Health Care in New York City Program

INSURING THE CHILDREN OF NEW YORK CITY'S LOW-INCOME FAMILIES

FOCUS GROUP FINDINGS ON BARRIERS TO ENROLLMENT IN MEDICAID AND CHILD HEALTH PLUS

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EXECUTIVE SUMMARY

Nearly 20 percent of children in New York City, or approximately 370,000 individuals under age 18, are uninsured—a proportion exceeding that for the nation and for New York State.[1] Uninsured children are more likely than those with health insurance to go without preventive care and immunizations, often lack primary care providers, and sometimes do not receive acute medical care when they need it.[2] Families of uninsured children are also at risk for incurring substantial medical bills should these children become ill.

The nation is poised to begin a massive expansion of insurance coverage for children in low-income households using newly available federal funds. New York State will use $256 million in annual Title XXI funds to further expand eligibility and benefits for Medicaid and Child Health Plus (CHP)—the state's insurance program for low-income children who do not meet Medicaid's eligibility requirements. These program expansions will ultimately reach families with incomes up to 250 percent of the federal poverty line ($41,059 per year for a family of four).

For these expansions to succeed, overcoming enrollment barriers and implementing effective outreach strategies will be crucial. The vast majority of uninsured children in New York—nearly three of four—are eligible for but are not enrolled in either Medicaid or CHP. The problem of lack of insurance among the city's children could be largely eliminated if all of those eligible were enrolled in these programs.

To gauge awareness of Medicaid and CHP, understand why so many eligible families are not participating in these programs, and inform efforts to increase participation, the Global Strategy Group, Inc., supported by The Commonwealth Fund, conducted seven focus groups with parents in August and September 1998 of children in families that are eligible for or participating in one of the programs. To gain multiple perspectives on why eligible children remain uninsured, Global Strategy supplemented these focus groups with two additional groups: one comprising Medicaid and CHP eligibility workers and one comprising community-based organization workers. Each of the focus groups comprised approximately 10 individuals and lasted about two hours. Global Strategy also conducted interviews with executives of six health plans that participate in Medicaid and CHP.

The focus groups revealed that low-income parents struggle to meet the health care needs of their children. Parents with household incomes below 250 percent of poverty often cannot afford the costs of private health insurance or of medical care for their children. As a

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[1] Tabulations by New York State Department of Health of *Current Population Survey*, U.S. Bureau of the Census, March 1994–March 1997.

[2] Cathy Schoen and Catherine DesRoches, *New York City's Children: Uninsured and at Risk*, The Commonwealth Fund, May 1998.

result, these parents sometimes do not get their children the preventive and primary care they need and delay seeking medical care when they are seriously ill. They sometimes take their children to emergency rooms for routine care, yet these facilities can often be as expensive as private physicians' offices.

Obtaining health insurance for their children is a high priority for low-income parents. They want to participate in Medicaid and CHP if they qualify and are eager to enroll their children given the opportunity. They are often unaware of the eligibility criteria for Medicaid and CHP, however, and encounter substantial barriers to participation.

Many choose not to attempt enrolling their children because they incorrectly assume that employment disqualifies them. Enrollees and potential enrollees lack understanding of how factors such as income, family size, assets, and child care expenses interact to make some families eligible and others ineligible, and they suspect that rules are applied arbitrarily. Parents also suspect that program administrators attempt to disqualify families whenever possible.

Familiarity with other public assistance programs often has a great deal to do with parents' awareness and knowledge about the Medicaid and CHP programs. Those who are not seeking welfare or other public assistance are especially unlikely to be aware that children's health insurance is available. Welfare reform efforts exacerbate this problem by potentially isolating more eligible families from information about Medicaid and CHP and also contribute to confusion about insurance eligibility.

Medicaid is relatively well-known among low-income parents. In contrast, CHP was virtually unheard of in the parents' focus groups. Eligibility workers confirmed that families are rarely referred to CHP.

Parents whose children are on Medicaid view the program as useful, cost-free, and comprehensive. CHP is also viewed very favorably by parents whose children are enrolled in it; they say the enrollment process is relatively easy and the program offers good access to quality health care. CHP participants are therefore potential ambassadors for the program: upon hearing reviews of CHP by parents whose children are enrolled, other parents take a keen interest in joining the program.

On the other hand, the Medicaid enrollment process is perceived as time-consuming, burdensome, and requiring a great deal of persistence and patience. Gathering the necessary documentation is a lengthy process in and of itself. Once the required materials have been submitted, the interview process often requires a full day. Many low-income workers are

nonsalaried, and the daylong application process and face-to-face interview for Medicaid eligibility is a financial hardship.

Parents say that enrollment is also demeaning, and their interactions with eligibility workers are often confrontational and uninformative. Applicants frequently perceive questions as unnecessarily prying into their personal lives, and view workers as uninformed, unconcerned, rude, and actively discouraging enrollment. Some parents have experienced hostility firsthand, while others have been jaded by the experiences of other parents. They also believe that eligibility workers play favorites and that factors such as physical appearance make a difference in whether someone is certified as eligible.

In addition to these issues, the systems designed to facilitate enrollment in Medicaid and CHP do not always work. Many parents of uninsured children report that their attempts to seek coverage have been limited to calling information hotlines, yet these hotlines are often automated and have no option to speak to a live individual, keep callers on hold for long periods, and provide misleading information.

Immigrant families often face additional difficulties such as language and cultural barriers. Enrollment workers report that they are sometimes unable to communicate with immigrant parents and are sometimes forced to complete paperwork for those who are illiterate.

To reduce the number of uninsured children in New York City, intensive efforts are needed to reach the parents of those who are eligible for Medicaid and CHP and to assist them in enrolling in these programs. Parents list schools, workplaces, local community centers, doctors' offices, and public benefits agencies as the best places to receive information. Direct mail is also an effective tool for reaching households.

While educational materials can help clarify eligibility rules and inform parents about the enrollment process, parents and eligibility workers indicate that information campaigns by themselves are not sufficient to boost enrollment of eligible children. Parents require one-on-one assistance to gather documentation, complete enrollment forms, file applications, and ensure timely and accurate processing of their applications.

Structural improvements are also needed to facilitate the enrollment of eligible children in Medicaid and CHP. Strategies could include eliminating Medicaid's requirement of a face-to-face interview, deputizing community-based organizations to conduct face-to-face interviews and assist families with the application process, shortening application forms, reducing documentation requirements, providing educational materials in multiple languages, staffing telephone hotlines with live operators, and extending office hours to evening and

weekends. Government agencies that administer Medicaid and CHP must also become more responsive to low-income families and foster a culture that treats applicants with dignity.

New York, and the nation, have an unprecedented opportunity to provide health insurance coverage and access to health care for virtually all low-income children. New York's longstanding commitment to the health of its low-income residents continues through expansion of the Medicaid and CHP programs. Effective outreach and enrollment efforts must be made a priority to fulfill the vision of health insurance for more of New York's children.

INSURING THE CHILDREN OF NEW YORK CITY'S LOW-INCOME FAMILIES: FOCUS GROUP FINDINGS ON BARRIERS TO ENROLLMENT IN MEDICAID AND CHILD HEALTH PLUS

INTRODUCTION

Nearly 20 percent of children in New York City, or approximately 370,000 individuals under age 18, are uninsured—a proportion exceeding that for the nation and for New York State.[3] Uninsured children are more likely than those with health insurance to go without preventive care and immunizations, often lack primary care providers, and sometimes do not receive acute medical care when they need it.[4] Families of uninsured children are also at risk for incurring substantial medical bills should these children become ill.

The nation is poised to begin a massive expansion of insurance coverage for children in low-income households using newly available federal funds. New York State will use $256 million in annual Title XXI funds to further expand eligibility and benefits for Medicaid and Child Health Plus (CHP)—the state's insurance program for low-income children who do not meet Medicaid's eligibility requirements. Beginning January 1, 1999, subsidized insurance under CHP will be available to families with gross incomes up to 230 percent of the federal poverty line, or $37,901 annually for a family of four. Effective July 1, 2000, eligibility for subsidized CHP coverage will be extended to families with gross incomes up to 250 percent of the federal poverty level, or $41,059 per year for a family of four. Similarly, eligibility for Medicaid coverage will ultimately be expanded so that children from 1 to 19 years of age will be eligible if their families' net household incomes are below 133 percent of the federal poverty line, or $22,020 for a family of four.

For these expansions to succeed, overcoming enrollment barriers and implementing effective outreach strategies will be crucial. The vast majority of uninsured children in New York are already eligible for public coverage. Nearly three of four uninsured children in New York City are currently eligible for but not enrolled in either Medicaid or CHP. Approximately 130,000 children are eligible for Medicaid but are not enrolled, and another 147,000 children are eligible for CHP but are not enrolled.[5] Lack of insurance among the city's children could be largely eliminated if all of those eligible were enrolled in these programs.

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[3] Tabulations by New York State Department of Health of *Current Population Survey*, U.S. Bureau of the Census, March 1994–March 1997.

[4] Cathy Schoen and Catherine DesRoches, *New York City's Children: Uninsured and at Risk*, The Commonwealth Fund, May 1998.

[5] U.S. Bureau of the Census, March 1994–March 1997.

To gauge perceptions of these programs and understand the barriers to participation, The Commonwealth Fund supported Peter Feld, Ph.D., of the Global Strategy Group, Inc., to conduct focus groups in August and September 1998 with low-income parents and eligibility workers and interviews with health plan administrators. The focus groups examined the enrollment processes for these programs and identified administrative, cultural, and other factors that may prevent eligible families from participating. This research project was designed to inform efforts to increase participation of eligible but uninsured families with children in Medicaid and CHP.

Key Research Questions

The questions the researchers sought to answer through the focus groups included:

- What are the experiences of New York City's low-income families in obtaining health insurance and health care for their children?
- What are the current levels of awareness and attitudes toward Medicaid and CHP?
- Why are children who are eligible for Medicaid and CHP not enrolled?
- Among parents with children enrolled in these programs, what has facilitated their participation?
- What are the points of satisfaction with and criticisms of the enrollment processes for Medicaid and CHP among those who are enrolled and those who are not enrolled, as well as among the professionals who assist these families?
- What strategies would increase awareness of Medicaid and CHP, improve outreach, facilitate the enrollment of more children, and maintain continuous enrollment?

Methodology

To satisfy these research goals, qualitative research methodology was implemented. Qualitative research is an inductive means of understanding the attitudes, perceptions, and experiences of individuals or a group. It also allows for the observation of people from their own frame of reference. Qualitative research is not intended to yield statistically reliable findings.

Nine focus groups were conducted from August 12, 1998, to September 16, 1998. Seven of these group discussions were conducted with parents in low-income households—that is, in households with incomes below 250 percent of the federal poverty level, or $41,059 per year for a family of four. At this income level, children are already eligible or will be eligible for coverage under Medicaid or CHP. Participants were recruited from samples of low-income families throughout the five boroughs of New York City, and through informal contacts with city agencies, private organizations, and community-based medical providers.

Focus Group	Description
1.	White, non-enrolled, without health insurance
2.	White, CHP/Medicaid enrolled
3.	African American, non-enrolled, without health insurance
4.	African American, CHP/Medicaid enrolled
5.	Spanish-speaking, non-enrolled, without health insurance
6.	Spanish-speaking, CHP/Medicaid enrolled
7.	Chinese-speaking, non-enrolled, without health insurance
8.	Human Resources Administration eligibility workers
9.	Community-based organization eligibility workers

The parent group discussions were structured to reflect the diverse population of New York City. Additionally, efforts were made to keep similar populations together—ethnicity and language, for example, were taken into consideration to facilitate discussion. The parent groups were also organized by coverage status (i.e., enrolled or non-enrolled). Specifically, the family group discussions included:

- Parents with children enrolled in either Medicaid or CHP. Participants were chosen from white, African American, and Spanish-speaking families.

- Parents who lack insurance but whose incomes and family size would make their children eligible for either Medicaid or CHP. Participants were chosen from white, African American, Spanish-speaking, and Chinese-speaking families.

Two additional focus groups were conducted with Medicaid and CHP eligibility workers. One group consisted of Medicaid eligibility workers who are employees of the New York City Human Resources Administration (HRA). The other comprised eligibility workers who are employees of community-based organizations (CBOs).

All nine focus groups were conducted in New York City by Global Strategy Group, Inc.,[6] a private research firm, in collaboration with staff from The Commonwealth Fund.

[6] An independent moderator from the Chinese community in New York City conducted the Chinese focus group.

Each focus group comprised approximately 10 individuals and discussions lasted about two hours.

In addition to the nine focus groups, Global Strategy conducted six in-depth interviews with administrators of health plans that participate in Medicaid and CHP. These interviews supplemented the focus group research findings.

FOCUS GROUP AND INTERVIEW FINDINGS

HEALTH CARE EXPERIENCES OF LOW-INCOME FAMILIES IN NEW YORK CITY

Low-income families in New York City often find obtaining health care coverage a challenge. The costs of medical care and insurance are often unaffordable for these families, and many work for employers who do not provide sufficient insurance benefits. Often, they must choose between paying for health insurance or other bills such as rent and food. Even with employer assistance, low-income families who have insurance find paying a monthly deductible difficult.

