

December 27, 2000

Cynthia Shirk
Health Care Financing Administration
State Children's Health Insurance Division
7500 Security Boulevard
Mail Stop: S2-01-16
Baltimore, MD 21244

Dear Ms. Shirk:

On behalf of the State of Ohio, I am pleased to submit Ohio's Annual SCHIP Report. The report reviews Ohio's Healthy Start Medicaid program for the period of October 1, 1999 - September 30, 2000.

Ohio implemented SCHIP as a Medicaid expansion to improve access to health insurance coverage for children. As of July 1, 2000, uninsured children up to age 19 in families with incomes at or below 200% of the federal poverty level are eligible for coverage.

We are completing additional analysis of Ohio's caseload experience over the last reporting period and will submit this as an addendum to the annual report in early 2001.

Questions about the evaluation may be directed to Sukey Barnum, Chief of the Bureau of Consumer and Program Support, or Lisa Coss, at (614) 728-8476.

Sincerely,

Barbara C. Edwards, Deputy Director
Office of Ohio Health Plans

Attachments

cc: Gwen Sampson, HCFA
Don Clifton, HCFA
Norm Massey, HCFA

Final Version 11/17/00 National Academy for State Health Policy

Cynthia Pernice, National Academy for State Health Policy

**FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT**

Preamble

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

Recognize the *diversity* of State approaches to SCHIP and allow States *flexibility* to highlight key accomplishments and progress of their SCHIP programs, **AND**

- Provide *consistency* across States in the structure, content, and format of the report, **AND**
- Build on data *already collected* by HCFA quarterly enrollment and expenditure reports, **AND**
- Enhance *accessibility* of information to stakeholders on the achievements under Title XXI.

**FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT**

State/Territory: Ohio

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

(Signature of Agency Head)

SCHIP Program Name (s) Healthy Start

SCHIP Program Type X **Medicaid SCHIP Expansion Only**

Reporting Period Federal Fiscal Year 2000 (10/1/99-9/30/00)

Contact Person/Title Lisa Coss

Address 30 East Broad Street, 33rd Floor
Columbus, OH 43266-0423

Phone 614-728-8476 Fax 614-728-9201

Email cossl@odjfs.state.oh.us

Submission Date _____

SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This sections has been designed to allow you to report on your SCHIP program-s changes and progress during Federal fiscal year 2000 (September 30, 1999 to October 1, 2000).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 1999 in the following areas and explain the reason(s) the changes were implemented.

Note: If no new policies or procedures have been implemented since September 30, 1999, please enter NC=for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

A. Program eligibility

On July 1, 2000, an eligibility expansion was implemented increasing the income limits for Healthy Start from 150% to 200% of the Federal Poverty Level (FPL). Only uninsured children are eligible for this expansion.

B. Enrollment process

On July 1, 2000, simplification measures were implemented for all Medicaid categories, including Healthy Start. Self-declaration became acceptable for identity, age, citizenship (unless the consumer identifies self as a non-citizen), and social security number (unless conflicting information exists). Verification is still required for income, pregnancy, and third-party insurance.

C. Presumptive eligibility

NC

D. Continuous eligibility

On September 29, 2000, Ohio submitted an 1115 waiver demonstration requesting approval for the implementation of 12 months continuous eligibility and a modest annual enrollment fee for Healthy Start children in the 150-200% FPL expansion group.

E. Outreach/marketing campaigns

Local outreach for family and child health coverage continues via allocation of matching funds to counties. The process for allocating funds to counties for outreach changed in SFY 2001. The plans required of the counties were redesigned, and the formula used to calculate the allocation amounts was modified. In addition, approved counties must now submit quarterly reports highlighting activities and expenditures. The state continues to do outreach, and partnering with schools was especially successful in FFY 2000. The most expansive outreach initiative in this period was the inclusion of 2.1 million Healthy Start program brochures in the information packets distributed to students on the first day of school, as well as the program information included on the school's free/reduced lunch application.

F. Eligibility determination process

The application simplification measures implemented on July 1, 2000 (see Enrollment Process, above) means that less verifications are required to complete the eligibility determination process.

G. Eligibility redetermination process

On July 1, 2000, 12 month redetermination periods were implemented for Healthy Start consumers. Prior to July 1, 2000, the redetermination period was every 6 months.

