2018 Ohio Medicaid Group VIII Assessment:

A Follow-Up to the 2016 Ohio Medicaid Group VIII Assessment

August 2018

The Ohio Department of Medicaid

John R. Kasich, Governor Barbara R. Sears, Director

Executive Summary: The Ohio Medicaid 2018 Group VIII Assessment

a. What is the 2018 Ohio Medicaid Group VIII Assessment?

In 2015, the Ohio General Assembly required the Ohio Department of Medicaid (ODM) to provide a report evaluating the impact of Ohio's 2014 Medicaid expansion, facilitated by the Affordable Care Act (ACA). Guided by that request, ODM developed the Ohio Medicaid Group VIII Assessment, which examined how Medicaid expansion affected new enrollees with respect to access and utilization of healthcare, physical and mental health status, financial distress/hardship, and employment. The study found that new enrollees reported improved access to care, better management of chronic diseases and health risk factors, and improvements in self-rated health and economic stability. ODM delivered its report and methodological supplement to the General Assembly in December 2016.

The Ohio Medicaid 2018 Group VIII Assessment (2018 Group VIII) is a follow-up report commissioned by the Ohio Department of Medicaid. The 2018 Group VIII focuses on the following research themes and questions:

1. **Enrollment Patterns**: What are the enrollment patterns for Group VIII Enrollees?
2. **Population Characteristics**: Has the Ohio Medicaid Group VIII population remained stable in terms of size and demographic characteristics since the initial assessment?
3. **Employment:** Does Medicaid enrollment impact greater workforce participation?
4. **Financial Hardship**: To what extent does Medicaid enrollment translate into greater financial security?
5. **Health System Capacity and Access**: Is Medicaid provider capacity adequate to meet the needs of Group VIII enrollees? What are the key barriers to accessing needed healthcare services?
6. **Health System Utilization**: How have health care utilization patterns of Medicaid enrollees changed since the initial assessment?
7. **Physical Health**: Does Medicaid enrollment translate into improvements in physical health?
8. **Mental and Behavioral Health:** Does Medicaid enrollment translate into improvements in mental/behavioral health?
9. **Health Risk Behaviors:** Is enrollment in Medicaid associated with changes in unhealthy behaviors, such as smoking?
10. **Family Stability**: Does Medicaid enrollment promote family stability?

The phrase "Group VIII" refers to the section of the Social Security Act that sets requirements for Medicaid expansion eligibility which allowed most Ohioans age 19 through 64 with incomes at or below 138% of the federal poverty level (FPL) to become eligible for Medicaid. Prior to January 1, 2014, Medicaid eligibility for adults was limited to those with certain qualifying characteristics such as parenthood or disability, and the income limitation for most Medicaid eligibility groups was at or below 90% of the FPL.

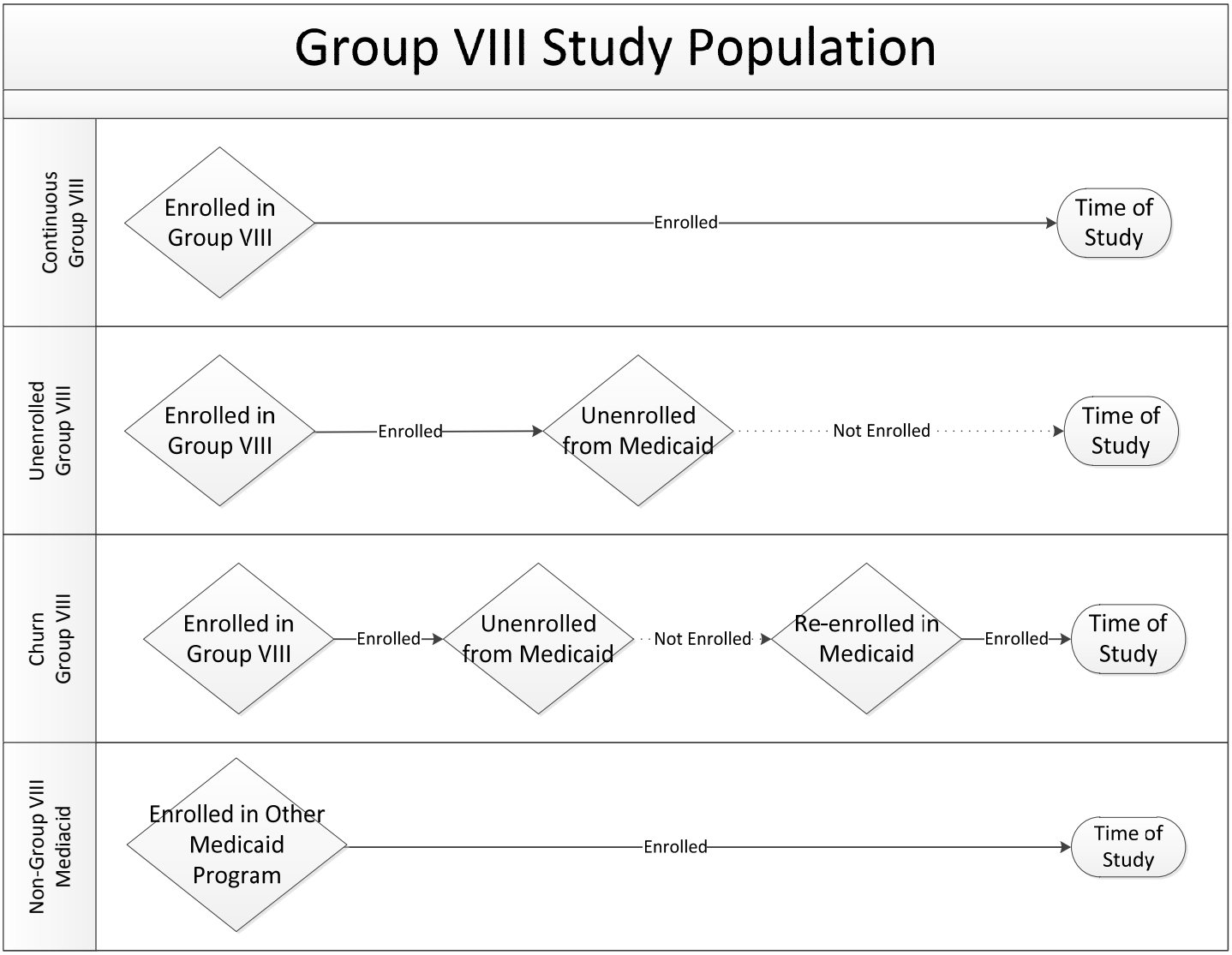
b. Who is Included in the 2018 Ohio Medicaid Group VIII Assessment?

Administrative data from ODM were used to identify study eligible persons with study participants being selected by stratified random sampling techniques. To enable comparisons between different populations, the study examined four different groups:

1) Those continuously enrolled in Group VIII (Continuous Group VIII);
2) Prior Group VIII enrollees no longer enrolled in Medicaid (Unenrolled Group VIII);
3) Those who were enrolled, unenrolled, and re-enrolled in Group VIII (Churn Group VIII); and
4) Those continuously enrolled under pre-ACA Medicaid eligibility criteria (Non-Group VIII Medicaid enrollees).

To enable comparisons, the study excluded those enrolled as dual-eligible, enrolled in the Aged, Blind, and Disabled Medicaid Program, pregnant, or living in institutions. A full elaboration of how Medicaid enrollees were selected for inclusion in the study is included in the 2018 Ohio Medicaid Group VIII Assessment Methodology Report.

Figure 1: Ohio Medicaid 2018 Group VIII Assessment Subpopulations



c. How was the Ohio Medicaid Group VIII Assessment Conducted?

Similar to the 2016 study, the 2018 Ohio Medicaid Group VIII Assessment is one of the nation's most comprehensive assessments of a state's ACA-associated Medicaid expansion. The assessment used the following methods to collect data:

- An analysis of Medicaid administrative data for all individuals who *ever enrolled* in Group VIII who participate in the program for at least 30 days, including individuals who had previously participated in other Medicaid programs (N= 1,263,038 Group VIII enrollees) – the review of administrative data was used to calculate enrollment trajectories, outside insurance status, and healthcare utilization;

- A detailed telephone survey of 5,867 Group VIII and Non-Group VIII Medicaid enrollees, including questions about the connections between enrollment status and access to care, health system utilization, physical and mental health, financial hardship, and employment;

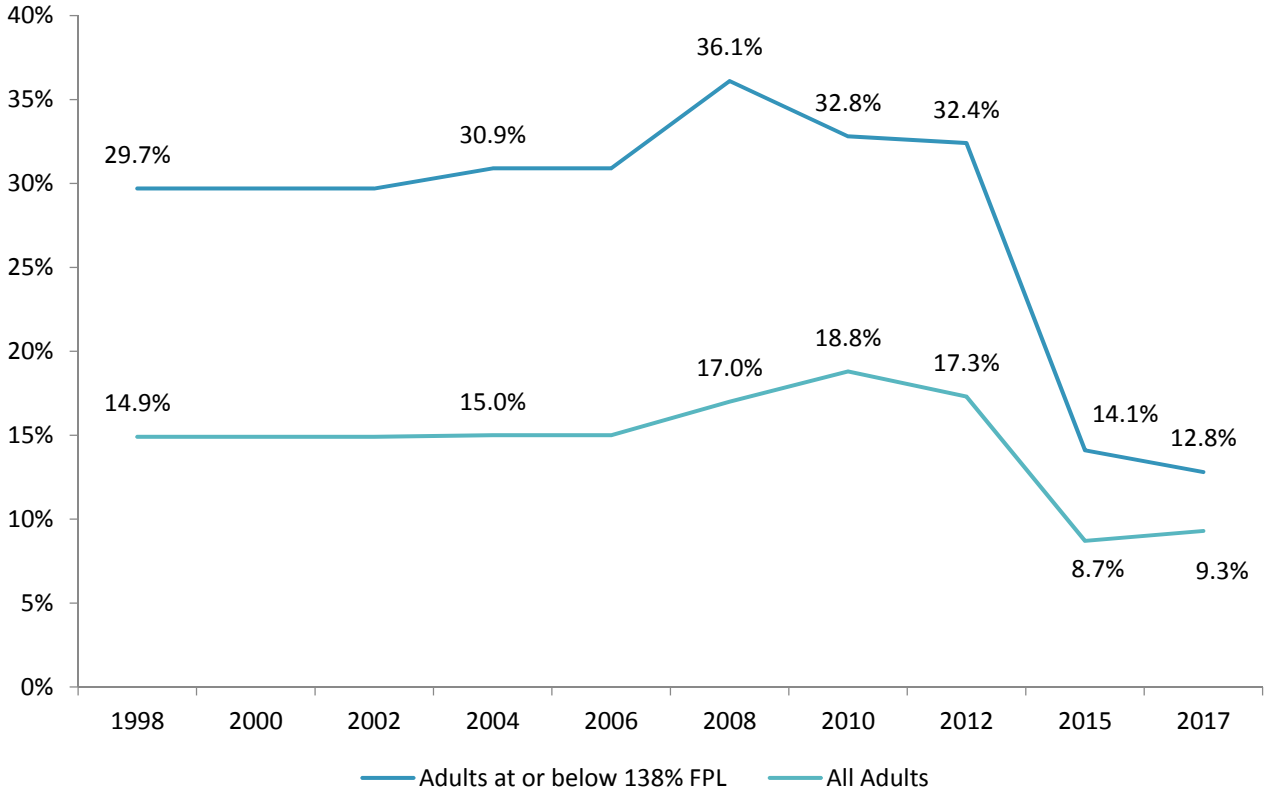
- A biometric screening of 313 respondents who completed the telephone survey, limited to Group VIII enrollees – the biometric screenings allowed for the systematic collection of comprehensive and verifiable clinical health-related data; and

- Qualitative interviews of 25 sessions for independent Group VIII enrollees who participated in the telephone survey (some participants completed the biometric screening as well) – the semi-structured interviews were designed to obtain more in-depth interpretive information about Medicaid administrative data findings and survey responses at the individual level.

d. What are the Key Findings of the Ohio Medicaid 2018 Group VIII Assessment?

(Please note that all comparisons stated as differences are statistically significant at $p<0.05$.)

Figure 2: Percentage of Ohioans Ages 19-64 with Family Income at or Below 138% Federal Poverty Level (FPL) who are Uninsured: 1998-2017



Source: Ohio Medicaid Assessment Survey Series (data collection years 1998, 2004, 2008, 2010, 2012, 2015, 2017)
Ohio's Group VIII Medicaid expansion began in 2014.
The Ohio Medicaid Assessment Survey was known as the Ohio Family Health Survey until 2010
Data collection periods not standardized by year

Enrollment Patterns (Section II of the Report)

1. Almost one fifth (17.5%) of Ohioans age 19-64 have participated in the Group VIII program since it began in 2014 (more than 1.26 million individuals).
2. About half (52.5%) of individuals who enrolled in Group VIII since 2014 were enrolled as of November 2017 – only one third (37.3%) of Group VIII have maintained continuous coverage since initial enrollment.
3. Medicaid expansion impacts Ohio's declining uninsured rate (12.8%) for low-income Ohioans ages 19 to 64 – in 2017 70.2% of Ohio adults 19-64 years of age participated in the workforce, full- and part-time.
4. The most common reported reasons why Group VIII enrollees unenrolled from Medicaid were that: 1) household income increased or the respondent got a job (71.1%); and 2) the respondent obtained non-Medicaid health coverage (48.8%) (*see Figure 4 on page 15*).
5. Many participants in the 2018 Group VIII Assessment were unaware of their Medicaid coverage status: 1) only 44.0% of Unenrolled Group VIII knew that they had lost Medicaid coverage; and 2) only 36.0% of Churn Group VIII were aware they had experienced a coverage gap (*see Figure 5 on page 16*).
6. In November 2017, 34 of Ohio's 88 counties had at least 10% of adults ages 19 to 64 covered by Medicaid expansion. These counties included almost every county in Appalachian Ohio and all major metropolitan counties except Franklin County (*see Map 1 on page 11*).
7. From January 2014 through November 2017, 74 Ohio counties (84.1%) had more than 10% of adults ages 19 to 64-year-old population ever enrolled in Medicaid expansion (*see Map 2 on page 12*). For 44 Ohio counties, 17% or more of their 19 to 64 year old population has been covered at some point in time through Medicaid expansion. These counties include all but 3 of Ohio's Appalachian counties, most of north Central Ohio counties, Preble County, and all urban counties, except for Franklin County.

Population Characteristics (Section III of the Report)

1. As found in the 2016 Group VIII Assessment, the Continuous Group VIII were more likely to be older, white, and male than the Non-Group VIII Medicaid enrollees (*see Table 1 on page 17* & *Table 2 on page 18*).
2. In comparison to Continuous Group VIII enrollees in 2016, the 2018 Continuous Group VIII were more likely to be younger, white, female, and have children (*see Figure 6 on page 19*).
3. Unenrolled Group VIII were younger and were more likely to be employed than those who were continuously enrolled (*see Table 1 on page 17*).
4. Churn Group VIII were younger but were slightly more likely to have chronic conditions than those who remained continuously enrolled (*see Table 3 on page 20*).

Employment (Section IV of the Report)

1. Approximately half of Continuous Group VIII (49.6%) reported being employed, compared to 43.2% in 2016 – a 6.4 percentage point increase (*see Figure 8 on page 22*).
2. A large majority of employed Group VIII enrollees (83.5%) reported that Medicaid made it easier to work; most unemployed enrollees (60.0%) reported that Medicaid made it easier to look for work (*see Figure 7 on page 21*).
3. Many Group VIII enrollees reported that Medicaid made it easier to work because they were able to obtain care for previously untreated health conditions. In the words of one enrollee: *"[Medicaid] allows me to get surgery which has allowed me to return to work."*

4. Most (93.8%) Continuous Group VIII were either employed, in school, taking care of family members, participating in an alcohol and drug treatment program, or dealing with intensive physical health or mental health illness (many had comorbid conditions).
5. Unenrolled Group VIII were more likely than Continuous Group VIII to be employed (62.3% vs. 49.6%) (*see Table 1 on page 17*).
6. Churn Group VIII were employed at nearly identical rates to Continuous Group VIII (*see Table 1 on page 17* & *Table 2 on page 18*).

Financial Hardship (Section V of the Report)

1. Nearly half of the Continuous Group VIII reported strained family budgets (47.8%) and housing instability (49.8%) during the past two years, similar to the 2016 Group VIII Assessment findings (*see Figure 11 on page 26*).
2. Continuous Group VIII were almost four times as likely (29.8%) to say that their financial situation had improved (e.g. paying for groceries, housing, and paying down debt) since enrolling in Medicaid than that their financial situation had worsened (7.7%) (*see Figure 12 on page 27*).
3. Continuous Group VIII were less likely to have medical debt than Unenrolled Group VIII (29.5% vs. 43.7%) (*see Figure 13 on page 28*).
4. Use of SNAP (food stamps) in the last twelve months was much less common among Continuous (48.5%) and Unenrolled Group VIII (31.6%) than among Non-Group VIII Medicaid enrollees (73.8%) (*see Figure 14 on page 29*).

Provider Capacity and Access to Care (Section VI of the Report)

1. The percentage of working age Medicaid enrollees (including Group VIII enrollees and participants in other Medicaid programs) with at least one primary care visit increased from 60.3% in 2013 to 64.5% in 2017 – a 4.2 percentage point increase (*see Figure 16 on page 33*).
2. The percentage of working age Medicaid enrollees receiving a primary care visit has remained level for the past two years (calendar years 2016 and 2017). This period of stability follows a three-year period where primary care access increased in all regions (*see Figure 16 on page 33*).
3. Rural and Appalachian regions had the highest primary care visit level for enrollees (*see Figure 16 on page 33*).
4. Provider participation in the Medicaid program continued to increase to meet higher health services demand. This growth was driven by increases in the number of participating Advance Practice Nurse Practitioners (APNPs) (53.4% increase from 2013 to 2017) and Physician Assistants (PAs) (95.8% increase from 2013 to 2017) (*see Figure 15 on page 30*).
5. Unenrolled Group VIII were considerably more likely than Continuous to report problems accessing at least one type of needed care than those who remained continuously enrolled (55.4% vs. 37.5%) (*see Figure 18 on page 35*).
6. From the 2017 Ohio Medicaid Assessment Survey, privately insured individuals at or below 138% FPL were equally likely to avoid obtaining needed health care as the Group VIII enrolled (31.7% versus 29.5%) – comparatively, the uninsured at or below 138% FPL were significantly more likely to avoid needed care (41.0%).

Health System Utilization (Section VII of the Report)

1. Most of the Continuous Group VIII enrollees in the 2018 telephone survey who reported having a chronic condition were receiving treatment for that condition (73.2% for hypertension, 66.2% for high cholesterol, and 85.8% for diabetes) (*see Figure 22 on page 40*).
2. Use of primary care as a usual source of care has increased. Most (78.7%) Continuous Group VIII reported having a *non*-emergency department usual source of care in 2018, an increase from 71.2% in 2016 (*see Figure 20 on page 38*).
3. As duration of enrollment increased, Group VIII enrollees' emergency department utilization declined (16.8% decline after two years since onset of enrollment according to Medicaid administrative data) (*see Figure 21 on page 39*).

Physical and Mental Health, and Health Risk Behaviors (Section VIII of the Report)

A. Physical Health

1. 30.6% of Continuous Group VIII reported that their physical health had improved since enrolling in Medicaid, compared to 9.5% who reported that their health was worse, and 59.3% who reported that their health was the same (*see Figure 23 on page 41*).
2. When asked what Medicaid meant to them, 35.7% of survey respondents specifically mentioned either their health or access to care. In the words of one respondent: "If it wasn't for Medicaid, I would not have been able to pay for surgery that was needed for a heart condition I was born with."
3. Almost one-third (28.3%) of Unenrolled Group VIII dropped Medicaid coverage because their health had improved or because they no longer thought they needed coverage (includes Unenrolled Group VIII who were aware that their coverage had ended).
4. Among Churn Group VIII, 25.7% cited declining health as a reason for reenrolling in Medicaid (includes Churn Group VIII who were aware of having had a coverage gap).

B. Mental Health

1. Continuous Group VIII were 3.4 times as likely to report that their mental health had improved since enrolling on Medicaid, compared to those reporting that it had worsened (*see Figure 24 on page 43*).
2. Around 1 in 4 (24.6%) individuals in the Continuous Group VIII, Churn, and Non-Group VIII Medicaid groups screened positive for depression, while the Unenrolled Group had lower rates (17.4%).
3. Continuous Group VIII enrollees who met screening criteria for depression and anxiety were significantly less likely to report being employed (26.9% versus 60.7%).
4. More than half (51.2%) of Unenrolled Group VIII who met screening criteria for anxiety or depression reported difficulties obtaining needed prescriptions, compared to less than one-fourth (22.1%) of the Continuous Group VIII who met such screening criteria.
5. The majority of Continuous Group VIII enrollees with depression or anxiety (84.3%) reported that access to mental health treatment was "not a problem".

C. Health Risk Behaviors

1. More than one third (37.0%) of Group VIII enrollees who quit smoking in the last two years said that Medicaid helped them to quit. This translates to approximately 26,000 Ohioans.

2. One in ten (9.8%) Group VIII enrollees received a primary diagnosis for any substance use disorder and 7.9% received a primary diagnosis for opioid use disorder in 2017. The majority (64.1%) of those diagnosed with OUD filled at least one prescription for medication-assisted treatment, and 85.8% received psychosocial treatment.
3. Obtaining behavioral health care made a significant difference in the lives of many enrollees with substance use disorder. In the words of one respondent: "[Medicaid] means a lot, it means I can get help with my addiction, gets me the counseling I need. If I didn't have it I would probably end up back in jail."
4. A small percentage (7.4%) of Continuous Group VIII reported having misused pain medications in the past, although the majority of those who did (60.0%) said that such misuse had occurred more than one year ago. (Note that misuse is not necessarily *abused*, defined as the habitual taking of addictive or illegal drugs.)
5. About one in five (18.2%) Continuous Group VIII reported that they drank more than four alcoholic beverages in a single day in the last thirty days (compared to 15.5% for Non-Group VIII Medicaid, 19.7% for Churn, and 23.8% for Unenrolled; the differences between these groups are not significant).

Family Stability (Section IX of the Report)

1. A significant amount of Continuous Group VIII reported being a parent to a non-adult child in the household (29.5%), or the primary caregiver of a family member with mental or physical health issues (22.0%) (*see Figure 27 on page 47*).
2. More than three-fourths (75.7%) of Continuous Group VIII who are family caregivers reported that Medicaid made it easier for them to care for their family member(s), as did more than four-fifths of parents (81.6%) (*see Figure 28 on page 48*).
3. Continuous Group VIII who are parents were more likely to report that Medicaid made it easier to buy food and pay rent or a mortgage than non-parents (57.6% vs. 37.5%) (*see Figure 29 on page 49*).

e. Conclusions

1. Medicaid reduces the rate of uninsured in Ohio.

Since 2014, more than 1.26 million individuals have enrolled in Ohio Medicaid through the ACA-associated Medicaid expansion, nearly one-fifth (18.1%) of the Ohio population ages 19-64. Even though Ohio' s total uninsured rate for 19-64 year olds is now trending slightly upwards (9.3%, up from 8.7% in 2015), Medicaid expansion has dramatically reduced the uninsured rate among the lowest-income Ohioans.

