

Ohio Annual CHIP Report

For Federal Fiscal Year 1998

Submitted to the Health Care Financing Administration

February 19, 1999

Ohio Annual CHIP Report

Table of Contents

Introduction	2
Healthy Start Coverage	3
Healthy Start Application Procedures	3
State Progress in Reducing the Number of Low-Income Uninsured Children	4
o Baseline Estimates	4
o Caseload Status	4
o Highlights	5
Status of Objectives, Performance Goals, and Performance Measures	6
o Objectives and performance goals	6
o Performance measures	6
Outreach for Children's Health Insurance	7
o State Level	7
o Local Level	8
o National Level	9
Quarterly Reports	9

- Attachment A History of Healthy Start Eligibility**
- Attachment B Managed Health Care Enrollment Report**
- Attachment C Combined Programs Application & Program Fact Sheet**
- Attachment D Expansion Caseload Analysis Bulletin**
- Attachment E Caseload Analysis of Families and Children covered by Medicaid**
- Attachment F Caseload Changes for Children and Adults**
- Attachment G Medicaid Quality Agenda**
- Attachment H Executive Summary of ODHS' 1997-1998
Managed Care Consumer Satisfaction Survey**
- Attachment I Statewide Managed Care Plan Progress Report**
- Attachment J Summary of State Outreach Activities**
- Attachment K HCFA 64.21U for Federal Fiscal Year 1998**

February 12, 1999

Ohio Annual CHIP Report for Federal Fiscal Year 1998

(Jan. 1 through Sept. 30, 1998)

Between January 1, 1998 and September 30, 1998, the State of Ohio provided health coverage to 64,292 children who would not have had access to comprehensive health insurance were it not for Ohio's child health eligibility expansion through the Healthy Start program.

On January 1, 1998, Ohio expanded eligibility for Healthy Start to cover children ages birth through 18, in families with income at or below 150% of the federal poverty level (FPL). Healthy Start has provided comprehensive health coverage to children and pregnant women since 1989, but at lower federal poverty levels, and ages (Attachment A shows the history of Healthy Start eligibility). This most recent expansion of children's health coverage was accomplished through two Medicaid State Plan Amendments, and Federal approval of Ohio's State Children's Health Insurance Plan (CHIP/Title XXI).

Ohio's State Fiscal year (SFY) 1998/99 Biennial Budget (H.B.215) was signed by Governor George Voinovich in June 1997. The State Biennial Budget included funding and authority for the State to implement a children's health insurance expansion through Medicaid for children birth through 18 in families with income at or below 150% of FPL. In August of 1997, the Federal Balance Budget Act created Title XXI, the Children's Health Insurance Program. In light of both the state and federal budget provisions, Ohio crafted a CHIP State Plan that coordinated the Medicaid eligibility expansion with the first phase of the State CHIP Plan.

On December 23, 1997, Ohio submitted its State CHIP Plan to the Health Care Financing Administration (HCFA). The Plan proposed to implement a Medicaid expansion to cover children birth through 18, in families with income at or below 150% of the FPL, to be effective January 1, 1998. This program design allowed the State to build on its support to families by making children's health coverage an option for families. Increasing access to quality health care for children supports working families whose employers do not offer family health benefits, or do so at a cost which may threaten the family's self sufficiency. This health care benefit option assuages parents' concerns about family health insurance when considering employment opportunities. Providing health care coverage for these vulnerable children also assures better school attendance and performance.

Ohio's State CHIP Plan was approved on March 23, 1998, retroactive to its implementation date of January 1, 1998. What follows is a brief description of the operation of Ohio's State CHIP Plan including information on: Healthy Start coverage; application procedures; state progress in reducing the number of uncovered low-income children in Ohio; an update on objectives, performance goals, and performance measures; outreach; and quarterly reports.