In spring of 2000, technical assistance sessions were conducted throughout Ohio on the expansion and simplification efforts implemented on July 1, 2000. During these sessions, emphasis was made on the delinking of cash assistance and Medicaid, and the importance of not terminating a consumer's Medicaid coverage during an eligibility redetermination for another program. Systems changes are also ongoing to support this delinking.

An ex parte policy was formally implemented in November 1999 as an integrated and comprehensive process, ensuring that consumers are evaluated for eligibility for all Medicaid/SCHIP programs prior to terminating coverage. Ohio's ex parte policy is called Pre-Termination Review.

H. Benefit structure

In early 2000, ODJFS implemented significant community-based provider fee increases, which helped stabilize provider participation in the Medicaid plan.

I. Cost-sharing policies

On September 29, 2000, Ohio submitted an 1115 waiver demonstration requesting approval for the implementation of continuous coverage and a modest annual enrollment fee for Healthy Start children in the 150-200% FPL expansion group.

The annual fee, when approved and implemented, will be \$25 per child, with a family maximum of \$75.

J. Crowd-out policies

The 1115 waiver for the annual enrollment fee is the only crowd-out mechanism planned in Ohio in addition to monitoring participation in private coverage for the population.

K. Delivery system

NC

L. Coordination with other programs (especially private insurance and Medicaid)

NC

M. Screen and enroll process

NC

N. Application

The Combined Programs Application (CPA) was revised in October 1999 to simplify the application, making the application process easier for both consumers and caseworkers. In addition, the CPA was translated into Spanish.

In 2000, the CPA was further streamlined, and changes were made in the application to reflect the shift in families moving from welfare to work (e.g., inclusion of a work phone number section, narrative emphasizing that a face-to-face interview is not required). In addition, changes were made to enable families to apply for 1931 family coverage using the CPA.

O. Other

NC

1.2 Please report how much progress has been made during FFY 2000 in reducing the number of uncovered, low-income children.

A. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2000. Describe the data source and method used to derive this information.

Information regarding the changes that have occurred to the number or rate of uninsured, low-income children will be included in an addendum that will be submitted in early 2001.

B. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

In Ohio, because SCHIP was implemented as a Medicaid expansion, Medicaid and SCHIP outreach activities are one and the same. It is therefore not possible to determine the number of children enrolled in Medicaid as a result of SCHIP outreach activities.

Ohio implemented enrollment simplification measures on July 1, 2000 for all Medicaid categories. Self-declaration became acceptable for age, identity, citizenship (unless the consumer identifies self as a non-citizen) and social security number (unless conflicting information exists). Verification is still required for income, pregnancy, and third-party insurance. Also in July, Ohio increased income limits for both the Healthy Start and Healthy Families programs.

Enrollment of children in Healthy Start and Healthy Families increased in FFY 2000. In October 1999, there were 491,979 children covered through Healthy Start and Healthy Families. In September 2000, there were 539,807, an increase of approximately 9.7%. The rate of growth is fastest in the 150-200% SCHIP expansion group and in Healthy Families.

C. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

NC

D. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

No

1.3 Complete Table 1.3 to show what progress has been made during FFY 2000 toward achieving your State's strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

- Column 1: List your State's strategic objectives for your SCHIP program, as specified in your State Plan.
- Column 2: List the performance goals for each strategic objective.
- Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

Note: If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter NC (for no change) in column 3.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
		Data Sources: Methodology: Progress Summary:
OBJECTIVES RELATED TO SCHIP ENROLLMENT		
		Data Sources: Methodology: Progress Summary:
OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		

Table 1.3		
		Data Sources: Methodology: Progress Summary:
OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		
		Data Sources: Methodology: Progress Summary:
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
		Data Sources: Methodology: Progress Summary:
OTHER OBJECTIVES		

		Data Sources: Methodology: Progress Summary:
--	--	----------------------------------------------------

1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.

No change at this point; the target dates for the performance goals are in the future. If the data delivered in the addendum indicates that there are performance goals that are not on track, barriers and constraints will be identified at that point.

1.5 Discuss your State's progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.

No issues in addition to the strategic objectives have been identified.

1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.

Information regarding future performance measurement activities will be addressed in the addendum.

1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here.