2. Medicaid benefits the health of enrollees.

"SINCE I ENROLLED IN MEDICAID) I DON'T HAVE A LOT OF STRESS. I WAS DIAGNOSED WITH IRRITABLE BOWEL SYNDROME AND YOU CAN'T BE STRESSED WITH THAT!"
(RURAL SINGLE WORKING WHITE FEMALE IN HER 40S)

As found in the 2016, Group VIII Assessments, Medicaid enables low income Ohioans to access primary care for non-emergency conditions. In many cases, this leads to a diagnosis or treatment of previously undetected chronic diseases and more time sensitive treatment of non-emergency acute conditions. Many Group VIII enrolled respondents reported that their Medicaid coverage: 1) was perceived as potentially lifesaving; 2) facilitated a better state of wellness; 3) was beneficial to mental health; 4) enabled participation in preventive health and mental health services; 5) aided in relief of psychological distress related to health concerns and socioeconomic circumstances; and 6) fostered better life functioning (e.g., work, family participation, and community engagement).

3. Medicaid reduces costly Emergency Department (ED) visits and may reduce long-term costs.

After initial enrollment, Group VIII enrollees' utilization of Emergency Department (ED) services declined (16.8% decline after two years of enrollment compared to initial enrollment period) while primary care utilization increased, indicating a shift towards preventative, cost-effective care.

"BEFORE I HAD INSURANCE, I WOULD) JUST GO TO THE EMERGENCY ROOM AT THE HOSPITAL AND LET THEM BILL ME. SOMETIMES I WOULDN'T PAY THEM. I COULDN'T AFFORD IT."
(RURAL SINGLE DISABLED WHITE MALE IN HIS 50S)

4. Medicaid enrollment facilitates/enables employment.

In qualitative interviews and open-ended 2018 Group VIII Survey responses, a common theme was that Medicaid enrollment enabled access to treatment for debilitating conditions, thereby making it possible for enrollees to return to work or seek employment. It should be noted, however, that the ability to find work is mediated by local (geographically specific) economic conditions, particularly for those living in financially distressed counties and communities. For instance, the study found that many Medicaid enrollees who live in socioeconomically distressed counties (i.e., interior Appalachian counties) are less likely to find work and to leave Medicaid. Accordingly, these counties have a higher rate of Continuous Group VIII enrolled.

The study also found a strong association between the ability to work and one's mental health status. The 2018 Group VIII Survey found a strong association between meeting the screening criteria for depression/anxiety and being unemployed. By facilitating treatment for mental health, Medicaid removed barriers to employment readiness and employment retention – these results were cross-confirmed from responses to the 2018 Group VIII Survey and qualitative interview questions.

5. Ohio Medicaid 1115 Waiver on Work Requirements, 2018.

At the request of the Ohio General Assembly, the Ohio Department of Medicaid has applied for a Section 1115 waiver from the U.S. Department of Health and Human Services to implement work and community engagement requirements for Group VIII enrollees. This assessment finds that most (93.8%) Group VIII enrollees are currently either employed or meet one of the exception criteria noted in the Ohio Department of Medicaid's *Group VIII Work Requirement and Community Engagement 1115 Demonstration Waiver Application*.[i] Future Group VIII Assessments will be designed to evaluate the primary and secondary impacts of Medicaid expansion on work and community engagement.

6. Medicaid enrollment assists with access to care and lessened medical debt.

A minority of Continuous Group VIII enrollees reported difficulty accessing routine health care (37.5%) and having medical debt (29.5%). Comparatively, a larger percentage of Unenrolled Group VIII enrollees reported difficulty accessing care (55.4%) and having medical debt (43.7%).

"BEFORE I HAD MEDICAID] I'D AVOID [GOING TO THE DOCTOR] AS MUCH AS POSSIBLE. I'D ONLY GO IF I ABSOLUTELY HAD TO. THOSE AMBULANCE RIDES, THEY COST $6-700 IF NOT A THOUSAND. I DON'T HAVE THAT!"
(URBAN SINGLE DISABLED WHITE FEMALE IN HER 40S)

[i] * https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/oh/oh-work-requirement-community-engagement-pa.pdf

7. General findings from the qualitative interviews.

The qualitative interviews were conducted with a demographically and geographically diverse group of current and former enrollees and supported the main findings from the telephone survey and Medicaid administrative data findings. Nearly all respondents reported feeling relieved once they learned that they were enrolled in Medicaid, with some saying that Medicaid allowed them to seek care for conditions that they had previously ignored and others saying that Medicaid enabled them to avoid Emergency Department visits. Many respondents said that Medicaid made it easier to work and care for family members because they were able to get care for chronic and mental health conditions that enabled better physical and mental functioning.

8. General conclusion.

In general, Medicaid expansion has been beneficial to Ohio Group VIII enrollees by: 1) facilitating continued employment, new employment, and job-seeking; 2) increasing primary care and reducing emergency department use; 3) lessening medical debt and financial hardship; 4) improving mental health; 5) assisting in addressing unhealthy behaviors such as tobacco use; and 6) enabling enrollees to act as caregivers for family members. Compared to the 2016 Group VIII Assessment, a higher percentage of all Group VIII enrollees are now employed, access primary care providers, use emergency department services less, report better mental health, and are optimistic about their individual functioning.

9. How does Ohio compare? Literature considerations and other's findings.

An overall literature review from more than 60 recent peer-reviewed studies found that the 2018 Ohio Medicaid Group VIII Assessment results are similar to the consensus of research performed nationally and regionally relating to Medicaid expansion. Comparatively, this assessment of Ohio's ACA-associated Medicaid expansion more inclusively addresses the overall health and wellbeing of Group VIII enrollees. All studies have shown significant benefits accruing to people living in Medicaid expansion states compared to similar people living in non-Medicaid expansion states, with no negative effects – in all instances the benefit generally gets stronger over time[ii,iii]. Notable benefits include:

- Greater access to health care accompanied by reduced delays to getting care[iv]
- Lessening of unmet health care needs[v]
- Improved health status[vi]
- An increase in people getting preventive care[vii]

[ii] Larisa Antonissse, Rachel Garfield, Robin Rudowitz and Samantha Artiga. (2018) The Effects of Medicaid Expansion Under the ACA: Updating Findings From A Literature Review. Henry J. Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-march-2018/

[iii] Olena Mazurenko, Casey P. Bailo, Rajnder Agarwal, Aarong E. Carroll and Nir Menachemi. (2018). The Effects of Medicaid Expansion Under the ACA: A Systematic Review. *Health Affairs, 37*(6), 944-950.

[iv] Benjamin D. Sommers, Bethany Maylone, Robert Blendon, E. John Orav, Arnold Epstein (2017). Three-year Imapcts of the Affordable Care Act: Improved Medical Care and Health Among Low-Income Adults. *Health Affairs, 36*(6), 1119-112.

[v] Katherine Baicker, Heidi L. Allen, Bill J Wright, Sarah L. Taubmann and Amy N. Finelstein. Forthcoming. The Effect of Medicaid on Dental Care of Poor Adults: Evidence From the Oregon Health Insurance Experiment. *Health Services Research Journal,* 1-18.

[vi] Kosali Simon, Aparna Soni and John Cawley. (2017). The Impact of Health Insurance on Preventive Care and Health Behaviors: Evidence From the First Two Years of the ACA Medicaid Expansion. *Journal of Policy Analysis and Management, 36*(2), 390-417.

- Increased use of tobacco cessation services[viii]
- Increased use of mental health and drug addiction services[ix]
- Earlier detection of serious health care conditions, such as cancer[x]
- Reduced stress[xi]
- Improved financial stability[xii]
- Reductions in health disparities[xiii]
- An increase in employment, with less likelihood of unemployment because of a disability and a greater probability of working more than 30 hours per week[xiv].

These benefits are especially significant for people who have chronic conditions. The benefits are also more prevalent in states, like Ohio, that provide their population a more inclusive benefit package – covering more optional services such as adult dental, vision, mental, and special needs.

[vii] Hugo Torres, Elisabeth Portman, Uma Tadepalli, Cynthia Schoettler, Chin Ho Fung, Nicole Mushero, Laruen Campbell, Gaurab Basu and Danny McCormick. (2017). Coverage and Access for Americans With Chronic Disease Under the Affordable Care Act: A Quasi-Experimental Study. *Annals of Internal Medicine, 166*(7), 472-480.

[viii] Johanna Catherine Maclean, Micahel F. Pesko and Steven C. Hill. (2017). The Effect of Insurance Expansions on Smoking Cessation Medication Use: Evidence From Recent Medicaid Expansions. NBER Working Paper Series, Working Paper 23450 May 2017, revised September 2017 http://www.nber.org/papers/w23450.

[ix] Hefei Wen, Jason M. Hockenberry, Tyrone Borders and Benjamin G. Druss. (2017). Impact of Medicaid Expansion on Medicaid-covered Utilization of Buprenorphine for OUD Treatment. *Medical Care, 55*, 336-341.

[x] Aparna Soni, Kosali Simon, John Cawley, Linsday Sabik. (2018). Effect of Medicaid Expansions of 2014 on Overall and Early-Stage Cancer Diagnoses. *American Journal of Public Health, 108*(2), 216-218.

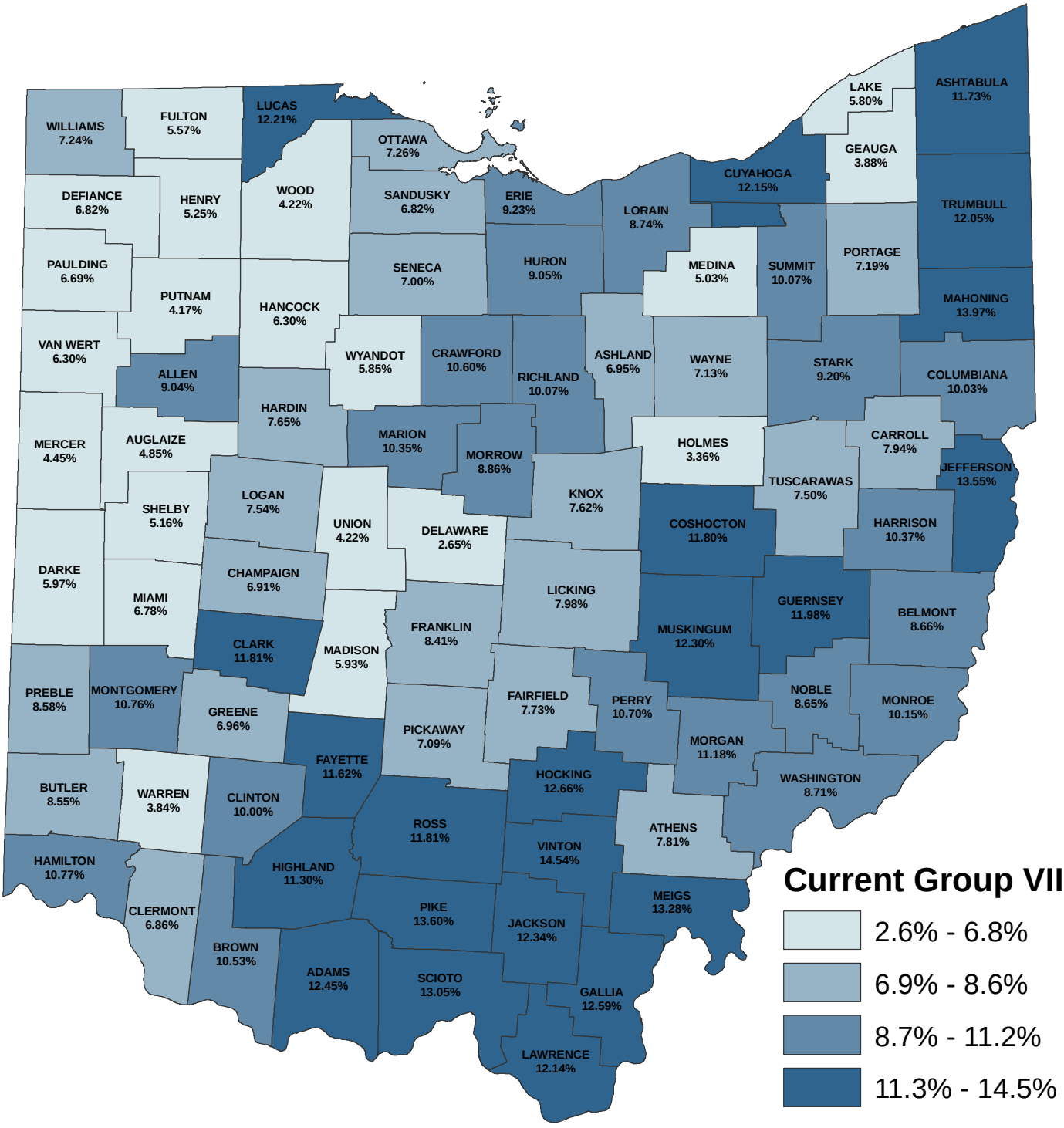
[xi] Kosali Simon, Aparna Soni and John Cawley. (2017). The Impact of Health Insurance on Preventive Care and Health Behaviors: Evidence From the First Two Years of the ACA Medicaid Expansion. *Journal of Policy Analysis and Management, 36*(2), 390-417.

[xii] Stacey McMorrow, Jason A. Gates, Sharon K. Long, Genevieve M. Kenney. (2017). Medicaid Expansion Increase Coverge, Improved Affordability and Reduce Psychological Distress for Low-Income Adults. *Health Affairs, 5,* 808-818.

[xiii] Charles Courtemanche, James Marton, Benjami Ukert, Aaron Yelowitz and Daniela Zapata. (2017). Early Impact of the Affordable Care Act on Health Insurance Coverage in Medicaid Expansion and Non-expansion States. *Journal of Policy Analysis and Management, 36*(1), 178-210.

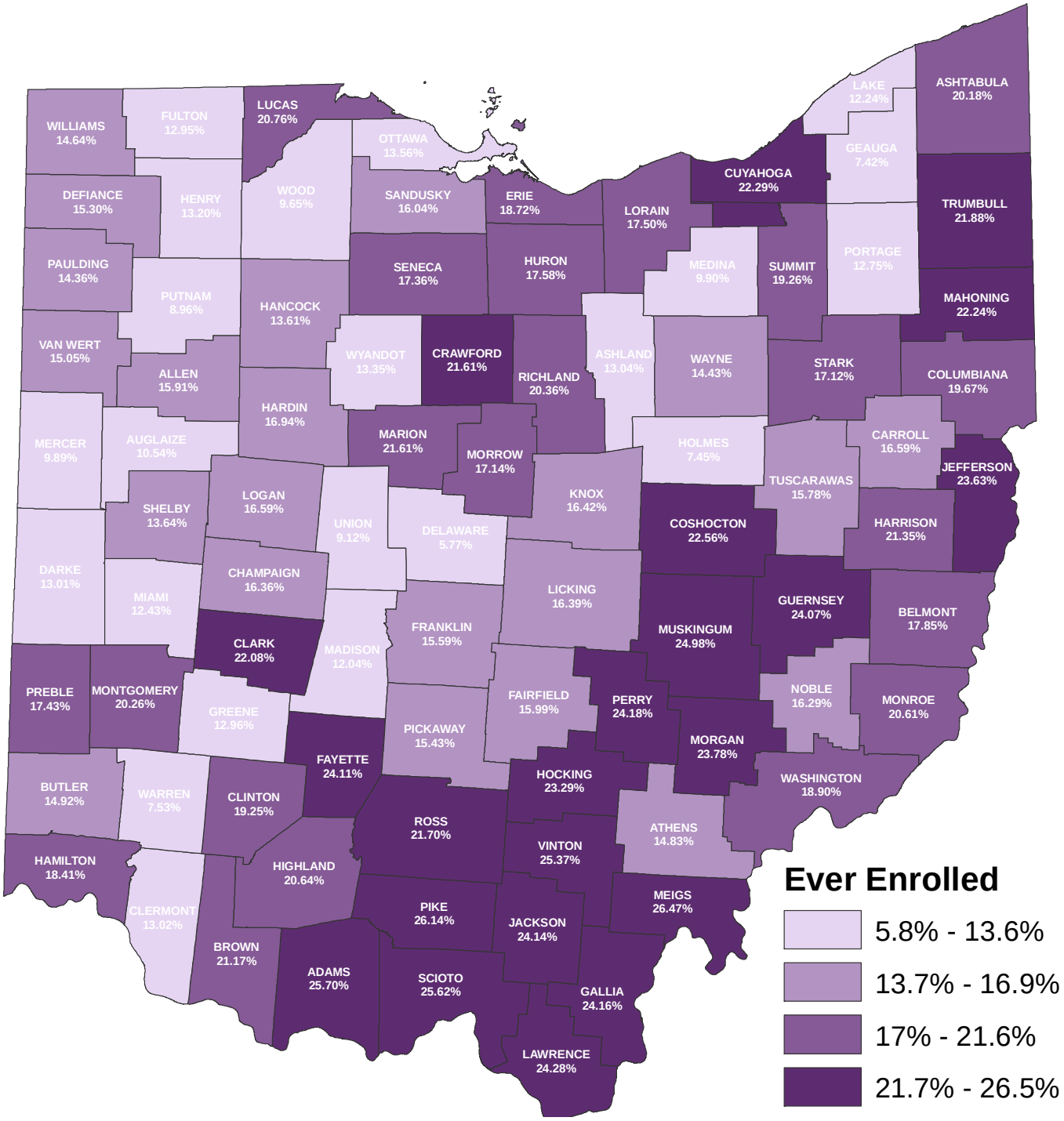
[xiv] Jean P. Hall, Adele Shartzer, Noelle K. Kurth and Kathleen C. Thomas. (2018). Effect of Medicaid Expansion on Workforce Participation For People with Disabilities. *American Journal of Public Health, 108*(2), 262-264.

Map 1: Percentage of All Adults Ages 19-64 Currently Enrolled in Group VIII by County, November 2017



Source: Medicaid Administrative Data
Enrollment Status as of November 30, 2017

Map 2: Percentage of All Adults Ages 19-64 Who Have Ever Enrolled (Since 2014) in Group VIII by County



Source: Medicaid Administrative Data
Enrollment Status as of November 30, 2017

I. Introduction and Background

The Ohio Medicaid 2018 Assessment is a follow-up to the 2016 Ohio Medicaid Assessment, which was commissioned by the Ohio General Assembly for the purpose of studying the effects of Ohio's Group VIII Medicaid expansion on new enrollees' access to care, health services utilization, physical and mental health, employment, and financial security. This study investigates whether Medicaid coverage continued to provide benefits for Group VIII enrollees, including greater access to care, better health, improved employment prospects, and stronger household finances. In addition, this study also covers topics not included in the 2016 study, including enrollment patterns for current and former Group VIII enrollees and the relationship between Medicaid and family stability.

The Ohio Medicaid 2018 Assessment used a different study design than the Ohio Medicaid 2016 Assessment. Whereas the 2016 study was limited to Continuous Group VIII and a Non-Group VIII Medicaid comparison group (referred to in that study as "Group VIII" and "Pre-expansion", respectively), the 2018 study added two additional groups: 1) Churn Group VIII, which included individuals who enrolled in Group VIII, had a coverage gap, and then re-enrolled in Medicaid; and 2) Unenrolled Group VIII, which included individuals who enrolled in Group VIII but then unenrolled and did not re-enroll in any Medicaid program.

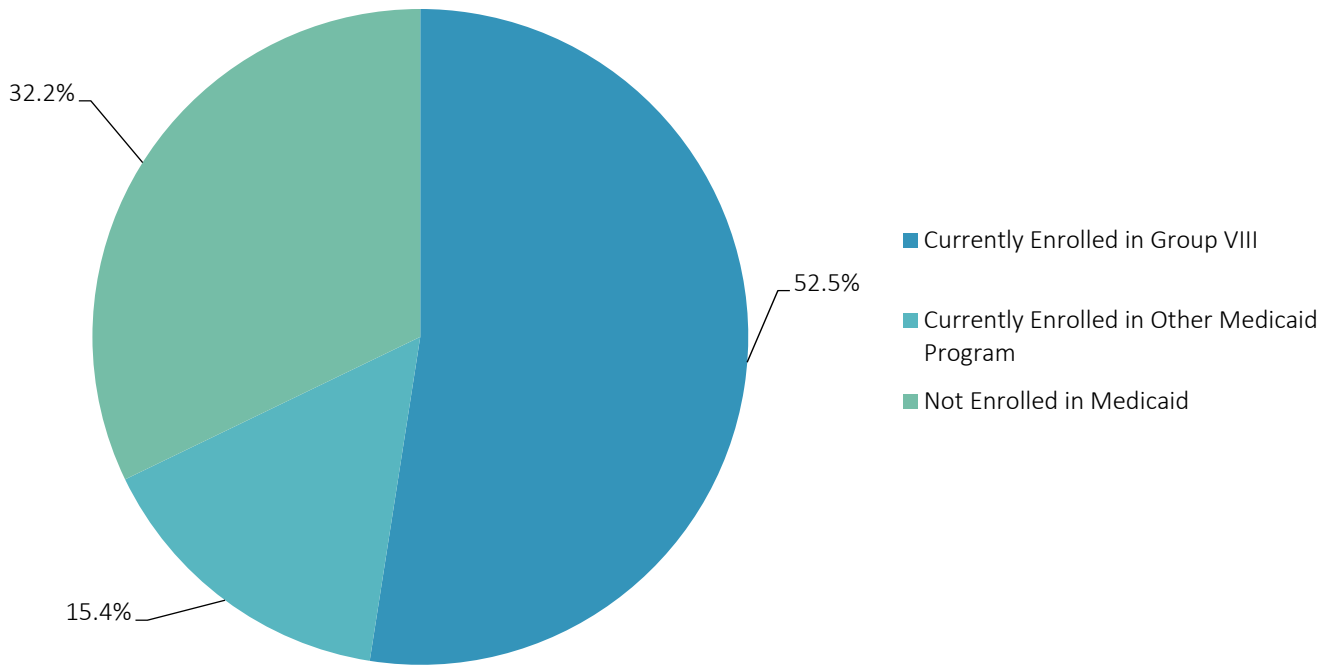
II. Enrollment Patterns

Participation in the Group VIII program is widespread. Since the onset of the program in 2014, more than 1.26 million Ohio Adults have enrolled. This equates to about 17.5% of Ohioans age 19-64[xv] enrolled at some point in the Group VIII expansion. On average, participation rates are higher in rural Appalachian (21.2% ever enrolling) and metropolitan counties (18.7%) than suburban (12.4%) and rural, non-Appalachian counties (15.5%) (see Map 1 and Map 2 in the Executive Summary). The county with the highest participation rate is Meigs County (26.5%), while Holmes County, which has a proportion of Amish residents who generally do not participate in the Medicaid program, has the lowest participation rate with 7.5% of adults ages 19-64 ever enrolling in the Group VIII expansion.

Although participation is widespread, Group VIII is a transitional program for most enrollees. Only about one third (37.5%) of individuals who ever enrolled have maintained continuous Group VIII coverage since initial enrollment. Of those who have ever enrolled in Group VIII, only about half (52.5%) are currently enrolled in the program, while 15.4% are enrolled in another Medicaid program such as the Aged, Blind and Disabled program or Medicaid for Pregnant Women, and 32.2% are not enrolled in any Medicaid program (Figure 3).

[xv] Population figure using the American Community Survey 2012-2016 5-year estimate.

Figure 3: All Adults Age 19-64 Ever Enrolled in Ohio Group VIII by Current Enrollment Status, 2014-2018



Source: Medicaid Administrative Data

What does having Medicaid mean to you?

"I was on unemployment, that's why I qualified for Medicaid. Now that I have a decent living wage, it's a lot better for me [since leaving Medicaid]."

