

**FRAMEWORK FOR ANNUAL REPORT  
OF STATE CHILDREN'S HEALTH INSURANCE PLANS  
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT**

**Preamble**

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

- C Recognize the *diversity* of State approaches to SCHIP and allow States *flexibility* to highlight key accomplishments and progress of their SCHIP programs, **AND**
- C Provide *consistency* across States in the structure, content, and format of the report, **AND**
- C Build on data *already collected* by HCFA quarterly enrollment and expenditure reports, **AND**
- C Enhance *accessibility* of information to stakeholders on the achievements under Title XXI.

**FRAMEWORK FOR ANNUAL REPORT  
OF STATE CHILDREN'S HEALTH INSURANCE PLANS  
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT**

State/Territory: Massachusetts  
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

\_\_\_\_\_  
(Signature of Agency Head)

SCHIP Program Name (s) MassHealth

SCHIP Program Type  Medicaid SCHIP Expansion Only  
 Separate SCHIP Program Only  
 Combination of the above

Reporting Period **Federal Fiscal Year 2000 (10/1/99-9/30/00)**

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Submission Date December 31, 2000

## SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

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*This sections has been designed to allow you to report on your SCHIP program-s changes and progress during Federal fiscal year 2000 (September 30, 1999 to October 1, 2000).*

### **1.1 Please explain changes your State has made in your SCHIP program since September 30, 1999 in the following areas and explain the reason(s) the changes were implemented.**

*Note: If no new policies or procedures have been implemented since September 30, 1999, please enter NC=for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.*

1. Program eligibility NC
2. Enrollment process NC
3. Presumptive eligibility NC
4. Continuous eligibility NC
5. Outreach/marketing campaigns

Outreach and marketing have been key focal points of the Division of Medical Assistance's (DMA) efforts to maximize enrollment for both the 1115 Waiver Expansion and the SCHIP populations. Massachusetts has engaged in almost all of the practices cited by the Kaiser Family Foundation in its study of states' marketing efforts for CHIP and Medicaid.<sup>1</sup> These practices include: promoting CHIP and Medicaid jointly, targeting specific populations, a combination of radio, TV, and print advertising, translating some ads into Spanish, working with diverse community based organizations (discussed below), and conducting some market research.

An important component of these MassHealth outreach and marketing efforts has been the collaborative effort with Community-Based Organizations (CBOs) through the mini-grant initiative, *Massachusetts Projects for Health Access*. The CBOs include health centers, hospitals, and a variety of human service organizations.

In June 1999, the second round of the mini-grant procurements was held. The Division, in conjunction with the Department of Public Health (DPH), issued a Request For Responses (RFR) to solicit proposals from CBOs to provide community-based outreach and enrollment services. CBOs selected through this procurement were awarded contracts to (a) market MassHealth and the Children's Medical Security Plan

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<sup>1</sup> [www.KFF.org/](http://www.KFF.org/) "Marketing Medicaid and CHIP: A Study of State Advertising Campaigns." October 2000.

(DPH's safety net insurance program for children), including dissemination of information and literature and other targeted outreach efforts, and to (b) educate, enroll, and retain members.

The June 1999 procurement resulted in State Fiscal Year 2000 (SFY00) outreach mini-grant awards to 57 organizations for the period September 1999 to June 2000. The ten-month funding amount was \$19,616 for the majority of mini-grantees, with a total allocation of \$1.6 million. (In its first mini-grant procurement, the Division—in conjunction with the Department of Public Health—had awarded 52 grants ranging from \$5,000 to \$20,000 per contract.)

In addition to the goal of reaching uninsured individuals and families and enrolling them in MassHealth, a second goal of the mini-grantees was to help retain those already enrolled through educating them about MassHealth member responsibilities and supporting the re-determination process.

The Division incorporated an evaluation strategy into the SFY00 mini-grant process. The main goals of the strategy are to monitor mini-grantee activities as a whole and compare them to the overall objectives of the procurement, to inform a description of the mini-grant process, and guide programmatic technical assistance to mini-grantees. The Division asked the Center for MassHealth Evaluation and Research (CMER) at the University of Massachusetts Medical School to assist in the evaluation of CBO mini-grant activities. Among the evaluation strategies are:

- *Reporting Format Improvements:* CMER assisted the Division in revising the reporting tool used by mini-grantees to capture information needed to monitor outreach, enrollment, and retention activities. The reporting tool was distributed to the 57 mini-grantees, and was used by them to report activities performed from December 1999 to June 2000. CMER is compiling these data into cumulative reports by mini-grantee, region, and on a statewide level.
- *Site Visits:* CMER conducted site visits to ten mini-grantees, representing a cross-section of grantee types, to gather in-depth information about outreach, enrollment, and retention at the community level. Information developed from these site visits will be incorporated into an overall description of the mini-grant process.
- *CBO Identifiers on MBRs:* DMA designed and implemented a process for stamping an identifying number on MBRs submitted by mini-grantees on behalf of those seeking MassHealth benefits. When a stamped MBR reaches the CPU, the unique identifier of the mini-grantee can be used to track and monitor the number of MBRs submitted by that CBO in a defined period of time.

*Evaluation Report:* The final data set for activities for the month of July 2000 was due from mini-grantees in August 2000. Data from the monthly reports, in conjunction with the findings from the site visits, are being analyzed by CMER, with an initial written report of findings to be presented to the Division in the fall of 2000. A final report will be delivered early in 2001.

6. Eligibility determination process NC

7. Eligibility redetermination process

An overall goal of the Division has been to develop the systems capacity to assure that eligibility is re-determined on an annual basis for each MassHealth member. This goal applies not only to children enrolled in MassHealth through Title XXI, but also to the entire 1115 Demonstration Waiver population. Massachusetts has instituted a combined Medicaid and SCHIP program, so that development and implementation of this capacity was unified for both programs. In SFY00 the goal was fully completed, with each MassHealth member, including SCHIP children, assigned a review date within an annual cycle. As discussed below, though re-determination has resulted in loss of eligibility for those who fail to respond to re-determination notification, an assessment of caseload activity indicates that many of those who lose eligibility regain their eligibility within the following 6 months. When the number of MassHealth cases closed in a month are compared to those both reopened during the same month or reopened within 1 to 6 months of being closed, it appears that a large number of individuals are regaining eligibility. It is assumed that many of the cases closed for failure to comply with the re-determination process for MassHealth are re-opened within the 6-month time frame. It is assumed that the same holds true for SCHIP children, and initial efforts to validate that have shown this to be true.

Beginning in SFY99 and continuing into SFY00 the Division, in conjunction with the Center for MassHealth Evaluation and Research (CMER), located at University of Massachusetts Medical School, conducted a retrospective review and assessment of the re-determination activity for all MassHealth members, including children eligible for SCHIP.

*Failure to Respond to Re-determination Notices:* Eligibility for MassHealth is re-determined annually. Along with implementation of MA21, the new eligibility determination system for MassHealth, the Division experienced an accrual of cases past due for annual re-determination. The Division is now on an annual re-determination cycle and currently has no backlog. The evaluation initiated in SFY99 was designed to provide a detailed look at some of the factors that may be affecting the response rate, including how the process itself and the materials used to communicate with members about re-determination and their responsibilities in the process are understood by members.

- *Self-Addressed Stamped Envelope:* During SFY00 the Division decided to include a self-addressed stamped envelope in the packet of re-determination information that is sent to MassHealth members including those on SCHIP. On average, 5000 re-determination packets are sent out each week. As a pilot test of the impact of including a self-addressed stamped envelope, 500 re-determination packets in one of the weekly mailings included the new envelopes, and their return rate was monitored to ascertain if there was any change in the response rate among people receiving the pilot packets. It was determined that the returns from the pilot group were 8% higher than the usual return rate. Based on that test the use of self-addressed stamped envelopes was implemented on a full scale, but unfortunately the improvement in the return rate experienced during the pilot test did not continue with full scale inclusion of the envelopes, and no improvement in the overall return rate was realized.

