

*Ohio Medicaid’s child population has been on a mostly downward trajectory since 2015 but has leveled off in 2019. While there is no single cause for the caseload decline, two primary reasons include a strong economy and Medicaid system-related reasons such as resuming annual eligibility renewals.*

## Introduction

This briefing will provide a thorough but concise explanation of the child Medicaid enrollment trends of the past few years. After a brief overview of caseload changes, the reader will find a rundown of some of the main contributory factors broken into two major categories followed by a discussion regarding what happens after individuals are discontinued from Medicaid and a list of some opportunities for improvement.

## Understanding the Child Caseload Decline

Child enrollment in the Ohio Medicaid program peaked in April 2015 with a caseload of 1,328,877 and declined over the next few years reaching its lowest enrollment total of 1,203,738 in December 2018. From that low, child enrollment leveled off and increased slightly to 1,204,860 by June 2019. As with any complex trend such as caseload decline, there is no single factor that can solely be credited for this fluctuating enrollment. There are many variables that impact participation in the Medicaid program, and this paper will highlight some of the major ones. By and large, the largest contributors to the shifting child enrollment fall into several major categories: system issues, economic factors, and human factors.

# Economic Factors

## Income Sensitivity

### Medicaid Caseload Variation August 2018-August 2019

Program	Caseload August 2018	Caseload August 2019	Net Change in Caseload	% Change in Caseload
<b>Covered Families and Children / MAGI</b>	1,641,892	1,592,035	(49,857)	-3.1%
<b>Group VIII Expansion</b>	647,141	605,933	(41,208)	-6.8%
<b>Aged, Blind, or Disabled / MBIWD / Dual **</b>	487,717	488,946	1,229	0.3%
<b>Subtotal Full Medicaid Benefits</b>	<b>2,776,750</b>	<b>2,686,914</b>	<b>(89,836)</b>	<b>-3.3%</b>
<b>Medicare Premium Assistance Only</b>	120,881	119,887	(994)	-0.8%
<b>Other Limited Medicaid Benefits ***</b>	14,724	13,248	(1,476)	-11.1%
<b>Total</b>	<b>2,912,355</b>	<b>2,820,050</b>	<b>(92,305)</b>	<b>-3.3%</b>

\*August 2019 totals are preliminary because all of the retroactive and backdated enrollments are not included. For this month retroactive and backdated enrollment was estimated with statistical forecasting methods that analyze retroactive and backdated enrollment trends during recent years.

\*\*Includes Breast and Cervical Cancer Program (BCCP)

\*\*\*Includes Presumptive Eligibility, Alien Emergency Medical Assistance (AEMA), and Refugee Medical Assistance (RMA).

The above table highlights the change in caseload across Medicaid populations over the course of one year from June 2018 to June 2019. The bulk of the decline in enrollees comes in the MAGI and Group VIII populations whereas there is a slight increase in Aged, Blind, or Disabled caseloads. Because the MAGI and Group VIII caseloads are the most sensitive to fluctuations in income, an improving economy will show a decrease in these populations, and a worsening economy will show a corresponding increase. It's also important to note that there is almost always a lag before a change in economic conditions impacts Medicaid participation. Since most children insured by Medicaid fall into the Covered Families and Children/MAGI population, the decrease in child enrollment is partially explained by the state of the economy. National child Medicaid enrollment data through 2018 reveals trends similar to those in Ohio, with enrollment increasing from 2008 through 2015, then decreasing from 2016 to 2018.<sup>1</sup> The Kaiser Family Foundation (KFF) attributed 2017 and 2018 Medicaid enrollment declines to:

1. A stronger economy.
2. Elimination of renewal delays for states that had implemented new or upgraded eligibility systems.
3. Data matching and enhanced verifications for several states.<sup>2</sup>

