Children's Medicaid eligibility in Ohio

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POLICY CONTEXT

Part I. Eligibility Design

Background

Enrollment in Medicaid and the Children's Health Insurance Program (CHIP) declined by 2.4 million between December 2017 and June 2019, after years of mostly increasing enrollment since the passage and implementation of the Patient Protection and Affordable Care Act (ACA).[1] Reasons for this decline are multi-faceted and complex.

State data suggests that an improving economy had an impact as household income increased, confirming the program's counter-cyclical nature.[2] However, an improving economy and the resultant increase in household income did not result in the maintenance of health insurance coverage. While public coverage decreased, there was an increase in the percentage of uninsured from 7.9 to 8.5 percent between 2017 and 2018. This suggests that many individuals did not leave public programs for private market options.[3] The increase of the uninsured was not limited to adults, however, as the number of children without insurance increased by .5 percentage points during that period.[4] According to Administrator Seema Verma of the Centers for Medicare & Medicaid Services (CMS), the rise in the

[1] Samantha Artiga, "Recent Medicaid/CHIP Enrollment Declines and Barriers to Maintaining Coverage," October 30, 2019, https://www.kff.org/medicaid/issue-brief/recent-medicaid-chip-enrollment-declines-and-barriers-to-maintaining-coverage/.
[2] Phil Galewitz, "Booming Economy Helps Flatten Medicaid Enrollment And Limit Costs, States Report," Kaiser Health News, October 25, 2018, https://khn.org/news/booming-economy-helps-flatten-medicaid-enrollment-and-limit-costs-states-report/.
[3] Edward R. Berchick, Jessica C. Barnett, and Rachel D. Upton, "Health Insurance Coverage in the United States: 2018," The United States Census Bureau, November 8, 2019, https://www.census.gov/library/publications/2019/demo/p60-267.html.
[4] Edward R. Berchick and Laryssa Mykyta, "Uninsured Rate for Children Up to 5.5 Percent in 2018," September 10, 2019, https://www.census.gov/library/stories/2019/09/uninsured-rate-for-children-in-2018.html.

uninsured, despite an improved economy, is due to ACA policies which did not adequately address the issue of escalating premiums in individual marketplaces, making many options unaffordable for individuals transitioning out of Medicaid.[5] Others, however, have cited challenges with state eligibility redetermination systems and individual state policy decisions around coverage.[6] Specifically, some research regarding this decline suggests operational decisions made by states and the federal government may be the root cause of these issues.[7] The following section will examine the sources of this decline and contextualize around Ohio's Medicaid program, focusing on trends as they relate to children's coverage.

The Economy

Nationally, between 2017 and the end of 2018, personal and per-capita income grew 5.18 percent and 4.61 percent, respectively. Ohio lagged these national numbers, growing by 4.29 percent and 4.15 percent.[8] At the same time, however, the enrollment trends in Ohio Medicaid volume across key categories declined at faster rate than per capita income grew:

Table 1: Enrollment Trends

	Change in Enrollment 2017 - 2018
Total Medicaid Population	-7.11%
CFC Children	-8.23%
CFC Adults	-16.81%
CHIP	0.87%

CFC = Covered Families and Children

Per capita income, which is a statewide number, and Medicaid enrollment, which is specific to the population, are not necessarily directly related or comparable, however and, in regards to income's effect on Medicaid enrollment, household income may be a better measure. When looking at data from the Ohio Department of Job and Family Services (ODJFS), household income grew by little over 4 percent, each year.[9] In order to look more deeply into the data, a Pearson product-moment correlation (Pearson) was performed for key combinations of eligibility groups and the per-household changes

