Ohio CARTS FY2020 Report

Welcome!

We already have some information about your state from our records.
If any information is incorrect, please contact the CARTS Help Desk.

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.

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
- ◉ No

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

- ○ Yes
- ◉ No

3b. What's the maximum premium a family would be charged each year?

$

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.

- ☑ Managed Care
- ☐ Primary Care Case Management
- ☑ 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 eligible for CHIP and receive Ohio Waiver Services are fee for service unless they are on an Ohio Department of Developmental Disabilities waiver who 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
- ◉ No
- ○ N/A

8. Have you made any changes to your cost sharing requirements?
For example: changing amounts, populations, or the collection process.

- ○ Yes
- ◉ 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
- ◉ No
- ○ N/A

Part 4: Separate CHIP Program and Policy Changes

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 2019	Number of children enrolled in FFY 2020	Percent change
Medicaid Expansion CHIP	242,786	211,086	-13.057%
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.

Year	Number of uninsured children	Margin of error	Percent of uninsured children (of total children in your state)	Margin of error
2015	73,000	7,000	2.7%	0.3%
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%

Percent change between 2018 and 2019
NaN%

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

3a. What is the alternate data source or methodology?

Ohio Family Health Survey (1998-2010)/ Ohio Medicaid Assessment Survey (2012, 2015, 2017, 2019)

3b. Tell us the date range for your data

Start

mm/yyyy

01 / 1998

End

mm/yyyy

12 / 2019

3c. Define the population you're measuring, including ages and federal poverty levels.

Uninsured Children Age 17 and Under Week Before Survey, all FPLs

3d. Give numbers and/or the percent of uninsured children for at least two points in time.

2010: 4.6%; 2012: 4.7%; 2015: 2.2%; 2017: 3.2%; 2019: 4.7%

3e. Why did your state choose to adopt this alternate data source?

It had a larger sample size and more precise estimates than the Current Population Survey

3f. How reliable are these estimates? Provide standard errors, confidence intervals, and/or p-values if available.

90% Confidence Intervals: 2010: 3.6% to 5.6%; 2012: 4.1% to 5.2%; 2015: 2.0% to 2.5%; 2017: 2.9% to 3.6%; 2019: 4.1% to 5.3%.

3g. What are the limitations of this alternate data source or methodology?

The most significant limitation is that the survey is not administered annually

3h. How do you use this alternate data source in CHIP program planning?

ODM has used this alternative data source to better understand the uninsured population and to estimate the fiscal impact for projected growth and new programming. This information has also been made available to others through a dynamic data analytics platform such as Tableau for analysis and academic inquiry. Communities are also able to access the data through a website for grant writing purposes

○ 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...

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

  2a. Have these efforts been successful? How have you measured the effectiveness of your outreach efforts?

  Ohio continues to look for ways to measure the effectiveness of targeted outreach to specific populations through our state agency partnerships and state partners.

- ○ 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 and the deeper understanding that has resulted. ODM has educated state agency partners and numerous community stakeholders that work with low-income families, expanding the qualified entities who 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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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
- ◉ No
- ○ N/A

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

- ○ Yes
- ◉ No
- ○ N/A

3. What percent of applicants screened for CHIP eligibility cannot be enrolled because they have group health plan coverage?

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?

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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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.

- (●) Yes

  1a. What percent of children are presumptively enrolled in CHIP pending a full eligibility determination?

  0 %

  1b. Of the children who are presumptively enrolled, what percent are determined fully eligible and enrolled in the program (upon completion of the full eligibility determination)?

  10 %

- ( ) 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

  3a. How many notices do you send to families before disenrolling a child from the program?

  Two notices are sent to the family during the renewal process.

  3b. How many days before the end of the eligibility period did you send reminder notices to families?

  The first notice is the manual renewal application sent to the family 45 days before the end of the current eligibility period when passive renewal cannot be completed. The second notice is mailed at least 10 days before the end of the current eligibility period when the family has not submitted the renewal application.

- ○ 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?

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. • The answer to Question 1b reflects only the number of children on Presumptive Eligibility who were found eligible for CHIP coverage. An additional 64% of children were found eligible for Medicaid coverage. (Last year, the answer reflected the number of children found eligible for either Medicaid or CHIP coverage.)

Part 2: CHIP Eligibility Denials (Not Redetermination)

1. How many applicants were denied CHIP coverage in FFY 2020?
Don't include applicants being considered for redetermination - this data will be collected in Part 3.

70680

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.

36104

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.

34576

3a. How many applicants were denied CHIP (Title XXI) coverage and determined eligible for Medicaid (Title XIX) instead?

0

4. How many applicants were denied CHIP coverage for other reasons?

0

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

• This data reflects the initial determination of an application. If an individual responded to a denial by providing additional information or appealing the denial, leading to the denial being rescinded and the application being reconsidered, the initial denial (and associated reason) are still reported here rather than a later approval or potentially-differing denial reason. • In this data, ODM is reporting denials based on the date of the eligibility determination, not the application date. In other words, if an individual applied for coverage on September 25, 2019, and coverage was denied on October 21, 2019, that denial would be reported in this data. On the other hand, if an individual applied for coverage on September 25, 2020, and coverage was denied on October 21, 2020, that denial would be reported in FFY2022. • Regarding Question 3a: Ohio is a Medicaid expansion state, and a child who is denied coverage is denied both Medicaid and CHIP coverage. Ohio cannot report separate numbers of children who were denied CHIP coverage versus Medicaid, nor can we give a number of children denied CHIP but found eligible for Medicaid, as there is only one decision determining whether a child is eligible for coverage. • Regarding Question 4: This data excludes non-denials, such as administrative closure of applications opened in error.

