

Ohio Children’s Health Insurance Plan

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Section 1. General Description and Purpose of the State Child Health Plan (section 2101)

The state will use funds provided under Title XXI primarily for (check appropriate box):

- 1.1 **9** Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (section 2103); **OR**
- 1.2 **:** Providing expanded benefits under the State’s Medicaid plan (Title XIX); **OR**
- 1.3 **9** A combination of both of the above.

Effective January 1, 1998, the State expanded its Medicaid Healthy Start program to cover children up to age 19, in families with incomes at or below 150% of the Federal Poverty Level (FPL). This expansion provides coverage for children ages 0 through 6 between 133% and 150% of FPL; for children ages 7 through 14 between 100% and 150% of FPL; and for children ages 15 through 18 between 33% and 150% of FPL.

Attachment A to this State CHIP Plan contains two Medicaid State Plan Amendments that co-exist to effect Ohio’s Medicaid eligibility expansion. The first amendment is Medicaid State Plan Amendment 97-029, based on a HCFA draft dated October 10, 1997, which expanded Medicaid eligibility, as authorized by 1902(a)(10)(A), from its levels as of October 1, 1997, to children up to age 19 in families with incomes at or below 150% of FPL for optional targeted low-income children. The state submitted an additional Medicaid State Plan Amendment, 97-028, to co-exist with 97-029, so that children who do not meet the definition of ‘optional targeted low-income children’ could still be found Medicaid eligible through the second State Plan Amendment. The 97-028 Medicaid State Plan Amendment, as authorized by 1903 (accelerated SOBRA) and 1902(r)(2), allows the state to provide Medicaid coverage to children who meet the income requirements for the eligibility expansion but who have creditable coverage.

Effective July 1, 2000, the State will expand its Medicaid Healthy Start program to cover uninsured children up to age 19 in families with incomes above 150% and at or below 200% of FPL.

Attachment E to this State Chip Plan is Medicaid State Plan Amendment 00-002, which supercedes 97-029. Medicaid state plan amendment 00-002 will expand Medicaid eligibility to uninsured children in families with incomes above 150% and at or below 200% of FPL.

The State has implemented systems changes that allow for identification of children eligible for Medicaid via CHIP so they can be reported separately from children eligible for Medicaid via the 97-028 Medicaid State Plan Amendment. This will allow CHIP eligible children (optional targeted low-income children) to be reported and claimed at an enhanced rate, and other new eligibles to be reported and claimed at the state’s standard FMAP.

Children newly eligible for health insurance as a result of the eligibility expansion will receive health care services through the same delivery systems that operate in the current Medicaid program. Each of Ohio's 88 counties has a fee-for-service delivery system in place. Sixteen counties have a managed care delivery system which Ohio offers through an 1115 waiver.

As is true for all eligibles in section 1931 coverage and healthy start, once eligibility is determined, a card is issued for fee-for-service coverage. In mandatory managed care counties, eligibles receive notice that they must choose an mcp, or they will be assigned to one. In voluntary managed care counties, eligibles are informed that they may choose to enroll in an MCP or remain in the fee-for-service delivery system.

The State understands that this State CHIP Plan submission secures the entire state allotment regardless of estimated budget for the Medicaid expansion. The State reserves the right to submit a State CHIP Plan amendment at any time.

Section 2. General Background and Description of State Approach to Health Coverage (Section 2101(a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B)

2.1 Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as ethnicity and geographic location, currently have creditable health coverage (as defined in section 2110(c)(2)). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements).

The information presented below best represents the information that was available at the time of initial CHIP state plan submission in December 1997 and serves as a benchmark. Current statistical information on Ohio’s children can be found in Ohio’s CHIP evaluation, and thereafter, in Ohio’s CHIP annual report.

Notes on the following table.

Source: U.S. Current Population Survey, March 1997 Supplement, Downloaded from www.bls.census.gov/cps/cpsmain.htm

- C Ohio is not able to distinguish the extent to which the coverage reflected below is creditable or non-creditable.
- C This chart represents a single month snapshot of the insurance status of the population. The number of uninsured during one month is considerably higher than the number uninsured for the entire year. The estimated number of Medicaid eligibles in March 1997 is an under-representation of exact eligibility counts for that time-period.
- C % of Federal Poverty Level is based upon annual income in 1996. For Medicaid eligibles, this might not reflect their financial status during the months that they were Medicaid eligible.
- C Health Insurance coverage in March, 1997- Respondents in the CPS were asked the following question:
Type(s) of plan(s) was (person’s name) covered by last week (up to 5 of the following types are carried including “other”).

- | | |
|-------------------------|--|
| 0 Not in Universe | 8 Other Gov’t Care |
| 1 Medicare | 9 Employer/Union-Provided (own plan) |
| 2 Medicaid | 10 Employer/Union- Provided (as dependent) |
| 3 Champus | 11 Privately Purchased (own plan) |
| 4 Champva | 12 Privately Purchase (as dependent) |
| 5 VA Health Care | 13 Plan of someone outside the household |
| 6 Military Health Care | 14 Other |
| 7 Indian Health Service | |

Children were assigned to the insurance coverage group based on the following hierarchy:
Coverage Group Codes

Medicaid	2
Other Public	1,3,4,5,6,7,8
Employer Sponsored	9,10
Individual	11,12,13,14
Uninsured	0

Demographic and Health Insurance Characteristics of Ohio's Child Population, March 1997.						
Demographic Characteristic	Total Children	Health Insurance Coverage in March 1997				
		Medicaid	Other Public	Employer Sponsored	Individual	Uninsured
% of Federal Poverty level						
< or = 100%	589,054	246,846	12,308	101,875	19,807	208,218
100-133%	182,679	25,571	6,648	34,944	30,581	84,936
133-150%	135,219	19,937		54,146	21,364	39,772
150-185%	224,173	7,110	10,482	106,607	23,583	76,391
185-200%	82,595	2,271		57,563	4,030	18,731
gt 200%	1,948,337	51,689	26,402	1,484,028	76,683	309,535
Age Group						
Age 0-1	302,620	66,284	2,978	142,793	20,376	70,188
Age 2-5	695,069	82,856	21,276	369,698	33,078	188,161
Age 6-12	1,217,750	133,199	18,983	742,787	45,882	276,900
Age 13-18	946,618	71,083	12,604	583,885	76,712	202,334
Race and Ethnicity						
White, Non Hispanic	2,611,339	171,835	53,010	1,636,831	168,299	581,364
Black, Non Hispanic	482,098	149,998	2,831	173,850	7,749	147,670
Hispanic	49,667	27,117		16,805		5,746
Amer Indian, Alaskan Native	4,473	4,473				
Asian or Pacific Islander	14,481			11,678		2,803
Location						
MSA	2,669,013	294,598	44,273	1,635,410	139,498	555,234
Non-MSA	493,045	58,825	11,567	203,753	36,550	182,349
Total	3,162,058	353,423	55,841	1,839,163	176,048	737,583

