OHREC
Oregon Health Research
&
Evaluation Collaborative

Oregon HEALTH PLAN

STATE COVERAGE INITIATIVES

What is OHREC ?

Vision:

Providing the opportunity for collaborative effort among health services researchers focusing on the Oregon Health Plan population.

Mission:

To investigate, evaluate and effectively disseminate health services information in the interest of informing health policy in Oregon.

Guiding Principles of OHREC

1. Consistent with legislative intent as expressed in HB 2519 and the waiver application
2. Allows Oregon legislative review of program successes/failures
3. Responsive to Centers for Medicaid and Medicare Services (CMS)
4. Provides information to manage the program (FHIAP; OHP2 in its entirety)
5. Provides information about broad social impacts

What are the Goals of OHREC?

1. Facilitate research efforts to inform legislature and stakeholders on Oregon Health Plan issues.
2. Procure a grant to fund a collaborative research project to study long term impacts to Oregon Health Plan changes.
3. Establish a working information network among health services researchers and the state for improved communication and efficiency of research efforts.
4. Create a streamlined process for health services research on the Oregon Health Plan including a data warehouse.

What are the Goals of OHREC?

Goal #1:

Facilitate research efforts to inform legislature and stakeholders on Oregon Health Plan issues.

Immediate Projects Workgroup

Purpose:

Identify research projects that are key to informing 2003 legislature.

1. Look at proposed and current projects that may have data ready for 2003 legislature
2. Identify gaps in research
3. Strategize approach to funding

Immediate Projects Workgroup:

Current/Proposed Projects

OMAP Short-Term Evaluations

- **Avoidable ER**
- **Inpatient Ambulatory Care Sensitive Conditions (ACSC)**
- **Preventive Services; Ambulatory Care Visits**
- **Disenrollment /Enrollment**
- **Churn Reports (OMAP to FHIAP and vice versa)**

OMHAS Short-Term Evaluations:

- **Evaluate impact of benefit changes in the alcohol/drug and mental health system.**

Immediate Projects Workgroup:
Current/proposed Projects

OHREC-sponsored Short-Term Evaluations

- **Indirect affects of OHP2 benefit reductions on SCHIP enrollees.**
- **FHIAP Survey**
- **Loss of prescription drug benefit for the OHP standard population.**
- **ER utilization survey**

What are the Goals of OHREC?

Goal #2:

Procure grants to fund collaborative research project to study long-term impacts of Oregon Health Plan changes.

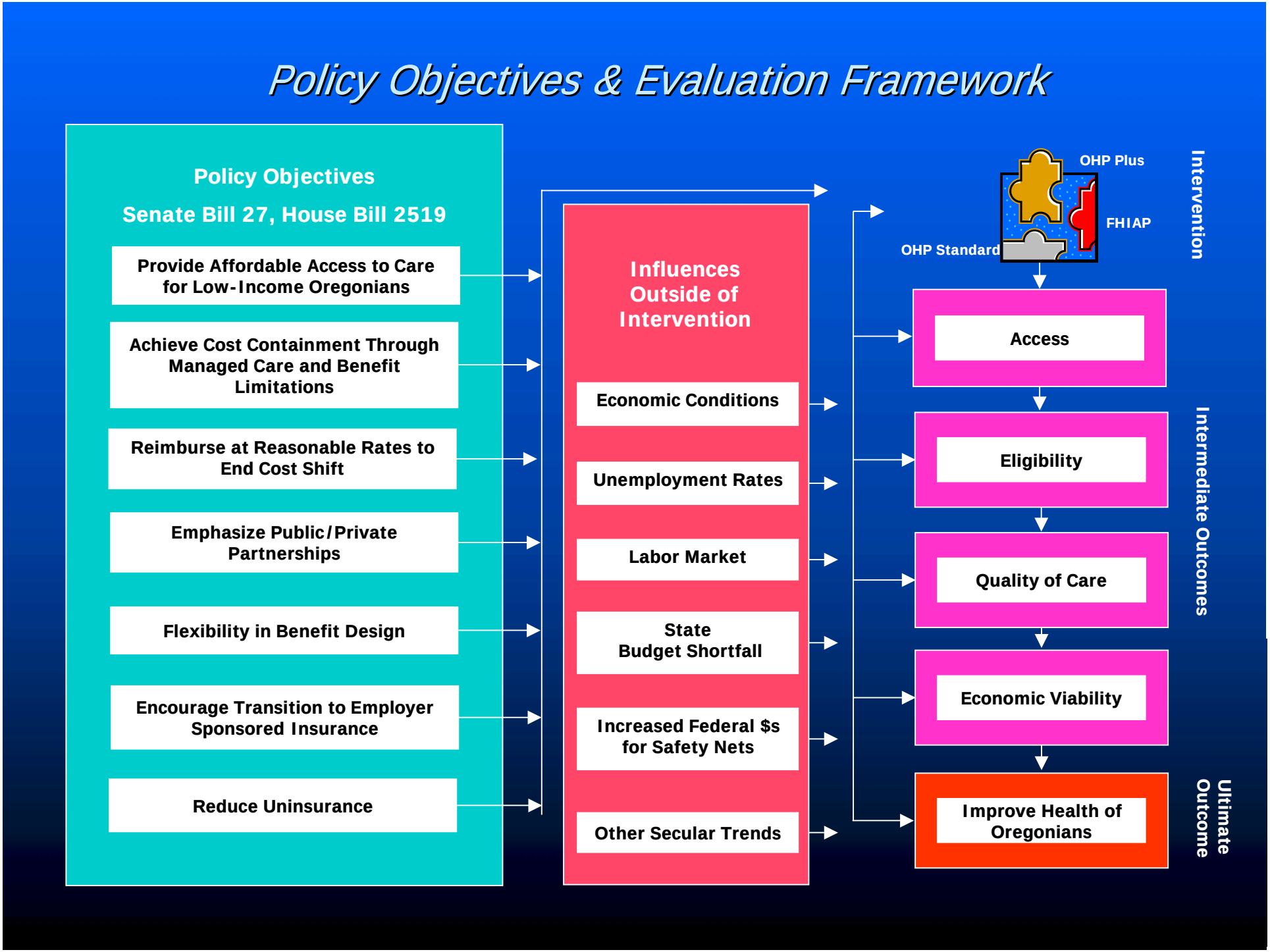
Longer-term Projects Workgroup

Purpose:

Secure a grant to fund collaborative research projects including:

1. Develop study design and collaboration of key questions
2. Strategize approach to funding
3. Grant writing & IRB application(s)
4. Identify data sources

Policy Objectives & Evaluation Framework



Longer-term Projects Workgroup: Proposed Grant Project

"What are the Impacts of the Benefit Redesign on the Oregon Health Plan Population?"

- **How does redesign impact access?**
- **How does redesign impact eligibility?**
- **How does redesign impact quality of care?**
- **How does redesign impact economic viability of the plan?**

Framework for Grant Project

What are the impacts of the benefit redesign on the Oregon Health Plan Population?

- How does the redesign impact **Access**?
- How does the redesign impact **Coverage**?
- How does the redesign impact **Quality** of care?
- How does the redesign impact **Economic** viability of the plan?

System Level Impacts

Administrative Data Sources

Delivery System Impact: Health Plans, FQHCs, Behavioral Health Clinics, Providers

Emergency Department Impacts

Economic Impacts on Medicaid: Substitution Analysis

Individual Level Impacts

Primary Data Collection

Administrative Data Sources

Longitudinal Cohort Study (One year pre-Two year post)

Sub-Analyses

- People with racial & ethnically diverse backgrounds
- People with disabilities
- Behavioral health diagnoses
- Ambulatory care sensitive conditions

What are the Goals of OHREC?

Goal #3:

Establish a working information network among health services researchers and the state for improved communication and efficiency of research efforts.

Communication efforts so far.....

Role of Office of Health Policy and Research (OHPR)

- **Schedule/staff all workgroups and public meetings.**
- **Facilitate communication between workgroups and OHREC to ensure all members remain informed regardless of workgroup participation.**
- **Maintain alliance with OMAP, FHIAP and relevant state agencies.**
- **Facilitate communication of research outcomes to Governor and the Legislature**

What are the Goals of OHREC?

Goal #4:

Create a streamlined process for health services research on the Oregon Health Plan including a possible data warehouse

Data Warehouse & Research Template Workgroup

Purpose:

Establish a working information network among health services researchers and the state for improved communication and efficiency of research efforts.

- Possible creation of data warehouse
- Development of streamlined research process

Data Warehouse & Research Template Workgroup: Current/proposed Projects

Workgroup just starting to share information about existing and possible future data warehouses.

Other considerations:

– HIPAA impact on collaborative data sharing

- Streamlining steps for researchers and state agencies to access/share data

Discussion Topic: Collaborative Communication

What are the best strategies to accomplish OHREC's Goal #3:

"Working information network among health services researchers."

Next Steps .....

OHREC information link on OHPR's website www.ohpr.state.or.us

Ongoing workgroup meetings

Periodic public meetings for updates on workgroups and research outcomes

Other ideas?

For more information about OHREC:

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The Oregon Health Plan, Managed Care, and Substance Abuse Treatment

Where We've Been and Where We Appear to Be Going

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Dennis D. Deck, Ph.D.
RMC Research Corporation

Invited Presentation of the Substance Abuse Prevention and Treatment Research forum sponsored by the Oregon Practice Improvement Collaborative, the Oregon Health and Science University, Center for Alcohol and Drug Policy and Research, and the Oregon Office of Mental Health and Addiction Services. Wilsonville, Oregon, February 20, 2003.

This Presentation Describes:

The expanded health care coverage in the innovative and progressive Oregon Health Plan, circa 1994 to 1995.

Its effects on access to and utilization of substance abuse treatment in subsequent years.

Characteristics of the newly Medicaid eligible population (OHP standard).

This Presentation is Based On:

Data from a series of CSAT, NIDA, and state-funded studies, 1996 to present, designed to examine the impact of managed care on substance abuse treatment in the Medicaid population.

Studies include:

Statewide administrative data analysis (CPMS, Medicaid enrollment).

Prospective longitudinal studies of clients in treatment.

Qualitative document reviews and interviews of key stakeholders (state and county administrators, treatment providers, consumers).

State of Washington (nonmanaged care) data for comparison purposes.

Background: The Oregon Health Plan

Series of legislative bills, 1989 to 1993, designed to provide health care coverage for all low income Oregon citizens.

Controversial rationing of conditions covered, using ranking of 696 condition/treatment pairs.

Initially, 565 condition/treatment pairs covered under OHP.

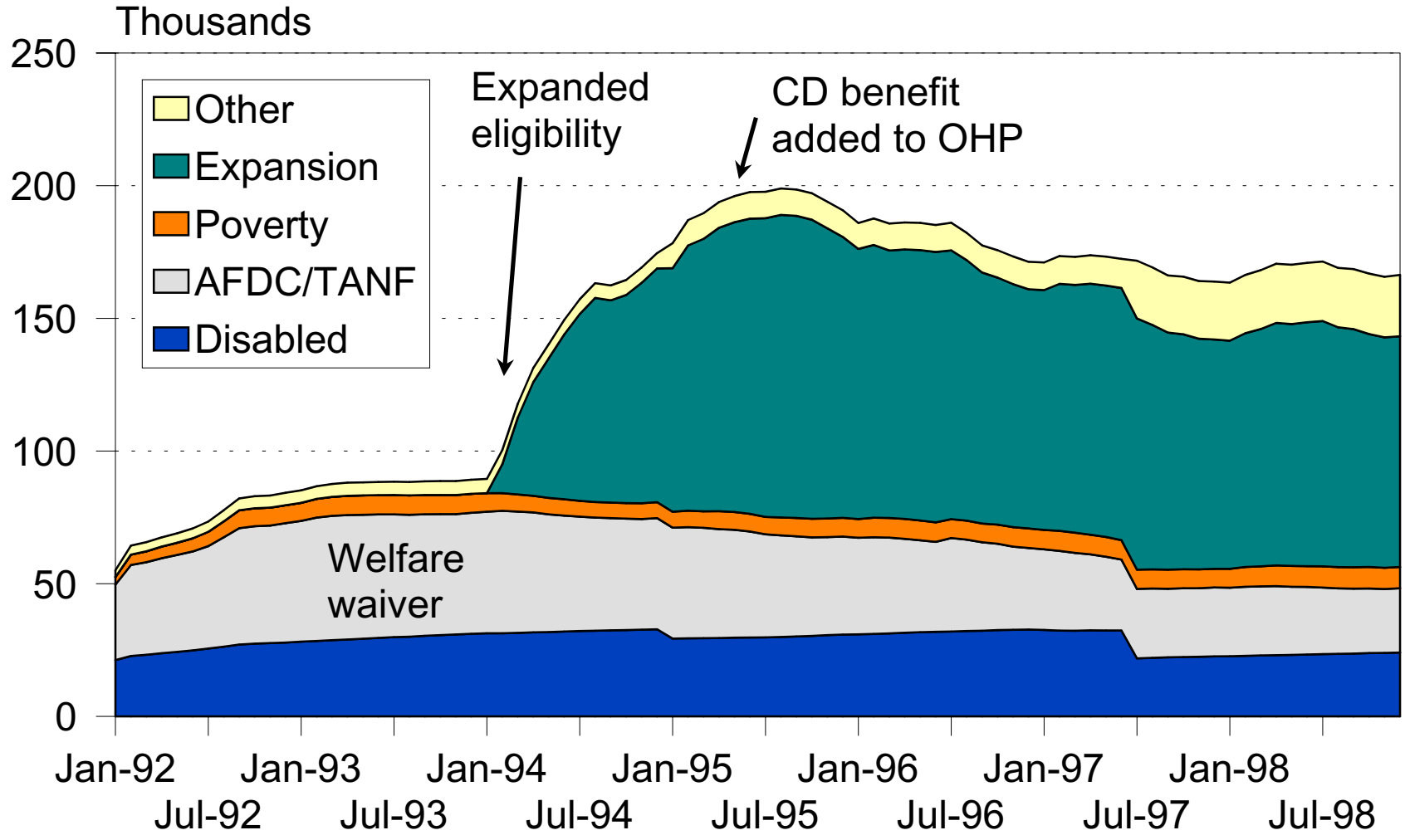
OHP implemented February 1994 using federal Medicaid waiver (1115) that expanded Medicaid eligibility.

Mandated managed care enrollment for all OHP members.

Began with 19 Managed Care Organizations (MCOs), all fully capitated health plans (FCHPs).

Oregon Medicaid-Eligible Adults*

Before and After Implementation of OHP



Eligibility Categories

Disabled - recipients of Supplemental Security Income (SSI) .

AFDC/TANF - welfare recipients under AFDC or TANF, mandatory Medicaid programs.

Other poverty - voluntary programs for low-income clients (e.g., pregnant women or refugees).

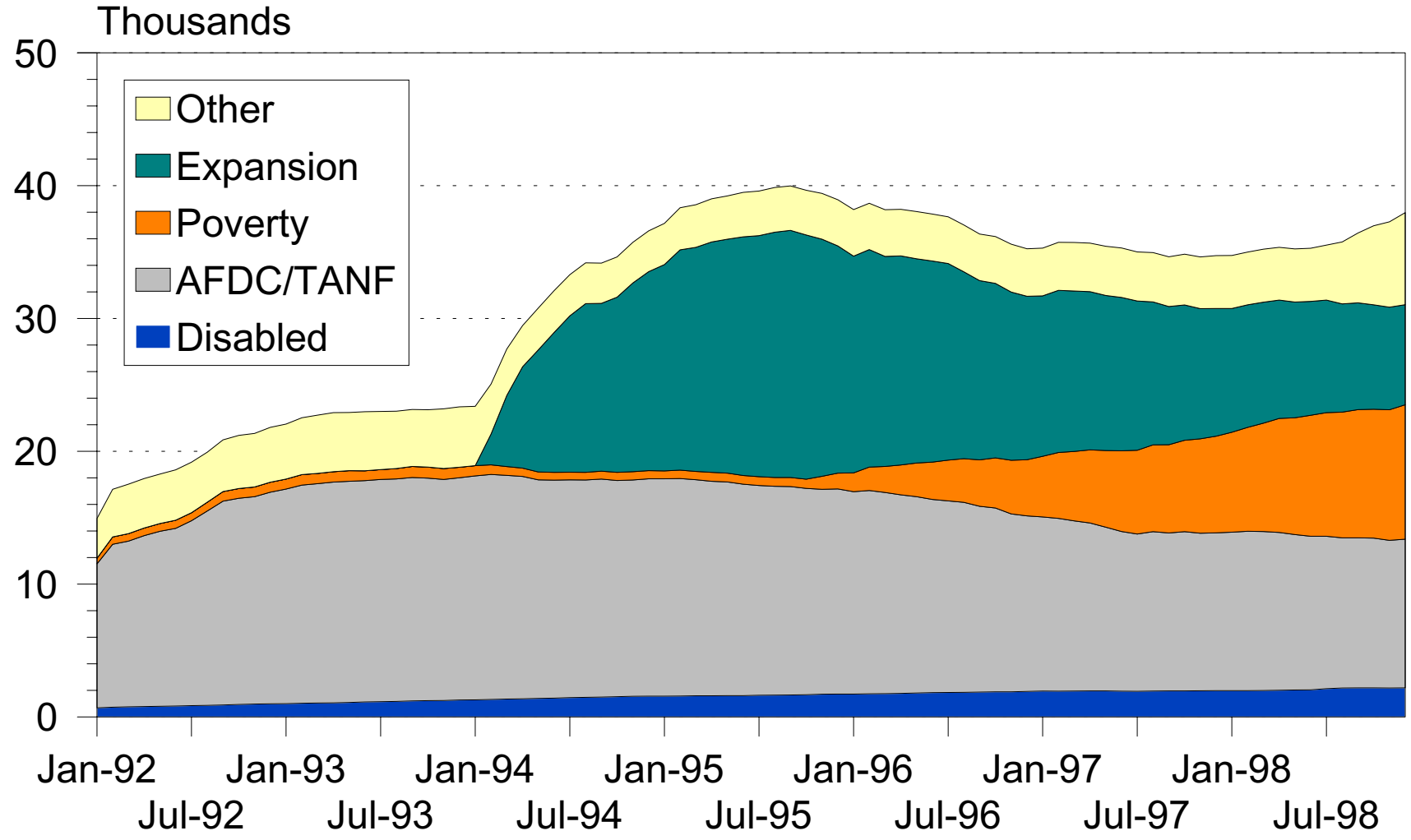
Expansion - single adults or childless couples newly eligible under Oregon's Section 1115 waiver that took effect February 1994.

Other - all other Medicaid or state programs (e.g., Washington's ADATSA program).

Category definitions developed in collaboration with team of researchers representing other SAMHSA study sites and key informants from OADAP/OMAP and DASA/MAA.

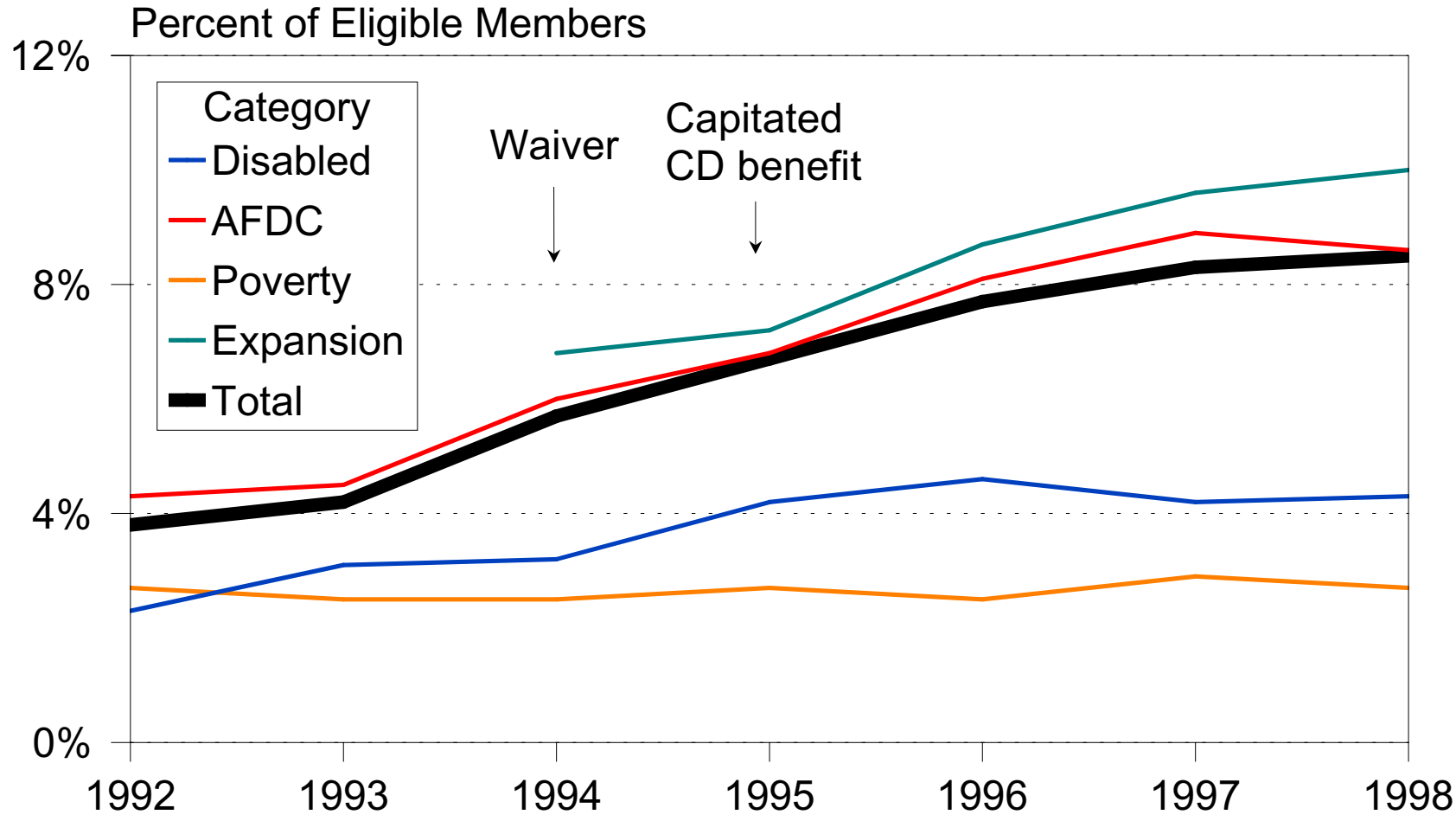
Oregon Medicaid-Eligible Adolescents*

Before and After Implementation of OHP



Oregon Adult Access Rates

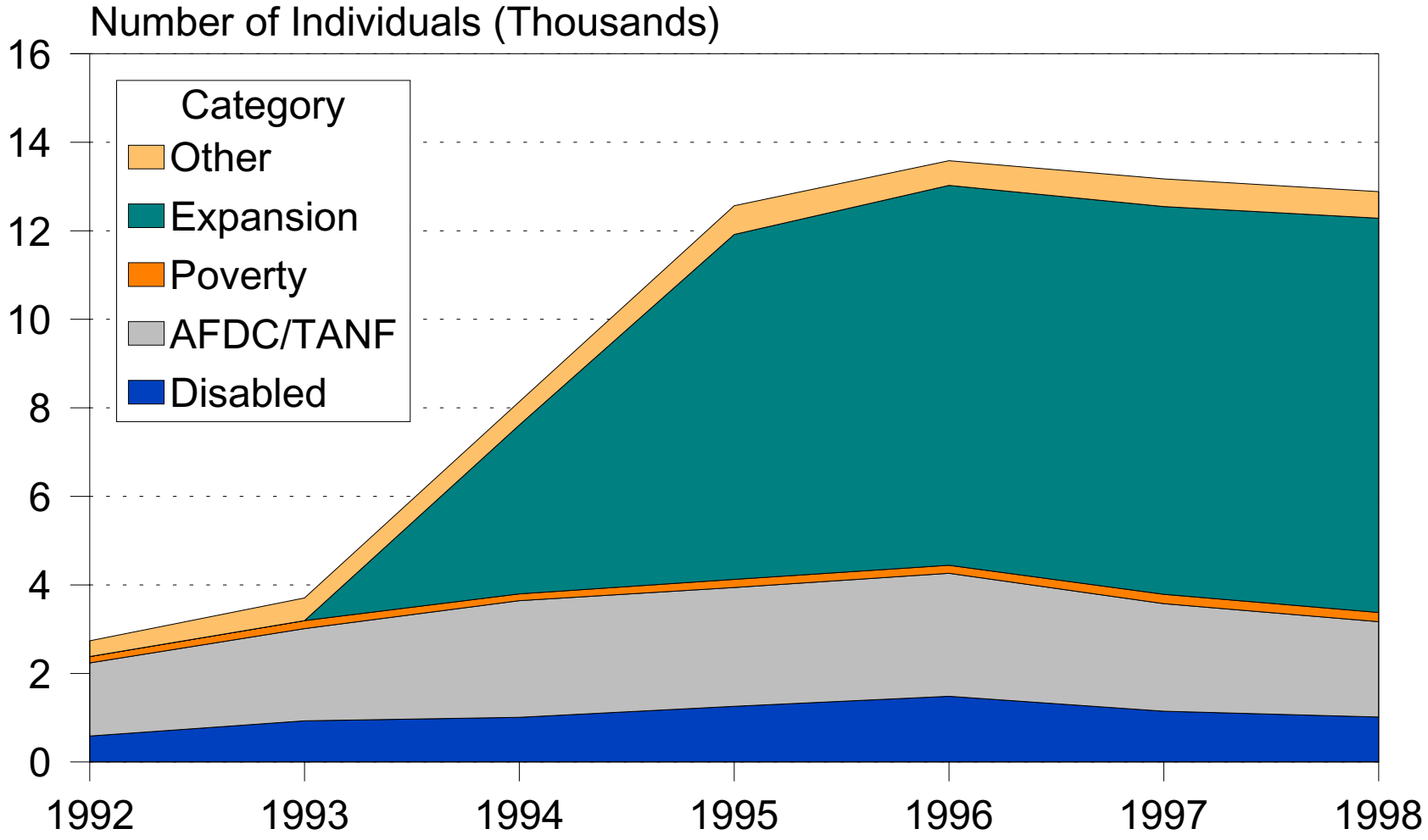
Adults admitted to treatment during year as percentage of average eligible members



Source: State treatment database (CPMS) and Medicaid eligibility files
Rate for Other not shown, small group with changing composition.

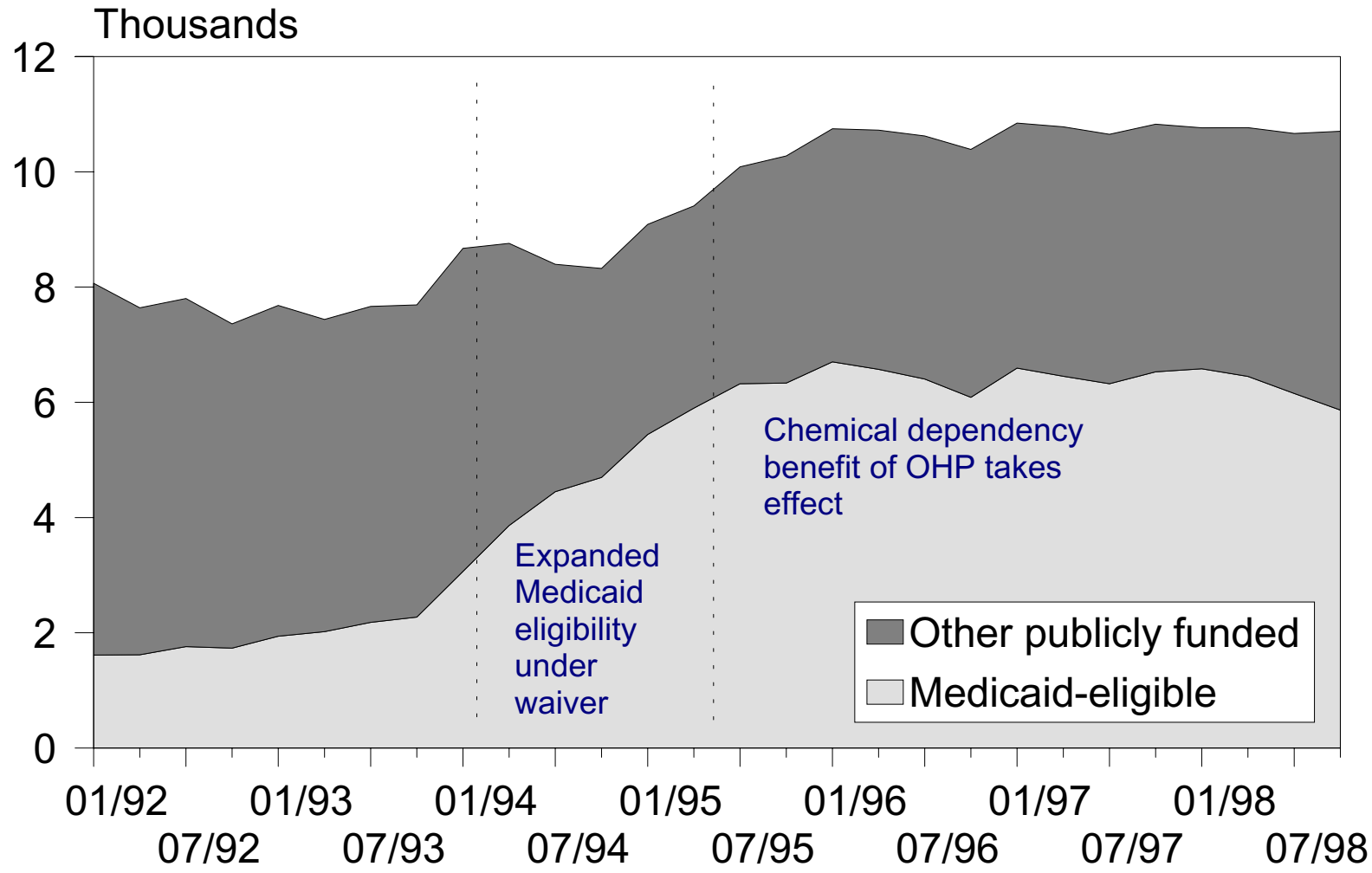
Oregon Admissions to Treatment

Number of Medicaid-eligible adults admitted to at least one treatment service during year



Source: State treatment database (CPMS) and Medicaid eligibility files.

Publicly Funded Admissions to Substance Abuse Treatment



Total admissions per quarter

Medicaid Expansion andSubstance Abuse Treatment Access

Summary

With the 1994 HCFA waiver, (adult) Medicaid-eligible population more than doubled within a year.

The newly eligible or *expansion* population comprised over half of the Medicaid population.

Access rates (adults) to substance abuse treatment more than doubled over this time period, from 4% of the Medicaid population in 1993 to over 8% in 1998.

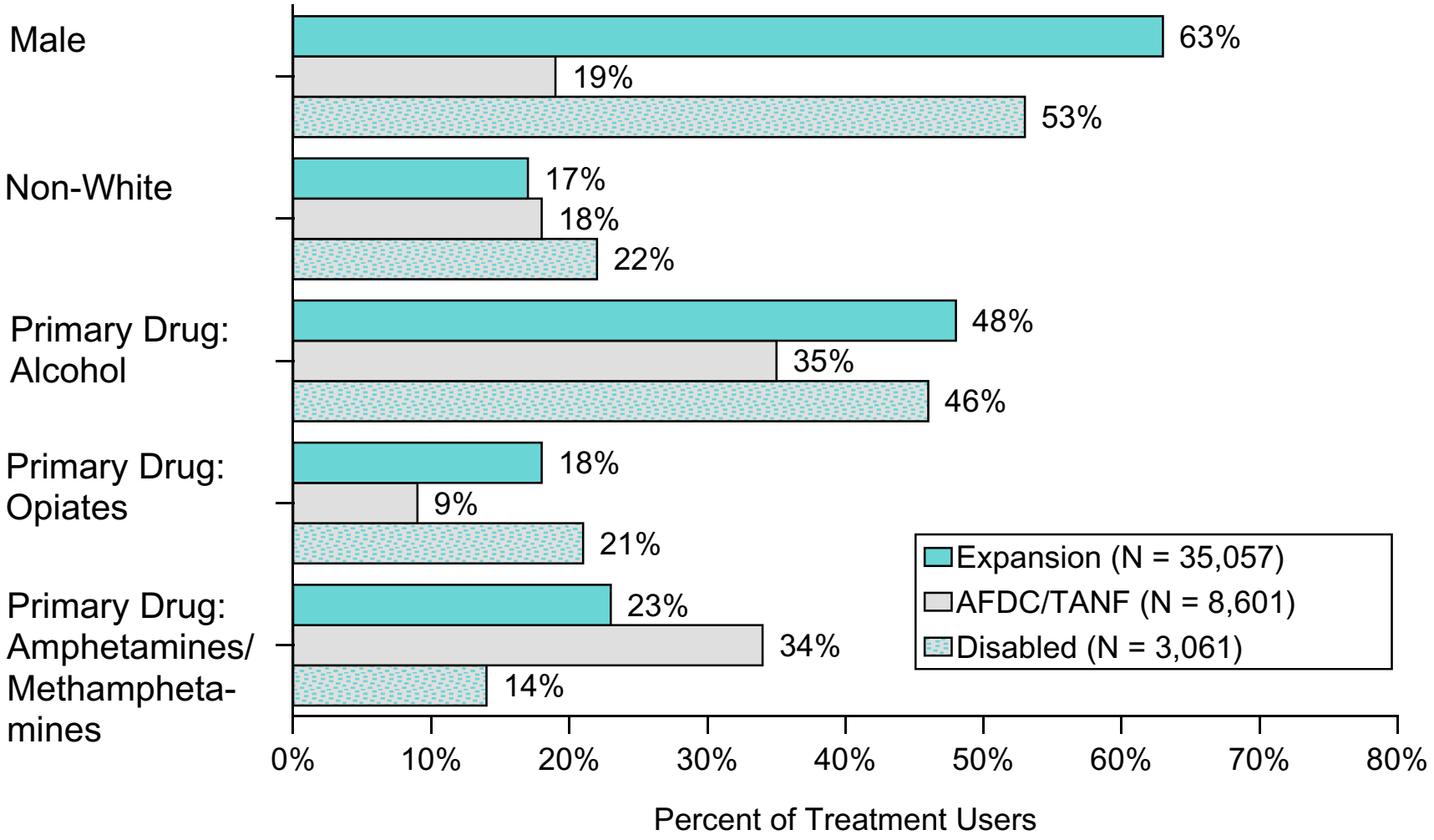
With the increase in the overall Medicaid population, this doubling in access rate yielded a fourfold increase in the number of admissions to treatment.

