

OREGON CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) FFY 1998 ANNUAL REPORT TO HCFA

Oregon has made substantial progress in recent years at promoting and protecting the health of the state's children. For example, between 1990 and 1996, infant mortality decreased from 8.3 to 7.1 per 1,000 births and the percentage of fully immunized two-year-olds jumped from 47 percent to more than 70 percent. In the same period, the percentage of Oregon's children without health insurance coverage decreased from 21 percent to 8 percent. This is in marked contrast to national figures, which show the population of uninsured children unchanged over recent years, at approximately 14 percent.

While availability of insurance is not the only factor that contributes to improved health status, insured children are more likely than uninsured children to have a regular source of care, to be fully immunized as preschoolers, and to receive needed care when they are sick. Since 1994 the Oregon Health Plan (OHP) Medicaid demonstration has provided comprehensive health benefits to children from birth to age 6 in households with incomes up to 133% of the federal poverty level (FPL) and children age 6 up to age 19 in households with incomes up to 100% FPL.

Although the trends toward increased health coverage and improved health status of children in Oregon are encouraging, work remains to be done. There are children in Oregon still without health insurance and, presumably, without dependable access to adequate health care. These children disproportionately share characteristics such as low-income status, minority status and/or rural life style that present barriers to getting insurance or health care.

Title XXI of the Social Security Act, the State Children's Health Insurance program (CHIP) was enacted in the first session of the 105th Congress as part of the Balanced Budget Act of 1997. It authorized a ten-year program to provide health insurance to children who are not eligible for any other insurance coverage, including Medicaid. States must provide matching funds, but these funds are matched with a higher percentage of federal dollars than the Medicaid match would be. That is, for the Medicaid program Oregon's share of each dollar spent is approximately 39 cents and the federal share is 61 cents, but each dollar of CHIP service only costs Oregon 27 cents while the federal government pays about 72 cents.

Oregon quickly seized this opportunity to provide comprehensive health insurance to children of the working poor, whose families earn too much to qualify for OHP Medicaid. The Legislature's Interim Emergency Board approved a recommendation to "refinance" a previously legislatively approved Poverty Level Medical (PLM) expansion for children under the OHP Medicaid program, which was not yet implemented and use the funding to develop the first component of Oregon's CHIP program.

A. State Plan Operation Information

1. Overview

From a legal and accounting standpoint the CHIP program is separate and distinct from OHP Medicaid so that Oregon can take advantage of the enhanced federal match rate as well as additional features that Congress built into the program. We could have chosen to expand our Medicaid program, but that option would have limited some of the program flexibility built into Title XXI, particularly the ability to make Oregon CHIP a non-entitlement program in which enrollment can be "capped," depending upon the availability of state funds. However, Phase I of the Oregon CHIP program, administered by the Oregon Office of Medical Assistance Programs (OMAP), is designed to be fully integrated with OHP Medicaid, also administered by OMAP. Outreach activities, the application process, the benefits available to CHIP enrollees, the managed care delivery system and program requirements of providers are practically identical.

Oregon submitted a Title XXI State Plan to the Department of Health and Human Services Health Care Financing Administration (HCFA) on February 28, 1998. HCFA approved the plan on June 12, 1998 and the program commenced operation July 1, 1998. The CHIP Program provides comprehensive medical, dental, chemical dependency and mental health benefits to Oregon resident children, birth to 19, with family incomes up to 170% of the Federal Poverty Level (FPL), e.g., \$1,934 for a family of three, with no more than \$5,000 in family liquid assets, and who are not covered by any other creditable health coverage for at least six months before application. The requirement that potential CHIP enrollees not be enrolled with private health insurance for at least six months prior to CHIP enrollment is to ensure against "crowd-out" of private benefits. However, to encourage self-sufficiency and support Oregon's welfare reform efforts, prior enrollment in OHP Medicaid is not counted as having prior medical coverage.

The CHIP benefit package is almost identical to the OHP Medicaid benefit package based on the Oregon Health Plan Prioritized List of Health Services and including all Title XIX services available to OHP Medicaid beneficiaries. The CHIP benefit package however, includes inpatient chemical dependency treatment, which is not part of the OHP Medicaid package. Table I is a comparison of program eligibility for OHP Medicaid or CHIP for children in Oregon families with incomes less than 170% of the FPL.