[5] Seema Verma, "Thank Obamacare for the Rise of the Uninsured" (The Centers for Medicare & Medicaid Services), accessed July 17, 2020, https://www.cms.gov/blog/thank-obamacare-rise-uninsured.
[6] Harris Meyer, "Faulty State Renewal Processes Blamed for Medicaid Coverage Declines," Modern Healthcare, April 19, 2019, https://www.modernhealthcare.com/government/faulty-state-renewal-processes-blamed-medicaid-coverage-declines.
[7] Brooks, Tricia, Edwin Park, and Lauren Roygardner. "Medicaid and CHIP Enrollment Decline Suggests the Child Uninsured Rate May Rise Again." Georgetown University Health Policy Institute Center for Families and Children, May 2019. https://ccf.georgetown.edu/wp-content/uploads/2019/05/Medicaid-and-CHIP-Enrollment-Decline_Summary.pdf.
[8] Analysis Conducted Using Data from the Bureau of Economic Analysis, The United States Department of Commerce: https://www.bea.gov/data/income-saving/personal-income-by-state
[9] "Ohio Labor Market Information." Quarterly Census of Employment and Wages (QCEW). Ohio Department of Job and Family Services. Accessed October 16, 2020. https://ohiolmi.com/Home/QCEWpubs.

throughout all eight quarters of the period in question. Additional data going back to the 3rd quarter of 2015 was used in order to increase observations from 8 to 14.

A Pearson is a measure of strength of an association between variables. The coefficient can range between values of +1 and -1, with a value of 0 indicating there is no association between the two variables and 1 meaning the opposite. If the value is positive, it means as the value of one variable increases so does the value of the other. If the value is negative, it means that as one variable increases, the other decreases. The following table represents the findings of the analysis.

Table 2: Pearson Correlation Analysis

	HOUSEHOLD INCOME	*TOTAL ENROLLMENT*	*CFC CHILDREN*	*CHIP*	*CFC Adults*
HOUSEHOLD INCOME	1.00				
TOTAL ENROLLMENT	-0.54	1.00			
CFC CHILDREN	-0.71	0.86	1.00		
CHIP	0.65	-0.28	-0.64	1.00	
CFC Adults	-0.75	0.72	0.96	-0.82	1.00

The analysis indicates the relationship between income increases and enrollment in Ohio vary. For total enrollment and Covered Families and Children (CFC) adult and children's enrollment, an increase in household income is associated with a decrease in enrollment. CHIP enrollment is also associated with increases in income, which is logical given the role CHIP plays in covering children as income increases.

Interestingly, there does seem to be a strong explanatory relationship between CFC adults and CFC children, suggesting that a parent's disenrollment may be predictive of their children being disenrolled. This is consistent with other research which suggests that a parent's enrollment, particularly through Medicaid expansion, is predictive of a child's enrollment in Medicaid.[10] [11]

It should be noted that with the limited number of observations correlation, as it often does, may not mean causation. This was due to the lack of available comparable data regarding enrollment by eligibility type. However, given the existing research denoting the relationship between parents' enrollment and that of children, and the operational reality of CHIP as a coverage source for children with higher incomes, the Pearson seems to indicate income may not be the sole factor in driving children's loss of coverage in Medicaid. Disenrollment, however, does not necessarily mean individuals became uninsured, so examining Ohio's trends in other areas provide insight.

[10] Hudson, J. L.; Moriya, A. S. (2017, September 01). Medicaid Expansion For Adults Had Measurable 'Welcome Mat' Effects On Their Children. Retrieved September 28, 2020, from https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0347

[11] DeVoe, J. E., MD. (2015, January 05). Health Insurance Coverage for Parents and Children. Retrieved September 28, 2020, from https://jamanetwork.com/journals/jamapediatrics/article-abstract/2086457

When the ACA was passed in 2010, the uninsured rate in Ohio was 12.9 percent. By 2018, the uninsured rate dropped to 5.8 percent, largely due to the expansion of Medicaid coverage to able-bodied adults also known as "Group VIII".[12] By 2019, this increased to 6.3 percent. With the increases in uninsured rates across the state for both adults and children, it would seem that both groups previously enrolled in Medicaid are ending up uninsured rather than achieving coverage through alternative means.

Eligibility Regulations

States must redetermine eligibility for most Medicaid enrollees every 12 months. In 2014 and 2015, as Ohio was implementing a new eligibility system, the federal government granted Ohio permission to pause redeterminations, which then had to be processed in 2016 and 2017. Additionally, CMS granted approval for a pause in renewals for ABD eligibility groups in 2016 when ODM transitioned from 209(b) to 1634 status.[13] This renewal delay led to some general stability in the program's enrollment until the state resumed redeterminations.