2.2 Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2101)(a)(2)

2.2.1 The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance):

In 1998, Ohio had 576,106 children with health care coverage through the Medicaid program. Eligibility for Medicaid continues to remain available for the following federal categories of children: those who qualify for the Ohio Works First Program (TANF); those who meet Ohio's Section 1931 Family Eligibility; those who qualify for the Healthy Start Program (SOBRA); and those who meet Medicaid disability criteria (keeping in mind that Ohio is a 209b state). Eligibility outreach to these populations is described in Section 5.

Ohio has attempted to make it easier to offer health insurance for employers in the small group market by passing insurance reforms in 1992 that encouraged the formation of small group purchasing cooperatives; placed limits on the length of pre-existing condition clauses; and set a rate corridor on premium increases. In addition, Ohio required indemnity plans to offer an annual open enrollment period.

Beginning in 1992, the Ohio Department of Health through its BCMH, Hemophilia and AIDS programs, started paying health insurance premiums for families who could not afford to keep their employer-based insurance. The Ohio Department of Health only pays insurance premiums where it is cost effective to maintain a person's private coverage. The Hemophilia insurance purchasing program currently serves 259 people; the BCMH insurance purchasing program serves 41 children; and the HIV Insurance purchasing program serves 120 people.

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 prior to purchasing insurance. Outreach for these programs is done through public health nurses and the provider networks for the BCMH, HIV and Hemophilia programs. While the Combined Program Application (CPA) is not an application for these health insurance purchasing programs, the information provided on the CPA can be used to initiate the exploration of eligibility for a health insurance purchasing program. A description of the CPA can be found in Section 5.1.

Ohio passed four significant pieces of legislation in 1999 to provide certain patient protections for Ohio's health consumers. They are 1) House Bill 4, which includes the establishment of requirements for conducting internal and external reviews of health care coverage decisions made by health insuring corporations, and sickness and accident insurers; 2) House Bill 361, which includes regulations of aspects of enrollees' access to covered health care services; 3) House Bill 698, which includes revisions of the standards for using electronic signatures in records of health care facilities; and 4) Senate Bill 67, which enacts a new laws to provide for the establishment, operation, and

regulation of “health insuring corporations,” to provide uniform regulation of providers of managed health care.

2.2.2 The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

The State does not participate in any public/private partnerships for children’s health insurance.

2.3 Describe how the new State Title XXI program(s) is(are) designed to be coordinated with such efforts to increase the number of children with creditable coverage so that only eligible targeted low income children are covered:

(Section 2102)(a)(3)

Because Ohio implemented CHIP as a Medicaid expansion, the state modified its information systems to identify those children newly eligible through CHIP. Children who meet Medicaid eligibility guidelines prior to January 1, 1998 are identified as regular Medicaid and continue to receive the State’s regular FMAP, as do children who meet age and income requirements of the Phase 1 expansion but have a group health plan or health insurance. Only children who are not in a group health plan or have health insurance, as defined by HIPAA, who meet age and income requirements are eligible for coverage in the 150-200% FPL income range.

The Ohio Department of Human Services and The Ohio Department of Health meet on a regular basis to coordinate different aspects of a variety of health services programs, and education and outreach issues.

Section 3. General Contents of State Child Health Plan (Section 2102)(a)(4)

- : Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 4.**

Section 4. Eligibility Standards and Methodology (Section 2102(b))

- : Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state’s Medicaid plan, and continue on to Section 5.**

Section 5. Outreach and Coordination (Section 2102(c))

Describe the procedures used by the state to accomplish:

5.1 Outreach to families of children likely to be eligible for assistance or under other public or private health coverage to inform them of the availability of, and to assist them in enrolling their children in such a program: (Section 2102(c)(1))

Ohio has a solid foundation on which to build its outreach and coordination efforts, with state and local processes in place to assist families enroll their children in the Medicaid program.

Combined Programs Application (Attachment): Several years ago ODHS and ODH jointly developed the Combined Programs Application (CPA), a two page, three-ply enrollment form for Ohio's Healthy Start, Women/Infant/Children (WIC), and Bureau for Children with Medical Handicaps (BCMh) programs, since many consumers are often eligible for more than one program. This mail-in form, available at county departments of human services (CDHS), WIC Clinics, child and family health services (CFHS) clinics, the Ohio Medicaid Web Page, the Ohio Medicaid Consumer Hotline, and a variety of other social, human, and medical services agencies is designed to facilitate enrollment of individuals as quickly and conveniently as possible. Staff at these sites are trained on the use of the CPA, which is to be submitted to the local CDHS for processing; there is no required visit to the CDHS. The CDHS, as well as the Ohio Medicaid Consumer Hotline, can also mail the CPA on request to a potential consumer. Redetermination of eligibility can be processed through the mail in the same way the initial application is handled.

A revised CPA was instituted in October 1999 to further simplify the form and provide a Spanish translation. To coincide with the July 1, 2000 expansion, the CPA will be revised to include Medicaid for low-income families (LIF) and to make the application process easier for both consumers and caseworkers. Changes will also 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 CPA that a face-to-face interview is not required. The revised form will also move to a single ply, color format for the purposes of simplifying and making the form more attractive.

