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CHIP State Review Schedule

STATE	REVIEW DATE
Alabama	4/3/99 - 4/5/99
Alaska	after 10/1/99
American Samoa	
Arizona	5/12/99 - 5/14/99
Arkansas	
California	7/7/99 - 7/9/99
Colorado	
Connecticut	
Delaware	Mar-99
District of Columbia	Nov-99
Florida	7/12/99 - 7/14/99
Georgia	Sep-99
Guam	
Hawaii	not yet implemented
Idaho	Sep-99
Illinois	
Indiana	
Iowa	Sep-99
Kansas	after 10/1/99
Kentucky	8/30/99 - 9/1/99
Louisiana	12/6/99 - 12/8/99
Maine	
Maryland	Oct-99
Massachusetts	
Michigan	
Minnesota	
Mississippi	
Missouri	after 10/1/99
Montana	
N. Mariana Islands	
Nebraska	8/5/99 - 8/6/99
Nevada	4/12/99 - 4/14/99
New Hampshire	
New Jersey	
New Mexico	4/11/99 - 4/15/99
New York	
North Carolina	Sep-99
North Dakota	
Ohio	
Oklahoma	
Oregon	after 10/1/99
Pennsylvania	9/27/99
Puerto Rico	
Rhode Island	
South Carolina	
South Dakota	
Tennessee	not yet approved
Texas	11/8/99 - 11/10/99
Utah	
Vermont	
Virgin Islands	
Virginia	Dec-99
West Virginia	Apr-99

**States that do not yet have an identified review date have been bolded.

CHIP STATE REVIEW GUIDE AND ATTACHMENTS

DRAFT DOCUMENT
7/12/99

Overview of State Children's Health Insurance Program (CHIP) Review Documents

need # on purpose of state reviews

A process has been established for formal State reviews of CHIP, and is outlined in the attached guide. State programs are dynamic and require coordinated expertise from various relevant program areas, and we recognize a similar need for coordination within the Department to effectively review State programs. A formal agreement has been established between HCFA and HRSA, and HCFA will coordinate HRSA's participation in the review process to assure representation and input from HRSA to all phases of the review process. Therefore, references to Central and Regional Office involvement in the review process will include collaborative input from HCFA and HRSA. Regions will establish cross-cutting review teams that will also include representation from other relevant agencies (e.g., ACF, OCR, etc.), however, HCFA will retain the authority to make any final determinations that result from the review process. HCFA/HRSA RO and CO review teams will be involved in the following CHIP State review activities:

can we shorten this?

- the review and discussion of written materials, data and information;
- discussions with States;
- site visits, as part of the review process (CO involvement as needed); and
- the identification of States' technical assistance needs, the linkage of States with resources within the State (e.g., other related child health agencies, etc.), region and national level, and the provision of technical assistance.

The review of State CHIP programs is an evolving process, therefore, review teams will congregate after the first round of State reviews to identify the effectiveness of the process outlined in these documents. If necessary, appropriate modifications will be made to current review protocols and process documents. Attached are three documents related to CHIP reviews: 1) a review guide; 2) a core review protocol that includes national core elements and will serve as the basis for each region's review protocol; and 3) a matrix of additional program elements which includes a list of State-specific elements review teams can use to supplement the national core protocol. In order to streamline the review process, minimize duplication and reduce State and Federal burden, review teams may use other Medicaid review processes, by supplementing them with national core and State-specific elements, to review State CHIP programs.

put this last

what does this mean? sounds like they can get away w/o doing a review.

State CHIP Review Guide. The review guide will serve as a set of instructions and guidance to review teams (with RO lead and CO involvement) as they begin the State CHIP review process. This document outlines the goals and outcomes of the CHIP review process; the process by which core and State-specific elements have been identified; and the incorporation of State-specific and CHIP-specific elements into review teams' final separate CHIP or extended Medicaid review protocols for CHIP. The guide also provides an overview of pre-review, review and post-review steps; and HCFA's enforcement strategy addressing issues from program enhancement of and technical assistance for State programs to substantial noncompliance with Federal requirements under title XXI. Review teams are beginning the process of finalizing the development of teams and final protocols. (The CHIP review guide has been included in Attachment A).

Core Review Protocol. The core review protocol (currently in matrix form) identifies nationally relevant elements in order to maintain the consistency necessary to analyze issues across States. Core elements outlined in this core review protocol include elements related to parts of CHIP that are statutorily required or are information included in a State's plan. Also included in the protocol are a list of suggested questions to assist review teams in examining each of the required core element areas. These suggested questions have been broken into two groups: 1) core questions (that are related specifically to the requirements under each of the core elements); and 2) additional questions (that are related to the core questions and may serve as probes to obtain additional information States may have collected). This core includes both national and regional elements and will form the basis for each region's comprehensive review protocol. To allow for innovation and ease, each region may format their own protocol using the required core elements and incorporating State-specific elements, in a manner that will best address each State's program. This is to allow review teams to include areas they may identify as relevant to specific States while also considering issues important to the Congress and the Administration. (The Core Review Protocol has been included in Attachment B).

Matrix of Additional Program Elements. This matrix provides a comprehensive list of additional State-specific program elements within the parameters of the title XXI statute to be included in teams' final protocols, as appropriate. The second column of the matrix provides a list of review questions for each program element. Regional review teams will use this matrix in the development of final protocols for each State. This matrix will allow review teams to tailor protocols to specific States while maintaining consistency across protocols developed within the ten regions' review teams. (The Matrix of Additional Program Elements has been included in Attachment C).

Table 1 provides an overview of the action steps related to the CHIP review process, a brief description of these steps and a proposed timeframe for each step.

Table 1. CHIP Action Steps and Timeframes

Action Steps	Brief Description	Timeline	Status
1) Develop review guide	Guide will provide instructions to regional review teams regarding pre-review, review and post-review processes.	Revised 5/20/99 Final May 1999	√
2) Establish national core protocol	Core protocol includes nationally-relevant elements and will serve as basis for each comprehensive, final regional protocol.	Revised 5/21/99 Final May 1999	√
3) Establish matrix of additional elements	Provides a comprehensive list of additional State-specific program elements within the parameters of the Title XXI	Final May 1999	√

	statute not included in the core protocol.		
4) Develop enforcement strategy	Guide will include an overview of the Department's enforcement strategies to address State needs for program enhancement and technical assistance to noncompliance with Federal CHIP requirements.	April 1999	√
5) Create template for onsite review reports	Workgroup will develop a standard template for use by review teams for reports produced from on-site reviews.	July 1999	
6) Establish review teams	Identify a cross-cutting review team with appropriate agency representation and including staff from HCFA/HRSA CO (e.g., ACF, OCR, etc.).	April-May 1999	√
7) Train review teams	HCFA CO/RO workgroup will train review teams on the review process, objectives and general expectations.	July 1999	√
8) Preparation for review a) Review team determines what constitutes a State's plan b) In addition to the core protocol, the review team must choose relevant State-specific elements to include in protocol for each State's review c) Establish review timeline	 HCFA/HRSA CO, the designated RO team and the State must agree on what is the final content of the State's plan (including original submission and written correspondence). From the comprehensive set of program elements, regions should determine additional State-specific elements to include in the final protocol for each State. State-specific elements should remain within the parameters of the content of a State's plan. Each RO review team should identify the timeline in which they will review each State program and submit reports to the State and Central Office. Regions should provide timeline to Central Office team.	May - June 1999	
9) Initiate review process	Regions will collect State-level information through interviews, site visits, etc.	Comprehensive review one year after implementation of program and every two years thereafter. Focused	

		reviews as needed.	
10) Report submission a) Criteria/template for cross-cutting analysis/reports	a) CO team to establish minimum set of elements to formulate a template for each review team's report of each State review. This report will subsequently be used for the cross-cutting analysis.	a) May 1999	√
b) State-specific reports	b) Regional offices will complete reports subsequent to State reviews and submit to CO team for review of issues identified. When significant issues are identified, review teams should be in immediate contact with CO for discussion of resolution.	b) One month subsequent to review.	
c) Cross-cutting analysis/report on selected CHIP issues	c) CO team to complete a cross-cutting analysis synthesizing important findings of regional reviews.	c) May 2000 (to examine alongside State evaluations due in March 2000)	
11) Establish feedback process and forum to share "best practices"	Regions to share protocols and experience with one another and CO team to identify best practices. In addition, ROs should be prepared to orally debrief with CO team after completion of review process.	After completion of first round of State program reviews.	

ATTACHMENT A

State CHIP Reviews: A Guide for Regional Review Teams

include ₱ on Admin accre: CHIP

Insert (A)

Title XXI has provided States with a substantial amount of flexibility in program design. Some State programs were operating well before the enactment of the Balanced Budget Act of 1997. Other States have chosen to establish programs under Title XXI that are Medicaid expansions, separate State programs or a combination of both. As a result, consideration of State flexibility in program design was important in the development of a program review process. However, there must be consistency across States in key policy areas. This review guide and protocol acknowledge that individual programs must be viewed within the context of both their particular design and phase of program development, yet this effort is intended to assure that all States are being reviewed in a consistent manner. States' title XXI programs are in a process of evolution. Therefore, RO/CO review of CHIP programs must also be structured within a continuous and evolving process to assure our capacity to capture States' program activities at a specific point in time while also acknowledging changing dynamics and ensuring a basic level of implementation within programs.

revise

Goals of the CHIP Review Process put this on 1st page as well

In order to establish our expectations of CHIP on-site reviews, it is important to first identify the specific goals related to this effort. Keeping in mind that this is a continuing and evolving process, four initial goals for CHIP reviews have been identified. They include:

- improving the quality of CHIP activities nationwide; — what does this mean?
- ensuring the quality and effectiveness of CHIP service delivery as outlined in the State's approved CHIP plan; and — what does this mean?
- tracking the collection and submission of requested data related to CHIP programs, including enrollment, expenditure, program data, etc., and other efforts related to ultimately ensuring enrollment of eligible children and the provision of appropriate services for both CHIP and Medicaid; and
- assuring State program integrity and compliance with both statutory requirements under Title XXI and the content of a State's Title XXI plan;

Outcomes of CHIP Reviews

CHIP on-site reviews will result in many outcomes. These include, yet are not limited to, the following:

(2) identifying States' needs for technical assistance and developing a consultation — what is this?

plan to assist States as they implement their plans;

- recognizing and sharing best practices that may lead to increased enrollment and effective delivery of quality services;
- clarifying federal policies, regulations, or statutory language as a consequence of both the Department's and States' experience with CHIP implementation and program operation;
- identifying the need for improvement within State title XXI programs, enforcement and corrective action; and
- advancing the national evaluation effort.