> *"Insurance, for my husband, just for him, from his job alone would be like $200 or something a month. For a family of four, it was, like, almost $400. We can't afford that." [white, non-enrolled]*

> *"The coverage that I got from the city was practically free, but working in the private industry is different, because you have to pay for everything. And the coverage is very expensive.... I ended up not really getting it because I couldn't afford to pay." [African American, non-enrolled]*

> *"To buy insurance costs over $4,000 a year. Each quarter we'll be charged over $1,000, but we have other expenses—putting food on the table. So the money I earn, after buying insurance—we'll have only a little left. So we do not really want to buy it. But if we do not buy it, we become worried. If we buy it, we will have no money left." [Chinese, non-enrolled]*

> *"In the job, they offered something to my husband. But they said, since we're a big family, the cost comes up to $400 a month. We just can't afford that." [Spanish-speaking, non-enrolled]*

> *"If the income is small, for example, $40,000, $50,000, the company mostly has medical insurance to be covered by the boss. It is those who are stuck in the middle that the boss does not cover." [Chinese, non-enrolled]*

Employment-based coverage is often unstable or discontinuous for low-income families. Changes in jobs or reduced work hours can result in a loss of coverage despite past premium payments. As a result, low-wage families find that they cannot depend on having coverage when they need it.

"My job does not cover me or my children, because it is part-time." [Spanish-speaking, non-enrolled]

"I work in catering now and you just get paid per party or per event you work at, so there is no insurance, because I guess we are all freelance." [white, non-enrolled]

"It's temporary, no guarantee to be insured permanently, because if you do not have enough work credit you will be cancelled. Our factory has a union, we have union insurance." [Chinese, non-enrolled]

"Formerly I had a job, and I was covered. Now I only work part-time, so I prefer to pay for each visit to the doctor." [Spanish-speaking, non-enrolled]

Eligibility workers believe that many low-income families who could benefit from Medicaid and CHP are not enrolled. Eligibility workers note that families often wait until a medical crisis occurs before applying for benefits. In addition, immigrant families, regardless of their legal status, are often afraid to apply for the health insurance to which they are entitled.

"Plenty of eligible families are missing benefits." [CBO caseworker]

"We don't have membership as big as it should be because so many people lose Medicaid for various reasons. But maybe those rules and regulations need to be looked at. Maybe people don't come back and apply because they're intimidated." [plan administrator]

"Many will wait until it's a crisis before trying to get Medicaid." [CBO caseworker]

"Working people miss out most." [HRA eligibility worker]

Uninsured children are at high risk for going without needed primary and preventive care. Uninsured, low-income parents struggle to obtain health care and pay their medical bills when their children become sick. They stretch their resources as far as possible, yet they often delay seeking care, try home remedies, and hope their children will get well so that medical bills can be avoided.

"Better not to get sick— my child is so young—if something happened to him, I fear I would have no way to get special care for him." [Chinese, non-enrolled]

"I struggle, but I take my son to the doctor." [white, non-enrolled]

"I take my kids to the doctor when they are almost dying." [Spanish-speaking, non-enrolled]

"Very often I went to see the doctor only when we have a problem. Then they said, 'You need to make an appointment.' By the time I make an appointment and wait for over a month later, I'm well again. I have to pay other doctor. It's very expensive." [Chinese, non-enrolled]

"I just buy some medicine without going to the doctor." [Chinese, non-enrolled]

"Mostly we would go to see our own doctor and we pay out-of-pocket." [Chinese, non-enrolled]

"I think most of the people just hold their pain." [Spanish-speaking, enrolled]

Parents without medical coverage often rely on clinics and emergency rooms. Some visit private physicians on an as-needed basis, while others visit free public and community clinics or use home care agencies. Parents also use emergency rooms for routine and preventive care, yet this health care can be as costly as private physician care and waiting times are often lengthy.

"Basically there is no choice under the circumstance that you have no insurance. It is pretty scary to live without insurance." [Chinese, non-enrolled]

"I used to go to emergency and it got to the point where my days were going by. So one day I say, 'Look, I am just going to have to get into a health plan.'" [white, enrolled]

"Right now I am looking for some insurance for my son. You know, because without that you are subjected to health clinics." [African American, non-enrolled]

"The fire department will get me to the hospital and I'll get cared for in about 45 minutes. If I go walk into an emergency room, I'll be there all night." [African American, non-enrolled]

EXPERIENCES WITH MEDICAID

Awareness of Medicaid

Medicaid is generally well known among low-income parents who have had any contact with other public assistance programs. Many Medicaid beneficiaries indicate that they were introduced to the program through contact with a public assistance office or through word-of-

mouth. Families who do not seek public assistance such as welfare are often unaware of their eligibility for Medicaid.

"When I was on public assistance it was much easier to get Medicaid." [white, enrolled]

"As soon as I applied for public assistance, I had Medicaid." [white, enrolled]

"I generally go by PA standards." [HRA eligibility worker]

"I didn't have an income, so they wouldn't have given me or my children Medicaid. She would have said, again, 'You have to go get welfare.'" [African American, enrolled]

Families in need will not be identified if public assistance is used as the key measure of eligibility for Medicaid and/or CHP. If families are not Medicaid beneficiaries, CHP cannot be passed on through that program, and parents do not want to feel pressured to take public assistance if all they need is Medicaid. Medicaid and CHP recipients are often working parents who do not want or do not need public assistance.

"If you just go to the Medicaid office they will deal with you accordingly that day.... My suggestion to you would be go straight to the Medicaid. Don't get on any welfare program." [African American, enrolled]

"As a matter of fact, the person, well she told me the first time, 'We have Aid for Dependent Children. You have to get on welfare.' And I said, 'I am not getting on welfare.'" [African American, enrolled]

Understanding Who Gets Medicaid

Many parents are confused and have misperceptions about their children's eligibility for Medicaid. They often believe that the program is a source of health coverage for children up to 18 years of age whose families are very needy. (Program expansions are geared to reach families with incomes up to 250 percent of the federal poverty level.) Among focus group participants who were not enrolled in Medicaid, "very needy" meant the unemployed or destitute, or illegal immigrants. Some low-income parents of uninsured children expressed resentment toward groups whom they felt unfairly qualified for benefits.

"To get any type of service in New York City, you have to have a certain aura about you—poor and needy." [African American, enrolled]

"We pay our taxes. We can have foreigners come in here and they can get more than we can being American blacks. And I can't understand that. I can come in here, their children will get more than our children?" [African American, enrolled]

"If you are, like, blond, blue eyes in New York, you may get Medicaid." [African American, enrolled]

"Why is it that those illegal aliens can get it and we cannot?" [Chinese, non-enrolled]

"You become eligible when you are almost in the street." [Spanish-speaking, enrolled]

"The best chance of getting this is being homeless." [African American, non-enrolled]

"I think Medicaid is for very low income. You take one to the government hospital, you do not have to pay for seeing a doctor." [Chinese, non-enrolled]

"But Medicaid won't give me nothing now because I just finished working. And I earned too much last year." [African American, non-enrolled]

Getting information about Medicaid generally requires a face-to-face visit, tenacity, and time. Many potential beneficiaries' questions could be answered by CBO caseworkers if they were given documentation to supplement their understanding of the program. Limited by a lack of sufficient information, CBO employees sometimes escort potential enrollees to a Medicaid office to get answers about the program. CBO caseworkers, however, do believe that they have some understanding of the eligibility rules. CBO focus group participants said they believed that Medicaid:

- Is a government-sponsored health program covering all low-income children under the age of 21, depending on the size of the family.

- Provides for working families as well as unemployed families.

HRA eligibility workers expressed greater confidence in their knowledge of Medicaid than did CBO caseworkers. HRA workers defined Medicaid as a state-sponsored program that reaches out to low-income families. They said that medical coverage is generally provided to these families free of charge, and that pregnant women automatically qualify for the program, although some might have to contribute to a "surplus program." HRA workers,

however, are concerned that information about changes in the system, such as a shift toward managed care, is not being passed along to them.

"There are too many confusing situations. Even supervisors are not always sure what to do in a tricky situation." [HRA eligibility worker]

Neither families, eligibility workers, nor CBO caseworkers believe that the Medicaid hotline is a reliable source of information about the program. Many non-enrolled parents reported that their attempts to seek coverage were limited to calling the eligibility hotline—which kept them on hold for long periods and was not particularly helpful. Some parents who have called the hotline for eligibility information found that the information conveyed was different from one call to the next.

"No, don't use the hotline. The hotline is better when you have a problem." [white, enrolled]

"If they really need information, come in." [HRA eligibility worker]

"I keep calling there and nobody answers the phone." [white, enrolled]

"The hotline says $18,000, but it doesn't apply to everyone. Everyone has different criteria for being accepted to Medicaid. It's not like there is a general standard." [African American, non-enrolled]

Perceptions of Medicaid

Parents of uninsured children want to participate in Medicaid. The program is viewed as useful, cost-free, and comprehensive by enrolled families—it enables them to obtain routine care as well as dental services that they could not otherwise afford. Most believe that the benefits of the program outweigh its shortcomings.

"Medicaid covers dental and so forth and so forth." [white, enrolled]

"Right, and they will give it to you for awhile until you get on your feet. That's what I heard." [white, enrolled]

Opinions differ on how widely accepted Medicaid is among providers. Some parents have encountered physicians who do not take Medicaid patients. While many HRA workers believe that doctors widely accept it, others believe that Medicaid is not as widely accepted as they are led to believe.

"Most of the doctors do not accept Medicaid patients." [Spanish-speaking, enrolled]

"The Medicaid and CHP, these two things, it is for you to go to the government hospitals. Sometimes private doctors would not accept it. It is not covered." [Chinese, non-enrolled]

"That's why people on Medicaid use emergency rooms or clinics—because the doctors don't take Medicaid." [white, non-enrolled]

"There is so much bureaucracy and so much paperwork and garbage involved. A lot of doctors don't even want to deal with it." [African American, non-enrolled]

"With Medicaid, very few doctors accept it and if you have a bigger problem it's very hard to find a good doctor. That was always a problem. Like, I was always left with the Medicaid, but I didn't use it. I was always going to private doctors paying out-of-pocket." [white, enrolled]

"You can go to a number of hospitals or private doctors." [HRA eligibility worker]

"Medicaid can go anywhere." [HRA eligibility worker]

"You can go to a number of good hospitals or private doctors." [HRA eligibility worker]

"Some private doctors don't accept Medicaid because they are only getting $6 or $7 per visit." [HRA eligibility worker]

Some Medicaid beneficiaries believe that they have been stigmatized and receive poorer quality care than parents with private insurance. They believe that certain doctors demonstrate bias against Medicaid recipients.

"I feel that I am being...I don't know...I just feel that doctors make you feel little." [white, enrolled]

"I feel that if somebody has private coverage they get, like, 'Oh, Mrs. Smith, come on in....' And it's just, 'Mrs. X, you have to wait in the corner over there. But Mrs. Smith, you *can come in.'" [white, enrolled]*

"I had a pediatrician and she accepted Medicaid as well as private insurance and she mistreated everybody with the Medicaid. Like, she looked at you like you were a

piece of garbage. And I just couldn't take that. I left her. Even though I paid for a different doctor, I felt better." [white, enrolled]

"It's more like not quality, the doctors, the way they treat you. If you don't have what they want you to have, they treat you like a nothing. And to me, that's discrimination." [African American, non-enrolled]

"If you have your own personal doctor...he is going to take care of you. A doctor that's exhausted because he has seen 25 kids before you got there...they are not going to give the best, you know, the quality care that you would actually expect." [African American, non-enrolled]

Enrollees and eligibility workers largely blame the Medicaid system for tension between parents and doctors. Parents believe that they (not their children directly) are punished because doctors are underpaid or not paid on time by Medicaid administrators.

"A reputable doctor doesn't want to pick up dealing with Medicaid patients, because they are not paying on a timely basis." [African American, non-enrolled]

"A doctor told me, 'I will only see you for 10 minutes, since I only get paid 10 dollars [by Medicaid].'" [Spanish-speaking, enrolled]

"I feel also that doctors are underpaid and that's why we don't have high-quality doctors." [white, enrolled]

"For one, they're bad pay masters. The city Medicaid is really bad. They pay late or sometimes doctors don't get paid and years go by." [African American, non-enrolled]

Barriers to Medicaid Enrollment

Many parents misunderstand income qualifications for Medicaid eligibility and often mistakenly assume that employment disqualifies them. Others do not apply based on the experiences of coworkers and friends who have applied and been denied. Parents also often lack understanding of how income, household size, and assets interact to make some families eligible and others ineligible, and they suspect that rules are applied arbitrarily. In the focus groups, parents reported that disqualification is often unexplained.

"I had asked about my daughter's case several times, but to no avail. I don't know why—I cannot understand." [Chinese, non-enrolled]

"They ask you what is the reason you were turned down the first time, like you had the answer to that. 'Oh, I see you applied before. What's the reason?' 'Hell if I know.'" [African American, non-enrolled]

Eligibility criteria are perceived to be outdated, unrealistic, and out-of-sync with the costs of living in New York City. Families, eligibility workers, and plan administrators agree that to qualify, household incomes must be very low and that families could not survive based on the eligible income standards.

"Who can live off of $250 for rent in New York City?" [plan administrator]

"You need to have a very low income in order to get Medicaid." [Chinese, non-enrolled]

"The money they are talking about is money you can't live on. They took me off because of what, I don't know. The money I am making can't feed people and pay for health care." [African American, non-enrolled]

"It should be a little bit different, because I still consider poor to be up until maybe $30,000 or $40,000. You're still struggling; that's not enough money." [African American, non-enrolled]

Medicaid's assets tests are also considered to be prohibitive to parents who have any assets, such as a car or very limited savings.

"You can't own anything—you can't have money in the bank." [African American, enrolled]

"If you have an account with $2,000, you don't qualify for Medicaid." [Spanish-speaking, non-enrolled]

"'Your income is not low enough, you cannot apply.' I did not even bother to consider it because my savings account is not below $3,000. So when they check the account this is the problem. But then the yearly income cannot be over $10,000—husband and wife get two jobs—how can it be so little?" [Chinese, non-enrolled]

Applying for Medicaid—Documentation Requirements

Gathering the proper documentation for eligibility determination is in itself a lengthy and time-consuming process. Applicants are aware that they must provide birth certificates,

Social Security cards, utility statements, pay stubs, housing contracts, proof of citizenship, divorce/marriage certificates (when applicable), and proof of ability to manage finances.

