

**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: Maryland

(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) Maryland Children's Health Program (MCHP)

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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SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

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 - Robert Wood Johnson "Covering Kids" national campaign

The Robert Wood Johnson Foundation included the Baltimore metropolitan marketing area in its national media campaign to promote enrollment in SCHIPs. Following the campaign kick-off by Governor Glendening in August, 2000, residents of the marketing area saw television public service announcements describing SCHIPs and encouraging enrollment. Radio announcements and interviews with MCHP officials, and articles and advertisements in various area newspapers were used to promote awareness of MCHP.

6. Eligibility determination process - See Section 1.1 (2).
7. Eligibility redetermination process - NC
8. Benefit structure - NC
9. Cost-sharing policies - NC (Not applicable to MCHP)
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 - See Section 1.1 (2).
- 15. Other - NC

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

- 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.

Our current data source—the Current Population Survey (CPS)—is not sufficient to allow us to track changes and trends in the number of and rate of uninsured, low-income children on an annual basis. Because the CPS samples less than 1,500 people in Maryland annually, we must aggregate three years of CPS data in order to derive estimates of the proportion of uninsured by age and income. Estimates derived from the most recent three-year aggregation, covering CPS reporting years 2000, 1998 and 1997, include data prior to MCHP’s inception. A mistake in the 1999 reporting year’s CPS questions concerning the name of Maryland’s Medicaid program resulted in data that was so inaccurate as to render it unusable. In short, the aggregation of CPS data coupled with the fact that our most recent estimates continue to use a large proportion of data from the years prior to the inception of MCHP, makes tracking year-to-year changes in the progress of MCHP in Maryland extremely difficult.

Because of the aforementioned issues with the CPS, we will be conducting the 2001 Maryland Health Insurance Coverage survey beginning March 1, 2001. This survey should give us more precise estimates at the state and regional levels of the number of uninsured by age and income. This, in turn, will allow the Department to more effectively monitor and evaluate the progress of our MCHP program.

Our estimated baseline for the number of uncovered low-income Maryland children remains at 100,000. This is the same estimate we submitted for our 1999 annual report, and it conforms with the estimate HCFA used in distributing the FFY 1998 State Children’s Health Insurance Program (SCHIP) allotments.

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

In addition to almost 74,000 enrollees in MCHP as of September 30, 2000, an estimated

15,000 to 20,000 children became eligible for Medicaid as a result of MCHP outreach activities.

This estimate is based on the increase in enrollment over that which would have been expected based on normal projected growth in the SOBRA population for FFY 2000.

Maryland made significant progress in reducing the number of uninsured children in FFY 2000, based on the increase in the total number of children served by the MCHP program as of September 30, 2000 (73,886) compared to the total number of children served as of September 30, 1999 (57,620). The estimate of the number of children enrolled in MCHP is based on Maryland Department of Health and Mental Hygiene (DHMH) administrative data.

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

Our MCHP program includes children who are: (1) in families with income between 185 and 200 percent of poverty; (2) born before October 1, 1983 and in families with income above approximately 40 percent of poverty; and (3) above the Sixth Omnibus Budget Reconciliation Act (SOBRA) levels but below 185 percent of poverty. As of September 30, 2000, we had enrolled a total of 73,886 children into MCHP.

- 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 “NC” (for no change) in column 3.

Table 1.3		
(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.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
Outreach to eligible low-income children	Reduce the number of non-covered children	Data Sources: See Narrative Methodology: Progress Summary:
OBJECTIVES RELATED TO SCHIP ENROLLMENT		
Outreach to eligible low-income children	Meet or exceed projected number of Medicaid eligibles enrolled in MCHP	Data Sources: See Narrative Methodology: Numerator: 73,886 children enrolled (9/30/00) Denominator: 60,000 (Number anticipated to enroll in first three years of MCHP.) Progress Summary: In two years, we have exceeded our three -year goal by 23 percent.
OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		
OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		

Table 1.3		
(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.)
Increase access to healthcare services for low-income populations	<ol style="list-style-type: none"> 1. Increase in primary care provider network capacity in areas where capacity is lowest. 2. Increase in the number of dental providers participating in HealthChoice. 3. Increase in the number of enrollees who indicate that they have improved access to the health care delivery system through satisfaction survey reports. 4. Increase in the satisfaction with specialty health care resources. 	<p>Data Sources: See Narrative for all</p> <p>Methodology:</p> <p>Progress Summary:</p>
		<p>Data Sources:</p> <p>Methodology:</p> <p>Progress Summary:</p>
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		

