NATIONAL ACADEMY
*for* STATE HEALTH POLICY

# If You Build It, Will They Come?

## *Case Studies on CHIP Implementation*

***Trish Riley***
***Cynthia Pernice***

**August 1999**

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The National Academy for State Health Policy (NASHP) is dedicated to excellence in state health policy and practice. Since its inception in 1987, NASHP has provided state health policy leaders with access to timely, unbiased information on pressing health care issues. Because NASHP recognizes that responsibility for health care does not reside in a single state agency, department, or branch of government, it strives to foster productive interchange across all lines of authority. Each year, NASHP conducts policy analysis, provides training and technical assistance to states, and — through its publications, annual state health policy conference, media briefings, and website — disseminates information designed to assist states in the development of practical, innovative solutions to complex health policy issues.

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- Connecticut
  - State Staff: David Parrella, Director of Medical Care Administration; Linda Mead, HUSKY Plan Project Manager; Yleana Sanchez, HUSKY B; Aurele Wilson, HUSKY B Nurse Consultant; James Linnane, Medical Administration Manager; and David Dearborn, Communications Manager..
  - Advocates: Moira O'Neill, Community Care Coordinator, Yale University School of Medicine; Carol Gordon, Special Needs Family Advocate, Yale University School of Medicine; Jean Adnopoz, Clinical Director, HUSKY Plus Behavioral

- Maine
  - State Staff: Francis Finnegan, Director of the Bureau of Medical Services; Linda Schumacher, Title XXI Program Manager; Maurice Gagnon, Comprehensive Health Planner; and Barbara Feltes Medicaid Program Manager.
  - Advocates: Joe Dietre, Executive Director, Consumers for Affordable Health Care; Bonnie Post, Executive Director, Maine Ambulatory Care Coalition; Elinor Goldberg, Executive Director, Maine Children's Alliance; and Chris Hastedt, Executive Director, Maine Equal Justice Project.

- Pennsylvania
  - State Staff: Patricia Stromberg, Executive Director; Jeannette Hoffman, Outreach Coordinator; Peg Dierkers, Director of the Office of Policy Development; George Hoover, Director of the Division of Health Services; and Jim Lyne, Director of the Division of Program Evaluation.
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## INTRODUCTION

The National Academy for State Health Policy conducted site visits to three states in May and June of 1999 to gather information about how states are implementing CHIP. Visits were one day long and included meetings with CHIP staff, Medicaid staff, and consumers and their advocates. The purpose of the visits was to gain a deeper understanding of the issues and challenges confronting states as they implement CHIP.

Title XXI of the Social Security Act created the Children's Health Insurance Program and granted states considerable discretion in how to design their program and whom to serve. States can expand Medicaid, establish a separate, free-standing program, or combine the two approaches. The law allowed three states to continue unique programs already established and operational. States could serve children whose family income did not exceed 200% of the Federal Poverty Level (FPL) or whose income was 50 percentage points above the current Medicaid eligibility threshold. States can determine how income is counted and therefore can even exceed 200% FPL.

NASHP selected three states representing different CHIP models and different CHIP eligibility target groups:

- Pennsylvania was chosen as a free-standing program, one of the three "grandfathered" under the Title XXI statute and one which targeted children 0-18 up to 200% of the FPL.

- Connecticut was selected as a combination program which included both Medicaid and a separate program for those with family incomes above 185% FPL.

- Maine was the third site visit and was selected because of its reliance on a Medicaid model and because it had a more narrow target population, serving children up to 185% of poverty. Maine's program is also a combination program of Medicaid expansions (to 150% FPL) and a separate program (to 185% FPL), but the separate program is a "look alike" that wraps around the Medicaid program and is administered by it.

All programs had nearly one year of experience in enrolling children in CHIP.

## *Snapshot of Site Visit States*

| | | CONNECTICUT | MAINE | PENNSYLVANIA |
|---|---|---|---|---|
| STATE DEMO-GRAPHICS | 7/1/98 POPULATION[1] | 3,274,069 | 1,244,250 | 12,001,451 |
| | RANKED BY[2]: AMERICAN INDIAN POP | 42 | 45 | 29 |
| | ASIAN & PACIFIC ISLANDER | 22 | 45 | 12 |
| | BLACK POPULATION | 24 | 46 | 14 |
| | HISPANIC POPULATION | 13 | 48 | 12 |
| | WHITE POPULATION | 26 | 39 | 5 |
| PROGRAM DESIGN | | Combination (HUSKY Program)<br>Medicaid CHIP Expansion - HUSKY A<br>State-Designed CHIP Program - HUSKY B | Combination<br>Medicaid CHIP Expansion<br>State-Designed CHIP Program - Cub Care | Grandfathered State-Designed Program - PaCHIP |
| CHIP ADMINISTRATION | | Department of Social Services (Same agency that administers Medicaid) | Bureau of Medical Services - the Medicaid agency - housed in the Department of Human Services | Department of Insurance (Not the same agency that administers Medicaid) |
| TRADITIONAL MEDICAID (TITLE XIX) | | 0-14 to 185% | 0-1 to185%<br>1-6 to 133%<br>6-18 to 125% | 0-1 to 185%<br>1-6 to 133%<br>6-16 to 100%<br>17-18 will be phased-in to 100% by 10/02 |
| MEDICAID CHIP EXPANSION (TITLE XXI) | | Husky Part A<br>14-18 to 185% | 1-6 from 133% to 150%<br>6-18 from 125% to 150% | No program |

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1 ST-98-2 State Population Estimates and Demographic Components of Population Change : April 1, 1998 to July 1, 1998. Population Estimates Program, Population Division, U.S. Bureau of the Census, Washington, DC 20233

2 States Ranked by Population in 1997. Population Estimates Program, Population Division, U.S. Bureau of the Census, Washington, DC 20233

| | [redacted] | MAINE | PENNSYLVANIA |
|---|---|---|---|
| **STATE-DESIGNED CHIP PROGRAM (TITLE XXI)** | Husky Part B<br>0 - 18 from 185% to 300% | Cub Care<br>1-18 from 150% to 185%<br>Will expand to 200% by July 2000 | 0-1 from 185% to 200%<br>1-6 from 133% to 200%<br>6-16 from 100% to 200%<br>0-18 from 200%-235% (not Title XXI, program funded by state) |
| **BEGAN ENROLLING CHILDREN IN TITLE XXI** | July 1, 1998 | Medicaid CHIP Expansion - July 1, 1998<br>Cub Care - August 1, 1998 | May 1993 as state-only program retroactive to October 1, 1997 |
| **CPS ESTIMATE OF UNINSURED CHILDREN UNDER 200%FPL** | 53,000 | 24,000 | 200,000 |
| **STATE ESTIMATE OF TARGETED LOW-INCOME UNINSURED CHILDREN AND NUMBER OF CHILDREN ENROLLED IN CHIP** | The state has a targeted enrollment of 36,000 children and as of March 1999 had enrolled nearly 17,000 (47%). | The state has a targeted enrollment of 6,968 children for its expansion up to 185% and will target an additional 4,032 children with a tentative expansion up to 200%. As of June 1999, 6,500 (93%) children had been enrolled. | The states has a targeted enrollment of 150,000 children and has enrolled 80,719 (53%) as of July 1999 . (80,719 includes 55,000 children who were previously enrolled in Pennsylvania's state-only grandfathered program. |

## KEY FINDINGS

### *Title XXI has allowed states to develop programs that address the unique needs of each state.*

As a block grant to states, Title XXI provides states with considerable flexibility, and states are using this flexibility to reflect different state cultures, political realities, and marketplaces. The system design choices that each state has made since the passage of Title XXI have resulted in CHIP programs unique to each state and have allowed states the opportunity to experiment with new and creative approaches to the challenges of providing health care coverage to low-income children. For instance,

- Pennsylvania's program builds on a successful commercial insurance model that was already in place before CHIP was created. Pennsylvania has been resistant to an expansion of Medicaid under CHIP in part because of an earlier class action suit directed at Medicaid. The state's marketing strategy for the new program strongly reflects the state's philosophy of assisting working families.

- Connecticut has used CHIP to build on its Medicaid program and to further its goal of ensuring that all children be insured. Its CHIP program builds on Title XIX, Medicaid, for administration but has created a separate program that is modeled on state employee coverage. And the state has renamed all of its children's insurance programs (both Medicaid and CHIP) in order to give its public health coverage a new identity: HUSKY (Healthcare for Uninsured Kids and Youth).

- Maine's approach to CHIP has been cautious, reflecting an earlier, state-funded program that grew too costly and was ultimately eliminated by the governor and legislature. Its Title XIX and Title XXI programs are look-alike programs in every way, except that its CHIP program requires cost sharing, uses gross income, not Medicaid disregards, to

determine eligibility and is not an entitlement (and can therefore be cut back if necessary).

Nearly every component of each state's program has been designed to reflect the specific realities within the state. For instance, the three states discussed here have devised outreach and marketing programs that differ in significant ways from one another, and each has developed targeted programs designed to reach and address the needs of specific groups with significant numbers of eligible children. Each state also has particular challenges serving parts of the population: in Pennsylvania, the Amish; in Maine, Native Americans and refugees; and in Connecticut, migrant workers.

### *Differing policy goals have resulted in mixed messages: to the states and to eligible families.*

The Federal government's reliance on incrementalism to increase health coverage has had consequences, the most significant of which may be the number of different programs that have been created to address specific needs. These numerous programs frequently reflect differing policy aims, resulting in a mix of messages to states and to the families these programs are intended to serve.

#### *Eligibility*

While the message to states from the Federal government is to provide health coverage to all eligible children, states have also been instructed to insure that children fit into the right eligibility box, the right program, before they can be covered. States have responded to these directives in a variety of ways:

- In Maine, which integrated CHIP into Medicaid, the state created different eligibility standards in an effort to simplify eligibility for CHIP. (CHIP eligibility is based on gross income, Medicaid on net income after disregards). The result not only complicates coordination between the two programs but, more importantly, has meant that fewer

children are actually eligible for CHIP.

- Connecticut created a streamlined, simplified, consumer friendly call-in/mail-in application system administered by a private company, but because Federal law requires that Medicaid determination be done by the state, Connecticut must still rely on regional offices to complete that task.

- Pennsylvania — which has long operated a separate program in which private insurers handled eligibility — has been stymied by the requirement to coordinate its CHIP efforts with Medicaid, which operates through state and local agencies.

In addition, states are often unclear about just how many eligible children there actually are. Maine did a costly study to try to arrive at an accurate number; Connecticut and Pennsylvania have had to extrapolate those numbers and, as a result, have had to change their baselines of projected numbers of children to be served. On average, the three states had already met about 65% of enrollment targets after one year or less of operation (PA-53%, CT-47%, ME-93%).

Nevertheless, all states are working hard to coordinate their programs and to ensure that as many eligible children as possible are identified and provided coverage.

### *Crowd-out and Equity Issues*

The message to cover all eligible children is further complicated by Federal concerns over crowd-out, in which no-cost or low-cost public health insurance replaces existing private coverage. The Federal government has required states to develop mechanisms aimed at discouraging families from dropping private coverage. As a result, states have devised crowd-out policies that sometimes make it impossible to provide comprehensive health coverage to deserving families and their children.

- Connecticut requires that a child be uninsured by employer-sponsored group coverage for six months before he or she can be eligible for CHIP. State officials worry that families covered by policies with limited benefits (especially those with special needs children who require costly primary and acute care) cannot afford to go without coverage for six months in order to qualify for CHIP's more comprehensive physical and behavioral health services, particularly the supplementary physical and behavioral health care Connecticut offers through HUSKY Plus.

- As required by Federal law, Maine, like other states, has excluded state employees from CHIP eligibility. Maine allows families who spend more than 10% of their income on health insurance to qualify for CHIP. Although some state employees (particularly seasonal workers) are exceeding 10% of family income to cover the cost of dependent coverage, nevertheless, they remain ineligible for Title XXI coverage.

### *Outreach*

While each of the three states has developed comprehensive outreach programs, all expressed a desire for more accurate measures of the success of their efforts. In addition, all three states voiced concerns about the mixed messages sometimes sent by the various players involved in promoting health coverage for children, specifically, state government, the Federal government, and the Robert Wood Johnson Foundation Covering Kids Initiative. The states note the need to improve coordination among these players.

### *System Design*

Some states believe that an impediment to reaching the uninsured is the availability of free care through clinics and emergency rooms. Health centers receive Federal grant funds to serve the uninsured and are reimbursed on a fee-for-service basis for Medicaid eligibles. Health centers may or may not participate as providers in managed care arrangements. Two of the three CHIP programs included here primarily deliver services through managed care plans, and state officials note that local providers may fear loss of revenue if clients are found eligible for CHIP and

enrolled in managed care.

### *The Stigma of Government Assistance*

Officials in the three states commented on the different messages frequently sent by Federal and state governments regarding public assistance. While welfare has been portrayed as a government program that public officials want people to leave as quickly as possible, health coverage is viewed as beneficial, and both state and Federal governments have actively encouraged parents to enroll their children.

Clearly, some stigma of government assistance persists, and the three states profiled here have gone to considerable lengths to avoid association with Medicaid and/or to overcome the stigma. Some core elements of CHIP programs have been designed specifically to avoid this association, among them outreach and marketing efforts, enrollment procedures and materials. Connecticut has chosen to give one name to all of its children's health coverage, thereby eliminating reference to Medicaid. Even the decision to expand Medicaid or create stand-alone CHIP programs is not infrequently based on the desire to avoid the Medicaid/government assistance stigma.

Because CHIP requires coordination with Medicaid, and because only states can determine Medicaid eligibility, states must maintain a relationship with Medicaid eligibility in building CHIP programs. But the perceived stigma to government programs may be rooted deep in the Medicaid program which historically imposed penalties on states that improperly determined eligibility. Medicaid eligibility systems are administered in the 3 states in regional offices by civil servants who are unionized. To change how eligibility is done requires changes in these offices which are not part of, or directly accountable to, Medicaid programs. In two states, eligibility for CHIP is done outside state government; in the other state, efforts are underway to train and re-orient regional eligibility staff for CHIP administration.

### *With CHIP program development and start-up complete, new challenges confront states.*

#### *Data Collection*

The urgent need to develop and implement CHIP programs has meant that states have had relatively little time and few resources to devote to certain elements of their systems, most notably, in the three states profiled here, data collection and management. Clearly, problems with data collection and processing is and will likely remain a significant challenge for states and is having an impact on states' abilities to conduct utilization reviews; assess, monitor, and assure quality; track trends in enrollment and disenrollment; and report to HCFA.

In addition, Y2K issues have slowed all three states' abilities to develop effective new data systems to chart CHIP. In Connecticut, the state's plan to privatize computing functions has resulted in uncertainty about the future of work among state information systems staff, some of whom have left state government for work elsewhere. All three states report the need for further refinements to their data collection and processing systems, and all three are working to ensure that those refinements are made as quickly as possible. For instance, Pennsylvania has contracted with a private vendor to design a data system that will create centralized and comparable reporting among plans and will hire two additional staff to develop a quality oversight system.

### *CHIP is a work in progress, but much progress has already been made.*

As the three state CHIP programs profiled here indicate, CHIP is a work in progress. States continue to adapt and refine their programs in response to the needs of the families they serve and in light of market realities and Federal requirements and expectations. Among recent or planned innovations:

- Pennsylvania has recently added important coverage benefits and simplified its eligibility by creating income disregards, which will increase the number of eligible children;

- Maine will raise its eligibility level to 200% FPL by next year; and

- Connecticut is working to simplify and coordinate marketing messages, improve data systems, and further coordinate Medicaid and CHIP within the limits of current Title XXI law.