"Applying for Medicaid is very difficult, especially considering that getting the required documents does not depend solely on you." [Spanish-speaking, non-enrolled]

"They wanted for me to establish that she was my daughter, so I had to go to Social Security, get a letter stating that she was born, and apply for her to get a card." [white, enrolled]

"They have to be notarized." [white, enrolled]

"'Oh, well, I don't know if the paperwork was lost. Let's do this all over again—you bring your life back again.' A fair hearing takes three to six months. It's supposed to take 90 days. By that time, you are just so frustrated-you don't want to be bothered.... After you do all of that you still didn't get no results. You do the whole process over again. And I have done that three times." [African American, non-enrolled]

"There are so many documents it turns people off. The reason it turns people off is it's a little bit confusing and intimidating." [plan administrator]

The Interview Process

Focus group participants reported that the interview process is time-consuming and inefficient. Once the necessary documentation has been gathered, the interview process often requires a full day of waiting. Many low-income workers are nonsalaried, and the daylong application process is therefore a hardship. Eligibility workers often send away applicants because their documentation is incomplete.

"They use this system to tire you out and make sure you won't come back. I think they do it on purpose." [Spanish-speaking, non-enrolled]

"You go down to that 34th Street office for Medicaid and you get in that line and you go back, and you go back, and you go back, and you go back until they give it to you. That's what you do. You just got to keep going and keep going. But you know, if you want coverage you can't get discouraged." [African American, enrolled]

"To apply they ask a lot of questions, so we have to go back and forth many times." [Chinese, non-enrolled]

"To try to get Medicaid you would never get a job, because there is too much time running back downtown." [African American, non-enrolled]

"They bug you so much—I think they do it on purpose so you just give up." [Spanish-speaking, non-enrolled]

"They make you miss days of work to get the documents required, and after all that, they tell you: 'You have two dollars more than we allow, you don't qualify.'" [Spanish-speaking, non-enrolled]

Eligibility workers find that much of their time with applicants is spent sorting documentation. Workers indicate that they are under a great deal of pressure to complete a number of appointments, and informing applicants of missing documentation is time-consuming.

"We try to explain but we don't have the time to spend." [HRA eligibility worker]

"People don't expect to wait. It's a government agency—what do they expect?" [HRA eligibility worker]

"First take your Prozac, because it's forever." [HRA eligibility worker]

"I hate sending people away because it's unclear what they need to bring." [HRA eligibility worker]

"We have a form that goes with them when they are given an application. It's explained to them." [HRA eligibility worker]

Tension Between Parents and Medicaid Eligibility Workers

The tension between parents and Medicaid eligibility workers is often reason enough not to apply for Medicaid. Parents, CBO caseworkers, and plan administrators view HRA eligibility workers as uninformed, unconcerned, and rude—and trying to keep people from enrolling. The application process is considered degrading and requires a great deal of persistence and resilience to complete. If not for the belief that Medicaid benefits are important for their children, many parents indicate they would not have accepted such treatment.

"I've worked in the system long enough to know about applying for Medicaid and public assistance. The staff you're dealing with needs a lot of customer service training. They are not user-friendly at all and that deters people." [plan administrator]

"They need to do something about the whole Medicaid enrollment application process. It's almost demeaning to people." [plan administrator]

"I go to these places and see lines and lines of people and you literally see people in tears because they've waited so long—and then they had to deal with someone so nasty. Eligibility workers need sensitivity training to make the process a lot easier." [plan administrator]

"I didn't even want to go for it. I sent my husband." [white, enrolled]

"First of all, they should handle every person personally, not like another number. And besides, they themselves should be more educated." [white, enrolled]

"That's why people go crazy there. That's why people want to kill people.... It's like a zoo." [white, enrolled]

"I think if they communicated with us...as human beings, I think it would run a lot smoother. There are people that want to smash the glass. They had some fights. That's what holds up everything. If he is in front of me and he explodes, then that holds up the whole rest of the line for a good hour, hour and a half. If they just communicate with him and maybe talk to him instead of just shutting him out..., I feel that would help." [white, enrolled]

"You have to swallow your pride and say, 'Oh, my god, I never thought I would be in this place.' But here I am, you know." [white, enrolled]

"The eligibility workers wanted me to beg from them personally." [white, enrolled]

"You just swallow your pride, because it's a real low-respect type of place if you don't." [white, enrolled]

"Even when you have to re-certify, they treat you like garbage. You feel so down that you have to go there." [white, enrolled]

Parents believe that eligibility workers ask questions that unnecessarily pry into their personal lives.

"They want to know from the day you were born." [white, enrolled]

"You shouldn't have to show management, because if you were able to manage your money then you wouldn't need Medicaid." [African American, enrolled]

"They want to know why you need the help and where you live and how you eat." [white, enrolled]

"They pry into your business." [white, enrolled]

"Ultimately, you have the Social Security number. Once you put that in, you know everything about me. So, why they asking me these questions?" [African American, non-enrolled]

"To apply, you almost need to bring the story of your life." [Spanish-speaking, enrolled]

Parents believe that eligibility workers play favorites, and that factors such as appearance make a difference in whether someone is ruled eligible. Eligibility decisions are often viewed as arbitrary and unfair.

"If the clerk does not like your face, you are fried." [Spanish-speaking, non-enrolled]

"You have to dress shabby and look poor. The way you look...it's really important to that person behind that desk. You look like you got more than what they got and you ain't getting any." [African American, enrolled]

"You got to look mean. You got to either look mean or look demanding. You are not going to get it: You are too intelligent. You are too intellectual. They will say to you, 'Please, spare me—you are making $14,000. You will make some more next year.'" [African American, enrolled]

HRA eligibility workers concur that problems exist and are well aware that turning families away and prying into personal lives makes them very unpopular. They, too, perceive the enrollment process as long and demeaning and express empathy for applicant families. In addition, they recognize that some of their coworkers carry a bias against families who apply.

"Parents think that I have a personal vendetta against them—that I'm trying to stop them from getting Medicaid." [HRA eligibility worker]

"Some eligibility workers care, some don't." [HRA eligibility worker]

"Some workers may be arbitrary in accepting documents." [HRA eligibility worker]

"The rules are different in different offices." [HRA eligibility worker]

"Photocopying and fingerprinting keeps a lot of people away." [HRA eligibility worker]

HRA staff are not necessarily in favor of the enrollment process but must carry it out to the best of their ability. Many of them feel overworked and overwhelmed and are looking for support. Workload, paperwork, and outdated information systems are cited as major problems.

"We don't have the time." [HRA eligibility worker]

"We book 50 clients per day." [HRA eligibility worker]

"A paperless system was promised but we'll never see it. We're still waiting for computers." [HRA eligibility worker]

"We have the oldest computers in the world. We have five computers for ten workers." [HRA eligibility worker]

"We have nowhere to vent our frustrations or talk about new procedures." [HRA eligibility worker]

"Most changes have to come from the top. In reality, our input doesn't matter." [HRA eligibility worker]

"It's a numbers game that nobody can win." [HRA eligibility worker]

Language

Interviews are difficult to complete when different languages are spoken and can be a deterrent to enrollment. Accommodations have been made for Spanish-speaking families, though communication difficulties still persist. Non-English and non-Spanish speaking families are less likely to be aware of Medicaid. Even when they are aware of the program, they find getting basic information difficult, often because no one can interpret for them. Hiring an interpreter is a costly option.

"We are not fluent in English, so we did not go to apply. If we are fluent in English, truly it would be very nice. Don't say that the program is no good, right, we are

ignorant, unable to speak the language. Of course it is good." [Chinese, non-enrolled]

"Yes, yes, the most important thing [is being able to communicate]. Truly it will be great if you can get it. If everybody could get it, it would be nice, but we do not speak English, we cannot communicate. Even if you speak English, we want to say something but cannot express ourselves—cannot understand what is being said. But I am not sure if there is any Chinese assistant there. Some places do have, sometimes they don't." [Chinese, non-enrolled]

"This is very true: the most important thing for our Chinese people, our English is no good.... If my English is good I want to apply for it, so when I go out to work I will have peace of mind. First you don't know anything, and everybody's working to make a living. You can't just go and ask someone constantly to be your interpreter—this is too hard." [Chinese, non-enrolled]

"They treat you like you are stupid.... 'You speak Spanish—you don't speak English.'" [Spanish-speaking, enrolled]

"A lot of people do not speak English. For them it is really difficult; they really give them a hard time." [Spanish-speaking, enrolled]

"I think they make people who do not speak English feel lower than the floor." [Spanish-speaking, enrolled]

EXPERIENCES WITH CHILD HEALTH PLUS

Awareness of Child Health Plus

Awareness of Child Health Plus (CHP) is significantly lower than awareness of Medicaid. Many parents of potentially eligible children have never heard of it. Those who are currently enrolled in the CHP program indicate that they learned of it from health plan representatives at a health fair, or from friends who had recently lost their Medicaid eligibility.

"They said they got my name through public assistance from when I was on Medicaid." [white, enrolled]

"I don't know how it is called in Chinese. I only know—only heard this phrase, 'Child Health Plus.'" [Chinese, non-enrolled]

"I want to see the information in Chinese. Sometimes there's a health forum—the Chinatown Health Clinic would have this thing. Sometimes I would go over there and hear them talk about this thing." [Chinese, non-enrolled]

Information about CHP has been slow in coming to HRA enrollment workers. They feel unable to alert the public about CHP because their clients are the ones informing them about the program. Enrollment staff have few information resources available to them; supervisory staff are not well-educated about CHP, and documentation is difficult to obtain. As a result, eligibility workers have a fragmented understanding of CHP and what it provides. Also, they find managing both CHP and Medicaid difficult. Based on the information that they have managed to acquire, HRA eligibility workers believe that CHP has been designed to cover children 19 years of age and younger who are ineligible for Medicaid. The service area of CHP is presumed to cover Brooklyn, Queens, and the Bronx, but workers are unclear whether Manhattan is covered as well.

"You have to be ineligible for Medicaid." [HRA eligibility worker]

"It takes care of ineligible children." [HRA eligibility worker]

"It's only in Brooklyn and Queens." [HRA eligibility worker]

Understanding and Perceptions of Child Health Plus

Parents of uninsured children who have heard of CHP believe it has a very good reputation. Low-income families believe that they can use the program to cover their children through age 18 and that the benefits are accepted city- or borough-wide. They also think that CHP covers many of the same services offered by Medicaid. Dental coverage has thus far not been part of the program; however, a number of enrollees have been led to believe that this will soon change.

"We read about Child Health Plus earlier: it's for those who do not meet the criteria of Medicaid." [Chinese, non-enrolled]

"I've heard [CHP] is really good." [Spanish-speaking, non-enrolled]

"Un seguro, seguro." [Spanish-speaking, non-enrolled]
(Note: The translation of this play on words is, loosely, "The insurance that gives you security," or, "The insurance that makes you feel assured." Many Spanish-speaking parents made this comment.)

"If you are able to get enrolled, you get a lot of benefits." [Spanish-speaking, non-enrolled]

"With CHP, one does not feel limited." [Spanish-speaking, non-enrolled]

"Starting in 1999, Child Health Plus is planning to include dental." [white, enrolled]

Parents whose children are enrolled in CHP report favorable experiences with the program and believe it has advantages over Medicaid, including clear qualification criteria. They report that CHP is easy to use and provides affordable access to quality health care. The doctors available through CHP are highly rated. Lack of coverage for dental care is the only issue taken with the program.

"Everything that should be changed about Medicaid—CHP has it." [Spanish-speaking, enrolled]

"To me, CHP is the best thing the government has come up with." [Spanish-speaking, enrolled]

"I'm very happy with CHP. I like it more than Medicaid, and even though I don't get covered, my children do." [Spanish-speaking, enrolled]

"I would recommend it.... My kids get whatever coverage they need.... I am really thankful that they have Child Health Plus, because that was the only type of coverage that I was able to get. And they didn't give me a whole bunch of problems or anything like that." [African American, enrolled]

CHP participants are potential ambassadors for the program. They implore other parents looking for child coverage to consider CHP. Upon hearing reviews of CHP by parents whose children are enrolled, parents of uninsured children take a keen interest in participating. Many parents requested informational materials about CHP (which was provided at the focus groups) and felt convinced that their children would qualify for enrollment.

"If it could benefit me and my children—forget me—it sounds good. And if it gives my children what they need, I am going for it." [African American, non-enrolled]

"I think Child Health Plus sounds just beautiful. Sounds like an insurance." [African American, non-enrolled]

CBO caseworkers also have favorable impressions of CHP. The program does not carry the same stigma as Medicaid, because CHP is a newer program and not often associated with the government. Community enrollment workers find the program particularly helpful in getting immigrant families to pursue coverage for their children.

"CHP is a lot more user-friendly...and a more lenient program." [plan administrator]

"It's good. It covers undocumented children." [CBO caseworker]

"Immigrants overstate their tax filings so that their family members can be brought in to the country. With CHP they can still get medical care and end up just having to pay a premium." [CBO caseworker]

Applying for Child Health Plus—Documentation and Income Requirements

Much of the same documentation is required to apply for CHP as it is for Medicaid. Pay stubs, birth certificates, and a driver's license are among the necessary documents. However, CHP's enrollment process is perceived to be less harrowing than Medicaid's. Provided all documentation is in order, eligibility for CHP is determined comparatively faster, and applications can be handled by mail.