In 2019, after Ohio's Medicaid eligibility system transition to the Ohio Benefits system was completed in 2017, the state worked aggressively to reduce its application and renewal backlog, which resulted in a more significant decline in enrollment. According to the Department, declines in enrollment due to processing backlog cases were appropriate terminations for individuals who would have left the program earlier, had the redetermination been completed in a timelier manner. Importantly, however, the Accenture-built system also seemed to have a number of existing data integrity challenges when Governor Mike DeWine took office, leading to a process of improperly documented determinations on the state level.[14] Also in 2019, CMS issued guidance building on the federal efforts to increase program integrity with significant financial and administrative sanctions tied to eligibility determinations.[15] Given the challenges with the system and the potential for sanctions, some researchers are concerned that these regulatory efforts may induce disenrollment through additional administrative burden and process requirements, further complicating the systems issues with transition, generally.[16] With the public emergency, though, the state is currently unable to discontinue enrollment for any current enrollee unless they meet specific criteria, meaning this issue is evolving as the state responds to federal guidelines.

In addition to the operational challenges, there were a few key federal and state policy decisions which may have impacted enrollment. First, the Department of Health and Human Services (HHS) cut funding awards to the federal marketplace navigator program in Ohio by 75 percent. This program, created by the ACA, financed state navigator programs to provide outreach, education and enrollment assistance to consumers eligible for marketplace and Medicaid coverage. Because there is one application for both

[12] U.S. Census Bureau, Health Insurance Coverage in the United States
[13] McCarthy, John. "Medicaid: Deferral of Scheduled Renewals for Aged, Blind, or Disabled Eligibility Groups." The Ohio Department of Medicaid, August 1, 2016. https://medicaid.ohio.gov/Portals/0/Resources/Publications/Guidance/MedicaidPolicy/Elig-Chip/MEPL-116.pdf.
[14] Laura Hancock, "State Reveals $1.2 Billion Ohio Benefits System Riddled with Defects a Year out from Medicaid Work Requirements," January 16, 2020, https://www.cleveland.com/open/2020/01/state-reveals-12-billion-ohio-benefits-system-riddled-with-defects-a-year-out-from-medicaid-work-requirements.html.
[15] Kelsey Waddill, "CMS Defines New Medicaid Integrity Guidelines," March 24, 2020, https://healthpayerintelligence.com/news/cms-defines-new-medicaid-integrity-guidelines.
[16] Andy Schneider et al., "Weaponizing Program Integrity: A New Assault on Medicaid Expansion," June 27, 2019, https://ccf.georgetown.edu/2019/06/25/weaponizing-program-integrity-a-new-assault-on-medicaid-expansion/.

sources, and no wrong door policies, navigators helped people enroll in Medicaid as well as the marketplace. Where every county in Ohio had at least one navigator in 2016, the majority of counties in Ohio now have none. Additionally, the Ohio Benefit Bank, a web-based, counselor-assisted program that helped Ohioans apply for and receive benefits (including health coverage), closed July 31, 2019. [17] With the absence of this program, many may have lost an additional community-based resource to process eligibility.

It is important to note, too, as a part of the ACA, states are obligated to simplify and streamline eligibility. In a 2012 rule, CMS issued rules mandating states may only request information that is necessary to make an eligibility determination.[18] This policy means Medicaid agencies must compare the applicant's or beneficiary's attestation to available electronic data sources and evaluate eligibility. If both the attestation and the data source are at or below the eligibility threshold, the Medicaid agency finds the individual eligible. In these situations, the difference between the attestation and data source doesn't affect eligibility, because the individual would be eligible using either the electronic data or the attestation.[19] It's important to note, too, the state is able to adjust how it leverages available electronic data through a "reasonable compatibility" standard, though more on that policy and its implications are covered in the subsequent section.