The experiences of Connecticut, Maine, and Pennsylvania make clear that much has been accomplished in the one year that CHIP programs have been up and running and providing comprehensive health coverage to low-income children. And these experiences suggest that program start-up takes time but progress has been and will continue to be steady.

## PENNSYLVANIA

Pennsylvania has built its Title XXI program on a rich tradition of providing children's health insurance. Pennsylvania was the home of the first Caring Foundation initiative to cover low-income children. The original CHIP legislation created health coverage for children up to their 13th birthday living in families below 185% FPL and for children up to age 6 whose family income was between 185% and 200%. Below 185% the program was free, between 185% and 200%, there was a 50% copay for the premium. In the original program, there was a $5 copay for prescription drugs. Over time, the program was expanded, so that by the time the Federal Title XXI legislation was enacted, Pennsylvania was covering children up to their 17th birthday in both the free and low-cost programs. Children with incomes up to 200% FPL were eligible at not cost for the "Free Program"; children from 200% to 235% to age 5 were eligible for the subsidized program, for which they paid premiums. The State CHIP program was administered though private health insurers.

Following enactment of Title XXI, which specifically allowed the Commonwealth of Pennsylvania to build on its preexisting CHIP program, the Commonwealth elected to create a program covering children up to 200% of the Federal Poverty Level and through age 18. Benefits to these children are free. The state has also continued its state-funded subsidized program for children from 201% to 235% of the Federal Poverty Level. Families in this component must pay a premium to participate. Because the Title XXI Statute allowed Pennsylvania to build from its existing program, it is important to remember that when Pennsylvania refers to "CHIP" it means both its Title XXI and the state-subsidized program. This report, however, addresses only the Title XXI funded component which covers children 0 through 18 to 200% FPL with no cost sharing imposed.

The Title XXI statute made special provisions permitting Pennsylvania, Florida, and New York to grandfather their pre-existing programs' comprehensive benefit package as a benchmark for benefits. In Pennsylvania, benefits include:

- prevention, including well child visits in accordance with the schedule established by the American Academy of Pediatrics, and services related to those visits;
- physical examinations, including x-rays if necessary, for any child exhibiting symptoms of possible child abuse;
- diagnosis and treatment of illness or injury; injections and medications provided at the time of the office visit or therapy; outpatient surgery; emergency accident and emergency care;
- prescription drugs;
- emergency, preventative and routine dental care;
- vision and hearing care;
- inpatient hospitalization up to 90 days per year; and
- mental health services both inpatient and outpatient

All insurers participating in CHIP must provide these services, at a minimum, and some offer additional services. For instance, some, but not all, insurers offer partial hospitalization for mental health services, substance abuse services, durable medical equipment, and rehabilitation therapy at no additional cost to the program. (Plans are underway to expand the scope of benefits, described later in this report.)

Pennsylvania's program is strongly rooted in managed care as the primary system of service delivery (either HMO or PPO). The vast majority of children in CHIP are served through managed care, except for children in 5 counties located in the northwestern part of the state where there are insufficient provider networks.

Children enrolled in Pennsylvania's CHIP program prior to passage of Title XXI legislation were "transferred" to Title XXI. The state officially began claiming Federal funding for CHIP in July 1998. Estimates based upon U.S. census data indicate that there are approximately 150,000 potentially eligible children and as of June 1999 had enrolled 78,998, with an average increase in enrollment of about 3% each month. By July, the state had enrolled 80,719 children. The state

has revised its baseline estimate of children to be served since first submitting its state plan to HCFA.

## Program Philosophy

Pennsylvania's decision to create a CHIP program based on a commercial model and administered largely through health insurers, reflects its confidence in the public/private partnership and a history of success in marketing an insurance product to cover children. The state's decision not to expand Medicaid reflects the history and a perception generally shared by advocates and CHIP and Medicaid officials that Medicaid is stigmatized in Pennsylvania. Advocates and state officials agree that the contentious debate around a class action case, *Scott vs. Snider,* (described below) was a factor leading to little support for using Medicaid to expand children's health coverage. Medicaid in Pennsylvania is generally viewed as a "regulatory, litigious and expensive program."

*Scott vs. Snider* was filed in November 1991 on behalf of children under age 21 by Philadelphia Community Legal Services, et. al., in U. S. District Court, Eastern District of Pennsylvania. Plaintiffs alleged that the state had not implemented certain provisions of Medicaid related to Early Periodic Screening Detection and Treatment (EPSDT). In particular, the plaintiffs charged that the Commonwealth was not providing all medically necessary and appropriate screening, diagnostic, and treatment services available under Medicaid, regardless of whether the service was covered under the State Medicaid Plan. In 1994, a settlement was reached between the parties that stipulated explicit performance goals with a phased implementation schedule. Examples of these performance goals include:

- By 1996, assure that 80% of all eligible children up to age six receive one comprehensive health screening annually; children 7-20 one screen bi-annually.
- By September 1998, increase to 80% the number of eligible children receiving hearing and vision assessments and dental care.
- By 1998, comply with the periodicity schedule included in the document for 80% of all screens.

- By June 1999, assure that 90% of 8 to14 year olds were to receive protective sealants.
- To increase visit services to low birth-weight children, and children with high blood lead levels.
- Provide prenatal services to expectant teens.

The settlement required the state to include the agreed upon performance measures and outcomes in all Medicaid managed care contracts and to require reporting about them. A baseline and follow-up study was required by a contractor approved by both parties. The settlement also required extensive outreach and specifies that a mechanism must be developed to coordinate eligibility and enrollment between Medicaid and state-funded CHIP.

In 1997, plaintiffs and defendants met to assess progress and obstacles in meeting the requirements of the *Scott* stipulation. The stipulation clearly stated that performance measures and outcomes could be changed if both parties agreed. As a result of that meeting a Quality Improvement Plan and four work groups were established.

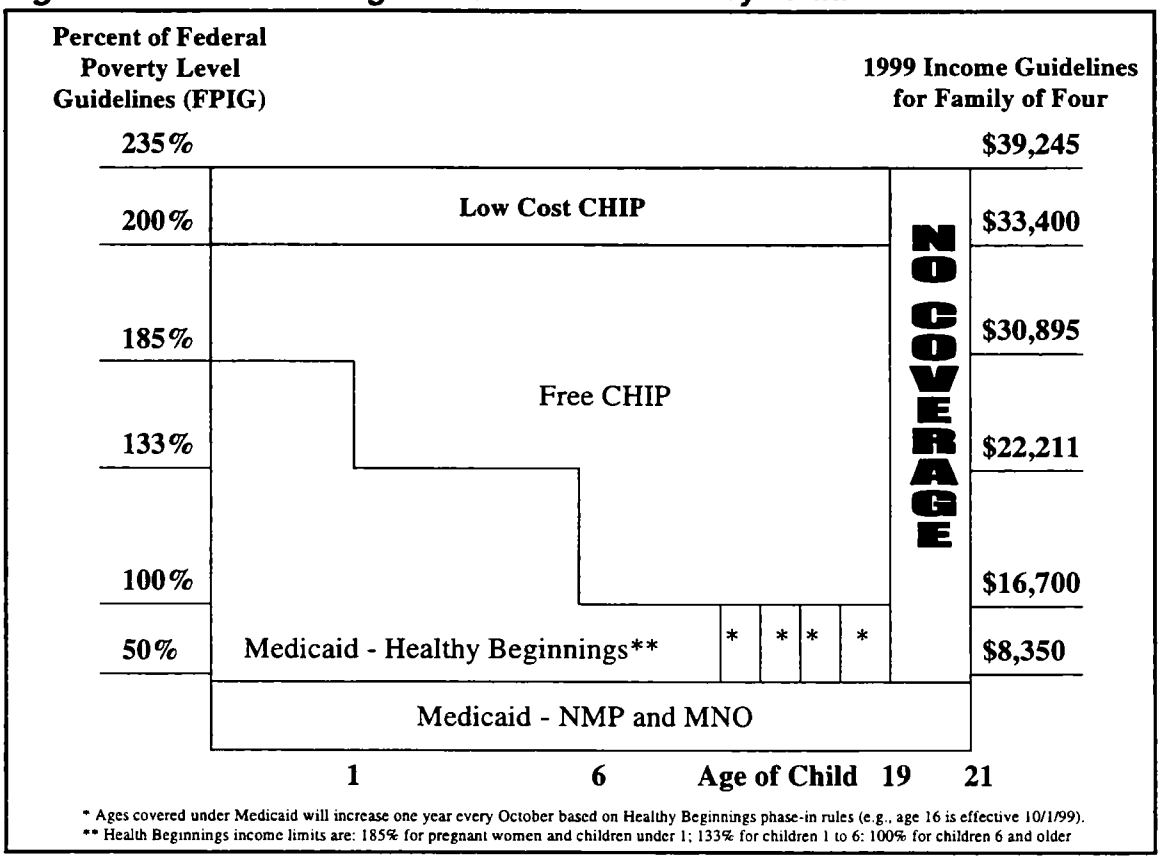
The work groups are: Quality Management, to propose a comprehensive quality improvement plan designed to ensure that children receive basic preventive care in accordance with recognized periodicity guidelines; Measurement/Data, to recommend options and/or modifications to existing data reporting and collection processes to ensure effective and accurate measurement or performance outcomes in all medical assistance health care delivery systems; Enrollment and Outreach, to recommend enhancements to current outreach and enrollment strategies to increase enrollment of eligibles and to increase the receipt of primary preventive care; and Managed Care/Family Care Network Some advocates report that the lawsuit has created much more effective communication between them and state government.

*Scott v. Snider*, coupled with the state's historic commitment to a non-Medicaid CHIP program, may help explain Pennsylvania's reluctance to embrace a new Medicaid expansion. Instead, Pennsylvania has adopted a "continuum of service" approach to coverage for children that

reflects its strong commitment to welfare reform and to enhancing the independence of low-income persons. This approach is designed to assist low-income persons in gaining access to work-based commercial insurance. The state views Medicaid as a safety net and the first step in health coverage for low-income persons.

Currently Medicaid eligibility varies by age and income. Children under one are eligible to 185% of the Federal Poverty Level, children ages 1 to 6 to 133%, and children 6 and older are eligible to 100%. The state is increasing coverage under Medicaid by one year each October with a goal of leveling off Medicaid eligibility for all children under 19 at 100% FPL by October 2001. As noted above, children who are no longer eligible for Medicaid and who have no other insurance are eligible for CHIP at no cost to the family up to 200% of poverty. From 201% to 235% of poverty, families receive state-subsidized health care as a transition to their

***Figure 1: Health Coverage for Children in Pennsylvania***



independence and work-based commercial insurance. This state-funded portion of CHIP requires monthly premiums ranging from $20 to $40 depending on where the family lives and their choice of insurer. These rates are 50% to 75% lower than the usual cost of similar insurance coverage. Figure 1 shows how a low-income person "steps" through eligibility with the ultimate goal of private, commercial coverage.

Pennsylvania's marketing materials for CHIP reflect its philosophy of assisting working families. Marketing materials are targeted to the working uninsured with the message: "If you're a working family but don't have health insurance for your kids, now you can cover them free or at low cost." The state also stresses that CHIP is Pennsylvania's program to provide quality health insurance for children of working families who otherwise could not afford it. It is not a welfare program. To further buttress the program's non-welfare image, outreach material clearly states that the program is administered though the Department of Insurance.

On April 8, 1999, Governor Ridge announced enhancements to the program that expand both eligibility and benefits. The following changes were announced and will be put into effect commensurate with the completion of a contracting process presently underway.

The program will implement income disregards similar to those used in Medicaid allowing more people to qualify for the program. CHIP will disregard $90 of earned income per month for each person and child care expenses of up to $200 per month for a child under age 2, and $175 a month for children 2 or older. These deductions reflect the state's philosophy of supporting working families and apply only to earned income. They are consistent with Medicaid disregards. The disregards will also eliminate a

For example, a four-year-old child with a family income just above 133% FPL could in fact be eligible for Medicaid or CHIP because Medicaid allows a family to "disregard" certain income when determining eligibility. Consequently, a family just over 133% FPL could subtract child care expenses disregards which would bring the family income down to 128% FPL, thereby making the child eligible for Medicaid. However, if this same child applied for CHIP which had used gross income he would be determined eligible for CHIP.

problem which created potential overlap between Medicaid and CHIP eligibility. Because income was counted differently in the two programs, a small band of children could be inappropriately denied eligibility, depending on which program they were being screened for and how their income was being counted. Children could be denied Medicaid because they seemed eligible for CHIP and denied CHIP because they seemed eligible for Medicaid.

With the new income disregards, this problem will be alleviated. By adopting a net income determination process, the CHIP program has moved to close the eligibility gap that existed between the program and Medicaid. Moreover, some children who are eligible for the state-funded CHIP program will now be eligible for Title XXI CHIP, and some children who were previously ineligible for the state-funded CHIP program will now have access to coverage in that program. It is estimated that as many as 24,000 additional children may be eligible for CHIP as a result of this change in the eligibility calculation.

Benefits being added include durable medical equipment, substance abuse, and home health care. Partial hospitalization for mental health was also added to the in-patient and out-patient mental health service package. A recently issued Request for Proposal also reflects the state's determination to provide maximum choice for families by expanding the number of insurers participating and by allowing indemnity plans to bid on CHIP. The state wants to maximize choice and access, particularly in rural areas. To date, all insurers in CHIP are commercial insurers that do not participate in Medicaid, although some of their subsidiaries do. Following the site visit, state officials reported that two bids were received from insurers that participate in Medicaid.

### Health Care Delivery System

In structuring the Title XXI CHIP program, the state has elected to build on but move beyond the program infrastructure that existed for the state-funded program. The five health care insurers currently administering CHIP have been participants in the program since its inception: Independence Blue Cross and PA Blue Shield Caring Foundation for Children, the Caring

Foundation of Central PA, the Caring Foundation of Northeastern PA, Western PA Caring Foundation, Inc., and Aetna U.S. Healthcare. Blue Cross and PA Blue Shield (now Highmark) are strong players in health care in Pennsylvania, insuring about 70% of the marketplace. Blue Cross was also the initiator of Caring Foundations that began the original, privately-funded children's health insurance program. Program identity has largely been with the insurers as a result. As stated earlier, none of these insurers participate in the state's Medicaid program. However, Medicaid officials note that although insurers are different in the two programs, there is considerable network overlap so families have access to many of the same providers, regardless of whether they are enrolled in Medicaid or CHIP.

### Administration

Pennsylvania's CHIP program is administered through the Department of Insurance. It's Director, Patricia Stromberg, reports directly to the Commissioner of Insurance. An Advisory Council, the Children's Health Advisory Council, has 14-members appointed by the Insurance Commissioner and advises about program administration. The Council includes the Commissioner and representatives from: the Secretary of Health, Secretary of Public Welfare, a representative with experience in children's health from a school of public health, a physician, a representative from a children's hospital or a hospital with pediatric outpatient clinic, a parent of a child who receives primary health care coverage from Title XXI, a representative of the mid-level health professionals, four legislators, a representative from a private, non-profit foundation, and a representative of business who is not a contractor or provider of primary health care insurance. Medicaid officials praise the work group, and Stromberg's leadership of it, as a successful vehicle of program coordination. While the Advisory Council does not include consumer advocates, consumer groups generally applaud the program's leadership and note that they are involved in informal ways in a "kitchen cabinet" role.

