

***Federal Fiscal Year 2001
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:

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

***Federal Fiscal Year 2001
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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); MCHP Premium

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

Reporting Period **Federal Fiscal Year 2001 (10/1/00-9/30/01)**

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Submission Date December 28, 2001

*(Due to your CMS Regional Contact and Central Office Project Officer by January 1, 2002)
Please cc Cynthia Pernice at NASHP (cpernice@nashp.org)*

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 2001 (September 30, 2000 to October 1, 2001).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 2000 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, 2000, 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.

A. Program eligibility

(1) Maryland Children's Health Program (MCHP)

Implemented Accelerated Certification of Eligibility (ACE) statewide, effective October 1, 2000. ACE processing allows the local health departments, the principal venue for MCHP applications, to perform screenings on applications filed by customers with pending or active TANF, Food Stamp or Medicaid cases at the local departments of social services, and to give 3 months temporary MCHP eligibility certification. Local health department staff use a worksheet to perform a basic income calculation and evaluate fundamental non-financial factors relevant to MCHP eligibility. The screening is designed so that applicants granted temporary eligibility are very likely to be eligible when the standard eligibility determination is completed by the local department of social services.

4,478 applications for 1,217 pregnant women and 3,261 children were processed through ACE in FFY 2001.

(2) MCHP Premium

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 obtain coverage through employer-sponsored insurance (ESI) or a Medicaid look-alike program (Default).

MCHP Premium was approved by CMS (then HCFA) on November 7, 2000.

a. Employer-Sponsored Insurance (ESI)

Children are enrolled in an employer-sponsored health benefit plan if qualifying coverage is available and it is determined cost-effective to enroll the child. MCHP Premium includes buy-in of 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.

All children enrolled in ESI are also enrolled in a State-sponsored secondary insurance to cover the cost of co-payments, deductibles, and co-insurance amounts related to the ESI coverage.

b. Default (Medicaid Look-alike)

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

c. Family Coverage

MCHP Premium provides premium assistance for family coverage to families of targeted low-income children with access to qualifying ESI coverage when it is cost-effective to enroll the children in the ESI family coverage. Thus, an uninsured spouse of the employed person may receive coverage through ESI along with the children for no additional cost. In all cases, however, the employed parent must pay the cost of his or her own coverage.

1,737 families were referred for MCHP Premium eligibility determination between July 1 and September 30, 2001.

B. Enrollment process

(1) MCHP

See 1.1A above.

(2) MCHP Premium

Maryland is using a joint application process to ensure that children receive coverage under the benefit package for which they are eligible. We revised the MCHP application form to include questions pertinent to MCHP Premium. We use the existing CARES computer-based eligibility determination system to ensure that applicants are reviewed first for eligibility for Medicaid and then for MCHP.

Review for eligibility for MCHP Premium is initiated for applicants determined ineligible for Medicaid or MCHP (up through 200% FPL) 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 for their children. A case manager from the Department's MCHP Premium Case Management Unit reviews the application and confers with the applicant to determine whether ESI is available for the children.

If the employer offers coverage for children, the case manager reviews ESI information on file with the Department to ascertain whether the employer's financial participation and plan benefits have been reviewed for compliance with requirements for participation (qualifying ESI). Children enrolled in ESI receive benefits equal to, or greater than, the services specified in the Comprehensive Standard Health Benefit Plan, the benchmark coverage approved by CMS (then HCFA) in the State Plan Amendment for the separate child health plan on November 7, 2000.

If the employer's financial participation and plan benefits have not been reviewed for MCHP Premium participation, the case manager sends a referral to the Department's contractor to contact the employer and develop ESI information to determine whether qualifying ESI is available.

If an applicant has access to qualifying ESI, the Department (or its designee) sends the applicant 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 issues 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.

If an applicant with income in the eligibility range does not have access to qualifying ESI, the Department (or its designee) sends a letter advising the applicant of eligibility for the MCHP Premium 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.

C. Presumptive eligibility

- (1) **MCHP** - NC
- (2) **MCHP Premium** - N/A

D. Continuous eligibility

- (1) **MCHP** - NC
- (2) **MCHP Premium** - N/A

E. Outreach/marketing campaigns

(1) MCHP

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. In February, 2001, 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.

(2) MCHP Premium

In May, 2001, the Department initiated a multi-month, multi-media outreach campaign to promote MCHP Premium. Public service announcements ran on radio stations statewide, including a Spanish language station in the Maryland suburbs of Washington, D.C., and on cable TV in the Baltimore metropolitan area. Bus, metro, and MARC commuter train placards and billboard ads were used in locations throughout Maryland.