Table: CHIP Eligibility Denials (Not Redetermination)
This table is auto-populated with the data you entered above.

	Percent
Total denials	100%
Denied for procedural reasons	51.08%
Denied for eligibility reasons	48.92%
Denials for other reasons	0%

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 2020?

176448

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

146504

3. How many children were retained in CHIP after redetermination?

131983

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.

14521

4a. How many children were disenrolled for procedural reasons?
This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

8163

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.

6358

4c. How many children were disenrolled for other reasons?

0

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

• Ohio is an expansion state. If children were initially enrolled in CHIP but were found eligible for Medicaid during renewal, they are not counted as "disenrolled" in this data. • Passive renewal has been attempted on all blocks due for renewal. • The number of renewals not processed is inflated by an unknown amount at this time. We expect to improve our tracking and reporting of this data over the next year as part of our CAP work. Those improvements should be reflected in next year's CARTS report. • Regarding Question 4c: This data excludes non-terminations, such as administrative closure of coverage and reopening coverage in another case.

Table: Redetermination in CHIP
These tables are auto-populated with the data you entered above.

	Percent
Children screened for redetermination	100%
Children retained after redetermination	90.09%
Children disenrolled after redetermination	9.91%

Table: Disenrollment in CHIP after Redetermination

	Percent
Children disenrolled after redetermination	100%
Children disenrolled for procedural reasons	56.22%
Children disenrolled for eligibility reasons	43.78%
Children disenrolled for other reasons	0%

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 2020?

726249

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

654654

3. How many children were retained in Medicaid after redetermination?

595667

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.

58958

4a. How many children were disenrolled for procedural reasons?
This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

40777

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.

18181

4c. How many children were disenrolled for other reasons?

0

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

• Ohio is an expansion state. If children were initially enrolled in Medicaid but were found eligible for CHIP during renewal, they are not counted as "disenrolled" in this data. • Passive renewal has been attempted on all blocks due for renewal. • The number of renewals not processed is inflated by an unknown amount at this time. We expect to improve our tracking and reporting of this data over the next year as part of our CAP work. Those improvements should be reflected in next year's CARTS report. • Regarding Question 4c: This data excludes non-terminations, such as administrative closure of coverage and reopening coverage in another case.

Table: Redetermination in Medicaid
These tables are auto-populated with the data you entered above.

	Percent
Children screened for redetermination	100%
Children retained after redetermination	90.99%
Children disenrolled after redetermination	9.01%

Table: Disenrollment in Medicaid after Redetermination

	Percent
Children disenrolled after redetermination	100%
Children disenrolled for procedural reasons	69.16%
Children disenrolled for eligibility reasons	30.84%
Children disenrolled for other reasons	0%

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 year you'll report on the number of children at the start of the cohort (Jan - Mar 2020) and six months later (July - Sept 2020). Next 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 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)

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)

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
<11	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
<11	21	36	15

7. How many children were no longer enrolled in CHIP six months later?
Possible reasons for no longer being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• 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?

These data include individuals from part 5 line 7 who were enrolled in Medicaid at any point after the CHIP disenrollment.

January - March 2021 (12 months later)
Next year you'll report this data. Leave it blank in the meantime.

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

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

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

13. How many children were no longer enrolled in CHIP 12 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

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

July - September of 2021 (18 months later)
Next year you'll report this data. Leave it blank in the meantime.

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

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

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

18. How many children were no longer enrolled in CHIP 18 months later?
Possible reasons for not being enrolled:
- Transferred to another health insurance program other than CHIP
- Didn't meet eligibility criteria anymore
- Didn't complete documentation
- Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

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

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 year you'll report the number of children identified at the start of the cohort (Jan-Mar 2020) and six months later (July-Sept 2020). Next 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.

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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 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)

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)

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:
• Transferred to another health insurance program other than Medicaid
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• 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?

These data include individuals from part 6 line 7 who were enrolled in CHIP at any point after the Medicaid disenrollment.

January - March 2021 (12 months later)
Next year you'll report this data. Leave it blank in the meantime.

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

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

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

13. How many children were no longer enrolled in Medicaid 12 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than Medicaid
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

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

July - September of 2021 (18 months later)
Next year you'll report this data. Leave it blank in the meantime.

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

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

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

18. How many children were no longer enrolled in Medicaid 18 months later?
Possible reasons for not being enrolled:
- Transferred to another health insurance program other than Medicaid
- Didn't meet eligibility criteria anymore
- Didn't complete documentation
- Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

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

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

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.

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
- ◉ No

Program Integrity

Dental Benefits

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.

1. Did you collect the CAHPS survey?

(●) Yes

1a. Did you submit your CAHPS raw data to the AHRQ CAHPS database?

(●) Yes

( ) No

( ) 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...

2020 CAHPS Attachment updated.docx

2. Which CHIP population did you survey?

- (●) 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
- (●) CAHPS 5.0H
- ( ) Other

4. Which supplemental item sets did you include in your survey?
Select all that apply.

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

4a. Which supplemental item sets did you include?

Includes CAHPS Item Set for Children with Chronic Conditions; Patient-Centered Medical Home item set (1 question); Health Literacy item set (1 question); and 2 Ohio-specific questions related to care coordination

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

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."

- (●) 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?

69665

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

67495

Computed: 96.89%

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 HSI Program in this list?

Optional

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.

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?

Currently CHIP SPA section 9 only lists well-child check-up metrics. For the SCHIP 2020 report our goal is to develop a new eligibility metric related to eligibility. This eligibly metric will be developed in 2021, added to the SPA, and we will begin tracking for the 2021 report.

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 Goal 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)

1314

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).