CHIP has six designated staff, including the director, an outreach coordinator, policy analyst, program analyst, operations manager for contract review, and a unit assistant. Plans are underway to hire two additional staff for monitoring and quality assurance. The program works

collaboratively with other state agencies and within the Department of Insurance. The Department provides actuarial assistance and other staff support. In addition, the Health Department and the Department of Public Welfare, which administers Medicaid, work closely with the Department of Insurance meeting together twice a month to assist in program management and outreach coordination.

Limited staffing and the pressures of program start-up have left state staff with two areas that require additional attention that they plan to address in the year ahead. The first is data collection and analysis and the second is monitoring and quality assurance. Currently the program has no central data base. A contract has been let to design a data system to create centralized and comparable reporting. Currently data is collected and retained at the plan level. The state targets March 2000 for implementation of a statewide computer system.

State officials also raised concerns about CHIP reporting to HCFA. They noted that the HCFA reporting requirements reflect a Medicaid bias. Separate programs like Pennsylvania's are still required to account for Medicaid data. The state noted that as part of the Department of Insurance it does not receive Medicaid data and feels that HCFA already gets significant Medicaid data from the Medicaid program that could be used at the Federal level to assure reporting requirements are met.

The enabling legislation which created Title XXI CHIP in Pennsylvania required a competitive process to select insurers. The state developed a new Request for Proposal (RFP) which included the additional benefits and established income disregards. The request for proposal was preceded by a concept paper that the state shared widely with stakeholders including insurers, providers, and consumers. Public meetings concerning the concept paper were conducted in December 1998. The RFP is available on the Internet as are the questions and answers regarding the RFP at http:/www.state.pa.us/chiprfp. It is also available in "hard copy" upon request. Advocacy groups expressed some concern that they did not have greater involvement in the crafting of the RFP itself as they did in RFPs developed previously for Medicaid managed care. CHIP program

administrators noted the rigid timetable under which they were operating and explained their sense of urgency to implement new program benefits and eligibility rules; they felt that the concept paper and public process provided sufficient input. Advocates raised concerns that the RFP may be too broad and does not sufficiently define benefits. And because the RFP came out in April and bids were due in May they wonder if sufficient time has been provided for insurers to respond. The advocates also expressed concern regarding the state's decision to allow indemnity insurers to bid for the first time. The RFP requires all successful bidders to meet managed care-like access and quality requirements. Advocates questioned whether indemnity insurers could meet these quality standards. They also point out that this new allowance for the inclusion of indemnity providers means that many Blue Cross insurers who are primarily indemnity based will, for the first time, have access to CHIP funds although they have no experience or capacity with this population. The response of state officials stresses their interest in expanding choice and coverage in rural areas by maximizing the number of insurers who can bid to participate in CHIP. State officials believe advocates are comparing the CHIP bidding process to an earlier Medicaid bid but stress that CHIP is not Medicaid. Following the site visit, state officials reported that this is now a moot issue since no indemnity plans responded to the RFP.

State officials concur with advocates that Medicaid has a more expansive benefit structure. Those benefits are rooted in Medicaid's historic fee-for-service program where it purchased services directly and not through managed care. However, they stress that CHIP is based upon a comparable commercial product and that the state very much wants CHIP to mirror commercial insurers. Therefore, there is some variety among the insurers with different benefits (beyond the core of required benefits) and benefit limitations. The state does have a goal to standardize benefits statewide and has, in the RFP, set the minimum benefit package for CHIP eligibles as exemplified by specifically defining durable medical equipment and substance abuse services. New benefits and limits include:

- SUBSTANCE ABUSE: The minimum benefits include
  - Detoxification - Lifetime limit of four admissions and reimbursement for

each admission is limited to seven days of treatment or an equivalent amount.

- Non-Hospital Residential Services - Minimum of 30 days per year for residential care. Lifetime benefit of 90 days.
- Outpatient Services - Minimum of 30 Outpatient full session visits or equivalent partial visits per year. Lifetime limit of 120 days. These days may be exchanged on a 2-to-1 basis to secure up to 15 additional non-hospital residential treatment days.
- DME: Minimum benefits must meet the following requirements:
  - equipment that is primarily and usually used to serve a medical purpose;
  - equipment that is generally not useful in the absence of an illness and injury;
  - equipment that is appropriate for use in the home; and
  - equipment that can withstand repeated use.

- HOME HEALTH CARE: The following services provided in the home by a participating hospital program for Home Health Care agency or by a licensed Home Health Care Agency:
  - Professional services
  - Intermittent skilled nursing care
  - Physical therapy
  - Speech therapy
  - Other medical services and supplies when provided along with a primary service, such as occupational/therapy, medical social services, home health aids in conjunction with skilled services.
  - Benefit Limit: 60 visits/year

- REHABILITATION THERAPY: 60 days per service type per year as long as there is a significant improvement.

- CHIROPRACTIC BENEFIT: Chiropractic benefits are not covered by CHIP.

The RFP provides for three-year contracts, although rates will be negotiated for each insurer each year. Medicaid and CHIP rates differ because service packages, populations, and administrative requirements are very different. The state developed actuarially adjusted rates and inflated them by 2% where insurers justified a need for the increase. However, rates are reviewed and renegotiated each year based on the plan's actual experience.

Title XXI requires states to limit their administrative and related expenses to 10% of program costs. As a free-standing, separate program, Pennsylvania's CHIP program is challenged to meet

this limit but reports it is likely to do so. In the Pennsylvania model, insurers conduct eligibility which counts as an administrative expense. In state statute, plans are required to spend no more than 7½% in administration. However, the law allows an exception under which plans can spend as much as 10% of program costs for administration if such expenditures can be justified and all CHIP insurers are doing so. In addition, the state has costs for its own administration, for outreach and marketing, and for oversight and evaluation. For example, the program is paying for a helpline, focus groups, and other initiatives described later in this report. In FY 99, the state had a $1 million budget for administration, and conducted a media campaign over and above the CHIP administrative budget, funded largely by the cigarette tax and general fund.

### Outreach

Pennsylvania's long tradition of providing children's health insurance and in administering the state-funded CHIP program has resulted in citizens having a fairly high awareness of the program, according to both state officials and advocates. The primary focus of Pennsylvania's outreach strategy has been to commission a statewide media campaign and to link with the Department of Health/Maternal and Child Health Helpline. The state has launched a series of imaginative media strategies, including baseball caps emblazoned with "CHIP" and publicity created by the active involvement of Governor Ridge in promoting the program. Caring Foundation and Aetna Neighborhood efforts have historically also helped to market the program and enroll families.

In choosing to build on the existing Helpline administered by the Department of Health through the Maternal and Child Health (MCH) program, CHIP pays for a portion of the Helpline, and for three staff and trained workers prior to launching CHIP to assure that they were well informed about program requirements. While the Helpline is available 24 hours a day, Monday through Friday, it is answered in person only during business hours. Voice mail is used when the line is not staffed.

The state's media campaign was launched in October 1998. The Department of Insurance CHIP

program entered into a Memorandum of Understanding with the Department of Health to conduct a CHIP media campaign linked with a broader one already underway through the Maternal and Child Health Program. PPO&S, a firm with 10 years' experience with social marketing in the health care field, was hired to conduct the campaign, which included television ads to establish an identify for CHIP and its message. The advocates expressed concerns that the state's CHIP ads have pushed the message that the program is designed for working families so aggressively that those who don't work may not come forward for service. Advocates suggest that there is too much focus on the working population as the target of enrollment. The state concurs that the campaign has a working family theme but sees no evidence that it deters applications or demeans the Medicaid program as suggested by the advocates. The Helpline helps callers apply for health care coverage whether or not they work. Advocates also worry that the advertisements create fear and guilt as they are stressing a message that "your child could get sick, disabled, or die" and that this message is not motivating. Again, the state notes that response to the ads by the number of calls do not substantiate the concerns raised by some advocates.

On average, the Helpline receives three to four thousand calls per month when health-related messages are being advertised. In October 1998 when CHIP's media campaign began, 33,000 calls were received in a six-week period. This volume overwhelmed the Helpline. A higher than usual number of callers were placed in voice mail and received a call back. The state subsequently decided to stagger the ads in different parts of the state to reduce the impact on the Helpline. Currently, because of the lack of a data system, the state cannot track the calls to show what happens to individuals who call the Helpline. However, future plans call for such monitoring capacity.

Current ads focus on getting kids "covered" (and use CHIP baseball hats as visuals). The ads are also placed on ethnic media and are provided in translation. Future ads will focus on older children (13 and older) which the program now covers. The ads include a 1-800 number referring to the Helpline. When a caller calls the Helpline, staffers screen for CHIP and/or

Medicaid eligibility and send the appropriate application. The Helpline data collection system, with support from the phone company, allows the state to track the time of calls and compare them against the media schedule. From this data, the state has concluded that they receive the greatest number of calls following ads on shows seen between 3 PM and 5 PM. and notes that General Hospital appears to be a popular program as ads placed on that program received significant response.

The state also encourages advertising directly by insurers. By state law, insurers must conduct outreach for CHIP. Advocates raise concerns about this advertising noting that its intention may be less to bring CHIP eligible children in and more to present a positive image of the plans to a broader commercial marketplace. Plan ads are heard on commercial television, National Public Radio, and in other venues that suggest to advocates their intention is primarily public relations for the plans. The state is currently considering whether it should develop grants for local outreach to local advocacy groups and other organizations and plans to better organize and coordinate marketing and outreach efforts.

The state has launched other outreach activities, including large signs on the sides of buses that are viewed by the advocates as highly effective. The state has information about CHIP on the Department of Insurance web site that is now being upgraded to be more effective. Plans participate in health fairs and school clinics which appear to be successful. The state also noted that legislators are important to successful outreach, as they conduct essential constituent-based outreach. The state has also reached out to the hospital associations and the medical societies and works with Medicaid's outstationed eligibility workers in the hospitals. Medicaid has also done a mailing to its providers informing them about CHIP. Outreach information is available in Spanish and English.

The state noted that they have found one strategy that does not seem to work effectively, and that is direct mail. A flyer was developed with the Department of Education and sent to 501 school districts to be distributed. The schools were asked to copy it and, as a result, it is unclear how

many were actually distributed. In general, the state and their media experts have concluded that flyers generally yield less than a 2% response. This response rate is consistent with what is generally known about advertising mailings sent to the general public, according to state officials.

Other initiatives are underway throughout the state to assist with outreach. The Covering Kids Coalition has received funding from The Robert Wood Johnson Foundation through its Covering Kids Initiative. Pennsylvania Partnerships for Children is the lead organization for the Covering Kids Initiative which has four pilot sites: Allegheny County; York County; Fayette, Washington and Green Counties; and the Greater Philadelphia region. The Covering Kids Coalition organizing the project includes many community groups, the Governor's office, the Department of Insurance, and the Department of Public Welfare/Medicaid. Plans exist to have telephones in health centers connected directly to eligibility workers to facilitate enrollment; to create an enrollment fee to pay agencies for completed applications; to work with organizations such as the Retired Senior Volunteer Program, the PACE Community, and with child care programs; and to have community health workers go door-to-door to assist with applications. Other activities include community outreach workers and enrollment campaign blitzes in a rural and an urban setting; volunteer enrollment through human services agencies, schools, and child care centers; and Head Start staff training.

State officials expressed frustration that, as yet, no mechanisms exist to determine what works and what doesn't in outreach. Once their data system is in place, they will be able to better track Helpline calls and the impact of other outreach initiatives. For the moment, state officials believe that their paid advertising and their carefully constructed media campaign is working as witnessed by the number of calls to the Healthline. In addition, the state believes that strong community connections and local activities are highly effective, such as activities underway by Philadelphia's Promise and the Health Care Coalition in Pittsburgh.

Each state has its own challenges in reaching all population groups. In Pennsylvania one of the

concerns relates to the Amish community. Included in the state's CPS rate of uninsurance are 8,000-10,000 Amish children. CHIP is a government-sponsored insurance program, in which the Amish will not participate because they elect not to partake of the benefits of any government program.

### Coordination with Medicaid

The Pennsylvania Title XXI program is a free-standing, separate program built on a history of a commercially-based, state-funded CHIP program. Because Title XXI requires coordination with Medicaid, the program has developed several initiatives to achieve that coordination. Program officials also note that both the CHIP Program Director and Outreach Coordinator previously worked in the Department of Public Welfare's Medicaid program. This knowledge base assists in coordination.

Pennsylvania's strong motivation to build a CHIP program in a commercial model makes coordination with Medicaid complicated. The Medicaid staff and CHIP staff believe coordination is achievable and participate together in biweekly meetings about the CHIP program. Generally, however, application forms differ, eligibility requirements differ, and benefits and plans are different between CHIP and Medicaid. Eligibility for CHIP is determined by insurers, while eligibility for Medicaid is determined at county assistance offices. However, plans are required to forward applications that appear to be Medicaid eligible in a speedy fashion to county assistance offices and efforts are underway to further streamline this process through a simplified application.

Advocates had previously attempted to maximize coordination between Medicaid and CHIP and had argued for Title XXI funds to be used for a Medicaid expansion. They sought to level off all Medicaid eligibility groups to one income level in order to eliminate the possibility that a family could have a child eligible for Medicaid served by one insurer and another child eligible for CHIP served through another insurer. The state legislature rejected the effort to create even a small Medicaid expansion. Advocates believe the resistance from the *Scott* case to entitlement

expansion as well as the administration's strong commitment to welfare reform and building programs that support the independence of low-income persons are the primary reasons that motivated the state's decision not to develop a Medicaid expansion. Similarly, suggestions that one form be developed for application to both CHIP and Medicaid were originally rejected in part because plans now have their own forms that they use for eligibility and did not want to change the format they use. By using one form for CHIP and commercial enrollment, CHIP was able to achieve its commercial focus. There was resistance to adding information to make the form look 'like Medicaid.' Despite this resistance, the state is actively engaged in developing a common application approach, although not a single form

State officials note that separate programs like Pennsylvania's sometimes find themselves in a "Catch 22." On the one hand, the state is committed to developing a CHIP program that is simple to administer and that provides low-income families access to insurance that is like that offered to other commercial enrollees; on the other hand, each time efforts are made to link to Medicaid, CHIP is required to take on activities that diminish the commercial nature of the process and make the process more complex. .

### Eligibility and Enrollment

It is estimated that as many as 150,000 children may be eligible for CHIP in Pennsylvania. As of July 1999, 80,719 children were enrolled. The average increase in enrollment has been approximately 3% each month since July 1998. State officials expressed concern about the rate of enrollment because of their stated goal of reaching all eligible children; however, advocates with whom we met were unanimous in their belief that the rate of enrollment in the CHIP program was acceptable.

The state is committed to streamlining the application process and maximizing coordination with Medicaid. CHIP program officials have been working with advocates and Medicaid on an initiative they call, "Any Form is a Good Form." This initiative attempts to build on the current diversity in applications to assure that all necessary information is received and that all

appropriate individuals are referred and enrolled in Medicaid. With the new process it will not matter whether a family completes a CHIP or a Medicaid application. If a family is not eligible for the program to which they first applied, the application is automatically forwarded for eligibility in the other program. Both CHIP contractors and county assistance offices are responsible for sharing applications for program eligibility. The state, then, is working to develop a single set of data elements, rather than a single form, and hopes that collection of that data will be standardized with enhanced automation being developed.

State CHIP officials are attempting to maximize Medicaid coordination without sacrificing the commercial look and simplicity of its CHIP form. Recent signals from HCFA suggest that some of the complexity of Medicaid eligibility may no longer be required, which could enhance coordination.