The CDHSs, who process the CPA, also administer Ohio's TANF program (Ohio Works First) by determining family needs and exploring eligibility for several other programs (i.e., Ohio Works First, Food Stamps and Medicaid). CRIS-E (Ohio's eligibility information system) has sophisticated programming that electronically explores eligibility for a variety of assistance programs. If a family is eligible for Ohio Works First (TANF), it is eligible for Medicaid. If a family is not eligible for Ohio Works First, CRIS-E takes several "passes" to see if eligibility criteria are met for other eligibility categories (e.g., Section 1931 Low-Income Families, Healthy Start). The CDHSs will also explore and process, through CRIS-E, children's eligibility for Ohio's CHIP.

Proposed Outreach Planning: The State has identified multiple barriers to enrollment which prevent full penetration of potential Medicaid consumers. Many people associate Medicaid with

welfare rather than health insurance, view it as a stigma and do not pursue eligibility. People may not know about the program or know where or how to apply. Many people who work or have third party insurance are not aware that they might be eligible for Medicaid. Some persons do not want to bother with what is perceived as a lengthy, complicated process for application and income verification.

To better address these barriers, ODHS and ODH are currently working together on several activities to enhance Ohio's outreach efforts. These include:

- C Surveying community agencies on how they conduct Medicaid eligibility outreach activities (including assisting families to enroll their children in Medicaid) and how they coordinate these activities with other local outreach efforts
- Working with Governor Voinovich's Ohio Family and Children First (OFCF) Initiative to improve Medicaid enrollment in Head Start populations. Initial work has involved facilitating conversations between several local Head Start agencies and CDHSs to identify eligibility and referral practices, and develop strategies to better coordinate services and referrals between the two systems. Future work includes educating Head Start staff about Medicaid programs and how best to facilitate application to these programs. Technical assistance on "best practices" is also being planned.
- C Generating outreach ideas and sharing best practices in dialogue sessions with local Family and Children First Councils, Early Intervention Collaboratives, Joint Advisory Councils, Title V agencies, and other groups
- C Developing media strategies for statewide education to Medicaid consumers and providers, including linking with OFCF's Help Me Grow program
- C Identifying age specific strategies based on different service utilization patterns of different age groups
- Coordinating CHIP outreach efforts with ODHS Welfare Reform Medicaid outreach activities. ODHS is making available to Ohio's 88 counties federal matching funds authorized through the Personal Responsibility and Work Opportunity Act, subject to the availability of allowable non-federal matching funds at the local level, to support Medicaid eligibility/enrollment for persons at risk of losing contact with Medicaid due to the federal delinking from cash assistance. Counties are submitting outreach proposals to receive enhanced match for allowable expenditures related to Medicaid eligibility outreach.

ODH and ODHS will continue to work together with other state and local entities to facilitate discussion and direction on proposed outreach endeavors.

Ohio's outreach strategy for the next phase of the Healthy Start expansion (151%-200% FPL), includes three approaches. Each approach helps us create a more informed strategy based on the efforts we employed for the initial Healthy Start expansion to 150% FPL, our sense of how successful they were and how to adjust them with improvement opportunities for this next phase. We will incorporate the following into our new outreach strategy:

Lessons Learned
Right Hand/Left Hand
Streamline Partnership Efforts

Lessons Learned - We now have the benefit of looking back to the outreach efforts made for the initial expansion of Healthy Start, identifying “lessons learned” and determining what action we need to take to improve our outreach efforts for the next expansion phase. Here is what we learned, how we reacted and how we plan to use it for future outreach efforts.

- C Application barriers- we learned that the Combined Programs Application (CPA) was difficult for families to complete and that the most common error in submitting applications was that signatures were missing. We also learned that it was very difficult for families to produce verification documents required as attachments to the application. We created a new application form with several improvements, including a very clear and defined signature area. We also implemented a new, family-friendly mail-in application process which eliminated the need for a face-to-face interview. Application assistance is available through our statewide toll-free Consumer Hotline where representatives can help families complete the application over the phone. The application was also made available through our web site. We are in the process of implementing new verification requirements (effective July 2000) which eliminate the hardship of producing many of the documents. Self declaration will be accepted for age, identity, citizenship, living arrangement, residence, and social security number. For the next expansion, we plan to revise the application again from its current NCR design to one that will become an attachment to an informational brochure with a perforated tear-off edge. It will be printed in color and include our Healthy Start logo.
- C Re-determination barrier - our outreach efforts paid off for initial applications, however, we then experienced enrollment drop-off due to families failing to re-apply within the 6 month redetermination cycle. Ohio recently announced a change in our re-determination cycle from 6 months to 12 months. This improvement will become part of our outreach message for the next expansion phase.
- C Family Coverage - we learned that families are more likely to enroll their children in a health plan that has potential for covering the entire family instead of just the children. Ohio was fortunate to pass within our biennial budget coverage for parents up to 100% FPL of (potentially eligible) Healthy Start children. This message will also be incorporated in our outreach effort.
- C Stigma of welfare - we learned that even though welfare reform initiatives are underway de-linking cash assistance from Medicaid, there is still a great deal of stigma associated with the Medicaid program. We are closely examining how we talk about the program, referring to it more as Healthy Start and less about Medicaid; more about targeting working families, less to Ohio Works First (OWF) or cash assistance participants; more entitlement (kids deserve good health), less public assistance, and more in terms of “insurance”, implying a sustained approach to medical care, less

about acute, episodic health needs which traditionally are met via emergency room visits. We intend to continue our outreach messages in this direction, especially since we will be targeting families whose income is even higher and who are not accustomed to using public assistance.

- C Marketing - we learned that developing specific marketing strategies to create a positive image and program awareness was important. We worked with a marketing firm to create a Healthy Start logo which is used on materials such as flyers, brochures, our web site and the new application form. We are in the process of revising the medical card with more consumer friendly components, streamlining more with commercial insurance, including wallet size, the name Healthy Start instead of Medicaid, adding color and using the Healthy Start logo. Marketing efforts will continue for the next phase and we will consider how to incorporate the family coverage message into our current Healthy Start logo.
- C Feedback from the Consumer Hotline - the toll-free statewide hotline offers us feedback about the program and how we are implementing it. We learned that when consumers have a problem, they will tell us about it. Consumers and/or consumer advocates will often report any problems they are experiencing with the program to the representatives of the hotline. Hotline staff then forward the concern to the department so we can intercede when necessary. For example, consumers may report an application process problem with one of the local county department of human services agencies, such as having to appear for a face-to-face interview. We have the ability to follow-up with the agency to determine what the problem is and propose a resolution. We will continue to use the hotline as a feedback source.
- C Importance of Consumer Advocate Organizations - we learned that working through consumer advocate organizations is an excellent way to be part of their infrastructure, their capacity to network

Right Hand/Left Hand - We recognize and value other efforts that are being made to increase enrollment into Healthy Start both internally within our department in our Access to Coverage area and externally on a county/local community level. We need to pay attention to and understand other initiatives that are happening concurrent to creating our statewide outreach strategy.