Review "Tools"

Two tools for CHIP on-site reviews have been developed: 1) a core review protocol; and 2) a comprehensive matrix of additional State-specific elements. Each is discussed briefly below.

A. Review Protocols

A "core" on-site review protocol, including program elements relevant to CHIP on a national level, has been developed. The intent of developing a core protocol is to maintain a minimum level of uniformity in the review process for all States. Each element outlined in the core protocol must be included in the protocol for each State review. Based on this core review protocol, review teams will establish comprehensive review protocols that integrate additional relevant elements listed in the matrix of State-specific elements. Teams will use these comprehensive protocols to determine States' compliance with statutory requirements under title XXI ~~(e.g., fiduciary responsibilities)~~ and programmatic responsibilities outlined in States' CHIP plans. The protocol will also serve as a basis for teams as they assess States' programs and needs for technical assistance. Teams will have flexibility in shaping final protocols for State reviews. This flexibility will allow review teams to also focus on State-specific issues, identified in the attached matrix of State-specific elements, not adequately addressed by the core review protocol and to develop innovative methods for the process of State reviews that encourage the enhancement of all State programs. See Attachment B for Core Review Protocol.

B. Matrix of Additional State-Specific Program Elements

This matrix provides a comprehensive list of additional State-specific program elements

included within the parameters of title XXI. The second column of the matrix provides review questions for each program element. Review teams will use this list of elements in the development of final review protocols for each State. This list will allow review teams to tailor protocols to specific States while still maintaining uniformity among protocols developed across all Regions. See Attachment C for the Matrix of Additional State-Specific Program Elements.

C. Optional Use of Medicaid Reviews to Review State Medicaid Expansions under C

As a substantial number of States have chosen to expand Medicaid under title XXI, teams may need to incorporate CHIP-specific program elements into their existing Medicaid reviews for either 1115 or 1915(b) programs. This will reduce both duplication and burden in the process of reviewing State Medicaid programs and will work to streamline the review process. Monitoring of Medicaid fee-for-service, 1115 or 1915(b) programs vary by Region. Each team planning to review a Medicaid expansion program within their Medicaid review process must assure that all relevant elements included in the national core protocol are included in this review. In addition, all relevant State-specific elements must also be included. Therefore, teams can choose to add these questions to their existing Medicaid monitoring protocols in order to review CHIP as part of other Medicaid reviews. This comprehensive review would replace the need for a separate CHIP review for State Medicaid expansion programs or the Medicaid portion of States' title XXI combination programs.

Focus of Review Protocols Based on State Experience

In the development of this review process for CHIP, much discussion revolved around variation in program design, date of implementation, and sophistication and experience of State programs. Through such discussion, it was determined that all States do not have the same amount of experience in implementing children's health insurance programs. It may be inappropriate to consider all programs equal in terms of experience, as some States implemented children's health insurance programs prior to the enactment of title XXI, while others are in rudimentary phases of establishing and operationalizing programs. This review process will identify issues and strategies, establishing a forum assisting teams in an effort to provide feedback to and share information with States promoting program effectiveness and enhancement.

Programs in early phases of implementation should be reviewed differently than those that have extensive experience. States with programs in operation either before the enactment of title XXI or early in the process may be more prepared to evaluate the impact and aspects of their programs' design than States that have recently implemented. The review of programs recently established should focus on assessing whether or not they have established the program aspects identified in their plans. In contrast, the review

of programs with extensive experience in providing health insurance to children should begin to examine program outcomes, to the extent possible. Recognizing that States' experience with implementing insurance programs for children exists along a continuum, teams' reviews should appropriately correspond to the level of States' experience. Therefore, teams should assess each program's experience as they review the elements included in the core review protocol and structure the review accordingly.

Assessing program experience is a subjective process. However, this will afford teams flexibility in the design of State reviews, while including elements outlined in the national core protocol and considering each State's phase of program operation. Particular attention should be paid to factors such as:

- experience with children's health insurance programs prior to title XXI;
- length of time program has been in operation;
- coordination of CHIP with other State programs (Medicaid, MCH, Head Start, etc.);
- size/accessibility of service and provider network; and
- sophistication of data collection efforts.

Content of Protocols and General State Reviews

There are two types of elements that should be included in teams' comprehensive review protocols: core national and State-specific elements. Protocols should incorporate appropriate elements that will assure general program integrity and will identify States' need for technical assistance. While one purpose of the review process is to assure that programs are operating efficiently, it should also promote interaction with the States in order to identify areas in which States may enhance their programs. Issues and best practices identified in the review process will be shared with States on an ongoing basis and subsequent reviews will become a forum for information-sharing that is specific and relevant to each State's programmatic needs.

A. Core Elements

A comprehensive list of elements has been established. Using the following criteria, elements which should be reviewed on a national basis were identified as: 1) elements upon which States are statutorily required to report under title XXI; 2) elements included in the State plan templates; and 3) elements clearly outlined in policy guidance to States (e.g., Dear State Health Official letters). These elements will serve as the basis for the core review protocol and should be included in each Region's comprehensive protocol. Also included in the protocol is a list of suggested questions to assist review teams in examining each of the required core element areas. These suggested questions have been broken into two groups: 1) core questions (that are related specifically to the requirements

under each of the core elements); and 2) additional questions (that are related to the core questions and may serve as probes to obtain additional information States have collected). It is important to note that the review of States' title XXI programs is an evolving process, and it is expected that the focus of reviews and the core protocol will require modification from year to year.

B. State-Specific Elements

Teams will use core national measures as the basis for review protocols and should add State-specific elements, when relevant. Optional State-specific elements outlined in the "Matrix of Additional Program Elements" are mutually exclusive from those elements included in the core review protocol. This process will provide a firm and structured basis for review which is grounded in the specific requirements of the statute and States' plans. Additionally, this approach maintains flexibility and fosters innovation while still considering issues most important to the Congress and the Administration. To be most effective, teams will need to tailor protocols to States' individual programs and apply them accordingly. This process may entail review teams commitment to a significant level of resources in order to ensure a productive on-site review process.

C. Enforcement of Statutory and Regulatory Requirements

As noted under the goals for CHIP review, this process is focused on assuring that States are in compliance with Federal statutory and regulatory requirements and to assist States in enhancing their programs. In the case that a State is in substantial noncompliance with Federal rules and has not made a good faith effort to establish solutions to the issues identified, the RO and CO review teams should work with Central Office to establish a plan for corrective action. For this purpose, Attachment E provides an overview of the Department's enforcement strategy.

General Review Process Steps

To effectively monitor individual State programs, an ongoing process is required which will allow for both structure and innovation. Listed below are a set of process steps for CHIP review at the Regional level. These activities are categorized into three major areas: 1) pre-review; 2) review; and 3) post-review, enforcement and follow-up. In addition, the Department is committed to identifying best practices for CHIP reviews.

A. Pre-Review Steps

1) HCFA and HRSA RO representatives are responsible for establishing cross-cutting review team to include Regional HCFA, HRSA and other relevant agency Regional staff (e.g., ACF, OCR, etc.). Also, CO staff should be included on

review teams and attend State reviews, when possible.

2) CO/RO workgroup will train review teams on the review process, objectives and general expectations.

3) CO/RO team staff and States must agree upon the final content of a State's CHIP plan, including both the original template-based submission as well as subsequent amendments, and written responses to requests for additional information. The review will be based on the final agreed upon core and State-specific program elements.

4a) Teams should use the matrix of additional program elements to identify additional Regional- and State-specific elements to include in their final protocols. This matrix provides a comprehensive set of elements to incorporate into final protocols, thus providing teams with the flexibility to develop appropriate combinations of elements for State review.

4b) If a review team decides to review a CHIP Medicaid expansion through a State Medicaid review, the team must assure that all core and relevant State-specific elements have been included in the FFS, 1115 or 1915(b) review .

5) Based on the core review protocol, finalize protocol by including all relevant State-specific elements. Also, consider areas in which program integrity is an important issue, e.g., screen and enroll.

a) Teams should share protocols with CO and other regions, as appropriate, for feedback.

b) Teams should also establish an appropriate timeline for review process, considering the need for both on-site reviews and phone interviews, the provision of timely feedback to the States, and the discussion of findings with HCFA/HRSA Central Office review teams. Teams should, at a minimum, formally review State programs after one year of program implementation. Subsequent comprehensive reviews should occur every two years unless otherwise necessary. In addition, teams may have frequent informal contact with States regarding CHIP programs. When appropriate, teams should keep a log of significant events and contacts with States that may inform the formal review process.

c) Teams should subsequently identify locations for site visits; identify materials needed for review; request an entrance meeting with the State, share the review protocol and request any needed materials.