"They ask for what is really necessary." [Spanish-speaking, non-enrolled]

"Well, [the CHP staff] were very helpful when I applied." [white, enrolled]

"It's easy because they are looking out for you." [Spanish-speaking, non-enrolled]

"The people at CHP are really kind. If they don't know something, they find it out for you." [Spanish-speaking, enrolled]

"They call you and encourage you to apply. They sent me the applications.... At first I thought, this really can't be true." [Spanish-speaking, enrolled]

"Actually, I think within a month I heard from them.... So, finally what they did is over the phone they gave me an ID number, and they said if you need to go to the doctor you just let them have this ID number." [white, enrolled]

"Very polite and very nice. They would return my calls. I sent them the information that I had provided previous to the application through the fax. And they were very nice." [white, enrolled]

"They give you an opportunity no matter how much you make." [Spanish-speaking, non-enrolled]

"Child Health Plus form is also in English, but there are few questions, like date, Social Security number, and this and that. Even I, myself, can fill it out." [Chinese, non-enrolled]

"It was very easy for me. It was at a health fair in the community. And I approached the table with Child Health Plus.... She came to my job, as a matter of fact. She picked up copies of my pay stubs and my driver's license. She attached that to my application and a little after I heard from them, and I was accepted." [white, enrolled]

The cost-sharing arrangements for CHP are affordable for low-income families. Parents might not get free care, but they can still obtain access with a small copayment. CHP makes child coverage affordable based on income level.

"I think it's really good. I am poor so I was definitely able to get it." [African American, enrolled]

"I do have a copayment of two dollars, which is not much." [African American, enrolled]

"Actually, if you are within a certain income they will pay for [your copayment]." [African American, enrolled]

"And the more money you make, you know, it has to come out-of-pocket. But it's still basically inexpensive." [African American, enrolled]

"I hope they can raise the CHP income level higher. The income level should not be set so low. And they should relax their criteria for those who have slightly high income, relax the income level a bit." [Chinese, non-enrolled]

Families are more confident that with CHP their incomes will not be a deterrent to receiving care. They also believe that they do not have the same pressure to humble themselves when asking for assistance. Overall, CHP is viewed as a sizable improvement over Medicaid, and parents would like to enroll their children in the program.

RECOMMENDATIONS

Increasing participation in Medicaid and CHP is largely dependent on building awareness and removing barriers to enrollment. Program benefits and copayments are not of major concern to enrollees or potential enrollees.

Building Awareness of Medicaid and Child Health Plus

- **Make greater use of referral structures.** HRA employees and CBO workers should better educate families seeking guidance about CHP. Systems should be put in place that refer those ineligible for Medicaid to CHP.

- **Efforts should be made to reach low-income parents through their employers.** Access to Medicaid is facilitated by the process of applying for public assistance. The system misses many working families through this narrow approach, however; alternative means should be implemented to reach them.

- **Support information dissemination within communities and at locations frequented by parents and children.** Any location that offers services to families or children should be targeted—doctors' offices, hospitals, clinics, schools, and libraries. Community-based organizations such as churches and daycare centers are also valuable resources. In addition, subways, grocery stores, and laundromats are valuable advertising sites.

- **Outreach and communications campaigns should be expanded.** Families seek information on health insurance programs from health fairs and advertisements (television, radio, and print). Radio can be especially effective for hard-to-reach populations. Parents do not object to receiving information by mail.

- **Provide documentation and incorporate communications campaigns in more languages, including Chinese, French, Russian, and Arabic.**

Removing Barriers to Enrollment in Medicaid and Child Health Plus

- **Provide communications training for eligibility workers.** Families must be comfortable with and trust the people who apply the rules and make eligibility determinations.

- **Improve support systems for eligibility workers.** Supervisory staff must be capable of answering questions when workers cannot. Documentation should also be readily

available to workers. Access to more information and the ability to spend time with government administrators of both Medicaid and CHP would help New York City HRA eligibility workers become a more active resource in increasing enrollment.

- **Increase the number of staff determining eligibility.** Mechanisms for expediting eligibility decisions should be developed.

- **Make improving computer systems a priority.** This improvement would eliminate the replication of documents and enable workers to provide more accurate and timely service to their clients.

- **Improve staffing and the accuracy of information available from telephone hotlines.**

- **Increase the number of staff members who are multilingual and make application forms available in multiple languages.**

- **Evaluate the feasibility of a single application form for Medicaid and CHP, and eliminate duplication of documentation requirements.**

- **Send eligibility workers into neighborhoods and delegate face-to-face interviews to CBOs.** Avoid the need for parents to visit Medicaid and welfare offices when possible. Consideration should be given to eliminating Medicaid's requirement for a face-to-face interview.

- **Offer extended business hours for enrollment.**

- **Build better relationships with physicians.** Medicaid and CHP programs should be parent-, child-, and physician-friendly to bring optimal services to families.

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VT

(I) phone call

Debbie
me/Jeanne → 1115
Base year
how long for exp. review?
>2wk → JEANNE

traditional monitoring

CHIP
5% cap
enrollment
premium/copayment

(II) RETROACTIVE REGARDLESS

VERMONT TITLE XXI PROGRAM
FACT SHEET

Name of Plan: n/a

Date Plan Submitted: November 6, 1998

Date Plan Approved: December X, 1998

Effective Date: October 1, 1998

Background

- Vermont's Title XXI Plan will create a separate state health insurance program to cover children up to age 18 in families with incomes between 225 and 300 percent of the Federal Poverty Level (FPL).
- Vermont's Medicaid Program currently covers uninsured children up to 225 percent of the FPL, and underinsured children up to 300 percent of the FPL. The State's section 1115 demonstration, the Vermont Health Access Plan, was amended on November 6, 1998 to expand coverage to underinsured children up to 300 percent of the FPL.

Children Covered Under Program

- Vermont anticipates an enrollment of 1,072 children by the end of FY 1999, 1,088 by the end of FY 2000, and 1,104 by the end of FY 2001.

Administration

- The Title XXI Program will be administered by the Office of Vermont Health Access, which also administers Vermont's Medicaid program.

Health Care Delivery System

- Health services to children under Vermont's Title XXI Plan will be delivered by the managed care organizations that currently provide services under the Vermont Health Access Plan, Vermont's Medicaid section 1115 demonstration. Non-capitated services will be provided on a fee-for-service basis.

Benefit Package

- The package of services for the Title XXI program is the same benefit package currently provided through Vermont's Medicaid program.

Cost Sharing

- Vermont will charge beneficiaries a premium of $10 per month per household. The State will increase this premium to $20 per month per household when administratively possible.

- Beginning on July 1, 1999, providers who bill using the HCFA 1500 billing form (physicians, podiatrists, optometrists, psychologists, audiologists, chiropractors, and nurse practitioners) and dentists will be allowed to charge a $10 copayment for office visits. No copayments will be charged for well-baby and well-child visits.

- Vermont will establish a single annual maximum cost sharing amount for all households which will not exceed 5% of the 225% FPL for a household of two. This arrangement will assure that no household in the CHIP program will exceed the 5% maximum. The maximum will be adjusted to reflect the annual premium cost, and the remaining amount will be apportioned between medical and dental services. Once the maximum is reached for the service type, medical or dental, no further copayment applies for that type. A beneficiary may reach the maximum for one service type and not the other. Beneficiaries will be informed of the 5% cost-sharing cap through the notice letters they receive upon determination of eligibility for the CHIP program.

Crowd-Out Strategy

- Applicants who had health insurance coverage within one month of the date of eligibility determination for the CHIP program will not be eligible unless the insurance is lost during this period because of loss of employment, death or divorce, or loss of eligibility for coverage as a dependent under a policy held by a parent.

- Vermont's eligibility application will include a request for information regarding other insurance, including enrollment, coverage type(s), and past availability of insurance coverage. Every six months, Vermont will select a sample of all individuals found eligible in the previous six month to determine the percentage of enrollees who had coverage prior to eligibility and dropped it. Surveys will be mailed to the sample to determine the reason(s) for dropping coverage. If crowd-out is determined to be a problem, Vermont will develop a strategy to discourage crowd-out.

Outreach Activities

- Outreach for the CHIP program will be integrated with existing outreach activities for the existing Medicaid program. These activities include: a multi-media campaign, including print, brochures, and flyers; outreach through community health and social service providers and other organizations (e.g., WIC clinics, local school health nurses, and free health clinics located in the larger population centers); educational sessions in community locations, including Department of Social Welfare district offices, and a toll-free telephone line which individuals can contact to learn about the program.

Coordination Between CHIP and Medicaid

- Vermont will determine eligibility for the CHIP program using the same system as it uses for the Medicaid program, and eligibility determination for the CHIP program will be fully integrated with Medicaid. All Medicaid eligibility requirements will apply to CHIP with the exception of the higher income test. Those children who meet eligibility requirements and who have family income between 225 and 300 percent of the FPL will be assigned an eligibility code for the CHIP program; those children who meet eligibility requirements and who have family income up to 225% of the FPL will be assigned an eligibility code for the Medicaid program.

Financial Information

Total Title XXI Reserved Allotment (FFY 1998) -- $3,536,354
Enhanced Federal Matching Rate (FFY 1999) -- 73.38%

First Year Costs: (October 1998 through September 1999)
State Share -- $218,812
Federal Share -- $603,170
Total --- $821,982

Second Year Costs: (October 1999 through September 2000)
State Share -- $331,776
Federal Share -- $923,525
Total -- $1,255,301

Third Year Costs: (October 2000 through September 2001)
State Share -- $351,731
Federal Share -- $979,071
Total -- $1,330,802

The state will charge qualified families a premium of $10 per month per household. The state plans to raise that amount to $20 per month per household soon. Providers will also be allowed to charge a $10 copayment for office visits. ~~Family~~ cost-sharing cannot exceed 5 percent of ~~that~~ family's annual income.

HOWEVER,

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

ASSOCIATE ADMINISTRATOR FOR EXTERNAL AFFAIRS
OFFICE OF MEDIA RELATIONS
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FAX TRANSMISSION

To: Deborah Adler **Date:** 3 Dec 98

Fax #: 456-5557 **Pages:**

From: Mary Kahn, 202-690-6145
E-mail: MKahn3
Internet: MKahn3@hcfa.gov

Subject:

COMMENTS:

Vermont CHIP materials

D - My computer crashed after I spoke to you, so I am sending this along very rough draft - Please just use as resource materials - Thanks

MKK

16. Q. Are there any strings attached to this money, or can states use the funds for other things?

A. States must use their allotments to provide health insurance to low-income, uninsured children. In order to access their allotments, states must have a children's health insurance plan that meets all the requirements of the law and is approved by the Department of Health and Human Services.

17. Q. What requirements are those?

A. States can choose among several options. They may simply expand their Medicaid program, they may design a new program with a benefit package based on one of several so-called benchmark plans or they can do a combination of both. A Benchmark model plan may be any of the following:

- the standard Blue Cross/Blue Shield Preferred Provider Option (PPO) offered by the Federal Employees Health Benefit Program (FEHPB);
- a health benefit plan that is offered to state employees;
- the HMO benefit plan with the largest commercial enrollment in the state.

18. Q. What about states with 1115 waivers? Will they be able to get the enhanced federal matching rate for these kids, or is the enhanced match only available to the new Title XXI plans?

A. The enhanced match available in the Title XXI program is intended to give states incentive to cover children who are *not currently covered* by an insurance plan. Children in 1115 waiver programs (granted under the Medicaid program) will be considered as having coverage and therefore they will not be eligible for the enhanced match. This is consistent with HCFA's policy that children currently enrolled in their state's Medicaid program will not be eligible for the enhanced federal match.

12. Q. When will HHS approve other state plans?

A. We anticipate being able to grant other state approvals very soon. We are working closely with states that have submitted plans and with states that are in the process of developing CHIP plans. Our goal is to get this program up and running as soon as possible and to get good quality health plans available to the kids who need them.

13. Q. The law says the federal government has 90 days to approve a state plan once it has been submitted. What about states where HCFA has stopped the clock on applications?

A. It is true that some states have taken longer than 90 days to approve because the "clock" had been stopped so HCFA could obtain more information or clarification related to the proposed plan. HCFA only stops the clock when it needs information to ensure that the state is complying with the statutory requirements to use CHIP funding to obtain meaningful health benefits coverage for uninsured children. Department reviewers are working closely with states to speed this process along so children can get the health services they need. The average time the agency has taken to review state applications has been approximately 102 days.

14. Q. Twenty-four billion dollars is a lot of money. Do we really need to spend this much on a new insurance program right now or is this just more big government?

A. Yes. Spending for children's health is the best investment we can make as a nation. Our best estimates show that at least 10 million children (up to age 19) lack health insurance coverage. Research shows that children who lack health insurance are:

- six times more likely to go without medical care than those with private health insurance;
- six times more likely to be unable to get prescription medicines;
- four times more likely to delay seeking medical care; and,
- three times more likely not to get dental care and eyeglasses.

15. Q. Won't this new children's health program just be used by families as a substitute for having to buy dependent health care for their kids?

A. HHS is making every effort to assure that private insurance is not dropped in favor of the new CHIP program. The law clearly states that CHIP funds are to be spent on children who are currently *not* covered by health insurance. As part of their CHIP plans, states are required to identify a mechanism that they will use to avoid "crowd out."

41. Arizona --50,000 by 2000
42. North Dakota --500 by Oct. 1999 (phase one of its plan)
43. Louisiana -- 28,350 by the end of 2000
44. Virginia -- 54,000 by October 2000
45. Mississippi -- 7,500 by October 1999
46. Kentucky -- 50,000 by June 2000
47. Alaska -- 5,050 by October 2001
48. Vermont -- 1,104 by October 2001

TOTAL: nearly 2.5 million

9. Q. Isn't HCFA favoring Medicaid expansion rather than the other options available to states, in effect denying states the flexibility Congress intended?

