

SECTION 1. SUMMARY OF KEY ACCOMPLISHMENTS OF YOUR CHIP PROGRAM

This section is designed to highlight the key accomplishments of your CHIP program to date toward increasing the number of children with creditable health coverage (Section 2108(b)(1)(A)). This section also identifies strategic objectives, performance goals, and performance measures for the CHIP program(s), as well as progress and barriers toward meeting those goals. More detailed analysis of program effectiveness in reducing the number of uninsured low-income children is given in sections that follow.

- 1.1 What is the estimated baseline number of uncovered low-income children? Is this estimated baseline the same number submitted to HCFA in the 1998 annual report? If not, what estimate did you submit, and why is it different?

Answers for 1.1, 1.1.1, and 1.1.2 are all located after question 1.1.2.

- 1.1.1 What are the data source(s) and methodology used to make this estimate?
- 1.1.2 What is the State's assessment of the reliability of the baseline estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

In the 1998 annual report submitted to HCFA, ODHS used information from the March 1998 Supplement of the United States Current Population Survey (CPS-98) to estimate the number of uncovered low income children below 150% of the Federal Poverty Level (FPL) in 1997, the year prior to implementation of Ohio's CHIP program. The data from CPS-98 yielded an estimated 165,000 uncovered low income children under 150% of FPL.

The CPS-98 baseline estimate was meant only to be an interim baseline, as ODHS had been expecting results from a survey fielded by the Gallup Organization, Inc. for the Ohio Department of Health, and funded in part by ODHS. This survey, the Ohio Family Health Survey (FHS-98), was conducted over the telephone from January 1998 thru August 1998. FHS-98 was designed, among other things, to be an improvement over the CPS in enumerating the insurance status characteristics of Ohio's population. FHS had a sample size of over 12,500 families, including 22,049 individuals (16,261 adults and 5,788 children). The sampling frame was stratified so that each of Ohio's 88 counties would be represented. For each strata, a random sample of Ohio's non-institutionalized population was created using the Bell Core Research (BCR) random digit

dialing method. FHS-98 was able to significantly reduce the sampling error for state-wide and sub-population analysis, and even be able to provide county-level synthetic estimates of the uninsured population. For more information about the methodology for FHS-98, see Appendix A.

The results of FHS-98 confirmed the estimate of CPS-98 for Ohio, with a similar estimate of 174,000 low income children under 150% of FPL without health insurance¹. This is shown with further breakdowns by geographic area, age and race in Table 1.1. The standard error for the estimate was approximately 16,000 children. This yields a 95 percent confidence interval of from 142,000 to 206,000 uncovered low income children.

¹

The Ohio Family Health Survey is scheduled to be repeated again in 2001. The extent of agreement between the 1998 Ohio Family Health Survey and the 1998 March Supplement of the U.S. Current Population Survey in estimating the size of the uncovered low-income children provides some confidence in using the CPS as an interim measure reflecting annual progress toward coverage goals.

Table 1.1 Ohio Medicaid Participation, and Uninsured Children below the Current 150% of Poverty Level Eligibility Standard, April 1998 (Standard Errors in Parentheses)

Demographic characteristic	FHS-98 TOTAL CHILDREN A	FHS - Total Children at or below the current Medicaid Income eligibility standard - 150% of FPL (adjusting for countable family income(1)) B	Children enrolled in Medicaid from Administrative Records (April 1998)(2) C	Percent of Population enrolled in Medicaid D=C/A	Percent of children below income standards enrolled in Medicaid E=C/B	Number of Children below income standards not enrolled in Medicaid F=B-C	Potentially Eligible children (Children Not Insured) G	% not insured H=G/F
Total	3026 (36)	919 (34)	529	17.5%	57.6%	390	174 (16)	44.6%
Appalachian	399 (9)	154 (10)	83	20.8%	53.9%	71	34 (5)	47.9%
Other Rural	439 (10)	132 (10)	55	12.5%	41.7%	77	25 (6)	32.5%
Suburban	506 (14)	117 (13)	46	9.1%	39.3%	71	18 (6)*	25.4%
Metro	1683 (30)	516 (28)	345	20.5%	66.9%	171	97 (13)	56.7%
Age 0	157 (13)	49 (7)	42	26.8%	85.7%	7	4 (4)*	57.1%
Age 1-4	632 (26)	203 (18)	151	23.9%	74.4%	52	33 (7)	63.5%
Age 5-9	786 (28)	238 (18)	159	20.2%	66.8%	79	39 (6)	49.4%

Developed by the National Academy for State Health Policy

Age 10-14	785 (29)	242				46.7%	129	49 (9)	38.0%
		(20)	113	14.4%					
Age 15-18	665 (29)	188 (17)	64	9.6%	34.0%	124	48 (9)	38.7%	
White	2489 (37)	627 (27)	306	12.3%	48.8%	321	137 (14)	42.7%	
Black	372 (24)	234 (21)	199	53.5%	85.0%	35	30 (8)	85.7%	
Other	164 (15)	58 (10)	22	13.4%	37.9%	36	6 (2)*	16.7%	

Numeric counts are in 1,000's.

(1) 5.4% of children enrolled in Medicaid had family gross income above the eligibility threshold, and became eligible as a result of their countable income (gross income - disregards)

(2) April 1998 eligibility is used as it is the midpoint of the fielding of the Ohio Family Health Survey

*The estimate may not be reliable because of high sampling variability (the ratio of the standard error to the estimate is greater than 30%).

It is important to note that although table 1.1 provides an estimate for the potentially eligible using the current standard of 150% of FPL, it does not indicate how many children would have been eligible under the standard that was in effect prior to the expansion of

the Ohio Medicaid program to 150% of FPL. This standard, which we have labeled the December 1997 Medicaid eligibility standard, includes:

- C less than or equal to 133% of FPL for children age 0 to 5
- C less than or equal to 100% of FPL for children age 6 to 14
- C less than or equal to 33% of FPL for children age 15 to 18.

The December 1997 eligibility standard and the current 150% of FPL standard are displayed in Figure 1.1. Note that the difference between these standards is represented by the **green** area. The green area represents all the children that would benefit by the expansion of Medicaid to 150% of FPL, including those that were uninsured (CHIP Healthy Start expansion) and those that did have some type of private health insurance coverage (Medicaid Healthy Start expansion). The **brown** area represents those children that were already potentially eligible for Medicaid under the previous standard, yet for a variety of reasons did not participate in Medicaid. While providing these children with Medicaid coverage is an important issue which Ohio is addressing through simplification of the eligibility process and outreach strategies, they are not the population that CHIP was established to cover. Table 1.2 estimates Medicaid participation and the size of the potentially eligible population below the December 1997 eligibility standard in April 1998, while Table 1.3 estimates the size of the potentially eligible population for the Medicaid Healthy Start Expansion and CHIP Healthy Start expansion, also for April 1998. In summary, there were:

Non-Medicaid covered children regardless of insurance status:

+390,000 children below 150% of FPL not on Medicaid

- 127,000 children below December 1997 eligibility standard not on Medicaid

263,000 children Potentially eligible for Healthy Start Expansion or CHIP Healthy Start expansion

non-covered children:

+174,000 children below 150% of FPL not on Medicaid

- 95,000 children below December 1997 eligibility standard not on Medicaid

79,000 children potentially eligible for CHIP Healthy Start expansion

Most of the potentially eligible children are in both urban and rural counties in Ohio. Suburban counties (those that are contiguous to the urban population centers) have smaller numbers of children. School age children (6-18) are most likely to have no coverage. Minorities are disproportionately more likely to be covered.

Table 1.2. Ohio Medicaid Participation, and Uninsured Children below the December 1997 Eligibility Standard. (Standard Errors in Parentheses)

Demographic characteristic	FHS-98 TOTAL CHILDREN A	FHS - Total Children at or below the December 1997 eligibility standard (adjusting for countable family income(1)) B	Children enrolled in Medicaid from Administrative Records (April 1998)(2) C	Percent of Population enrolled in Medicaid D=C/A	Percent of children below income standards enrolled in Medicaid E=C/B	Number of Children below income standards Not enrolled in Medicaid F=B-C	Children Not Insured G	% not insured H=G/F
Total	3026 (36)	656 (30)	529	17.5%	80.6%	127	95 (12)	74.8%
Appalachian	399 (9)	108 (10)	83	20.8%	76.9%	25	16 (4)	64.0%
Other Rural	439 (10)	80 (8)	55	12.5%	68.8%	25	13 (3)	52.0%
Suburban	506 (14)	73 (11)	46	9.1%	63.0%	27	9 (3)*	33.3%
Metro	1683 (30)	395 (25)	345	20.5%	87.3%	50	57 (10)	114.0%
Age 0	157 (13)	47 (7)	42	26.8%	89.4%	5	4 (4)*	80.0%
Age 1-4	632 (26)	175 (16)	151	23.9%	86.3%	24	23 (6)	95.8%
Age 5-9	786 (28)	179 (16)	159	20.2%	88.8%	20	21 (5)	105.0%
Age 10-14	785 (29)	150 (16)	113	14.4%	75.3%	37	20 (5)	54.1%
Age 15-18	665 (29)	105 (14)	64	9.6%	61.0%	41	25 (7)	61.0%
White	2489 (37)	401 (23)	308	12.4%	76.8%	83	69 (10)	83.1%

Black	372 (24)	214 (20)	199	53.5%	93.0%	25	22
Other	164 (15)	42 (8)	22	13.4%	52.4%	20	3

Numeric counts are in 1,000's.

(1) 10.9% of children enrolled in Medicaid had family gross income above the eligibility threshold, and became eligible as a result of their count disregards)

(2) April 1998 eligibility is used as it is the midpoint of the fielding of the Ohio Family Health Survey.

*The estimate may not be reliable because of high sampling variability (the ratio of the standard error to the estimate is greater than 30%).

Demographic characteristic	Current 150% Standard		December 1997 Standard		Potentially Eligible Children For Medicaid Healthy Start Expansion E=(A-B)-(C-D)	Potentially Eligible Children for CHIP Healthy Start F=D-B
	Number of Children below income standards Not enrolled in Medicaid A	Children Not Insured B	Number of Children below income standards Not enrolled in Medicaid C	Children Not Insured D		
Total	390	174 (16)	127	95 (12)	216	79
Appalachian	71	34 (5)	25	16 (4)	5	18
Other Rural	77	25 (6)	25	13 (3)	43	12
Suburban	71	18 (6)*	27	9 (3)*	41	9
Metro	171	97 (13)	50	57 (10)	56	40
Age 0	7	4 (4)*	5	4 (4)*	10	0
Age 1-4	52	33 (7)	24	23 (6)	18	10
Age 5-9	79	39 (6)	20	21 (5)	39	18
Age 10-14	129	49 (9)	37	20 (5)	81	29
Age 15-18	124	48 (9)	41	25 (7)	59	23
White	321	137 (14)	83	69 (10)	168	68
Black	35	30 (8)	25	22 (7)*	-9	8
Other	36	6 (2)	20	3 (2)*	27	3

Numeric counts are in 1,000's.

Estimates by age group may be unreliable due to extremely small numbers. Estimates for non-whites could not be broken out due to extremely small numbers for non-black minorities.

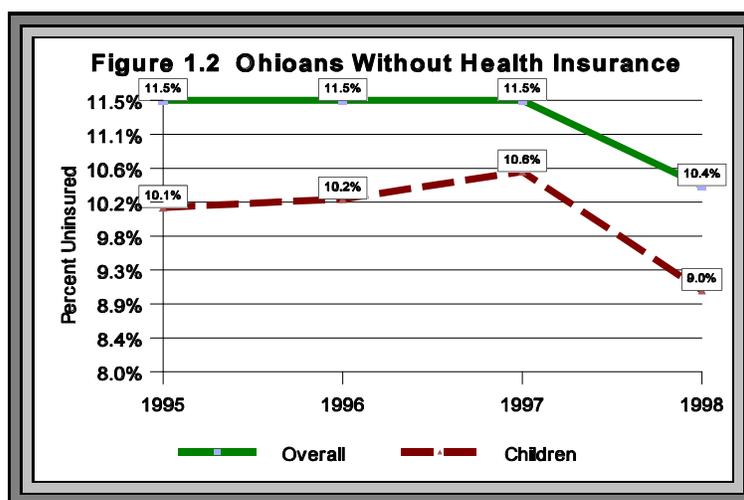
*The estimate may not be reliable because of high sampling variability (the ratio of the standard error to the estimate is greater than 30%).

1.2 How much progress has been made in increasing the number of children with creditable health coverage (for example, changes in uninsured rates, Title XXI enrollment levels, estimates of children enrolled in Medicaid as a result of Title XXI outreach, anti-crowd-out efforts)? How many more children have creditable coverage following the implementation of Title XXI? (Section 2108(b)(1)(A))

1.2.1 What are the data source(s) and methodology used to make this estimate?

1.2.2 What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

There have been some important changes in the way that low income children and adults are covered by health insurance in Ohio in 1998. Overall, the percentage of Ohioans without health insurance has decreased from 11.5% in 1997 to 10.4% in 1998, or a decrease of approximately 120,000 persons. This is in stark contrast to the estimates for the entire U.S. According to the U.S. Bureau of the Census, the percentage of Americans that were uninsured increased from 16.1% to 16.3%, an increase of approximately 1 million persons (1). For the U.S. "the number of uninsured children (under 18 years of age) was 11.1 million in 1998, or 15.4 percent of all children. The status of children's health care coverage did not change significantly from 1997 to 1998 (2)." The percentage of children without health insurance in Ohio has decreased from 10.6% to 9.0% from 1997 to 1998, a decrease of about 55,000 children. Figure 1.2 illustrates the changes in the uninsured population between 1995 and 1998 based upon the United States Current Population Survey (CPS), March Supplement (1996 thru 1999).



Economic and work force development factors

The changes in health coverage might seem to reflect favorably on the Ohio Medicaid program. This significant decrease came during the first year of Ohio's Healthy Start Expansion and CHIP program. Yet, there are some economic and work force development factors that seem to have intervened and perhaps have changed the volume of the baseline from which progress can be measured.

The distribution of children by the poverty status of their families has changed significantly since 1995, according to CPS estimates. Using the Medicaid eligibility standards illustrated previously, there has been a marked shift upwards in family income as a percent of the federal poverty level from 1995-96 to 1997-98. Since 1996, welfare reform moved large numbers of families from cash assistance to employment. This resulted in a decrease of eligibles in the Ohio Works First (OWF) program (the federal acronym for this is TANF) by over 60% from nearly 700,000 to around 250,000 in 1999. This seems to have had an effect on overall numbers of families and children in poverty. Table 1.4 shows that while overall there is a small decrease (-1.9%) in the number of children below 200% of FPL, there is a large decrease (-12.4%) in the population of children below the December 1997 Medicaid eligibility standard, and an even larger decrease (-16.2%) in the number of children between the December 1997 standard and the current standard of 150% of FPL. As a result, there has been a very large increase (+39%) in the population of children between the current standard and 200% of FPL.

Medicaid Eligibility Standard as a percent of FPL	Year		% change in population 1997-98
	1995-96 Average	1997-98 Average	

<=200%	1,235,402	1,211,611	-1.9%
151 to 200%	269,543	374,758	39.0%
<= 150%	966,837	837,036	-13.4%
Dec. 97 to 150%	275,083	230,754	-16.2%
<Dec. 97	691,754	606,282	-12.4%
Source: U.S. Current Population Survey, March Supplement (1996-1999)			

In fact, many parents have left OWF and found jobs that put their family income just above the income standard which would allow their children to be on Medicaid. Have these parents found jobs that provide health insurance benefits for themselves and their children? In the paragraphs below, this and other issues, and in the interplay between Medicaid and private insurance participation, are examined.

Uninsured, Medicaid Participation and Private Health Insurance Participation Rates among low-income and near poverty children

In order to calculate uninsured rates, as well as Medicaid and private health insurance participation rates, it is important to highlight the differences in eligibility criteria for different populations and the difficulty in using the CPS to model the eligibility criteria. Yet, despite these limitations, we have found that the CPS is still an effective method of measuring changes in health insurance status and Medicaid participation.

It is feasible to measure Medicaid participation for children on Medicaid and CHIP because the eligibility standards are, with the notable exception of pregnant women, based upon family income as a percent of the federal poverty level, and not on health status or disability. In calculating the denominator of the participation rate using the CPS, that is estimating the “total potentially eligible population”, it is important to note that the CPS captures income and family poverty status based upon the entire previous year, while actual Medicaid eligibility standards are based upon monthly family income. Additionally, Medicaid eligibility exempts some types of income and “disregards” certain expenses and income when calculating countable income. While others (Lewin Group, Urban Institute) have tried to simulate some of these differences, we think that for the purposes of measuring changes in gross participation rates these simulations are not necessary.

Table 1.5 illustrates the uninsured rates between the different standards of Medicaid eligibility. Note that while there have been some recent decreases in the uninsured rates among those below the December 1997 eligibility standard, and almost no change in the uninsured rates among the population targeted for CHIP, there has been a significant decrease (from 17% in 1995 to 9.6% in 1998) in the uninsured rate for children that are just above the current Medicaid

standard in the 151% to 200% of FPL range.