Healthy Start Coverage

As a result of the January 1, 1998 Healthy Start expansion, children birth through 18 in families with income at or below 150% of the FPL are potentially eligible for coverage. Coverage through Healthy Start provides the comprehensive Medicaid State Plan Benefit package, including HealthChek (Ohio's EPSDT program). The delivery system for Healthy Start differs depending on which county a Healthy Start consumer lives in.

In all 88 counties, Medicaid operates a fee-for-service delivery system in which Medicaid consumers, including Healthy Start consumers, receive a Medicaid card which is used as proof of coverage. Providers who accept the Medicaid card provide covered services to Medicaid consumers, and bill the State Medicaid Program for those services after they have been rendered.

In 16 Ohio counties, Medicaid operates a Managed Health Care delivery system for Healthy Start and Ohio Works First (Ohio's cash assistance) and related consumers. There are ten mandatory managed care enrollment counties, and six voluntary managed care enrollment counties. Attachment B is a Managed Health Care Enrollment report for

September 1998 that details managed care enrollment by county and by managed care plan (MCP).

Children eligible for Healthy Start via the January 1, 1998 eligibility expansion were not immediately able to enroll in an MCP. MCP capitation rates were not yet available to account for this new eligible population. Deloitte and Touche, Medicaid's contracted actuary at the time, developed rate cells and capitation rates for MCPs which included the expansion population. The revised rate cell structure was put into place to begin MCP enrollment of the "expansion eligibles" beginning July 1, 1998. Beginning July 1, 1998, new eligibles in mandatory counties are systematically informed of the MCP enrollment requirements. Expansion eligibles found eligible between January 1 and June 30, 1998 are informed as part of their eligibility redetermination of the MCP enrollment requirement, in the same way new applicants are instructed to pursue MCP enrollment.

Healthy Start Application Procedures

In order to gain coverage under Healthy Start for a child, a parent or guardian must complete and submit a Combined Programs Application (CPA) to the County Department of Human Services (CDHS) in the county of residence (Attachment C, Combined Programs Application & Program Fact Sheet). The CPA collects information necessary to determine whether a child meets the eligibility criteria established for Healthy Start. CDHS use the CPA and accompanying documentation to determine and verify eligibility for coverage. In addition to submitting the CPA, applicants must provide documentation of identity, social security number, age, and household income. Counties have some latitude in determining if additional documentation is needed in order to determine eligibility.

The CPA is considered "Combined" because it also serves as application to WIC (Special Supplemental Nutrition Program for Women, Infants, and Children); Child and Family Health Service Programs; and the Bureau of Children with Medical Handicaps (diagnosis and treatment program for children with special health care needs, Title V).

To the extent possible, the CPA and the application process were designed to be short and simple. The form is two pages long and is submitted through the mail. There is no face-to-face interview requirement, nor is there a resource limit for Healthy Start. With increased emphasis on enhancing children's access to health coverage, the Department assessed its capacity to further simplify the application process. Concurrent with the expansion, Medicaid expanded the function of the Ohio Consumer Hotline to include application assistance. Since January 1998, the Consumer Hotline has not only provided information about Healthy Start to callers, but has also provided assistance with the form. Hotline Call Representatives fill out the CPA over the phone and then send it to the potential applicant, highlighting outstanding information and necessary documentation. The applicant can then review and sign the form, attach the necessary documentation, and submit it to the appropriate CDHS for processing. A bi-lingual version (Spanish/English) will be available once piloting and final revision is complete.

State Progress in Reducing the Number of Low-Income Uninsured Children

Baseline Estimates of the number of uninsured children in Ohio

When analysis of the Ohio Family Health Survey is complete, results of this survey, in conjunction with the Current Population Survey data, will be used to establish a baseline estimate of the number of uninsured children in Ohio. When the Ohio Family Health Survey analysis is complete, ODHS will prepare and submit a supplement to this annual report that will describe the baseline for measuring the impact of the Healthy Start expansion and the State's progress in reducing the number of uninsured low-income children.