A. No, states have a choice of expanding their Medicaid program, creating a separate health insurance program, or doing a combination of the two. Some states are choosing the Medicaid expansion route because the benefit package is already in place and delivery systems are already operating. The administration is working hard to assure that no single approach is favored. The statute sets out three options and states are free to choose among them.

10. Q. What is the status of the other state CHIP applications?

A. All state applications that have been received are under a 90-day period of review. HHS is working closely with states to approve these plans as quickly as possible. In addition to the plans that have been approved, we have received CHIP applications from the following states and territories. The plans currently under review are: Tennessee, New Mexico, Hawaii and American Samoa.

11. Q. What process do states have to go through to get their programs approved?

A. All states wishing to participate in the CHIP program must submit an application to the Health Care Financing Administration (HCFA). HCFA has provided states with a draft template which serves as a model application form. The template outlines the statute (Title XXI of the Social Security Act) and explains what information is required from the states. States must include information such as: the program design it has elected (whether it is a Medicaid expansion or newly designed insurance plan), how it will raise the state matching funds for the program, and how it will design a program to avoid "crowd out" or the dropping of private insurance in favor of the public program.

2. California -- 501,000 by the end of FY 1999
3 Colorado -- 23,047 by FY 99-00
4. Florida - 175,000 enrollees by the end of FY 1998.
5. Illinois -- 40,400 (no time line given)
6. Ohio -- 133,000 children to enroll by June 1999.
7. South Carolina -- 75,000 kids by this year.
8. New York -- 360,000 total children by end of FY 1999.
9. Michigan--133,000 children by the end of FY 2000.
10. New Jersey-- 102,000 children by March 1999
11. Connecticut -- 15,000 children by June 2000
12. Missouri -- 90,000 children by July 1999
13. Rhode Island --3,000 by 2000
14. Pennsylvania – 63,000 by the end of fiscal 1999
15. Oklahoma -- 71,000 by the of fiscal 1999
16. Massachusetts -- 37,000 by the end of fiscal year 2000
17. Wisconsin -- 2,000 by the end of fiscal 1999
18. Idaho -- 5,000 by the end of fiscal 1999
19. Oregon -- 16,807 by July 1, 1999
20. Texas -- 57,500 children by the end of FY 1999
21. Indiana - 57,950 by the end of FY 2000
22. Puerto Rico - 20,000 by the end of FY 1998 (A total of 165,000 children in Puerto Rico will be covered by federal funds and over-matching state funds)
23. Utah - 21,000 by the end of fiscal year 2000
24. North Carolina -- 35,000 by October 1, 1999
25. Minnesota - a small number of children in the first year, expansion being planned
26. Maryland - 15,500 children by the end of FY 1999
27. Arkansas -- 3,600 by July 1, 1999
28. Nebraska -- 17,000 by July 1, 1999
29. Maine -- 10,400 by July 2000
30. Nevada -- 43,500 by October 1999
31. South Dakota - 7,350 for FY 1999
32. Iowa - 15,000 by June 1999
33. Kansas -- 30,000 by end of 2000
34. Delaware - 10,500 by the end of 1999
35. Georgia -- 58,000 by 2000
36. Montana -- 9,000 by 2000
37. New Hampshire - 4,000 by September 2000
38. West Virginia -- about 700 by July 1999
39. Virgin Islands -- no new children (CHIP funds support pre-existing program)
40. Washington, D.C. -- nearly 8,400 by 2000

up to their allotment, but are only reimbursed if they spend money on insuring children. States must have approved plans by Sept. 30, 1999 to secure their allotments, but they receive only that portion of their allotments that is spent on the CHIP program. States also have up to three years to spend any one year's allotment.

6. Q. The administration has announced that the CHIP program can reach nearly 2.5 million kids. Why did it take so long and does this mean there's no way you can reach your goal of insuring five million kids in five years?

A. Not at all. Because of the enormous flexibility CHIP provides, the states are using different timetables and estimates. Some of the states have estimated new enrollments for only the first year, while others have estimated enrollments over three years. Even with all those differences taken into account, we're still looking at an estimate nearly 2.5 million enrolled in health insurance when the plans are fully implemented. That number will grow as the rest of the state plans are approved. In addition, several states have already amended their programs to reach to reach thousands more children. Many other states have told us they plan to expand their programs as well.

7.Q. Are you going to get to five million or not? Haven't you already approved almost all of the states?

A. I'm confident we will reach five million in five years. This early success with CHIP states is extremely encouraging. And, remember, we've always said that we would reach that five million through a combination of CHIP and Medicaid outreach. There are four million children out there eligible for Medicaid who aren't enrolled. We are working hard to ensure that those 4 million kids are enrolled.

We are engaged in a wide-ranging program of outreach, both through the resources of HHS and the rest of the federal government, and through strong, innovative private/public partnerships.

8. Q. HHS says that more than 2.5 million kids can now be covered by CHIP. How does the Department know that?

A. Actually, we estimate that nearly 2.5 million children could be covered under state CHIP plans by the end of the year 2000 using federal funds. The 2.5 million number is based on state estimates by the currently approved plans. The breakdown by the states' estimates in all approved plans is as follows:

1. Alabama -- 36,000 children by the end of FY 1999

Children's Health Insurance Program
Questions and Answers - Vermont
FOR INTERNAL USE ONLY

1. Q. You have just approved Vermont's CHIP plan. How does the state propose to expand health insurance to children?

A. Vermont will use its federal allotment to create a new state health insurance program to cover children up to age 18 in families with incomes between 225 and 300 percent of the federal poverty level (the federal poverty level is $16,450 for a family of four). Vermont's Medicaid program currently covers uninsured children up to 225 percent of poverty and underinsured children up to 300 percent of poverty.

2. Q. How many children will the state enroll?

A. The state hopes to enroll over 1,000 by the end of fiscal year 2001.

3. Q. What will the benefit package be for the new enrollees?

A. The benefit package will be the same as the state's Medicaid program benefit plan.

4.Q. Will Vermont's CHIP plan include costs for the families?

A. The state will charge qualified families a premium of $10 per month per household. The state plans to raise that amount to $20 per month per household soon. Providers will also be allowed to charge a $10 copayment for office visits. ~~Family~~ cost-sharing cannot exceed five percent of ~~that~~ A family's annual income.

5. Q. Many states have multi-million dollar allotments, but are only insuring a few thousand kids. Why are we giving so much money to insure so few kids?

A. Expanding health insurance coverage to children is one of the administration's top priorities. Far too many children -- nearly 11 million ages 18 and under -- are currently living without health insurance. At least 4 million of those kids are eligible for Medicaid yet not enrolled. The **single biggest step** toward enrolling these kids is the passage of the Children's Health Insurance Program. This program will greatly increase funding for states to do outreach, find and enroll children in Medicaid when they are eligible, and in CHIP when they are eligible for that. CHIP allotments are based on an estimated number of uninsured children in each state that below 200 percent of poverty. States can receive

"The success of the CHIP program has shown an inspiring amount of cooperation between the federal government and the states," said Nancy-Ann DeParle, administrator of the Health Care Financing Administration, which administers CHIP, Medicaid and Medicare. "It is through those efforts that we will realize the administration's goal of providing health insurance to those who need it."

"We're pulling together to help hard-working, low-income parents give their kids the same kind of high quality health care others take for granted," said Claude Earl Fox, M.D., M.P.H., administrator of the Health Resources and Services Administration, the agency working with HCFA and states to implement CHIP. "Free or low-cost health insurance is what families need to ensure their kids can grow up strong and healthy."

For the first year of the program, allotments totaling $4.3 billion are available to states whose plans are approved by HHS by Sept. 30, 1999. CHIP plans have been approved in 47 states and U.S. territories. In order of their approval, they are: Alabama, Colorado, South Carolina, Florida, Ohio, California, Illinois, New York, Michigan, Missouri, New Jersey, Connecticut, Rhode Island, Oklahoma, Pennsylvania, Massachusetts, Wisconsin, Oregon, Texas, Idaho, Puerto Rico, Indiana, Utah, North Carolina, Minnesota, Maryland, Arkansas, Nebraska, Maine, Nevada, South Dakota, Iowa, Kansas, Delaware, Georgia, Montana, New Hampshire, West Virginia, Virgin Islands, the District of Columbia, Arizona, North Dakota, Louisiana, Virginia, Mississippi, Kentucky, Alaska and Vermont. The following states have pending plan proposals: Tennessee, New Mexico and Hawaii.

###

Note: HHS press releases are available on the World Wide Web at: *http://www.hhs.gov.*

① expedited review of 1115 Jeanne needs to say

Debbie called governor's office

governor's on call

OR fam. cov.

ID benefit pkg

WE data

eval

draft plan — Verbal comments

substantiate 1100 #
$ go over that
then strategy
① call genie
② call Kate 57815

performance goals
not measurable
strategic objectives

end of day Monday

crowd out
- they have an estimate if it goes above they'd do a study
statement of private coverage philosophy

OMB not happy, wants more specific →
as to trigger level
strategy is backwards
one month waiting period
# of enrolled kids.
as trigger level

budget neutrality

@ trend rate

base year negotiation

Sid doesn't want to go back to the State

position to lower w/o waiver baseline

2 State estimates

#56 SFY 97
all kids elig under MC $
uninsured

going back to State

Copayments
- 5% cap
? Copayments for dental
? Medical / dental apport.
? Copayments as offset

budget
- FFY rather than SFY
- Source of non Fed share
- admin costs
- 3 year budget

1APPLICATION FOR

STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

STATE CHILDREN ' S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2102(b)))

STATE OF VERMONT

October 1998

APPLICATION FOR
STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
STATE CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: **Vermont**

As a condition for receipt of Federal funds under Title XXI of the Social Security Act,

_____Howard Dean, M.D.,
Governor Date

submits the following State Child Health Plan for the State Children's Health Program and hereby agrees to administer the program in accordance with the provisions of the State Child Health Plan, the requirements of Title XXI of the Act and all applicable Federal regulations and other official issuances of the Department.

Application for

State Child Health Plan under Title XXI of The Social Security Act

State Children's Health Insurance Program

State of Vermont

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State of Vermont
Vermont Health Access Plan

Overview
State Children's Health Insurance Program (SCHIP)

I. Introduction

The State of Vermont applauds the federal government for its enactment of Title XXI of the Social Security Act and its promotion of affordable and accessible health coverage for low-income children and families. Vermont is equally committed to this objective.

Vermont considers itself one of the leaders in promoting accessibility to health coverage for low-income individuals through expansion of its medical assistance program. Working with HCFA, the State has expanded coverage to children up to 225% of FPL via the Dr. Dynasaur program and expanded coverage to uninsured adults up to 150% of FPL via its 1115 Waiver program, the Vermont Health Access Plan (VHAP).

The State wishes to build on the success of the current Dr. Dynasaur programs to provide coverage, relying on the guidelines of Title XXI and accessing the federal funds available for this purpose. This application therefore requests federal authority for Vermont to provide coverage to low-income uninsured children with a State designed, Medicaid-like program. The eligibility expansion described below will enable Vermont and the federal government to further extend coverage to more than 1,100 low-income children. The State intends to adhere to the requirements of Titles XXI.

The remainder of this document is divided into the following sections:

- Overview of Current Program
- Proposed Eligibility Requirements
- Description of Benefits
- Implementation Activities
- Projected Budget for SCHIP

Attached to this amendment request is Vermont's completed Title XXI application template.

II. Overview of Current Program - Dr. Dynasaur

Vermont has made extensive efforts to ensure access to health care services for its children. Children (up to age 18) in families with incomes up to 225 percent of the Federal Poverty Level (FPL) are eligible for enrollment in Dr. Dynasaur, a Medicaid 1902 (r)(2) expansion program, which covers a full range of health insurance benefits. Approximately 16,000 children are enrolled in Dr. Dynasaur, which has been operating in Vermont since 1989 as a state-funded

program and since 1992 as a state-federal Medicaid expansion program. The Dr. Dynasaur program became part of the State's 1115 Waiver in January, 1996.

Dr. Dynasaur is available to low-income children regardless of private health insurance coverage status. Children who do not have major insurance coverage, defined as hospital and physician coverage, are enrolled with a managed health plan. All Medicaid services that are not part of the managed care benefit package are accessed on a fee-for-service basis. Children with private, major coverage are eligible for all Medicaid services on a fee-for-service basis. However, in accordance with federal regulations, Medicaid is the payer of last resort. In some cases, these children have coverage through a managed care plan.

The State is proud of the Dr. Dynasaur program's success in extending health care benefits to children. Approximately one-third (1/3) of all Vermont children are covered through this program. Another success of the program relates to its ability to provide low-income, insured children with coverage for important children's services often not covered or inadequately covered by commercial plans, including dental services, personal care, home health services and vision care. The modest cost of providing these services to an insured child is an important long-term investment in the child's overall health.

The State charges a monthly premium of $10.00 per household for children living in households with incomes between 185 and 225 percent of the Federal Poverty Level.

III. Proposed Eligibility Expansion

The State proposes to extend SCHIP eligibility to low-income children to provide comprehensive benefits to uninsured children in families with incomes at or below 275 percent of FPL. The actual income level will extend to 300 percent of FPL through application of 1902 (r)(2) income disregard rules for calculation of income. The State estimates that approximately 1,100 children are likely to enroll in the first full federal fiscal year.

IV. Description of Benefits

A. Covered Services

All children enrolled under the SCHIP will be eligible for benefits equal to the full Medicaid/Dr. Dynasaur benefit package. Children will be enrolled in managed care plans. Non-capitated services will be provided on a fee-for-service basis.