Table 1.5 Uninsured Rates for Children, By Year, 1995 to 1998.				
Year	% of children that were uninsured			
	Total Population	< or = December 1997 Standard	December 1997 Std. to 150% of FPL	151 to 200% of FPL*
1995	10.02%	17.25%	20.49%	17.02%
1996	10.23%	19.32%	21.36%	13.19%
1997	10.58%	20.24%	20.89%	11.52%
1998	9.05%	18.04%	21.90%	9.57%

What happened to these children? Did they get private health insurance? Did they get on Medicaid for part of the year while their income was transitioning upward? Table 1.6 shows that private health insurance participation has been increasing steadily for the children in the 151 to 200% of FPL range. The rate of private insurance increased from 78.1% in 1995 to 84% in 1998. Table 1.7 shows that Medicaid participation also increased among these children from 44.2% in 1995 to 56.3% in 1998, the largest jump being from 1997 to 1998. (Remember that the income standard for Medicaid is calculated on a monthly basis, and that a family whose annual income is above the Medicaid standard could still have had children eligible for Medicaid during part of the year.)

Table 1.6 Private Health Insurance Participation Rates for Children, By Year, 1995 to 1998, Excluding Children who also have Medicaid.				
Year	% of children that were enrolled in Private Health Insurance and not Medicaid			
	Total Population	< or = December 1997 Standard	December 1997 to 150% of FPL	151 to 200% of FPL
1995	68.00%	17.27%	61.23%	78.10%
1996	70.06%	22.33%	51.30%	79.60%
1997	71.65%	17.78%	55.46%	85.60%
1998	70.33%	18.85%	45.70%	84.03%

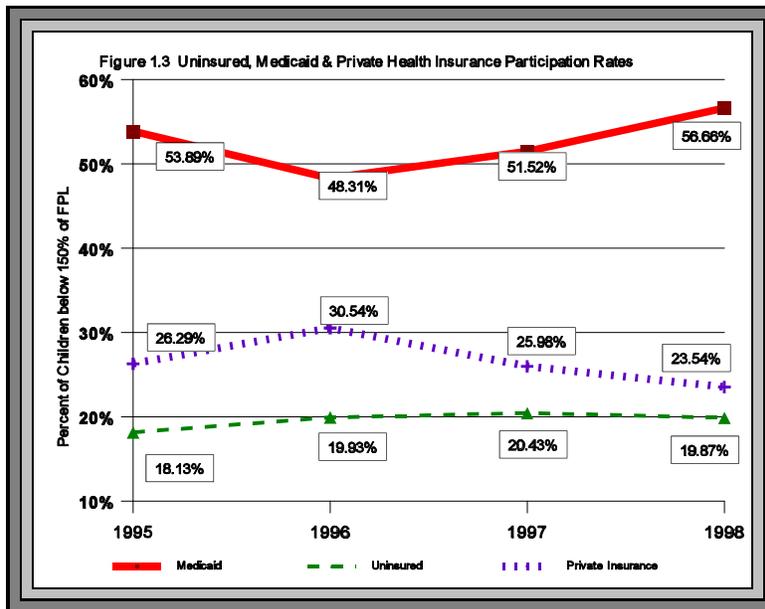
Table 1.7 Medicaid Participation Rates for Children, By Year, 1995 to 1998.				
Year	% of children that were enrolled in Medicaid			
	Total Population	< or = December 1997 Standard	< or = 150% of FPL	< or = 200% of FPL
1995	20.06%	64.14%	53.89%	44.17%
1996	17.28%	57.64%	48.31%	47.61%
1997	15.84%	60.12%	51.52%	50.00%
1998	18.46%	62.11%	56.66%	56.34%

Crowd out

While private health insurance participation of the population of children between 150% of FPL has been increasing, for those below 150% of FPL it has been decreasing. Furthermore, the Medicaid participation for the population under 150% of FPL has been increasing, while the uninsured rates below 150% of FPL have not really changed. This is illustrated in Figure 1.3. Because the Ohio Medicaid CHIP implementation up to 150% of FPL is also a Medicaid expansion regardless of insurance status, there is no strategy to reduce crowd out for this population. At the time of Medicaid application there is an assessment of whether a child currently has private health insurance. Whether a child has just dropped coverage to get onto Medicaid is not assessed. For children that do not have private coverage, their expenditures are allocated to Title XXI. For those that do, their expenditures are allocated to Title XIX. As can be seen in Figure 1.3, there is a relatively strong inverse relationship between Medicaid participation and private insurance participation between 1995 and 1998. Whether the decrease in private insurance participation would have occurred absent the Healthy Start expansion has not been thoroughly examined.

Participation in the CHIP program

The Ohio Healthy Start expansion and CHIP program began in January of 1998. Participation in both of these programs has been measured on a monthly and year-to-date basis for



State Fiscal Year 1998, 1999 and for the 1st half of SFY 2000. Table 1.8 shows enrollment for these programs in December 1999, 24 months after enrollment began. There were 65,000 children enrolled in the programs in December 1999. Approximately 45,000 enrolled in CHIP, and 20,000 enrolled in Healthy Start Expansion. As mentioned previously, private health

insurance status is assessed at enrollment². Those enrollees that indicate that they do have insurance are labeled as Healthy Start Medicaid Expansion. Those enrollees that indicate that they do not have insurance are labeled as Healthy Start CHIP. Through analysis of Medicaid eligibility files, we determined whether any of these children had any Medicaid eligibility in the 12 months previous to the beginning of their first eligibility span.

Previous Medicaid Eligibility Status	Private Health Insurance Status at Enrollment				Total	
	With Private Health Insurance (Healthy Start Expansion Enrollment)		Without Private Health Insurance (CHIP Enrollment)			
	N	% of total	N	% of Total	N	% of Total
Ohio Works First /Healthy Start	13,383	20.6%	33,000	50.7%	46,383	71.3%
Not Ever OWF/Healthy Start	6,227	9.6%	12,430	19.1%	18,657	28.7%
Total	19,610	30.2%	45,430	69.8%	65,040	100.0%

Children that had a previous Medicaid eligibility span

More than 71% of all children in the programs had a previous eligibility span for Medicaid or regular Healthy Start. This indicates that this program has been used by families to maintain coverage for their children while they transition into a higher income category (most likely as a result of employment), and has provided coverage for the approximately 20,000 children per

²i.e., Do you currently have any private health insurance? Note that this assessment was already established in the eligibility determination process for the coordination of third party liability. The two questions that are not asked are: 1) Are you dropping any private health insurance upon enrollment in this program, and 2) how many months has it been since you last had private health insurance?

month who would have aged out of eligibility.

For 33,000 of the children that were in this group there was no current private health insurance. This serves to maintain health coverage for some children that would probably have become uninsured. Approximately 13,000 children of those that were previously eligible had private health insurance at enrollment. They may have enrolled in the program because the coverage was more comprehensive.

It is unknown how many of the 33,000 children that became eligible for CHIP but had previous Medicaid eligibility within the past 12 months can be associated with the goal of reducing the number of uninsured children, because we do not know how many of them would have gone without insurance for a long period of time in the absence of CHIP. Certainly, these effects would not be showing up in CPS surveys reflecting on the first year of implementation (1998), and only slightly in the second year (1999).

Children that did not have a previous Medicaid eligibility span

Approximately 28.7% of all children in the programs had no previous Medicaid eligibility span, and among those, over 12,000 of these children did not have private health insurance coverage at enrollment. It is assumed that some of these 12,000 children did not have prior health insurance coverage in the previous 12 months, and that they would be showing up in CPS surveys as reducing the number of uninsured children in 1998. However, judging from the CPS data which reflects the changes in private health insurance coverage rates as a function of Medicaid coverage, some of these children could have had private health insurance coverage in the previous 12 months, and are reflected in the crowd-out phenomenon. Furthermore, the volume of these changes are so small that a population based survey such as the CPS is not likely to be able to distinguish these effects from random sampling error.

Conclusions regarding impact of CHIP on the number of uninsured children

For Ohio there is pretty strong agreement between two data sources about the size of the uninsured child population at the beginning of the CHIP program. One year of data from the CPS about calendar year 1998 shows significant downward movement in the rate and number of uninsured children. It is known that some of this is related to movement of families out of poverty status and into jobs for parents that provide health insurance for their children. Some of this may be related to CHIP, although it is too early to discern whether the movement of children from regular Medicaid and Healthy Start prevented a future sustained period of no health insurance.

Finally, the changes that are likely due to CHIP in 1998 are so small that they would barely register in survey data.

The good news is that after 24 months of enrolling children in these programs, they have not yet reached a level of equilibrium where the number of new children coming on during the month is equal to the number leaving the program. There continues to be a net increase in children in the program, and as seen in Table 1.9 this trend has strengthened within the last 6 months. Where as between December 1998 and June 1999 the net average monthly increase for CHIP was 833, for June 1999 thru December 1999 the net average increase for CHIP was 1,167.

Table 1.9 Growth in the Number of Eligible Children				
Month	Number of Eligibles during the month		Average monthly increase in eligibles over a 6 month period	
	Healthy Start Expansion	CHIP	Healthy Start Expansion	CHIP
June 1998	11,000	21,000	1,833	3,500
December 1998	15,000	33,000	667	2,000
June 1999	18,000	38,000	500	833
December 1999	20,000	45,000	333	1,167

While the monthly statistics in Table 1.9 provide a valuable snapshot of information, they do not reflect the full impact of the Healthy Start Medicaid and CHIP expansion program on Ohio’s children: from implementation in January 1998 through September 1999, 144,832 children received medical coverage through the Healthy Start expansion. For more information, please see Appendix B, the Caseload Analysis Bulletin for September 1999.

In addition to children covered by the Healthy Start expansions, the number of children covered by Healthy Start under the December 1997 standard increased, from approximately 115,000 in December 1997 to approximately 193,000 in September 1999. This is in part due to movement from OWF and Transitional Medicaid, but also overall outreach to raise awareness of Healthy Start.

1.3 What progress has been made to achieve the State’s strategic objectives and performance goals for its CHIP program(s)?

Please complete Table 1.3 to summarize your State’s strategic objectives, performance goals, performance measures and progress towards meeting goals,

as specified in the Title XXI State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

- Column 1: List the State’s strategic objectives for the CHIP program, as specified in the 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).

Table 1.10 Strategic Objectives and Performance Goals		
<i>(1) Strategic Objectives</i>	<i>(2) Performance Goals for each Strategic Objective</i>	<i>(3) Performance Measures and Progress</i>
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED		
Objective 1: Increase the percent of children with credible coverage below 150% of the FPL	The percent of children with credible 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	Data Sources: U.S. Current Population Survey, March Supplement (1998-2001) Methodology: Inclusion Criteria: Children ages 0 thru 18 Ohio Residence Family income less than or equal to 150% of FPL Weighting Criteria: March Supplement Weight Numerator: Children who had one or more sources of health care coverage at any time during the year. Denominator: Total Children Progress Summary: 1998 - 80.9%

<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.</p>
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<p><i>Table 1.10 Strategic Objectives and Performance Goals (continued)</i></p>		
<p>(1) <i>Strategic Objectives</i></p>	<p>(2) <i>Performance Goals for each Strategic Objective</i></p>	<p>(3) <i>Performance Measures and Progress</i></p>

<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>
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<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%</p>
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OBJECTIVES RELATED TO INCREASING ACCESS TO CARE

<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%.</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></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 ACCESS TO PREVENTIVE CARE		
Objective 5: Increase access to preventive health care services for children below 200% of FPL.	<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%</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%</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 Methodology: 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%</p>
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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 INCREASING ACCESS TO PREVENTIVE HEALTH CARE		
<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 = 32.8%</i></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%.)</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).</p>	<p>Data Sources: Medicaid claims and encounter data. Methodology: See Appendix C. 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. Progress Summary: (Baseline data for SFY 1998 has not yet been calculated.)</p>
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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>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. Progress Summary: 1998 Baseline - managed care plans: 46.2% Fee-for-service: 44.2% CHIP: 39.1%</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>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%</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>Data Sources: Medicaid Consumer Satisfaction Survey. Managed Care, January 2000.</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. Children who screened positive in the 5 item CAHPS CSHCN screener. Estimated 600 respondents.</p> <p>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.</p> <p>Progress Summary 1999 - Baseline: Preliminary date - 84.1%.</p>
	<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).</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. Denominator: Number of children.</p>

Section 2. Background

This section is designed to provide background information on CHIP program(s) funded through Title XXI.

2.1 How are Title XXI funds being used in your State?

2.1.1 List all programs in your State that are funded through Title XXI. (Check all that apply.)

Providing expanded eligibility under the State's Medicaid plan (Medicaid CHIP expansion)

Name of program: **Healthy Start**

Date enrollment began (i.e., when children first became eligible to receive services):
January 1, 1998

2.1.2 If State offers family coverage: Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

Section 1931 of the Social Security Act enables Medicaid to provide family coverage to families meeting income and other eligibility requirements. The current income methodology results in coverage for families with income ranging from 70% to 90% of FPL, depending on family size and other factors affecting countable income. Families who meet current eligibility criteria for 1931 coverage fall in one of three categories:

- < eligible to receive TANF/OWF;
- < choose not to receive cash assistance; and
- < may not qualify for cash assistance.

In July 2000, Ohio will expand coverage to families by modifying the eligibility budgeting methodology, the result being that families will be eligible with incomes at or below 100% of FPL regardless of family size.

Ohio established a policy to ensure families and individuals do not inappropriately lose Medicaid coverage. Prior to terminating any coverage, in this case family coverage, under Section 1931, an "exparte" redetermination must be completed to assure that the entire family, and individuals in the family, are assessed for potential ongoing eligibility under the same or another category of Medicaid. This policy is called Pre-Termination Review. This policy is not substantively new, but crystalizes in one rule what had been previously spread through out the Medicaid eligibility and application rules. The policy requires that a case worker identify whether or not the family, or any individual in the family, is eligible for health coverage through other programs offered by Medicaid - such has Transitional, Healthy Start, or coverage for individuals with disabilities.

2.1.3 If State has a buy-in program for employer-sponsored insurance: Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

N/A

2.2 What environmental factors in your State affect your CHIP program?
(Section 2108(b)(1)(E))

2.2.1 How did pre-existing programs (including Medicaid) affect the design of your CHIP program(s)?

Ohio's SOBRA coverage provided health coverage to pregnant women and children through a Medicaid program called Healthy Start. Pregnant women were covered to 133% of FPL. Children birth through five were covered to 133% of FPL, children six through fourteen were covered to 100% of FPL. Children older than fourteen were not covered through Healthy Start, but could be eligible if covered by virtue of 1931 or a disability.

Ohio's 1998-1999 state biennial budget, signed in June of 1997, authorized a Medicaid eligibility expansion for children. Through this expansion, Ohio made a commitment to cover all children up to age 19 in families with countable income at or below 150% of FPL. The impact of such an expansion was to both expand and level eligibility so that all children in a family could get coverage if income eligibility was met.

Title XXI came on the heels of Ohio's budget– in August of 1997 in the Federal Balanced Budget. Because of Ohio's commitment to expand coverage to all children at or below 150%, and the desire to level eligibility so all children in a family could be covered, Ohio opted to implement CHIP as a Healthy Start Medicaid expansion, and to implement an underlying Medicaid expansion so that under insured children could be covered at the Title XIX reimbursement rates.

By expanding the pre-existing program to encompass CHIP, Ohio was able to maintain a seamless application process for eligible consumers and offer coverage through the same benefit package and delivery systems. Additionally, linking Ohio's Medicaid program for children and pregnant women to CHIP enabled use of the same application which is accessible through existing public health networks, the ODHS web site, and the statewide Consumer Hotline. This hotline provides general Medicaid information as well as assistance in completing the application.

2.2.2 Were any of the preexisting programs “State-only” and if so what has happened to that program?

X No pre-existing programs were “State-only”

2.2.3 Describe changes and trends in the State since implementation of your Title XXI program that “affect the provision of accessible, affordable, quality health insurance and healthcare for children.” (Section 2108(b)(1)(E))

Examples are listed below. Check all that apply and provide descriptive narrative if applicable. Please indicate source of information (e.g., news account, evaluation study) and, where available, provide quantitative measures about the effects on your CHIP program.

Changes to the Medicaid program

Revised and Translated Application - The Combined Programs Application (CPA) is the current 2-page form used for families to apply for Healthy Start. It has recently been revised to make the application process easier for both consumers and caseworkers. Changes reflect the shift in families moving from welfare to work with the inclusion of such sections as work phone number and emphasizing on the top of the application that “no face-to-face interview is required”. Also, the CPA is now available in Spanish.

CPA on Web Page - Families & consumer advocates can get information about Medicaid or download the CPA by visiting the Ohio Medicaid Web Page. The web page gives on-line instructions for printing and details required verifications. In addition, county specific addresses for mailing to the local county department of human services for appropriate eligibility determination are provided.

Removal of 185% Gross Income Test for Healthy Start - Previously, families with income above 185% of the state-determined need standard were deemed ineligible for coverage before taking into consideration certain disregards that are allowed in determining countable income (i.e., child care expense, child support payments). By removing this screening methodology, families are appropriately assessed through a complete calculation of countable income and correct eligibility determination.