The federal government establishes a few indicators of a state's performance in administering its Medicaid program. Using state provided data, one report, under CMS's Scorecard related to State Administrative Accountability, shows the percentage of applications processed within seven days. According to these reports, Ohio's previously documented rate is between 20 and 40 percent and Ohio is higher than the national average in regards to application processing that takes more than 45 days.[20] Additionally, according to data collected by Kaiser Family Foundation in 2018, over 75 percent of Ohio's renewals are automated. With that said, only 25 percent of applications for eligibility happen in real time.[21][22]

Given all this context of the pandemic, economy, enrollment, policy and operations, Ohio still faces the significant challenge regarding a trend in the diminished enrollment of children in its Medicaid program along with a rising number of uninsured children. While the improving economy during the time frame examined may have explained why the Medicaid population, writ large, declined, it does not seem to be the sole factor for this disenrollment. Instead, it appears that the combination of policy and eligibility system design in Ohio are other key factors for this trend. Ohio is subject to federal regulations regarding program integrity, which puts pressure on states to ensure applications for eligibility are

[17] Eran Hami, "Ohio Benefit Bank Files for Bankruptcy Affecting 300 People Locally," Your Hometown Stations, July 23, 2019, https://www.hometownstations.com/news/ohio-benefit-bank-files-for-bankruptcy-affecting-300-people-locally/article_e51a3e52-ad86-11e9-b612-873af7dbfa1a.html.

[18] Karina Wagnerman and Tricia Brooks, "Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost Sharing Policies as of January 2018: Findings from a 50-State Survey," KFF, March 19, 2019, https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2018-findings-from-a-50-state-survey/.

[19] 42 CFR §435.952(c)(1)

[20] "Medicaid MAGI and CHIP Application Processing Times," Medicaid, accessed July 17, 2020, https://www.medicaid.gov/state-overviews/scorecard/medicaid-magi-and-chip-application-processing-times/index.html.

[21] Medicaid MAGI and CHIP Application Processing Time Report. (2019, November 7). Retrieved September 3, 2020, from https://www.medicaid.gov/state-overviews/downloads/magi-and-chip-application-processing-time/magi-application-time-report-2019.pdf

[22] "Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey (Kaiser Family Foundation, 2020), http://files.kff.org/attachment/Table-10-Medicaid-and-CHIP-Eligibility-as-of-Jan-2020.pdf.

consistent with regulation. As such, leveraging its federally granted powers to implement automated eligibility may provide a more reliable system of determinations, overall, especially in comparison to its current system. The next section of this analysis will explore this further, looking more deeply into the differences between the eligibility systems of Ohio and other states.

Part II. Other State Approaches

Ohio in Context

As a state and federal partnership, the operational design of Medicaid, even under the legal constraints of federal regulation, varies greatly, state to state. Automated renewal policies are not immune to these variations, nor are updating eligibility information technology systems.

To evaluate Ohio relative to other states, the authors used January 2020 data from the Kaiser Family Foundation 50 state survey of Medicaid programs policies on Medicaid and CHIP eligibility, enrollment and cost sharing.[23] While the survey collects a myriad of information across the program, key metrics were selected for this analysis. The metrics the authors chose focus on policies regarding eligibility, and highlight instances where Ohio is underperforming relative to its potential or where polices could be enacted but have not been.

[23] Lauren Roygardner and Tricia Brooks, "Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey - Tables," March 31, 2020, https://www.kff.org/report-section/medicaid-and-chip-eligibility-enrollment-and-cost-sharing-policies-as-of-january-2020-findings-from-a-50-state-survey-tables/.