However, while HCFA may be reinterpreting requirements to achieve more flexibility in Medicaid eligibility, the state continues to worry about Federal penalties or error rate, in future years. Even if the state simplifies Medicaid eligibility reducing verification requirements, for example, the state is concerned that individuals will be inappropriately determined eligible for Medicaid and a potential increase in the quality control error rate could result in fiscal penalties.

Eligibility for CHIP is determined by the insurers - currently five - that contract with the Department of Insurance which administers the CHIP program. Eligibility for Medicaid is done by 67 County Assistance Offices. County-based eligibility workers are employees of the state Department of Public Welfare. Eligibility workers are unionized, and all forms are reviewed by union representatives prior to implementation. The CHIP application form was reviewed by union representatives to determine the number of key strokes required to complete it and other information. State officials are sensitive to this reality as an earlier change in work resulted in changing job responsibilities different from those represented in bargaining units of workers, which was a violation of the collective bargaining agreement. This further complicates efforts to create a single application with Medicaid.

CHIP insurers are required to forward potential Medicaid eligible applications to the appropriate County Assistance Office for eligibility determination and processing. According to Federal law, states have 45 days to process a Medicaid application. Pennsylvania regulation requires disposition within 30 days. The Insurance Department and Department of Public Welfare have agreed that all applications should be processed within 15 days by the receiving entity (either at one of the five insurers or at a County Assistance Office). If the application needs to be forwarded for further action, the balance of the remaining days are available to make an eligibility determination. Medicaid and CHIP continue to require an original signature; income verification is required before Medicaid eligibility can be determined. Advocates believe that all verification information is not being forwarded by insurers, which requires additional follow-up for potential Medicaid eligibles.

Advocates note that County Assistance Offices have created a disability assistance program to assist individuals who qualify for SSI instead of general cash assistance. They believe this model could be a good one for CHIP outreach and eligibility. They also note that the CHIP application process through insurers is smooth and expeditious and that County Assistance Offices have a number of significant problems. The advocates note that recently the Department of Public Welfare has simplified Medicaid eligibility procedures, but that in some counties they continue to use the old procedures and applications. Advocates are skeptical that some county offices will take responsibility for accepting and forwarding CHIP applications to health insurers when they have not even responded to simplification in Medicaid. Advocates also raised concerns that the new benefit package provides services especially needed by special needs children. These new benefits are likely to attract sicker children, but if eligibility for CHIP is done by insurers, will they have incentive to accept those sicker children and how will adverse selection be avoided? There is a general suspicion by advocates regarding whether applications will be processed in a timely and effective manner. It was noted that the Covering Kids Initiative has extensive community-based outreach to facilitate applications but because of concerns about county workers, there is worry about whether these applications will, in fact, be processed properly and expeditiously. The state explains that there is no empirical evidence to suggest adverse selection

is occurring and explain that Pennsylvania's managed care legislation as well as CHIP contracts with insurers prohibit these practices.

Although advocates raise such concerns about the eligibility process, the state reports considerable activity to improve the application process. For example, the state has developed a system through which the Social Security numbers of new CHIP enrollees are forwarded to Medicaid to assure current Medicaid enrollees are identified and stay in that program. However, advocates expressed concern about whether children eligible but not enrolled in Medicaid were being found and enrolled. This could be because the AFDC/TANF caseload has dropped by about 87,000 children since welfare reform, and advocates worry families are not being screened for eligibility for transitional Medicaid benefits. To assure enrollment in transitional Medicaid, the state developed a one page application mailed to all families who had lost Medicaid. Although the form was simple, requiring name, Social Security number, and a list of people living in the household, the state had a very low response rate. State officials are concerned about this low response and conjecture that some of these families gained work with health coverage but others are not signing up for the program who would be eligible.

Advocates and the state remain concerned that individuals eligible for transitional Medicaid benefits may be losing their entitlement to Medicaid and/or are inappropriately becoming eligible for CHIP. CHIP eligibility is triggered by income only. Only those children who meet Medicaid eligibility income levels are now referred to Medicaid. These traditional Medicaid limits that are the trigger for Medicaid referrals do not include "welfare to work" eligibles who have higher incomes but may still be eligible for Medicaid. Similarly, the Medicaid program each year will transition a new group of children into Medicaid eligibility. As a result, some children who may now be served by CHIP, will become eligible for Medicaid, and care will need to be taken to assure placement in the appropriate program. Phased Medicaid expansions will also likely cause some drops in CHIP enrollment.

## Cost Sharing and Crowd-Out

The Commonwealth of Pennsylvania has no cost-sharing requirements for its Title XXI eligible beneficiaries up to 200% of poverty. Families between 200% and 235% of poverty are required to pay a premium and are eligible for the state-funded CHIP program only. Pennsylvania has no waiting period for coverage and will allow individuals who previously had health insurance to become eligible for CHIP. The new data set being designed for application forms has three questions relating to crowd-out, and the state is committed to studying crowd-out over time.

The state noted that the decision not to include cost sharing in the CHIP program resulted from a determination to keep the program simple. The original state-funded CHIP program did not have cost sharing, and the state decided that to create one would result in too much administrative cost with questionable results.

## Disenrollment, Re-enrollment and Retention

At the time of the site visit, Pennsylvania's CHIP program was about to reach its one-year anniversary of Title XXI enrollment. Since the program provides 12 months of continuous eligibility, the issue of re-enrollment was of some concern to the state. The program has already noticed that there is a drop-off of eligibles at the point of redetermination. As a result of their concerns about this drop out, the CHIP program contracted with PPO&S, the same company that designed CHIP's marketing approach, to conduct focus groups. Two different groups were convened. Participants in the first group knew that they had failed to renew their coverage with CHIP and that they had no coverage. Participants in the second group were unaware that they had lost coverage. On average about 1½% to 2% of eligibles were not renewing at redetermination because of non-response. Despite numerous reminders to reapply and the simplicity of the insurer-based application process, these eligibles were not reapplying.

Preliminary findings from the focus groups suggest that the reason most often cited for failure to enroll is that applicants forget and become busy with other life activities and fail to make their reapplication. A third focus group will be conducted in the near future. The focus group report

will be available soon but until it is complete, the state had a series of hypotheses regarding why re-enrollment may not occur. The state wondered if individuals were not reapplying for the program if they had not used services. The state will be looking at encounter and utilization data in the future to determine if there is a correlation between use of service and the value placed on it by beneficiaries and will try to determine whether beneficiaries who use services more often reapply in greater numbers than those who use services less frequently.

Nationally, some have suggested that cost sharing is a primary cause of disenrollment and/or failure to renew eligibility. However, the Pennsylvania CHIP program does not require any cost sharing to 200% FPL, so disenrollment is not affected by cost incurred by clients.

Pennsylvania has had considerable experience with a premium-based program as well as this free program. They have concluded that individuals who were required to pay a premium have a shorter length of stay in the program. Experience shows that the average length of stay on the program that requires premiums is about nine months, while the average length of stay for the free program is eighteen months. Pennsylvania also has experiential data that suggests individuals do join premium-based programs when their children have a specific health care need.

When asked why individuals may not enroll in programs, the state reported on their preliminary experience and the preliminary findings of the focus group. Individuals in the focus group reported a welfare bias; explained that they don't want to sign up for government help they want to be like other people and have a commercial product; or they reported that a spouse would not accept coverage from a government program. The focus groups' preliminary findings suggest that eligible individuals value health insurance and that they are not reapplying in part because they view even the simplified application to be too much paperwork and "in my business". Other impediments to enrollment include the mixed messages provided across the state by the many actors involved in CHIP outreach: the Federal government, advocates, the Robert Wood Johnson Foundation-supported Covering Kids Initiative, and by advertising from border states that is seen

by Pennsylvania citizens. The state notes that the Federal marketing initiative to promote CHIP sends a different message and carries a different label than the Pennsylvania CHIP program. The "Insure Kids Now" message may further confuse eligible citizens as it has a very different message than the message of Pennsylvania's CHIP program which focuses on working families. In addition, the Covering Kids Initiative is conducting much local marketing that is not necessarily coordinated with state efforts. However, when the State agreed to sign on to the Covering Kids initiative, Pennsylvania Partnerships for Children made a strong commitment to coordinate outreach efforts and messages. The Partnership reaffirmed its commitment and noted that, as the two pilots roll out their campaigns, there will be significant efforts to coordinate with the State to make sure that the Helpline is not overwhelmed, that messages are not confusing to families, and that they test out some of the areas that both the state and Covering Kids are interested in assessing.

The state notes that many eligible beneficiaries may not be enrolling because they have strong affiliations with public and community providers. Low-income residents know that they can go to federally qualified health centers, public hospitals, and emergency rooms for care and may feel that they do not need health insurance. It is unclear whether these providers have the incentive necessary to encourage CHIP enrollment, particularly since CHIP eligibility places children in managed care plans that may or may not use community providers. The Covering Kids Initiative will be working with communities and should be able to address some of these concerns.

Finally, it is noted that Pennsylvania was recently reported to have a 13% reduction in Medicaid enrollment since welfare reform. State officials note that Medicaid enrollment has decreased about 3% since the passage of TANF but that Medicaid enrollment had been going down since January 1996. It was also noted that CHIP enrollment has increased by 41%, or 3% a month, since July 1998.

## Children with Special Health Care Needs

The Pennsylvania CHIP program has had no discrete provisions for children with special needs but new benefits being added to the program (e.g., durable medical equipment and therapies) will help address those needs. Because Pennsylvania's Medicaid program has an eligibility category for a family of one for disabled children, most special needs children are Medicaid eligible. Advocates raise concerns about recent Federal laws that changed the definition of disability for purposes of eligibility determination, making some disabled children no longer eligible for Medicaid. Some small groups of disabled children may also not be eligible for Medicaid if they receive, for example, Social Security Survivor's benefits or child support. These children are unlikely to be able to meet the Medicaid spend down and advocates believe they would be CHIP eligible. However, the state believes that these children would still not be income eligible for CHIP. This issue of eligibility again raises coordination concerns with Medicaid.

State officials note that Aetna has been providing substance abuse throughout its participation in the state CHIP program and that utilization by CHIP children appears to be like that of commercially-insured children. While the new benefits will address the needs of special needs children, it is unknown how many will make use of the additional services. Advocates also warn that because insurers conduct eligibility, the state will need to monitor to assure that sicker children are not inappropriately refused coverage by insurers at eligibility. Again the state explains that adverse selection would violate both state law and CHIP contracts.

## Quality and Oversight

Pennsylvania's CHIP program builds on years of experience with a state-funded program delivered through health insurers that are required to meet all the state's licensing and quality requirements. As required by Pennsylvania law, the adequacy, accessibility, and availability of services provided to CHIP children must be reviewed and evaluated. To facilitate this, health insurers must provide a description of: how their health delivery system complies with the state's "Preventative Health Services Standards," special features of their health delivery system; quality assurance and utilization review systems including inpatient pre-certification; complaints

and grievance resolution system; utilization and financial reports regarding service; and general operation of the program. Insurers are also required to participate in medical audits to assess quality and access to care. However, state officials are quick to note that their priority for the year ahead is to build systems for CHIP. The foundation for all that work will be the new state data system, to be implemented early in 2000. The CHIP program has been approved to hire two additional staff to develop and implement a quality oversight system. The state also hopes to conduct an independent evaluation and has encouraged three different applicants seeking funding through the Agency for Health Care Policy and Research/Packard Foundation Research Initiative on Children's Health Coverage.

## Summary

In its first year of implementing Title XXI, Pennsylvania has integrated the new program into an existing, state-funded Children's Health Insurance Program administered by the Department of Insurance through contracts with commercial insurers. Title XXI is available for children from families with income below 200% of the Federal Poverty Level. The state funds and subsidizes children from 201% to 235% FPL and charges cost sharing in that state-funded portion of the CHIP program.

Insurers are responsible, by state law, for outreach for CHIP and for conducting eligibility determination. To facilitate the Federally-mandated coordination between CHIP and Medicaid eligibility determination, state officials are at work on a strategy dubbed "any form is a good form" which will establish a single set of data elements to be collected for both CHIP and Medicaid eligibility. Similarly, the state has clarified CHIP financial eligibility to establish income disregards similar to those in the Medicaid program. A committee of key state officials meets regularly to maximize coordination among agencies.

Pennsylvania is committed to a program based on a commercial model and a design to assure simplicity for its enrollees. To that end, no cost sharing is required and families may qualify for CHIP if they were previously insured. However, the state will be asking applicants about

previous coverage and studying any crowd-out that may occur over time.

Pennsylvania's CHIP program, administered by the Insurance Department, has developed a strong relationship with the Department of Health's Maternal and Child Health Program to market CHIP and has developed, through a contract with an experienced social marketing firm, a carefully conceived CHIP media campaign focusing on low-income, working families. The MCH toll-free Helpline is also used as the CHIP toll-free line.

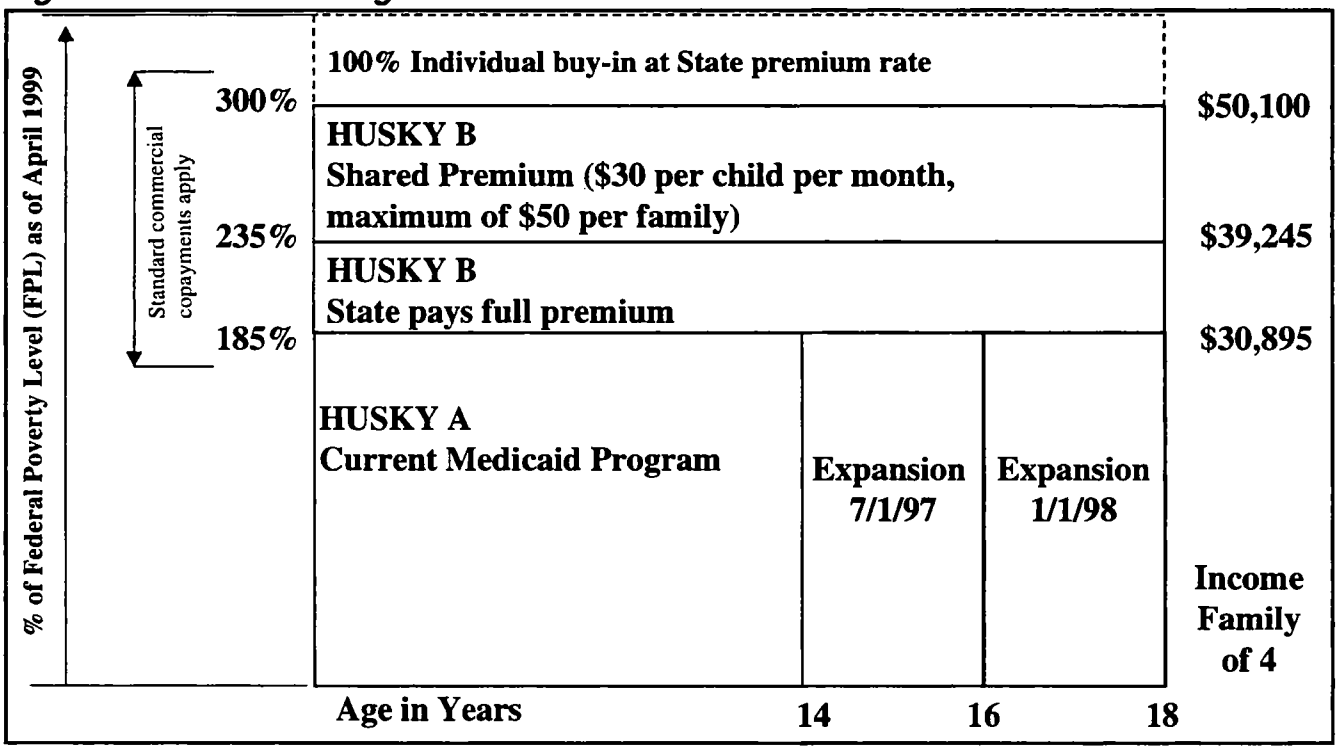
Pennsylvania has reached over half of its children eligible for CHIP as of July 1999. After a year of operation, CHIP enrollees now must re-enroll in the program. Like other states visited, Pennsylvania is seeing some drop in enrollment at the point of redetermination of eligibility and is at work to determine why, particularly since the program is free to eligible families.