Removal of 18 month time limitation and initial applicant test for earned income disregard—In October, 1999 Ohio removed the 18 month time limitation for the \$250 & ½ earned income disregard for calculation of financial eligibility for families covered under Section 1931 provisions. This means that each employed adult in a family is entitled to this earned income disregard as long as they have earnings.

Ohio also removed an additional initial test that prevented applicant wage earners with income above 100% of a state-determined need standard from receiving the \$250 and ½ earned income disregard. This means that applicants will be treated the same as newly employed recipients and will automatically receive earned income disregards with no pre-test.

Pre-Termination Review (PTR) or Ex Parte - Ohio policy requires caseworkers to conduct a pre-termination review (PTR) to explore potential Medicaid eligibility for other categories prior to proposing to terminate Medicaid coverage for any individual.

Impact of welfare reform on Medicaid enrollment and changes to AFDC/TANF

In Ohio, individuals in receipt of cash assistance are eligible to receive Medicaid. The federal welfare reform legislation which replaced AFDC with TANF also mandates that each state protect Medicaid coverage for families who would have qualified under AFDC guidelines that existed in the state on July 16, 1996.

Effective October 1, 1997, Ohio implemented TANF as “Ohio Works First” (OWF). OWF includes a time-limit restriction of three years for receiving cash assistance. Ohio’s families in receipt of cash assistance through OWF are also eligible to receive Medicaid. Families remain eligible for Medicaid even when their OWF time limits expire, as long as they continue to meet Medicaid eligibility criteria or are covered under transitional coverage. Income eligibility for OWF is currently almost identical to income eligibility for Section 1931 family coverage for Medicaid.

Although Ohio has used the flexibility provided under Section 1931 to expand options for family coverage, increased awareness regarding the delinking of Medicaid to cash assistance is needed to maximize enrollment for families not receiving cash assistance.

The implementation of welfare reform initiated a movement to get families into jobs, resulting in a significant drop in OWF caseloads between July 1997 and September 1999. Despite the availability of LIF, Transitional Medicaid, and the Healthy Start expansion for children up to 150 percent of the FPL, a drop in Medicaid caseloads occurred which was attributed to low unemployment rates in Ohio, gains in family income, and the assumptions by families that they were no longer eligible for cash assistance or Medicaid.

Some consumers seem to have received a mixed message from welfare reform and have not pursued Medicaid due to their resulting misconception that the movement to get families moved off cash assistance means moving families off all programs. In addition, a stigma is sometimes attached to Medicaid. Many consumers have defined success as moving away from welfare and disassociating from the county department of human services. They have erroneously included Medicaid in their definition of welfare and do not realize that many working families may be eligible for Medicaid coverage.

This phenomena further highlighted the need to implement a process for informing potentially eligible families about the services available through Medicaid. The decline in caseload was anticipated at a federal level through the formulation of exparte redetermination requirements. Effective November 1, 1999, Ohio implemented an integrated exparte redetermination requirement known as Pre-Termination Review (PTR). This policy requires that the caseworker explore Medicaid under all other categories before proposing termination under the current eligibility category.

Ohio has also developed informational materials that advise families who are not receiving cash assistance of the availability of medical coverage, food stamps, and child care. These materials were developed to address both families who are currently not in receipt of cash as well as those losing it due to the impositions of OWF time limits which will begin affecting families in October, 2000.

- X Changes in the private insurance market that could affect affordability of or accessibility to private health insurance

In Ohio, four significant pieces of legislation were passed in 1999 to provide certain patient protections for Ohio's health care consumers. They are:

House Bill 4: Establishes requirements for conducting internal and external reviews of health care coverage decisions made by health insuring corporations, as well as decisions made by sickness and accident insurers. It also addresses a woman's right to obtain services from specific providers without a referral, sets specific requirements for health insuring corporations and sick and accident insurers, and allows for deductions from the Ohio income tax for certain medical expenses.

House Bill 361: Regulates aspects of enrollees' access to covered health care services, including their access to emergency services, specialists, and nonformulary drugs, and provides for an external review of a health insuring corporation's denial of coverage for certain terminally-ill enrollees. It also requires the Superintendent of Insurance to prescribe a standard credentialing form to be used by health insuring corporations in credentialing providers.

House Bill 698: Revises the standards for using electronic signatures in records of health care facilities and specifies when certain existing health care facilities are required to improve the structure or fixtures of the facility to comply with the safety and quality-of-care standards and quality-of-care data reporting requirements established by the Director of Health.

This bill also changes the manner of determining the amount the Department of Human Services pays for eligible nursing facilities and intermediate care facilities for the mentally retarded, in specified circumstances in which there is a transfer or lease between related parties.

Senate Bill 67: The Ohio Revised Code formerly recognized prepaid dental plan organizations, medical care corporations, health care corporations, dental care corporations, and health maintenance organizations as forms of managed health care corporations. The act repeals the laws governing these entities. The bill enacts a new chapter to provide for the establishment, operation, and regulation of "health insuring corporations," to provide uniform regulation of providers of managed health care.

X Changes in the delivery system

Since 1978, the Ohio Medicaid program has contracted with Managed Care Plans (MCPs) to enhance the level of access to services. This service delivery system has been an option for children and pregnant women and operational in as many as 16 Ohio counties. At one point, over 50% of the children and pregnant women covered by Medicaid were receiving services through an MCP.

In the period January 1, 1998 through September 30, 1999, three MCPs contracting with the state left the Medicaid program. In August 1998, the Ohio Department of Insurance (ODI) placed Personal Physician Care (PPC) into court-ordered liquidation and PPC agreed to the immediate termination of their provider agreement. In March 1999, ODI took similar action against DayMed and they also agreed to immediate provider agreement termination. Also in March 1999, ODI took action to revoke Health Power's license to operate as a health insuring corporation, and the plan was placed into self-liquidation. Health Power

agreed to the immediate termination of their ODHS provider agreement.

The managed care industry as a whole has shifted, causing a decline in participation by plans. Many Ohio Medicaid consumers who were once receiving health care through an MCP have now been returned to fee-for-service status, which ODHS believes decreases the chances of consumers finding a “medical home”.

Changes in the demographic or socioeconomic context

Changes in economic circumstances, such as unemployment rate (specify)

According to the U. S. Current Populations Survey (March supplement ‘97 and ‘99), there has been a large decrease in the number of families whose income meets Medicaid eligibility criteria. In Ohio, the number of children potentially eligible for Healthy Start has decreased by 13.83%, while the number of children in families with income above Healthy Start income guidelines has increased by 37.42%. In addition, Ohio’s low unemployment rate is holding steady around 4%. These figures may be one reason for lower than anticipated take-up rates.

Other

In 1997, the Ohio Supreme Court declared Ohio’s system of funding public schools unconstitutional and ordered an overhaul of the way the state pays for public education. Since this decision, the Ohio Legislature has made funding schools a priority by allocating \$2.8 billion in state funding into operations and construction. However, Medicaid fared well in the state’s biennial budget process, with funding for three eligibility expansions (pregnant women to 150% FPL, Section 1931 expansion for parents up to 100% FPL, and uninsured children 150-200% FPL) and a funding for fee increases for targeted community providers.

SECTION 3. PROGRAM DESIGN

This section is designed to provide a description of the elements of your State Plan, including eligibility, benefits, delivery system, cost-sharing, outreach, coordination with other programs, and anti-crowd-out provisions.

3.1 Who is eligible?

3.1.1 Describe the standards used to determine eligibility of targeted low-income children for child health assistance under the plan. For each standard, describe the criteria used to apply the standard. If not applicable, enter “NA.”

Table 3.1.1

	Medicaid CHIP Expansion Program	State- designed CHIP Program	Other CHIP Program*
Geographic area served by the plan (Section 2108(b)(1)(B)(iv))	State of Ohio		
Age	Birth through 18		
Income (define countable income)	Ages 0-5: 133-150% FPL Ages 6-14: 100-150% FPL Ages 15-18: 0-150% FPL (Countable income is gross income minus disregards and exemptions. See addendum for details of what types of earned and unearned income are included in the calculation)		
Resources (including any standards relating to spend downs and disposition of resources)	N/A		
Residency requirements	Reside in the state of Ohio		
Disability status	N/A		

Access to or coverage under other health coverage (Section 2108(b)(1)(B)(i))	Individuals with other health coverage are not eligible for Title XXI. However, Ohio has implemented a tracking mechanism that identifies children with other health coverage and covers them under a separate Medicaid expansion.		
Other standards (identify and describe)_____	N/A		

*Make a separate column for each “other” program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

3.1.2 How often is eligibility redetermined?

<i>Table 3.1.2</i>			
Redetermination	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Monthly			
Every six months	X		
Every twelve months			

Other (specify) <u> X </u>	If a family also gets Food Stamps, Food Stamp recertification is every three months. If the family complies with the redetermination, then eligibility for all programs is redetermined. If a family does not comply with the redetermination, then their Healthy Start should not be redetermined until another three months has passed.		
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3.1.3 Is eligibility guaranteed for a specified period of time regardless of income changes? (Section 2108(b)(1)(B)(v))

X No

3.1.4 Does the CHIP program provide retroactive eligibility?

X Yes Which program(s)? Medicaid and Medicaid Expansion

How many months look-back? Three months

3.1.5 Does the CHIP program have presumptive eligibility?

X No

3.1.6 Do your Medicaid program and CHIP program have a joint application?

X Yes Is the joint application used to determine eligibility for other State programs? If yes, specify.

Because Ohio's CHIP is a Medicaid expansion, all application and eligibility processes are the same. There are two primary means of applying for coverage. The Combined Programs Application (CPA) is a mail-in shortened form which is used to apply for Healthy Start, and can also initiate an application for programs through Women, Infants, and Children (WIC), Child and Family Health Services (CFHC), and Children with Medical Handicaps (CMH). If a family wishes to apply for cash or food stamps in addition

to health coverage, they must complete a face to face interview at the county department of human services.

The CPA is available at a number of sites other than CDHS and health department sites, including the Ohio Consumer Hotline and is posted on the ODHS Internet web site. In some areas, child care providers distribute and help in completing the CPA.

- 3.1.7 Evaluate the strengths and weaknesses of your eligibility determination process in increasing creditable health coverage among targeted low-income children

Strengths:

Ohio started in a good place relative to other states. In the latter 1980's Ohio implemented coverage for poverty level pregnant women and children as "Healthy Start". A shortened two page application has been in place for over 10 years. The application process allows for applications to be mailed in, without an in-person interview. The process also supports allowing families to apply only for medical coverage which helps to separate this coverage from other public assistance benefits. Applications can be initiated by referral from other health programs: WIC, Children with Medical Handicaps, and CFHS clinics. However, because eligibility for this coverage can also be determined when a family applies for other benefits, such as food stamps, this helps to maximize application opportunities without requiring the family to make numerous contacts.

At the inception of Healthy Start, Ohio simplified some other aspects of the eligibility requirements. Ohio does not test for resources for this covered group. Families who want other benefits, such as Food Stamps and cash benefits, are also able to have Healthy Start eligibility determined for children and pregnant women concurrent with the application for those other benefits. A separate application for medical benefits is not required.

Activities since expansion:

In January 1998, when Healthy Start expanded, Ohio was in a position to provide other supports and make some changes in the application and eligibility systems. Ohio's statewide toll free Consumer Hotline began to assist people with completing the application. This assistance includes Hotline staff completing the application over the phone and mailing it to the consumer for signature. The applicant can then review, sign, and attach other paperwork before returning it to the local human services agency for processing.

The shortened, mail-in application was revised in 1999 to make it easier to complete. The application and supporting materials have been translated into Spanish. The application and supporting materials are available on the Internet as a PDF document. Applications and materials are developed with the goal that they be understandable and that they clearly communicate program requirements to applicants. Applications are also available through providers, as well as social and health services agencies. By

allowing applications to be available through these other sites, Healthy Start can be marketed as a program distinct from “welfare”.

Since January, 1998 Ohio has continued to simplify eligibility requirements for this group. Certain gross income tests have been eliminated which were tied to the receipt of cash assistance. Ohio continues to review and clarify regulations to prohibit imposition of OWF cash requirements (work activity penalties, self-sufficiency contracts) on this group. Ohio has also worked with IV-D agencies to ensure that practices that impose diversions are not imposed on this group (e.g., inappropriate referrals of pregnant women for IV-D activities).

Weaknesses:

Despite what was viewed as a simple application process, when Healthy Start was expanded and outreach was increased, the weaknesses of the application process became clear. The process became the focus of a major lobbying effort, and many groups coordinated a strong advocacy for a simplified application process. Appendix D, “New Faces”, a publication from the Children’s Defense Fund, provides an example of these advocacy efforts.

Ohio is a state supervised/county administered eligibility system. County agencies determine eligibility and authorize benefits. It is difficult to maintain statewide consistency because county agencies sometimes inappropriately impose additional documentation and other process requirements, such as requiring a face-to-face interview. In some cases, county case workers are perceived as not being helpful in the application/eligibility determination process. Many caseworkers delay approving benefits for a completed Healthy Start application until all of the other an eligibility determination is rendered for all other benefits associated with that application (e.g. food stamps). Many county agencies inappropriately terminate Healthy Start eligibility (even in situations where Medicaid eligibility is protected) due to the family’s failure to renew food stamps certification. A recent Medicaid Quality Control review targeted Healthy Start terminations and denials over a period of time. The review findings reflected that approximately 25% of terminations/denials were erroneous due to inappropriate county agency actions for reasons discussed above.

As Ohio reviewed the eligibility rules and processes, outdated rules were identified that required redeterminations for pregnant women, newborns, and families receiving transitional benefits. Although the rules have been revised, the Client Registry Information System - Enhanced (CRIS-E), (the automated eligibility determination/benefits issuance system), does not fully support different programs’ eligibility determination and application processes. Lack of CRIS-E support has largely contributed to the previously-cited problem with county agency inappropriate termination of Healthy Start concurrently with a food stamp closure. As Ohio moves to simplify Medicaid verification requirements, efforts are complicated by the fact that CRIS-E does not allow for reflecting different verification requirements as imposed by the food stamp and cash assistance programs.

Through anecdotal feedback, the above-referenced MEQC review, and other close case reviews it is

evident that many people are denied and terminated for procedural reasons. Recorded reasons for a denied/terminated cases reflect a high proportion process-related reasons: failure to cooperate, failure to provide verifications, loss of contact. It became clear that many potential eligibles were terminated/denied for procedural reasons, meaning that they have failed to “prove” they are eligible—not that they’re necessarily ineligible.

Steps Ohio Is Taking:

Ohio has begun a series of technical assistance and training initiatives to local agency staff concerning Medicaid eligibility and processes. Beginning in July of 1999, a series of Healthy Start technical assistance sessions were conducted for front line eligibility staff. The sessions were formulated to cover more than basic eligibility—consistency, a consumer-friendly philosophy, and changes in program rules, processes, and direction were promoted. A series of sessions will begin in May 2000 to review and discuss the July 2000 program simplification and expansions.

One of the major components of the July 2000 policy transmittal will be a restructuring of application and redetermination rules. This restructuring is designed to “delink” Medicaid application and reapplication requirements and procedures from the other program areas. One of the most significant rule changes is reflected in a movement to self-declaration as verification for most eligibility factors. To maintain program integrity, second party verification will be required for several items, primarily income. However, hard copy documentation as verification of birth and identity will no longer be required, and will only be required for a Social Security number if it cannot be matched electronically.

Many application and notification forms are changing to promote understandability and simplicity. The Healthy Start application and associated forms have been translated into Spanish; previously, there was no state-approved application form for Spanish-speaking applicants. Forms continue to be updated to reflect changes in program requirements and expansions.

Ohio has begun developing a systems agenda to identify what Client Registry Information System - Enhanced/Medicaid Management Information System (CRIS-E/MMIS) changes will better support county agency staff in supporting and maintaining eligibility. CRIS-E support will soon be in place to continue Medicaid eligibility when other programs, such as Food Stamps, expire or are being terminated for requirements not part of Medicaid.

Since 1999, Ohio has more closely engaged state Medicaid Quality Control staff in the identification of process deficiencies and to help promote simplification/expansion initiatives. MEQC staff participated in the regional Healthy Start technical assistance sessions and shared the findings of the targeted termination/denial review. MEQC has provided much helpful documentation of inappropriate local agency practices as well as identification of areas in which program rules lack clarity.

- 3.1.8 Evaluate the strengths and weaknesses of your *eligibility redetermination* process in increasing creditable health coverage among targeted low-income children. How does the redetermination

process differ from the initial eligibility determination process?

The strengths, weaknesses, and corrective actions for the application process are much the same for the reapplication process.

Strengths:

Redeterminations for families who are only receiving this health coverage are via the mail-in process and therefore promote retention for working families.

Per policy, once verification for information that is not subject to change is submitted, individuals are not required to reverify this information at subsequent redeterminations.

Ohio rules support mandatory protection for pregnant women and newborns. These protections are applicable regardless of the category of Medicaid under which these individuals are receiving coverage. Children who are born to women receiving Medicaid are deemed eligible for an entire year without reapplication. Once eligibility is established for pregnant women, they remain eligible throughout the pregnancy and the 60 day postpartum period.