6. Denominator (total number)

2055

Computed: 63.94%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2019

End

mm/yyyy

12 / 2019

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 FFY2020 rate (61.57%) exceeds the CY 2019 National 25th HEDIS Percentile (61.31%).

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.

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 2019 (calculated using hybrid methodology) for the five Ohio Medicaid managed care plans (MCP). The numerator and denominator are the totals reported for the five MCPs' hybrid samples. The reported rate (see #10 below) is the weighted average of the reported rates (i.e. weighted using the eligible population reported for each MCP).

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 Goal 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 in the Third, Fourth, Fifth, and Sixth Years of Life

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 3-6 years of age who received one or more well-child visits with a primary care practitioner during the measurement year.

4. Numerator (total number)

1468

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)

6. Denominator (total number)

2055

Computed: 71.44%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2019

End

mm/yyyy

12 / 2019

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 FFY2020 rate (72.83%) exceeds the CY 2019 National 25th HEDIS Percentile (68.61%).

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.

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 2019 (calculated using hybrid methodology) for the five Ohio Medicaid managed care plans (MCP). The numerator and denominator are the totals reported for the five MCPs' hybrid samples. The reported rate (see #10 below) is the weighted average of the reported rates (i.e. weighted using the eligible population reported for each MCP).

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 Goal in this list?

Optional

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

Adolescent Well-Care Visits

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.

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?

Adolescents and young adults 12-21 years of age who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year

4. Numerator (total number)

1105

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

Denominator includes CHIP and Medicaid (Title XIX)

6. Denominator (total number)

2055

Computed: 53.77%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2019

End

mm/yyyy

12 / 2019

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 FFY2020 rate (54.59%) exceeds the CY 2019 National 25th HEDIS Percentile (48.42%).

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.

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 2019 (calculated using hybrid methodology) for the five Ohio Medicaid managed care plans (MCP). The numerator and denominator are the totals reported for the five MCPs' hybrid samples. The reported rate (see #10 below) is the weighted average of the reported rates (i.e. weighted using the eligible population reported for each MCP).

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 Goal 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

/

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 Goal 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

/

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 Goal 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?

The Ohio Department of Medicaid (ODM)'s Quality Strategy serves as a framework for communicating Ohio's approach to ensuring that individuals have timely access to high quality services in a coordinated, cost-effective manner that ultimately contributes to the improved health of our population. ODM's strategy delineates the complexity of the populations served and utilizes a person-centered approach to meet health needs within the context of community, supporting sustainability through actionable data linked to how care is financed through Value-Based Purchasing (VBP). See ODM's Quality Strategy here: https://www.medicaid.ohio.gov/MEDICAID-101/-Quality-Strategy-and-Measures . Ohio's efforts to improve quality are consistent with the HHS National Quality Strategy and focus on reliably delivered, proven interventions to prevent, diagnose, and treat conditions within the context of family. Ohio's Comprehensive Primary Care (CPC) Program builds upon Patient Centered Medical Home infrastructures with operational effectiveness to achieve the population health outcomes summarized in Figure1. Using Ohio CPC as a foundation, Ohio launched CPC Kids in 2020 to close equity gaps for children statewide. 1. VBP Initiatives a. CPC/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 health care data that creates population risk-tiering to guide more effective, holistic care. In addition to the traditional 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. 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. b. Episodes of Care Ohio's Episodes of Care program initially launched with 43 episodes or bundles of care that cover a diverse array of conditions and procedures. While this program was paused due to COVID in 2020, initial results from the program for 2019 suggest a positive impact on cost with no adverse impact on quality. See ODM's website for more information: https://www.medicaid.ohio.gov/Provider/PaymentInnovation c. The Care

Innovation and Community Improvement Program (CICIP) This program was implemented in SFY 2019 to rethink care within health systems and bring person-centered focus to prevention and more effective treatment, for opioid use disorder to improved care for the maternity and frequent Emergency Department populations. The four health systems are large Medicaid safety-net and academic medical centers that worked together to develop strategies to optimize care, creating data dashboards to track progress along agreed-upon measures and sharing lessons learned. To date, most of the systems have leveraged their electronic health records to bring different parts of the health system together, creating alerts and engaging patients. In addition, peer supports, and community workers have been deployed effectively, for engagement and connectivity to care, and to support a cultural shift of compassion for those struggling with addiction. 2. Quality Measurement Strategies with MCPs Ohio's 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 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. MCP performance is evaluated through a system of: • internal compliance reviews, • monitoring in key areas (e.g., clinical quality, access, consumer satisfaction), • self-evaluations submitted as part of the annual QAPI submission, and • 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 Quality Withhold (QW), Clinical Quality Measures Financial Penalties (CQMFP), and Quality Based Assignments (QBA). Key results of the CQMs and Consumer Surveys include: a. HEDIS Clinical Performance Measures Primary Care, Well-Care, and Behavioral Health HEDIS measures 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 for measure results that do not meet minimum performance thresholds that are designed to ramp up over a period of time. For children receiving comprehensive preventive well-care visits, the percent of children in the first 15 months of life who received 6 or more visits increased from 59.1% in FFY 2019 to 61.6% in FFY 2020.