Medicaid Expansion and Substance Abuse Treatment Access (continued)

This increase was not a simple cost shift from other publicly funded sources. All publicly funded admissions to substance abuse treatment increased over this time period.

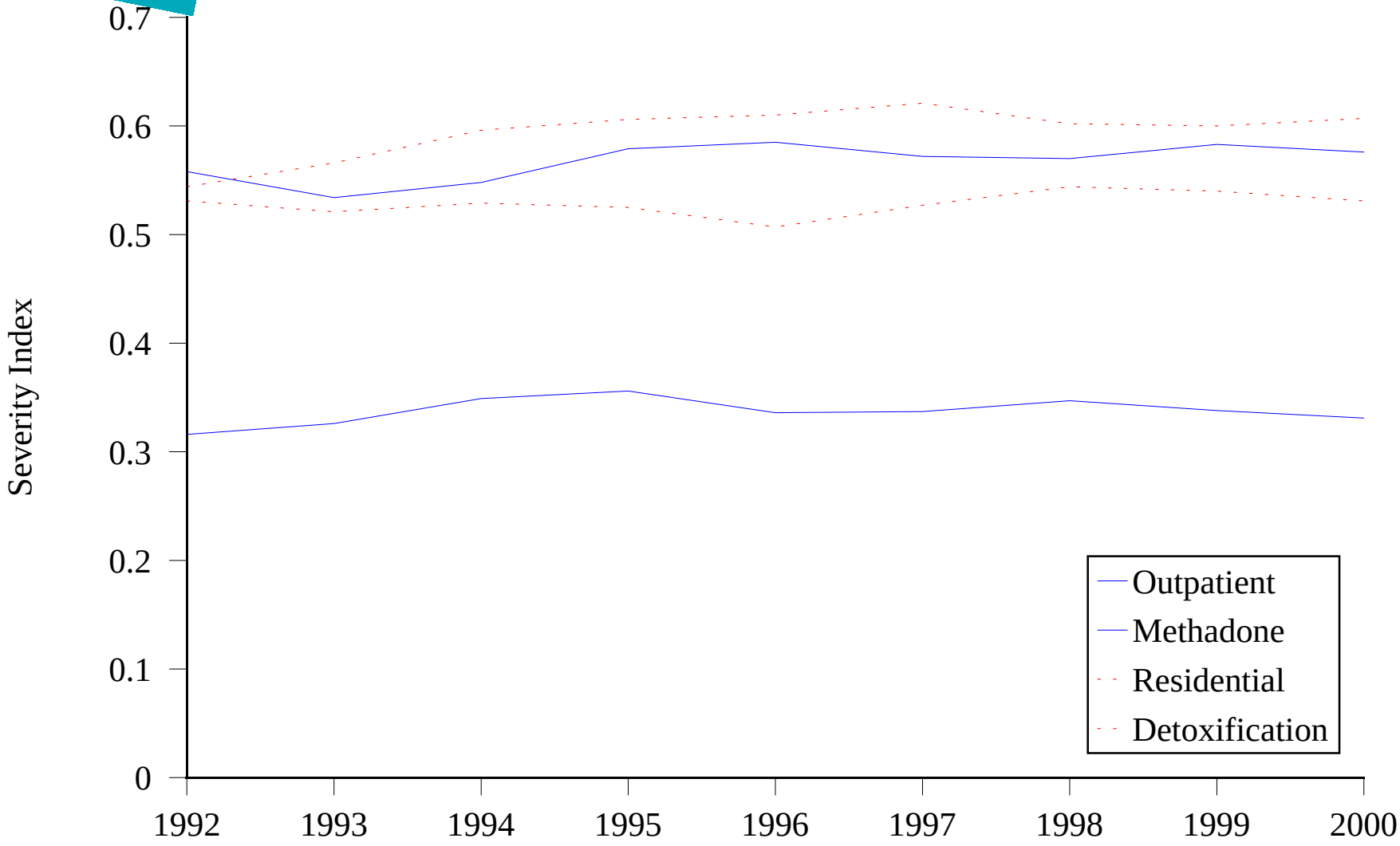
The expansion population was heavily represented among treatment use. Over 60% of the Medicaid population in treatment were these newly eligible adults.

Characteristics of Substance Abuse Treatment Clients by Selected Medicaid Eligibility Group; First Admissions 1997 to 2000*



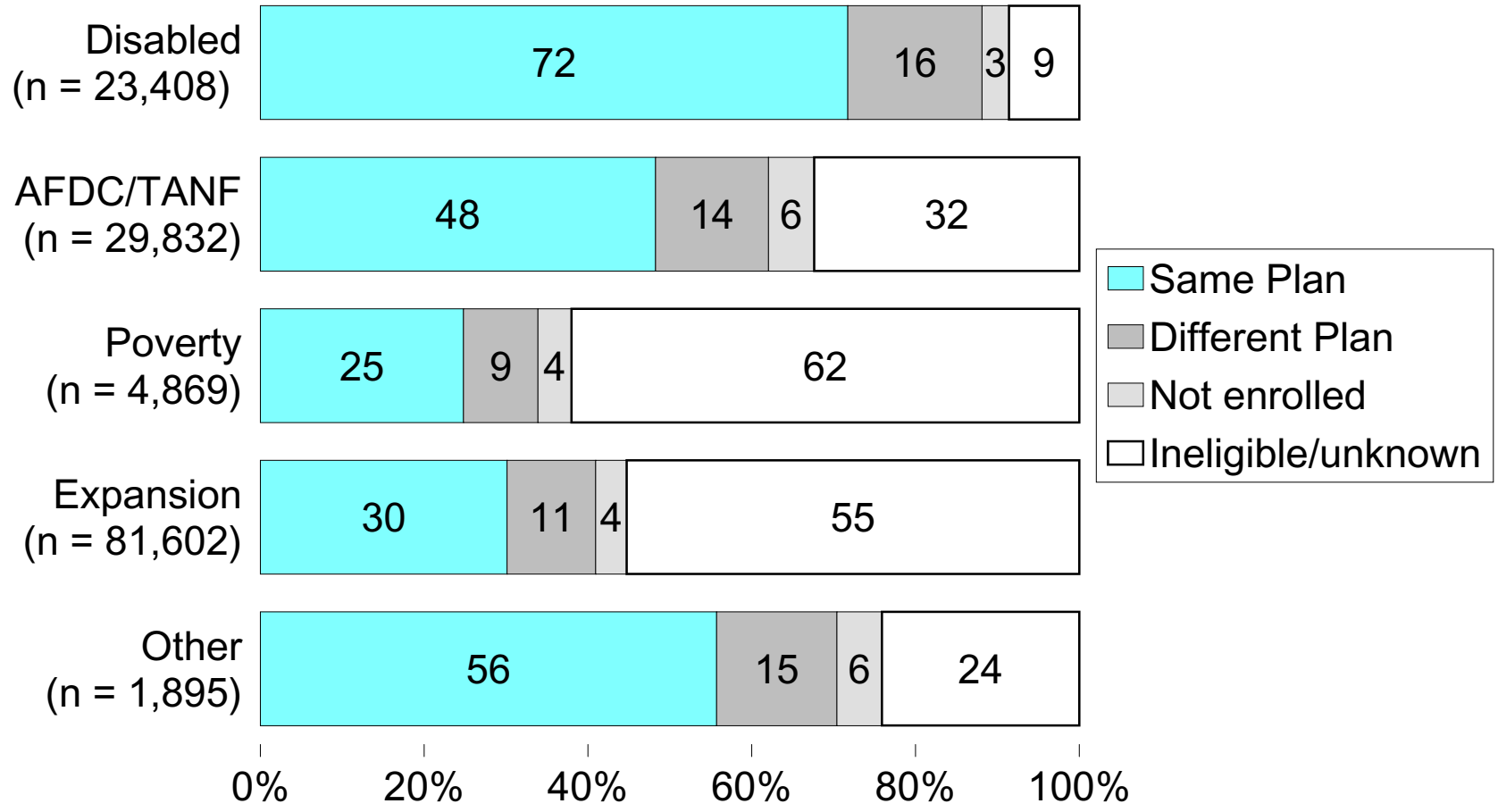
*Total unduplicated N = 50,994

Average Severity of Medicaid-EligibleTreatment Users



Stability of Enrollment

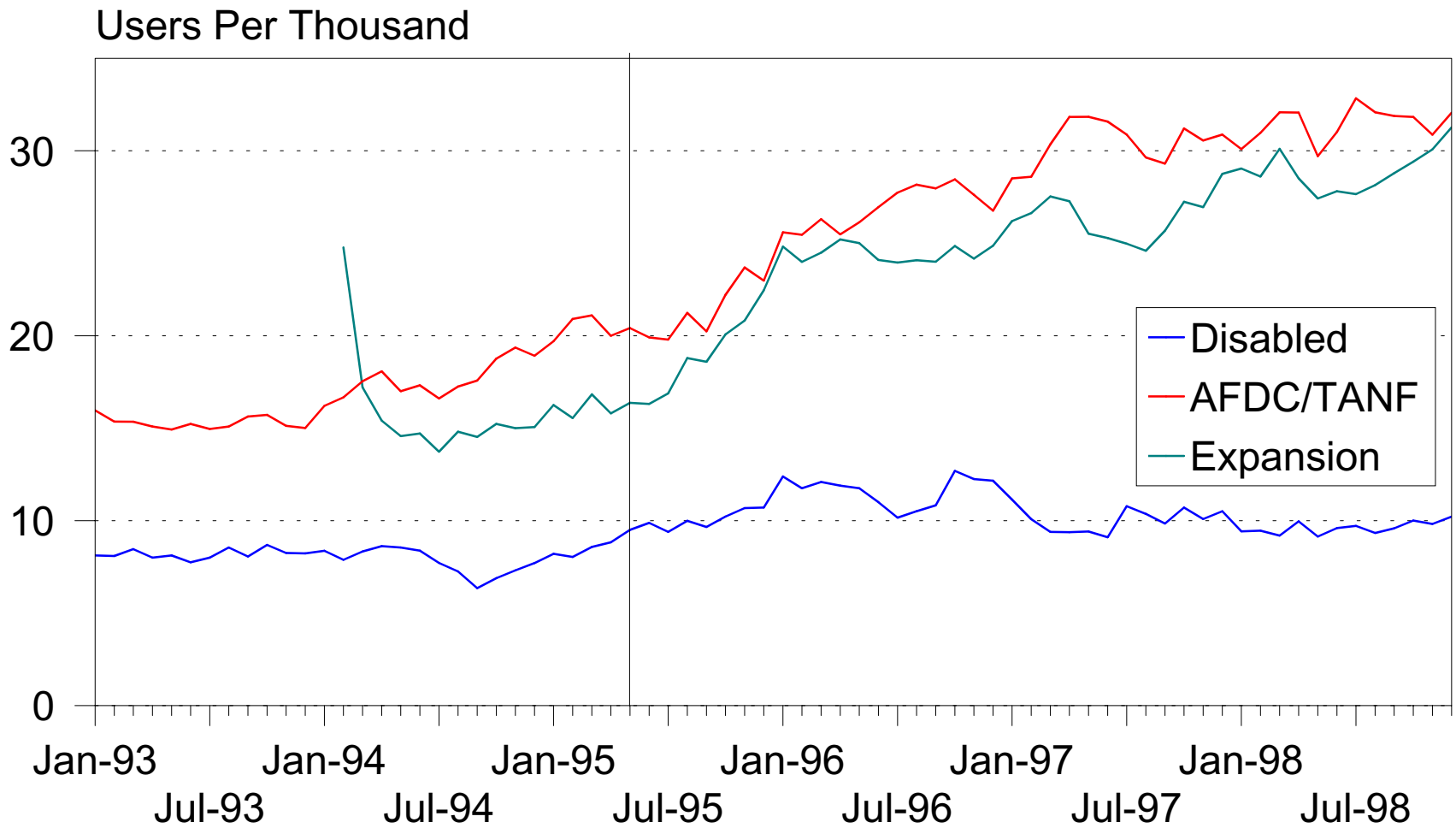
Enrollment status of Oregon adults one year later by their eligibility category on 1/1/96



RMC Research Corporation

Oregon Outpatient Utilization

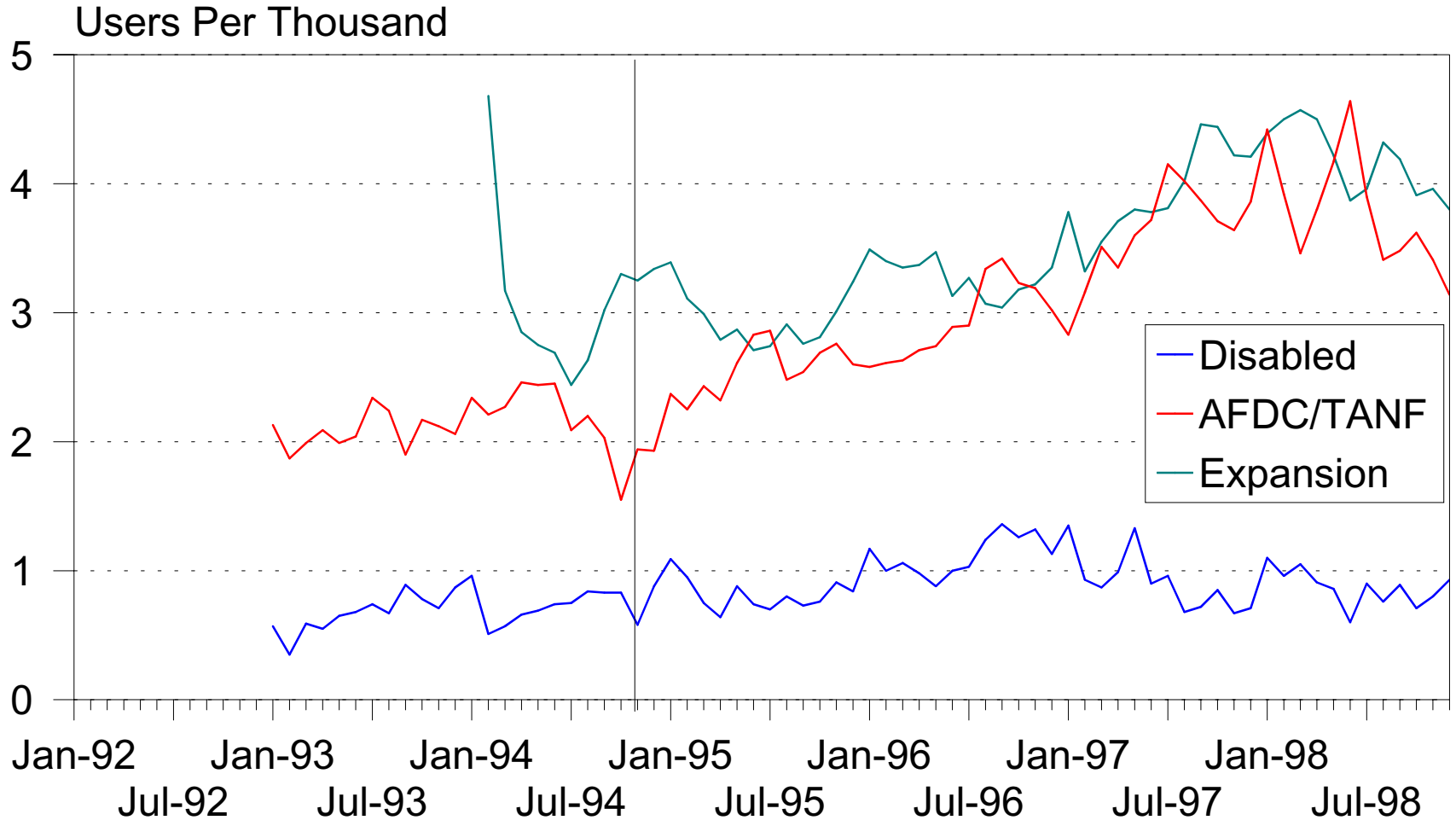
Adults in treatment per thousand eligible adults on first of month



Source: State treatment database (CPMS) and Medicaid eligibility files. Imputations made for missing or outlier discharge dates.

Oregon Residential Utilization

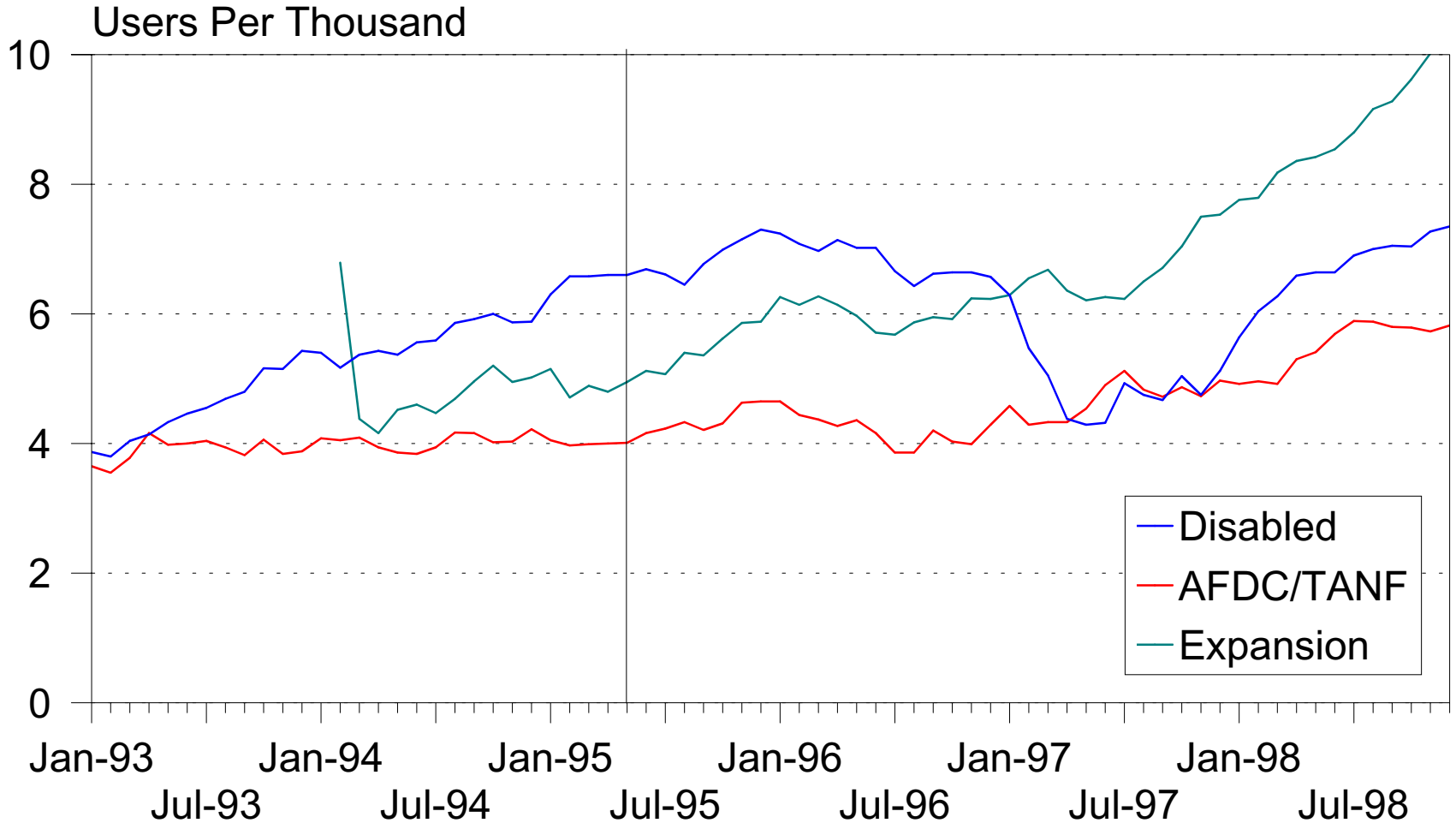
Adults in treatment per thousand eligible adults on first of month



Source: State treatment database (CPMS) and Medicaid eligibility files. Imputations made for missing or outlier discharge dates.

Oregon Methadone Utilization

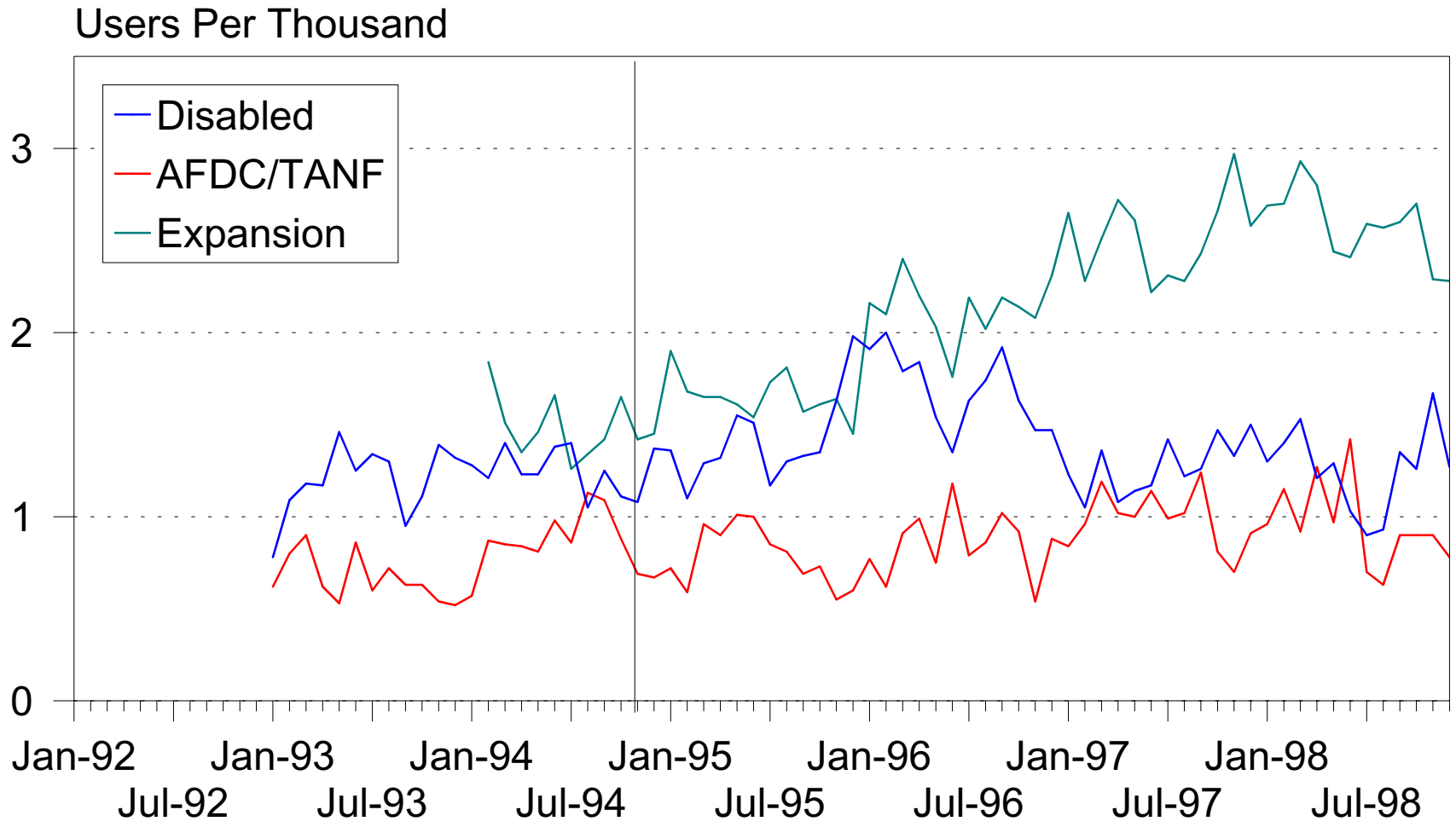
Adults in treatment per thousand eligible adults on first of month



Source: State treatment database (CPMS) and Medicaid eligibility files. Imputations made for missing or outlier discharge dates.

Oregon Residential Detox Utilization

Adults in treatment per thousand eligible adults on first of month



Source: State treatment database (CPMS) and Medicaid eligibility files. Imputations made for missing or outlier discharge dates.

Participation in Substance Abuse Treatment Modalities 1997 to 2000* by Medicaid Eligibility Group

Medicaid Eligibility Group

Treatment Modality	Expansion (*N* = 53,312)	AFDC/TANF (*N* = 12,752)	Disabled (*N* = 4,425)	All Medicaid (*N* = 76,944)
Regular Outpatient	31,990 (60%)	9,854 (77%)	2,548 (58%)	48,664 (63%)
Residential/CIRT	7,271 (14%)	1,563 (12%)	382 (8%)	9,864 (13%)
Methadone Maintenance	2,780 (5%)	342 (3%)	399 (9%)	3,929 (5%)
Detoxification	11,271 (21%)	988 (8%)	1,096 (25%)	14,487 (19%)
Total	**53,812**	**12,752**	**4,425**	**76,944**

*Duplicated Count

The Medicaid "Expansion" Population Characteristics and Substance Abuse Treatment Utilization

Summary

Demographics

More likely male and employed
Includes childless couples

Medicaid Eligibility

Very unstable---nearly 60% lose Medicaid eligibility within a year. Recent work with OHSU colleagues (McFarland et al.) indicates Medicaid clients 3 to 4 times more likely to complete treatment when eligibility remains stable for at least a year.

The Medicaid "Expansion" Population Characteristics and Substance Abuse Treatment Utilization (continued)

Primary Drug of Abuse

Greater prevalence of alcohol and opiates than AFDC/TANF.

Lower prevalence of amphetamines/methamphetamines than AFDC/TANF.

Treatment Utilization by Modality

Heavier representation in methadone maintenance and detoxification than AFDC/TANF, but not quite as high as disabled. RMC Research (Deck et al.) currently studying financing and outcomes of methadone maintenance programs in Oregon and Washington.

In Medicaid population, comprise over 70% of methadone maintenance episodes statewide.

Outcomes of Substance Abuse Treatment Under OHP and Managed Care

Statewide Outcomes: Retention, completion, abstinence at discharge and readmission.

Little change from preOHP expansion and premanaged care to expansion and managed care eras.

Performance as good or better than nonexpansion, nonmanaged care comparison state.

Prospective Study: Addiction Severity Index

Significant declines in alcohol, drug, and psychiatric problems 6 months after treatment entry. Improvement persisted through 12 months.

These outcomes as good or better than nonmanaged care comparison sample.

Where Do We Appear to Be Going?

Roughly 60% of OHP adults receiving treatment will no longer be covered for these services.

This is approximately 8,000 to 9,000 adults (aged 18 to 64) statewide.

For certain types of treatment, methadone and detox, the percentages are even higher.

For these particular treatment services, health consequences of not receiving treatment will be felt very quickly in hospitals, emergency rooms, and jails, all of which are far more expensive than substance abuse treatment. Colleagues at OHSU (McCarty et al.) are actively seeking funding to study consequences for methadone clients specifically.

And What About Cost Savings?

Over 60 studies of cost effectiveness and cost benefit of substance abuse treatment[1].

Pre/Post/Follow-up of treatment recipients.
Treated versus untreated (but need treatment).
Comparisons of different treatment approaches.

Considering health care employment and criminal justice savings.

For every dollar spent on treatment, the ensuing year sees:

$5.60 in savings to tax payers (Oregon).
$7.00 in savings to tax payers (California).

Considering only health care costs, the ensuing year sees:

$500 less for those treated (Ohio).
$1,000 less for individuals with co-occurring disorders (Washington).

[1]Reviewed by Harwood et al. (2002) for CSAT-funded National Evaluation Data Services.