The rules do not allow imposing requirements of other programs to this group, when other program benefits are received (e.g., if food stamps are received under a shortened certification period). Ohio has implemented an integrated exparte redetermination policy (Pre-Termination Review) which prohibits the termination of benefits without fully exploring all other Medicaid eligibility programs.

Weaknesses:

Despite rules and policies, county agencies often impose redetermination requirements of other programs (e.g., food stamps). The lack of system support has made it difficult to enforce compliance in this area. The CRIS-E system does not prevent inappropriate terminations of pregnant women and newborns.

County agency caseworkers often require families to reverify information that has been previously verified and not subject to change (e.g. birth verifications).

Steps Ohio Is Taking:

Ohio is in the early stages of developing a retention agenda as a complement to the access agenda. Options are being explored for developing a simplified redetermination process, and passive redetermination processes that are being implemented by other states are being reviewed.

Effective July of 2000, Ohio is instituting 12 months continuous eligibility for children with family income

from 151% to 200% FPL. For children with family income through 150%, the redetermination period is being extended from the current 6 months to 12 months.

As discussed in 3.1.7, Ohio is significantly reducing the number of factors that need to be verified. Work is being done to identify electronic data exchanges that will allow the caseworker to verify income without requiring pay stubs. Ohio is exploring verification standards for other programs that serve children to identify coordination opportunities.

3.2 What benefits do children receive and how is the delivery system structured?
(Section 2108(b)(1)(B)(vi))

3.2.1 Benefits

Please complete Table 3.2.1 for each of your CHIP programs, showing which benefits are covered, the extent of cost-sharing (if any), and benefit limits (if any).

<i>Table 3.2.1 CHIP Program Type Medicaid Expansion</i>			
Benefit	Is Service Covered? (T = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Inpatient hospital services	T	N/A	
Emergency hospital services	T	N/A	
Outpatient hospital services	T	N/A	
Physician services	T	N/A	
Clinic services	T	N/A	
Prescription drugs	T	N/A	Drugs not contained in the Ohio Medicaid Drug Formulary can be requested through the prior or post authorization process.
Over-the-counter medications	T	N/A	Drugs not contained in the Ohio Medicaid Drug Formulary can be requested through the prior or post authorization process.
Outpatient laboratory and radiology services	T	N/A	
Prenatal care	T	N/A	
Family planning services	T	N/A	Infertility, hysterectomies performed for sterilization purposes, and abortions to terminate an unwanted pregnancy are not covered.
Inpatient mental health services	T	N/A	
Outpatient mental health services	T	N/A	
Inpatient substance abuse treatment services	T	N/A	

<i>Table 3.2.1 CHIP Program Type Medicaid Expansion</i>			
Benefit	Is Service Covered? (T = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Residential substance abuse treatment services	T	N/A	Substance abuse services are covered when provided in a residential or other community-based setting.
Outpatient substance abuse treatment services	T	N/A	Services must be provided by a provider certified by the Ohio Department of Alcohol and Drug Addiction Services.
Durable medical equipment	T	N/A	Coverage may be limited depending on the item.
Disposable medical supplies	T	N/A	Coverage may be limited depending on the item.
Preventive dental services	T	N/A	Limited to 2 exams per year. Screenings performed as a component of the EPSDT benefit.
Restorative dental services	T	N/A	
Hearing screening	T	N/A	
Hearing aids	T	N/A	
Vision screening	T	N/A	Limited to 1 exam per year. Screenings performed as a component of the EPSDT benefit.
Corrective lenses (including eyeglasses)	T	N/A	Limited to one pair per year.
Developmental assessment	T	N/A	
Immunizations	T	N/A	
Well-baby visits	T	N/A	
Well-child visits	T	N/A	

Table 3.2.1 CHIP Program Type Medicaid Expansion

Benefit	Is Service Covered? (T = yes)	Cost-Sharing (Specify)	Benefit Limits
Physical therapy	T	N/A	Limited to 48 modalities per 12 mo
Speech therapy	T	N/A	
Occupational therapy	T	N/A	Only covered as components of the hospital benefits.
Physical rehabilitation services	T	N/A	
Podiatric services	T	N/A	
Chiropractic services	T	N/A	Limited to 48 visits for manipulat
Medical transportation	T	N/A	
Home health services	T	N/A	
Nursing facility	T	N/A	
ICF/MR	T	N/A	
Hospice care	T	N/A	
Private duty nursing	T	N/A	
Personal care services	T	N/A	Activities of Daily Living are cover health benefit for individuals enroll
Habilitative services	T	N/A	Covered under the Rehabilitation C
Case management/Care coordination	T	N/A	Covered for certain targeted group
Non-emergency transportation	T	N/A	Provided through the county admin Transportation (EMT) program.
Interpreter services			
Other (Specify) _____			
Other (Specify) _____			
Other (Specify) _____			

3.2.2 Scope and Range of Health Benefits (Section 2108(b)(1)(B)(ii))

Please comment on the scope and range of health coverage provided, including the types of benefits provided and cost-sharing requirements. Please highlight the level of preventive services offered and services available to children with special health care needs. Also, describe any enabling services offered to CHIP enrollees. (Enabling services include non-emergency transportation, interpretation, individual needs assessment, home visits, community outreach, translation of written materials, and other services designed to facilitate access to care.)

Healthy Start provides a rich and comprehensive benefit package to eligible consumers. Medical necessity is the fundamental concept underlying the coverage of services. Physicians, dentists and limited practitioners may render or authorize medical services within the scope of their licensure and based on their professional judgment of those services needed by an individual. Medically necessary services are services which are necessary for the diagnosis or treatment of disease, illness or injury. A medically necessary service must: meet accepted standards of medical practice; be appropriate to the illness or injury for which it is performed as to type and intensity of service and setting of treatment; provide essential and appropriate information when used for diagnostic purposes; provide additional essential and appropriate information when a diagnostic procedure is used with procedures as described above.

Covered services include, but are not limited to: physician visits; family planning services; obstetrical services; immunizations; HEALTHCHEK

(EPSDT services); therapeutic injections and prescribed drugs; dialysis; vision care services and corrective lenses; diagnostic and therapeutic services; cardiovascular diagnostic and therapeutic services; gastroenterology, otorhinolaryngology, neurology and special dermatology services; pulmonary services; allergy services; chemotherapy treatment; anesthesia services; surgical services; laboratory services; radiology services; physical medicine services; medical supplies and durable medical equipment; services provided for the diagnosis and treatment of mental and emotional disorders; inpatient and outpatient hospital services; clinic services; substance abuse services; preventive and restorative dental services; hearing screenings; podiatric services; chiropractic services; medical transportation; home health services; nursing facilities; ICF/MR; hospice care; private duty nursing; habilitative services and case management/care coordination. (See Table 3.2.1)

In addition to medically necessary services, the program also covers the following preventive health services and associated diagnostic services: all HEALTHCHEK (EPSDT) services and routine infant checkups; immunizations; routine pelvic examinations, pap smears and breast examinations; family planning visits and services; and pregnancy related services. The extent of preventive services provided and covered is dependent on the age of the patient, sex, family medical history, ethnic background, and abnormalities encountered during the examinations.

There are no cost sharing requirements for medically necessary or covered preventive health services.

Enabling services include: non-emergency transportation available at the county level through the Enhanced Medicaid Transportation (EMT) program; and certain pregnancy related services to promote positive birth outcomes by supplementing regular obstetrical care such as care coordination, group education, nutrition intervention and home visits.

3.2.3 Delivery System

Identify in Table 3.2.3 the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Check all that apply.

<i>Table 3.2.3</i>			
Type of delivery system	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*
A. Comprehensive risk managed care organizations (MCOs)	Yes		

Table 3.2.3

Statewide?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mandatory enrollment?	<input checked="" type="checkbox"/> * Yes <input type="checkbox"/> No *In some metro counties; in other counties voluntary enrollment is available and in other counties a FFS delivery system is available. See Appendix E for details on MCPs by county.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Number of MCOs	Eleven		
B. Primary care case management (PCCM) program	N/A		
C. Non-comprehensive risk contractors for selected services such as mental health, dental, or vision (specify services that are carved out to managed care, if applicable)	N/A		
D. Indemnity/fee-for-service (specify services that are carved out to FFS, if applicable)	Yes, Statewide		
E. Other (specify)_____	N/A		
F. Other (specify)_____	N/A		
G. Other (specify)_____	N/A		

3.3 How much does CHIP cost families?

3.3.1 Is cost sharing imposed on any of the families covered under the plan? (Cost sharing includes premiums, enrollment fees, deductibles, coinsurance/ copayments, or other out-of-pocket expenses paid by the family.)

No, skip to section 3.4

Yes, check all that apply in Table 3.3.1

<i>Table 3.3.1</i>			
Type of cost-sharing	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*
Premiums			
Enrollment fee			
Deductibles			
Coinsurance/copayments**			
Other (specify) _____			

3.3.2 If premiums are charged: What is the level of premiums and how do they vary by program, income, family size, or other criteria? (Describe criteria and attach schedule.) How often are premiums collected? What do you do if families fail to pay the premium? Is there a waiting period (lock-out) before a family can re-enroll? Do you have any innovative approaches to premium collection?

N/A

3.3.3 If premiums are charged: Who may pay for the premium? Check all that apply. (Section 2108(b)(1)(B)(iii))

N/A

3.3.4 If enrollment fee is charged: What is the amount of the enrollment fee and how does it vary by program, income, family size, or other criteria?

N/A

3.3.5 If deductibles are charged: What is the amount of deductibles (specify, including variations by program, health plan, type of service, and other criteria)?

N/A

3.3.6 How are families notified of their cost-sharing requirements under CHIP, including the 5 percent cap?

N/A

3.3.7 How is your CHIP program monitoring that annual aggregate cost-sharing does not exceed 5 percent of family income? Check all that apply below and include a narrative providing further details on the approach.

N/A

3.3.8 What percent of families hit the 5 percent cap since your CHIP program was implemented?

N/A

3.3.9 Has your State undertaken any assessment of the effects of premiums on participation or the effects of cost sharing on utilization, and if so, what have you found?

N/A

3.4 How do you reach and inform potential enrollees?

Ohio's state level outreach strategy consists of conveying simple messages in targeted ways to different audiences. Ohio takes a statewide approach that pays attention to what is happening on a county/local level so that state level efforts complement local efforts where they are happening and fill the gap where they may not be happening. Included in the strategy are three main objectives; several components and processes are used to implement the strategy. To reach different audiences, outreach is performed:

- C Direct to the consumer - direct mailings that compel the consumer to enroll**
- C General public awareness about the program - create positive image messages through media (e.g., radio, television, health fairs)**
- C Indirect to consumer advocates or other community resource agencies/interveners (e.g., faith communities, schools, providers, employers, public health agencies).**

A KISS approach is used to get to know the consumer and provide timely and accurate information in a

simple fashion.

Know the consumer - Know what the consumers value, what their needs and wants are, what they are doing now instead of the desired behavior, what the immediate benefit is and what the reward is connected to the desired action. It is important to be sensitive to consumers moving from welfare to work, to deal with culture changes about willingness to accept government assistance, to capitalize on other community resources consumers are using, and to realize that the consumer known to Medicaid is different than the consumer unknown to Medicaid.

Information - Identify what the message is and why it is important, raise awareness, clarify program myths and misconceptions, inform consumers that health insurance is important, share the process to obtain/retain health insurance, and promote that there are no time limits, work requirements, sanctions, face-to-face interviews, or cost. Consumers must be educated about new programs and be provided with access/assistance to coverage and services, and barriers to the application process must be reduced. Effective messages must be used that speak to consumers, such as graphic illustrations, stories, testimonials, slice-of-life, dramas and comical presentations that bring facts or feelings to life.

Simple - Family friendly, easy to understand, explaining the application process and accessing services equates to the ease of taking care of the family's health needs. It is important to be culturally sensitive and utilize translation services and ethnic media for diverse communities such as immigrants, tribal families, American Indians and Alaskan natives.

Support - Involve partners to support ongoing health insurance coverage, seek partnerships with providers and other agencies to build on their existing relationships with families, and develop comprehensive delivery systems. It is not enough just to provide coverage, it is vital to also promote preventive care, lower emergency room usage, increase health promotion, and lower rates of unmet health care needs.

Ohio's outreach strategy contains several components that can be tailor-made to the specific audience and message. Potential enrollees can be reached and informed in many different ways with varying degrees of impact. Much of the work is based on establishing positive working relationships with local level stakeholders and consumer advocates who work directly with consumers. For example, workshops are offered to staff at Head Start agencies who work directly with parents who may have a need for health insurance for their children. If the Head Start staff is well informed about the program they become a reliable referral source for the clients. The major components of the outreach strategy include:

- C** Health fairs, community events, festivals - consumer directed dialogue, materials distribution and sometimes promotional premium (e.g., key chain, magnet) give-aways.
- C** Community meetings/presentations - establish presence on local agendas where the audience consists of local stakeholders (e.g., social service agency workers, public health dept. staff, Head Start agency directors/teachers).

- C** **Materials/messages - direct mailing of materials to consumers and consumer advocates.**
- C** **Partners - establish partnerships with other state and local agencies where the same target audience of working families with children is shared.**
- C** **Toll-free Consumer Hotline - the hotline is staffed with representatives who can answer questions about the program and assist with the application process.**
- C** **Electronic Media - a paid campaign using HCFA grant money was used to generate public service announcements.**

In addition to the state level outreach, many counties are implementing outreach plans.

3.4.1 What client education and outreach approaches does your CHIP program use?

Please complete Table 3.4.1. Identify all of the client education and outreach approaches used by your CHIP program(s). Specify which approaches are used (T=yes) and then rate the effectiveness of each approach on a scale of 1 to 5, where 1=least effective and 5=most effective.

Because outreach approaches occurred at both state and local levels, the following table is completed with an “S” indicating state level approaches and with an “L” if we have information indicating the approach is utilized at a local level. In some cases the same approaches were used by both state and local levels.

<i>Table 3.4.1</i>						
Approach	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program*	
	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)
Billboards	L					
Brochures/flyers	S/L					
Direct mail by State/enrollment broker/administrative contractor	S/L					
Education sessions	S/L					
Home visits by State/enrollment broker/administrative contractor	L					
Hotline	S/L					
Incentives for education/outreach staff	L					
Incentives for enrollees						
Incentives for insurance agents						
Non-traditional hours for application intake	S/L					
Prime-time TV advertisements	L					
Public access cable TV	S/L					
Public transportation ads	L					

<i>Table 3.4.1</i>						
Radio/newspaper/TV advertisement and PSAs	S/L					
Signs/posters	S/L					
State/broker initiated phone calls						
Other (specify) _____						
Other (specify) _____						

Enhanced Medicaid Outreach Funding was established in The Personal Responsibility and Work Opportunity Act of 1996 (PRWORA). In order to ensure those eligible for Medicaid did not lose coverage due to the delinking of cash assistance and Medicaid, the PRWORA legislation included the establishment of a \$500 million dollar federal outreach fund. The 16.9 million allocated to Ohio was made available through the administrative portion of Ohio’s Medicaid Program (Title XIX). The outreach program was set up such that expenditures would receive an enhanced federal reimbursement rate of 75% or 90% depending on the activity which greatly expanded the funds available.

Since Ohio used PRWORA funding to support local level outreach on a county basis across its 88 counties, statewide outreach efforts have been designed to compliment local efforts. Over 70 counties utilized available enhanced funding to conduct various local level outreach activities over an 18-month period. Please see section 3.4.3 for the explanation of measuring effectiveness for the local level approaches.

In evaluating the statewide efforts, concrete baseline data was not established, outside of our budget projections, to help determine the outcome or results of outreach efforts. In accomplishing outreach strategy objectives, different outreach activities were pursued with different goals in mind. In many cases, the goal was to simply raise the floor of understanding about our program, to create a positive image, and to enhance awareness. In other cases, the goal was to drive the outcome towards enrollment into the program. The effectiveness of the efforts is derived more out of sensing what was successful based on a cause and effect relationship. For example, the call volume on the Consumer Hotline increased after a direct mailing to 13,000 churches affiliated with the Ohio Council of Churches. Other indicators of successful outreach efforts are:

- ‘ requests for workshops or attendance at local level meetings**
- ‘ repeat invitations by groups with whom ODHS partners (i.e. Head Start Association, School Nurses, Graduation Reality and Dual Roles Skills [GRADS])**

3.4.2 Where does your CHIP program conduct client education and outreach?

Please complete Table 3.4.2. Identify all the settings used by your CHIP program(s) for client education and outreach. Specify which settings are used (T=yes) and then rate the effectiveness of each setting on a scale of 1 to 5, where 1=least effective and 5=most effective.

Because outreach approaches occurred at both state and local levels, the following table is completed with an “S” indicating state level approaches and with an “L” if we have information indicating the approach is utilized at a local level. In some cases the same approaches were used by both state and local levels.