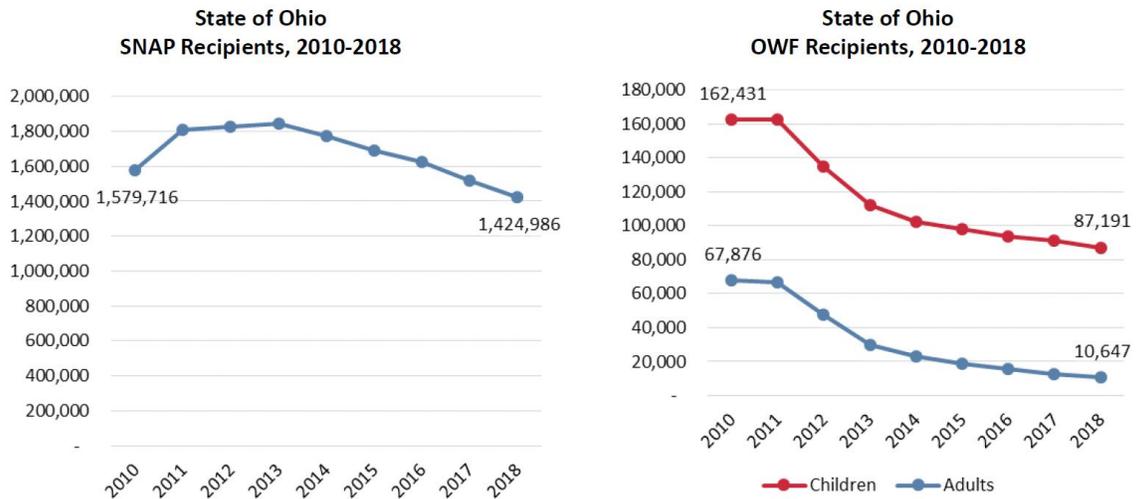
It is important to note that a decline in caseload does not always result in a corresponding increase in private health insurance. Medicaid is a safety net program with eligibility thresholds established in accordance with

<sup>1</sup> "Medicaid and CHIP Enrollment Decline Suggests the Child Uninsured Rate May Rise Again", Georgetown University Health Policy Institute, Center for Children and Families, May 2019, "Children's Health Insurance Coverage Nationwide and in the States, 2016 to 2017", State Health Access Data Assistance Center (SHADAC), May 2019

<sup>2</sup> "Medicaid Enrollment and Spending Growth, FY2018 and FY2019", Henry J. Kaiser Family Foundation (KFF), October 2018.

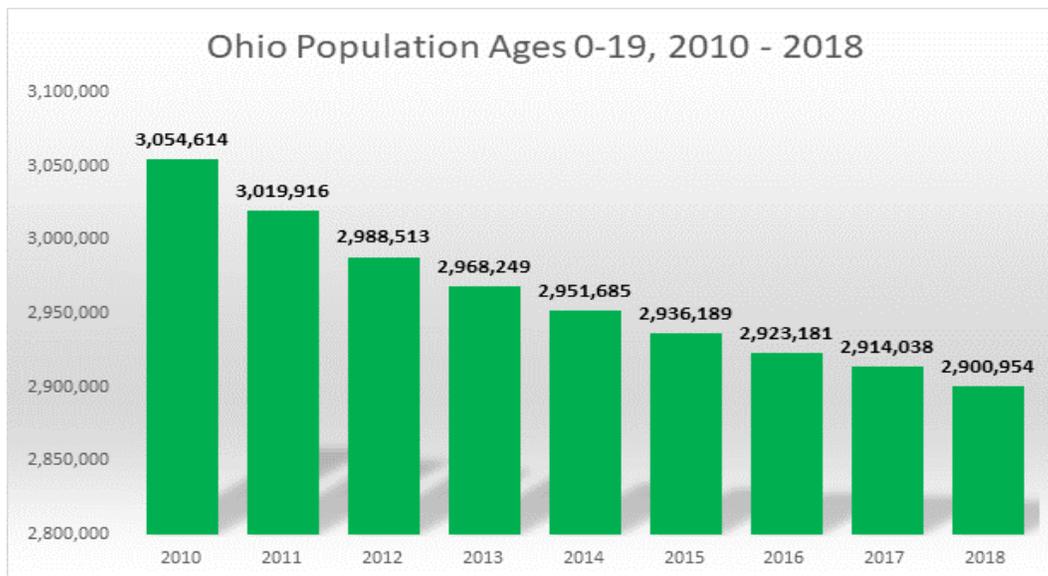
federal law. Consequently, a decline in Medicaid enrollment coinciding with rising incomes is not unusual, but a concomitant increase in private insurance is not expected in every case.

### Mirroring Utilization of Other State Programs



The decline in caseloads across all Medicaid populations including children mirrors utilization for other state programs such as the Supplemental Nutrition Assistance Program (SNAP) and Ohio Works First (OWF), which is also known as Temporary Assistance for Needy Families (TANF), another indicator that rising incomes are partially responsible for Medicaid enrollment declines.

