Overview
Medicaid pays for medically necessary healthcare services for over three million Ohioans and is the primary source of coverage for low-income Ohioans who generally do not have access to or cannot afford other health insurance coverage. The program also pays for services for people who are elderly and disabled, including long term services and supports that are not covered by Medicare and most private health insurance coverage. As a healthcare payer for one in four Ohioans, Medicaid is an important driver of payment reform and quality measurement initiatives in the healthcare system.

Access to care is necessary but not sufficient
While there is evidence that Medicaid coverage improves access to care\(^1\), it is important to note that overall health is influenced by a number of factors. However, only 20 percent of the modifiable factors that influence health are attributed to clinical care.\(^2\) Access to quality clinical care is necessary, but not sufficient, to improving health.

Why do people enroll in Medicaid?
Medicaid is often the most financially feasible health coverage option for people with low incomes. Many Ohioans face barriers to obtaining private coverage due to:
- Low employer-sponsored health insurance offer rates
- Unemployment and other changes in life circumstances that impact coverage (such as death of a partner, divorce, illness, attending school or caregiving for family or friends)
- Unaffordability of private individual health insurance coverage
- Inability to afford cost-sharing
- Limited ability to work due to disabling conditions

Medicaid eligibility categories and cost differences
People who are eligible for Medicaid must have incomes below a specific amount, usually set as a percentage of the federal poverty level (FPL). Eligibility for Medicaid is separated into categories based on age, household composition and medical need. Eligibility categories include Covered Families and Children (CFC), Aged, Blind and Disabled (ABD), Medicaid Expansion (Group VIII) and Other Medicaid. Income levels set for Medicaid eligibility vary by each category.

Individuals enrolled in the ABD category of Medicaid generally have health challenges that are expensive to treat. As a result, the percentage of total Medicaid spending dedicated for this population is proportionally higher than other groups (see figure ES.1).
Medicaid expansion (Group VIII)

Beginning January 1, 2014, Medicaid coverage was expanded to adults between ages 19 and 64 who have incomes less than 138 percent FPL and who are not eligible under other categories. As of February 2017, about 723,000 Ohioans were enrolled in Group VIII (see figure ES.2).

Medicaid financing and spending

Medicaid is a federal-state partnership in which the federal government and states share the cost of providing coverage to Medicaid enrollees. Including both state and federal funding, Ohio’s Medicaid program cost over $25.5 billion in SFY 2016, representing 37.8 percent of the state’s total budget. The federal share of Ohio’s Medicaid program was $17.8 billion (69 percent) with Ohio’s General Revenue Fund contributing $5.8 billion (21 percent) (see figure ES.3).

Figure ES.2. Group VIII enrollment by month, July 2014-February 2017

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<tbody>
<tr>
<td>2014</td>
<td>397,881</td>
<td>467,986</td>
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<td>722,873</td>
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Source: Ohio Department of Medicaid, caseload reports

Note: To the extent possible, this graphic reports back-dated and retroactive eligibility.

Figure ES.3. Ohio Medicaid spending by funding sources, SFY 2016

Federal 69%
GRF state 21%
Non-GRF state 8%
Local 2%

Source: Ohio Department of Medicaid, Annual Report (2016)

Notes

3. This eligibility limit includes a five percent income disregard. Income counting and disregards are discussed in the full publication.