TABLE 1. OHP Medicaid/CHIP Eligibility Grid

	Under Age I Non-Medicaid Birth	Under Age I Medicaid Birth	Age 1-5	Age 6-18
<ul style="list-style-type: none"> • < 100% FPL 				

With Insurance	OHP Medicaid	OHP Medicaid	OHP Medicaid	OHP Medicaid
Without Insurance	OHP Medicaid	OHP Medicaid	OHP Medicaid	OHP Medicaid
• 100% FPL <133% FPL				
With Insurance	OHP Medicaid	OHP Medicaid	OHP Medicaid	Not Eligible
Without Insurance	OHP Medicaid	OHP Medicaid	OHP Medicaid	CHIP
• 133% FPL <170% FPL				
With Insurance	Not Eligible	OHP Medicaid	Not Eligible	Not Eligible
Without Insurance	CHIP	CHIP	OHP Medicaid	CHIP

2. Progress in Reducing the Number of Low-Income Uncovered Children in Oregon

In the first quarter of CHIP program operations, Oregon has made excellent progress toward reducing the number of uninsured low-income children in the state. As of September 30, 1998 there were 5,476 children under the age of 19 enrolled in the CHIP program statewide. This enrollment represents 22% of the estimated CHIP-eligible children statewide.

In the same time period, Oregon's Family Health Insurance Assistance Program (FHIAP), a state-funded program that provides direct subsidies to purchase health insurance to low-income working people who cannot afford to buy health insurance through their employer or through the individual market, enrolled an additional 85 children under age 19 who meet eligibility criteria similar to those of the CHIP program. Table 2 gives the latest baseline estimates of uninsured children statewide and by county, estimates of potential CHIP-eligible children statewide and by county, and gives estimates of CHIP penetration.

TABLE 2. Oregon CHIP Enrollment as of September 30, 1998

	Est. Uninsured < 19	Est. CHIP Eligible	CHIP Enrolled 9/30/98	% CHIP Enrolled of Est. Eligible

Statewide	79,099	24,886	5,476	22.0%
Baker	590	185	44	23.8%
Benton	1,409	443	74	16.7%
Clackamas	5,158	1,612	330	20.5%
Clatsop	795	250	59	23.6%
Columbia	1,011	318	37	11.6%
Coos	2,206	694	113	16.3%
Crook	444	140	30	21.4%
Curry	714	224	26	11.6%
Deschutes	2,741	882	215	24.4%
Douglas	3,715	1,168	212	18.2%
Gilliam	36	11	1	9.1%
Grant	257	81	20	24.7%
Harney	237	75	32	42.7%
Hood River	405	127	95	74.0%
Jackson	6,433	2,022	349	17.3%
Jefferson	548	172	45	26.2%
Josephine	2,707	851	192	22.6%
Klamath	2,008	631	140	22.2%
Lake	241	76	22	28.9%
Lane	6,332	1,990	494	24.8%

Lincoln	918	288	95	33.0%
Linn	2,258	710	151	21.3%
Malheur	1,241	390	97	24.9%
Marion	6,376	2,005	626	31.2%
Morrow	198	62	31	50.0%
Multnomah	10,221	3,213	992	30.9%
Polk	1,250	393	113	28.8%
Sherman	31	10	7	70.0%
Tillamook	505	159	58	36.5%
Umatilla	1,384	435	149	34.3%
Union	858	270	33	12.2%
Wallowa	254	80	18	22.5%
Wasco	430	135	56	41.5%
Washington	6,759	2,125	421	19.8%
Wheeler	26	8	1	12.5%
Yamhill	1,358	427	98	23.0%

3. Objectives, Goals and Performance Measures

The Objectives, Goals and Performance Measures are outlined in Sections 9.1 and 9.2 of Oregon's Title XXI State Plan.

The strategic objective for Oregon's State Children's Health Insurance Program (CHIP) will be to expand coverage of the Oregon Health Plan (OHP) to include eligible low income children. The current OHP delivery system will assure quality medical care to the CHIP population by removing financial barriers and providing access to inpatient, outpatient, primary and preventive health care services. Specific strategic objectives include:

1. Expand OHP eligibility rules to include uninsured children:
 - **Birth through age 5.** Living in households with three months average gross income between 133% and 170% of the federal poverty level (FPL) and liquid assets amounting to less than \$5,000.
 - **Age 6 through 18.** In household with three months average gross income between 100% and 170% of the FPL and liquid assets amounting to less than \$5,000.
2. Identify CHIP eligibles through coordinated and ongoing outreach activities.
3. Enroll CHIP eligibles in the OHP health care delivery system to assure a usual source of health care coverage.
4. Monitor access and utilization patterns among CHIP enrollees.
5. Improve the health status of CHIP enrollees through provider and client programs specific to the needs of this population.