Access to Coverage - this area of the department addresses a number of the barriers discussed in the first approach. Their major initiatives include eligibility policy formulation, eligibility simplification, creating administrative rules to support our expansion programs and communication of these things to the local county departments of human services. In creating our outreach strategy it is important to understand these initiatives and to be able to support them through outreach messages and program promotion. It is equally important to identify what strategies are access related (i.e., eligibility simplification) and which strategies are outreach related (i.e., marketing) and to be able to create focused, complimentary work in each area.

Local/county Outreach Efforts - the Personal Responsibility and Work Opportunity Reconciliation Act provided funding to support outreach activities for families at risk of losing Medicaid due welfare

reform (de-linking Medicaid from cash assistance). It is important for us to know where local outreach efforts are taking place and to what extent, and where they may not be occurring so that those areas can be reached through statewide efforts. The department has moved, and will continue to move, forward with outreach activities that compliment the local efforts.

Streamline Partnership Efforts - We will continue to capitalize on the relationships we have built with our many partners like the Ohio Department of Health, Ohio Head Start Association, Ohio Minority Health Commission, Children's Defense Fund, and others. For the next phase of the expansion we will be working towards a more streamlined approach with our partners. We will continue to use broad based outreach efforts but specifically charge partners to work within their areas of expertise. For example, we will charge the Head Start Association to focus primarily on all Head Start agencies, their teachers/staff to ensure they know about Healthy Start and how to refer parents to the program. We will also help them to devise a strategy to train all staff, to coordinate ongoing program updates for existing staff, to incorporate Healthy Start information into orientation training for new staff so that all personnel within the agency from regional coordinators to family services workers can be "spokespersons" for Healthy Start.

In addition, the outreach strategy will include continued participation in annual and ongoing work with our advocacy groups, specifically the Children's Outreach Advisory Group and the Ohio Family and Children First council(s).

The annual events we plan to continue to support:

January through April - continue to partner with the IRS- Earned Income Tax Credit (EITC) program by providing Healthy Start information at volunteer tax preparation sites along with IRS-EITC program information

January/February - the ODH sponsors regional project directors' meetings for their Children and Family Health Services (CFHS) clinics. We are typically invited to conduct a Healthy Start presentation at each of their four regional meetings.

April - the Ohio Minority Health Commission offers grants to local agencies to sponsor health fairs during "Minority Health Month". We participate in the annual kick-off event as well as many local health fairs by staffing an exhibit booth, conducting presentations, and/or supplying Healthy Start materials such as flyers and brochures.

Spring/Summer - the Head Start Association holds statewide conferences, usually two per year, for their association members. We participate in both full conference presentations, as well as break-out session workshops.

June through August - We provide Healthy Start materials for many community festivals held in Columbus which are directed at specific minority audiences, such as the Asian Fest and the Latino Festival.

August - We staff and display an exhibit booth at the Ohio State Fair. This is our biggest outreach effort because of the exposure to so many people from all parts of the state. During the 17 fair, we have the potential to be seen by approximately 612,000 fair visitors.

August - We participate in a two-day event called the “Black Family Expo” by staffing an exhibit booth. Attendance at this event usually yields about 400-500 people per day.

September - The Ohio Department of Health provides grant funding for local agencies to sponsor health fairs targeting women’s health. We participate in several local events by staffing an exhibit booth, conducting presentations, and/or supplying Healthy Start informational materials.

October - We participate in the Ohio Department of Education, Early Childhood Education Annual Conference by conducting presentations at one of the break-out sessions.

Ongoing events, without specific associated time frames are:

Welcome Home Project - this program, sponsored by the Ohio Department of Health, provides a home visit by a nurse to all parents with a newborn child. This “welcome home” gesture is for first-time parents and all teen parents regardless of the number of children. The purpose of the visit is to introduce the parents to the services available to their children, including Healthy Start.

Center for New Directions - this is a monthly outreach opportunity for us to conduct a workshop for women who are entering the work place for the first time, or re-entering after a period away from working. The women in this program gain insight on being successful at a job (i.e., child care issues/needs, self-sufficiency, health insurance).

We will continue to support and participate in the Children’s Outreach Advisory Group and the Ohio Families and Children First Initiative. The Children’s Outreach Advisory Group was formed to solicit guidance from both new and traditional partners to identify strategies and opportunities to reach children who are potentially eligible for coverage under Healthy Start. The intent of this advisory group is to bring together representatives from a variety of agencies and organizations to assist the state in furthering its outreach strategy that supports both statewide and local outreach efforts. By forming this group, ODHS has established a way for members to provide ideas and suggestions and to determine what work is being done by which organization.

The group assesses what is happening at national, state, and local levels with regard to outreach for children's health insurance; and to discuss upcoming priorities and opportunities. Topics that the advisory group has had input: Healthy Start logo and slogan, CHIP annual report, Small Business Day, Minority Health Month Activities, identified enrollment barriers, CPA revision, Medical Card revision, School-based outreach (i.e., free and reduced price lunch program), Healthy Start expansion to 200% FPL, marketing strategies, and outreach evaluation.

The group membership consists of representatives from organizations such as Children's Defense Fund, Association of Ohio Children's Hospitals, Ohio Primary Care Association, Franciscan Health Partnership Program, Universal Health Care Action Network of Ohio, Ohio Minority Health Commission and various County Departments of Human Services.

We will also continue supporting the Ohio Family and Children First Initiative (OFCF). This initiative has a statewide administering council as well as local councils within the 88 counties of Ohio. The membership of the local councils consists of major community stakeholders such as child consumer advocates and social service agencies. ODHS participates on the statewide council meetings and recently created a School-Based outreach workgroup based on Improving Access to Health Care, directed by the OFCF. We will incorporate our outreach message about the next expansion into our school-based outreach efforts.