Table 3: Eligibility System Comparison*

STATE	Share of Applications Submitted Online	Go Paperless and Receive Notices Electronically	Reasonable Compatibility Standard at 10%	Share of Determinations Completed in Real-Time					Account for Reasonably Anticipated Changes in Income	Account for Projected Annual Income for Remainder of Calendar Year	Proactively Update Address Information for Enrollees
				<25 %	25%-50%	50%-75%	75%-90%	>90 %			
TOTAL	**55%**	**32**	**25**	**21**	**11**	**5**	**6**	**3**	**34**	**11**	**10**
Alabama	40%		10%				Y		Y		Y
Alaska	9%		10%						Y	Y	
Arizona	72%	Y	None		Y				Y		
Arkansas	Not reported		10%			Y			Y		
California	36%	Y	None	Y					Y	Y	
Colorado	36%	Y	10%		Y				Y	Y	Y
Connecticut	27%	Y	10%					Y			Y
Delaware	64%	Y	10%	Y					Y	Not Reported	Not Reported
Florida	90%	Y	10%				Y		Y		
Georgia	Not reported	Y	None		Y						
Hawaii	60%	Y	10%	Y					Y		Y
Idaho	30%		None		Y				Y	Y	Y
Illinois	57%	Y	5%				Y		Y		Y
Indiana	89%		None	Y						Y	
Iowa	42%		10%	Y					Y		
Kansas	60%		20%	Y							
Kentucky	65%	Y	10%	Y							
Louisiana	57%		10%			Y			Y		Y
Maine	26%	Y	None		Y						
Maryland	100%	Y	10%	Y					Y		
Massachusetts	16%		10%			Y			Y		
Michigan	63%	Y	10%		Y				Y		
Minnesota	61%		10%		Y				Y		
Mississippi	18%		50%	Y					Y		
Missouri	69%		$50		Y				Y	Y	
Montana	25%	Y	10%	Y					Y		
Nebraska	48%	Y	10%	Y					Y		
Nevada	30-40%	Y	None	Y					Y		
New Hampshire	90%	Y	10%	Y					Y		
New Jersey	51%	Y	10%	Y					Y	Y	Y
New Mexico	65%		None				Y		Y		
New York	95%	Y	10%					Y	Y	Y	Y
North Carolina	6%		None	Y							
North Dakota	25%	Y	None	Y					Y		
Ohio	Not reported		5%	Y							
Oklahoma	89%	Y	5%					Y	Y		
Oregon	Not reported	Y	10%			Y			Y		
Pennsylvania	54%	Y	5%	Y					Y		
Rhode Island	Not reported	Y	10%				Y			Not Reported	
South Carolina	Not reported		Not reported						Not Reported	Not Reported	Not Reported
South Dakota	10%		None						Y		
Tennessee	55%	Y	10%	Y							Y
Texas	90%	Y	None							Y	
Utah	66%	Y	None	Y					Y		
Vermont	62%		None			Y					
Virginia	Not reported	Y	10%		Y						
Washington	Not reported	Y	None				Y		Y	Y	
West Virginia	48%	Y	10%	Y						Y	
Wisconsin	42%	Y	None		Y						
Wyoming	20%	Y	None		Y				Y		

**Table was created using various data retrieved from the KFF Survey, including tables 5, 6, 7, 8, 9 and 11.*

Looking at the process of eligibility determinations, Ohio can borrow insights for improvement from several states. Out of the nine states that complete more than 75 percent of eligibility determinations in real-time, the majority accept applications submitted online and have a reasonable compatibility standard of 10 percent. It's worthy to note that all states are required to have an online application, but many states do not report this information, publicly. Reasonable compatibility means that when verifying income, state Medicaid agencies can compare the attestations clients make on their applications and renewal forms to available electronic data. The attestation and data sources are considered "reasonably compatible" if they are both below, at, or above the eligibility threshold, even if the amount of income in the attestation is different from the amount in the electronic data source.

Under reasonable compatibility, states can require documentation only when the difference between the attestation and data source affects eligibility, meaning the percentage listed above represents the level of tolerance for variation if the data source shows income above eligibility levels.[24] However, some states treat attestation above the eligibility threshold with a presumption of ineligibility and thus request documentation. Reasonable compatibility only applies when the attestation is below the eligibility threshold and the data source is above the threshold, but within the reasonable compatibility standard established by the state. Ohio's current standard is 5 percent, though the public emergency declaration has allowed Ohio's standard to be set to 15 percent until the emergency ends.[25] In Ohio, the state conducts data matches between annual renewal periods, which is not unusual. However, with the standard of 5 percent, this matching between eligible periods can affect the number of times eligible individuals are contacted and matching may not achieve consistent results due to address changes, mailing difficulties, etc.

Additionally, seven of the nine states with the highest quintile in real-time completions account for reasonably anticipated changes in income and are more likely to project annual income and proactively update address information when compared to the lowest quintile of states. To explain, reasonably anticipated changes mean that the state can elect to identify types of income based on predictability of work (like seasonality of position), future income (like household composition) and are able to establish a method for predicting that future income (using proration). These data points can come from multiple sources, including other, existing eligibility systems, but can include a prior year's tax return, a signed contract for employment or documentation showing a history of a person's income. If a person's historical information shows a pattern of income changes that cannot be established through electronic sources or paper documentation, states may accept self-attestation.[26]

Beyond this data, there are themes from other states which provide additional context:

Table 4: Experiences from Other States

[24] Jennifer Wagner, "Reasonable Compatibility Policy Presents an Opportunity to Streamline Medicaid Determinations," Center on Budget and Policy Priorities, October 11, 2017, https://www.cbpp.org/research/reasonable-compatibility-policy-presents-an-opportunity-to-streamline-medicaid.