<i>Table 3.4.2</i>						
Setting	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program*	
	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)
Battered women shelters						
Community sponsored events	S/L					
Beneficiary's home	L					
Day care centers	S/L					
Faith communities	S/L					
Fast food restaurants	L					
Grocery stores	L					
Homeless shelters						
Job training centers	L					
Laundromats	L					
Libraries	S/L					
Local/community health centers	S/L					
Point of service/provider locations	L					
Public meetings/health fairs	S/L					
Public housing						

Developed by the National Academy for State Health Policy

<i>Table 3.4.2</i>						
Refugee resettlement programs						
Schools/adult education sites	S/L					
Senior centers						
Social service agency	S/L					
Workplace	L					
Other (specify) _____						
Other (specify) _____						

Again, no formal baseline was established to use as a concrete measure of effectiveness regarding the location or setting client education and outreach. The sense of successful locations and settings indicated above are determined by the receptiveness of the audience, the popularity of the materials distributed, the ability to dialogue with consumers directly and the opportunity to target low-income families. Settings such as child care centers, community health centers and schools created a better opportunity to dialogue with consumers directly than in other settings. Community sponsored events, health fairs and social service agencies were also effective settings because, due to the nature of their respective “business”, they naturally generate interest to the target population.

Appendix F summarizes outreach activities from January 1998 through September 1999.

Section 3.4.3 addresses the evaluation of the local level settings.

- 3.4.3 Describe methods and indicators used to assess outreach effectiveness, such as the number of children enrolled relative to the particular target population. Please be as specific and detailed as possible. Attach reports or other documentation where available.

In an effort to allow maximum flexibility for counties to develop outreach plans that would be tailored to the specific county needs and resources, no statewide requirements for outreach activities were implemented, nor was there a formal evaluation component mandated.

In order to describe what activities have occurred throughout the state, a survey was distributed to counties to solicit feedback on how implemented activities have affected Medicaid enrollment, application activity and public awareness. Currently, The John Glenn Institute for Public Service & Public Policy, at The Ohio State University, is compiling information received from counties and reviewing county level data on caseload and application activity. A report is expected in spring 2000.

A more comprehensive study and analysis of outreach activities will be completed as a part of a larger research grant made available by the department through the Medicaid Technical Assistance & Policy Program (MEDTAPP), which was awarded to Wright State University - Center For Healthy Communities. The final results of this program are expected before the end of calendar year 2000.

- 3.4.4 What communication approaches are being used to reach families of varying ethnic backgrounds?

The statewide outreach materials (e.g., flyers and brochures) are translated into Spanish. The two-page CPA is available in Spanish. Ohio is seeking a contractor to translate other materials into Spanish, and other languages as needed. During efforts to use more culturally sensitive materials, Ohio has learned that there is a high degree of illiteracy among the Spanish speaking population in the northwest area of the state. This raises awareness about language translations and literacy levels among target populations.

In addition to statewide outreach materials, counties also produced bilingual and culturally balanced items.

- 3.4.5 Have any of the outreach activities been more successful in reaching certain populations? Which methods best reached which populations? How have you measured their effectiveness? Please present quantitative findings where available.

Ohio has participated in outreach events that are specific to minority populations, such as health fairs for April's Minority Health Month. Exhibit booths are staffed in several different counties/locations throughout the state, and these events draw a number of minority populations. Ohio also participates in health fairs during September's Women's Health Month and at an annual weekend- long event called Black Family Expo. Several workshops are conducted for the GRADS program, which targets pregnant teenagers. Ohio also provides materials to minority related community events, such as the Asian Festival and the Latino Festival.

3.5 What other health programs are available to CHIP eligibles and how do you coordinate with them?
(Section 2108(b)(1)(D))

Describe procedures to coordinate among CHIP programs, other health care programs, and non-health care programs. Table 3.5 identifies possible areas of coordination between CHIP and other programs (such as Medicaid, MCH, WIC, School Lunch). Check all areas in which coordination takes place and specify the nature of coordination in narrative text, either on the table or in an attachment.

<i>Table 3.5</i>				
Type of coordination	Medicaid*	Maternal and child health	Other (specify) _____	Other (specify) _____
Administration				
Outreach		Interagency Agreement		
Eligibility determination		Shared application for WIC, CFHS, BCMH		
Service delivery				
Procurement				
Contracting				
Data collection				
Quality assurance				
Other (specify) _____				
Other (specify) _____				

*Note: This column is not applicable for States with a Medicaid CHIP expansion program only.

3.6 How do you avoid crowd-out of private insurance?

3.6.1 Describe anti-crowd-out policies implemented by your CHIP program. If there are differences across programs, please describe for each program separately. Check all that apply and describe.

X Eligibility determination process:

X Information on current or previous health insurance gathered on application:

Health insurance information is collected on the application in order to sort eligibles between Title XXI (no other insurance) and Title XIX (other insurance in place), and for the purposes of cost avoidance and recovery. Crowd out is discussed in 1.2.2.

NA Benefit package design:

NA Other policies intended to avoid crowd out (e.g., insurance reform):

3.6.2 How do you monitor crowd-out? What have you found? Please attach any available reports or other documentation.

The Ohio Medicaid CHIP implementation up to 150% of FPL was combined with an underlying Medicaid expansion regardless of insurance status. At the time of Medicaid application there is an assessment of whether a child currently has private health insurance. Whether a child had coverage within the last year or last month, or has just dropped coverage to get onto Medicaid is not assessed. For children that do not have private coverage, their expenditures are allocated to Title XXI. Expenditures for children that do have private coverage are allocated to Title XIX.

SECTION 4. PROGRAM ASSESSMENT

This section is designed to assess the effectiveness of your CHIP program(s), including enrollment, disenrollment, expenditures, access to care, and quality of care.

4.1 Who enrolled in your CHIP program?

4.1.1 What are the characteristics of children enrolled in your CHIP program? (Section 2108(b)(1)(B)(i))

Please complete Table 4.1.1 for each of your CHIP programs, based on data from your HCFA quarterly enrollment reports. Summarize the number of children enrolled and their characteristics. Also, discuss average length of enrollment (number of months) and how this varies by characteristics of children and families, as well as across programs.

States are also encouraged to provide additional tables on enrollment by other characteristics, including gender, race, ethnicity, parental employment status, parental marital status, urban/rural

location, and immigrant status. Use the same format as Table 4.1.1, if possible.

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose “select” “table.” Once the table is highlighted, copy it by selecting “copy” in the Edit menu and then “paste” it under the first table.

<i>Table 4.1.1 CHIP Program Type Medicaid Expansion</i>						
Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children	49,565	83,688	3.7	6.2	22,600	58,145
Age						
Under 1	250	384	2.56	4.08	147	319
1-5	4,115	8,213	2.99	4.80	2,149	6,697
6-12	17,435	32,577	3.42	5.80	7,963	23,423
13-18	27,765	42,514	4.04	6.77	12,341	27,706
Countable Income Level*						
At or below 150% FPL	49,565	83,688	3.7	6.2	22,600	58,145
Above 150% FPL						
Age and Income						
Under 1						
At or below 150% FPL	250	384	2.56	4.08	147	319
Above 150% FPL						
1-5						

Table 4.1.1 CHIP Program Type Medicaid Expansion

Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
At or below 150% FPL	4,115	8,213	2.99	4.80	2,149	6,697
Above 150% FPL						
6-12						
At or below 150% FPL	17,435	32,577	3.42	5.80	7,963	23,423
Above 150% FPL						
13-18						
At or below 150% FPL	27,765	42,514	4.04	6.77	12,341	27,706
Above 150% FPL						
Type of plan						
Fee-for-service	45,405	62,421	3.83	6.58	21,876	54,945
Managed care	4,160	21,267	2.61	5.05	724	3,200
PCCM						

*Countable Income Level is as defined by the states for those that impose premiums at defined levels other than 150% FPL. See the HCFA Quarterly Report instructions for further details.

SOURCE: HCFA Quarterly Enrollment Reports, Forms HCFA-21E, HCFA-64.21E, HCFA-64EC, HCFA Statistical Information Management System, October 1998

In addition to the HCFA quarterly reports, ODHS generates a monthly Caseload Analysis Bulletin that provides expansion information. The attached bulletin for September 1999 (Appendix B) shows that during the period 1/1/98-9/30/99, disenrollees lost coverage due to a variety of factors. Approximately 54.8% became ineligible as a result of increases in family income or because they failed to re-apply after six months. Approximately 45.2% became eligible for regular Healthy Start or Medicaid as a result of

decreased family income.

4.1.2 How many CHIP enrollees had access to or coverage by health insurance prior to enrollment in CHIP? Please indicate the source of these data (e.g., application form, survey). (Section 2108(b)(1)(B)(i))

At the point of application, there is an assessment of whether a child currently has private health insurance. In Ohio, CHIP was implemented along with a Title XIX expansion, so the assessment is made for the purposes of determining funding codes and third party liability, not consumer eligibility. Expenditures for children that do not have private coverage are allocated to Title XXI, while expenditures for children that do have private coverage are allocated to Title XIX. In any given month, expenditures for approximately 65-70% of expansion participants are allocated to Title XXI.

Table 4.1.2 shows the approximate percentage by month of expansion participants whose allocations are coded as Title XXI and Title XIX for the period January 1998 - September 1999.

Table 4.1.2 Funding Allocations		
Month	Title XXI	Title XIX
January 1998	75%	25%
February 1998	67%	33%
March 1998	68%	32%
April 1998	67%	33%
May 1998	66%	34%
June 1998	66%	34%
July 1998	67%	33%
August 1998	66%	34%
September 1998	69%	31%
October 1998	67%	33%
November 1998	67%	33%
December 1998	69%	31%

January 1999	67%	33%
February 1999	69%	31%
March 1999	65%	35%
April 1999	68%	32%
May 1999	66%	34%
June 1999	66%	34%
July 1999	66%	34%
August 1999	69%	31%
September 1999	70%	30%

4.1.3 What is the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children? (Section 2108(b)(1)(C))

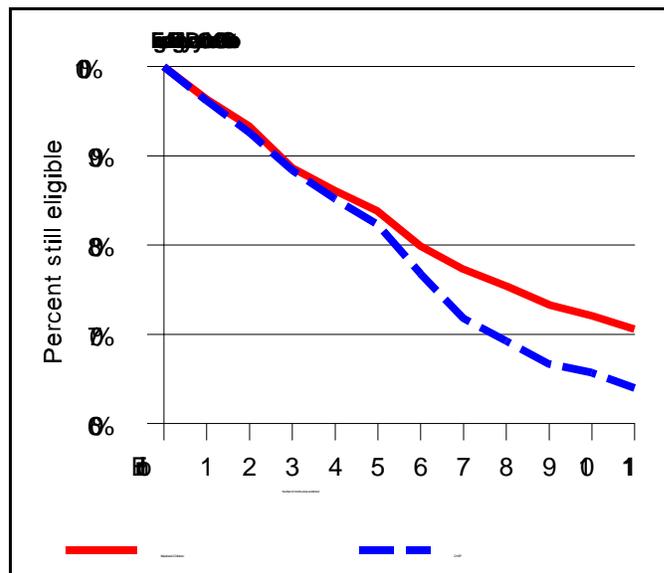
In September, 1999, 251,000 individuals in Ohio received Medicaid through OWF eligibility, 144,000 received Transitional or Low-Income Families (LIF) Medicaid and 148,000 individuals were covered by pre-expansion Healthy Start.

Beginning in 1992, the Ohio Department of Health, through its Bureau for Children with Medical Handicaps, Hemophilia and AIDS programs, started paying health insurance premiums for families who could not afford to keep their employer-based insurance. These three public health insurance purchasing programs screen potentially eligible candidates to determine that the people for whom health insurance is being purchased are not eligible for Medicaid.

4.2 Who disenrolled from your CHIP program and why?

4.2.1 How many children disenrolled from your CHIP program(s)? Please discuss disenrollment rates presented in Table 4.1.1. Was disenrollment higher or lower than expected? How do CHIP disenrollment rates compare to traditional Medicaid disenrollment rates?

As a Medicaid expansion, Ohio’s CHIP program enrollment process is completely integrated into the overall Medicaid enrollment procedure. Eligibility is redetermined every six months so that families must re-apply to continue in the CHIP program. Eligibility for the program is not guaranteed continuous eligibility, so that at any time during the six month period, if there is an income change, the family is obligated to report the change. The figures in section 4.1 would indicate that there is a relatively high disenrollment rate (58,145 out of 83,688 or 69.5%). Yet, most of those who leave CHIP (54.9% since the beginning of the CHIP program) are eligible for a Medicaid program in the month following their last month of CHIP eligibility. In fact, all that has happened procedurally is that the family income reported at re-enrollment had declined from the previous enrollment, and the eligibility determination process resulted in a different eligibility category. In a small number of cases, a child’s



SSI and disability eligibility determination may have moved them into the category of eligibility for people with disabilities. About 45.1% of the children who disenroll from CHIP, have left the

Medicaid program entirely. Some leave prior to the scheduled redetermination. The reasons are captured in section 4.2.3. CHIP children lose eligibility or do not reapply at a higher rate than children on Medicaid. In the latest enrollment month for which there is a full year of data, the decay in the number of eligible months has been tracked. In Figure 4.1, for all of the Medicaid children that enrolled in

October 1998, approximately 70.6% were still enrolled at the end of a year. For CHIP children, 64% were enrolled at the end of the year. The figure clearly shows that the experience for CHIP and Medicaid children is fairly similar before the 6th month, the month of re-enrollment. At that point, the rate of decay in eligibility months increases more for CHIP children than Medicaid children.

4.2.2 How many children did not re-enroll at renewal? How many of the children who did not re-enroll got other coverage when they left CHIP?

While it is possible to estimate disenrollment rates for the CHIP population from the month that enrollment began, it is almost impossible to specifically determine rates of re-enrollment at a renewal month. Administrative records for the existing Client Registry Information System (CRIS-E) overwrite application dates so that electronic enrollment history is lost. Additionally, because a three month retro-active eligibility period exists, and children who do not reapply at scheduled redeterminations can have eligibility back-dated, eligibility can appear to be continuous. Finally, for those who lose eligibility, while there is an effort to track cases that are ‘closed’, the system does not include a mechanism to track whether a former eligible is now getting private health insurance.

4.2.3 What were the reasons for discontinuation of coverage under CHIP? (Please specify data source, methodologies, and reporting period.)

Table 4.2.3

Reason for discontinuation of coverage	Medicaid CHIP Expansion Program		State-designed CHIP Program		Other CHIP Program*	
	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total
Total	147,281	100%				
Access to commercial insurance						
Eligible for Medicaid	83,815	56.91%				
Income too high	8,892	6.04%				
Aged out of program	466	0.32%				

Moved/died	1,274	0.87%				
Nonpayment of premium						
Incomplete documentation	2,083	1.41%				
Did not reply/unable to contact	114	0.08%				
Other (specify) failure to meet eligibility criteria, failure to cooperate in re-application process, failure to cooperate in establishing an eligibility program, failure to sign a self sufficiency contract	20,749	14.09%				
Other (specify) _____						
Don't know	29,888	20.29%				

The analysis in Table 4.2.3 covers 24 months (January 1998 to January 2000) of CRIS-E extract files. Subsequent six month periods from April 1998 through December 1999 were analyzed, except for the beginning and end of the study period which covers three (January 1998 - March 1998) and four (October 1999 - January 2000) months of analysis respectively.

Disenrollees are those who had at least a one month CHIP eligibility, but left the CHIP program (either transferred to another Medicaid program or “dropped-off”) during the study period. “Drop-off” is defined as a CHIP eligible who has at least six months continuous disenrollment.

4.2.4 What steps is your State taking to ensure that children who disenroll, but are still eligible, re-enroll?

Ohio policy requires caseworkers to conduct a pre-termination review (PTR) to explore potential Medicaid eligibility for other categories prior to proposing to terminate Medicaid coverage for any individual. In addition, some counties are initiating follow-up contact with individuals whose coverage has

ended to evaluate whether eligibility again exists.

At a county level, several county departments of human services are making concerted efforts to contact families who have lost contact with the department in order to inform them about potential health coverage and assist them in applying. However, this is not happening systematically throughout the state.

4.3 How much did you spend on your CHIP program?

4.3.1 What were the total expenditures for your CHIP program in federal fiscal year (FFY) 1998 and 1999?

FFY 1998: **\$12,218,003.00**

FFY 1999: **\$50,680,978.00**

Please complete Table 4.3.1 for each of your CHIP programs and summarize expenditures by category (total computable expenditures and federal share). What proportion was spent on purchasing private health insurance premiums versus purchasing direct services?