Summary: State Outreach Activities

Report: An Analysis of Medicaid Enrollment in Franklin County

Reports: The 2000 Medicaid Managed Care Consumer Satisfaction Survey

- Executive Summary Report

- Final Report

Report: Parents' Perceptions Regarding Communications About the Healthy Start Program

Table 1.10 Strategic Objectives and Performance Goals

(1) Strategic Objectives	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
<p>Objective 1: Increase the percent of children with creditable coverage below 150% of the FPL</p>	<p>The percent of children with creditable coverage for the entire year whose family income for the entire year is below 150% of the FPL will be increased from 79.6% in CY 1997 to 87% in CY 2000</p>	<p>Data Sources: U.S. Current Population Survey, March Supplement (1998-2001)</p> <p>Methodology:</p> <p>Inclusion Criteria: Children ages 0 thru 18 Ohio Residence Family income less than or equal to 150% of FPL</p> <p>Weighting Criteria: March Supplement Weight</p> <p>Numerator: Children who had one or more sources of health care coverage at any time during the year.</p> <p>Denominator: Total Children</p> <p>Progress Summary: 1998 - 80.9%</p> <p>Will be updated in early 2001.</p>

Table 1.10 Strategic Objectives and Performance Goals

(1) Strategic Objectives	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress
<p>Objective 2: Increase the percent of children with creditable coverage between 150% and 200% of the FPL</p>	<p>The percent of children with creditable coverage for the entire year whose family income for the entire year is between 150% and 200% of the FPL will be increased from 89.5% in CY 1998 to 95% in CY 2003</p>	<p>Data Sources: U.S. Current Population Survey, March Supplement (1999-2004)</p> <p>Methodology:</p> <p>Inclusion Criteria: Children ages 0 thru 18 Ohio Residence Family income less than or equal to 200% of FPL and greater than 150% of FPL</p> <p>Weighting Criteria: March Supplement Weight</p> <p>Numerator: Children who had one or more sources of health care coverage at any time during the year.</p> <p>Denominator: Total Children</p> <p>Progress Summary: Program will begin in July 2000. Will be updated early 2001.</p>

Table 1.10 Strategic Objectives and Performance Goals (continued)

<i>(1)</i> <i>Strategic Objectives</i>	<i>(2)</i> <i>Performance Goals for each Strategic Objective</i>	<i>(3)</i> <i>Performance Measures and Progress</i>
OBJECTIVES RELATED TO CHIP ENROLLMENT		
<p>Objective 3. Increase the number of children with creditable coverage through enrollment in the CHIP program</p>	<p>Enroll children in the CHIP program at a rate that is equivalent to 75% of the potentially eligible children by December 2000.</p>	<p>Data Sources: Medicaid Management information System, Recipient Master File (RMF); Ohio Family Health Survey, 1998 and 2001(planned).</p> <p>Methodology: inclusion Criteria: Children ages 0 thru 18 Countable family income is less than 150% of FPL Ohio residence Exclusion Criteria: otherwise eligible for Medicaid or Healthy Start using December 1997 financial eligibility criteria.</p> <p>Numerator: Number of children enrolled for month (RMF)</p> <p>Denominator: Number of potentially eligible children in 1998 (76,000 children) and 2001 (FHS).</p> <p>Progress Summary: June 98 28% December 98 43% June 99 50% December 99 59%</p> <p>Will be updated early 2001.</p>

<p>Objective 4: Increase access to health care to children below 200% of FPL.</p>	<p>Goal A: Decrease the percent of children who have no usual source of care or use the emergency room from 9.4% in 1998 to 8.7% in 2001 and 8.0% in 2004</p>	<p>Data Sources: Ohio Family Health Survey, 1998. Ohio Family Health Survey, 2001 (planned).</p> <p>Methodology: Inclusion Criteria: Children age 0-18, Family income less than or equal to 200% of FPL, Ohio residence.</p> <p>Numerator: Children who have either no usual source of care or use emergency room for usual source.</p> <p>Denominator: Total Children</p> <p>Progress Summary: 1998 Baseline - 9.4% No Change</p>
----------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

