Contract No.: 500-96-0016(03)
MPR Reference No.: 8644-610

MATHEMATICA
Policy Research, Inc.

SCHIP in Ohio: Evolution and Outlook for the Future

Final Report

March 18, 2004

Carol Irvin
Nancy Fasciano
Margo Rosenbach

Submitted to:

Centers for Medicare & Medicaid Services
Office of Research, Development, and Information
7500 Security Boulevard
Baltimore, MD 21244

Project Officer:
Susan Radke

Submitted by:

Mathematica Policy Research, Inc.
50 Church Street, 4th Floor
Cambridge, MA 02138
Telephone: (617) 491-7900
Facsimile: (617) 491-8044

Project Director:
Margo Rosenbach

This report was prepared for the Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, under contract number 500-96-0016 (03). The contents of this publication do not necessarily reflect the views or policies of CMS or DHHS, nor does the mention of trade names, commercial products, or organizations imply endorsement by CMS, DHHS, or Mathematica Policy Research, Inc. The authors are solely responsible for the contents of this publication.

ACKNOWLEDGMENTS

The authors acknowledge the contributions of Susan Radke and Johanna Barraza-Cannon, of the Centers for Medicare & Medicaid Services, for their useful comments on an earlier version of this report. The authors also wish to express their appreciation to case study and focus group respondents in Ohio, especially Lisa Coss and Sukey Barnum. We also are indebted to numerous Mathematica Policy Research, Inc. staff for their contributions to this report: Ruth-Ann Alger, Roy Grisham, Margaret Hallisey, Megan Kell, Jason Markesich, Julita Milliner-Waddell, Joanne Pfleiderer, Amy Quinn, and Judith Wooldridge.

THIS PAGE LEFT INTENTIONALLY BLANK

FOR DOUBLE SIDED COPYING

SCHIP IN OHIO: EVOLUTION AND OUTLOOK FOR THE FUTURE

Ohio's Healthy Start program focused on making Medicaid coverage more accessible and consumer-friendly. Already poised to expand poverty-related Medicaid coverage for children when the legislation was enacted in August 1997, Healthy Start began covering children through age 18 with family income up to 150 percent of poverty in January 1998. Ohio further expanded Medicaid coverage in July 2000, raising eligibility to 200 percent of poverty ($36,800 for a family of four in 2003 dollars). Enrollment in Healthy Start has steadily grown over the years, demonstrating the success of Ohio's efforts to make Medicaid more accessible to more children.

FINDINGS IN BRIEF

Enrollment Progress. Enrollment in Ohio's Healthy Start was slower than anticipated during the first year, but has grown steadily since. In particular, enrollment grew rapidly after July 2000, when the state raised the eligibility threshold. Nearly 208,000 children were enrolled in Ohio's State Children's Health Insurance Program (SCHIP) program during federal fiscal year 2003.

Outreach Strategies. Most Healthy Start outreach has been conducted by the county offices that determine eligibility for Medicaid, rather than through statewide campaigns. This decentralized approach is credited with promoting some highly successful grassroots campaigns. Nevertheless, most observers believe that the state should have retained more resources with which to coordinate county efforts, avoid duplication, and disseminate effective practices. State financing of county-level outreach no longer exists, but the state continues to distribute information about Healthy Start with applications for the National School Lunch Program, an approach that took several years to develop and refine.

Application Process. Ohio had already streamlined the Medicaid application process before it implemented its SCHIP Medicaid expansion, by shortening the application form and eliminating the requirement for a face-to-face interview. The state further streamlined the process in July 2000 by reducing verification requirements. Advocates and others applauded the state's efforts to simplify the application process, although some cited a need for greater consistency in county implementation of eligibility policies and procedures, such as uniform documentation requirements.

Renewal Process. In response to the high level of enrollee turnover early in its SCHIP program, Ohio extended the redetermination period from 6 to 12 months, beginning in July 2000. Enrollee retention improved slightly as a result. The state is considering additional simplifications to the renewal process, such as preprinted renewal forms, to make renewal easier and further improve enrollee retention.

Health Care Delivery and Access. Healthy Start enrollees' access to care is generally perceived to be good, regardless of whether children are served in fee-for-service or managed care settings. As in other states, many families reported barriers to obtaining dental care. These difficulties are widely viewed as resulting from providers restricting the number of Medicaid patients they serve.

Outlook for the Future. Like most other states, Ohio is facing daunting budget pressures that have raised the specter of reductions in state support for Healthy Start. However, most observers believe that the SCHIP program will be spared from any cuts in the Medicaid budget, in part because of the generous federal matching rate under title XXI. The Medicaid family coverage expansions under Section 1931 are at greater risk because of higher than expected growth in title XIX caseloads.

About the Study

Mathematica Policy Research, Inc. (MPR) conducted a week-long site visit to Ohio in September 2002, as part of its national evaluation of SCHIP for the Centers for Medicare & Medicaid Services (CMS). To gather information about both state policy and local implementation of Healthy Start, we interviewed state and county Medicaid agency staff, public health officials, child health advocates, front-line eligibility workers, health care providers, and staff of organizations involved in outreach and application assistance in Columbus (the state capitol), Cleveland (Cuyahoga County), and Mansfield (Richland County). In April 2003, MPR convened focus groups in Cleveland and Mansfield with parents of Healthy Start enrollees and disenrollees. More information about the study appears at the end of this document.

THE EVOLUTION OF OHIO'S SCHIP PROGRAM

Ohio's initial eligibility expansion under SCHIP was modest but the program has evolved and grown over time (Exhibit 1). During its initial years, Healthy Start eligibility processes were simplified to reduce barriers to enrollment and improve retention rates. Subsequently, the state raised the eligibility threshold to 200 percent of poverty to provide more low-income, uninsured children with coverage.