<i>Table 4.3.1 CHIP Program Type</i> Medicaid Expansion				
Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures	\$12,218,003	\$50,680,978	\$8,638,128	\$35,871,996
Premiums for private health insurance (net of cost-sharing offsets)* <i>(Capitation rates paid to HMOs)</i>	1,457,115	10,008,051	1,030,180	7,083,699
Fee-for-service expenditures (subtotal)	10,760,888	40,672,927	7,607,948	28,788,298
Inpatient hospital services	3,371,122	10,658,560	2,383,383	7,544,129
Inpatient mental health facility services	729,431	371,601	515,708	263,019

Table 4.3.1 CHIP Program Type Medicaid Expansion

Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Nursing care services	0	6,510	0	4,608
Physician and surgical services	1,564,861	5,380,809	1,106,357	3,808,537
Outpatient hospital services	1,165,508	6,388,768	824,014	4,521,970
Outpatient mental health facility services	0	0	0	0
Prescribed drugs	1,351,186	5,055,094	955,289	3,577,996
Dental services	755,347	1,731,320	534,030	1,225,428
Vision services	Numbers are not isolated for this service. Coded under “Other practitioners’ services”			
Other practitioners’ services	235,358	736,668	166,398	521,413
Clinic services	850,515	8,044,088	601,314	5,693,605
Therapy and rehabilitation services	0	0	0	0
Laboratory and radiological services	41,820	129,223	29,567	91,464
Durable and disposable medical equipment	0	0	0	0
Family planning	0	0	0	0
Abortions	0	0	0	0
Screening services	0	0	0	0
Home health	38,053	171,914	26,903	121,681
Home and community-based services	11,512	7,476	8,139	5,292
Hospice	9,096	0	6,431	0
Medical transportation	56,563	0	39,990	0

Table 4.3.1 CHIP Program Type Medicaid Expansion

Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Case management	193,172	129,914	136,573	91,953
Other services	387,344	1,860,982	273,852	1,317,203

4.3.2 What were the total expenditures that applied to the 10 percent limit? Please complete Table 4.3.2 and summarize expenditures by category.

What types of activities were funded under the 10 percent cap? **None**

What role did the 10 percent cap have in program design? **None**

Table 4.3.2

Type of expenditure	Medicaid Chip Expansion Program		State-designed CHIP Program		Other CHIP Program*	
	FY 1998	FY 1999	FY 1998	FY 1999	FY 1998	FY 1999
Total computable share	0	0				
Outreach						
Administration						
Other						
Federal share						
Outreach						
Administration						
Other _____						

4.3.3 What were the non-Federal sources of funds spent on your CHIP program (Section 2108(b)(1)(B)(vii))

- State appropriations
- County/local funds
- Employer contributions

- ___ Foundation grants
- ___ Private donations (such as United Way, sponsorship)
- ___ Other (specify) _____

4.4 How are you assuring CHIP enrollees have access to care?

4.4.1 What processes are being used to monitor and evaluate access to care received by CHIP enrollees? Please specify each delivery system used (from question 3.2.3) if approaches vary by the delivery system within each program. For example, if an approach is used in managed care, specify ‘MCO.’ If an approach is used in fee-for-service, specify ‘FFS.’ If an approach is used in a Primary Care Case Management program, specify ‘PCCM.’

<i>Table 4.4.1</i>			
Approaches to monitoring access	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*
Appointment audits			
PCP/enrollee ratios			
Time/distance standards			
Urgent/routine care access standards			
Network capacity reviews (rural providers, safety net providers, specialty mix)			
Complaint/grievance/ disenrollment reviews	MCO FFS		
Case file reviews	MCO FFS		
Beneficiary surveys	MCO FFS		
Utilization analysis (emergency room use, preventive care use)	MCO FFS		
Other: Encounter Data	MCO		
Other (specify) _____			

Table 4.4.1

	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*
Approaches to monitoring access			_____
Other (specify) _____			

4.4.2 What kind of managed care utilization data are you collecting for each of your CHIP programs? If your State has no contracts with health plans, skip to section 4.4.3.

Table 4.4.2

	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*
Type of utilization data			_____
Requiring submission of raw encounter data by health plans	<input checked="" type="checkbox"/> Yes ___ No	___ Yes ___ No	___ Yes ___ No
Requiring submission of aggregate HEDIS data by health plans	<input checked="" type="checkbox"/> Yes ___ No	___ Yes ___ No	___ Yes ___ No
Other (specify) _____	___ Yes <input checked="" type="checkbox"/> No	___ Yes ___ No	___ Yes ___ No

4.4.3 What information (if any) is currently available on access to care by CHIP enrollees in your State? Please summarize the results.

Three general sources of information are used to monitor access to care and quality of care (note that an integrated approach to monitor access and quality exists. The answers to 4.4, in part, serve as the answers to 4.5.). They include: 1) utilization and medical records reviewed by a qualified vendor, 2) fee-for-service claims and managed care plan encounter data, and 3) consumer surveys by a qualified vendor. Additionally, there are other activities performed specifically around the managed care program which are used to monitor access to care, including focused quality of care studies.

Utilization and medical records review has been performed for many years under authority of Title XIX, for both hospital utilization review, and managed care external quality review . These reviews have been contracted out to qualified vendors who are federally designated peer review organizations (PROs) or more recently “PRO like.” The hospital contract has included two parts, one for pre-admission and post-payment review of inpatient hospital care, and another for studying the quality and access to care in the hospital setting. Numerous studies have been completed in the past few years, including:

Outpatient Ambulatory Services Study/Market Profile

- ' **Description of Ambulatory Care Systems in Selected Ohio Counties & Facilities**
- ' **Ambulatory Care Patient and Visit Profiles**
- ' **Community Acquired Pneumonia Study (Inpatient)**
- ' **Upper Respiratory Tract Infection Study (Outpatient)**
- ' **Acute Myocardial Infarction**
- ' **Hypertension**
- ' **Congestive Heart Failure**
- ' **Chronic Pain Management ***
- ' **Childhood Diabetes ***
- ' **STDs ***

*** Current SFY00 Studies**

The managed care external quality review also has two parts. One for measuring and assuring the administrative capacity of managed care plans, and another for measuring quality and access to non-institutional services specific to individual managed care plans. Staff have used the results of these studies to set performance improvement objectives for each plan. Numerous studies have been completed in the past few years, including:

Adult Asthma

Case Management: Ohio Works First

Case Management: ABC

Childhood Immunizations

Childhood Asthma

Denials of Authorizations for Services

Dental Care

Depression

Diabetes

Emergency Department Diversion

Encounter Data Validation

Grievance Management System

HealthChek

Inpatient Care

Medical Record Audit

Omissions Study

Otitis Media

Prenatal Care

Provider Site Audits

Quality Assurance Programs

Respiratory

Utilization Management Systems

Fee-for-service claims and managed care plan encounter data are used for measuring access to care. Since 1997, this data has been used to calculate specific performance measures for both fee-for-service and managed care delivery systems. A baseline "Fee-for Service Performance Measurement Report" was published in December 1997, and a "Medicaid Managed Care Performance Measurement Report" was published in May 1998. A second year managed care report is in draft form, and will be published soon. Specific data for CHIP enrollees is just becoming available now, as the first full year of

implementation of CHIP concluded in December 1998. Fee-for-service providers have up to one-year from the date of service to submit claims, and managed care plans are accorded the courtesy of reviewing their plan specific data prior to it being published. Measures that have been used in the performance measurement reports include:

**Initiation of prenatal care
low birth weight rate
cesarean section rate
post partum visit rate
comprehensive exam for children rates (Age 0, Age 1, and Age 2-18)
immunization rate
hospitalization and emergency department use by asthmatic children
appropriate antibiotic for otitis media
chemical dependency follow-up after hospitalization*
chemical dependency re-admission rate*
chemical dependency hospital discharge rate*
Mental health follow-up after hospitalization*
Mental health re-admission rate*
Mental health hospital discharge rate***

*** used only in fee-for-service report.**

Geographic Information System (GIS) technology is being used to measure access in both the FFS and MCP delivery systems using claims, encounter and eligibility. This includes measuring proximity and geographic distance from primary care providers, dentists, and hospital care. It also includes measuring utilization and market share by county and sub-county geographic boundaries.

Consumer surveys have recently been used to measure enrollees' perception of both quality and access to care. Our strategy has been to measure each managed care plan and the fee-for-service delivery system on a basis which allows adequate comparisons of performance without being handicapped by methodological considerations. This has led us to contract with a single qualified vendor to perform all of the survey and analytical work. In January 1998 a survey of managed care plan enrollees was completed using the Consumer Assessment of Health Plans (CAHPS) version 1 methodology. This was a telephone based stratified random sample of persons who were enrolled in an MCP for six months or more. A separate survey was conducted later in 1998 for fee-for-service enrollees using the FFS version of the survey. The "Medicaid Managed Care Consumer Satisfaction Survey" was published in September 1998, and the fee-for-service survey was published in November 1999. A new CAHPS survey (version 2) for managed care plans began data collection in February 2000. It includes a cross-sectional sampling frame for both CHIP eligibles and children with special health care needs using the CAHPS CSHCN screening questions. Preliminary unweighted results of the survey are included in the strategic

goals and objectives in this document. Plan specific information will be compared to results from the previous managed care survey to determine how much improvement plans have made.

4.4.4 What plans does your CHIP program have for future monitoring/evaluation of access to care by CHIP enrollees? When will data be available?

A new strategy is being employed regarding utilization and medical records review as a result of the CHIP requirements. In the past, hospital quality and access studies did not include patients in managed care plans. There has also never been quality and access studies performed for the non-institutional components of fee-for-service. Recent RFPs for these services have included hospital studies for MCP enrollees, and non-institutional studies of fee-for-service enrollees. The hospital contract has been awarded, but studies have not yet been completed. The non-institutional contract has not yet been awarded. Additionally, for the non-institutional studies particular to managed care plans, studies which show there is significant room for improvement are now being repeated on a regular cycle (either 1 or 2 years between studies) so that plan improvements can be measured.

A significant amount of work remains in performing utilization and access measures around children using FFS claims data and MCP encounter data. This includes further improvements in the validation of MCP encounter data, expanding the set of measures, looking closely at the data for a fully implemented CHIP program (current data only includes the start-up period), and implementing recent improvements in health care measurement technologies.

Consumer surveys will continue to be used and improved to capture information from consumers that are relevant to delivery system improvements. Managed care plan surveys will now be performed annually, at the same time during the year, so that plans that are Medicaid-only can use these results to achieve their NCQA accreditation.

4.5 How are you measuring the quality of care received by CHIP enrollees?

4.5.1 What processes are you using to monitor and evaluate quality of care received by CHIP enrollees, particularly with respect to well-baby care, well-child care, and immunizations? Please specify the approaches used to monitor quality within each delivery system (from question 3.2.3). For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in primary care case management, specify 'PCCM.'

<i>Table 4.5.1</i>			
Approaches to monitoring quality	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program
Focused studies (specify)	In the past, focused studies have been only for the managed care plans. Focused studies beginning with a new vendor contract will have FFS sampling units. Studies have included/will include EPSDT/Healthchek, immunizations, asthma, depressions, etc.		
Client satisfaction surveys	MCO FFS		
Complaint/grievance/ disenrollment reviews	MCO		
Sentinel event reviews	MCO		
Plan site visits	MCO		
Case file reviews			
Independent peer review			
HEDIS performance measurement			
Other performance measurement (specify)	A full set of performance measurement indicators is used from fee-for-service claims and managed care plan encounter data (see section 4.4.3). The measures are not HEDIS compliant, even through the HEDIS methodology is followed on most measures, as we have not required managed care plans to do the work themselves, and have their work audited. Validation and omission studies are performed by a vendor to improve the reliability of data.		
Other (specify)			
Other (specify)			
Other (specify)			

4.5.2 What information (if any) is currently available on quality of care received by CHIP enrollees in your State? Please summarize the results.

Please see section 4.4.3, which describes information currently available on access and quality.

4.5.3 What plans does your CHIP program have for future monitoring/evaluation of quality of care received by CHIP enrollees? When will data be available?

Please see section 4.4.4, which describes future monitoring/evaluation of access and quality.

4.6 Please attach any reports or other documents addressing access, quality, utilization, costs, satisfaction, or other aspects of your CHIP program's performance. Please list attachments here.

Please find the Managed Care Progress Report in Appendix G, which addresses access, quality, etc. for consumers (including CHIP eligibles) enrolled in managed care.

SECTION 5. REFLECTIONS

This section is designed to identify lessons learned by the State during the early implementation of its CHIP program as well as to discuss ways in which the State plans to improve its CHIP program in the future. The State evaluation should conclude with recommendations of how the Title XXI program could be improved.

5.1 What worked and what didn't work when designing and implementing your CHIP program? What lessons have you learned? What are your "best practices"? Where possible, describe what evaluation efforts have been completed, are underway, or planned to analyze what worked and what didn't work. Be as specific and detailed as possible. (Answer all that apply. Enter 'NA' for not applicable.)

5.1.1 Eligibility Determination/Redetermination and Enrollment

The January 1, 1998 expansion of children's health insurance was the impetus for a significant review of Ohio's eligibility and application rules and processes. As described in section 3.1.7 of this evaluation, Ohio's Healthy Start application process was believed to be quite simple in January 1998. The application was short, could be mailed in, and there was no resource test. And, in conjunction with the Healthy Start expansion, the Consumer Hotline began providing application assistance. Yet, it soon became clear that in spite of the "simple" application process, there remained barriers to accessing Healthy Start.

From the beginning, as State staff conducted public education to WIC staff, Head Start staff, county and city public health department staff, school nurses, and other partners, there was consistent feedback about the application process:

- **the required verifications were burdensome to families and prevented people from completing the application process;**
- **verification for other programs were being imposed on families who were only applying for Healthy Start;**
- **when families applied for Healthy Start through the mail, sometimes the county department of human services required that they come in for a face-to-face interview to be reviewed for eligibility for other programs;**
- **at re-application, consumers were required to re-provide verifications for factors that had not changed;**
- **re-application for other programs (e.g., food stamps) was affecting Healthy Start and causing people to lose eligibility.**

Frustrations around these issues were high because of the intense outreach many communities were engaging in. Many local partners were enhancing the information and referral to Healthy Start, even providing application assistance, but were seeing the families they worked with ultimately denied. Denials

were occurring not because families were financially ineligible, but rather for failure to complete the process, which in most cases meant some form of verification. This feedback from community partners, combined with momentum at federal and state levels to increase access to health coverage for low-income children and minimize barriers to successful application, led to a review of policies and processes.

As state staff captured the concerns and complaints that emerged, it became clear that many of the procedural barriers were not a result of current policy, but rather current practice. State staff began to compile a Myth vs. Reality list as it related to the application process. Some myths resulted from unclear policy that led to local and various interpretations, some resulted from confusion about how different programs interact with one another, and several sprang forth from the ever popular “that’s how we’ve always done it.”

To get better information about the actual practices of county departments of human services, and to identify where state policy was unclear, Medicaid eligibility staff worked closely with the Medicaid Eligibility Quality Control area which was conducting a Negative Case Review. The Negative Case Review examined procedural issues in cases which had been terminated or denied to determine whether the negative action had been appropriate. Preliminary findings identified as many as 25% of cases reviewed had been inappropriately denied or terminated. With this data in hand and with the anecdotal feedback from community partners, staff developed a technical assistance agenda to work with county departments of human services to clarify policies, and identify opportunities to modify policies to better assist county department staff in appropriately establishing and maintaining eligibility.

Simultaneously, a review was begun to cull information from the closed case files to better understand in aggregate how many cases are denied or terminated for procedural reasons as opposed to demonstration of ineligibility. This began with a review of “reason codes”. In Ohio’s automated eligibility system, CRIS-E, all actions both positive and negative require a reason and all reasons have a code with associated text and rule citations. Because CRIS-E supports Medicaid, Food Stamps, and Ohio Works First, and has history for a state program of general relief, there are over 900 reason codes programmed into the system. Some of these codes are no longer used due to program changes, but they remain in the system and in documentation to support history. Work with the closed case file is relatively new for the Medicaid program, so for a first attempt at culling information, eligibility policy and research staff reviewed some frequency tables and identified the high volume denial and termination codes and determined whether they were for procedural issues or identified actual ineligibility. Using this information, the closed cases for April 1999 were reviewed.

In April of 1999 there were 6,877 cases closed for families and children under Ohio’s Covered Families and Children groups including Healthy Start, 1931 coverage, and Transitional. Of these, approximately 33% were closed due to a processing reason, while 67% were closed due to a change in family income or other reason not related to processing issues. Of the cases closed for procedural reasons the following codes were most common:

- **failure to cooperate in verifying income**
- **failure to cooperate**
- **failed to acknowledge rights and responsibilities**
- **failed to complete a face-to-face interview**
- **failed to sign application**
- **failed to cooperate in reapplication process**
- **failure to appear for scheduled interview.**

This particular analysis has only been done for April of 1999, but it will be repeated for other months. It is telling for several reasons. Most obviously, it demonstrates a high percentage of people not completing the application process. There is no way of knowing how many of the cases would have been eligible had the process been completed, but the goal is to have people complete the process and be determined eligible or ineligible based on the criteria, not the process.

The other lesson learned by this analysis is that the actual reason codes and use of them by eligibility workers is not standardized. Even from the list above, all of the reasons are a subset of “failure to cooperate”. Depending on training and county history, any number of codes could be used given the same circumstance. As Ohio continues efforts to increase access to health coverage for families and children, the reason codes for both positive and negative actions will be scrutinized, and technical assistance and mechanisms for ensuring correct coding will be necessary.

As procedural issues have been identified, so too have policy and rule issues. As recounted in section 3.1.7, several modifications to the Medicaid eligibility policies have been made to eliminate unnecessary budgeting steps, revise forms, and clarify policy.