<p>Objective 4: Increase access to health care to children below 200% of FPL. (Continued)</p>	<p>Goal B: Increase the percent of children on Medicaid and CHIP who reported having a personal doctor or nurse from 90% in 1999 to 95% in 2004</p>	<p>Data Sources: Medicaid Consumer Satisfaction Survey. Managed Care, Spring 2000 (panned).</p> <p>Methodology: Stratified random sample of Medicaid managed care plans, telephone survey, estimated 3900 respondents, Inclusion criteria: Children who were enrolled in a MCP for six months or more.</p> <p>Numerator: Number of children who reported having a personal doctor or nurse.. Denominator: Number of children</p> <p>Progress Summary 1999 - Baseline: Preliminary data - Medicaid =90.6%, CHIP=87.2%. Will be updated early 2001.</p>
	<p>Goal C: Decrease the percent of children that report any unmet health care needs from 10.9% in 1998 to 10.4% in 2001 and 9.9% in 2004.</p>	<p><i>Data Sources and Methodology: See Goal A.</i></p> <p><i>Numerator:</i> <i>Children who reported an unmet health care need, including dental care, prescription drug, medical exams, tests, procedures, or physician visits.</i></p> <p><i>Denominator</i> <i>Total Children</i></p> <p><i>Progress Summary</i> <i>1998 Baseline - 10.9%</i> <i>No Change</i></p>

<i>(1)</i> <i>Strategic Objectives</i>	<i>(2)</i> <i>Performance Goals for each Strategic Objective</i>	<i>(3)</i> <i>Performance Measures and Progress</i>
OBJECTIVES RELATED TO ACCESS TO PREVENTIVE CARE		
<p>Objective 5: Increase access to preventive health care services for children below 200% of FPL.</p>	<p>Goal A: Increase the percent of children who had at least one well child/well baby visit from 76.8% in 1998 to 78.4% in 2001 and 80% in 2004</p>	<p>Data Sources: Ohio Family Health Survey, 1998. Ohio Family Health Survey, 2001 (planned).</p> <p>Methodology: Inclusion Criteria: Children age 0-18, Family income less than or equal to 200% of FPL, Ohio residence.</p> <p>Numerator: Children who reported received at least one well child/well baby visit.</p> <p>Denominator: Total Children</p> <p>Progress Summary: 1998 Baseline - 76.8% No Change</p>
	<p>GOAL B: Increase the percent of children enrolled in CHIP who had the number of comprehensive exams recommended by the American Academy of Pediatrics: Infants - from 19.7% in 1998 to 40% in 2004. Age 1 - from 43.4% in 1998 to 50% in 2004. Age 2-18 from 27% in 1998 to 36% in 2004</p>	<p>Data Sources: Medicaid claims and encounter data.</p> <p>Methodology: See Appendix C.</p> <p>Numerator: - Number of infants who had at least 6 comprehensive exams. - Number of children age 1 who had at least 2 comprehensive exams. - Number of children ages 2 thru 18 that had at least 1 comprehensive exam.</p> <p>Denominator: Total number of eligibility years at age 0, 1, and 2-18.</p> <p>Progress Summary: 1998 Baseline - Infants: 19.7% Age 1: 43.4% Age 2- 18: 27% Will be updated early 2001.</p>
	<p>Goal C: Increase the percent of children who had at least one dental visit from 61.1% in 1998 to 62% in 2001 and 63% in 2004.</p>	<p>Data Sources and Methodolgy: See Goal A.</p> <p>Numerator: Children who reported at least one dental visit.</p> <p>Denominator Total Children</p> <p>Progress Summary 1998 Baseline - 61.1% Wil be updated early 2001</p>

<p>Objective 5: Increase access to preventive health care services for children below 200% of FPL (continued).</p>	<p>Goal D: Increase the percent of children age 3-18 enrolled in Medicaid and CHIP who had at least one dental visit from 34% in 1998 to 45% in 2004.</p>	<p>Data Sources: Medicaid claims and encounter data.</p> <p>Methodology: See Appendix C.</p> <p>Numerator: Number of children ages 3 thru 18 that had at least 1 Dental visit. Denominator: Total number of eligibility years at age 3-18.</p> <p>Progress Summary: 1998 Baseline - <i>Medicaid FFS and HMO</i> = 32.8% Will be updated in early 2001.</p>
	<p>Goal E: Increase the percent of two year old children on Medicaid and CHIP who had all of their recommended immunizations by age two from 48% to 65%.</p>	<p>Data Sources: Medical records extraction.</p> <p>Methodology: See Appendix C.</p> <p>Inclusion Criteria: Children age two on Medicaid or CHIP. At least 6 months of continuous eligibility.</p> <p>Numerator: Children who received all of their immunizations by the age of two.</p> <p>Denominator: Total children age two with at least 6 months of continuous eligibility.</p> <p>Progress Summary: (Baseline data for SFY 1998 has not yet been collected. For Medicaid children in HMOs in 1996 this rate was 48%.) No Change</p>
	<p>Goal F: Increase the percent of children on Medicaid and CHIP age 0-6 who had a lead lab test from XX% in 1998 to XX% in 2004 (This goal is under development). Will be updated early 2001.</p>	<p>Data Sources: Medicaid claims and encounter data.</p> <p>Methodology: See Appendix C.</p> <p>Numerator: Number of children ages 0 thru 6 that had a claim or encounter for a lead lab test. Denominator: Total number of eligibility years at age 0-6.</p> <p>Progress Summary: (Baseline data for SFY 1998 has not yet been calculated.) Will be updated early 2001.</p>