The following performance goals and measures will be utilized to measure the effectiveness of

Oregon's identified strategic objectives for CHIP:

Performance Goals for Objective 1:

By July 1, 1998, the Office of Medical Assistance Programs (OMAP) will expand the capacity of the OHP to meet the needs of 17,000 CHIP eligibles. OMAP's data and operational systems will be structured to accommodate CHIP criteria in the areas of eligibility determination, enrollment, client information, and utilization of health care services. OMAP staff and Department of Human Resources (DHR) field personnel will receive CHIP-related training.

Status of Performance Goals for Objective 1:

All accomplished according to schedule.

Performance Goals for Objective 2:

By January 1, 1999, OMAP will develop and implement outreach efforts among current Medicaid OHP channels to identify, enroll, and meet the health care needs of the CHIP population.

Status of performance Goals for Objective 2:

In process. See below under C. Additional Program Indicator Data, 1. Outreach, for a description of our activities through September 30, 1998.

Performance Goals for Objective 3:

By July 1, 1999, 17,000 low income children will be enrolled in Oregon's CHIP. As OHP members they will have access to a usual source of health care coverage in the form of a stable health care plan and an assigned primary care provider (PCP). The provision of a usual source of health care will remove financial barriers presented to the parents of low income children.

Status of Performance Goals for Objective 3:-

See above A.2., Progress in Reducing the Number of Low-Income Uncovered Children in Oregon. As of September 30, 1998, approximately 22% of the estimated number of children who meet CHIP criteria in the state have been enrolled. This represents 32.2% of our target enrollment.

Performance Goals for Objective 4:

By July 1, 1998, CHIP enrollees will be assigned a unique code that distinguishes among the general OHP population. OMAP will monitor access and utilization patterns among the CHIP population to assure client access to health care and the delivery of medically appropriate care.

Status of Performance Goals for Objective 4:

The unique code has been assigned so that we are able to distinguish the CHIP population data from the OHP Medicaid population in our information system. New evaluation staff have been hired specifically to evaluate the CHIP program.

Performance Goals for Objective 5:

By July 1, 1999, the following health status and health care system measures for Oregon's CHIP enrollees will be collected and analyzed to demonstrate acceptable incremental improvement in the following areas: childhood and adolescent immunization status, well child and adolescent well care visits, early childhood caries prevention and treatment, treating children's ear infections, and client satisfaction with access to, choice of, and quality of health care.

Status of Performance Goals for Objective 5:-

Work is currently in progress to establish baseline measures by July 1, 1999 in the following areas using encounter data from the CHIP population: child and adolescent immunization status; child and adolescent well-care visits; early childhood caries prevention and treatment; and treating children's ear infections. Because it will be

necessary to collect a year's worth of data on the CHIP population and because of the lag time in the receipt of encounter data, measures demonstrating incremental performance improvements in these areas should be available by March 2000. Work is also in progress to include the CHIP population in the next client satisfaction survey conducted by OMAP.

OMAP staff directly responsible for the implementation and delivery of the CHIP program continuously monitor program administration and take necessary actions to ensure strategic objectives are met.

4. Barriers to Implementation

The interaction of Title XXI provisions with the design Oregon has chosen for our CHIP program is the source of some barriers to fully effective implementation. For example, Oregon's CHIP program "piggybacks" on to our OHP Medicaid program, but with some significant differences. Since we have chosen not to expand the Medicaid program exactly, the CHIP portion of the program, which is mostly fully integrated, has to adhere to Title XXI, not Title XIX requirements. One aspect of our Title XIX is our payment of Health Insurance Premiums (HIP) for employer-sponsored commercial insurance for OHP Medicaid families, if we assess the payment to be cost-effective.