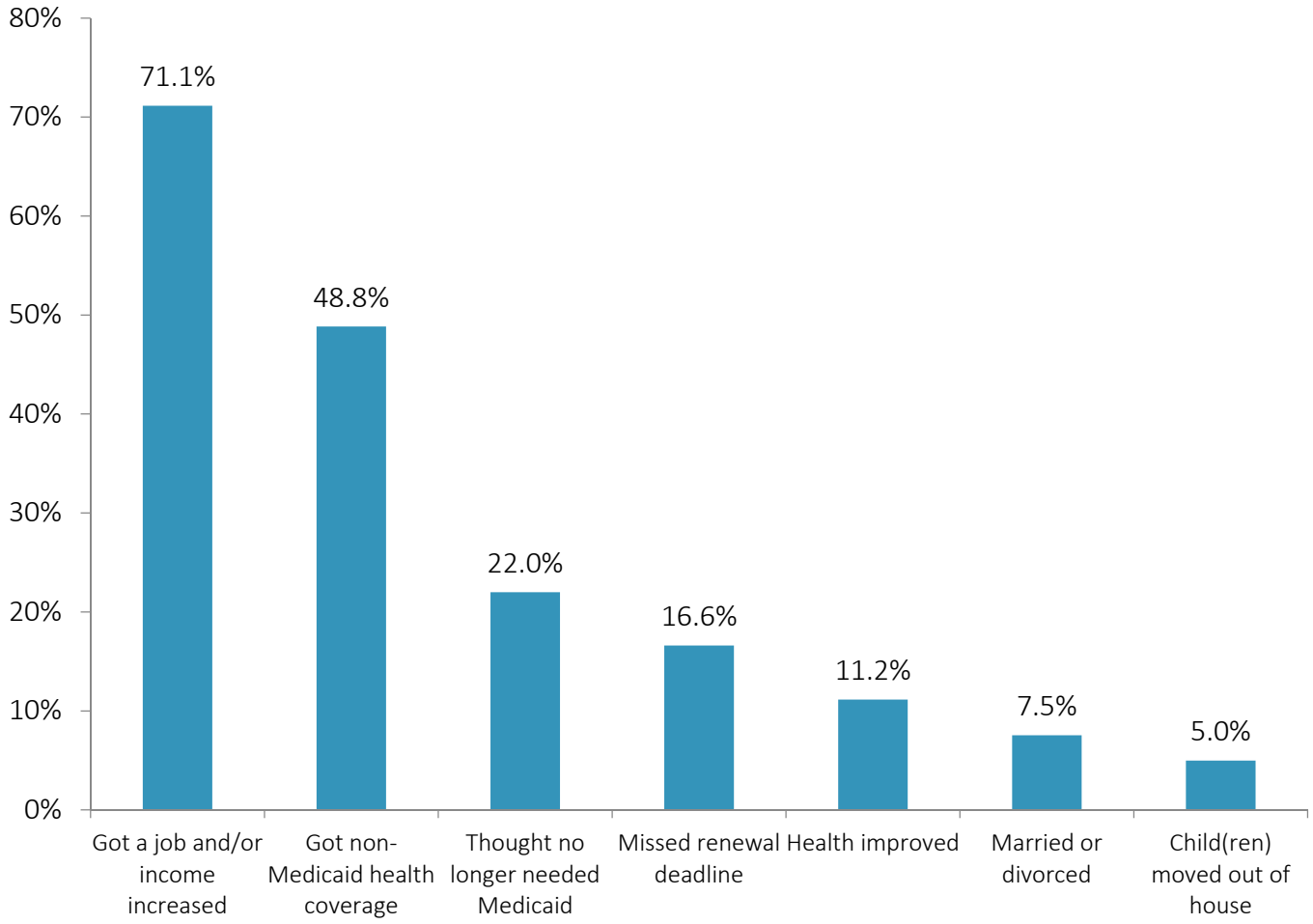
"[My situation since leaving Medicaid] has improved as far as being able to complete nursing school, get my license, and get a full time job with employer sponsored healthcare benefits."

"[Since leaving Medicaid] it has become easier because now I have a full time job."

Source: 2018 Group VIII Telephone Survey

For many enrollees, Group VIII is a stepping-stone towards greater economic self-sufficiency. When former enrollees who were aware that their coverage had ended were asked why they disenrolled from the program (44.0% of total Unenrolled Group VIII knew that their coverage had ended), a large majority stated that their family income had increased and/or the respondent got a job (71.1%). The next most frequently stated reason was that the respondent obtained non-Medicaid health coverage (48.8%). These responses were not exclusive: most (74.6%) individuals who reported leaving Medicaid because their income increased and/or they got a job also reported obtaining outside insurance. The next most common reasons given for leaving Medicaid was that coverage was no longer needed (22.0%), having missed the renewal deadline (16.6%), health improved (11.2%), marriage or divorce (7.5%), and children moving out of the household (5.0%). The last two reasons might affect coverage by changing household income levels or adjusting the calculations for eligibility. In general, former enrollees usually report leaving the program because their economic situation improved, their health care needs declined, or both.

Figure 4: Group VIII Unenrolled: Reasons for Unenrolling from Medicaid, 2018



Source: 2018 Group VIII Telephone Survey. Options are not mutually exclusive.

Just as Medicaid helps enrollees build economic self-sufficiency, it also serves as a safety net when families face economic hardship. When Group VIII enrollees with a coverage gap (Churn) were asked why they returned to Medicaid, more than half (54.4%) stated that they had lost a job and/or family income declined. By helping to buffer families against economic shocks, Medicaid allows enrollees to regain their economic footing. (For more on this please see section IV: Employment.)

Administrative complexity also contributes to changes or disruption in enrollment status. Enrollees must regularly recertify their enrollment, verify income, and verify place of residence. Enrollees may be unable to provide all supporting documentation in time or may only intermittently use health care services covered by Medicaid. Indeed, more than half (56.0%) of individuals who were unenrolled according to Medicaid administrative data reported still being enrolled in Medicaid when surveyed, and nearly two thirds (64.0%) of enrollees who had a recent coverage gap were unaware of that gap (Figure 5). Among the Churn group who were aware of having had an enrollment gap (36.0% of Churn Group VIII), more than one-third (37.7%) reported that this was due to missing the renewal deadline. This mismatch between individual perceptions, preferences, and enrollment records suggests an opportunity for greater enrollee education and outreach, and further improvements in program administration to enable more enrollment and renewal continuity.

What does having Medicaid mean to you?

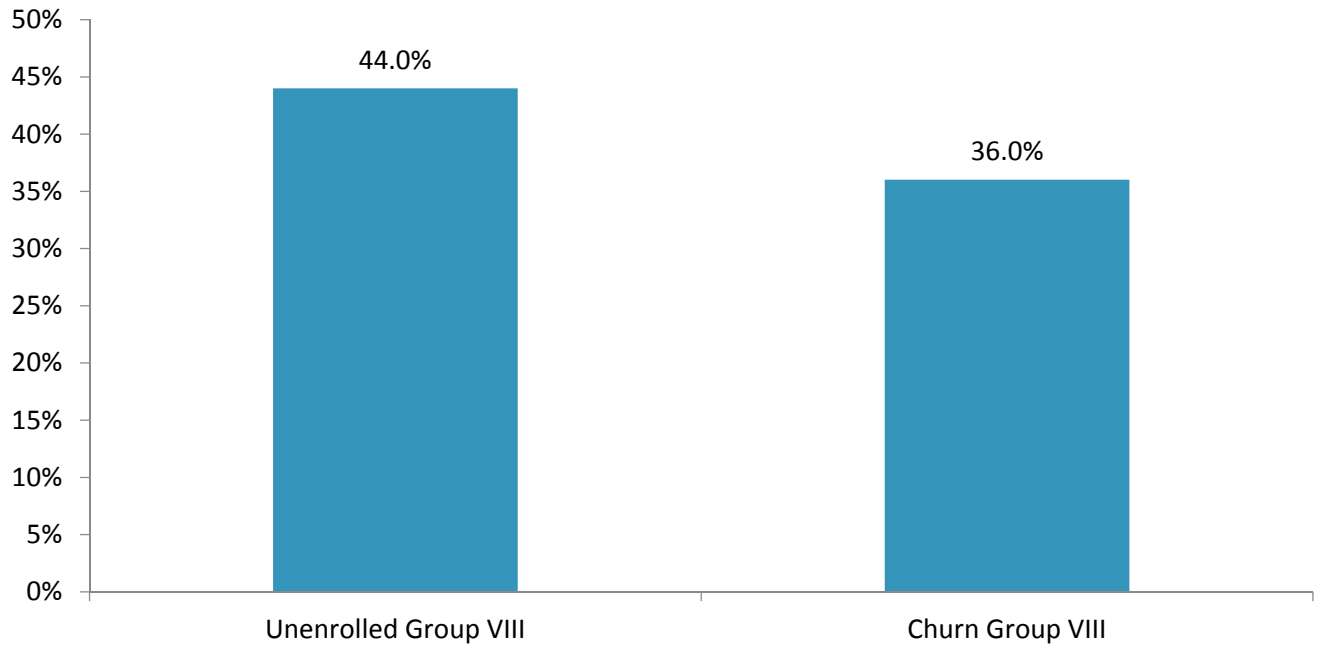
"Medicaid has helped me in my situation because when my lungs collapsed, I lost my job and I couldn't work, so when I got on the program it helped out tremendously"

"I guess [Medicaid] is alright but I'd rather pay my own medical one day, once I'm done with school and more doors open for me. I appreciate the help I am receiving, because I need it right now until I get on my feet."

"Medicaid enables me to have health care after I lost my job as I previously had healthcare through my job"

Source: 2018 Group VIII Telephone Survey

Figure 5: Percentage Aware of Having Lost Medicaid Coverage (Unenrolled Group VIII) or Having Experienced a Coverage Gap (Churn Group VIII) in the Last Year, 2018



Source: 2018 Group VIII Telephone Survey

III: Population Characteristics

As found in the 2016 Group VIII Assessment, Continuous Group VIII who completed the survey are more likely to be older, white, and male than Non-Group VIII Medicaid enrollees (Table 1). Compared to Continuous Group VIII, Unenrolled Group VIII are younger, more likely to be employed, more likely to be married, and more likely to have children.

Table 1: Demographic Characteristics of Continuous Group VIII, Unenrolled Group VIII, Churn Group VIII, and Non-Group VIII Medicaid, 2018 (Part 1)*

	Continuous Group VIII			Unenrolled Group VIII		
	Weighted %	Std. Err.	Unweighted N	Weighted %	Std. Err.	Unweighted N
Children in household	37.9%	0.015	588	43.4%	0.017	767
Marital Status						
married	20.5%	0.013	353	28.1%	0.016	511
divorced/separated	27.4%	0.013	518	23.2%	0.014	554
widowed	3.1%	0.004	75	3.7%	0.005	94
never married	41.9%	0.015	673	37.6%	0.017	751
member of an unmarried couple	6.8%	0.009	87	6.8%	0.009	126
Spouse/partner employed						
over entire survey population	14.0%	0.011	214	21.7%	0.014	382
over those with partners	51.2%	0.030	214	62.3%	0.029	382
Veteran	4.2%	0.007	71	4.6%	0.006	104
Educational attainment						
high school or less	60.5%	0.015	1,019	57.0%	0.017	1,140
some college	29.1%	0.014	515	30.3%	0.016	637
4-year degree or higher	10.1%	0.010	170	12.2%	0.011	263
Hispanic	2.8%	0.005	57	2.7%	0.006	58
Race						
white	84.1%	0.010	1,278	82.5%	0.012	1,527
black	11.5%	0.008	351	12.5%	0.009	451
other	4.4%	0.007	81	5.0%	0.009	76
Age						
19-44	62.2%	0.003	811	69.8%	0.004	1,087
45-64	37.8%	0.003	899	30.2%	0.004	967
Currently employed	49.6%	0.016	780	62.3%	0.016	1,151
Average household size	2.5	0.109	-	2.5	0.480	-
Respondent is a Caregiver	22.0%	0.014	370	14.8%	0.011	352

Source: 2018 Group VIII Telephone Survey

* The collected unadjusted counts for the 2018 Group VIII Assessment data strata are as follows: 1) The Continuous Group VIII count is 1,710; 2) the Unenrolled Group VIII count is 2,054; 3) the Churn Group VIII count is 1,153; and 4) Non-Group VIII Medicaid is 950. The total collected sample is 5,867.

Table 2: Demographic Characteristics of Continuous Group VIII, Unenrolled Group VIII, Churn Group VIII, and Non-Group VIII Medicaid, 2018 (Part 2)*

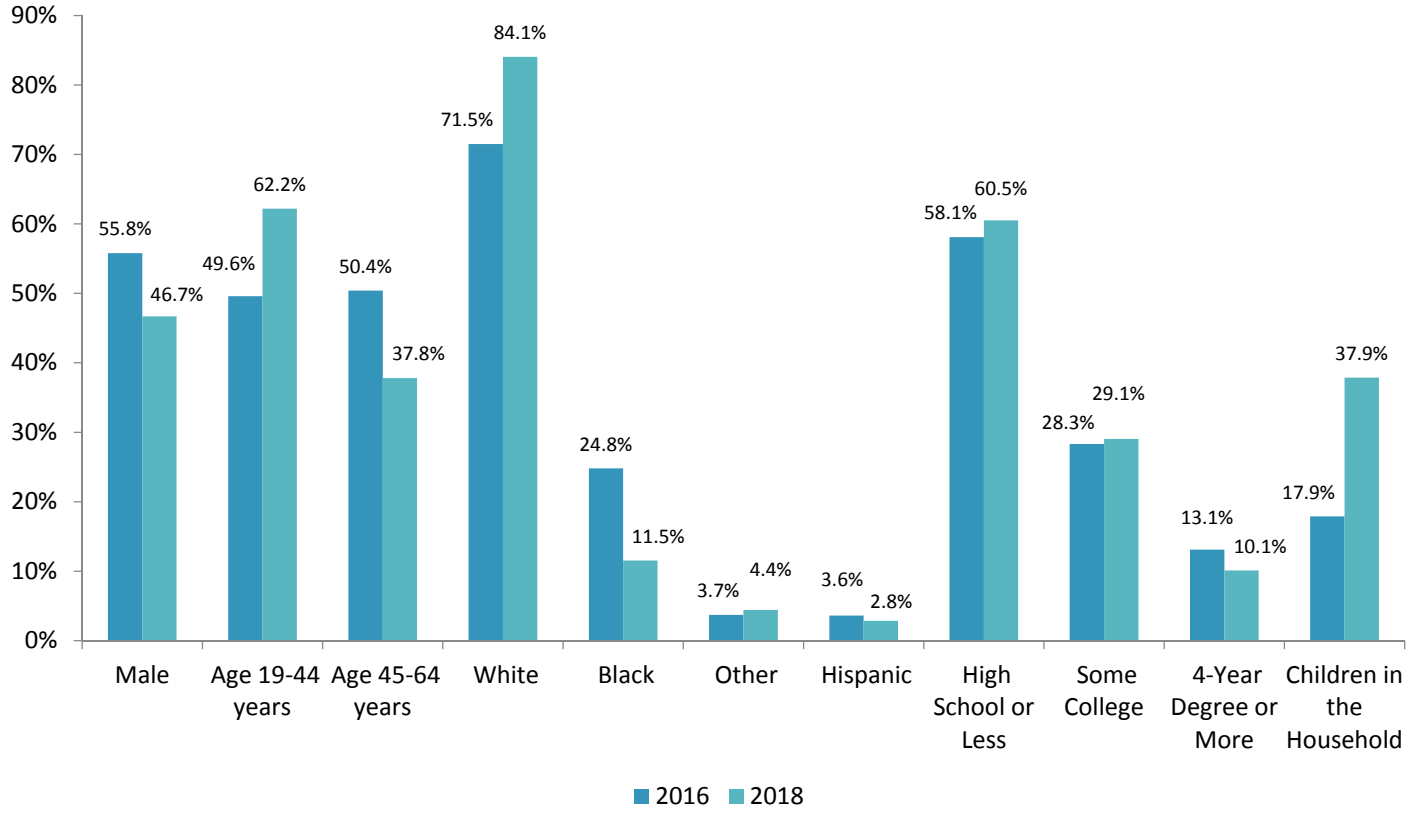
	Churn Group VIII			Non-Group VIII Medicaid		
	Weighted %	Std. Err.	Unweighted N	Weighted %	Std. Err.	Unweighted N
Children in household	49.5%	0.015	535	67.3%	0.014	598
Marital Status						
married	22.1%	0.013	240	21.9%	0.015	204
divorced/separated	23.5%	0.012	311	27.1%	0.014	291
widowed	2.8%	0.004	42	3.4%	0.006	39
never married	43.9%	0.015	484	43.3%	0.017	375
member of an unmarried couple	7.3%	0.009	71	3.8%	0.007	36
Spouse/partner employed						
over entire survey population	15.6%	0.012	166	13.3%	0.012	120
over those with partners	53.1%	0.029	166	51.9%	0.034	120
Veteran	3.7%	0.006	44	2.8%	0.006	28
Educational attainment						
high school or less	65.8%	0.014	732	66.3%	0.016	641
some college	26.9%	0.014	328	25.3%	0.015	236
4-year degree or higher	7.0%	0.008	90	7.6%	0.010	66
Hispanic	4.2%	0.006	46	4.9%	0.008	38
Race						
white	68.2%	0.013	790	67.0%	0.015	659
black	26.4%	0.013	304	28.3%	0.015	250
other	5.3%	0.007	59	4.7%	0.008	41
Age						
19-44	70.3%	0.002	678	67.9%	0.003	539
45-64	29.7%	0.002	475	32.1%	0.003	411
Currently employed	48.8%	0.015	538	31.5%	0.016	262
Average household size	2.6	0.480	-	3.0	0.513	-
Respondent is a Caregiver	20.4%	0.012	238	22.0%	0.014	200

Source: 2018 Group VIII Telephone Survey

* The collected unadjusted counts for the 2018 Group VIII Assessment data strata are as follows: 1) The Continuous Group VIII count is 1,710; 2) the Unenrolled Group VIII count is 2,054; 3) the Churn Group VIII count is 1,153; and 4) Non-Group VIII Medicaid is 950. The total collected sample is 5,867.

Given that Group VIII is a transitional program for most enrollees, it is expected that the demographic characteristics of enrollees will evolve over time. Compared to 2016, for example, Continuous Group VIII enrollees in 2018 are more likely to be younger, white, female, and have children (Figure 6). These demographic differences are likely due to the fact that initial enrollees in Group VIII were individuals with a disproportionate number of serious health issues and pent up demand for health services.

Figure 6: Demographic Characteristics of Continuous Group VIII Enrollees, 2016-2018



Source: 2016 & 2018 Group VIII Telephone Surveys

The shifting demographics of the continuously enrolled Group VIII enrollees in 2018 as compared to 2016 may partially account for the decrease in the self-reported diagnosis of certain chronic diseases, including hypertension (38.1% to 30.5%) and high cholesterol (28.2% to 24.5%). The rate of chronic diseases such as emphysema (2.9% vs. 4.3%), COPD (7.9% vs. 8.5%), and cancer (5.1% vs. 6.1%), remained stable.

Among current and former Group VIII enrollees in 2018, the Continuous Group VIII (30.4%) and Churn Group VIII (30.5%) were more likely to report having fair or poor health as compared to Unenrolled Group VIII (24.9%). Continuous Group VIII and Churn Group VIII were also more likely to report incapacity for mental and physical health reasons than Unenrolled Group VIII. Although Churn Group VIII enrollees tend to be younger than Continuous Group VIII, Churn Group VIII is slightly more likely to have chronic conditions than the Continuous Group VIII. The presence of these chronic conditions may be leading to the dynamic of churn: when individuals with chronic conditions lose Medicaid coverage, they may not obtain treatment, and having untreated conditions may make it difficult to maintain employment and ultimately necessitate Medicaid re-enrollment.

Table 3: Prevalence of Self-Reported Chronic Diseases among Continuous Group VIII Enrollees, 2018*

	Continuous Group VIII			Unenrolled Group VIII		
	Weighted %	Std. Err.	Unweighted N	Weighted %	Std. Err.	Unweighted N
Fair/poor health	30.4%	0.014	577	24.9%	0.014	621
Hypertension diagnosis	30.5%	0.013	635	28.8%	0.014	715
High cholesterol diagnosis	24.5%	0.012	505	19.2%	0.011	543
Diabetes diagnosis	13.0%	0.010	254	10.8%	0.009	289
Coronary heart disease	4.1%	0.005	90	2.9%	0.004	98
Heart attack	4.2%	0.005	94	2.7%	0.005	82
Congestive heart failure	2.2%	0.004	48	2.2%	0.004	74
Stroke	3.5%	0.005	71	1.9%	0.004	62
Emphysema	4.3%	0.006	83	3.2%	0.005	80
COPD	8.5%	0.007	196	5.5%	0.006	173
Asthma	22.2%	0.013	403	18.6%	0.013	415
Cancer	6.1%	0.007	118	3.9%	0.005	112
7 or more days of physical incapacity	25.5%	0.013	506	18.7%	0.013	477
7 or more days of mental incapacity	17.9%	0.117	331	12.4%	0.011	300
	Churn Group VIII			Non-Group VIII Medicaid		
	Weighted %	Std. Err.	Unweighted N	Weighted %	Std. Err.	Unweighted N
Fair/poor health	30.5%	0.014	379	39.9%	0.016	432
Hypertension diagnosis	31.0%	0.014	392	35.9%	0.015	403
High cholesterol diagnosis	20.3%	0.011	275	27.0%	0.013	311
Diabetes diagnosis	13.0%	0.010	169	14.9%	0.011	174
Coronary heart disease	4.2%	0.006	57	5.5%	0.008	64
Heart attack	3.8%	0.006	52	4.1%	0.006	52
Congestive heart failure	2.3%	0.004	31	3.6%	0.005	44
Stroke	2.6%	0.005	34	4.9%	0.006	59
Emphysema	3.7%	0.006	50	5.0%	0.006	63
COPD	7.3%	0.007	99	10.8%	0.009	133
Asthma	21.6%	0.013	260	29.0%	0.015	299
Cancer	4.7%	0.006	67	5.4%	0.007	62
7 or more days of physical incapacity	23.4%	0.012	302	30.7%	0.015	329
7 or more days of mental incapacity	16.3%	0.011	198	23.8%	0.014	249

Source: 2018 Group VIII Telephone Survey

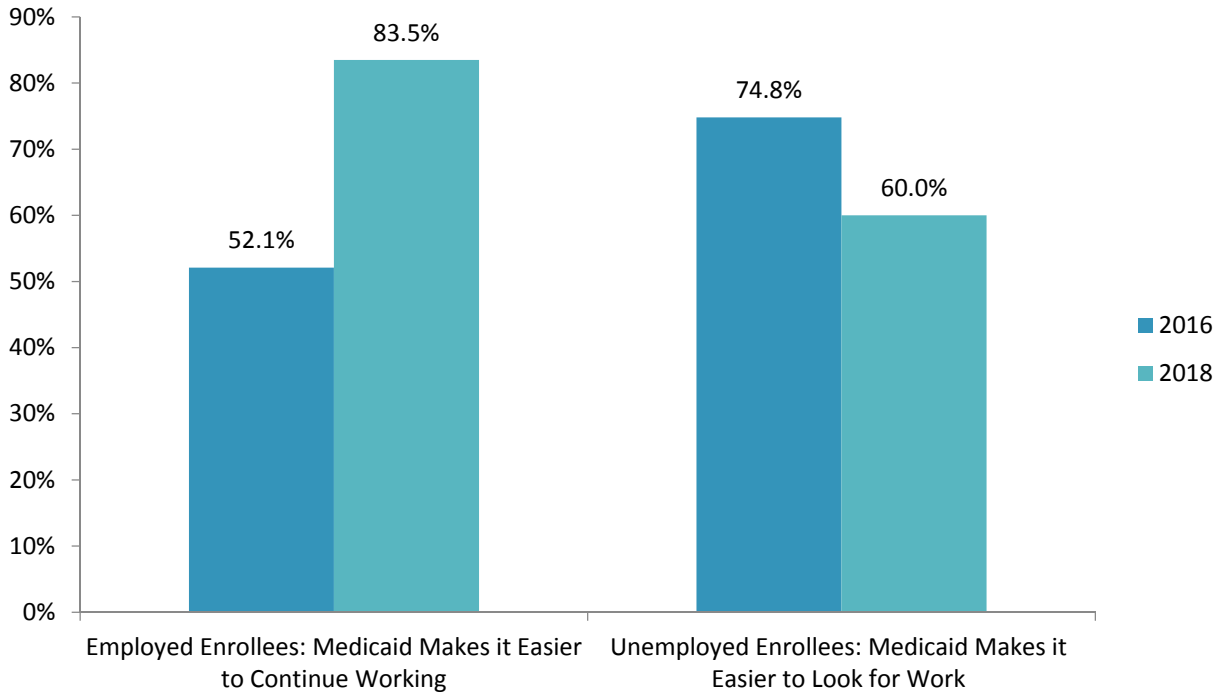
* The collected unadjusted counts for the 2018 Group VIII Assessment data strata are as follows: 1) The Continuous Group VIII count is 1,710; 2) the Unenrolled Group VIII count is 2,054; 3) the Churn Group VIII count is 1,153; and 4) Non-Group VIII Medicaid is 950. The total collected sample is 5,867.