B. Review Steps

6) Conduct review(s) in each State of their title XXI program. When information cannot be directly obtained by the State, the review team should contact relevant parties.

7) Analyze findings from review process, and use standard review report template to draft a report containing findings, recommendations and State's best practices.

a) Share preliminary findings as part of exit conference with State.

b) Share draft report with CO. Following agreement on findings, the report should be shared with the State and a request should be made for responses. Prepare formal report that has incorporated States' responses to issues raised by review teams.

c) Information should be prepared on best practices and shared with the States on the HCFA website. An outcome of the State review process is to provide relevant and timely information to States to assist them in enhancing their programs.

d) Regional staff should use weekly CO/RO calls to provide updates on States' CHIP programs and compliance issues.

C. Post-Review Steps, Enforcement and Follow-up

8) Final reports should be shared with HCFA/HRSA CO for review. Brief appropriate agencies and staff within DHHS on findings and solicit comments.

9) In cases of noncompliance where a State has not made a good faith effort to meet requirements, RO review teams will work in consultation with the CO review team to identify steps which need to be taken in order to comply either with title XXI statutory requirements, Federal regulation, or issues identified by States within their plans and to ensure that these steps are carried out. Teams should consult with HCFA/HRSA Central Office prior to formal action. Teams will monitor and follow-up States' efforts for corrective action in subsequent reviews and provide necessary feedback to both the States and HCFA CO, as necessary.

D. Identifying Best Practices for CHIP Reviews

10) Teams share protocols with one another, HCFA/HRSA Central Office, and other

DHHS Regional offices in order to identify innovative methods and "best practices" for reviews. This will assist in the effective review of State programs.

11) Debrief between HCFA/HRSA Regional and Central Offices regarding the use of protocols and their effectiveness, the identification of new or shifting priorities, and the review process in general.

12) Review protocols may be in continuous evolution as program priorities and structures shift and change. Therefore, debriefings to share the effectiveness of review protocols and methods for review should continue on an ongoing basis.

APPENDIX B

Core Review Protocol

submitted data ?

PROGRAM ELEMENTS and CITATION (statutory reference, included in state plan/amendment)	CORE QUESTIONS	ADDITIONAL ELEMENTS RELATED TO CORE QUESTIONS
GOAL 1: REDUCING THE NUMBER OF LOW-INCOME UNINSURED CHILDREN		
A. Enrollment of eligible children into CHIP §2102 (b)(3)(B)	• Is the State having difficulty establishing a baseline estimate and/or identifying the number of children enrolled in both CHIP and Medicaid? Is there any need for technical assistance? • Please describe the State's progress at enrolling children in CHIP and in regular Medicaid. • Has the State met its enrollment goal? If not, what strategies is it employing to help meet that goal? Is the State having problems with particular segments of the target population? What is it doing to alleviate those problems?	• Does the State have an effective mechanism for tracking the number of applications that have been submitted? If so, how many applications have been submitted?
B. Disenrollment and denials §2102 (b)(3)(E) -- Screen and enroll authority	• How many denials have there been for CHIP? Has the State program seen a significant number of denials that appear to be inappropriate? If so, how has the State handled these cases? • Have you collected data on the reasons for denials? (both initial and upon redetermination): ☐enrollment in commercial insurance ☐eligible for Medicaid ☐ income too high (specify by State) ☐ unable to contact ☐ incomplete documentation ☐ unqualified alien ☐ not a State resident	• Does the State have an unduplicated count of disenrollees for the fiscal year? Have you collected information on the reasons for disenrollment? ☐enrollment in commercial insurance ☐eligible for Medicaid ☐ income too high (specify by State) ☐ aged out ☐ moved/died ☐ non-payment of premium ☐ unable to contact ☐ incomplete documentation ☐ unqualified alien

PROGRAM ELEMENTS and CITATION (statutory reference, included in state plan/amendment)	CORE QUESTIONS	ADDITIONAL ELEMENTS RELATED TO CORE QUESTIONS
	☐ other - specify _____ • Is this data based on anecdotal information or reliable data?	☐ not a State resident ☐ other - specify _____ • How do disenrollment rates differ from traditional Medicaid disenrollment rates? • How many children did not re-enroll at renewal? How many children obtained coverage after leaving CHIP? • Is this data based on anecdotal information or reliable data? • What is the State's "failure to pay" policy or established process to protect beneficiaries from disenrollment due to non-payment of premiums and other cost-sharing? ☐ adopting grace periods ☐ establishing payment schedules to assist ☐ beneficiaries in making late payments observing beneficiaries' patterns of non-payment before disenrollment
C. Specific strategic objectives relating to increasing extent of creditable health coverage among targeted low-income and other low-income children §2107(a)	• How is the State progressing in meeting its strategic objectives and performance goals related to reducing the number of uninsured? Has the State developed and implemented processes to gather data and meet these goals? If not, what barriers has the State encountered and how does it intend to overcome them? • Describe the processes, data sources, and results the State used or plans to use to measure the reduction of uninsured children in the State. ☐ focused studies	• Describe the process and results of addressing the special and behavioral health needs of the children enrolled in Medicaid expansions and CHIP stand-alone programs?

PROGRAM ELEMENTS and CITATION (statutory reference, included in state plan/amendment)	CORE QUESTIONS	ADDITIONAL ELEMENTS RELATED TO CORE QUESTIONS
	☐ client satisfaction surveys ☐ complaint/grievance/disenrollment reviews ☐ sentinel event reviews ☐ plan site visits ☐ HEDIS performance measurement ☐ other-specify_____ • How is the State using measures and its overall experience with program implementation to make interim corrections/improvements and to direct future program changes?	
D. Variance for family coverage* §2105(c)(3)	• Please provide updated information regarding how many families are being covered under CHIP, how family coverage under the State's CHIP continues to be coordinated with other CHIP programs, the participation of employers, and the overall administration of the State's program to provide family coverage. • Is the State encountering difficulty in ensuring that purchase of family coverage is cost-effective (relative to the amount that the State would have paid to obtain comparable coverage only to the targeted low-income children involved)? • Is the State finding that purchase of family coverage under CHIP is replacing the purchase of otherwise purchased private coverage? If so, to what extent?	• Has the State (or others) conducted any studies on the extent of crowd out related to the provision of family coverage under CHIP?
E. Providing premium assistance for employer-	• Is the State assuring that coverage under the PA program is cost-effective (i.e., that it does not cost more than it	• Has the State (or others) conducted any studies regarding the use of premium

PROGRAM ELEMENTS and CITATION (statutory reference, included in state plan/amendment)	CORE QUESTIONS	ADDITIONAL ELEMENTS RELATED TO CORE QUESTIONS
sponsored coverage under group health plans 2/2/98 letter	would for the State to enroll the child in the State CHIP program)? How is this working? Is the State encountering any difficulties? • Are employers contributing at least 60% (or the percent contribution amount agreed upon in the State's plan) of the cost of family coverage? • Is the State monitoring cost-sharing restrictions and limitations? Do you have any information regarding how many enrollees have reached the 5% cap? • Is the State continuing to assure that the benchmark benefit package is met and continues to be maintained (e.g., recertifying/verifying participating plans and the coverage provided)? Have there been any issues associated with maintaining coverage requirements? ➢ Is the State collecting data on who (in the family unit) is being served under the PA program, including all adults and other dependents? Does the State have any conclusions on the impact of providing family coverage or premium assistance for the coverage of children under employer-sponsored group health plans?	assistance programs and/or the extent to which crowd out is occurring in the State's program?
GOAL 2: TARGETING ELIGIBLE CHILDREN THROUGH EFFECTIVE OUTREACH TECHNIQUES		
F. Strategies to target eligible children and enable enrollment and utilization of health care system §2102(c)(1)	• Has the State used the outreach strategies outlined in its State plan? If the State has deviated from its plan, why and what are the strategies utilized? • What strategies have been used to educate and encourage enrollment of children eligible for CHIP? (for example): ☐ community outreach workers	

PROGRAM ELEMENTS and CITATION (statutory reference, included in state plan/amendment)	CORE QUESTIONS	ADDITIONAL ELEMENTS RELATED TO CORE QUESTIONS
	☐ outstationed eligibility workers ☐ shortened and/or combined application ☐ use of the media ☐ enrollment brokers ☐ others _____ • Where does your CHIP program conduct client education and outreach activities? • Has the State instituted any process to follow-up with those that have failed to fill out their applications? • In simplifying enrollment applications, has the State pre-tested the applications in different populations, i.e., is the application process working and in which populations are they able to actually enroll kids successfully? • Are there any employer-based outreach efforts? • Are there any provider-based outreach efforts? • Has the State provided training to individuals conducting outreach?	
G. Effectiveness of Chosen Outreach and Enrollment Strategies §2102(c)(1)	• Is the State conducting any studies/evaluations of their enrollment and outreach strategies? What study methodologies are they using? What do preliminary findings show? • Describe methods and indicators used to assess outreach effectiveness, i.e., programs for client education and outreach. • Have any outreach strategies been more successful in reach specific groups? In reaching the general target population?	