[25] "Medicaid and CHIP Disaster Relief MAGI-Based Verification Plan Addendum." The Ohio Department of Medicaid, 1AD. https://www.medicaid.gov/medicaid/eligibility/downloads/ohio-disaster-addendum.pdf.

[26] MAGI 2.0: Building MAGI Knowledge. (2016, September 1). Retrieved September 28, 2020, from https://www.medicaid.gov/state-resource-center/mac-learning-collaboratives/downloads/part-2-income.pdf.

State	Lesson Learned
Arkansas	While work requirements drove some disenrollment in the state's Medicaid program, the determination process, renewals and applications, automatically disenrolled individuals if any mail is returned as undeliverable, primarily affecting transient populations such as the housing insecure and college enrollees.[1]
Idaho	Idaho saw broad disenrollment of children in its Medicaid program, but was the first state to directly attribute the disenrollment to the program integrity policies of CMS.[2]
Louisiana	An upgraded eligibility system automatically disenrolled individuals after the implementation of quarterly eligibility checks which required income verification. While the automated function was discontinued, the frequency of checks has led to increased call volume and lapses in coverage. Louisiana still auto-terminates for returned mail.[3]
Minnesota	Disenrollment was experienced as a result of the federal program integrity requirements wherein individuals had to verify their assets through form-based verification system or be auto-disenrolled.[4]
Missouri	Of the 70,000 individuals who lost coverage in 2018, 60 percent lost that coverage due to failure to return a mailed renewal form.[5]
Tennessee	220,000 children lost coverage after the state restarted renewals after a period of suspension as it migrated to an automated redeterminations system.[6]
Texas	Texas has a system of frequent income checks for households with children which require families to respond to state issued letters within ten days of sending. Estimates show this process of paper-based renewals with high frequency of income checks lead 50,000 children to lose coverage each year.[7]

Thematically, the issues which led to disenrollment in these states include a reliance on a mail-based system of asset confirmation, automation oriented towards disenrollment rather than continuance, and CMS' increased program integrity efforts as an underlying characteristic to the renewal process. Considering the previously identified relationship between states with higher real-time completions to automated address updating, it becomes clear that accurate address information is a key factor in continuity. Additionally, periodic data checks with the mail and short timeframe to reply seem to lead to disenrollment. Ohio is a state that does periodic data checks and while there is 12-month continuous eligibility for kids, the same is not the case for adults which the evidence suggests can impact Children's coverage. Ohio should audit its own practices in these areas to ensure eligible children stay connected to health coverage.

INTERVIEW RESULTS

To supplement the research of this report, interviews were conducted with experts in the field to identify the systemic factors that influence Ohio's experience in Medicaid enrollment. A total of 11 interviews were conducted in June and July 2020, with individuals representing government, policy advocacy and provider organizations, both in Ohio and on a national level. As interviews were conducted confidentially, there is no attribution provided. Additionally, given the diversity of the responses, researchers have organized the feedback into several areas, synthesizing comments into narrative form.

The following represents the results of that process and should be considered individual, anecdotal representations of the issues addressed in this research and not the opinion of the Center for Community Solutions nor the views of the employers of interviewees.

Part I. Shifting eligibility standards from Patient Protection and Affordable Care Act (ACA) while changing eligibility systems created disruption and confusion when the system started in 2014 and issues evolved through 2018

At the same time the ACA created and required use of the new Modified Adjusted Gross Income (MAGI) standard to determine Medicaid eligibility, Ohio's Client Registry Information System Enhanced (CRIS-E) system was being replaced by the Ohio Benefits Worker Portal (OBWP). [27] According to some case managers, emphasis was placed on enrollment over ensuring data availability for processing determinations and, as a result, there was duplication of individuals determined eligible. This was exacerbated by several issues including the case increase due to the opioid use disorder epidemic and the utilization of presumptive eligibility, requiring data integration across multiple systems, specifically that of the provider payment portal, the Medicaid Information Technology System (MITS). Additionally, guidance/instruction for families regarding reportable information was confusing and difficult to navigate, making it hard for enrollees to understand what they need to do in the eligibility process and at what frequency they needed to engage with the system. Local eligibility workers also seemed to have

[27] "Eligibility," Medicaid, accessed September 3, 2020, https://www.medicaid.gov/medicaid/eligibility/index.html.

a difficult time navigating the transition as they seemed to be unable to receive data from the state regarding county-level determination and caseload data.