IV: Employment

Medicaid and Employment

Group VIII participants report that Medicaid expansion has allowed them to both 1) look for work and 2) continue working. Almost 9 out of 10 (85.3%) employed continuous Group VIII enrollees said that having Medicaid made it easier to continue working, an increase from 52.1% in 2016 (Figure 7). Similarly, 60% of unemployed enrollees indicated that Medicaid made it easier for them to look for work.

Figure 7: The Effects of Medicaid Enrollment on Employment for Continuous Group VIII Enrollees, 2016-2018

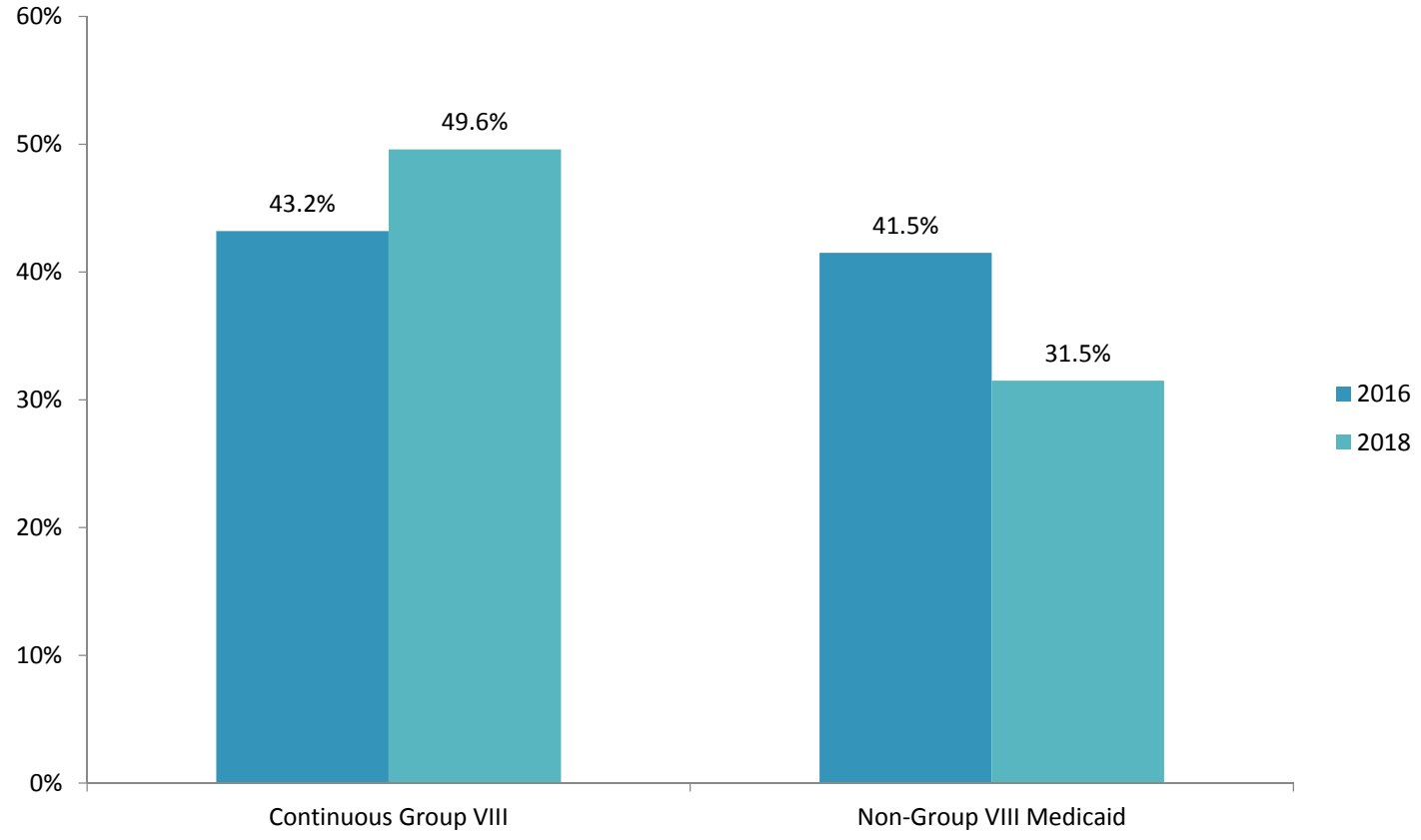


Source: 2016 and 2018 Group VIII Telephone Surveys

The share of Group VIII enrollees with a job continues to increase. The percentage of Continuous Group VIII enrollees who were employed rose from 43.2% in 2016 to 49.6% in 2018. In contrast, the percentage of Non-Group VIII enrollees who were employed fell from 41.5% to 31.5%. The increase in employment rates among Continuous Group VIII from 2016 to 2018 may be partially the result of improving economic conditions: the unemployment rate in Ohio fell from 5.0% in April 2016 to 4.3% in April 2018[xvi].

[xvi] Bureau of Labor Statistics, Local Area Unemployment Statistics (https://www.bls.gov/lau/home.htm)

Figure 8: Continuous Group VIII and Non-Group VIII Medicaid: Percentage Employed 2016 to 2018



Source: 2016 and 2018 Group VIII Telephone Surveys

What does having Medicaid mean to you?

"[Medicaid] has helped me to continue to keep the current job I have as a real estate agent."

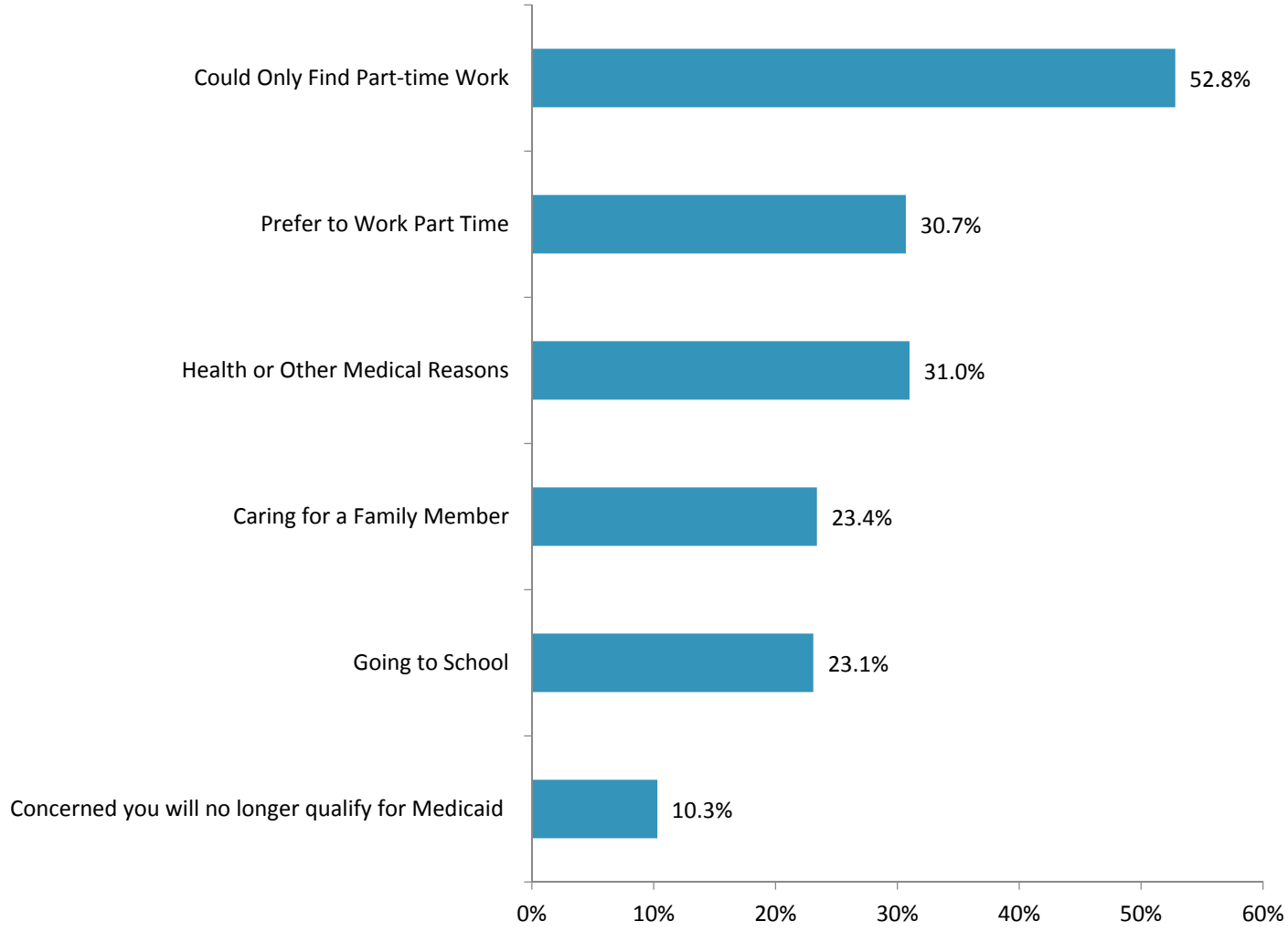
"[Medicaid] allows me to get surgery which has allowed me to return to work."

"[Medicaid] has been a godsend. I had some serious issues going on. My insurance was so bad at my job, it was a 80/20 plan/6000 deductible, I just couldn't get the care that I needed."

Source: 2018 Group VIII Telephone Survey

More than half (50.9%) of employed, continuously enrolled Group VIII have full-time jobs, while almost one third (31.4%) have jobs that require working 20-35 hours per week. The most commonly cited reason for working part time (under 20 hours per week) was that full-time jobs were unavailable (52.8%), followed by preferring to work part time (30.7%) and health or other medical reasons (31.0%). Only 10.4% said they worked part-time because they were concerned that working full-time would cause them to lose Medicaid coverage.

Figure 9: Respondents Working Under 20 Hours per Week: Reasons for Not Working Full-Time by Enrollment Group, 2018



Source: 2018 Group VIII Telephone Survey
Analysis limited to current Group VIII enrollees (Continuous Group VIII and Churn Group VIII)

Ohio Medicaid 1115 Work Requirement Waiver

In the summer of 2017, the Ohio General Assembly enacted House Bill 49 (HB 49), which included Ohio Revised Code (ORC) section 5166.37, requiring Ohio to seek a waiver to establish new employment eligibility conditions for the Group VIII Medicaid expansion population. This new eligibility rule requires Group VIII Medicaid enrollees to be employed unless they meet one of the listed exemptions (below). To implement this section of HB 49, the Ohio Department of Medicaid submitted a Section 1115 waiver to the Centers for Medicare and Medicaid Services (CMS) to enable it to develop a Work and Community Engagement Requirement for the Medicaid Group VIII population[xvii].

[xvii] http://www.healthtransformation.ohio.gov/Portals/0/Ohio%20Medicaid%20Work%20Requirements%20Final.pdf

In order to comply with CMS guidance, ODM has proposed aligning the Work and Community Engagement Requirement with existing Supplemental Nutrition Assistance Program (SNAP) work requirements (including the Able-Bodied Adults Without Dependents (ABAWD) requirements). The proposed Work and Community Engagement Requirement therefore utilizes the following ABAWD exemptions for Group VIII adults:

- 55 years of age or older
- Physically or mentally unfit for employment
- Caring for a disabled/incapacitated household member
- Pregnant woman
- Parent/caretaker/individual residing in same house with minor child
- Applied for or receiving Unemployment Compensation
- In school at least half-time
- Participating in drug or alcohol treatment
- An assistance group member subject to and complying with any work requirement under the Ohio Works First (OWF) program
- Applicant for or recipient of Supplemental Security Income (SSI)

In addition, the following Medicaid-specific exemptions are appended to the Work and Community Engagement Requirement:

- Participant in the Specialized Recovery Services Program
- Eligible incarcerated individual

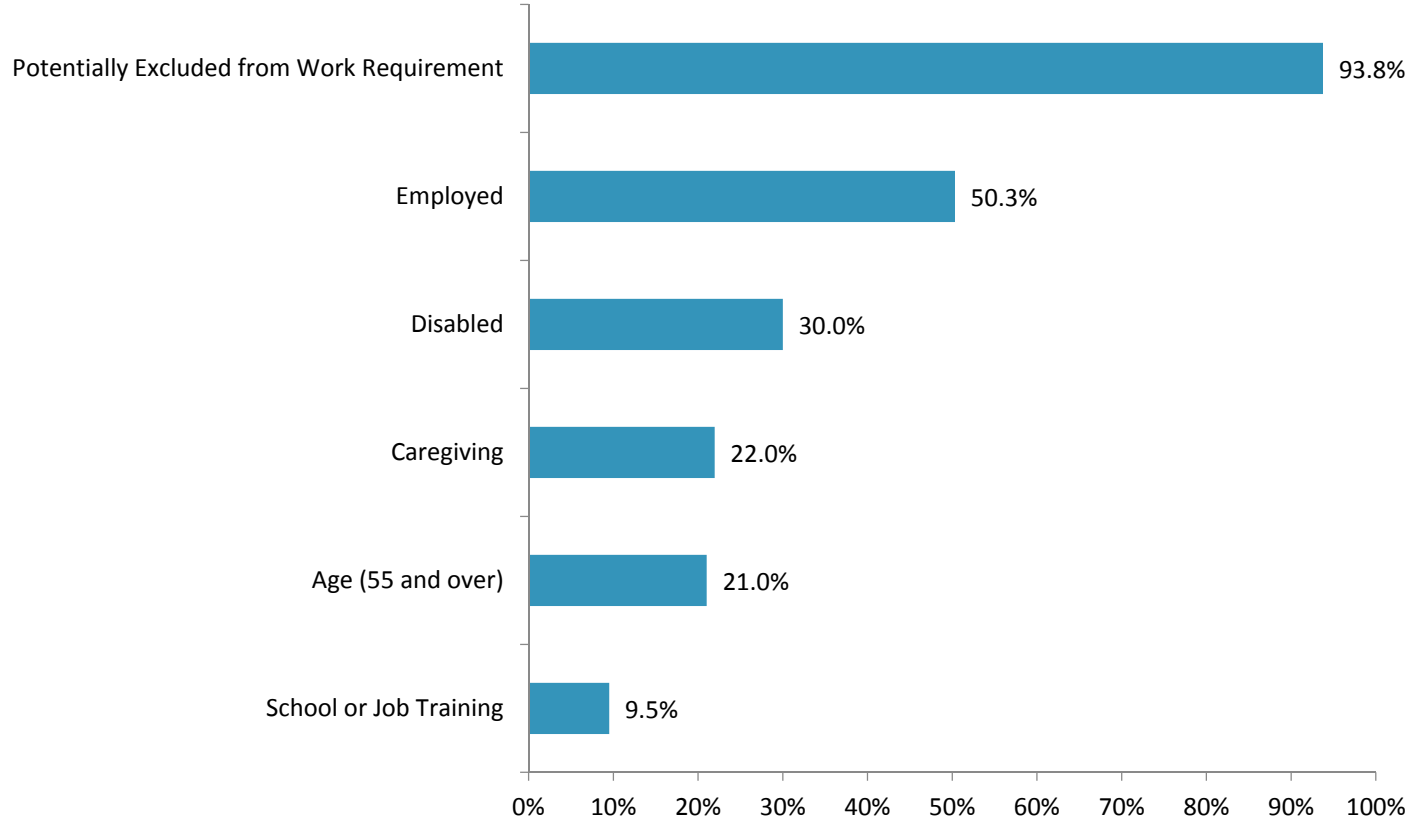
Individuals who are not exempt from the Work and Community Engagement Requirement must work, participate in a community engagement activity, or do some combination of the two for at least 20 hour per week (80 hours averaged monthly). Community engagement activities include SNAP education and training activities, job search/job readiness programs (for no more than 30 days), and the Work Experience Program (WEP).

In the waiver application, ODM determined that of the estimated 702,000 individuals expected to participate in Group VIII during State Fiscal Year (SFY) 2019, about 36,000 individuals will be considered not exempt from the work requirement and not working, about 5.1% of Group VIII enrollees[xviii].

Results from the Group VIII Telephone Survey support the estimates in ODM's 1115 waiver application. About one out of sixteen (6.3%, 95% confidence interval 4.9%-7.9%) current Group VIII enrollees do not meet work requirements or one of the exclusion criteria (Figure 10), with many enrollees qualifying for multiple criteria (for example, an enrollee may work and be over age 55). Most of these meet the requirement because they are already working (50.3%) or are disabled (30.0%). Another 22% are primary caregivers, 21% are over age 55, and 9.5% are attending school or job training. Note that the difference between the 6.3% Group VIII Telephone Survey result and the 5.1% ODM estimate is not statistically significant.

[xviii] http://www.healthtransformation.ohio.gov/Portals/0/Ohio%20Medicaid%20Work%20Requirements%20Final.pdf

Figure 10: Percentage of Current Group VIII Enrollees Potentially Exempt from the 1115 Waiver Work Requirement, 2018

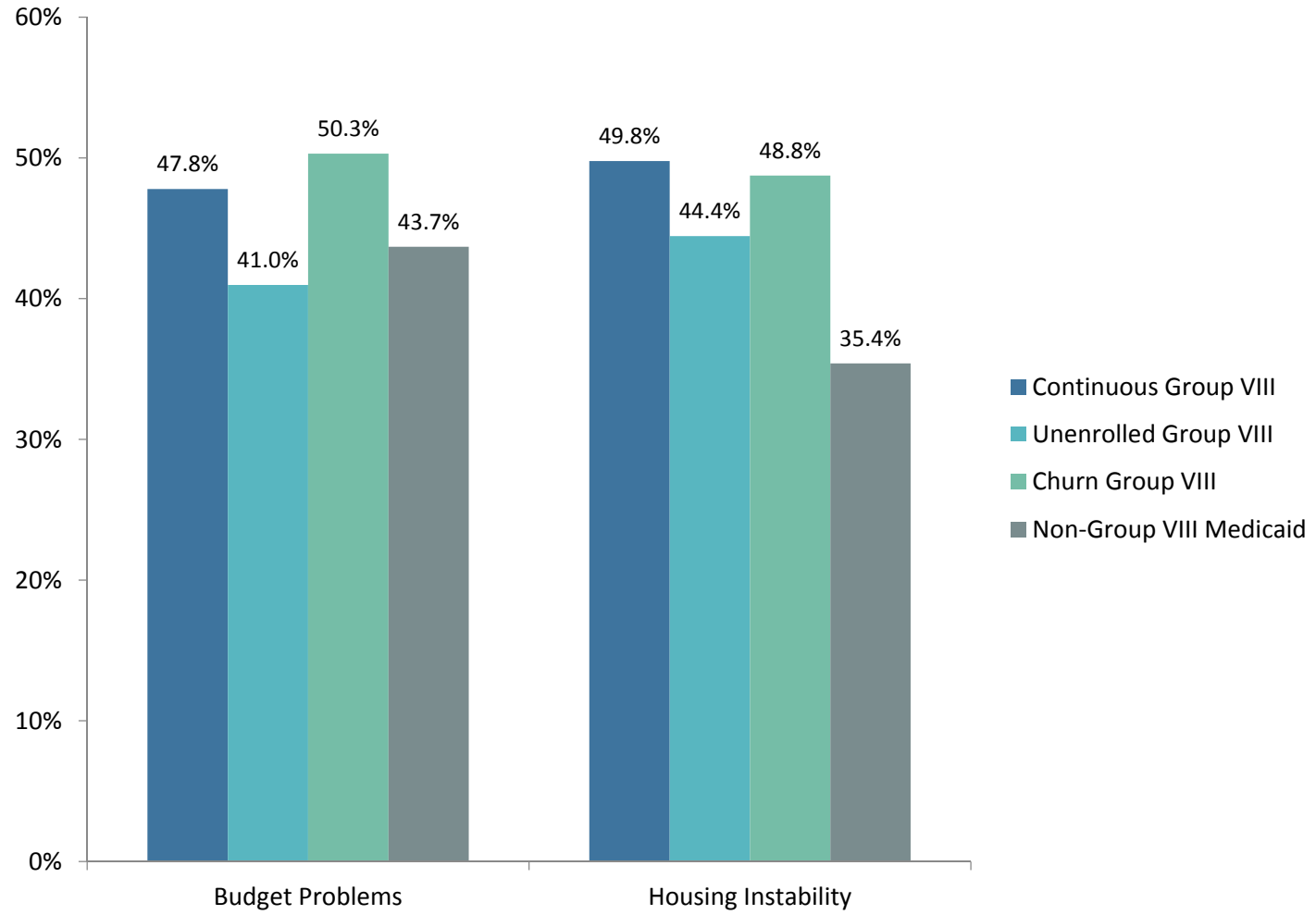


Source: 2018 Group VIII Telephone Survey
Analysis limited to currently enrolled Group VIII (Continuous Group VIII and Churn Group VIII)

V: Financial Hardship

Current and former Medicaid enrollees experience high levels of economic distress. When asked about their household's finances, almost half reported having budget problems, indicating either that it was tough to make ends meet or that they were "in over [their] heads" (47.8% for Continuous, 41.0% for Unenrolled, 50.3% for Churn and 43.7% for Non-Group VIII Medicaid, Figure 11). Housing insecurity is also common, with nearly half (49.8%) of Continuous Group VIII enrollees reporting one or more instances of housing instability in the last two years, such as moving multiple times, being evicted, or being homeless. Given these financial difficulties, is it not surprising that 17.6% of current and former Group VIII enrollees also report having filed for bankruptcy in the past.