Doing the Math

An illustration

Number of Oregonians (adults) losing chemical dependency benefit who would otherwise receive treatment:	9,000
Cost if treated: (estimated $1,800 per client)	$ 16.2 million
Societal cost savings if treated: ($5.60 per dollar spent)	$ 90.7 million
NET SAVINGS	**$ 74.5 million**

Projected Impact of OHP Changes

Robert Wheeler, MD

LIPA Chief Medical Officer

Oregon Research and Evaluation Collaborative

Salem, June 5, 2003

Overview

- What was studied
- Databases
- Funding
- Findings and observations
- Policy implications

What was studied

1. Population analysis
   - Number of members, percent of categories
   - Enrollment categories
   - Mental health status
   - Drug and alcohol dependence indicators
   - Clinical scores

What was studied (continued)

2. Cost of care
   - Allowed dollars
   - Allowed pmpm
3. Prescriptions
   - Therapeutic categories
   - Member categories
   - Prescriber categories

Databases

- **Lane OHP**
- **LaneCare**
- **MedImpact**
- **First Health**

- Physical health claims
- Mental health claims
- “Physical” Rx claims
- “Mental” Rx claims

Funding

- OMAP “Grant” contract #100966

Mental Health Diagnosis Groups

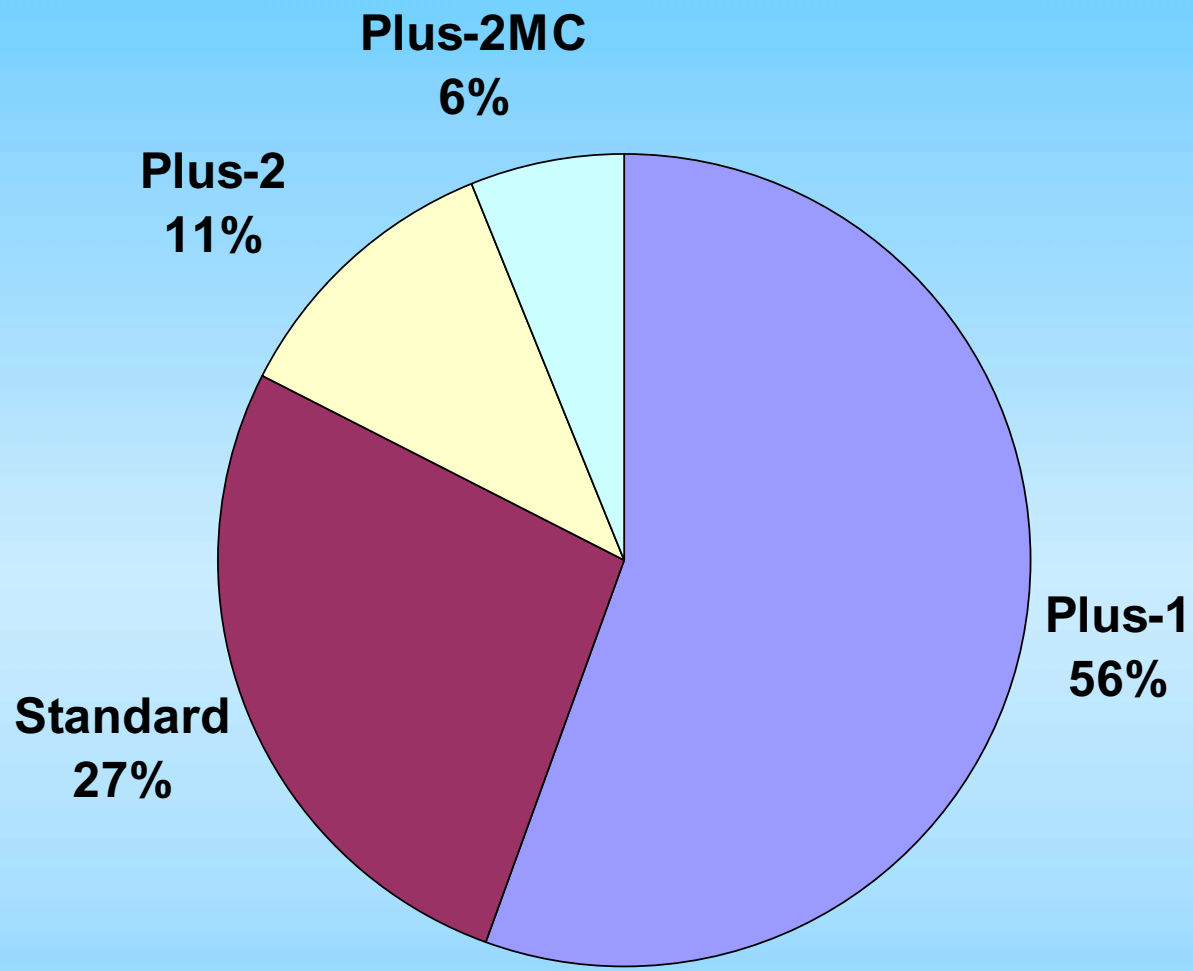
- SPMI
  - Severely and persistently mentally ill, industry standard (e.g.: schizophrenia)
- LCPMI
  - Other severe mental illness seen by Lane Care (e.g.: post traumatic stress disorder, psychotic depression)
- AllOther
  - All others

Findings

Population analysis

December 2002 Enrollment Categories

OHP Enrollment Category	Number	Pct
Plus Phase 1	16,500	55.5%
Standard	7,962	26.8%
Plus Phase 2 no MC	3,367	11.3%
Plus Phase 2 with MC	1,850	6.4%


Plus-2MC
6%
Plus-2
11%
Plus-1
56%
Standard
27%

2002 Cost pmpm by Payment Source

(Omits capitated Lab costs)

Group	LOHP	Rx	Lane Care	MH Rx	Total
Plus-1	$107	$12	$11	$7	$137
Standard	$173	$36	$19	$24	$175
Plus-2	$240	$69	$73	$76	$458
Plus-2MC	$71	$113	$35	$101	$320

Population by MH category

Group %row % column	SPMI	LCPMI	ALLOTHER
Plus-1	1,374 8% 39%	642 4% 39%	14,483 88% 59%
Standard	1,027 13% **29%**	439 5% **27%**	6,501 82% 26%
Plus-2	791 24% 22%	378 11% 23%	2,199 65% 9%
Plus-2MC	349 18% 10%	170 9% 10%	1,388 73% 6%

2002 Cost pmpm by MH Category

Group	SPMI	LCPMI	ALLOTHER
Plus-1	$337	$154	$114
Standard	$478	$349	$202
Plus-2	$857	$345	$352
Plus-2MC	$594	$320	$247

2002 Cost pmpm by Payment Source

(Omits capitated Lab costs)

Group	LOHP	Rx	Lane Care	MH Rx	Total
SPMI	$222	$69	**$150**	$71	$511
LCPMI	$153	$46	$5	$63	$268
ALLOTHER	$123	$24	$2	$15	$164

Observations

- OHP Standard has vulnerable members
- Loss of MH benefit for OHP Standard removed coverage for 29% of SPMI members
- An important part of the MHO budget (91%) was for SPMI members
- 25% of the MHO budget was for OHP Standard members loosing MH benefit

Population by Drug Dependency Dx

Group %row % column	Drug Dx		None	
Plus-1	711 32%	4%	15,788 57%	96%
Standard	1,071 **48%**	12%	6,891 25%	88%
Plus-2	373 17%	11%	2,995 11%	89%
Plus-2MC	85 4%	4%	1,822 7%	96%

2002 Cost pmpm by Drug Depend. Dx by enrollment category

Group	Drug Dx	None
Plus-1	$333	$127
Standard	$451	$221
Plus-2	$721	$425
Plus-2MC	$536	$310

2002 Cost pmpm by Drug Depend. Dx by payment source

Group	Drug Dx	None
LOHP	$301	$112
Rx	$49	$32
LaneCare	$49	$18
MH Rx	$62	$23

2002 Cost pmpm by Drug and MH Dx

(Omits capitated Lab costs)

Group	Drug Dx	None	All
SPMI	$715	$468	$511
LCPMI	$393	$243	$268
ALLOTHER	$341	$153	$164

Observations

- Drug dependency dx is associated with increased cost in all enrollment categories and across all payment sources
- Dual diagnosis (MH + drug) greatly increases cost
- Ending chemical dependency coverage removed that benefit from 48% of the members with a recent history of drug dependency diagnosis and 41% of those with MH + drug dx

2002 Rx cost pmpm

Rx Class	SPMI	LCPMI	OTHER	ALL
Psychotherapeutic	$65.78	$55.90	$12.96	$22.32
CNS	$25.93	$17.79	6.59	9.75
Anti-infective	$8.87	$5.74	$3.60	$4.41
Respiratory	$7.45	$5.48	$3.44	$4.08
Hormones	$8.29	$5.34	$3.01	$3.83
CV	$4.67	$3.50	$2.18	$2.58
GI	$5.98	$4.25	$1.76	$2.45
Antihyperlipidemic	$3.28	$2.80	$1.34	$1.67
All other	$9.33	$8.78	$4.10	$5.05

2002 Rx cost pmpm
Selected subcategories

Rx Class	SPMI	LCPMI	OTHER	ALL
PSYCH				
Antidepressants	$28.93	$30.04	$6.36	$10.68
Antipsychotics	$27.73	$21.97	$5.22	$9.12
Anxiolytics	$5.50	$3.51	$0.88	$1.63
CNS stimulants	$3.62	$0.39	$0.48	$0.88
CNS AGENTS				
Anticonvulsants	$14.30	$9.12	$3.44	$5.17
Analgesics	$8.97	$7.42	$2.55	$3.67

Observations

- Members with persisting mental illness have much higher cost per member in psychotherapeutic and CNS prescriptions
- Such members have higher costs in many other therapeutic categories
  - Anti-infectives (much due to antivirals)
  - GI (much due to PPI's)
  - Immunologics (much due to interferons)

2002 Rx Antidepressant cost

	SPMI	LCPMI	OTHER	ALL
Pmpm	$28.93	$30.04	$6.36	$10.68
Dollars	$1,360,502	$649,101	$1,883,152	$3,892,755
Pct total $	35%	14%	47%	100%

Observation

- Program cost depends both on cost per member and on number of members per category

Percent of Antidepressant Rx/s by specialty (pct of column)

Spec	SPMI	LCPMI	OTHER
MH	23%	10%	30%
Gen	7%	59%	24%
MedSpec	1%	2%	3%
Surg/OB	11%	3%	10%
NP's	4%	2%	4%
Unknown	53%	24%	28%
Total	100%	100%	100%

Observation

- “Unknown” prescribers due to pharmacy handling of ID numbers limits analysis
- Of identifiable prescribers, MH specialists handle 50% of antidepressant Rx’s for SPMI members
- Of identifiable prescribers, generalists handle 45% of all antidepressant Rx’s, but only 14% of antidepressant Rx’s for SPMI members
- Loss of MH benefit by SPMI members in OHP Standard makes access to antidepressant prescribers a difficult problem

Percent of Antipsychotic Rx/s by specialty (pct of column)

Spec	SPMI	LCPMI	OTHER
MH	31%	29%	32%
Gen	15%	30%	24%
MedSpec	0%	0%	1%
Surg/OB	1%	1%	0%
NP's	1%	3%	1%
Unknown	51%	38%	41%
Total	100%	100%	100%

Observations

- Of identifiable prescribers, MH specialists write 64% of antipsychotic rx's for SPMI members and 55% of antipsychotic rx's for members without persisting MH diagnoses
- Generalists report lack of training and skill in managing antipsychotic medications, although some write refill prescriptions
- Other specialists have little involvement with antipsychotic prescriptions

Conclusions – data system

- Combining data sets yields important insights
- Combining cost data with clinical indicators (SPMI, drug dependence, etc.) yields additional important information
- Interactive hierarchical analysis can reveal utilization and cost patterns in enough detail to lead to action

Policy implications – data system

- Consider contracting to continue combined data set analysis to detect impact of loss of benefits for various enrollment groups
- Consider expanding analysis to combined data sets across entire program

Conclusions – cost of care

- “Physical” diagnoses such as drug dependence can be associated with substantially higher “mental” health treatment costs
- “Mental” diagnoses such as in the SPMI categories can be associated with substantially higher “physical” health treatment costs

Policy Implications – cost of care

- Because of the substantial interaction between “physical” and “mental” disorders, coordination or combination of management systems should be encouraged
- Because prescription medications play an important role in treating both “mental” and “physical” conditions, consideration should be given to maintaining coverage

Policy Implications – cost of care

- Because of the overlap of “physical” and “mental” prescription drugs and the substantial costs in both categories, consider coordinating or combining management across all prescription drugs
- Because of the cost of “mental” prescription drugs, consider using all available management tools to optimize utilizations

Policy implications – care safety

- Because of potential drug-drug interactions, and issues of non-compliance, consider supporting electronic prescription programs that identify problems at the time of prescribing

Conclusions – program

- Enrollment categories do not reflect medical need or physical need
  - SPMI members in many enrollment categories
  - Drug dependent members in many enrollment categories
- Cost of care is more highly related to clinical category than enrollment category

Policy Implications - program

- Prioritization of enrollment by clinical category within current enrollment categories could allow a more rational program
- Prioritization of benefit packages may make more sense by clinical category than by current enrollment categories

Policy implications – Chemical Dependency

- Because of the large cost implications of drug dependence, consider paying more for drug treatment programs that can demonstrate lower recidivism rates

OHREC Public Meeting

I. Introductions

II. Legislative Update

III. Brief update of OHREC activities

Research Projects

Professional Development Program

IV. Presentation and Q&A:

Bob Lowe MD, MPH

Changes in Access to Primary Care for OHP Beneficiaries and the Uninsured

2003 Legislative Update

Jeanene Smith MD, MPH

Oregon Health Plan Survives!

Expand children under OHP Plus from 185% to 200% FPL

Expand Family Health Insurance Assistance Program (FHIAP) from 185% to 200% FPL

Maintain coverage for OHP Standard

(non-categorical adults < 100% FPL)

Add back outpatient Mental Health and Chemical Dependency for OHP Standard

Still, some changes for OHP

- Limited hospital benefit for OHP Standard
  - Emergency services
  - Admissions for those conditions for which prompt treatment will prevent life threatening health deterioration
- Prioritized List of Health Services reduction
  - Request to move line by 30 conditions/treatments pairs

Medically Needy Program

8,500 low-income seniors and people with disabilities in program originally.

Provided prescription drugs and some mental health care – Cut February 1, 2003

Legislature restored money at approx. 40% and will offer via OHP Waiver amendment

Grandfathering in the 400 + currently still getting help with HIV/Transplant meds.

Other Health-Related Bills

HB 3630: Reduces cost of medical liability insurance for rural providers

SB 875: Establishes a program for making prescription drugs available to govt. employees and low-income seniors at lowest possible costs

HB 2439: Creates Patient Safety Corporation- an indept. public body focused on improving patient safety

Oregon Health Policy Commission

HB 3653 transitions the Oregon Health Council to a new structure, and includes 4 legislators as members

Will be key advisors to the Governor and the Legislature on health policy issues.

OHPR will staff the Commission, with the Administrator acting as key link.

OHREC research can provide vital to information to the Commission

For more information:

Full text of the bills are available at:

www.leg.state.or.us

If questions, contact

Jeanene Smith at jeanene.smith@state.or.us

Bruce Goldberg at bruce.goldberg@state.or.us

OMAP website: www.dhs.state.or.us

OHPR website: www.ohpr.state.or.us

OHREC Research Projects

ED Pilot Study

- Preliminary results released!
- ED Survey to be fielded this fall.

Medically Needy Survey

- Telephone survey of 429 former Medically Needy clients
- Results in October

OHREC Research Projects

Safety Net Interviews & Survey

- Preliminary results in October
- Full report out in November

Cohort Baseline Survey

- Focus on impacts of premiums and co-pays
- Survey of 10,000 OHP clients
- To be fielded this Fall

OHREC Research Projects

RWJF/HCFO Proposal

Large, 3-year study proposal

Invited to write full proposal

If questions, contact

Tina Edlund at Tina.edlund@state.or.us

OHREC Professional Development Program

- Includes students in the Oregon MPH Program, which includes OHSU, PSU & OSU
- Utilizes academic training & provides mentorship
- Learn practical skills for linking research to policy makers
- Growing future health services researchers for Oregon's future

Past/Future Student Opportunities

- FHIAP survey
  - Continued Winter Term
- Data Dictionary
  - Continued Fall Term
- Endnotes Database
  - Continued Fall Term
  - Will also include creation/dissemination of Research Briefs

Past/Future Student Opportunities cont.

- Cohort Baseline Survey
  - Data analysis
- Legislative Survey
  - Assess information needs of Oregon's decision-makers
- Qualitative Analysis of Medically Needy Survey

If questions or student recommendations, contact

Lisa Krois at Lisa.Krois@@state.or.us

Upcoming OHREC Meetings: October 15, 2003

9:00 – 11:00 AM

Clackamas Community College Wilsonville, Rooms 111 & 112

29353 Town Center Loop East, Wilsonville, OR 97070

Judy Zerzan MD, MPH will be presenting her findings from the OHREC sponsored "**OHP Medically Needy Survey"**

Dr. Ann Hamer, Judy Robison MA/MSW and Matt Carlson PhD will be presenting their findings from **"Targeted Case Management of CareOregon Members Prescribed Antidepressant and/or Antipsychotic Medications"**

Changes in Access to Primary Care for Oregon Health Plan Beneficiaries and the Uninsured: A Preliminary Report

Oregon Health &
Science University

Center for
Policy & Research
in Emergency Medicine

Changes in Access to Primary Care for Oregon Health Plan Beneficiaries and the Uninsured: A Preliminary Report

Robert A Lowe, MD, MPH
K. John McConnell, PhD
Jodi Lapidus, PhD
Cody Weathers, BS
Annette Adams, MPH
Beverly Bauman, MD

The context

- 1990's
  - Oregon Health Plan created
  - Expansion group of ~100,000 Oregonians added to the ~300,000 Oregon Medicaid enrollees
- 2000's
  - Reduction in scope of benefits
  - Reduction in eligibility
  - Premiums, co-payments, and deductibles

Impact of OHP changes?

- Ideal study
  - Prospective cohort
  - Primary data collection
  - Follow OHP beneficiaries and uninsured Oregonians for several years
- But
  - Need for quick data

Opportunity

Poor access to primary care high ED use

ED claims data rapidly available

Objective

- To describe changes in ED use before and after the OHP changes
  - Phase 1: OHSU data
  - Phase 2: representative sample of Oregon EDs
- Uninsured and OHP
- Types of diagnoses
  - All
  - Behavioral health, chemical dependency alcohol-related
  - Ambulatory-care treatable and potentially preventable visits

Methods

- Study subjects
  - OHSU ED visits, March, 2002 through May, 2003
- Variables
  - Predictor: March-May, 2002 versus March-May, 2003
  - Outcomes
    - Payer mix
    - Behavioral health
    - Ambulatory care treatable/potentially preventable
      - Billings algorithm

Data analysis

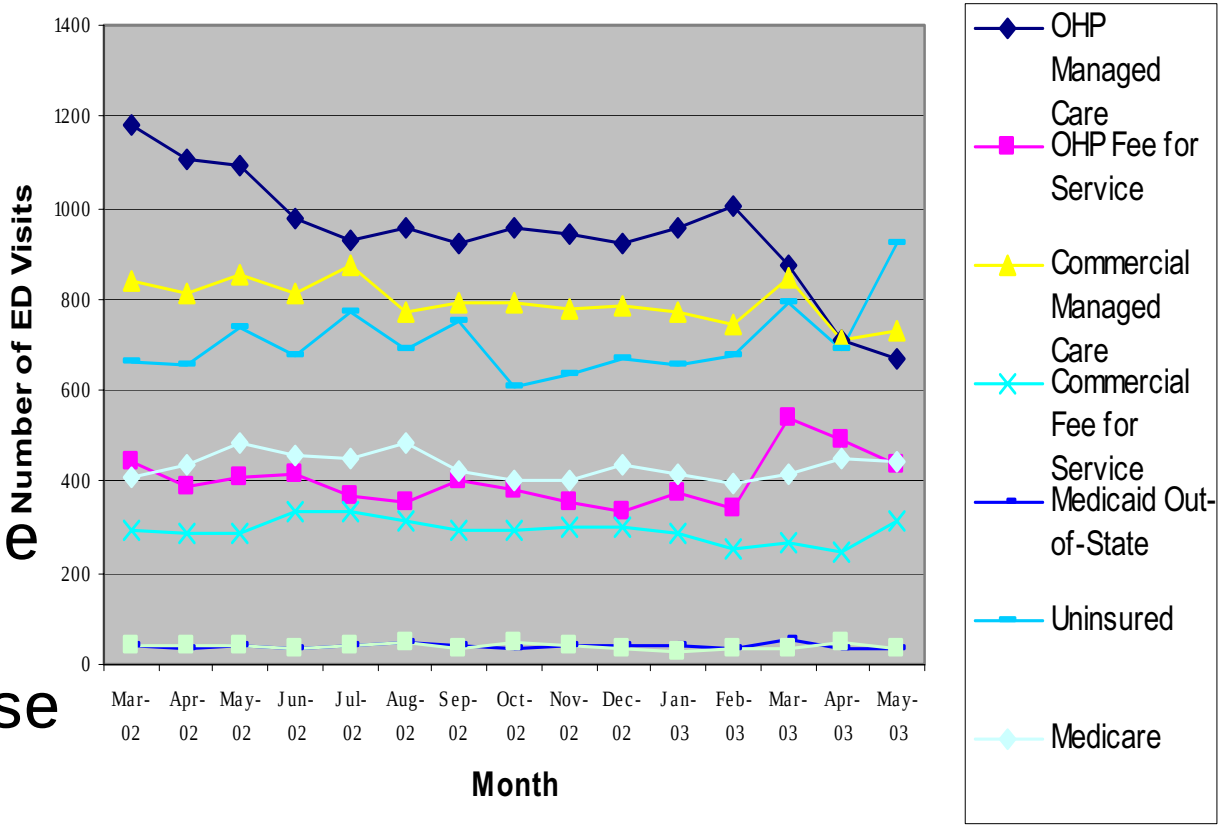
- Numbers of ED visits
  - % change
  - Not a rate
- “Standardized ED visits” for OHP enrollees
  - Number of OHP visits / number of OHP enrollees in tri-county

Results

Payer mix by month

March-May 2002 vs. 2003

- OHP 20% decrease
- Commercial 8% decrease
- Uninsured 17% increase

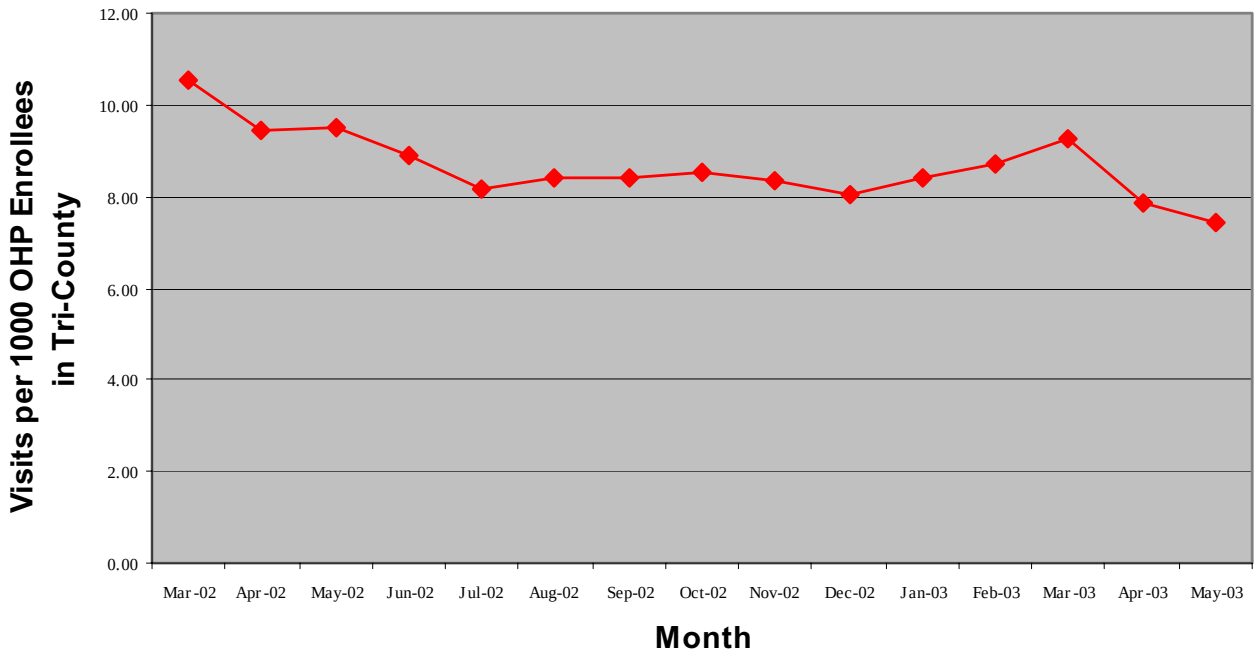


Standardized OHP ED visits

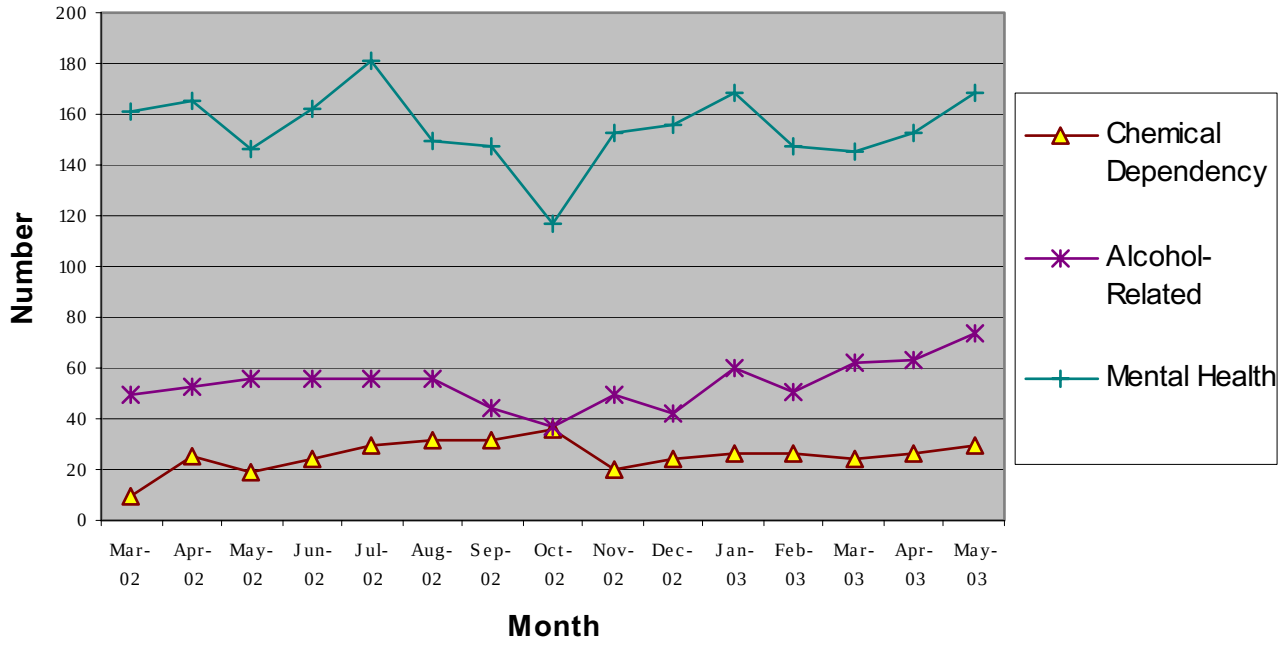
Visits/1000 enrollees/month:

March - May, 2002: 9.7

March - May, 2003: 8.1



Behavioral health ED visits

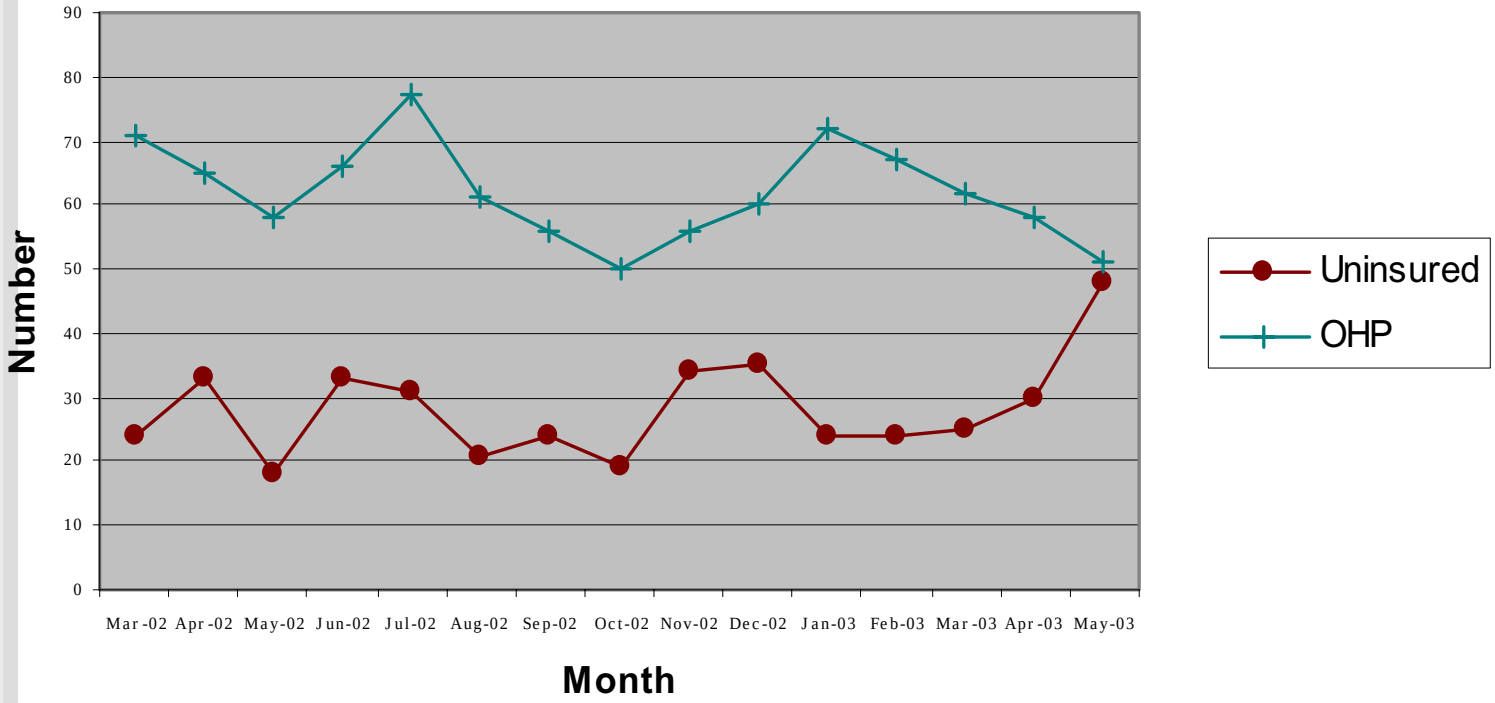


	Change, 2002-2003	Total/15 months
Chemical dependency	46% increase	382
Alcohol	26% increase	808
Mental health	No change	2,318

Ambulatory care treatable ED visits

- Only 46% could be classified using Billings algorithm
- No change over time

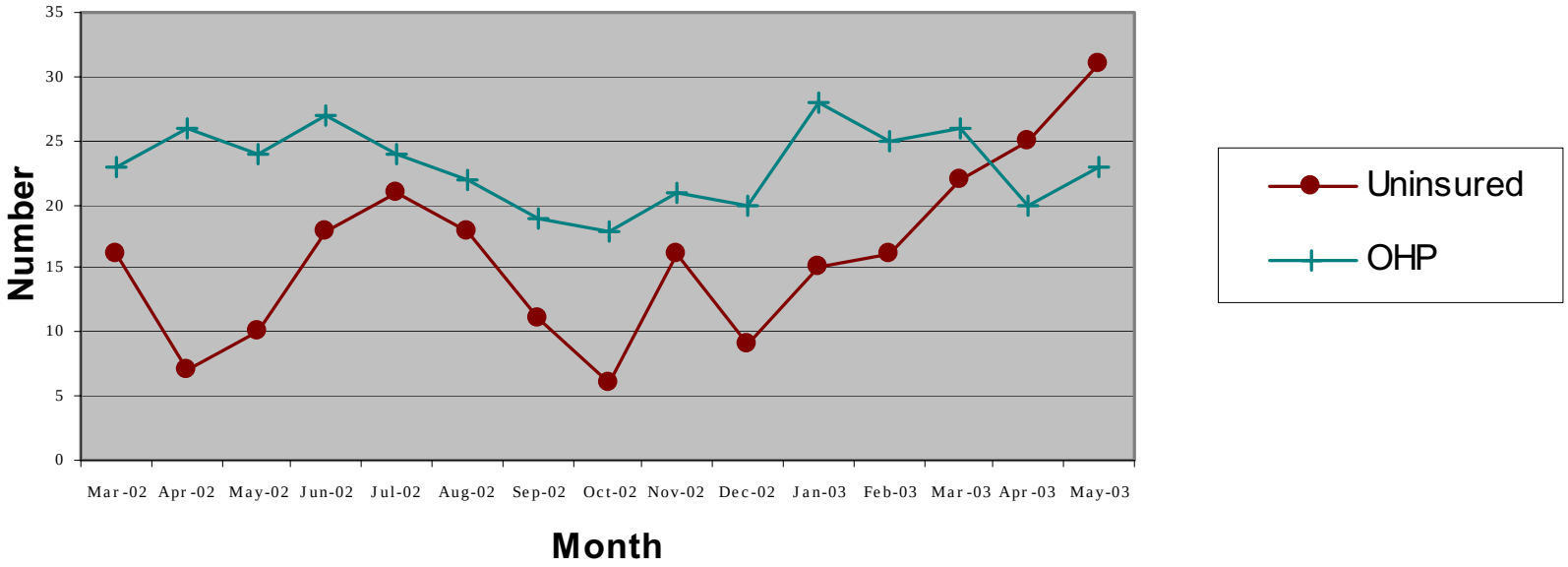
Mental health ED visits for OHP and uninsured patients



OHP: 12% decrease (ns)

Uninsured: 37% increase

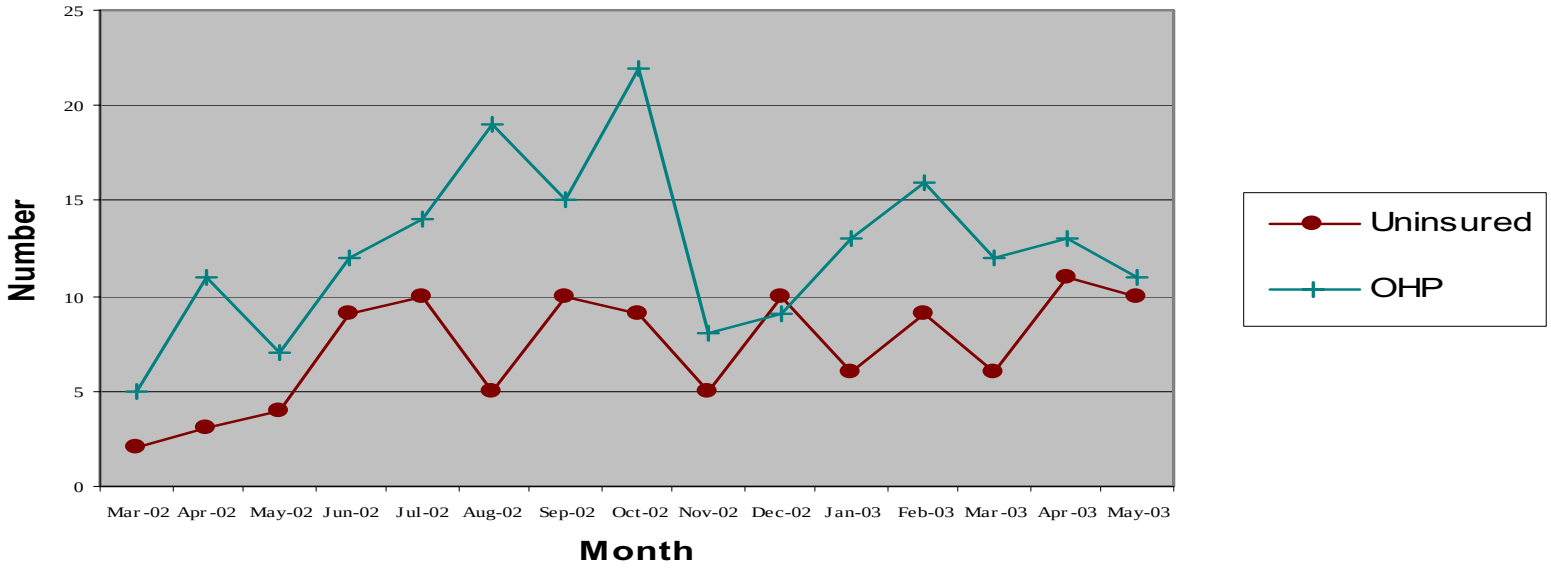
Alcohol-related ED visits for OHP and uninsured patients



OHP: 5% decrease (ns)

Uninsured: 136% increase

Chemical dependency visits for OHP and uninsured



OHP: 56% increase (ns)

Uninsured: 200% increase

Interpreting the results

- 17% rise in ED use by uninsured
  - ? more uninsured Oregonians?
  - ? fewer alternatives to ED?
  - ? end of retroactive eligibility for OHP?

