# Ohio CARTS FY2021 Report

## Basic State Information

## Welcome!

We already have some information about your state from our records. If any information is incorrect, please contact the mdct_help@cms.hhs.gov.

1. State or territory name:

Ohio

2.

Program type:

- ○ Both Medicaid Expansion CHIP and Separate CHIP
- ◉ Medicaid Expansion CHIP only
- ○ Separate CHIP only

3. CHIP program name(s):

All, Ohio

Who should we contact if we have any questions about your report?

4. Contact name:

Awa Daro Mbodj

5. Job title:

MHS Administrator 1

6. Email:

awa.mbodj@medicaid.ohio.gov

7. Full mailing address:

Include city, state, and zip code.

50 West Town Street, Suite 400, Columbus OH 43215

8. Phone number:

614-502-7125

PRA Disclosure Statement.

This information is being collected to assist the Centers for Medicare & Medicaid Services (CMS) in partnership with States with the ongoing management of Medicaid and CHIP programs and policies. This mandatory information collection (42 U.S.C. 1397hh) will be used to help each state meet the statutory requirements at section 2108(a) of the Social Security Act to assess the operation of the State child health plan in each Federal fiscal year and to report the results of the assessment including the progress made in reducing the number of uncovered, low-income children. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #1). The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

# Program Fees and Policy Changes

## Part 1: Medicaid Expansion CHIP Enrollment Fees, Premiums, and Delivery Systems

1.

Does your program charge an enrollment fee?

○ Yes

◉ No

2.

Does your program charge premiums?

- [ ] Yes
- [x] No

3.

Is the maximum premium a family would be charged each year tiered by FPL?

- [ ] Yes
- [ ] No

4. Do premiums differ for different Medicaid Expansion CHIP populations beyond FPL (for example, by eligibility group)? If so, briefly explain the fee structure breakdown.

5.

Which delivery system(s) do you use?

Select all that apply.

- [x] Managed Care
- [ ] Primary Care Case Management
- [x] Fee for Service

6. Which delivery system(s) are available to which Medicaid Expansion CHIP populations? Indicate whether eligibility status, income level, age range, or other criteria determine which delivery system a population receives.

All children eligible for CHIP are enrolled in Managed Care in the month they are determined eligible for CHIP. All children who are eligible for CHIP who also receiving HCBS Waiver Services are fee for service unless they are on an Ohio Department of Developmental Disabilities waiver, in which case they have and have the option to enroll in Managed Care.

# Part 2: Separate CHIP Enrollment Fees, Premiums, and Delivery Systems

# Part 3: Medicaid Expansion CHIP Program and Policy Changes

Indicate any changes you've made to your Medicaid Expansion CHIP program policies in the past federal fiscal year. Many changes listed in this section require a State Plan Amendment (SPA), while some don't, such as changing outreach efforts or changing the health plan enrollment process. Please submit a SPA to reflect any changes that do require a SPA.

1.

Have you made any changes to the eligibility determination process?

- ○ Yes
- ◉ No
- ○ N/A

2.

Have you made any changes to the eligibility redetermination process?

- ○ Yes
- ◉ No
- ○ N/A

3.

Have you made any changes to the eligibility levels or target populations?

For example: increasing income eligibility levels.

- ○ Yes
- ◉ No
- ○ N/A

4.

Have you made any changes to the benefits available to enrollees?

For example: adding benefits or removing benefit limits.

- ○ Yes
- ◉ No
- ○ N/A

5.

Have you made any changes to the single streamlined application?

- ◯ Yes
- ◉ No
- ◯ N/A

6.

Have you made any changes to your outreach efforts?

For example: allotting more or less funding for outreach, or changing your target population.

- ◯ Yes
- ◉ No
- ◯ N/A

7.

Have you made any changes to the delivery system(s)?

For example: transitioning from Fee for Service to Managed Care for different Medicaid Expansion CHIP populations.

- [ ] Yes
- [x] No
- [ ] N/A

8.

Have you made any changes to your cost sharing requirements?

For example: changing amounts, populations, or the collection process.

- [ ] Yes
- [x] No
- [ ] N/A

9.

Have you made any changes to the substitution of coverage policies?

For example: removing a waiting period.

- ◯ Yes
- ◯ No
- ◉ N/A

10.

Have you made any changes to the enrollment process for health plan selection?

- ◯ Yes
- ◉ No
- ◯ N/A

11.

Have you made any changes to the protections for applicants and enrollees?

For example: changing from the Medicaid Fair Hearing process to the review process used by all health insurance issuers statewide.

- ○ Yes
- ◉ No
- ○ N/A

12.

Have you made any changes to premium assistance?

For example: adding premium assistance or changing the population that receives premium assistance.

- ○ Yes
- ○ No
- ◉ N/A

13.

Have you made any changes to the methods and procedures for preventing, investigating, or referring fraud or abuse cases?

- ○ Yes
- ◉ No
- ○ N/A

14.

Have you made any changes to eligibility for "lawfully residing" pregnant women?

- ○ Yes
- ◉ No
- ○ N/A

15.

Have you made any changes to eligibility for "lawfully residing" children?

- ○ Yes
- ◉ No
- ○ N/A

16.

Have you made changes to any other policy or program areas?

- [ ] Yes
- [x] No
- [ ] N/A

17. Briefly describe why you made these changes to your Medicaid Expansion CHIP program.

| In order for Ohio to be in compliance with the conditions of the Families First Coronavirus Response Act and ensure that individuals in receipt of Medicaid retain coverage during the public health emergency, most individuals enrolled in Medicaid received continuous coverage during the reporting period. |
|---|

18.

Have you already submitted a State Plan Amendment (SPA) to reflect any changes that require a SPA?

- [ ] Yes
- [ ] No
- [x] N/A

# Part 4: Separate CHIP Program and Policy Changes

# Enrollment and Uninsured Data

## Part 1: Number of Children Enrolled in CHIP

This table is pre-filled with your SEDS data for the two most recent federal fiscal years (FFY). If the information is inaccurate, adjust your data in SEDS (go to line 7: "Unduplicated Number Ever Enrolled" in your fourth quarter SEDS report) and then refresh this page. If you're adjusting data in SEDS, allow one business day for the CARTS data below to update.

| Program | Number of children enrolled in FFY 2020 | Number of children enrolled in FFY 2021 | Percent change |
|---|---|---|---|
| Medicaid Expansion CHIP | 211,086 | 220,188 | 4.312% |
| Separate CHIP | 0 | 0 | 0% |

1. If you had more than a 3% percent change from last year, what are some possible reasons why your enrollment numbers changed?

Economic and policy changes related to the COVID-19 pandemic

## Part 2: Number of Uninsured Children in Your State

This table is pre-filled with data on uninsured children (age 18 and under) who are below 200% of the Federal Poverty Level (FPL) based on annual estimates from the American Community Survey. Due to the impacts of the COVID-19 PHE on collection of ACS data, the 2020 children's uninsurance rates are currently unavailable. Please skip to Question 3.

| Year | Number of uninsured children | Margin of error | Percent of uninsured children (of total children in your state) | Margin of error |
|---|---|---|---|---|
| 2016 | 54,000 | 6,000 | 2% | 0.2% |
| 2017 | 70,000 | 8,000 | 2.6% | 0.3% |
| 2018 | 74,000 | 8,000 | 2.8% | 0.3% |
| 2019 | 69,000 | 7,000 | 2.6% | 0.3% |
| 2020 | Not Answered | Not Answered | Not Answered | Not Answered |

| Percent change between 2019 and 2020 |
|---|
| Not Available |

1. What are some reasons why the number and/or percent of uninsured children has changed?

| |
|---|

2.

Are there any reasons why the American Community Survey estimates wouldn't be a precise representation of the actual number of uninsured children in your state?

- ○ Yes
- ○ No

3.

Do you have any alternate data source(s) or methodology for measuring the number and/or percent of uninsured children in your state?

- ◉ Yes
- ○ No

4. Is there anything else you'd like to add about your enrollment and uninsured data?

5.

Optional: Attach any additional documents here.

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

Browse...

# Eligibility, Enrollment, and Operations

## Program Outreach

1.

Have you changed your outreach methods in the last federal fiscal year?

- ○ Yes
- ● No

2.

Are you targeting specific populations in your outreach efforts?

For example: minorities, immigrants, or children living in rural areas.

- ○ Yes
- ● No

3. What methods have been most effective in reaching low-income, uninsured children?

For example: TV, school outreach, or word of mouth.

Ohio works with sister state agencies and community partners to reach families, and low-income uninsured children through community organizations, activities, and referrals. Ohio does not have an effective way to measure these methods.

4. Is there anything else you'd like to add about your outreach efforts?

Efforts to bring a population health focus to work around shared goals has strengthened agency partnerships through data linkages, resulting in a shared deeper understanding of improving population-level outcomes. ODM has educated state agency partners and numerous community stakeholders that work with low-income families, expanding the qualified entities that can assist with Medicaid applications.

5.

Optional: Attach any additional documents here.

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

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# Eligibility, Enrollment, and Operations

# Substitution of Coverage

Substitution of coverage (also known as crowd-out) occurs when someone with private insurance drops their private coverage and substitutes it with publicly funded insurance such as CHIP.

1.

Do you track the number of CHIP enrollees who have access to private insurance?

- [ ] Yes
- [x] No
- [ ] N/A

2.

Do you match prospective CHIP enrollees to a database that details private insurance status?

- [ ] Yes
- [x] No
- [ ] N/A

0.3 %

5. Is there anything else you'd like to add about substitution of coverage that wasn't already covered? Did you run into any limitations when collecting data?

No

6.

Optional: Attach any additional documents here.

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

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# Eligibility, Enrollment, and Operations

## Renewal, Denials, and Retention

## Part 1: Eligibility Renewal and Retention

1.

Does your state provide presumptive eligibility, allowing children to access CHIP services pending a final determination of eligibility?

This question should only be answered in respect to Separate CHIP.

- (selected) Yes
- No
- N/A

2.

In an effort to retain children in CHIP, do you conduct follow-up communication with families through caseworkers and outreach workers?

- ○ Yes
- ◉ No

3.

Do you send renewal reminder notices to families?

- ◉ Yes
- ○ No

4. What else have you done to simplify the eligibility renewal process for families?

Passive renewals

5. Which retention strategies have you found to be most effective?

The retention strategy Ohio found to be most effective is passive renewals.

6. How do you measure the effectiveness of your retention strategies? What data sources and methodology do you use to track retention?

We utilize our eligibility data warehouse system to monitor retention in our programs over time. In particular, we have used this data to construct a Kids Churn Dashboard. This monitors monthly patterns of disenrollment, reenrollment, and termination reasons over time. The dashboard includes multiple metrics and views including county level statistics on the rates of churn and new disenrollment by characteristics such as major caseload, medical conditions, and length of coverage gap. Among other things, the tracking of termination reasons on this dashboard has reenforced the importance of ex parte renewal for retention. The agency implemented an improved process for passive renewals, which to effect late in 2021. The impact of that change is not reflected in the numbers reported on this report due to the timing of its implementation, but we would expect it to be reflected on reporting for FFY 2022.