Table 1.10 Strategic Objectives and Performance Goals (continued)

(1) Strategic Objectives	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress
OBJECTIVES RELATED TO CARE FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS		
<p>Objective 6: Increase access and coordination of services to children with special health care needs which prevent health care needs from moving into an acute episode.</p>	<p>Goal A: Decrease the percent of asthmatic children age 1 to 18 enrolled in CHIP who had one or more emergency room visits or inpatient admissions from 39.1% in 1998 to 35% in 2004.</p>	<p><i>Data Sources: Medicaid claims and encounter data. Methodology: See Appendix C. Numerator: - Number of asthmatic children age 1-18 who had at least 1 emergency room visit or 1 inpatient admission. Denominator: Total number of asthmatic children.</i></p> <p><i>Progress Summary: 1998 Baseline - managed care plans: 46.2% Fee-for-service: 44.2% CHIP: 39.1%</i></p> <p>No Change</p>
	<p>Goal B: Increase the percent of children ages 11 to 18 enrolled in Medicaid and CHIP who were hospitalized for treatment of specific mental health and chemical dependency disorders who were seen on an ambulatory basis within 30 days of hospital discharge.</p>	<p><i>Data Sources: Medicaid claims and encounter data. Methodology: See Appendix C. Numerator: Children ages 11 to 18 who had inpatient discharge and had a specific mental health or substance abuse CPT code within 30 days of discharge. Denominator: Children ages 11 to 18 who had at least one inpatient admission. Progress Summary 1998 Baseline - Managed health care: 44.8%</i></p> <p>Will be updated early 2001.</p>
	<p>Goal C: Increase the percent of children with special health care needs that were satisfied with the quality of care provided by medical specialists from 84% in 1999 to 87% in 2004</p>	<p><i>Data Sources: Medicaid Consumer Satisfaction Survey. Managed Care, January 2000.</i></p> <p><i>Methodology: Stratified random sample of Medicaid managed care plans, telephone survey, estimated 3900 respondents, Inclusion criteria: Children who were enrolled in a MCP for six months or more. Children who screened positive in the 5 item CAHPS CSHCN screener. Estimated 600 respondents.</i></p> <p><i>Numerator: Number of CSHCNs who rated their specialists an 8 or higher on a scale of 0 to 10. Denominator: Number of children who reported that they had at least one visit to a specialist.</i></p> <p><i>Progress Summary 1999 - Baseline: Preliminary date - 84.1%.</i></p> <p>No Change</p>

Table 1.10 Strategic Objectives and performance Goals (continued)

(1) Strategic Objectives	(2) Performance Goals for each Strategic Objective	(3) <i>Performance Measures and Progress</i>
	<p>Goal D: Increase the percent of children with special health care needs that were satisfied with case management and care coordination from XX% in 2000 to XX% in 2004 (This goal is under development). Will be updated early 2001.</p>	<p>Data Source and Methodology: See Goal C, above.</p> <p>Numerator: Composite indicator reflecting likert scale responses on satisfaction with physicians knowledge of medical history, involvement in health care decisions, receiving necessary treatment, and follow up care.</p> <p>Denominator: Number of children.</p>

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to allow you to address topics of current interest to stakeholders, including: states, federal officials, and child advocates.

2.1 Family coverage:

- A** If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.

Though not a Title XXI program, Ohio offers family coverage through its Healthy Families program. Families with incomes up to 100% FPL are eligible, and can apply using the same application used to apply for the Healthy Start program. Also like Healthy Start, no face-to-face interview is required. Healthy Families is Ohio's 1931 coverage for families.

- B.** How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2000 (10/1/99 - 9/30/00)?

Not applicable (Ohio's family coverage program is not a SCHIP program).

- C.** How do you monitor cost-effectiveness of family coverage?

Not applicable.

2.2 Employer-sponsored insurance buy-in:

- A. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).**

Not applicable; Ohio does not have a buy-in program.