In August, 2001, Lt. Governor Kathleen Kennedy Townsend presided at the official kick-off for MCHP Premium at the Martin Luther King, Jr. Early Day Care Center in Baltimore.

Throughout FFY 2001, Maryland Children’s Health Program Division staff attended statewide meetings and events focussed on children and employers, and completed numerous speaking engagements to promote MCHP Premium.

F. Eligibility determination process

(1) MCHP - NC

(2) MCHP Premium - See 1.1B above.

G. Eligibility redetermination process

(1) MCHP - NC

(2) MCHP Premium

Redetermination is required to establish continued eligibility. All applicants for renewal of MCHP Premium eligibility will be tested for MCHP eligibility first; those whose income exceeds MCHP limits but is not above MCHP Premium’s maximum allowable income, and who indicate a continued willingness to pay the family contribution amount,

will be referred to the Department's MCHP Premium Case Management Unit for renewal processing.

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 based on date of enrollment.

Unscheduled Redetermination will occur when changes in circumstances or relevant facts are reported by someone on the enrollee's behalf, or brought to the attention of the Department from other responsible sources.

H. Benefit structure

(1) **MCHP** - NC

(2) **MCHP Premium**

Benefits for MCHP Premium-eligible children are determined by their enrollment in Health Choice, the Maryland Managed Care Program, or in ESI.

MCHP Premium-eligible children enrolled in HealthChoice receive the same benefits as MCHP-eligible children in HealthChoice. Coverage for MCHP Premium-eligible children does not begin until the effective date of enrollment in HealthChoice.

Children enrolled in ESI receive benefits equal to, or greater than, the services specified in the Comprehensive Standard Health Benefit Plan, the benchmark coverage approved by CMS (then HCFA) in the State Plan Amendment for the separate child health plan on November 7, 2000. Coverage begins when the ESI plan establishes an enrollment date for the child. Children enrolled in ESI also receive secondary insurance to pay for co-payments, deductibles, and co-insurance costs for ESI plan-covered services.

I. Cost-sharing policies

(1) **MCHP** - NC (Not applicable to MCHP)

(2) **MCHP Premium**

All MCHP Premium enrollees pay a family contribution amount of \$38* or \$48* per family per month.

- (a) HealthChoice enrollees pay the family contribution amount directly to the Department, by check, money order, or credit card.
- (b) ESI enrollees have standard payroll deduction withheld, with repayment of the excess withholding amount (the amount of the children's portion of the premium in excess of \$38 or \$48) by the Department directly to the head of household.

*The amount of premium is set in State law at 2% of the federal poverty level (FPL) for a family of 2 at 200%FPL and 250%FPL. Families with income between 200% and 250% FPL pay the lower amount; families above 250% FPL pay the higher amount. The amounts change each April, based on changes in FPL.

J. Crowd-out policies

(1) **MCHP** - NC

(2) **MCHP Premium**

MCHP Premium applies the same crowd-out policy currently applied in MCHP.

K. Delivery system

(1) **MCHP** - NC

(2) **MCHP Premium**

See 1.1A above.

L. Coordination with other programs (especially private insurance and Medicaid)

(1) **MCHP** - NC

(2) **MCHP Premium**

See 1.1A above.

M. Screen and enroll process

(1) **MCHP**

See 1.1A above.

(2) **MCHP Premium** - N/A

N. Application

(1) **MCHP** - NC

(2) **MCHP Premium**

See 1.1A and B above.

O. Other - NC

1.2 Please report how much progress has been made during FFY 2001 in reducing the number of uncovered, low-income children.

A. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2001. Describe the data source and method used to derive this information.

We are currently in the process of compiling and analyzing data from two discrete sources: Maryland's first statewide survey of the uninsured and the Current Population Survey (CPS). Together, these data should allow us to better understand changes in the number and proportion of uninsured children that have occurred in Maryland between the late 1990's and 2001 and give us a more precise baseline estimate.

At present, we are fielding the 2001 Maryland Health Insurance Coverage Survey. This survey of 5,000 Marylanders should give us a more precise estimate of the proportion and number of uninsured children below 300 percent of the Federal Poverty Level (FPL) in both urban and rural areas of the state than we have had in the past. The survey results will be available in February, 2002.