Interpreting the results

- Drop in ED use by OHP (20%) and commercially insured (8%)
  - Good news?
    - ? better access to care outside the ED?
  - Bad news?
    - ? loss of coverage?
    - ? impact of co-payments?
    - ? confusion?

Interpreting the results

Dramatic rise in ED use for behavioral health problems by uninsured Oregonians

- ? increased stress increased illness?
- ? preferentially dropping out of OHP?

Limitations

- Counts not rates
- One ED
- 3 months of post-change data
- Under-reporting of behavioral health diagnoses
- Lag period before definitive insurance data available

Conclusion

- Probably not good news
- Multiple potential causes
  - Loss of commercial insurance
  - Loss of OHP
  - Deteriorating safety net

Conclusion

- Further research
  - Longer time period
  - More EDs
- Is it better to wait for definitive data or to act on limited data?

Oregon Health Plan Medically Needy Survey

Judy Zerzan, MD, MPH
Assistant Professor Department of Medicine
Oregon Health and Sciences University
October 15, 2003

Medically Needy

- What is it?
  - Federally-matched optional program of Medicaid
  - States may chose to provide Medicaid coverage and/or Medicare premium assistance to certain groups not otherwise eligible for Medicaid
  - 34 states currently have this program.

- It provides coverage for people who have high medical expenses so that by "spending-down", their income falls below a state established Medically Needy income limit

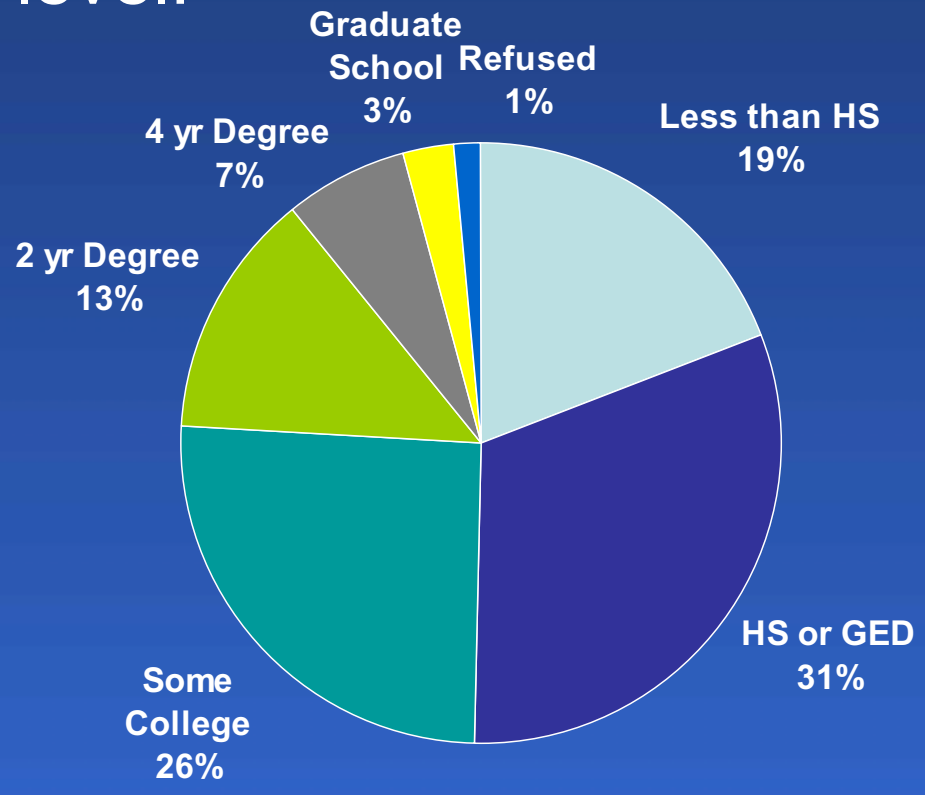
OHP Medically Needy Program

- As of Jan 2003 in OR 8,750 people covered
  - 69% adults ages 19-65 with disabilities
  - 30% adults over 65

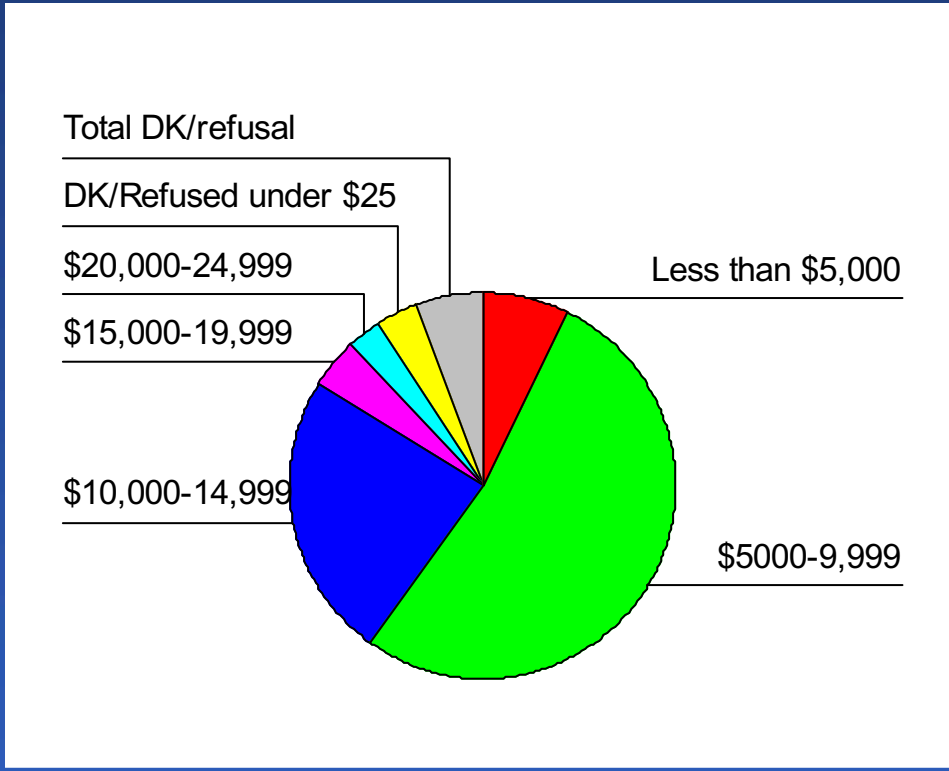
- Random state-wide sample of 1,500 individuals
- Phone survey conducted by Gilmore Research
- 439 respondents
  - 105 refusals
  - approximately 22% wrong numbers
- Participation Rate: 58%

Characteristics of Participants

- 36.2% men and 63.8 % women
- Average age = 58 (range 22-91)
- Predominantly white ethnic background (91.6%)
- Education level:



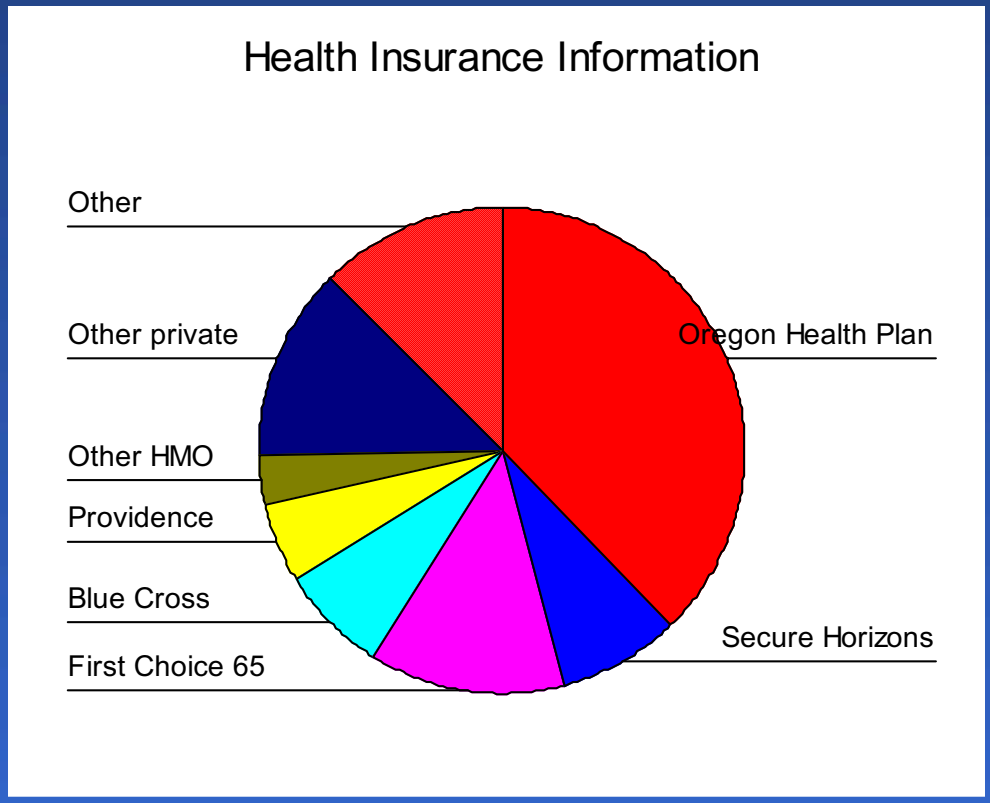
- 95% of this population was unemployed with 2002 gross income levels:



- Estimated that 70% to 75% are <133% FPL

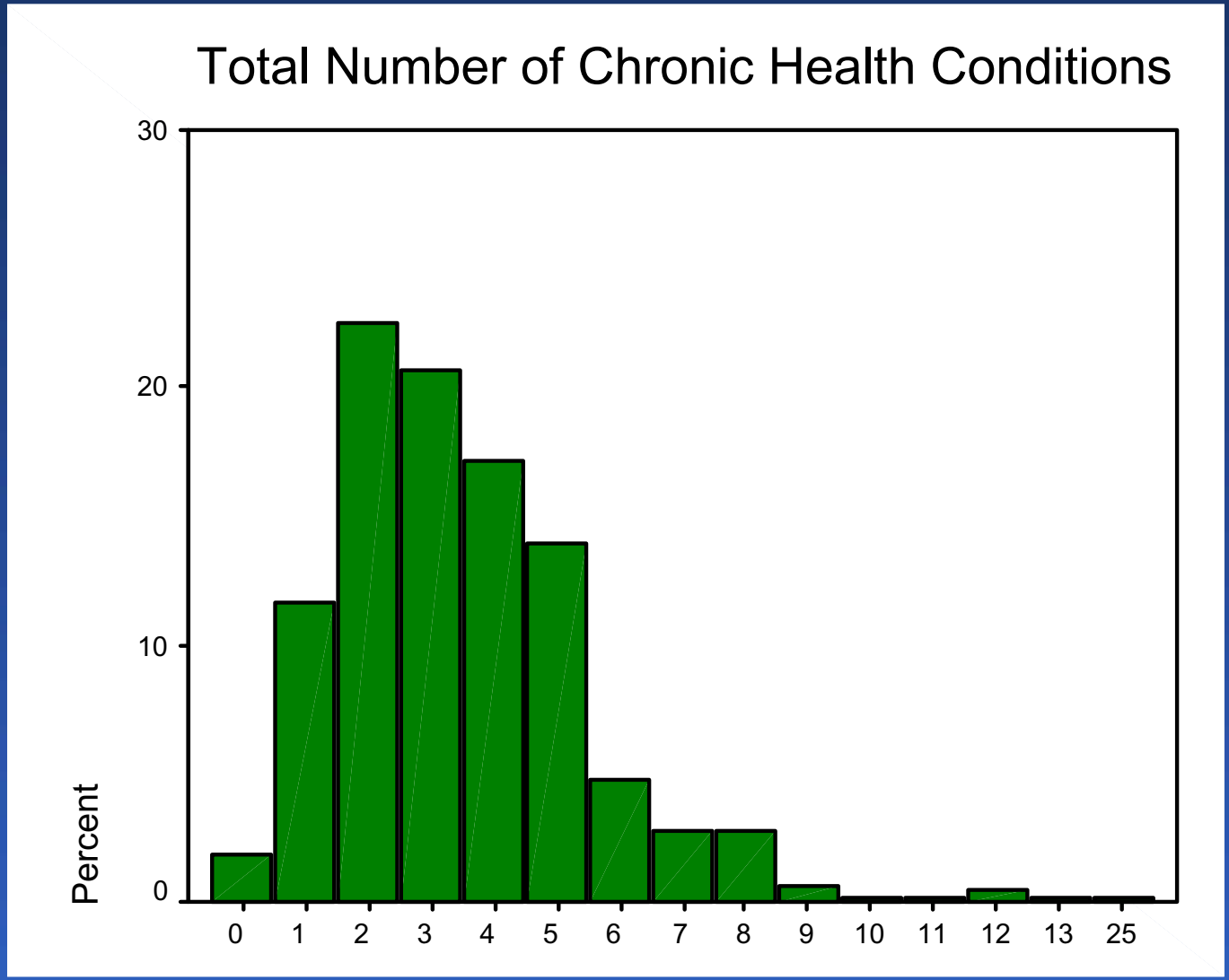
Health Insurance

- 92% covered by Medicare
- 34.4% are covered by other health insurance
  - 22% of health insurance provides Rx drug coverage



Mean 3.5

Range 0-25



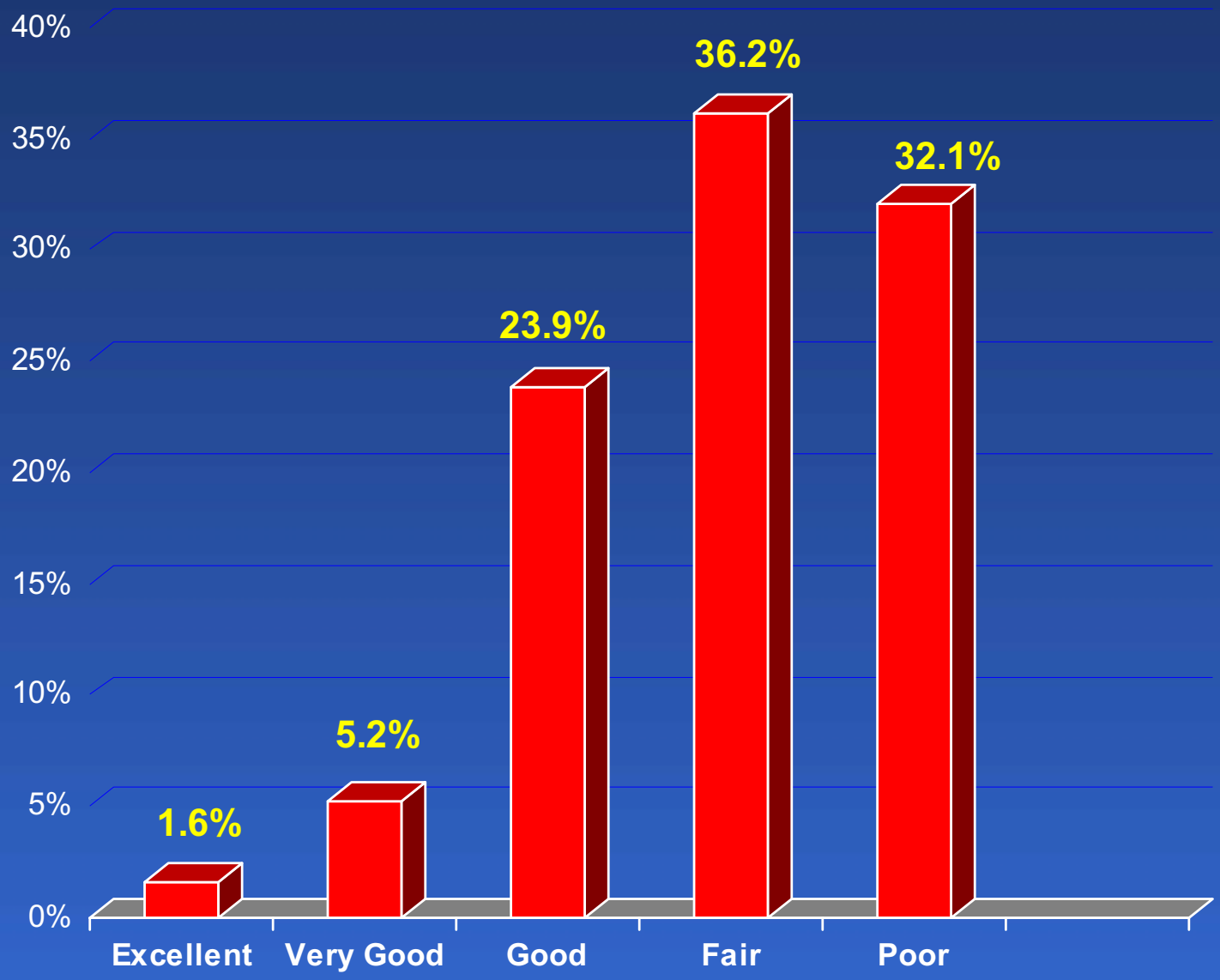
Top 10 Disease Groups

- Hypertension 59.23%
- Mental Health 53.99%
- Pulmonary 42.82%
- Endocrine 39.41%
- Rheumatologic 25.06%
- Pain 20.05%
- GI 17.54%
- Coronary Artery Disease 16.63%
- Other Cardiovascular 15.72%
- Neurologic 11.85%

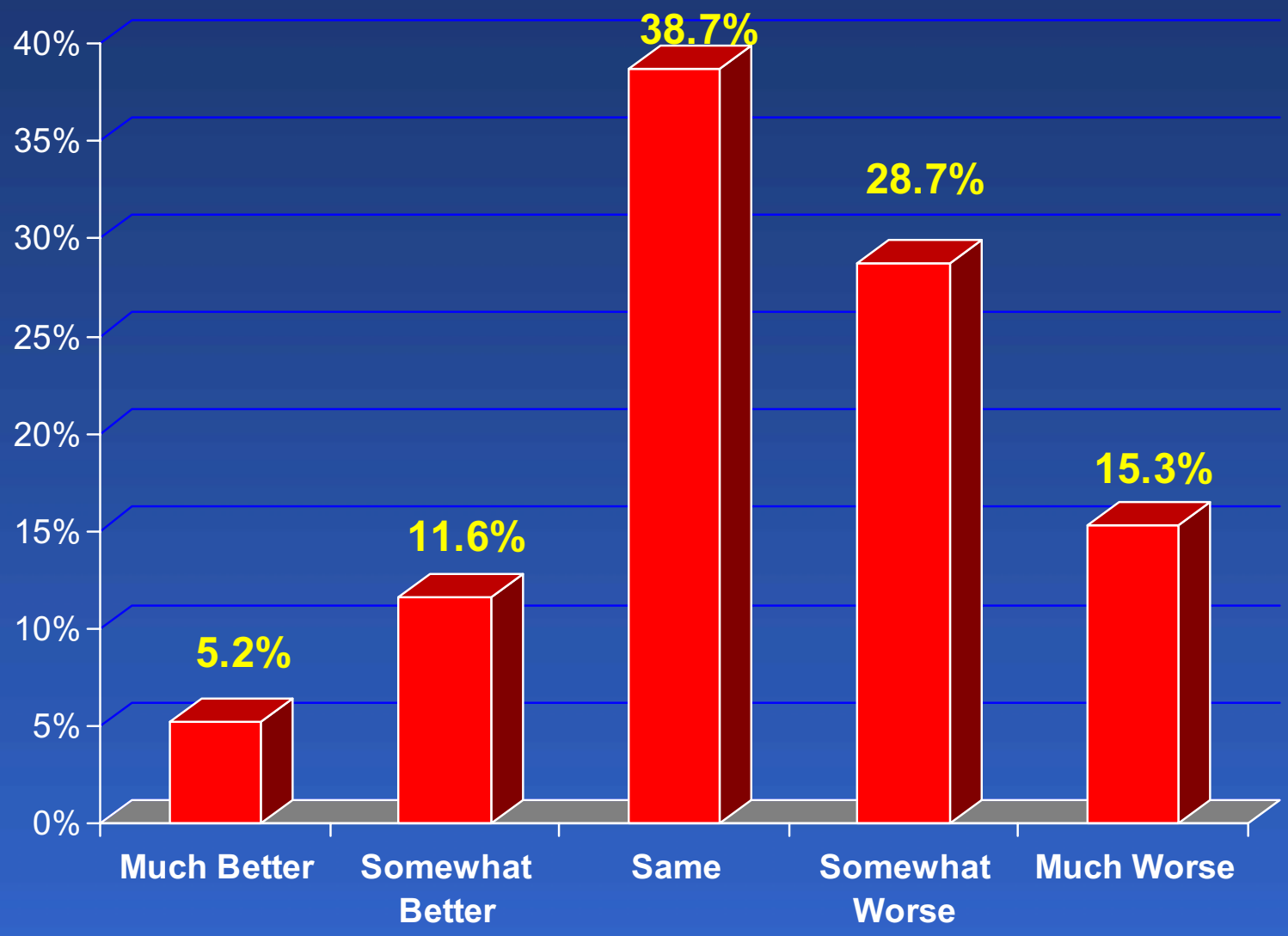
Specific Diseases

- Hypertension 59.23%
- Asthma 30.75%
- Diabetes 28.25%
- Arthritis or any kind of rheumatism 20.27%
- Depression 18.45%
- Back, neck or spine conditions 16.86%
- Heart disease, heart attack 14.81%
- High cholesterol 12.30%
- Bipolar Mood Disorder 8.66%
- Schizophrenic or Schizo-Affective Disorder 8.43%

Current Overall Health

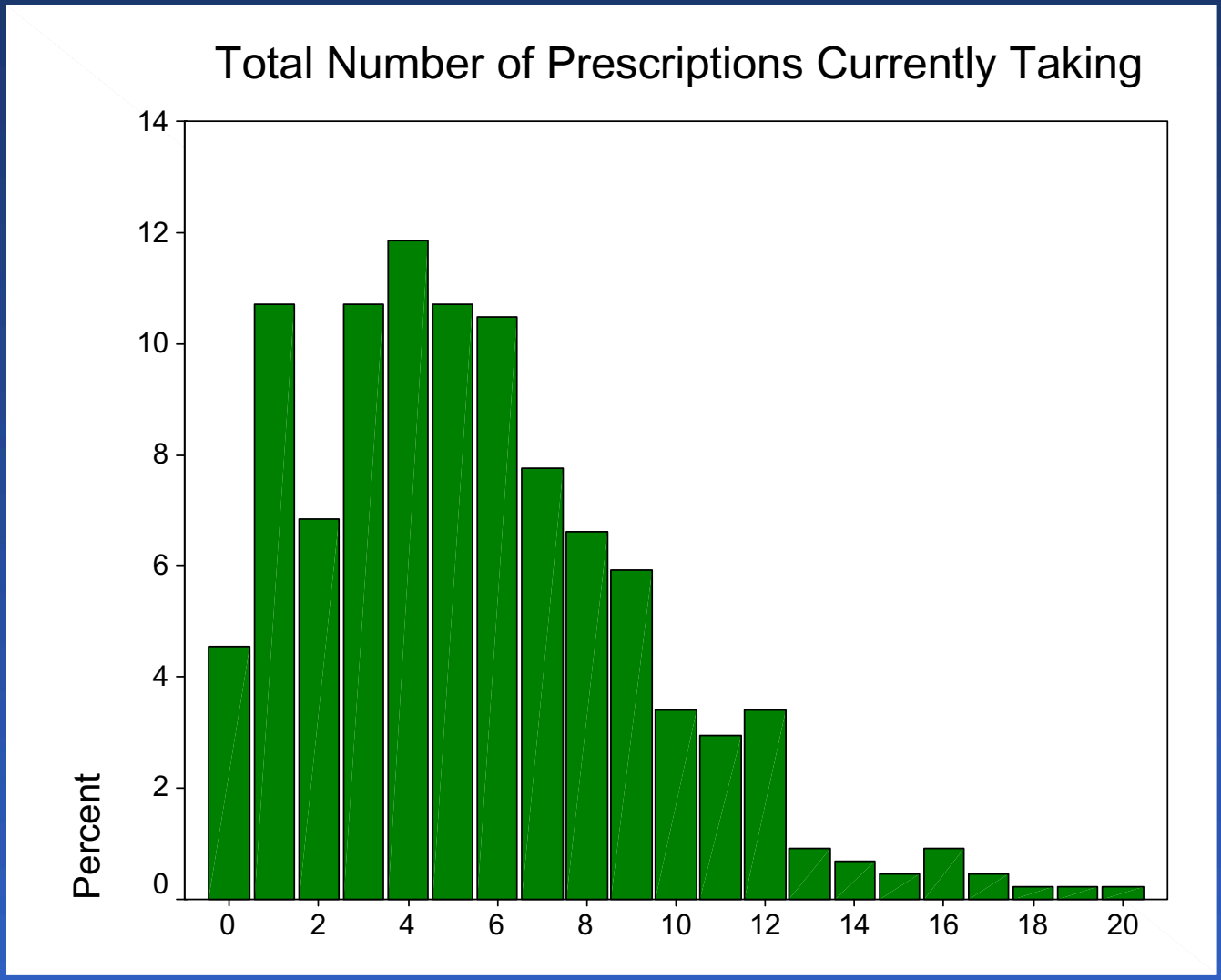


Current Health Compared to One Year Ago



Mean 5.5

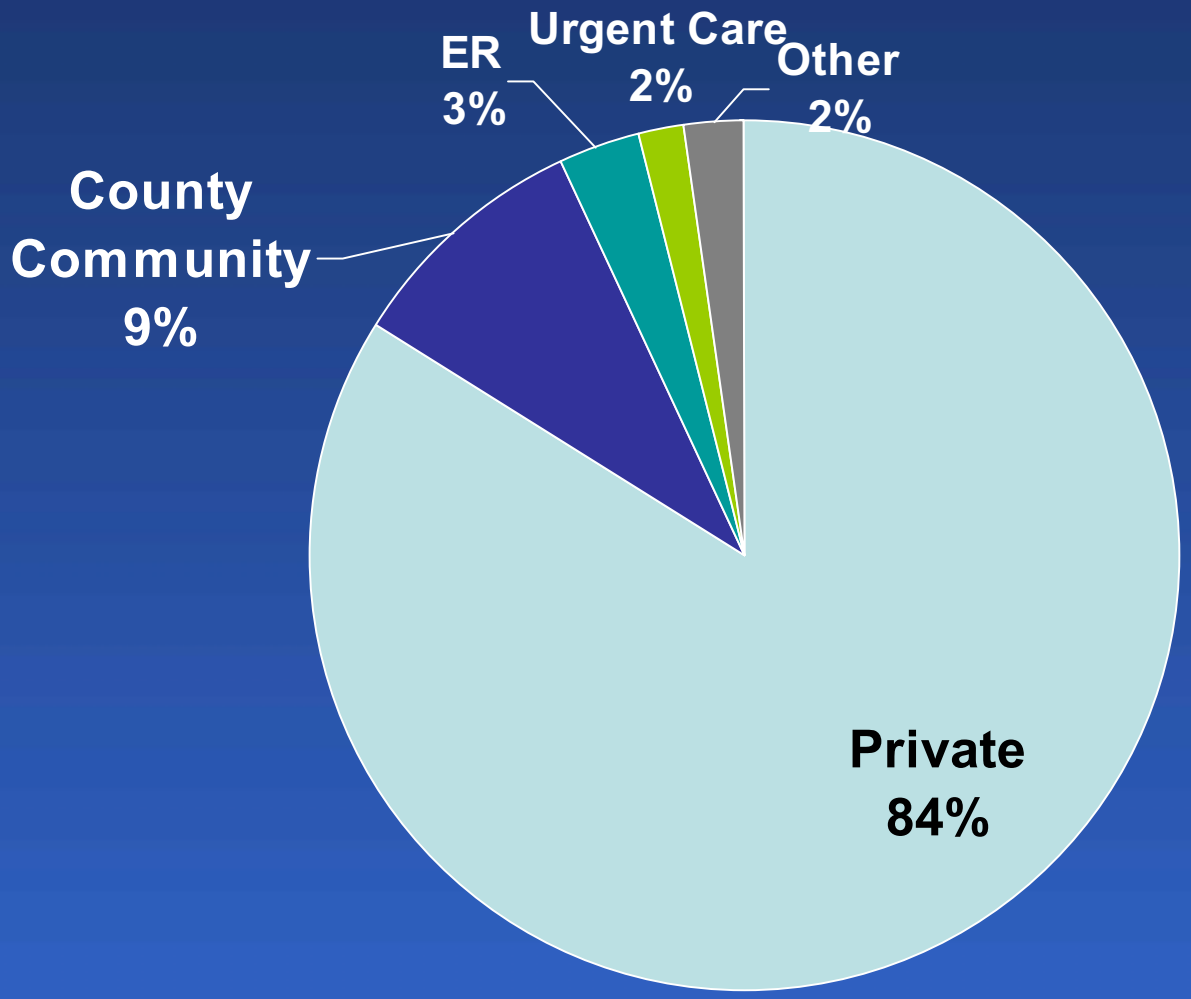
Range 0-20



Most Commonly Prescribed Drug Classes

- Antidepressants 52.9%
- Narcotics 29%
- Anxiolytics 28%
- Oral DM 25.7%
- Anti-psychotics 25.5%
- Statins 24.8%
- ACE 24.2%
- Beta-blocker 22.1%
- Diuretic 21%
- Thyroid 18.7%
- Anti-inflammatories 17.7%
- PPI 15.3%
- Hormones 13.2%
- Calcium Channel blocker 13%
- Vitamins 13%
- Insulin 11.4%
- Anti-convulsant 11.4%
- Combination inhalers 10.5%
- Inhaled B-agonists 10%
- Other neuro 9.3%
- Inhaled steroids 9.3%