### Fewer Children in Ohio

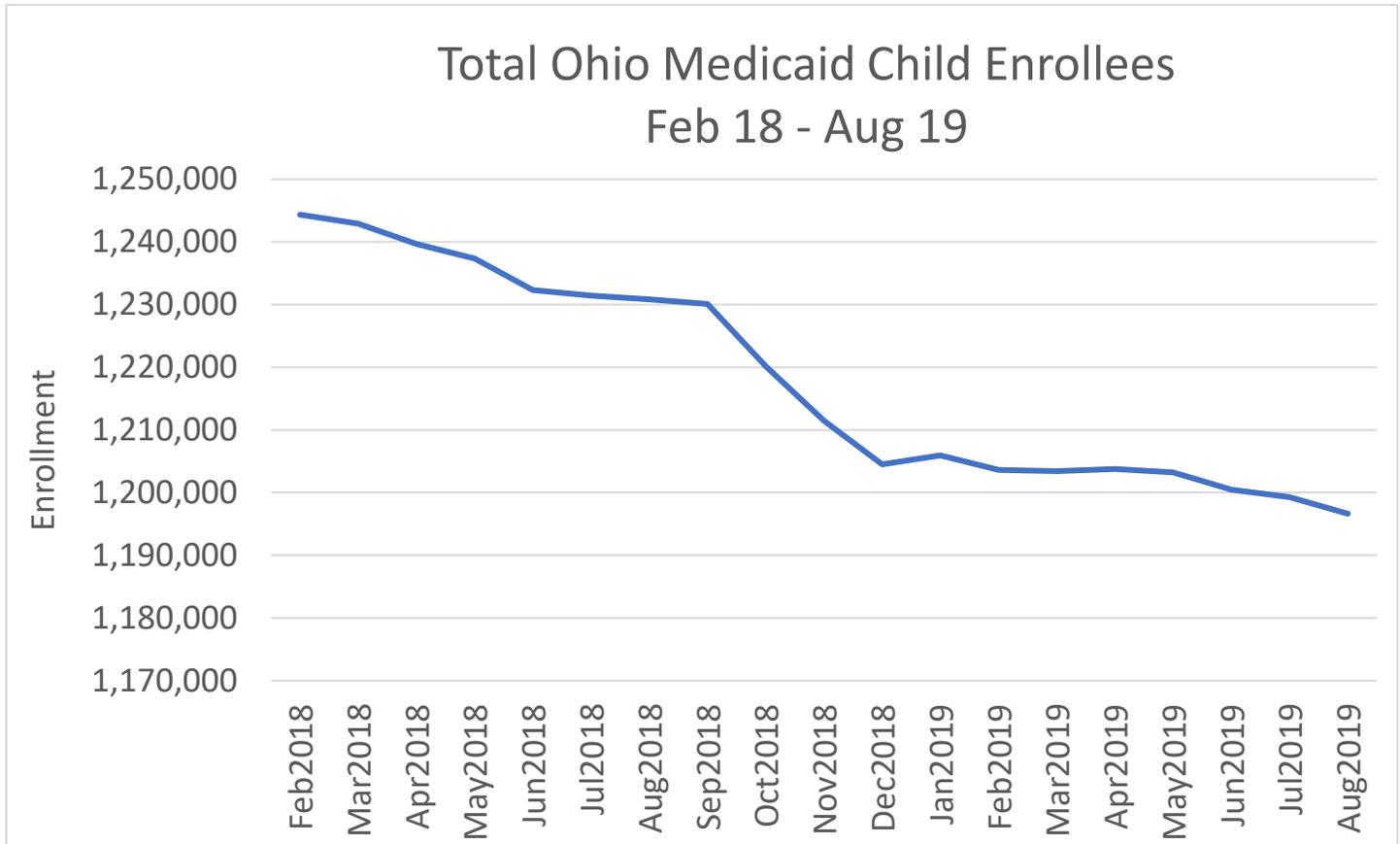


The decline in the total Ohio child population is a likely contributor to the 2017-18 drop in the Ohio Medicaid child caseload, though it is not known to what extent. The total number of children living in Ohio decreased by approximately 22,000 between 2016 and 2018.<sup>3</sup> Additionally, there has been a decrease in live births in Ohio in

<sup>3</sup> | H S Global Insight, July 2019.

recent years. From 2016 to 2018, the number of live births in the state decreased by 3,000.<sup>4</sup> The link between demographic changes and Medicaid enrollment is complex, but the lower total child population in Ohio partially explains declining Medicaid participation.