Table 1.3		
(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.)
		Data Sources: Methodology: Progress Summary:
OTHER OBJECTIVES		
		Data Sources: Methodology: Progress Summary:

1. Outreach to eligible low-income children

1. Reduce the number of non-covered children:

The data to measure our progress in reaching this goal is not available. We are developing, in conjunction with the Maryland Health Care Commission, a survey which we believe will provide good baseline data for measuring the number of uninsured children in Maryland. The survey will be conducted in 2001, with preliminary results available by July, 2001.

2. Meet or exceed projected number of Medicaid eligibles enrolled in MCHP:

Our internal enrollment data indicates that we had enrolled 73,886 children in MCHP by September 30, 2000. This compares quite favorably with our projected estimate in our MCHP application that we would cover 60,000 children in MCHP by June 30, 2001. We have exceeded our goal by 23 percent.

Increase Access to health care services for low-income populations:

1. Increase in primary care provider network capacity in areas where capacity is lowest:

In the HealthChoice program, we have continually monitored primary care provider network capacity through: a) quarterly capacity update reports; and b) the online complaint system. Attachment A includes the provider network capacity reports showing the network as of September, 1999 and October, 2000. These reports demonstrate that provider network capacity remained more than adequate to handle the current enrollment in each local access area during that time period, even though the network capacity statewide was reduced by 0.3 percent overall. Furthermore, we believe the low number of complaints (approximately 200 per month to a program with approximately 370,000 current enrollees) related to provider access is an indication that access to care has remained consistently high.

2. Increase in the number of dental providers participating in HealthChoice:

648 dental providers participated in the HealthChoice program in October, 1999. 733 dental providers participated in the Program in September, 2000, which is an increase of 13 percent. This information is based on the monthly provider file submitted to DHMH from each MCO. The statewide ratio of oral health providers to adult and children enrollees is 1 to 400.

For the second consecutive year, the percentage of enrollees receiving oral health services has also increased. This information is based on dental encounter data provided by the MCO's.

DHMH continues to work collaboratively with the State's Oral Health Advisory Committee, dentists, MCOs, advocates, parents, the dental school and local health departments to make sure that children with Medicaid coverage in Maryland access their covered dental benefit.

DHMH published a revised fee schedule for oral health services that raised most rates by 300 percent, on average, for services delivered on a fee-for-service basis. While MCO's are not required to use this fee schedule to reimburse their oral health providers, many use this schedule as a basis for their own fee schedules, which have been considerably higher than the fee-for-service program's schedule over the past few years.

DHMH is also working with the federal government to recruit oral health providers to designated shortage areas. These areas include parts of Baltimore City, western Charles County, Allegany County, Caroline County, and Somerset County.

DHMH also worked with the Maryland General Assembly during the 2000 legislative session to enact a loan forgiveness program, Dent-Care, for oral health professionals serving a percentage of Medical Assistance enrollees in their practices.

3. Increase in the number of enrollees who indicate that they have improved access to the health care delivery system through satisfaction survey reports:

The Satisfaction Survey includes the MCHP population as part of the overall HealthChoice program. The 1999 Satisfaction Survey (using CAHPS instrument) had a response rate of 22 percent. In the 1998 and 1999 surveys, 84 percent of respondents indicated that they always or usually got regular care for their children as soon as they wanted. In another question, 59 percent of respondents in 1998 indicated that their children always got urgent care as soon as they wanted and this increased to 73 percent in 1999. In 1998, 79 percent of those responding indicated that they usually or always got the tests and treatments they thought they needed. On a similar question in the 1999 survey, 85 percent of the respondents indicated that it was not a problem to get the care they or their doctor believed necessary.

4. Increase in the satisfaction with specialty health care resources:

The Satisfaction Survey included a question on satisfaction with specialty care. In 1998, 80 percent of surveyed HealthChoice children rated their specialist a 7, 8, 9, or 10 (on a scale of 0-10) and this increased to 86 percent in 1999. In the 1998 survey, 78 percent of the respondents indicated that it was always easy to get a referral. Similarly, in the 1999 survey, 87 percent of the respondents indicated that it was not a problem or only a small problem to get a referral to a specialist.