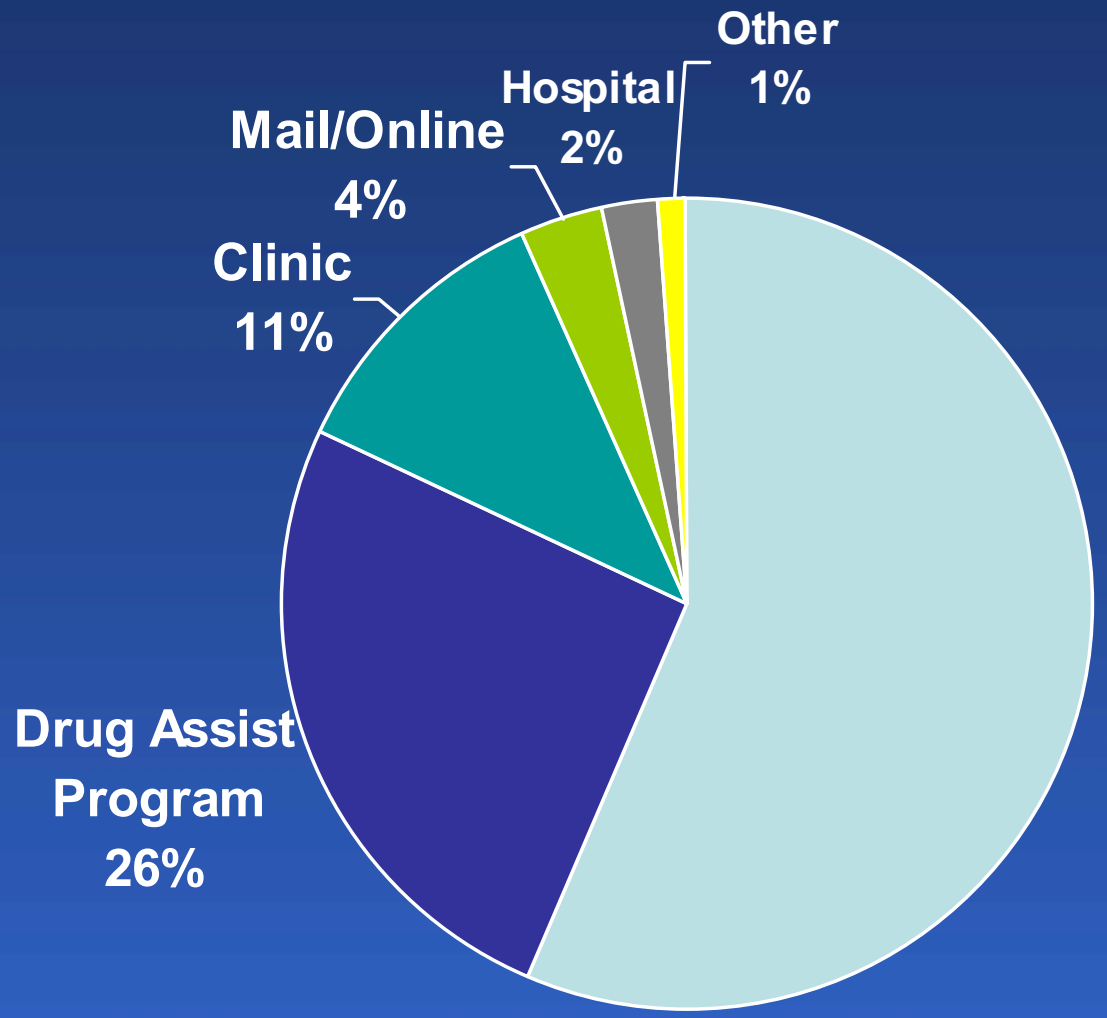
Current Place of Medical Care



12.5% have changed

Most moved from a private office to a county or community clinic

Where Get Prescriptions

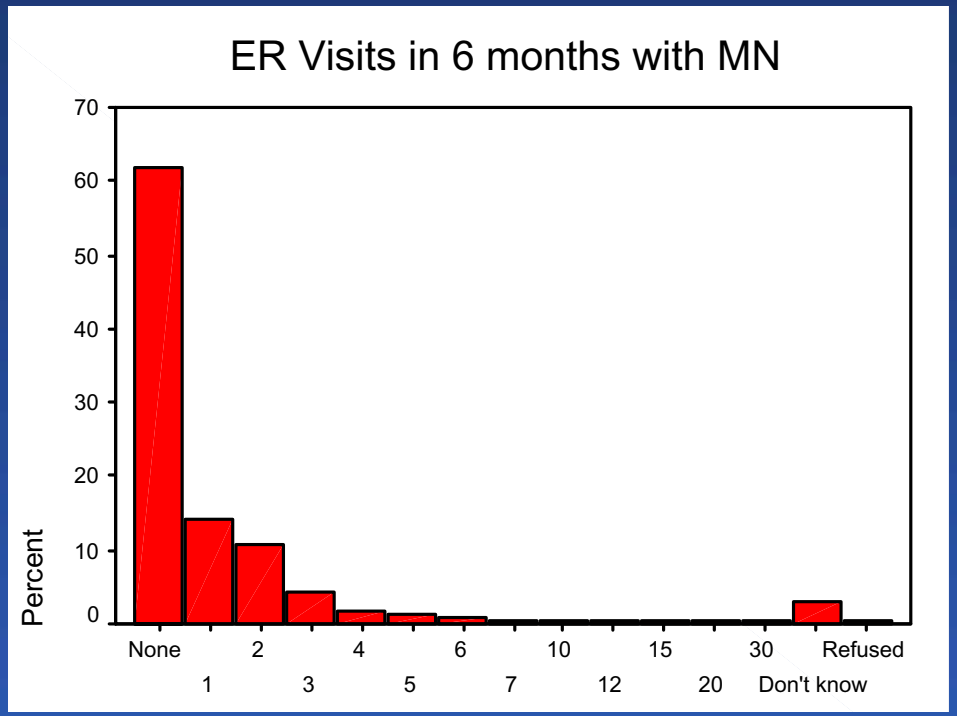


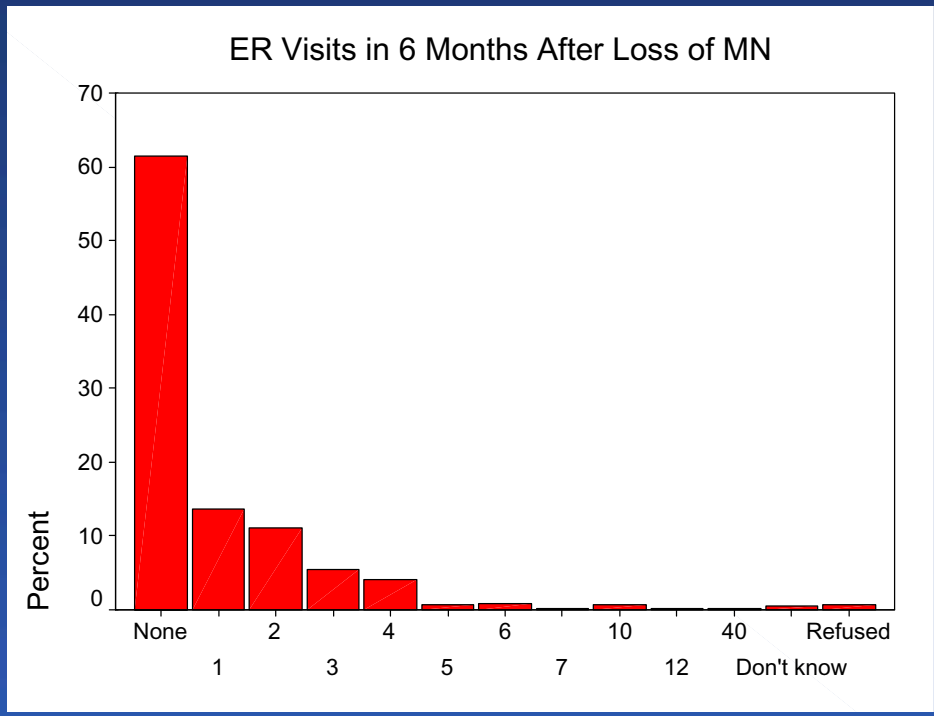
30% have changed where they get Rx since loss of the MN program

85% of people used to get Rx from retail pharmacies

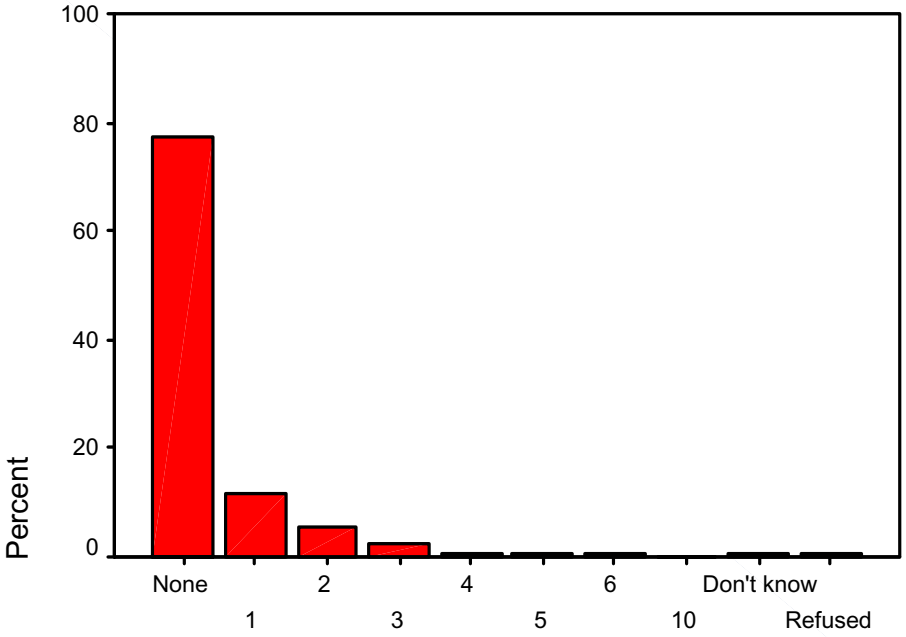
Health Impact

- About 60% reported no ER visits and 77% without hospitalization in each time period
- Significant difference in ER visits by self-report in 6 months before and after
  - $p = 0.012$
- Significant difference in hospitalizations by self-report in 6 months before and after
  - $p = 0.002$

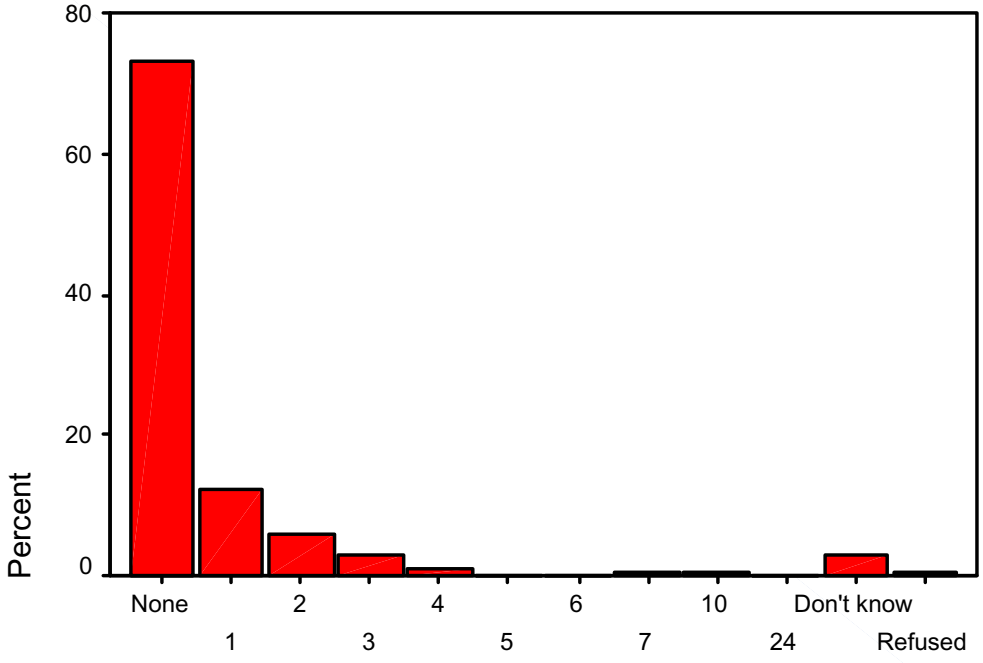

ER Visits in 6 months with MN
Percent
70
60
50
40
30
20
10
0
None
1
2
3
4
5
6
7
10
12
15
20
30
Don't know
Refused


ER Visits in 6 Months After Loss of MN
Percent
70
60
50
40
30
20
10
0
None
1
2
3
4
5
6
7
10
12
40
Don't know
Refused

Hospitalizations in 6 Months with MN



Hospitalizations in 6 Months After Loss of MN

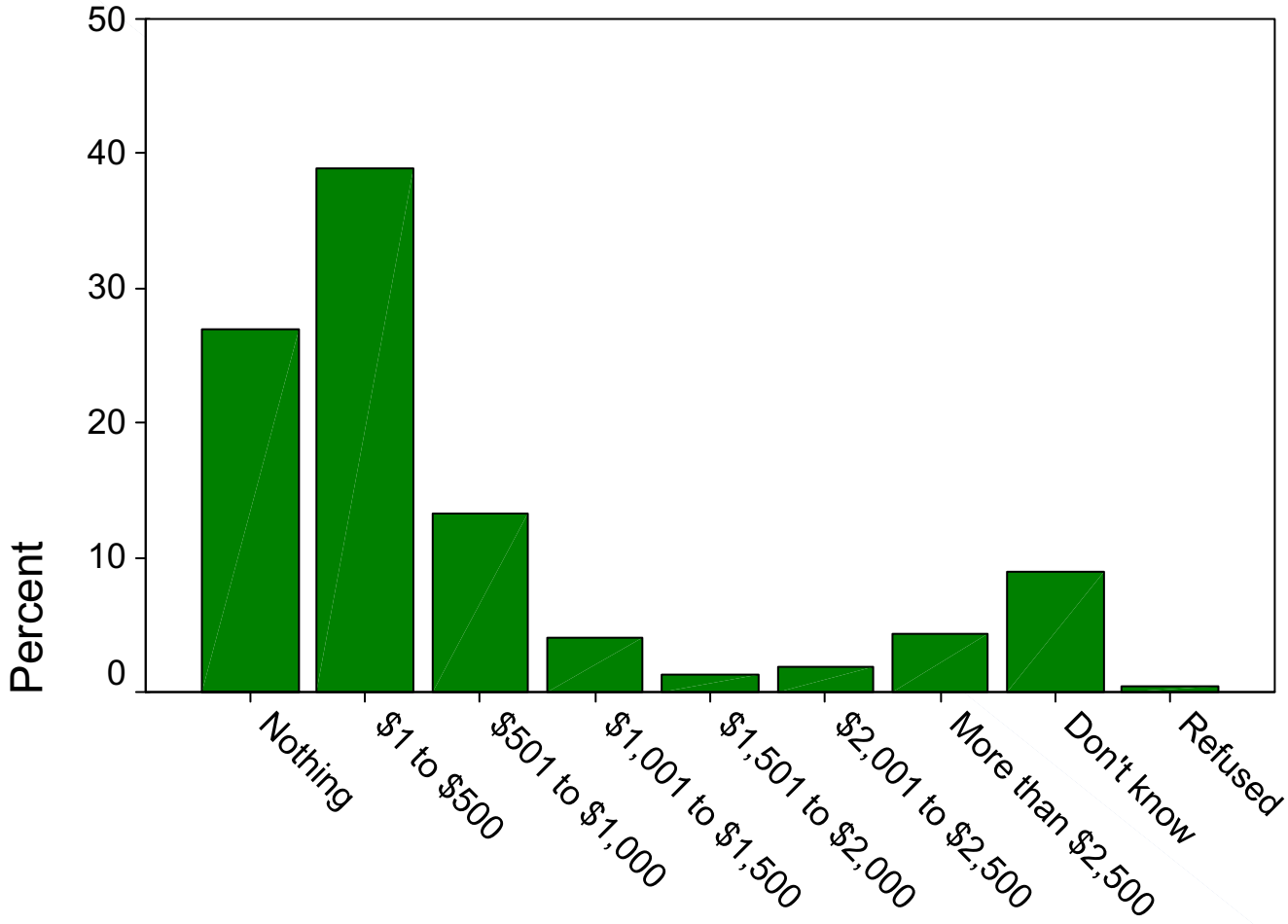


Reasons for Hospitalization

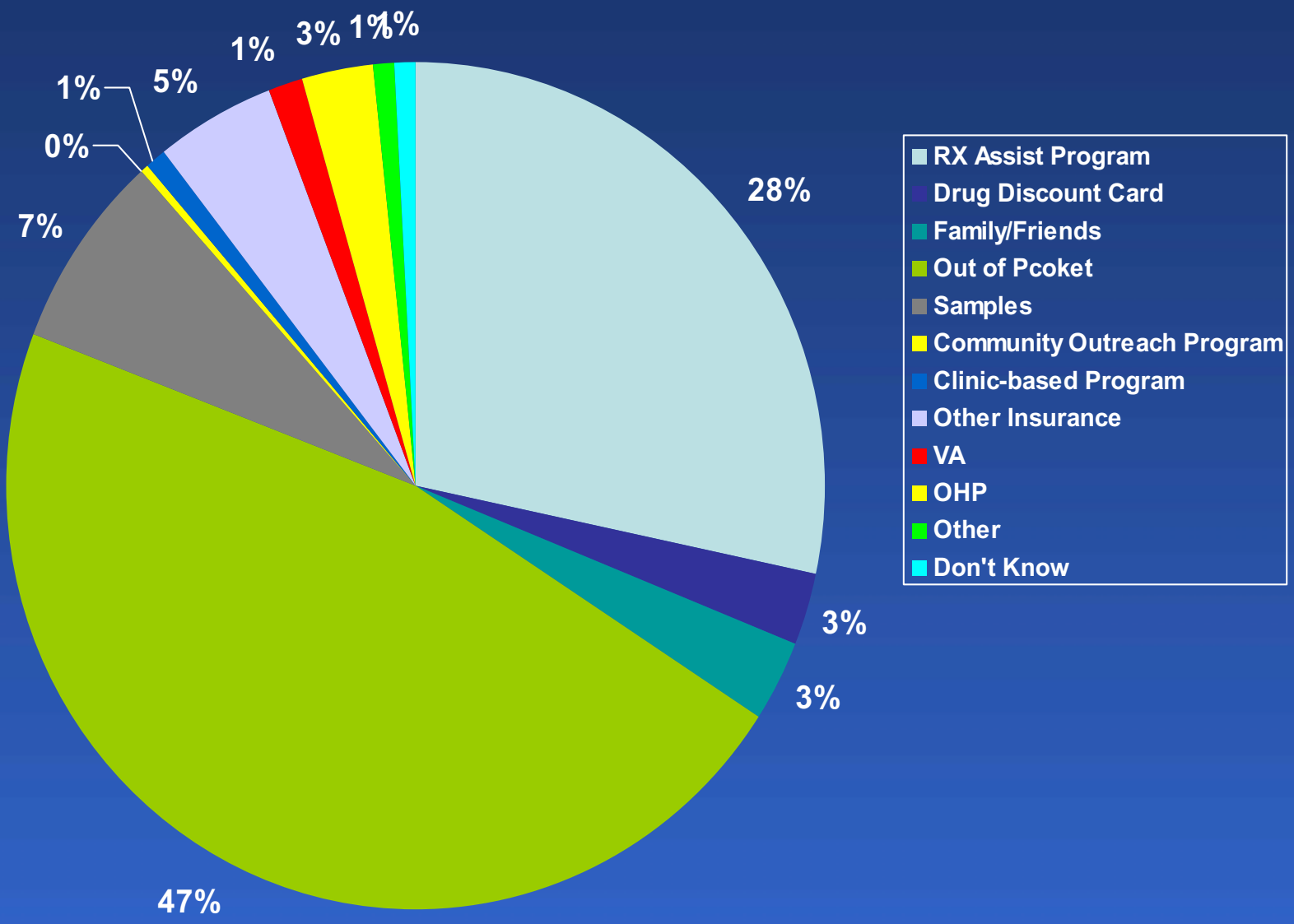
- **With MN**
- 140 cases
  - Heart disease 21%
  - Mental health 9%
  - Pneumonia 9%
  - Diabetes 3%
  - Gastrointestinal 2%

- **After MN**
- 119 cases
  - Heart disease 22%
  - Mental health 11%
  - Pneumonia 10%
  - Diabetes 6%
  - Gastrointestinal 7%

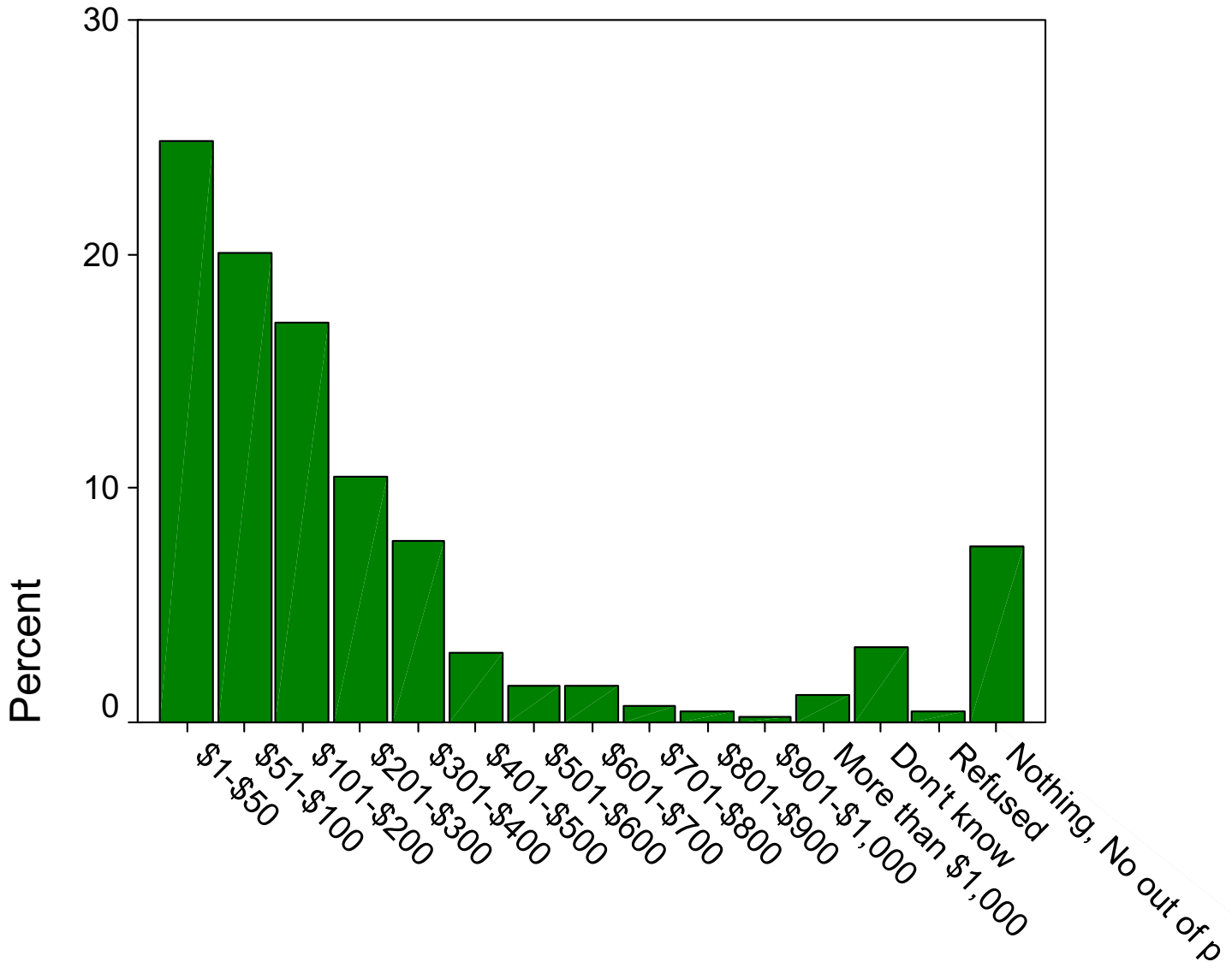
Healthcare Spending Last 6 Months



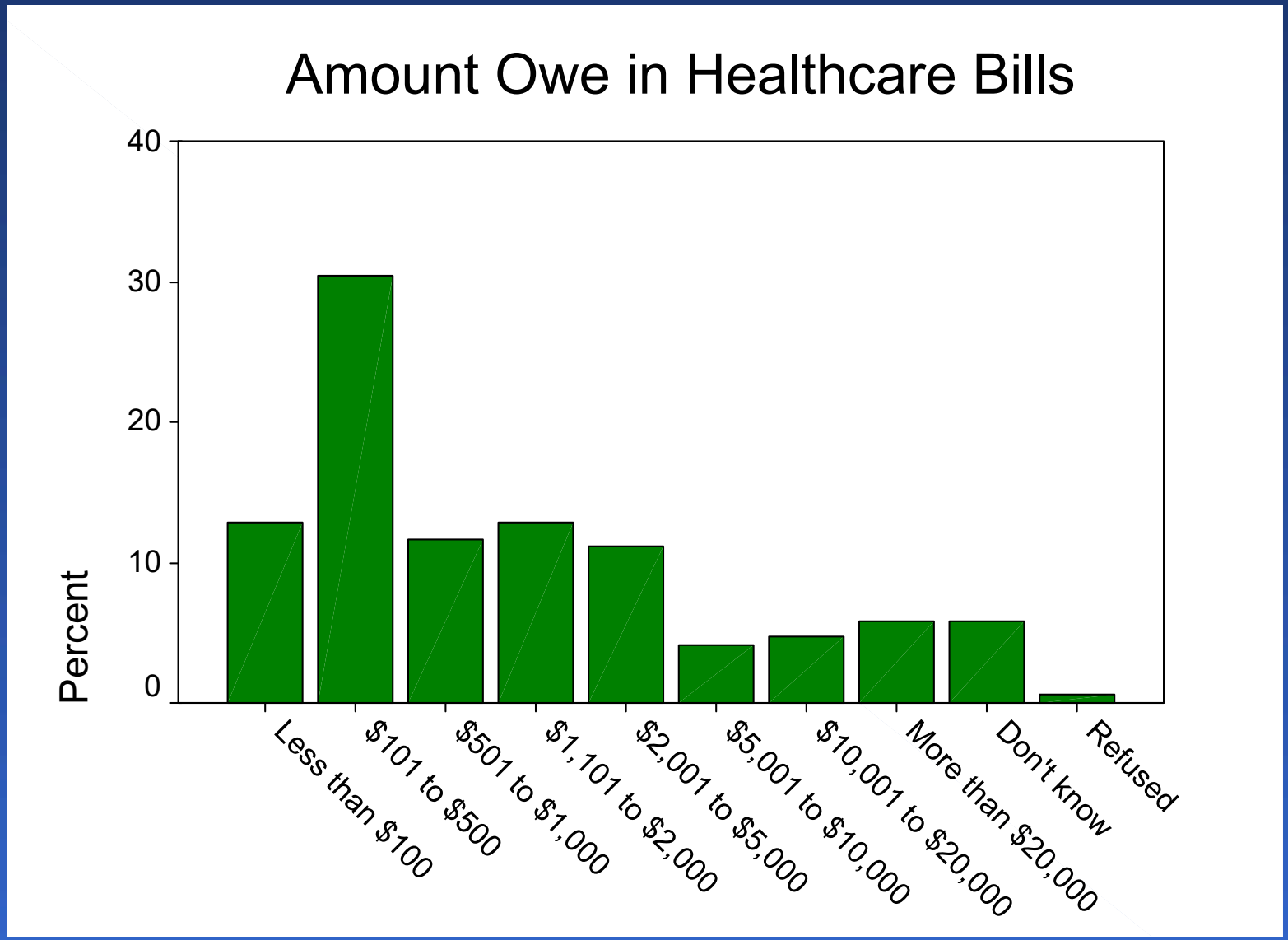
How Pay for Prescriptions



Average Out-of-Pocket RX Expenses



- 39% currently owe outstanding healthcare bills



Medication Impact:
In the 6 months after the MN program ended:

- 60.6% have skipped dosed or took less of a medication
- 63.8% have gone without filling a prescription

Drugs Not Taking

- 49% (214) respondents reported there are prescriptions they are supposed to be taking but are not

- 493 specified drugs:
  - Anti-depressant 10%
  - Anxiolytic 5.1%
  - Anti-inflammatories 4.9%
  - Statins 4.1%
  - Narcotics 4.1%

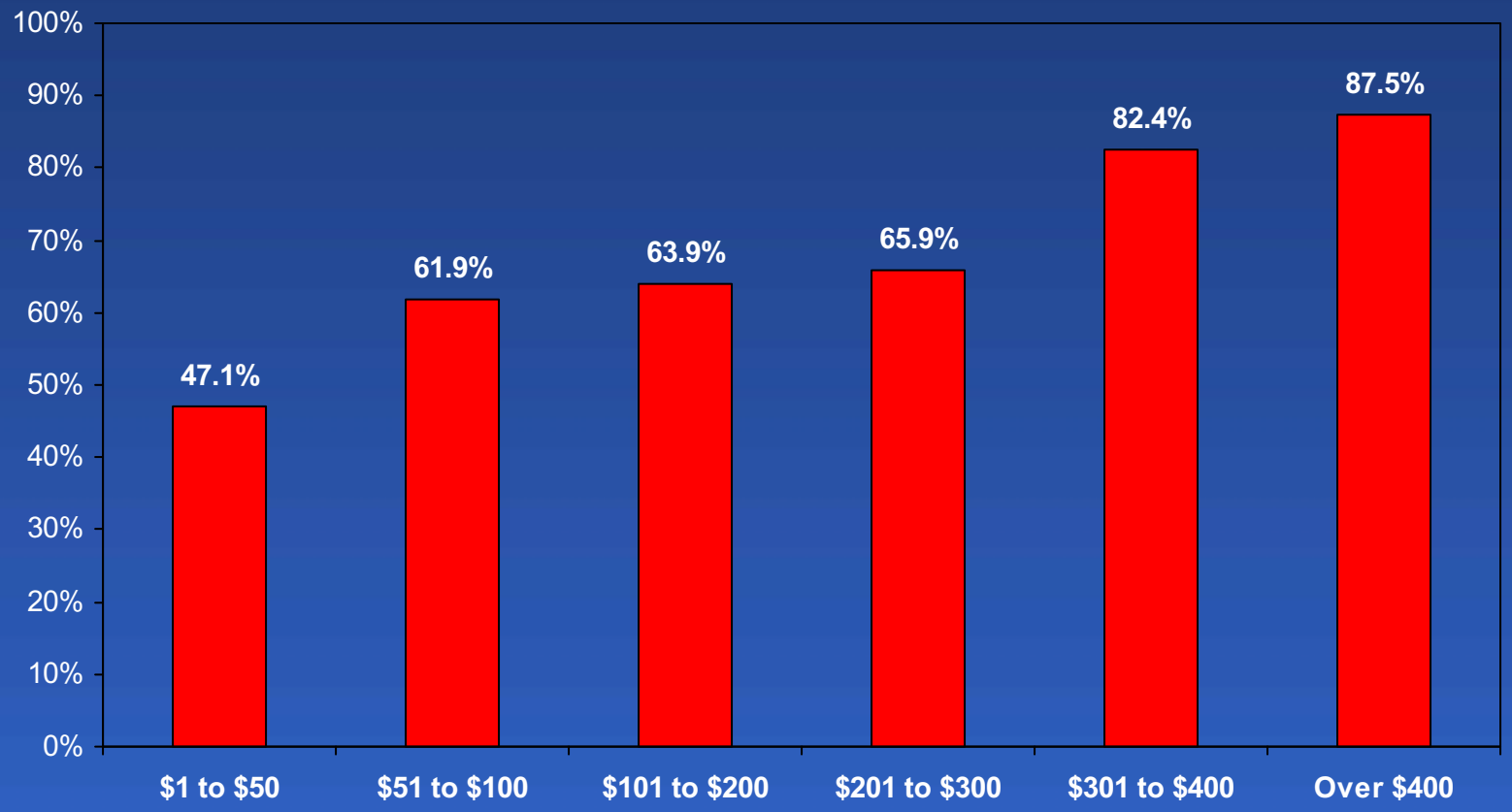
In the 6 months after the MN program ended:

- 36% got advice about switching to a similar but lower cost medication or discontinuing a prescription
  - Most of this advice came from their physician or other health care professional
  - 61% of people found this advice very or somewhat helpful