### Where Are the Disenrolled Children Going?



Medicaid’s ability to track the health insurance status of those who leave the program is limited. In those cases where a reason can be determined, Ohio Benefits identifies the following: over-income, out-of-state, deceased, and withdrawing from Medicaid among the most common discontinuance reasons after failure to comply with the renewal process. Individuals with discontinued coverage because of income-related issues increased by nearly 11 percentage points between 2015 and 2018. The chart above illustrates the trend referenced earlier; child enrollment declined through 2018 before leveling off and slightly increasing in 2019.

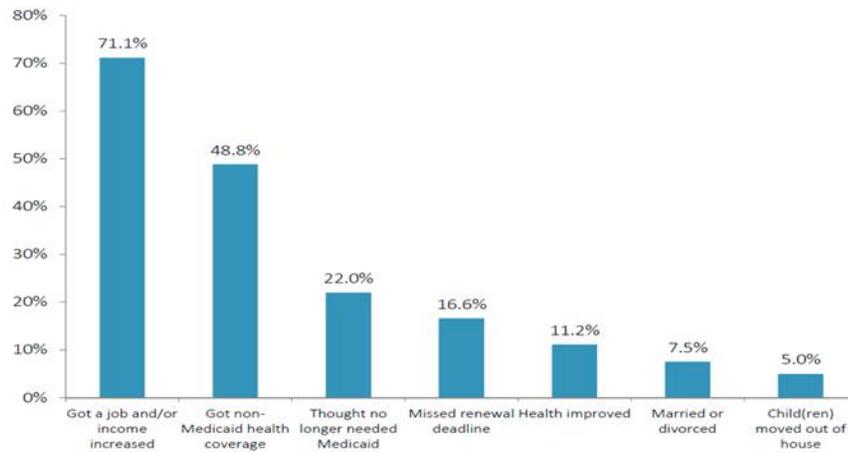
For those who fail to comply, Ohio Medicaid reaches out to individuals by phone and performs periodic assessments to gain what insight we can into these trends. The *2018 Ohio Medicaid Expansion Assessment*<sup>5</sup> included information regarding reasons people were discontinued from Medicaid. The following chart displays the responses from discontinued Group VIII participants who were aware that their Medicaid eligibility had ended. While this assessment did not focus on child enrollment, some Group VIII enrollees, particularly those falling between 91% and 138% FPL may have dependent children. Similar trends are likely occurring in the MAGI/CFC population. Of the group surveyed, 71 percent reported they left Medicaid because they got a job

<sup>4</sup> Ohio Department of Health, Ohio Public Health Data Warehouse, accessed 8/1/19

<sup>5</sup> Ohio Department of Medicaid. [2018 Ohio Medicaid Group VIII Assessment](#). August 2018.

and/or their income had otherwise increased, and nearly 50 percent reported they obtained other health coverage.

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



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

The Department recently investigated the current insurance status for people who left Group VIII Medicaid coverage. Of that group, more than three quarters of those discontinued from Expansion left Medicaid completely, 13 percent switched to CFC coverage, and fewer than 5 percent had transferred to Aged, Blind, or Disabled (ABD) coverage. The survey only included individuals who were aware their coverage had been terminated; 56% percent were unaware that they had been discontinued. While we don't know how many go on to acquire private insurance, some of them likely become uninsured. Data from the Kaiser Family Foundation supports this notion.<sup>6</sup> Ohio expanded Medicaid in 2014, and an increase in both adult and child enrollment soon followed. During the same period, there was a decline in Ohio's child uninsured rate as shown in the table below. This decrease is likely due to the correlation between children obtaining insurance as their parents do. However, also mirroring the national trend, while Ohio's Medicaid caseload declined during 2017, there was an uptick in the child uninsured rate in 2017.

Percent of Uninsured Children in Ohio (0-18)	
2013	5.2%
2014	5.1%
2015	4.5%
2016	3.6%
2017	4.1%

## System Issues

### The Correlation Between Parent and Child Coverage

<sup>6</sup> Kaiser Family Foundation. Ohio: Health Coverage and Uninsured. <https://www.kff.org/state-category/health-coverage-uninsured/?state=OH>

Children in the Modified Adjusted Gross Income (MAGI)-based eligibility population are eligible up to 206% of the federal poverty level; this population is sometimes referred to as a component of Covered Families and Children (CFC). Low-income parents and caretaker relatives are eligible up to 90%, and the Group VIII or Expansion population is eligible up to 138% of the federal poverty level. From the increase in child enrollment that accompanied the rollout of the Group VIII expansion and the corresponding decrease in child enrollment as MAGI enrollment has declined, we know there is a strong correlation between a child having health insurance and the parent having health insurance. Because many Medicaid-eligible adults are unaware of their own income eligibility cutoffs as well as those of their dependents, there are likely many uninsured children in families that are over-income for the adults despite the child still being Medicaid-eligible. These children frequently are added to the rolls again when presenting at a healthcare provider that is qualified to perform presumptive eligibility determinations such as a hospital, but it significantly decreases the likelihood that the child is receiving preventative and primary care treatment such as screenings for lead.