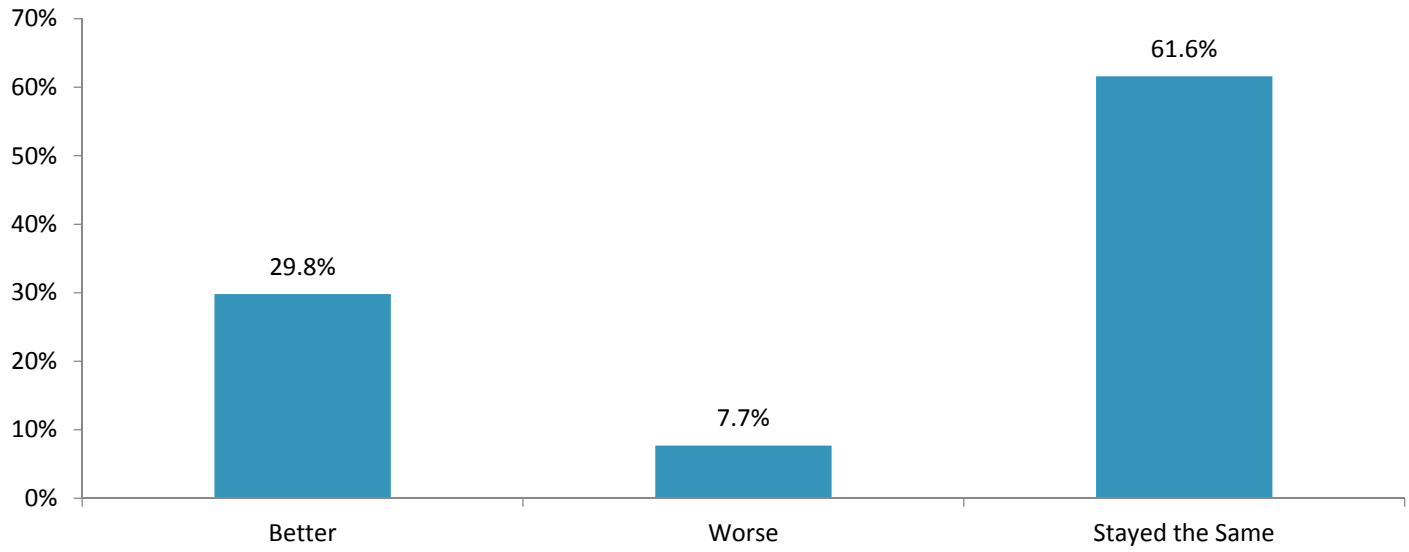
Figure 11: Current and Former Medicaid Enrollees Reporting Budget Problems or Housing Instability, 2018



Source: 2018 Group VIII Telephone Survey

Although many Medicaid enrollees are financially stressed, Medicaid promotes economic security. About half (49.1%) of Group VIII enrollees reported that having Medicaid made it easier to pay for necessities including groceries, rent, or mortgage payments, and to pay down debt. Overall, Continuous Group VIII enrollees were almost four times more likely to say that their family's financial situation improved than that it had gotten worse since enrolling in Medicaid (29.8% improved vs. 7.7% worse, Figure 12).

Figure 12: Group VIII Enrollees: Changes in Household Financial Situation since Enrollment, 2018



Source: 2018 Group VIII Telephone Survey
Calculations for Continuous Group VIII enrollees

What does having Medicaid mean to you?

"[Having Medicaid] has meant that I'm able to pay my rent and get the healthcare that I need to stay healthy so I can keep working."

"Medicaid means a lot to me knowing that if something happens to me I don't have to go to the hospital and worry about being in debt."

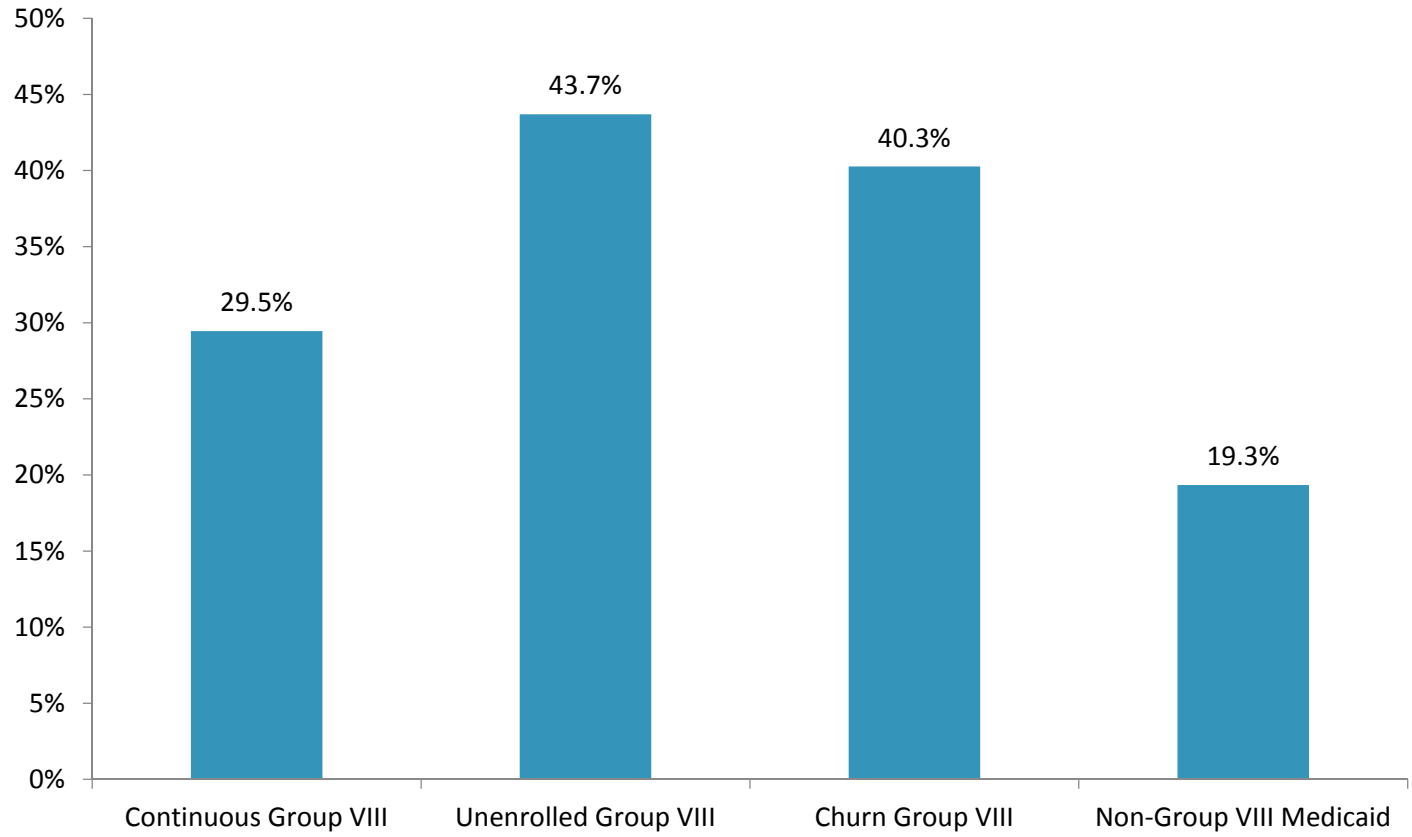
"[Having Medicaid means] being able to go to the doctor when I need to, rather than have to save a whole bunch of money when I do it."

Source: 2018 Group VIII Telephone Survey

The Group VIII program provides an important financial benefit for both enrollees and the health care system by helping enrollees pay down medical debt. The 2016 Group VIII Assessment found that 55.8% of Group VIII enrollees had medical debt prior to initially enrolling but only 30.8% had such debt at the time of the study. Debt holding levels for Continuous Group VIII were similar in 2018 (29.5%) but substantially higher for those who unenrolled (43.7%) and those who had a coverage gap (Churn) (40.3%) (Figure 13). Debt levels were lowest for Non-Group VIII Medicaid enrollees (19.3%). These statistics indicate that even after a relatively short time without Medicaid coverage, medical debt levels rose once again. Qualitative interviews revealed that, prior to Medicaid coverage, some enrollees ended up with medical bills that were so big that they did not even try to pay them. For example, one respondent said, "(Before I had Medicaid, I would) just go to the emergency room at the hospital and let them bill me. Sometimes I wouldn't pay them. I couldn't afford it." By providing timely and predictable reimbursement for services, Medicaid lowers the rate of uncompensated care and helps providers minimize credit risk.

"BEFORE I HAD INSURANCE, I WOULD) JUST GO TO THE EMERGENCY ROOM AT THE HOSPITAL AND LET THEM BILL ME. SOMETIMES I WOULDN'T PAY THEM. I COULDN'T AFFORD IT."
(RURAL SINGLE DISABLED WHITE MAN IN HIS 50S)

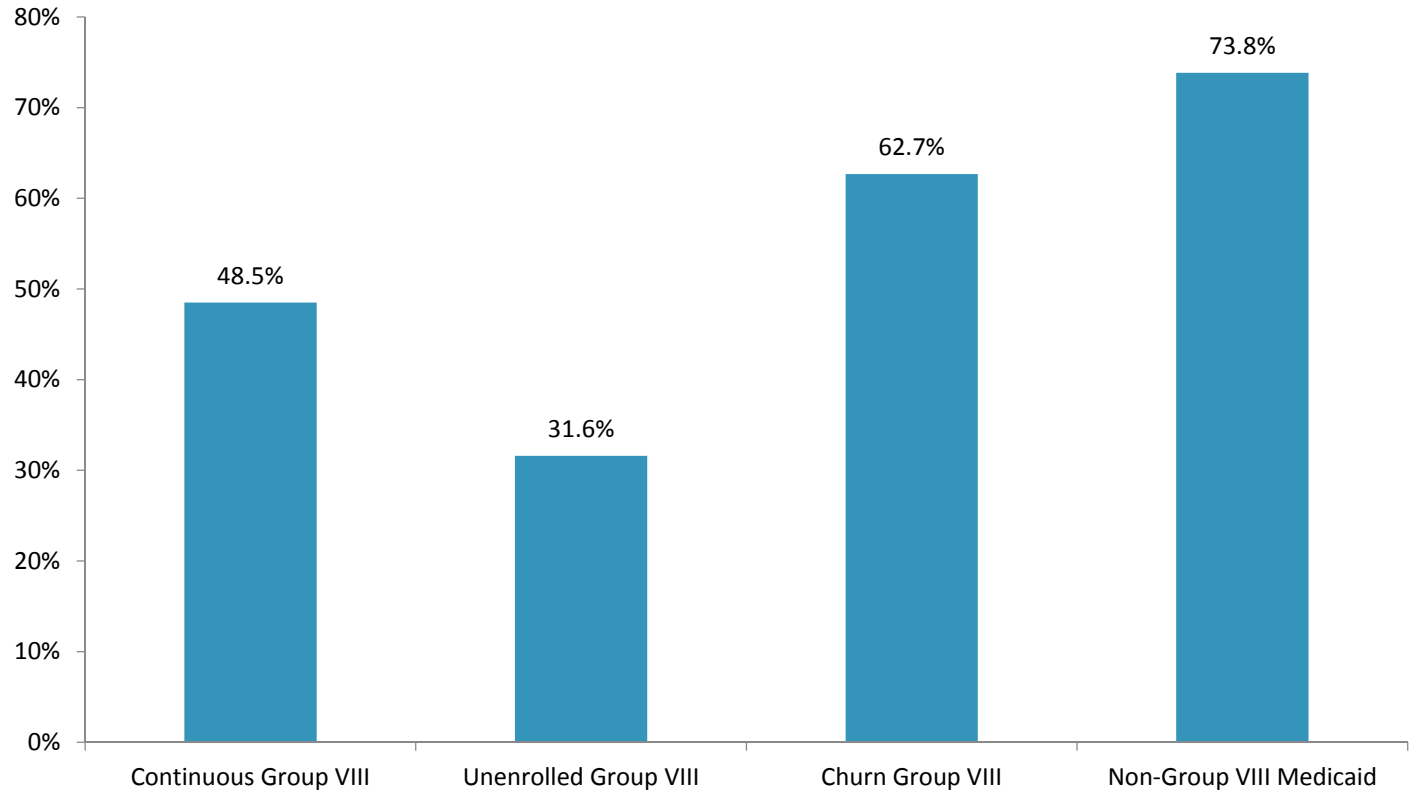
Figure 13: Percentage of Group VIII Enrollees with Medical Debt by Enrollment Status, 2018



Source: 2018 Group VIII Telephone Survey

Less than half (48.5%) of continuously enrolled Group VIII enrollees reported using SNAP benefits in the last twelve months, as did less than one third (31.6%) of unenrolled former enrollees (Figure 14). Nearly two thirds (62.3%) of Churn Group VIII used such benefits in the last twelve months, with Non-Group VIII Medicaid enrollees having the highest utilization rate (73.8%). These findings indicate that while there is significant overlap between Medicaid and SNAP participation among enrollees who are enrolled through pre-expansion eligibility criteria, the Group VIII population is less reliant on the SNAP program.

Figure 14: Percentage of Group VIII and Non-Group VIII Enrollees Receiving SNAP (Food Stamps) Benefits in the Last Twelve Months, 2018



Source: 2018 Group VIII Telephone Survey

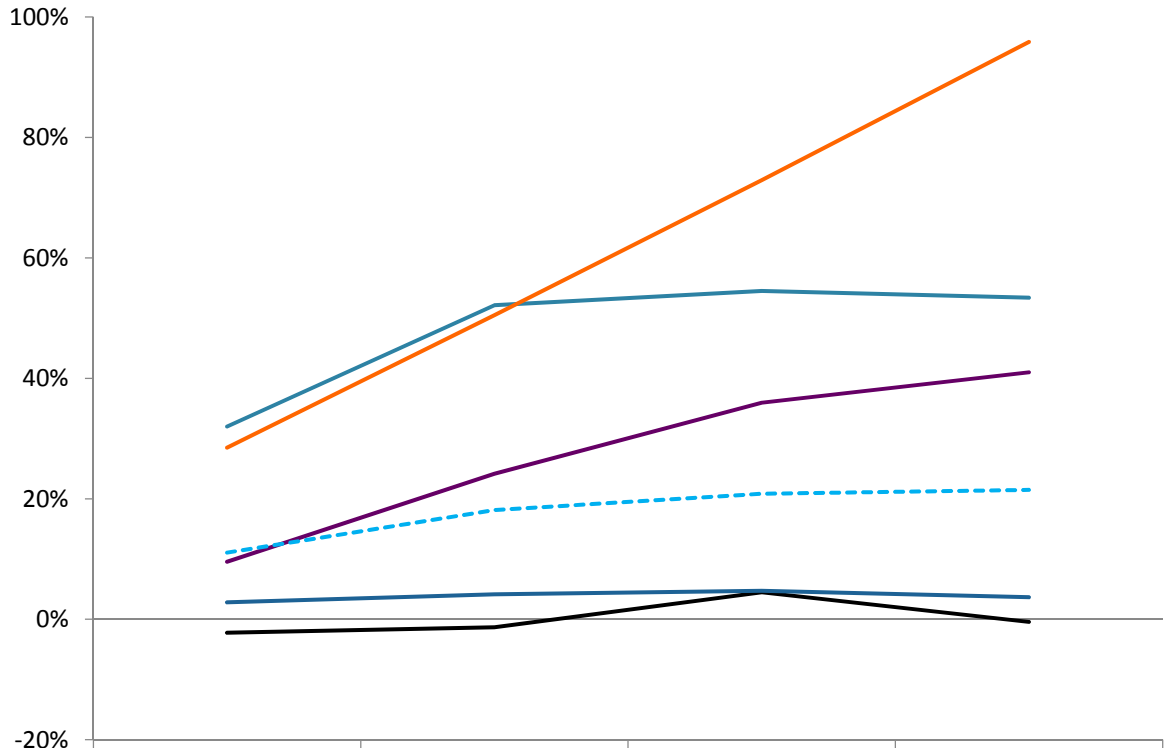
VI: Provider Capacity and Access to Care

There has been an increase in consumer demand among Medicaid enrollees for health services as a result of the Group VIII expansion. In order for all Medicaid enrollees to receive the same access to care as in the pre-expansion period, the delivery system needed to expand capacity. Without expanded capacity, enrollees would have less access to their usual source of care for preventive, primary, and chronic disease services, and likely use the emergency department more.

In 2013 there were 19,235 primary care practitioners located in Ohio serving the adult Medicaid population. This included physicians/osteopaths (13,213), advanced practice nurse practitioners (4,238), physicians assistants (1,373), and primary care practitioners serving in FQHCs (178) and other clinics (223)[xix]. By 2017 there were 23,356 practitioners serving the Medicaid population, a 21.4% increase. Most of that increase occurred by 2015 (18.1%). By 2017, the number of physician assistants serving Medicaid patients increased by 95.8%, advanced practice nurse practitioners increased by 53.4%, and FQHCs increased by 41%. Physicians/osteopaths increased by 3.6%.

[xix] Excludes all practitioners with a specialty of pediatrics. Note that FQHC's and other clinics may have multiple practitioners providing service, but may be counted only once as an organization as a result of data limitations.

Figure 15: Ohio Medicaid by Year: Percent Change from 2013 in Number of Primary Care Practitioners, 2014-2017



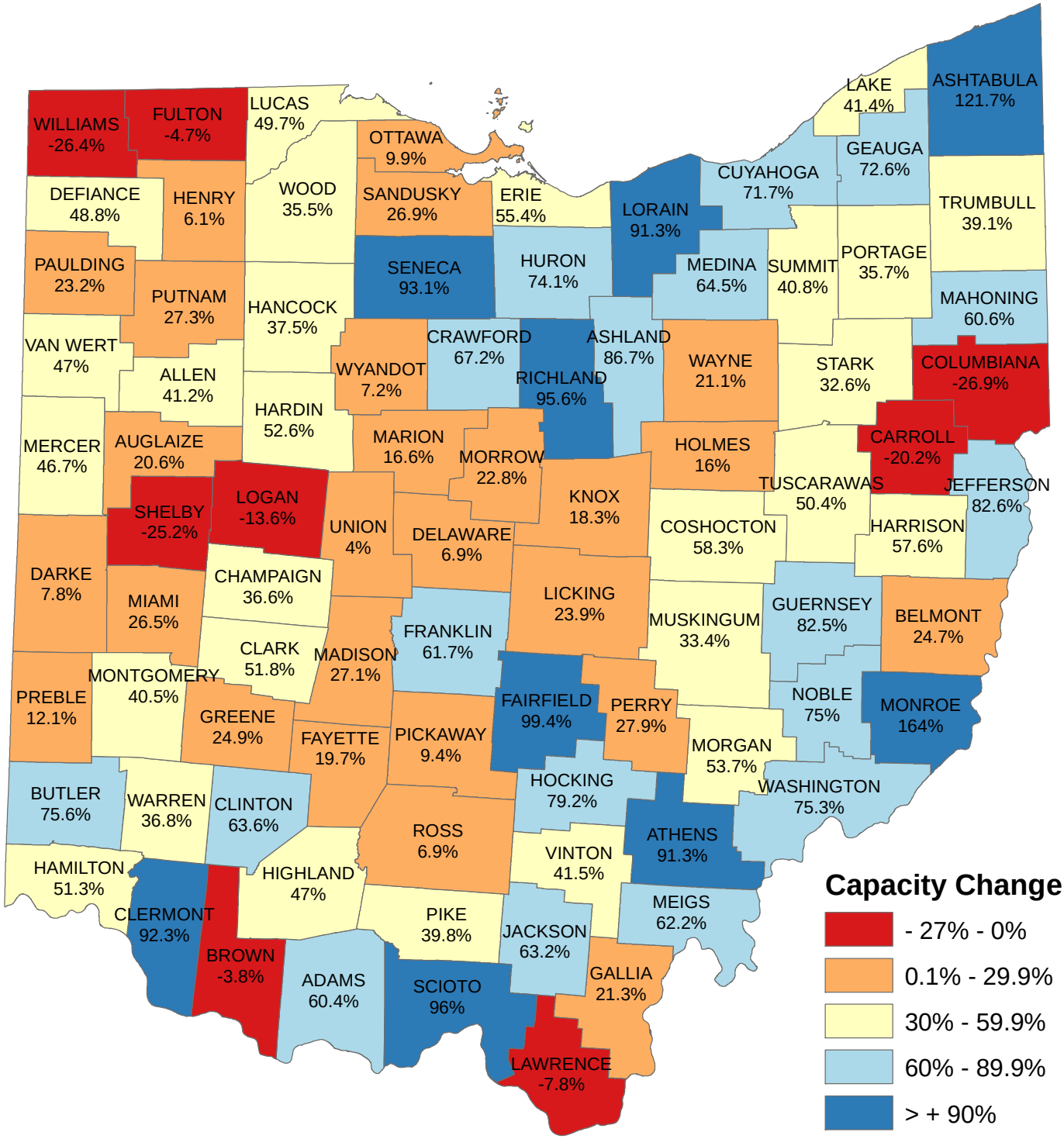
	2014	2015	2016	2017
Nurse Practitioner	32.0%	52.1%	54.5%	53.4%
Physician Assistant	28.5%	50.5%	72.9%	95.8%
FQHC	9.6%	24.2%	36.0%	41.0%
Other Clinics	-2.2%	-1.3%	4.5%	-0.4%
Physicians	2.8%	4.1%	4.7%	3.6%
Total	11.1%	18.1%	20.8%	21.5%

Source: Medicaid administrative data
2013 is the baseline year for calculations

Growth in practitioner supply was not just limited to increases in the number of practitioners. It also included increases in the number of patients that a practitioner provided services for during the year. The median panel size across all practitioner types grew from 125 patients per practitioner in 2013 to 153 patients per practitioner in 2017, a 22.4% increase. Median panel size grew for physician assistants (167%) advanced practice nurse practitioners (100%), FQHCs (22.4%), and physicians (22.4%). The change in provider capacity can be measured overall, by multiplying the change in the number of practitioners by the change in their median panel size. The total increase in provider capacity from 2013 to 2017 was +48.7%.

Changes in primary care capacity were not uniform across the state by county. There were large increases in Monroe (164%), Ashtabula (122%), Fairfield (99%), Scioto (96%), Richland (95%) Seneca (93%), Clermont (92%), Lorain (91%), and Athens county (91%). There were decreases in capacity in Columbiana (-27%), Williams (-26%), Shelby (-25%), Carroll (-20%), Logan (-14%), Lawrence (-8%), Fulton (-5%), and Brown county (-4%).

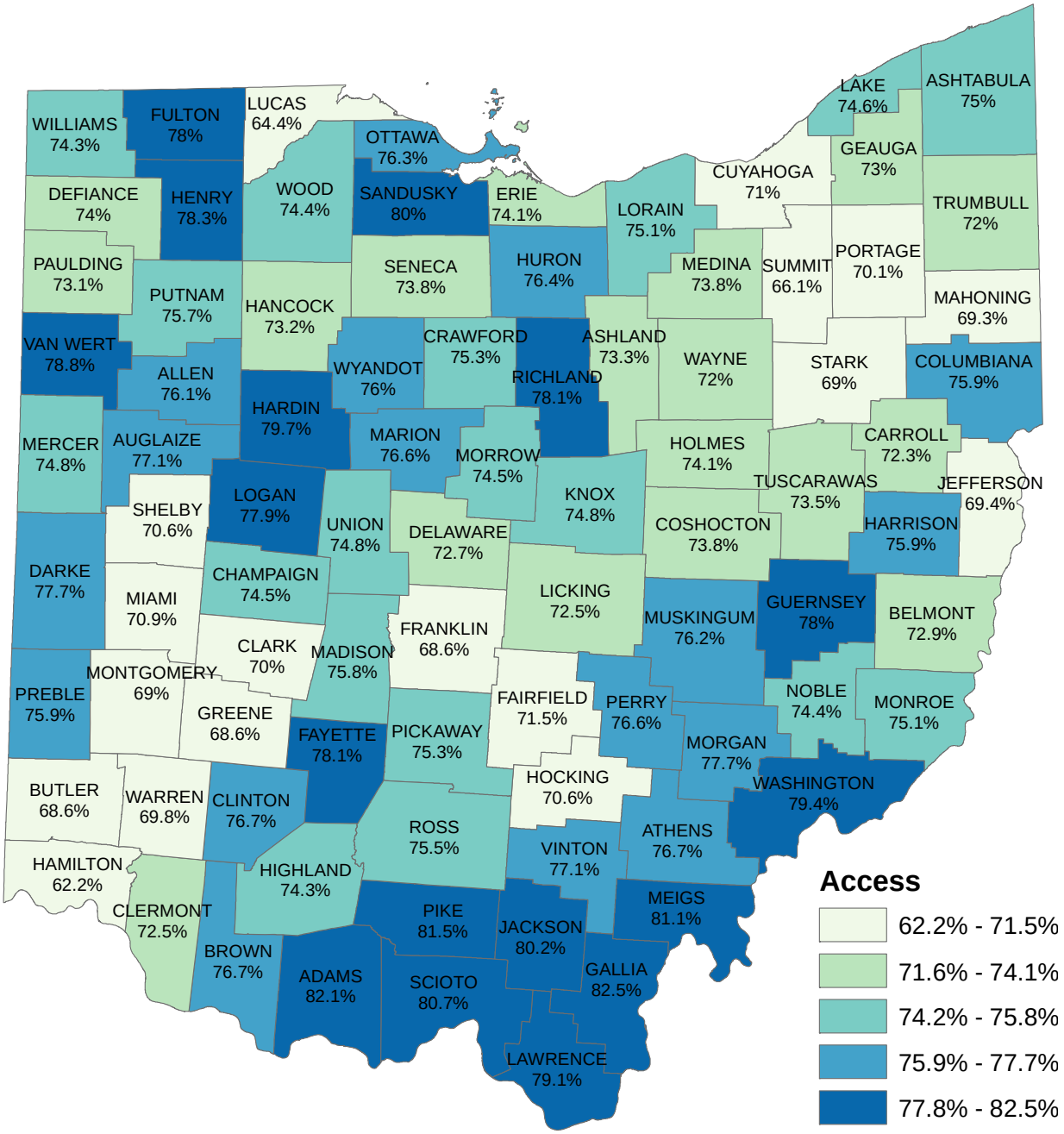
Map 3: Ohio Medicaid, Primary Care Delivery System, Percent change from 2013 to 2017 in Total Practitioner Capacity.