PROGRAM ELEMENTS and CITATION (statutory reference, included in state plan/amendment)	CORE QUESTIONS	ADDITIONAL ELEMENTS RELATED TO CORE QUESTIONS
	• Have there been any identified barriers to enrollment, e.g., public charge, application process issues, access (i.e. physical barriers including transportation issues, language and literacy barriers)?	
GOAL 3: COORDINATION WITH OTHER STATE AND FEDERAL PROGRAMS AND THE PRIVATE MARKET		
H. Program Coordination		How is CHIP coordinating with other State programs with respect to the following: ☐ Administration ☐ Service Delivery ☐ Service Payment ☐ Procurement ☐ Contracting ☐ Data Collection ☐ Quality Assurance ☐ Other _____
I. Screen and Enroll §2102(b)(3)(E)	• Please describe the State's method for screening CHIP applicants for Medicaid eligibility and enrolling Medicaid eligible children into Medicaid if different than in State plan (e.g., use of joint applications for CHIP and Medicaid). • Are joint applications used to determine eligibility for other State programs? Are these joint efforts working well? • How is the program coordinating between/among other	

PROGRAM ELEMENTS and CITATION (statutory reference, included in state plan/amendment)	CORE QUESTIONS	ADDITIONAL ELEMENTS RELATED TO CORE QUESTIONS
	children's health-related programs, (e.g., Medicaid, Title V, WIC, community and migrant health centers, etc.) to assure compliance with screen and enroll requirements under Title XXI? • Is there any follow-up with families whose children have been identified as Medicaid eligible to see if they are actually enrolled in Medicaid? If so, what has been found? Are there any reports that the State can provide? ➢ What are beneficiaries' hearing rights if eligibility is denied?	
J. Referral of eligible children to other State programs, when appropriate §2102(b)(3)(B)	Please describe referral processes including: • Referral by Medicaid eligibility workers of non-Medicaid eligible children to CHIP; and • Referral of non-CHIP, non-Medicaid eligible children to other publicly-funded child health programs, e.g., MCH	
K. Coordination of outreach efforts with current Medicaid and other State-only children's health insurance programs §2102(c)(2)	• What efforts has the State made to coordinate outreach efforts with other relevant entities in the State, e.g., immunization programs, family planning, WIC, Title V, other State agencies, etc.? (for example): ☐ conducting data matches with other programs which may serve similar populations ☐ coordination with other States agencies (list agencies) _____	
GOAL 4: ASSURING QUALITY, APPROPRIATENESS, AND ACCESS TO CARE		
L. Ability of beneficiaries	• Describe the State's process for educating beneficiaries	

PROGRAM ELEMENTS and CITATION (statutory reference, included in state plan/amendment)	CORE QUESTIONS	ADDITIONAL ELEMENTS RELATED TO CORE QUESTIONS
and the public to obtain information on program §2103(e)	about the following (for example): ☐ benefits ☐ accessing services (e.g. benefit carve-outs, provider networks) ☐ choice of health plans/providers ☐ grievance and appeals procedures ☐ cultural competency and language issues • Describe the State's process for educating beneficiaries about cost-sharing requirements including: (for example): ☐ notification of the amount of cost-sharing individual beneficiaries will be required to pay ☐ notification of how and where premiums and/or copays are to be paid ☐ notification that cost-sharing is not allowed for certain services, e.g., well-baby care, preventive care, etc. ☐ notification of any rules related to cost-sharing which could affect access or utilization of services, e.g., nonpayment of premiums results in disenrollment for a specified time, coverage does not begin for a specified period after enrollment into program ☐ inclusion of educational efforts in contracts with enrollment brokers	
M. Access and service delivery issues	• Do beneficiaries have adequate access to covered services? (adequacy could be determined through factors such as beneficiary input from surveys, sizes of provider	• Describe the process and results of addressing the special physical and behavioral health needs of the children

PROGRAM ELEMENTS and CITATION (statutory reference, included in state plan/amendment)	CORE QUESTIONS	ADDITIONAL ELEMENTS RELATED TO CORE QUESTIONS
§2102(a)(7)(B)	panels as compared to the number of enrollees, geographic distribution of providers, etc.) • Please describe the State's progress at increasing access to care for CHIP and Medicaid-eligible children. • How is the State assuring adequate delivery of health care to enrolled children, particularly with respect to well-baby care, well-child care, and immunizations?	enrolled in Medicaid expansions and CHIP stand-alone programs.
N. Quality and appropriateness of care §2102(a)(7)(A)	• Has the State been able to implement and obtain data using the methods outlined in its CHIP plan to assure the quality and appropriateness of care? • Which quality assessment and improvement strategies (e.g. quality of care standards, performance measurement, information and reporting strategies, licensing standards, credentialing, periodic and external reviews) has the State been able to use successfully, if any? • Is the State experiencing difficulty in measuring the performance goals outlined in the State's plan? Can the Department assist in reducing barriers to collecting this data?	• How effective has the State been at assuring access to covered services, including emergency services?
O. Delivery systems §2102(a)(4)	• Has the State established and defined a delivery system for the CHIP program? ☐ comprehensive risk managed care organizations (MCOs) -- statewide, mandatory enrollment, # of MCOs ☐ Primary care case management (PCCM)	

PROGRAM ELEMENTS and CITATION (statutory reference, included in state plan/amendment)	CORE QUESTIONS	ADDITIONAL ELEMENTS RELATED TO CORE QUESTIONS
	☐ Non-comprehensive risk contractors for selected services (e.g., MH, dental, vision) -- specify if services are carved out ☐ indemnity/FFS (specify if services are carved out) ☐ other _____ • Has the State faced any barriers related to acquiring and maintaining appropriate delivery systems for CHIP enrollees across the State (or service area)? • How is the State program addressing issues related to varying geography, including varying populations and needs by region, such as rural and urban settings and children with special health care needs? • How is the State program working to coordinate with and among other health-related and children's services systems? • What mechanisms does the State use to monitor and assess provider capacity and participation in CHIP?	
P. Provision of Assistance to Indians* 2/24/98 letter §2102(b)(3)(D)	• Did the State consult with Federally-recognized Tribes and other Indian Tribes and organizations in development and implementation of CHIP? • Does the State continue to follow the procedures outlined in their CHIP plan regarding provision of services to targeted low-income American Indian/Alaska Native children? • Do Native Americans/Alaska Natives report that they are able to access CHIP services? If not, does the State have any data on what barriers are reported? What is the State	

PROGRAM ELEMENTS and CITATION (statutory reference, included in state plan/amendment)	CORE QUESTIONS	ADDITIONAL ELEMENTS RELATED TO CORE QUESTIONS
	and State standards and does it have a mechanism for reporting fraud and abuse to the proper governmental authorities?* • Does the program include procedures to ensure program integrity and detection of fraud and abuse? Does the State have procedures for coordination between the State program integrity unit and the OIG, DOJ, FBI, etc.? • How has the State facilitated communication between it and the public in terms of reporting possible fraud or abuse? (Does it have a toll-free number for this purpose?) • For those States with separate CHIP programs, is the State applying the Medicaid privacy protections pertaining to the protection of enrollee data, medical records and mental health history, and privacy of minors?*	

PROGRAM ELEMENTS and CITATION (statutory reference, included in state plan/amendment)	CORE QUESTIONS	ADDITIONAL ELEMENTS RELATED TO CORE QUESTIONS
	doing to respond to the reported barriers? ➢ What methods does the State plan to utilize to ensure ongoing input from these groups?	
GOAL 5: ASSURING THAT STATES MEET STATUTORY FEDERAL AND STATE REQUIREMENTS		
Q. Crowd out Strategies §2102(b)(3)(C)	• How is the State monitoring crowd out (if different than effort outlined in State plan)? • To what extent is the State finding the existence of crowd out as a result of the implementation of CHIP? Please indicate if this is anecdotal information. • Has the State conducting any studies/evaluations of crowd-out? What study methodologies are being used?	• Have there been any issues raised regarding the use of anti-crowd out mechanisms (e.g., limiting access to coverage for eligible children)? If so, please describe. • Are there differences in the existence/level of crowd out across programs?
R. Cost-sharing for enrollees §2103(e)	• Please describe any cost-sharing the State is imposing on beneficiaries, including any requirements or exceptions for Native Americans if different from approved State plan. Types of cost-sharing used: ☐ premiums ☐ enrollment fees ☐ deductibles ☐ coinsurance/copayments ☐ others_____ • Does this system ensure that cost-sharing requirements do not favor children from families of higher income? • Describe the process the CHIP program is using to monitor that the annual aggregate cost-sharing does not exceed 5% of family income, including the methods through which the families will be notified if different	• Has the State program assessed the effects of premiums on participation or effects of cost-sharing on utilization? If so, please describe. •

PROGRAM ELEMENTS and CITATION (statutory reference, included in state plan/amendment)	CORE QUESTIONS	ADDITIONAL ELEMENTS RELATED TO CORE QUESTIONS
	from approved State plan. ☐ shoebox method ☐ health plan administrator ☐ audit reconciliation ☐ other _____ • Describe the process by which the State will assure that beneficiaries are not directly billed for premiums or other coinsurance and subsequently reimbursed if they have reached the 5% cap on cost-sharing • How many beneficiaries have reached the 5% cap on cost-sharing? (if State has data available) • Is there any evidence of cost-sharing creating a barrier to access and utilization of services? • How is the State ensuring that health plans, providers, or other entities responsible for collecting cost-sharing (e.g., premiums, copayments, enrollment fees) are complying with all cost-sharing guidelines outlined in either the statute or the regulations?	
S. Objective and independent measurement of health plan compliance		• What mechanism is the State using to monitor health plans' compliance with regard to meeting Federal requirements for CHIP related to coverage, cost-sharing, etc.?
T. Assurance State will provide reports to Secretary as requested	• Has the State identified any problems in meeting reporting requirements under title XXI? For quarterly financial and statistical and annual reports and State evaluations? If so, what are you doing to address data	