7. Is there anything else you'd like to add that wasn't already covered?

The answer to Question 1a reflects the fact that all children found Presumptively Eligible are enrolled in Medicaid pending a full eligibility determination. There were 15,595 children enrolled as Presumptively Eligible during this period. The answer to Question 1b reflects only the number of children on Presumptive Eligibility who were then found eligible for CHIP coverage.

## Part 2: CHIP Eligibility Denials (Not Redetermination)

1.

How many applicants were denied CHIP coverage in FFY 2021?

Don't include applicants being considered for redetermination - this data will be collected in Part 3.

51920

2.

How many applicants were denied CHIP coverage for procedural reasons?

For example: They were denied because of an incomplete application, missing documentation, or a missing enrollment fee.

27455

3.

How many applicants were denied CHIP coverage for eligibility reasons?

For example: They were denied because their income was too high or too low, they were determined eligible for Medicaid instead, or they had other coverage available.

24452

3a.

How many applicants were denied CHIP (Title XXI) coverage and determined eligible for Medicaid (Title XIX) instead?

4.

How many applicants were denied CHIP coverage for other reasons?

13

5. Did you have any limitations in collecting this data?

Because Ohio is using a single application process wherein individuals are assessed for eligibility in all programs, including CHIP, simultaneously we cannot separate out CHIP-specific denials. If someone is determined ineligible, it is because they are ineligible for all programs. Thus, the above figures are the initial determinations made for all children in the fiscal year. This number is also slightly inflated because when additional information is provided after the initial determination that results in successful enrollment it is not captured in these data.

Table: CHIP Eligibility Denials (Not Redetermination)

This table is auto-populated with the data you entered above.

| Type | Number | Percent |
| --- | --- | --- |
| Total denials | 51920 | 100% |
| Denied for procedural reasons | 27455 | 52.88% |
| Denied for eligibility reasons | 24452 | 47.1% |
| Denials for other reasons | 13 | 0.3% |

# Part 3: Redetermination in CHIP

Redetermination is the process of redetermining whether a child is eligible to renew in CHIP (Title XXI) every 12 months. This section doesn't apply to any mid-year changes in circumstances that may affect eligibility (for example: income, relocation, or aging out of the program).

1.

How many children were eligible for redetermination in CHIP in FFY 2021?

151153

2.

Of the eligible children, how many were then screened for redetermination?

109191

3.

How many children were retained in CHIP after redetermination?

106727

4.

How many children were disenrolled in CHIP after the redetermination process?

This number should be equal to the total of 4a, 4b, and 4c below.

2418

**Computed:** 2418

4a.

How many children were disenrolled for procedural reasons?

This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

295

4b.

How many children were disenrolled for eligibility reasons?

This could be due to income that was too high or too low, eligibility in Medicaid (Title XIX) instead, or access to private coverage.

2106

4c.

How many children were disenrolled for other reasons?

17

5. Did you have any limitations in collecting this data?

If, at redetermination, a child was determined eligible for Medicaid instead of CHIP then they are not counted as a CHIP redetermination in this data and instead are included below in the Medicaid redeterminations. Excluded from these counts are 700 redeterminations where the ID was disenrolled due to being aided on another case and/or under another ID or similar reason that would not result in the disenrollment of the individual.

Table: Redetermination in CHIP

These tables are auto-populated with the data you entered above.

| Type | Number | Percent |
|---|---|---|
| Children screened for redetermination | 109191 | 100% |
| Children retained after redetermination | 106727 | 97.74% |
| Children disenrolled after redetermination | 2418 | 2.21% |

Table: Disenrollment in CHIP after Redetermination

| Type | Number | Percent |
| --- | --- | --- |
| Children disenrolled after redetermination | 2418 | 100% |
| Children disenrolled for procedural reasons | 295 | 12.2% |
| Children disenrolled for eligibility reasons | 2106 | 87.1% |
| Children disenrolled for other reasons | 17 | 0.7% |

## Part 4: Redetermination in Medicaid

Redetermination is the process of redetermining whether a child is eligible to renew in Medicaid (Title XIX) every 12 months. This section doesn't apply to any mid-year changes in circumstances that may affect eligibility (for example: income, relocation, or aging out of the program).

1.

How many children were eligible for redetermination in Medicaid in FFY 2021?

836375

2.

Of the eligible children, how many were then screened for redetermination?

642580

3.

How many children were retained in Medicaid after redetermination?

619076

4.

How many children were disenrolled in Medicaid after the redetermination process?

This number should be equal to the total of 4a, 4b, and 4c below.

23053

**Computed:** 23053

4a.

How many children were disenrolled for procedural reasons?

This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

1794

4b.

How many children were disenrolled for eligibility reasons?

This could be due to an income that was too high and/or eligibility in CHIP instead.

21027

4c.

How many children were disenrolled for other reasons?

232

5. Did you have any limitations in collecting this data?

If, at redetermination, a child was determined eligible for CHIP instead of Medicaid then they are not counted as a Medicaid redetermination in this data and are instead included in the section above regarding CHIP redeterminations. Excluded from these counts are 13,744 redeterminations where the ID was disenrolled due to being aided on another case and/or under another ID or similar reason that would not result in the disenrollment of the individual.

Table: Redetermination in Medicaid

These tables are auto-populated with the data you entered above.

| Type | Number | Percent |
|---|---|---|
| Children screened for redetermination | 642580 | 100% |
| Children retained after redetermination | 619076 | 96.34% |
| Children disenrolled after redetermination | 23053 | 3.59% |

Table: Disenrollment in Medicaid after Redetermination

| Type | Number | Percent |
| --- | --- | --- |
| Children disenrolled after redetermination | 23053 | 100% |
| Children disenrolled for procedural reasons | 1794 | 7.78% |
| Children disenrolled for eligibility reasons | 21027 | 91.21% |
| Children disenrolled for other reasons | 232 | 1.01% |

# Part 5: Tracking a CHIP cohort (Title XXI) over 18 months

Tracking a cohort of children enrolled in CHIP (Title XXI) will indicate how long a specific group of children stays enrolled over an 18-month period. This information is required by Section 402(a) of CHIPRA.

To track your cohort, identify a group of children ages 0 to 16 years who are newly enrolled in CHIP and/or Medicaid as of January through March 2020 (the second quarter of FFY 2020). Children in this cohort must be 16 years and 0 months or younger when they enroll to ensure they don't age out of the program by the end of the 18-month tracking period.

You'll identify a new cohort every two years. This last year you reported on the number of children at the start of the cohort (Jan - Mar 2020) and six months later (July - Sept 2020). This year you'll report on the same cohort at 12 months (Jan - Mar 2021) and 18 months later (July - Sept 2021). If data is unknown or unavailable, leave it blank - don't enter a zero unless the data is known to be zero.

Helpful hints on age groups

Children should be in age groups based on their age at the start of the cohort, when they're identified as newly enrolled in January, February, or March of 2020. For example, if a child is four years old when they're newly enrolled, they should continue to be reported in the "ages 1-5" group at 6 months, 12 months, and 18 months later.

The oldest children in the cohort must be no older than 16 years (and 0 months) to ensure they don't age out of the program at the end of the 18-month tracking period. That means children in the "ages 13-16" group who are newly enrolled in January 2020 must be born after January 2004. Similarly, children who are newly enrolled in February 2020 must be born after February 2004, and children newly enrolled in March 2020 must be born after March 2004.

1.

How does your state define "newly enrolled" for this cohort?

○ Newly enrolled in CHIP: Children in this cohort weren't enrolled in CHIP (Title XXI) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in CHIP in December 2019.

◉ Newly enrolled in CHIP and Medicaid: Children in this cohort weren't enrolled in CHIP (Title XXI) or Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in CHIP or Medicaid in December 2019.

2.

Do you have data for individual age groups?

If not, you'll report the total number for all age groups (0-16 years) instead.

◉ Yes

○ No

January - March 2020 (start of the cohort): included in 2020 report.

You completed this section in your 2020 CARTS Report. Please refer to that report to assist in filling out this section if needed.

3.

How many children were newly enrolled in CHIP between January and March 2020?

| Ages 0-1 | Ages 1-5 | Ages 6-12 | Ages 13-16 |
| --- | --- | --- | --- |
| 343 | 1410 | 2657 | 1043 |

July - September 2020 (6 months later): included in 2020 report.

4.

How many children were continuously enrolled in CHIP six months later?

Only include children that didn't have a break in coverage during the six-month period.

| Ages 0-1 | Ages 1-5 | Ages 6-12 | Ages 13-16 |
| --- | --- | --- | --- |
| 221 | 990 | 2030 | 813 |

5.

How many children had a break in CHIP coverage but were re-enrolled in CHIP six months later?

| Ages 0-1 | Ages 1-5 | Ages 6-12 | Ages 13-16 |
|---|---|---|---|
| 3 | 24 | 41 | 20 |

6.

Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

| Ages 0-1 | Ages 1-5 | Ages 6-12 | Ages 13-16 |
|---|---|---|---|
| 1 | 21 | 36 | 15 |

7.

How many children were no longer enrolled in CHIP six months later?

Possible reasons for no longer being enrolled:b" Transferred to another health insurance program other than CHIPb" Didn't meet eligibility criteria anymoreb" Didn't complete documentationb" Didn't pay a premium or enrollment fee

| Ages 0-1 | Ages 1-5 | Ages 6-12 | Ages 13-16 |
|---|---|---|---|
| 119 | 396 | 586 | 210 |

8.

Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid six months later?

| Ages 0-1 | Ages 1-5 | Ages 6-12 | Ages 13-16 |
| --- | --- | --- | --- |
| 104 | 381 | 560 | 201 |

9. Is there anything else you'd like to add about your data?

January - March 2021 (12 months later): to be completed this year.

This year, please report data about your cohort for this section

10.

How many children were continuously enrolled in CHIP 12 months later?

Only include children that didn't have a break in coverage during the 12-month period.

| Ages 0-1 | Ages 1-5 | Ages 6-12 | Ages 13-16 |
| --- | --- | --- | --- |
| 7 | 22 | 42 | 11 |

11.

How many children had a break in CHIP coverage but were re-enrolled in CHIP 12 months later?

| Ages 0-1 | Ages 1-5 | Ages 6-12 | Ages 13-16 |
|---|---|---|---|
| 120 | 475 | 711 | 248 |

12.

Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

| Ages 0-1 | Ages 1-5 | Ages 6-12 | Ages 13-16 |
|---|---|---|---|
| 120 | 475 | 707 | 246 |

13.

How many children were no longer enrolled in CHIP 12 months later?

Possible reasons for not being enrolled:b" Transferred to another health insurance program other than CHIPb" Didn't meet eligibility criteria anymoreb" Didn't complete documentationb" Didn't pay a premium or enrollment fee

| Ages 0-1 | Ages 1-5 | Ages 6-12 | Ages 13-16 |
|---|---|---|---|
| 216 | 913 | 1904 | 784 |

14.

Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid 12 months later?

| Ages 0-1 | Ages 1-5 | Ages 6-12 | Ages 13-16 |
| --- | --- | --- | --- |
| 201 | 895 | 1875 | 771 |

July - September of 2021 (18 months later): to be completed this year

This year, please report data about your cohort for this section.

15.

How many children were continuously enrolled in CHIP 18 months later?

Only include children that didn't have a break in coverage during the 18-month period.

| Ages 0-1 | Ages 1-5 | Ages 6-12 | Ages 13-16 |
| --- | --- | --- | --- |
| 6 | 20 | 38 | 11 |

16.

How many children had a break in CHIP coverage but were re-enrolled in CHIP 18 months later?

| Ages 0-1 | Ages 1-5 | Ages 6-12 | Ages 13-16 |
|---|---|---|---|
| 155 | 588 | 910 | 339 |

17.

Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

| Ages 0-1 | Ages 1-5 | Ages 6-12 | Ages 13-16 |
|---|---|---|---|
| 155 | 586 | 904 | 333 |

18.

How many children were no longer enrolled in CHIP 18 months later?

Possible reasons for not being enrolled:b" Transferred to another health insurance program other than CHIPb" Didn't meet eligibility criteria anymoreb" Didn't complete documentationb" Didn't pay a premium or enrollment fee

| Ages 0-1 | Ages 1-5 | Ages 6-12 | Ages 13-16 |
|---|---|---|---|
| 182 | 802 | 1709 | 693 |

19.

Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid 18 months later?

| Ages 0-1 | Ages 1-5 | Ages 6-12 | Ages 13-16 |
| --- | --- | --- | --- |
| 167 | 787 | 1684 | 684 |

20. Is there anything else you'd like to add about your data?

## Part 6: Tracking a Medicaid (Title XIX) cohort over 18 months

Tracking a cohort of children enrolled in Medicaid (Title XIX) will indicate how long a specific group of children stays enrolled over an 18-month period. This information is required by Section 402(a) of CHIPRA.

To track your cohort, identify a group of children ages 0 to 16 years, who are newly enrolled in Medicaid and/or CHIP as of January through March 2020 (the second quarter of FFY 2020). Children in this cohort must be 16 years and 0 months or younger when they enroll to ensure they don't age out of the program by the end of the 18-month tracking period.

You'll identify a new cohort every two years. This last year you reported the number of children identified at the start of the cohort (Jan-Mar 2020) and six months later (July-Sept 2020). This year you'll report numbers for the same cohort at 12 months (Jan-Mar 2021) and 18 months later (July-Sept 2021). If data is unknown or unavailable, leave it blank - don't enter a zero unless the data is known to be zero.

Helpful hints on age groups

Children should be in age groups based on their age at the start of the cohort, when they're identified as newly enrolled in January, February, or March of 2021. For example, if a child is four years old when they're newly enrolled, they should continue to be reported in the "ages 1-5" group at 6 months, 12 months, and 18 months later.

The oldest children in the cohort must be no older than 16 years (and 0 months) to ensure they don't age out of the program at the end of the 18-month tracking period. That means children in the "ages 13-16" group who are newly enrolled in January 2021 must be born after January 2004. Similarly, children who are newly enrolled in February 2021 must be born after February 2004, and children newly enrolled in March 2021 must be born after March 2004.

1.

How does your state define "newly enrolled" for this cohort?

○ Newly enrolled in Medicaid: Children in this cohort weren't enrolled in Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in Medicaid in December 2019.

◉ Newly enrolled in CHIP and Medicaid: Children in this cohort weren't enrolled in CHIP (Title XXI) or Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in CHIP or Medicaid in December 2019.

2.

Do you have data for individual age groups?

If not, you'll report the total number for all age groups (0-16 years) instead.

◉ Yes

○ No

January - March 2020 (start of the cohort): included in 2020 report

You completed this section in your 2020 CARTS Report. Please refer to that report to assist in filling out this section if needed.

3.

How many children were newly enrolled in Medicaid between January and March 2020?

| Ages 0-1 | Ages 1-5 | Ages 6-12 | Ages 13-16 |
| --- | --- | --- | --- |
| 16116 | 11466 | 10613 | 4116 |

July - September 2020 (6 months later): included in 2020 report

You completed this section in your 2020 CARTS report. Please refer to that report to assist in filling out this section if needed.

4.

How many children were continuously enrolled in Medicaid six months later?

Only include children that didn't have a break in coverage during the six-month period.

| Ages 0-1 | Ages 1-5 | Ages 6-12 | Ages 13-16 |
| --- | --- | --- | --- |
| 15257 | 10185 | 9323 | 3621 |

5.

How many children had a break in Medicaid coverage but were re-enrolled in Medicaid six months later?

| Ages 0-1 | Ages 1-5 | Ages 6-12 | Ages 13-16 |
| --- | --- | --- | --- |
| 139 | 219 | 174 | 59 |

6.

Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

| Ages 0-1 | Ages 1-5 | Ages 6-12 | Ages 13-16 |
| --- | --- | --- | --- |
| 22 | 35 | 46 | 12 |

7.

How many children were no longer enrolled in Medicaid six months later?

Possible reasons for no longer being enrolled:b" Transferred to another health insurance program other than Medicaidb" Didn't meet eligibility criteria anymoreb" Didn't complete documentationb" Didn't pay a premium or enrollment fee

| Ages 0-1 | Ages 1-5 | Ages 6-12 | Ages 13-16 |
| --- | --- | --- | --- |
| 720 | 1062 | 1116 | 436 |

8.

Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP six months later?

| Ages 0-1 | Ages 1-5 | Ages 6-12 | Ages 13-16 |
| --- | --- | --- | --- |
| 50 | 174 | 338 | 117 |

9. Is there anything else you'd like to add about your data?

January - March 2021 (12 months later): to be completed this year

This year, please report data about your cohort for this section.

10.

How many children were continuously enrolled in Medicaid 12 months later?

Only include children that didn't have a break in coverage during the 12-month period.

| Ages 0-1 | Ages 1-5 | Ages 6-12 | Ages 13-16 |
| --- | --- | --- | --- |
| 14741 | 9553 | 8761 | 3361 |

11.

How many children had a break in Medicaid coverage but were re-enrolled in Medicaid 12 months later?

| Ages 0-1 | Ages 1-5 | Ages 6-12 | Ages 13-16 |
| --- | --- | --- | --- |
| 247 | 413 | 351 | 120 |

12.

Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

| Ages 0-1 | Ages 1-5 | Ages 6-12 | Ages 13-16 |
| --- | --- | --- | --- |
| 39 | 78 | 98 | 27 |

13.

How many children were no longer enrolled in Medicaid 12 months later?

Possible reasons for not being enrolled:b" Transferred to another health insurance program other than Medicaidb" Didn't meet eligibility criteria anymoreb" Didn't complete documentationb" Didn't pay a premium or enrollment fee

| Ages 0-1 | Ages 1-5 | Ages 6-12 | Ages 13-16 |
| --- | --- | --- | --- |
| 1128 | 1500 | 1501 | 635 |

14.

Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP 12 months later?

| Ages 0-1 | Ages 1-5 | Ages 6-12 | Ages 13-16 |
| --- | --- | --- | --- |
| 64 | 279 | 451 | 173 |

July - September of 2021 (18 months later): to be completed next year

This year, please report data about your cohort for this section.

15.

How many children were continuously enrolled in Medicaid 18 months later?

Only include children that didn't have a break in coverage during the 18-month period.

| Ages 0-1 | Ages 1-5 | Ages 6-12 | Ages 13-16 |
| --- | --- | --- | --- |
| 13753 | 8706 | 7836 | 2973 |

16.

How many children had a break in Medicaid coverage but were re-enrolled in Medicaid 18 months later?

| Ages 0-1 | Ages 1-5 | Ages 6-12 | Ages 13-16 |
|---|---|---|---|
| 394 | 630 | 597 | 243 |

17.

Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

| Ages 0-1 | Ages 1-5 | Ages 6-12 | Ages 13-16 |
|---|---|---|---|
| 105 | 177 | 263 | 97 |

18.

How many children were no longer enrolled in Medicaid 18 months later?

Possible reasons for not being enrolled:b" Transferred to another health insurance program other than Medicaidb" Didn't meet eligibility criteria anymoreb" Didn't complete documentationb" Didn't pay a premium or enrollment fee

| Ages 0-1 | Ages 1-5 | Ages 6-12 | Ages 13-16 |
|---|---|---|---|
| 1969 | 2130 | 2180 | 900 |

19.

Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP 18 months later?

| Ages 0-1 | Ages 1-5 | Ages 6-12 | Ages 13-16 |
| --- | --- | --- | --- |
| 508 | 556 | 841 | 335 |

20. Is there anything else you'd like to add about your data?

# Eligibility, Enrollment, and Operations

## Cost Sharing (Out-of-Pocket Costs)

States can choose whether or not to require cost sharing in their CHIP program. Cost sharing includes payments such as enrollment fees, premiums, deductibles, coinsurance, and copayments.

# Eligibility, Enrollment, and Operations

## Employer Sponsored Insurance and Premium Assistance

States with a premium assistance program can use CHIP funds to purchase coverage through employer sponsored insurance (ESI) on behalf of eligible children and parents.

1.

Does your state offer ESI including a premium assistance program under the CHIP State Plan or a Section 1115 Title XXI demonstration?

- [ ] Yes
- [x] No

# Eligibility, Enrollment, and Operations

## Program Integrity

# Eligibility, Enrollment, and Operations

## Dental Benefits

# Eligibility, Enrollment, and Operations

## CAHPS Survey Results

Children's Health Insurance Program Reauthorization Act (CHIPRA) requires that all CHIP programs submit survey results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS). The survey assesses your CHIP program quality and customer satisfaction. For the 2021 CARTS report, we highly encourage states to report all raw CAHPS data to the Agency for Healthcare Research and Quality (AHRQ) CAHPS Database instead of reporting a summary of the data via CARTS. For 2022, the only option for reporting CAHPS results will be through the submission of raw data to

ARHQ.

1.

Did you collect the CAHPS survey?

(•) Yes

( ) No

## Part 2: You collected the CAHPS survey

Since you collected the CAHPS survey, please complete Part 2.

1.

Upload a summary report of your CAHPS survey results.

This is optional if you already submitted CAHPS raw data to the AHRQ CAHPS database. Submit results only for the CHIP population, not for both Medicaid (Title XIX) and CHIP (Title XXI) together. Your data should represent children enrolled in all types of delivery systems (Managed Care, PCCM, and Fee for Service).

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

Browse...

2.

Which CHIP population did you survey?

- [x] Medicaid Expansion CHIP
- [ ] Separate CHIP
- [ ] Both Separate CHIP and Medicaid Expansion CHIP
- [ ] Other

3.

Which version of the CAHPS survey did you use?