Source: Medicaid administrative data

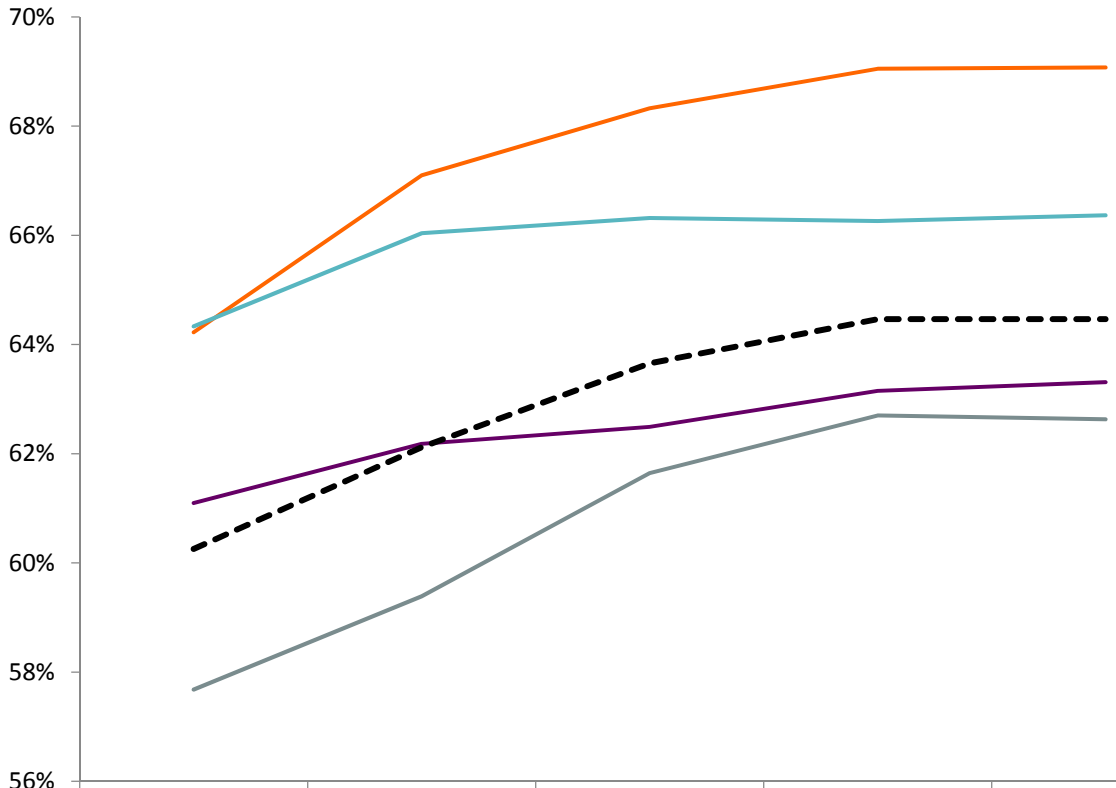
Access to primary care, measured as utilization of primary care services, increased for all Medicaid adults age 19-64 during the period immediately prior to the Group VIII expansion (2013), and during the first three years (2014-2017) of Group VIII Expansion (Figure 16). Overall, the percent of enrollees with at least one primary care visit increased from 60.3% in 2013 to 64.5% in 2017. Primary care utilization was higher among Appalachian (69.1%) and Rural (66.4%) counties compared to Suburban (63.3%) and Urban counties (62.6%) (Map 4).

Map 4: Ohio Medicaid, by County, 2017: Percent of Adults (19-64) Enrolled for 12 months with at least 1 Primary Care Visit.



Source: Medicaid administrative data

Figure 16: Ohio Medicaid, by Region and Year: Percent of Adult (age 19-64) Enrollees with at least 1 Primary Care Visit, 2013 to 2017

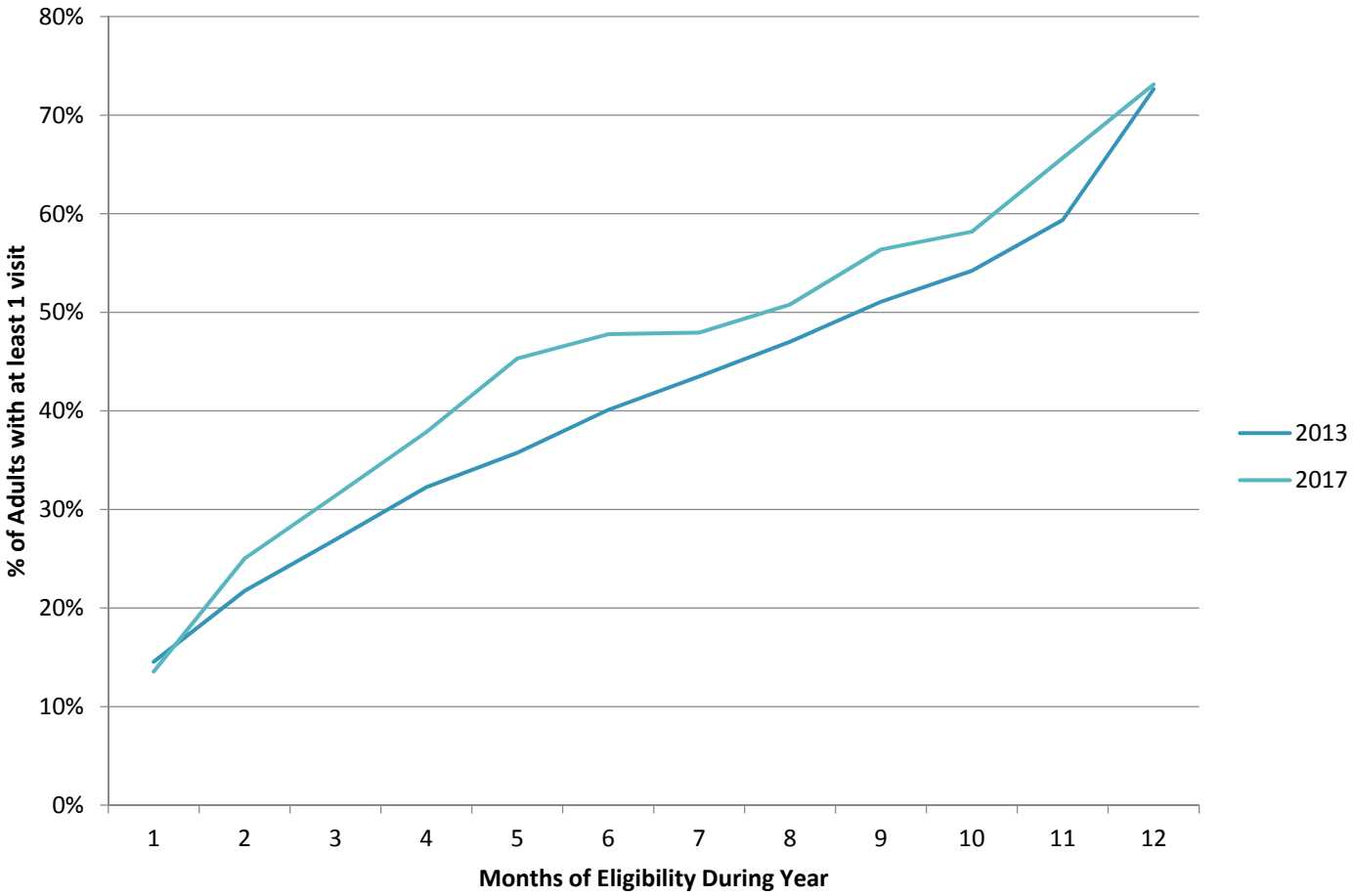


	2013	2014	2015	2016	2017
Appalachian	64.2%	67.1%	68.3%	69.1%	69.1%
Rural	64.3%	66.0%	66.3%	66.3%	66.4%
Suburban	61.1%	62.2%	62.5%	63.2%	63.3%
Urban	57.7%	59.4%	61.6%	62.7%	62.6%
Total	60.3%	62.1%	63.7%	64.5%	64.5%

Source: Medicaid administrative data

Demand for primary care increased as a result of at least two factors. Medicaid enrollment of adults age 19-64 increased by 754,136 from 2013 to 2017. Additionally, the average number of months that adults age 19-64 were enrolled in Medicaid increased from 9.8 months in 2013 to 10.3 months in 2017, and the percent enrolled continuously for 12 months during the year increased by 11.6%. Improvements in continuous enrollment occurred because of enhancements in systems for processing eligibility redeterminations. Also, parents and disabled patients under the pre-expansion eligibility rules were able to stay on longer if their family income increased as a result of the higher financial eligibility criteria (138% of FPL) of Group VIII. Continuous enrollment is a factor in the demand for primary care use. Enrollees with 12 months of eligibility during the year are more likely to use primary care (73%) than enrollees with only 1 month of eligibility (14%).

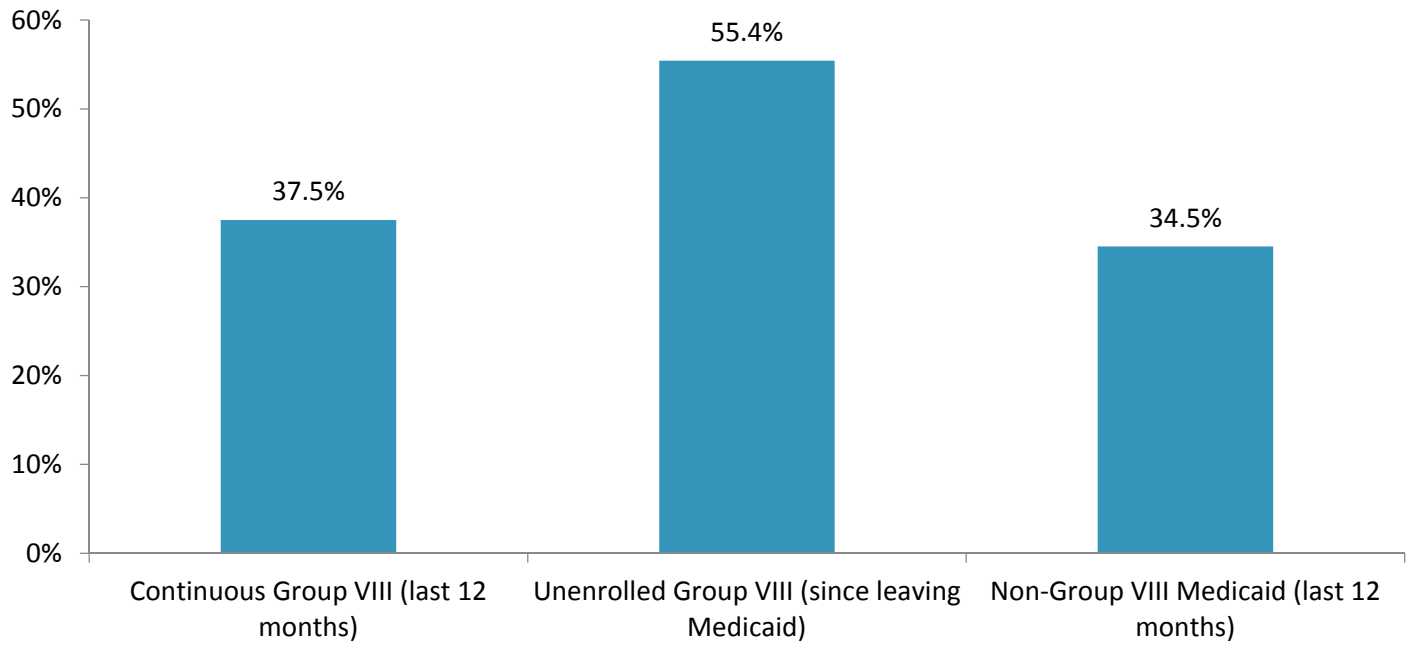
Figure 17: Ohio Medicaid, 2013 and 2017, by Months of Eligibility during the Year: Percent of Adults (Age 19-64) with at least 1 Primary Care Visit



Source: Medicaid administrative data

For those who lost their Group VIII coverage, accessing health care became more difficult. For instance, more than half (55.4%) of the Unenrolled Group VIII population reported one or more difficulties accessing care, 47.7% higher than Continuous Group VIII enrollees (37.5%) (Figure 18). This difficulty in accessing coverage for those who no longer have Group VIII coverage holds for both those who gained other coverage and those who had no coverage: two-thirds (66.1%) of Unenrolled Group VIII without insurance reported difficulties accessing care, while nearly one half (49.3%) Unenrolled Group VIII with other health insurance reported such difficulties.

Figure 18: Percent of Group VIII Enrollees Reporting Difficulties Accessing One or More Types of Care, 2018



Source: 2018 Group VIII Telephone Survey

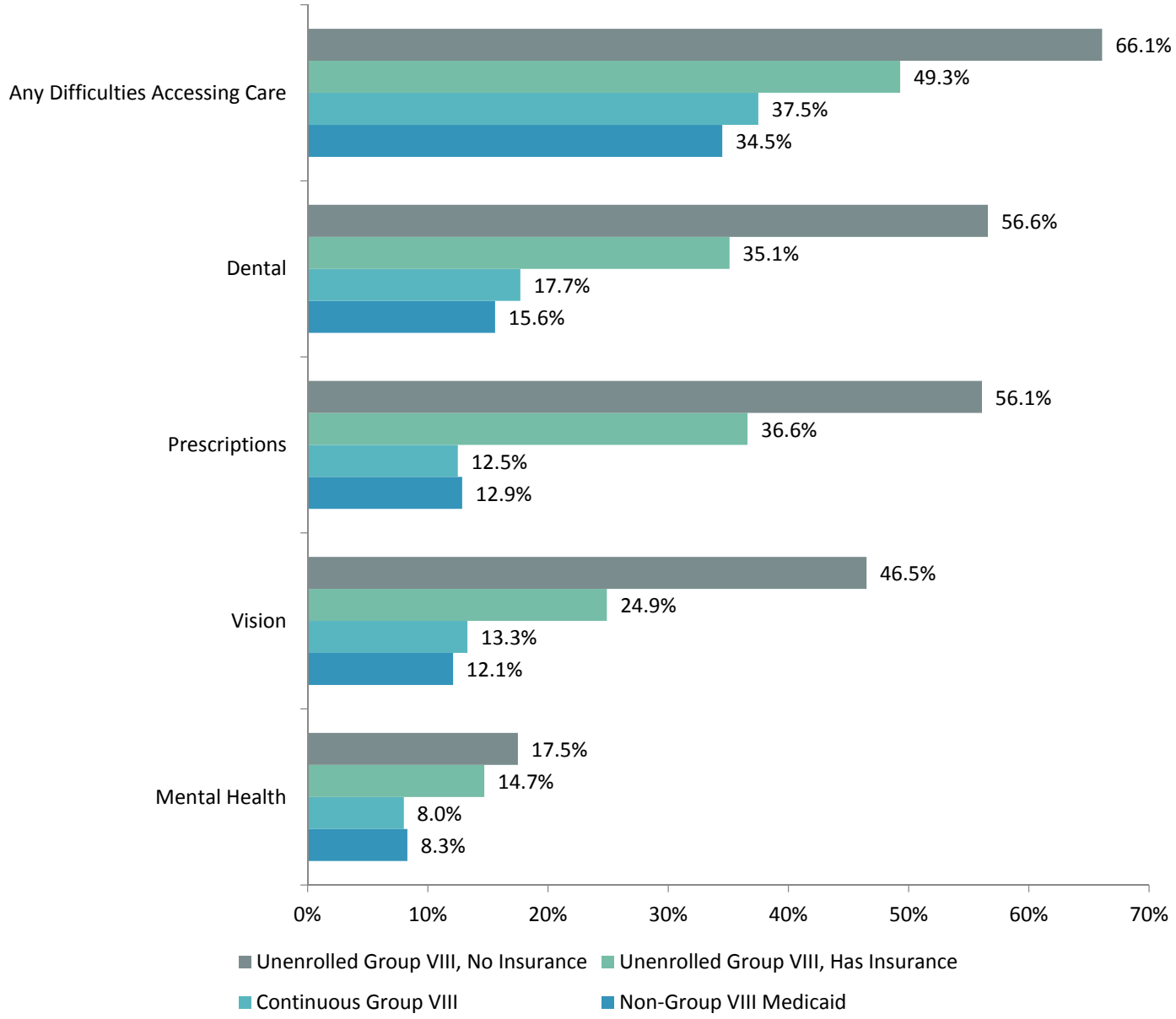
The degree of problems for Unenrolled Group VIII compared to Continuous Group VIII was especially pronounced for certain types of care. At the most extreme, difficulty in accessing prescriptions was 4.5 times more likely for those who were unenrolled and had no insurance and 2.9 times more likely for those who were unenrolled and had other coverage, compared to Continuous Group VIII enrollees. The lowest difference in difficulty was for mental health care, where it was 2.2 times more likely for individuals who were unenrolled with no insurance and 1.8 times more likely for individuals who were unenrolled and had insurance to report difficulties accessing care.

Table 4: Relative Likelihoods of Having Difficulties Accessing Care, Continuous Group VIII and Unenrolled Group VIII

	Continuous	Unenrolled, No Insurance		Unenrolled, Has Insurance	
Type of care	**Access Issues**	**Access Issues**	**Times More Likely to have Access Issues than Continuous Group VIII**	**Access Issues**	**Times More Likely to have Access Issues than Continuous Group VIII**
All care	37.5%	66.1%	1.8X	49.3%	1.3X
Dental	17.7%	56.6%	3.2X	35.1%	2.0X
Vision	13.3%	46.5%	3.5X	24.9%	1.9X
Mental Health	8.0%	17.5%	2.2X	14.7%	1.8X
Prescriptions	12.5%	56.1%	4.5X	36.6%	2.9X

Source: 2018 Group VIII Telephone Survey

Figure 19: Percentage of Non-Group VIII Medicaid, Continuous Group VIII, and Group VIII Unenrolled Reporting Issues Accessing Care in the Last Year (Continuous and Pre-expansion) or Since Loss of Medicaid Coverage (Unenrolled), 2018



Source: 2018 Group VIII Telephone Survey

VII. Health System Utilization

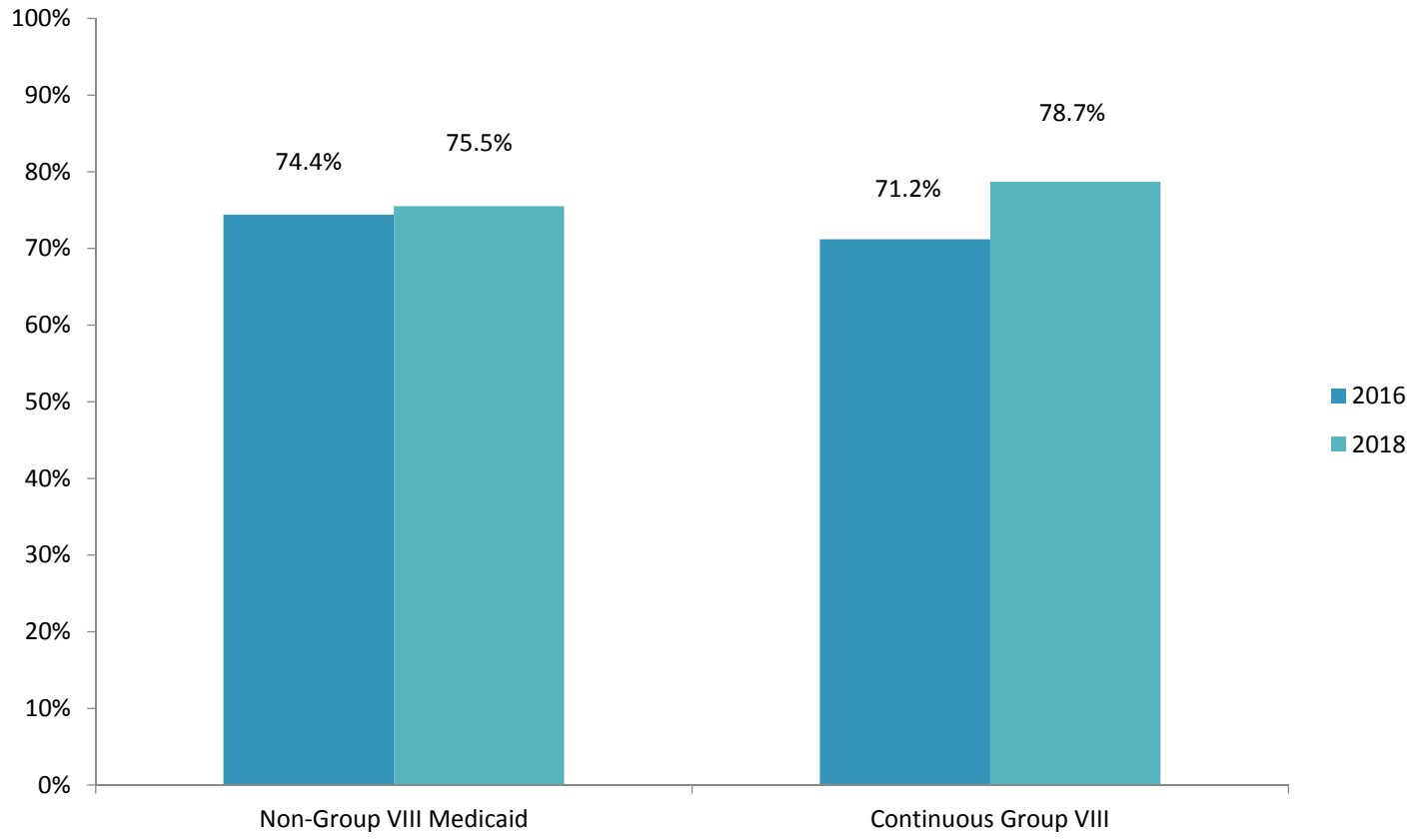
The different analyses on the experience of Ohio's GVIII population confirm findings from other states on the impact of Medicaid expansion on access to care and utilization of care. These findings include:

- Continued improvement in having a usual source of care;
- Continued decreases in delays in getting care and unmet care needs;
- Increased use of primary and ambulatory care;
- Reduced ER use over time as people have longer period of continuous coverage;
- Significant increases in access issues for people after they lose their Medicaid expansion coverage, for both those who obtained other insurance coverage and those who are uninsured; and
- Access and utilization gains for the Group VIII population that did not come at the expenses of those already eligible for Medicaid (to the contrary, Medicaid expansion may have enhanced access to care for the non-Group VIII population).