Exhibit 1. Major Milestones in Ohio's SCHIP Program

Implementation Date	Milestone
January 1998	➢ SCHIP enrollment began, covering children through age 18 up to 150 percent of poverty.
	➢ State expanded the role of its toll-free Consumer Hotline to include helping people complete the Combined Programs Application and posted the application on the Internet.
July 1999	➢ State initiated training and technical assistance for local agency staff concerning Medicaid eligibility determination to promote consistency.
October 1999	➢ Combined Programs Application was simplified and translated into Spanish.
November 1999	➢ State required caseworkers to determine eligibility for all Medicaid categories (including SCHIP) before terminating coverage (known as an *ex parte* review).
July 2000	➢ SCHIP eligibility was extended to uninsured children up to 200 percent of poverty.
	➢ The redetermination period was extended from 6 to 12 months.
	➢ The state implemented self-declaration as verification of birth, U.S. citizenship and identity, and electronic verification of social security number.

SOURCE: Ohio Title XXI Annual Reports from 1999 through 2002.

Program Development and Administration

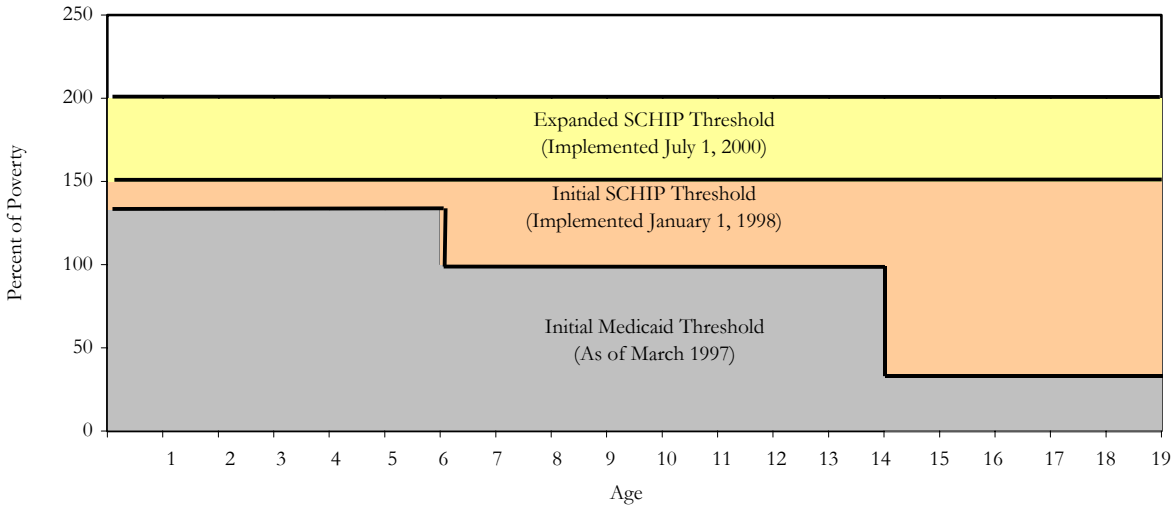
The state of Ohio was among the first to launch its SCHIP program. When enhanced federal matching funds became available through title XXI, Ohio implemented its already-planned eligibility expansion as a SCHIP Medicaid expansion, raising the eligibility threshold for children's Medicaid coverage to 150 percent of poverty on January 1, 1998 (Exhibit 2).

At the same time, Ohio expanded Medicaid (title XIX) eligibility to fill additional coverage gaps. The state opted to provide wrap-around Medicaid benefits to children with family incomes up to 150 percent of poverty who have health insurance coverage and hence are not eligible for SCHIP. In addition, the state raised the income eligibility threshold for family coverage under Section 1931 of title XIX (known in Ohio as Healthy Families), making Medicaid coverage available to all parents with family income below the poverty level.

Plans to further expand SCHIP coverage were underway almost immediately. Shortly after January 1998, the governor appointed a task force that included representatives of the Ohio Department of Health, other state agencies, and the insurance industry to consider the options for expanding coverage. The task force recommended that the state implement a separate child health program, with Medicaid benefits and cost sharing, for children with family incomes between 150 and 200 percent of poverty. After weighing the administrative burden of establishing a separate program, the Governor and state legislature, on July 1, 2000, chose instead to expand Medicaid coverage and raised the income eligibility threshold for the SCHIP Medicaid expansion to 200 percent of poverty. State policymakers decided not to implement a separate SCHIP program because it would have involved financing another insurance program and its bureaucratic structure, including contracting procedures, enrollment systems, and consumer and provider outreach and support mechanisms.

The SCHIP program is administered by the Ohio Department of Job and Family Services (ODJFS). This agency administers Medicaid and most social service programs in Ohio, including Ohio Works First (Ohio's Temporary Assistance for Needy Families [TANF] program), Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and food stamps. Reflecting Ohio's overall philosophy of decentralization, county ODJFS offices are responsible for implementing SCHIP (including outreach, eligibility determination, and renewals) and other social services. By decentralizing the operation of social services, counties were given considerable autonomy in how they implemented program policies and procedures.

Exhibit 2. Ohio Medicaid and SCHIP Eligibility Thresholds



SOURCE: CMS's State Title XXI Program and Title XXI Amendment Fact Sheet.

