August 23, 2019

Director Maureen Corcoran
Ohio Department of Medicaid
Columbus, Ohio 43215

Dear Director Corcoran,

Thank you for the opportunity to review and comment on the proposed evaluation methodology for the Group VIII work requirement demonstration study.

- We hope the final evaluation plan will include a review of program administration, which is conducted in 88 different ways across Ohio's county-based system. Individual county protocols may affect who is subject to work requirements and outcomes for those who are required to participate.
- The evaluation plan needs a research question on the outcomes of loss of Medicaid on Group VIII enrollees who fail to succeed at work requirements or who fail to enroll because of the work requirement.
- The evaluation needs to include a plan for transparency: for regular release of data for the public to review and analyze for short-cycle impacts.
- We need more information on the 32 categories of people to be evaluated for outcome. Does it include people who have dropped out or lost coverage because of work requirements and eligible people who never sign up for Medicaid because of the work requirement?
- Much of the evaluation is based on surveys and focus groups (self-reporting). Can Medicaid, in partnership with managed care plans and providers, develop data that meets HIPA requirements to allow a more rigorous evaluation of health outcomes? We see Medicaid case closure data will be utilized, but up to half of case closures are not given a code.

More information on each of our recommendations is provided below.

The proposal does not include evaluation of program administration that may affect enrollment, continued coverage and exemption of Group VIII patients subject to work requirements.

A. The evaluation does not address the variation in administrative process across Ohio's 88 counties, which are responsible for health and human service program administration.

Ohio's Legal Aid organizations find significant variation in administration protocols related to work requirements and overall administration of human service programs, including determination and redetermination of eligibility and how and when exemptions are granted.

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The evaluation should include a comparison of outcomes in counties where work requirement exemptions are granted generously and those where granting of exemptions is rare; where case closure codes are used carefully and where they are not used at all, where redetermination has gone well and where it is problematic, to better understand the 1115 demonstration project outcomes.

B. Program administration matters to the success or failure of a public service enrollee subject to work requirements, as identified and evaluated in the TANF program, Ohio Works First (OWF).[1]

Ohio's counties fear the fiscal impact of an unresolved federal penalty for failing to meet TANF work requirements during the recession. An evaluation of Ohio's work requirements in OWF found caseworkers sanctioned people to ensure compliance with work requirements, reducing the denominator (caseload) to enhance ratios, which led to a sanction rate (dropping people from the program) so far above the national average that it caught legislators' attention.[2] Concern over the penalty has been heightened by eight years of deep state cuts in revenue sharing through the local government fund. These fiscal concerns could affect program administration, leading to the granting of fewer exemptions and sanctioning people for minor infractions, which could harm enrollees and lead to unnecessarily high loss of coverage. The evaluation should investigate this in the context of workplace culture of offices administering the work requirement.

C. A drop in enrollment among children led CMS to require a corrective action plan of Ohio; one component contributing to this decline is identified as Ohio's redetermination process.

Problems in the redetermination process have contributed to decline in Medicaid enrollment.[3] The evaluation should examine how administration of eligibility and redetermination affects outcomes of the Medicaid work requirement.

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[1] The state "all family" work participation rate of 35.2 percent in 10/2011 jumped to 55 percent in 11/2012 due to a 45 percent drop in the "denominator" (total caseload). Public Consulting Group, "Ohio Works First Participation Improvement Project," 5/2013 (p.9).The first observation of the consultant's report: "An after effect of procedural and process changes at the county level is <that it> has had the impact on reducing the denominator <case load> to improve the work participation rate." See Patton, Wendy, "Shrinking aid for Ohio's poorest families," Policy Matters Ohio, November 21, 2013 at https://bit.ly/2P8tdeX

[2] Ibid.

[3] "Medicaid Director Maureen Corcoran points to a couple of reasons enrollment has declined: an improving economy, and "systems issues," including a sometimes-clumsy computerized renewal process that beneficiaries must complete every year to maintain coverage." Catherine Candisky, "250,000 fewer Ohioans are on Medicaid, but even the experts don't know why," The Columbus Dispatch, July 31, 2019 at https://bit.ly/2K63L5o

The evaluation plan needs a research question on the outcomes of loss of Medicaid on Group VIII enrollees who fail to succeed at work requirements, or who fail to enroll because of the work requirement.

Attrition from the study will mask disenrollment. This is already a problem in Ohio's Medicaid program, as evidenced by the CMS mandate for corrective action within the CHIP program. Given decline in enrollment among those subject to work requirements in Arkansas, Ohio can expect rates of disenrollment to increase due to work requirements. This needs to be monitored in the evaluation process.

We need a set of protocols to identify why Group VIII participants engaged in work requirements or subject to work requirements drop out – and what happens to their health and access to health care.

We also need to specifically examine whether the added stigma and burden of seeking exemptions from work requirements affect enrollees more generally, including non-Group VIII enrollees who drop out, especially children whose parents may feel discouraged from applying or renewing coverage.

The evaluation needs to include a plan for transparency: for regular release of data for the public to review and analyze for short-cycle impacts.

Data collected for evaluation should be made publicly available on regular intervals so short-cycle outcomes can be broadly evaluated by stakeholders.

Of particular importance is data regarding enrollment, disenrollment, case closure data, and reporting and non-reporting of work hours by those subject to work requirements.

In addition, average wait times for those reporting by phone, ease of using on-line reporting and efficacy of other modes of reporting should be made available.

Data on costs of administering the work requirement program should be made public and available on regular intervals to short cycle fiscal outcomes can be evaluated by the public. This data should include local administrative costs as well as costs to the state.

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The evaluation plan summary should provide needed information on the 32 categories for focus groups.

The summary provided to stakeholders fails to give complete information on what groups will be evaluated for outcomes. Groups evaluated should include those who disenrolled in Medicaid, to find out reasons for disenrollment and outcomes for them in terms of health and health access.

Participants should be paid for time spent in surveys, focus groups, and related travel time. Payment should be no less than $15 per hour.

Development of quantitative data to evaluate outcomes in health and medical debt

Much of the evaluation is based on self-reporting. The evaluation should, if possible, include quantitative analysis of health and medical debt outcomes from histories of work requirement participants (within HIPA parameters.) Working with managed care companies and providers, the state should develop a database for longitudinal analysis of health outcomes, health access and medical debt (if possible) prior to work requirements, and after.

Comparing outcomes of Group VIII participants with Medicaid participants who are not subject to a work requirement (able bodied parents) may yield sub-optimal understanding because of all the differences noted in the evaluation summary. Historical data based on participants or groups of participants of similar age and health history prior to the imposition of work requirements and after the work requirements go into effect may provide a better basis for comparison.

Some Medicaid data mentioned in the summary – case closure data – is at present unreliable because such a large percentage of cases closed are not coded. A better method of analyzing disenrollment needs to be developed.

Thank you for the opportunity to review the evaluation summary and provide comments.

Sincerely,

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