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

All performance goals have been met.

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.

N/A

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

Administrative reports and the Satisfaction Survey mentioned above will be continued in FFY 2001, with relevant results included in Maryland’s FFY 2001 annual report.

In conjunction with the Maryland Health Care Commission, DHMH will conduct a survey to establish baseline data, including the number of uninsured children in Maryland, during 2001. Preliminary results of this survey are expected in June, 2001.

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.

Attachment A—MCO Network Capacity Reports for September, 1999 and October, 2000.

Attachment B—Summary of Local Health Department Outreach Activities for SFY 2000.

SECTION 2. AREAS OF SPECIAL INTEREST

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 for FFY 2000.

- B. 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

N/A for FFY 2000

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

N/A for FFY 2000

2.2 Employer-sponsored insurance buy-in:

- A. 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).

N/A for FFY 2000

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

Number of adults

Number of children

N/A for FFY 2000

2.3 Crowd-out:

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

Crowd-out or substitution of coverage is the replacement of privately funded coverage with publicly funded coverage. Maryland imposes a 6-month waiting period for individuals who dropped employer-sponsored insurance.

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

The MCHP application asks whether anyone applying for MCHP dropped health insurance coverage in the past 6 months. If the answer is yes, the applicant must complete information about the insurer, policy number, group number, effective date, and end date. Any child who dropped employer-sponsored health insurance within the past 6 months prior to application will be denied coverage.

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

Anecdotal evidence from the field suggests that not many individuals are turned down because of dropping health insurance. We do not have specific data on the number of MCHP enrollees who had access to coverage by health insurance prior to enrollment in MCHP.

- D. 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.

Anecdotal information indicates the 6-month waiting period has been a deterrent to crowd-out.

2.4 Outreach:

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

A variety of outreach efforts have been initiated at the local, State, and national levels (such as the Covering Kids media campaign) and efforts are not specific to any geographic area or one type of activity. We have, therefore, found it difficult to evaluate the effectiveness of individual activities in reaching low-income children. We believe our hotline, radio, and newspaper ads and PSA's, cable TV and billboards to be the most effective in reaching low-income children. This judgement is based on the number of telephone calls for information and the number of applications received, both of which have increased noticeably and often dramatically as a result of the media information campaigns.

- B. 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?

The principal agents for outreach and enrollment activities in the State have been the 24 local health departments (LHD). Each LHD has worked with and through its community's public and private resources to reach and enroll children in MCHP. A detailed list of LHD outreach activities is attached to this report at Attachment B. We have not conducted a formal evaluation of the success of various outreach efforts in reaching certain populations. However, we are cooperating with the National Covering Kids media campaign to identify the effects of targeted outreach campaigns in the Baltimore metropolitan area and have received a technical assistance grant. Through this funding, the Health Resources and Services Administration is evaluating our outreach program and we will be developing a plan to more effectively monitor the effectiveness of our outreach activities. We are currently conducting focus groups and examining various outreach materials to determine which are more effective.

- C. Which methods best reached which populations? How have you measured effectiveness?

Maryland is currently conducting focus groups as part of the technical assistance HSR is providing. We have developed a listing of potential focus group participants and the LHD's have recruited the participants. We have asked the contractor to develop options so we can monitor which strategies are most effective.

2.5 **Retention:**

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

Redetermination of eligibility is initiated with a computer-generated notice of redetermination due approximately 2.5 months before the end of current eligibility. The notice is mailed to the head of household for the eligible child along with an application form.

Approximately 3 weeks before the end of current eligibility, a follow-up letter is sent if the renewal has not been received.

We are examining the reasons for disenrollment in MCHP. Some LHD's are contacting families to see if they may still be eligible and providers often encourage families to apply on behalf of their children. Through the HSR technical assistance grant, we are conducting focus groups to determine the barriers to re-enrollment that may exist.

We have begun discussions with our State University to conduct a study of disenrollments in 2001. The study will be conducted in conjunction with an outreach campaign to foster re-enrollment.

B. 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 : Renewal reminders are sent; notices and applications are sent.

Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe: See above

Other, please explain

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

Follow-up by caseworkers and renewal notices are employed in Medicaid. The simplification of the re-enrollment process and focus groups are specific to MCHP and our SOBRA-related children.