As we have in the past, we are also currently analyzing information from the March supplements of the CPS, which are released in the fall of each year. Because the CPS samples fewer than 1,500 Marylanders annually, we must aggregate several years of data in order to achieve sufficient sample size to estimate the proportion of uninsured by age and income. Unfortunately, the Maryland CPS data for reporting year 1999 is inaccurate and unusable because the survey referred to the state's Medicaid program by the wrong name. As a result, we will only be able to aggregate two years of CPS data (for reporting

years 2000 and 2001). It is important to note that this will probably not afford us sufficient sample size to derive reasonably precise estimates of uninsured children by income level for the 1999-2000 period. However, the most recent CPS data, when viewed together with estimates derived from the 2001 Maryland Health Insurance Coverage Survey as well as aggregated data from the CPS for reporting years 2000, 1998, and 1997 should give us a better sense of changes in insurance coverage for children since the inception of the state's SCHIP program.

Until February, 2002, when we complete our analyses of the Maryland Health Insurance Coverage Survey and the CPS data, our current baseline for the number of uninsured low-income Maryland children remains at 100,000. This is the same estimate that we submitted for our 1999 and 2000 annual reports. Additionally, it conforms to the estimate HCFA used in distributing the initial State Children's Health Insurance Program allotments.

- B.** 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.

It is difficult to discern what proportion of the increase in our Medicaid enrollment in FFY 2001 is directly attributable to MCHP outreach and simplification efforts as opposed to other factors.

Maryland's MCHP enrollment in FFY 2001 stood at almost 91,000 children, a 23 percent increase over our enrollment of approximately 74,000 children in FFY 2000. Similarly, our SOBRA enrollment increased by approximately 12 percent, from 118,000 to 132,000 children during the same time period.

The vast majority of MCHP enrollees and a significant proportion of Medicaid SOBRA enrollees apply to the program using a simplified, mail-in application. We estimate that approximately 15,000 to 20,000 Medicaid enrollees have joined the program as a result of the simplified application process coupled with local health department, face-to-face outreach efforts.

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

In FFY 2001, the number of children enrolled in the state's MCHP and Medicaid programs increased approximately 11 percent from 303,000 to 337,000 children.

In July, 2001, we expanded MCHP eligibility to children in families with incomes between 200 and 300 percent FPL. Thus, insurance coverage for children is now more accessible and affordable for a higher number of Maryland families.

D. 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 2001 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		
<p>MCHP: Outreach to eligible low-income children</p> <p>MCHP Premium: Develop and implement a multi-faceted outreach strategy that targets the eligible population for the Program.</p>	<p>Reduce the number of non-covered children</p> <p>Reduce percentage of non-covered children under 300% FPL</p>	<p>Data Sources: See Narrative</p> <p>Methodology:</p> <p>Progress Summary:</p> <p>Data Sources: See Narrative</p> <p>Methodology:</p> <p>Progress Summary:</p>
OBJECTIVES RELATED TO SCHIP ENROLLMENT		

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.)
<p>MCHP: Outreach to eligible low-income children</p> <p>MCHP Premium: Outreach to eligible low-income children</p>	<p>Meet or exceed projected number of Medicaid eligibles enrolled in MCHP</p> <p>Meet or exceed the number of MCHP Premium enrollees as compared to projections</p>	<p>Data Sources: See Narrative</p> <p>Methodology:</p> <p>Numerator: 88,694 children enrolled (06/30/01) 90,789 children enrolled (9/30/01)</p> <p>Denominator: 60,000 (Number anticipated to enroll in first three years of MCHP.)</p> <p>Progress Summary: At the end of the first three years of MCHP (06/30/01), we exceeded our anticipated enrollment by 48 percent.</p> <p>Data Sources: See Narrative</p> <p>Methodology:</p> <p>Numerator: 303 children enrolled (9/30/01)</p> <p>Denominator: 19,000 (Number anticipated to enroll in first year of MCHP Premium.)</p> <p>Progress Summary: Based on the first calendar quarter of operation, it is unlikely that we will achieve the anticipated first-year enrollment.</p>
OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		

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 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.)
	<p>3. Increase in the number of enrollees who indicated that they have improved access to the health care delivery system. This will be measured through satisfaction survey reports.</p> <p>4. Increase in the number of enrollees who indicate that they are satisfied with specialty care resources.</p>	<p>Data Sources: See narrative</p> <p>Methodology:</p> <p>Progress Summary:</p>
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
MCHP Premium: Increase the use of Appropriate preventive Services by enrollees.	Provide appropriate preventive care to enrollees.	<p>Data Sources: See Narrative</p> <p>Methodology:</p> <p>Progress Summary:</p>
OTHER OBJECTIVES		
		<p>Data Sources:</p> <p>Methodology:</p> <p>Progress Summary:</p>

1. Outreach to eligible low-income children

MCHP:

Reduce the number of non-covered children:

The data to measure our progress in reaching this goal is not available. We are presently fielding the 2001 Maryland Health Insurance Coverage Survey, which we developed in conjunction with the Maryland Health Care Commission, in FFY 2001. We believe the survey will provide good baseline data for measuring the number of uninsured children in Maryland. The survey results will be available in February, 2002.