Well-care visit rates for children ages 3 thru 6 increased from 72.2% to 72.8%. Well-care visit rates for adolescents increased from 50.8% in FFY 2019 and 54.6% in FFY 2020. The percent of children receiving at least one primary care service increased slightly from FFY 2019 to FFY 2020 for all age groups with increases ranging from 0.1% to 0.8%. The changes by age group are as follows: 94.4% to 95.2% for the 12-24 month age group, 86.4% to 87.1% for 25 months to 6 years. 89.4% to 89.6% for 7 to 11 years, and 89.2% to 89.3% for 12 to 19 years. 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, improved from 78.3% in FFY 2019 to 81.3% in FFY 2020. Ohio's children's clinical performance measure overall improved from 2018 to 2019. However, when compared to national benchmarks, they are on average 0.6% below the nation average. b. 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 2019 to 2020, mean scores for the Ohio Medicaid general child population improved for 6 of the 9 core survey measures, with two scores remaining unchanged (Rating of Personal Doctor and Customer Service), and one score decreasing (Rating of Specialist Seen Most Often). Compared to 2020 national Medicaid percentiles, the Ohio Medicaid Managed Care Program's performance for the general child population was good to excellent for 7 of the 9 core survey measures. The mean scores for the Rating of Health Plan and Rating of Personal Doctor measures were between the 25th and 49th percentiles, indicating opportunity for improvement in performance. Areas of good performance (above the 50th percentile) included Rating of All Health Care and Customer Service. Rating of Specialist Seen Most Often and Getting Needed Care ranked above the 75th percentile, while the areas of excellent performance above the 90th percentile included Getting Care Quickly, How Well Doctors Communicate, and Coordination of Care.

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?

A. 2019 Quality Withhold Program Beginning in CY 2018, ODM phased in a Quality Withhold (QW) incentive system using Quality Indices to measure the effectiveness of the Ohio Medicaid managed care plans' (MCPs) population health management strategy. Quality indices align with the population streams and incentives are awarded to MCPs based on improved plan performance as evaluated by multiple measures for each index. The 'Healthy Children' index performance measures include 'Well-Child Visits in the First 15 Months of Life, 'Well-Child Visits in the 3rd, 4th, 5th, 6th Years of Life,' 'Adolescent Well-Care Visit's', and 'BMI percentile documentation for children and adolescents'. The children and adolescent well care visit measures are included in the QW incentive system for calendar years 2018 and 2019, with the BMI measure added in 2019. The 'Behavioral Health (BH)' index also includes measures for the child and adolescent populations. For calendar year 2019, BH index measures included the 'Initiation of Alcohol and Other Drug Dependence (AOD) Treatment' (to include adolescents age 13 and older), 'Follow-Up After Hospitalization for Mental Illness (MH Follow-Up) 7-day visit' (to include children and adolescents ages 6 and older) and one measure specific to children and adolescents: 'Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics'. It should be noted that for CY 2018 and 2019, the AOD and Follow-Up measures included, but were not limited to, children and adolescents. The calculated rates were for the overall measure population, including adults. In order to incentivize more focused performance improvement on the children and adolescent segments of the behavioral health population stream, an 'Engagement of AOD Treatment' measure specific to adolescents (ages 13 -17) and a 'MH Follow-Up' visit measure for children and adolescents (ages 6 -17) were added to the Behavioral Health QW Index. Results for 2019 showed improvement in each index. When compared to national benchmarks, the Behavioral Health index is well above the national 50th percentile at the 83rd percentile, but the Children's index is much lower at the 56th percentile. B. Comprehensive Primary Care for Kids Providers participating in CPC for Kids are measured against established thresholds for the following clinical quality metrics: well-child visits in the first 15 months of life; well-child visits in the 3rd, 4th, 5th, 6th years of life; adolescent well care visits; weight assessment and counseling for nutrition and physical activity for children and adolescents; lead screenings; immunizations for children, combination 3; and immunizations for

adolescents, combination 2. Providers must pass at least half of the metrics for which they have at least 30 patients in the denominator. In addition, providers must pass at least one of the following metrics: lead screenings; immunizations for children, combination 3; or immunizations for adolescents, combination 2. Providers received information for tobacco cessation for adolescents, and fluoride varnish, but no thresholds or passing rates were applied to those two metrics. Providers that fail to meet these standards may be disenrolled from the program. C. Community-Based Care Management ODM Infant Mortality Community Partnerships: Infant Mortality Community Partnerships were developed to specifically address the disparities in preterm birth and infant mortality. This effort brought together Ohio's nine counties with the highest disparities, activating communities to address racism, social determinants of health. Some communities are already demonstrating measurable improvements in preterm birth and sleep-related deaths in particular to better understand the issues pertinent at a person level. ODM hosted focus groups of women to their pregnancy and postpartum experiences. Women in the Medicaid program expressed distrust in the health systems in general, 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. ODM subsequently embarked upon a person-centered design for a maternal and infant support program. ODM's Multi-System Youth Support Effort: In 2019, ODM partnered with the Ohio Department of Job and Families Services which houses Child Protective Services to develop a state-level program to provide technical and financial assistance to children, youth and families with complex multi-system needs. The aim of this program is to prevent custody relinquishment of children and youth solely for the purpose of obtaining needed treatment, and 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 that include intensive care coordination, wraparound services as well as respite or residential (room and board) assistance is supported through this effort in order to fill well-documented gaps for Ohio's youth. 1115 Substance Use Disorder (SUD) Waiver: In January 2019, ODM submitted an 1115 Demonstration waiver for Medicaid funded SUD treatment for adults and children. ODM obtained CMS approval on September 24, 2019 and began implementation of this five-year waiver on October 1, 2019. Conditions of the SUD 1115 waiver require that Ohio Medicaid cover a full continuum of SUD services and assure sufficient provider capacity to meet the