This report's findings come from analysis of both survey data and claims data. They are further supported by comments from study participants either as part of the survey or during the focus group sessions.

In 2018, 78.7% of the continuous Group VIII population reported having a non-ED source of care compared to 71.2% in 2016, a 7.5% point increase (Figure 20). Having continuous Group VIII Medicaid coverage made a difference in having such a usual source of care. Only 73.9% of those patients who no longer had Group VIII coverage and 73.4% of those who have churned on and off Group VIII coverage reported having a non-emergency room usual source of care.

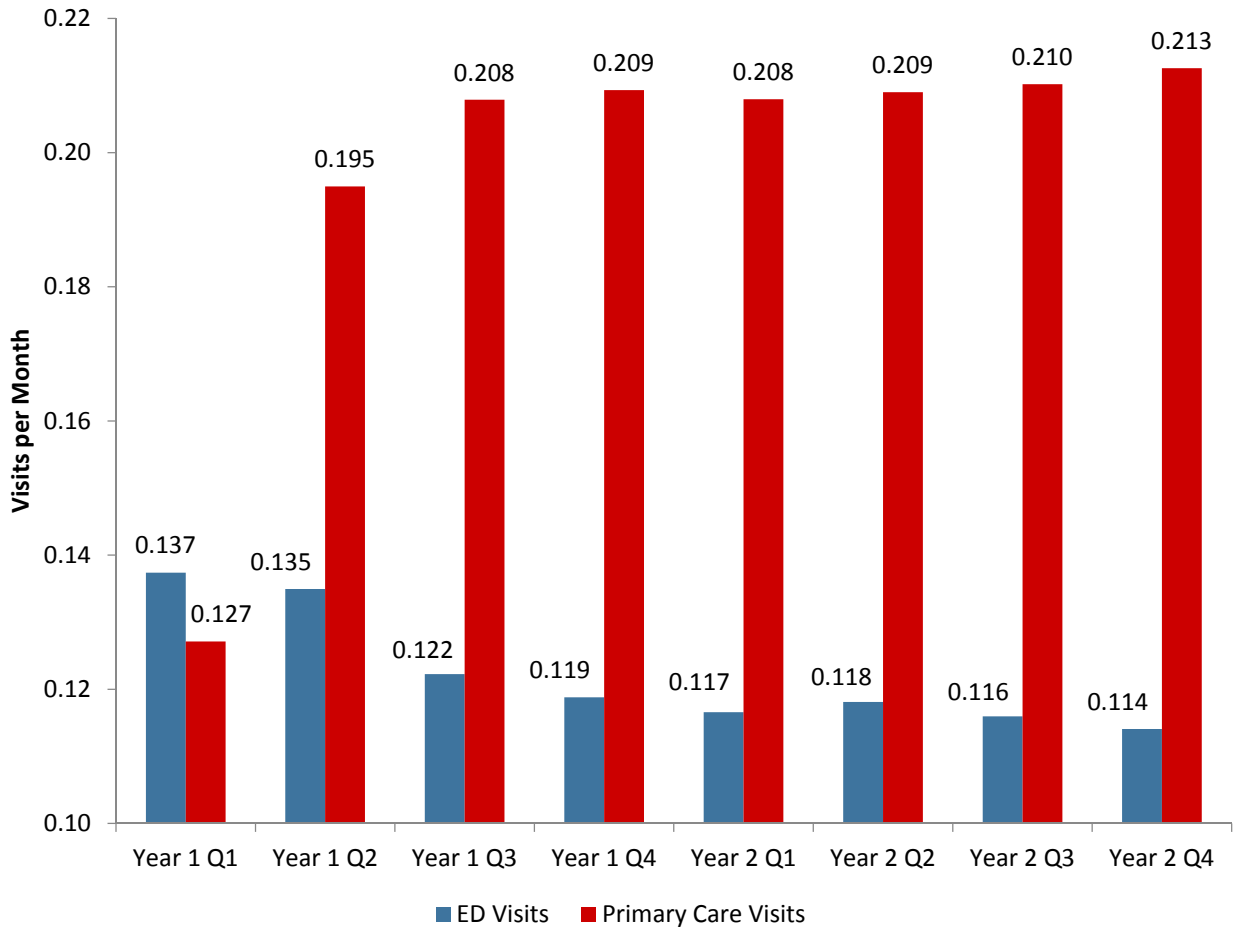
Figure 20: Percent of Continuous Group VIII Enrollees and Non-Group VIII Medicaid Enrollees with a Non-Emergency Department Usual Source of Care, 2016-2018



Source: 2016 & 2018 Group VIII Telephone Surveys

The improvements in provider capacity and access to primary care documented in the previous section translated into changing utilization patterns. The 2016 Group VIII Assessment Study found a shift from Emergency Department (ED) utilization towards primary care: 33.9% of the respondents who gained coverage through Group VIII Medicaid reported using the ED less often, while 15.8% reported using it more often. Medicaid administrative data also indicate that Group VIII enrollees rely less on ED services and more on primary care services over time. Over two years of continuous enrollment, the percent of ED visits per member, per month, fell by 16.8%, while the number of primary care visits increased by 67.2%. The greatest increase in primary care use took place within the second quarter of having Medicaid coverage, while the decrease in ED visits showed a slower rate of decline.

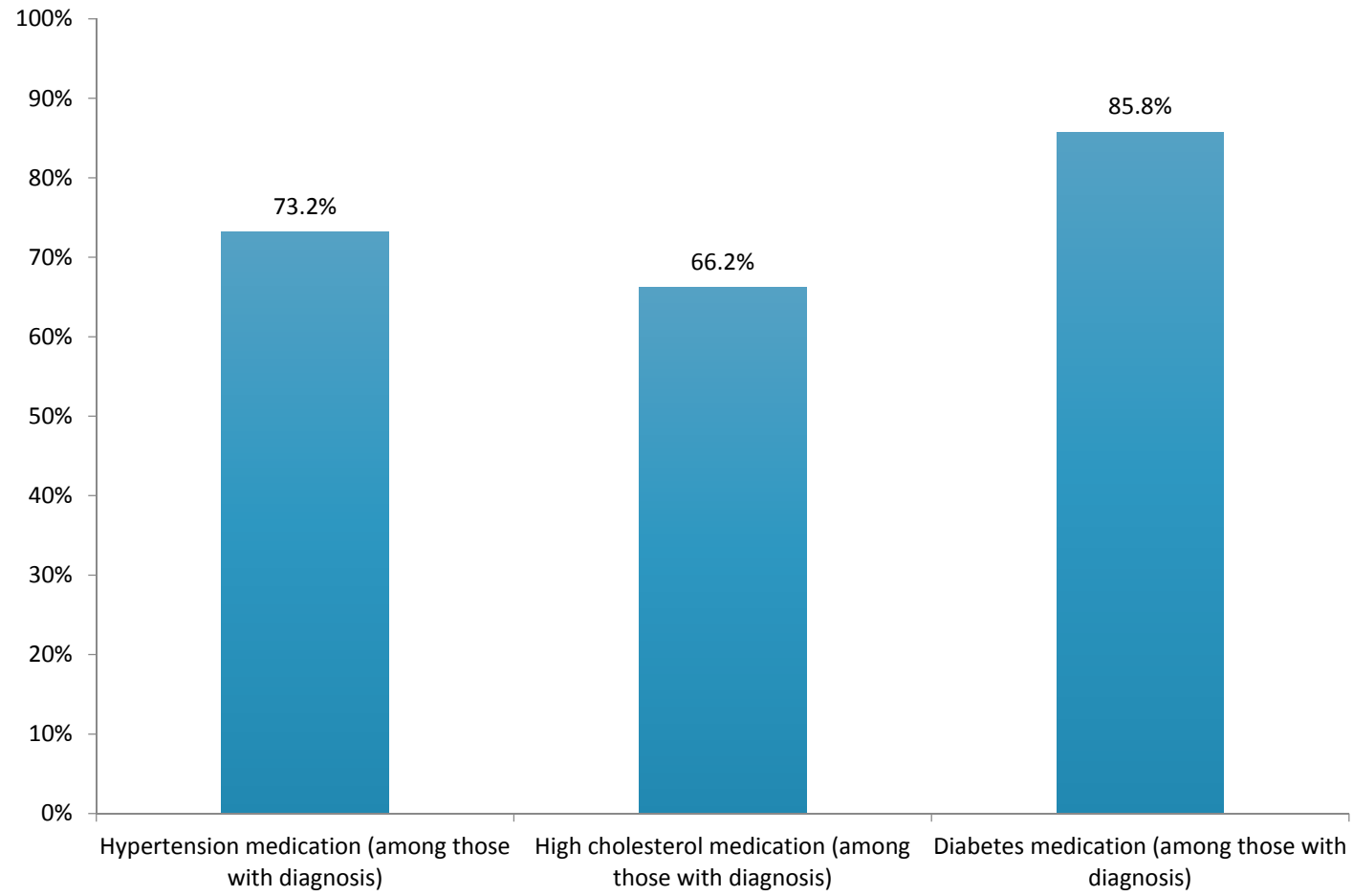
Figure 21: Average Number of Emergency Department and Primary Care Visits Per Month for Group VIII Enrollees (Year 1 Q1 is the First Quarter of Enrollment), 2014 through 2017



Source: Medicaid Administrative Data
Analysis limited to Continuous Group VIII enrollees

Consistent access to primary care enables enrollees to obtain treatment for chronic conditions that may limit ability to work or even become life threatening if left untreated. Large majorities of Continuous Group VIII enrollees who reported having a chronic condition diagnosis also reported taking medication for those conditions (73.2% for hypertension or high blood pressure, 66.2% for high cholesterol, and 85.8% for diabetes). The rates of medication use are higher to that seen in national datasets for similar populations.

Figure 22: Percent of Continuous Group VIII Enrollees with Self-Reported Chronic Condition Diagnoses Taking Medication for Chronic Conditions, 2018



Source: 2018 Group VIII Telephone Survey

What does having Medicaid mean to you?

"It's been a Godsen[d]. Without it I would be in trouble. I would not be able to afford my prescription."

"Thankful that they helped me get the surgery that I needed to get for my gallbladder with no hassle."

"I don't have to worry about my blood pressure medicine and my diabetic medication and coming up with the money for them."

Source: 2018 Group VIII Telephone Survey

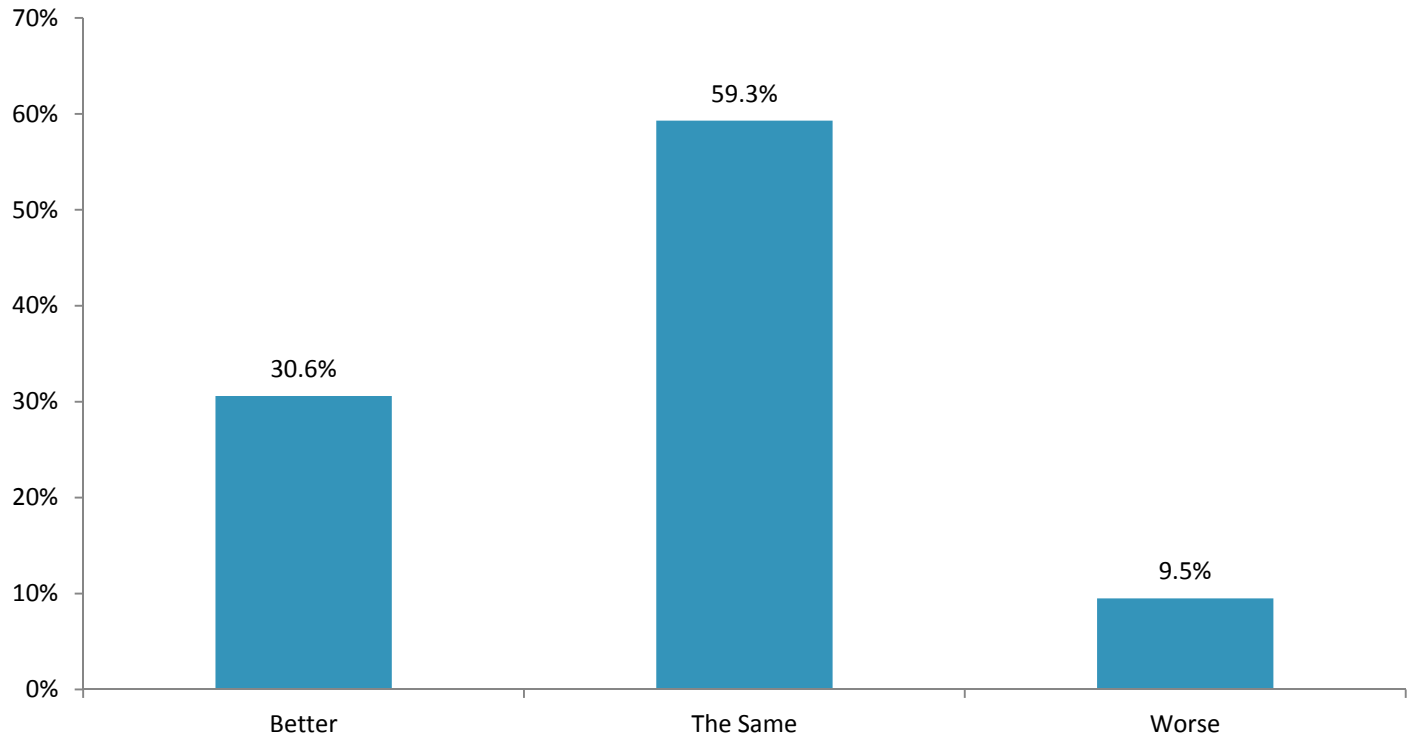
VIII. Physical, Mental, and Behavioral Health

Physical Health

By Enrolling in Medicaid, many Group VIII enrollees were able to access care that appreciably improved their day-to-day health. Continuous Group VIII beneficiaries were more than three times as likely to report that their physical health has improved than worsened (30.6% v. 9.5%)[xx] since enrolling in Medicaid (Figure 23). Literature indicates that survey respondents' self-rated health status is a better predictor of overall and general health than many clinical observations[xxi].

Biometric screenings appeared to confirm respondents self-report reported health status. Participants who reported diabetes were 34.6 times more likely to show an elevated A1c (≥ 6.5%); those who reported hypertension were 3.7 times more likely to show elevated blood pressure. Although they were not a representative sample of the overall Group VIII population, participants in the biometric sample faced significant physical health challenges. For instance, within the biometric sample, 48.6% of individuals were obese and an additional 24.4% were overweight.

Figure 23: Changes in Self-Reported Physical Health since Enrolling in Medicaid, 2018



Source: 2018 Group VIII Telephone Survey
Estimates are for Group VIII Continuous Enrollees

[xx] In 2016, nearly half of Group VIII enrollees (47.7%) reported improvements in their general health status since enrolling on Medicaid, compared to only 3.5% who reported a decline. The somewhat lower rate of Group VIII enrollees reporting improved health in 2018 could be attributable to a change in the wording of the survey question ("physical health" vs. "health").
[xxi] Ellen L. Idler and Yael Benyamini. 1997. "Self-Rated Health and Mortality: A Review of Twenty-Seven Community Studies." Journal of Health and Social Behavior 38:21-37.

As discussed in Section II, transitions in and out of Medicaid enrollment are often the result of changes in health status. Almost one-third (28.3%) of Unenrolled Group VIII dropped Medicaid coverage because their health had improved or because they no longer thought they needed coverage. Likewise, almost one-third (27.5%) of Churn Group VIII reported re-enrolling because of declining health.

What does having Medicaid mean to you?

"If it wasn't for Medicaid, I would not have been able to pay for surgery that was needed for a heart condition I was born with."

"Medicaid made it so that I could get an insulin pump, which has drastically improved my health."

"I am getting my cancer medicine because I have Medicaid."

Source: 2018 Group VIII Telephone Survey

Mental Health

Mental health conditions are prevalent among Group VIII enrollees. Approximately one third (32.7%) of Group VIII enrollees met survey screening criteria for depression or anxiety, while 13.0% of enrollees had a primary depression diagnosis in 2017 according to Medicaid administrative data.[xxii] Around 1 in 4 (24.6%) individuals in the Continuous Group VIII, Churn, and Non-Group VIII Medicaid groups screened positive for depression, while the Unenrolled Group had lower rates (17.4%).

Since Medicaid expansion, Group VIII enrollees with mental illness are making progress toward obtaining needed medical care. Those Group VIII enrollees who screened positive for depression or anxiety reported a non-ED usual source of care as frequently as other Group VIII enrollees (68.9% versus 71.7%). The majority of Group VIII enrollees with depression or anxiety (86.1%) reported that access to mental health treatment was "not a problem," and most (77.5%) Group VIII enrollees with a primary depression diagnosis received psychosocial treatment according to 2017 Medicaid administrative data. Nonetheless, survey data showed that mental health impairment is associated with greater difficulty obtaining needed services. Continuously enrolled Group VIII who screened positive for depression or anxiety reported more difficulty obtaining prescription medication (22.2% vs 7.9%), accessing mental health care (13.9% vs. 5.4%), and accessing other medical care (18.4% vs 6.5%), compared to those who did not meet the screening criteria. These differences were observed even after correcting for age, gender, and co-occurring chronic conditions.

Respondents reported that mental health impairment was a barrier to employment and a factor influencing Medicaid enrollment patterns. Among those who met depression or anxiety screening criteria, 89.3% reported that their condition kept them from work or other usual activities for 7 days or more in the last month, and Continuous Group VIII enrollees who met screening criteria for depression and anxiety were significantly less likely to report being employed (26.9% versus 60.7%). Additionally, those who met depression or anxiety screening criteria were less likely to unenroll from Medicaid (24.1% vs. 17.4%).

[xxii] A brief screening questionnaire on the PHQ4 standardized screening measure (Kroenke et al., 2010) was used to assess symptoms of depression and anxiety. High scores on this scale suggest that an individual is likely to meet the diagnostic criteria for depression or anxiety.

What does having Medicaid mean to you?

"Medicaid means a lot, it means that I can get help with my addiction and gets me the counseling that I need. If I didn't have it I would probably end up back in jail."

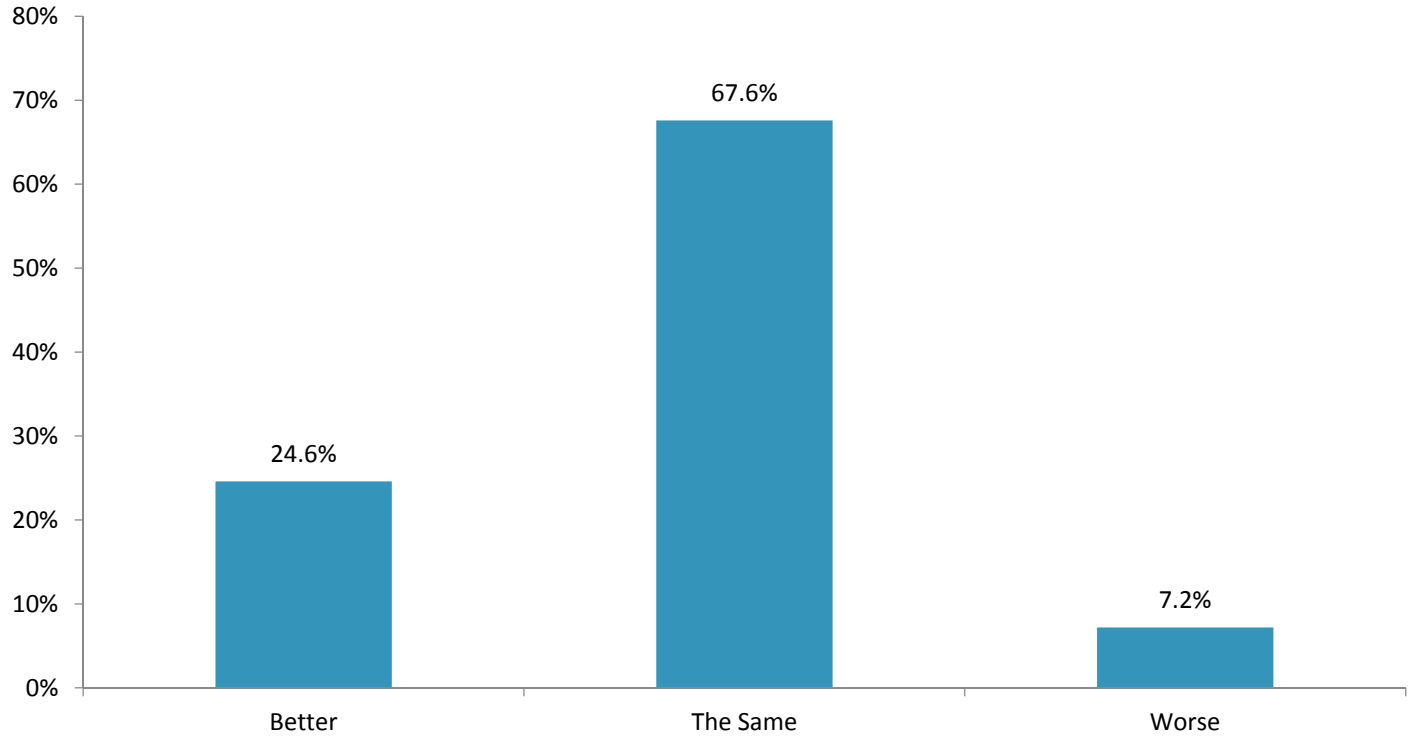
"Having Medicaid coverage has meant getting my mental health and my disability somewhat under control. It has changed my life. It is life changing and I am so thankful."

"It provides me the care I need to [help] with [my] mental condition and able to get my medications to keep living."

Source: 2018 Group VIII Telephone Survey

Medicaid enrollment was associated with improved mental health status, helping to remove a key barrier to employment and economic self-sufficiency. Group VIII enrollees with continuous Medicaid enrollment were 3.4 times more likely to report that their mental health had improved since enrolling on Medicaid than they were to report that it had worsened (24.6% better vs. 7.2% worse, Figure 24).