B. Premiums

The State will charge a premium for all children enrolled under this initiative. The premiums were designed to be reasonable and consistent with premiums charged under the current program. The premiums will be the same as the current Dr. Dynasaur program until such time as the administrative systems are in place to implement a premium of $20 per household per month. Premiums for current and future periods are as follows:

Population	Income level (% FPL)	Premium
Current (Dr. Dynasaur)	185 to 225%	$10 per month per household
Proposed		
Effective 10/1/98	*225% to 300%*	*$10 per month per household*
When administratively possible	*225% to 300%*	*$20 per month per household*

C. Copayments

The State proposes to permit providers to collect modest copayments for services provided. Initially, no copayment will apply. Effective July 1, 1999, physicians and other professional providers will be permitted to collect a copayment of $10.00 per office visit. The Medicaid paid amount will be reduced by the copayment amount. There will be no cost-sharing requirements for well-baby, well-child visits including age appropriate immunizations or for diagnostic and preventive dental services.

Since the maximum cost sharing for premiums and copayments is 5% of annual income, Vermont proposes to establish a single annual maximum for all households with incomes 225% to 300% of the Federal Poverty Level (FPL). The maximum is then adjusted to reflect the annual premium cost and the remaining amount is apportioned to apply to medical and dental services. This accommodates the fact that medical services will be tracked in the managed care delivery system and dental services will be tracked in the fee for service delivery system.

Effective July 1, 1999, the maximum after premiums is $950 per calendar year. The medical/dental apportionment is $650/$300.

V. Implementation Activities

Implementation of this proposal will include the following key activities:

- Development of outreach and education strategy and materials
- Eligibility systems changes
- MMIS modifications
- Staff training
- Provider education

The State recently undertook similar activities to implement VHAP and will rely on these approaches, where proven effective, to implement this proposal. The State's Title XXI template application (attached) provides a description of implementation activities.

The State intends to commence implementation activities as soon as the application is approved, and in some cases earlier. Enrollment will begin during October, with a current targeted effective date of October 1, 1998 for coverage under the program.

State of Vermont
Title XXI Application
State Children's Health Insurance Program
October 1998

VI. Projected Budget

Summary of Expenditures: Federal Fiscal Years 1999 and 2000

	Uninsured Children
SFY 1999	
Year End Enrollment	965
Average Caseload	480
Total Eligible Months	5,761
Program Expenditures per Eligible Month	$83.41
Total Program Expenditures	$480,530
Federal Share	
Federal Match (62.18%)	$298,794
Enhanced Match (30% of 37.82%)	$54,521
Subtotal: Federal Match	$353,315
State Share	$127,216
SFY 2000	
Year End Enrollment	1,084
Average Caseload	1,068
Total Eligible Months	12,815
Program Expenditures per Eligible Month	$87.13
Total Program Expenditures	$1,116,546
Federal Share	
Federal Match (62.18%)	$694,268
Enhanced Match (30% of 37.82%)	$126,683
Subtotal: Federal Share	$820,952
State Share	$295,594

See notes and sources on next page.

State of Vermont
Title XXI Application
State Children's Health Insurance Program
October 1998

Summary of Expenditures: Federal Fiscal Years 1999 and 2000

Notes:

- Totals not exact due to rounding.

- Since copayments are not being used as an offset to state expenditures, the federal allotment shown here is not net of copayments. It is, however, net of premiums.

Sources:

- Eligible estimates based on data from State of Vermont Health Insurance Survey. Eligibles converted to enrollees 85% (historical rate for Dr. Dynasaur)

- PMPM cost estimates based on current VHAP health plan capitation rates and historical cost experience within the Dr. Dynasaur program.

State of Vermont
Title XXI Application
State Children's Health Insurance Program
October 1998

General Information:

NOTE: Vermont appendices are numbered to coincide with the sections to which they apply; for example, Appendix 2, item 2.2.1 refers to Section 2, 2.2.1.

Additional documents available for review upon request include the following:

Agency of Human Services Brochures:

Doctor Dynasaur: A Health Care Program for Vermonters

Medicaid Covered Services

Maximus Policy and Procedures Manual

Medicaid Policy Manual

Medicaid Procedures Manual

Office of Vermont Health Access Brochures:

Answers to Your Questions About Managed Care

Health Care Programs Handbook

VHAP: To Help Pay for Your Medical Care

VHAP Pharmacy and VScript: Programs to Help Pay for Prescription Drugs

Vermont Health Access Plan (VHAP) Policy Manual

VHAP Operational Protocol

Vermont State Employee Dental Assistance Plan

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

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

1.1. ☒ Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (Section 2103); **OR**

1.2 ☐ Providing expanded benefits under the State ' s Medicaid plan (Title XIX); **OR**

1.3 ☐ A combination of both of the above.

Section 2. General Background and Description of State Approach to Child Health Coverage (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

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

See Appendix 2.

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: **(Section 2102)(a)(2)**

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

See Appendix 2.

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

See Appendix 2.

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

(Section 2102)(a)(3)

See Appendix 2.

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

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

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children: **(Section 2102)(a)(4)**

Vermont proposes to use the same methods of delivery as are used under its Medicaid plan.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children: **(Section 2102)(a)(4)**

Vermont proposes to use the same utilization controls as are used under its Medicaid plan.

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

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

A summary of eligibility standards is provided in Appendix 4. In general, existing Vermont methodologies for establishing Medicaid/Dr. Dynasaur/VHAP eligibility and enrolling recipients in managed care will apply to Title XXI. Related Medicaid, Dr. Dynasaur, and VHAP policy and procedures and the procedures and protocols of our benefits counseling and enrollment contractor, Maximus, are available upon request.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102)(b)(1)(A))

4.1.1. ☐ Geographic area served by the Plan:_____

4.1.2 ☒ Age:_____

4.1.3 ☒ Income:_____

4.1.4 ☐ Resources (including any standards relating to spend downs and disposition of resources):_____

4.1.5. ☒ Residency:_____

4.1.6. ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility):_____

4.1.7. ☒ Access to or coverage under other health coverage:_____

4.1.8. ☐ Duration of eligibility:_____

4.1.9. ☐ Other standards (identify and describe):_____

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: **(Section 2102)(b)(1)(B))**

4.2.1. ☒ These standards do not discriminate on the basis of diagnosis.

4.2.2. ☒ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.

4.2.3. ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment. **(Section 2102)(b)(2))**

4.4. Describe the procedures that assure:

4.4.1. Through intake and followup screening, that only targeted low-income children who are ineligible for either Medicaid or other creditable coverage are furnished child health assistance under the state child health plan. **(Section 2102)(b)(3)(A))**

4.4.2. That children found through the screening to be eligible for medical assistance under the state Medicaid plan under Title XIX are enrolled for such assistance under such plan. **(Section 2102)(b)(3)(B))**

4.4.3. That the insurance provided under the state child health plan does not substitute for coverage under group health plans. **(Section 2102)(b)(3)(C))**

4.4.4. The provision of child health assistance to targeted low-income children in the state who are Indians (as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c). **(Section 2102)(b)(3)(D))**

4.4.5. Coordination with other public and private programs providing creditable

coverage for low-income children. **(Section 2102)(b)(3)(E))**

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

Describe the procedures used by the state to accomplish:

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

See Appendix 5.

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

See Appendix 5.

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

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

6.1. The state elects to provide the following forms of coverage to children:
(Check all that apply.)

6.1.1. ☐ Benchmark coverage; (Section 2103(a)(1))

6.1.1.1.☐ FEHBP-equivalent coverage; (Section 2103(b)(1))
(If checked, attach copy of the plan.)

6.1.1.2.☐ State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)

6.1.1.3.☐ HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)

6.1.2. ☐ Benchmark-equivalent coverage; (Section 2103(a)(2)) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach signed actuarial report that meets the requirements specified in Section 2103(c)(4). **See instructions.**

6.1.3. ☐ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3)) [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If Aexisting comprehensive state-based coverage@ is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of

8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for Aexisting comprehensive state-based coverage.

6.1.4. ☐ Secretary-Approved Coverage. **(Section 2103(a)(4))**

6.2. The state elects to provide the following forms of coverage to children:

(Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) **(Section 2110(a))**

Vermont proposes to provide the same amount, duration and scope of services to children as are provided under its Medicaid plan. See Appendix 6.

6.2.1. ☒ Inpatient services **(Section 2110(a)(1))**

6.2.2. ☒ Outpatient services **(Section 2110(a)(2))**

6.2.3. ☒ Physician services **(Section 2110(a)(3))**

6.2.4. ☒ Surgical services **(Section 2110(a)(4))**

6.2.5. ☒ Clinic services (including health center services) and other ambulatory health care services. **(Section 2110(a)(5))**

6.2.6. ☒ Prescription drugs **(Section 2110(a)(6))**

6.2.7. ☒ Over-the-counter medications **(Section 2110(a)(7))**

6.2.8. ☒ Laboratory and radiological services **(Section 2110(a)(8))**

6.2.9. ☒ Prenatal care and prepregnancy family services and supplies **(Section 2110(a)(9))**

6.2.10. ☒ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services **(Section 2110(a)(10))**

6.2.11. ☒ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services **(Section 2110(a)(11)**

6.2.12. ☒ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) **(Section 2110(a)(12))**

6.2.13. ☒ Disposable medical supplies **(Section 2110(a)(13))**

6.2.14. ☒ Home and community-based health care services (See instructions) **(Section 2110(a)(14))**

6.2.15. ☒ Nursing care services (See instructions) **(Section 2110(a)(15))**

6.2.16. ☒ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest **(Section 2110(a)(16)**

6.2.17. ☒ Dental services **(Section 2110(a)(17))**

6.2.18. ☒ Inpatient substance abuse treatment services and residential substance abuse treatment services **(Section 2110(a)(18))**

6.2.19. ☒ Outpatient substance abuse treatment services **(Section 2110(a)(19))**

6.2.20. ☒ Case management services **(Section 2110(a)(20))**

6.2.21. ☒ Care coordination services **(Section 2110(a)(21))**

6.2.22. ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders **(Section 2110(a)(22))**

6.2.23. ☒ Hospice care **(Section 2110(a)(23))**

6.2.24. ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) **(Section 2110(a)(24))**

6.2.25. ☒ Premiums for private health care insurance coverage **(Section 2110(a)(25))**

6.2.26. ☒ Medical transportation **(Section 2110(a)(26))**

6.2.27. ☒ Enabling services (such as transportation, translation, and outreach services (See instructions) **(Section 2110(a)(27))**

6.2.28. ☒ Any other health care services or items specified by the Secretary and not included under this section **(Section 2110(a)(28))**

6.3. **Waivers - Additional Purchase Options.** If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate waiver. Review and approval of the waiver application(s) will be distinct from the state plan approval process. To be approved,

the state must address the following: **(Section 2105(c)(2) and(3))**

6.3.1. ☐ **Cost Effective Alternatives.** Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following:

6.3.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; **Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28.** **(Section 2105(c)(2)(B)(i))**

6.3.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; and **Describe the cost of such coverage on an average per child basis.** **(Section 2105(c)(2)(B)(ii))**

6.3.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923 of the Social Security Act. **Describe the community based delivery system.** **(Section 2105(c)(2)(B)(iii))**

6.3.2. ☐ **Purchase of Family Coverage.** Describe the plan to provide family

coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: **(Section 2105(c)(3))**

6.3.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.)** **(Section 2105(c)(3)(A))**

6.3.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. **(Section 2105(c)(3)(B))**

Section 7. Quality and Appropriateness of Care

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

Vermont proposes to use the same methods used to assure the quality and appropriateness of care and to assure access to covered services as are used under its Medicaid plan.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. **(2102(a)(7)(A))**

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

7.1.1. ☒ Quality standards
7.1.2. ☒ Performance measurement
7.1.3. ☐ Information strategies
7.1.4. ☐ Quality improvement strategies

7.2. Describe the methods used, including monitoring, to assure access to covered services, including emergency services. **(2102(a)(7)(B))**

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

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

See Appendix 8 for a summary of cost sharing and payment aspects.

8.1. Is cost-sharing imposed on any of the children covered under the plan?

8.1.1. ☒ YES

8.1.2. ☐ NO, **skip to question 8.5.**

8.2. Describe the amount of cost-sharing and any sliding scale based on income: **(Section 2103(e)(1)(A))**

8.2.1. Premiums: *Effective 10/1/98 - $10 per month per household. When administratively possible - $20 per month per household_*

8.2.2. Deductibles_____

8.2.3. Coinsurance:_____

8.2.4. Other: *Copayments: $10 per office visit for physician and other professional providers.*

8.3. Describe how the public will be notified of this cost-sharing and any differences based on income:

8.4. The state assures that it has made the following findings with respect to the cost sharing and payment aspects of its plan: **(Section 2103(e))**

8.4.1. ☒ Cost-sharing does not favor children from higher income families

over lower income families. **(Section 2103(e)(1)(B))**

8.4.2. ☒ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. **(Section 2103(e)(2))**

8.4.3. ☒ No child in a family with income less than 150% of the Federal Poverty Level will incur cost-sharing that is not permitted under 1916(b)(1).

8.4.4. ☒ No Federal funds will be used toward state matching requirements. **(Section 2105(c)(4))**

8.4.5. ☒ No premiums or cost-sharing will be used toward state matching requirements. **(Section 2105(c)(5)**

8.4.6. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. **(Section 2105(c)(6)(A))**

8.4.7. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. **(Section 2105(d)(1))**

8.4.8. ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. **(Section 2105)(c)(7)(B))**

8.4.9. ☒ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). **(Section 2105)(c)(7)(A))**

8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's annual income for the year involved: **(Section 2103(e)(3)(B))**

8.6. The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan:

8.6.1. ☒ The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services **(Section 2102(b)(1)(B)(ii))**; **OR**

8.6.2. ☐ The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.3.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA **(Section 2109(a)(1),(2))**. Please describe:

_____

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

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: **(Section 2107(a)(2))**

See Appendix 9.