- [ ] CAHPS 5.0
- [x] CAHPS 5.0H
- [ ] Other

4.

Which supplemental item sets did you include in your survey?

Select all that apply.

- [ ] None
- [x] Children with Chronic Conditions
- [ ] Other

5.

Which administrative protocol did you use to administer the survey?

Select all that apply.

- [x] NCQA HEDIS CAHPS 5.0H
- [ ] HRQ CAHPS
- [ ] Other

6. Is there anything else you'd like to add about your CAHPS survey results?

## Part 3: You didn't collect the CAHPS survey

# Eligibility, Enrollment, and Operations

## Health Services Initiative (HSI) Programs

All states with approved HSI program(s) should complete this section.States can use up to 10% of their fiscal year allotment to develop Health Services Initiatives (HSI) that provide direct services and other public health initiatives for low-income children. [See Section 2105(a)(1)(D)(ii) of the Social Security Act.] States can only develop HSI programs after funding other costs to administer their CHIP State Plan, as defined in regulations at 42 CFR 457.10.

1.

Does your state operate Health Service Initiatives using CHIP (Title XXI) funds?

Even if you're not currently operating the HSI program, if it's in your current approved CHIP State Plan, please answer "yes."

- [x] Yes
- [ ] No

Tell us about your HSI program(s).

1. What is the name of your HSI program?

Lead Abatement

2.

Are you currently operating the HSI program, or plan to in the future?

- (•) Yes
- ( ) No

3. Which populations does the HSI program serve?

Ohio Medicaid children under the age of 19 and pregnant women

4.

How many children do you estimate are being served by the HSI program?

76392

5.

How many children in the HSI program are below your state's FPL threshold?

65353

**Computed:** 85.55%

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

7. What outcomes have you found when measuring the impact?

8. Is there anything else you'd like to add about this HSI program?

9.

Optional: Attach any additional documents.

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

Browse...

## Do you have another in this list?

Optional

# State Plan Goals and Objectives

# Part 1: Tell us about your goals and objectives

Tell us about the progress you've made on your performance goals in the past year. The objectives and goals you add to this section should match those reflected in your CHIP State Plan, Section 9. Submit a CHIP State Plan Amendment (SPA) if any of them

are different. Objective 1 is required. We've provided examples for other objectives, but you can edit them so they match the objectives in your CHIP State Plan. You can add additional objectives and goals to fit what's in your CHIP State Plan.

1. Briefly describe your goal for this objective.

For example: In an effort to reduce the number of uninsured children, our goal is to enroll 90% of eligible children in the CHIP program.

In an effort to reduce the number of uninsured children in the state, our goal is to reduce the disenrollment of children due to administrative or procedural reasons. In this way, we expect to maintain coverage for children who would otherwise be disenrolled for reasons not directly related to their eligibility.

2.

What type of goal is it?

- (•) New goal
- ( ) Continuing goal
- ( ) Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children enrolled in CHIP in the last federal fiscal year.

The number of children disenrolled from CHIP during the last federal fiscal year due to administrative/procedural reasons, such as failure to verify income.

4.

Numerator (total number)

297

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of eligible children in the last federal fiscal year.

The number of children disenrolled from CHIP during the last federal fiscal year for any reason.

6.

Denominator (total number)

6883

**Computed:** 4.31%

7.

What is the date range of your data?

## Start

mm/yyyy

10 / 2020

## End

mm/yyyy

09 / 2021

8.

Which data source did you use?

- (•) Eligibility or enrollment data
- ( ) Survey data
- ( ) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

This is the first time we are reporting these figures.

10. What are you doing to continually make progress towards your goal?

Due to the PHE preventing most administrative disenrollments, we do not expect to significantly improve the rate for this measure for several years. However, we have already developed and routinely utilize a dashboard to monitor children's disenrollment and churn patterns over time and location. We are also developing predictive capabilities that will support the early identification of eligible children who are likely to drop eligibility due to missed procedural deadlines or lacking information.

11. Anything else you'd like to tell us about this goal?

We will continue to pursue and report this goal. However, we do not expect that the data from this year or next will function as reasonable benchmarks due to the Covid-19 related moratorium on most disenrollments and the subsequent unwinding. We expect that data from FFY 2023 will become our baseline and reasonable targets can be set thereafter.

12.

Do you have any supporting documentation?

Optional

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

Browse...

1. Briefly describe your goal for this objective.

For example: In an effort to reduce the number of uninsured children, our goal is to enroll 90% of eligible children in the CHIP program.

2.

What type of goal is it?

- ◯ New goal
- ◯ Continuing goal
- ◯ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children enrolled in CHIP in the last federal fiscal year.

4.

Numerator (total number)

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of eligible children in the last federal fiscal year.

6.

Denominator (total number)

**Computed:**

7.

What is the date range of your data?

## Start

mm/yyyy

/

## End

mm/yyyy

/

8.

Which data source did you use?

- ◯ Eligibility or enrollment data
- ◯ Survey data
- ◯ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

10. What are you doing to continually make progress towards your goal?

11. Anything else you'd like to tell us about this goal?

12.

Do you have any supporting documentation?

Optional

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

Browse...

## Do you have another in this list?

Optional

1. What is the next objective listed in your CHIP State Plan?

You can edit the suggested objective so it matches what's in your CHIP State Plan.

Well-Child Visits in the First 15 Months of Life - 6 or More Visits

1. Briefly describe your goal for this objective.

For example: In an effort to increase access to care, our goal is to increase the number of children who have visited a primary care physician by 5%.

Ohio's goal is to meet or exceed the NCQA Medicaid Self-Audited National 25th HEDIS Percentile for this measure.

2.

What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children enrolled in CHIP who visited a primary care physician in the last federal fiscal year.

The number of children who turned 15 months old during the measurement year and had 6 or more well-child visits with a primary care physician during their first 15 months of life.

4.

Numerator (total number)

31393

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children enrolled in CHIP in the last federal fiscal year.

Denominator includes CHIP and Medicaid (Title XIX). Children turning 15 months of age during the measurement year (CY 2020).

6.

Denominator (total number)

55437

**Computed:** 56.63%

7.

What is the date range of your data?

## Start

mm/yyyy

01 / 2020

## End

mm/yyyy

12 / 2020

8.

Which data source did you use?

- ( ) Eligibility or enrollment data
- ( ) Survey data
- (•) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The FFY2021 rate (56.63%) exceeds the CY 2020 National 25th HEDIS Percentile (44.99%).

10. What are you doing to continually make progress towards your goal?

ODM enhanced its Comprehensive Primary Care program to focus on Medicaid children called Comprehensive Primary Care for Kids (CPC Kids). This program emphasizes preventative care, including quality metrics such as well-checks, lead testing and immunizations. FFY 2021 (CY 2020) was the initial year for CPC Kids and ODM expects the program to continue to have a positive impact on the access to well-care for children and to drive improvement in the Well-Care visit measure rates.

11. Anything else you'd like to tell us about this goal?

Note: The data source used for this goal is self-reported, audited HEDIS data for measurement year 2020 for the five Ohio Medicaid managed care plans (MCP). The numerator and denominator are the totals reported for the five MCPs'. The reported rate (see #10 above) is the total numerator divided by the total denominator.

12.

Do you have any supporting documentation?

Optional

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

Browse...

## Do you have another in this list?

Optional

1. What is the next objective listed in your CHIP State Plan?

You can edit the suggested objective to match what's in your CHIP State Plan.

Well-Child Visits for Age 15 Months to 30 Months (2 or more visits)

1. Briefly describe your goal for this objective.

For example: In an effort to increase the use of preventative care, our goal is to increase the number of children who receive one or more well child visits by 5%.

Ohio's goal is to meet or exceed the NCQA Medicaid Self-Audited National 25th HEDIS Percentile for this measure.

2.

What type of goal is it?

- (•) New goal
- ( ) Continuing goal
- ( ) Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children who received one or more well child visits in the last federal fiscal year.

The number of children who turned 30 months old during the measurement year and had 2 or more well-child visits with a primary care physician between the child's 15-month birthday and the 30-month birthday.

4.

Numerator (total number)

32584

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children enrolled in CHIP in the last federal fiscal year.

Denominator includes CHIP and Medicaid (Title XIX). Children turning 30 months of age during the measurement year (CY 2020).

6.

Denominator (total number)

49141

**Computed:** 66.31%

7.

What is the date range of your data?

## Start

mm/yyyy

01 / 2020

## End

mm/yyyy

12 / 2020

8.

Which data source did you use?

- ○ Eligibility or enrollment data
- ○ Survey data
- ◉ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The FFY2021 rate (66.31%) was slightly less than the CY 2020 National 25th HEDIS Percentile (66.43%).

10. What are you doing to continually make progress towards your goal?

ODM enhanced its Comprehensive Primary Care program to focus on Medicaid children called Comprehensive Primary Care for Kids (CPC Kids). This program emphasizes preventative care, including quality metrics such as well-checks, lead testing and immunizations. FFY 2021 (CY 2020) was the initial year for CPC Kids and ODM expects the program to continue to have a positive impact on the access to well-care for children and to drive improvement in the Well-Care visit measure rates.

11. Anything else you'd like to tell us about this goal?

The data source used for this goal is self-reported, audited HEDIS data for measurement year 2020 for the five Ohio Medicaid managed care plans (MCP). The numerator and denominator are the totals reported for the five MCPs'. The reported rate (see #9 above) is the total numerator divided by the total denominator.

12.

Do you have any supporting documentation?

Optional

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

Browse...

1. Briefly describe your goal for this objective.

For example: In an effort to increase the use of preventative care, our goal is to increase the number of children who receive one or more well child visits by 5%.

2.

What type of goal is it?

- New goal
- Continuing goal
- Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children who received one or more well child visits in the last federal fiscal year.

4.

Numerator (total number)

0

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children enrolled in CHIP in the last federal fiscal year.

6.

Denominator (total number)

0

**Computed:**

7.

What is the date range of your data?

**Start**

mm/yyyy

01 / 2021

**End**

mm/yyyy

12 / 2021

8.

Which data source did you use?

- ○ Eligibility or enrollment data
- ○ Survey data
- ○ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

10. What are you doing to continually make progress towards your goal?

11. Anything else you'd like to tell us about this goal?

12.

Do you have any supporting documentation?

Optional

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

Browse...

## Do you have another in this list?

Optional

1. What is the next objective listed in your CHIP State Plan?

Child & Adolescent Well-Care Visits (at least one visit per year) for ages 3 to 11, 12 to 17, and 18 to 21

1. Briefly describe your goal for this objective.

Ohio's goal is to meet or exceed the NCQA Medicaid Self-Audited National 25th HEDIS Percentile for this measure, by age group.

2.

What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

The number of children age 3 to 21 as of December 31, 2020 who had at least one visit with a primary care physician during the measurement year (CY 2020).

4.

Numerator (total number)

414512

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

Children and adolescents age 3 to 21 as of December 31st of the measurement year (CY 2020).

6.

Denominator (total number)

930509

**Computed:** 44.55%

7.