While Pennsylvania's Title XXI program is being built upon an existing, successful state-funded program, officials here - as in all other states visited - note that it takes time for the program to fully develop and become known and used by all eligible. Pennsylvania has identified two priority areas for future work. The first is data collection, for which the state has contracted to design a data system that will create centralized and comparable reporting among plans. The second concern relates to monitoring and quality assurance. In addition to the new data system, the state will hire two additional staff to develop a quality oversight system.

## CONNECTICUT

Connecticut has taken advantage of Title XXI to develop the HUSKY Program - Healthcare for Uninsured Kids and Youth - which is a combination Medicaid expansion and state-designed CHIP program. HUSKY offers free, low-cost, or full-cost health insurance to all children from birth through age 18. Medicaid and the Title XXI expansion program are known as HUSKY Part A and serve children to 185% FPL; the state-designed CHIP Program, HUSKY Part B, serves children from 185%-300% FPL and provides benefits based on the state employees' health insurance plan. (See Figure 2.) Children eligible for HUSKY B who are in need of more intensive physical health and/or behavioral health services are also eligible for two supplemental programs known as HUSKY Plus. The state also provides a HUSKY B buy-in program available to families over 300% FPL who pay full cost and are not eligible for HUSKY Plus.

***Figure 2: Health Coverage for Children in Connecticut***



The HUSKY plan began processing applications on June 1, 1998, with the first official enrollment date of June 9, 1998. Health coverage began on July 1, 1998 for eligible children. The state has a targeted enrollment of 36,000 children and as of March 1999 had enrolled nearly 17,000. Although there are an estimated 90,000 uninsured children in Connecticut according to CPS data, the state was skeptical of the CPS estimates. The state's Office of Health Care Access worked with the department to determine the target population. Unlike the national experience in Medicaid, Connecticut's Medicaid enrollment has not seen decreases and reports increased enrollment.

## Program Philosophy

Connecticut's approach to CHIP reflects the state's commitment that all children should be insured, regardless of income. Healthcare for UninSured Kids and Youth is marketed to families in a way to eliminate the distinction between Medicaid and CHIP and materials focus on messages like, "The HUSKY Plan: Your Child's New Best Friend in Health Care." Children can participate in HUSKY either through Medicaid, Title XXI, or full premium buy-in.

Continuing the commitment to ensure that every child in Connecticut has access to health care, the state may take the next step by ensuring every person in the state has access to health care. Under section 1931(b) of Medicaid law, states have the option to expand coverage to more of the population. Currently, the Connecticut Legislature is considering the option to cover parents of children in HUSKY A (up to 185% FPL) with no assets test and 6 months of continuous eligibility. Approximately 20,000 parents would be eligible. Some believe expanding coverage may help increase participation in the HUSKY program as parents may be more likely to enroll their children in insurance if they too were to get coverage.

## Administration

HUSKY is administered by the Connecticut Department of Social Services, the same agency that administers Medicaid. Although HUSKY Parts A and B are both administered within the Medicaid agency under the direction of David Parrella, Medical Care Administrator, Parts A and

B have exclusive staff. HUSKY Part A is administered under the direction of Jim Gaito, Health Program Planning Manager. HUSKY Part B is administered under the direction of Linda Mead, Project Manager. Both report to David Parrella, Medical Care Administrator, who in turn reports to a Deputy Commissioner in the Department of Social Services (DSS).

The HUSKY A expansion was rolled into the Medicaid program and is administered by the Medicaid agency using the same policies, procedures, and staff that serve the Title XIX Medicaid program. Eligibility is conducted through 14 regional eligibility offices in the state.

HUSKY B has a project manager and four additional staff dedicated exclusively to that program: two staff managed care plan liaisons; one nurse-consultant, who is responsible for data reporting and HUSKY Plus; and one administrative professional. HUSKY B is marketed as a more commercial product than traditional Medicaid, is delivered through managed care, and eligibility is determined through a single point of entry service operating under contract by Benova.

The state administers the HUSKY Plan with the help of a steering committee that includes the Department of Social Services and the Office of Policy and Management. No advocates or consumers are members of the steering committee. There are separate steering committees for the HUSKY Plus Behavioral and Physical programs and advocates participate on those steering committees.

Connecticut has shown great commitment to the HUSKY program. The state reports that the 10% limit for administrative costs under CHIP significantly under-represents the cost of starting-up and marketing this program. The state's start-up costs have exceeded the 10% cap, but because the CHIP program is a combination of both a Medicaid expansion and a state-designed program, some of those costs have been able to be absorbed by Medicaid and matched at the Medicaid reimbursement rate rather than at the 65% enhanced matching for Title XXI available in Connecticut.

## Data Collection

DSS is responsible for data collection for HUSKY A. Because Title XXI dollars (HUSKY B) and Medicaid are viewed as a funding source to help expand coverage, the program is marketed as one program and client tracking for Part A is done only to document Federal Medicaid match. Y2K compliance programming and external demands on data processing, have restricted the state's capacity to report data for the Medicaid expansion children separate from all children in Medicaid. For matching purposes, aggregate numbers are collected and Part A children are manually disaggregated and reported. However, the state intends to change this system over time. The state's effort to improve its data collection system to meet Title XXI reporting requirements has been complicated by a proposed initiative by the state government to privatize information systems. The state's plan to turn state computing systems to private contractors has resulted in uncertainty about the future of work for state information systems staff, and they are leaving the state work force. This churning creates problems in gaining necessary support to meet the data needs of CHIP.

The state's contract with Benova includes responsibility for data collection and reporting on HUSKY B enrollees. The state has expressed considerable satisfaction with the responsiveness of Benova in providing data, described later in this report. The state reports difficulties with HCFA's Title XXI data collection requirements, notably that HCFA is requiring reports on items the state has not had to report on in the past and that systems are not programed to capture information in the required HCFA format; e.g., ethnicity of children and income eligibility level broken at 150% FPL.

## Health Care Delivery System

HUSKY A services are provided through the existing Medicaid network of 5 managed care organizations[3] (MCOs) and their providers and through fee-for-service for those granted an

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[3] BlueCare Family Plan; Community Health Network of Connecticut; Kaiser Permanente; PHS Healthy Options and Preferred One.

exemption from managed care . HUSKY B services are delivered through 4 MCOs[4]. Managed care is the only delivery system available to Part B enrollees. All the participating MCOs in HUSKY B also participate in HUSKY A. However, not all HUSKY A MCOs participate in HUSKY B. The state has worked to establish appropriate rates for HUSKY B and Medicaid enrollees and provides four different rates for each program.

Currently HUSKY B per-member, per-month rates are significantly lower than Medicaid rates. However, all enrollees in HUSKY B pay some cost sharing; there is no cost sharing in HUSKY A. The benefits in the two programs are also somewhat different.

The benefit structure under HUSKY B is a relatively rich one, reflecting benefits provided to state employees who are unionized and negotiate for benefit packages. In designing HUSKY B, the state reports taking the best from each of the three state employee plans.

HUSKY Plus Physical services are delivered through two Centers of Excellence that have local access statewide. The HUSKY Plus Plan for children with special physical needs is jointly administered through a state contract with the Connecticut Children's Medical Center and the Yale Center for Children with Special Health Care Needs, in conjunction with the Yale University School of Medicine. The HUSKY Plus Behavioral Health Plan is administered through a state contract with the Yale Child Study Center. HUSKY Plus is discussed in greater detail later in this report.

## Outreach

Connecticut has taken a multifaceted approach to outreach, both through its own department and through a series of community-based grants. The state planned its launch of CHIP outreach

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[4] Anthem Blue Cross/Blue Shield of Connecticut; Community Health Network of Connecticut; HealthChoice of Connecticut, which is also called Preferred One; and Kaiser Permanente.

carefully to stagger information, fearing a flood gate of response that the system could not handle. The state has developed advertising and promotional materials and, through a request for application process, awarded ten grants for community-based outreach. Two grants, each at $100,000, were awarded to statewide groups, one to the primary care coalition and another to an organization representing school-based health centers. Five additional grants of $20,000 and three grants of $30,000 were given to local community agencies across the state.

The Robert Wood Johnson Foundation has provided funding under its Covering Kids Initiative for an additional statewide program that is being organized through a broad coalition, with the Children's Health Council as lead agency. This initiative will fund some statewide interventions as well as pilot programs in three areas of the state. The pilots will create intense community-wide efforts to enroll uninsured children and will place a special emphasis on adolescents and children in immigrant families. One of the Covering Kids Initiatives is to assure that no newborn leaves the hospital without insurance coverage.

The state has established two toll-free information and application lines, provides information about the HUSKY Plan on a web page, and has contracted with a single point of entry service provider, Benova. Benova provides one toll-free telephone line open from 9 AM to 8 PM Monday through Thursday; 9 AM to 6 PM on Friday; and 10 AM to 2 PM on Saturday. The Connecticut HUSKY line provides two options - one for general information and an application line shared with Benova.

The state points out that program promotion is a very new role for state officials who do not have experience as marketers. The state considered allowing direct marketing through the plans but feared that doing so could create abuse. The value of broad marketing is perceived in its capacity to bring in large numbers of children with a mix of low and high need children. The state has operated a publicly financed outreach and public information campaign, but feels it may not be presenting a coherent and understandable message that distinguishes between the encouragement of independence under welfare reform and the empowerment of working families through the

provision of health care to their children. The state raises some concerns that marketing is being conducted like Medicaid because of Medicaid's screening requirements and that the program may suffer from this approach. It was also noted that marketing a child health benefit is like marketing an individual insurance product: such marketing is difficult to do and requires costly one-on-one attention.

Advocates agree that face-to-face marketing is needed and that the state has done extensive outreach. They, too, note that the coordination with Medicaid, while facilitating appropriate placement of eligible individuals, creates a marketing challenge. Advocates suggested that we review the HUSKY application as they believe it has the tone and language of welfare. Low-income people distrust the welfare system and have taken to heart the welfare-to-work initiative, according to advocates. They report that any government program still holds a stigma of welfare and, therefore, makes it difficult to market to this population. Consumers and their advocates believe that local outreach, such as that provided through community and local health fairs, is highly effective, but they suggest that there remains a significant amount of confusion about HUSKY and that some mixed messages about the program further complicate outreach efforts.

The state shares the concern about mixed messages noting that, on the one hand, Federal and state governments are trying to get people off government programs and on the other trying to bring them in to government health programs. They also note that there are multiple mixed messages through uncoordinated outreach efforts. For example, the state is currently drafting a new application to try to make it more consumer friendly and has made a priority to link the ten state grantees for outreach with the Covering Kids initiative. However, Covering Kids continues to provide customized information that is different from the state's information. The state believes that the Federal hot line for access is working well and has worked with HCFA to custom design a HCFA ad to assure it was "on message" for use in Connecticut. It is unclear whether different messages help clients understand, as people learn in different ways at different times, or if it further complicates and confuses information about CHIP. Consumers and state officials alike agree that there need to be better measures to determine what works in outreach.

The state has also conducted targeted outreach directly with its own staff. Efforts have targeted schools, school nurses and social workers, the Small Business Development Center at the University of Connecticut, medical providers, and others. The state is considering placing Benova workers in unemployment offices to facilitate applications for HUSKY B. The state is currently developing a relationship with the Connecticut River Valley Farm Workers Health Program to try to make eligible the children of migrants and seasonal workers. This is a multi-state initiative in the Connecticut River Valley. Finally, the program has developed creative marketing materials, including stuffed animals (huskies), balloons, pencils, and refrigerator magnets to further their reach into the community.

The state notes that because of the access provided in the program to people above 185% of poverty, different marketing strategies need to be considered for higher income populations. Because many citizens have episodic experiences with uninsurance and unemployment, it is difficult to reach and enroll them. The state is particularly sensitive to the need to refine its message and make clear that health care is different from welfare.

### Coordination with Medicaid

HUSKY in Connecticut is administered by the same agency that administers Medicaid thereby facilitating coordination. As a first step in that coordination, Connecticut simplified and streamlined its application process for both CHIP and Medicaid. This current form is two pages (double-sided) long: one page of instructions and one page of information gathering for eligibility determination. Although the traditional Medicaid application was 18 pages long, advocates still believe that the HUSKY application is more complicated than need be. They cite, for example, that the application requires verification of income, non-citizen status, and out-of-pocket child care expenses, some of which could be self-declared rather than verified with documentation. The application must be signed. The state is currently revising and streamlining the application a second time. Advocates were involved in the crafting of the original application but report feeling less involved in the revision. The state, however, reports significant involvement with advocates.

## Eligibility and Enrollment

The state has created a relatively seamless system of application for HUSKY A and B. The joint, simplified application collects information to determine eligibility for both Medicaid and CHIP. Neither program requires a financial assets test and many of the documentation requirements that were once standard in the Medicaid eligibility process have been eliminated. In addition, personal appearance is not required to determine eligibility or to enroll. The income disregards are the same for Husky A and B (i.e., child care expenses, child support, and work related expenses) and is based on a sliding scale. The amount of disregard ranges from 1% to 65%. Using the sliding scale of disregards allows them to make children above 235% eligible for Title XXI.

For example, a family at 300% FPL has 65% of income disregarded to make them eligible at 235% and a family at 250% would have 15% disregarded to make them eligible at 235%. Title XXI Statute allows states to cover children up to 200% of FPL or 50 percentage points higher than covered at the time the Title XXI program was passed in Congress. Connecticut covered children up to 185% FPL so they are able to claim enhanced match under Title XXI up to 235% FPL.

**Sample of Connecticut's Sliding Scale of Income Disregards**

| Income (as % of FPL) | Income Disregarded (as % of FPL for ages 0-13 | Income Disregarded (as % of FPL) for ages 14-18 | Husky Plan |
|---|---|---|---|
| 100 | 0 | 0 | Part A |
| 200 | 0 | 0 | Part B |
| 235 | 0 | 35 | Part B |
| 250 | 15 | 50 | Part B |
| 275 | 40 | 65 | Part B |
| 300 | 65 | 65 | Part B |

Connecticut has initiated a single point of entry system through a contract with Benova. Benova conducts eligibility and enrollment for HUSKY B, but, by Federal Medicaid law, may not determine eligibility for HUSKY A. Benova transfers applications for HUSKY A to regional DSS offices for final eligibility determination for HUSKY A (Medicaid). Key contractors determine eligibility for HUSKY Plus.

Applications can also be taken by Benova over the phone through a toll-free number. An application is forwarded to the caller following an inquiry. Face-to-face interaction is not necessary, but each application must have a signature of the responsible family member. A number of applications are still taken at regional DSS offices as this has been the standard procedure for many years.

All mail-in applications sent to Benova are first screened for Medicaid eligibility. Any that appear Medicaid eligible are forwarded to the appropriate regional DSS office and a notice is sent to the family that identifies a caseworker whom they may call for their application's status. If the application appears to be eligible for HUSKY B, it remains at Benova for final eligibility determination.