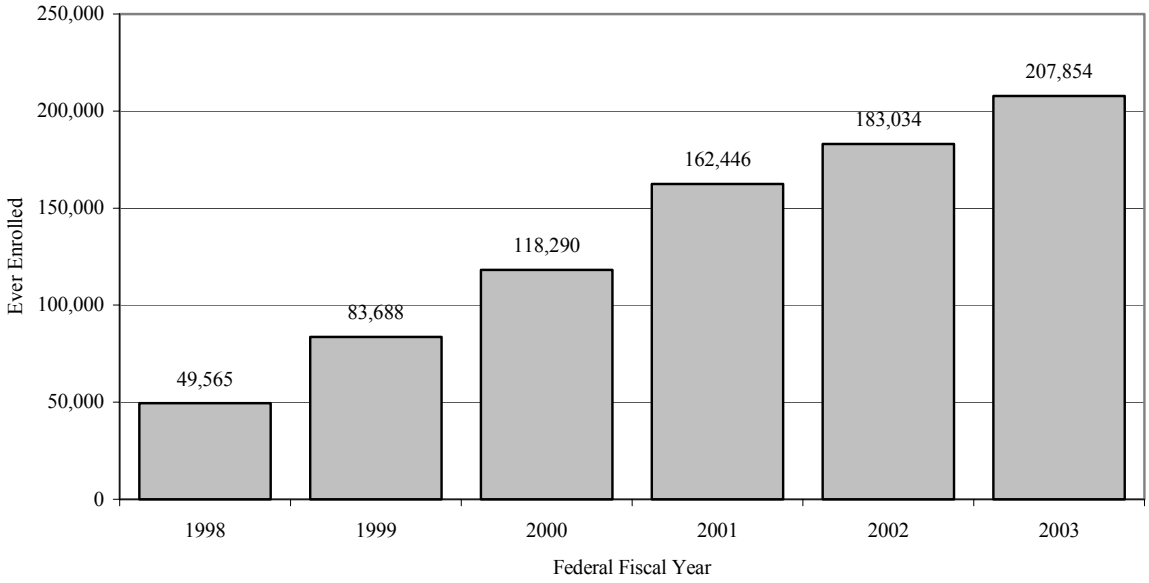
NOTE: Under federal law, states are required to provide title XIX Medicaid coverage to children older than age 5 who were born after September 30, 1983, in families with incomes below 100 percent of poverty. On March 31, 1997 (the maintenance-of-effort date set by the SCHIP statute), the oldest children affected by this provision were age 14. In Ohio, the income eligibility standard for children older than age 14 at this time was 33 percent of poverty.

Enrollment Progress

Enrollment in Ohio's Healthy Start program was slower than expected during the first year, according to state officials, but picked up in subsequent years (Exhibit 3).[1] The state attributes this enrollment growth not only to the enrollment expansion in July 2000, but also to refinements in its retention strategies. The state extended the redetermination period from 6 to 12 months and implemented procedures designed to retain children in Medicaid and SCHIP even when they have lost eligibility for other benefits (such as cash assistance or food stamps). Ongoing state and local outreach efforts, including the school-based enrollment efforts launched in fall 2000, also contributed to enrollment growth.

[1]Ohio used the 1998 Ohio Family Health Survey to develop a baseline estimate of 79,000 uninsured children under 150 percent of poverty and potentially eligible for SCHIP. Nearly 84,000 children were enrolled in Ohio's SCHIP during the second year of the program (federal fiscal year 1999).

Exhibit 3. Annual Enrollment in Ohio's SCHIP Program: FFY 1998 - FFY 2003



SOURCE: CMS's SCHIP Statistical Enrollment Data System (SEDS), obtained on November 12, 2003.

NOTE: Annual enrollment is defined as the number of children ever enrolled during the federal fiscal year.

SCHIP enrollment rose sharply immediately after the expansion from 150 to 200 percent of poverty. The expansion occurred at the beginning of the last quarter of federal fiscal year 2000. The number of children ever enrolled during the fourth quarter grew to 86,477, a 28 percent increase over the 67,455 ever enrolled in the previous quarter. [2] During the year leading up to the expansion, quarter-to-quarter enrollment growth ranged from 1.0 to 9.4 percent.

State Medicaid agency staff believe the state may have "reached the saturation point" in Healthy Start enrollment. They note that enrollment is now growing more rapidly in the traditional Medicaid eligibility categories than in the title XXI Medicaid expansion.

[2]Marilyn Ellwood, Angela Merrill, and Wendy Conroy, "SCHIP's Steady Enrollment Growth Continues," Cambridge, MA: Mathematica Policy Research, Inc., February 2003.

Outreach Strategies

Ohio used a county-level approach to outreach that was spearheaded by the county social service offices. County outreach efforts have been financed primarily by the state's allocation from the federal TANF/Medicaid "delinking" fund.[3] The state Medicaid agency lacked the funds required to draw down the federal funding, which were available at a 90 percent match rate, and most of its $16.9 million allocation was available only to counties willing to provide the state's 10 percent match, which almost all did. Despite the evidence of steady enrollment growth, many believe that had the state devoted more resources to overall coordination of county activities, outreach could have been even more effective.

State-Level Outreach. State-level outreach was limited to a few key activities. The state Medicaid agency produced public service announcements and educational videos, dispatched its three community educators to promote Healthy Start in collaboration with various state programs (for example, Head Start, WIC, and the Children with Medical Handicaps program (title V)), and established a statewide school-based initiative to distribute information through the National School Lunch Program. These efforts promoted the Medicaid consumer hotline, which provides information about all Medicaid-eligibility guidelines and benefits. The managed care plans that serve Healthy Start enrollees are prohibited from approaching individual families, but they can promote plan services. CareSource, a Medicaid-only plan and the largest plan in the state's Medicaid managed care program, has eight community education representatives who conduct state-approved presentations to communities, providers, local social services offices, and families who approach them. Interested families can call the plan's hotline, which refers callers to the state's Medicaid consumer hotline.

The school-based effort is now the state's chief outreach activity. Partnerships with schools were slow to develop, because of the decentralized nature of school systems. The partnership did not take root until 2000, when staff from the National School Lunch Program got involved. The state's approach to school-based outreach has undergone several permutations since then. In 2000, the state Medicaid agency distributed Healthy Start applications with school lunch materials, but 40 percent of resulting applications were from families whose children were already enrolled in Medicaid. In 2001, the agency switched to a detachable form that parents could use to request Healthy Start information, but there were difficulties collecting the forms from schools. In 2002, the agency changed its approach again and provided a hotline number for parents to call for information. This effort generated 1,929 calls between July and mid-September 2002.