What is the date range of your data?

## Start

mm/yyyy

01 / 2020

## End

mm/yyyy

12 / 2020

8.

Which data source did you use?

- [ ] Eligibility or enrollment data
- [ ] Survey data
- [x] Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

This is the initial year for reporting these measures. Please refer to Part 2: Additional questions. For the 3 to 11 age group, the FFY2021 rate (49.89%) exceeded the CY 2020 National 25th HEDIS Percentile (45.60%). For the 12 to 17 age group, the FFY2021 rate (45.19%) exceeded the CY 2020 National 50th HEDIS Percentile (39.15%). For the 18 to 21 age group, the FFY2021 rate (24.02%) exceeded the CY 2020 National 25th HEDIS Percentile (19.02%). For the combined 3 to 21 age group, the FFY2021 rate (44.55%) exceeded the CY 2020 National 25th HEDIS Percentile (39.41%).

10. What are you doing to continually make progress towards your goal?

ODM enhanced its Comprehensive Primary Care program to focus on Medicaid children called Comprehensive Primary Care for Kids (CPC Kids), or children and adolescents under the age of 21. This program emphasizes preventative care, including quality metrics such as well-checks, lead testing and immunizations. FFY 2021 (CY 2020) was the initial year for CPC Kids and ODM expects the program to continue to have a positive impact on the access to well-care for children and to drive improvement in the Well-Care visit measure rates.

11. Anything else you'd like to tell us about this goal?

The data source used for this goal is self-reported, audited HEDIS data for measurement year 2020 for the five Ohio Medicaid managed care plans (MCP). The numerator and denominator are the totals reported for the five MCPs'. The reported rate (see #10 above) is the total numerator divided by the total denominator.

12.

Do you have any supporting documentation?

Optional

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

Browse...

## Do you have another in this list?

Optional

1. What is the next objective listed in your CHIP State Plan?

1. Briefly describe your goal for this objective.

2.

What type of goal is it?

- ◯ New goal
- ◯ Continuing goal
- ◯ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

4.

Numerator (total number)

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

6.

Denominator (total number)

**Computed:**

7.

What is the date range of your data?

## Start

mm/yyyy

01 / 2021

## End

mm/yyyy

12 / 2021

8.

Which data source did you use?

- ◯ Eligibility or enrollment data
- ◯ Survey data
- ◯ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

10. What are you doing to continually make progress towards your goal?

11. Anything else you'd like to tell us about this goal?

12.

Do you have any supporting documentation?

Optional

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

Browse...

## Do you have another in this list?

Optional

1. What is the next objective listed in your CHIP State Plan?

1. Briefly describe your goal for this objective.

2.

What type of goal is it?

- New goal
- Continuing goal
- Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

4.

Numerator (total number)

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of eligible children in the last federal fiscal year.

6.

Denominator (total number)

**Computed:**

7.

What is the date range of your data?

## Start

mm/yyyy

01 / 2021

## End

mm/yyyy

12 / 2021

8.

Which data source did you use?

- ○ Eligibility or enrollment data
- ○ Survey data
- ○ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

10. What are you doing to continually make progress towards your goal?

11. Anything else you'd like to tell us about this goal?

12.

Do you have any supporting documentation?

Optional

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

Browse...

## Do you have another in this list?

Optional

## Do you have another objective in your State Plan?

Optional

# Part 2: Additional questions

1. Do you have other strategies for measuring and reporting on your performance goals? What are these strategies, and what information have you found through this research?

1. Introduction Ohio is poised to improve health outcomes for people enrolled in Medicaid through its Next Generation of Managed Care program, which focuses on doing better for the individuals we serve and leverages comprehensive managed care plans (MCPs), a new OhioRISE prepaid inpatient health plan that will specialize in improving outcomes for a targeted group of children and youth who have the most complex behavioral health needs, and a prepaid ambulatory health plan that will serve as a Single Pharmacy Benefit Manager (SPBM). Collectively, ODM refers to these three types of managed care partners as our Managed Care Entities (MCEs). ODM's new contracts with the MCEs outline overhauled goals and methods for improving quality and population health by leveraging collective impact improvement efforts across all MCEs. Key requirements for all future MCEs in this area include developing new capabilities in quality improvement and implementation science, working collectively to improve quality and population health goals in a cooperative manner, and supporting rapid cycle bi-directional feedback at the individual member and provider level to improve their experiences of care. The new MCEs will welcome a broader team of contributors to their population health and quality improvement efforts through member/family and provider advisory councils, and they will develop relationships with community partners to reinvest a set amount of their profits back into the organizations that are best trusted by people enrolled in Medicaid. These requirements go beyond the mere compliance of a standard; they demand a shift in the mindset and consistently reinforced behaviors that define a culture of care. In addition to taking a new collective approach to improving health outcomes across MCEs, ODM will also continue many of its existing innovation efforts. Key elements of new and existing improvement efforts are outlined below. 2. Value-Based Purchasing (VBP) a. VBP in ODM's Next Generation of Managed Care ODM's vision for Next Generation Managed Care includes a focus on VBP efforts. Ohio Medicaid's MCPs and the OhioRISE plan will design and implement VBP initiatives with the goals of: b" Improving individual and population health outcomes. b" Improving member experience. b" Improving provider experience by aligning with other payers and decreasing provider burden where possible. b" Containing the cost of healthcare expenditures by rewarding the quality of services over quantity. VBP efforts provide a unique opportunity to enhance population health and wellness

outcomes for members by providing opportunities for practice transformation and flexibilities for provider networks. MCPs and the OhioRISE plan will set clear population health and system performance goals, design contracting and payment methodologies to enhance competition among providers, cut waste, and improve quality in ways that are sustainable and transparent. MCPs and the OhioRISE plan will work in tandem with providers to provide relevant actionable cost and quality data. Starting in 2023, ODM will require the comprehensive managed care plans to make a certain percentage of their total payments through value-based arrangements that offer shared savings or shared savings and downside risk. The percentage of payments will increase each year. Ohio's commitment to VBP builds on a foundation established with innovative VBP programs described below. b. Comprehensive Primary Care (CPC) and CPC Kids Programs Ohio CPC is an investment in Ohio's primary care infrastructure that is accompanied by a financing methodology intended to support improved population health outcomes by attributing members to specific providers. This process allows every Medicaid member to participate in population health improvement even if the individual does not actively seek care. CPC is anchored in team-based care with transparency in healthcare data that creates population risk-tiering to guide more effective, holistic care. In addition to the traditional fee-for-service (FFS) payment structure, practices are paid a tiered per-member-per-month (PMPM) for a cluster of activities associated with ideal care and for meeting both efficiency and quality metric targets. Some of these activities include risk stratification, team-based care, closed loop referrals, and effective family councils. Using Ohio CPC as a foundation, Ohio launched CPC Kids in 2020 to focus on children's outcomes and close equity gaps for children statewide. In FFY21, 936,160 children, 74% of the total number of children with Medicaid coverage in Ohio, were attributed to CPC for Kids practices. CPC for Kids practices received quarterly reports for their attributed patients showing their performance on metrics measuring well checks, screenings, and immunizations. These reports are intended to help practices close gaps in care, especially those due to the pandemic. Preliminary report results for performance year 2021 indicate that practices have largely succeeded in ensuring critical preventive care services such as well checks and immunizations for children have been performed despite the challenges presented by COVID-19. CPC for Kids also has encouraged practices to strengthen and expand the ways in which their pediatric patients are supported by incentivizing bonus activities and offering technical support from ODM's external quality review organization. Population health activities encouraged through additional incentives include foster care

supports, behavioral health linkages, school-based health care, transitions of care, and performance on informational metrics such as adolescent tobacco cessation and fluoride varnish application. All of these areas are identified as gaps in ideal performance. Every single child counts. c. Care Innovation and Community Improvement Program (CICIP) The CICIP program was implemented beginning in SFY 2019 to rethink care within health systems and bring person-centered focus to prevention and more effective treatment for opioid use disorder, with an emphasis in improved care for the maternity and frequent emergency department populations affected by opioid use disorder. The four health systems are large Medicaid safety-net and academic medical centers that worked together to develop strategies to optimize care by creating data dashboards to track progress along agreed-upon measures and sharing lessons learned. The systems continue to leverage their electronic health records to bring different parts of the health system together, creating alerts and engaging patients in new ways, often utilizing a more diverse and community-anchored workforce. In addition, the systems have accelerated sharing clinical and quality improvement expertise and are organizing for collective impact by adopting innovative practices from each other. Key focus areas under design include dyad care for high-risk mothers and babies and integrating behavioral health into physical health settings and vice versa. 3. Current Quality Measurement Strategies with MCPs Ohio's current work to promote evidence-based prevention and treatment practices at the clinical practice level continues to focus on the performance of our five contracted MCPs, which serve the majority of the SCHIP population. Given that most children eligible for Medicaid in Ohio are enrolled in an MCP, all the MCPs are expected to participate in the state's efforts to meet the associated requirements and outcomes established in the Ohio Medicaid Quality Strategy. Current MCP performance is evaluated through a system of: b" internal compliance reviews, b" monitoring in key areas (e.g., clinical quality, access, consumer satisfaction), b" self-evaluations submitted as part of the annual Quality Assessment and Performance Improvement (QAPI) submission, and b" independent reviews by an external quality review organization (EQRO). Financial penalties and incentives are used for both program compliance and continuous performance improvement. The key quality-related performance areas to which MCPs are held accountable include clinical quality measures as well as consumer and provider satisfaction ratings. Thresholds are set for clinical performance measures, and plans are held accountable in both incentive and penalty programs. These programs include Clinical Quality Measures Financial Penalties (CQMFP) and Quality-Based