MCHP Premium:

Develop and implement a multi-faceted outreach strategy--See MCHP Premium, 1.1E.

2. SCHIP Enrollment

MCHP:

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

Our internal enrollment data indicates that we had enrolled 88,694 children in MCHP by June 30, 2001, 148% of our projected estimate in our MCHP application of 60,000 children by that date. Enrollment as of September 30, 2001 was 90,789.

MCHP Premium:

At the end of the first quarter of operation, we have received 1,737 applications for enrollment. 301 children have been enrolled in HealthChoice and two (2) in employer-sponsored insurance plans.

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

MCHP:

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 October, 2000 and October 1, 2001. 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, with an increase in the network capacity statewide of 1.5 percent overall. Furthermore, we believe the low number of complaints (approximately 180 per month to a program with approximately 426,000 current enrollees) related to provider access is an indication that access to care has remained consistently high.

Increase in the number of dental providers participating in HealthChoice:

733 dental providers participated in the Program in September, 2000. 485 dental providers participated in the Program in September, 2001, which is a decrease of 35 percent. This information is based on the monthly provider file submitted to DHMH from each managed care organization (MCO). The statewide ratio of oral health providers to adult and children enrollees is 1 to 800.

Despite the decrease in the number of dental providers, the percentage of enrollees receiving oral health services increased, for the third consecutive year. 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 continues to work 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 is in the process of applying to have additional areas designated as underserved.

DHMH has implemented Dent-Care, the loan forgiveness program for oral health professionals which was enacted by the Maryland General Assembly during the 2000 legislative session. Dent-Care forgives education loans for oral health professionals serving a percentage of Medical Assistance enrollees in their practices. DHMH has selected the first five dental providers for Dent-Care, increasing the number of oral health providers in Baltimore City, Baltimore County, Anne Arundel County, and Prince George's County.

During 2001, DHMH also provided \$24 million in additional funding to the MCOs to be used specifically to increase dental utilization for children.

MCHP Premium:

Increase in the percentage of children with MCHP Premium coverage in HealthChoice who receive dental services.

No baseline data exist to assess this performance goal at present. We will monitor utilization and include our findings in the annual report for FFY 2002.

MCHP Premium:

Increase in the number of HealthChoice dental providers who provided services to 10 or more MCHP Premium children.

No baseline data exist to assess this performance goal at present. We will monitor utilization and include our findings in the annual report for FFY 2002.

MCHP and MCHP Premium:

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.

The 2001 Adult and Child Satisfaction Surveys used the NCQA approved CAHPS instrument to collect CY 2000 data. The Department solicited to contract a NCQA certified survey vendor to fully conduct and report on the satisfaction of enrollees in the HealthChoice program. The child survey contained not only the CAHPS core questions, but also, screening and supplemental questions developed by the Foundation of Accountability (FACCT) in order to measure satisfaction of children with special needs. The results are pending and the report will be completed by January, 2002.

MCHP and MCHP Premium:

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.

The 2000 Adult and Child Satisfaction Surveys included CAHPS core questions pertaining to getting health care from a specialist. The results are pending and the report will be completed by January, 2002.

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

All **MCHP** performance goals have been met, with the exception of increasing the number of dental providers. However, the overarching goal of increasing access to dental care for children has been met, as evidenced by the increase in the percentage of enrollees receiving dental services.

The **MCHP Premium** performance goal for outreach has been met; it is too early to assess performance on other MCHP Premium performance goals.

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 2002, with relevant results included in Maryland's FFY 2002 annual report. We will continue to collect application and enrollment data, MCO capacity data, complaint information, provider information, and MCO/provider encounter data.

In conjunction with the Maryland Health Care Commission, DHMH is conducting the 2001 Maryland Health Insurance Coverage Survey to establish baseline data, including the number of uninsured children in Maryland. Results of this survey are expected in February, 2002.

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 October, 2000 and October 1, 2001.

Attachment B—Summary of Local Health Department Outreach Activities for SFY 2001.

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.

MCHP and MCHP Premium - N/A

- B. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2001 (10/1/00 -9/30/01)?

Number of adults N/A

Number of children N/A

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

N/A

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).

See Section 1.1A and B.

- B. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2001?