County-Level Outreach. Counties pursued a variety of outreach initiatives and used some of their outreach funds to finance initiatives of local community groups. The two

[3]Authorized under Section 1931(h) of the Social Security Act, the $500 million fund was created to help states improve their Medicaid enrollment and eligibility determination processes in light of welfare reform.

counties we visited, Cuyahoga and Richland, both mounted multifaceted campaigns that were widely viewed as effective in raising awareness of the program. Both counties conducted mass media campaigns that included radio and print advertising and billboards. County staff also played an active role in promoting the program locally. In Cuyahoga, four full-time-equivalent staff members were dedicated to outreach, and another 15 eligibility specialists spent time marketing the program to schools, county agencies, and other groups. In Richland County, eight staff members made presentations to local groups and managed the county information hotline.

Both counties also financed outreach activities of local groups. Richland County used a competitive proposal process to award outreach grants to local community groups. Cuyahoga County paid a "finder's fees" to community groups that identified and enrolled children who were eligible for Healthy Start. In addition, the county contracted with a large hospital to operate a Healthy Start hotline and hire outreach workers to help patients complete Medicaid applications, including the Combined Programs Application for Healthy Start.

Perspectives and Prospects. The state's decentralized, county-based approach to outreach reflects the state's philosophy that counties know their own populations best and, thus, are best equipped to customize outreach strategies to meet their local needs. The decentralized approach to outreach is credited with promoting some creative and highly successful grassroots campaigns, such as those in Cuyahoga and Richland counties.

Most observers, including state agency staff, believe outreach could have been even more effective had the state played a larger coordinating role to ensure that "the face of the program" was presented uniformly across the state. The reasons offered for the state's limited involvement in county outreach activities include: the agency's inexperience conducting outreach prior to Healthy Start, insufficient staff and resources to monitor counties' activities, and a preference on the part of the Medicaid agency not to dictate a uniform outreach strategy. As a result, say advocates, counties used some outreach dollars to "reinvent the wheel," experimented with approaches that had failed elsewhere, and promoted the program under different names, thus undercutting efforts to create brand recognition. It was not until July 2000 that the state required all counties to use the "Healthy Start" name and logo. Until that time, both Richland and Cuyahoga counties had promoted the program as "CHIP." In retrospect, state agency administrators think that it would have been useful to hire a communications firm at the outset to create a single set of promotional materials and toolkits for counties to use. Advocates believe the state could have enhanced the effectiveness of county efforts by identifying and promoting counties' "best practices."

Most groups involved in outreach agreed that the stigma attached to Medicaid as a "welfare" program posed a significant challenge to promoting Healthy Start. However, steps the state has taken to improve families' experience with the application process—eliminating face-to-face interviews, reducing verification requirements, and creating more attractive materials—have been credited with reducing stigma. Marketing the program under a new name, such as "CHIP" or Healthy Start, and making no mention of the Medicaid agency in their promotional materials, further reduced the stigma attached to the program. As one

advocate put it, "'Medicaid' is not on the marquee." Some efforts to dissociate SCHIP from Medicaid have backfired, however; both advocates and county staff reported that some families who thought they had applied for a new program felt deceived when they received a Medicaid card.

Findings from the focus groups we conducted with parents in Cleveland and Richland county suggest that a multifaceted outreach approach was a wise strategy, since families learned about SCHIP through a wide range of sources. Parents variously said they had heard about Healthy Start through television or radio advertisements, by word of mouth from family and friends, at county offices when they applied for other kinds of assistance, and from health care providers. A few applied after receiving materials from their child's school. In Richland County, billboards were particularly memorable for families.

Parents' different impressions of the program from radio and television ads underscore both the importance and the difficulty of conveying accurate information about SCHIP coverage in brief media spots. First impressions varied, with some parents saying that the advertisements they had seen were unclear. Some said they thought Healthy Start was "welfare" when they first heard about it, but others recalled advertisements stating that the program was for "working families." In one Cleveland focus group, parents were confused about the message regarding coverage for working families, pointing out that parents rarely qualified because of the low income standards for family coverage (Healthy Families). Further, parents in one Richland County focus group felt they had been given the wrong impression from some advertisements, which seemed to suggest that all uninsured children were eligible for Healthy Start, regardless of family income.

Ohio recently cut back its outreach because the state exhausted its allocation from the federal TANF/Medicaid delinking fund in 2002. State agency staff indicated that "high profile" outreach would have been curtailed, in any case, because the state was facing a budget crisis and the Medicaid caseload had already exceeded projections by some 120,000 enrollees.

Application Process

Respondents applauded the steps the state took to streamline the Healthy Start application process (Exhibit 4). Nevertheless, county-level variation in eligibility policies and procedures, as well as problems with the state's automated eligibility system, remain concerns.

Forms and Procedures. The Combined Programs Application serves as an application for Healthy Start, Healthy Families, WIC, and two title V programs (Child & Family Health Services and Children with Medical Handicaps). Implemented in 1991, the form was shortened to two pages in 1999 and revised again in 2000. The form is available in English and Spanish and can be obtained at a variety of sites, including WIC clinics, county social service offices, local health departments, hospitals and other provider sites, or by calling state or county hotlines.

Exhibit 4. Ohio SCHIP Eligibility Policies, Forms, and Procedures at a Glance[a]

Eligibility Policies	
Income disregards	Yes
Asset test	No
Continuous eligibility	No[b]
Waiting period[c]	No
Presumptive eligibility	No
Retroactive eligibility	Up to 3 months
Application Form(s)	
Joint Medicaid/SCHIP form	NA
Form length	2 pages[d]
Languages in which form is available	English, Spanish
Application Procedures	
Mail-in application	Yes
Telephone application	No
On-line application	No
Face-to-face interview required	No
Verification of income required	Yes

SOURCE: Ohio Title XXI Annual Reports from 2000 through 2002.

[a]Policies are as of August 2003.

[b]The state adopted, but never implemented, a policy of 12-month continuous eligibility for children with family incomes over 150 percent of poverty.

[c]A requirement that children be uninsured for a certain period of time before enrolling in SCHIP.

[d]The application is packaged in a booklet that includes eight pages of instructions, program information, and additional space to provide information that will not fit on the form.