Assignments (QBA). Key results of the CQMs and consumer surveys include: a. Healthcare Effectiveness Data and Information Set (HEDIS) Clinical Performance Measures HEDIS measures that are specific to primary care, well-care, and behavioral health for children and adolescents are used to monitor and evaluate MCP performance. Financial penalties are applied to measure results that do not meet minimum performance thresholds and are designed to ramp up over a period of time. Well-Care: For children in the first 15 months of life, 56.6% received six or more comprehensive well-care visits, and 66.3% of children ages 15 to 30 months received two or more comprehensive well-care visits in FFY 2021. The percentage of children and adolescents who received at least one comprehensive well-care visit in FFY 2021 was 49.9% for children ages 3 to 11, 45.2% for adolescents ages 12 to 17, and 24.0% for older adolescents ages 18 to 21. The total rate for children and adolescents ages 3 to 21 was 44.6% for FFY 2021. Due to significant changes to the FFY 2021 (MY 2020) methodology for the "first 15 months of life" measure, rates cannot be trended for comparison with prior FFY rates. Similarly, for the FFY 2021(MY 2020) "child and adolescent" well-care visits measures, the measure methodologies were revised and replace the former "Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life" and "Adolescent Well-Care Visits" HEDIS measures; rates for these measures also cannot be trended for comparison with prior FFY rates. The "15 to 30 months of age" well-care visit measure is new for FFY 2021 (MY 2020). In comparison to national Medicaid benchmarks, the FFY 2021 rates for the children in the first 15 months of life and the children ages 12 to 17 both exceeded the national Medicaid 50th percentile benchmark. Rates for children ages 3 to 11, older adolescents ages 18 to 21, and the total for ages 3 to 21 all exceeded the national Medicaid 25th percentile benchmark. The FFY 2021 rate for the 15 to 30 months of age group was 66.3% compared to the national Medicaid 25th percentile benchmark of 66.4%. Behavioral Health: Behavioral health measures for children and adolescents on antipsychotics focused on psychosocial services. Use of psychosocial care for children and adolescents on antipsychotics, ages 1 to 17 years, decreased slightly from 81.3% in FFY 2020 to 79% in FFY 2021. In comparison to national Medicaid benchmarks, the FFY 2021 rate of 79% exceeded the national Medicaid 75th percentile benchmark. It should be noted that the national Medicaid 75th percentile benchmark also decreased from 72.5% for FFY 2020 (MY 2019) to 69.5% for FFY 2021 (MY 2020). b. Consumer Assessment of Healthcare Providers and Systems (CAHPS) Annual CAHPS surveys are used to collect information on members' experiences with their health plans' care and services. Survey results are

used to evaluate MCP performance, identify opportunities for quality improvement, aid consumers in plan selection, and increase program transparency through public reporting. From 2020 to 2021, mean scores for the Ohio Medicaid general child population improved for three of the nine core survey measures: Rating of Personal Doctor, Rating of Specialist Seen Most Often, and Getting Needed Care. Although mean scores decreased for six of the nine measures, for two measures (Getting Care Quickly and How Well Doctors Communicate), the mean scores remain in the 75th to 89th percentile. Compared to 2020 national Medicaid percentiles, the Ohio Medicaid managed care program's performance for the general child population was good to excellent for six of the nine core survey measures. Areas of high performance include: Getting Needed Care, which ranked above the 90th percentile, as well as Getting Care Quickly and How Well Doctors Communicate, which both ranked above the 75th percentile. Rating of Personal Doctor, Rating of Specialist Seen Most Often, and Customer Service ranked in the 50th to 74th percentile. The mean scores for the Rating of Health Plan, Rating of All Health Care, Customer Service, and Coordination of Care measures were between the 25th and 49th percentiles, indicating opportunity for improvement in performance.

2. Do you plan to add new strategies for measuring and reporting on your goals and objectives? What do you plan to do, and when will this data become available?

1. The Maternal and Infant Support Program In 2021, Ohio began to implement its Maternal and Infant Support Program (MISP), which focuses on providing services and strategies to advance the goals of reducing and eliminating racial disparities in maternal and infant outcomes and reducing infant mortality. Through the MISP, Ohio Medicaid is supporting perinatal and infant care through clinical interventions, evidence-based and evidence-informed community-based services, and by creating a space for improved cultural competencies and individually configured services. Personalized care gives families the clinical and community supports they need to improve outcomes while helping them build a longitudinal trusting relationship with the healthcare system. The MISP uses an electronic Pregnancy Risk Assessment Form (PRAF) as a cornerstone to link women to clinical and community-based care. Effective January 2022, ODM is making several changes to offer pregnant women additional services and supports: b" updated lactation consulting provider requirements to expand access to breastfeeding resources and services. b" updated group prenatal care reimbursement to provide additional reimbursement for innovative approaches to evidence-based group pregnancy education. b" new coverage of evidence-based home visiting provided by nurses in a manner that is consistent with the Nurse Family Partnership model of home visiting. In April 2022, ODM plans to extend Medicaid eligibility for pregnant and postpartum women from the end of the month of the 60th day postpartum to the end of the 12th month postpartum for all women. Extending eligibility for a full year postpartum ensures women have access to critical services that impact maternal morbidity and mortality as well as infant health, including treatment for postpartum depression, medical care for chronic conditions such as cardiovascular disease, breastfeeding resources, family planning resources, and continued evidence-based home visiting. Throughout 2022, ODM will meet with stakeholders to develop a framework for additional maternal and infant supports, including doula services, comprehensive maternal care, postpartum home visits, and concurrent care for moms and babies affected by substance use disorders. 2. ODM Infant Mortality Community Partnership ODM and Medicaid's managed care organizations established the Community Infant Mortality Partnership with community-based organizations in Ohio's nine counties with the highest infant mortality disparities. This partnership's purpose is to activate communities to address the racial disparities and social determinants of health and isolation that

negatively impact this critical period of life. In SFY 2020-2021, MCOs awarded over $25 million to 121 community-based organizations to focus on key evidence-based interventions including prenatal care (group education formal and informal), home visiting (e.g., Nursing Family Partnership), and utilization of community health workers independently and through Pathways Hub model. In addition, a variety of other interventions were funded including doulas, peer-to-peer support, women's neighborhood advisory groups, support groups, breastfeeding support, fatherhood initiatives, and centralized intake/care connectors. To date, 35,000+ women and their families have received support and services through this partnership. Community-based organizations have activated communities/ neighborhoods and report different improvements, including improved connectivity and trust among women, improved breastfeeding rates, and reduced preterm births. ODM also has hosted focus groups to listen to the voices of women in their pregnancy and postpartum experiences. Women in the Medicaid program expressed distrust in the health systems citing lack of provider empathy and inadequate communication. They also expressed a lack of social supports, community resources, and routine coverage of community services such as doulas and lactation nurses. These are all being taken into consideration as ODM implements strategies to continuously improve maternal and infant outcomes. While some efforts to improve pre-term birth rates are anchored in Ohio's health systems, there is growing awareness of the importance of the social factors or determinants that contribute to poor birth outcomes. As such, ODM and the MCOs continue to support community infant mortality grants that attempt to scale community-based work that may garner more trust for the culturally appropriate social and emotional support that families require given the extra stressors of pregnancy. Most of the communities have chosen to support evidence-based home visit programs, group prenatal care efforts, and the use of community health workers. This community initiative also welcomes innovation from doulas, fatherhood groups, and others committed to the care of mothers and infants. Based on the experiences and learnings from the MCOs' community-based infant mortality reduction grant efforts, as well as the feedback provided to ODM in the focus groups referenced above, the Department of Medicaid began implementing new statewide benefits and enhanced coverage for additional perinatal supports through its MISP, which is outlined in detail in the previous section. 3. 2020 Quality Withhold Program ODM adopted a population health approach aimed at improving the health of the entire population by understanding the distribution of health factors within a community. This approach enables the agency to more

effectively identify and reduce health inequities, gain insights into a broad range of factors that influence health, and to strengthen focus on the individual. Three population health initiatives impacting children were launched during the pandemic. Each is designed to address the pandemic's impact on MCP members, address unintended consequences of COVID-19 prevention protocols, and leverage newly enacted telehealth expansions to extend access to care to small community and rural healthcare providers. Three strategic solutions were launched to close the gap in childhood immunizations. These initiatives included: b" Increased mobile immunization capabilities. Providers with mobile care units (e.g., hospital systems and health departments) worked with Medicaid and the MCPs to orchestrate immunization events in neighborhoods where a high percentage of children covered by Medicaid needed vaccinations. b" Provided outreach and scheduling support to Vaccines for Children (VFC) program providers for immunizations. Practice-identified children with vaccine gaps were contacted and connected to schedule appointments, eliminated barriers (e.g., transportation), and follow-up afterward. b" Expanded options for families to obtain vaccinations by growing the provider network. This initiative temporarily reimbursed providers not enrolled in VFC program to give more options to members. 4. Community-Based Care Management a. ODM's Multi-System Youth Support Effort In 2019, with leadership from the Governor's Office of Children's Initiative, ODM partnered with sister state child-serving agencies to develop a state-level program that provides technical and financial assistance to children, youth, and families with complex multi-system needs. The aim of this program is two-fold. First, to prevent custody relinquishment of children and youth solely for the purpose of obtaining needed treatment. And second, to assist local entities with obtaining services that support children and youth who have been relinquished and are transitioning back to community and/or non-custody settings. In-home and community supports, which include intensive care coordination, wraparound services as well as respite or residential (room and board) assistance, are supported to fill these well-documented gaps. General revenue (non-Medicaid) funds are used for this effort. b. 1115 Substance Use Disorder (SUD) Waiver: ODM continues to collaborate with CMS on demonstration monitoring and evaluation requirements. Monitoring measures are submitted quarterly in accordance with the approved monitoring protocol, and evaluation activities are ongoing for interim evaluation submission in fall 2023. The midpoint assessment will reflect the updated guidance CMS issued in fall 2021 and is due to CMS by March 2022. Main areas of measurement (CMS 1115 SUD goals) are: b"

reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services; b" increased rates of identification, initiation, and engagement in treatment; b" increased adherence to and retention in treatment; b" improved access to care for physical health conditions among beneficiaries; b" reductions in overdose deaths, particularly those due to opioids; b" and fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate.

3. Have you conducted any focused studies on your CHIP population? (For example: studies on adolescents, attention deficit disorder, substance use, special healthcare needs, or other emerging healthcare needs.) What have you discovered through this research?

Each year, ODM selects quality improvement topics that are burgeoning issues or high-priority clinical issues for the Ohio Medicaid managed care population and also reflect our Quality Strategy. ODM's current improvement projects include the following: 1. Preterm Birth Prevention ODM's long-standing Preterm Birth Prevention effort is anchored in a partnership between the agency, the MCPs, and the clinicians participating in Ohio's Perinatal Quality Collaborative. While this effort has achieved moderate past success in reducing preterm births (in part linked to identifying candidacy for progesterone use), most recent efforts have focused on simplifying notification of pregnancy and related risks to ensure continued coverage through the postpartum period and more timely intervention. To facilitate pregnancy and risk identification, ODM created and implemented a web-based version of the Pregnancy Risk Assessment Form (PRAF 2.0) and a new Report of Pregnancy (ROP) form to automate data collection for real-time population health management. Both forms are used for timely pregnancy identification and directly link to Ohio's eligibility system to prevent the inadvertent loss of healthcare coverage during pregnancy. Both forms also serve as referrals to the Ohio Department of Health's home visiting, tobacco cessation, and WIC programs, and allow Medicaid managed care plans to link women to other needed services. The forms differ in the depth of information collected and the provider types that use the forms. The ROP is used by non-obstetric providers and community partners to identify pregnant women who can then be connected with an obstetrician by their MCP to facilitate earlier receipt of prenatal care. The PRAF is used by providers of obstetric services to identify additional medical needs and can be used both to create a progesterone prescription and to choose at-home administration of progesterone to home health agencies who provide this service. 2. Smoke Free Families Pediatric Learning Collaborative Acknowledging that smoke exposure puts the entire family at greater risk for poor health outcomes, from SIDS to COVID-19 complications, in 2021, ODM continued spreading the work of the Smoke Free Families Pediatric Learning Collaborative to reduce infant smoke exposure. The Smoke Free Families Pediatric Learning Collaborative, led by the Ohio Chapter of the American Academy of Pediatrics, builds upon existing relationships between primary care providers and families by addressing caregiver