### **Delayed Renewals**

Prior to implementing OhioBenefits, Ohio used the Client Registry Information System (CRIS-E) to process its Medicaid applications. CRIS-E was developed in the mid-1980's and did not have the capacity to exchange real-time information with verification sources, as required by the Affordable Care Act (ACA). During replacement of the eligibility determination system, Ohio obtained permission from the Centers for Medicare and Medicaid Services (CMS) to delay eligibility renewals through 2014. Many renewals were completed by early 2015, but many more were delayed for much longer than one year resulting in an artificially high enrollment in 2015-2016 followed by atypical declines in 2017-2018. The one-year delay in renewals took several years to work through and, consequently, much of the decline in the following years can be attributed to the period of time during which annual renewals were not performed.

### **Application Backlog**

The DeWine administration has been working to reduce the Medicaid application backlog that existed prior to January 2019. To date, the backlog is down by about 50% overall and is continuing to decline due to extensive work with ODM's county partners. The number of applications delayed by between 45 and 180 days is down by 65%, and applications overdue by more than 180 days are down by 80%. ODM is currently in the process of writing a plan of corrective action for CMS detailing how we will continue to address the backlog going forward. During the last six months, child enrollment increased slightly despite a declining unemployment rate, suggesting that the large reduction of backlogged applications may be partially responsible for the recent uptick in child Medicaid participation.

### **The Renewal Process**

CMS requires states to annually renew eligibility for Medicaid enrollees to ensure that Medicaid recipients meet the defined eligibility criteria. This is another area of concern that the DeWine Administration is working to fix. Certain enrollees can be renewed passively through a process in which Ohio Benefits performs a search of available information, and in some cases can renew the enrollee without the need to directly contact them. For the remainder, a manual renewal form is mailed to the enrollee, informing them of the need to complete the renewal process. Because of the sensitive nature of the information involved in the Medicaid renewal process, ODM and its county partners are limited in terms of how those communications are made. Much of the

correspondence must be done through mailing physical letters, while emails can be used for little more than to advise an individual to log into the secure Self Service Portal or call a support line.

This system presents several limitations since mailed letters often go unopened due to the Medicaid enrollees being homeless, having moved, or simply not opening the letter in a timely manner. Additionally, emails and automated calls do not always result in the enrollee taking action to resolve their need to renew. Of the reasons identified in Ohio Benefits as the reason for discontinuance, roughly half of them are due to the individual's failure to comply with the renewal process, clearly some due to system complexities and some due to other human considerations that are more difficult to qualify.

### **Loss of Federal Funding for Navigators**

The ACA federal funding for Ohio navigators was cut from \$1.6 million in 2016 to \$82,360 in 2017 followed by a partial restoration to \$316,818 in 2018. These navigators have served as community resources to reach out to current and potential enrollees to guide them through the enrollment and renewal processes. While the magnitude is unclear, the decrease in the program's funding has likely resulted in fewer individuals completing a Medicaid application as well as decreased compliance with the renewal process.

### **Next Steps**

The Ohio Department of Medicaid is working in the following areas to ensure that all Medicaid-eligible children remain enrolled and avoid experiencing lapses in coverage:

1. Collaborating with our county partners to reduce backlog and process applications and renewals in a timely manner, including identification and sharing of best practices across counties.
2. Reviewing eligibility requirement and streamlining IT systems to simplify for enrollees and reduce workload for county caseworkers, e.g. increasing the number of "no touch" or one touch transactions.
3. Doubling the number of Ohio Medicaid staff dedicated to processing applications and assisting counties that experience work stoppages or excessive backlogs.
4. Implementing the Work Requirement and Community Engagement 1115 Demonstration waiver in a way that provides a "warm handoff" to a job or private insurance to the greatest extent possible.
5. Considering the best possible use of managed care case managers to proactively identify individual's eligibility renewal dates to prevent loss or a gap in coverage.