Lastly, our outreach strategy will include a modification of our overall message. So far, our main outreach message has been geared towards getting children enrolled into the program. It included specifically describing what the program is, what services are covered, how to apply and how to get additional information via the consumer hotline and our web site. We will be modifying our message for the next phase, by extending it to include information about retention - how to re-apply and why it's important, how to gain access to providers offering the health care services, and how to appropriately utilize the services.

5.2 Coordination of the administration of this program with other public and private health insurance programs: (Section 2102(c)(2))

Public health insurance programs in Ohio include those described in Section 2.2.1 of this plan: BCMH, Hemophilia, and Ryan White. These three programs are administered by the Ohio Department of Health. Coordination of administration between these public programs and Medicaid is described in Section 2.

Section 6. Coverage requirements for Children’s Health Insurance (Section 2103)

- : Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state’s Medicaid plan, and continue on to Section 7.**

Section 7. Quality and Appropriateness of Care

- : Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state’s Medicaid plan, and continue on to Section 8.**

Section 8. Cost Sharing and Payment (Section 2103(e))

: Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state’s Medicaid plan, and continue on to Section 9.

Ohio may elect to pursue cost sharing through an 1115 waiver for uninsured children whose family income is above 150% and at or below 200% FPL.

**Section 9. Strategic Objectives and Performance goals for the Plan Administration
(Section 2107)**

9.1(strategic objectives) and 9.2 (performance goals)

The following strategic objectives and performance goals are taken from Ohio’s CHIP Evaluation, submitted on March 30, 2000. The target percentages under each performance goal were derived from estimating the number of potential enrollees in the expansion, in conjunction with a review of historical data and trend analysis.

STRATEGIC OBJECTIVES	PERFORMANCE GOALS FOR EACH STRATEGIC OBJECTIVE	PERFORMANCE MEASURES AND PROGRESS
1. INCREASE THE PERCENT OF CHILDREN WITH COVERAGE BELOW 150% FPL.	THE PERCENT OF CHILDREN WITH COVERAGE FOR THE ENTIRE YEAR WHOSE FAMILY INCOME FOR THE ENTIRE YEAR IS BELOW 150% FPL WILL BE INCREASED FROM 79.6% IN CY97 TO 87% IN CY00.	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%
2. INCREASE THE PERCENT OF CHILDREN WITH COVERAGE BETWEEN 150% AND 200% FPL	THE PERCENT OF CHILDREN WITH 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	DATA SOURCES: U.S. CURRENT POPULATION SURVEY, MARCH SUPPLEMENT (1999-2004) METHODOLOGY: 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 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: PROGRAM WILL BEGIN IN JULY 2000.

<p>3. INCREASE THE NUMBER OF CHILDREN WITH COVERAGE THROUGH ENROLLMENT IN THE CHIP PROGRAM.</p>	<p>ENROLL CHILDREN IN THE CHIP PROGRAM AT A RATE THAT IS EQUIVALENT TO 75% OF THE POTENTIALLY ELIGIBLE CHILDREN BY DECEMBER 2000.</p>	<p>DATA SOURCES: MEDICAID MANAGEMENT INFORMATION SYSTEM, RECIPIENT MASTER FILE (RMF); OHIO FAMILY HEALTH SURVEY, 1998 AND 2001 (PLANNED).</p> <p>METHODOLOGY: INCLUSION CRITERIA: CHILDREN AGES 0 THRU 18 COUNTABLE FAMILY INCOME IS LESS THAN 150% OF FPL OHIO RESIDENCE EXCLUSION CRITERIA: OTHERWISE ELIGIBLE FOR MEDICAID OR HEALTHY START USING DECEMBER 1997 FINANCIAL ELIGIBILITY CRITERIA.</p> <p>NUMERATOR: NUMBER OF CHILDREN ENROLLED FOR MONTH (RMF)</p> <p>DENOMINATOR: NUMBER OF POTENTIALLY ELIGIBLE CHILDREN IN 1998 (76,000 CHILDREN) AND 2001 (FHS).</p> <p>PROGRESS SUMMARY: JUNE 98 28% DECEMBER 98 43% JUNE 99 50% DECEMBER 99 59%</p>
<p>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>

<p>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>4. INCREASE ACCESS TO HEALTH CARE TO CHILDREN BELOW 200% OF FPL (CONTINUED).</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>DATA SOURCES AND METHODOLOGY: SEE GOAL A.</p> <p>NUMERATOR: CHILDREN WHO REPORTED AN UNMET HEALTH CARE NEED, INCLUDING DENTAL CARE, PRESCRIPTION DRUG, MEDICAL EXAMS, TESTS, PROCEDURES, OR PHYSICIAN VISITS.</p> <p>DENOMINATOR TOTAL CHILDREN</p> <p>PROGRESS SUMMARY 1998 BASELINE - 10.9%</p>
<p>5. INCREASE ACCESS TO PREVENTIVE HEALTH CARE SERVICES FOR CHILDREN BELOW 200% OF FPL.</p>	<p>GOAL A: INCREASE THE PERCENT OF CHILDREN WHO HAD AT LEAST ONE WELL CHILD/WELL BABY VISIT FROM 76.8% IN 1998 TO 78.4% IN 2001 AND 80% IN 2004</p>	<p>DATA SOURCES: OHIO FAMILY HEALTH SURVEY, 1998. OHIO FAMILY HEALTH SURVEY, 2001 (PLANNED).</p> <p>METHODOLOGY: INCLUSION CRITERIA: CHILDREN AGE 0-18, FAMILY INCOME LESS THAN OR EQUAL TO 200% OF FPL, OHIO RESIDENCE.</p> <p>NUMERATOR: CHILDREN WHO REPORTED RECEIVED AT LEAST ONE WELL CHILD/WELL BABY VISIT. DENOMINATOR: TOTAL CHILDREN</p> <p>PROGRESS SUMMARY: 1998 BASELINE - 76.8%</p>