If a family applies for HUSKY through a DSS office, final eligibility determination for HUSKY A can be made, but applications that appear to be eligible for HUSKY B are forwarded to Benova for eligibility determination. Applications taken over the phone by Benova through a question and answer process are printed out and sent to the family for verification and signature. Once eligibility is determined for the appropriate program, Benova conducts MCO enrollment for all HUSKY A and B individuals.

The eligibility process for HUSKY B initially had some weaknesses. However, the state reports that Benova has been responsive and hired Deloitte & Touche to help them address management concerns. Benova has a two-year contract and is paid a fixed rate rather than an incentive-based payment for enrollment. Their contract requires that they complete the application process in

seven days if all information to process the application is received initially. Benova reports that most applications received are not complete. Since program implementation, approximately 95% of applications received were incomplete (e.g., lack signature or proper documentation) and required follow-up with the applicant. With incomplete applications, Benova has 30 days to follow-up to get the necessary information to complete the application. If an application is not completed within 30 days, the application is denied. (Similarly, since there is no default enrollment, if a client who has been made eligible for HUSKY B fails to choose a plan within the first three months of eligibility, the eligibility is closed due to non-interest of the client. During this three-month period, attempts are made to contact the client, via three efforts by telephone and two written notices.)

Follow-up of an incomplete application is done through mail correspondence and telephone contact, however the follow-up process is difficult. Benova conducted a small study and found that of the 77 individuals called regarding missing information, 34 could not be reached even after three calls. Confidentiality concerns and privacy rights add additional complications as Benova representatives do not want to leave extended messages on answering machines citing as an example that some individuals may not want other family members to know they are seeking assistance from the state.

The eligibility process for HUSKY A also has had reported problems and advocates raise concern about the regional DSS offices. Inherently, there is a disconnect between the regional DSS eligibility offices as they do not report to the Medicaid office in the DSS Central Office, but through a separate chain of command in the Department of Social Services. It is generally believed by advocates that local offices do not have sufficient information and have not "bought into the program." Advocates believe little referral to HUSKY B is being undertaken by the regional DSS offices and that there is confusion about the coverage available through HUSKY A and HUSKY B. Because HUSKY A has been rolled into Medicaid, regional eligibility workers process those applicants as they have historically processed Medicaid applications. HUSKY B, the "separate program," is disassociated from Medicaid in that regional offices cannot determine

eligibility and must pass applications not eligible for Medicaid to Benova to determine eligibility for HUSKY B. Advocates report that applications can get "lost in the shuffle" or applicants ineligible for Medicaid are not informed of their impending eligibility for HUSKY B. At least one regional DSS office was reported as having no materials for HUSKY B or HUSKY Plus. Regional offices are also supposed to have individual experts on HUSKY to help with the coordination, but advocates question their capacity.

The state confirmed the advocates' concern that there have not been significant numbers of referrals from Medicaid to HUSKY B even though coordination has been facilitated with daily courier trips between DSS regional offices, DSS central offices, and Benova. To alleviate the coordination concerns, the state has scheduled another round of training for regional DSS eligibility workers which will be conducted in the very near future. Initially, there were Benova workers in all the regional offices. There was little work for them to do. Now there is a DSS person in the Benova office, and she has been busy coordinating HUSKY A and B in both new applications and annual redeterminations.

There was also general agreement among advocates that regional DSS offices have not been effectively implementing transitional Medicaid. Medicaid has now established a tracking procedure within its information system to assure that those eligible for Medicaid who leave welfare-for-work are automatically provided transitional Medicaid benefits. The state confirmed that the automatic transfer from cash assistance to transitional Medicaid could have experienced problems for those who had previously dropped out of Medicaid and then applied to re-enroll in Medicaid at a later date. Those families who were likely eligible for transitional Medicaid instead could have been determined eligible for HUSKY B or spend-down categories of Medicaid.

The state is giving some consideration to implementing presumptive eligibility for Medicaid to facilitate enrollment. Since many applications for Medicaid are screened for eligibility through Benova, the state would like to allow them to grant presumptive eligibility. However, Federal regulations restrict who can determine Medicaid eligibility and Benova is not sanctioned by law to

do so. Furthermore, presumptive eligibility requires systems support and information and technology that DSS does not have.

Connecticut reports that for every one child enrolled in HUSKY, three are enrolled in Medicaid. In addition, there has been a significant increase in applications to Title V which the Centers of Excellence believe is tied to the increase in numbers of children applying for and found eligible for Medicaid.

### Crowd-Out

Because Connecticut is serving a higher income population than most states, there is considerable attention directed to the state regarding crowd-out. Connecticut's crowd-out policy applies only to group coverage and not individual coverage. Children are not eligible for HUSKY B if they had employer-sponsored group insurance within six months, unless the reason for the discontinuation was clearly unrelated to the availability of HUSKY B. In the first six months of program operation, the state reported few problems with crowd-out and had identified 34 children who had been specifically denied for having been covered by employer-sponsored group insurance in the last six months; an additional 395 applications were denied because the children had health insurance at the time of application.

Benova, the single point of entry service contractor, sends letters to employers and a sample of applicants to determine the accuracy of application statements. Through this verification process, it does not appear that applicants are hiding employer coverage to qualify for HUSKY.

The state reports a concern that aggressive treatment of crowd-out provisions will cause further disincentive for clients to seek enrollment. Specifically, state officials raise concerns about those who are underinsured, families covered by policies with limited benefits. HUSKY and HUSKY Plus provide better benefits than these limited plans, but families with special needs children who require costly primary and acute care cannot afford to go without coverage for 6 months to qualify

for HUSKY. Thus, crowd-out provisions serve as a disincentive for families to gain quality and appropriate physical and behavioral health services for children in need.

### Cost Sharing

HUSKY A (family income up to 185% FPL) is a free program with the full Medicaid benefits to eligible enrollees. In HUSKY B, premiums are based upon family income. The state pays the full cost of the premium for children in families with income between 185% and 235% FPL, but the family is responsible for paying some co-payments for certain services. Children in families with income between 235% and 300% FPL are responsible for paying a monthly premium of $30 per child or $50 for two or more children plus some co-payments. The state has established policies and procedures to ensure that no family spends more than the annual Federal limit of 5% of family annual income on cost sharing requirements for purchasing health insurance through Title XXI. Specifically, families enrolled in HUSKY B that are required to pay only co-payments (185% to 235%) will have an out-of-pocket maximum amount of $650 per year. Families with incomes from 235% to 300% FPL are required to pay both premiums and co-payments but out-of-pocket expenditures are limited to $1,250 per year. Families pay their required premium amount to the MCO and pay the co-payment amount to the provider from whom they receive the service. Cost-sharing provisions follow a commercial model and enrollees are locked-out of service for failure to pay premiums. Connecticut also allows families whose incomes exceed 300% FPL to buy-into the HUSKY program at full cost. No one had done so at the time of the site visit.

MCOs, Benova, and the DSS are responsible for ensuring that once a family meets their out-of-pocket maximum, no additional premiums or co-payments are charged or collected. MCOs are required to track cost-sharing obligations and to report that to Benova who in turn reports to the state. Each managed care organization gathers co-payment collection information from providers and integrates the information with their premium collection system. Once their system shows a family has reached the out-of-pocket maximum amount, payments are no longer required from the family.

At the time of the NASHP site visit, no families had reached the out-of-pocket maximums even though some families had been enrolled for almost a year. (Health coverage began on July 1, 1998, and our site visit was conducted in May 1999.) Advocates report that cost-sharing requirements are generally believed to be fair but that it is difficult for clients to understand the concept of premiums and the requirement to pay them on time and monthly.

### Disenrollment, Re-enrollment and Retention

The HUSKY Program provides for continuous eligibility for 12 months; individuals with premium requirements who do not meet them cannot receive health services but do remain eligible for the HUSKY program. There is a three-month lock out for non-payment of premiums.

Benova has conducted a survey of families in lock-out. Because of the difficulty reaching people by phone as noted above, only 43 of 77 clients called were available to answer the survey. Of these, 26 reported themselves no longer interested in HUSKY, while 17 were still interested. Of those 26 no longer interested in HUSKY, 13 had obtained other insurance and 8 reported that they could not afford the program. When asked why clients had not met their financial obligation, the single largest response was that financial and life situation had changed and they had less money to afford the program.

At the time of the site visit, Connecticut was about to celebrate its one-year anniversary. Clients who had exhausted the12-month continuous eligibility period needed to be redetermined for eligibility. Already the state has found some disenrollment from the HUSKY Program. A total of 483 children have disenrolled from HUSKY B since the program began enrollment through the beginning of May 1999;

- 148 were disenrolled for non-payment of premium;
- An additional 134 were in the lock-out period for either non-payment of premium or because they had other insurance;
- 221 had become eligible for HUSKY A. Of these 150 were switched from

HUSKY B to A in part because the 1999 Federal Poverty Guidelines went into effect during the year increasing the eligibility for Medicaid;

- 66 no longer needed HUSKY because they had employer sponsored insurance or other medical insurance;
- 23 aged out of the program reaching the age of 19 (Title XXI statute specifically targets low-income children under the age of 19);
- 20 voluntarily terminated enrollment; and
- 5 were not residents of the state.

State officials stressed that "disenrollment' is not always a negative; more than half of those "disenrolled" from CHIP became eligible for Medicaid or commercial coverage.

At the time of the site visit, 85 individuals were approaching the end of their one-year eligibility and had to renew. Benova prepared applications based on previous applications for clients needing redetermination and sent those to the clients to report changes, sign and send back in postage-paid envelopes. At eligibility redetermination, enrollees are also able to switch plans. On April 15, 1999, a letter went to all enrollees who will need a redetermination. Enrollees have 90 days to provide information. Re-enrollment applications are beginning to trickle in and Benova will track and report. The deadline for re-enrollment is June 1, 1999.

Advocates reported that the redetermination process is a complicated one and that cost sharing may not be the most significant reason individuals disenroll. It was noted that Medicaid, too, has a considerable loss of eligibles at renewal time even though that program is free. The state reports that enrollment in HUSKY B is lower than expected, Further, a review of data suggests that most children becoming eligible for HUSKY A (Medicaid) are new enrollees and not individuals who had mistakenly been excluded from Medicaid during a welfare-to-work transition.

State officials and advocates were asked why they felt HUSKY B enrollment was lagging behind expectations. Absent data to document the problem, advocates and state officials agree that

several barriers exist to enrollment:

1. Mixed messages
   - The message of welfare reform was one of independence from government programs, but CHIP encourages enrollment in a government program, sending a mixed message that could confuse potentially eligible families.
   - State, Federal and foundation supported initiatives have different messages that likewise may confuse potential enrollees.

2. Changing Eligibility
   - 1999 Federal poverty guidelines were issued, increasing Medicaid eligibility levels during the year and making more people eligible for Medicaid who otherwise would have been eligible for HUSKY B.

3. Consumer Reluctance to Join Program
   - Some years ago Medicaid had an asset test, and while it has long been eliminated, potential enrollees fear a lien on property and assets and do not apply.
   - Immigrants fear under new INS rules that they will be deported if they apply for benefits, that their reliance on a public program will affect their ability to become a U.S. citizen, and oftentimes do not understand that their U.S. born children are eligible for benefits.
   - Clients resent being made to provide information and to have the government "in my business."

4. Program Start-Up Issues
   - It takes more time and outreach than anticipated to develop the program and attract enrollees.

5. Availability of Direct Services for Uninsured
   - Availability of publicly supported "free care" means low-income uninsured receive care through health centers and hospitals. Therefore, potential CHIP eligibles may not value insurance for which they may need to make some payments.
   - Connecticut law, for example, requires all hospital emergency departments in the state to provide care regardless of ability to pay.
   - The state expresses worry about a possible conflict of interest among these community health centers who are being asked to conduct outreach for HUSKY but who may not have incentives to actually enroll potential clients. Health centers receive Federal grant funds to serve the uninsured and are reimbursed fee-for-service for Medicaid eligibles. Since HUSKY is administered through managed care plans, local providers may fear loss of revenue if clients are found eligible for HUSKY and enrolled in a managed care plan. Those plans receive Medicaid payment directly and may or may not contract for services with health centers.

## Children with Special Health Care Needs

Connecticut has developed HUSKY Plus, two supplemental programs that provide additional coverage for HUSKY B enrollees who have intensive physical and behavioral health needs. HUSKY B children are eligible for HUSKY Plus services based on clinical factors. Children from families with incomes greater than 300% FPL are not eligible for HUSKY Plus.

### *HUSKY Plus Behavioral Program*

HUSKY Plus Behavioral (HPB) is a program designed to meet the intensive behavioral health needs of HUSKY B eligible children through an array of community-based mental health and substance abuse service providers that were selected through an RFP process. The state has contracted with the Yale Child Study Center to serve as the lead provider and fiduciary agent. They, in turn, contract with providers across the state and provide specific HPB services. Many of these HPB providers are also traditional Medicaid behavioral health providers. Behavioral health is presently a carve-out in Medicaid managed care. Medicaid, HUSKY B and HUSKY Plus generally contract with the same providers. The Child Guidance Centers receive grants directly from the Department of Children and Families and operate in every region in the state.

HUSKY B provides a limited in-patient, day program and out-patient benefit for behavioral services as well as pharmaceutical coverage. HUSKY Plus Behavioral provides intensive home-based services, mental health and substance abuse, crisis intervention, and care management services and supplements out-patient and day program benefit limits under HUSKY B. HUSKY Plus Behavioral does not provide in-patient mental health and substance abuse benefits. Care is provided in a team approach by licensed clinicians, social workers, or psychiatric professionals and a mental health counselor. Team members are available 24 hours a day, 7 days a week. The Yale Intensive In-home Child Psychiatry Service has developed good relationships with Medicaid managed care plans and has built on that experience to develop HUSKY Plus. The Yale Child Study Center provides clinical consultation and back-up to the HPB centers. Children may be referred for HPB by parents, providers, or by HUSKY B plans. Children are eligible for referral to HUSKY Plus Behavioral if they are (a) currently enrolled in a HUSKY B health plan; (b) have family income of over 185% FPL and up to and including 300% of FPL; (c) have had recent,

within six months, comprehensive psychiatric, substance abuse, or psychological assessment including an assessment of the child's and family's strengths and problems; and (d) the child must have used at least 20 out-patient treatment visits and 5 hospital days of the annual HUSKY B behavioral benefits. However, the last two criteria, (c) and (d), are not currently enforced according to the providers and state officials.

HUSKY Plus Behavioral requires no additional co-payments, deductibles, or premiums. Children who are referred to the program undergo an eligibility assessment conducted by the local HUSKY Plus Behavioral Center. That assessment is reviewed by a multi-disciplinary eligibility review committee that makes a determination based on severity of illness, functional management, and integrity of service need. Care planning and care coordination across HUSKY B and HUSKY Plus Behavioral is conducted through a team approach, including parents, center clinicians, educators, HUSKY B and HUSKY Plus Behavioral Plan representatives, the primary care provider, and other behavioral health providers. Despite the complexity of this coordination, state officials and representatives of HUSKY Plus Behavioral report no significant problems. However, plans are referring relatively few special needs children to HUSKY Plus.