- B. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2000?**

Not applicable.

2.3 Crowd-out:

A. How do you define crowd-out in your SCHIP program?

Prior to the expansion of the Healthy Start program in July 1, 2000, crowd-out was not an issue for Ohio because both insured and uninsured children whose families met the income limits were eligible for coverage, either by virtue of SCHIP (for uninsured) or an underlying Medicaid expansion (for underinsured).

The July expansion was implemented for uninsured children only. As time passes, crowd-out for this expansion group be will be observed, measured, and defined.

B. How do you monitor and measure whether crowd-out is occurring?

Ohio is monitoring participation in private insurance for targeted low-income populations, based upon Current Population Survey data. Also, crowd-out will be addressed in the next Consumer Satisfaction Survey.

C. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

Results are not yet available for the July 1, 2000 expansion.

D. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

Not applicable.

2.4 Outreach:

A. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

Partnerships with a variety of groups, including Head Start, the Covering Kids Coalition, and the Ohio Department of Education (ODE) have been very effective in reaching low-income, uninsured children. A recent example is the partnership with ODE, the Ohio Department of Health, and other community stakeholders to distribute Healthy Start information in the packets sent home with children on the first day of school. The success of the effort was seen in the large volume of postage-paid cards that were returned requesting information, and in the increase of consumer calls to the Medicaid hotline.

An evaluation component is planned for the school-based outreach initiative. Follow-up will be done on ten percent of the individuals who indicated interest in the Healthy Start program. If information in the Client Registry Information System - Enhanced (CRIS-E) does not indicate that the individual applied for the Healthy Start program, the individual will be contacted to determine why an application was not submitted.

Another successful outreach activity was the partnership with Governor Bob Taft and First Lady Hope Taft in spreading the word about the Healthy Start expansion through press conferences and public service announcements.

B. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

NC

C. Which methods best reached which populations? How have you measured effectiveness?

NC

2.5 Retention:

A. What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

Ohio issued an integrated, comprehensive, and prescriptive ex parte policy (Pre-termination Review), and has trained local agencies on the policy. Also, Ohio expanded Healthy Start redetermination periods to 12 months on July 1, 2000.

B. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

___ Follow-up by caseworkers/outreach workers

State Renewal reminder notices to all families

___ Targeted mailing to selected populations, specify population _____

___ Information campaigns

___ Simplification of re-enrollment process, please describe _____

___ Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe _____

State Other, please explain

- Working with local agencies and consumers to emphasize the delinking of cash assistance and medical coverage.

- The Ohio Family Medical Project, in which consumers who may have erroneously lost medical coverage are reinstated.

In addition to the state activities above, counties are doing their own outreach activities. Activities vary from county to county, and are targeted to their specific populations and consumer needs.

C. Are the same measures being used in Medicaid as well? If not, please describe the differences.

The same measures are being used in Medicaid.

D. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

The measures that Ohio has found to be the most effective in ensuring that eligible children stay enrolled is the implementation of an ex parte policy, the work being done to delink medical coverage from cash assistance, and the implementation of 12 month redetermination periods.

E. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.

Information about insurance coverage of those who disenroll or do not reenroll will be addressed in the addendum.

2.6 Coordination between SCHIP and Medicaid:

A. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

The same application and redetermination procedures are used for Medicaid and SCHIP.

B. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes.

In Ohio, SCHIP was implemented as a Medicaid expansion. When a consumer transfers between Medicaid and SCHIP, it is seamless to the consumer. The consumer receives the same Medicaid card, benefit package, and delivery system.

C. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

The same delivery systems, including provider networks, are used in Medicaid and SCHIP.

2.7 Cost Sharing:

A. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

As of 10/1/00, no cost sharing provisions are in place. However, Ohio has submitted an 1115 waiver demonstration requesting permission to collect a modest annual enrollment fee. The fee would be \$25 per child per year, with a family maximum of \$75 per year.

B. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?

Not applicable

2.8 Assessment and Monitoring of Quality of Care:

- A. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.**

No change from the CHIP evaluation.

- B. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?**

No change from the CHIP evaluation.

- C. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?**

No change from the CHIP evaluation.

SECTION 3. SUCCESSES AND BARRIERS

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

3.1 Please highlight successes and barriers you encountered during FFY 2000 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.

Note: If there is nothing to highlight as a success or barrier, Please enter NA for not applicable.