The state Medicaid agency eliminated the face-to-face interview requirement for most categories of Medicaid coverage in 1991 when it introduced the Combined Programs Application. Most applications are mailed, although families can still apply at county social service offices, at provider sites with on-site eligibility workers, or over the phone with hotline staff (who mail the completed form to the applicant to sign and submit with the required verification). With the eligibility expansion in July 2000, the state reduced verification requirements for Healthy Start, eliminating the need for applicants to document age, identity, or social security number. Currently, families must attach documentation of

one month's income and, if applicable, confirmation of pregnancy and third-party insurance coverage. Each county social service office determines what type of income documentation it will accept.

Although the state does not directly support application assistance delivered by community-based organizations, some counties have used TANF outreach dollars to compensate organizations that help families complete applications. Until June 2002, for example, Cuyahoga County paid contracted organizations $42 for each person they helped enroll.[4]

Perspectives and Prospects. State Medicaid agency staff believe that the mail-in application was a key to making the process easy and less stigmatizing for families applying for coverage under SCHIP. In the words of one county caseworker, "A lot of people don't want to walk through the door of the county office and be seen here. Having a mail-in process eliminates the humiliation." Focus group participants who had mailed in their applications described the process as undemanding. Said one, "It was so easy. I filled it out, sent it in. I was surprised. I expected much more of a hurdle." When asked about the best aspects of the program, one Cleveland parent stated, "Well, the fact that I applied over the phone, because I was really hesitant about it. Because I thought I would have to go down to the welfare building. But my neighbor gave me the number and I just called and got it all sent through the mail."

Most eligibility workers and individuals who assist families with applications praised the two-page application form. However, some said that the 10-page booklet in which the application appears (along with a list of required documentation, an explanation of applicants' rights and responsibilities, and other information) is daunting. For example, despite instructions at the beginning of the booklet to sign the form in two places—once on the application itself and a second time on the rights and responsibilities section—some applicants miss the second of the two signature lines, rendering their application incomplete.

Income documentation is the item most commonly missing from applications. Eligibility staff in Cuyahoga and Richland counties estimated that about half of all applications lack documentation of earnings and require follow up by caseworkers (typically consisting of one or two reminder notices). Staff in both counties reported that most of these applications eventually are completed.

The state tested a policy of self-declaration of income as a means of reducing application burden. For one year ending November 2001, Cuyahoga County allowed families to self-declare their income. The experiment resulted in higher approval rates (85 percent versus 65 percent before the policy change), faster processing times (15 to 30 days versus 30 to 60 days), and a 98 percent accuracy rate. Five percent of Healthy Start applicants were found to understate their income, but only 2 percent of those enrolled were determined to be ineligible. Although the pilot was deemed a success, the state has no plans

[4]This program was terminated when TANF outreach funding began to dry up.

to implement the policy statewide, because the issue of potential fraud is "too emotionally charged in the current environment," in the words of one state official.

As with outreach, county-level variation in eligibility policies and procedures was viewed as a significant problem by advocates. "The policy isn't flawed," said one. "County implementation is." Several respondents mentioned instances of caseworkers asking for more information or documentation than was required by the state—a problem one advocate attributed to caseworkers' concerns about food stamp sanctions. (The U.S. Department of Agriculture previously had sanctioned the state because of its high error rates.)

In addition, some parents reported not receiving all the information they felt they needed from caseworkers to fully understand the program. For example, some parents attending the focus groups did not realize that dental and vision services are covered by SCHIP. One Richland County parent stated, "My biggest problem was the lack of information given out at the initial application… Now, maybe in [the caseworker's] mind, medical meant all encompassing. And that was probably a question I didn't ask, which I probably should have asked. But medical to me meant medical. Not dental, not eye."

The state's automated eligibility system, the Client Registry Information System–Enhanced (CRIS-E), also drew criticism. Several respondents described the notices generated by the system as hard to read and occasionally misleading. Moreover, updates to reflect new application policy, such as the elimination of certain verification requirements, frequently lagged. State Medicaid staff acknowledged that the system does not adequately support a mail-in application process, often requiring manual overrides by caseworkers. Although upgrades are planned, state staff said that, because system work is driven by county priorities, upgrades to modules relating to the Food Stamp Program tend to take precedence.

Renewal Process

Due to concerns about the high level of turnover among enrollees in the first years of its SCHIP program, the state sought to improve retention of eligible children by extending the redetermination period from 6 to 12 months in July 2000 (Exhibit 5). Because the renewal process essentially entails a reapplication, the state is considering further simplifications (such as preprinted renewal forms) to reduce barriers to retaining coverage.

Exhibit 5. Ohio SCHIP Renewal Policies, Forms, and Procedures at a Glance[a]

Renewal Policies	
Frequency of renewal	12 months
Passive renewal[b]	No
Renewal Form(s)	
Pre-printed renewal form	No
Renewal Procedures	
Mail-in renewal	Yes
Face-to-face interview required	No
Verification of income required	Yes

SOURCE: Ohio Title XXI Annual Reports from 2000 through 2002.

[a]Policies are as of August 2003.

[b]Passive renewal policies require families to submit information during the renewal period only when changes in income or household composition have occurred since the application or last renewal period. If no changes occurred, the family is not required to respond.

Forms and Procedures. The renewal process is essentially a reapplication. Families must complete the same form and provide the same documentation they did at application. Renewal packets typically are sent out during the eleventh month of coverage, but the number and timing of reminder notices vary by county. Richland County sends the initial notice 30 days before the termination date and follows up with a reminder notice before closing the case. Cuyahoga County starts the process 45 days before termination and sends up to three reminder notices. Caseworkers are required to review Medicaid/SCHIP eligibility before terminating coverage.

Perspectives and Prospects. Retention has increased since the redetermination period was extended from 6 to 12 months. In its 2001 annual report to CMS, the state

reported that the percentage of children who retained coverage a full year increased from 74 to 82 percent after the policy change.[5]

State officials reported that they had adopted (but never implemented) changes in eligibility policy for the newest group of eligibles (children with family incomes between 150 and 200 percent of the federal poverty level).[6] In addition to offering continuous eligibility to this group, the state planned to require an annual enrollment fee ($25 per child, up to $75 per family) under the authority of a Section 1115 demonstration. Although the fee was approved by CMS in February 2002, the state Medicaid agency chose not to implement the enrollment fee because staff concluded that it would be too costly to administer. Consequently, state agency administrators reported that continuous eligibility was never formally implemented either.

