aligned with State Plan coverage, and all services excluded from State Plan coverage are excluded under the Healthy Ohio Program. There are no additional excluded services for this population.

5.6 Long-term services and supports

Long-term services and supports are covered under the Healthy Ohio Program. Coverage of these services, including member's self-direction opportunities, are aligned with the provision of services under the Ohio Medicaid State Plan.

5.7 Fee-for-service

Individuals may initially be eligible for the Healthy Ohio Program and then transfer to fee-for-service coverage. However, there will be no services paid fee-for-service under the Healthy Ohio Program.

5.8 Capitated payments

Risk-based managed care capitation rates will be developed using principles consistent with federal regulations and actuarial standards of practice. As the majority of the Healthy Ohio

Program population is currently served in the state's risk-based Medicaid managed care program, the State will initially utilize historical experience from this delivery system as the basis for the Healthy Ohio Program capitation rates. For populations served by fee-for-service or services provided via fee-for-service where the Healthy Ohio Program will be the new coverage vehicle, the fee-for-service experience will be referenced to develop capitation rates. Capitation rates will reflect differences between the existing Medicaid managed care delivery system and the Healthy Ohio Program, including member cost sharing and premium requirements, estimated population morbidity differences, and the exclusion of individuals with annual or lifetime costs above specified thresholds from the program. Following implementation of the Healthy Ohio Program, the State will transition the rate-setting process to utilize available Healthy Ohio Program historical enrollment data and financial experience.

5.9 Quality

Quality metrics and payments for the Healthy Ohio Program will be detailed in the Scope of Work for the new Healthy Ohio Program managed care plans. Quality and performance incentives for Healthy Ohio Program managed care plans may follow a model similar to the current quality initiatives present in Ohio's existing managed care program. All Healthy Ohio Program managed care plans will be required to submit Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), and additional administrative and performance measures targeted to Healthy Ohio Program specific quality and operational goals. Plans failing to submit the required data may be subject to fines. Pay-for-performance bonuses may also be available to health plans based on Healthy Ohio Program specific performance measures.

Section 6: Implementation of the Demonstration

The Healthy Ohio Program is targeted for implementation on January 1, 2018. Implementation of the Healthy Ohio Program will require a new competitive procurement for managed care plans to serve the Healthy Ohio Program population, a readiness review process for the selected plans, and execution of a transition plan for members currently enrolled in managed care or fee-for-service. In parallel to the managed care plan procurement, contracting, and readiness review process, State systems, policy, and operations will prepare for management and oversight of the Healthy Ohio Program and implementation of the transition plan for members and applicants.

6.1 Implementation Schedule

Proposed Healthy Ohio Program Implementation Schedule*	
Managed Care	
Managed care procurement	July 1, 2016 to January 1, 2017
Contract award	March 1, 2017
Readiness review	March 1, 2017 to December 31, 2017

State Systems, Policy and Operational	
Develop detailed policy	July 1, 2016 to January 1, 2017
Systems requirements and updates	January 1, 2017 to December 31, 2017
Finalize operational processes and procedures	September 1, 2017 to December 31, 2017
Stakeholder Outreach	
Outreach to provider community	July 1, 2016 to December 31, 2017
Outreach to advocacy organizations	
General public/community outreach	
Member Transition	
Current member initial notification and education on Healthy Ohio Program	September 1, 2017
Follow-up member education and member notification of opportunity to select Healthy Ohio Program managed care plan	October 1, 2017
Follow-up member education and member notification of their 2% contribution amount	November 1, 2017
Member education and invoicing for initial 2% contribution amount	November 2, 2017 to December 31, 2017
Member coverage transition: Members that made contribution transitioned to Healthy Ohio Program, and members that did not make contribution disenrolled from benefits	January 1, 2018
*Schedule is subject to waiver approval	

6.2 Enrollment

Current Ohio Medicaid members that will be transferred to the Healthy Ohio Program upon implementation will begin to receive communication and education on the new program beginning at least ninety days prior to implementation. Beginning sixty days prior to implementation, members transitioning to the Healthy Ohio Program will be notified of the opportunity to choose their Healthy Ohio Program managed care entity. At this time, members will also be notified of their required contribution amount to their Buckeye Account and will receive additional education about the account and the payment processes. Effective January 1, 2018, members will begin coverage in the Healthy Ohio Program, will receive their first invoices, and will have the opportunity to make their first contribution. Members that have not made their contribution within sixty days of the transition date will be disenrolled from the program. Members may change their health plan selection within the first three months of enrollment.