When asked if eligibility criteria requiring clients to have used five hospital days and twenty inpatient days prior to admission could deter referrals, HPB providers and state officials stated that this requirement has never been enforced. Its presence in early materials may have had a disincentive affect early on. For example, if a plan had a 30-day behavioral health benefit in the plan and referred the child to HUSKY Plus Behavioral on day 15, the plan would still be responsible for paying the additional 15 days of behavioral service even though it was now provided by HUSKY Plus. However, since HUSKY Plus Behavioral and HUSKY B tend to use the same behavioral health providers, the reason for low referrals remains a question. It may be that there are financial incentives for the Child Guidance Clinics not to refer to HUSKY Plus since these children are currently covered by HUSKY B and by grant funds available directly to the Centers from the state's Department of Children and Families.

HUSKY Plus Program providers, state officials, and advocates all agreed that they were surprised with the low rates of referrals to both HUSKY Plus programs. Only a handful of clients have come forward in a year of operation. The reasons for this lack of enrollment are unknown, but several are cited.

1. HUSKY B enrollees are a different population than Medicaid and may use mental health services differently. The need for HUSKY B services was developed from a Medicaid utilization base which may overestimate actual need.

2. The program is not well understood yet. For example, parents do not know that they do not need to go to New Haven to access the special supplemental services and are unaware of the state wide capacities of the HUSKY Plus Behavioral network.

3. It takes time to develop a new program and only when sufficient numbers of satisfied users exist will the program be effectively marketed.

4. There continues to be resistance to behavioral health services which serves as a disincentive to enrollment.

5. Incentives may exist for community providers not to refer to the program.

6. It may be that the HUSKY B benefit package provides a rich enough benefit to meet the behavioral health needs of children. The benefit package in HUSKY B is modeled on that provided to state employees through collective bargaining agreements.

7. Connecticut has the highest health spending per capita in the U.S. and provides many services through a variety of funding sources to special needs children which may help meet behavioral health needs. Specifically, children with severe disabilities may be served by Medicaid having become eligible through SSI or spend-down provisions.

State officials reiterated that the benefit package is based on the state employees' plan. As a unionized benefit that is collectively bargained, it tends to have good behavioral health benefits.

HPB has identified a problem related to crowd-out provisions in the law. Specifically, it has become apparent to program organizers that many families are under insured, particularly when it comes to coverage for behavioral health. However, because they have special needs children, they cannot afford to drop employer-based coverage for six months to gain access to HUSKY B. The

crowd-out provisions that prevent families from dropping coverage and immediately qualifying for HUSKY, in fact, may serve as a disincentive to get quality and appropriate services to children in need.

### *The HUSKY Plus Physical Program*

The HUSKY Plus Physical Program (HPP) is a supplemental health insurance program available to children with intense physical health needs who are enrolled in HUSKY B. Children are eligible for HPP benefits if they are currently in HUSKY B with family income below 300% and meet certain diagnostic criteria or the definition of children with special health care needs. That definition is: "children who have or are at elevated risk for chronic physical, developmental, behavioral, or emotional conditions (biological or acquired). They must also require health and related services (not educational or recreational) of a type and amount not usually required by children of the same age." This eligibility definition mirrors that of Title V of the Maternal and Child Health Block Grant. In addition to the definition above, some children can be automatically referred to HPP, such as those who have a need for hearing aids or powered wheelchairs.

The Department of Social Services has contracted with the Centers for Children with Special Health Care Needs at Connecticut Children's Medical Center and Yale School of Medicine to administer HPP. The Centers in turn contract with Title V Maternal and Child Health providers across the state to assure statewide, local access.

The benefits for HPP are intended to supplement the HUSKY B program, maximizing available benefits and services for the child with special physical health needs. Children who have special health care needs may receive benefits through HUSKY B and HPP at the same time.

The HUSKY B Plan, health providers, or parents themselves make referrals. Referrals are based on a variety of needs for services made available through HPP, including needs assessment and care coordination, expert pediatric consultation, family support, linkage to financial and clinical resources, and advocacy for care in all realms. In addition, HPP benefits include payment for certain types of services and equipment not covered by the HUSKY B Plan or any other

community resource. Covered services include but are not limited to adaptive and specialty equipment; specialty medical, pharmacy and nutritional formulas; transdisciplinary team conferences; physical, occupational and speech therapy; specialty dental/orthodontic services (with some restrictions); medical supplies; hearing aids and augmentative communication devices.

Children receive primary and specialty care, hospitalization, durable medical equipment, rehabilitation, and other services as part of their HUSKY B Plan benefits. Families do not change their child's health care providers. HPP staff work closely with and provide technical assistance or guidance to primary care providers across the state.

HPP is intended to supplement HUSKY B services provided through managed care organizations. For example, if a powered wheelchair is not a covered benefit in the MCO, HUSKY Plus Physical will pay as the payer of last resort for that wheelchair. HPP administrators report that the state has high expectations for the program and assures that MCO's pay for services they are contracted to cover and that HUSKY Plus Physical funds are used only as a payer of last resort.

Care coordination, advocacy, and support are provided directly from the two centers, with linkage to appropriate community-based support for the family. Referrals to HUSKY Plus Physical have also been lower than expected. There have been considerable referrals to the Centers, but most referred have turned out to be eligible for Title V. The Yale Center reports that for every HPP eligible child enrolled, Title V has enrolled fourteen additional children.

### Quality and Oversight

Connecticut will contract with an external quality review entity, Qualidigm (formerly known as the Connecticut Peer Review Organization), to measure performance of its CHIP contract. Qualidigm will conduct an annual evaluation, including sampling of patient charts, evaluation of access to care, medical record standards, provider credentialing, and patient satisfaction surveys. Plans are also required to provide semiannual and annual reports, based on a combination of HUSKY A modified HEDIS measures and HEDIS measures. HUSKY B will require no

encounter data. In addition, the managed care plans are required to have in place an internal quality assurance plan.

## Summary

In its first year of operation, Connecticut's HUSKY Program has built into its Medicaid agency a Medicaid expansion (HUSKY A) for children to 185% of poverty, developed a separate program modeled after state employees' benefits plan (HUSKY B), provided a full-cost, buy-in for families over 300% of FPL, and developed a supplemental package of services, HUSKY Plus, for children with intensive physical or behavior needs. A premium structure has been designed for HUSKY B; a simplified application mail-in process for Medicaid and/or CHIP eligibility established; and discrete staff hired to launch HUSKY B. A contract has been let to establish a single point of entry for the clients, and another is being developed to measure the performance of the program. Grants have been made to community agencies, and a number of diverse strategies developed to reach and enroll children eligible for CHIP.

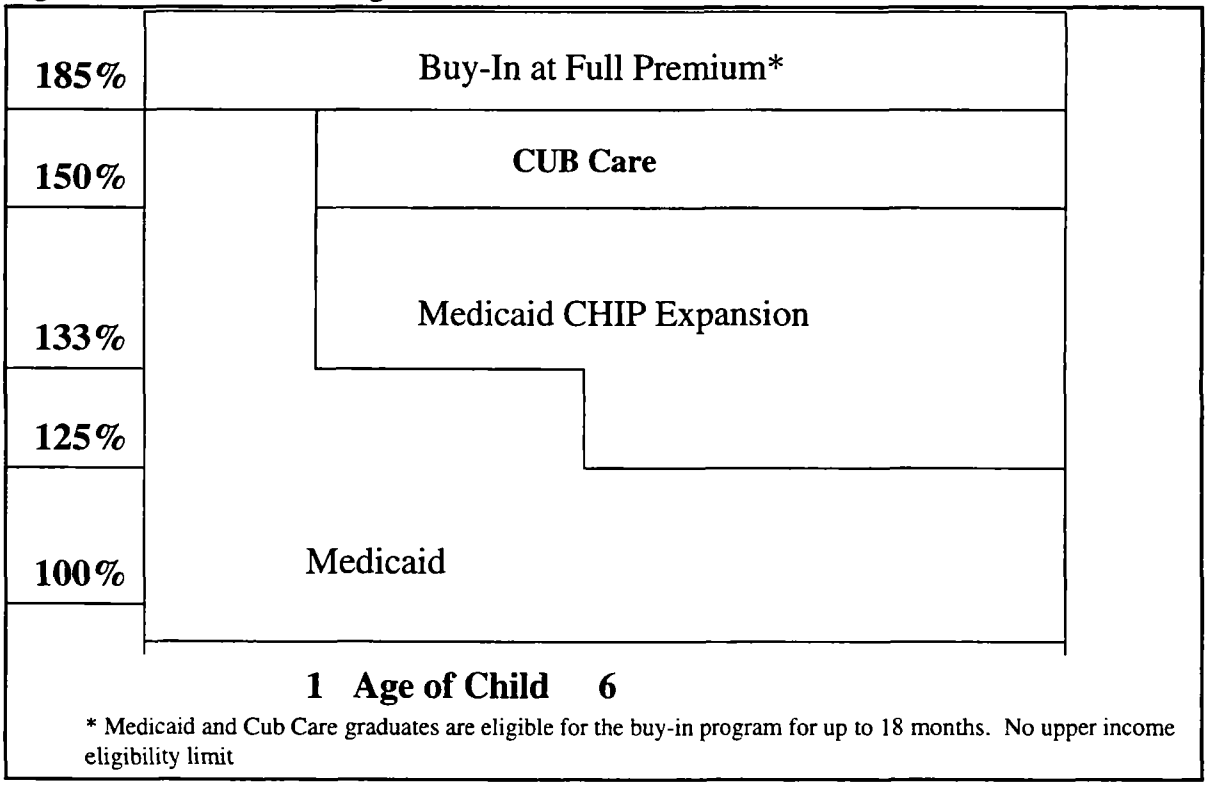
By June 1999, Connecticut had reached nearly half of its targeted enrollment. Despite all this work, the state identifies numerous challenges ahead, particularly since only about half of eligible enrollees have been identified, and few have been referred to HUSKY Plus. The state is working to simplify and coordinate marketing messages, improve data systems, and further coordinate Medicaid and CHIP within the limits of current Title XXI law. However, state officials, advocates, and providers agree that the program is well-conceived and needs more time to develop fully.

## MAINE

### Program Philosophy

Maine's CHIP program reflects the state's commitment to building on the Medicaid program through cautious and incremental expansion. The program expands Medicaid coverage to all children up to 18 who live at or below 150% of the Federal Poverty Level (FPL) and creates a "look alike," separate state-administered program, Cub Care, to cover children up to 18 who live at or below 185% of poverty. Cub Care is not an entitlement and requires family cost sharing, but otherwise mirrors Medicaid, providing the same benefits through the same delivery system. A buy-in at full cost is also available for children who graduate from Medicaid and Cub Care eligibility but do not have private coverage. The buy-in is available for 18 months. Medicaid eligibility includes provisions to disregard certain child care and work related expenses; Cub Care uses a gross income eligibility standard with no disregards. Medicaid has a 3 month retroactive eligibility period, not currently available through Cub Care.

***Figure 3: Health Coverage for Children in Maine***



Advocates and state officials alike note that Maine's use of Title XXI to extend coverage to 185% FPL reflects expansion that many states had already undertaken under Medicaid. But respondents all stressed that Maine wanted to build on the experience of an earlier initiative, the Maine Health Program, to expand coverage to uninsured children and adults. During a difficult economic period, the Maine Health Program had grown beyond expectations and exceeded cost projections and had been eliminated by the Governor and Legislature. The memory of phasing out a popular program looms large in the collective memory of Maine public officials and advocates who were committed to building a CHIP program that did not suffer the same experience.

In addition, in 1997 the Legislature had enacted a children's health insurance program funded by a tobacco tax increase. The Governor opposed the bill because he objected to new taxes that were not being offset by tax cuts in other areas and vetoed the bill. Later a compromise between the Governor and Legislative leaders was reached in which $8 million was set aside in a trust fund and the Maine Commission on Children's Health Care was established. The Commission's mission was to develop a children's health plan for Maine. Fortuitously, Congress enacted Title XXI after the Maine Legislature adjourned in 1997. The 16-member Commission was appointed in the summer by the Governor, Senate President, and House Speaker, and with $8 million secured for match to the newly created Title XXI program, convened in the Fall of 1997 to craft a program to meet the Federal Title XXI requirements and operate within the available matching funds. After considerable deliberation, the Commission developed a proposal for Maine's CHIP Program which was enacted by the Legislature and has been implemented. Stakeholders concur that the Commission had strong legislative participation and served as a vehicle of negotiation. As a result, enabling legislation mirrored the Commission's recommendation. In the most recent legislative session concluded in June of 1999, the Legislature enacted and the Governor signed a proposal to expand CHIP eligibility to 200% of the FPL by July of 2000. A bill to expand coverage to parents failed to be enacted.

## Administration

Maine's Title XXI program is administered through the Bureau of Medical Services, the state's Medicaid agency housed in the Department of Human Services (DHS). The Program Manger is Linda Schumacher who reports to Marianne Ringel, Division Director, who in turn reports to the Deputy Director who reports to the Bureau Director. Linda Schumacher is the only full-time dedicated staff to CHIP (Cub Care). However, because the program is largely a Medicaid expansion and a Medicaid "look alike," existing Medicaid staff are responsible for its implementation. A sister agency in the Department of Human Services, the Bureau of Family Independence, administers eligibility for the program through DHS regional offices. Title XXI funds pay for the Program Manager's cost as well as six income maintenance positions and one clerk typist in the Bureau of Family Independence. The state has this year separated TANF and Medicaid eligibility. Separate income maintenance workers are responsible for Medicaid eligibility. Barbara Feltes serves as the Program Manager for Medicaid eligibility in the Bureau of Family Independence. Eligibility staff are trained and supervised to promote Medicaid and CHIP coverage. There is general concurrence that the state has exceeded for FFY99 the 10% cap on administrative expenditures imposed by the Federal statute. As its success in reaching enrollment targets testifies, the state spent considerable resources in program start-up, noting that they spent their full 10% allotment during the three months the program had been implemented in FFY98. However, because Maine is largely a Medicaid expansion program, Medicaid administrative funds are used to cover some additional administrative costs.

Maine began enrollment in the Medicaid expansion in July 1998 and in Cub Care in August 1998. The state had a first year target to enroll 6,968 children and had enrolled approximately 6,500 children by June 1999. The state plans to increase enrollment to and maintain enrollment at 10,452 children for Years 2-5 of the program.

Maine's baseline of uninsured children to be served by CHIP was constructed through a study conducted for the Commission. The Maine Department of Human Services contracted with the Institute for Health Policy of the Edmund S. Muskie School of Public Service, University of

Southern Maine, to conduct a survey of children's health insurance coverage in Maine. The survey was subcontracted to and conducted by Mathematica Policy Research, Inc. and was co-sponsored and co-funded by Blue Cross and Blue Shield of Maine, the Maine Children's Alliance, the Maine Community Foundation, and Maine Health.

In October and November of 1997, Mathematica called 13,291 Maine households and completed telephone interviews with 2,449 households with children. They found that approximately 10%, or 31,000, of Maine children lacked health insurance; of these, one-third lived in families with incomes below 125% FPL making them eligible for Medicaid. Another 11,440 lived in families with incomes between 125% and 185% FPL making some of them eligible for the Medicaid CHIP expansion and the rest for the state-designed program, Cub Care.

In addition, Mathematica obtained information about health insurance coverage for children in the state. 63.2% of all Maine children had employer-sponsored health insurance coverage. An additional 5.8% had private insurance. Medicaid provided coverage to18%, while 2.7% more were covered by other government insurance.

### Data Collection

The Maine Medicaid Program has developed an extensive decision support computer system to track Medicaid expenditures and service utilization. However, the state had identified significant problems with its third party vendor and its system's development capacity including the failure of the system to have an archiving capacity. Due to relationship changes with third party vendors, input of claims data was slowed and the system has been significantly delayed in implementation. The state reports that conflicts have been resolved and claims data is being inputted rapidly. Once in place, the state will be able to track service use of Title XIX, Title XIX expansion, and Title XXI children. Without the claims data, the state has not been able to conduct utilization review, but will soon be able to do so.