9.2. Specify one or more performance goals for each strategic objective identified: **(Section 2107(a)(3))**

See Appendix 9.

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

See Appendix 9.

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

9.3.1. ☒ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.

9.3.2. ☒ The reduction in the percentage of uninsured children.

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

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

9.3.5. ☐ HEDIS Measurement Set relevant to children and adolescents younger than 19.

9.3.6. ☐ Other child appropriate measurement set. List or describe the set used.

9.3.7. ☐ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:

9.3.7.1.	☐	Immunizations
9.3.7.2.	☐	Well child care
9.3.7.3.	☐	Adolescent well visits
9.3.7.4.	☐	Satisfaction with care
9.3.7.5.	☐	Mental health
9.3.7.6.	☐	Dental care
9.3.7.7.	☒	Other, please list:

Minimum Data Set as approved for VHAP 1115 Demonstration Waiver Program

9.3.8. ☐ Performance measures for special targeted populations.

9.4. ☒ The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. **(Section 2107(b)(1))**

9.5. ☒ The state assures it will comply with the annual assessment and evaluation required under Section 10.1. and 10.2. (See Section 10) Briefly describe the state ' s plan for these annual assessments and reports. **(Section 2107(b)(2))**

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

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

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

9.8.1. ☒ Section 1902(a)(4)(C) (relating to conflict of interest standards)

9.8.2. ☒ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)

9.8.3. ☒ Section 1903(w) (relating to limitations on provider donations and taxes)

9.8.4. ☒ Section 1115 (relating to waiver authority)

9.8.5. ☒ Section 1116 (relating to administrative and judicial review), but only insofar as consistent with Title XXI

9.8.6. ☒ Section 1124 (relating to disclosure of ownership and related information)

9.8.7. ☒ Section 1126 (relating to disclosure of information about certain convicted individuals)

9.8.8. ☒ Section 1128A (relating to civil monetary penalties)

9.8.9. ☒ Section 1128B(d) (relating to criminal penalties for certain additional charges)

9.8.10. ☒ Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. **(Section 2107(c))**

See Appendix 9.

9.10. Provide a budget for this program. Include details on the planned use of funds and

sources of the non-Federal share of plan expenditures. **(Section 2107(d))**

See projected budget within "Overview – State Children's Health Program (SCHIP)" section of this document.

Section 10. Annual Reports and Evaluations (Section 2108)

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

10.1.1. The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.1.2. Report to the Secretary, January 1 following the end of the fiscal year, on the result of the assessment.

The State assures that it will meet all Title XXI reporting requirements. The State has and will continue to use the chart suggested to allow comparisons to be made between states and on a nationwide basis. Vermont's baseline submittal is found at Appendix 2 of the application and represents data obtained from its Medicaid Management Information System (MMIS) and a survey performed by the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) in December 1997. See Appendix 10.

Below is a chart listing the types of information that the state's annual report might include. Submission of such information will allow comparisons to be made between states and on a nationwide basis.

State of Vermont
Title XXI Application
State Children's Health Insurance Program
October 1998

Attributes of Population	Number of Children with Creditable Coverage XIX OTHER SCHIP	Number of Children without Creditable Coverage	**TOTAL**
Income Level:			
< 100%			
≤ 133%			
≤ 185%			
≤ 200%			
> 200%			
Age			
0 – 1			
1 – 5			
6 – 12			
13 – 18			
Race and Ethnicity			
American Indian or Alaskan Native			
Asian or Pacific Islander			
Black, not of Hispanic origin			
Hispanic			
White, not of Hispanic origin			
Location			
MSA			
Non-MSA			

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

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

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

10.2.2.1. ☒ The characteristics of the children and families assisted under the state plan including age of the children, family income, and the assisted child's access to or coverage by other health insurance prior to the state plan and after eligibility for the state plan ends;

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

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

10.2.2.4. ☒ The service area of the state plan;

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

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

10.2.2.7. ☒ The sources of non-Federal funding used in the state plan.

10.2.3. ☒ An assessment of the effectiveness of other public and private programs in the state in increasing the availability of affordable quality individual and family health insurance for children.

10.2.4. ☒ A review and assessment of state activities to coordinate the plan under this Title with other public and private programs providing health care and health care financing, including Medicaid and

maternal and child health services.

10.2.5. ☒ An analysis of changes and trends in the state that affect the provision of accessible, affordable, quality health insurance and health care to children.

10.2.6. ☒ A description of any plans the state has for improving the availability of health insurance and health care for children.

10.2.7. ☒ Recommendations for improving the program under this Title.

10.2.8. ☒ Any other matters the state and the Secretary consider appropriate.

10.3. ☒ The state assures it will comply with future reporting requirements as they are developed.

10.4. ☒ The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

Appendix 2 General Background and Description of State Child Health Coverage

Current Child Health Coverage

Attributes of Population	Number of Children with Creditable Coverage Title XIX	Number of Children Without Creditable Coverage	**TOTAL**
Income Level:			
< 100%	23,997	766	24,763
≤ 133%	5,371	360	5,731
≤ 185%	1,815	2,081	3,896
≤ 200%	12,023	320	12,343
> 200%; ≤ 300%	6,161	2,520	8,681
Age:			
0 – 1	2,930	0	2,930
1 – 5	14,825	1,286	16,111
6 – 12	21,106	2,457	23,558
13 – 17	11,506	2,303	13,809
Race and Ethnicity:			
American Indian or Alaskan Native	59	17	76
Asian or Pacific Islander	174	43	217
Black, not of Hispanic origin	323	24	347
Hispanic	88	78	166
White, not of Hispanic origin	48,723	5,885	54,608
Location:			
MSA	7,752	1,078	8,830
Non-MSA	41,615	4,969	46,584

Sources: State of Vermont MMIS and Health Insurance Survey. Differences due to rounding.

2.2.: Public Health Insurance Programs

Vermont has made extensive efforts to ensure access to health care services for its children. Children (up to age 18) in families with income up to 225 percent of the Federal Poverty Level are eligible for enrollment in Dr. Dynasaur, a Medicaid 1902 (r) (2) expansion program, which covers the full range of Medicaid health care benefits. In September, 1998, 16,000 children were enrolled in Dr. Dynasaur, which has been operating in Vermont since 1989 as a state funded program, and since 1992 as a Medicaid expansion program.

2.2.1.: Identification and Enrollment

Efforts to identify and continue to enroll children in Dr. Dynasaur have been ongoing since the program's inception. The Department of Social Welfare through its district offices and the Department of Health through WIC clinics, local school health nurses, its local offices, and free health clinics located in the larger population centers do continuous outreach to potentially eligible families and children. The State covers 49,000 children through Medicaid/Dr. Dynasaur, approximately 34% of all children under age 18.

Since the implementation of the Vermont Health Access Plan (VHAP) in 1995, the State's outreach activities have been enhanced by the addition of a contracted benefit-counseling firm. The firm's efforts have included:

- A multi-media campaign, including print, brochures, and flyers, targeting individuals eligible for enrollment in VHAP, the State's program for the uninsured, under which services are provided through managed care plans. This has had the related "case-finding" effect of encouraging participation of children eligible for coverage under the Dr. Dynasaur program. Children covered by Dr. Dynasaur are also enrolled in managed care, unless they have private health insurance for hospital and physician coverage. The efforts of the benefit-counseling organization have been supplemented by press stories and television and radio interviews with State officials about the State's efforts to provide health insurance coverage to eligible populations;

- Outreach through community groups and organizations;

- Educational sessions in community locations, including Department of Social Welfare district offices, for individuals eligible for enrollment; and

- Operating a toll-free telephone line, individuals can contact to learn about the program.

2.2.2.: Public-Private Health Insurance Programs

VHAP is a public-private partnership to the extent that the State contracts with private sector managed care plans to provide services to some eligible individuals. The current coverage of children through managed care is described in Section 2.2.1. There are no other large-scale public-private programs in the State that provide health insurance coverage to low income children.

2.3.: Coordination of Titles XIX and XXI

The State intends to fully integrate the Children's Health Insurance Program (SCHIP) with the current Medicaid Program, which includes the VHAP program for the uninsured covered as a result of the VHAP 1115 Research and Demonstration program. The State intends to use the same covered services benefit package and service delivery systems for SCHIP as are used for Medicaid, Dr. Dynasaur, and VHAP with the exception of dental services. Initially, the dental component of this program will be provided through the State's fee for service delivery system. In the future, the State plans to explore a self-funded, commercially administered dental plan that will be selected through a competitive bidding process.

Outreach and enrollment efforts will be conducted by the Department of Social Welfare and the State's contracted benefits-counseling firm. In addition, special outreach efforts through the Department of Health and school health nurses will be made to inform potentially eligible families of the availability of coverage through SCHIP. Materials used for outreach and enrollment purposes will be developed or modified to incorporate information regarding the newly eligible populations.

Actual determination of eligibility for all populations, including those newly eligible, will be the responsibility of the Department of Social Welfare, as it is today. General eligibility policy found in the Medicaid and VHAP Policy Manuals will be used with modifications as necessary for SCHIP. Existing application forms and other materials used to determine eligibility will be modified as necessary to include the new population. In addition, the

Department's automated eligibility system, ACCESS, will be modified to identify the newly eligible.

Appendix 4 Eligibility Standards and Methodology

4.1. and 4.2.: Eligibility Standards

Currently, uninsured children (up to age 18) up to 225% of poverty are eligible for Medicaid benefits under the Dr. Dynasaur program. In conjunction with the SCHIP initiative, Vermont proposes a State SCHIP program to expand eligibility to 300% of the Federal Poverty Level (FPL) and to define the children covered from 225% of the FPL as an optional group of targeted low income children. SCHIP eligibles will be entitled to the full range of health services covered under the State's Medicaid plan. Vermont estimates that 1,100 children will become eligible.

To be eligible, children must meet the following specific requirements (as well as all the general types of eligibility requirements used for Medicaid/Dr. Dynasaur):

Age: the child must be under age 18.

Income: the child must reside in a household with income up to 300% of the FPL.

Resources: current Medicaid standards will be used, no resource test applies.

Uninsured: the child must not have or qualify for Medicare or other creditable insurance coverage and must not have dropped such coverage without good cause in the month prior to the date of eligibility.

4.3.: Methodology for Determining Eligibility

The Department of Social Welfare is responsible for determining eligibility for all medical assistance programs, including eligibility made possible by Medicaid, Dr. Dynasaur, and VHAP. The Department will also be responsible for determining eligibility for SCHIP. The process for determining eligibility is essentially the same, requiring an application and evaluation of program requirements. Applications for medical assistance are processed at the centrally located Health Access Eligibility Unit in Waterbury or in the district eligibility offices. With this application process, the State can ensure that applications are processed using appropriate program standards and that eligibles can be identified by program and fully integrated into the existing service delivery mechanisms. Individuals under the SCHIP expansion will be given unique eligibility codes which will allow access to SCHIP services,

assure appropriate payments to providers or contracted health plans, and facilitate expenditure tracking under the State's MMIS system.

4.4.: Availability of Creditable Coverage

The rules for eligibility are found in the Medicaid Policy Manual. This SCHIP program will not alter the financial eligibility determination procedures but will increase the income eligibility test to 300% of the FPL. Children in families found to meet the lower income tests for Dr. Dynasaur or Medicaid will be eligible for enrollment under those programs, as opposed to SCHIP.

Vermont intends to monitor to assure that SCHIP does not substitute for coverage under group health plans; that is, that "crowd-out" does not occur. It has always been the State's philosophy that applicants and eligibles be encouraged to obtain and retain any insurance coverage they can to minimize program expenditures and assure that insurance continues to be available should eligibility end.

The State plans to pursue eligibility coverage under its Waiver for the insured. Providing coverage for deductibles, coinsurance, and copayments as well as benefits not available or exhausted diminishes the possibility of low-income families dropping existing coverage in order to participate in Medicaid, Dr. Dynasaur, or SCHIP. Vermont currently offers Dr. Dynasaur to both uninsured and insured children. Approximately 40 percent of children enrolled in Dr. Dynasaur also have private coverage. Of this group, less than 9 percent lose or drop private coverage after six months of Dr. Dynasaur enrollment. This experience is not unique. Evidence from Minnesota, as reported in the *New England Journal of Medicine* (October 8, 1997), indicates that only 7.1 percent of the population covered by MinnesotaCare have given up insurance prior to enrollment in the program.

Vermont's eligibility application will include a request for information regarding other insurance for each individual. Information captured will include enrollment, coverage type(s), and current and past availability of insurance coverage. This information will be used in the eligibility process. Applicants with creditable coverage will not be eligible for Title XXI coverage. In addition, those who had such insurance within one month of the date of determination will not be eligible unless the insurance is lost during this period because of :

- loss of employment, or

- death or divorce, or
- loss of eligibility for coverage as a dependent under a policy held by a parent(s).

Eligibility staff will note if applicants report that employers have dropped insurance coverage so that their employees must rely on public programs for coverage.

Eligibles will be required to have their eligibility reviewed at least annually. At that time their insurance status will be reviewed as well.

The Department of Social Welfare had contacted the Vermont Banking, Insurance, Securities and Health Care Administration (BISHCA) to determine our authority to use tape matches to determine if employer coverage is in place but was not reported or became available after eligibility determination. We have no specific authority and the two largest insurers, BlueCross BlueShield of Vermont and Kaiser Permanente, are reluctant to do tape matches. They are more concerned that they would be responsible for additional coverage for their current beneficiaries who are simultaneously eligible for Vermont's publicly funded health insurance programs.