6.3 Managed Care

The Healthy Ohio Program will require a new competitive managed care procurement. The awarded contracts will ensure that all managed care entities appropriately provide all benefits to beneficiaries under the Healthy Ohio Program demonstration.

Section 7: Demonstration Financing and Budget Neutrality

Milliman was engaged to develop the response to the Budget Neutrality Form section of the 1115 Waiver. Appendix 1 illustrates the 1115 Waiver Budget Neutrality spreadsheet. The rest of this section documents the supporting data included in the spreadsheet, using guidance provided by CMS in the Budget Neutrality Form.

I. Without- and With-Waiver Projections for Historical Medicaid Populations

A. Recent Historical Actual Data

Historical data is provided separately for three Medicaid populations: Covered Families and Children (CFC) Age 18, CFC Adults, and Extension.

For both the CFC Age 18 and the CFC Adults populations, historical data is provided for calendar years 2012 through 2015. For the Extension population, historical data is provided for the program's first two years, CY 2014 and 2015. For each population, the historical data includes capitation payments and fee-for-service experience for members who were enrolled in the State's Medicaid Managed Care (MMC) program, as well as fee-for-service experience for beneficiaries historically served outside of the MMC program that will be eligible for the Healthy Ohio Program.

B. Bridge Period

The bridge period is January 1, 2016 to December 31, 2017 (24 months).

C. Without-Waiver Trend Rates, PMPM costs and Member Months with Justification

For the CFC Age 18 and CFC Adults populations, annual trend rates were developed for member months based on CY 2012 to CY 2015 eligible member months. The PMPM cost trend used the average of one-year historic trend rates observed for CY 2013 and CY 2015. Please note that the CY 2014 experience was not considered when developing without-waiver trend rates. CY 2014 trends were an outlier due to Medicaid expansion under the ACA and a pause in eligibility redetermination instituted by ODM during this time period.

Reasonable enrollment trends could not be observed for the Extension population due to the infancy of the program. Therefore, Milliman used a trend rate for member months that was equal to the average of the trend rates used for the CFC Age 18 and CFC Adults

populations. The Extension population's PMPM cost trend was established using the one-year historic trend rate observed for CY 2015.

D. Historical Medicaid Populations: With-Waiver PMPM Cost and Member Month Projections

To project with-waiver PMPM cost and member months, analysis was completed for all CFC Age 18, CFC Adults, and Extension members, including those enrolled in a managed care plan, as well as those who receive services on a fee-for-service basis. For each population, expenditures were estimated through the use of historical encounter and fee-for-service data.

One key component of the Healthy Ohio Program is the requirement of members to make contributions to Buckeye Accounts. In practice, these contributions will be used for members to pay required copayments. Milliman modeled both the enrollment and corresponding morbidity effects of members leaving the program due to the introduction of these member contributions, as a subset of members have projected claims costs that are lower than their projected contributions. This impact is projected to be less for members who have household income above 100% of the Federal Poverty Level (FPL) because the ACA's individual mandate provides an incentive for these members to maintain health insurance coverage. In addition, the service utilization impact associated with increased member accountability for healthcare purchasing decisions from the introduction of Buckeye Accounts was modeled.

Milliman also modeled the change in projected copayments for Healthy Ohio members. Under the State's current Medicaid Managed Care program, members are required to pay copayments for certain services. However, projected copay amounts will be greater under the Healthy Ohio Program.

Under the Healthy Ohio Program, the State will contribute incentive dollars to the Buckeye Accounts of members who complete certain healthy behaviors. These incentive contributions range from $0 to $200 per member per year. In addition, each member will have the ability to retain the balance of his or her Buckeye Account in the event the individual transitions to the commercial insurance market. These features of the Healthy Ohio Program are estimated to increase projected PMPM cost for the Healthy Ohio enrolled population relative to the current MMC program. However, it is assumed the Buckeye Account and cost sharing requirements of the Healthy Ohio Program may also aid in increasing member accountability for healthcare purchasing decisions, resulting in lower healthcare costs.

The Healthy Ohio Program stipulates that a member will lose eligibility if he or she meets an annual claims expenditure limit of $300,000 or a lifetime limit of $1,000,000. Milliman estimated the enrollment and morbidity impact associated with this provision of the proposed program.

E. Justification for With-Waiver Trend Rates, PMPM Costs and Member Months

The impact of each feature of the Healthy Ohio Program is fully reflected in the DY00 trend rate displayed in Appendix 1. To annually trend member months and PMPM cost from DY01 through DY05, Milliman used the historic trend rates that were developed and used for the without-waiver projections. The development and justification for these rates is described in section C above.