Part II. Renewal process is fragmented and underperforming

Some national experts highlighted Ohio's inefficiency leveraging its ex-parte obligations to avoid the adjudication of renewal eligibility without the need for recipient intervention. Ohio seems to be an underperformer in this regard, not implementing the reasonable compatibility threshold for income efficiently, failing to use alternative eligibility information on behalf of recipients from programs like SNAP and being overly reliant on expensive and inaccurate contact protocols -- notably using traditional mail for renewal. Some national experts also highlighted the need for better alignment with SNAP and enabling managed care to assist in keeping member contact information current to facilitate renewals. Beyond the state, however, it seems increased federal scrutiny on eligibility created pressure on states to forego ex-parte processes in lieu of more direct intervention on the part of beneficiaries, creating hurdles for individuals as they sought to maintain coverage.

Part III. Improvement in the economy created confusion for parents

Eligibility for parents and children is different, and as parents' income increased, their ineligibility for Medicaid meant fewer children maintained coverage when their parents were unaware their children may still be eligible for the program. National and county-level data, combined with interviewee feedback confirmed this trend and noted concern that this could be an explicit violation of regulations, putting the state at risk. Eliminating navigator program funding by the Department of Health and Human Services led to confusion on the part of consumers, and strained case-management resources to prevent unnecessary coverage loss in Medicaid and the ACA's Health Insurance Marketplace.

Part IV. Eligibility system design, effectiveness and awareness

The Ohio Benefits eligibility system has created some efficiencies, but has also created challenges for beneficiaries, providers and county case managers. The online application is error-prone, difficult to navigate for customers and not mobile friendly. Case managers noted the document management system allows for more accessibility and reliability for necessary documentation, but communication between systems including the Job and Family Services (JFS) document imaging system and the child welfare system is not available – each is separate from Ohio Benefits. The increased use of the County Shared Services call center platform and the associated Interactive Voice Response (IVR) system has been helpful, though there are opportunities to expand its reach and align the experience over the phone with what is available in person.

On a local level, many caseworkers still do not know how to effectively navigate the new system or access all its components. County leaders identified variability in training, county to county, and were interested in more standardized training availability on the Ohio Benefits Worker Portal (OBWP), particularly in an online format. As a result, caseworkers are thankful for the standardized training currently being rolled out by JFS and ODM. There remain concerns, however, about the system's user experience on the beneficiary side, with concerns that consumers are not familiar with their benefits, how to achieve or retain them, and that literacy expectations, in health and computer contexts, are beyond many who rely on the system's effectiveness.

Part V. Miscellaneous concerns and suggestions

Caseworkers welcomed and appreciated shared service opportunities for counties. These efforts helped small and medium counties respond to emergencies and allocate local resources toward other emergent needs.

Most interviewees cited the importance of removing barriers to enrollment and reenrollment as being paramount to efficiency regardless of economic conditions. In fact, some caseworker interviewees cited the benefits of barrier removal afforded by COVID-19 and expressed support for 12-month continuous eligibility, more proactive outreach and support for community-based enrollment assistance beyond the period of the pandemic. Some others, on the state and national level, expressed concern over the chilling effect recent public charge regulation has had in some Ohio counties. This rule increased restrictions for some legal immigrants eligible for public benefits and there was an indication some eligible individuals were avoiding contact with agencies due to confusion about use of public benefits and how that would impact legal immigration status.

RECOMMENDATIONS

1. Maximize use of electronic resources and streamline processes

Other states, particularly those with higher shares of real-time determinations, have higher reasonable compatibility thresholds compared to Ohio, and the state should try to consider revising its established standard and the way it is implemented, operationally, using the higher standard authorized during the public emergency. This would also give the state more flexibility to conduct determinations by lowering the barriers for comparable data. In fact, the eligibility changes implemented during the public emergency have already accommodated significant increases in enrollment patterns for children, with over 75,000 children enrolling between March and September of 2020.[28] As such, the state should consider the impact of the policy flexibilities achieved through the emergency (like that of compatibility) and consider adoption, permanently, where possible.