Caseload Status

Attachment D is a Caseload Analysis Bulletin that describes the monthly changes in the Healthy

Start expansion caseload, from implementation through September of 1998. The Caseload Analysis Bulletin explains the methodology used to project the number of children that would be covered over the course of the year (January 1, 1998 through September 30, 1998), the number of children covered in the month of September, and the number of children covered who were previously uninsured, hence covered via Title XXI, rather than Title XIX.

Attachment E, a caseload analysis of families and children covered by Medicaid, shows a caseload increase in the number of children eligible for Healthy Start by virtue of pre-expansion eligibility guidelines. These documents combined help show the impact of not only the Healthy Start expansion, but also potentially the impact of increased outreach and attention to children's health coverage. Increases in coverage of children meeting the pre-expansion guidelines is also impacted by Ohio's welfare reform and declining caseloads in Ohio's cash assistance program, Ohio Works First. As families lose Medicaid coverage that had been based on receipt of cash assistance, many children are subsequently covered by Healthy Start, either in the expansion population, or base eligibility.

Attachment F is a chart that shows overall caseload changes for children and adults covered by Medicaid. While the number of adults covered continues to decrease as a result of welfare reform efforts, the number of children covered in Ohio has actually increased since the expansion was implemented, beginning to reverse an earlier drop in coverage for children. Increases are seen primarily in Healthy Start and the Healthy Start/CHIP expansion.

Highlights from these caseload analyses include:

- In the month of September, 27,511 of the children eligible for the expansion did not have any other insurance. Compared with Lewin Group estimates of 60,000 uninsured children in families not previously eligible for Healthy Start and at or below 150% of FPL, the expansion is currently covering 45.9% of the targeted CHIP children.
- 64,292 children were found eligible for and covered by the Healthy Start expansion between January 1, 1998 and September 30, 1998.
- 42,095 children were covered by the Healthy Start expansion in the month of September 1998.
- The cumulative number of children covered throughout the year is higher than the number of children covered in a given month because even as children gain eligibility for coverage, there are children losing eligibility on an ongoing basis due to periodic redetermination of eligibility.
- 55% of children losing coverage under the Healthy Start expansion lose coverage through Medicaid due to increases in income or failure to complete redetermination, while 45% go on to gain eligibility for coverage through a different category of Medicaid.
- In January 1998 there were approximately 123,000 children eligible for coverage by virtue of pre-expansion eligibility criteria. This caseload, which had relatively flat growth prior to the expansion, has increased to be approximately 139,000 children eligible in the month of September.

The actual caseload is lower than original projections of caseload. This could be for a variety of reasons, including but not limited to originally inflated estimates of low-income children; the eligibility determination process; or problems with outreach impacting enrollment of some populations. The extent to which any of the above three things may impact the caseload variation from projections is unknown. A variety of efforts are underway to identify whether any or all of these have resulted in a lower actual caseload than projected.

Analysis of the Ohio Family Health Survey should help determine whether data used to project caseload over represented potential eligibles leading to inflated estimates. Examination of eligibility policy and processes at the state and local levels should help reveal the extent to which the eligibility process hinders children health coverage. Evaluation of outreach efforts may help State and local level outreach partners understand the extent to which outreach efforts may or may not be reaching certain populations in the State.

It is interesting to note that while the expansion has not covered as many children as anticipated, a much larger than expected number of teenage females have become eligible. This trend in coverage has affected the case-mix, resulting in a higher Per Member Per Month (PMPM) cost than projected.

Status of Objectives, Performance Goals, and Performance Measures

Objectives and performance goals

The Ohio Family Health Survey, conducted by Gallup under contract to the Ohio Department of Health, is complete and analysis of the data collected is under way. The State intends to use the results of this survey, as well as information from the Current Population Survey, as a baseline from which to target objectives and performance goals. Once defined, these objectives and performance goals will be shared with HCFA and other interested parties.