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

We believe our simplification of the enrollment process and follow-up by caseworkers have been most effective in ensuring that the eligible children stay enrolled. We will know more following our studies described above.

E. 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.

Based on data extracted from CARES, the eligibility computer system, less than 1 percent of MCHP disenrollments are health insurance-related. This probably understates the number of MCHP children who gain private coverage, however, as the CARES system only records one disenrollment reason. The acquisition of health insurance coverage may be the result of a change in parental employment, which also brought an increase in family income to a level greater than the maximum allowable amount for continued coverage. The single reason for ineligibility recorded in CARES for these children would be income in excess of the maximum allowable amount. For example, acquisition of health insurance may coincide with a move out of state or a request by the parent to voluntarily terminate MCHP eligibility; the recorded reason for ineligibility in CARES would reflect the loss of State residence or the voluntary termination of eligibility.

2.6 Coordination between SCHIP and Medicaid:

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

MCHP is a Medicaid expansion. We use a short, 3-page application form for all children applying for MCHP and the earlier SOBRA expansion populations of pregnant women and children.

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

At the time of application, caseworkers will check for Medicaid eligibility first, then proceed to MCHP eligibility determination for those who do not qualify for Medicaid.

Caseworkers at the LHD and LDSS also review eligibility status when changes occur in the child's circumstances which warrant redetermination of eligibility. If necessary based on these changes, caseworkers will amend the CARES eligibility file to indicate transfer between Medicaid and MCHP.

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

The same delivery systems are used in Medicaid and MCHP. MCHP children are enrolled in Maryland's HealthChoice program, which provides a comprehensive package of benefits and, more importantly, a medical home for eligible children.

2.7 Cost Sharing:

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

In the state law, which established MCHP, the Maryland General Assembly directed DHMH to study how to expand eligibility for MCHP using private-market insurance coverage. As directed, DHMH formed a Technical Advisory Committee (TAC) composed of representatives of the Maryland Insurance Administration, the Maryland Health Care Foundation, the Maryland Health Care Commission, the business community and the health-care insurance industry. The TAC prepared a discussion paper for cost-sharing issues and presented recommendations to the General Assembly. In 2000, the General Assembly authorized DHMH to design and implement an expansion to MCHP which would raise the income-qualifying level to 300 percent of the federal poverty level and impose cost-sharing, effective July 1, 2001.

- B. 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?

N/A at this time; no baseline data exists yet.

2.8 Assessment and Monitoring of Quality of Care:

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

All MCHP enrollees are given the same assurances of access to care as built into the HealthChoice program for all Medicaid recipients. For example, each child enrolled in HealthChoice is assigned to a primary care provider that is a certified EPSDT provider. This primary care provider is responsible for ensuring that children receive EPSDT and follow-up treatment services.

In the application process for each MCO, the MCO has to provide information about its provider network for serving special needs populations. This information includes: a description of the provider's clinical expertise and experience; evidence of the MCO's ability to comply with the specific quality, access, data, and performance standards; and the MCO's ability to provide adequate clinical and support services to assure appropriate and coordinated services.

The following methodologies are used to monitor the quality of care and assure the access to care of all HealthChoice enrollees:

Encounter data collected from MCOs provides information on health care services utilization for children;

HealthChoice Financial Monitoring Report submitted by MCOs quarterly provides information on MCO expenditures;

Health Risk Assessments completed at the time of HealthChoice enrollment are used to alert MCOs to immediate health needs of new recipients;

State Complaint and Grievance process that includes Recipient and Provider Hotlines, Complaint Resolution and provides tracking and resolving of recipients' complaints including coordination and interacting with MCOs and other internal and external agencies. It also includes monthly monitoring for trends and is used to make programmatic changes;

MCO internal complaint process: The State receives quarterly logs from the MCOs for all member and provider complaints. The State may use the information it receives from MCO complaint logs to follow up on the calls it refers to the MCO for action, to analyze patterns of calls for each MCO for quality and completeness of log recording and to assess quality, appropriateness and completeness

of the MCO's resolution/interventions taken;

Ombudsman Program at the local health department: provides local intervention through the health department to investigate disputes between enrollees and MCOs, provide education about services and enrollees rights and responsibilities. Additionally, the ombudsman may act as an advocate on the enrollee's behalf;