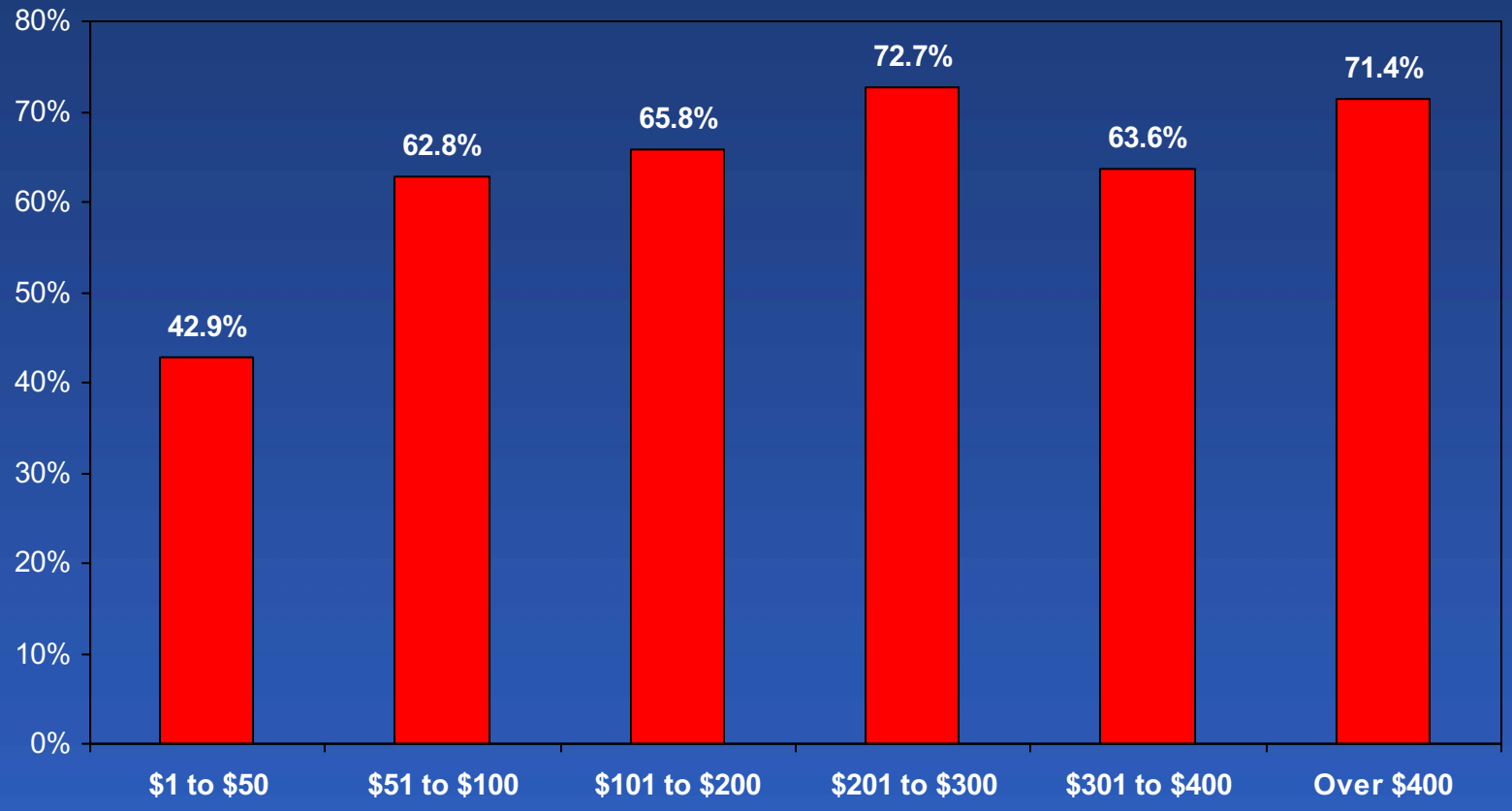
Financial Impact:
In the 6 months after the MN program ended:

- 59.9% of respondents have cut back on their food budget in order to pay for their medications
- 48.5% have skipped paying other bills or paid bills late
- 47.2% have borrowed money from family and friends to pay for medications
- 20.5% have added credit card debt to pay for rx

Percentage Going Without Filling a Prescription by Monthly Out-of-Pocket Prescription Expense Levels

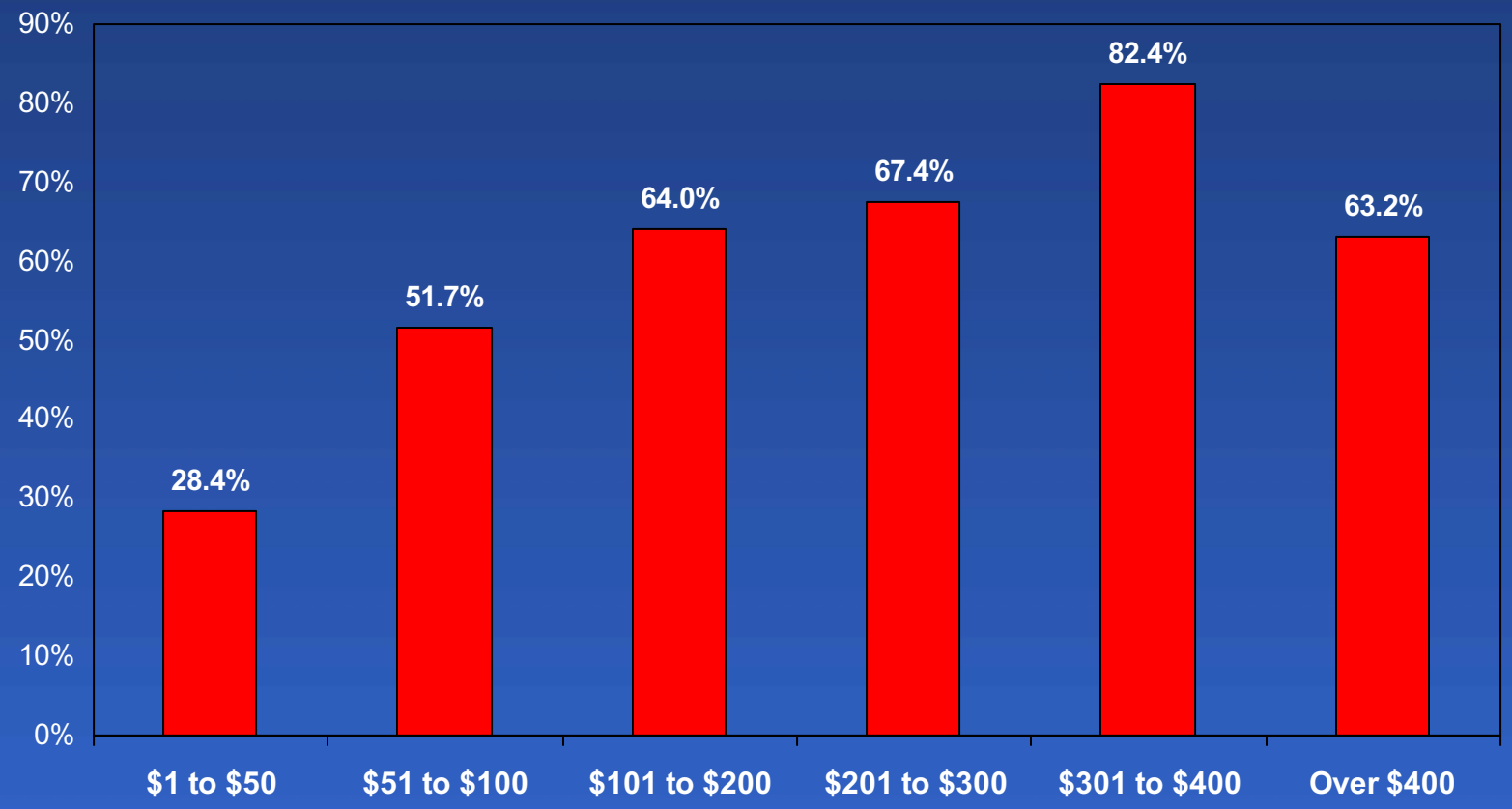


Percentage Skipping Doses or Taking Less of a Medication by Monthly Out-of-Pocket Prescription Expense Levels

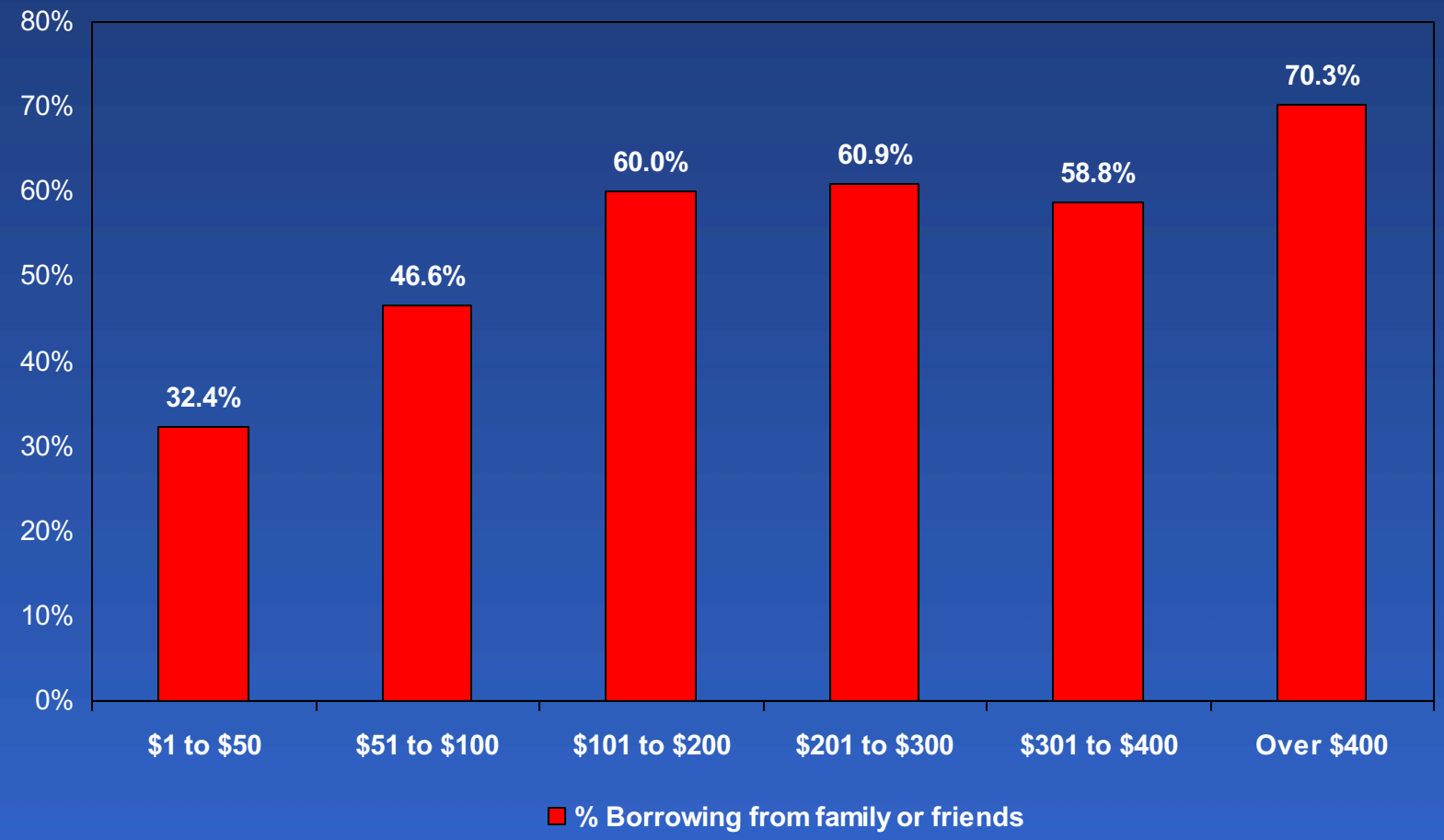


Percentage Cutting Back on Food Budget to Pay for Prescriptions by Monthly Out-of-Pocket Prescription Expense Levels

Percentage Who Skipped Paying Other Bills or Paid Bills Late to Pay for Prescriptions by Monthly Out-of-Pocket Prescription Expense Levels



Percentage Borrowing Money from Family or Friends to Pay for Prescriptions by Monthly Out-of-Pocket Prescription Expense Levels



Drug Company Patient Assistance Programs

- 45.3% of respondents use
- 67.8% get assistance filling out paperwork
  - primarily from a doctor's office or clinic
- 55.3% report using these programs is very or somewhat hard to do

Drug Company Patient Assistance Programs

- 37.1% get only some of their drugs
  - Mostly because not all of their medications are covered by these programs
- 38.7% of people are very or somewhat confident they can continue to use these programs
- 52.3% are not very or not at all confident

Respondents Not Using Drug Company Assistance

- 2/3 are aware that these programs exist
- 2/3 of these have applied for these programs in the past
  - 29% waiting to hear the status of their application
  - 22% were approved
  - 19% were approved for some but not all medications
  - 6% have been refused
  - 8% didn't finish the paperwork

Respondents Not Using Drug Company Assistance

- Survey participants who have not applied give the following reasons:
  - 21.3% don't know much about
  - 13.1% can afford some of their prescriptions
  - 13.1% too much hassle
  - 11.5% need someone to help them with the paperwork
  - 11.5% aren't available of the drugs they need

Summary

- OHP's Medically Needy are vulnerable, chronically ill people
- Loss of the Medically Needy program has resulted in:
  - Significantly more ER visits and hospitalizations
  - Patients taking less of their medications
  - Financial impact in the daily life of patients

Thanks to:

Tina Edlund and Lisa Krois from OHPR

Daniel Touchette and Dean Haxby from OHSU

Targeted Case Management of CareOregon Members Prescribed Antidepressant and/or Antipsychotic Medications

OHREC Presentation - Wilsonville

Presenters: Judy Robison, Matt Carlson, Ann Hamer

October 15, 2003

Targeted Case Management Grant Team

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Peter Davidson, Multnomah County/Verity Medical Director
Rick Ralston, Legacy Good Samaritan Behavioral Health Manager
Rupert Goetz, Clackamas County/ MHO Medical Director

CareOregon's Pilot Sites

- Clackamas County Mental Health (CCMH)
- Legacy Good Samaritan NW Clinic
- Multnomah County Health Dept./NE Clinic

Targeted Case Management (TCM)*

Goals

1. Increase consultation between clinical pharmacists, primary care providers, and mental health professionals to improve medication management
2. Implement Depression Recognition and Care Management in primary care pilot sites

*State Office of Medicaid Assistance Programs (OMAP)
Grant Award #99927 - 2002-2003

What Was Studied

Population Analysis

- Number of members, percent receiving antidepressant and/or antipsychotic medication
- Enrollment categories
- Effect of clinical pharmacy training/consult to improve medication management
- Effect of care management on patient care for depression in primary care

The Database

- Office of Medical Assistance Programs (OMAP) pharmacy and mental health utilization claims
- CareOregon enrollment and claims
  - Demographic characteristics
  - Eligibility categories
  - Outpatient utilization

Figure 1: CareOregon Member Enrollment in MHOS 1/1/01 to 6/30/02

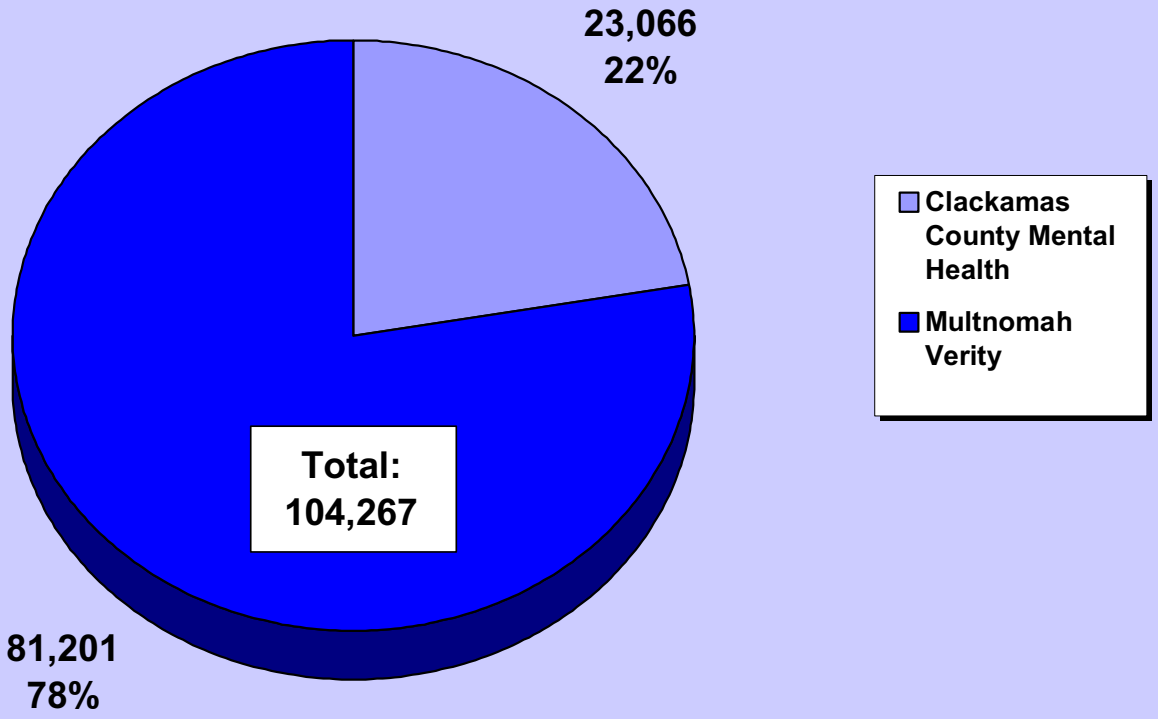


Figure 2. Dually Enrolled Members Receiving an Antidepressant or Antipsychotic Medication 1/1/01 to 6/30/02

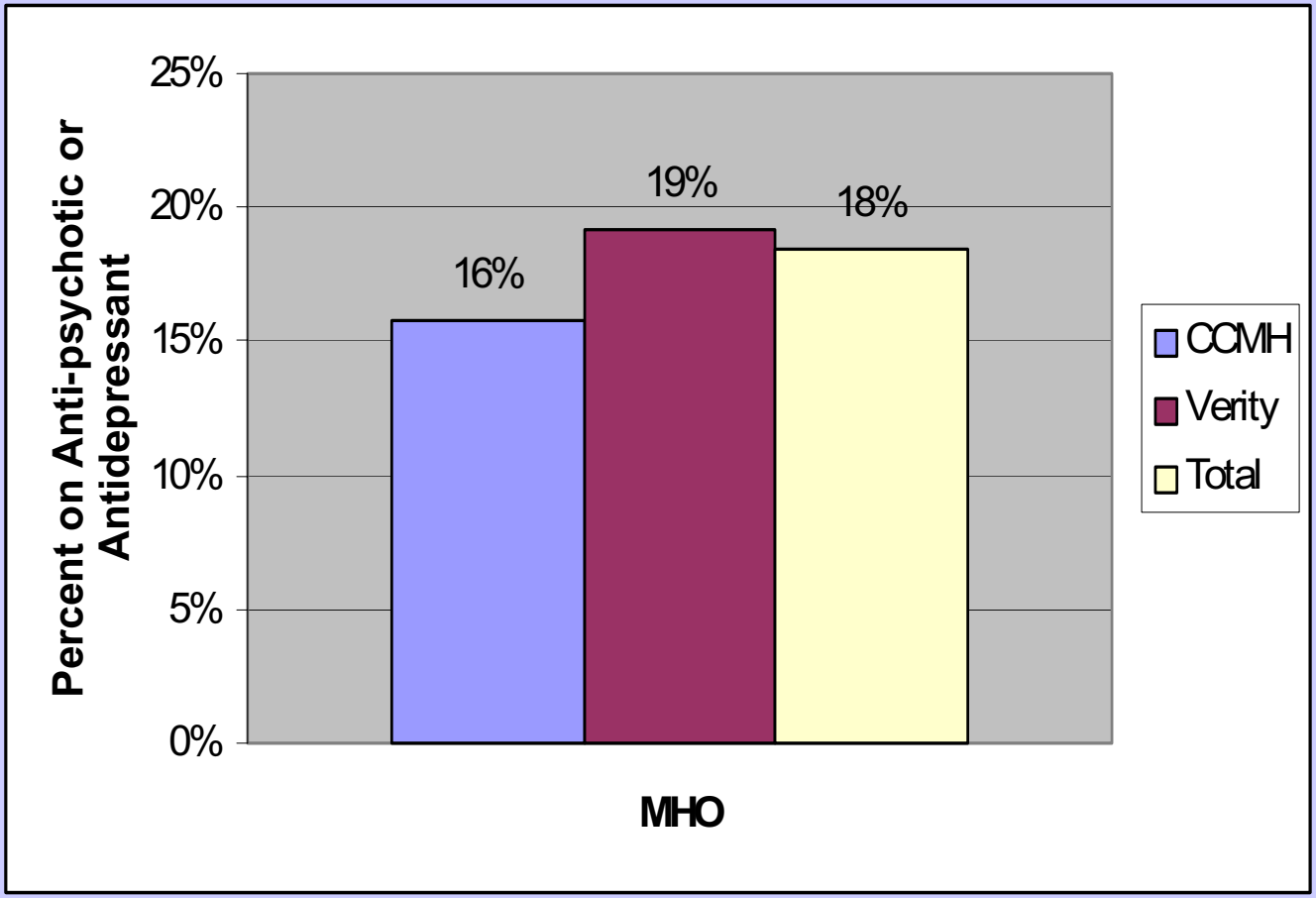
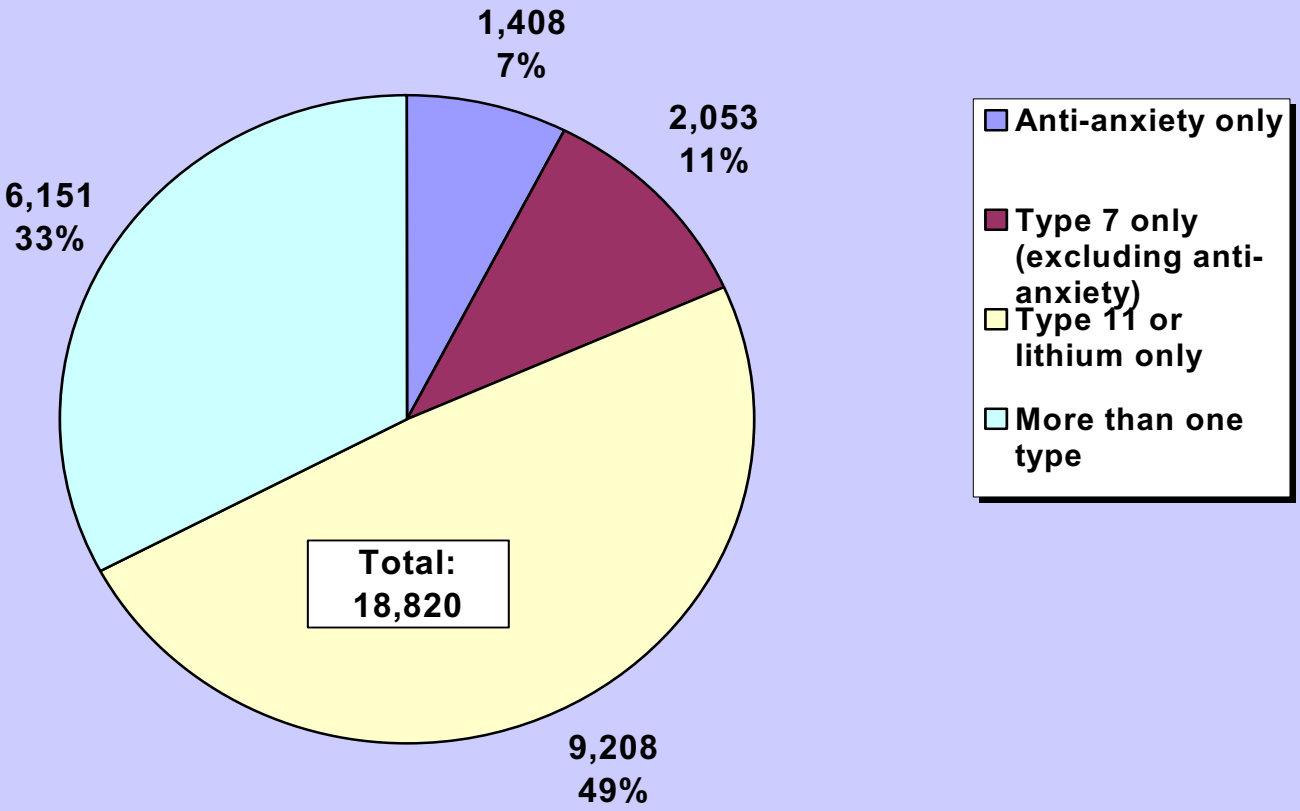


Figure 3. Percent of Members Receiving Antipsychotics or Antidepressants by Drug Type 1/1/01 to 6/30/02



Treating Depression In Primary Care

- Screening for depression improves outcomes (US Preventive Services Task Force 2002)
- 50% of patients stop medication within first 3 months*
- Medication often not used at dosage sufficient to give full remission*

Depression Recognition and Care Management Guidelines Pilot Sites

- Multnomah County Health Dept NE Clinic
- Legacy Good Samaritan NW Clinic

Care Manager Role

- Care management to monitor high risk medically ill patients with moderate to severe depression
- Reinforce patient instructions to increase treatment adherence through monitoring effects/side effects
- Problem solve with patients for emerging problems
- Facilitate patient referral to specialty mental health for complex cases

Appropriate Medication Management for Dually Enrolled Members with a New Prescription for Antidepressant Medication

	CareOregon	MHOs	HEDIS 2000 Medicaid %		
			25th	50th	75th
3 month Medication Adherence	45%	47%	39%	44%	50%
6 month Medication Adherence	27%	27%	24%	28%	36%
3 or more PCP visits in 3 months	34%	NA	10%	15%	26%

Pharmacist Consultation

- Offered at each site, primary focus at CCMH
- Clinical Pharmacist provided support to providers with challenging patients about multiple medications/multiple diagnoses
- Developed Psychopharmacology “Tidbits”

Pharmacy Intervention

- Pharmacy Education
  - All three sites (focus on primary care sites)
  - Topic: Appropriate utilization of antidepressants and dispelling industry rumors
- Provider Profiling
  - Patient profiles
  - Antidepressant utilization profile
  - Voluntary SSRI change order form

Pharmacy Intervention

- Voluntary SSRI Change Order Forms
  - Form sent to prescribers describing patients' antidepressant use and described cost effective alternatives
  - QD dosing, ½ tablets, generic fluoxetine
  - Distributed, collected and executed by primary care "care managers"

Figure 4. Average Monthly Costs Per Member for SSRIs in Calendar Year 2002

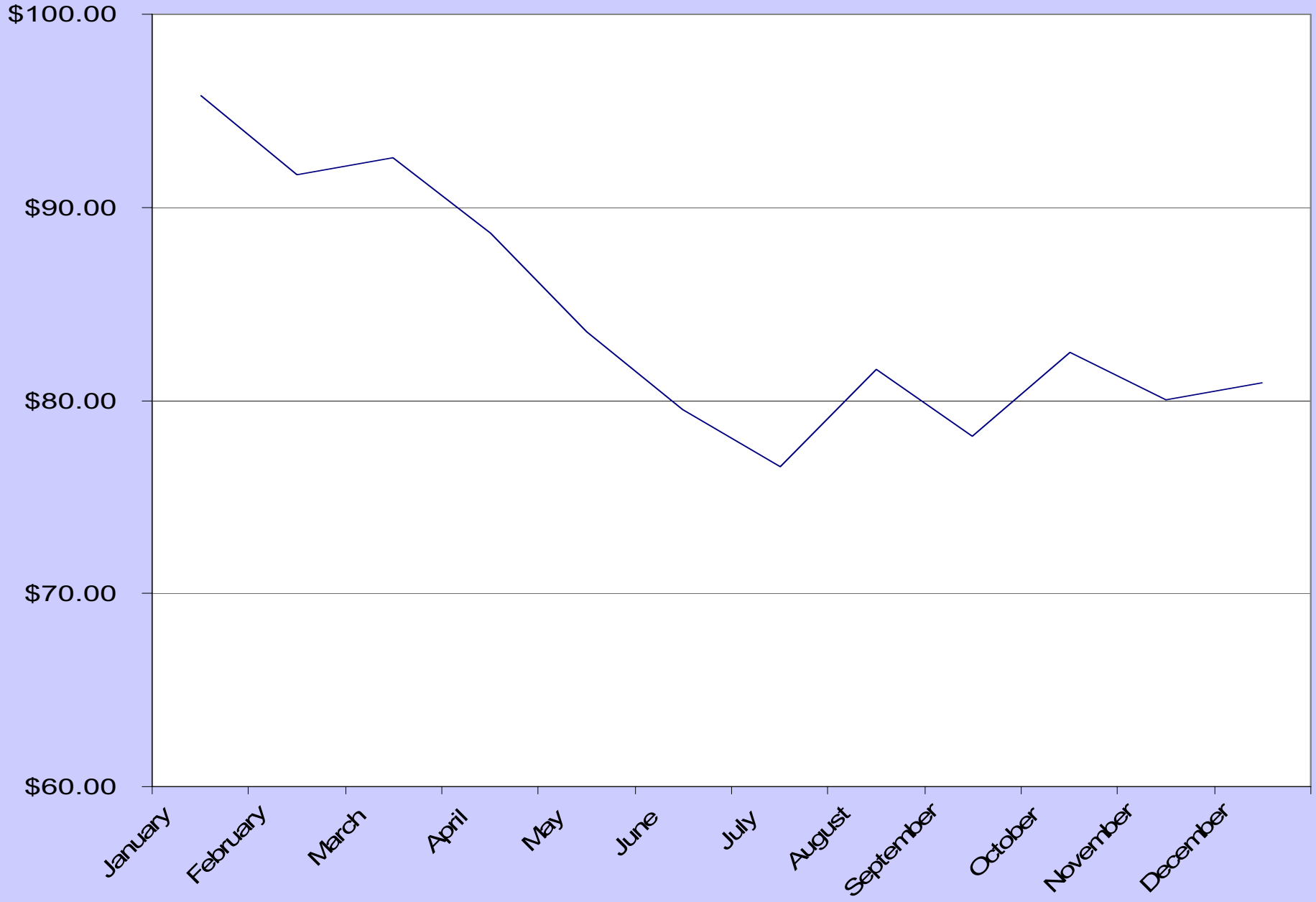


Figure 5. Average Monthly Costs Per Member for Brand SSRIs and Fluoxetine

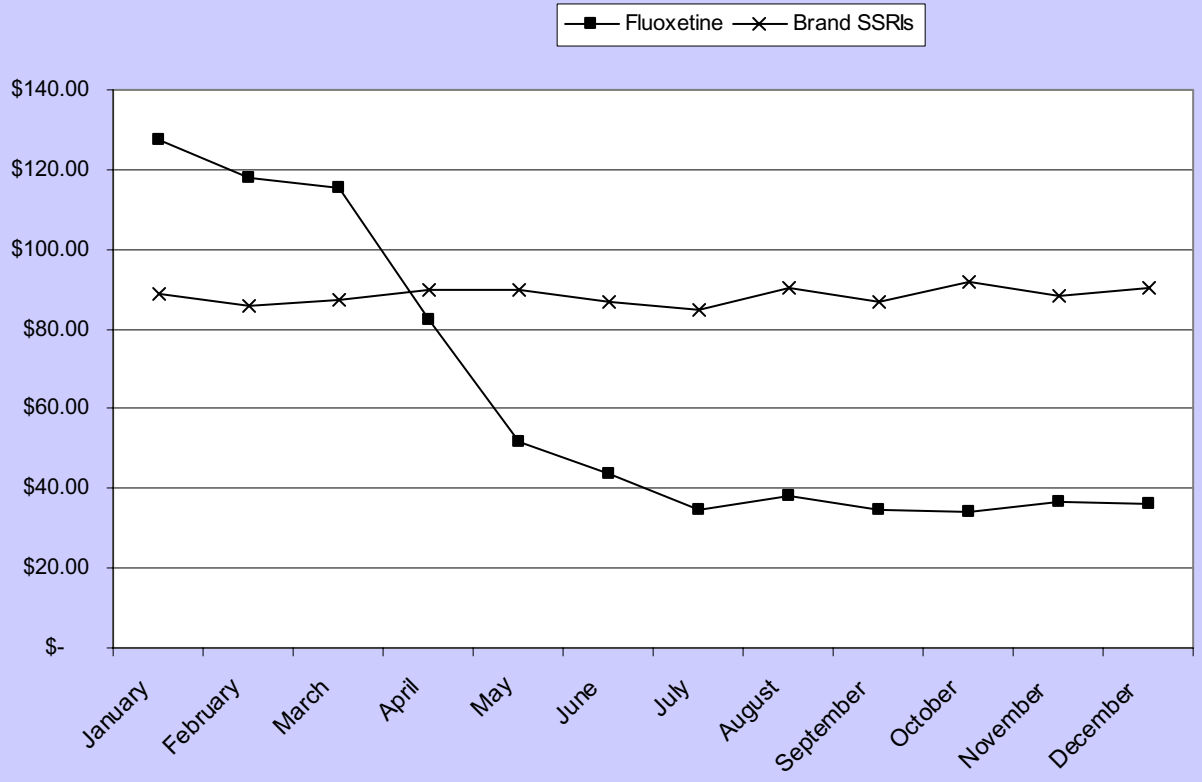


Figure 6. What Happened to Change Orders (n=211)

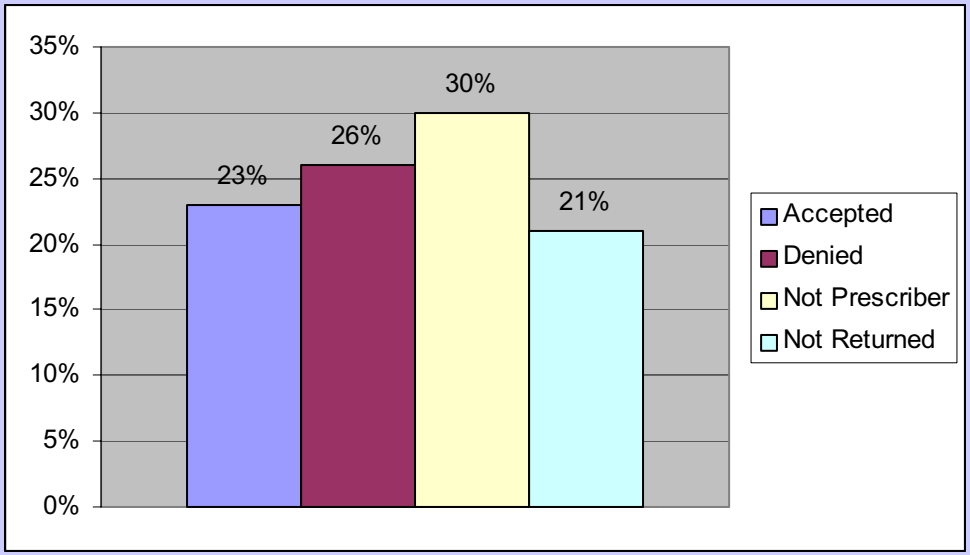


Figure 7. Accepted Change Orders by Type (n=48)

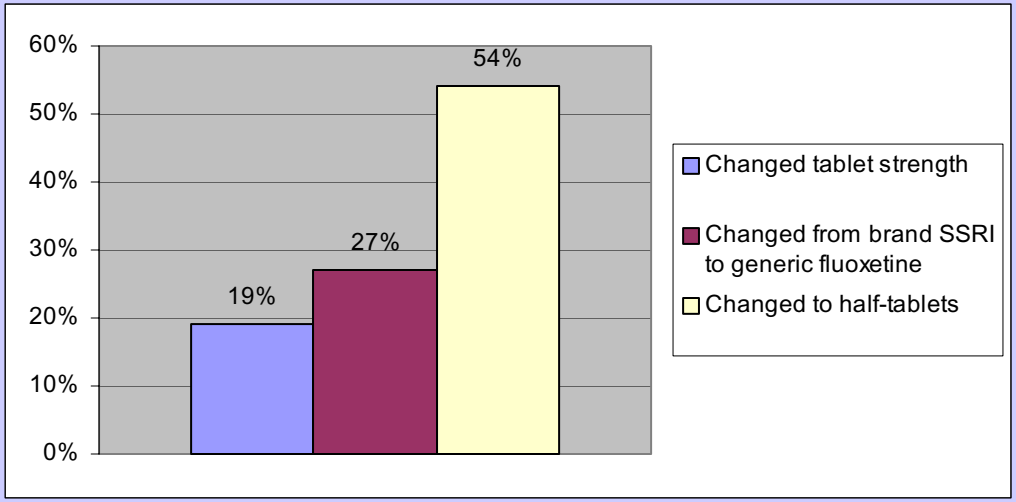


Figure 8. Reasons for Change Order Denial (n=54)

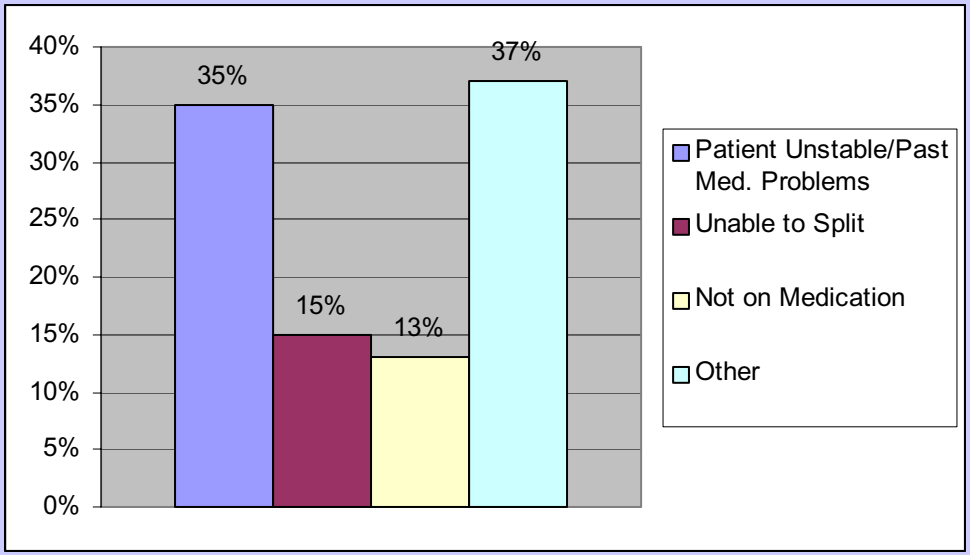


Table 1. Projected Cost Savings Based on Project Findings*

	Average Annual Cost Before Treatment	Average Annual Cost After	Total Estimated Cost Before	Total Estimated Cost After	Annual Projected Savings	% Annual Savings
Entire Sample	$269	$242	$2,809,974	$2,528,767	$281,207	10%
Returned Change Orders	$268	$212	$2,800,363	$2,218,312	$582,051	21%

* Because these are 2002 data, the OHP Standard Population is included.