PROGRAM ELEMENTS and CITATION (statutory reference, included in state plan/amendment)	CORE QUESTIONS	ADDITIONAL ELEMENTS RELATED TO CORE QUESTIONS
§2107(b)(1)	problems? Does the State require technical assistance to meet reporting requirements?	
U. Budget submission §2105(c)(4) §2107(b),(d)	Are there any issues related to the State's budget submission? Have there been any unexpected changes in the budget and expenditures for the program? Issues may be related to the following: • planned use of funds • sources of non-Federal share of plan expenditures • assurance of maintaining specified expenditures (e.g., administration, outreach, services) to the 10% cap • deferrals • disallowances • review for potential fraud and abuse • change in the use of a State's allocation	
V. Program Integrity §2101(a)	• Does the program provide safeguards necessary to ensure that eligibility is appropriately determined? • How has the State ensured that contracts with MCOs include enrollment and other required data and the MCO has attested to the accuracy and integrity of enrollee claims and payment data?* • With fee-for-service systems, has the State established procedures to ensure the integrity of provider claims?* • Has the State ensured that MCOs have procedures in place to guard against and investigate fraud and abuse? Is the State enforcing MCO compliance with all Federal	

APPENDIX C

MATRIX OF ADDITIONAL PROGRAM ELEMENTS

Although review efforts should be consistent on a national level, efforts will be most effective if Regions are afforded enough flexibility to tailor review protocols to individual State programs. To accommodate programmatic and developmental differences that exist among State programs, the review process for CHIP encourages Regional Offices to design final protocols that include both the core national and State-specific elements. These elements may include:

Coverage Requirements for Children's Health Insurance

- Specific elements in the benefits package
- Variances of the 10% cap
- Purchasing vaccines
- Special provisions for children with special health care needs
- Abortion coverage meeting Hyde requirements

General Contents of State Child Health Plans

- Utilization control systems

Eligibility Standards and Methodology

- Implementation of eligibility standards (including presumptive and continuous eligibility)
- Maintenance of effort

Quality and Appropriateness of Care

- Methods to assure quality and appropriateness of care not discussed in core protocol
- Issues the state agreed to monitor in their state plans not included in the core elements (i.e issues related to children with special needs, access related issues, etc.)

Assurances

- Ongoing public involvement

Although the core review protocol provides an extensive list of elements to be monitored, it does not capture issues that are unique to State programs or that review teams may consider important issues for review. Review teams are encouraged to expand the review process to include elements that may be relevant to the effective administration of State programs. The detailed matrix of State-specific elements is provided below.

MATRIX OF ADDITIONAL ELEMENTS: STATE-SPECIFIC DRAFT 7/12/99			
PROGRAM ELEMENTS	**SUB-ELEMENTS (Additional areas for specific focus)**	**CITATION (statute, Q&As, letters, regs)**	**SUGGESTED REVIEW QUESTIONS**
Coverage Requirements for Children's Health Insurance			
Identification of type, scope, amount and duration, limitations and exclusion of services	• Core benefits offered • Availability and accessibility of services • Special provisions or carve outs for MH/SA services • Special provisions for dental services • Provisions for CSHCNs • Any changes in benefits and coverage	§2110(a) [State plan]	• Does the State use a carve out or special provider provisions for MH/SA services? • Does the State have special programs targeted toward children with special needs? • If managed care, does the state carve out services delivered to CSHCNs? • How does the state ensure that services/benefits offered are accessible to enrollees? • Does the state offer benefits beyond those identified in the State plan?
Variance for a cost-effective alternatives	• Community-based delivery system	§2105(c)(2)(B)(iii)	• If the State operates under a waiver for a cost-effective alternative, how does the State ensure that coverage provided meets or exceeds the

MATRIX OF ADDITIONAL ELEMENTS: STATE-SPECIFIC DRAFT 7/12/99			
PROGRAM ELEMENTS	**SUB-ELEMENTS (Additional areas for specific focus)**	**CITATION (statute, Q&As, letters, regs)**	**SUGGESTED REVIEW QUESTIONS**
			coverage requirements under § 2103 and that the cost is not greater?
Abortion coverage meets Hyde		§2105(c)(7)(B)	• How is the State ensuring that CHIP funds are only being used to pay for abortion in the case of rape or incest or when the life of the mother is in danger?
Purchase and provision of vaccines		5/11/98 letter	• What mechanism does the state use to track the delivery and administration of vaccines to children? • Is there a mechanism to coordinate vaccine services with other State immunization programs?
General Contents of State Child Health Plan			
Utilization control systems	• Reviewing, coordinating, and implementing assurances for cost-effective and efficient care	§2102(a)(4)	• What types of UR mechanisms is the State using? How effective have they been? • Are there particular services that the State is monitoring for utilization (not including those that are part of

MATRIX OF ADDITIONAL ELEMENTS: STATE-SPECIFIC DRAFT 7/12/99			
PROGRAM ELEMENTS	**SUB-ELEMENTS (Additional areas for specific focus)**	**CITATION (statute, Q&As, letters, regs)**	**SUGGESTED REVIEW QUESTIONS**
			the State's performance goals)? What are preliminary findings if available?
Eligibility Standards and Methodology			
Eligibility standards	• Changes in eligibility standards • Assuring non-discrimination on the basis of diagnosis • Using appropriate methods to establish and assure eligibility and enrollment (e.g., procedures for applying eligibility standards, organization and infrastructure responsible for making and reviewing determinations, process for enrollment • Assuring the adequacy of Medicaid screening • Assuring, where applicable, continuous enrollment or presumptive eligibility	§2102(b)	• How has the State ensured that eligibility is not being denied on the basis of preexisting conditions?
Maintenance of Effort	• As defined for Medicaid	§2105(d)(1)	• Has the State redefined Medicaid

PROGRAM ELEMENTS	SUB-ELEMENTS (Additional areas for specific focus)	CITATION (statute, Q&As, letters, regs)	SUGGESTED REVIEW QUESTIONS
	expansions in Section 2105 (d)(1)		eligibility standards with income and resource standards that are more restrictive than those applied as of June 1, 1997?
Quality and Appropriateness of Care			
Methods to assure quality and appropriateness of care	• Qualifications of entities providing coverage; conditions of participation • Use of state agency staff vs contractors • Use of HEDIS or other existing tested measures • External and periodic review of health plans • Identification of quality improvement goals • Coordination with State CSHCN agency • Contract monitoring • Grievance measures		• How is the State ensuring that CHIP providers are qualified/credentialed? • If contractors are being used in some aspects of program operations, how is quality being insured? • Is the State requiring MCOs to use existing performance measures such as HEDIS? • Is the State monitoring MCO performance in any other way? • Is the State monitoring consumer satisfaction? If so, what have been the findings to date? • Is the State coordinating the quality and performance monitoring with data obtained from other State

MATRIX OF ADDITIONAL ELEMENTS: STATE-SPECIFIC DRAFT 7/12/99			
PROGRAM ELEMENTS	**SUB-ELEMENTS (Additional areas for specific focus)**	**CITATION (statute, Q&As, letters, regs)**	**SUGGESTED REVIEW QUESTIONS**
			agencies (e.g., Title V, State DOH, etc.)?
Assurances			
Process and documentation of activity involving public in design and implementation of plan; method for ensuring ongoing public involvement (e.g., public meetings, announcements)			• How has the State involved the public in CHIP design, development, and implementation? Are they continuing to do so? If so, how?

APPENDIX D
CHIP Program Improvement and Enforcement Continuum

ATTACHMENT E

Enforcement of Statutory and Regulatory Requirements

Under Subpart B, Section 457.200 of the CHIP financial regulation, HCFA has the authority to review State and local administration of the State CHIP plan through analysis of the State's policies and procedures, on-site reviews of selected aspects of agency operation, and examination of samples of individual case records. If Federal or State reviews reveal serious problems with respect to compliance with any Federal or State plan requirement, the State must correct its practice accordingly. Under Section 457.204 of the financial regulation, HCFA has the authority to withhold payment if it is found that States are in substantial noncompliance with requirements defined under title XXI. If a State is found to be in substantial noncompliance, a team should complete the following steps:

- Notify Central Office of the noncompliance and provide Central Office with a recommendation for action that might include a plan for correcting the States' area of noncompliance or for corrective action;
  draft a preliminary notice to the State that will be sent by the Administrator, if required;

- provide State with an opportunity for corrective action;

- provide final notice to the State;

- allow the State the opportunity for a hearing; and

- in instances where noncompliance continues, work in conjunction with CO staff to withhold funding until State is found to be in compliance.

Although the financial regulation clearly outlines the process of enforcement and corrective action in the case of substantial noncompliance, the enforcement strategy for CHIP is based on the understanding that enforcement exists along a continuum. This continuum ranges from substantial noncompliance in meeting Federal requirements under CHIP on one end, to program enhancement on the other. See Attachment D for a visual description of this continuum.

CHRIS/SARAH/~~JOEANNE~~ –
Joe Lieberman's daughter runs a CHIP outreach program in NYC. HRC + the VP should know about it. Maybe she could be part of whatever you do on Back-to-School outreach.
–BR

OFFICE OF PUBLIC POLICY & CLIENT ADVOCACY

Rebecca Lieberman, J.D.
Director of Policy & Program

Cathleen Clements, Esq.
Legal Director

August 20, 1999

Bruce Reed
Assistant to the President &
Director of Domestic Policy Council
The White House
Washington, DC 20502

Dear Mr. Reed:

Thank you for taking the time to speak with me last week about The Children's Aid Society's efforts to make the promise of the State Child Health Insurance Program (SCHIP) a reality for New York City children. The priorities outlined by President Clinton in his address to the National Governors' Association match the strategy we have adopted: using the institution with which all young people must affiliate – the schools – to identify and enroll uninsured children.

Of course, the Administration's commitment to covering America's children has been clear from the start. I was fortunate to attend the Health Care Finance Administration's technical advisory panel on SCHIP outreach to immigrants, which illustrated the depth of this commitment. Over two days, advocates and public health officials from across the country shared experiences and developed strategies about how to reach one of our neediest and most diverse populations– immigrant children.