For example, a family of four consisting of a mother and three children under six years old, with family income at 125% FPL, might qualify for an employee HIP payment that would cover the whole family with commercial insurance sponsored by the mother's employer and half paid for by that employer. This is because under our guidelines, all the children would be eligible for Medicaid and we can pay the employee's share of the commercial premium and cover the whole family for the same amount or less than it would cost to cover the children alone in the Medicaid program. If, however, the family consists of a mother, one child under six and two children between six and eighteen, then only the younger child would be Medicaid-eligible. The older children would be eligible for CHIP. Because the CHIP benefit package is not as flexible, i.e., would have to get each commercial package we buy for the CHIP-eligibles approved by HCFA, we do not have the option of paying HIP payments. Thus, although we will pay the same amount, or possibly more, money each month for this family, we can't pay for health insurance for the mother in the combined Medicaid/CHIP family.

The larger issue of CHIP payment of premiums for employer-sponsored benefit packages is being investigated for Phase 11 of our CHIP program. We will continue to work with HCFA to identify ways to maximize the flexibility of CHIP funding within existing guidelines.

5. Need for Technical Assistance

Oregon has no need for technical assistance from the Department of Health and Human Services at this time for the existing CHIP program. We are working with HCFA to

identify mechanisms for our FHIAP program to access Title XXI for payment of premiums for employer-sponsored benefit packages.

B. Additional Program Indicator Data

1 . Outreach Activities

In April, OMAP hosted a meeting with community advocates, health professionals, and government officials to discuss outreach activities for the CHIP program and OHP Medicaid. An enhanced OMAP outreach program began in conjunction with the implementation of the CHIP on July 1, 1998 and was largely based upon outcomes of the April meeting. Between July 1, 1998 and September 30, 1998 quarter, the following activities occurred to implement the outreach program:

- We identified potential outreach facilities as the following types:
 - County health departments
 - Federally Qualified Health Centers (FQHCS)
 - Hospitals
 - Family planning Clinics
 - Rural Health Clinics
 - Tribal health clinics
 - Migrant Health Clinics
- We mailed letters to 193 facilities inviting their participation in outreach
- A service agreement was created to allow facilities access to all OHP (including CHIP) materials and applications. The agreement outlines requirements to offer:
 - application date stamping
 - application completion assistance
 - health plan choice counseling
 - managed care information
- We developed a 4-hour training for outreach facility employees. We are offering this training monthly to accommodate staff changes. The training includes information on:
 - government health care programs, OHP Medicaid and CHIP
 - state government agencies and relationships
 - all OHP/CHIP materials
 - basic eligibility criteria
 - eligibility determination process
 - resource phone numbers and agencies

As of September 30, 1998 there are 77 contracted outreach facilities, including: 32 county health departments; 15 hospitals; 17 Federally Qualified Health Centers (FQHC); and, 13 other health clinic types (rural, migrant, family planning, tribal).

Fig. 1 shows the distribution of these facilities within the state.

2. Crowd-Out

With the exception of applications that indicate the applicant has a condition that could be life threatening or disabling if it were not treated within the next six months, all CHIP potential enrollees who report they have or have had commercial health insurance within the prior six months are determined not eligible for CHIP. Once a child is enrolled in CHIP, if we determine he or she does have other health insurance, the enrollee is notified that they will be disenrolled at the end of the current month. We believe these policy safeguards in place are acting and will continue to act as deterrents to crowd-out. The effectiveness of these policies will be evaluated as the program matures.

C. Expenditure and Financial/Statistical Data

1. Enrollment Data

TABLE 3. Oregon CHIP Children Served FY 98

7/1/98-9/30/98	AGE			
	<1	1-5	6-12	13-18
1 Unduplicated children ever enrolled in CHIP in the quarter				
Fee-For-Service	60	352	992	468
Managed Care Plans	121	1082	2273	1072
Primary Case Management	1	15	33	19
	182	1449	3298	1559
2 Unduplicated number of new enrollees in the quarter				
Fee-For-Service	151	1125	2751	1317

Managed Care Plans	30	317	538	231
Primary Case Management	1	7	9	11
	182	1449	3298	1559
3 Unduplicated number of disenrollees in the quarter				
Fee-For-Service	1	13	36	16
Managed Care Plans	7	49	125	64
Primary Case Management	0	1	1	0
	8	63	162	80
4 Number of Member Months of enrollment in the quarter				
Fee-For-Service	96	597	1634	747
Managed Care Plans	266	2227	4892	2305
Primary Case Management	1	25	58	28
5 Average number of months of enrollment (line 4 divided by line 1)				
Fee-For-Service	1.60	1.70	1.65	1.60
Managed Care Plans	2.20	2.06	2.15	2.15
Primary Case Management	1.00	1.67	1.76	1.47