- *Member Interviews, Provider Focus Groups and Administrative Data Analysis:* In order to learn more about what influences member decisions regarding response to re-determination notices, CMER is conducting face to face interviews. Interviews are being conducted both with members who responded to the re-determination questionnaire, as well as with those who failed to respond and were closed for failure to return forms. CMER has conducted focus groups with providers and outreach workers to gain an understanding of how re-determination is understood from their perspectives. CMER will also analyze administrative data to identify utilization patterns among those who were closed to determine if there is any discernable pattern related to the use of services that may distinguish MassHealth members who do not return re-determination materials from members who responded. The administrative data analysis will also include examination of records to identify if any closed for failure to respond to the re-determination notices re-opened, at what rate, and within what timeframes. It is expected that a report from CMER will be available in the summer of SFY01, outlining findings and recommendations.

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| 8. Benefit structure   | NC |    |
| 9. Cost-sharing policies   | NC |    |
| 10. Crowd-out policies   | NC |    |
| 11. Delivery system  | NC |    |
| 12. Coordination with other programs (especially private insurance and Medicaid) |    | NC |
| 13. Screen and enroll process  | NC |    |
| 14. Application  | NC |    |
| 15. Other  |    |    |

**1.2 Please report how much progress has been made during FFY 2000 in reducing the number of uncovered, low-income children.**

1. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2000. Describe the data source and method used to derive this information.

Massachusetts has made significant progress in reducing the number of uninsured, low-income children

in the state. One indication of the progress that has been made in providing coverage to low income children is evident from the fact that on September 30, 2000 there were 53,613 children enrolled in SCHIP in Massachusetts.

In addition to the enrollment in SCHIP, there is other evidence of the state's success in reducing the number of low-income children in the state. The Division carefully monitors different surveys that are conducted to estimate changes in the number of uninsured in Massachusetts in order to assess the impact that expansion activities, including the SCHIP program, has had on improving coverage among low-income populations. Massachusetts is fortunate to have a biannual survey of the impact of our health care reform Demonstration conducted by the Massachusetts Division of Health Care Finance and Policy (DHCFP) in accordance with legislative mandate. Preliminary results from the DHCFP's *2000 Health Insurance Status of Massachusetts Residents Survey* show an overall decline in the number of uninsured in Massachusetts from 8.2% of the population in 1998 to 5.9% in the spring of 2000. The rate of uninsured declined in every age-category, and for children less than 18 years of age the rate of uninsurance dropped from 5.8% in 1998 to 2.8% in 2000.

The Urban Institute's National Survey of American Families (NSAF) also points to the success that the Demonstration and SCHIP is having in reducing the number of uninsured in the State. Massachusetts is one of thirteen states participating in the NSAF as part of the Urban Institute's *Assessing the New Federalism* initiative. Among the areas being surveyed are changes in health care coverage for children and adults within different income groups.

NSAF found that there were statistically significant reductions in the Massachusetts uninsurance rate for children, with the uninsured dropping from 6.2% in 1997 to 3.4% in 1999. For low-income children (below 200% of FPL) in Massachusetts, NSAF found the rate of uninsured dropped as well, from 13.8% in 1997 to 6.5% in 1999.

NSAF has cited several factors as the underlying explanations for the statistically significant reduction in the uninsurance rate for low-income children in Massachusetts. These include the state's efforts to create a single, seamless program which includes the incorporation of SCHIP, and the substantial investments made to raise awareness about MassHealth and streamline the enrollment system.

NSAF also cited Massachusetts' creation of a single, seamless program that covers parents, and the substantial investments made to raise awareness about MassHealth and streamline the enrollment system as factors contributing to the reductions in uninsured in the state.

In addition, the Current Population Survey (CPS) March Supplement provides important information on trends in health insurance status for the population in Massachusetts, particularly in contrast to other states and the nation as a whole. Nationally the CPS found that the uninsured rate fell from 16.3% in 1998 to 15.5% in 1999.

The differences in survey estimates between the DHCFP, the NSAF and CPS result from differences in

the surveys themselves. Factors such as survey design, sampling methodology and timing of the surveys (the DHCFP survey years were 1998 and 2000, while the NSAF's were 1997 and 1999, and CPS is annual) are different for each of the surveys. However, each survey is reporting similar trends in the reduction in the number of uninsured in Massachusetts, including within low-income populations.

2. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

Because Massachusetts operates its SCHIP program in conjunction with its Medicaid program under the single umbrella of MassHealth, a single application is used for both programs. Efforts to streamline and simplify the application form to be used for MassHealth had begun to be spearheaded under the 1115 Demonstration Waiver when the provisions of Title XXI were enacted. The importance of the efforts that were underway under the 1115 waiver were amplified with passage of SCHIP, and Massachusetts' efforts to enhance its enrollment, outreach and marketing efforts have resulted in an increased number of children brought into the combined MassHealth effort.

From the expansions of MassHealth with the implementation of the 1115 Waiver on July 1, 1997 to September 30, 2000 the enrollment of children in MassHealth has increased by 86,462 children, which represents a 28% increase in the number of children eligible for MassHealth.

Of the 86,000 children enrolled in MassHealth, 53,624 children enrolled in MassHealth under SCHIP rules between October 1997 and September 30, 2000.

3. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

Our success in enrolling children, as a result of both the 1115 Demonstration expansions and the State's Children's Health Insurance Plan (SCHIP) implementation is evidenced by our leadership among states in covering low-income children. Massachusetts ranks second best among all states in its average monthly progress in enrolling eligible children for health insurance coverage under SCHIP and Medicaid combined. The Children's Defense Fund calculated this ranking based on setting a target number of uninsured children for each state (those uninsured children in the state at or below 200% of FPL), and then calculating the states' average monthly rates of progress toward covering the target number. States were then ranked from highest to lowest by their monthly progress rates. <sup>2</sup>

The Kaiser Family Foundation has reported on changes in states' enrollment of uninsured residents in Medicaid during the period 1996 through 1998.<sup>3</sup> In that report, Massachusetts is cited as second

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<sup>2</sup> "All Over the Map – A Progress Report on the State Children's Health Insurance Program" Children's Defense Fund, Washington, D.C. July, 2000

<sup>3</sup> [www.KFF.org/](http://www.KFF.org/) Medicaid and the Uninsured. October 2000.

among the 50 states in its increase of Medicaid enrollment, which increased by 32.5% during that time. Among the 10 states with the largest Medicaid enrollments, Massachusetts was the only state with a Medicaid enrollment increase greater than 10%. And Massachusetts was cited as one of the 6 states with an increase of over 100,000 in Medicaid enrollment, with Florida the only other state in that group besides Massachusetts from the 10 states with the largest Medicaid enrollments.

4. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

No, skip to 1.3

Yes, what is the new baseline?

What are the data source(s) and methodology used to make this estimate?

What was the justification for adopting a different methodology?

What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

**1.3 Complete Table 1.3 to show what progress has been made during FFY 2000 toward achieving your State's strategic objectives and performance goals (as specified in your State Plan).**

In Table 1.3, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

- Column 1: List your State's strategic objectives for your SCHIP program, as specified in your State Plan.
- Column 2: List the performance goals for each strategic objective.
- Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter ANC@(for no change) in column 3.*

<b>Table 1.3</b>		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
<b>OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN</b>		
Expand access to health coverage for low-income children in the Commonwealth.	Reduce the number of uninsured children in the Commonwealth.	<p><b>Data Sources:</b> CPS Data; NSAF '97 and '99 Data; DHC FP '98 and '00 Data.</p> <p><b>Methodology:</b> Decrease the ratio of uninsured children to insured children from 2:3 to 1:9.</p> <p><u>Numerator:</u> Measure 1) Number of uninsured children in the state. Measure 2) Number of insured children in the state.</p> <p><u>Denominator:</u> Measure 1) Total number of children in the state. Measure 2) Total number of children in the state.</p> <p><b>Progress Summary:</b> Estimates continue to show that the number of uninsured children in Massachusetts continue to decrease. Two key surveys have been tracking the insurance status of Massachusetts' residents over time, and both have found a decrease in the number of uninsured children. The survey conducted by DHC FP found that the rate of uninsured children (&lt;18) in the state dropped from 5.8% in 1998 to 2.8% in 2000. The NSAF found that the number of uninsured children dropped from 6.2% in 1997 to 3.4% in 1999, and that for low income children, NSAF found the rate of uninsured dropped as well, from 13.8% in 1997 to 6.5% in 1999.</p>