Among parents in our focus groups, experiences with renewal varied enormously. Some who had renewed their children's coverage said the process was relatively straightforward. Others said they lost coverage at least temporarily, usually because they did not receive the renewal packet or did not open it. A sizeable number whose children had been enrolled in Healthy Start for more than a year could not recall ever renewing the coverage and did not know that they were supposed to. In some cases, parents may have unknowingly renewed coverage in the course of reporting information required by other programs, such as food stamps. In other cases, coverage may have been automatically extended because renewals have become a low priority for understaffed county offices. According to some reports, renewals may be delayed as much as a year, and coverage is automatically continued during that time.

The state Medicaid agency is considering streamlining the renewal process by sending parents renewal forms that are partially preprinted using the information currently on file. Agency administrators oppose a completely passive renewal process, because of concerns about caseload integrity and problems with undeliverable mail. State officials believe it is essential to require families to respond in some way, to ensure that the state does not pay capitation for those who are no longer eligible.

Health Care Delivery and Access

Most stakeholders believe that children enrolled in Healthy Start generally have good access to care—a perception supported by the focus groups with families. Most families were satisfied with their selection of providers and quality of care, regardless of whether their

[5]The state compared two cohorts—one whose eligibility was redetermined in October 1998 and another whose eligibility was redetermined in July 2000, when the 12-month eligibility period was implemented—and calculated the percentage still enrolled 11 months after redetermination.

[6]Under federal law, states have the option to allow children to retain coverage for up to 12 months in their Medicaid and SCHIP programs, regardless of a change in family circumstances that might affect eligibility. States were accorded the flexibility to adopt "continuous eligibility" for children in Medicaid in 1997, in the same legislation that created SCHIP.

children received care through the fee-for-service or the managed care delivery system. In both systems, however, access to dental care was widely reported to be a problem. Moreover, some families who did not have an established provider relationship before enrolling in Healthy Start reported difficulty finding a doctor for their children.

Selecting a Managed Care Plan. Approximately 33 percent of Healthy Start enrollees receive care through the Medicaid managed care system (the remaining two-thirds receive care on a fee-for-service basis).[7] Managed care enrollment currently is concentrated in a single plan, CareSource, which accounts for 61 percent of all Medicaid managed care enrollment in the state.[8] Enrollment in a managed care plan is mandatory in only 3 of the state's 88 counties and voluntary in another 12.[9] In 5 of the 12, plan enrollment is the "preferred option," meaning that individuals are assigned to a plan unless they explicitly request fee-for-service coverage. Medicaid enrollees in the mandatory managed care counties must select a plan within 30 days of notification of eligibility, otherwise they will be assigned to one.[10] Until plan membership is activated, enrollees obtain care in the fee-for-service system.

The number of plans participating in the Medicaid managed care program, known as PremierCare, has steadily declined, from a high of 13 in 1998 to 6 in September 2002. This decline is partly explained by a July 1998 policy requiring plans to have at least a 15 percent market share (10 percent in Cuyahoga County) to continue operating in a county.[11] Most advocates and some others we interviewed said that, despite plan mergers and withdrawals, the changes in the managed care market were not particularly disruptive for enrollees, largely because of overlap in plan provider networks.

---

[7]Ohio Job & Family Services, "Ohio Medicaid Managed Care Monthly Enrollment Reports," January 2003.

[8]Managed care enrollment figures reflect non-disabled adult and child title XIX enrollees and title XXI enrollees combined (Ohio Job & Family Services, January 2003).

[9]Healthy Start enrollment in the three counties represents nearly 40 percent of the state's total eligible population, and 88 percent of enrollees in these counties are enrolled in a plan (Ohio Job & Family Services, January 2003).

[10]If an applicant does not choose a plan within 15 days, the state's managed care enrollment broker sends a second notice that specifies the plan to which the applicant will be assigned if he or she does not contact the broker within 15 days.

[11]Opinions differed about the reasons for the decline in the number of plans in the Medicaid managed care market. Some observers believe the state policy mandating a minimum market share contributed significantly to plan exits because it effectively limited to six the number of plans that could participate in most counties. After the introduction of the market-share requirement, Ohio experienced a series of mergers, sales, and financial failures among the plans, many of which were Medicaid-focused. Other observers, including state Medicaid officials, believe that the decline in plan participation is also attributable to larger forces at work in the managed care industry and to the program's having initially attracted some plans that did not possess the infrastructure or the understanding of the Medicaid population needed to survive. Managers of two large health plans also cited low capitation rates and increasing state regulation as key reasons some plans pulled out, and one Cleveland hospital administrator said that the state's initial policy of allowing enrollees to change plans every month hurt some plans.

After being determined eligible for Healthy Start, families receive an enrollment packet from the enrollment broker that contains provider lists for each plan in the county and information on how to choose a plan. Families complete and return the plan selection form which includes a section for listing the family's choice of primary care physician. Failure to select a plan results in the broker assigning one based on several criteria, including the child's primary care provider (PCP) from a previous enrollment period, the provider the child used while in the fee-for-service system, or the proximity of the child's residence to PCPs accepting new Healthy Start patients. Families can change their plan membership either within the first 90 days of enrollment or during the open enrollment period, which occurs once a year.[12] Data reported by the Bureau of Managed Health Care indicate the plan enrollment process is working well. During the month of December 2002, only 719 Medicaid enrollees in the 3 mandatory managed care counties changed plans during the initial 90-day window. This represents slightly more than 3 percent of all new enrollees that month in these counties (22,588) or 0.3 percent of all managed care enrollees in the mandatory counties, as of the beginning of January 2003.[13]

As is typical in most states, experiences with the plan enrollment process varied among focus group participants in Ohio. Some parents understood the process from the start and were able to identify and select a plan whose network included the PCP and/or hospital they wanted. Others were happy to have been assigned to a plan and PCP, since they had had no particular provider in mind and were pleased with the choice made for them. But others seemed poorly informed about the delivery system and how to choose a plan. For example, some mistakenly selected a plan that did not include their chosen providers and reported not being able to switch; others said they learned that their child had been assigned to a plan only when they tried to continue using the fee-for-service system and were turned away by providers who were not in the plan's provider network.