Performance measures

Because Ohio's CHIP plan was an expansion of Healthy Start, Medicaid coverage for children and pregnant women, the quality monitoring and data collection for performance measures is integrated into Ohio's Medicaid Quality Agenda (Attachment G, Medicaid Quality Agenda). Quality information collected for the Medicaid program will reflect performance for the January 1, 1998 expansion.

Ohio is preparing for the release of two Requests for Proposals soliciting contractors to improve and continue the external quality review activity of the Office of Medicaid. The first resulting contract will evaluate the quality of non-institutional health services provided in both managed care and fee-for-service delivery systems. The second resulting contract will implement and manage a statewide quality and utilization management for institutional health services provided to Ohio Medicaid recipients. Reports from these contracted quality initiatives will be shared with HCFA.

The following measures were identified in Ohio's State CHIP Plan and will be included in reports from the contracted entities for both FFS and Managed Care Plans. These reports will be shared with HCFA.

- Immunizations
- Dental Care
- Pediatric Asthma

Using claims data from the FFS delivery system, and encounter data from the managed health care delivery system, the Office of Medicaid will report on performance measures for the following measures identified in Ohio's State CHIP Plan.

- Well Child Care
- Adolescent well visits
- Mental Health

Attachment H is the executive summary of ODHS' 1997-1998 Medicaid Managed Care Consumer Satisfaction Survey. The survey was conducted from December 1997 through February 1998 drawing from a sample of MCP enrollees who were enrolled in the same MCP for six months, from June 1997 through November 1997. Therefore, this survey does not include the 1998 expansion population. However, this report is illustrative of information that will be available in other consumer satisfaction survey reports. Results of a consumer satisfaction survey of the Ohio Works First (cash assistance) and Healthy

Start FFS consumers has been fielded and survey results will be available in June of 1999. The 1999 MCP consumer satisfaction survey will be fielded beginning March of 1999. Both the FFS consumer satisfaction survey, and the 1999 MCP consumer satisfaction survey will include the expansion population.

Attachment I is the Statewide Managed Care Plan Progress Report for January through June of 1998. The progress reports are produced semi-annually, but information for the data may be collected monthly, semi-annually, or annually. The Progress Report provides statistics on key indicators, such as voluntary disenrollment reasons, grievances, utilization reports, and net worth. This Progress Report does not include the experience of the expansion population because enrollment of the expansion population into MCPs did not begin until July 1, 1998. However, the next Statewide Managed Care Plan Progress Report for July through December of 1998 will begin to include the experience of the expansion population.

Outreach for Children's Health Insurance

Outreach for children's health insurance has been an important emphasis at county, state, and federal levels. A spotlight is on expansion of the availability of coverage for children, and the success of the expansions will be measured by the increase in access to health care coverage for children. By virtue of implementing an expansion, Ohio made a commitment to identify potential eligibles and facilitate their application for coverage. Ohio is also committed to a public process that values communities and local direction to the extent possible. This community focus has greatly shaped the outreach that has occurred in the State.

State Level Outreach

At a State level, it has been essential to define an outreach strategy that takes advantage of the natural connections, and logical focus for state level efforts, and a focus that gives communities the opportunities to develop efforts that are not hindered by State activity. This strategy has evolved into four major areas of outreach work at the state level: inter-systems coordination; outreach to "interveners" through state level partnerships; materials and education support; and major media activity. Pursuit of all four of these outreach components has relied on partnership with a wide variety of public, private and non-profit agencies and organizations. What follows is a description of the four components of State outreach activities. Attachment J provides a summary of State outreach activities by month for 1998.

Inter-systems coordination- A variety of state agencies and public programs have existing networks of communication, data collection, and information sharing with local communities. Partnering with these programs and agencies has enabled ODHS to quickly reach out to thousands of local agencies that are in a position to share information about Healthy Start and make appropriate referrals. A primary example is the partnership ODHS has with the Ohio Department of Health (ODH). ODH has assisted the State's outreach effort by ensuring that local health departments and clinics are all aware of

Healthy Start coverage for children; by sharing data of families participating in WIC for targeted outreach; and by facilitating ODHS involvement in statewide school nurse training coordinated out of ODH.