<b>Table 1.3</b>		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
<b>OBJECTIVES RELATED TO SCHIP ENROLLMENT</b>		

**Table 1.3**

<p>(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)</p>	<p>(2) Performance Goals for each Strategic Objective</p>	<p>(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)</p>
<p>Develop programs to expand health coverage while maximizing employer-sponsored health insurance to low income children.</p>	<p>Implement MassHealth Family Assistance in state fiscal year 1998.</p>	<p><i>Data Sources: Premium Assistance Summary by Plan Enrollment Snapshot Report</i></p> <p><b>Methodology:</b>  <u>Measure 1:</u> Comparison of children enrolled in Family Assistance Premium Assistance (FA/PA) with those enrolled in Family Assistance Direct Coverage (FA/DC).  <u>Measure 2:</u> Comparison of those in FA/PA who came in insured with those who came in uninsured.  <u>Measure 3:</u> Comparison of those in FA/PA who came in uninsured with access to ESI and met Title XXI access requirements with those who came in uninsured with access to ESI and met 1115 Waiver requirements.</p> <p><b>Numerator:</b>  <u>Measure 1:</u> Children in FA/PA as of November 30, 2000.  <u>Measure 2:</u> Children in FA/PA who came in uninsured.  <u>Measure 3:</u> Children in FA/PA who came in uninsured and met Title XXI requirements.</p> <p><b>Denominator:</b>  <u>Measure 1:</u> Children in FA/DC as of November 30, 2000.  <u>Measure 2:</u> Children in FA/PA who came in insured.  <u>Measure 3:</u> Children in FA/PA who came in uninsured and 1115 Waiver requirements.</p> <p><b>Progress Summary: *</b>  <u>Measure 1:</u> 3,236 children are in FA/PA as of 11/30/00. An additional 21,822 children are in FA/DC  <u>Measure 2:</u> 1,059 children in FA/PA came in uninsured. 2,114 children in FA/PA came in insured as of 11/23/00.  <u>Measure 3:</u> 63* children in FA/PA met Title XXI requirements for access to ESI. 966 children in FA/PA met the Title XIX 1115 Waiver requirements for access to ESI.                      *Figures generally reflect SCHIP and 1115 combined, unless specifically noted as SCHIP..</p>

<b>Table 1.3</b>		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
<b>OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT</b>		
Improve the efficiency of the eligibility determination process.	<p><u>Performance Goal A:</u> Develop a streamlined eligibility process by eliminating certain verifications.</p> <p><u>Performance Goal B:</u> Develop a fully automated eligibility determination process.</p>	<p>Data Sources: Goal A: MassHealth Benefit Request (MBR) application Goal B: MA21 system</p> <p>Methodology: Determine 90% of applicants eligibility status within 15 days receipt of a completed (MBR)</p> <p><u>Numerator:</u> Number of applicants for whom eligibility status is determined within 15 days</p> <p><u>Denominator:</u> Number of MBR applications filed</p> <p>Progress Summary: The average turnaround time in SFY00 to process a completed MBR was 2.0 days compared to 2.6 days in SFY99.</p>
<b>OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)</b>		
N.A.		<p>Data Sources:</p> <p>Methodology:</p>

<b>Table 1.3</b>		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
		Progress Summary:
<b>OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)</b>		
Improve the health status and well-being of children enrolled in MassHealth direct coverage programs.	<p><u>Performance Goal A:</u> Improve the delivery of well childcare by measuring the number of well child visits and implementing improvement activities as appropriate.</p> <p><u>Performance Goal B:</u> Improve the immunization rates by measuring the rate of immunization administration and implementing improvement activities as appropriate.</p>	<p><b>Data Sources:</b> HEDIS, Summary Analysis of Clinical Indicators, HCFA and CDC GPRA initiative.</p> <p><b>Methodology:</b> <u>Performance Goal A:</u> 1) The Massachusetts Health Behavioral Partnership implements Treatment Improvement Series, which are improvement activities targeted at behavioral health providers. Treatment Improvement Series #3 was implemented in early 2000, and it asks behavioral health providers to help families they are seeing to identify their PCC and to remind families about the importance of well-child care, and the recommended frequency; 2) The PCC Plan Profile Report Support materials for Profile IX included a copy of the Child Health Diary, developed by the DPH which is being distributed to all new parents at time of birth, and which helps parents keep up with the recommendations for well-child care; 3) A mailing was sent to Early Intervention providers, with information on the recommended schedule of well-child visits, and a request for EI providers to remind families with whom they work about the importance of well-child care. This allows us to reach children who may not be accessing preventive health care services, but are accessing EI services; 4) The Division is co-leading with DPH a workgroup that is looking to develop a public awareness campaign targeted at teens to increase the rate at which teens access preventive health care services.</p> <p><u>Numerator:</u> number of MassHealth pediatric members with at least one well child visit in accordance with HEDIS and EPSDT specifications</p> <p><u>Denominator:</u> number of continuously enrolled children during CY98, who had a well-child visit in accordance with HEDIS and EPSDT specifications.</p> <p><b>Progress Summary:</b> <u>Performance Goal A:</u> 99 HEDIS MassHealth mean rates for HEDIS 99 well-child care measures.</p> <p><u>Performance Goal B:</u> 1) One of 16 states participating in Phase One of the GPRA Initiative to improve immunization rates for 2 year olds. 2) submitted an article to the ShotClock,, the newsletter of the Mass Chapter of the AAP's Immunization Initiative, sharing the MassHealth mean immunization rates, and</p>

<b>Table 1.3</b>		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
		<p>letting providers know we would be working on improvement initiatives; 3) so-sponsored with DPH an Immunization Improvement workshop for PCCs in June, 2000. Providers gave favorable evaluations of the workshop, and many implemented improvement activities in their practices; 4) Included DPH's Vaccine Administrative Record on cardstock in the Profile Support materials for Profile X, to encourage PCCs to document vaccines on a standard form.</p> <p><u>Numerator</u>: # of children received 4 DTP/DtaP, 3 Polio (IPV/OPV), 1 MMR, 3 Hep B, 1 Hib.  <u>Denominator</u>: # of children who turned 2 in 1997, continuously enrolled in MCO or PPC Plan for 12 months preceding 2<sup>nd</sup> birthday, with no more than one gap in enrollment up to 45 days.</p> <p><b>Progress Summary</b>: The baseline GPRA measurement is 64.3% for MassHealth. Remeasurement efforts are currently underway and a new measurement will be available at end of CY2000. The remeasurement will look at the rate at which children who turned 2 in CY99, and met the continuous eligibility requirements described above, received the combination of immunizations listed above.</p>
<b>OTHER OBJECTIVES</b>		
Coordinate with other health care programs – specifically the state funded Children's Medical Security Plan (CMSP), to create a seamless system for low income children in need of health care.	<p><u>Performance Goal A</u>: Develop single application for both MassHealth and CMSP.</p> <p><u>Performance Goal B</u>: Enroll all CMSP members eligible for MassHealth prior to August 24, 1998.</p> <p><b><u>This goal has been</u></b></p>	Both Performance Goal A and Performance Goal B have been met. A single application form is in use for both MassHealth and CMSP. 70% of CMSP members eligible for MassHealth prior to August 24, 1998 were enrolled in MassHealth in a coordinated effort between the two agencies. An additional 5500 children on CMSP were ineligible for MassHealth benefits other than MassHealth Limited because of immigration status. In all, 80% of children on CMSP who were eligible for MassHealth benefits based on income and other factors are estimated to have been enrolled.

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**1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.**

**N.A.**

**1.5 Discuss your State=s progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.**

NA

**1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.**

Presumptive Eligibility: The Division has asked the Center for MassHealth Evaluation and Research (CMER) at UMass Medical School to assess how effective presumptive eligibility has been as a mechanism for bringing children onto MassHealth. Using administrative data for the first 18 months of presumptive eligibility (August 1998 through December 1999), CMER is looking to determine whether there were any differences between presumptively eligible children subsequently submitting necessary verifications, and those who did not follow through on verifications and therefore were terminated. Among the factors being assessed are the demographics and utilization patterns of these two groups of children, as well as their initial “door” to MassHealth, such as a doctor’s office or the emergency room. In addition, CMER is also looking at how many of those who “timed out” at 60 days, subsequently were reopened. Interviews with providers and outreach workers are also being held to understand how well these providers and outreach workers understand presumptive eligibility themselves. A final report is expected in June of 2001 and a copy will be sent to HCFA.