<p>5. INCREASE ACCESS TO PREVENTIVE HEALTH CARE SERVICES FOR CHILDREN BELOW 200% OF FPL (CONTINUED)</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. METHODOLOGY: SEE APPENDIX C. 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. DENOMINATOR: TOTAL NUMBER OF ELIGIBILITY YEARS AT AGE 0, 1, AND 2-18. PROGRESS SUMMARY: 1998 BASELINE - INFANTS: 19.7% AGE 1: 43.4% AGE 2- 18: 27%</p>
<p>5. INCREASE ACCESS TO PREVENTIVE HEALTH CARE SERVICES FOR CHILDREN BELOW 200% OF FPL (CONTINUED)</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. Numerator: Children who reported at least one dental visit. Denominator Total Children Progress Summary 1998 Baseline - 61.1%</p>
<p>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. METHODOLOGY: SEE APPENDIX C. 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. PROGRESS SUMMARY: 1998 BASELINE - <i>MEDICAID FFS AND HMO</i> = 32.8%</p>
<p>5. INCREASE ACCESS TO PREVENTIVE HEALTH CARE SERVICES FOR CHILDREN BELOW 200% OF FPL (CONTINUED)</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. METHODOLOGY: SEE APPENDIX C. INCLUSION CRITERIA: CHILDREN AGE TWO ON MEDICAID OR CHIP. AT LEAST 6 MONTHS OF CONTINUOUS ELIGIBILITY. NUMERATOR: CHILDREN WHO RECEIVED ALL OF THEIR IMMUNIZATIONS BY THE AGE OF TWO. DENOMINATOR: TOTAL CHILDREN AGE TWO WITH AT LEAST 6 MONTHS OF CONTINUOUS ELIGIBILITY. 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>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 (CONTINUED)</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 CSHCN 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>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 (CONTINUED).</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>

9.3 Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state’s performance, taking into account suggested performance indicators as specified below or other indicator the state develops: (Section 2107(a)(4)(A)(B))

Check the applicable suggested performance measures listed below that the state plans to use: (Section 2107(a)(4))

9.3.1 : The increase in percentage of Medicaid eligible children enrolled in Medicaid.

9.3.2 : The reduction in the percentage of uninsured children.

9.3.3 9 The increase in the percentage of children with a usual source of care.

9.3.4 9 The extent to which outcome measures show progress on one of more of the health problems identified by the state.

- 9.3.5 9 **HEDIS Measurement set relevant to children and adolescents younger than 19.**
- 9.3.6 : **Other child appropriate measurement set. List or describe the set used.**
 - 9.3.6.1 : **Immunizations-** chart review conducted by External Quality Review Organization for people in managed care
 - 9.3.6.2 : **Well Child Care-** encounter and claims data
 - 9.3.6.3 : **Adolescent well visits-** encounter and claims data
 - 9.3.6.4 : **Satisfaction with care-** consumer satisfaction survey
 - 9.3.6.5 : **Mental Health-** encounter data
 - 9.3.6.6 : **Dental Care-** chart review conducted by External Quality Review Organization for people in managed care
 - 9.3.6.7 : **Pediatric Asthma-** chart review conducted by External Quality Review Organization for people in managed care p
- 9.3.7 9 **If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected:**

- 9.4 : **The state assures it will collect all data. Maintain records and furnish reports to the Secretary at the times and in standard format that the secretary requires. (Section 2107(b)(1))**
- 9.5 : **The state assures it will comply with the annual assessment and evaluation required under Section 10.1 and 10.2 (See Section 10). Briefly describe the state’s plan for these annual assessments and report. (Section 2107(b)(2))**

Using data currently available (Current Population Survey and State Medicaid data bases) and data sources identified over time, the State expects to be able to annually assess progress toward reducing the number of uninsured low-income children. Likewise, using the same data resources, the State expects to be able to describe, analyze, and assess the effectiveness of its plan, and offer recommendations for improving the plan. The assessment will include, to the extent data is available, an evaluation of the effectiveness of other public and private initiatives around children’s health coverage, and an analysis of changes and trends in the state which may affect the provision of health care to children.

- 9.6 : **The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3))**

- 9.7 : The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed.**

The State will participate in a process with other states and HCFA to help develop relevant, feasible measures that may be collected and comparable nationally.

- 9.8 The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e))**

- 9.8.1 : Section 1902(a)(4)(C) (relating to conflict of interest standards)**
- 9.8.2 : Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)**
- 9.8.3 : Section 1903(w) (relating to limitations on provider donations and taxes)**
- 9.8.4 : Section 1115 (relating to waiver authority)**
- 9.8.5 : Section 1116 (relating to administrative and judicial review), but only insofar as consistent with Title XXI**
- 9.8.6 : Section 1124 (relating to disclosure of ownership and related information)**
- 9.8.7 : Section 1126 (relating to disclosure of information about certain convicted individuals)**
- 9.8.8 : Section 1128A (relating to civil monetary penalties)**
- 9.8.9 : Section 1128B(d) (relating to criminal penalties for certain additional charges)**
- 9.8.10 : Section 1132 (relating to periods within which claims must be filed)**

- 9.9 Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement.**

During the summer of 1996 as part of the biennial budget planning process, the Ohio Department of Human Services, in conjunction with The Lewin Group, held a series of public forums. Forums were held in Athens, Toledo, Cincinnati, Cleveland, and Columbus. Invitations to these forums were sent to a wide variety of public and private sector health, social, and human services agencies, and association throughout the state. These forums were designed to gather public input on priorities for the Medicaid program that should be pursued in the biennial budget, and to identify available dollars to pay for any of these initiatives. Overwhelmingly, one of the highest priorities identified through these forums was to expand Medicaid coverage for children.

The Department of Human Services responded to this request by including a Medicaid eligibility expansion in its budget request. This eligibility expansion was examined through the state budget

public process, including a series of public hearings and legislative examination. The Medicaid eligibility expansion was included in the enacted Ohio Biennial Budget for SFYs 1998 and 1999.

Information about the planned Medicaid eligibility expansion, and how it corresponds with Title XXI of the Balanced Budget Act, has been shared extensively at a variety of meetings around the state. Attachment D provides a list of meetings and speaking engagements at which the State has shared its plans for the children's health insurance program eligibility expansion at or below 150% of FPL.