Number of adults 1

Number of children 2

2.3 Crowd-out:

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

MCHP and MCHP Premium:

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 voluntarily dropped employer-sponsored insurance.

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

MCHP and MCHP Premium:

The application form, as revised effective July 1, 2001, asks whether anyone applying for MCHP or MCHP Premium has dropped health insurance coverage in the past 0-3, 3-6, 6-9, or 9-12 months. The application also asks the reason for dropping employer-sponsored insurance. If applicants have dropped employer-sponsored insurance within the six (6) months prior to the month of application, the applicant must complete information about the insurer, policy number, group number, effective date, and end date. Voluntary dropping of employer-sponsored health insurance within the past six (6) months prior to application will result in denial of coverage.

The CARES eligibility computer system was modified effective July 1, 2001, to record specific reasons for dropping health insurance. The system assembles and reports this information as requested by DHMH.

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

MCHP:

Based on CARES reports for July and August, 2001, it appears that not many individuals are turned down because of dropping health insurance.

While we do not have detailed information in CARES on reasons for dropping insurance prior to July 1, 2001, we do have information on the number of children denied due to voluntary dropping of employer-sponsored insurance for each year of MCHP's operation. That number has consistently reduced each year since 1998, indicating that fewer families apply for MCHP within six (6) months of dropping insurance.

MCHP Premium:

With only one quarter's data on file, it is too early to assess the extent of access to potentially qualifying employer-sponsored insurance available to MCHP Premium families.

Applicants for MCHP Premium have initial eligibility determined for MCHP through the CARES system. The same limitations regarding voluntary dropping of employer-sponsored health insurance apply to MCHP Premium applicants. MCHP Premium

applicants are not identified separately in CARES from MCHP applicants.

- 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.

The consistent reduction in the number of children denied due to voluntary dropping of employer-sponsored insurance for each year of MCHP's operation indicates that the six-month waiting period has been effective. Maryland does not apply any other crowd-out policies to MCHP and MCHP Premium.

2.4 Outreach:

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

MCHP and MCHP Premium:

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.

Our back-to-school campaign conducted in September and October, 2000, also proved effective. Every public school child in Maryland received an application form in their back-to-school packets. The forms were color-coded so that results of the campaign could be identified. Supported by the Covering Kids media campaign, this activity resulted in a five (5) percent increase in number of applications filed with local health departments during September and October, 2000.

Media campaigns and special outreach such as back-to-school campaigns and the MCHP Premium kick-off event are time-limited activities. Continuous grassroots outreach, through the 24 local health departments and their networks of community contacts, has supported and sustained MCHP since its implementation and continues to be an effective outreach methodology.

- 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?

MCHP and MCHP Premium:

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. 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 cooperated with the National Covering Kids media campaign to identify the effects of targeted outreach campaigns in the Baltimore metropolitan area and received a technical assistance grant. Through this funding, the Health Resources and Services Administration contracted with Health Systems Research, Inc. (HSR) to qualitatively evaluate our outreach program. HSR conducted focus groups in four (4) areas of the state and concluded that our outreach campaign was effective.

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

MCHP:

Based on focus group findings, HSR concluded that community-based outreach worked best. Examples include partnerships with schools, medical and doctors' offices, churches, community centers, various retail stores, post offices, child care centers, and libraries. Outreach to the Spanish-speaking population was not as successful, due in part to the Spanish literacy level of many applicants.

The fact that Maryland has enrolled 150 percent of its projected enrollment affirms the effectiveness of the various outreach campaigns undertaken by the Department. Regarding the Spanish-speaking population, outreach materials have been developed and the latest radio campaign included Spanish language ads.

MCHP Premium:

The initial response to a multi-media campaign to launch MCHP Premium has been positive. Callers to the MCHP or MCHP Premium hotlines have mentioned hearing the radio or seeing the television announcements, bus placards, billboards, etc.

It is too early to measure the success of MCHP Premium outreach activities.

2.5 Retention:

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

MCHP:

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 LHDs 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, focus group participants identified the barriers to re-enrollment as lack of time to go to the Local Department of Social Services (LDSS) for a face-to-face interview (for customers eligible for other assistance programs for which LDSS determines eligibility. These customers are scheduled for renewal of all programs at one time for the convenience of the customer.) and receipt of materials in English (for Spanish-speaking customers).

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.

MCHP Premium:

Redetermination is initiated by notice of redetermination due. Notice is prepared by the MCHP Premium Case Management Unit at the Department and sent approximately 2.5 months before the end of current eligibility.