II. Cost Projections for New Populations

Not applicable

III. Disproportionate Share Hospital Expenditure Offset

Not applicable

IV. Summary of Budget Neutrality

Appendix 1 illustrates the 1115 Waiver Budget Neutrality spreadsheet, which includes the following applicable tables:

i. Historic Data
ii. WOW (Without-Waiver)
iii. WW (With-Waiver)
iv. Summary (of Budget Neutrality)

V. Additional Information to Demonstrate Budget Neutrality

Milliman does not believe there is any other information necessary for CMS to complete its analysis of the budget neutrality submission.

Section 8: List of Proposed Waivers and Expenditure Authorities

1. Eligibility **Section 1902(a)(10)(A)**

To the extent necessary to enable Ohio not to provide medical coverage for Healthy Ohio Program members until the first day of the month in which the first contribution to their Buckeye Account is received.

2. Retroactive Eligibility **Section 1902(a)(34)**

To the extent necessary to enable Ohio not to provide medical coverage to Healthy Ohio Program members for any month prior to the month in which their initial contribution to their Buckeye Account is received and processed.

3. Cost Sharing **Section 1902(a)(14) insofar as it incorporates 1916 and 1916A**

To the extent necessary to enable Ohio to require all Healthy Ohio Program members to make contributions to the Buckeye Account of approximately 2 percent of income, but not to exceed $99 per year. To allow cost sharing in the form of copayments to be applied towards all covered services. To allow cost sharing to be imposed on otherwise exempt populations, except pregnant women.

4. Amount, Duration, and Scope **Section 1902(a)(10)(B)**

To the extent necessary to allow the Healthy Ohio Program to establish three hundred thousand dollar annually or one million dollar benefit thresholds per member lifetime. Members that meet this limit will no longer be eligible for the Healthy Ohio Program.

To the extent necessary to allow the member to use the core portion of their Buckeye Account to pay for qualifying additional health-related benefits.

To the extent necessary to enable Ohio to provide members with a Bridge Account when they leave the program due to an increase in income. The member can use the Bridge Account to pay for the costs of covered services on their commercial health insurance.

5. Reasonable Promptness **Section 1902(a)(3)/Section 1902(a)(8)**

To the extent necessary to enable Ohio to make enrollment in the plan contingent on the payment of the required contribution to the Buckeye Account. To the extent necessary to disenroll members from the Healthy Ohio Program who do not continue to make their required monthly contribution, and to require repayment of past due contributions amount as a condition of eligibility and program reentry.

6. Freedom of Choice **Section 1902(a)(23)**

To the extent necessary to enable Ohio to restrict the freedom of choice of providers for demonstration eligibility groups and require mandatory managed care enrollment for all eligible populations.

Section 9: Public Comment Period

Ohio's formal public comment period on the draft Healthy Ohio Program waiver transition was held from April 15, 2016, through May 16, 2016.[1] During this period, the State received 937

[1] The abbreviated and full public notice may be accessed via: *http://medicaid.ohio.gov/RESOURCES/PublicNotices/HealthyOhioHSA.aspx*

submissions from a variety of sources including individuals receiving services, providers, stakeholders and advocates.

The State used the following methods to provide notice to the public about the opportunity for public comment:

- **Web postings –** On April 15, 2016 Ohio posted a public notice, summary of the draft waiver, the draft waiver itself, and questions and answers on the Ohio Department of Medicaid (ODM) website at http://medicaid.ohio.gov/RESOURCES/PublicNotices.aspx. In addition, an abbreviated version of the public notice with a link to the full notice and applicable documentation was published online in the Register of Ohio.

- **Electronic mailing –** Ohio Office of Health Transformation issued its newsletter to 4,410 subscribers on April 7, 2016 with the article, "Ohio Medicaid seeks public comment on Healthy Ohio." This article summarized the Healthy Ohio Program waiver and included a link to the Medicaid web site mentioned above.

Ohio provided five (5) methods for the public to provide input on the draft waiver plan and/or request a non-electronic copy of the plan; all of which were utilized. They included:

- **E-mail -** Ohio established a dedicated e-mail box named HealthyOhio.medicaid.gov, which received a total of 683 e-mails by the May 16, 2016 deadline.

- **Written comments -** Ohio provided a U.S. Postal Service address, which was Healthy Ohio Program 1115 Demonstration Waiver, Bureau of Health Plan Policy, Ohio Department of Medicaid, 50 W. Town St., 5th Floor, Columbus, OH 43218. It received a total of 217 mailed items, by the May 16, 2016, deadline.