After over two years of experience with the Healthy Start expansion, and review of the application process during most of that time, Ohio is on the verge of implementing several significant changes to the application process for children’s health coverage and family health coverage. Effective July 1, 2000, proposed changes go into effect to simplify the application process in several ways:

- **Reduced verification requirements: most non-financial eligibility factors will be accepted via self declaration by the applicant. Earned and unearned income will continue to be required verifications. Social Security number will be verified electronically and only require applicant verification if there is no electronic match.**
- **Twelve month redetermination cycle: redetermination for Healthy Start will be scheduled once every twelve months instead of the current six month cycle.**
- **Mail-in application for families: families will no longer be required to complete a face-to-face interview in order to apply for coverage under section 1931. Families will have the option of using the Combined Programs Application, which is the current application for Healthy Start, if they wish to apply for only health coverage.**

These changes should significantly modify the experience that applicants have when applying for health coverage, and increasingly closed cases should reflect reason codes related to eligibility criteria rather than procedural issues. The changes are strongly supported both in the child advocacy community and the provider community as a means to improve access for children to health care, and to help ensure that children have uninterrupted care and are able to establish a medical home.

Implementation of these changes, however, is complicated by the fact that the same information system and eligibility workers complete eligibility determinations for Medicaid/Healthy Start, Food Stamps, and Ohio Works First. The application processes for these programs have been maintained together; in part for case workers, since CRIS-E cannot automate all components, and in part for the purpose of ensuring that applicants have their eligibility explored for all programs.

Outreach was an underlying principle in developing the CRIS-E information systems and underlies many of the application rules that have been shared by programs. As Medicaid modifies its processes allowing for Medicaid only options, some fundamental design principles are called into question. The primary goal of outreach was to enable families to apply for all programs via one application. In a world of welfare reform, in which the Ohio Works First program encourages people to leave the program and imposes significant program requirements on participants, other programs, such as Medicaid and Food Stamps, sometimes get lost. Program requirements for OWF are not clearly distinct from the availability of Medicaid and Food Stamps, and if a family chooses not to pursue OWF, they may not understand that they may still be eligible for Medicaid or Food Stamps, neither of which have no time limits or self sufficiency contracts.

Significant declines in Ohio's Food Stamp caseload have resulted in increased attention to outreach and promotion, but due to concerns about payment accuracy error rates, the application process for Food Stamps continues to be burdensome for families. Food Stamps requires significantly more verification than Medicaid, and imposes a three month face-to-face redetermination cycle. While the program goal of increasing access is shared, the programs cannot simultaneously modify the application process due to the error rate concerns.

At the State level, eligibility policy staff and CRIS-E systems staff are exploring these coordination issues and how to best ensure that eligibility and application process are implemented correctly. At the county departments of human services, significant support will be needed to clearly communicate the direction that Ohio has chosen, and to help eligibility workers understand how the different program policies work together, and when they do not. In the short term, much of the distinction between programs will fall to the eligibility workers, but a system agenda is being developed identifying ways to automate to the extent possible the differences between programs.

This direction will require leadership and commitment, but it is essential to the success of health coverage programs for families and children. The direction incorporates the elements that have been found helpful

to families in successfully completing the application process: toll free hotline with evening and weekend hours, reduced paperwork and hassle, and minimized connection with the county department of human services which is often viewed as the “welfare” agency.

5.1.2 Outreach

Ohio’s outreach efforts as described in this evaluation culminate into several lessons learned and best practices.

The first lesson learned was that in promoting the Healthy Start expansion, efforts not only had to educate and promote what was new and exciting (the expansion), but also had to re-train and re-educate many people about the pre-existing Healthy Start program. Through implementation of welfare reform, many messages were delivered specific to Ohio Works First, but were erroneously applied uniformly to all programs at the community level. Some very fundamental program information was needed to overcome some of the effects of welfare reform.

Similarly, the national media attention paid to CHIP raised awareness in certain advocacy and provider communities about Title XXI specific provisions that were not the case in a Medicaid expansion, especially not in Ohio where, with an underlying regular Medicaid expansion, both children with and without insurance could gain coverage under the Healthy Start expansion.

Between these two factors, much of the early outreach and public education was focused on replacing pre-existing beliefs about a program rather than conveying completely new information.

Another lesson the state learned relates to coordination issued between state and local levels. Ohio allocated the Medicaid outreach funds created in the Personal Responsibility and Work Opportunity and Reconciliation Act of 1996 to the county level to implement outreach plans. These outreach plans were geared at identifying families who lost contact with, or were at risk of losing contact with, the Medicaid program as a result of welfare reform. The target population included families and children potentially eligible for Medicaid and Healthy Start. The allocation of these funds to the county level encouraged counties to test different outreach methods with a belief that each community could best identify the outreach methods that would work in a specific community, given its social services network, employment market, size, and other factors. One of the outcomes of this local funding and outreach development was that several counties began to market coverage under county specific names. The name “Healthy Start” is in statute and rule and has been used since poverty level coverage for children and pregnant women began in 1989. At the State level, there was a decision to continue use of the name Healthy Start, since it was designed as a marketing name (as opposed to the term “Low-Income Families” which is the term used in Ohio rule for families covered under section 1931) and enjoyed broad recognition in social, health, and human services networks. The State, however, never clearly communicated this to the county level, and soon there were multiple names throughout the State being used to describe Healthy Start.

A fundamental principle of marketing is repetition, consistency and enforcement. For a statewide program to have multiple identities throughout the State violates this principle and weakens the momentum that could otherwise build as county activities and state activities reinforce a single name and identity. In addition to fractured marketing, the multiple name issue causes problems for consumers and providers. Medicaid and Healthy Start are statewide health coverage programs, not county programs. Providers have a relationship with the State and get most of their information from the State. They see consumers from all over the State, not just the county in which their office resides. Consumers have a relationship with the county because that is where eligibility is determined, but the benefit package and delivery systems are statewide and a consumer can receive services in any county of the State. Additionally, consumers receive materials from the State, and it causes confusion if the program information received does not match the program information provided by the county.

For these reasons there is support for further development of a statewide marketing strategy and approach. The State is developing its marketing strategy with input from its Medical Care Advisory Committee and its Children's Outreach Advisory Committee. While the creation of a statewide image and identity is the goal, there is also a desire to move forward in a manner that complements the significant efforts that have occurred in some counties.

In order to best structure upcoming outreach, Ohio is developing a profile of families under 150% of the FPL who remain uninsured. This profile is being developed with data from the Ohio Family Health Survey and may be further augmented by focus groups to identify the primary reasons people have not taken advantage of Healthy Start. These reasons will guide marketing approaches and outreach strategies.

In April of 2000, county evaluations of outreach plans are due. Also, this spring the John Glenn Institute at The Ohio State University should complete its evaluation of county outreach plan as compared to application activity and caseload data. Later in 2000, a more comprehensive study will be completed through the Medicaid Technical Assistance & Policy Program (MEDTAPP). These evaluations taken as a whole will help the state determine how best to move forward with statewide outreach and marketing, and also help govern parameters for use of funds allocated locally.

A final comment on outreach goes back to the stigma issue. Either because of the connection with the county department of human services which also administers OWF, or due to the public funding of the program, there are individuals who will not take advantage of Healthy Start for their children. To diminish this effect, the application process has been made as simple as possible and does not require a face-to-face interview at the county department of human services. Also, outreach and promotion has been designed to portray Healthy Start as similar to the commercial health coverage for children that a family would get through employment. However, because the coverage is at no cost to the family and the application materials disclose the public nature of the program, it becomes evident to many families very quickly that Healthy Start is a public program. There has been anecdotal feedback to the department that some families immediately stop the application process at that point in time. Families that have received

information through the mail and not read everything might not realize Healthy Start is a public health coverage program until they get the Medicaid card. There has been anecdotal information that some families have contacted the county agency to terminate coverage when they came to that realization.

Despite efforts to change people’s beliefs about public health coverage, and to separate this health coverage from the umbrella of welfare, many potential consumers remain highly sensitive to the receipt of any publicly funded assistance. Therefore, the State must balance its efforts to attract families and increase the perceived value of taking advantage of the program with the reality that Healthy Start is a publicly funded program. There is an obligation not to represent Healthy Start as something it is not.

5.1.3 Benefit Structure

One of the compelling reasons for Ohio in using CHIP to expand Medicaid coverage for children was the comprehensive benefit package for children. Ohio’s Medicaid benefit package, including services covered through EPSDT, is as extensive a benefit package as could be offered.

5.1.4 Cost-Sharing (such as premiums, copayments, compliance with 5% cap)

N/A.

5.1.5 Delivery System

Because Ohio implemented a Medicaid expansion, all of the pros and cons that exist with the Medicaid program now also exist in Ohio’s CHIP program. This is true in both the fee-for-service delivery systems which exists in all 88 Ohio counties, and the managed health care delivery system which exists in 16 Ohio counties.

In the fee-for-service delivery system there has always been discussion about appropriate access and provider reimbursement. Because Ohio Medicaid covers 1.4 million people, the reimbursement rates reflect the State’s purchasing power. Also, due to the large population covered, changes in reimbursement can result in significant budget impacts. With expanded eligibility for children through Healthy Start, there has been well coordinated lobbying to address several provider reimbursement issues pointing to access as the crucial issue. Conversely, in spite of the Healthy Start expansion the State saw significant Medicaid caseload decline related to welfare reform and some members of the provider community were suffering due to decreased Medicaid business.

The State’s biennial budget bill, H.B. 283, signed in June of 1999, included funding for targeted community provider fee increases. Fee increases were implemented in January of 2000 and most significantly impacted non-institutional providers. These fee increases begin to address some of the concerns that providers have expressed with regard to the impact of provider participation in Medicaid

declining due to reimbursement issues. From the program standpoint, there is yet to be demonstration of a provider access issue for Medicaid that exceeds the community access standard for commercially insured or private pay. The fee increases that went into effect January 1, 2000 are reflected in the State's capitation rates for Managed Care Plans (MCP). The increases related to the fee-for-service increases came subsequent to modifications in the MCP capitation rates to adjust for caseload declines due to welfare reform.

The health care market place has been somewhat unstable, and the MCP participation in the State Medicaid program has been in flux. As described in section 2.2.3 of this evaluation, several plans have left the Medicaid market due to financial solvency issues, and several plans have left the Medicaid market for other reasons. Having experienced this market adjustment, and in an attempt to stabilize the program, the Ohio Department of Human Services is modifying its MCP contracting approach. Historically, MCP contracts have been for provision of coverage for Medicaid consumers in a county defined service area. In order to increase the volume of contracts and take into consideration some of the known utilization patterns of consumers in different geographic areas, the department is beginning the process of contracting with MCPs based on multi-county service areas. The department has a request for proposals currently out for bid with responses due by April 14, 2000. Resulting contracts are targeted for effective dates of July 1, 2000, and will bind the MCP to provide coverage to Medicaid consumers in defined service areas that in many cases are multi-county.

5.1.6 Coordination with Other Programs (especially private insurance and crowd-out)

Because Ohio implemented a Medicaid expansion, coordination with other programs is no different than with the Medicaid program as a whole.

5.1.7 Evaluation and Monitoring (including data reporting)

Again, because Ohio implemented a Medicaid expansion, much of the evaluation and monitoring is based on quality initiatives for the entire Medicaid program, or age based studies which focus on children covered by Medicaid, but not specific poverty level groups. Break out of CHIP populations is being pursued in several contracted surveys and studies and will be available in the future. However, for many quality indicators, evaluation of the Medicaid program as a whole, or based on age, is most helpful in terms of coverage and benefit policies.

An area that has been much more thoroughly examined since the implementation of the Healthy Start expansion is Medicaid eligibility, particularly evaluation and monitoring of applicants' experience in applying for the program, and retention issues. This increased interest has been motivated in part by the concerns that surfaced about the application process, but also because of some administrative reorganization within the Ohio Department of Human Services. In January of 1998, the Medicaid Eligibility Policy Unit was moved within the organization. The unit had been housed within the Public

Assistance Policy area which also held responsibility for Food Stamp eligibility policy and Ohio Works First eligibility policy. The Medicaid eligibility policy unit moved into the Office of Medicaid and began the process of integrating into the work of the Office. It quickly became clear the central role eligibility policy plays in both Medicaid and CHIP and the tremendous impact that the design of eligibility has on the experience that consumers have with the program. It also became apparent that even the most subtle eligibility and application process changes can have an enormous budget impact.

Because eligibility policy is now more closely affiliated with the rest of the operations of the Office of Medicaid, and because of increased scrutiny of policies and procedures, a tremendous amount of time and effort has been devoted to developing models to estimate the cost of certain eligibility/application process changes, and data sources that had not previously been utilized, such as the closed case file, became central to monitoring the program.

5.1.8 Other (specify)

N/A

5.2 What plans does your State have for “improving the availability of health insurance and health care for children”? (Section 2108(b)(1)(F))

In July 2000, Ohio will further expand Healthy Start to uninsured children up to 200% of FPL. Ohio Family Health Survey data and Current Population Survey data point to estimates of approximately 30,000 children being potentially eligible. Ohio’s experience to date with the January 1998 expansions leads to an estimate of 11,000 children eligible through this expansion by the end of the first year of implementation.

In addition to expansion of children’s coverage, Ohio is also modifying its section 1931 family coverage to cover families up to 100% of the FPL. While this does not expand coverage for children, it does provide coverage for some parents who would not be otherwise eligible. Ohio hopes to see the number of families accessing family coverage increase, and to see that children whose parents have health coverage are more likely to assure that their children get health coverage and utilize that health coverage appropriately. This expansion also takes effect on July 1, 2000.

In combination with the family and children eligibility expansions, July 1, 2000 is also the target date for significant simplification of the application process for families and children as described in section 5.1.1 of this evaluation.

5.3 What recommendations does your State have for improving the Title XXI program? (Section 2108(b)(1)(G))

The excitement and promise of Title XXI was twofold: first and foremost it was a significant expansion

of and commitment to providing health coverage for uninsured children; secondly, it allowed states new flexible options for providing coverage. As the Questions and Answers were provided from HCFA following initial passage of the Balanced Budget Act of 1997, and more recently as draft regulations have been shared and reviewed, there is some concern that the program parameters being developed reflect a Medicaid mind set rather than the more flexible program that was first envisioned by many states. What follows are modest recommendations addressing either statutory issues, or issues that have surfaced as a result of reviewing the draft regulations:

- **Modify requirements for determining actuarial equivalence to a chosen benchmark package in order to ease states' burden in pursuing purchase of employer offered coverage for Title XXI eligibles.**
- **Modify the statute to allow states to maintain unspent balances from their first year allocation.**
- **Eliminate the exclusion of eligibility for public employees with access to the state's health plan. As a back up position, specify state employees as the excluded group, as opposed to public employees with access to the state's health plan.**

The following are Title XIX regulations that are recommended for review with the goal of allowing Medicaid expansion states some of the flexibility that is afforded via Title XXI. Modification to these requirements could aid states in increasing participation in children's health coverage programs, and in creating incentives for appropriate utilization.

- **Modify Title XIX regulations and statute to allow states more flexibility in imposing cost sharing in Medicaid, such as targeted co-pays designed at creating disincentives for inappropriate usage of emergency departments.**
- **Modify Title XIX regulations easing states' burden in demonstrating cost effectiveness for purchasing employer offered health coverage.**

Children's Health Insurance Outreach **State Activity Summary**

JANUARY 1998

Governor's Press Conference - Governor George V. Voinovich held a press conference on January 1, 1998 to formally announce the beginning of the Healthy Start Expansion. Fliers and press releases were given to the statewide press core that resulted in a tremendous amount of statewide media coverage.

Ohio Legislators - Following the press conference, Ohio Legislators received informational packets that contained information on the Healthy Start expansion to request their assistance in providing information to constituents about the expansion.

Presentations/Meetings

Mahoning County Department of Human Services (CDHS)

Trumbull CDHS

Cuyahoga CDHS

Stark CDHS

Lucas CDHS

Wood CDHS

Miami CDHS

CDHS Video Conference

Pickaway CDHS

Franklin CDHS

Butler CDHS

Hamilton JAC

Montgomery CDHS

Miami County Information and Referral

Franklin County GRADS

Family Resource Center

Cuyahoga County Early Intervention Local Collaborative

Child and Family Health Services, Regional Project Director's Meeting (4)

Greene County GRADS Teachers

FEBRUARY 1998

Woman, Infants & Children (WIC) - ODHS sent a notice to these 80,000 households inviting families to call the hotline to get information and/or apply for Healthy Start. ODHS received a tremendous response from WIC recipients through the Consumer Hotline. ODHS has also provided materials and presentations to local WIC sites.

Presentations/Meetings

COSERRC - Central OH Special Education Regional Resource Center
Upper Valley Joint Voc. School
Tuscarawas County Child Support Enforcement Staff
Ohio Child Care Advisory Board
Ability Center (Lucas Co. SSA)

MARCH 1998

Ohio Bureau of Employment Services (OBES) - ODHS staff attended a meeting of projected coordinators for OBES' "One Stop-Shops" to share information about Healthy Start Coverage for children. This meeting resulted in agreement to carry Healthy Start informational materials at the one stop shops to make available to parents seeking employment whose employment choices would be broadened by the availability of health insurance for their children.