Annual Quality of Care Audit: includes a review of the MCO's system performance, medical record review, utilization management and case management activities, and focused studies that include preventive health studies and educational programs and services;

HEDIS data 2000 are collected from all the MCOs. We are concentrating on preventive services for pregnant women and for children;

EPSDT Nurse Review: provides office-based medical record review for comprehensive health and developmental history, physical exam, immunizations, appropriate laboratory tests, health education, vision, hearing and dental screening, follow-up diagnostic and treatment services necessary to prevent, treat, or ameliorate physical, developmental, or any other conditions identified by an ESPDT provider. These reviews are conducted on: (1) an annual basis for those providers who receive satisfactory reviews (the most common outcome of a review), (2) an every two year cycle for providers who receive excellent reviews, and (3) more frequently for those who receive a less than satisfactory review, to assist providers and their staff to improve the quality of care provided in their offices;

Focused Studies of health care services give information of health care services provided to children with specific health care conditions, such as cerebral palsy and asthma;

Enrollee Satisfaction Survey: is designed to assess enrollee satisfaction with various aspects of the HealthChoice Program. This is an annual survey using a statistically valid research instrument;

Provider Satisfaction Survey: performed annually and helps the HealthChoice Program evaluate access to services. Providers are asked how satisfied they are with the MCO referral processes, case management and formulary management;

Public involvement and participation: fostered by the HealthChoice Program to maintain active partners and seek information and participation through several ongoing committees. These committees include:

- Quality Assurance Liaison Committee: to address topics of general interest concerning quality improvement issues;
- Medicaid Advisory Committee: comprised of HealthChoice enrollees, enrollee advocates, providers, representatives from the legislature and MCOs. The main function of this committee is to review and make recommendations on the operation and evaluation of

managed care programs under HealthChoice;

- Special Needs Children Advisory Council: conducts regular reviews of available data, and participate in the effectiveness study for children with special health care needs; and
- Medical Review Panel for the Rare and Expensive Case Management Program: reviews and recommends changes to the conditions appropriate and eligible for REM.

Bi-Weekly MCO Meetings: A meeting of the MCOs with the purpose of problem solving and offering an opportunity for MCOs to express actual or potential barriers to the successful operation of HealthChoice, including quality of care issues..

C. 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?

Encounter data, the Annual Quality of Care Audit, HEDIS data, the Maryland EPSDT Quality Improvement Program, and focused studies are utilized to monitor and assess quality of care, especially for preventive care, mental health, substance abuse treatment and dental care.

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

The State is planning to use encounter data to analyze a wide variety of performance and outcome measures during FFY 2001.

The State will continue to monitor the HealthChoice program through the use of satisfaction surveys, the complaint and grievance process, EPSDT reviews, MCO systems operational reviews, and medical record reviews.

The State will also continue to monitor access through: appointment audits; beneficiary surveys; utilization analysis; and review of : (1) PCP/ enrollee ratios, (2) time/distance standards, (3) urgent/routine care access standards, (4) network capacity, (5) complaints/grievance disenrollment, (6) case files, and (7) EPSDT records for compliance.

SECTION 3. SUCCESSES AND BARRIERS

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.

- Eligibility

This is a success because Maryland extended Medicaid coverage (using regular match funds) to pregnant women with income at or below 200 percent of the Federal poverty level (FPL). Maryland also extended Medicaid coverage (using enhanced match funds) to eligible children under age 19 who were born:

- After September 30, 1983 in families with income too high to qualify for SOBRA, but at or below 200 percent of FPL;
- Before October 1, 1983 in families with income above 40 percent FPL, but at or below 200 percent of FPL.

In addition, Maryland has taken the following actions to streamline the eligibility process:

- Adopting a shortened, simplified application form (3 pages);
- Allowing applicants two new application options – applying by mail or face-to-face at local health departments (instead of the still-available alternative of applying at local departments of social services);
- Allowing self-declaration of income;
- Eliminating the asset test;
- Eliminating the mandatory face-to-face interview; and
- Establishing a “1-800” number for anyone who has questions or wants an application form.