treatment needs of Ohio Medicaid beneficiaries with opiate and other substance use disorders. Under the SUD 1115 waiver, ODM will continue to implement and improve multiple interventions and strategies to improve coordination and transition of care for youth and other individuals with SUD. The SUD 1115 Waiver has several monitoring and evaluation measurement requirements on which ODM has been collaborating on with CMS: mid-point assessment due 12/31/2021; monitoring measures which will be quarterly through 2024 with the monitoring protocol approved 10/9/2020; an evaluation with the design approved 11/9/2020; an interim evaluation due 9/30/2023; and final evaluation due 3/30/2026. Main areas of measurement (CMS 1115 SUD goals) are: 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; increased rates of identification, initiation, and engagement in treatment; increased adherence to and retention in treatment; improved access to care for physical health conditions among beneficiaries; reductions in overdose deaths, particularly those due to opioids; 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 Quality Improvement Projects (QIPs) include the following: A. Preterm Birth Prevention ODM has a long-standing Preterm Birth Prevention effort anchored in the 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 risk for more timely intervention for a larger group of women. ODM created and implemented a web-based version of the Pregnancy Risk Assessment Form (PRAF 2.0) to automate data collection for real-time population health management. Data submitted directly links to Ohio's eligibility system to prevent the inadvertent loss of health care coverage during pregnancy and creates direct referrals to other maternal and infant supports, including tobacco cessation, home visiting, and smoking cessation. ODM also continues to work with preterm birth prevention partners, especially in communities of greatest infant mortality disparities, to improve use of the PRAF database to spur immediate connectivity to community and health services, including evidence-based home visiting programs such as Nurse Family Partnership. B. The Maternal Opiate Medical Supports Plus (MOMS+) Building on the success of earlier MOMS and MOMS+, Ohio continues to improve the initiation and adherence to medication for opioid use disorder (MOUD) for pregnant mothers in the context of comprehensive, person-centered holistic care. The effort now has taken on a hub and spoke structure in which the hubs (also known as mentoring sites), often associated with tertiary care centers support the obstetricians in outlying communities, ensuring evidence-based behavioral health and obstetrical care with family and community supports. ODM is redesigning the Maternal Opiate Medical Supports Plus (MOMS+) Project to focus on continuation of care for the mother and baby dyad throughout the first year of life with persistent focus on infant and maternal mortality. Stakeholders contributing to the design of the project include pediatricians, family medicine doctors, obstetricians, addiction specialists, and behavioral healthcare providers. who will develop best-

practices related to preventive care, specific developmental and infectious-disease-related considerations, parenting and social services support, and continued trauma-informed care. C. Pediatric Comprehensive and Coordinated Behavioral Health Services project In January 2019, ODM launched the Pediatric Comprehensive and Coordinated Behavioral Health Services project to improve behavioral health outcomes for children 0-5 years of age. The project utilizes quality improvement (QI) processes to evaluate to the effectiveness of preventive behavioral health services at the time of well child checks at three high volume Medicaid clinic sites affiliated with Cincinnati Children's Hospital Medical Center. The goals are to reduce Emergency Room and urgent care utilization following a Well Child Care (WCC) visit, to increase adherence to the WCC visit at 6 months of life, and to improve behavioral health outcomes for the target population. To date, WCC at 6 months have improved, as has the percentage of children also seen by a psychologist. Parents consistently rate that they feel clearer about the things they can do to support their child to be the healthiest they can be. Parents consistently rate that they feel valued by the psychologist. D. Smoke Free Families Pediatric Additional recruitment began for 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. E. The Preschool Vision Screening Learning Collaborative Through funding from the Ohio Department of Medicaid, The Preschool Vision Screening Learning Collaborative brought together key partners including 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) to prevent vision loss in preschool age children by supporting pediatric primary care providers in increasing screening rates, improve billing practices, and increase 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. The project launched in January 2020 with six pediatrics sites and continued through October 2020. 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. As of September 1, 2020, 100% preschoolers seen at the participating clinical site had vision screening attempted via observation and 89% had vision screening attempted via Distance Visual Acuity (DVA). One hundred percent of vision screening attempts were successful via observation and practices reported an eighty-eight percent success rate for vision screening attempts via DVA. One hundred percent of screened preschoolers with an abnormal or untestable result had documentation of an appropriate referral to an eye care specialist. F. Hypertension Improvement Project For CYs 2017 to 2019, the quality improvement project chosen to serve as a the federally required and externally validated performance improvement project (PIP) focused on identifying and refining proven strategies to increase hypertension control, particularly for minority populations. The Hypertension Improvement Project was continued into 2020 with a new wave of practices serving a disproportionate percentage of Black patients. Although the PIP targets adults, it may impact children indirectly by improving the care and health outcomes of their caregivers and extended family. G. Diabetes PIP The federally required PIP for 2020, focuses on helping patients with HbA1c>9 manage their diabetes. As with the Hypertension PIP, the Diabetes PIP is focused on adults. However, the healthy lifestyle factors and the impact on patient outcomes may indirectly benefit children who are family members of patients seen by participating practices. H. Reduce Impact of COVID on Members Using QI Science In 2020, ODM and its Medicaid managed care plans have taken a unique approach to combatting the impact of the COVID-19 pandemic on Medicaid recipients by using quality improvement science to collaboratively improve immunizations, increase the use of telehealth, and provide transportation for medical and health-related social needs (e.g., food, prescriptions). Results to date include an increased the number of immunization events, grants from the MCOs supporting local entities in their telehealth efforts, and increased trips to allow for transportation for health-related social needs.

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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FFY 2020 SCHIP - Section 4 Part 2 Question 4.docx

Tell us how much you spent on your CHIP program in FFY 2020, and how much you anticipate spending in FFY 2021 and 2022.

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 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 466,200,345	**$** 473,257,593	**$** 509,731,231

2. How much did you spend on Fee for Service in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 56,316,709	**$** 65,763,457	**$** 65,763,457

3. How much did you spend on anything else related to benefit costs in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$	$	$ 0

4. How much did you receive in cost sharing from beneficiaries to offset your costs in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$	$	$

Table 1: Benefits Costs
This table is auto-populated with the data you entered above.