Outreach to "interveners" through state level partnerships- The State has identified a variety of citizens and organizations as "interveners", people who are in a position to intervene in the life of a family and have some influence on behavior. The outreach goal has been to make sure that these interveners have sufficient information about Healthy Start that they are able to make appropriate referrals to the Consumer Hotline, or a local resource when they identify that a child needs health coverage. Many statewide associations have assisted the outreach effort by sharing information with members, and by allowing ODHS to communicate directly with their members. Additionally, many agencies have data that help ODHS identify some targeted outreach efforts. A primary example is child care providers. Both ODHS and the Ohio Department of Education (ODE) license child care providers. The State sent Healthy Start information to all licensed child care providers in Ohio.

Materials and education support- In addition to targeted initiatives with statewide agencies and associations, ODHS developed several presentations and Healthy Start promotional materials. Requests for speakers and/or for materials come into the department and the Consumer Hotline. State outreach staff frequently travel to make presentations and share information about Healthy Start and Medicaid. Requests for materials are fulfilled and documented.

Media activity- With the help of a grant from HCFA, Ohio conducted a four week television campaign in the Cleveland, Youngstown and Columbus markets. The impact of this campaign and those completed through local initiatives will help determine how the state will make use of mass media in the future. The State has not engaged in additional mass media promotional activity. This decision is in large part due to local use of mass media. The State hopes to learn from the local efforts in order to determine how best to further promote children's health insurance.

Local Outreach Activities

The Personal Responsibility and Work Opportunity Act of 1996 (PRWORA) provided one time enhanced federal matching funds for targeted administrative expenditures attributable to Medicaid eligibility outreach related to welfare reform law. The funds are targeted to individuals and families who may meet Medicaid eligibility requirements, but are at risk of losing or not gaining access to Medicaid due to welfare reform. ODHS decided to make most of the PRWORA dollars available at the county level upon approval of a collaborative local outreach proposal that identified allowable activities and allowable match funds.

In 1998 a total of 69 counties submitted county outreach plans ranging from high profile media campaigns to more grass roots efforts. These efforts target families and children at risk of losing contact with Medicaid due to welfare reform, including children in families

that are no longer eligible for family coverage due to increase in income, but whose children may still get health coverage through Healthy Start. Activities also target families and children who may be deterred from even considering health coverage through Medicaid because of the increased attention to welfare reform, and employment. Despite the fact that Medicaid coverage is not contingent on receipt of cash assistance and has no time limits, there is still a great deal of confusion about what Medicaid is, and who can get health coverage.

National Outreach Activities

In addition to the state and local outreach efforts, Ohio is also impacted by national outreach efforts. The response to national outreach efforts in the State is mixed. On one hand, the presence of both State and local outreach initiatives creates some confusion due to variations on name, marketing messages, and phone numbers. By adding a national campaign in the mix, things only become further confused. The confusion is aggravated because national campaigns refer to a health plan available to children with no other coverage. Because Ohio simultaneously implemented a CHIP and a Medicaid expansion, children with other coverage are able to get Healthy Start. On the other hand, there is a momentum around the promotion of health insurance for children that generates a heightened public awareness about the importance of health insurance for children. To the extent this heightened awareness makes people more likely to pay attention to other advertisements and resources, there may be a positive effect coming from the multiple layers of outreach. As of yet, no studies have been completed that evaluate the effect of this potentially confusing, yet possibly effective approach.

Quarterly Reports

The operation of the State CHIP Plan requires quarterly reporting of expenditures and financial and statistical data. Attachment K is a copy of the HCFA-64.21U for the 2nd, 3rd, and 4th quarters of Federal Fiscal Year 1998. The State is finalizing programming that will allow for the completion of reporting on age and service delivery as specified by HCFA. When programming is complete, the State will submit the HCFA 21-E, and the 64EC for the quarters since implementation of the State's CHIP Plan, and ongoing thereafter.