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

Redetermination requires filing a new application form with the local health department. If eligible for MCHP, the MCHP Premium case is closed. If ineligible for MCHP but qualified for referral to MCHP Premium, the application is referred to the MCHP Premium Case Management Unit.

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

MCHP and MCHP Premium:

- 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 Medicaid children.

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

enrolled?

Focus group participants indicated that the simplification of the enrollment process and follow-up by caseworkers have been most effective in ensuring that the eligible children stay enrolled.

- 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.

MCHP:

Based on data extracted from CARES, the eligibility computer system, less than 1 percent of MCHP disenrollments are health insurance-related. This agrees with last year's findings. 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.

MCHP Premium:

To date, no disenrollments have occurred in MCHP Premium. Our automated case management system is programmed to record the specific reason for disenrollment.

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:

MCHP is a Medicaid expansion. We use a short, 4-page application form for all children applying for MCHP and the earlier SOBRA expansion populations of pregnant women and children.

MCHP Premium:

MCHP Premium uses the same application form as MCHP.

- 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.

MCHP:

The same delivery systems and provider networks 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.

MCHP Premium:

An MCHP Premium child who does not have access to qualifying ESI is enrolled in HealthChoice, with access to the same delivery system and provider networks as Medicaid and MCHP children.

An MCHP Premium child who is enrolled in an ESI plan receives services from providers contracted by the plan. These providers may or may not be participating Medicaid providers.

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 premiums, effective July 1, 2001.

The MCHP application form collects data on whether applicants are willing to pay a premium. Preliminary data from the first three months of the MCHP Premium program's operation indicate that less than 0.5 percent of potential enrollees refused to participate based on cost.

- 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—State only has premiums.

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.

MCHP:

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 local health departments: 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 2001 measures have been collected from the Managed Care Organizations since the implementation of the Maryland Medical HealthChoice Program in 1997. Full utilization of these measures for evaluation of MCO performance, however, has been limited due to inability to validate the data from the MCOs until this year. The HealthChoice Program is now implementing the use of selected HEDIS measures as a means of evaluating the quality of care delivered to all Medicaid enrollees, including SCHIP enrollees. Data results for CY 2000 are due for release by the Department in December, 2001;

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 practices that receive a less than satisfactory review, to assist providers and their staff to improve the quality of care provided in their offices, (2) a two-year cycle for practices that receive satisfactory reviews. The MCO quality improvement departments are encouraged to visit practices within 6 months when unsatisfactory reviews occur;

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: in CY 2001, provider focus groups were conducted to replace the provider satisfaction survey. Either a survey or focus group is performed annually to evaluate access to services within the HealthChoice Program. Providers are asked about their satisfaction with the MCO referral process, case management, formulary management and other related issues. The results of the CY 2001 provider focus groups will be finalized by January, 2002;

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: to review and make recommendations on the operation and evaluation of managed care programs under HealthChoice. This committee is comprised of Medicaid enrollees, enrollee advocates, providers, legislative representatives, and MCOs;
- 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..

MCHP Premium:

No baseline data exist yet to assess quality of care. For MCHP Premium children enrolled in HealthChoice, we will utilize the monitoring tools, reports, etc. listed above. For MCHP Premium children enrolled in ESI, we will conduct a separate customer satisfaction survey. We will report our findings for both groups in the annual report for FFY 2002.

- B. 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?

MCHP:

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.

MCHP Premium:

As stated for MCHP above, for MCHP Premium children enrolled in HealthChoice. For MCHP Premium children enrolled in ESI, we plan to conduct satisfaction surveys.

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

MCHP:

The State is in the process of implementing a value-based purchasing initiative for CY 2002. The change will allow the State and the MCOs to focus on the HealthChoice Program's key clinical and administrative priorities for improving overall quality of care

and services provided to Medicaid enrollees, including SCHIP enrollees. The value-based purchasing initiative will improve the assessment of MCO performance by using Health Plan Employer Data and Information Set (HEDIS) standards and methodologies that allow for comparison with nationally accepted performance standards established by the National Committee for Quality Assurance (NCQA). This streamlining of the audit process will begin by focusing on clinical and administrative needs identified in past audits and will culminate in the revision of the audit process to better focus on current program priorities. Baseline data using 16 HEDIS 2002 measures (CY 2001 MCO data) will be reported by FY 2002.

The State will continue quality improvement monitoring of the HealthChoice program using satisfaction surveys, focus groups, the complaint and grievance process, EPSDT reviews, MCO systems operational reviews, focused medical record reviews, and performance improvement projects.