	FFY 2020	FFY 2021	FFY 2022
Managed Care	466200345	473257593	509731231
Fee for Service	56316709	65763457	65763457
Other benefit costs			0
Cost sharing payments from beneficiaries			
Total benefit costs	522517054	539021050	575494688

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 2020? How much do you anticipate spending in FFY 2021 and 2022?
This includes wages, salaries, and other employee costs.

2020	2021	2022
$ 4,269,811	**$** 3,512,085	**$** 3,512,085

2. How much did you spend on general administration in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 21,668,005	**$** 17,822,778	**$** 17,822,778

3. How much did you spend on contractors and brokers, such as enrollment contractors in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$	**$**	**$**

4. How much did you spend on claims processing in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 4,665,992	**$** 3,837,960	**$** 3,837,960

5. How much did you spend on outreach and marketing in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$	**$**	**$**

6. How much did you spend on your Health Services Initiatives (HSI) if you had any in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 3,875,257	**$** 5,000,000	**$** 5,000,000

7. How much did you spend on anything else related to administrative costs in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$	**$**	**$**

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.

	FFY 2020	FFY 2021	FFY 2022
Personnel	4269811	3512085	3512085
General administration	21668005	17822778	17822778
Contractors and brokers			
Claims processing	4665992	3837960	3837960
Outreach and marketing			
Health Services Initiatives (HSI)	3875257	5000000	5000000
Other administrative costs			
Total administrative costs	34479065	30172823	30172823
10% administrative cap	58057450.44	59891227.78	63943854.22

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 2022 will be calculated once the eFMAP rate for 2022 becomes available. In the meantime, these values will be blank.

	FFY 2020	**FFY 2021**	**FFY 2022**
Total program costs	556996119	569193873	605667511
eFMAP	85.61	74.54	74.87
Federal share	476844377.48	424277112.93	453463265.49
State share	80151741.52	144916760.07	152204245.51

8. What were your state funding sources in FFY 2020?
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 2020? How many do you anticipate will be eligible in FFY 2021 and 2022?

2020	2021	2022
195557	191096	192066

2. What was your per member per month (PMPM) cost based on the number of children eligible for Managed Care in FFY 2020? What is your projected PMPM cost for FFY 2021 and 2022?
Round to the nearest whole number.

2020	2021	2022
$ 199	**$** 206	**$** 221

	FFY 2020	FFY 2021	FFY 2022
PMPM cost	199	206	221

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 2020? How many do you anticipate will be eligible in FFY 2021 and 2022?

2020	2021	2022
4789	5229	5229

2. What was your per member per month (PMPM) cost based on the number of children eligible for Fee For Service in FFY 2020? What is your projected PMPM cost for FFY 2021 and 2022?
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.

2020	2021	2022
$ 980	**$** 1,048	**$** 1,048

	FFY 2020	**FFY 2021**	**FFY 2022**
PMPM cost	980	1048	1048

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 2020, 2021 and 2022 are net of drug rebates. b. Amounts estimated in the Health Services Initiative line are for lead abatement activities. c. In Part 2: Administrative Costs - Table 3: Federal and State Shares does not reflect accurate eFAMP amounts applicable to Ohio. Please see the optional attachment for Ohio's submission.

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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FFY 2020 SCHIP - Section 5 Federal and State Shares.docx

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

Governor Mike DeWine's administration has been enthusiastically supportive regarding Ohio's ability to provide healthcare to low-income children and families. After being elected to office, Governor DeWine created the Governor's Children's Initiative and appointed LeeAnne Cornyn to lead this office. The Governor's Children's Initiative aims to "Create Opportunity for Every Ohio Kid" by spearheading priority policy initiatives and facilitating collaboration and coordination among Ohio's child-serving systems. Even as families with Medicaid face added challenges brought on by the pandemic, the DeWine's Administration remains focused on children and families, and ODM has continued or initiated several programs to these aims. In 2020, ODM: • Provided a two-year continuation of ODM's Infant Mortality grant program, to support coordinated community programs that target the disparity in the African American infant mortality rate. ODM awarded $25 million dollars in nine counties for state fiscal years 20 and 21 to support this targeted disparity reduction effort; • Significantly expanded telehealth services in response to the pandemic, and adapted existing population health improvement plans to address pandemic conditions; • Started a multi-system youth innovation fund targeted at existing programs' non-billable services for children with complex needs to create pathways to coverage under Medicaid. To date, ODM has spent $10 million dollars in 74 counties in state fiscal years 20 and 21 to serve 348 multi-system youth as well as provide technical assistance to counties to build capacity to serve even more children; • Started a patient-centered medical home program called Comprehensive Primary Care for Kids, which incentivizes pediatric primary care providers to meet children's specific quality metrics such as immunizations and lead testing, as well as performing pediatric-specific activities such as caring for foster youth, transitioning older children to adult care, and providing school-based care. In 2020, ODM has paid over $7 million dollars in per-member per-month incentives to CPC for Kids practices covering over 700,000 children receiving Medicaid services; • Released a Request for Applications to administer OhioRISE, a specialized managed care program for youth with complex behavioral health and multi-system needs that will provide new services to children under 21 enrolled in Medicaid through a collaborative delivery system. OhioRISE will customize care for those children most at risk for out of home placement and will align policy across ODM and the Ohio Department of Job and Family Services, which is working to implement the Family First

Prevention Services Act. This much needed program is even more important as the pandemic has brought on significantly greater challenges for this population. • Plan in place to address gaps in immunizations due to the pandemic. MCPs are working collaboratively within a quality improvement framework learn how best to catch-up on childhood immunizations. MCPs are offering incentives, sponsoring mobile vans, and coordinating with pediatricians to restore immunization rates to pre-pandemic levels.