- **Fax -** Ohio provided a fax number, which was (614) 995-1301, which received 2 transmissions.

- **Courier –** Ohio provided the Department street address for delivery of comments.

- **Testimony at public hearings -** Ohio held two public hearings on April 21 and April 26, 2016. The first was held during the regularly scheduled Medical Care Advisory Committee at the Department in Columbus, the second was held in Cincinnati, Ohio. Each hearing was documented by a stenographer. The director and assistant director were positioned in the front of the room facing attendees to hear testimony. Speakers were called in the order in which they signed in.

At the public hearings, a presentation was given by a departmental contractor providing an overview of the Healthy Ohio Program waiver. Approximately 100 individuals attended the

April 21 hearing, at which 13 testified. Approximately 50 individuals attended the April 26 hearing, at which 15 testified. A total of 28 testimonials were received at both hearings.

Summary of Public Comments and Modifications Made Based Upon Public Comments

The table below highlights the unduplicated 956 comments received during the April 15, 2016 through May 16, 2016 comment period. Many respondents requested changes be made to various parts of the waiver. However absent a state statutory change, the Department is unable to modify the waiver.

Healthy Ohio Response Summary

Healthy Ohio would be unaffordable for Medicaid recipients	84%
Healthy Ohio would result in decreased Medicaid enrollment	72%
Healthy Ohio would be too complex for Medicaid recipients, resulting in premiums not being paid	65%
Medicaid recipients would forego medical care in order to meet other expenses	63%
Healthy Ohio would interfere with continuity of care, especially for those with behavioral health issues, cancer and AIDs	57%
Healthy Ohio would be administratively complex for state and managed care companies, costing more money than is collected in premiums	55%
Healthy Ohio's administrative burden for providers would result in providers leaving the Medicaid program	53%
Healthy Ohio would be difficult to administer given communication issues with highly transient population and this population not proficient with banking	51%
Healthy Ohio would limit a recipient's access to care	14%
Healthy Ohio's lifetime/annual limits violate the Affordable Care Act	6%
Healthy Ohio would cause an increase in emergency department visits for non-emergency care	5%
Healthy Ohio would increase the amount of uncompensated care for providers given loss of retroactive eligibility	3%
Supportive of Healthy Ohio	1%

Section 10: Demonstration Administration

Contact information for the State's point of contact for the demonstration application is as follows.

Name and Title: Director John McCarthy

Email Address: HealthyOhio@medicaid.ohio.gov

Appendix 1: Demonstration Financing and Budget Neutrality

5 YEARS OF HISTORIC DATA						
SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:						
CFC Age 18	**N/A**	**2012**	**2013**	**2014**	**2015**	**4-YEARS**
TOTAL EXPENDITURES		$ 112,041,363	$ 105,176,117	$ 108,293,905	$ 123,255,298	$ 448,766,684
ELIGIBLE MEMBER MONTHS		531,301	490,010	523,718	578,995	
PMPM COST		$ 210.88	$ 214.64	$ 206.78	$ 212.88	
TREND RATES						**4-YEAR**
			ANNUAL CHANGE			**AVERAGE**
TOTAL EXPENDITURE		N/A	-6.13%	2.96%	13.82%	3.23%
ELIGIBLE MEMBER MONTHS		N/A	-7.77%	6.88%	10.55%	2.91%
PMPM COST		N/A	1.78%	-3.66%	2.95%	0.31%
CFC Adults	**N/A**	**2012**	**2013**	**2014**	**2015**	**4-YEARS**
TOTAL EXPENDITURES		$ 2,906,006,350	$ 2,971,200,033	$ 2,914,061,695	$ 3,115,063,880	$ 11,906,331,959
ELIGIBLE MEMBER MONTHS		6,518,658	6,568,006	6,777,437	7,015,538	
PMPM COST		$ 445.80	$ 452.37	$ 429.97	$ 444.02	
TREND RATES						**4-YEAR**
			ANNUAL CHANGE			**AVERAGE**
TOTAL EXPENDITURE		N/A	2.24%	-1.92%	6.90%	2.34%
ELIGIBLE MEMBER MONTHS		N/A	0.76%	3.19%	3.51%	2.48%
PMPM COST		N/A	1.48%	-4.95%	3.27%	-0.13%