The State will also continue monitoring access to care through enrollee surveys, utilization analysis, and assessment of MCO network adequacy through review of appointment audits; beneficiary surveys; utilization analysis; and review of : PCP/enrollee ratios, appointment audits, time/distance standards, urgent/routine care access standards, network capacity, complaints/grievance disenrollment, case studies, and new enrollee access to EPSDT services.

Reports of MCO performance are published in July of each year.

MCHP Premium:

As stated for MCHP above, for MCHP Premium children enrolled in HealthChoice. For MCHP Premium children enrolled in ESI, we plan to conduct satisfaction surveys.

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 2001 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.

A. Eligibility

MCHP:

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). This level increased to 250% FPL effective July 1, 2001. 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 (4 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;

- Establishing a “1-800” number for anyone who has questions or wants an application form; and
- Implementing Accelerated Certification of Eligibility (ACE) statewide, effective October 1, 2000. Through September 30, 2001, 4,478 applicants had been granted ACE certification.

MCHP Premium:

In July, 2001, Maryland implemented MCHP Premium.

- Raised the qualifying level for children age 0 through 18 to 300% FPL
- Added option of receiving coverage through qualifying employer-sponsored insurance.

B. Outreach

MCHP:

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). See Section 2.4 for more information.

MCHP Premium:

Maryland conducted a multi-month, multi-media campaign to launch MCHP Premium. See Section 2.4 for more information.

C. Enrollment

MCHP:

Maryland is pleased to report that enrollment has far exceeded our target enrollment numbers. Maryland exceeded its three-year enrollment target of 60,000 by 28,694; as of June 30, 2001, 88,694 eligible children were enrolled. That number grew to 90,789 by September 30, 2001.

MCHP Premium:

Response to MCHP Premium in the first three (3) months of the program’s operation has been gratifying, with 1,737 families applying for coverage for their children.

D. Retention/disenrollment

MCHP:

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. Through a technical assistance grant, we conducted focus groups to determine the barriers that may exist to re-enrollment. We also entered 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.

MCHP Premium:

No disenrollments have occurred, so no baseline data exist.

E. Benefit structure

MCHP:

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 six (6) 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.

MCHP Premium:

Children without access to ESI are enrolled in HealthChoice, with the same benefits from date of enrollment that MCHP children receive. Children with access to ESI are enrolled in ESI plans which equal or exceed the services required by the approved benchmark coverage. In addition, unique among the states, these children receive a secondary insurance coverage for co-payments, deductibles, and co-insurance costs for ESI plan-covered benefits. This secondary coverage eliminates out-of-pocket expenditures for covered services. We believe this will be a successful model for management of cost-sharing above the required family contribution amount for participation in an SCHIP.

F. Cost-sharing

MCHP: Not Applicable.

MCHP Premium:

Preliminary data from the first quarter of the Program's operation indicate that cost-sharing (i.e., payment of a monthly premium) has not been a barrier to enrollment. Less than 0.5 percent of applicants declined enrollment because of cost-sharing and no enrollee dropped out of the Program because of the cost-sharing requirements.

G. Delivery systems

MCHP and MCHP Premium:

See section 3.1(E).

H. 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.

I. Crowd-out

See Section 2.3.

J. 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 2001, your current fiscal year budget, and FFY 2003 projected budget. Please describe in narrative any details of your planned use of funds.

Note: Federal Fiscal Year 2001 starts 10/1/00 and ends 9/30/01).

	Federal Fiscal Year 2001 costs (Actual)	Federal Fiscal Year 2002 (Projected)	Federal Fiscal Year 2003 (Projected)
Benefit Costs			SEE NOTE #1.
Insurance payments			
Managed care	\$ 99,840,373	\$ 136,700,000	
per member/per month rate X # of eligibles			
Fee for Service	32,953,567	34,600,000	
Total Benefit Costs	132,793,940	171,300,000	
(Offsetting beneficiary cost sharing payments)	(10,883)	(2,790,000)	
Net Benefit Costs	132,783,057	168,510,000	
Administration Costs			
Personnel	1,880,020	2,230,000	
General administration	626,673	730,000	
Contractors/Brokers (e.g., enrollment contractors)	2,709,853	3,240,000	
Claims Processing			
Outreach/marketing costs (See Note #2)	4,892,502	7,980,000	
Other			
Total Administration Costs	10,109,048	14,180,000	
10% Administrative Cost Ceiling	14,753,673	18,723,333	
Federal Share (multiplied by enhanced FMAP rate)	92,879,868	118,748,500	
State Share	50,012,237	63,941,500	
TOTAL PROGRAM COSTS	142,892,105	182,690,000	

Note #1: FFY 2003 projected budget will be submitted after the State's budget has been finalized in January, 2002.