Premium Collection: The Division has also asked CMER to assess whether premium contribution requirements for those between 150% and 200% of FPL are a barrier to participation in MassHealth. Using administrative data for the period from August 24, 1998 through December 31, 1999, CMER is looking at data to determine whether there are discernable difference between those who have been closed for failure to pay premiums and those who have paid the premiums. Among the factors being assessed is family size, income level, and other access issues to determine whether any of these may be different among the two groups. Focus groups are being held to learn more about the factors influencing decisions about premium payments. In addition, CMER is assessing whether there is a difference in rate of premium payment between former MassHealth members who have to pay premiums for the first time, and those newer members who have always had to pay a premium. Seasonal variation are been assessed, as well as patterns to determine the rate at which those who are dropped for failure to pay come back, and at what rate. A final report is expected in June of 2001 and a copy will be sent to HCFA.

**1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program=s performance. Please list attachments here.**

Several studies and evaluations are underway that are relevant to the SCHIP population.

The Division has asked the Center for MassHealth Evaluation and Research (CMER) at University of Massachusetts Medical School to evaluate several aspects of MassHealth's program performance. The following is a summary of the status of these efforts.

- CMER is conducting an evaluation of the effectiveness of the mini grant initiative. (See Section 1.1 #5 for a description of the mini-grant initiative and the CMER evaluation.) A preliminary report has been drafted and a final report is expected early in 2001. Copies of the report will be sent to HCFA when completed.
- A retrospective review of re-determination and its impact on enrollment is underway. (See Section 1.1 #7 for a description of study components.) A final report is expected in the July of 2001. Copies of the report will be sent to HCFA when completed.
- The Division has asked CMER to assess how effective presumptive eligibility has been as a mechanism for bringing children onto MassHealth. (See Section 1.6 for a description of the study.) A final report is expected in the June of 2001. Copies of the report will be sent to HCFA when completed.
- The Division has also asked CMER to assess whether premium contribution requirements for those between 150% and 200% of FPL are a barrier to participation in MassHealth. Using administrative data for the period from August 24, 1998 through December 31, 1999, CMER is looking at data to determine whether there are discernable difference between those who have been closed for failure to pay premiums and those who have paid the premiums. (See Section 1.6 for a description of the study.) A final report is expected in the June of 2001. Copies of the report will be sent to HCFA when completed.

In addition, to the studies noted above, Massachusetts is one of the thirteen states participating in the **Urban Institute's National Survey of American Families**. As discussed earlier, the findings from that survey are carefully watched to determine the impact of MassHealth on reducing the uninsurance rate among children in the state.

The **Children's Defense Fund's "All Over the Map"** has also provided importance insight into the effectiveness of Massachusetts' efforts to reduce the number of uninsured children in the state.

## SECTION 2. AREAS OF SPECIAL INTEREST

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*This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.*

### 2.1 Family coverage:

- A. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.

N.A. (See 2.2)

2. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2000 (10/1/99 -9/30/00)?

Number of adults \_\_\_\_\_

Number of children \_\_\_\_\_

3. How do you monitor cost-effectiveness of family coverage?

### 2.2 Employer-sponsored insurance buy-in:

1. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).

Under our Title XXI State Plan, Massachusetts has an approved family coverage waiver to cover families through an Employer-Sponsored Insurance buy-in program.

Under this waiver, to be eligible for Family Assistance Premium Assistance for employer sponsored coverage the child must be uninsured at the time of application. Several access criteria must also be met including: the employer pays at least 50% of the premium, a cost effectiveness standard is met, and the benefit package meets the benchmark for coverage; if the child does not have access to health insurance through the above criteria or through criteria that meets the Division's 1115 waiver, then the child is enrolled in MassHealth Family Assistance Direct Coverage.

2. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2000?

As of September 30, 2000 there were 5,208 adults and 4,653 children benefited from at least one family member receiving Family Assistance Premium Assistance. This number represents the total

number in employer sponsored insurance buy-in under both the SCHIP and 1115 Demonstration Waiver. Of these, 3,093 adults were not eligible for Family Assistance Premium Assistance, but were covered by default, because only through the purchase of a family plan could their child gain access to ESI coverage.

Number of adults: parents of eligible children by default

Number of children 62 (remainder of children covered under our 1115 Waiver)

Sixty-two (62) children with income between 150% and 200% of FPL are enrolled under SCHIP in the Family Assistance Premium Assistance Program. It is believed that more of these children would qualify for SCHIP but the administrative complexities of assessing an employer's benefit package has precluded the assessments from occurring in a timely or resource efficient manner.

Massachusetts has an alternative route to employer-sponsored insurance through the 1115 Demonstration Waiver. Of the 4,653 children in ESI, 1,000 met eligibility requirements for Family Assistance Premium Assistance under the 1115 waiver, in that they have access to employer-sponsored insurance for which the employer contributes at least 50% of the premium share, the coverage is cost effective, and the coverage met the basic benefit level. These children may also have met requirements for SCHIP under the Massachusetts Title XXI State Plan in that they were uninsured when they applied for benefits. However, because of the resource intensity required to assess whether an employer-sponsored benefit package met the benchmark level of benefits, assessments were not conducted for approximately half of the children whose access is through a small employer, and they were made eligible under the Title XIX 1115 Waiver. For the other half of children whose parents mostly work for large employers and whose access to employer-sponsored insurance is investigated through a different process (through PCG, a contracted vendor), benefit packages are assessed to determine if they meet the benchmark level of benefits. Under the method currently in use by PCG to assess this group, benefits are measured against a summary of the benchmark benefit (which in Massachusetts is a benefit package offered by the largest commercial HMO). The vast majority of benefit packages that have been assessed against the benchmark benefit level were determined not to meet the benchmark standard. The Division believes that the failure of so many benefit packages to meet the benchmark reflects the difficulty inherent in comparing benefit plans because of the lack of standardization in terminology, language or measurement used to define levels of benefits, rather than the fact the benefit packages are not equivalent. The Division is in the preliminary stage of thinking about a new process that would allow the Division to more efficiently and consistently assess a benefit package. Preliminary thinking includes determining the feasibility of devising a system that assesses whether a benefit plan is the actuarial equivalent of the benchmark standard. This approach would be based on assigning weights to components of the benchmark standard, and then assigning points to a benefit package and determining whether it is actuarially equivalent, based on the number of points it receives. As part of this effort the Division may work with insurance carriers to identify a product that meets the benchmark standard, and brand it so that employers will know that by selecting it their employees who are eligible for MassHealth will be able to participate in Premium Assistance.

### 2.3 Crowd-out:

1. How do you define crowd-out in your SCHIP program?

Crowd-out would occur if employees drop coverage in order to obtain MassHealth Direct Coverage. However, under MassHealth rules, access to employer sponsored insurance is investigated as part of the eligibility determination process and applicants with access are required to enroll in their employer's coverage. Because enrollment in ESI is required for those with access, potential for crowd out is diminished. Massachusetts requires for the Family Assistance Premium Assistance program that if a family has access to ESI then they have to purchase it or they do not receive a benefit. If families don't have access, then the child is placed in the Direct Coverage group.

2. How do you monitor and measure whether crowd-out is occurring?

Massachusetts has a larger proportion of its population covered by employer-based health insurance than the rest of the nation. In 1990 and 1998, it was estimated that proportion of Massachusetts non-elderly residents with employer sponsored health insurance was 69.8%. Massachusetts is monitoring this rate in a number of ways. The Division of Health Care Finance and Policy (DHCFP) monitors the rate by analyzing a variety of survey data including the US Bureau of Census data, which produced the estimate above. In addition, Massachusetts is one of 11 states funded by HRSA to collect and analyze data to use in developing an insurance profile of the state. The profile will assess health insurance coverage from a number of perspectives including those of employers and residents. In addition the data will look at take up rates, demographics, and employer thinking such as tiers of coverage, and whether coverage is available for families or only the employee. It is expected that this information will help states develop options and recommendations about steps and initiatives that could lead to universal health coverage. A report will be issued to HRSA by September 30, 2001.

3. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

The HRSA employer survey will be completed by September 30, 2001.

4. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

While information is not available at this time to assess the effectiveness of anti-crowd-out policies, Massachusetts will be continuing to identify access to insurance through information on applications and matching efforts with carriers and individual health insurance investigations.

Similarly, information from surveys will be assessed to determine if there is a shift in the number of employers offering insurance and the number of employees without access to insurance.

## 2.4 Outreach:

- A. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

Massachusetts has pursued a number of outreach strategies to reach low-income and uninsured children, as well as families and individuals, as described below. In general, Massachusetts has found that multi-modal approaches are the most effective. We are looking to the results of our evaluation of our mini-grantees to learn more about effectiveness of approach. Below are a summary of impressions to date on the effectiveness of approaches being pursued in Massachusetts.

SFY00 Targeted Strategies: During SFY00 the Division continued to pursue strategies to increase enrollment in MassHealth among targeted groups. Reaching children was an important focus of these efforts. Targeted strategies to reach those who are eligible for MassHealth are highlighted below.

- **Promoting Local Strategies**: Through the mini-grant initiatives, the Division has found local efforts are an important component of an effective outreach strategy to reach eligible families and children. The key to success in working through local efforts is using strategies that are effective in the context of the targeted community. A few of the effective local strategies being pursued are highlighted below.

Collaboration in the City of Lynn: The Lynn Public School System's aggressive outreach campaign to ensure that all children in Lynn have health insurance is an example of a successful system wide initiative that builds on internal and external collaborations.

*Parent Information Center*: Working through the Parent Information Center, where all new and transferring students must register, as the primary internal collaborator, insurance information is requested at the time of registration and referrals for those without health insurance are given to the school nurses. The nurses also receive information on uninsured students from the student/parent emergency forms, and beginning in September 2000, School Lunch Program forms (for free or reduced lunches) will also include insurance information. In addition, school nurses frequently conduct home visits to families needing more information about available or low cost health insurance and application assistance.

*External Collaborators*: The primary external collaborator is the Lynn Community Health Center, which operates four School Based Health Centers (SBHC) funded by the Department of Public Health, with four more opened in the fall of 2000. The SBHC staff works closely with school nurses to identify students in need of primary care. Other external collaboration is provided through a mobile van operated by the North Shore Medical Center that offers information on health insurance in addition to providing access to care on a neighborhood basis. The Lynn Public School System has developed a close relationship with Community Development and Lynn Parks and Recreation. School nurses

attend many sports and other community events, and coaches and other group leaders often refer youth they deem in need of insurance follow-up to the school nurses.

*Partners:* The Mayor of Lynn has been a primary partner for Lynn Public Schools, initiating the insurance outreach program and other efforts such as the “Gold Card” program. The Gold Card program offers Lynn’s youth free or reduced memberships to the Boys & Girls Club, YMCA and Gregg House, and health insurance information is requested on the Gold Card application and forwarded to the Lynn Public Schools.

*Child Care Resource Center (CCRC), Cambridge:* This outreach program uses diverse (and often innovative) strategies to reach uninsured families. Examples of their multiple activities include:

*Mailings:* A mailing during SFY00 to all childcare centers/home daycare providers in Cambridge and surrounding towns included information about the outreach program. A mail-back needs assessment was included to elicit information from childcare and home daycare providers about their health care needs, interest in hosting a training/enrollment night at their facility, and ideas for what they would want to see in a health fair run by the CCRC.

*Training:* A one hour training was provided to family childcare providers on various health care options available to them personally as well as the families they serve. The training covers eligibility and responsibilities associated with MassHealth and the Children’s Medical Security Plan (the state-funded initiative providing preventive and primary care to children not eligible for MassHealth). The training was well received, with attendees often not aware that they were eligible for MassHealth. Interest was expressed in the Insurance Partnership. CCRC evaluated the training and used this information to improve subsequent training.

*Codman Square Health Center:* The nutritionist at the health center gave a “community baby shower” for new mothers, and the mini-grant outreach program was invited to set up a table and participate in the event. The outreach worker commented: “It was wonderful. I was able to get to know the needs of the mothers and make connections for follow-up. The best part was holding all of the babies.” In addition to the baby shower, Codman Square also actively promotes its services and information about MassHealth in local newspapers, has translated its promotional and screening materials into Spanish and Haitian Creole, and has found that posters with tear-off sheets in community stores produce an excellent response.

- *Working with the Schools:* The Division’s SFY00 school-based outreach activities for children are described below.

*MassHealth Informational Flyer Distributed:* For the fourth straight year, the Division sent a

one-page MassHealth informational flyer to the 1.5 million children enrolled in childcare settings, and public, private and parochial schools in the state.

*The School Nurse Initiative* continued as the Division, in partnership with the Department of Public Health, worked closely with the school nurses throughout Massachusetts and their professional association to promote MassHealth. This school nurse initiative helps disseminate information, identify uninsured children, and provide enrollment assistance.

- Ongoing activities continued during SFY00 including the following:
  - Active review of a child’s health insurance status at appropriate opportunities, such as kindergarten registration, or at the time a child transfers into the school;
  - Inclusion of a question about the child’s health insurance coverage on the child’s emergency card;
  - Collaboration with local health care access project grantees to provide information and assist families with health insurance enrollment;
  - Routine inclusion of information about MassHealth and the Children’s Medical Security Plan in school publications.
  
- Special events during SFY00 included:
  - 2 statewide meetings were held with strong attendance by school nurses and School-Based Health Center personnel at which MassHealth information was disseminated and school nurses were assisted in their efforts to enroll children in health care.
  - School Nurse *MassHealth Enrollment* promotional kits were distributed, including travel mugs with an inscription recognizing school nurses for their efforts in helping school children enroll in MassHealth, and a guidebook highlighting all health programs in the state, including MassHealth and the state-funded Children’s Medical Security Plan.

*Health Care Access Projects with the Schools*: Mini-grantees continued to actively disseminate MassHealth information during on-site school registrations, school meetings and parent nights.

- Posters were distributed to school-based health centers, community agencies, and health centers across the state informing potentially eligible children and their families about the availability of MassHealth, and encouraging them to apply for coverage.

*School Superintendent Project*: The Division, Department of Public Health, the Executive Office of Health and Human Services, and the Massachusetts Department of Education worked together on the School Superintendent Project to obtain the active support of Massachusetts public school superintendents for the MassHealth initiative. This effort was timed to coincide with the Secretary of Education’s campaign *America Goes Back to School*, part of a school initiative, “Insure Kids Now”.

*Covering Kids*: Massachusetts is a Robert Wood Johnson Foundation *Covering Kid’s* site. The

Division works closely on this initiative with the Director of the Massachusetts *Covering Kids*, located at *Health Care for All*, a health advocacy group. There is an active collaboration between the two organizations, with shared enrollment and outreach activities. Several joint initiatives have been undertaken as part of the Massachusetts *Covering Kids* initiative:

- *School lunch enrollment*: *Covering Kids* has facilitated changes in the school lunch enrollment form. Information is now requested on school lunch applications about the child's health insurance coverage, which can then be used as an outreach tool to identify families who may be interested in submitting an application for MassHealth benefits.
- *School Pilot Sites*: Eleven schools have been identified as *Covering Kids* pilot sites in Massachusetts and are actively working with *Health Care for All* and the Division to identify ways to reach children and get them enrolled in MassHealth.
- *Nutrition*: Nutritionists from the eleven school sites around the state are working to get MassHealth information out when nutritional information is sent to parents.
- *School Nurse Follow Up*: School nurses, who are city employees, are supported in the pilot sites by *Covering Kids* to follow up prospectively with MassHealth eligible children. Each of the eleven participating schools has developed their own model, and an evaluation is being conducted to determine which models are most effective.

In addition to school based and pilot site activities, Division representatives and the Massachusetts Director of *Covering Kids* participated in a regional conference sponsored by RWJF, and received valuable comments and technical assistance on the MassHealth Benefits Request (MBR) application package, and re-determination materials.

*Targeted Cities and Towns Initiative*: The Division continues to target individual cities and towns for increased MassHealth enrollment potential. The Division works closely with elected officials, school administrators, public housing directors, civic leaders, and other community stakeholders to develop specific strategies to increase enrollment in targeted areas.

