Testimony in Opposition of Medicaid Trigger Language in the State Operating Budget
Delivered to the Senate Medicaid Committee
Jodi Whitted—Assistant Professor and Former Medical Social Worker
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Chair Romanchuk, Vice Chair Huffman, Ranking Member Liston, and members of the Senate Medicaid Committee, thank you for the opportunity to testify today. My name is Jodi Whitted, and I am an Assistant Professor of Social Work at the University of Cincinnati in Cincinnati, Ohio and a former practicing medical social worker. This testimony is my own and I am not here as a representative of my place of employment. Prior to my time in academia, I worked as a clinical social worker in both home health and medical settings where I worked to reduce readmission rates for patients who were chronically ill and experiencing diagnoses such as Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Acute Kidney Injury, and Cerebrovascular Accidents. I worked alongside CMS, the Centers for Medicare and Medicaid Services. I also spent a year working directly for Blue Cross Blue Shield of Tennessee as a Utilization Manager in Medicaid Services.

Today, I stand in opposition of the inclusion of both trigger language and federal mirror language in the state operating budget as it relates to Medicaid Expansion. While the entirety of my time in Ohio has been as an academic and politician, my work started as a licensed practitioner in medical settings in Chattanooga, TN. I worked for a hospital that served all the uninsured patients in the region and also had an operating home health arm within the hospital system. The goal of the home health services was to provide care in the home setting to reduce readmissions. Care at home was good for the patient and the hospital's bottom line.

What made my tenure unique was that I practiced before, during, and after the passage of the Affordable Care Act. As many in this room are likely aware, Tennessee was one of 10 states that opted not to expand Medicaid.[1]

While many others have provided hard statistics and facts, and while my inclination as a professor is to cite journal articles and NIH studies, I would like to use the majority of my time to tell you about a family I met. While I was working for the home health arm of the hospital system, I was referred to see a patient who lived in a rural city near Chattanooga. Upon entering the home, I could see that the family had fallen on hard times. The nurse, who referred me, had warned me that the home was in disrepair and the family was desperate for help of any kind. The patient had been a hard-working man who worked in construction for years before becoming ill with a chronic condition. His wife continued to work two jobs in an attempt to provide for their basic needs and cover the medical expenses of her husband. I entered the home and was greeted warmly by the patient who was bed bound. Although this was approximately 10 years ago, I can remember both the man's smile and the shame he reported for having a social worker come to talk to him about community resources. As I sat to speak with him, I learned that he had worked for years in construction but had fallen ill. I can remember how emaciated he was in appearance. The scent of his unchanged and soiled bedding… as his wife was not yet home from work to assist him with his

toileting. He could not walk. He was in pain. He was tearful. His wife left him in his bed daily, from 8-5 to go to work. Her employment provided a salary that put them just slightly above the cutoff to qualify for any type of relief… including Medicaid. As a social worker, I often ask what is known as the miracle question during my sessions. It helps with goal setting and to determine priorities. It goes like this: If you were to wake up tomorrow and a miracle happened, what would your life look like? I will never forget that man looking me in the eyes and saying, "I know I won't get better. I don't qualify for insurance. I think my miracle would be that I would die, and my wife could just be happy." I continued to meet with the family a few more times, delivering food baskets, helping them locate a resource to build a wheelchair ramp, and connecting them to other miscellaneous resources. A few months later, I learned that this patient did, indeed, die. He was only in his 50s.

I remember thinking that this man might not have died if Medicaid had been expanded and he was able to receive better care. If he hadn't felt like he was burdening his wife by racking up medical bills. He was a living, breathing human being who had worked hard for years, but died feeling like a burden.

But because this story will not appeal to many on this committee, I will add that Tennessee is first in the nation for hospital closures, in the bottom rankings for maternal and infant health, and at the top for uninsured residents. Specifically related to Ohio, in 2019, Ohioans reported that Medicaid Expansion made it easier for them to work.[2]

As public officials who are elected to serve Ohioans, not just Ohioans who are fortunate to have health coverage, I am pleading that we do not follow in the footsteps of Tennessee by stripping our residents of health coverage. Please don't make decisions that will allow for the construction of new stadiums under the guise of economic growth while allowing rural hospitals to close, people to go untreated, and people to die.

Thank you for your time.

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[1] See https://www.kff.org/medicaid/issue-brief/how-many-uninsured-are-in-the-coverage-gap-and-how-many-could-be-eligible-if-all-states-adopted-the-medicaid-expansion/
[2]See https://www.rwjf.org/en/insights/our-research/2019/02/medicaid-s-impact-on-health-care-access-outcomes-and-state-economies.html