Note #2: Outreach/Marketing includes grants to Local Health Departments for eligibility determination.

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2001.

N/A.

4.3 What were the non-Federal sources of funds spent on your CHIP program during FFY 2001?

- 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)	MCHP Premium
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 checked="" 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 checked="" 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 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 <u>9.3 months</u>	Specify months <u>Unknown; no baseline data exist yet</u>
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

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 checked="" 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 checked="" 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 checked="" type="checkbox"/> Yes, specify number of months <u>6</u> What exemptions do you provide? Same as MCHP
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 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>\$38* or \$48** per family per month. *family income above 200% FPL but not above 250% FPL **family income above 250% FPL but not above 300% FPL. The amounts are established based on a formula at 2% of FPL for a family of 2 at 200% FPL and 250% FPL respectively; the actual amounts change each April.</u> Who Can Pay? <input checked="" type="checkbox"/> Employer <input checked="" type="checkbox"/> Family <input checked="" type="checkbox"/> Absent parent <input checked="" type="checkbox"/> Private donations/sponsorship <input checked="" type="checkbox"/> Other (specify) <u>For children enrolled in HealthChoice, the MCHP Premium Case Management Unit invoices the head of</u>

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
		household monthly; no limitation is placed on the head of household's use of the resources above to obtain the funds to pay the monthly contribution, however, the MCHP Premium Case Management Unit interacts only with the head of household regarding payment. For children enrolled in employer-sponsored insurance, the employer deducts the full standard payroll deduction for the selected insurance coverage and the MCHP Premium Case Management Unit's contractor refunds the portion of the premium for the children's coverage in excess of the required \$38 or \$48 contribution.
Imposes copayments or coinsurance	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No Provides secondary insurance for employer-sponsored insurance enrollees to cover co-payments, deductibles, and co-insurance costs for covered services under the employer's plan. <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.

MCHP:

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.

MCHP Premium:

Same as MCHP, except that notices are generated by the MCHP Premium Case Management Unit rather than CARES.

SECTION 6: INCOME ELIGIBILITY

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

6.1 As of September 30, 2001, 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 6 th birthday) 100% of FPL for children aged 6 and above
Medicaid SCHIP Expansion	200% of FPL for children aged 0 through 18 (to 19 th Birthday) ____% of FPL for children aged _____
Separate SCHIP Program	300% of FPL for children aged 0 through 18 (to 19 th birthday) ____% of FPL for children aged _____ ____% of FPL for children aged _____

6.2 As of September 30, 2001, 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	Separate SCHIP Program
Earnings	\$90/month	\$90/month	\$ 90/month
Self-employment	\$actual	\$actual	\$ actual
Alimony payments Received	\$0	\$0	\$ 0
Paid	\$actual	\$actual	\$ actual
Child support payments Received	\$50 per family per month	\$50 per family per month	\$ 50 per family per month
Paid	\$actual	\$actual	\$ actual
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)	\$ actual, not to exceed \$175/month per child (\$200 per month per child if under age 2)
Medical care expenses	\$0	\$ 0	\$ 0
Gifts	\$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.	<p>\$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.</p> <p>The above MCHP Phase I income disregards are deducted from an applicant's gross family income to determine Phase II threshold family income. MCHP Phase II income disregards apply to applicants whose Phase II threshold family income exceeds 235 percent of poverty. For these applicants, family income over 235 percent of poverty but at or below 300 percent of poverty is subtracted from the Phase II threshold family income.</p>

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 _____

Separate SCHIP program 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, 2001?

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 2002(10/1/01 through 9/30/02)? Please comment on why the changes are planned.

A. Family coverage

B. Employer-sponsored Insurance Buy-In

MCHP Premium will assist the employee with buy-in of qualifying employer-sponsored insurance (ESI) for his children, if it is cost-effective to do so and the full employer contribution available is applied to the cost of the family coverage.

C. 1115 waiver

On June 4, 2001, the Department submitted an 1115 waiver request to receive enhanced match for pregnant women with incomes between 185% and 250% FPL.

On November 16, 2001, the Department submitted an 1115 waiver request to maintain current crowd-out provisions in MCHP.

D. Eligibility including presumptive and continuous eligibility

N/A

E. Outreach

The outreach strategy for MCHP Premium will focus on increasing employer participation.

F. Enrollment/redetermination process

The Department will study the feasibility of an interactive, on-line application.

G. Contracting

N/A

H. Other

N/A

Attachments

Attachment A
Provider Network Capacity

Attachment B

Local Health Department Outreach Activities