A. Eligibility

The Healthy Start expansion to 200% FPL implemented July 1, 2000 has been a highlight for Ohio. More working families are now eligible for the program, and enrollment has been higher than anticipated. As of September 2000, 8,136 individuals were enrolled as a result of the expansion.

B. Outreach

School-based outreach efforts were successful at informing families about the Healthy Start program. Healthy Start brochures were distributed on the first day of the 2000-2001 school year in all districts in Ohio, and attached to the brochures were postage-paid postcards that families could return for more information on the program. Also, parents could indicate their interest in the Healthy Start program on the free/reduced school lunch application. As of December 11, 2000, 15,062 postcards have been returned requesting information, and 11,799 referrals were received from the school lunch program.

C. Enrollment

Enrollment figures show that the SCHIP population in the 150% FPL and under is holding steady. As of September 2000, 55,987 individuals were enrolled in SCHIP. The expansion group, at 150-200% FPL, is growing faster than expected. The enrollment as of September 2000 was 8,136. An additional 483,820 children were covered in September 2000 under either Healthy Start or Healthy Families through Medicaid only.

D. Retention/disenrollment

With the July 1, 2000 implementation of 12 month redetermination periods for Healthy Start consumers, Ohio expects retention to increase and disenrollment to decrease. Also, the ex parte policy implemented in November 1999 is believed to have increased retention.

E. Benefit structure

There has been acknowledgment from providers that the fee increases implemented in early 2000 make a difference in their participation in the Medicaid program.

F. Cost-sharing

NA

G. Delivery system

NA

H. Coordination with other programs

NA

I. Crowd-out

NA

J. Other

NA

SECTION 4. PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

4.1 Please complete Table 4.1 to provide your budget for FFY 2000, your current fiscal year budget, and FFY 2002 projected budget. Please describe in narrative any details of your planned use of funds.

(Note: Federal Fiscal Year 2000 starts 10/1/99 and ends 9/30/00).

	FEDERAL FISCAL YEAR 2000 COSTS	FEDERAL FISCAL YEAR 2001	FEDERAL FISCAL YEAR 2002
BENEFIT COSTS			
INSURANCE PAYMENTS			
MANAGED CARE	14,943,000	25,288,081	27,476,106
PER MEMBER/PER MONTH RATE X # OF ELIGIBLES	82.21643 x 181,752	88.34 x 286,275	93.09 x 295,151
FEE FOR SERVICE	59,360,813	78,602,482	91,603,447
TOTAL BENEFIT COSTS	74,303,813	103,890,563	119,079,553
(OFFSETTING BENEFICIARY COST SHARING PAYMENTS)	0		
NET BENEFIT COSTS	74,303,813	103,890,563	119,079,553
ADMINISTRATION COSTS			
PERSONNEL			
GENERAL ADMINISTRATION	368,262	1,977,000	2,152,000
CONTRACTORS/BROKERS (E.G., ENROLLMENT CONTRACTORS)			
CLAIMS PROCESSING			
OUTREACH/MARKETING COSTS			
OTHER			
TOTAL ADMINISTRATION COSTS	368,262	1,977,000	2,152,000
10% ADMINISTRATIVE COST CEILING	8,255,979	11,543,396	13,231,061
FEDERAL SHARE (MULTIPLIED BY ENHANCED FMAP RATE)	261,724	1,409,996	1,531,148
STATE SHARE	106,538	567,004	620,852
	74,672,075	105,867,563	121,231,553

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2000.

Not applicable. Ohio's family coverage program is a Title XIX program.

4.3 What were the non-Federal sources of funds spent on your CHIP program during FFY 2000?

- State appropriations
- County/local funds
- Employer contributions
- Foundation grants
- Private donations (such as United Way, sponsorship)
- Other (specify) _____

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures.

No

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	Medicaid Expansion SCHIP program
Program Name	Healthy Start
Provides presumptive eligibility for children	No
Provides retroactive eligibility	Yes, for all Medicaid categories for three months.
Makes eligibility determination	Other (<i>specify</i>) - County Medicaid eligibility staff
Average length of stay on program	Unavailable
Has joint application for Medicaid and SCHIP	Yes
Has a mail-in application	Yes
Can apply for program over phone	No - Can request application and receive application assistance over phone, but cannot apply over the phone.
Can apply for program over internet	No - Can download an application over the Internet, but cannot apply over the Internet.
Requires face-to-face interview during initial application	No
Requires child to be uninsured for a minimum amount of time prior to enrollment	No
Provides period of continuous coverage <u>regardless of income changes</u>	Yes - Newborns receive 12 months of coverage if mother was a Medicaid recipient at the time the baby was delivered. Coverage would be lost if the child moved out of state or died. - Ohio has submitted an 1115 waiver demonstration requesting 12 months continuous coverage for the 150-200% FPL expansion group. Coverage would be lost if the child died, moved out of state, or turned 19 years of age. - Once determined eligible, pregnant women receive coverage until 60 days post partum.
Imposes premiums or enrollment fees	Ohio has submitted an 1115 waiver requesting permission to collect an annual enrollment fee.
Imposes copayments or coinsurance	No