For the past sixteen months, The Children's Aid Society's Health Care Access Program has been providing bilingual child health insurance outreach, screening, and enrollment assistance in five public schools in Upper Manhattan. The program enables parents, the vast majority of whom are immigrants, to complete the enrollment process in a setting that is familiar, trusted, and central to their daily routines. Between April 1998 and July 1999, our school-based staff screened 970 parents and children, connecting over 750 of them to government-sponsored health insurance.

We have learned a great deal about effective ways to reach and enroll uninsured children, and both local and national advocacy groups have recognized our expertise, seeking information, training, and guidance on program design. We have participated in initiatives that will shape the widespread implementation of SCHIP, including the state's pilot and revision of the unified Medicaid/Child Health Plus application, the development of a simplified recertification process for children, and the city's pilot of procedures for handling Medicaid applications completed by community-based organizations.

The Health Care Access Program has demonstrated the success of the school-based model of facilitated enrollment. Schools offer a highly effective setting for enrollment, particularly for children at the elementary and intermediate school levels, for several reasons:

- **Schools are central to the lives of families with children and young adolescents,** providing many opportunities for education and screening.
- **The convenient location makes follow-up easy.** After the initial screening, parents can quickly stop by with needed documents or sign forms as they pick up their kids from school.
- **Word-of-mouth promotes the program.** Parents whose children attend the same elementary and intermediate schools live in the same community – they are neighbors, they talk with each other at the laundromat, at school functions, at dismissal time. Once a facilitated enrollment program is up and running, the word spreads among parents and they are eager to participate.
- **School functions and mailings provide great opportunities for outreach.** Integrating the program into the life of the school grants access to large numbers of parents. Administrators and PTAs work hard to engage parents, and insurance enrollment programs can benefit from those efforts.

Needless to say, we would welcome the opportunity to be a part of the Administration's effort to highlight child health insurance as young people head back to school. Following, for your information, is a more detailed description of the Health Care Access Program.

Thank you again for taking the time to speak with me last week. I look forward to speaking with you further about our work in the near future. Should you have any questions, I can be reached at 212-358-8930.

Sincerely,

Rebecca Lieberman

Cc: Joe Lieberman

JULY 1999

THE HEALTH CARE ACCESS PROGRAM
Reaching Uninsured Children at School

INTRODUCTION

Few organizations have undertaken the challenging work of child health insurance enrollment without the support of public funds. The Children's Aid Society has. In April of 1998, we launched the Health Care Access Program (HCAP), a school-based health insurance enrollment initiative. The agency's mission – to provide children with the support and opportunities needed to become healthy and successful adults – drove the undertaking. The hundreds of uninsured young people passing through our school-based health clinics and programs highlighted the need.

HCAP provides bilingual outreach, screening, and enrollment assistance for New York State's public health insurance programs for children, Medicaid and Child Health Plus. HCAP enables parents to complete the enrollment process in a setting that is familiar, trusted, and central to their daily routines. **Between April 1998 and July 1999, the program's school-based staff screened 970 parents and children, connecting over 750 of them to government-sponsored health insurance.**

The five public elementary and intermediate schools where HCAP operates are Children's Aid Society "community schools," located in Upper Manhattan's Washington Heights neighborhood. Through a close partnership with the New York City Board of Education, the agency offers social services and recreational programs that complement the schools' academic programs. Agency staff work full time in the schools, providing Early Head Start and Head Start programs; medical, dental and mental health services; evening classes for parents, and after-school and Saturday programs.

HCAP's ability to reach families depends largely on the integral role that The Children's Aid Society already plays in the lives of the schools' students and their families. **Institutional trust developed over years of service to the community facilitates HCAP's ability to identify and enroll uninsured children.**

Trust is a critical commodity in the largely immigrant community in which we work. The vast majority of families who apply through HCAP are immigrants from the Dominican Republic. As Latino immigrants, they represent the population with the nation's highest rate of uninsured children, despite their eligibility for public programs. Through our work with this population, we grapple with the reality that underlies these statistics. The application process requires families to present information on informal living arrangements and survival strategies that are often difficult for immigrants to document. In addition, many come to this country with a strong distrust of government programs.

105 EAST 22nd STREET • NEW YORK, NEW YORK 10010 • (212) 949-4800

Still others fear that a child's receipt of public insurance will jeopardize undocumented family members or their own ability to sponsor relatives or adjust their immigration status. HCAP's bilingual staff works closely with families to overcome such barriers.

Strategies for Outreach and Enrollment

HCAP works with administrators, teachers, health clinic staff, and parents to identify uninsured children.

- **Social workers, educators, and health care providers** who have ongoing relationships with families conduct **one-on-one outreach**. Confidential eligibility screenings are provided to all interested families. HCAP staff members are available to meet with parents in the evenings and on weekends.
- **Teacher** orientation packets include information on Medicaid and Child Health Plus and how to refer families for enrollment assistance. Program staff reinforce this printed message through presentations at faculty meetings.
- **Parents** receive similar information from HCAP workers who are positioned in front of the school for student arrival and dismissal during the first week of classes. Later in the year, HCAP workers staff **parent-teacher conferences** and report card signing nights. Because the individuals who staff these events are the same people who provide enrollment assistance, parents have the opportunity to schedule an appointment for a comprehensive screening or to get quick advice on their eligibility.
- **Parent-to-parent referral**, or word-of mouth, provides one of HCAP's most effective outreach mechanisms. Parents whose children attend the same elementary and intermediate schools live in the same community – they are neighbors, they talk with each other at the laundromat, at school functions, at dismissal time. Word of HCAP's work has spread among parents and many are eager to access the program's services.
- Throughout the year, HCAP staff hold **weekly office hours** at the schools during times that are convenient for working parents. Families may drop in for a screening, bring insurance questions, or complete the application process. In addition, staff conduct more formal **information sessions** for groups at the invitation of parent organizations, health educators, and Head Start administrators.

Results

Between April 1998 and July 1999, HCAP's school-based staff screened 691 children and 279 adults to determine their eligibility for public health insurance. **All** of the children qualified for either Medicaid or Child Health Plus and 54 percent of the adults qualified for Medicaid.

Eligible families receive intensive application assistance which typically entails three visits with HCAP staff, including the initial screening. At these visits, parents are helped to complete the application, to collect needed documentation, and to select a managed care plan, if appropriate. As needed, families receive basic information on how managed care functions. HCAP staff then finalize and submit the client's application and are available to troubleshoot should problems arise with either the Department of Social Services or a managed care plan.

These methods have yielded the following results:

- ***SCHOOL-BASED ENROLLMENT AS OF JULY 31, 1999***

Eligible Individuals		Enrolled Individuals
Adult	151	125
Children	691	625

Of the 625 children enrolled, 372 are now insured through Medicaid and 253 through Child Health Plus. Ninety-two individuals were found to be eligible but are not yet insured, 21 of whom have applications currently in process and 63 of whom have failed to complete the application process. As these figures show, intensive application assistance provided in the schools works.

LESSONS LEARNED

In the course of connecting hundreds of individuals to public health insurance, we have learned many lessons, some of which follow.

- **Institutions that are central to young people's lives offer the best setting for enrollment initiatives.** However, leveraging the advantages that are inherent in such settings requires more than simple co-location. Facilitated enrollment should be integrated into a program's fabric, and staff regarded as full members of its client-service team.

- **Facilitated enrollment is a complicated and time-consuming business that demands specialized staff whom parents can trust.** Determining whether a family is eligible and which documents are required can be an extremely complicated task. The application process can be very intrusive, often touching on sensitive information about a family's finances, household composition, and immigration status.

- **School-based health insurance enrollment works.** Ninety-four percent of eligible children and 89 percent of eligible adults screened by HCAP have completed the application process. The majority of parents who have applied for insurance through HCAP are employed. Many receive hourly wages. Providing application assistance in the schools removes some of the barriers parents encounter when trying to access health insurance for their children. **Working parents greatly appreciate the convenience of applying for child health insurance in a place that is already part of their daily routine.**

- **The entire family should be enrolled whenever possible.** In over half of the cases that resulted in a Medicaid application, at least one parent was eligible and applied. While the application form used when applying only for children is one

page and requires less documentation, HCAP is committed to enrolling every family member who is eligible. By providing parents with the means to access the health care system, we hope that they will be more likely to seek health care for their children.

- **The enrollment process is not complete until the family is accessing services.** The application can become derailed at a number of points after it has been submitted to Medicaid or a health plan. Forms may be lost or errors may occur in determining whether a family is eligible. Supervisors must be prepared to troubleshoot and advocate on behalf of applicants. Once families have their insurance, they often need guidance on such matters as their rights under managed care or how to navigate the health care system.

For more information please contact Rebecca Lieberman, Director of Policy and Program, Office of Public Policy and Client Advocacy, (212) 358-8930.

The Children's Aid Society was founded in 1853 and serves over 120,000 New York City children and their families each year, without regard to race, religion, nationality or socio-economic status. Our mission is to ensure the physical and emotional well-being of children and families and to provide each child with the support and opportunities needed to become a happy, healthy, and successful adult. Our services address every aspect of a child's life from infancy through adolescence and parenthood, including adoption and foster care, medical and dental care, counseling, preventive services, winter and summer camps, recreation, the arts, education and job training.

HEALTH CARE FINANCING ADMINISTRATION

ADDRESSEE:

Mary Beth Hance
David Cade
Rhonda Rhodes
✓Devorah Adler
Melissa Skolfield

PHONE: _____

FROM: Peter Harbage

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FAX : 202-690-6262

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REMARKS:

FOR YOUR INFORMATION.