Finding a Doctor. How families select a PCP varies by delivery system. Families in the fee-for-service system can seek services from any provider willing to accept Medicaid reimbursement. Families can obtain lists of providers participating in HealthChek, the state's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, from the Medicaid consumer hotline and their local social service offices and health departments. Those enrolled in managed care chose a PCP from their plan's network of providers. Families indicate their PCP choice on the plan selection form they submit to the enrollment broker. When the family fails to select a PCP, the plan assigns one. Families can change their PCP selection at any time.

Whether a child had an established relationship with a provider prior to enrolling in Healthy Start seemed to determine whether finding a PCP was easy or difficult for families. Most families in our focus groups were able to retain their existing primary care provider or clinic because practices commonly continue to serve established patients, regardless of

[12]In Cuyahoga county, which includes Cleveland, open enrollment occurs in February of each year.

[13]Ohio Job & Family Services, January 2003.

changes in insurance coverage. As one parent commented, "I enjoy Healthy Start. I have really nothing negative to say. I was able to keep the same doctor that I had previously, so that was a good thing." Another parent stated, "…I have absolutely no problems either…I always found doctors close to home, and a reasonable distance, and everything's been fine for me."

However, some families without an established provider relationship described frustrating experiences calling around to find a provider willing to see their child. They found that certain practices were closed to new Healthy Start patients because many providers limit the number of Medicaid patients they serve. A few families who needed to select a doctor from a managed care network complained that plan provider lists were outdated, requiring them to call numerous providers to locate one accepting new Healthy Start patients. Plans typically have staff available to assist families, but it was not clear whether families reporting these experiences were aware they could obtain help from the plan. Similarly, families in the fee-for-service system complained about the accuracy of the provider lists they received, and several turned to the local telephone book to search for a provider. As one focus group member in Mansfield noted: "I think once you can find the doctor or dentist, then you're okay. But that's the hard part, finding them."

Because some providers restrict the number of Healthy Start patients they serve, there was a perception among stakeholders that children in Healthy Start have access to fewer providers, have to travel longer distances (especially for specialty care), and appear to wait longer for some appointments than children with commercial coverage. Staff of the largest pediatric practice in Mansfield reported that the other pediatric and family practices in town have always strictly limited the number of Medicaid patients they see, and specialists are increasingly doing the same. Richland County families frequently travel outside the county because the area lacks many types of pediatric specialty care and because a few specialists, such as dermatologists, refuse to see Medicaid patients.

Poor provider payment rates are frequently cited as the reason for limited Medicaid provider participation. Providers interviewed during the site visit said that rapidly increasing costs, particularly for malpractice insurance and employee health insurance, have more than offset a 2000 rate increase.[14] "Physicians are underwriting the state, and consequently the state does not see an access problem," said one physician who serves on the ODJFS Medical Care Advisory Committee and whose own practice stopped taking new Medicaid patients six years ago.

Although provider participation is known to be an issue for Healthy Start, most observers believe that SCHIP enrollees can ultimately obtain the care they need. This

[14]Ohio pediatricians surveyed by the American Academy of Pediatrics in 2000 were somewhat more likely than their colleagues nationwide to report that Medicaid payments do not cover overhead (68 percent in Ohio versus 53 percent nationally) and to cite low payment rates as a very important reason for limiting participation in Medicaid (66 percent versus 58 percent). (Beth K. Yudkowsky, Suk-Fong S. Tang, and Alicia M. Siston, "Pediatrician Participation in Medicaid/SCHIP: Ohio," American Academy of Pediatrics, Survey of Fellows of the American Academy of Pediatrics: 2000, September 28, 2000.)

perception was echoed in the focus groups; none of the parents reported instances of needing care for their children but not receiving it. Moreover, nearly all parents seemed to be satisfied with the program and the quality of care their children received. As one parent from Richland County noted, "When I needed it, I was real grateful to have it." A Cleveland parent stated "…we complain. But at the same time you realize that it's still a blessing to get it."

Finding a Dentist. Across most states, low-income children experience difficulties accessing dental care because they cannot find a provider willing to provide the care they need.[15] Children's access to dental care in Healthy Start reflects theses national trends. Access to dental care is widely viewed as inadequate in Ohio, primarily because most dentists in the state do not participate in the Medicaid program. In 2000, 75 percent of Ohio dentists filed no Medicaid claims, and of the 25 percent who did, more than half served 50 or fewer Medicaid enrollees. A 1999 survey found that most dentists who participated in the program limited the number of Medicaid patients they served and, in many cases, did not accept new Medicaid patients. Many parents in Richland County reported difficulties accessing dental care. "I actually took the phone book and called every dentist in the book," said one parent. "And the very last one accepted Healthy Start, but when we got there, he said he didn't do pediatric dentistry and referred me to Columbus."

The state has made a concerted effort to improve access to dental care, implementing back-to-back dental fee increases of 45 percent in 2000 and 56 percent in 2001. They worked with representatives of the Ohio Dental Association to target these increases to services identified by the association as particularly poorly paid.[16] Dental association spokesmen indicated that the 2001 rate increase brought fees to the levels paid by most commercial PPOs, but added that increasing costs have chipped away at these gains. Concerns about paperwork and broken appointments also keep many dentists from participating in Medicaid.[17] However, dental association spokesmen believe that Medicaid claims processing has improved tremendously and now compares favorably with that of many commercial insurers.

Increasing the number of participating dentists may not eliminate all barriers to dental care, however. Some parents raised concerns in the focus groups about how they were

[15]United States General Accounting Office, "Oral Health: Factors Contributing to Low Use of Dental Services by Low-Income Populations," GAO/HEHS-00-149, September 2000 and Robert Wood Johnson Foundation, "Keep America Smiling: Oral Health in America," 2003.