- Outreach

Significant progress has been made in Maryland in reducing the number of uninsured children since the State began its outreach efforts for the Maryland Children's Health Program (MCHP) in July, 1998. To increase enrollment, Maryland instituted a variety of outreach efforts through local, state and national levels (such as the Covering Kids media campaign). The variety of activities makes it difficult to evaluate the effectiveness of individual activities in reaching low-income children, but we believe our hotline, radio and newspaper ads and PSAs, cable TV and billboards to be the most effective means of reaching low-income children. This judgement is based on the increased number of telephone calls for information and the number of applications received shortly after the media information campaigns.

- Enrollment

Maryland is pleased to report that enrollment has far exceeded our target enrollment numbers. Maryland's three-year enrollment target was 60,000; as of September 30, 2000 approximately 74,000 eligible children were enrolled. Significant progress has been made in Maryland in reducing the number of uninsured children since the State began its outreach efforts for the Maryland Children's Health Program (MCHP) in July, 1998. We have measured our progress by reporting the total number of children served by the CHIP program as of September 30, 2000. In the future, when more reliable Maryland data are available from our survey of the uninsured, we will compare the current estimate of uninsured children with our baseline estimate.

- Retention/disenrollment

Although Maryland has streamlined the re-enrollment process, some MCHP-eligible children do not renew their eligibility timely or re-enroll within a few months of losing eligibility. To overcome this barrier Maryland is examining the reasons for disenrollment in MCHP. Some local health departments are contacting families to see if they may still be eligible and providers often encourage families to apply on behalf of their children. Through a technical assistance grant, we are conducting focus groups to determine the barriers that may exist to re-enrollment. We are also entering into an agreement with our State University to complete a survey of disenrolled children to give us better baseline information to support adjustment of our re-enrollment process.

- Benefit structure

This has been successful because the State established the HealthChoice Program of managed care as the delivery system for MCHP. The scope and range of the health benefits for MCHP enrollees is the same as that provided in the State's managed care program, and is a complete and comprehensive benefit package equivalent to the benefits that have been available to Maryland Medicaid recipients through the fee-for-service delivery system. There are eight MCOs. Mental health services are carved out. Services provided on a fee for service basis include: IEP/IFSP, occupational therapy, physical therapy, speech therapy, audiology, personal care, medical day care, transportation, targeted case management and covered services for recipients in the rare and expensive case management (REM) program.

- Cost-sharing

Not Applicable.

- Delivery systems

See section 3.1(E).

- Coordination with other programs

Maryland has several alternatives for children who are ineligible for MCHP. These include Children's Medical Services (CMS) and several local jurisdiction initiatives. While all of these programs provide vital services to low income uninsured individuals, they all have significant restrictions in benefits and capped funding. None of the programs provides creditable coverage as defined by SCHIP. Most of these programs have adapted to meet the needs of children not served by MCHP.

- Crowd-out

See Section 2.3.

- Other—N/A

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
Benefit Costs			
Insurance payments			
Managed care	\$ 91,256,837	\$ 68,766,360	\$ 89,720,220
per member/per month rate X # of eligibles			
Fee for Service	43,233,403	32,360,640	42,221,280
Total Benefit Costs (See Note A.)	134,490,240	101,127,000	131,941,500
(Offsetting beneficiary cost sharing payments)	(0)	(910,000)	(3,776,500)
Net Benefit Costs	134,490,240	100,217,000	128,165,000
Administration Costs			
Personnel	3,541,000	3,959,492	5,831,070
General administration			
Contractors/Brokers (e.g., enrollment contractors)	1,751,332	1,832,909	3,253,117
Claims Processing			
Outreach/marketing costs	1,999,978	5,646,526	8,138,917
Other (Over CAP; 50% FFP) (See Note B.)		(303,705)	(2,982,549)
Total Administration Costs	7,292,410	11,135,222	14,240,555
10% Administrative Cost Ceiling	14,943,360	11,135,222	14,240,555
Federal Share (multiplied by enhanced FMAP rate)	92,158,723	72,378,944	92,563,610
State Share	49,623,927	38,973,278	49,841,945
TOTAL PROGRAM COSTS	141,782,650	111,352,222	142,405,555

Note A: Includes Statewide MCHP claims, including “voucher only” claims from Maryland State Department of Education and Mental Hygiene Administration as follows: FFY 2000 Actual \$5,206,727; FFY 2001 Estimated \$5,467,000; FFY 2002 Estimated \$5,740,000 for voucher only. Also, FFY 2000 includes FFY 1998 and FFY 1999 back claims for former Maryland Kids Count population.