In the event that actual SCHIP enrollment appears to exceed anticipated enrollment, Vermont will plan to survey eligibles to determine the cause.

Appendix 5 Outreach and Coordination

5.1.: Outreach to New Eligibles

As described in Appendix 2, the State will coordinate SCHIP outreach efforts with the existing outreach and enrollment activities performed by the Department of Social Welfare and the Department of Health. Some outreach activities will be a responsibility of the State ' s contracted benefits counseling firm. Specific activities related to the newly eligible populations include but are not limited to the following:

Modification of current outreach and enrollment materials to include information for newly eligible populations.

Development of outreach materials (flyers, brochures) to be distributed through public schools.

Conducting/participating in education and training sessions on the new eligibility standards and current procedures for application with organizations that serve the target populations, such as public schools, community-based service organizations, hospitals, FQHCs and RHCs, etc.

Continuation of current media campaign strategies, including radio and print advertising.

Continued presence of benefit counseling staff at Department of Social Welfare offices, free health clinics, and other community settings.

Ongoing operations of the toll-free information line.

Activities of the Department of Health to identify eligible children through WIC clinics, local school health nurses, and local offices of the Department. A particular focus will be through the local schools and special education staff at both the State and local level.

5.2.: Coordination with Other Public/Private Health Insurance

As described in Appendix 2, the State intends to integrate the Children's Health Insurance

Program with the health plans providing services under the Vermont Health Access Plan. Currently, Vermont's two largest private health insurance carriers contract with the State to provide managed care services under the Vermont Health Access Plan (VHAP) program: BlueCross BlueShield of Vermont and Kaiser Permanente. Most providers in Vermont are participating in one or both of these health plans. Thus, SCHIP eligible uninsured children are not only integrated into the State's current public health insurance programs, but are integrated into Amainstream@ health plans.

Appendix 6 Coverage Requirements

6.2.: Covered Benefits

All SCHIP eligible children will have available the full range of services covered by Medicaid. The majority of services will be provided through one of the contracted managed care organizations; the balance will be covered using the fee-for-service delivery system.

The following list provides a brief summary of covered services. Limits and exclusions may apply. A more detailed description of services is available in the Medicaid Policy Manual. Services provided by managed care organizations are described in the VHAP Operational Protocol.

Core Services

Inpatient hospital care
Outpatient services in a general hospital or ambulatory surgical center
Physician services
Oral surgery
Cornea, kidney, heart, heart-lung, liver and bone marrow transplants, including expenses related to providing the organ or doing a donor search
One comprehensive vision examination in a 24-month period
Home health care
Hospice services by a Medicare-certified hospice provider
Outpatient therapy services (home infusion therapies and occupational, physical, speech and nutrition therapy)
Prenatal and maternity care
Ambulance services
Short-term inpatient rehabilitation services
Medical equipment and supplies
Skilled nursing facility services for up to 30 days length of stay per episode
Mental health and chemical dependency services
Podiatry services
Prescription drugs and over-the-counter drugs prescribed by a physician for a specific disease or medical condition

Out of Plan Supplemental Services for Uninsured Children (up to 300% of the FPL)

Dental
Family Planning
Eyeglasses
Chiropractic Services (for individuals 12 years of age and older, and under twelve with prior authorization)
Non-emergency transportation services
Nursing home care
Other long term care services

Appendix 8 Cost Sharing and Payment

8.2.: Cost Sharing

Nominal cost sharing will be required for SCHIP eligible populations just as it is currently required under the Dr. Dynasaur and Vermont Health Access Plan (VHAP) programs. The State believes that the incomes of these families is sufficient to allow them to pay out-of-pocket for many covered services, so that the added coverage will represent a substantial benefit despite the requirement for supplemental payments. The State further believes that it can reasonably assure that the cost sharing does not favor children from higher income families over lower income families and that costs will not exceed five percent (5%) of any family's income in a given year. Specific cost sharing requirements are as follows:

There are no deductibles or coinsurance for covered services. The following premiums will apply:

Families up to 185% of the FPL (Medicaid):
No share of cost as Medicaid eligible.

Families above 185%, up to 225% of the FPL (Dr. Dynasaur):
$10 per month per household (as approved by HCFA and currently charged).

Families above 225%, up to 300% of the FPL (SCHIP):
$10 per month per household effective 10/1/98.
$20 per month per household when administratively possible.

Copayments: Copayments only apply to families above 225%, up to 300% of the FPL. Selected providers, identified as those who bill using the HCFA 1500 billing form (physicians, podiatrists, optometrists, psychologists, audiologists, chiropractors, and nurse practitioners), will be allowed to charge a $10.00 copayment per office visit when in managed care. There will be no cost-sharing requirements for well-baby, well-child visits including age appropriate immunizations or for diagnostic and preventive dental services.

Non-covered services and services that are not medically necessary do not count toward the family out-of-pocket limit.

8.3.: Public Notification

Premium payments are related to current Dr. Dynasaur payments but will be increased to reflect the higher income of the SCHIP families. Notification has been provided under the same public notification requirements used for public policy promulgated under Vermont's Administrative Procedures Act. Information on the specific cost sharing amounts will be included in outreach activities, as described in Appendix 5. Additionally, the State will continue to use the committees established for the VHAP/Medicaid program as sources of feedback and input on this initiative. For more information on these committees see Appendix 9.

8.5.: Annual Aggregate Cost Sharing

Vermont proposes to establish a single annual maximum for all households with incomes 225% to 300% of the Federal Poverty Level (FPL). Generally this maximum will be an amount that does not exceed 5% of the 225% FPL for a household of two. This assumes that at least one child must be in the household to qualify for Title XXI and that selecting the 225% FPL income level to set the maximum assures that no household in the income bracket will exceed the 5% mark.

The maximum is then adjusted to reflect the annual premium cost and the remaining amount is apportioned between medical and dental services. This accommodates the fact that medical services will be tracked in the managed care delivery system and dental services will be tracked in the fee for service delivery system.

Effective July 1, 1999, the maximum after premiums is $950 per calendar year based on the 225% FPL for a household of two in 1998 of $24,413. The medical/dental apportionment is $650/$300.

Appendix 9 Strategic Objectives and Performance Goals

9.3. through 9.8.: Objectives and Goals

This initiative will build upon the objectives of the Vermont Health Access Plan (VHAP) 1115 Waiver Demonstration Project, which are summarized as follows:

To improve access to health care services for low income Vermonters by offering affordable health insurance.

To improve access, service coordination, and quality of care for the beneficiaries of the program.

To provide prescription drug benefits to lower income disabled or elderly Vermonters on Medicare.

To maintain the long-term fiscal viability of the program.

Under the SCHIP initiative, the State anticipates enrolling an additional 1,100 uninsured children. Additionally, the State will build upon current efforts aimed at improving access and assuring the coordination and quality of care.

The State will evaluate the SCHIP initiative as part of the overall evaluation of the VHAP 1115 Waiver Demonstration Project.

9.9.: Public Notification and Involvement

The Primary Care Advisory Committee of the Department of Health discussed the plan at one of its meetings. The design of this program has been routinely discussed to the Legislative Oversight Committee, which was established to oversee the implementation of the VHAP program. In addition, the Medicaid Advisory Board has had the opportunity to discuss the SCHIP proposal on numerous occasions throughout 1998. The State policy has been reviewed by the public and presented and approved by the Vermont Administrative Rules Committee.

Separately, the State has relied on the above and a third work group to provide feedback and input on this initiative. Specifically:

Quality Improvement Advisory Committee: This committee, which includes consumers, advocates, health plan representatives, provider representatives, and State staff, has formed work groups to address specific issues such as children with special health needs, prenatal care and birth outcomes, data collection activities, and primary and behavioral care integration.

Medicaid Advisory Board: The Board, comprised of beneficiaries, providers, advocates and State staff, meets monthly to address all aspects of the Medicaid program.

Legislative Oversight Committee: This committee includes members from both houses of the Vermont Legislature, and is directed to oversee and monitor the VHAP program with respect to compliance with legislative mandates, program expenditures, and overall administration.

Administrative Rules Committee: This committee includes appointed members from both houses of the Vermont Legislature charged with reviewing all policies promulgated by the State.

Appendix 10 Annual Reports and Evaluations

10.2.: State Evaluations

Vermont plans to administer Title XXI along with other publicly funded health insurance programs through the Agency of Human Services, Department of Social Welfare, Office of Vermont Health Access (OVHA). OVHA collaborates with the Vermont Department of Health on maternal and child health services for all eligible children through a formalized memorandum of understanding.

The State plans to enroll eligibles in managed care and offer the same benefit package to all eligible children as is available to children covered under Medicaid/Dr. Dynasaur. It will be available on a statewide basis with no time limits. State funding will be provided through the Vermont General Fund in the same manner as Medicaid/Dr. Dynasaur.

The State intends to provide all the information necessary for the evaluation of SCHIP. Information will be used in comparison to the baseline information found in Appendix 2. The Department's eligibility determination system, ACCESS, and the MMIS will be used to determine enrollments and expenditures. This includes such factors as age and income with income identified based on eligibility category codes that are assigned at eligibility based on reported income; geographic information, including district office, county, and/or town; and eligibility segments.

Access to or coverage by other insurance information will be gathered on eligibility applications at the time of initial eligibility and as part of periodic reviews. Information will include enrollment status and coverage type(s). In the event that actual SCHIP enrollment appears to exceed anticipated enrollment, the Department will plan to survey eligibles to determine the cause.

The State will rely on theVermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) in its oversight and licensing roles for information about private insurance and the insurance status of all Vermonters. Periodic surveys have and will continue to assess private coverage, including coverage before and after SCHIP eligibility.

Quality of care for SCHIP eligibles will be assessed using 1115 Waiver quality monitoring and improvement activities and amount and level of assistance will be

identified using the MMIS and the State's Decision Support System.

The State is confident that the methodologies, systems, and relationships described here will be sufficient for required Title XXI evaluations.

MASSACHUSETTS TITLE XXI PLAN SUMMARY

Background

On January 15, 1998, Massachusetts submitted a Title XXI State Plan to expand children's access to health coverage by expanding Medicaid eligibility to children in families with incomes up to 150 percent of the Federal poverty level (FPL) and by creating a separate state health insurance program, the Family Assistance Plan, for children in families with incomes between 150 percent and 200 percent of the FPL. The Family Assistance Plan includes direct coverage and financial assistance to enable families to participate in employer-sponsored health insurance (ESI). The State implemented a streamlined eligibility process, which includes a gross income test, and an eligibility expansion to 133 percent of the FPL through a Section 1115 demonstration on July 1, 1997.

The State intends to implement their children's health insurance program during July 1998, and has requested access to their allotment beginning on October 1, 1997.

Administration

The plan will be administered by the Single-State Agency.

Individuals Covered Under Program

Massachusetts expects to cover an additional 37,100 children under their CHIP plan by the end of FY 1999.

In addition, the State expects to provide assistance to 6,000 adults through the employer-sponsored health insurance portion of the Family Assistance Plan.

Health Care Delivery System

Health care services will be provided to the Medicaid expansion eligibles and to eligibles of the direct coverage option of the Family Assistance Plan through the existing Medicaid managed care delivery network, which consists of Primary Care Case Management, Health Maintenance Organizations and a mental health and substance abuse managed care contract.

Participants in the Premium Assistance Option will obtain services through contractual arrangements of the ESI.

Benefit Package and Cost Sharing

Children eligible for Medicaid will receive the State's regular Medicaid benefit package and have full protection from cost-sharing.

Children in families with incomes between 150 percent and 200 percent of the FPL will be eligible for either a direct coverage option or financial assistance for ESI coverage, which is the premium assistance option. The direct coverage option will provide FEHBP-equivalent benchmark coverage These children will not be assessed co-payments, but there will be a monthly premium of $10 per child to maximum of $30 per family.

Under the Premium Assistance Option, service delivery and access will be limited to the contractual arrangements of the qualifying health plans of families with access to employer sponsored insurance plans. The ESI plans will have to meet a Title XXI benchmark benefit level. Children in families with access to cost-effective ESI family coverage will have to utilize ESI. Premiums will be up to $10 per child per month to a maximum of up to $30 per month. There is no cost sharing for well baby and well child services, nor will there be cost sharing in excess of the 5 percent of income statutory limit.

State Action to Avoid Crowd-out and Outreach Activities

Proposed outreach includes school-based campaigns, community-wide enrollment campaigns, creation and distribution of promotional materials, and funding community-based organizations through mini-grants to assist in enrollment of hard to reach individuals. There will be coordination and activity initiation with other state agencies and collaboration with primary care providers.

This program builds upon their current Medicaid demonstration which includes provisions to preserve and enhance

ESI coverage. The Title XXI plan would continue support for private coverage.

- Families that are currently insured with existing ESI coverage will be able to obtain premium assistance through the existing Medicaid 1115 demonstration at the regular rate of Federal match.
- If a family has access to employer sponsored insurance but is currently not enrolled, and family coverage is determined to be cost-effective, then financial assistance would be available through the Title XXI plan to enable these families to obtain ESI.
- The State will be monitoring the enrollment practices relating to ESI and the direct coverage option. The State will also be studying statewide trends in ESI access and employee participation in ESI. If it is determined that crowd out is occurring the State will implement a 3-month period of no insurance coverage or HCFA and the State will collaborate on an alternative corrective action.

Financial Information
Total CHIP Reserved Allotment -- $42,847,242
Enhanced Federal Matching Rate -- 65%
First Year Costs: (FFY 1998)
State Share -- $6.7 million
Federal Share -- $12.5 million
Total -- $19.2 million
May 29, 1998


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