The state should also review the way it processes determinations and minimize the need for direct, paper-based eligibility applications, attestations and renewals. Its worthwhile to note Ohio did receive an approval for ODM's State Plan Amendment to elect the reasonably predictable changes methodology for income. While this means Ohio is adopting a good practice from other states, Ohio could consider automating the process further and require less in regards to the current, document-based system of attestation. This could include, but is not limited to, going electronic where feasible by using recently verified information from other programs, like SNAP, before requesting it from beneficiaries.

2. Enhance county capacity with data, training and access

[28] "Ohio Department of Medicaid Demographic and Expenditure Dashboard." analytics.das.ohio.gov. The Ohio Department of Medicaid. Accessed October 16, 2020. https://analytics.das.ohio.gov/t/ODMPUB/views/MedicaidDemographicandExpenditure/WhoWeServe-Timeline?%3AisGuestRedirectFromVizportal=y .

Counties should be able to access data in regards to determinations and related processing time and the state should facilitate. This effort should be coupled with comparative data from other counties to help create an opportunity for learning and process improvement and involve addressing the data integrity issues that lead to case manager intervention. In particular, the state could develop performance standards relative to data-informed metrics for processing, and incentivize counties in achieving those benchmarks. This data process should include collecting timelier enrollment information, made publicly available, and a caseworker feedback mechanism to monitor trends closer to real time.

In addition to better performance data availability, the state should offer more training and education on Ohio Benefits, and its capabilities, generally. This should include creating and distributing a workflow diagram outlining the eligibility process for caseworkers. The state should also look to training staff around integration. While comments from interviewees indicated there was no interoperability between the child welfare system and Ohio Benefits, there is an available interface and it may just be a matter of awareness and effective utility.

Also, while the system is intended to connect more holistically to other systems in the state, county leaders described their frustration in these information management systems remaining separate. To remediate this, the state should look at ways to create better data integration and exchange between Ohio Benefits and other document and case management platforms; and to empower more caseworkers with permission rights to access those systems, though privacy restrictions and minimum necessary requirements may often prevent access. This could include, but is not limited to, procurement of new systems, particularly that of the document imaging system currently used by JFS, and a user-oriented design process that accommodates the needs of caseworkers relying on integration to be successful.

3. Focus on outreach and enrollment

Eliminating navigator program funding and the Ohio Benefit Bank network created additional pressure on counties and Ohio Benefits to more actively support those who struggle with the Medicaid enrollment and renewal process.[29] In addition to trying to reinstall these or similar networks of outreach workers, Ohio could work with the state's managed care plans and enable them to use the data they have to improve renewal rates, where allowed. This does not mean plans would adjudicate eligibility as much as conduct proactive outreach to assist in the renewal process. This should not, however, be prioritized over enabling trusted local organizations or individuals currently embedded in communities who could serve in a similar navigation role.

Regardless of mechanism, Ohio should conduct targeted outreach both for individuals affected by public charge regulations and parents. Even though Ohio does have continuing eligibility for children 12 months after their parents disenroll, they may not understand the impact that has on coverage for their children. In regards to individuals affected by public charge, Ohio could partner with trusted immigrant community partners to communicate eligibility information to people who are eligible, but have been deterred from participating. In regards to parents, Ohio could partner with early learning providers,

[29] Cahill, Rachel. "Ohio Community Groups Face Challenges Helping Needy Ohioans Navigate New Benefits System." The Center for Community Solutions, January 11, 2019. https://www.communitysolutions.com/research/ohio-community-groups-face-challenges-helping-needy-ohioans-navigate-new-ohio-benefits-system/ .

schools, Women, Infants, and Children (WIC) providers, and others, to efficiently refer families for eligibility renewals.

Lastly, Ohio's technological solutions should more actively contemplate the user experience in design. While the potential utility of the system is profound, caseworkers and beneficiaries often face difficulties navigating the system. In future procurement efforts, both inside and outside of Medicaid, Ohio should build in specific contractual obligations regarding user experience.

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