Additionally, the State conducted another set of forums as a means to further share the State's planned health insurance expansion and to get statewide input from interested parties regarding the Children's Health Insurance Program option of covering children up to 200% of poverty. Forums were held in Athens, Akron, Dayton, Columbus, and Cleveland. Input received at the forums regarding the State's option to cover children up to 200% of FPL is currently under review. These forums are included in the list of meetings and speaking engagements contained in Attachment D. State staff will continue to seek opportunities to get feedback on health insurance options for children between 150% and 200% of FPL as planning efforts proceed.

In January of 1998, then Governor Voinovich requested Bill Ryan, Director of the Ohio Department of Health, establish an Advisory Task Force to propose recommendations on how Ohio could use Title XXI to expand coverage to Ohio's uninsured children living in families with income between 151 and 200% of FPL.

The Task Force consisted of 17 members, representing health care providers, consumer advocates, business, State, public health agencies, and health care plans. The Task Force met ten times between February and June 1998.

Three critical factors helped shape the Task Force's final recommendations: the Medicaid Healthy Start benefit package provides the best model for children's health insurance of the benchmark coverage options specified by Title XXI; the anticipated number of potentially eligible children and how many of those could be expected to apply; and effective outreach, which is critical to the success of a Title XXI, CHIP program.

Task Force recommendations that are being planned for the July 2000 expansion include the selection of healthy start as the covered benefit package, twelve month continuous eligibility, and modest cost sharing. A recommendation to impose a 90 day waiting period to combat crowd out will not be implemented July 1, 2000. Instead, monitoring will be ongoing to determine whether crowd out is an issue that will need to be addressed in the future.

The July 1, 2000 eligibility expansion was included in the enacted Ohio Biennial Budget for SFYs 2000 and 2001, and was examined through the state budget public process, including a series of public hearings and legislative examination, and was approved with little debate.

Methods for Ensuring Ongoing Public Involvement

Ohio has several methods for ensuring ongoing public involvement in its Medicaid program expansion.

In each of the counties with mandatory managed care for certain Medicaid consumers, there is a Joint Advisory Council (JAC). JACs and their subcommittees are attended by agency staff from county departments of human services; consumer advocacy organizations; social, health and human service organizations; health maintenance organizations, and state associations. These meetings provide feedback to ODHS on program design, implementation, and consumer needs. Consumers enrolled in managed care currently represent 40% of Healthy Start and Ohio Works First (Ohio's TANF) Medicaid consumers in the state. This percent will increase as mandatory managed care is phased into additional counties and new JACs are formed.

The State also has a statewide Medical Care Advisory Committee (MCAC) which provides input and feedback to ODHS on the design, development, implementation and evaluation of the Medicaid program. The MCAC has two subcommittees: Program Design and Development, and Program Outcome and Evaluation.

ODHS convened the Children's Outreach Advisory Group in November of 1998 in order to solicit guidance from both new and traditional partners to identify strategies and opportunities to reach the thousands of children who are potentially eligible for coverage under Healthy Start. By forming this group, ODHS has established an ongoing channel for communication where members can provide ideas and suggestions.

ODHS staff also sits on Ohio's RWJ Covering Kids Coalition, which is coordinated by The Ohio Commission on Minority Health.

Lastly, as the State pursues its Value Purchasing Strategy, a main focus has been to develop and maintain community relationships that allow for two way information sharing. Many relationships have been forged through the community work that has been done as part of the Medicaid managed care program and this work will continue to encompass other counties' delivery systems and populations. ODHS has staff dedicated to developing these relationships, sharing information, and bringing feedback from our local partners into the planning, implementation, and evaluation work of the Office of Medicaid.

9.10 Provide a budget for this program. Include details on the planned use of funds and sources of the non-Federal share of plan expenditures. (Section 2107(d))

Ohio's CHIP plan will provide Medicaid coverage to an estimated 48,336 children per month over the six-month period from January 1, 1998 through June 30, 1998, resulting in estimated SFY 1998 service payments of \$12,758,331. The projected average monthly enrollment in SFY 1999 is 102,749 children; projected number of children served by the end of SFY 1999 is 133,000. SFY 1999 service payments are estimated to be \$69,883,311. In total, service payments over the SFY 1998-99 biennium are estimated to be \$82,641,643.

**Ohio Children's Health Insurance Program
Services Budget
(Dollars reflect service expenditures only)**

(by State Fiscal Year)	(Enrolled)	per Eligible	Costs	Payments	Share	Share	Rate
SFY 1998 (from Jan. 1, 1998 through June 30, 1998)							
Children who are uninsured or have individual insurance (i.e. CHIP match)	23,838	\$58.98	\$7,742,144	\$5,772,482	\$1,691,337	\$4,081,145	70.70%
Children who have employer sponsored insurance (i.e. Medicaid match)	24,498	\$58.98	\$9,362,037	\$6,985,849	\$2,924,276	\$4,061,573	58.14%
All Children	48,336	\$58.98	\$17,104,181	\$12,758,331	\$4,615,614	\$8,142,717	63.82%
SFY 1999 (from July 1, 1998 through June 30, 1999)							
Children who are uninsured or have individual insurance (i.e. CHIP match)	48,255	\$61.22	\$32,562,292	\$30,231,591	\$8,839,717	\$21,391,874	70.76%
Children who have employer sponsored insurance (i.e. Medicaid match)	54,494	\$61.22	\$42,925,624	\$39,651,720	\$16,562,523	\$23,089,197	58.23%
All Children	102,749	\$61.22	\$75,487,916	\$69,883,311	\$25,402,241	\$44,481,070	63.65%
State Biennium 1998-1999							
Children who are uninsured or have individual insurance (i.e. CHIP match)			\$40,304,436	\$36,004,073	\$10,531,054	\$25,473,019	70.75%
Children who have employer sponsored insurance (i.e. Medicaid match)			\$52,287,661	\$46,637,569	\$19,486,800	\$27,150,769	58.22%
All Children			\$92,592,097	\$82,641,643	\$30,017,855	\$52,623,788	63.68%

Note: Ohio does not necessarily assume that all children with employer sponsored insurance have creditable coverage. The designation is used as a proxy for creditable coverage for the purpose of this budget only.

Source of Non-Federal Share of Expenditures

This program will use the same non-federal revenue sources used by the Ohio Medicaid program (General Revenue Fund); however, provider taxes and provider related donations will not be used. Ohio will comply with all federal matching requirements in the operation of this program.