and family member smoking behavior early in a child's life, during infant well visit appointments. The collaborative provides practices with education and resources to reduce smoke exposure for infants. Among the provided resources is an easily implemented screening tool developed to allow the clinical practice to seamlessly screen for family member smoking and utilize the 5As (Ask, Advise, Assess, Assist, and Arrange) for smoking cessation. 3. Preschool Vision Screening Learning Collaborative In 2021, ODM, the Ohio Chapter of the Academy of Pediatrics, Prevent Blindness Ohio, and the Ohio Department of Health continued collaborating to assist children with sensory impairment. This effort resulted in over 20,000 preschool-age children receiving vision screening that meets best-evidenced standards without undue hardship to the families or the practices that streamlined the processes and received the appropriate equipment. This effort shed light on the opportunities to extend collaboration with the Department of Health for other sensory-related measures such as hearing deficits so that all children with sensory needs receive appropriate attention to maximize normal growth and development and school readiness. 4. Diabetes Performance Improvement Project (PIP) The federally required PIP for 2021 focuses on helping patients with HbA1c>9 manage their diabetes. Although the Diabetes PIP is focused on adults, the healthy lifestyle factors and the impact on patient outcomes may indirectly benefit children who are family members of patients seen by participating practices. 5. QI Science Use to reduce COVID-19 Impact The success of 2020 collaborative quality improvement efforts led to ODM continuing using QI science in 2021 to reduce the impact of COVID-19 on members. 2021 efforts focused on COVID-19 vaccinations and diabetes identification and management. Early results indicate that over one million Medicaid enrollees received the initial does of the COVID-19 vaccine in 2021. The MCPs' collaborative efforts in neighborhoods with lower opportunity, where the difference between the Medicaid and non-Medicaid vaccination rate is highest, resulted in a reduction in the vaccination rate gap. 6. Special Surveys The pandemic forced action to ensure near real-time understanding of the impact of the rapid spread of COVID-19 for both adults and children in the Medicaid program. ODM leveraged existing partnerships with academic partners to pivot to answering key questions related to the distancing, masking, and gathering behaviors of adults of different ages in order to better understand the epidemiology in Ohio. A special assessment of the spread of COVID-19 in school settings with masking and distancing overseen by teachers allowed for an earlier and more confident return to in-person school for Ohio's youth, thereby minimizing the mental health anguish experienced by so

many students. In 2021, fielding began to survey women who experienced a stillbirth, and survey fielding remained ongoing for Ohio women who recently gave birth. Survey questions were added or modified to ask about prenatal care and the use of telehealth for prenatal visits during the pandemic.

4.

Optional: Attach any additional documents here.

For example: studies, analyses, or any other documents that address your performance goals.

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

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# Program Financing

Tell us how much you spent on your CHIP program in FFY 2021, and how much you anticipate spending in FFY 2022 and 2023.

# Part 1: Benefit Costs

Please type your answers in only. Do not copy and paste your answers.

1.

How much did you spend on Managed Care in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

| 2021 | 2022 | 2023 |
|---|---|---|
| $ 533,628,389 | $ 569,475,330 | $ 588,390,302 |

2.

How much did you spend on Fee for Service in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

| 2021 | 2022 | 2023 |
|---|---|---|
| $ 61,401,074 | $ 81,443,347 | $ 107,892,668 |

3.

How much did you spend on anything else related to benefit costs in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

| 2021 | 2022 | 2023 |
|---|---|---|
| $ | $ | $ |

4.

How much did you receive in cost sharing from beneficiaries to offset your costs in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

| 2021 | 2022 | 2023 |
|---|---|---|
| $ | $ | $ |

Table 1: Benefits Costs

This table is auto-populated with the data you entered above.

| Type | FFY 2021 | FFY 2022 | FFY 2023 |
|---|---|---|---|
| Managed Care | 533628389 | 569475330 | 588390302 |
| Fee for Service | 61401074 | 81443347 | 107892668 |
| Other benefit costs | Not Answered | Not Answered | Not Answered |
| Cost sharing payments from beneficiaries | Not Answered | Not Answered | Not Answered |
| Total benefit costs | 595029463 | 650918677 | 696282970 |

## Part 2: Administrative Costs

Please type your answers in only. Do not copy and paste your answers.

1.

How much did you spend on personnel in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

This includes wages, salaries, and other employee costs.

| 2021 | 2022 | 2023 |
| --- | --- | --- |
| **$** 4,591,034 | **$** 5,000,000 | **$** 5,000,000 |

2.

How much did you spend on general administration in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

| 2021 | 2022 | 2023 |
| --- | --- | --- |
| **$** 14,579,499 | **$** 15,000,000 | **$** 16,000,000 |

3.

How much did you spend on contractors and brokers, such as enrollment contractors in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

| 2021 | 2022 | 2023 |
| --- | --- | --- |
| **$** 6,815,409 | **$** 7,500,000 | **$** 8,500,000 |

4.

How much did you spend on claims processing in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

| 2021 | 2022 | 2023 |
| --- | --- | --- |
| **$** 4,346,312 | **$** 4,500,000 | **$** 4,500,000 |

5.

How much did you spend on outreach and marketing in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

| 2021 | 2022 | 2023 |
| --- | --- | --- |
| **$** | **$** | **$** |

6.

How much did you spend on your Health Services Initiatives (HSI) if you had any in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

| 2021 | 2022 | 2023 |
| --- | --- | --- |
| **$** 2,889,423 | **$** 5,000,000 | **$** 5,000,000 |

7.

How much did you spend on anything else related to administrative costs in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

| 2021 | 2022 | 2023 |
| --- | --- | --- |
| $ | $ | $ |

Table 2: Administrative Costs

This table is auto-populated with the data you entered above. Your total administrative costs cannot be more than 10% of your total CHIP program costs (the sum of your benefit and administrative costs). The 10% administrative cap is calculated by dividing the total benefit costs by 9.

| Type | FFY 2021 | FFY 2022 | FFY 2023 |
| --- | --- | --- | --- |
| Personnel | 4591034 | 5000000 | 5000000 |
| General administration | 14579499 | 15000000 | 16000000 |
| Contractors and brokers | 6815409 | 7500000 | 8500000 |
| Claims processing | 4346312 | 4500000 | 4500000 |
| Outreach and marketing | Not Answered | Not Answered | Not Answered |
| Health Services Initiatives (HSI) | 2889423 | 5,000,000 | 5000000 |
| Other administrative costs | Not Answered | Not Answered | Not Answered |
| Total administrative costs | 33221677 | Not Available | 39000000 |
| 10% administrative cap | Not Available | Not Available | Not Available |

Table 3: Federal and State Shares

CHIP is funded by federal and state budgets. The federal share of funding is calculated by multiplying your state's Federal Medical Assistance Percentage (eFMAP) by your total program costs (the sum of your benefit and administrative costs). The remaining amount of your total program costs is covered by your state share of funding. This table is auto-calculated using the data you entered above. The federal and state shares for FFY 2023 will be calculated once the eFMAP rate for 2023 becomes available. In the meantime, these values will be blank.

| FMAP Table | FFY 2021 | FFY 2022 | FFY 2023 |
| --- | --- | --- | --- |
| Total program costs | Not Available | Not Available | Not Available |
| eFMAP | 74.54 | 74.87 | Not Available |
| Federal share | Not Available | Not Available | Not Available |
| State share | Not Available | Not Available | Not Available |

8.

What were your state funding sources in FFY 2021?

Select all that apply.

- [x] State appropriations
- [ ] County/local funds
- [ ] Employer contributions
- [ ] Foundation grants
- [ ] Private donations
- [ ] Tobacco settlement
- [ ] Other

9.

Did you experience a shortfall in federal CHIP funds this year?

- ○ Yes
- ◉ No

## Part 3: Managed Care Costs

Complete this section only if you have a Managed Care delivery system.

1.

How many children were eligible for Managed Care in FFY 2021? How many do you anticipate will be eligible in FFY 2022 and 2023?

| 2021 | 2022 | 2023 |
|---|---|---|
| 206127 | 213342 | 210928 |

2.

What was your per member per month (PMPM) cost based on the number of children eligible for Managed Care in FFY 2021? What is your projected PMPM cost for FFY 2022 and 2023?

Round to the nearest whole number.

| 2021 | 2022 | 2023 |
|---|---|---|
| **$** 216 | **$** 222 | **$** 232 |

| Type | FFY 2021 | FFY 2022 | FFY 2023 |
|---|---|---|---|
| Eligible children | 206127 | 213342 | 210928 |
| PMPM cost | 216 | 222 | 232 |

## Part 4: Fee for Service Costs

Complete this section only if you have a Fee for Service delivery system.

1.

How many children were eligible for Fee for Service in FFY 2021? How many do you anticipate will be eligible in FFY 2022 and 2023?

| 2021 | 2022 | 2023 |
| --- | --- | --- |
| 3325 | 4329 | 5693 |

2.

What was your per member per month (PMPM) cost based on the number of children eligible for Fee For Service in FFY 2021? What is your projected PMPM cost for FFY 2022 and 2023?

The per member per month cost will be the average cost per month to provide services to these enrollees. Round to the nearest whole number.

| 2021 | 2022 | 2023 |
| --- | --- | --- |
| **$** 1,539 | **$** 1,568 | **$** 1,579 |

| Type | FFY 2021 | FFY 2022 | FFY 2023 |
| --- | --- | --- | --- |
| Eligible children | 3325 | 4329 | 5693 |
| PMPM cost | 1539 | 1568 | 1579 |

1. Is there anything else you'd like to add about your program finances that wasn't already covered?

a. Costs reflected in the Benefit Costs section for managed care and fee for service for fiscal years 2021, 2022 and 2023 are net of drug rebates. b. Amounts estimated in the Health Services Initiative line are for lead abatement activities.

2.

Optional: Attach any additional documents here.

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

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## Challenges and Accomplishments

1. How has your state's political and fiscal environment affected your ability to provide healthcare to low-income children and families?

Shortly after being signed into office at the beginning of 2019, Governor DeWine signed an executive order to create the Governor's Office of Children's Initiatives. This office has been charged with taking bold steps to give Ohio kids a platform for lifelong success by: b" Elevating the importance of children's programming in Ohio and driving improvements within the many state programs that serve children. b" Advancing policy related to home visiting, early intervention services, early childhood education, foster care, and child physical and mental health. b" Initiating and guiding enhancements to the early childhood, home visiting, foster care, education, and pediatric health systems. b" Improving communication and coordination across all state agencies that provide services to Ohio's children. b" Engaging local, federal, and private sector partners to align efforts and investments in order to have the largest possible impact on improving outcomes. Medicaid is incredibly important to ensuring coverage and access to care for Ohio's youngest citizens. As the health insurance for more than 1.3 million children in the state, and, in some Ohio counties, as the insurer for more than 80% of children under the age of 5 residing in the county, Medicaid has great opportunity to improve the lifelong potential for Ohio's kids. Governor DeWine's administration has been enthusiastically and financially supportive of Ohio's ability to provide healthcare to low-income children and families. Despite substantial challenges created and exacerbated by the COVID-19 pandemic, ODM initiated and continued several programs to support the Governor's Children's Initiative in CY 2020-2021. These programs are described in detail below as a response to Question 2 regarding the greatest accomplishments our CHIP program has experienced in FFY 2020.