[16]Another proposal introduced in 2002, but never implemented, would have shifted the responsibility for administering the Medicaid dental benefit to a public-private partnership between the state Medicaid agency and the Delta Dental Plan of Ohio. The proposal's approach was modeled after a similar partnership developed by Delta Dental and the state of Michigan for its Healthy Kids Dental program

[17]According to a survey conducted by the Ohio Department of Health, 77 percent of dentists reported low reimbursement as a reason for not participating in the Medicaid program. Other common reasons included paperwork (40 percent) and broken appointments (34 percent) (Ohio Department of Health, Bureau of Oral Health Services, "Access to Dental Care in Ohio, 2000," July 2002).

treated by dentists and their office staff, asserting that staff either treated them with disrespect or were inattentive. Several noted that, because their children were covered by Healthy Start, they could get appointments only on certain days or at certain times. One mother recalled, "They would only take us during certain hours of the day because you were that kind of insurance… they say that you can only come between twelve and two, and I [said], 'Well, my daughter goes to school 'til three.' Well because of your insurance, you can only come between twelve and two." Another family who lost their private coverage and switched to Healthy Start was told they could stay with the same dentist, but that they would need to be seen at another office that was less convenient for the family. The mother noted, "I mean I liked them, but I didn't like their treatment at all."

OUTLOOK FOR THE FUTURE

Ohio enrolled more than 183,000 children in its Medicaid SCHIP expansion program in federal fiscal year 2002, and is currently experiencing high levels of growth in traditional Medicaid eligibility categories. Despite the steady growth in SCHIP enrollment, state officials believe that federal funding will be adequate for the next few years. Whereas Ohio spent 84 percent of its 1998 federal SCHIP allotment and 77 percent of its 1999 allotment within each three-year period of availability, state officials believe that 2003 is the last year the state will spend less than its full allotment. Nevertheless, they anticipate that future allotments will be sufficient to support the program through 2007.

State funding is less secure, as Ohio, like many other states, is facing serious budget pressures. The state was forced to cut $231 million from its 2002 budget and nearly double that amount ($459 million) from its 2003 budget.[18] Both state administrators and advocates expressed guarded optimism that the title XXI Healthy Start expansion will be spared budget cuts, given the high-level support for the program. They indicated that family coverage expansions under Section 1931 were at greater risk because of the lower federal match under title XIX. Advocates noted that the Ohio Medicaid program has never been particularly generous, with some of the most restrictive eligibility requirements in the country for coverage of pregnant women and of the aged, blind, and disabled. Term limits may also have increased Medicaid's vulnerability to cuts, since many new legislators do not understand the program. Said one state official, "the conversation right now is just about getting through the next two years."

[18]National Governor's Association, "The Fiscal Survey of States," November 2002.

STUDY METHODOLOGY

This case study of the Healthy Start program is based primarily on a site visit to Ohio conducted September 16-20, 2002, and on focus groups with parents of Healthy Start enrollees and disenrollees held April 29 to May 1, 2003. The case study was conducted as part of the National Evaluation of the State Children's Health Insurance Program for the Centers for Medicare & Medicaid Services (CMS). Ohio is one of eight states included in the case-study component of the evaluation. The other states are: Georgia, Kansas, Kentucky, Maryland, Pennsylvania, South Carolina, and Utah.

To gather information about both state policy and local implementation of Healthy Start, we conducted on-site interviews in the state capitol (Columbus) and two communities: the City of Cleveland in Cuyahoga County, and Mansfield in Richland County. Focus groups were held in the same two communities. These communities were chosen to gain perspective on program experiences in both urban and rural areas (Exhibit 6). In addition, the two communities have a disproportionate share of children living in poverty relative to the state as a whole, and Cuyahoga County has a diverse racial and ethnic mix. The two communities also provide a contrast in Medicaid health care delivery systems. In Cleveland, as in most other urban areas in Ohio, SCHIP enrollees access care through managed care organizations, while in largely rural Richland County, services are delivered on a fee-for-service basis. Cuyahoga County has more health care resources (physicians and hospital beds per capita) than Richland County, although parts of both counties are designated health professional shortage areas for one or more services. Safety net providers—rural health clinics and federally-qualified health centers—augment other health care resources in both communities.

The site visit included interviews with state and county Medicaid agency staff, public health officials, child health advocates, front-line eligibility workers, health care providers, and staff of organizations involved in outreach and application assistance. The focus groups included parents of recent enrollees and parents whose children recently had their eligibility redetermined. Upon completion of the field work, we used ATLAS.ti to code and analyze site visit notes and focus group transcripts. We designed the coding scheme to assist in the production of the individual state profiles and cross-state analyses.

Exhibit 6. Characteristics of Ohio Case Study Communities

Characteristics	Ohio		
	Cuyahoga County	Richland County	State
Demographic Characteristics			
Total population (2000 Census)	1,393,978	128,852	11,353,140
Population per square mile	3,040	259	277
Race (percent)			
White	67.4	88.2	85.0
African american	27.4	9.4	11.5
Asian	1.8	0.5	1.2
Other	3.4	1.9	2.4
Hispanic origin (percent)	3.4	0.9	1.9
Per capita income	$32,362	$23,451	$27,977
Children living in poverty (percent)	20.5	17.2	14.0
Health System Characteristics			
Hospital beds per 1,000 population	2.8	1.4	1.7
Physicians per 1,000 population	4.6	2.6	2.9
HMO penetration rate (percent)	29.1	0.8	22.2
Number of FQHC sites	9	1	71
Number of rural health clinics	0	2	16
Health professional shortage areas			
Primary care	Partial	Partial	--
Dental care	Partial	Partial	--
Mental health care	Partial	No	--

SOURCE: Analysis of Area Resource File by Mathematica Policy Research.

NOTE: HMO = health maintenance organization
FQHC = Federally qualified health center