Impact of the Oregon Medicaid Demonstration on Preventable Hospitalization Rates

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Data and technical support from the
Oregon Office for Health Policy and Research

Funding from the Medical Research Foundation of Oregon

Background

- Preventable (avoidable) hospitalization (PH)
  - Hospitalization for “ambulatory-care-sensitive” (ACS) conditions
  - Acute conditions for which early and appropriate ambulatory care prevents progression (e.g., cellulitis)
  - Chronic conditions for which regular and appropriate ambulatory care prevents exacerbation (e.g., asthma)
- PH rates hypothesized to be an indicator of ambulatory (primary) care access and quality

Background

- Rates of preventable hospitalization vary among populations with different levels of access to 1^{o} care
  - Uninsured vs. insured
  - Poor vs. non-poor
  - Blacks vs. whites
  - Low vs. high self-rated access to care
- PH rates validated as index of population-level access to care

Background

- In 1994, Oregon expanded Medicaid eligibility to all persons under 100% FPL
  - Increased state funding
  - Capitated managed care
  - Prioritized list of services (explicit rationing)
- Increased access by most measures
  - Provided coverage to 130,000 previously uninsured persons
  - Reduced state uninsured rate from 18% to 11%
  - Provided access to over 90% of physicians in Oregon
  - Reduced ED visits and uncompensated care statewide
- Did the OHP Medicaid Demonstration reduce PH rates?

Hypotheses

PH rates within the Medicaid+uninsured population decreased after the Medicaid expansion

AND

This decrease in PH rates was greater than any concurrent decrease in PH rates for Oregonians with private and public insurance other than Medicaid (non-Medicaid insured)

Methods

- Calculated annual PH rates from 1990-2000
  - Medicaid+uninsured
    - Pooled because we were unable to isolate directly affected cohort of newly insured persons
  - Non-Medicaid insured
  - Rates standardized by age and sex (direct method)
- Hypothesis testing:
  - Compared PH rates before and after 1994 (1990-93 vs. 1995-2000) within Medicaid+uninsured group
  - Compared temporal change in PH rates for Medicaid+uninsured group vs. non-Medicaid insured ("control") group

Methods

$$\text{PH rate} = \frac{\text{\# of preventable hospitalizations}}{\text{population count}}$$

- Numerator:
  - Source: Oregon state hospital discharge database
  - Conditions: asthma, COPD, CHF, diabetes, hypertension, cellulitis, gangrene
  - Excluded: <18 or ≥ 65, non-Oregon resident, transfers, federal hospital, Medicare listed as payor
- Denominator
  - Medicaid beneficiaries: from Medicaid eligibility files
  - Uninsured: from Oregon Population Survey (odd years interpolated)
  - Non-Medicaid insured: (total OR pop'n – uninsured – Medicaid)
  - Included adults 18-64

Methods

- Calculated hospitalization rates for “marker” conditions
  - Appendicitis, GI obstruction, subarachnoid hemorrhage
  - Hospitalization rates assumed to be stable over time and across populations
  - To account for potential errors from inaccurate population counts or coding changes
- Multivariate model

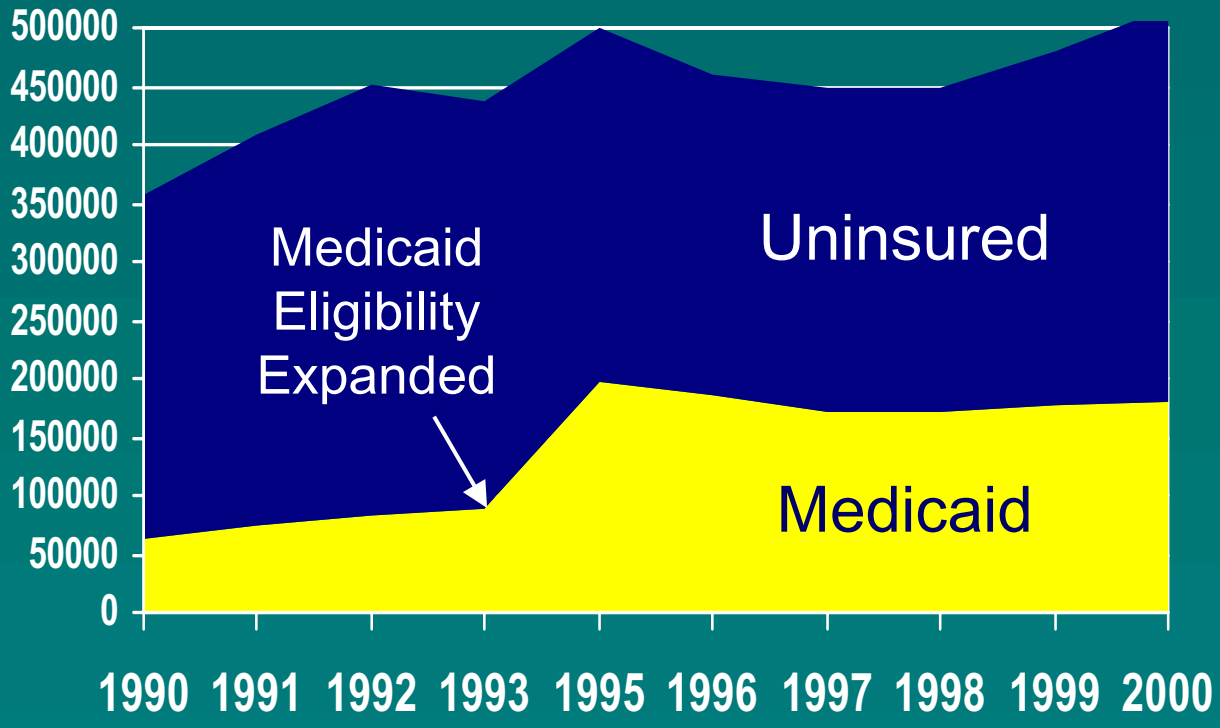
$$\text{Logit (PH rate)} = \text{age} + \text{sex} + \text{marker} + \text{time} + \text{payor} + \text{time payor}$$

: change in PH rates over time

: change in PH rates relative to non-Medicaid insured population

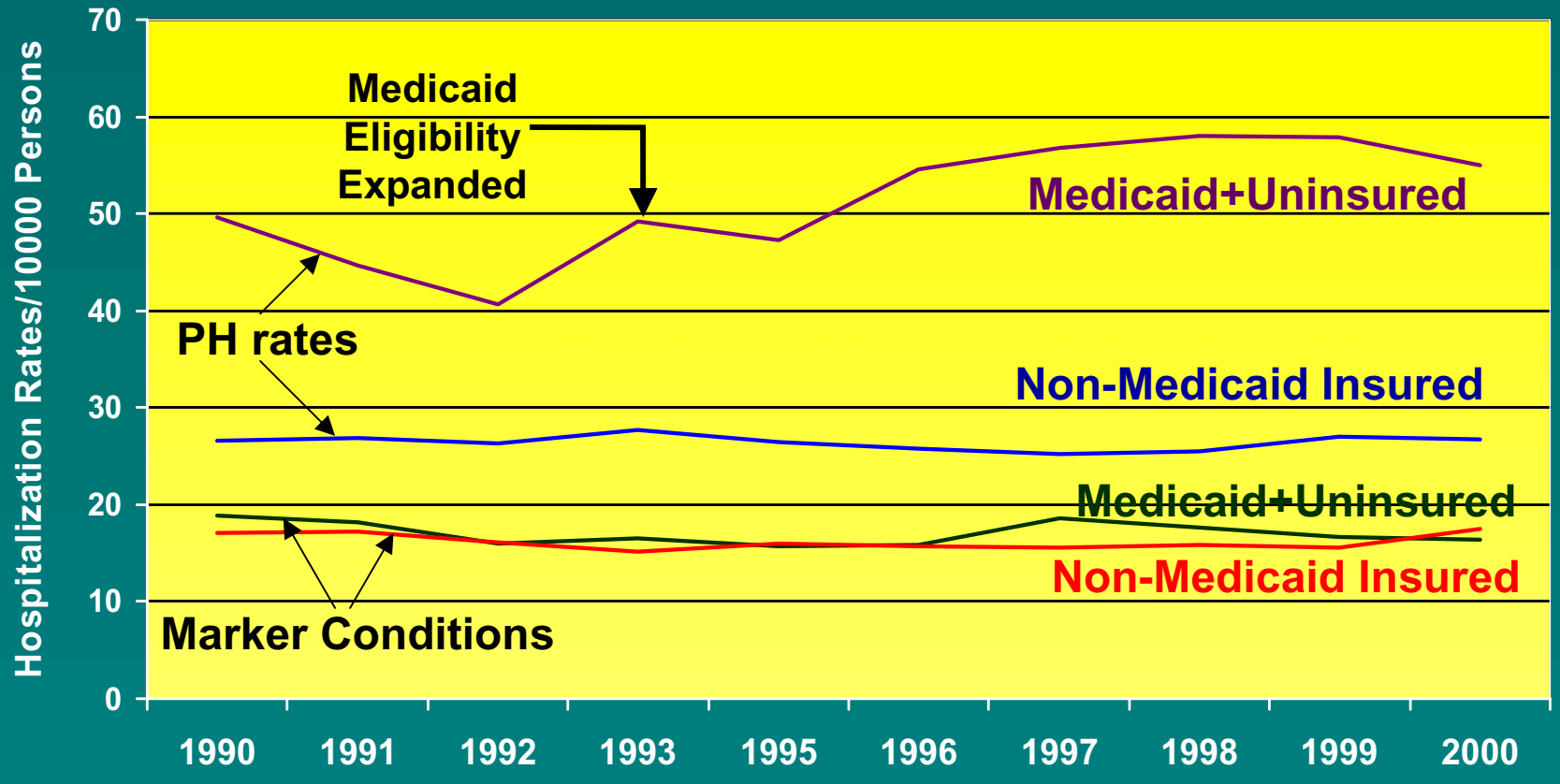
Results

- With eligibility expansion number of Medicaid beneficiaries aged 18-64 doubled



Results

- PH rates for Medicaid+uninsured group ***increased*** after Medicaid expansion
  - Rates for non-Medicaid insured were relatively stable



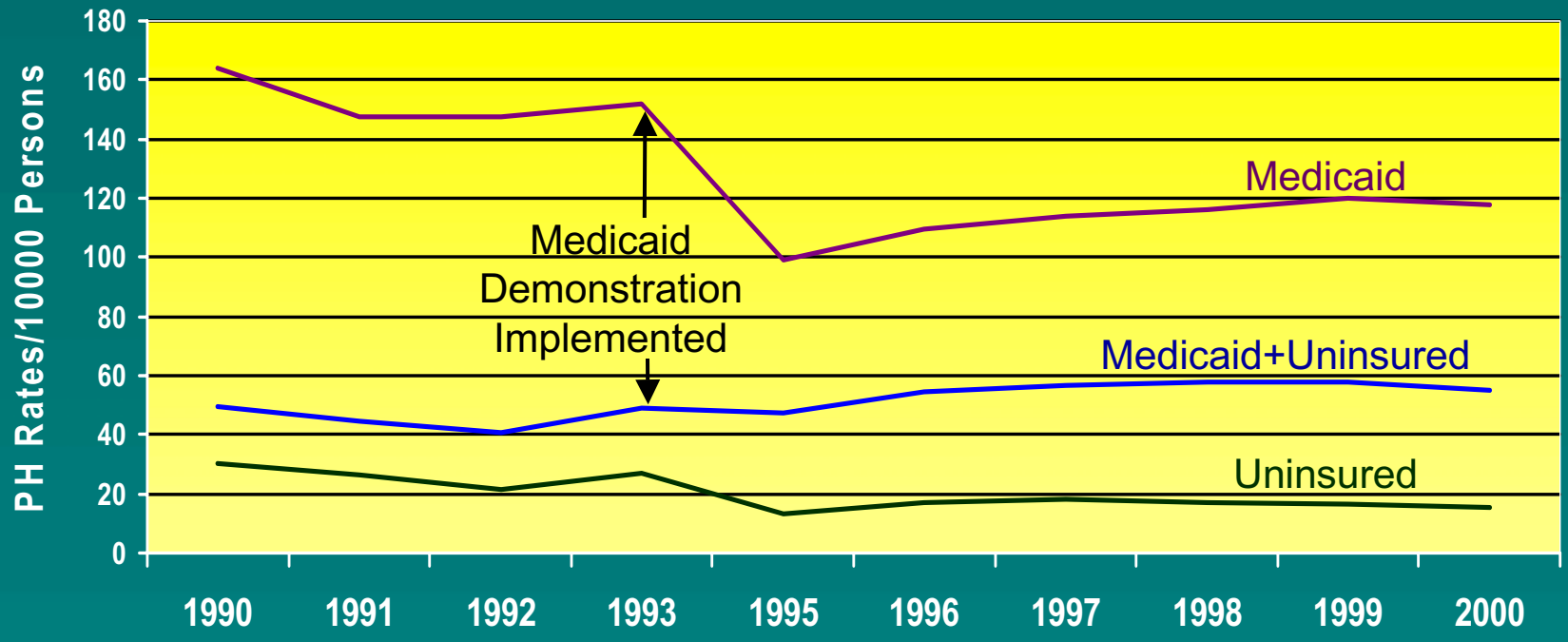
Results

PH Rates Before and After Medicaid Expansion

	Standardized PH Rate per 10,000		Post- vs. Pre-1994 (odds ratios)		Time x Payor Comparison
	1990-93	1995-2000	Unadjusted	Adjusted* (95% CI)	Adjusted*
Medicaid+ Uninsured	46.05	54.88	1.19	1.18 (1.14-1.21)	p < .001
Non-Medicaid Insured	26.86	26.11	0.97	1.01 (.99-.1.03)	
* Adjusted for age, sex, and hospitalization rates for marker conditions					

Results

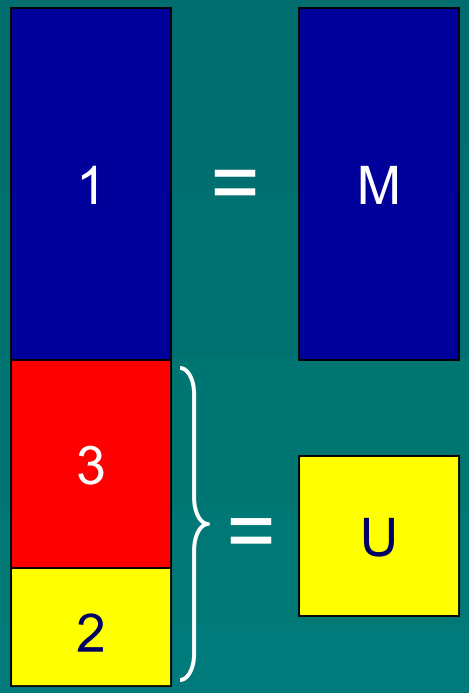
- PH rates declined for Medicaid and uninsured groups individually, but increased for combined Medicaid+uninsured group



Summary

- PH rates were lower among Medicaid beneficiaries after 1994 as compared with before 1994
- PH rates were lower among uninsured after 1994 as compared with before 1994
- PH rates were *higher* for Medicaid + uninsured after 1994 as compared with before 1994
- Ecological study – can only speculate as to how to explain this “paradoxical” finding

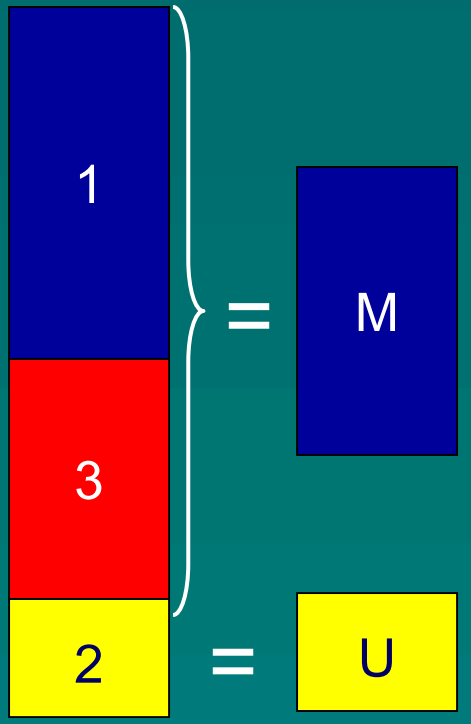
Explanation 1: Simplistic



Pre-1994

Group	Pre-1994	Post-1994
1	Medicaid	Medicaid
2	Uninsured	Uninsured
3	Uninsured	Medicaid

M = Medicaid
U = Uninsured



Post-1994

Explanation 1: Simplistic

- Potential reasons for increase in PH rates among newly insured
  - Access to 1° care may have facilitated access to hospitals
  - Insurance coverage may have diminished disincentives for patients to seek care and for providers to admit to hospital ("pent-up demand")
  - Churning between uninsured and Medicaid pools
    - Medicaid eligible persons disenrolled when well, re-enrolled when ill, potentially during a hospitalization

But…

- New eligibles entering Medicaid program in 1994 were generally *less healthy* than categorical eligibles
- Hypothesis that PH rates in Medicaid group declined due to a bolus of healthy new eligibles does not have face validity

Explanation 2: Complex

- Why did PH rates in Medicaid group decline?
  - Improved access to primary care within Medicaid program, for both categorical Medicaid beneficiaries and new eligibles
- Why did PH rates in the uninsured group decline?
  - Exodus of 100,000 persons under 100% FPL, who were relatively less healthy than those who remained uninsured

Explanation 2: Complex

- Why did PH rates in Medicaid + uninsured group increase?
  - Undercounting of uninsured persons in PH rate denominator
  - Lot of churning between uninsured and commercially insured in 2nd half of 1990s
    - People obtained insurance due to healthy economy but were not able to keep insurance
  - Churners may have been counted in OPS cross-section as being insured but hospitalized after losing insurance
  - Other uninsured may also not have been counted in OPS (migrant workers, people moving to Oregon)
  - Undercounting of uninsured in OPS in 2nd half of 1990s would artificially inflate PH rates in uninsured group

Assessing the Early Impacts of OHP2: FQHC Case Study

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OREGON HEALTH POLICY INSTITUTE

HIFA Waiver and OHP2

HIFA provides federal authorization for states to waiver provisions of their Medicaid state plan for the purpose of expanding access to Medicaid coverage

- HIFA requires that states expand eligibility while permitting differential benefit packages to non-mandatory populations
- HIFA requires that states promote public-private partnerships in insurance products developed under their waiver

OHP2: Medicaid redesign

Eligibility Group	Original OHP	OHP2
Mandatory Groups: Aged, Blind, Disabled, AFDC/TANF	Full benefit package, no co-pays, FPL set at AFDC needs standard	No change in benefits, no co-pays, now known as *OHP Plus*
Low-income pregnant women and children up to 19 yrs	Full benefit package, no co-pays, eligibility set at 170% of FPL	No change in benefits, no co-pays, eligibility set at 185% of FPL, now *OHP Plus*
Optional (Expansion) Groups: Low-income parents and childless adults	Full benefit package, no co-pays, eligibility set at 100% of FPL	Leaner benefits, comparable to commercial benefit package for working adults, co-pays for most services, now known as *OHP Standard,* capped appropriation
Family Health Insurance Assistance Plan (FHIAP)	Eligibility set at 170% of FPL, commercial equivalent benefit package, co-pays, 100% state-funded, capped appropriation	Eligibility set at 185% of FPL, commercial equivalent benefit package, co-pays, 60/40 federal match, capped appropriation

OHP Standard a leaner benefit package with cost-sharing …

Co-payments for *Standard* enrollees include:

Outpatient office visits ($5), ED ($50), prescription drugs ($2/$3)

Benefits not included in ***OHP Standard***:

Durable medical equipment

Reduced dental

Vision and eyeglasses

Non-emergency medical transportation

OHP2: February 2003 Implementation

Legislature dealing with revenue shortfalls, budgetary demands, high unemployment, escalating medical care cost inflation

- *OHP Plus* and *OHP Standard* implemented against a backdrop of confusion regarding eligibility and coverage levels due to on-going legislative budget deliberations:

  OHP Standard income threshold set at 100% of FPL
  OHP Standard group loses MH/CD and all dental benefits
  Elimination of prescription drug coverage (mid-March-June)

OHREC agrees to study short-term impacts of OHP2 implementation

Focus on Safety Net Providers --

- Lowe study of OHSU ED utilization
- OHPI study of safety net clinics (FQHCs)

Portland Area FQHC Case Study

- Clinic administrators' key informant interviews (n=6) conducted in June 2003
- Patient interviews (n=320) conducted in August 2003

Key Informant Interviews

*** Administrative and fiscal adaptations in response to OHP2**

*** Issues related to quality and continuity of care**

*** Diminished access to primary care**

Key Informant Finding #1: Lack of and/or inconsistent information

- There was widespread confusion reported among providers and patients regarding eligibility, benefits, and cost-sharing obligations when OHP2 was implemented in February 2003
- Clinic administrators shared this sense of confusion and were in an anticipatory mode regarding further cuts to be made by the legislature in June 2003

Key Informant Finding #2: Unmet demand for MH/CD services stresses PCPs

- The loss of mental health and chemical dependency benefits for the *OHP Standard* population was reported to have created a demand for these services that could not be met by primary care providers (PCPs)

Signs of the MH/CD problem...

- In Washington County five safety net clinic sites were sharing one social worker
- All FQHC informants reported not having the capacity to absorb the increased demand for mental health services brought on by the loss of Medicaid eligibility or coverage by the large number of individuals with significant mental health/chemical dependency problems who visit their clinics

Key Informant Finding #3: Loss of pharmacy coverage strains clinic resources

- With the imposition of co-payments for office visits and prescription drugs, coupled with the loss of Medicaid eligibility for many patients in need of prescription drugs, Portland area FQHCs reported aggressive efforts to assure continued access to the drugs needed by their patients

- Pharmacy assistance programs are time and resource intensive, thus clinics experienced a significant increase in administrative costs as they sought out alternatives to secure needed pharmaceuticals for their patients

As noted by one clinic administrator…

"All the pharmaceutical assistance programs are pretty time-intensive, so we've actually got to make an investment in order to make them work. They're not something you can do in your spare time. They take a great deal of time, and so we have put some personnel dollars in the next budget year to assign someone to help clients access pharmaceutical assistance programs."

Key Informant Finding #5: Communication gaps regarding coverage, benefits, co-pay responsibilities

- Patients not scheduling follow-up visits because of the $5 office visit co-pay
- Patients not getting prescriptions filled or not taking the proper dosage because of drug costs
- Higher rates of no-shows from patients that can't afford the co-pays

As noted by one clinic administrator…

"I've actually heard physicians talk about patients coming in and having to sit them down, especially if it's somebody who's been dropped off of OHP, and making the decision with the patient about which medications are the most important. Patients are saying 'I can't afford all of this' so their physicians are put in the position of saying, 'Well, you really can't get off of this one, this one I prefer you don't get off. But if you have to choose between the two, this is the most important.' This is not optimal, that's for sure. Providers are having to go in and help figure this out with their patients. Some people are taking a pill every other day or they're cutting their pills in half. Patients are making all kinds of adaptations."

Key Informant Finding #6: Increased administrative burden of co-pays

- *Standard* patients are confused, not scheduling and/or not showing up because of co-pays for each visit
- Clinics are responsible for collecting co-pays or 'turning in' their patients to OMAP for not paying
- Co-payments are a direct cost-shift to providers
- Many private physicians not seeing *Standard* patients because of increased administrative burden associated with co-pays

To summarize…

- Significant confusion reigned for several months post-OHP2 implementation because of the uncertainties around the state budget
- Lack of reliable information available to providers and consumers most likely exacerbated any negative impacts from the policy changes that were enacted
- Attention to patient and provider education are critical in any systems/policy change initiatives and particularly during times of fiscal uncertainty when the challenge can become an opportunity for increased accountability and innovation

2003 FQHC Patient Survey

The Face of FQHC Patients….

Demographic Profile of FQHC Patients in Sample

Demographic Characteristic	Total Sample	Insured Patients	Uninsured Patients	2002 OHP/CAHPS
Children (0-18 yrs)	24%	82%	18%	N/A
Adults	76%	70%	30%	N/A
Female	60%	70%	30%	67%
Marital Status:				
Married	32%	35%	56%	N/A
Single	24%	35%	22%	N/A
Ethnicity:				
Hispanic	42%	30%	70%	N/A
Race:				
White	52%	62%	26%	90%
Health Status Adults:				
Fair/Poor	55%	N/A	N/A	45%

Observations about the FQHC patients interviewed…

- The FQHC patients interviewed are a more diverse population than the general OHP population, particularly from a racial and ethnic perspective
- As a group, the respondents at the FQHC clinics were significantly less likely to be White relative to OHP enrollees; in much more dramatic proportions if they were uninsured (25% versus 52% and 90% respectively)
- The uninsured patients in the FQHC sample were employed at twice the rate of those who were insured
- There was an eight-fold difference in the proportion of African-Americans in the FQHC sample relative to the OHP population
- The children in the FQHC sample were three times more likely to have a parent or guardian report their health status as 'fair'

Peeling back the onion: Impact of clinic location

Demographic Profile of Respondents by Clinic Location

CLINIC	Virginia Garcia	North County	Westside	Mid-County
Children (ages 0-18)	24%	16%	9%	34%
Adults (ages 19+)	76%	84%	91%	66%
Gender				
%Female	63%	68%	48%	76%
Marital Status:				
Married/Partner	58%	48%	25%	61%
Single	21%	29%	40%	22%
Employment Status:				
Employed	31%	23%	16.5%	31%
Unemployed	69%	77%	83.5%	69%
Ethnicity:				
Hispanic	73%	37%	24%	29%
Non Hispanic	27%	63%	76%	71%
Race:				
White	22%	60%	68%	62%
African American	2%	14%	20%	10%
Reason for Visit:				
Follow-up Appt	51%	63%	61%	31%
Preventive Care	23%	19%	12%	36%
Urgent Care	17%	8%	22%	9%
Non-urgent care	9%	10%	5%	24%
Insurance status:				
Insured	44%	84%	84%	89%
Uninsured	56%	16%	16 %	11%

Site variations in patient profiles: Why is this important?

- To view the 'safety net' as a homogenous entity is to miss the differential impacts of policy change as they affect distinct population groups
- The adult patient respondents at Virginia Garcia Clinic and Mid-County were more likely to be employed; while the adults at Virginia Garcia were disproportionately more likely to be uninsured relative to the other three clinics (56% versus 16%, 16% and 11% respectively)
- The respondents at Westside Clinic were virtually all adults with a significantly higher proportion of men relative to the other three clinics and they also had the highest percentage of unemployed adults

What picture does the FQHC survey data paint?

Adults in the FQHC sample report an exceptionally high burden of illness:

- 49% reported having symptoms lasting in excess of 6 months
- 56% reported a physical or mental condition expected to last at least 12 months
- 54% were at the clinic for a follow-up visit
- 18% had had an overnight stay in a hospital during the past 6 months
- 58% reported currently taking at least one prescription medication
- 80% had seen a doctor more than twice in the past 6 months
- 45% reported their health status as 'fair' or 'poor'
- 32% reported a worsening of their health from last year

Does the safety net represent the 'canary in the mine'?

ORIGINAL RATIONALE FOR STUDYING SAFETY NET CLINICS...

"Safety net clinics have historically seen a disproportionate share of the uninsured in Oregon and elsewhere. Since the implementation of OHP in 1994, the safety net has also seen a growing number and percentage of Medicaid patients throughout the state. As a result, we might expect that the early system shocks resulting from eligibility and cost-sharing changes in Medicaid, will be most acutely felt by health care providers in this sector of local health care markets."

Why monitoring the 'health' of the safety net is an important public policy function

- Any changes in eligibility and benefits in Medicaid will surely send a significant wave of change through the safety system as it seeks to absorb the 'shock'
- The safety net system exists to serve the un- and underinsured and as such has striven to maintain access in the face of current and future Medicaid cuts
- As financing options for basic coverage continue to be debated, the safety net represents a model of coordinated, comprehensive care delivery worthy of study and replication, particularly for the marginalized populations they have historically served

SCHIP vs. FHIAP:
Oregon's Alternatives for Insuring Low-Income Children

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This research was funded by the Agency for Healthcare Research and Quality (AHRQ), the David and Lucile Packard Foundation, and the Health Resources and Services Administration (HRSA) under the Child Health insurance Research Initiative (CHIRI).