MEDICAID'S PROBLEM WITH CHILDREN

BY MARILYN WERBER SERAFINI

LIZ LYNCH

ALINA SALGANICOFF: "We need to focus energy on how Medicaid is doing, how we get people into Medicaid."

President Clinton generated headlines—and a little bit of head-scratching—a few weeks ago when he went to the annual meeting of the National Governors' Association in St. Louis and chided governors for not being aggressive enough in implementing a new health insurance program for children. Clinton's complaint centered on the Children's Health Insurance Program, which Congress enacted, as part of the 1997 Balanced Budget Act, to make insurance more available to children in low-income households.

Clinton's criticism was puzzling on two counts: First, CHIP seems to be working. In less than two years, states have signed up 1.3 million children, half of all of the uninsured children eligible for the program, according to some estimates. Even some Clinton Administration officials acknowledge privately that they're pleased with the states' progress.

Second, the government program that appears to be lagging in providing health insurance for children isn't CHIP—it's Medicaid. Health care analysts have detected a decline in the number of children covered by Medicaid, the federal-state program that provides health insurance for poor families. In 1997, Medicaid covered some 21 million children, but another 5 million who were eligible were not enrolled. From 1995-97, the enrollment of children in Medicaid dropped 1.4 percent, according to estimates by the Urban Institute, a Washington think tank.

"We need to focus energy on how Medicaid is doing, how we get people into Medicaid," said Alina Salganicoff, associate director of the Kaiser Commission on Medicaid and the Uninsured. "Medicaid is a much larger program than CHIP will ever be. It's an important point that often gets lost."

Anecdotal evidence suggests that the Medicaid problem is worsening. Although CHIP is turning up some children who are being placed in Medicaid, it ironically also may be causing states to place less emphasis on Medicaid. States are eligible for higher matching rates from the federal government when they enroll children in CHIP than when they sign up kids for Medicaid. Some analysts say this may be causing states to treat CHIP as a higher priority.

There are other factors as well. As families move off the welfare rolls, they're also leaving Medicaid—even though the children in those families often remain eligible for the program. And illegal immigrants are hesitant to sign up children born in the United States, and thus eligible for Medicaid, for fear of drawing attention to themselves.

Since the mid-1960s, Medicaid has provided health insurance to the nation's poorest children. After 1994, when Congress rejected President Clinton's Health Security Act, which would have guaranteed health insurance for every American, Congress began exploring less costly solutions to expanding coverage.

The first target was low-income children whose families earned too much money to qualify for Medicaid, but not enough to buy insurance on their own. The result was CHIP. The idea was for states to develop new health insurance programs, or expand Medicaid, to serve 2.6 million children who were falling between the cracks.

States moved quickly to take advantage of generous federal matching funds totaling $24 billion over five years. Some called special legislative sessions to construct new insurance programs for children, and many have instituted aggressive outreach programs to find and enroll eligible children. Alabama, for example, sent information packets home with every school-age child in the state.

"All the data we've collected to this point show states are doing an incredible job reaching out to kids and enrolling them in the CHIP program," said Terrell Halaska, the manager of media relations at the governors' association.

But the challenge is far greater for Medicaid. Indeed, a recent Kaiser Commission study that concluded CHIP had passed the halfway mark also turned up anecdotal evidence that many states are losing ground in the Medicaid program. In talking with CHIP officials in each state, the study's author, Vernon K. Smith, a principal at Health Management Associates in Lansing, Mich., also heard a lot about Medicaid. (Many CHIP programs are run through Medicaid, and CHIP administrators typically work together with Medicaid administrators. Sometimes they're the same people.) Medicaid's shortcomings prompted Smith to begin a new study on the insurance program.

There's little official national data documenting what's happening with Medicaid in the states. The Administration hopes this fall to unravel some of the mystery. Starting next week, officials from the Department of Health and Human Services' Health Care Financing Administration will visit each state's Medicaid office to collect enrollment data, work with states that are experiencing trouble, encourage greater enrollment, and pass along success stories.

Cindy Mann, senior fellow at the Center on Budget and Policy Priorities, a Washington think tank, has identified three states—New York, Texas, and Florida—that have experienced declines in recent years in the coverage of children. Both she and Smith agree the problem is widespread. New York, for instance, increased its enrollment of kids in CHIP from 270,683 in December 1998 to 352,273 in June —a 30 percent jump in six months. However, the number of New York's young Medicaid beneficiaries has declined by more than 200,000 since 1995, according to data from the New York State Department of Family Assistance.

Smith doesn't fault the states. He says many state officials are as determined to sign up children for Medicaid as they are for CHIP. Smith found evidence that outreach activities for CHIP were identifying many people eligible for Medicaid. For example, Alabama reported that for every 100 applications for CHIP, the state enrolled 50 children in Medicaid and 30 in CHIP.

But Mann, pointing to CHIP's bigger matching funds, questions whether states are as enthusiastic about Medicaid as they are about CHIP. States with the highest per capita incomes, for example, generally get a federal match of 50 percent for Medicaid, but a 65 percent federal match for CHIP, according to the National Governors' Association. At the other end, states such as Mississippi with the lowest per capita incomes get a 77 percent match for Medicaid, and a 84 percent match for CHIP. "Regular Medicaid kids don't get the enhanced match, so states are focusing on CHIP," says Mann.

Perhaps an even bigger factor in the decline in Medicaid enrollment is welfare reform. Although considered successful at moving people from welfare to work, the Welfare Reform Act of 1996 has played a large role in removing people from Medicaid—even some who still qualify.

A report released in May by Families USA, an advocacy group in Washington, found that welfare reform directly left 675,000 people uninsured in 1997, and that 62 percent of that number were children. "The reward many are receiving for coming off welfare, even when they get jobs, is the loss of health care coverage," said Ron Pollack, the group's executive director. "And while politicians from both sides of the aisle are celebrating the reduction in the welfare rolls, they are ignoring this nasty side effect of welfare reform."

As people leave the welfare rolls, some are getting employer-sponsored health insurance for their families. Others, though, don't have jobs, and still more are getting jobs that either don't offer health insurance or make it available at a price that low-income workers can't afford.

The good news is that people who leave welfare are allowed under federal law to temporarily continue their Medicaid coverage. Some states allow people to stay on Medicaid for as long as two years after they become employed. The bad news is that many people don't know that.

Welfare cash assistance used to be tied closely to Medicaid; when welfare cash assistance ended, so did Medicaid. Now, when families leave welfare, some assume they no longer qualify for Medicaid. And some states are a bit confused, too. There has been a recent surge of lawsuits against states that wrongfully terminated Medicaid coverage when the families stopped receiving cash assistance.

Medicaid enrollment for children peaked in 1995, when 21.6 million children received coverage. At that time, 11.2 million were automatically enrolled because their families received cash assistance. Another 10.4 million were not on welfare. By 1997, 21 million children had Medicaid coverage, with only 8.9 million getting the help in conjunction with cash assistance.

States aren't happy about this change,

CINDY MANN: "Regular Medicaid kids don't get the enhanced match, so states are focusing on CHIP."

and they're looking for answers, said Smith. "They're trying to find ways to make sure when people work their way off of welfare, where Medicaid eligibility exists, they will continue to be enrolled in Medicaid."

Then there are those people who know about Medicaid, but who choose not to sign up their kids. Since the Welfare Reform Act was enacted in 1996, immigrants have feared that enrolling their children in Medicaid will cause the government to investigate their immigration status, even though the federal government has clarified that this won't be the case, according to Mann.

Administering the program is another barrier to Medicaid enrollment. In many states, applicants have to show up in person and sit through an interview, and sometimes even produce months of pay stubs. Moreover, some states aren't applying their simple CHIP enrollment procedures to their Medicaid programs. For example, four of the 25 states with separate CHIP programs have mail-in applications for CHIP, but not for Medicaid, says Mann. Seven of those states have adopted 12-month continuous eligibility periods for CHIP, but not for Medicaid. Some states also require more verification and paperwork for Medicaid.

"It's more the rule than the exception that Medicaid enrollment has been declining," said Smith. "In some ways this is good because people are off of welfare and in jobs, and some people are getting health insurance that way. But the system is still not perfect. Half of the kids that could still be on Medicaid are not staying on when they could." ■

NATIONAL GOVERNORS' ASSOCIATION

Thomas R. Carper
Governor of Delaware
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Michael O. Leavitt
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Vice Chairman

Raymond C. Scheppach
Executive Director

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444 North Capitol Street
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Telephone (202) 624-5300
http://www.nga.org

December 8, 1998

Chris Jennings
Deputy Assistant to the President for
Health Policy
216 R OEOB
Washington, D.C. 20503

Dear Chris:

Now that we have launched the first pilot phase of the Insure Kids Now hotline I want to clarify the role of the National Governors' Association (NGA) as a partner in this effort. The current relationship between the NGA staff working on the hotline, the White House and administration staff is very positive and the NGA is pleased to be a part of this important effort.

When NGA agreed to oversee the initial implementation of the hotline and contracted with AT&T to pay the long distance telephone charges on behalf of the states, we did so with the understanding that the administration planned to include funding for ongoing operations of the hotline in the federal fiscal year 2000 budget request. We assume this is still the case. It is still our plan that when that funding becomes available in the federal budget in the fall of 1999, we will transfer the management and operations of the hotline to the U.S. Department of Health and Human Services. Joan Henneberry, the Director of Maternal and Child Health, will coordinate the transition for NGA.

Currently, the expenses for long distance calls are being paid for by a contribution we received from Bell Atlantic, which was made possible through the work of the administration. As you know this is a fixed amount of money ($36,000), with no commitment from Bell Atlantic to provide additional funds should this amount be inadequate to support the hotline until federal funding is available. We want to reiterate that should the volume of telephone calls exceed the estimates and exceed the budget for long distance charges, NGA will not be able to assume those costs without additional, new funding. We will monitor the progress of the hotline and call volume closely, and will continue to keep all interested parties informed.