In the Bureau of Family Independence (BFI), however, eligibility systems have not been

modernized. During this year, throughout all state agencies, programming staff have been fully engaged in planning for Y2K implementation. BFI has been able to track enrollment and disenrollment data, but because of system problems the data needs some "fine tuning." Respondents note that the state has an old computer system for eligibility and it is one that does not calculate eligibility automatically. The system relies on workers for input, but workers resist inputting data that is not necessary to determine eligibility. Workers always calculate eligibility by hand. Nevertheless, the state is confident that once Y2K implementation is in place data will be available on enrollment and disenrollment.

### Health Care Delivery System

Maine's Medicaid Program is still largely fee-for-service. One managed care organization, NYLCare, participates in Medicaid but covers fewer than 5% of all eligible children in its voluntary program. Children eligible for Title XXI receive the same benefits through the same providers as Medicaid eligible children. The state is now launching Maine PrimeCare, a statewide system of primary care case management through which the Title XIX and Title XXI programs will operate. Maine has also created a provider incentive system for physicians. Physicians with high Medicaid participation who meet performance measures established by the state for immunization and other preventive services are eligible for bonuses. This initiative assists the state in assuring provider participation statewide and has helped gain participation of new providers.

### Outreach

The state conducted outreach efforts initially with its own resources and with support and collaboration from advocacy and provider groups. Based upon a recommendation from the Commission enacted by the legislature, the state developed a one-page, two-sided, application that beneficiaries can mail in to the state. Verification of income and signature are required for eligibility. The single application form was developed by experienced DHS eligibility workers and supervisors, was reviewed by the Maine Ambulatory Care Coalition, Consumers for Affordable Health Care, the Maine Equal Justice Partners, and the Children's Alliance and was

field tested and revised. HCFA provided additional input for revisions on the form.

In addition to the single application form, the state conducted aggressive outreach at program start-up in September, mailing applications and brochures to every school child in Maine and mobilizing public health nurses to spread the word about the program. Applications and brochures were mailed to all town offices, Medicaid providers, WIC, Head Start, community action programs, and child abuse and neglect councils. Extensive radio and television public service announcements were developed and aired. The Department of Human Services convened an Outreach Committee of state officials representing the Bureau of Health, Bureau of Family Independence, Bureau of Medical Services, and advocates. The Bureau of Health took an early lead in outreach initiatives. The Maine Hospital Association also continued with its Campaign for Coverage which was a strong outreach initiative.

While Maine is not an ethnically diverse state, there are pockets of populations for whom English is not their first language. In response, the state published its brochures in eleven languages, working closely with Catholic Charities. In addition, an AT&T translation line is used. The state also has a significant Native American population. While the state believes that most Native American children are eligible for Medicaid, they continue to work with HCFA to develop an appropriate strategy of outreach for Native Americans.

State officials and advocates agree that while enrollment has been on target, there remain about 4,000 children who are believed to be eligible but not yet enrolled in Title XXI. The state and advocates concur that these are likely to be hard-to-reach children. In addition, the state's problems with data collection make it impossible to know if all Medicaid eligible children are being enrolled. As a result, the outreach campaign will target hard-to-reach children and teenagers. The Robert Wood Johnson Foundation's Covering Kids Initiative has recently funded a coalition in Maine to extend outreach. Under the leadership of the Maine Ambulatory Care Coalition, the group includes the Maine Equal Justice Partners, Consumers for Affordable Health Care, and the Maine Children's Alliance, each of whom receive funds for particular outreach

initiatives.

All organizations participating in the coalition will conduct training for volunteers and staff to help learn how to fill out the applications and to provide public education about the program. The Maine Children's Alliance will conduct outreach in rural areas where under-enrollment appears to be a problem. Consumer's for Affordable Health Care will conduct similar outreach projects in an urban area. Both the urban and rural areas will be identified by the Department of Human Services as areas with under-enrollment. The Consumers for Affordable Health Care will staff a hotline for consumer questions. Two local coalitions have been established. One, located in Bangor, is led by a community action agency. Another, in rural Washington County, has a health center as lead. These coalitions will work on local enrollment and focus on teens. Six task forces have been established and are staffed by the participating partner agencies. The task forces focus on social and religious clubs, business and labor, education, social service and child care, parents and community, and health providers and insurers. A toll-free telephone number is also available for information.

The state has plans to effectively coordinate its outreach strategy with the Covering Kids initiative. First, the state is providing matching funds to the grantees and will be requiring one marketing message for all involved in outreach. The message will likely focus on the availability of free or low-cost health insurance for children to avoid any confusion over different program names. State officials will focus on statewide initiatives and media, while Covering Kids will retain its grassroots, local presence. The state has reconvened its internal planning and oversight committee which consists of the Commissioner of the Department of Human Services, the Directors of the Bureaus of Health, Medical Services, and Family Independence, the CHIP Program Manager and other key staff. The CHIP Program Manager works closely with the Covering Kids grantees and will continue to serve as liaison to the lead organization for the initiative, the Maine Ambulatory Care Coalition.

## Coordination with Medicaid

Maine has created a seamless system of coverage for children in Medicaid and those served by Title XXI in the Medicaid expansion and the "look alike" program. Applications are taken by mail and through DHS regional offices. One application, described earlier, provides eligibility for each part of the program. The program assures that the same benefits, offered through the same plans and providers, are available to Medicaid and Cub Care children.

> In Maine, Medicaid and Cub Care use different procedures to determine financial eligibility. Medicaid uses disregards, Cub Care doesn't this means that for Medicaid, families with gross income over 150% FPL may actually be eligible for Medicaid.

There are some significant differences between Medicaid and Cub Care eligibility. Specifically, the Medicaid program uses net income to determine eligibility. Child care, work-related expenses, and $50 of child support are deducted from income before Medicaid eligibility is determined. Cub Care eligibility is determined on gross income. The decision to establish Cub Care eligibility using gross income was based on two reasons. First, the Commission establishing the children's health insurance program in Maine was working within budget limitations. Second, state officials made a strong argument that eligibility for Title XXI should be more streamlined and simpler than Medicaid, that the new Federal program provided states the opportunity to experiment with simpler eligibility designs. Rather than develop the cumbersome disregards, state officials advocated for a simple gross income test. However, this limits the number of eligibles in the Cub Care program in Maine and advocates note that, since Medicaid eligibility must be determined as a screen for Title XXI, the disregards must still be determined (see box inset for explanation). Thus, they suggest Title XXI eligibility should be increased to allow disregards and increase the number of eligible children. However, recent Legislative action will increase Title XXI eligibility in Maine to 200% FPL (gross income) in July 2000.

As noted earlier, one application exists for Medicaid and Title XXI and, while it requires income verification and a signature, it can be mailed-in to determine eligibility. The state's eligibility

process is a flexible one. Regulations require applications to be processed within 45 days. If an incomplete application is received, the beneficiary receives a letter providing 12 days to submit additional information. If no response is received, a denial letter is forwarded at which time, the potential beneficiary can again provide additional information. Beneficiaries receive a piece of paper making them eligible, but the state has plans to develop a new eligibility card sometime in the future. There is general agreement that the form is a simple and effective one, although some advocates believe it could use additional revision, particularly regarding how income is counted and how family is defined for the two programs.

Advocates generally praise the Department's eligibility efforts, noting that Barbara Feltes has "changed the culture" within that agency. Feltes notes that Medicaid is in the business to enroll people and assure health coverage. She points out that there is a mixed message between Medicaid and TANF eligibility and that Maine is trying to build a kinder and gentler Medicaid program, one that is understanding of the human aversion to bureaucratic forms and paperwork, and forgiving of people when mistakes are made.

The state has worked hard to assure Medicaid beneficiaries transitioning to work retain Medicaid coverage. The state notes that its data system is not sufficiently operational at this time to give them needed data about the program enrollment. However, while TANF caseloads have shown significant declines, the state sees no evidence to date that Medicaid enrollment has declined; rather, it appears to be stable. The state has developed policies to assure health coverage continues for people transitioning off Medicaid. In addition to the buy-in provision, the state has a mechanism of automatic coverage for up to two months for any individual deemed no longer eligible for the TANF cash grant. Medicaid is extended for up to two months while the state assess the family situation to assure eligibility has been properly determined. In this way the state feels strongly that all eligible for transitional Medicaid benefits are receiving them.

### Disenrollment, Re-enrollment, and Retention

The state has maintained a consistent caseload of CHIP eligibles and reports no more than a 1% rate of disenrollment. However, some advocates question this data, noting that the data system is insufficient to document numbers. Of the 6,500 individuals enrolled through June, 4,700 are Medicaid expansion populations and 1,800 are Cub Care. Enrollment was strong from October through January and has leveled to an average of about 250 new enrollees per month from February through June.

### Cost Sharing and Crowd-Out

Children in families up to 150% FPL participating in the Medicaid expansion are not required to cost share; children from 150% to 185% FPL enrolled in Cub Care are charged premiums based on family income and family size. Premiums are limited in order to meet the Federal statutory limit of requiring cost sharing not to exceed 5% of family income. Premiums are required on the following schedule:

| | |
|---|---|
| Below 150% | No premiums |
| 150%-160% | Premium of 5% of benefit cost per child ($5 per month), with a limit of 5% of the cost for 2 children ($10 per month) per family. |
| 160-170% | Premium of 10% of benefit cost per child ($10 per month), with a limit of 10% of the cost for 2 children ($20 per month) per family |
| 170-185% | Premium of 15% of benefit cost per child ($15 per month), with a limit of 15% of the cost for 2 children ($30 per month) per family. |

Because of the sliding scale premium design, cost sharing required of a family will never exceed 1.6% of family income for those at the lowest end of the FPL range. There are no co-payments for services.

Premiums are collected by mail by the Bureau of Family Independence. Beneficiaries receive an easy-to-read, computerized print out summarizing their premium charges and are asked to make payment through a prepaid envelope that is included with the bill.

Cub Care has six months of continuous eligibility. Because the program began to enroll in August 1998, families were required to have eligibility redetermined beginning in February. According to state officials, it appears that fewer than 1% of families have failed to pay premiums or have failed to re-enroll in the program. Planned improvements in data systems will result in more reliable information soon.

The state has a plan to call disenrollees or those who did not reapply. One supervisor in Portland did make such calls, but did not get much response. The state has seen anecdotal evidence that there are individuals who wish to pay and want to join Cub Care, even though they are eligible for Medicaid. Advocates are skeptical of these assertions and believe they are so unusual that they tend to be remembered and repeated and this creates a sense that such incidents happen more often than they do. Further data is needed to make a determination about whether or not people who are Medicaid eligible are refusing Medicaid and seeking to enroll in Cub Care.

Maine's Cub Care law requires a penalty period for those who do not pay premiums. Individuals have six months to pay a premium, and if they do not do so, they are disenrolled from the program for one month for each month they do not pay a premium. There is a three-month maximum penalty period. State officials believe this provision in the law is too complicated. Today, if someone reapplies after a period of non-payment, DHS re-opens the case and tells the enrollee when they will be eligible for services again after a one to three month waiting period. Department officials would like to eliminate the penalty period for non-payment and simply ask people to pay in order to become eligible again.

Maine has provisions in its enabling legislation to prevent eligible families from dropping employer-based group coverage. Children who had employer-based group coverage within three months of application for Title XXI are not eligible for the program unless the cost of that coverage was prohibitive. A child with employer-based group coverage could drop that coverage if the cost to the family for that coverage exceeds 10% of their income. If a family indicates that they have dropped coverage during the three months prior to application, the employer will be

contacted to verify information such as when insurance was dropped by family, the amount the employee was required to pay and the amount the employer paid. If the cost to the family exceeded 10% of their income their children could enroll in CHIP without the 3 month waiting period. The state has some data on how many have been denied CHIP because they had health insurance however, the data has not yet been validated. Families may also drop individual coverage and be eligible for CHIP without a waiting period and the state, through enabling legislation, has provided some relief for families so that they may drop coverage in certain situations to gain eligibility for CHIP. Advocates report that families are reluctant to drop coverage and suggest the state consider two provisions: a wrap-around program or a provision that allowed eligibility to be determined prior to families dropping insurance so that they would have the assurance of being eligible.

State officials and advocates agree that the law's exclusion of state employees is unfortunate since some state employees, particularly seasonal workers, are exceeding 10% of family income to cover the cost of dependent coverage. Respondents also question the impact of crowd-out requirements that prohibit parents who have insufficient coverage (are under-insured) from dropping these plans to become eligible for the more comprehensive benefits of Maine's Title XXI program.

### Children With Special Health Care Needs

The State of Maine has no particular provision for children with special health care needs, but notes that because the benefit program in Title XXI in Maine is the Medicaid benefit, extensive services are available for special needs children.

### Quality and Oversight

The state is quick to point out the limits of its current data system. Efforts are underway to advance the decision support system to be fully operational soon, which will provide significant data and information regarding access and utilization of services by Title XXI enrollees. Eligibility data, however, must rely on an outmoded computer system which will have limited

capacity but will be able to provide data regarding the program once Y2K problems have been resolved.

The state has instituted a quality improvement program in its Medicaid program that has been extended to Title XXI and that includes oversight of the medical director and a review of the provider incentive system through which physicians receive bonuses for meeting performance targets for asthma, immunization, and other preventive services for children. The State, as part of the Commission's planning, contracted with Mathematica Policy Research and the Muskie School of Public Service at the University of Southern Maine to conduct an extensive survey of uninsured children in Maine. The state plans to contract to update the survey as a measure of Title XXI impact. In addition, in January and February 1999, The Muskie School surveyed 633 CHIP eligible children to determine their opinions about the program. A preliminary report suggests access problems are not a significant issue for CHIP eligible children. The bigger problem seems to be confusion between Medicaid and Cub Care. In addition, the state has identified problems with dental access which will require additional attention in the years ahead. The state has had significant difficulty completing its annual report for HCFA largely because of resource limitations and data staff time required to respond to Y2K compliance. However, the state does express confidence that the report will soon be done and that data will be available in a more accurate and timely fashion soon.

### Summary

Maine's CHIP program has enabled the state to extend health insurance coverage to all children up to age 18 who live at or below 185% of poverty. In an effort to avoid a costly repeat of an earlier state initiative to expand health coverage to uninsured children and adults, the state has chosen to use CHIP as a way to cautiously and incrementally build on its Medicaid program.

Cub Care is not an entitlement and requires family cost sharing but otherwise mirrors the state's Medicaid program, providing the same benefits through the same delivery system, a system that is largely fee-for-service.

Maine has created a seamless system of coverage for children in Medicaid and those served by Title XXI in the Medicaid expansion (up to 150% FPL) and the "look alike" program (150% FPL to 185% FPL). One application determines eligibility for each part of the program, and the same benefits, offered through the same plans and providers, are available to Medicaid and Cub Care children. The state had enrolled 6,500 children into Title XXI by June 1999 towards its first year target (August 1999) of 6,968. The state plans to increase enrollment to cover 10,452 children in each of the next four years and will expand CHIP eligibility to 200% by July 2000.

Many of the implementation challenges that Maine has faced with Cub Care have involved data collection and analysis. Y2K concerns have kept state programming staff fully engaged, causing the state to continue to rely on an old computer system that does not calculate eligibility automatically. However, efforts are underway to improve the system, and the state soon expects to have significant data and information regarding access and utilization of services by Title XXI enrollees.