Table 5.1	Medicaid Expansion SCHIP program
Provides preprinted redetermination process	No

5.2 Please explain how the redetermination process differs from the initial application process.

The redetermination process begins with a contact from the county agency to the head of the case. The contact includes provision of the Combined Programs Application (CPA), the same form used for application. The head of the case is required to complete the form and update any information that has changed, including re-verification of income. Coverage continues throughout the redetermination, and would not end unless: the person/persons are found ineligible, in which case they would receive notice of proposed termination and hearing rights; or they did not cooperate in redetermination (i.e., did not return forms or other required information), in which case the caseworker would complete an ex parte review prior to termination.

SECTION 6: INCOME ELIGIBILITY

This section is designed to capture income eligibility information for your SCHIP program.

6.1 As of September 30, 2000, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

**Title XIX Child Poverty-related Groups or
Section 1931-whichever category is higher**

up to 150% of FPL for children under age 19

Medicaid SCHIP Expansion

up to 200% of FPL for children under age 19

Note: some children under 150% are SCHIP eligible
if they are uninsured and family income is higher
than eligibility levels in place in December of 1997.

Table 6.2

Type of Disregard/Deduction	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* ----- -
Earnings	Earned Income (\$30 and one-third disregard given for one year to assistance groups who received TANF cash in at least one of preceding four months)	Earned Income (\$30 and one-third disregard given for one-year to assistance groups who received TANF cash in at least one of preceding four months)	\$	\$
Self-employment expenses	Operating Expenses, Earned Income (available only if the assistance group received TANF cash or Section 1931 coverage in at least one of preceding four months)	Operating Expenses, Earned Income (available only if the assistance group received TANF cash or Section 1931 coverage in at least one of preceding four months)	\$	\$
Type of Disregard/Dissolution	Title XIX Child Poverty-related Groups preceding four months)	Title XXI Medicaid SCHIP Expansion preceding four months)	Title XXI State-designed SCHIP Program	Other SCHIP Program*

Table 6.2

Alimony payments Received	N/A	N/A	\$	\$
Paid	N/A	N/A	\$	\$
Child support payments Received	\$50	\$50	\$	\$
Paid	Court ordered amount	Court ordered amount	\$	\$
Child care expenses	\$175/child; \$200 if the child is under age 2	\$175/child; \$200 if the child is under age 2	\$	\$
Medical care expenses	N/A	N/A	\$	\$
Gifts	Depends on the amount	Depends on the amount	\$	\$
Other types of disregards/deductions (specify)			\$	\$

6.3 For each program, do you use an asset test?

Title XIX Poverty-related Groups No

Medicaid SCHIP Expansion program No

6.4 Have any of the eligibility rules changed since September 30, 2000?

No.

Section 7: Future program changes

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2001(10/1/00 through 9/30/01)? Please comment on why the changes are planned.

Family coverage

None

Employer sponsored insurance buy-in

None.

1115 waiver

Ohio submitted an 1115 waiver on September 29, 2000 requesting permission to implement 12 months continuous coverage and a modest annual enrollment fee, for the most recent expansion group (150-200% FPL).

Eligibility, including presumptive and continuous eligibility

See 1115 waiver.

Outreach

ODJFS plans to enter into an interagency agreement with the Ohio Department of Health to do outreach targeting various groups, including Native Americans, Appalachian/Rural Areas, and the Homeless.

Enrollment/redetermination process

HCFA awarded a grant to ODJFS on behalf of a Cuyahoga County pilot to implement self-declaration of income. This will affect the Healthy Start and Healthy Families programs in Cuyahoga County, began December 1, 2000, and will last 12 months.

ODJFS is also planning to redesign redetermination notices and forms to better communicate with consumers regarding the need for redetermination and the requirements of the consumer.

Contracting

None.

Other

None.