Methods and Data

Telephone survey of parents of children enrolled in OHP's SCHIP and in FHIAP

Conducted in both English and Spanish in 2002.

Included both currently enrolled, and recently disenrolled, children

N= 1,545 (1,206 SCHIP and 339 FHIAP)

Response rate=54%

Study Questions

Who enrolls in SCHIP vs. FHIAP?

What factors affect parent's choice of one program over the other?

Does the choice of program make a difference for the children? Do program differences in benefit package and copayments affect the use of services?

Prior Knowledge of Programs

Almost all FHIAP parents had heard of SCHIP (96%), but only 14% of SCHIP parents had heard of FHIAP.

Why did FHIAP parents choose FHIAP over SCHIP?

- Over half (52%) thought their child was ineligible for SCHIP.
- Some did not want to be in a public program (12%).
- Others wanted to have the entire family insured (16%).

Of those SCHIP parents familiar with FHIAP, why did they choose SCHIP?

- One-fifth (20%) preferred the SCHIP benefit package.
- Some said the cost of insurance purchased through FHIAP was too high (12%).
- Others did not know how to apply (13%).
- And 19% said that they were on the FHIAP waiting list.

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How Do Parents First Learn About Programs?

One-fourth of all parents hear from a friend or relative.

The remaining SCHIP parents learn from someone in a health care setting (25%) or in a welfare setting (32%).

FHIAP parents are somewhat less likely to hear from someone in these two settings (22%).

Remaining FHIAP parents hear from an employer (7%), when applying for OHP (12%), or when turned down for private insurance (8%).

The Application Process

	SCHIP	FHIAP
Wanted or needed assistance with application (% yes)	30.9	26.5
Received assistance (%)	39.6	36.8
Very/somewhat satisfied with assistance (%)	91.6	92.9
Application easy to read: % somewhat or strongly agree	87.7	91.6
Collecting documentation easy: % somewhat or strongly agree	74.7	71.9

Who Enrolls?

	SCHIP	FHIAP
Child's age (in years, %):		
0-5	22.6	24.8
6-12	50.0	45.2
13-18	27.3	30.0
Hispanic (%)	29.3	8.1*
Two parent family (%)	60.2	69.5*
At least one parent employed full-time (%)	74.6	84.5*
Parent is high school graduate (%)	70.9	95.2*
Family lives in:		*
Portland MSA	33.6	23.2
Other urban	31.7	38.7
Rural	34.7	38.1

* Statistically significant from SCHIP children at <0.05 level.

Health Status of Children and Their Families

	SCHIP	FHIAP
Child's general health status is excellent/very good (%)	69.6	79.5*
Child has special health care needs (% with based on LWI screener)	26.2	17.8*
Sibling has special health care needs (% yes)	26.8	23.2
Parent has special health care needs (% yes)	39.3	37.5

* Statistically significant from SCHIP children at <0.05 level.

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Child's Insurance History at Time of Enrollment

	SCHIP	FHIAP
Child insured at least 1 month of prior 12 (%)	50.3	50.7
Type of insurance (% distribution):		
Employer-sponsored	27.7	31.9
Other private	5.6	23.6*
Oregon Health Plan	66.8	47.4*
Other	9.6	6.0
Main reason child was uninsured:		*
Insurance not available from employer	17.8	12.8
Cost was too high	49.5	77.4
Not eligible for OHP/FHIAP	10.4	6.0
Other	22.3	3.8

* Statistically significant from SCHIP children at <0.05 level.

Eligibility for Employer-Sponsored Health Insurance

At the time of application, SCHIP and FHIAP parents were equally likely to have been eligible for ESI (23% and 28%).

But FHIAP parents were more likely to actually have had that insurance (82% of those eligible vs. 57% of eligible SCHIP parents).

At time of application, FHIAP children were more likely to be eligible for ESI – 27% vs. 18% for SCHIP.

Of those eligible, FHIAP children also more likely to actually have that insurance.

Family History with Health Insurance and Assistance Programs (% yes)

	SCHIP	FHIAP
Enrolled in the Oregon Health Plan	78.1	73.2
Covered by private insurance	58.9	78.1*
Paid a premium for health insurance	58.6	70.1*
Received Food Stamps, TANF, or AFDC	71.8	60.9*

* Statistically significant from SCHIP children at <0.05 level.

What Factors Explain Choice of FHIAP Over SCHIP?

Prior experience paying premiums for private health insurance.

Belief that insurance is important for paying for possible **future** accident or illness.

At least one parent is employed.

Parent is high school graduate and/or has been to college.

Not of Hispanic origin.

Usual Source of Care

	SCHIP	FHIAP
% with usual source	94.7	97.7
Location of usual source (% distribution):		*
Emergency room	2.0	1.0
Hospital clinic	18.0	7.9
Doctor's office or HMO	58.1	84.8
Community health center	21.9	6.2
Child sees a particular doctor at this place (% yes)	81.6	87.3*

* Statistically significant from SCHIP children at <0.05 level.

Utilization of Health Care Services (% within past 6 months)

	SCHIP	FHIAP
Routine exam/check-up	55.4	49.3
Primary care visit (including check-up)	74.6	70.2
Inpatient stay	5.0	2.5
Emergency room visit	26.5	15.8*

* Statistically significant from SCHIP children at <0.05 level.

Unmet Need for Services (% within past 6 months)

	SCHIP	FHIAP
Primary care visits	4.1	1.3*
Specialist care	2.5	0.8*
Dental care	17.2	27.2*
Prescription medicines	2.0	2.9
Mental health care	2.2	1.3

* Statistically significant from SCHIP children at <0.05 level.

Satisfaction with Care

	SCHIP	FHIAP
Average rating of child's health care (scale of 0-10)	8.1	8.8*
Parent very or somewhat satisfied with program benefit package (%)	88.2	89.9
Paid out-of-pocket for some of child's health care costs (% yes)	16.6	85.8*

* Statistically significant from SCHIP children at <0.05 level.

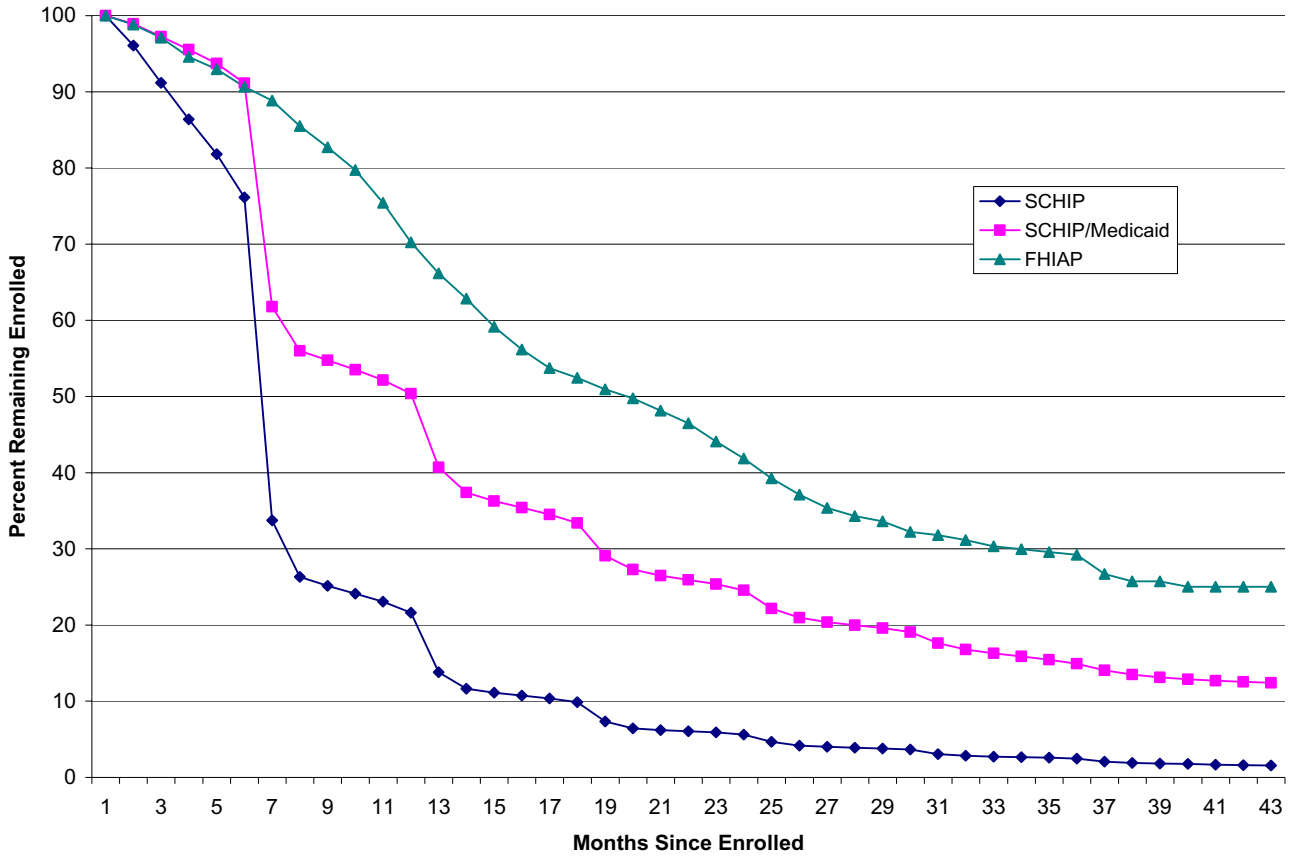
Study Questions

Why do large numbers of SCHIP children disenroll after 6 months? How does this compare with FHIAP?

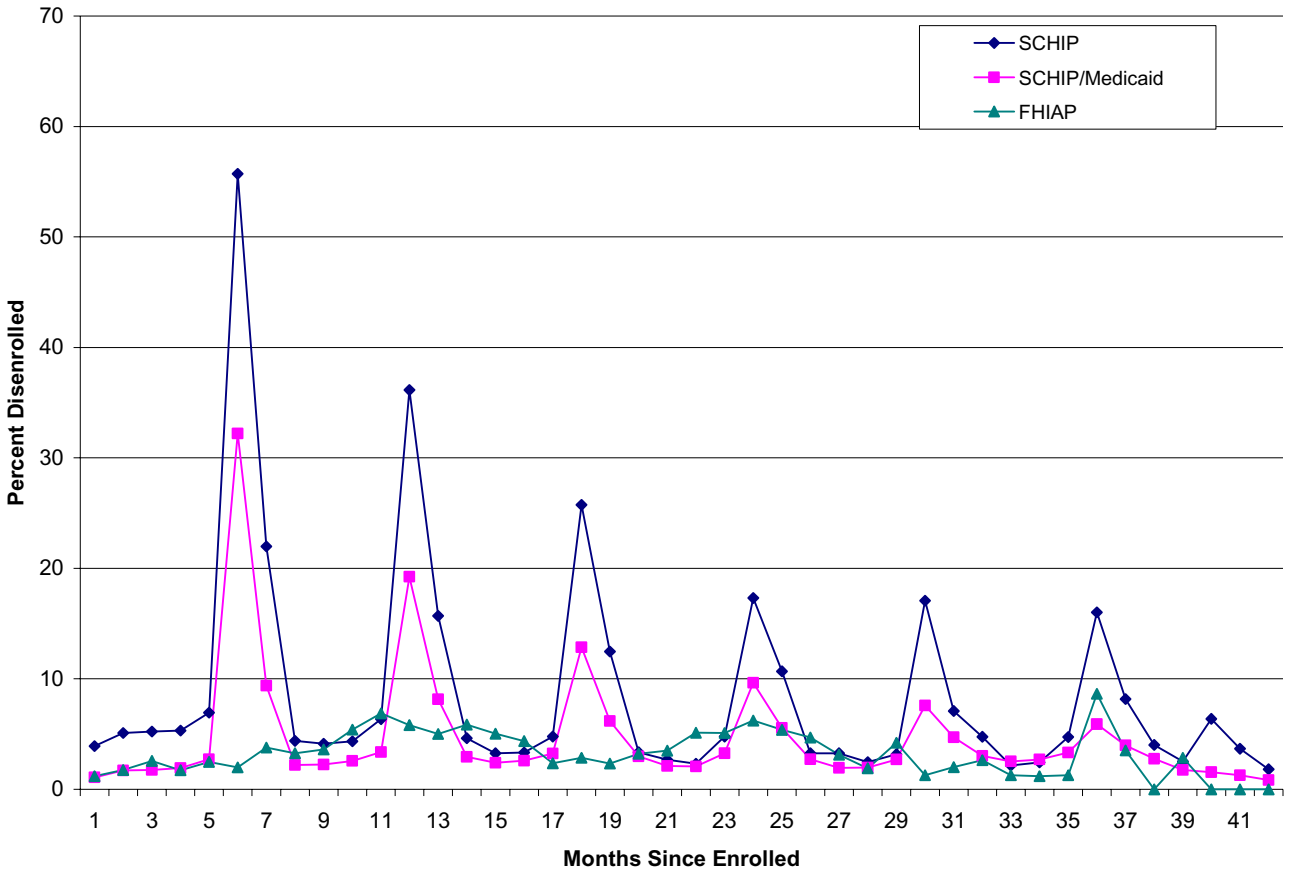
What happens to children after they lose coverage?

Are these children transitioning to private health insurance, or are they uninsured?

Children Remaining Covered by Time Since Enrolled



Children Losing Coverage by Time Since Enrolled



Why Is Child No Longer Enrolled?

	SCHIP	FHIAP
Did not reapply at all	31.9	27.7
Started but did not finish, or did not send in, application	9.7	13.5
Sent in application, but program did not receive it	7.5	1.9
Reapplied but child no longer qualified	50.9	56.9

Why Didn't Parent Reapply?

One-third of SCHIP parents did not think their child was eligible (36%).

Over one-third had gotten private insurance (40%).

Others found the paperwork too difficult (7%) or forgot or missed the deadline (7%)

One-third of FHIAP parents (37%) no longer needed assistance with premiums.

One-quarter had enrolled their child in OHP (25%)

Others did not think their child was eligible (10%) or could not afford the premiums (10%).

Why Did Child No Longer Qualify?

	SCHIP	FHIAP
Family's income too high	79.8%	67.4%
Family's assets too high	1.4	13.8
Did not have all the needed paperwork	6.6	4.8
Other	12.2	14.0

Outcomes for Children Following Disenrollment

	SCHIP	FHIAP
Child is currently insured (%)	32.6	53.2*
Type of insurance (% distribution):		*
Private insurance from employer or union	85.8	69.9
Private insurance purchased from insurer	6.3	25.3
Other	7.9	4.8
Family must pay premium for this insurance (% yes)	79.8	88.6
Premium is big or moderate financial hardship (% yes)	58.0	67.1

* Statistically significant from SCHIP children at <0.05 level.

Outcomes for Children Following Disenrollment (continued)

	SCHIP	FHIAP
Child goes to same usual source of care as when enrolled (% yes)	67.8	74.0
Child has seen doctor since disenrolling (% yes)	45.6	74.1*
Unmet need for doctor care since disenrolling (% yes)	19.0	10.1
Family would have kept child in program if possible (% yes)	89.4	85.2

* Statistically significant from SCHIP children at <0.05 level.

Hispanic Children in SCHIP

Nearly one-third of SCHIP population is Hispanic

- 71% of Hispanic parents do not speak English at home
- 55% of Hispanic children do not speak English at home

Do Hispanic children differ from non-Hispanic children?

- Are these differences explained by acculturation (as measured by language)?

Do the differences between these populations have implications for using insurance premium subsidies as a strategy for covering uninsured children?

Characteristics of SCHIP Children

	Hispanic		
	Spanish-speaking	English-speaking	Non-Hispanic
Child's age (in years, %)	*	*	
0-5	32.0	29.0	19.1
6-12	54.0	54.4	48.4
13-18	14.0	16.6	32.5
Two parent family (%)	78.1*,†	55.3	55.9
At least one-parent employed full-time (%)	87.6*	82.6*	69.8
Parent is high school graduate (%)	22.3*,†	85.4	83.8
Parent born outside US (%)	94.0*,†	10.3	8.4
Family lives in (%):	*,†	*	
Portland MSA	45.3	44.3	28.9
Other urban	32.8	19.9	32.8
Rural	21.9	35.8	38.4

*Statistically significant from non-Hispanic children at <0.05 level.
†Statistically significant from English-speaking Hispanic children at <0.05 level.

Health Status of SCHIP Children

	Hispanic		
	Spanish-speaking	English-speaking	Non-Hispanic
General health status is excellent/very good (%)	51.7*,†	76.5	74.1
Special health care needs (% with based on LWI screener)	12.0*,†	25.2	30.5

*Statistically significant from non-Hispanic children at <0.05 level.
†Statistically significant from English-speaking Hispanic children at <0.05 level.

Insurance History of SCHIP Children at Time of Enrollment

	Hispanic		
	Spanish-speaking	English-speaking	Non-Hispanic
Child insured at least 1 month of prior 12 (%)	69.3*,†	43.4	47.7
Type of insurance (%):			
Employer-sponsored	11.7*	20.4	35.9
Other private	1.6*	4.9	7.5
Oregon Health Plan	89.8*,†	72.7	55.5
Other	3.3*,†	13.7	12.0
Main reason child was uninsured (%):	†		
Insurance not available from employer	18.9	12.0	18.2
Cost was too high	28.4	75.2	49.8
Not eligible for OHP	21.7	0.0	9.9
Other	31.0	12.8	22.1

*Statistically significant from non-Hispanic children at <0.05 level.
†Statistically significant from English-speaking Hispanic children at <0.05 level

Reason for Having Health Insurance for SCHIP Child

	Hispanic		
	Spanish-speaking	English-speaking	Non-Hispanic
	*,†		
To pay for possible future accident of illness	52.4	34.9	44.3
To pay for current medical condition	10.8	12.8	17.5
To pay for routine checkups	35.9	52.4	36.0
Other	1.0	0.0	2.3

*Statistically significant from non-Hispanic children at <0.05 level.
†Statistically significant from English-speaking Hispanic children at <0.05 level

Eligibility of SCHIP Families for Employer-Sponsored Health Insurance

About one-quarter of Hispanic and non-Hispanic parents were eligible for ESI at the time of application.

- Among those employed full-time, Spanish-speaking Hispanic parents were less likely to be eligible for ESI.

About half of eligible Hispanic and non-Hispanic parents actually had ESI.

About one-fifth of Hispanic and non-Hispanic children were eligible for ESI at the time of application.

- No difference in the likelihood for children whose parents work full-time

Of those eligible, Spanish-speaking Hispanic children were more likely to actually have that insurance – 32% vs. 12-17%.

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SCHIP Family History with Health Insurance and Assistance Programs (% yes)

	Hispanic		
	Spanish-speaking	English-speaking	Non-Hispanic
Enrolled in the Oregon Health Plan	83.3*	81.1	76.2
Covered by private insurance	29.7*,†	66.4	66.7
Paid a premium for health insurance	30.2*,†	55.2	67.4
Received Food Stamps, TANF, or AFDC	55.4*,†	77.9	75.9

*Statistically significant from non-Hispanic children at <0.05 level.
†Statistically significant from English-speaking Hispanic children at <0.05 level

How Do SCHIP Parents First Learn about OHP?

Half of Spanish-speaking Hispanic parents learn about SCHIP from someone in the health care setting, but less than 20% of other parents

Over one-third of English-speaking Hispanic and non-Hispanic parents learn about SCHIP in a welfare setting, but only 13% of Spanish-speaking Hispanic parents

The OHP Application Process

	Hispanic		
	Spanish-speaking	English-speaking	Non-Hispanic
Wanted or needed assistance with application (% yes)	59.7*,†	22.7	23.4
Received assistance (%)	61.3*,†	35.1	33.8
Very/somewhat satisfied with assistance (%)	95.4	82.2	90.7
Application easy to read: % somewhat or strongly agreed	83.1*	90.8	88.7
Collecting documentation easy: % somewhat or strongly agree	80.5*,†	73.4	71.7

*Statistically significant from non-Hispanic children at <0.05 level.
†Statistically significant from English-speaking Hispanic children at <0.05 level

Usual Source of Care for SCHIP Children

	Hispanic		
	Spanish-speaking	English-speaking	Non-Hispanic
% with usual source	92.5†	98.3	94.9
Location of usual source (% distribution):	*,†		
Emergency room	4.2	0.4	1.6
Hospital clinic	32.7	20.3	13.6
Doctor's office or HMO	14.2	63.3	69.7
Community health center	48.9	16.1	15.0
Child sees a particular doctor at this place	68.0*,†	88.4	84.7

*Statistically significant from non-Hispanic children at <0.05 level.
†Statistically significant from English-speaking Hispanic children at <0.05 level

Utilization of Health Care Services by SCHIP Children (% within past 6 months)

	Hispanic		
	Spanish-speaking	English-speaking	Non-Hispanic
Routine exam/check-up	48.3*	53.2	57.7
Primary care visit (including check-up)	66.0*	69.9	77.7
Inpatient stay	5.1	6.9	4.7
Emergency room visit	25.3	28.9	26.6

*Statistically significant from non-Hispanic children at <0.05 level.
†Statistically significant from English-speaking Hispanic children at <0.05 level

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Unmet Need for Services among SCHIP Children (% within past 6 months)

	Hispanic		
	Spanish-speaking	English-speaking	Non-Hispanic
Primary care visits	0.6*,†	3.9	5.2
Specialist care	1.3	0.0	3.1
Dental care	9.1*,†	21.9	18.9
Prescription medicines	0.6	0.4*	2.6
Mental health care	0.5*,†	2.7	2.7

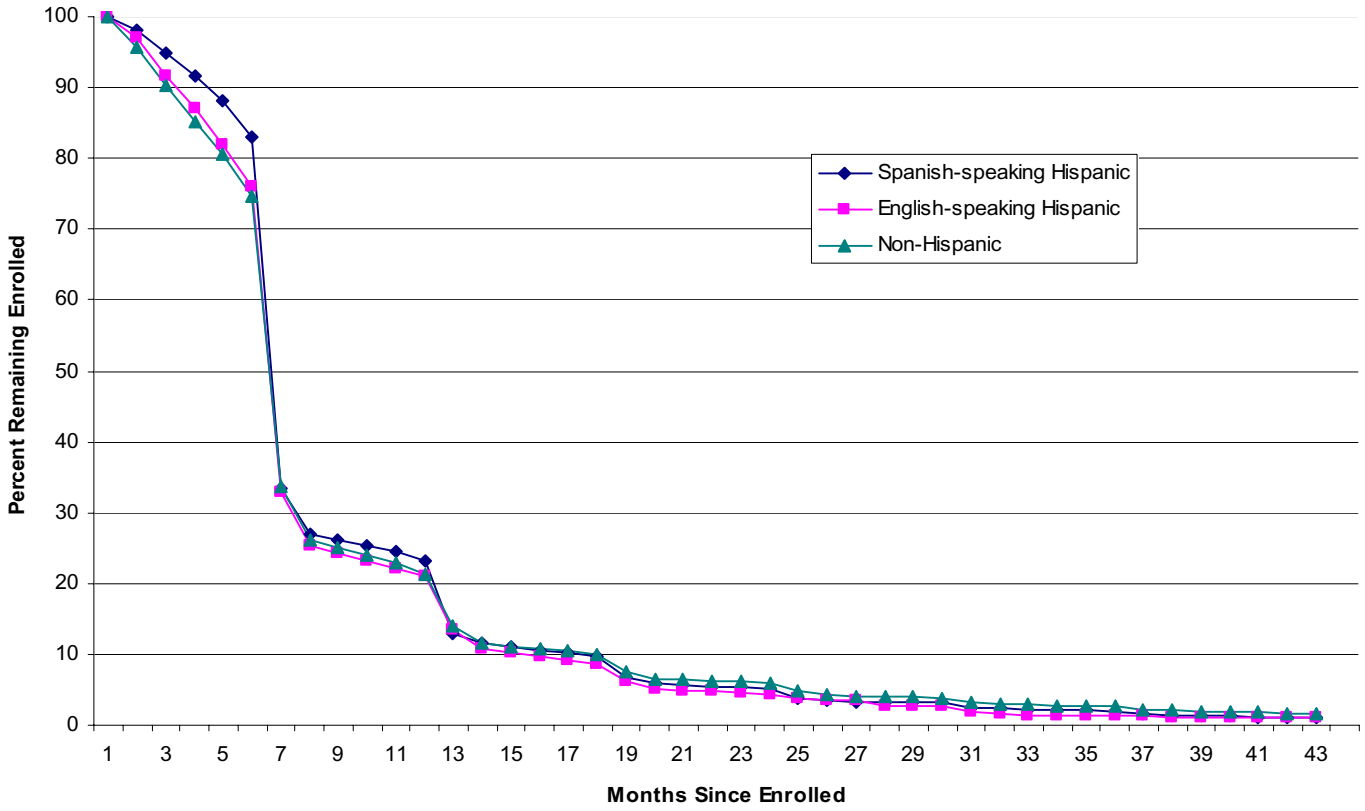
*Statistically significant from non-Hispanic children at <0.05 level.
†Statistically significant from English-speaking Hispanic children at <0.05 level

Satisfaction with Care for SCHIP Children

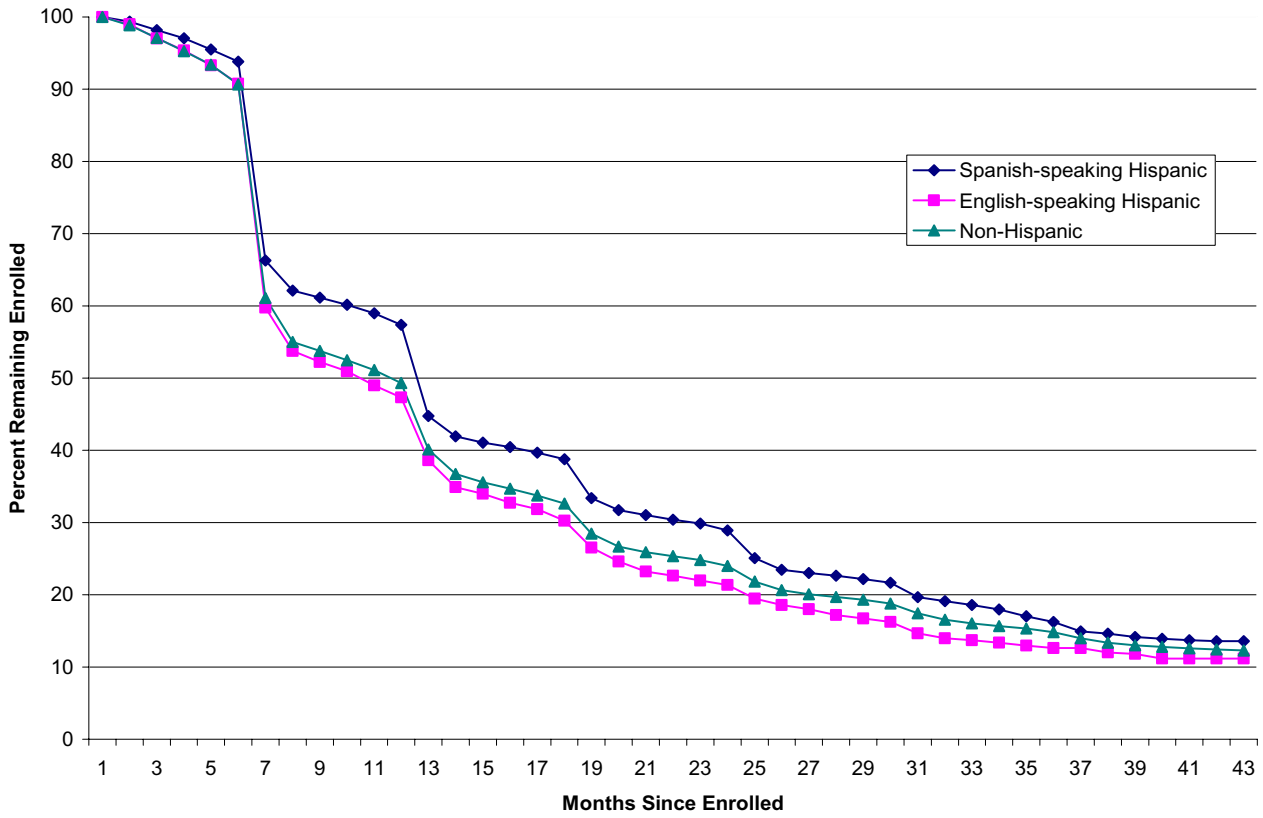
	Hispanic		
	Spanish-speaking	English-speaking	Non-Hispanic
Average rating of child's health care (scale of 0-10)	8.4	8.6	8.1
Parent very or somewhat satisfied with benefit package (%)	90.7*,†	81.6	87.5
Paid out-of-pocket for some of child's health care costs (% yes)	9.9*	13.3	18.9

*Statistically significant from non-Hispanic children at <0.05 level.
†Statistically significant from English-speaking Hispanic children at <0.05 level

Children Remaining Covered in SCHIP by Time Since Enrolled



Children Remaining Covered in SCHIP/Medicaid by Time Since Enrolled



Why is SCHIP Child No Longer Enrolled?

	Hispanic		
	Spanish-speaking *	English-speaking	Non-Hispanic
Did not reapply at all	23.1	19.6	35.1
Started but did not finish, or did not send in, application	2.8	10.3	11.3
Sent in application, but program did not receive it	12.7	2.1	6.6
Reapplied but child no longer qualified	61.4	68.1	47.0

*Statistically significant from non-Hispanic children at <0.05 level.
†Statistically significant from English-speaking Hispanic children at <0.05 level

Why Didn't SCHIP Parent Reapply?

- Non-Hispanic and English-speaking Hispanic parents
  - One-third did not think child was eligible.
  - Over 40% had gotten private insurance.
- Spanish-speaking Hispanic parents.
  - One-fifth reported each of these reasons.
  - More likely to say child was healthy and didn't need insurance, the paperwork was too difficult, or they missed deadline.

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Why Did SCHIP Child No Longer Qualify?

	Hispanic		
	Spanish-speaking	English-speaking	Non-Hispanic
Family's income too high	72.9	76.0	82.4
Family's assets too high	0.0	6.8	1.2
Did not have all the needed paperwork	15.0	6.2	4.0
Other	12.1	11.1	12.4

*Statistically significant from non-Hispanic children at <0.05 level.
†Statistically significant from English-speaking Hispanic children at <0.05 level

SCHIP Child's Insurance Status Following Disenrollment

	Hispanic		
	Spanish-speaking	English-speaking	Non-Hispanic
Child is currently insured (%)	22.4†	50.7	33.2
Type of insurance (% distribution):			
Private insurance from employer or union	79.8	75.9	87.6
Private insurance purchased from insurer	0.0	11.8	6.5
Other	20.2	12.3	6.0
Family must pay premium for this insurance (% yes)	94.8†	66.1	79.2
Premium is big or moderate financial hardship (% yes)	47.0	68.0	59.1

*Statistically significant from non-Hispanic children at <0.05 level.
†Statistically significant from English-speaking Hispanic children at <0.05 level

SCHIP Child's Service Use Following Disenrollment

	Hispanic		
	Spanish-speaking	English-speaking	Non-Hispanic
Child has usual source of care (%)	70.6*	83.4	88.2
Child goes to same usual source of care as when enrolled (% yes)	61.1	74.1	68.9
Child has seen doctor since disenrolling (% yes)	36.7	57.4	46.9
Unmet need for doctor care since disenrolling (% yes)	13.6†	34.7	19.3
Family would have kept child in program if possible (% yes)	98.9*	94.9	87.3

*Statistically significant from non-Hispanic children at <0.05 level.
†Statistically significant from English-speaking Hispanic children at <0.05 level

Conclusions

SCHIP and FHIAP appear to be equally effective in ensuring access to care for low-income children.

Despite copayments in FHIAP, there were no meaningful differences in utilization and unmet need (with the exception of dental care.

FHIAP has advantage of covering parents as well.

Barriers to enrollment in FHIAP:

- Limited access to ESI, even among full-time working parents.
- Lack of experience with private health insurance and with paying premiums.

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Conclusions (continued)

SCHIP's 6 month eligibility period contributes to high disenrollment rates.

Increases in family income is the most important reason SCHIP and FHIAP children lose coverage.

The majority of these children, especially those in SCHIP, do not transition to private insurance. Instead, they become uninsured.

Conclusions (continued)

Covering Spanish-speaking Hispanic children through policies that promote ESI may be challenging.

- Lack of experience with private insurance.
- Reliance on traditional safety net providers.

Despite having poorer health status, Spanish-speaking Hispanic children in SCHIP use fewer services.

- Differences in perceptions of need for care.
- May be cultural differences in rating health status.

Important to consider acculturation when analyzing the experience of Hispanic children.

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