**Ohio Children's Health Insurance Program
State/Federal Funding Shares
(Dollars reflect service expenditures only)**

State Fiscal Year	Total Payments	State Share	Federal Share	Matching Rate
1998	\$12,758,331	\$4,615,614	\$8,142,717	63.82%
1999	\$69,883,311	\$25,402,241	\$44,481,070	63.65%
Biennium	\$82,641,643	\$30,017,855	\$52,623,788	63.68%

Ohio's July 1, 2000 expansion of the CHIP plan is expected to provide Medicaid coverage to an estimated 11,201 additional children per month during State Fiscal Year 2001 (July 1, 2000 through June 30, 2001). Expenditure estimates for children between 150% and 200% of FPL are as follows:

Newly Eligible by County Group and Age Group	Average Monthly Eligibles	Total Incurred Costs	Average Monthly Incurred Costs per Eligible	Total Out-the-Door Payments
Infants	50	\$326,843	\$543.40	
Age 1	61	\$77,791	\$106.51	
Age 2-5	2,074	\$1,536,243	\$61.73	
Age 6-13	6,418	\$4,790,624	\$62.20	
Age 14-18 Males	555	\$432,695	\$64.99	
Age 14-18 Females	2,043	\$3,899,143	\$159.01	
Total	11,201	\$11,063,338	\$82.31	

**Ohio Children's Health Insurance Program
Services Budget
(Dollars reflect service expenditures only)**

Coverage Group State Fiscal Year)	Average Monthly Eligibles (enrolled)	Average Monthly Incurred Costs per Eligible	Total Incurred Costs	Total Payments	State Share	Federal Share	Matching Rate
SFY 2000 (July 1, 1999 through June 30, 2000)							
Children who are uninsured whose countable family income is below 150% of FPL (CHIP I)	50,206	\$91.56	\$55,162,290	\$53,092,304	\$15,359,604	\$37,732,700	71.07%
Children who have insurance whose countable family income is below 150% of FPL (Medicaid Match)	22,406	\$91.56	\$24,617,882	\$23,694,086	\$9,792,766	\$13,901,320	58.67%
All Children	72,612	\$91.56	\$79,780,172	\$76,786,390	\$25,152,369	\$51,634,021	67.24%
SFY 2001 (July 1, 2000 through June 30, 2001)							
Children who are uninsured whose countable family income is below 150% of FPL (CHIP I)	60,064	\$94.29	\$67,959,465	\$66,157,450	\$18,973,957	\$47,183,494	71.32%
Children who have insurance whose countable family income is below 150% of FPL (Medicaid Match)	26,805	\$94.29	\$30,329,018	\$29,524,813	\$12,096,316	\$17,428,497	59.03%

Children who are uninsured whose countable family income is between 150% and 200% of FPL (CHIP II)	11,201	\$82.31	\$11,063,338	\$8,756,229	\$2,511,286	\$6,244,943	71.32%
All Children	98,070	\$92.92	\$109,351,821	\$104,438,492	\$33,581,559	\$70,856,933	67.85%
SFY 2002 (July 1, 2001 through June 30, 2002)							
Children who are uninsured whose countable family income is below 150% of FPL (CHIP I)	64,902	\$96.06	\$74,813,822	\$74,409,722	\$21,340,708	\$53,069,013	71.32%
Children who have insurance whose countable family income is below 150% of FPL (Medicaid Match)	28,965	\$96.06	\$33,387,986	\$33,207,644	\$13,605,172	\$19,602,472	59.03%
Children who are uninsured whose countable family income is between 150% and 200% of FPL (CHIP II)	21,609	\$84.14	\$21,817,454	\$20,410,181	\$5,853,640	\$14,556,541	71.32%
All Children	115,476	\$93.83	\$130,019,262	\$128,027,547	\$40,799,520	\$87,228,027	68.13%

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Administrative Costs

The following are the estimated expansion administrative costs for the next three years.

FFY00 \$1,314,852

FFY01 \$6,229,820

FFY02 \$6,407,705

The costs are estimated based on a percentage of current Medicaid administrative costs. No specific cost breakdowns are available because administrative costs will be allocated to CHIP based on cost allocation plans at the state and local level.

Ohio's first quarter of claiming CHIP administration will be July-September of FFY00. The state match for CHIP administration is provided through the state's General Revenue Fund.

Section 10. Annual Reports and Evaluations (Section 2108)

10.1 Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2))

10.1.1 : The progress made in reducing the number of uncovered low-income children and

10.1.2 : Report to the secretary by January 1 following the end of fiscal year on the result of the assessment.

10.2: State Evaluations. The state assures that by March 31, 2000, it will submit to the Secretary an evaluation of each of the items described and listed below: (Section 2108(b)(A)-(H))

10.2.1 : An assessment of the effectiveness of the state plan in increasing the number of children with creditable health coverage.

10.2.2 : A description and analysis of the effectiveness of elements of the state plan, including:

10.2.2.1: The characteristics of the children and families assisted under the state plan including age of the children, family income;

10.2.2.2: The quality of health coverage provided including the types of benefits provided;

10.2.2.3: The amount and level (including payment of part or any of premium) of assistance provided by the state;

10.2.2.4: The service area of the state plan;

10.2.2.5: The time limits for coverage of a child under the state plan;

10.2.2.6: The state's choice of health benefits coverage and other methods used for providing child health assistance, and

10.2.2.7: The source of non-federal funding used in the plan.

- 10.2.3 :** An assessment of the effectiveness of other public and private programs an the state in increasing the availability of affordable quality individual and family health insurance coverage for children.
- 10.2.4 :** A review and assessment of state activities to coordinate the plan under this Title with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services.
- 10.2.5 :** An analysis of changes and trends in the state that affect the provision of accessible, affordable, quality health insurance and health care to children.
- 10.2.6 :** A description of any plans the state has for improving the availability of health insurance and health care for children.
- 10.2.7 :** Recommendations for improving the program under this Title.
- 10.2.8 :** Any other matters the state and Secretary consider appropriate.
- 10.3 :** The state assures it will comply with future reporting requirements as they are developed.
- 10.4 :** The state assures that it will comply with all applicable Federal laws and regulation, including but not limited to Federal grant requirements and Federal reporting requirements.