- Springfield and New Bedford are examples of two Massachusetts cities that the Division has worked closely with in its efforts to offer support and a national perspective to assist city workers with their efforts to increase enrollment in MassHealth.
- The success of the City of Lynn's school enrollment initiative (described above) is attributable in large part to the support of the Mayor, who has been actively involved in efforts to enroll Lynn children in MassHealth.

*Hispanic/Latino Initiative*: Reaching the state's eligible Hispanic/Latino population continued to be a top priority. The Division's sponsorship of a television program on a station with a large Hispanic/Latino viewing audience (discussed below) is an example of collaborations that the Division has engaged in to increase awareness in the Hispanic/Latino communities about MassHealth and encourage applications. Other activities include bilingual in-house publications, and collaborations with Hispanic/Latino Internet

marketing, television, radio, and print media.

*Medical Community Effort:* The Division continues to work closely with the Massachusetts Hospital Association, the Massachusetts Medical Society and the Massachusetts Chapter of the American Academy of Pediatrics to promote the state's MassHealth program. Provider's front office and billing staff are encouraged to participate in regional training sessions through direct mail and organizational publications. Additionally, MassHealth enrollment kits ("What to Do When an Uninsured Child Shows Up at Your Door...") are widely distributed. In SFY00 the Mass Hospital Association and Mass League of Community Health Centers were both given contracts to support media and other outreach efforts to reach potentially eligible MassHealth members and encourage them to apply for benefits.

**SFY00 Media and Promotional Activities:** The Division has pursued an aggressive media and promotional agenda to reach those who are eligible for MassHealth and support targeted outreach efforts.

*Promotional Materials and Literature:* The Division continues to produce and widely distribute MassHealth promotional items, or "give-a-ways". In addition to the supply of pens, magnets, Rolodex cards, emergency phone cards, post-it notes and other items previously available, in SFY00 Frisbees, water cups, jar openers, electric plug covers, magnet frames were also made available – all with the MassHealth logo and an 800 telephone number for more information. These items are for use by intermediaries to reach potential members. In addition, a breast self-exam shower card was produced as a health promotion item, as well as a growth chart for parents to use to chart their children's growth.

Outreach materials have been translated into the following languages: Spanish, Portuguese, Chinese, Vietnamese, Haitian Creole, Russian, Cambodian, Laotian, French and Arabic.

*Mass Media Outreach and Education Efforts:* Other vehicles utilized for outreach and marketing by the Division and mini-grant contractors included:

- Mass media was used to target specific groups as well as support the Insurance Partnership.
  - The Division aired radio and television Public Service Announcements, with an emphasis on the Latino market. DMA has sponsored a TV program series that addresses health issues. It is broadcast over Channel 27, Univision, with a large Latino viewing audience. DMA is the major sponsor of the program, and provides subject matter experts on a broad range of health topics, with a strong focus on health promotion. MassHealth and how to access it are also featured topics.
  - TV, radio, print and billboards were used by the MassHealth Insurance Partnership vendor to reach low income workers employed by small businesses who may be eligible for MassHealth Family Assistance Premium Assistance under the expansion.
- Press releases were issued.

**Area Health Education Centers Regional Meetings:**

To support outreach efforts, Health Access Networks have been established in partnership with the University of Massachusetts Medical School's Area Health Education Center (AHEC). Health Access

Networks have been established in each of 6 regional areas and continued to meet monthly during SFY00 to share information, strategies and experiences on effective outreach programming. The meetings promote information dissemination, sharing of best practices, and building of community/public sector linkages to increase health care access in Massachusetts.

The Health Access Network has three key components:

**Information Sharing/Dissemination:** The Health Access Networks serve as a vehicle for sharing resource information about health care programs and access-related issues, and changes in programs, practices and policies from the Division. The Division, the Department of Public Health and other state or federal health-care related agencies, including the SCHIP representative from the HCFA Regional Office, actively participate, seeing Health Access Networks as opportunities to provide accurate and appropriate information to consumers. In addition, the networks are a good mechanism for keeping regional providers and outreach staff informed of developments regarding health care programs, and access, outreach and services initiatives. HCFA Regional Office staff have also participated in the selection committee for mini grants.

**Development of Best Practices:** The Health Access Networks share information about outreach practices that work in engaging and informing people in need of health care and enrolling people into health care programs. The best practices explored range from those provided by other programs and initiatives within the region and Massachusetts to those from across the nation.

**Serve as a Link Between Communities, State Agencies and Institutions:** The Health Access Networks also serve as an important link with community-based efforts and state agencies and institutions. For example, state agencies such as the Division, Department of Public Health or other health care-related institutions/ organizations are able to link with local providers through this network. The networks provide a forum for community-based groups and state-funded providers to directly and productively communicate with state agencies and institutions. One focus of forum activities includes problem-solving challenges or problems regarding eligibility, coverage and service utilization encountered by field-based providers. The networks also provide a mechanism to assist state agencies and institutions develop and/or implement campaigns to increase enrollment and access to health coverage programs. In addition, they help identify gaps or problems related to eligibility, coverage and service utilization and provide clear and timely feedback to the appropriate entities regarding solutions which can promote community-based outreach and access.

Member Services has found the regional Health Access Networks to be very effective vehicles for supporting MassHealth's outreach goals.

2. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

MassHealth instituted an evaluation component through its *Massachusetts Projects for Health Access* mini-grant initiative. Findings from that evaluation are expected to begin to help identify best practices. As part of the evaluation effort, MBRs (MassHealth Benefit Requests – the standard application used to apply for all MassHealth benefits) are being stamped with a unique identifier by mini-grantees. In this way, tabulations can be compiled of the number of applications submitted as by a particular mini-grantee as a result of specific outreach activities, and an analysis conducted to determine if certain activities have been more successful than others.

**3. Which methods best reached which populations? How have you measured effectiveness?**

Again, as stated above, the results of the evaluation currently being conducted of by CMER of mini-grantee efforts is expected to identify best practices and may also differentiate between methods for different populations. (The report will be completed early in 2001 and a copy will be sent to HCFA.)

**2.5 Retention:**

**1. What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?**

As enrollment in MassHealth stabilizes, maintaining the level of enrollment is the next challenge. Failure to respond to re-determination notices has resulted in the loss of some SCHIP children. However, analysis of caseload information from the MassHealth population indicates that many of those who lose eligibility for failure to respond to a re-determination packet regain coverage within the following 6 months. We believe this is true for SCHIP children as well, since they are a subset of the MassHealth population and all members go through the same redetermination process.

As part of the MassHealth re-determination process, several reminders (4 letters) are sent. MassHealth is also giving managed care providers the names of their enrollees who are up for re-determination, so they can also help reach and remind their patients of the importance of following through with this effort.

In addition, self-addressed stamped envelopes have been used to help with response rates to re-determination. The mini-grantees have also been enlisted in an effort to help MassHealth enrollees retain their eligibility through the re-determination process, as well as increase the number of new enrollees coming onto MassHealth.

The Division has also received a grant for rolling re-determination. Under this 1 year planning grant funded by HCFA, point of service re-determination will be explored to determine whether we can successfully enlist the provider community as a partner in our efforts to ensure that MassHealth members retain their eligibility during re-determination. Under this initiative, when providers check a member's eligibility status in the REVS system, they will also see information related to re-determination, and if it is determined that the member is due for re-determination, will be empowered to help that member complete and file the necessary information.

The Center for MassHealth Evaluation and Research (CMER) at the University of Massachusetts Medical School is studying the re-determination process. CMER is focusing particularly on why members fail to respond to re-determination notices, and how to improve response rates and eliminate gaps in coverage that result from these terminations.

In addition, our mini grant contracts with Community Based Organizations (CBOs) now include the goal of assisting MassHealth members retain eligibility during re-determination as well as enrolling those newly eligible.

2. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

Follow-up by caseworkers/outreach workers

Renewal reminder notices to all families

Targeted mailing to selected populations, specify population \_\_\_\_\_

Information campaigns

Simplification of re-enrollment process, please describe \_\_\_\_\_

Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe \_\_\_\_\_

Other, please explain see below

Based on insight gained through re-determination activities, there will be two mini-grant outreach models defined for SFY01. These models are distinguished by the goals of the outreach effort, with one model targeted toward identifying and enrolling new MassHealth members, and the second to ensuring that those already enrolled in MassHealth retain their eligibility during the re-determination process. Outreach activities for the latter group are focused on member education about the rights and responsibilities of membership in MassHealth, and accessing services.