2. What's the greatest challenge your CHIP program has faced in FFY 2020?

Beginning in March 2020, Ohio, along with the rest of the globe, began experiencing the worst pandemic in a century, which continues to beleaguer Medicaid and children's services agencies, stretching already limited resources even thinner and requiring rapid innovation and flexibility in order to continue to meet the health care needs of children in Ohio. Children have been unable to attend school, have suffered from additional mental health burdens, have experienced greater food insecurity and housing instability, and have gaps in health care 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. Despite an increasing Medicaid caseload due to the extended economic ramifications of the pandemic that continues to challenge staffing and budgets, and the need to rapidly transition provision of and reimbursement for many in-office services to virtual and remote services, 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 2020 to begin much of the operational and foundational work that is required in order to rapidly bring up additional services and supports for children and their families as the pandemic loosens its grip in 2021.

3. What are some of the greatest accomplishments your CHIP program has experienced in FFY 2020?

A. In 2019, the Ohio Department of Medicaid (ODM) 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: • Improve wellness and health outcomes. • Emphasize a personalized care experience. • Support providers in better patient care. • Improve care for children and adults with complex needs. • Increase program transparency and accountability. B. To strengthen care for children with complex medical and behavioral health needs, ODM developed OhioRISE (Resilience through Integrated Systems and Excellence), a formalized model of care coordination, to tailor behavioral health services to meet the unique needs of children served by multiple state systems and children with other complex behavioral health needs, and to create robust partnerships between community-based organizations and managed care organizations. C. Single Pharmacy Benefit Manager (sPBM) An RFI was released 11/2019, the RFP was posted 7/2020, and anticipated selection will occur 1/2021. This project will form a new prepaid ambulatory health plan (PAHP) that will serve as a single PBM for all managed care members of Ohio Medicaid. FFS members will be added later. This will unbundle the PBM responsibilities in a way to avoid potential conflicts of interest and increase transparency and oversight into the PBM space. ODM will have assistance in this process from a Pharmacy Operations Support Vendor(POSV), which will assist with pricing, channel management and auditing. D. Unified Preferred Drug List (uPDL) Initiated 1/1/2020, all Medicaid managed care plans and Fee for Service Medicaid pharmacy programs operate from the same preferred drug lists and same prior authorization guidelines. In addition to saving ODM tens of millions of dollars in added rebates, this has significantly decreased the administrative burden for our prescribers and pharmacy providers. E. Building on the framework of the Comprehensive Primary Care Program, Ohio started a patient-centered medical home program called Comprehensive Primary Care for Kids, which incentivizes pediatric primary care providers to meet children's specific quality metrics such as immunizations and lead testing, as well as performing pediatric-

specific activities such as caring for foster youth, transitioning older children to adult care, and providing school-based care. In 2020, ODM has paid over $7 million dollars in per-member per-month incentives to CPC for Kids practices covering over 700,000 children receiving Medicaid services; F. Expanding telehealth 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: • Expanded telehealth services to include a wide array of medical, clinical and behavioral health providers and counselors • Eased technology restrictions on patient-physician interaction to deliver telehealth services • Reduced prior authorization requirements to for many medical and behavioral services • Enhanced pharmacy benefits, eliminating in- and out-of-network restrictions, pharmaceutical co-pays while increasing pharmacy reimbursements for over the counter medications • Enabled nursing home and congregate care members to access telehealth services with no prior authorization G. Reshaped the Quality Withhold to address needs that impact children during the pandemic, i.e., telehealth, immunizations, and transportation, through a population health approach to these initiatives - a method aimed at improving the health of the entire population by understanding the distribution of health and factors contributing to it within a community. It enabled the agency to more effectively identify and reduce health inequities, to gain insights into a broad range of factors that influence health, and to strengthen its focus on the individual. The goal of the redesigned program was to reduce the spread of coronavirus, address unintended consequences of COVID-19 prevention protocols, and leverage newly enacted telehealth expansions to extend access to care to small community and rural health care providers. These initiatives were based on 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 - quality components required by Medicaid MCPs to meet annual performance requirements. H. ODM has a long-standing Preterm Birth Prevention effort anchored in the 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 risk for more timely intervention for a larger group of women. ODM created and implemented a web-based version of the Pregnancy Risk Assessment Form (PRAF

2.0) to automate data collection for real-time population health management. Data submitted directly links to Ohio's eligibility system to prevent the inadvertent loss of health care coverage during pregnancy and creates direct referrals to other maternal and infant supports, including tobacco cessation, home visiting, and smoking cessation. ODM also continues to work with preterm birth prevention partners, especially in communities of greatest infant mortality disparities, to improve use of the PRAF database to spur immediate connectivity to community and health services, including evidence-based home visiting programs such as Nurse Family Partnership. I. The Maternal Opiate Medical Supports Plus (MOMS+) Building on the success of earlier MOMS and MOMS+, Ohio continues to improve the initiation and adherence to medication for opioid use disorder (MOUD) for pregnant mothers in the context of comprehensive, person-centered holistic care. The effort now has taken on a hub and spoke structure in which the hubs (also known as mentoring sites), often associated with tertiary care centers support the obstetricians in outlying communities, ensuring evidence-based behavioral health and obstetrical care with family and community supports. The mentoring sites also help maternity care providers develop the capacity to provide induction therapy close to home, collaborate with local child welfare, and link to housing and other social service resources in their communities, culminating in more effective plans of safe care as referenced in the Comprehensive Addiction and Recovery Act (CARA). ODM is redesigning the Maternal Opiate Medical Supports Plus (MOMS+) Project to focus on continuation of care for the mother and baby dyad throughout the first year of life with persistent focus on infant and maternal mortality. Stakeholders contributing to the design of the project include pediatricians, family medicine doctors, obstetricians, addiction specialists, and behavioral healthcare providers. who will develop best-practices related to preventive care, specific developmental and infectious-disease-related considerations, parenting and social services support, and continued trauma-informed care. J. Ohio's Healthy Student Profiles are the 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. These profiles distributed in February 2020 are intended to support school districts in building relationships with health care providers and community agencies to better meet the non-academic needs of their student populations. K. In January 2019, ODM launched the Pediatric Comprehensive and Coordinated Behavioral Health Services project to improve behavioral health outcomes for