Note B: FFY 2001 and FFY 2002 negative adjustments are administrative costs in excess of the cap which will be claimed at 50% FFP.

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

N/A for FFY 2000.

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	Maryland Children's Health Program (MCHP)	
Provides presumptive eligibility for children	<input checked="" type="checkbox"/> No Because we believe we have a better, more streamlined process. <input type="checkbox"/> Yes, for whom and how long?	<input type="checkbox"/> No <input type="checkbox"/> Yes, for whom and how long?
Provides retroactive eligibility	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, for whom and how long? All applicants; maximum of 3 months prior to the month of application	<input type="checkbox"/> No <input type="checkbox"/> Yes, for whom and how long?
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 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 <u>7.6 months</u>	Specify months
Has joint application for Medicaid and SCHIP	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Has a mail-in application	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Can apply for program over phone	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Can apply for program over internet	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Requires face-to-face interview during initial application	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, specify number of months <u>6</u> What exemptions do you provide? 1. Involuntary loss of coverage based on employer termination of coverage for all employees, 2. Job change, 3. Involuntary loss of employment, 4. Move out of service area of all plans offered by employer, 5. Expiration of COBRA benefits, 6. Termination of limited benefit insurance (vision plan, dental plan, etc.) that didn't include inpatient hospital coverage	<input type="checkbox"/> No <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 type="checkbox"/> No <input checked="" type="checkbox"/> Yes, specify number of months <u>6</u> Explain circumstances when a child would lose eligibility during the time period: A child will receive continuous coverage for 6 months unless the child: 1. Moves out of state, 2. Attains age 19, or 3. Dies.	<input 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 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)
Imposes copayments or coinsurance	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input 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"/> No <input type="checkbox"/> Yes, we send out form to family with their information and:

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
	precompleted and: _____ ask for a signed confirmation that information is still correct _____ do not request response unless income or other circumstances have changed	information and: _____ ask for a signed confirmation that information is still correct _____ 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.

Approximately 2.5 months before the end of the current certification period, the recipient is sent a written notice that eligibility will end on a specified date and a renewal application must be completed to continue eligibility beyond that date. A blank application form is enclosed with the notice letter.

Approximately 3 weeks before the end of the current certification period, the recipient who has not renewed eligibility is sent another written notice that eligibility will end on a specified date if a renewal application is not submitted to the LHD before the specified date.

Both notices are generated automatically by CARES, the Client and Recipient Eligibility System, which contains all eligibility records for MCHP recipients.

There are no other differences in the eligibility process for redetermination from the eligibility process for initial application.

SECTION 6: INCOME ELIGIBILITY

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 or
Section 1931-whichever category is higher

185% of FPL for children under age 1
133% of FPL for children aged 1 through 5 (to 6th birthday)
100% of FPL for children aged 6 and above

Medicaid SCHIP Expansion

200% of FPL for children aged 0 through 18 (to 19th .
Birthday)
____% of FPL for children aged _____

State-Designed SCHIP Program--N/A

____% of FPL for children aged _____
____% of FPL for children aged _____
____% of FPL for children aged _____

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"

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) _____

Yes No

If yes, please report rules for applicants (initial enrollment).

Table 6.2

	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	SNAP
Child support payments received	\$90/month	\$90/month	\$0
Child care expenses	\$actual	\$actual	\$0
Child support payments received	\$50 per family per month	\$50 per family per month	\$0
Child care expenses	\$actual	\$actual	\$0
Child care expenses	\$actual, not to exceed \$175/month per child (\$200 per month per child if under age 2)	\$actual, not to exceed \$175/month per child (\$200 per month per child if under age 2)	\$0
Medical care expenses	\$0	\$0	\$0
Other types of disregards/deductions (specify)	\$0	\$0	\$0
Other types of disregards/deductions (specify)	\$actual student earnings for a full-time student employed full-time or part-time or a part-time student who is not employed full-time	\$actual student earnings for a full-time student employed full-time or part-time or a part-time student who is not employed full-time.	\$0

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 N/A No Yes, specify countable or
allowable level of asset test _____
Other SCHIP program N/A 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

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.