3. Are the same measures being used in Medicaid as well? If not, please describe the differences.

Yes.

4. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

As noted above, this is being evaluated. Some of the activities being conducted are described below.

Several targeted efforts are underway to increase response rates from families who are notified that their eligibility is being redetermined in accordance with regulations and that they must provide information as requested. The new activities being taken to increase response rates by families include: a series of 4 letters are being sent, a self addressed stamped envelop has been added, and phone calls are being made. In addition, the Division is looking into a computer generated form that indicates current information about the family and requires that they correct any information that has changed, sign the

form and return it to DMA.

In addition, Massachusetts is engaged in several activities to learn more about the children who disenroll from CHIP, their continuing eligibility for the program, and what steps are needed to get them re-enrolled. Among the initiatives that are targeted toward this is:

- A profile of the characteristics of people who drop out of the program is being compiled. The profile will be reviewed to determine if there are characteristics that can be used to define any groups who then can be contacted for either participation in a focus group activity or individual survey to identify program barriers.
  - an assessment of premium collection and whether premiums are a barrier to participation in the program.
  - Mini grant activity that provides community based support for outreach and helps to identify those who may be eligible and help them enroll as well as help those who are enrolled maintain eligibility.
5. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.

We do not have specific data on the insurance coverage status of SCHIP children who disenroll or who do not reenroll in SCHIP. However, for MassHealth in general there is a trend that within 6 months of disenrolling the majority of MassHealth members come back into MassHealth within 6 months. In addition, except for those who voluntarily disenroll, the Division refers all others to the Children's Medical Security Plan (CMSP), a state funded program that provides preventive and primary care services to uninsured children.

## **2.6 Coordination between SCHIP and Medicaid:**

1. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

Yes, the same procedures are used.

2. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes.

Because MassHealth encompasses both Medicaid and SCHIP within a single system, and uses a single application, this is not an issue for Massachusetts.

Massachusetts has created a single, seamless system for eligibility MA 21, the MassHealth computerized eligibility system, does not distinguish between payor when determining the category for which a child is eligible for benefits. Instead, MA21 places the child in the richest benefit package available given that child's age, income and other pertinent characteristics. Determination of funding source (i.e. Medicaid or SCHIP) is determined based on the

appropriate characteristics of the child or family.

3. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

Yes, there is no distinction between delivery systems based on Medicaid or SCHIP.

## **2.7 Cost Sharing:**

1. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

Yes, in process. See response to question 1.6 for scope of study.

2. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?

No, not at this time.

## **2.8 Assessment and Monitoring of Quality of Care:**

1. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.

All of the Division's quality improvement activities are conducted for all MassHealth members, including SCHIP children. Measures include member satisfaction surveys and HEDIS measures. Information is collected from a number of ongoing efforts including the following: appointment audits, PCP enrollee ratios, time/distance standards, urgent/routine care access standards, network capacity reviews, compliant and grievance filings, disenrollment reviews, case file reviews, utilization surveys.

2. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?

As discussed in 1.3, MassHealth has engaged in several strategic initiatives have been undertaken to increase the number of children receiving well child visits in accordance with EPSDT guidelines and in FY99 93.4% of MassHealth pediatric members had at least one well child visit in accordance with those guidelines. Other activities include communication with pediatricians about the ESPDT schedule and materials to help them and the parents of the children they see support well child visit schedules.

Similarly, the Division has several efforts underway to improve compliance with immunization schedules for children enrolled in MassHealth.

For children receiving premium assistance and enrolled in employer sponsored health insurance MassHealth does not have direct information on access to care. Commercial HEDIS measures may be helpful, as well as surveys and focus groups that may be undertaken in the future.

3. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

The Division is continually assessing its efforts to monitor and evaluate access to care by its members. The Division has a goal of creating a seamless system of health coverage for those eligible for MassHealth benefits, regardless of whether they are insured or uninsured when applying for benefits. Measures have been put into place to monitor and evaluate access not targeted toward children eligible through the 1115 waiver or Title XXI, but rather seeking to assess access for children in MassHealth on a system wide basis. Methods of assessing access for those in Family Assistance Premium Assistance and enrolled in ESI are being developed.

## SECTION 3. SUCCESSES AND BARRIERS

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*This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.*

**3.1 Please highlight successes and barriers you encountered during FFY 2000 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.**

*Note: If there is nothing to highlight as a success or barrier, Please enter NA=for not applicable.*

1. Eligibility
2. Outreach - See previous discussion in Section 2.4.
3. Enrollment – SCHIP enrollment has grown 7.7% in the past federal fiscal year from 49,778 children enrolled in FFY99 to 53,613 enrolled in FFY00.

SCHIP has been important in our success in improving coverage rates for children. As discussed in our response to Question 2.4, Massachusetts has pursued a number of outreach strategies to reach low-income and uninsured children. Our collaboration with community-based organizations, which has been a focal point of our efforts, has enabled outreach efforts to incorporate local strategies into our overall approach.

4. Retention/disenrollment – As discussed in Section 2.5 redetermination of SCHIP children resulted in a number of children losing coverage for failure to comply with redetermination notifications and verifications. However, analysis of caseload indicates that many of those who lose eligibility regain coverage within the following months.

5. Benefit structure

6. Cost-sharing

As discussed in response to 1.6 preliminary reports indicate that charging a premium is not a barrier, and that we are not losing children as a result of premiums.

7. Delivery systems

8. Coordination with other programs

SCHIP has brought an important vehicle for fostering collaboration between the Department of Public Health and the Division of Medical Assistance, as well as strengthening relationships with advocates, such as through our collaborative work with the Covering Kids initiative.

## 9. Crowd-out

Massachusetts continues to have a high rate of employer sponsored insurance, and there is no evidence that they are dropping insurance. The MassHealth program is structured so that those who have access to employer-sponsored insurance are required to enroll, and they are not allowed to drop coverage in order to get a direct coverage for a child.

## 10. Other

### SCHIP Barriers to Employer Sponsored Buy-In:

Massachusetts has been working to incorporate an employer sponsored buy-in program into its MassHealth program. The concept of keeping private market coverage available for the low-income population and incorporating it into the MassHealth strategy remains a high priority because it is critical for mitigating crowd-out. The Division has been fortunate in that an employer sponsored buy-in provision was approved as part of both the 1115 Waiver and its SCHIP program. The rules governing employer sponsored buy-in for SCHIP are restrictive, the restrictive nature of which Massachusetts commented on when the SCHIP rules were initially proposed. Implementation of the employer buy-in program began in August 1998. The Division has found it comparatively more difficult from both an administrative and time-period perspective to identify that a child has access to employer sponsored buy-in under the SCHIP rules in contrast to the provisions of the 1115 Waiver. Consequently, given the availability of an alternative under the 1115 waiver rules, the great majority of children with access to employer sponsored insurance have been enrolled through the 1115 waiver. As pointed out earlier (Section 2, Question 2.2 Employer Sponsored Buy-In, page 16-17), it is estimated that of the 4,653 children enrolled in employer-sponsored insurance through the MassHealth Family Assistance Premium Assistance program, approximately 1,000 may have been eligible under SCHIP rules. However, only 62 were actually enrolled under SCHIP because of the administrative difficulties; the primary difficulty was the extraordinarily long-time it takes to determine whether the Benchmark has been met. The Division would rather enroll the child in health coverage through the 1115 Waiver option than keep the family waiting.

Given these concerns, the Division is considering revisiting the administrative review process now in place for SCHIP employer sponsored buy-in to determine if there are other approaches that should be pursued. The goal of this review would be to evaluate if it is feasible to simplify the process for assessing access to employer sponsored insurance under SCHIP rules and develop a less time-consuming process that is at least more efficient from an administrative perspective. As a result of this evaluation, we may consider proposing a more streamlined approach to determining access.