2. What's the greatest challenge your CHIP program has faced in FFY 2021?

Beginning in March 2020, Ohio, along with the rest of the globe, began experiencing the worst pandemic in a century. COVID-19 continues to beleaguer Medicaid and children's services agencies, stretching already limited resources and requiring rapid innovation and flexibility in order to continue to meet the healthcare needs of children in Ohio. Throughout 2020 and 2021, children were unable to attend in-person school, suffered from additional mental health burdens, experienced greater food insecurity and housing instability, and experienced gaps in healthcare due to lack of provider availability and fear of contracting an infectious disease in the process of obtaining routine care. The impact of decreased services due to the pandemic not only affects preventative care, such as immunizations and well-child visits, but the opportunity for pediatric clinicians to diagnosis conditions and start effective treatments earlier. The pandemic presented many challenges: An increasing Medicaid caseload due to the extended economic ramifications of the pandemic continues to challenge staffing and budgets, and there was a need to rapidly transition provision of and reimbursement for many in-office services to virtual and remote services. Regardless, Ohio has risen to this challenge and continues to provide comprehensive care and coverage to the neediest children. While it became necessary to delay or postpone some planned initiatives due to the need to make critical modifications to existing service delivery and coverage, children remain a top priority in Ohio. Medicaid has used 2021 to continue operationalizing the work that is required to rapidly implement additional services and supports for children and their families in the coming years.

3. What are some of the greatest accomplishments your CHIP program has experienced in FFY 2021?

Ohio Medicaid's greatest accomplishments from FFY 2020 are outlined below: 1. In 2019, the Ohio Department of Medicaid launched the Medicaid Managed Care Procurement process with a bold new vision for Ohio's Medicaid program - one that focuses on people and not just the business of managed care. This is the first structural change since CMS' approval of Ohio's program in 2005. With the implementation of the next generation of Medicaid managed care in Ohio, ODM intends to put the individual at the center of focus and improve the design, delivery, and timeliness of care coordination. Through this effort, we are working to achieve the following goals: b" Improve wellness and health outcomes. b" Emphasize a personalized care experience. b" Support providers in better patient care. b" Improve care for children and adults with complex needs. b" Increase program transparency and accountability. In 2020, ODM released requests for proposals for managed care vendors to implement the vision outlines above. In 2021, ODM selected and began working with managed care partners to implement the Next Generation program, which is slated to begin in 2022. 2. Within the Next Generation of Managed Care, ODM developed a specialized platform to strengthen care for children with complex behavioral health needs - called OhioRISE (Resilience through Integrated Systems and Excellence). OhioRISE will leverage a specialized managed care plan that will offer enhanced care coordination and tailored community-based behavioral health services to meet the unique needs of children with the greatest mental health and substance use disorder challenges. In 2021, ODM selected and began working with a managed care vendor to partner in implementing OhioRISE, which is set to begin in 2022. 3. ODM continued telehealth efforts to make access to care easier and more flexible during the COVID-19 pandemic. The agency, in partnership with the governor's office, our sister agencies as well as managed care plans, providers, and consumers, has: b" Expanded telehealth services to include a wide array of medical, clinical, and behavioral health providers and counselors. b" Eased technology restrictions on patient-physician interaction to deliver telehealth services. b" Reduced prior authorization requirements to for many medical and behavioral services. b" Enhanced pharmacy benefits, eliminating in- and out-of-network restrictions, pharmaceutical co-pays while increasing pharmacy reimbursements for over-the-counter medications. b" Enabled nursing home and congregate care members to access telehealth services with no prior authorization. 4. In 2021, Ohio Medicaid

leveraged our current managed care Quality Withhold to incentivize our managed care partners to work toward increasing Medicaid's COVID-19 vaccination rate. Managed care plans were required to use a collective approach to improving vaccination rates for the entire managed care population, rather than solo efforts to increase rates for only their own enrolled members. Interventions to improve vaccination uptake were designed using the Institute for Healthcare Improvement's (IHI) "science of improvement," a model that accelerates quality improvement and traces back to W. Edwards Deming's total quality management philosophy. The IHI model calls for collaborative design, disciplined implementation, and rigorous measurements. 5. In 2021, ODM worked to incentivize automatic real-time data collection for women experiencing pregnancy by implementing a new payment differential for electronic submission of its Pregnancy Risk Assessment Form (PRAF) and implemented payment for a new Report of Pregnancy (ROP) form that can be submitted by non-OB/GYN providers to alert ODM and its managed care plans of a new pregnancy. Electronic PRAF and ROP submission facilitates real-time population health management, access to care coordination, and linkage to Ohio's Medicaid eligibility system (OhioBenefits) to ensure women who become pregnant have opportunities to remain eligible for Medicaid throughout the duration of their pregnancy. 6. Ohio's Healthy Student Profiles are the continued result of a collaboration between Medicaid and the Ohio Department of Education. The profiles, sent to all 600+ traditional school districts across the state, feature aggregate data on healthcare utilization, health outcomes, and educational outcomes for each district's Medicaid-enrolled student population. Profiles were distributed in 2020 and 2021 to support school districts in building relationships with healthcare providers and community agencies to better meet the non-academic needs of their student populations. 7. ODM continued to host learning collaboratives in 2021: a. Work continued with the Smoke Free Families Pediatric Learning Collaborative. This initiative provides practices with education and resources to reduce smoke exposure for infants. Smoke exposure puts the entire family at greater risk for poor health outcomes, from SIDS to COVID-19 complications. The Smoke Free Families Pediatric Learning Collaborative, led by the Ohio Chapter of the American Academy of Pediatrics, aims to build upon the existing relationships between primary care providers and families by addressing caregiver and family member smoking behavior early in a child's life during infant well visit appointments. A screening tool has been developed for easy implementation into clinical practice to allow providers to seamlessly screen for family member smoking and utilize the 5As (Ask, Advise,

Assess, Assist, and Arrange) for smoking cessation. b. Through funding from the Ohio Department of Medicaid, The Preschool Vision Screening Learning Collaborative continued in 2021 and involved The Ohio Chapter, American Academy of Pediatrics (Ohio AAP), Prevent Blindness Ohio (PBO), The Ohio Department of Health (ODH), and The Ohio Colleges of Medicine Government Resource Center (GRC). The collaborative works to prevent vision loss in preschool-age children by supporting pediatric primary care providers in increasing screening rates, improving billing practices, and increasing referral to an eye care specialist for preschool-age children who do not pass a vision screen. As part of the project, primary care practices were trained in evidence-based approaches to screening and referral and provided with up-to-date vision screening equipment. While the COVID-19 pandemic provided unexpected challenges, the project achieved a high degree of success with project aims being met and participating practices reporting a high degree of satisfaction with the project. 8. On Aug. 19, 2019, Governor DeWine announced that CMS approved Ohio's CHIP initiative to enhance and expand Medicaid's lead abatement program in partnership with the Ohio Department of Health. This approval built on a more limited program that was launched in December 2017. The Lead CHIP Program enables Medicaid to fund ODH lead hazard control projects in residences in which a Medicaid-eligible child or pregnant woman live or spend significant time (over 6 hours per week) and to remove lead hazards in residential properties within targeted areas of the state. Work on this initiative continued in 2021. Despite challenges caused by the COVID-19 pandemic, the program continued abatement activities for enrolled homes and recruited new homes into the program. The program also continues to populate the Lead Free Housing Registry. 9. The Medicaid Equity Simulation Project was created to advance health equity for the Medicaid population by increasing Medicaid provider cultural competency, raising awareness of implicit bias, and promoting empathy through training composed of virtual reality and simulated patient experiences. Six academic medical centers/health sciences colleges participate in the Medicaid Equity Simulation Project: Case Western Reserve University, Ohio University, The Ohio State University, University of Cincinnati, University of Toledo, and Wright State University. In 2021, three new simulations were developed to assist providers with understanding children and young who have co-occurring behavioral health challenges and developmental disabilities. One simulation scenario is outlined below to provide an example of this work: Patient is Brian, age 19, who has several physical and intellectual disabilities including cerebral palsy, intellectual disability, autism spectrum disorder,

generalized anxiety disorder, obsessive compulsive disorder, and epilepsy. He lives with his mother Debbie, a single parent who has cared for his activities of daily living since birth. Brian has significant spasticity of extremities and is unable to ambulate independently. He uses a wheelchair and requires a Hoyer lift for transfers from chair to bed. He has mixed expressive receptive language disorder and communicates with TouchChat on his iPad. Participants experience three perspectives: Debbie, Brian, and the provider. Participants experience barriers getting to the appointment, discrimination in the office by staff, and an office that does not have the proper accommodations to address Brian's physical disabilities.

4. What changes have you made to your CHIP program in FFY 2021 or plan to make in FFY 2022? Why have you decided to make these changes?

As outlined in the response to the previous question, Ohio Medicaid's primary efforts related to improving outcomes for children and families in FFY 2020 included continued work to implement the Next Generation of Managed Care in Ohio, including the OhioRISE Program; continued telehealth efforts to make access to care easier and more flexible during the COVID-19 pandemic; use of our managed care Quality Withhold to incentivize increasing Medicaid's COVID-19 vaccination rate; implementing payment changes to incentivize automatic real-time data collection using the electronic Pregnancy Risk Assessment Form (PRAF) and Report of Pregnancy (ROP) form; continued release of the Ohio's Healthy Student Profiles; continued work to host learning collaboratives; continuation of our lead abatement program in partnership with the Ohio Department of Health (ODH); continuation of the Medicaid Equity Simulation Project and the development of new child-focused scenarios. Ohio Medicaid worked in each of these areas to respond to the needs of children and families enrolled in our program and to support Governor DeWine's Children's Initiative, which aims to help create opportunity for every child in Ohio. In the coming year, Ohio Medicaid will continue work to improve health and life outcomes for children and their families by: b" Implementing the Next Generation of Managed Care in Ohio, including the OhioRISE program that targets improving outcomes for children and youth with complex behavioral health challenges. b" Continuing development and implementation of the Maternal and Infant Support Program, where our next efforts will focus on extending postpartum Medicaid coverage to women for 12 months, developing a Comprehensive Maternal Care (CMC) medical home model, considering innovative options to care for infants with neonatal abstinence syndrome and their mothers through a "dyad" care approach, and considering options to help women in Medicaid access doula services.

5. Is there anything else you'd like to add about your state's challenges and accomplishments?

6.

Optional: Attach any additional documents here.

**Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.**

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png)

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