During the Maryland 2000 legislative session, the General Assembly and the Governor enacted the Maryland Health Programs Expansion Act of 2000. The Act authorized an “MCHP Private Option Plan” (MCHP Premium) effective July 1, 2001, expanding MCHP eligibility to children in families with income above 200 percent but at or below 300 percent of the Federal Poverty Level (FPL). Payment of a family contribution premium is required to participate in MCHP Premium.

Uninsured children who are eligible for MCHP Premium will obtain coverage through employer-sponsored insurance (ESI) or a Medicaid look-alike program (Default).

1. Employer-Sponsored Insurance (ESI)

Children will be enrolled in an employer-sponsored health benefit plan if qualifying coverage is available and it is determined cost-effective to enroll the child. All children enrolled in ESI will also be enrolled in a State-sponsored secondary insurance to cover the cost of co-payments, deductibles, and co-insurance amounts applicable to the ESI coverage.

2. Default (Medicaid Look-alike)

Eligible children whose parents do not have access to qualifying employer-sponsored insurance will be enrolled in a “default” Medicaid look-alike program operated through the HealthChoice program.

- Family coverage

MCHP Premium was approved by HCFA on November 7, 2000, and will provide premium assistance for cost-effective family coverage to families of targeted low-income children with access to qualifying ESI coverage. Family coverage, however, will depend on coverage options offered by the employer, the number of eligible children in the family, and the results of cost-effectiveness calculations. In all cases, the employed parent must pay the cost of his or her own coverage.

- Employer-sponsored Insurance Buy-In

MCHP Premium will include buy-in of employer-sponsored insurance (ESI) which offers benefits equal to or greater than the federally approved benchmark coverage and to which the employer contributes at least 50 percent of the cost of the family coverage.

- 1115 waiver

NA

- Eligibility including presumptive and continuous eligibility

NA

- Outreach

The outreach strategy for MCHP Premium will be coordinated with the outreach strategies which have proven effective for MCHP, including:

- A grassroots information dissemination campaign involving collaboration with state agencies, advocacy groups, community-based groups, and provider organizations;
 - A public media and advertising campaign; and
 - Specific outreach through a variety of media to employers.
- Enrollment/redetermination process

Maryland is using a joint application process to ensure that children receive coverage under the most generous benefit package for which they are eligible. We will revise the current MCHP application form to include questions pertinent to MCHP Premium. We will use the existing MCHP eligibility determination system to ensure that applicants are first reviewed for eligibility for Medicaid and then for MCHP. Review for eligibility for MCHP Premium will be initiated for applicants determined ineligible for MCHP whose income falls within the MCHP Premium range and who have indicated on the application form that they are willing to pay a family contribution to obtain coverage

If an applicant with income in the eligibility range does not have access to qualifying ESI, the Department (or its designee) will send a letter advising the applicant of eligibility for the MCHP Expansion Medicaid look-alike program (HealthChoice enrollment) and the family contribution due. After the first family contribution payment is received, the MCO enrollment process is initiated.

If an applicant with income in the eligibility range does have access to qualifying ESI, the Department (or its designee) will send a letter explaining the ESI program, and the family contribution requirement, and how premium collection will work. In ESI, the employer withholds the employee's share of insurance premium, and the State will issue checks to families once a month, prior to the payroll deduction to cover the State subsidy. When ESI enrollment is confirmed, the employee reimbursement payment process is initiated.

- Redetermination is required to establish continued eligibility.
- 1. Scheduled Redetermination requires completion of the application and determination of eligibility for MCHP by the local health department or the local department of social services for renewal of program eligibility.
 - a. For ESI, redetermination will be scheduled concurrently with the open enrollment period established by the employer, and at least annually.
 - b. For Default, redetermination will be scheduled annually.
- 2. Unscheduled Redetermination will occur when changes in circumstances or relevant facts are reported by someone on the recipient's behalf, or brought to the attention of the Department from other responsible sources.
- Contracting

The Department is requesting proposals from one or more qualified vendors to administer operations of MCHP Premium, including: (1) outreach for employer participation in the employer sponsored insurance (ESI) program, (2) screening and investigation services for applicants with available ESI, (3) premium subsidy payments, and (4) secondary benefit administration services.

- Other—N/A

Attachment A

MCO Network Capacity Reports for September, 1999 and October, 2000

These reports will be submitted in hard-copy only.

Attachment B

Summary of Local Health Department Outreach Activities for SFY 2000

This report will be submitted in hard-copy only.