## SECTION 4. PROGRAM FINANCING

*This section has been designed to collect program costs and anticipated expenditures.*

**4.1 Please complete Table 4.1 to provide your budget for FFY 2000, your current fiscal year budget, and FFY 2002 projected budget. Please describe in narrative any details of your planned use of funds.**

*Note: Federal Fiscal Year 2000 starts 10/1/99 and ends 9/30/00).*

	Federal Fiscal Year 2000 costs	Federal Fiscal Year 2001	Federal Fiscal Year 2002
<b>Benefit Costs</b>			
Insurance payments	820,807	1,073,374	1,180,712
Managed care			
per member/per month rate X # of eligibles	15,583,771	20,378,990	22,416,889
Fee for Service	25,450,581	33,281,876	36,610,064
<b>Total Benefit Costs</b>	<b>41,885,159</b>	<b>54,734,240</b>	<b>60,206,664</b>
(Offsetting beneficiary cost sharing payments)			
Net Benefit Costs			
<b>Administration Costs</b>	<b>2,309,989</b>	<b>3,010,383</b>	<b>3,311,366</b>
Personnel			
General administration			
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/marketing costs			
Other			
<b>Total Administration Costs</b>			
10% Administrative Cost Ceiling			
Federal Share (multiplied by enhanced FMAP rate)			
State Share			
<b>TOTAL PROGRAM COSTS</b>	<b>44,165,148</b>	<b>57,744,623</b>	<b>63,518,030</b>

**4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2000.**

\$537,687 in premium assistance payments.

**4.3 What were the non-Federal sources of funds spent on your CHIP program during FFY 2000?**

- State appropriations
- County/local funds
- Employer contributions
- Foundation grants
- Private donations (such as United Way, sponsorship)
- Other (specify) \_\_\_\_\_

**A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures.**

NO

## SECTION 5: SCHIP PROGRAM AT-A-GLANCE

*This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.*

**5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information.** If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Program Name	MassHealth	MassHealth
Provides presumptive eligibility for children	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, for whom and how long? 60 days	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, for whom and how long? 60 days
Provides retroactive eligibility	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, for whom and how long? 10 days prior to receipt of completed application	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, for whom and how long? 10 days prior to receipt of completed application
Makes eligibility determination	<input checked="" type="checkbox"/> State Medicaid eligibility staff <input type="checkbox"/> Contractor <input type="checkbox"/> Community-based organizations <input type="checkbox"/> Insurance agents <input type="checkbox"/> MCO staff <input type="checkbox"/> Other (specify) _____	<input checked="" type="checkbox"/> State Medicaid eligibility staff <input type="checkbox"/> Contractor <input type="checkbox"/> Community-based organizations <input type="checkbox"/> Insurance agents <input type="checkbox"/> MCO staff <input type="checkbox"/> Other (specify) _____
Average length of stay on program	Specify months _____	Specify months _____
Has joint application for Medicaid and SCHIP	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
Has a mail-in application	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
Can apply for program over phone	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
Can apply for program over internet	<input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> No

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Requires face-to-face interview during initial application	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, specify number of months _____ What exemptions do you provide?	<input checked="" type="checkbox"/> No - Just at time of application <input type="checkbox"/> Yes, specify number of months _____ What exemptions do you provide?
Provides period of continuous coverage <u>regardless of income changes</u>	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, specify number of months _____ Explain circumstances when a child would lose eligibility during the time period	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, specify number of months _____ Explain circumstances when a child would lose eligibility during the time period
Imposes premiums or enrollment fees	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, how much? _____ Who Can Pay? <input type="checkbox"/> Employer <input type="checkbox"/> Family <input type="checkbox"/> Absent parent <input type="checkbox"/> Private donations/sponsorship <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, how much? <u>\$10 per child up to \$30 per month maximum</u> Who Can Pay? <input type="checkbox"/> Employer <input checked="" type="checkbox"/> Family <input type="checkbox"/> Absent parent <input type="checkbox"/> Private donations/sponsorship <input type="checkbox"/> Other (specify) _____
Imposes copayments or coinsurance	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
Provides preprinted redetermination process	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, we send out form to family with their information precompleted and: <input type="checkbox"/> ask for a signed confirmation that information is still correct <input type="checkbox"/> do not request response unless income or other circumstances have changed	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, we send out form to family with their information and: <input type="checkbox"/> ask for a signed confirmation that information is still correct <input type="checkbox"/> do not request response unless income or other circumstances have changed

**5.2 Please explain how the redetermination process differs from the initial application process.**

The information required for re-determination is essentially the same information requested for the initial application process on the MBR (Medical Benefits Request) application form. MassHealth members are asked to up-date the information contained on the MBR with any changes in their status noted. As well, they are required to submit verification of income as they did in the initial application (two pay stubs).

## SECTION 6: INCOME ELIGIBILITY

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*This section is designed to capture income eligibility information for your SCHIP program.*

**6.1 As of September 30, 2000, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group?** If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups	<u>185</u> % of FPL for children under age <u>1</u>
	<u>133</u> % of FPL for children aged <u>1-5</u>
	<u>114</u> % of FPL for children aged <u>6-14</u> (D.O.B > 9/30/83)
	<u>86</u> % of FPL for children aged <u>14 - &lt;18</u> (D.O.B before 9/30/83)
Title XXI Medicaid SCHIP Expansion	> 185% ≤ 200 % of FPL for children aged <u>≤1</u>
	>133% ≤ 150 % of FPL for children aged <u>1-5</u>
	>114% ≤ 150 % of FPL for children aged <u>6-14 (D.O.B &gt;9/30/83)</u>
	> 86% ≤ 150 % of FPL for children aged <u>14 - &lt; 18 (D.O.B before 9/30/83)</u>
Title XXI State-Designed SCHIP Program (Family Assistance)	>150 ≤ 200 % of FPL for children aged <u>1-&lt;18</u>
	≤ 200 % of FPL for children aged <u>18</u>
Other SCHIP program / CommonHealth	>150 ≤ 200 % of FPL for children aged <u>1-&lt;18</u>
	≤ 200 % of FPL for children aged <u>18</u>

**6.2 As of September 30, 2000, what types and amounts of disregards and deductions does each program use to arrive at total countable income?** Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter *NA*.@

NA – only use gross income as countable income.

Do rules differ for applicants and recipients (or between initial enrollment and redetermination)  Yes  No  
 If yes, please report rules for applicants (initial enrollment).

<b>Table 6.2</b>			
	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	State-designed SCHIP Program
Earnings	\$	\$	\$
Self-employment expenses	\$	\$	\$
Alimony payments Received	\$	\$	\$
Paid	\$	\$	\$
Child support payments Received	\$	\$	\$
Paid	\$	\$	\$
Child care expenses	\$	\$	\$
Medical care expenses	\$	\$	\$
Gifts	\$	\$	\$
Other types of disregards/deductions (specify)	\$	\$	\$

**6.3 For each program, do you use an asset test?**

Title XIX Poverty-related Groups  No  Yes, specify countable or allowable level of asset test \_\_\_\_\_  
 Medicaid SCHIP Expansion program  No  Yes, specify countable or allowable level of asset test \_\_\_\_\_  
 State-Designed SCHIP program  No  Yes, specify countable or allowable level of asset test \_\_\_\_\_  
 Other SCHIP program \_\_\_\_\_  No  Yes, specify countable or allowable level of asset test \_\_\_\_\_

**6.4 Have any of the eligibility rules changed since September 30, 2000?**  Yes  No

## **SECTION 7: FUTURE PROGRAM CHANGES**

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*This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.*

### **7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2001( 10/1/00 through 9/30/01)? Please comment on why the changes are planned.**

1. Family coverage
2. Employer sponsored insurance buy-in

Massachusetts may be assessing alternatives to the administrative process for determining access to insurance including engaging the assistance of insurance carriers in determining which of their products meet the benchmark and/or looking at alternative methods of determining actuarial equivalency.

3. 1115 waiver
4. Eligibility including presumptive and continuous eligibility
5. Outreach
6. Enrollment/redetermination process

Massachusetts is considering a couple of changes to the re-determination process in order to reduce the number of terminations resulting from failure to comply with the re-determination process.

A rolling re-determination process which engages providers in assisting members respond in a timely manner to redetermination requirements is being piloted

Consideration is also being given to a passive re-determination form – ie a preprinted form that requires members to change information that is incorrect, rather than having to completely fill out the whole form.

7. Contracting
8. Other