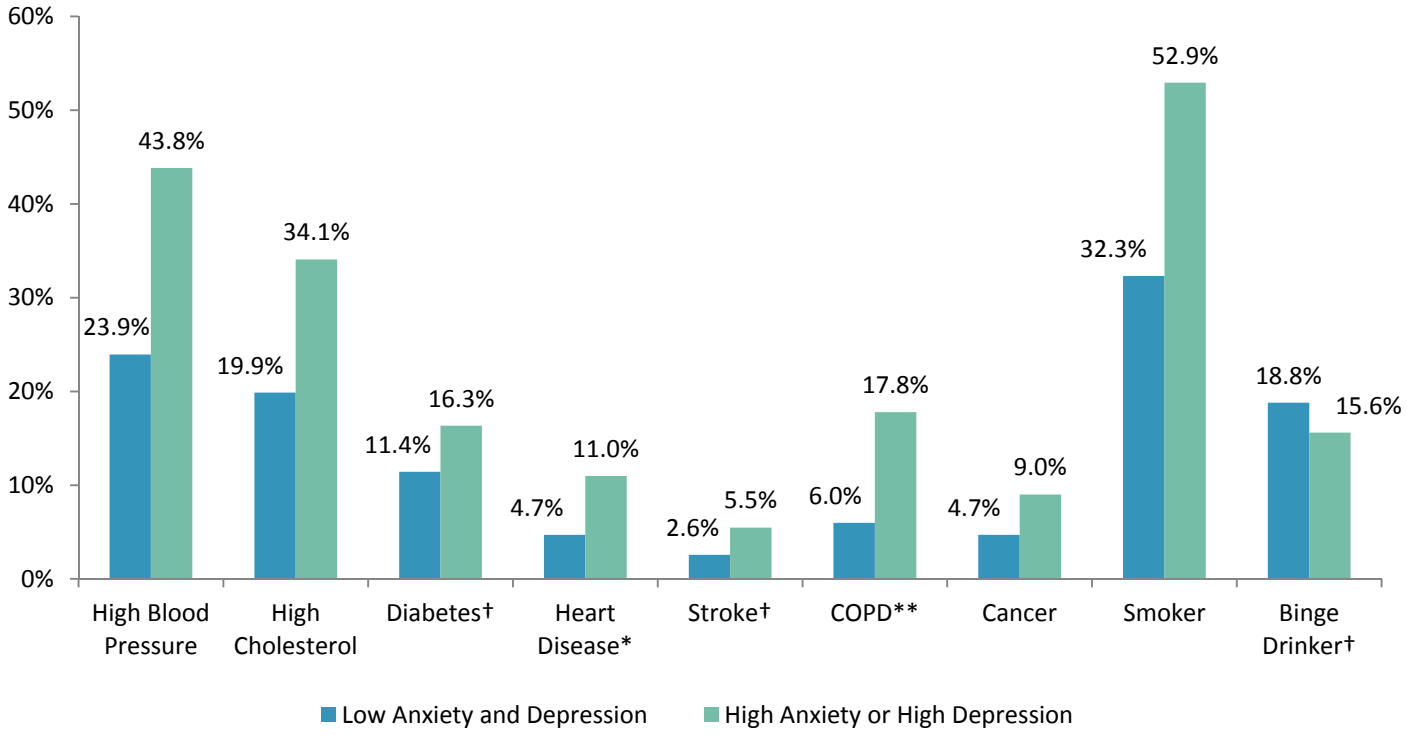
Figure 24: Continuous Group VIII: Changes in Self-Reported Mental Health since Enrolling in Medicaid, 2018



Source: 2018 Group VIII Telephone Survey
Estimates are for Group VIII Continuous Enrollees

The continuous Group VIII enrollees who met depression or anxiety screening criteria had higher rates of chronic disease and risk behavior than those who did not meet the screening criteria (73.6% versus 45.7%). They were more likely to have a diagnosis of high blood pressure, high cholesterol, diabetes, heart disease, stroke, chronic obstructive pulmonary disease, and cancer, in addition to higher rates of smoking (Figure 25).

Figure 25: Percent of Group VIII Enrollees with Self-Reported Chronic Condition Diagnoses by Mental Health Screening Status, 2018



Source: 2018 Group VIII Telephone Survey Data
† Not statistically significant
* Coronary heart disease, heart attack, and/or heart failure
** COPD and/or emphysema

Health Risk Behaviors

Tobacco

A substantial portion of Group VIII enrollees who are smokers are accessing smoking cessation support, including counseling combined with medication, through Medicaid: more than one third (37.0%) of Group VIII enrollees who quit smoking in the last two years said that Medicaid helped them to quit. This would translate into approximately 26,000 Ohioans who have quit smoking with Medicaid's assistance.

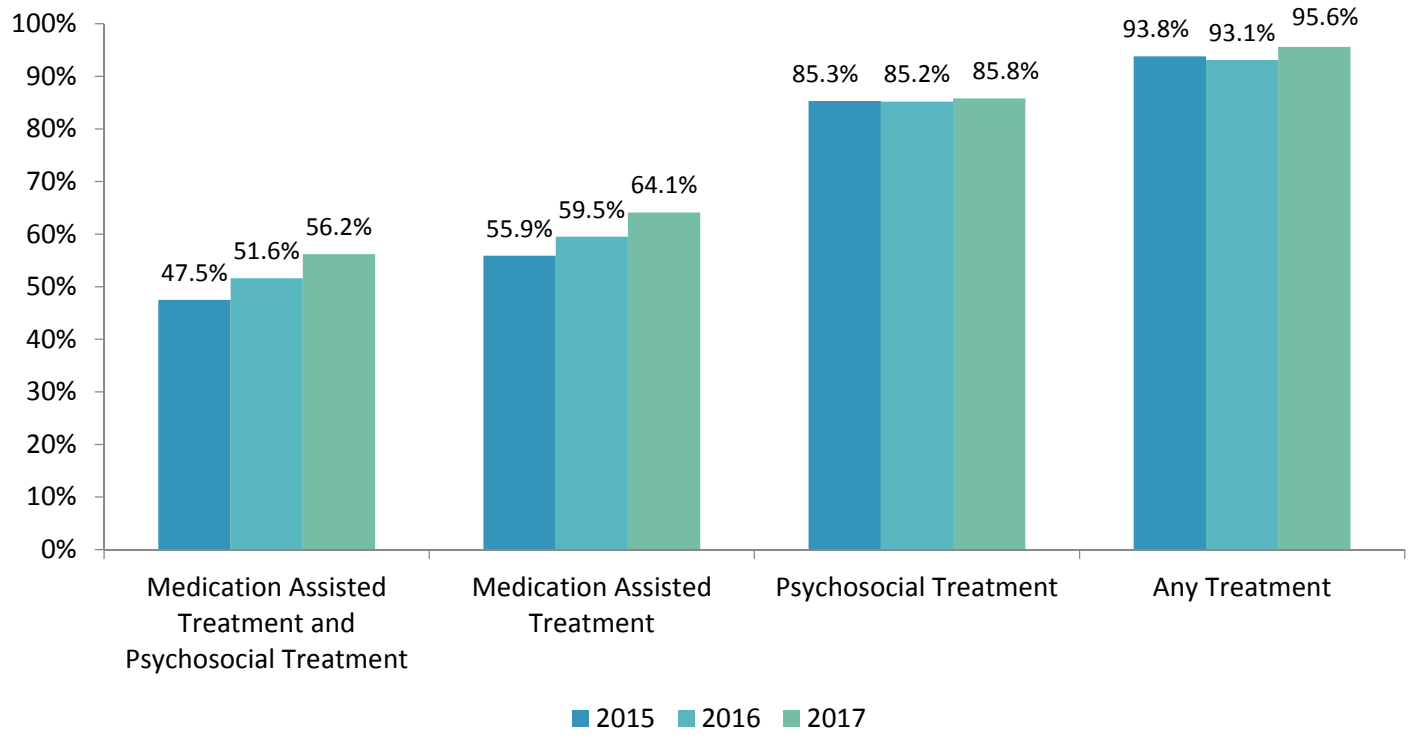
Smoking cessation has important implications for both public health and public finance. Tobacco use is the leading cause of preventable death in the state, killing more than 20,000 Ohioans every year, and by some estimates, 15% of Medicaid

costs are attributable to smoking-related illnesses[xxiii]. Investment in smoking cessation support has been shown to be highly cost effective for Medicaid programs.[xxiv] Through the Group VIII expansion, Ohio's Medicaid program is helping thousands of enrollees to stop smoking.

Opioids

One tenth (9.8%) of Group VIII enrollees received a primary diagnosis for any substance use disorder and 7.9% received a primary diagnosis for opioid use disorder (OUD) in 2017 according to Medicaid claims[xxv]. Among those with a primary diagnosis of opioid use disorder in 2017, 64.1% received pharmacy-dispensed or office-administered Medication Assisted Treatment (MAT), 85.8% received psychosocial treatment, 95.6% received at least one treatment, and 56.2% received both MAT and psychosocial treatment (Figure 26). This reflects an increase in the utilization of treatment from 2015, during which only 47.5% of individuals with a OUD primary diagnosis received both MAT and psychosocial treatment.

Figure 26: Percentage of Group VIII Enrollees with a Primary Opioid Use Disorder Diagnosis Receiving Treatment, 2015-2017



Source: Medicaid Administrative Data
Billing codes used to define MAT and psychosocial treatment are in the Methodological Report

[xxiii] Xu, X., Bishop, E. E., Kennedy, S. M., Simpson, S. A., & Pechacek, T. F. (2015). Annual healthcare spending attributable to cigarette smoking: an update. *American journal of preventive medicine*, *48*(3), 326-333.
[xxiv] Richard P, West K, Ku L. The return on investment of a Medicaid tobacco cessation program in Massachusetts. PLoS ONE 2012;7(1):e29665.
[xxv] This finding is based on diagnosed opioid use disorder, which is likely to be an underestimate of the actual prevalence of opioid use disorder.

Pain Prescription Misuse

Prescription pain medication *misuse* is not the same as *abuse*. "Misuse" refers to "use contrary to the directed pattern of use," while "abuse" refers to "intentional abuse for a nonmedical purpose"[xxvi]. For example, using fewer pills than prescribed would qualify as misuse, but not as abuse. This assessment did not seek to quantify levels of prescription opioid abuse. In survey responses, 7.4% of continuous Group VIII reported that they had misused prescription pain relievers in the past. Rates of misuse were slightly higher for Unenrolled Group VIII and Churn Group VIII (7.8% for both groups). These numbers are similar to Ohio Medicaid Assessment Survey findings regarding rates of prescription pain medication misuse in the population as a whole (6.0%). More than 60% of the continuous Group VIII who reported prescription pain medication misuse stated that such misuse had occurred more than a year ago.

Binge Drinking (four or more drinks on one occasion)

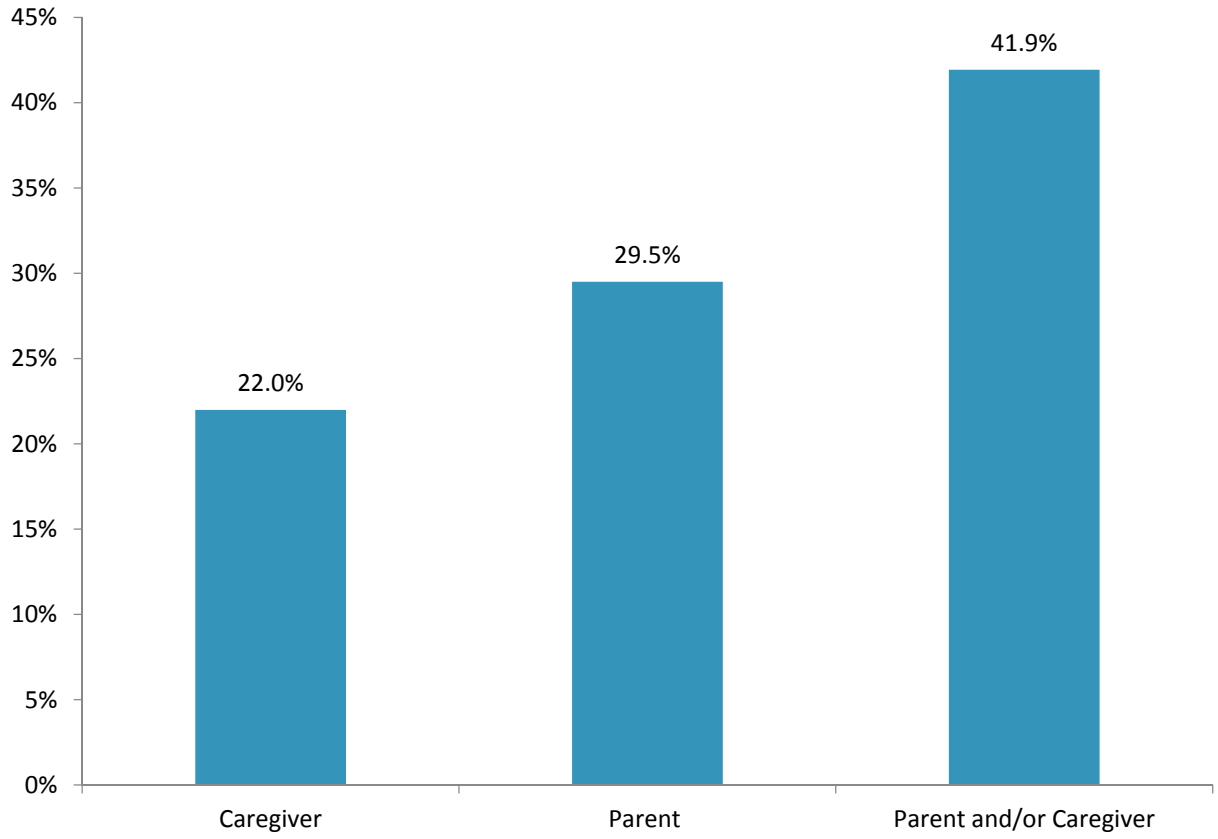
Most (81.8%) Continuous Group VIII reported that they did not drink more than four alcoholic beverages on one occasion in the last thirty days. The other subpopulations in this study reported similar rates of non-binge drinking: 84.5% for Non-Group VIII Medicaid, 80.3% for Churn Group VIII, and 76.2% for Unenrolled Group VIII. The differences between these groups were not statistically significant.

[xxvi] Morley, K. I., Ferris, J. A., Winstock, A. R., & Lynskey, M. T. (2017). Polysubstance use and misuse or abuse of prescription opioid analgesics: a multi-level analysis of international data. *Pain*, *158*(6), 1138-1144.

IX. Family Stability

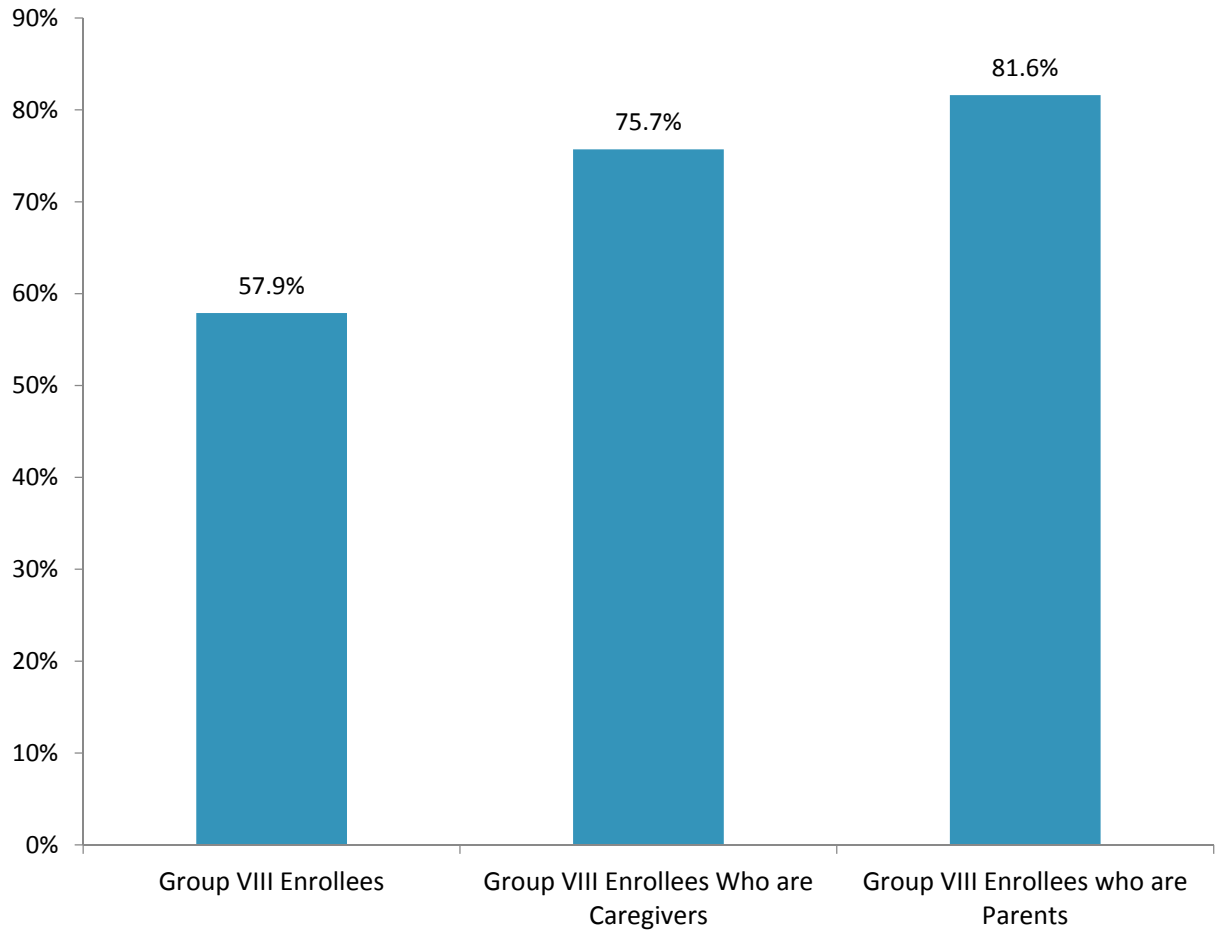
Almost half of Group VIII enrollees (41.9%) are primary caregivers for disabled family members or have minor children in the household. Almost one-third (29.5%) of continuous Group VIII enrollees have non-adult children in the household, 22.0% are primary caregivers for a family member with special mental or physical health needs, and 41.9% are either a parent, a caregiver, or both (Figure 27).

Figure 27: Percentage of Group VIII Enrollees Caring for Family Members with Physical or Mental Health Issues (Caregivers) and/or who are Parents of non-adult Children in the Household, 2018



Source: 2018 Group VIII Telephone Survey
Estimates are for Group VIII Continuous Enrollees

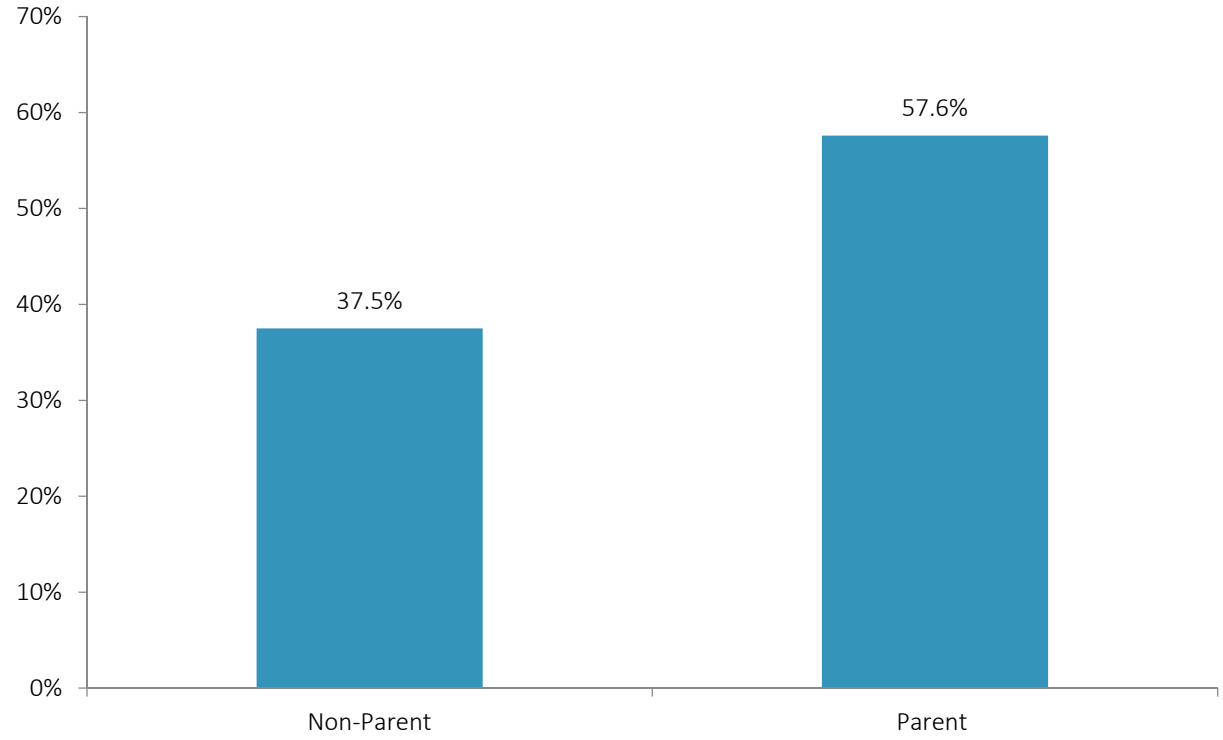
Figure 28: Percentage of Group VIII Enrollees Reporting that Having Medicaid Makes it Easier to Care for their Family, 2018



Source: 2018 Group VIII Telephone Survey
Estimates for Group VIII continuous enrollees

Medicaid makes it easier for enrollees to care for their families. More than half (57.9%) of Group VIII Continuous enrollees reported that Medicaid makes it easier to care for family members (Figure 28). More than three-quarters (75.7%) of enrollees who were caregivers reported that Medicaid made it easier to care for family members, as did more than four-fifths (81.6%) of parents.

Figure 29: Percentage of Group VIIII Enrollees Reporting that Having Medicaid Makes it Easier to Pay for Food or Shelter, 2018



Source: 2018 Group VIII Telephone Survey
Estimates for Group VIII continuous enrollees

Medicaid makes it easier for enrollees to care for their families by helping secure basic needs. While more than one-third (37.5%) of non-parent enrollees reported that Medicaid made it easier to pay for groceries or to pay rent or a mortgage, 57.6% of enrollees who were parents reported that this was the case (Figure 29). When asked in the telephone survey what Medicaid meant to them, one respondent said: "Having Medicaid has meant to me having a stable home, being able to provide food for my family, peace of mind about medical care that I receive. The constant worry is gone about paying for me." By freeing up resources that might otherwise be spent on health care, enrollees are better able to secure food and housing for their families.

What does having Medicaid mean to you?

"[Medicaid coverage] takes the worry away from having something happen and not being able to support myself or my family."

"I am able to take care of myself, so I can take care of my family."

Source: 2018 Group VIII Telephone Survey

X. Conclusion

Over 17 percent of Ohio non-elderly adults have had coverage through Group VIII Medicaid since January 2014. More than one third (34 out of 88) of Ohio counties currently have more than 10% of their 18 to 64 year old population enrolled through Group VIII Medicaid, while 74 Ohio counties have had more than 10% of this population covered through Group VIII Medicaid at some point in time. The significance of Group VIII coverage makes it important to examine the effects of this coverage for Ohioans.

Employment and financial stability

A very high percent of employed Group VIII enrollees (83.5%) reported that having Medicaid made it easier to work, while 60.0% of those who were unemployed reported that having Medicaid made it easier to look for work.

Continuous group VIII enrollees were much less likely to have medical debt than those who are now unenrolled, with 29.8% reporting that their financial situation had improved since coverage began.

Access to care

The percent of enrollees with a usual source of care has increased since 2016, rising to from 71.6% to 78.5%. In addition, the percent of enrollees with at least one primary care visit continued to increase, rising from 60.3% in 2013 to 64.5% in 2017. This increase also corresponds to a decline in ED visits for those with continuous coverage.

Provider Capacity

Provider capacity has increased since 2014. Medicaid expansion appears to have not resulted in increased delays in getting needed care and it may have made access easier given the increase in provider capacity.

Physical Health

Almost one-third of the Continuous Group VIII population (30.6%) reported that their health had improved, compared to 9.5% who said that it had worsened. Roughly one-fourth (28.3%) of the Unenrolled Group VIII group indicated that they left Medicaid because their health had improved or they no longer felt a need for coverage, while 25.7% of the Churn Group VIII cited declining health as a reason for reenrolling.

Mental Health

Having coverage appears to be benefiting the mental health status of Continuous Group VIII enrollees. Over 80% of the Continuous Group VIII enrollees with depression or anxiety (84.3%) reported no difficulties with accessing mental health treatment.

Final Conclusion

In summary, as with the 2016 Assessment, the consensus of the data collected for this report is that Ohio's Medicaid expansion continues to be beneficial to Ohio's Group VIII enrollees in terms of the following:

- Expanding access to care with reduced delays to care and to unmet needs
- Providing access to preventive care, including services like tobacco cessation
- Diagnosing and treating chronic health conditions
- Reducing financial stress and enhanced financial stability
- Increasing treatment for addictions
- Supporting maintaining existing employment and seeking new job opportunities

Methodology Note

The 2018 Ohio Medicaid Group VIII Assessment accompanying Methodology Report is forthcoming and will be available through the Ohio Department of Medicaid.