The School Nurse Association invited ODHS to participate in 4 regional conferences, the first of which was held in March. These conferences provided an excellent opportunity to share information and materials that subsequently get into the hands of school children and parents. Following participation at these conferences, ODHS has been contacted by multiple school nurses who shared various local initiatives they implemented using the information and materials provided at the conferences.

Presentations/Meetings

School Nurses Regional Conferences (1 of 4, see description above)
Child Care Resource and Referral Agencies
New Albany School District
Ohio Public Health Association
GRADS Regional Meeting
Clark County Planned Parenthood
The Center for Healthy Communities, Dayton
The Sight Center, Toledo
Family Stability Project Directors' Meeting

APRIL 1998

Ohio Commission on Minority Health - ODHS participated in eight (8) Minority Health Month Events stationed throughout Ohio. Written materials requested through the Consumer Hotline were provided to numerous organizations in recognition of Minority Health Month.

Bureau of Children with Medical Handicaps (BCMh) - BCMh is Ohio's Title V program for the children with

special health care needs. BCMH provides coverage for diagnosis specific treatment services. Families with income at or below 185% of the federal poverty level are required to apply for Healthy Start before BCMH will cover treatment. A one time mailing was sent to 5,000 current BCMH families with information about Healthy Start and the requirement to apply. Subsequently, every month, BCMH mails out information about Healthy Start and application requirements to approximately 2,000 families who are either applying for BCMH or are being re-certified for BCMH enrollment.

Presentations/Meetings

School Nurses Regional Conferences (2 of 4, see March for description)

Head Start Conference

Blanchard Valley Health Association, Findlay

Ohio Department of Alcohol and Drug Addiction Conference

Ohio Family and Children First Retreat

Sycamore/Kettering Hospital

Wellness/Health Promotion Work Group (Ohio Parents for Drug-free Youth)

ODHS Region 6 Meeting

MAY 1998

Ohio Legislators - A second packet of information pertaining to the Healthy Start expansion was delivered to the legislative body to reinforce the importance of informing their constituency of the availability of health coverage for Ohio's children.

Ohio Churches - In conjunction with the Governor office, ODHS provided Healthy Start information to 80 of Ohio's Clergy leadership.

Presentations/Meetings

School Nurses Regional Conferences (3 & 4 of 4, see March for description)

Summit CDHS

Ohio Family & Children First - Takin' it to the Streets (1 of 6)

Youngstown Head Start

Stark County Joint Advisory Council Formulation Meeting

JUNE 1998

Child Care Centers (home & center based) - ODHS mailed fliers to 10,000 home and center based child care centers licensed by ODHS to ensure that all child care providers have information to share with families about Healthy Start.

School Nurses- In response to one of the Regional School Nurse training sessions ODHS participated in, a school nurse notified ODHS of her follow up activity. She mailed Healthy Start information to 11,000 families in her school

district.

Ohio Churches - ODHS has also partnered with the Commission on Minority to Health to initiate the process of notifying Ohio churches of the Healthy Start expansion. In June an informational mailings was sent to targeted minority churches in the Cleveland area.

Presentations/Meetings

Juneteenth Festival

Ohio Head Start Association, Inc.- Quarterly Meeting

Ohio Family & Children First - Takin' it to the Streets (2-6 of 6)

Ohio Pediatric Medical Assistants Association

Public Health (BCMh) Nurses Conference

Center for Alternative Resources - Child Care Connect

Tuscarawas County Child Support Enforcement Association Directors' Meeting

Latino Festival

Community Integrated Services Healthy Child Care Ohio

JULY 1998

North American Indian Cultural Centers - Through an initial contact in Summit County, ODHS provided informational materials to seven additional Indian Cultural Centers throughout Ohio.

Information & Referral Lines - ODHS works with a variety of information and referral lines throughout Ohio to share information about Healthy Start in person and through their state wide newsletters. ODHS also provided information packets about the expansion and the opportunity it presents for children. I & R lines are able to make appropriate referrals and know what materials are available.

Presentations/Meetings

Wesley Child Care Center

Preble County Youth Birth-12

Ohio Association of Medical Equipment Suppliers (3)

AUGUST 1998

Health Care Financing Administration - HCFA offered several grant awards to states for the purchase of television air time to do advertisement for children's health insurance. Ohio applied for and received the grant.

State Fair - The Ohio State Fair runs for two weeks every August and attracts an average of 900,000 plus visitors each year from all over Ohio. In cooperation with the Ohio Department of Health, Healthy Start information was made available throughout the two week fair.

Presentations/Meetings

Ohio State Medical Association (10 of 18)

Lorain County Joint Advisory Council (JAC) Formulation Meeting

Wood County JAC Planning Meeting

SEPTEMBER 1998

Women's Health Month - ODHS participated in several events, sharing information about Healthy Start, both as health coverage for children, and for pregnant women.

Ohio Hunger Task Force - ODHS partnered with this agency to mail Healthy Start information to the Task Force's affiliated agencies.

Ohio Department of Education (ODE) - ODHS provided Healthy Start information through ODE's monthly newsletter to Ohio Superintendents. Superintendents were encouraged to spread the word about this opportunity to their respective school districts, and encourage principals, teachers, counselors, coaches, and school nurses to help make referrals for families and children to get health coverage through Healthy Start.

ODE-licensed Child Care Centers - ODHS sent information about Healthy Start to the 2,000 child care centers licensed by ODE.

Presentations/Meetings

Ohio State Medical Association (11-18 of 18)

ODH Women's Health Month Events (3)

Adolescent Advisory Board Meeting

Wellness on Wheels

Ohio Ambulance Association

Ohio Dental Association

Bureau of Child Support

Marietta Hospital

Children's Defense Fund Outreach Networking Conference

OCTOBER 1998

Healthy Start Video - With help from the Ohio Association of Children's Hospitals, ODHS was able to distribute a mass quantity of the Healthy Start video to a number of agencies and organizations across the state. This video was also provided to television stations throughout Ohio to be used as a public service announcement.

Ohio Family and Children First Conference (OFCF)- ODHS staff participate in the OFCF Conference to help share information and materials about Healthy Start.

Presentations/Meetings

Black Family Expo
Ohio Hospital Association (4)
Head Start Conference
Greene County Family and Children First Retreat
ODHS Changing Trends in Ohio Healthcare
Ohio Family and Children First Fall Conference
Ohio Welfare Conference
Special Needs Children Video conference, Dr. Ekvall

NOVEMBER 1998

Kids Outreach Advisory Group - ODHS convinced this advisory group to solicit input from various organizations that could assist in the promotion of and education about Healthy Start. This group includes broad representation from the advocacy, provider and business communities, as well as other state agencies.

In conjunction with Commission on Minority Health, ODHS provided Healthy Start information to Ohio Churches over 200 Ohio based ministers to discuss the importance of health in the minority community.

Media - In November a 4 week media campaign, using the state developed PSA, was staged in the Cleveland, Columbus, and Youngstown markets. This media campaign was funded through the HCFA grant that Ohio applied for in August.

Presentations/Meetings

ODE Early Childhood Education Conference
Ohio Pediatric Medical Assistants Association
Upper Valley Medical Center

JANUARY 1999

Welcome Home Project - ODHS partnered with the Ohio Health Department (ODH) to include informational materials about Healthy Start in a “welcome home” packet that was distributed to all homes with a new born infant. ODH hired home visiting nurses to visit all first time mothers and all teen mothers regardless of the number of children. This started out as a pilot project for six months and was continued throughout the year. ODH projected a need for 5,000 Healthy Start flyers per month, totaling 30,000 for the first six month.

Ohio Educational PBS Television - ODHS, the Ohio Family and Children First Initiative and the Ohio Educational Television Stations embarked on a venture to promote the Help Me Grow themes of Help Me Be Happy, Help Me Be Healthy and Help Me Learn. Parents and care givers had opportunities to learn effective ways of reinforcing these early childhood development concepts through daily family activities or during the hours that a child may be in an out-of-home care arrangement. ODHS contracted with the Ohio Public Broadcasting Station to produce and

air 4 video vignettes, develop a statewide workshop curriculum, host 300 workshops in Ohio, provide educational materials to the participants of the workshops and establish 8 local lending libraries for parents and care givers. A train-the-trainer workshop on Healthy Start was conducted in January for the purpose of this project.

Presentations/Meetings

Summit County Joint Advisory Council (JAC)
Stark County JAC
Hamilton County JAC
Montgomery County JAC
Mahoning County JAC
Cuyahoga County Consumer Sub-Committee
Lorain County Consumer Sub-Committee
Wood County JAC
Franklin County JAC
Ohio State University Medical Center
North Central Care Net

FEBRUARY 1999

IRS - Earned Income Tax Credit (EITC) - ODHS partnered with the IRS-EITC program in developing a display combining EITC and Healthy Start brochures for use at outlets (banks, post offices and libraries) distributing tax forms, at the Voluntary Income Tax Assistance sites, IRS offices that provide walk-in assistance, major employers and at state or local government offices. *Presentations/Meetings*

Cuyahoga County JAC
Lorain County Provider Sub-Committee
Stark County JAC
Wood County Behavioral Health Sub-Committee
Summit County Provider/Consumer Sub-Committee
Cuyahoga Consumer Sub-Committee
Wood County JAC
Franklin County JAC
Lorain County JAC
Stark County Professional Relations Sub-Committee

MARCH 1999

Ohio Head Start Association, Inc. - ODHS staff conducted a presentation for over 300 Head Start annual conference participants and then hosted a total of four break-out sessions. The presentation called “Medicaid Today” was a take from the news publication, USA Today, where staff presented in “newsboys” style the updates for Healthy Start.

Ohio Podiatric Medical Assistants Association - Approximately 50 people attended the first of two presentations ODHS conducted to a provider-related audience. The same presentation referenced in the above event was used for this audience.

Ohio Primary Care Association, Medicaid Outreach Planning Day - This association sponsored event brought together many of the local outreach plan coordinators from throughout the state. It gave local and state level representatives an opportunity to share what outreach activities were being used and how successful they are. An ODHS staff member served as a panelist for an outreach question and answer session.

Presentations/Meetings

Lorain County Provider Sub-Committee
Lorain County Consumer Sub-Committee
Stark County JAC
Montgomery County JAC
Mahoning/Trumbull County JAC
Cuyahoga Consumer Sub-Committee
Wood County JAC
Stark County Professional Relations Sub-Committee
Summit County JAC
Franklin County JAC

APRIL 1999

Minority Health Month - The Ohio Commission on Minority Health sponsors grant funding for various organizations to host health fairs throughout the month of April, which is deemed “Minority Health Month”. The department created a table-top exhibit and staffed the kick-off day which was attended by approximately 400 people. ODHS also participated in a total of other events held throughout the month in various locations in the state by staffing a booth, conducting a workshop, and/or supplying Healthy Start informational materials.

Presentations/Meetings

Cuyahoga County JAC
Hamilton County JAC
Cuyahoga Consumer Sub-Committee
Stark County JAC
Mahoning County Children’s Health Coalition
Wood County JAC
Franklin County JAC
Stark County Professional Relations Sub-Committee
Miami Valley Child Development Center
Fostoria Hospital

MAY 1999

Ohio Podiatric Medical Assistants Association - See March 1999.

GRADS Program - The Ohio Department of Education (ODE) sponsors an educational program called Graduation, Reality and Dual Roles (GRADS) which encourages pregnant teens to remain in school to receive regular curriculum course work as well as course work in parenting skills. The department has partnered with the teachers of the GRADS program to conduct Healthy Start presentations in the classroom for these students.

Small Business Day Conference - ODHS participated in this conference by staffing an exhibit booth and distributing Healthy Start informational materials to people who own small businesses. Approximately 350 businesses attended the conference. ODHS partners with the National Federation of Independent Businesses (NFIB), the sponsor of the event, to share Healthy Start information with the business community who employ people that could potentially benefit from our health care program.

Presentations/Meetings

Mahoning County Children's Health Coalition

Lorain County JAC

Stark County JAC

Montgomery County JAC

Cuyahoga Consumer Sub-Committee

Franklin County JAC

Combined Health Agencies Conference

JUNE 1999

Heads UP! Network - The department contracted with a vendor called Resource Instruction for Staff Excellence (RISE), Inc. to produce two 30 minute videos and air them on the national Heads UP! Network. The network is a national satellite broadcasting network sponsored by the National Head Start Association for the purpose of airing educational programming for the professional development of parents, early childhood education teachers and care givers. In Ohio, there were two hours per month dedicated to Ohio audiences only. There are a total of 1,500 satellites installed in various public school, Head Start and child care center locations throughout the state who can access the programming. The two videos called "Humpty Dumpty Healthy Start" and "Medicaid As a Health Plan" aired on the network monthly from June 1999 to September 1999. Over 200 copies of each of the videos were distributed to Head Start Agencies and other interested parties.

NW Ohio Community Action/Head Start - A group of Head Start administrators and family service workers invited ODHS to a staff meeting to discuss Healthy Start and the application process. The audience of 40 people work directly with families in enrolling their children in Healthy Start.

Presentations/Meetings

Cuyahoga County JAC

Mahoning County Children's Health Coalition
Cuyahoga Consumer Sub-Committee
Summit Provider/Consumer Sub-Committee
Cuyahoga Service Integration Sub-Committee
Franklin County JAC
MH/Social Security
Aids Case Management Conference

JULY 1999

Healthy Start County Technical Assistance Session - This is the first in a series of 28 technical assistance sessions that were offered from July through September to county department of human services staff (IM supervisor, caseworkers, etc.). The presentations included an update on statewide outreach efforts, the new Combined Programs Application, Healthy Start rule review, MEQC and CRIS-E.

Presentations/Meetings

Mahoning County Children's Health Coalition
Hamilton County JAC
Wood County JAC

AUGUST 1999

The Ohio State Fair - The department staffed an exhibit booth, distributed materials and premiums for the 17 day run of the Ohio State Fair. This is our biggest outreach effort because of the exposure to so many people and the amount of staff resource needed to plan and implement the event. Approximately 68% of the 900,000 plus visitors who attended the Ohio State Fair potentially visited the building where our exhibit was displayed.

Black Family Day - ODHS staffed an exhibit booth, distributed materials and premiums at this event which is targeted specifically to black families. Attendance at this event yielded about 400-500 people.

Presentations/Meetings

Cuyahoga County JAC
Lorain County JAC
Cuyahoga Consumer Sub-Committee
Medicare Partners
School-Based Health Clinic
Ohio Rehab Services
Ohio Education Association
Piketon Junior High School
Dana Elementary School
Dreshler Elementary School

SEPTEMBER 1999

Women's Health Month - the Ohio Department of Health provides grant funding for local agencies to sponsor health fairs targeted at women's health. ODHS participated in several local events by staffing an exhibit booth, conducting a presentation, and/or supplying Healthy Start informational materials.

Public Children Services Association of Ohio (PCSAO) Conference - ODHS conducted a Healthy Start workshop for participants of the conference in one of the break-out sessions. Approximately 40 Children Services workers attended this break-out session.

New School Nurse Orientation Conference - ODHS staff conducted a Healthy Start presentation for approximately 125 new school nurses. The presentation was a take-off from Mr. and Mrs. Potato Head with home-grown solutions to health care needs of children in the school setting.

Presentations/Meetings

Mahoning Children's Health Coalition

Cuyahoga Consumer Sub-Committee

Stark County JAC

Wood County JAC

Montgomery County JAC

Summit County JAC

Franklin County JAC

Child Welfare Community Forum

Medicare Partners

University of Cincinnati, Nutritional Services for Children with Special Health Care Needs

Senior Expo

Bellevue Hospital

QMB Outreach in Ashtabula County and Lake County

Medicare Conference on Dual Eligibles

School-Based Health Center Regional Workshop

United States Department of Labor

OCTOBER 1999

Ohio Department of Education, Early Childhood Education Annual Conference - ODHS conducted a presentation for one of the many break-out sessions. The audience consisted of approximately 35 early childhood education teachers who learned about how Healthy Start applies to classroom learning.

Presentations/Meetings

Cuyahoga County JAC

Mahoning County Children's Health Coalition

Hamilton County JAC

Cuyahoga Consumer Sub-Committee
Lorain County JAC
GRADS - 4 events
ODH Project Director's Meeting
Western Reserve Area on Aging
Tri-County Community Action, Head Start

NOVEMBER 1999

Ohio Welfare Conference - ODHS participated in the annual conference whose theme was "What's Growing on in Medicaid"

Family Information Network - ODHS conducted two break-out sessions on Healthy Start with a combined attendance of approximately 80 people.

Presentations/Meetings

Cuyahoga Consumer Sub-Committee
Franklin County JAC
Medicare Carnival
GRADS - 6 events

DECEMBER 1999

Center for New Directions - The department is partnering with this community agency on a monthly basis to conduct a Healthy Start presentation to women who are entering the work place for the first time, or re-entering after a period away from working. These women are working through this center's program to gain more insight on being successful at a job (i.e., child care issues/needs, self-sufficiency, health insurance).

Presentations/Meetings

Cuyahoga County JAC
Hamilton County Medical Services Workgroup
Montgomery County JAC
Medicare Partners