children 0-5 years of age. The project utilizes quality improvement (QI) processes to evaluate to the effectiveness of preventive behavioral health services at the time of well child checks at three high volume Medicaid clinic sites affiliated with Cincinnati Children's Hospital Medical Center. The goals are to reduce Emergency Room and urgent care utilization following a Well Child Care (WCC) visit, to increase adherence to the WCC visit at 6 months of life, and to improve behavioral health outcomes for the target population. To date, WCC at 6 months have improved, as has the percentage of children also seen by a psychologist. Parents consistently stated that they feel clearer about the things they can do to support their child to be the healthiest they can be. Parents consistently rate that they feel valued by the psychologist. L. Additional recruitment began for 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. M. Through funding from the Ohio Department of Medicaid, The Preschool Vision Screening Learning Collaborative brought together key partners including 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) to prevent vision loss in preschool age children by supporting pediatric primary care providers in increasing screening rates, improve billing practices, and increase 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. The project launched in January 2020 with six pediatrics sites and continued through October 2020. 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. As of September 1, 2020, 100% preschoolers seen at the participating clinical site had vision screening attempted

via observation and 89% had vision screening attempted via Distance Visual Acuity (DVA). One hundred percent of vision screening attempts were successful via observation and practices reported an eighty-eight percent success rate for vision screening attempts via DVA. One hundred percent of screened preschoolers with an abnormal or untestable result had documentation of an appropriate referral to an eye care specialist. N. On August 19, 2019, Governor DeWine announced that the Centers for Medicare and Medicaid Services (CMS) approved Ohio's Children's Health Insurance Program (CHIP) initiative to enhance and expand Medicaid's lead abatement program in partnership with the Ohio Department of Health (ODH). 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. Ohio plans to eliminate lead in homes in two phases: • Phase 1 - focuses on homes with lead hazard control orders issued by ODH or one of its delegated boards of health. These targeted properties are known to have poisoned at least one child. This phase will continue throughout the program. Phase 1 properties will be prioritized over referrals received in Phase 2. • Phase 2 - targets primary prevention before a child is poisoned. This phase began implementation in June 2019. The focus of Phase 2 is to prevent children and pregnant women from exposure to lead in their environments. O. 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. Fourteen examples of patient experiences with clinical encounters showcased the challenges of patients with conditions such as psychosis, dementia, pregnancy, substance use disorder, wheelchair confinement and others, all offering diverse patient perspectives. Six academic medical centers/health sciences colleges participated 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. P. The Care Innovation and Community Improvement Program (CICIP) was implemented in SFY 2019 to rethink care within health systems and bring person-centered focus to prevention and more effective treatment, for opioid use disorder to improved care for the maternity and frequent Emergency Department populations. The four health systems are large Medicaid safety-net and academic medical centers that worked

together to develop strategies to optimize care, creating data dashboards to track progress along agreed-upon measures and sharing lessons learned. To date, most of the systems have leveraged their electronic health records to bring different parts of the health system together, creating alerts and engaging patients. In addition, peer supports and community workers have been deployed effectively, for engagement and connectivity to care, and to support a cultural shift of compassion for those struggling with addiction.

4. What changes have you made to your CHIP program in FFY 2020 or plan to make in FFY 2021? Why have you decided to make these changes?

As referenced in question one above, in FFY 2020 Ohio initiated a program to support multi-system youth, initiated a patient centered medical home program for children, extensively expanded telehealth services, and reshaped the quality withhold program to respond to the needs of members impacted by the pandemic. Ohio made these changes to support the Governor's priorities of improving the everyday experiences and life trajectories of Ohio's children. By incentivizing comprehensive, coordinated care for many of Ohio's most vulnerable children, offering specialized assistance to county and local partners who care directly for children with the highest needs, and reimbursing providers for care provided in a safe, convenient setting for children and families, Ohio has made great strides in implementing systems and processes to improve children's health statewide. In FFY 2021, Ohio intends to remain focused on children while operating within the constraints of the pandemic and the budget limitations the pandemic has precipitated. In addition to continuing to administer the programmatic changes initiated in FFY 2020, Ohio plans to: • Implement to the extent possible programs, providers and services that support moms and babies through data-driven, evidence-based initiatives; • Begin the implementation of the next generation of Medicaid managed care in Ohio • Begin the implementation of OhioRISE to support multi-system youth through new services and supports provided within a framework of coordinated care; • Promote the expansion of telehealth to improve access to those with limited access to services • Continue the collaborative quality improvement projects linked to the quality withhold focusing on closing the gap in immunizations and lead testing • ODM has initiated rules that will allow pharmacists to be credentialed as Medicaid providers and subsequently bill ODM and the MCPs for medical services within their scope of practice and with appropriate collaborative agreements. This will take effect 1/2021.

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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