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR DY 00	TREND RATE 2	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL WOW
CFC Age 18										
Pop Type:	**Medicaid**									
Eligible Member Months	1.9%	24	601,218	2.9%	618,714	636,718	655,247	674,314	693,937	
PMPM Cost	2.4%	24	$ 223.23	2.4%	$ 228.51	$ 233.91	$ 239.44	$ 245.10	$ 250.90	
Total Expenditure					$ 141,382,228	$ 148,934,728	$ 156,892,243	$ 165,274,426	$ 174,108,745	$ 786,592,369
CFC Adults										
Pop Type:	**Medicaid**									
Eligible Member Months	1.8%	24	7,267,021	2.5%	7,447,243	7,631,934	7,821,206	8,015,172	8,213,948	
PMPM Cost	-1.1%	24	$ 434.31	2.4%	$ 444.60	$ 455.13	$ 465.91	$ 476.95	$ 488.25	
Total Expenditure					$ 3,311,044,064	$ 3,473,522,224	$ 3,643,978,178	$ 3,822,836,337	$ 4,010,460,294	$ 18,261,841,096
Extension										
Pop Type:	**Medicaid**									
Eligible Member Months	7.7%	24	8,645,688	2.7%	8,878,689	9,117,970	9,363,699	9,616,051	9,875,203	
PMPM Cost	2.8%	24	$ 579.62	6.8%	$ 618.86	$ 660.76	$ 705.49	$ 753.25	$ 804.25	
Total Expenditure					$ 5,494,665,452	$ 6,024,789,613	$ 6,605,995,945	$ 7,243,290,113	$ 7,942,132,143	$ 33,310,873,265

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	DEMO TREND DY 00	RATE	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL WW
CFC Age 18								
Pop Type:	**Medicaid**							
Eligible Member Months	601,218	-12.7%	524,578	539,844	555,553	571,720	588,357	
PMPM Cost	$ 223.23	18.5%	$ 264.44	$ 270.69	$ 277.09	$ 283.64	$ 290.35	
Total Expenditure			$ 138,719,529	$ 146,130,290	$ 153,938,222	$ 162,162,588	$ 170,829,394	$ 771,780,024
CFC Adults								
Pop Type:	**Medicaid**							
Eligible Member Months	7,267,021	-5.1%	6,893,158	7,064,108	7,239,298	7,418,832	7,602,819	
PMPM Cost	$ 434.31	8.7%	$ 472.12	$ 483.30	$ 494.75	$ 506.47	$ 518.47	
Total Expenditure			$ 3,254,397,546	$ 3,414,083,332	$ 3,581,642,557	$ 3,757,416,008	$ 3,941,833,757	$ 17,949,373,200
Extension								
Pop Type:	**Medicaid**							
Eligible Member Months	8,645,688	-7.3%	8,016,409	8,232,451	8,454,316	8,682,159	8,916,144	
PMPM Cost	$ 579.62	15.9%	$ 671.70	$ 717.17	$ 765.72	$ 817.56	$ 872.91	
Total Expenditure			$ 5,384,621,859	$ 5,904,066,970	$ 6,473,638,601	$ 7,098,186,309	$ 7,782,990,983	$ 32,643,504,723

For a per capita budget neutrality model, the trend for member months is the same in the with-waiver projections as in the without-waiver projections. This is the default setting.

Budget Neutrality Summary

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Populations						
CFC Age 18	$ 141,382,228	$ 148,934,728	$ 156,892,243	$ 165,274,426	$ 174,108,745	$ 786,592,369
CFC Adults	$ 3,311,044,064	$ 3,473,522,224	$ 3,643,978,178	$ 3,822,836,337	$ 4,010,460,294	$ 18,261,841,096
Extension	$ 5,494,665,452	$ 6,024,789,613	$ 6,605,995,945	$ 7,243,290,113	$ 7,942,132,143	$ 33,310,873,265
DSH Allotment Diverted	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 8,947,091,743	$ 9,647,246,565	$ 10,406,866,366	$ 11,231,400,875	$ 12,126,701,182	$ 52,359,306,731

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Populations						
CFC Age 18	$ 138,719,529	$ 146,130,290	$ 153,938,222	$ 162,162,588	$ 170,829,394	$ 771,780,024
CFC Adults	$ 3,254,397,546	$ 3,414,083,332	$ 3,581,642,557	$ 3,757,416,008	$ 3,941,833,757	$ 17,949,373,200
Extension	$ 5,384,621,859	$ 5,904,066,970	$ 6,473,638,601	$ 7,098,186,309	$ 7,782,990,983	$ 32,643,504,723
TOTAL	$ 8,777,738,934	$ 9,464,280,592	$ 10,209,219,381	$ 11,017,764,906	$ 11,895,654,134	$ 51,364,657,947

VARIANCE	$ 169,352,809	$ 182,965,973	$ 197,646,985	$ 213,635,969	$ 231,047,048	$ 994,648,784