Again, we are pleased to be part of this project and on behalf of the states remain committed to its success. Please call me if you have any questions or would like to discuss this further.

Sincerely,

Ray

Raymond C. Scheppach

Insure Kids Now

1-877-KIDS NOW
FREE CALL


Home


State Plans


Feedback


Other Resources


Help

State of Massachusetts

LOW-COST OR FREE HEALTH INSURANCE IS NOW HERE FOR KIDS WHO NEED IT

The State of Massachusetts has expanded **MassHealth** in order to provide health insurance to children who are presently uninsured.

MASSHEALTH

Your children can receive the medical services they need through MassHealth. Covered services include regular check-ups and immunizations, school and sports physicals, prescription drugs, dental care, vision and hearing testing, hospital visits, and more.

COULD MY CHILDREN QUALIFY FOR MASSHEALTH?

It's very likely that your children could qualify for MassHealth or other public health insurance programs sponsored by the State of Massachusetts. Take your income and compare that number, along with your family size (including parents), with the income figures shown in the chart below. If your income falls at or below the amount on the chart, your children may be eligible for MassHealth or other State sponsored health insurance coverage.

Number of Family Members	Annual Income Under
2	21,700
3	27,300
4	32,900

NOTE: These income amounts may be revised because of changes in the State program or the economy. Always call your State at the number listed below for the most accurate numbers.

It is important to remember that these numbers are approximate. If your family income is more than the amounts on the chart, your children may still qualify. The best way to find out if your children are eligible for MassHealth is to apply for the program.

HOW TO GET MORE INFORMATION ABOUT MASSHEALTH

For more information about MassHealth,

- call **1-800- 841-2900.** The operator can answer any questions that you may have about the program and can even send you an application in the mail.

- Visit the MassHealth website
- Watch the video presentation
- Listen to the audio presentation

HEALTH INSURANCE GIVES YOUR CHILDREN A HEALTHY FUTURE

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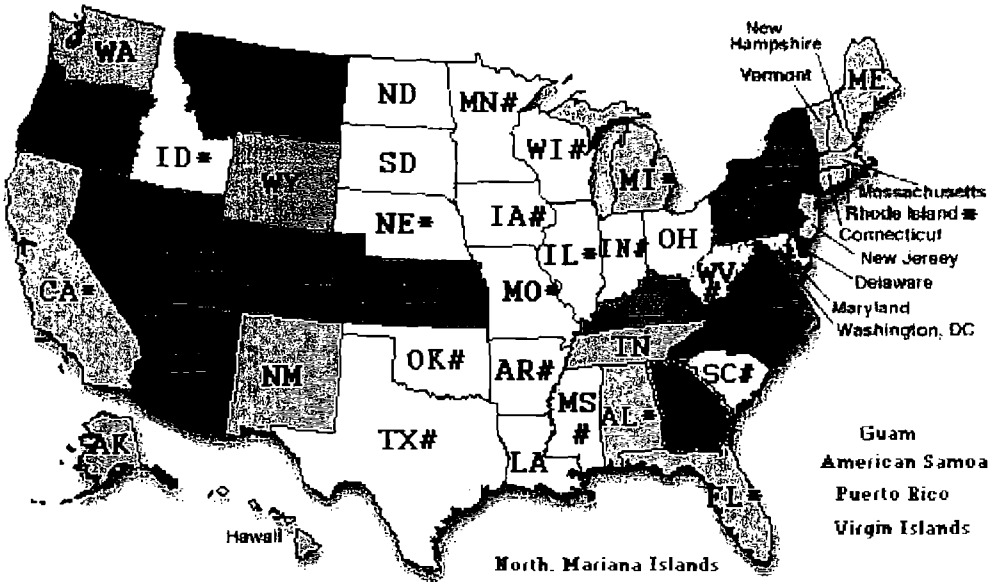
CHILD HEALTH INSURANCE PROGRAM
STATE PLANS



APPROVED

- Separate State Child Health Plan
- Medicaid Expansion
- Combination

PENDING

- Separate State Child Health Plan
- Medicaid Expansion
- Combination

NO SUBMISSION

* State Plan Amendment

\# State has indicated submission is an initial phase; plan amendment is anticipated.

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Sincerely,

Raymond C. Scheppach

National Governors' Association
Center for Best Practices
444 North Capitol Street
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Telephone (202) 624-5300
http://www.nga.org/Center

NGA Center for Best Practices

Date: 10/23/98 Time: 1:35:19 PM Pages: 5

To: Devorah Adler Fax Number: 4565557

From: Joy Horner

Subject: Draft Survey to states about hotlines

Note:

Jeanne and Devorah-
I thought you might want to have a chance to add suggestions or edits to this draft survey before we send it out to states.

You can mark it up and fax it back to me at 202-624-5313.
Joy

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NGA *Center for Best Practices*

DRAFT 10/23/1998

To:
From: *Joy Horner/Joan Henneberry*
Re: *Information Request and Verification about State Toll-Free Numbers for Children's Health Insurance Outreach and Enrollment Efforts*

Thank you for your participation in the National Children's Health Insurance Hotline. The pilot phase of the effort is currently underway in ten states and we are working toward the national launch in early 1999. As we approach the national launch we wanted to take an opportunity to verify information that has been provided to the NGA about your state's hotline and to collect some information that will be published in an upcoming NGA Issue Brief on hotlines. The Issue Brief will provide information about trends and innovations in state hotlines and will feature several states that have been found to have especially helpful and efficient hotlines.

The NGA is particularly interested in the quality of state hotlines because of the potential impact they have on the success of the Governors' efforts to expand health insurance to eligible, uninsured children. In support of this goal the NGA is involved in the collaborative effort with the Administration to establishing the national hotline, which will link directly to state hotlines, and is seeking private sector involvement to promote the national hotline.

The accuracy and timeliness of your response will enhance the success of this effort. Again, thank you for participating and we look forward to receiving the response to the survey. If you have any questions please feel free to call Joy Horner at (202) 624-7854 or better yet, e-mail her at Jhorner@nga.org. Please fax the response to this survey to Joy Horner at (202) 624-5313.

SURVEY INFORMATION ON STATE-WIDE HOTLINES

The following questions refer to information about the hotline that your state has chosen to link to the National Children's Health Insurance Hotline. Detailed information about the line is listed in the next section for your verification. Please consider only the capacity of the identified hotline in answering the questions.

1) What is the "group size" of the hotline? That is, how many people can call the line at one time without getting a busy signal or being transferred to voice mail?

Group Size: _____

2) Are hotline operators able to address questions and assist the caller with issues related to eligibility for SCHIP and Medicaid? Yes ☐ No ☐ Medicaid only ☐ SCHIP only ☐

3) Does the caller receive the requested information or application through the mail within 5 working days?

Yes ☐ No ☐

4) If the state requires a birth certificate or citizenship verification in order to enroll, do hotline operators or enrollment and eligibility staff have access to state vital statistics data systems such that the potential client is not required to supply the information?

Yes ☐ No ☐ N/A because state does not require ☐

5) In the preliminary moments of the call, is the caller provided with a prompt that would transfer them to a hotline operator that speaks a language other than English?

Yes ☐ No ☐

6) Do hotline operators offer assistance in filling out the application over the phone?

Yes ☐ No ☐

7) Can the hotline operator submit the application on behalf of the client?

Yes ☐ No ☐ Medicaid only ☐ SCHIP only ☐

8) Does the hotline have the internal capacity to determine how the caller found out about the hotline?

Yes ☐ No ☐

9) Does the hotline have the internal capacity to collect basic demographic data?

Yes ☐ No ☐

10) Does the hotline have the internal capacity to determine the rate at which applications are submitted and the outcome of the applications (approved or denied- if denied, for what reason)?

Yes ☐ No ☐

11) What has been the best decision or strategy that has allowed the hotline to achieve the goal of enrolling eligible children?

12) What have been some of the state's biggest challenges in implementing and operating the statewide toll free hotline?

13) Has the state developed private-public partnerships that have helped to promote the program or the hotline?

Yes ☐ No ☐

If "yes", please describe:

14) What types of vehicles has your state utilized to promote the hotline?

- ☐ TV ads
- ☐ Radio ads
- ☐ Newspaper ads or inserts
- ☐ Flyers in schools
- ☐ Targeted multi-ethnic media
- ☐ Private- partnership promotion
- ☐ Informed/involved community based organizations
- ☐

Please describe any of these activities that you feel were particularly innovative?

15) In your opinion or based on data collected from the hotline, what type of publicity has resulted in the highest number of calls or potentially eligible clients?

(Emily has already collected information about which states have short applications, dropped assets tests, and combined applications etc., so I probably won't get into that in this survey.)

VERIFICATION OF INFORMATION FOR NATIONAL HOTLINE:

(I will be using a mail merge to fill in the following information...)

Your state has indicated that they wish to participate in the National Children's Health Insurance Hotline and has provided the following information to the NGA. Please verify that it is accurate and fill in any missing information.

The statewide toll-free number that will be linked to the national hotline is:

The POTS (Plain Old Telephone) line or terminating line that is associated with the toll free number listed above is:

The line is a "dedicated access line" or a "ready line"):
(If you have a POTS number then your line is a "ready line.")

If the line is a "dedicated access" line, what company is the long distance carrier? _____

The hours of operation of the line are:

There is voice mail during off hours: (Yes or No)

The billing address is:

The actual physical location where calls will be answered is:

The name and number of the contact person is:

Please provide the fax and the e-mail address for the contact person: