

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

(Developed by States, for States to meet requirements under Section 2108(b) of the Social Security Act)

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

The following State Evaluation is submitted in compliance with Title XXI of the
Social Security Act (Section 2108(b)).

(Signature of Agency Head)

Date: _____

Reporting Period: FFY98 and FFY99

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SECTION 1. SUMMARY OF KEY ACCOMPLISHMENTS OF YOUR CHIP PROGRAM

This section is designed to highlight the key accomplishments of your CHIP program to date toward increasing the number of children with creditable health coverage (Section 2108(b)(1)(A)). This section also identifies strategic objectives, performance goals, and performance measures for the CHIP program(s), as well as progress and barriers toward meeting those goals. More detailed analysis of program effectiveness in reducing the number of uninsured low-income children is given in sections that follow.

- 1.1 What is the estimated baseline number of uncovered low-income children? Is this estimated baseline the same number submitted to HCFA in the 1998 annual report? If not, what estimate did you submit, and why is it different?

As reported in the 1998 Annual Report, rates of health insurance among children of the Commonwealth appear to be improving as a result of the expansion. A study published in October 1998 by the Commonwealth's Division of Health Care Finance and Policy (DHCFP) entitled "The 1998 Survey of Health Insurance Status of Massachusetts Residents," finds that the number of uninsured residents of the state dropped by 179,000 (29%) from the previous study done in 1995. Contrary to national trends, the study also states that the number of uninsured Massachusetts residents fell from 11.4% of the population to 8.1% of the population during the three-year time period, 1995 to 1998. The study reports that overall 5.3% of children (birth – 18 years) in Massachusetts were uninsured. The same study indicated that among children <200% FPL, 13.2% were uninsured, but that among children >200% FPL, only 1.9% were uninsured.

The January 1999 results of the Urban Institute's National Study of American Families (NSAF) corroborated the findings of the DHCFP survey. The NSAF study found lack of health insurance among 12.8% of children <200% FPL and 2.3% of children > 200% FPL. The NSAF study is considered one of the few that provides reliable estimates in selected states (Massachusetts is one of the study states), as well as for the nation as a whole. Moreover, the survey pays particular attention to low-income families.

As reported in the 1998 Annual Report, the Division measures the impact of its policy on insurance status of Massachusetts children at 0-200% FPL by tracking the changes in the Bureau of Census Current Population Survey ("CPS") report. The baseline is the combined 1995-97 CPS data, which estimates the level and type of insurance of children in three age groups: birth – 6 years of age, 7 – 12 years of age, and 13 – 17 years of age.

In March 1998 the Division provided HCFA with the 1995, 1996 and 1997 merged CPS data which reported the health insurance status of children in Massachusetts by age and income level, as follows:

Uninsured Children

<u>Federal Poverty Level</u>	<u>Age 0-6</u>	<u>Age 7-12</u>	<u>Age 13-17</u>	<u>Age 18*</u>
<u>TOTAL</u>				
0 – 100% FPL	12,738	10,215	9,581	2,072
101-133% FPL	7,985	1,840	5,710	828
134-150% FPL	3,149	266	2,600	353
151-200% FPL	2,338	6,623	9,506	1,410
201-400% FPL	15,016	10,868	15,380	3,544
401%+ FPL	<u>14,055</u>	<u>2,941</u>	<u>4,432</u>	<u>2,607</u>
TOTAL	55,281	32,753	47,210	10,814

Insured Children

<u>Federal Poverty Level</u>	<u>Age 0-6</u>	<u>Age 7-12</u>	<u>Age 13-17</u>	<u>Age 18*</u>
<u>TOTAL</u>				
0 – 100% FPL	92,244	69,043	38,390	4,005
101-133% FPL	32,829	27,732	23,640	1,948
134-150% FPL	14,899	9,679	10,841	1,072
151-200% FPL	39,240	29,630	21,585	2,832
201-400% FPL	194,427	161,942	135,331	17,751
401%+ FPL	<u>178,375</u>	<u>151,055</u>	<u>122,694</u>	<u>32,066</u>
TOTAL	552,013	449,080	352,482	59,674

* Estimate based on CPS and Census

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

DHCFP’s “The 1998 Survey of Health Insurance Status of Massachusetts Residents,” was conducted by the Center for Survey Research (CSR) of the University of Massachusetts. The study was conducted in two phases: 1) from February through July 1998, the CSR conducted over 2600 telephone surveys; 2) during the summer of 1998, an additional 1000 field surveys were conducted, including in-person interviews. In total, the CSR collected health insurance-related information on approximately 10,000 Massachusetts residents.

The NSAF study is a national household survey that provides information on over 100,000 children and non-elderly adults representing the non-institutionalized civilian population under age 65. The NSAF over-samples the low-income population (those with incomes below 200 percent of the federal poverty level [FPL]) and also over-samples the population in 13 states, one of which is the Commonwealth.

The CPS is an annual demographic survey in which over 90 percent of the interview are conducted by telephone. The U.S. Bureau of the Census reduced its sample for surveys conducted in 1997 and later for Massachusetts from approximately 2,200 households (half followed for two years and the other half replaced by a follow-on group which in turn would be followed for two years) to 1,100 households.

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

Both the DHCFP and NSAF studies that took place in Massachusetts point to higher rates of health insurance than the latest available data from the Current Population Survey (CPS). Inconsistencies in the findings may be due to a number of factors such as differences in the time periods in which the data were collected, in sampling technique, and in methodology.

The Division does question the reliability of the CPS data due to its small sample size in Massachusetts. Therefore, the baseline CPS statistics will continue to be compared to CPS data and future studies, such as the DHCFP survey conducted by the CSR at University of Massachusetts and NSAF studies will be used. As well other corroborative evidence such as the reduction in the Uncompensated Care Pool will be reviewed, and the baseline may be adjusted accordingly, as new information becomes available.

- 1.2 How much progress has been made in increasing the number of children with creditable health coverage (for example, changes in uninsured rates, Title XXI enrollment levels, estimates of children enrolled in Medicaid as a result of Title XXI outreach, anti-crowd-out efforts)? How many more children have creditable coverage following the implementation of Title XXI? (Section 2108(b)(1)(A))

With the policy goal of increasing insurance coverage among the residents of the Commonwealth, the Division utilized two mechanisms provided by HCFA to expand eligibility and coverage to children living in low-income families, namely the 1115 Research and Demonstration Waiver and the Title XXI State Plan. Enrollment in these programs can be reported in two different ways: (1) using the Division's unduplicated count of enrollees on a given day (the "Snapshot Report"), and (2) using the format required by HCFA, which reports individuals ever enrolled with a specified quarter or year.

As of December 31, 1999 the 1115 Research and Demonstration Waiver and SCHIP together have a total enrollment of 397,825 children. This represents an increase in enrollment of 90,681 or 30% for all MassHealth children since July 1, 1997. In the Commonwealth's Title XXI State

Plan, the Division estimated covering 37,100 SCHIP eligible children at full enrollment. At the completion of the first quarter of FFY 2000, MassHealth had service 58,437 SCHIP children, as shown in HCFA's Children's Health Program Quarterly Statistical Report for FFY 2000.

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

The Division's enrollment numbers come from the internally prepared Snapshot Report for December 31, 1999. The Snapshot Report provides the actual number of enrollees on a given date.

Additional information came from the HCFA Statistical Report for first quarter FFY 2000, and represents all individuals ever enrolled within a given quarter or year.

1.2.2 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.)

The Division has confidence in its Snapshot Report as it represents all individuals enrolled on a given date.

The Division believes the HCFA Statistical Report numbers are slightly inflated. Under certain circumstances if an individual newly enrolled in MassHealth during the quarter is disenrolled from one coverage type and entered into another during that same quarter, the individual enrollee may be counted in two different benefit programs within a given quarter, and thus be "double counted".

1.3 What progress has been made to achieve the State's strategic objectives and performance goals for its CHIP program(s)?

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

Column 1: List the State's strategic objectives for the CHIP program, as specified in the 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.

For each performance goal specified in Table 1.3, please provide additional narrative discussing how actual performance to date compares against performance goals. Please be as specific as possible concerning your findings to date. If performance goals have not been met, indicate the barriers or constraints. The narrative also should discuss future performance measurement activities, including a projection of when additional data are likely to be available.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		

Table 1.3

<p>Expand access to health coverage for low income uninsured children in the Commonwealth.</p>	<p>Reduce the number of uninsured children in the Commonwealth.</p>	<p>Data Sources: CPS 1999 Data; NSAF Survey; DHCFP Survey</p> <p>Methodology: Decrease the ratio of uninsured children to insured children from 2:3 to 1:9.</p> <p><u>Numerator:</u> Measure 1) Number of uninsured children in the state. Measure 2) Number of insured children in the state.</p> <p><u>Denominator:</u> Measure 1) Total number of children in the state Measure 2) Total number of children in the state</p> <p>Progress Summary: Estimates indicate that the number of uninsured residents of Massachusetts is dropping. The survey conducted by DHCFP in 1998 found that 8.1% of the population are uninsured, while a previous survey conducted in 1995 and cited by DHCFP found 11.4% of the population uninsured. Rates of health insurance among children in Massachusetts appear to be improving as a result of the expansion. The 1998 DHCFP study found the number of uninsured children dropped by 179,000 (29%) from findings of a 1995 study. Overall, 5.3% of children (birth – 18) in Massachusetts were uninsured, while among children <200% FPL, 13.2% were uninsured. The January 1999 Urban Institute’s NSAF study corroborated the findings of the DHCFP survey with a finding that 12.8% of children <200% FPL and 2.3% of children >200% of FPL were uninsured.</p>
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OBJECTIVES RELATED TO CHIP ENROLLMENT

Table 1.3

<p>Develop programs to expand health coverage while maximizing employer-sponsored health insurance to low income children.</p>	<p>Implement MassHealth Family Assistance in state fiscal year 1998.</p>	<p>Data Sources: Insurance Access Investigation Reports Enrollment Snapshot Report</p> <p>Methodology: <u>Measure 1:</u> Comparison of children enrolled in Family Assistance Premium Assistance (FA/PA) with those enrolled in Family Assistance Direct Coverage (FA/DC). <u>Measure 2:</u> Comparison of those in FA/PA who came in insured with those who came in uninsured. <u>Measure 3:</u> Comparison of those in FA/PA who came in uninsured with access to ESI and met the benchmark benefit level with those who came in uninsured with access to ESI and met basic benefit level.</p> <p>Numerator: <u>Measure 1:</u> Children in FA/PA as of February 29, 2000. <u>Measure 2:</u> Children in FA/PA who came in uninsured. <u>Measure 3:</u> Children in FA/PA who came in uninsured and met benchmark benefit level.</p> <p>Denominator: <u>Measure 1:</u> Children in FA/DC as of February 29, 2000. <u>Measure 2:</u> Children in FA/PA who came in insured. <u>Measure 3:</u> Children in FA/PA who came in uninsured and met basic benefit level.</p> <p>Progress Summary : <u>Measure 1:</u> 2,677 children are in FA/PA as of 2/29/00. An additional 14,956 children are in FA/DC, of which 1800 are on time limited status, awaiting the results of the insurance investigation. <u>Measure 2:</u> 601 children in FA/PA came in uninsured. 2,076 children in FA/PA came in insured. <u>Measure 3:</u> 86 children in FA/PA came in uninsured and met the benchmark benefit level. 515 children in FA/PA came in uninsured and met the basic benefit level.</p>
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Table 1.3

OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		
<p>Improve the efficiency of the eligibility determination process.</p>	<p><u>Performance Goal A:</u> Develop a streamlined eligibility process by eliminating certain verifications.</p> <p><u>Performance Goal B:</u> Develop a fully automated eligibility determination process.</p>	<p>Data Sources: Goal A: MassHealth Benefit Request (MBR) application Goal B: MA21 system</p> <p>Methodology: Determine 90% of applicants eligibility status within 15 days receipt of a completed (MBR)</p> <p><u>Numerator:</u> Number of applicants for whom eligibility status is determined within 15 days</p> <p><u>Denominator:</u> Number of MBR applications filed</p> <p>Progress Summary : The average turnaround time in FY99 to process a completed MBR was 2.6 days compared to 3.3 days in FY98.</p>
OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		
<p>N.A.</p>		<p>Data Sources:</p> <p>Methodology:</p> <p>Numerator:</p> <p>Denominator:</p> <p>Progress Summary:</p>
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		

Table 1.3

<p>Improve the health status and well-being of children enrolled in MassHealth direct coverage programs.</p>	<p><u>Performance Goal A:</u> Improve the delivery of well childcare by measuring the number of well child visits and implementing improvement activities as appropriate.</p> <p><u>Performance Goal B:</u> Improve the immunization rates by measuring the rate of immunization administration and implementing improvement activities as appropriate.</p>	<p>Data Sources: HEDIS, Summary Analysis of Clinical Indicators, CDC GPRA initiative.</p> <p>Methodology: <u>Performance Goal A:</u> 1) Mailed PCCs information on frequency standards for well child care visits under EPSDT; 2) developed Children’s Well Visit Schedule Cards for clinicians to distribute to parents to use as reminders for when their children need to visit their PCC for a well visit; 4) updated health care protocols for children in foster care to require a screening visit within 7 days of the child being placed in foster care, with additional visits at age 7 and 9 added for children in foster care, and mailed to all PCC and non-PCC providers likely to see foster children in the Division’s network, both managed care and fee for service Medicaid.</p> <p><u>Numerator:</u> number of MassHealth pediatric members with at least one well child visit in accordance with EPSDT visit requirements</p> <p><u>Denominator:</u> number of EPSDT-eligible children enrolled in MassHealth during FFY98, adjusted for the average period of enrollment during the measurement period.</p> <p>Progress Summary: <u>Performance Goal A:</u> 93.4% of MassHealth pediatric members had at least one visit in accordance with EPDST visit requirements, an increase from the previous year’s rate.</p> <p><u>Performance Goal B:</u> 1) One of 16 states participating in GPRA Initiative to improve immunization rates for 2 year olds. 2) mailing to PCC and non-PCC clinicians on HEDIS rates and GPRA initiative; 3) a comprehensive information to help PCCs understand and be in compliance with immunization requirements, maintain vaccine records, and adhere to Mass. Dept. of Public Health schedules and school requirements was mailed to every PCC as well as distributed to MCO providers through their MCOs. PCC Plan Regional Network Managers also distributed and discussed the packet during their semi-annual meetings with PCCs</p> <p><u>Numerator:</u> # of children received 4 DTP/DtaP, 3 Polio (IPV/OPV), 1 MMR, 3 Hep B, 1 Hib.</p> <p><u>Denominator:</u> # of children who turned 2 in 1997, continuously enrolled in MCO or PPC Plan for 12 months preceding 2nd birthday, with no more than one gap in enrollment up to 45 days.</p> <p>Progress Summary: The baseline GPRA measurement is 64.3% for MassHealth. Remeasurement efforts are currently underway and a new measurement will be available at end of CY2000. The remeasurement will look at the rate at which children who turned 2 in CY99, and met the continuous eligibility requirements described above, received the combination of immunizations listed above.</p>
<p>OTHER OBJECTIVES</p>		

Table 1.3

<p>Coordinate with other health care programs – specifically the state funded Children’s Medical Security Plan (CMSP), to create a seamless system for low income children in need of health care.</p>	<p><u>Performance Goal A:</u> Develop single application for both MassHealth and CMSP. <u>Performance Goal B:</u> Enroll all CMSP members eligible for MassHealth prior to August 24, 1998.</p>	<p>Data Sources: <u>Performance Goal A:</u> application used in MassHealth and CMSP <u>Performance Goal B:</u> CMSP file, MBRs, Enrollment Snapshot Methodology: <u>Performance Goal A:</u> Goal has been met and a single application, the MBR, is in use for both programs. <u>Performance Goal B:</u> 82% of the children on CMSP on 12/31/97 were estimated at or below 200% FPL. Of those, 75% were estimated to be eligible for MassHealth, with a large portion of the remaining only eligible for MassHealth Limited benefits, a program for emergency services only because of immigration status. Numerator: <u>Performance Goal A:</u> NA – goal has been met <u>Performance Goal B:</u> Children on CMSP at or below 200% of FPL who were eligible for MassHealth and who enrolled in MassHealth. Denominator: <u>Performance Goal A:</u> NA – goal has been met <u>Performance Goal B:</u> Number of children on CMSP at or below 200% of FPL who are eligible for MassHealth. Progress Summary: <u>Performance Goal A:</u> MBR, single application in use. <u>Performance Goal B:</u> On July 1, 1997 there were 47,000 children in CMSP, with 82% of them estimated to be at or below 200% of FPL, making 38,540 children income eligible for MassHealth. As of March 12, 2000 there were 26,625 children previously on CMSP who were enrolled in MassHealth. This represents 70% of income eligible children. It is estimated that 5500 children on CMSP are ineligible for MassHealth benefits other than MassHealth Limited because of immigration status. Thus 80% of children on CMSP who were eligible for MassHealth benefits based on income and other factors are estimated to have been enrolled.</p>
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SECTION 2. BACKGROUND

This section is designed to provide background information on SCHIP program(s) funded through Title XXI.

2.1 How are Title XXI funds being used in your State?

Title XXI funds are being used in conjunction with other federal funds, and state funds as described below. The sources of state funds are Cigarette Tax Revenue, General Fund Revenue, and Children's and Seniors' Health Care Fund Revenue. Title XXI and the 1115 Waiver expansions build upon existing coverage types and benefit packages at MassHealth. For the most part, children and their families are served by the same delivery systems of health plans and health providers, regardless of the category of assistance under which they became eligible for MassHealth. There are three coverage types for which Title XXI MassHealth children may be eligible: MassHealth Standard, MassHealth CommonHealth, and MassHealth Family Assistance. The following coverage types describe the benefits for children regardless of whether they are funded under Title XXI or the 1115 Waiver.

1. MassHealth Standard (Medicaid MCHIP Expansion). Eligible children include all under age 19 with family income at or below 150% FPL, and pregnant women and infants less than one year of age with income at or below 200% FPL. Most MassHealth Standard members receive services under managed care arrangements (MCO, PCC and MH/SA). Standard services include Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and unrestricted access to family planning services.
2. MassHealth Family Assistance. Family Assistance provides assistance to families with incomes between 150% and 200% FPL whose children are ineligible for MassHealth Standard or CommonHealth. They can obtain coverage for their children through two mechanisms.
 - Direct Coverage/Purchase of Medical Benefits (State-Designed SCHIP Program). For children under age 19, who do not have access to employer-sponsored health insurance, the Division provides families the opportunity to purchase the MassHealth benefit package for their children under CHIP. The cost to families is no more than \$10 per child or \$30 per family per month. The benefit package is similar to MassHealth Standard but excludes long-term care, day habilitation, private duty nursing, and non-emergency transportation. The services will generally be provided under managed care arrangements (MCO, PCC, MH/SA).
 - Premium Assistance, an Employer-Sponsored Health Insurance Buy-in Program (Other State SCHIP Program). For children under the age of 19 years who have access to employer-sponsored health insurance through a parent where the employer

contributes at least 50% of the cost of the health insurance and meets the benchmark benefit level (equivalent to Harvard Pilgrim Health Plan, the HMO with the largest commercial enrollment in the Commonwealth), the Division provides premium assistance under SCHIP toward the purchase of employer-sponsored health insurance. If the employer sponsored health insurance meets only the basic benefit level, the Division provides premium assistance under the 1115 waiver. The cost to families will generally not exceed \$10 per child or \$30 per family per month. Families chose a health insurance plan from the offerings of the employer. For children who were uninsured prior to coming to MassHealth the Division will pay for all co-payments and deductibles associated with well child visits, as well as pay co-payments and deductibles for all other health services for the eligible children that exceed certain limits. Total out-of-pocket expense to families for premiums, co-payments and deductibles for their children will not exceed 5% of income.

3. MassHealth CommonHealth (Other State SCHIP Program). Disabled children (1-18 yrs.) living in households with incomes greater than 150% FPL, but less than or equal to 200% FPL, get all current MassHealth Standard services. MassHealth CommonHealth is also available to uninsured disabled children with family incomes above 200% FPL based on a sliding fee scale under the Division's 1115 waiver. All CommonHealth children receive their services on a fee-for-service basis from any approved MassHealth provider.

2.1.1 List all programs in your State that are funded through Title XXI. (Check all that apply.)

See Table 9-1 from Title XXI State Plan, submitted as Attachment 1: Title XXI MassHealth Eligibility Standards for composite view of programs

X Providing expanded eligibility under the State's Medicaid plan (Medicaid SCHIP expansion)

Name of program: MassHealth Standard
MassHealth Prenatal

Date enrollment began (i.e., when children and pregnant women first became eligible to receive services):
MassHealth Standard: 10/1/97 (up to or equal to 133% of FPL); and 8/24/98 (above 133% and up to or equal to 150% of FPL)
MassHealth Prenatal: 10/1/97 (up to 185% of FPL), and 8/24/98 (newborns and pregnant women at or below 200% of FPL).

Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (State-designed SCHIP program)

Name of program Family Assistance Direct Coverage –

Date enrollment began (i.e., when children first became eligible to receive services):
Family Assistance Direct Coverage - enrollment began 8/24/98

Other - Family Coverage

Name of program: NA

Date enrollment began (i.e., when children first became eligible to receive services):

Other - Employer-sponsored Insurance Coverage

Name of program: Family Assistance Premium Assistance

Date enrollment began (i.e., when children first became eligible to receive services): 8/24/98

Other - Wraparound Benefit Package

Name of program: none

Date enrollment began (i.e., when children first became eligible to receive services):

___ Other (specify) Disabled___

Name of program CommonHealth

Date enrollment began (i.e., when children first became eligible to receive services): 10/1/97 (no income limits)

2.1.2 **If State offers family coverage:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP programs.

N.A.

2.1.3 **If State has a buy-in program for employer-sponsored insurance:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP programs.

In addition to expanding the health insurance coverage of low-income children in the Commonwealth, the Division has the policy goal of encouraging expansion of employer-sponsored health insurance. The vast majority of poor and near-poor children who lack health insurance coverage qualify for health insurance, but cannot afford the premium.

The Division has chosen to address this gap in insurance by covering eligible children without access to insurance through MassHealth at modest premiums and by subsidizing the purchase of employer-sponsored insurance where available. The route to covering eligible children with access to employer-sponsored insurance is through the purchase of family coverage with a combination of public, employer and employee funds. The latter is designed to:

- provide incentives for families between 150-200% FPL to purchase employer-sponsored health insurance when offered;

- stimulate a cost effective expansion of health insurance coverage for children through the purchase of family coverage that covers children as well as their parents; and,
- help families to receive services from a single health plan.

In many ways, Family Assistance operates in the same way as all MassHealth programs. To establish eligibility, the family fills out an MBR. Upon filing the application with the required documentation of income, time-limited benefits are extended to the children, for up to 60 days, while the Division's contractor performs an insurance investigation on all applicants whose family income is 150-200% FPL. This may result in one of several findings:

- 1) Family actually has employer-sponsored health insurance. If the health insurance meets the basic benefit level**, the family is eligible for premium assistance. (If the employer-sponsored health insurance does not meet the BBL; then the family is not eligible for MassHealth.)
- 2) Family does not have, but has access to health insurance. The family enrolls in an employer-sponsored health insurance that meets the benchmark level* or basic benefit level**, the family is eligible for premium assistance.
- 3) Family has no access to health insurance. Family can purchase MassHealth benefits directly for their children. *

*Title XXI

**1115 Waiver

MassHealth Family Assistance Premium Assistance program is coordinated with other state SCHIP programs through a single application process. Massachusetts has in place a single application for all programs, the Medical Benefits Request (MBR) form. Information from the MBR is entered into the Division computer-based eligibility system, which searches for the richest benefit package available for the child and enrolls them in that coverage type. If the child's family income is greater than 150% the Division investigates the health insurance status of the family and determines whether access to employer sponsored insurance is available. If it is the family is required to enroll. If it is not, the child is enrolled in Family Assistance, Direct Coverage/Purchase of Benefits.

2. What environmental factors in your State affect your CHIP program?
(Section 2108(b)(1)(E))

2.2.1 How did pre-existing programs (including Medicaid) affect the design of your CHIP program(s)?

At the beginning of SFY 1998, the Commonwealth implemented certain provisions of its 1115 Waiver. The 1115 Waiver, approved by HCFA in April 1995 and the state legislature in July 1996 (Chapter 203 of the Acts of 1996), allowed the Division to streamline eligibility requirements and expand benefits to new populations. Under the 1115 Waiver, the Division expanded eligibility to children and parents whose incomes are at or below 133% of the Federal Poverty Level (FPL); pregnant women and newborns under 185% FPL; children with disabilities at or below 200% FPL; and, disabled children in families with incomes above 200% FPL upon payment of a premium (adjusted by family income).

Subsequently the state legislature (Chapter 170 of the Acts of 1997) authorized further expansions of eligibility to children whose family income is at or below 200% FPL. Federal law authorized SCHIP in October 1997 and the Massachusetts legislature approved the SCHIP expansion in November 1997. HCFA approved the Massachusetts SCHIP State Plan in May 1998. Implemented in August 1998, the children's expansion under Title XXI includes the following provisions:

1. Expansion of Title XXI (MassHealth Standard) coverage for uninsured children through age 18 from 133% to 150%.
2. Assistance for uninsured children with family income between 150% and 200% FPL through the age of 18. Families with income above 150% FPL must contribute to the cost of coverage.
3. Presumptive eligibility granted to children in families with self-declared income at or below 200% FPL for up to 60 days to cover health care expenditures while the family supplies additional information and verification as required.
4. Expansion of coverage for pregnant women and their newborns from 185% to 200% FPL.

The 1115 Waiver allows the Division to implement new MassHealth eligibility rules designed to optimize the use of employer-sponsored health insurance, to encourage employers to offer insurance, and to prevent "crowd out" of private health insurance among low income workers. For children who had access to employer-sponsored insurance, Massachusetts uses a combination of 1115 and Title XXI funds to provide coverage through the purchase of family health insurance policies when cost effective. Low-income families who purchased employer-based insurance coverage for their children prior to health reform receive the same benefit (subsidy)

as low income families getting employer-based health insurance for the first time. However, Title XXI program funds will only be used for eligible children who are uninsured. Coverage for children who do not meet SCHIP criteria is provided under the 1115 Waiver or state-only funds.

2.2.2 Were any of the preexisting programs “State-only” and if so what has happened to that program?

No pre-existing programs were “State-only”

One or more pre-existing programs were “State only” ! Describe current status of program(s): Is it still enrolling children? What is its target group? Was it folded into SCHIP?

The Children’s Medical Security Plan (CMSP) was a State-only program that pre-existed SCHIP. This program is administered by the Massachusetts Department of Public Health which is the state’s Title V agency. It provides limited coverage for primary and preventive care for children below 19 (age 18 and under). Upon implementation of the 1115 Waiver in Massachusetts, the two agencies enrolled in MassHealth all of those children in CMSP who were newly eligible for MassHealth under the expanded eligibility guidelines effective July 1, 1997. Subsequently all of those children who were eligible for MassHealth under the expanded eligibility guidelines implemented in August 1998 were also transferred. CMSP and MassHealth use a single application form, and applications for children determined ineligible for MassHealth are automatically forwarded to CMSP for eligibility determination. The Division submits the applications of those children whose family income exceeds 200% of the FPL or who are undocumented aliens to CMSP. CMSP continues to enroll children who are ineligible for MassHealth.

At the time of the initial 1115 Waiver request, the State’s CommonHealth program served two populations – disabled working adults and disabled children who are not eligible for Medicaid. The program required the disabled adult or the parent of the disabled child to purchase health insurance, if available, from an employer. The program also requires the individual or family to make premium payments based on a sliding fee scale that considers gross income, family size, and insurance status. CommonHealth provides indemnity-type, wraparound coverage. If health insurance is not available from an employer, CommonHealth provides coverage and, depending on income, may require the individual or family to pay all or some portion of the CommonHealth premium. The 1115 Waiver obtained HCFA approval for inclusion of CommonHealth as a component of MassHealth and expanded it to include both working and non-working disabled population. The Division claims enhanced federal reimbursement for disabled individuals (See

Section 3.1 for eligibility). Aliens with special status who are otherwise eligible will receive CommonHealth at full state cost. Disabled children (1-18 years) living in households with incomes greater than 150% FPL, but less than 200% FPL, receive all current MassHealth Standard services and are not responsible for paying a share of the premium. MassHealth CommonHealth is also available to uninsured disabled children with family incomes above 200% FPL based on a sliding fee scale.

2.2.3 Describe changes and trends in the State since implementation of your Title XXI program that “affect the provision of accessible, affordable, quality health insurance and healthcare for children.” (Section 2108(b)(1)(E))

Examples are listed below. Check all that apply and provide descriptive narrative if applicable. Please indicate source of information (e.g., news account, evaluation study) and, where available, provide quantitative measures about the effects on your SCHIP program.

 X Changes to the Medicaid program

To create a seamless program of coverage, the Division submitted its Title XXI State Plan along with revisions to the 1115 Waiver Protocol Document. With the approval of these two documents, the state expanded benefits to all low-income children in the Commonwealth. The Title XXI State Plan covers newly eligible children who are uninsured. The newly eligible population includes the children eligible due to the July 1, 1997 expansion and the children eligible with the August 24, 1998 expansion.

On July 1, 1997 the Commonwealth implemented certain provisions of its 1115 Research and Demonstration Waiver (the 1115 Waiver). The 1115 Waiver, approved by the Health Care Financing Administration (HCFA) in April 1995 and the state legislature in July 1996 (Chapter 203 of the Acts of 1996), allowed the Division to streamline eligibility requirements and expand benefits to new populations. Under the 1115 Waiver, the Division expanded eligibility to: children and their parents who are at or below 133% of the FPL; disabled individuals at or below 133%; and long term unemployed adults at or below 133% FPL. Subsequently, Chapter 170 of the Acts of 1997 was enacted allowing the Division to expand eligibility further to children with family income at or below 200% FPL. The children’s expansion under Title XXI was implemented in August 1998 and included the following provisions:

- Expansion of Title XIX (MassHealth Standard) coverage for uninsured children through the age of 18 from the current level at 133% FPL to 150% FPL.
- Implement MassHealth Family Assistance for uninsured children through the age of 18 with family income between 150% FPL and 200% FPL. Families with income above 150% FPL must contribute to the cost of coverage through a premium payment of \$10 per child per month, up to \$30.
- Ensure that children receive the most comprehensive coverage available by limiting eligibility for the state funded Children’s Medical Security Plan (CMSP) to children who are ineligible for MassHealth programs.

- Provide presumptive MassHealth eligibility to children for a limited duration (up to 60 days) to cover health care services required while their MassHealth application is processed.
- Expand MassHealth coverage for pregnant women from 185% FPL to 200% FPL. This provides a continuum of care for all low-income children beginning with comprehensive prenatal care.

Chapter 170 along with the legislation authorizing the implementation of the insurance reimbursement program (Chapter 47 of the Acts of 1997) also allows the Division to implement new MassHealth eligibility rules and provide premium assistance to maximize utilization of employer-sponsored health insurance.

- Presumptive eligibility for children
- Coverage of Supplemental Security Income (SSI) children
- Provision of continuous coverage (specify number of months ____)
- Elimination of assets tests
- Elimination of face-to-face eligibility interviews
- Easing of documentation requirements

Presumptive Eligibility for Children:

A child may be determined presumptively eligible for Standard or Family Assistance through a presumptive eligibility process based on the household’s self declaration of gross income. A child may only be presumptively eligible for MassHealth Family Assistance if he or she has no health insurance coverage at the time of the application.

Presumptive eligibility begins 10 calendar days prior to the date the MBR is received at the MEC and lasts for 60 days or until the Division makes a determination of eligibility, whichever is earlier. A child may receive presumptive eligibility only once in a twelve-month period. Presumptively eligible children in MassHealth Family Assistance are not assessed a monthly health insurance premium.

Elimination of Asset Tests

MassHealth eliminated the asset test for non-institutionalized applicants under 65 years of age as part of its 1115 waiver.

Prior to the Demonstration, verifying and checking an applicant's assets was the most time consuming task involved in processing applications. Since applicants at lower income levels typically have no assets, checking assets was rarely productive for the Division, and may have delayed or discouraged applicants who would have been found eligible.

Elimination of Face-to-Face Eligibility Interviews

MassHealth does not have face-to-face eligibility interviews requirement.

Easing of Documentation Requirements

MassHealth streamlined its application process, including an easing of documentation requirements, such as requiring only 2 pay stubs to document income

 X Impact of welfare reform on Medicaid enrollment and changes to AFDC/TANF
(specify) _____

Massachusetts has increased its Medicaid enrollment even while AFDC/TANF enrollment has decreased. Overall there has been an increase of approximately 40,000 children enrolled in MassHealth since implementation of Title XXI who would have been eligible even in the absence of any expansion activity.

 X Changes in the private insurance market that could affect affordability of or accessibility to private health insurance

 X Health insurance premium rate increases

- Legal or regulatory changes related to insurance
- Changes in insurance carrier participation (e.g., new carriers entering market or existing carriers exiting market)
- Changes in employee cost-sharing for insurance
- Availability of subsidies for adult coverage
- Other (specify)

Health insurance premium rate increases: There have been substantial double digit rate increases in recent years in Massachusetts health insurance premiums. In addition, 3 of the 4 largest insurers in the state have sustained losses in the past year.

Legal or regulatory changes: Prior to implementation of Title XXI, HCFA had previously approved an Insurance Reimbursement Program (now the Insurance Partnership) for Massachusetts. That program was designed to assist individuals and families with incomes at or below 200% of the FPL with purchasing their employer sponsored health insurance. Part of the goal of the IRP is to encourage small employers to provide insurance to their employees. Under the Division's Title XXI State Plan, the Division provides premium assistance payments to those children whose families have access to employer sponsored health insurance if the family has not already purchased that insurance when applying for MassHealth benefits. State legislative changes were implemented to recognize eligibility for MassHealth as a qualifying event that enables an individual to change or enroll in MassHealth independent of an employer's open enrollment period.

Changes in insurance carrier participation: Massachusetts has a fairly stable private group health insurance market. Various market reforms have created a guaranteed issue renewal requirement as well as tight rate bands that are moving the small group market toward a pure community rating. These reforms ensure that health insurance companies may not exclude individuals based on health status nor may individuals be adversely effected economically in purchasing health insurance based on their health status.

All plans offered in the small group market in Massachusetts offer a basic standard set of comprehensive services, including all state mandated benefits. Moreover, because Massachusetts has a high managed care penetration rate, all insurance products offered in the state, whether or not regulated, provide comprehensive benefits in order to be competitive.

Changes in the Employee Cost-Sharing: There has not been significant changes in employee cost-sharing in Massachusetts because of the tight labor market conditions in the state.

Availability of Subsidies: In August 1998 the Insurance Partnership was introduced as part of the 1115 Waiver initiatives. The Insurance Partnership is targeted to families and adults with income at or below 200% of FPL employed by a small business employer. In February 1999 the Division's Insurance Partnership, which offers premium assistance to adults employed by small businesses and incentives for their employers to provide health insurance coverage went into effect. Adults working for qualified small employers purchasing health insurance through a Billing and Enrollment Intermediary (BEI) are eligible for Premium Assistance as part of this initiative. Qualified small employers whose employees participate receive premium assistance through MassHealth are eligible for an incentive payment as part of the Insurance Partnership.

- Changes in the delivery system
- Changes in extent of managed care penetration (e.g., changes in HMO, IPA, PPO activity)
- Changes in hospital marketplace (e.g., closure, conversion, merger)
- Other (specify) _____

As noted above, several of the HMOs have sustained losses in the past several years and premiums have been raised. One HMO left the state during the past year.

- Development of new health care programs or services for targeted low-income children (specify)

- Changes in the demographic or socioeconomic context

There do not appear to have been significant changes in demographics or socioeconomic context during the two and a half years since Title XXI initiatives were implemented in Massachusetts.

- Changes in population characteristics, such as racial/ethnic mix or immigrant status (specify)

- Changes in economic circumstances, such as unemployment rate (specify)

___ Other (specify) _____
___ Other (specify) _____

SECTION 4. PROGRAM ASSESSMENT

This section is designed to assess the effectiveness of your CHIP program(s), including enrollment, disenrollment, expenditures, access to care, and quality of care.

4.1 Who enrolled in your CHIP program?

4.1.1 What are the characteristics of children enrolled in your CHIP program? (Section 2108(b)(1)(B)(i))

Please complete Table 4.1.1 for each of your CHIP programs, based on data from your HCFA quarterly enrollment reports. Summarize the number of children enrolled and their characteristics. Also, discuss average length of enrollment (number of months) and how this varies by characteristics of children and families, as well as across programs.

States are also encouraged to provide additional tables on enrollment by other characteristics, including gender, race, ethnicity, parental employment status, parental marital status, urban/rural location, and immigrant status. Use the same format as Table 4.1.1, if possible.

Please Note: The Mathematica analysis of our HCFA statistical reports has brought to light the fact that we have some systems programming problems in capturing the number of disenrollees. We plan to correct these problems, rerun our data and resubmit the 2 years worth of HCFA statistical reports. We believe the other data we have submitted is accurate.

Characteristics	Number of children ever enrolled		Average number of months of enrollment	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children	9,240	43,444	3.4	6.9

Age				
Under 1	59	133	1.8	6.1
1-5	1,435	7,728	2.2	4.3
6-12	3,668	14,137	2.3	7.2
13-18	4,078	21,446	4.8	7.7
Countable Income Level*				
At or below 150% FPL	8,900	40,144	3.3	7.2
Above 150% FPL	340	3,330	4.8	3.1
Age and Income				
Under 1				
At or below 150% FPL	8	38	2.1	1.1
Above 150% FPL	51	95	1.8	8.1
1-5				

At or below 150% FPL	1,370	6,562	2.1	4.7
Above 150% FPL	35	1,166	5.1	2.4
6-12				
At or below 150% FPL	3,550	12,882	2.2	7.6
Above 150% FPL	118	1,255	5.3	3.1
13-18				
At or below 150% FPL	3,972	20,662	4.7	7.8
Above 150% FPL	106	784	5.4	3.8
Type of plan				
Fee-for-service	2,068	3,174	2.9	7.4
Managed care	1,072	12,419	6.3	6.7
PCCM	6,100	27,851	3.0	7.0

*Countable Income Level is as defined by the states for those that impose premiums at defined levels other than 150% FPL. See the HCFA Quarterly Report instructions for further details.

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose “select” “table.” Once the table is highlighted, copy it by selecting “copy” in the Edit menu and then “paste” it under the first table.

Table 4.1.1 S-SCHIP Program Type _____

Characteristics	Number of children ever enrolled		Average number of months of enrollment	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children	8,218	24,408	1.6	6.6
Age				
Under 1	12	80	2.0	<0.1
1-5	2,426	7,063	1.8	6.5
6-12	3,609	10,258	1.6	6.8
13-18	2,171	7,007	1.5	6.3
Countable Income Level*				
At or below 150% FPL	2,556	2,176	1.7	3.1
Above 150% FPL	5,662	22,232	1.5	6.9
Age and Income				
Under 1				

At or below 150% FPL	0	4	-	0.0
Above 150% FPL	12	76	2.0	<0.1
1-5				
At or below 150% FPL	2,426	638	1.8	3.1
Above 150% FPL	0	6,425	-	1.8
6-12				
At or below 150% FPL	86	924	1.5	3.3
Above 150% FPL	3,523	9,334	1.6	6.8
13-18				
At or below 150% FPL	44	610	1.5	2.7
Above 150% FPL	2,127	6,397	1.5	6.7
Type of plan				
Fee-for-service	1,735	1,056	1.4	6.7
Managed care	345	4,211	2.7	6.3

PCCM	6,138	19,141	1.6	6.6
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SOURCE: HCFA Quarterly Enrollment Reports, Forms HCFA-21E, HCFA-64.21E, HCFA-64EC, HCFA Statistical Information Management System, October 1998

4.1.2 How many CHIP enrollees had access to or coverage by health insurance prior to enrollment in CHIP? Please indicate the source of these data (e.g., application form, survey). (Section 2108(b)(1)(B)(i))

Massachusetts does not have a look back program as part of its MassHealth Demonstration or its Title XXI plan. Access is in accordance with definition in Table 3.1.1.

A key goal for the Division in constructing its Title XXI program, was to ensure that it complimented the MassHealth expansion program, as defined in the 1115 waiver and state legislation. In April 1995, the US Department of Health and Human Services (DHHS) approved a five-year Medicaid research and demonstration project for the Massachusetts Division of Medical Assistance (the Division) under authority of section 1115 of the Social Security Act. The state legislature then passed enabling legislation for the MassHealth demonstration, Chapter 203 of the Acts and Resolves of 1996 (“An Act Providing Improved Access to Health Care”) in July 1996. A special legislative commission was then convened to consider the Insurance Reimbursement Program (IP). The IP aspect of the Demonstration was incorporated in legislation in Chapter 47 of the Acts and Resolves of 1997 (“An Act to Assist in Making Health Care Available to Low Income Uninsured and Underinsured Residents of the Commonwealth”) passed in July 1997. This legislation authorized premium assistance to eligible families. Subsequently, Chapter 170 of the Acts and Resolves of 1997 (“An Act Expanding Access to Quality Health Care for Working Families, Children and Senior Citizens in the Commonwealth”), passed in November 1997. This legislation provided for the expansion of MassHealth up to 200% of the federal poverty level (FPL) for certain adults, children, pregnant women, and newborns.

Children in families with income at or below 150% of the FPL who are eligible are provided with coverage in MassHealth Standard. Those who were uninsured at the time of their submission of a MBR application to MassHealth are funded under provisions of Title XXI while those who were insured at the time of application are covered under provisions of the MassHealth Demonstration 1115 Waiver.

If a child is in a family with income above 150% of the FPL and meets the eligibility requirements for Family Assistance and is currently uninsured but has access to employer sponsored insurance (ESI) coverage, the Division may cover the family through MassHealth Family Assistance Premium Assistance. During the eligibility determination period, the Division will conduct an investigation of an applicant's access to ESI coverage. If the benefits are determined to meet the benchmark benefit level and it is cost effective for the Division, the family is instructed to enroll in a family plan through their employer and the family will either be reimbursed directly by DMA for their share of the cost of premium participation or DMA will pay the employer for the family's share of the premium on behalf of the family. The children covered through this premium assistance payment are CHIP children.

If the children in the family meet the eligibility requirements for Family Assistance and currently have insurance coverage that meets the basic benefit level as defined in accordance with the 1115 Waiver, the Division will provide MassHealth Family Assistance Premium Assistance to this family. These families are eligible for coverage under the Division's 1115 Demonstration Project and are not CHIP children.

As of February 2000 2,677 children were eligible for SCHIP were receiving premium assistance for health insurance through an employer sponsored health plan. Of these, 601 children were uninsured when they applied for benefits and had access to ESI, while the remaining 2076 were insured when they applied. Of the 601 who were uninsured, 86 had access to ESI that met the benchmark benefit level and are covered under Title XXI. 515 of those children who were uninsured had access to ESI that met the basic benefit level and were therefore covered under the 1115 Waiver. Additionally, 1800 uninsured children are enrolled in Family Assistance Direct Coverage on a time limited basis while an investigation of their access to ESI is conducted.

In addition to the number of children that Massachusetts has been able to enroll in health coverage as a result of the implementation of Title XXI, when looked at from the perspective of covered lives there are additional individuals who have received health coverage as a result of this initiative. Uninsured children in families with access to ESI are eligible for premium assistance and accordingly their parents are required to purchase family coverage through their employer in order to provide their children with coverage. As a result of purchasing a family plan, the parents are also covered. Therefore, when the impact of the Massachusetts program is assessed it is important to note that 1400 family policies have been purchased, covering a total of 5,233 individuals. This number includes the 2,677 children noted above and an additional 2,556 other family members.

In comparing the number of children receiving Family Assistance Direct Coverage Purchase of Benefits with those receiving Family Assistance Premium Assistance it is important to note that when Title XXI was implemented there were a large number of children on

the state funded Children's Medical Security Plan (see Section 2.2.2). This population was uninsured and targeted for enrollment in MassHealth as soon as the program began. All of the children from CMSP were enrolled in Family Assistance Direct Coverage under the assumption that it was unlikely that they would have had access to employer sponsored insurance, which was confirmed by initial investigations of the insurance status of this group.

4.1.3 What is the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children? (Section 2108(b)(1)(C))

MassHealth Demonstration: As summarized above in 4.1.2. in designing its MassHealth Demonstration initiative, the Division constructed a continuum to provide health coverage to both insured and uninsured children and adults with income at or below 200% of FPL. Overall, there has been significant growth in the number of children who are insured as a result of the Demonstration. As of December 31, 1999 there were a total of 397,825 children in MassHealth, an increase of 91,364 children, or 30% growth.

This increase includes both children eligible for MassHealth through the 1115 Demonstration waiver rules and through the Title XXI State Plan provisions. Not all of the children newly found eligible for MassHealth are funded through Title XXI. MassHealth expansion activities have been targeted to both CHIP eligible children and children eligible under the 1115 Waiver and include activities for outreach, marketing and other efforts directed toward increasing children's enrollment, and have also resulted in increased enrollment in the traditional Medicaid population.

Thus, MassHealth outreach efforts have been successful in enrolling three groups of children: those who would have otherwise been eligible for MassHealth, those who were eligible as a result of the expansion provision in the 1115 Waiver, and those who are eligible under Title XXI. (The distinguishing characteristic of children eligible for Title XXI from some of the children eligible under provisions of the 1115 Waiver is that children eligible for Title XXI are uninsured when they apply for benefits, while those receiving coverage under the 1115 Waiver may be insured when they apply for benefits.)

The following is a summary of the increase in the number of children enrolled in those 3 MassHealth programs:

MassHealth Programs	6/15/97	9/30/98	9/30/99	12/21/99
Otherwise eligible	304,695	328,042	343,497	339,844
1115 Waiver Expansion	1,768	10,063	6,071	6,808
Title XXI	0	17,436	49,778	51,173
Total	306,463	355,541	399,346	397,825

Children’s Medical Security Plan (CMSP): CMSP is administered by the Massachusetts Department of Public Health and provides limited coverage for primary and preventive health care for children under age 19. Any child 18 or under who is not enrolled in MassHealth is eligible for CMSP. Families contribute toward the CMSP premium based on family size and income, with families below 200% of FPL not required to contribute to the premium. Families with income between 200% and 400% of FPL must pay a premium of \$10.50 per child per month, up to a maximum of \$31.50 per family per month. Families with incomes greater than 400% of the FPL must pay a premium of \$52.50 per child per month.

As of July 1997 there were approximately 47,000 children enrolled in CMSP, with 82% of them under 200% of FPL, 17% with income between 201% and 400% of FPL, and 1% over 400%. Of the estimated 38,540 who were <200% of FPL 26,625 were enrolled in MassHealth, which is in accordance with the Massachusetts Department of Public health estimate that 70% of those on CMSP below 200% were eligible for MassHealth based on income and other characteristics.

There is also evidence of the impact that MassHealth expansion is having on reducing the number of uninsured in the state through the reduction of hospital claims to the state’s uncompensated care pool. Between SFY96 and SFY98 the hospitals’ allowable claims to the uncompensated care pool have decreased by over 16%, resulting in a \$78.2 million dollar reduction in hospital claims.

4.2 Who disenrolled from your CHIP program and why?

- 4.2.1 How many children disenrolled from your CHIP program(s)? Please discuss disenrollment rates presented in Table 4.1.1. Was disenrollment higher or lower than expected? How do CHIP disenrollment rates compare to traditional Medicaid disenrollment rates?

At the end of FFY98 a total of 355 SCHIP children had disenrolled. At the end of FFY99, a total of 8585 SCHIP children had disenrolled. A preliminary analysis of the basis for these children's disenrollment has been conducted by CMER. This assessment is occurring in conjunction with a larger evaluation that CMER is conducting for the Division on a number of aspects of the MassHealth Demonstration related to enrollment and redetermination, including the impact of redetermination, presumptive eligibility and premium cost share on disenrollment rates.

The Division and the Center for MassHealth Evaluation and Research at University of Massachusetts Medical School are working with Health Care for All to understand the full range of implications resulting from the presumptive eligibility process, and ways to improve it. Key issues under review include:

- How well is presumptive eligibility working?
- Is presumptive eligibility meeting the goals of providing immediate access to coverage?
- How many of those found presumptively eligible become MassHealth members?
- Are there discernable trends in the response to presumptive eligibility termination notices?
- Are there differences in characteristics among those who responded to notices from those who did not?
- What is the financial impact of presumptive eligibility policy on state, 1115, and Title 21 funding?

Among the issues CMER is assessing is the rate of voluntary disenrollment from S SCHIP and whether premiums are a barrier that is causing that rate. What was surprising in the preliminary assessment conducted to complete Table 4.2.1 was the high number of voluntary disenrollments from M SCHIP, since individuals in this program do not pay a share of premium costs.

Also shown on Table 4.2.1 are the number of children disenrolled from SCHIP for failure to pay premiums, which represents about 7% of all of those enrolled in SCHIP programs.

4.2.2 How many children did not re-enroll at renewal? How many of the children who did not re-enroll got other coverage when they left CHIP?

Massachusetts does not have a renewal process. However, an annual redetermination of eligibility is conducted. As a result of the redetermination process, 418 SCHIP children were disenrolled in FFY99, either because there was no response to requests for

information in conjunction with the redetermination process, or they did not provide the required verifications needed to redetermine eligibility.

4.2.3 What were the reasons for discontinuation of coverage under CHIP? (Please specify data source, methodologies, and reporting period.)

Table 4.2.3 FFY98 Total Caseload: 33,567								
Reason for Discontinuation of Coverage	Medicaid CHIP Expansion Program		State CHIP Program Family Assistance Direct Coverage		State CHIP Program Fam Assistance Premium Assistance		CommonHealth	
	Total Caseload							
	Number Dis-enrolled	% of total Caseload	Number Dis-enrolled	% of total Caseload	Number Dis-enrolled	% of total Caseload	Number Dis-enrolled	% of total Caseload
Total	323	.012%	2	.0003%	0	0	30	.059%
Access to Commercial Insurance	0	0	0	0	0	0	0	0
Eligible For Medicaid	30	.0011%	0	0	0	0	1	.0019%
Income too high	33	.0011%	0	0	0	0	0	0
Aged out of Program	2		0	0	0	0	0	0
Moved/Died	3		0	0	0	0	0	0
Non-payment of Premium	0	0	0	0	0	0	0	0
Incomplete Documentation	30	.0011%	0	0	0	0	15	.029%
Did not reply/unable to contact	27	.0010%	0	0	0	0	1	.0019%
Other: Voluntary	89	.003%	2		0	0	9	.017%

Withdrawal								
Other: Presumptive Eligibility Expired	0	0			0	0	0	0
Other: non specified	109	.004			0	0	4	.007%

*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

Table 4.2.3 FFY99 Total Caseload: 69,457								
Reason for Discontinuation of Coverage	Medicaid CHIP Expansion Program		State CHIP Program Family Assistance Direct Coverage		State CHIP Program Fam Assistance Premium Assistance		CommonHealth	
	Number Dis-Enrolled	% of total Caseload	Number Dis-Enrolled	% of total Caseload	Number Dis-enrolled	% of total Caseload	Number Dis-Enrolled	% of total Caseload
Total Caseload	49,785	71.6%	19,013	27%	75	.001%	584	.008%
Total	6,184	.12%	2,361	.12%	2	.026%	38	.065%
Access to Commercial Insurance	66	.0013%	256	10%	0	0	1	0
Eligible For Medicaid	636	.012%	94	4%	0	0	5	.008%
Income too high	665	.013%	302	13%	0	0	0	0
Aged out of Program	40	.008%	37	1.5%	0	0	0	0
Moved/Died	262	.005%	57	2%	0	0	6	.010%
Non-payment	4	.00008%	871	37%	0	0	8	.013%

of Premium								
Incomplete Documentation	564	.011%	43	1.8%	0	0	0	0
Did not reply/unable to contact	370	.007%	135	6%	1	0	0	0
Other: Voluntary Withdrawal	646	.013%	531	22%	1	0	9	.015%
Other: Presumptive Eligibility Expired	2837* includes children in all programs	.056%	0	0	0	0	0	0
Other: non specified	111	.002%	35	1.5%	0	0	0	0

4.2.4 What steps is your State taking to ensure that children who disenroll, but are still eligible, re-enroll?

Several targeted efforts are underway to increase response from families notified that their eligibility is being redetermined in accordance with regulations, and that they must provide information as requested. The new activities being taken to increase response rates by families include: a series of 4 letters are being sent, a self addressed envelop is being added, and phone calls are being made. In addition, the Division is looking into a computer generated form that indicates current information about the family and requires that they correct any information that has changed, sign the form and return it to DMA. It is expected that this will increase compliance because the information is already on the form and only erroneous information needs to be corrected.

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

- A profile of the characteristics of people who drop out of the program is being compiled. The profile will be reviewed to determine if there are characteristics that can be used to define any groups who then can be contacted for either participation in a focus group activity or individual survey to identify program barriers.
- an assessment of premium collection and whether premiums are a barrier to participation in the program.
- minigrant activity that provides community based support for outreach and helps to identify those who may be eligible and help them enroll as well as help those who are enrolled maintain eligibility.

4.3 How much did you spend on your CHIP program?

4.3.1 What were the total expenditures for your CHIP program in federal fiscal year (FFY) 1998 and 1999?

FFY 1998 _____\$8,849,900_____

FFY 1999 _____\$45,105,563_____

Please complete Table 4.3.1 for each of your CHIP programs and summarize expenditures by category (total computable expenditures and federal share). What proportion was spent on purchasing private health insurance premiums versus purchasing direct services?

32% (includes MCO capitation payments) and an additional \$27,733 has been expended on Family Assistance Premium Assistance. The totals do not include children in Premium Assistance who will be claimed in March 2000. In addition, the Division will be applying claims for those in PE and found ineligible to the 10% allotment.

Table 4.3.1 CHIP Program Type: Title XIX Expansion (1905 U2/U3)				
Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures	\$8,849,900	\$37,244,798	\$5,752,483	\$24,209,118
Premiums for private health insurance (net of cost-sharing offsets)*	\$2,044,329	\$11,804,515	\$1,328,832	\$7,672,934
Fee-for-service expenditures (subtotal)	\$6,805,571	\$25,440,283	\$4,423,621	\$16,536,184
Inpatient hospital services	\$1,544,768	\$4,526,331	\$1,004,099	\$2,942,115
Inpatient mental health facility services	\$ 305,583	\$ 377,231	\$ 198,629	\$ 245,200
Nursing care services	\$ 144	\$ 1,597	94	\$ 1,038

Physician and surgical services	\$ 802,133	\$3,840,939	\$ 521,388	\$2,496,610
Outpatient hospital services	\$1,066,293	\$4,060,039	\$ 693,085	\$2,639,025
Outpatient mental health facility services	\$ 2,097	\$ 7,814	\$ 1,363	\$ 5,079
Prescribed drugs	\$ 685,363	\$ 3,089,601	\$ 445,491	\$2,008,241
Dental services	\$ 553,274	\$2,595,891	\$ 359,641	\$1,687,329
Vision services	\$ 36,335	\$ 188,156	\$ 23,619	\$ 122,301
Other practitioners' services	\$ 4,342	\$ 13,955	\$ 2,822	\$ 9,071
Clinic services	\$ 218,490	\$ 723,337	\$ 142,023	\$ 470,170
Therapy and rehabilitation services				
Laboratory and radiological services	\$ 31,826	\$ 119,755	\$ 20,687	\$ 77,841
Durable and disposable medical equipment	\$ 601,687	\$ 3,884,372	\$ 391,103	\$ 2,524,842
Family planning				
Abortions				
Screening services	\$ 25,789	\$ 115,005	\$ 20,687	\$ 74,753

Home health	\$ 500,307	\$ 419,329	\$ 391,103	\$ 272,564
Home and community-based services	\$ 289,194	\$ 779,838	\$ 187,976	\$ 506,895
Hospice	\$ 3,461	\$ 546	\$ 2,249	\$ 355
Medical transportation	\$ 30,289	\$ 122,867	\$ 19,689	\$ 79,866
Case management	\$ 104,198	\$ 547,670	\$ 67,728	\$ 355,986
Other services		\$ 26,010		\$ 16,906

Table 4.3.1 CHIP Program Type: State Chip				
Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures		\$7,860,765		\$5,109,497
Premiums for private health insurance (net of cost-sharing offsets)*		\$2,395,510		\$1,557,082

Fee-for-service expenditures (subtotal)		\$5,465,255		\$3,552,415
Inpatient hospital services		\$ 691,051		\$ 449,183
Inpatient mental health facility services		\$ 21,120		\$ 13,728
Nursing care services		\$ 267		\$ 174
Physician and surgical services		\$ 1,179,910		\$ 766,942
Outpatient hospital services		\$ 1,176,195		\$ 764,527
Outpatient mental health facility services		\$ 734		\$ 477
Prescribed drugs		\$ 823,653		\$ 535,375
Dental services		\$ 627,958		\$ 408,173
Vision services		\$ 43,281		\$ 28,133
Other practitioners' services		\$ 2,345		\$ 1,524
Clinic services		\$ 178,224		\$ 115,846
Therapy and rehabilitation services				

Laboratory and radiological services		\$ 23,783		\$ 15,459
Durable and disposable medical equipment		\$ 612,395		\$ 398,057
Family planning		\$ 11,737		\$ 7,629
Abortions				
Screening services		\$ 38,531		\$ 25,045
Home health		\$ 23,023		\$ 14,965
Home and community-based services				
Hospice				
Medical transportation		\$ 11,048		\$ 7,181
Case management				
Other services				

4.3.2 What were the total expenditures that applied to the 10 percent limit? Please complete Table 4.3.2 and summarize expenditures by category.

What types of activities were funded under the 10 percent cap? A limited amount of outreach and administrative costs related to the general operations of the Medicaid program.

What role did the 10 percent cap have in program design? It caused us to report presumptive eligibility expenditures after an eligibility determination was made.

Table 4.3.2						
Type of expenditure	Medicaid Chip Expansion Program **		State-designed CHIP Program***		Other CHIP Program*	
	FY 1998	FY 1999	FY 1998	FY 1999	FY 1998	FY 1999
Total computable share				\$498,298		
Outreach				\$ 2,990		
Administration				\$495,308		
Other _____						
Total Federal share				\$323,894		
Outreach				\$ 1,994		
Administration				\$321,950		

Other						
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*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

** Medicaid CHIP Expansion administrative costs are reported at regular Medicaid matching rates.

*** Includes only 9/99 administrative costs. Additional administrative costs related to FFY 99 will be claimed in FY 2000.

4.3.3 What were the non-Federal sources of funds spent on your CHIP program (Section 2108(b)(1)(B)(vii))

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

4.4 How are you assuring CHIP enrollees have access to care?

What processes are being used to monitor and evaluate access to care received by CHIP enrollees? Please specify each delivery system used (from question 3.2.3) if approaches vary by the delivery system within each program. For example, if an approach is used in managed care, specify ‘MCO.’ If an approach is used in fee-for-service, specify ‘FFS.’ If an approach is used in a Primary Care Case Management program, specify ‘PCCM.’

Table 4.4.1				
Approaches to monitoring access***	Medicaid CHIP Expansion Program*	State-designed CHIP Program* Family Assistance Direct Coverage	Other CHIP Program** _Employer Sponsored Health Insurance/ Premium Assistance_	Other CHIP Program CommonHealth
Appointment audits	X	X		
PCP/enrollee ratios	X	X		
Time/distance standards	X	X		
Urgent/routine care access standards	X	X		
Network capacity reviews (rural providers, safety net providers, specialty mix)	X	X		
Complaint/grievance/ Disenrollment reviews	X	X		
Case file reviews	X	X		
Beneficiary surveys	X	X		
Utilization analysis (emergency room use, preventive care use)	X	X		
Other (specify) _____				
Other (specify) _____				

Other (specify) _____				
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*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

**Approaches with X are used by MCO, PCC Plan and FFS Medicaid.

***The Division is developing a survey for those in ESI to see their levels of satisfaction with access.

4.4.2 What kind of managed care utilization data are you collecting for each of your CHIP programs? If your State has no contracts with health plans, skip to section 4.4.3.

Table 4.4.2				
Type of utilization data	Medicaid CHIP Expansion Program	State- designed CHIP Program Family Asst. Direct Coverage	Other CHIP Program *** Employer Sponsored_ Health Insurance/ Premium Assistance_ _____ ____	OTHER CHIP Common- Health
Requiring submission of raw encounter data by health plans**	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Requiring submission of aggregate HEDIS data by health plans	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Other (specify) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

**For MCO contracted plans, summary level data is being collected on 17 minimum data set indicators

***Many of the MCOs that employers offer to their employees participate in Commercial HEDIS assessments.

4.4.3 What information (if any) is currently available on access to care by CHIP enrollees in your State? Please summarize the results.

Access to care for Title XXI children enrolled in direct coverage/purchase of benefits is monitored in accordance with the process and procedures established for members of MassHealth Demonstration. These include provisions for processes and standards included in MCO contracts as well as with the NMS vendor for their work with the PCC Plan providers.

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

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

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

4.4.4 What plans does your CHIP program have for future monitoring/evaluation of access to care by CHIP enrollees? When will data be available?

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

4.5 How are you measuring the quality of care received by CHIP enrollees?

4.5.1 What processes are you using to monitor and evaluate quality of care received by CHIP enrollees, particularly with respect to well-baby care, well-child care, and immunizations? Please specify the approaches used to monitor quality within each delivery system (from question 3.2.3). For example, if an approach is used in managed care, specify ‘MCO.’ If an approach is used in fee-for-service, specify ‘FFS.’ If an approach is used in primary care case management, specify ‘PCCM.’

Table 4.5.1

Approaches to monitoring quality	Medicaid CHIP Expansion Program	State-designed CHIP Program Family Assistance/Direct Coverage	Other CHIP Program Employer Sponsored Health Insurance Premium Assistance	Other CHIP Program CommonHealth
Focused studies (specify)	X	X	X	
Client satisfaction surveys	X	X	X	
Complaint/grievance/disenrollment reviews	X	X		
Sentinel event reviews	X	X		

Plan site visits	X	X		
Case file reviews	X	X		
Independent peer review	X	X		
HEDIS performance measurement	X	X		
Other performance measurement (specify)				
Other (specify) _____				
Other (specify) _____				
Other (specify) _____				

*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

The Health Plan Employer Data and Information Set (HEDIS) is a standardized measurement and reporting strategy for health plans and managed care organizations, directed by the National Committee for Quality Assurance (NCQA). The Division of Medical Assistance (the Division) uses a subset of HEDIS measures on a rotating basis to assess the performance of the contracted capitated Managed Care Organizations, and the PCC Plan. The Division’s rotation-of-measures strategy continues to evolve.

The Division conducts an annual MassHealth Member Survey for the purpose of eliciting member feedback in a number of areas including availability and access to services, utilization and experience with health services, as well as member satisfaction with the services delivered by their health plan or provider. The Division uses the information to identify and develop opportunities for improvement.

1998-1999 Member Survey: The most recent MassHealth Managed Care Member Survey (1998-99) was conducted for the Division by the Center for Survey Research at the University of Massachusetts (Boston) using the Consumer Assessment of Health Plans Survey (CAHPS) instrument.

4.5.2 What information (if any) is currently available on quality of care received by CHIP enrollees in your State? Please summarize the results.

The Division employs a variety of methods to monitor the quality of its health plans and member satisfaction. For example, the Division incorporates specific quality standards into its MCO contracts. The Division also applies HEDIS measures to all managed care plans to assess clinical quality. In addition, the Division conducts an extensive survey of members of all plans to ascertain levels of satisfaction and to identify areas in need of improvement.

The quality management activities for the PCC Plan are derived from goals developed by the Division and by the PCC Plan. Relevant data from plan operations guide the development of plan goals. Among the sources of information are aggregate PCC data, HEDIS measures and the MassHealth Member Survey. After analyzing baseline data from these sources, PCC Plan improvement goals are set. The goals for the PCC Plan for SFY99 focused on improvements in asthma care, well childcare, cancer screening for women, and decreasing non-emergency care in emergency rooms.

The MCO program continues to focus its quality improvement and measurement activities in four areas: MCO contract status meetings, member satisfaction surveys, Health Employer Data and Information Set (HEDIS) measures, and MCO clinical topic reviews. HEDIS and member satisfaction survey activities for the MCO Program are conducted in conjunction with the PCC Plan and Behavioral Health Partnership.

4.5.3 What plans does your CHIP program have for future monitoring/evaluation of quality of care received by CHIP enrollees? When will data be available?

Similar to the Division's approach for monitoring and evaluating access, the quality of care received by children in MassHealth is monitored and evaluated in a number of ways as described in 4.5.2 above. The quality of care received by children enrolled through

CHIP is not distinguished from that received by children enrolled through Title XIX or provisions of the 1115 Waiver in those monitoring and evaluating activities.

4.6 Please attach any reports or other documents addressing access, quality, utilization, costs, satisfaction, or other aspects of your CHIP program's performance. Please list attachments here.

- See Attachment 4 for copy of Executive Summary of 1999 HEDIS Report.

Section 5. Reflections

5.1.1. Eligibility Determination/Redetermination and Enrollment

The overall philosophy guiding Massachusetts' Title XXI design has worked well. The goal of designing a program that built upon existing initiatives, i.e. Medicaid expansion and the 1115 Waiver Demonstration, and was coordinated with other state initiatives such as the Children's Medical Security Plan (CMSP), has been effective. A single application, the MBR, is used to determine eligibility for all MassHealth benefits and is also used by CMSP. The process for determining eligibility was also streamlined and is used for all MassHealth program types. This has created operational efficiencies, not only for Medicaid programs but also for Title XXI that has benefited from development of an eligibility determination system and process that can be shared across all program areas. The asset test was eliminated in favor of an income test. Applications can be mailed in. The average turnaround time in SFY99 to process a completed MBR was 2.6 days compared to 3.3 in SFY98. In total, it generally takes an average of 5 days from the date a person mails in an application to the date when they are notified of their eligibility status (this includes those being notified that additional information is needed). The streamlining has also been effective in that one system determines eligibility both initially and for redetermination.

Massachusetts is one of 5 states that have instituted presumptive eligibility. As a result of the experience to date with presumptive eligibility the Division is looking at whether the policy decision and goal to implement a presumptive eligibility system to get coverage to children as early as possible is working as intended. Among the issues being assessed is whether those made presumptively eligible are actually eligible for the program. In addition we are assessing whether individuals made presumptively eligible were in fact within income and other requirements. As well we are looking at whether individuals in PE are responding to verification requirements.

Additionally, we are also assessing the following: whether presumptive eligibility is meeting the goals of providing immediate access to coverage, how many of those found presumptively eligible become MassHealth members, whether there discernable trends in the response rates to presumptive eligibility notices sent to inform members of the verifications needed within 60 days in order to continue coverage, and whether there are differences in characteristics among those who responded to notices from those who did not. Finally we are assessing what the financial impact of presumptive eligibility is on the state, 1115, and Title 21 funding.

5.1.2. Outreach

A single eligibility system has been put into place that utilizes the same outreach workers and community based organizations are used for all MassHealth programs. As a result efficiencies in marketing costs have also been realized, since marketing can occur under the single, unified banner of MassHealth for Title XIX expansions, the 1115 Waiver and Title XXI.

The Division's primary customer is the MassHealth member, and the Division developed the Member Services Unit as an embodiment of that philosophy. Outreach to potential MassHealth eligibles is a multi-pronged effort. DMA employs 27 out-stationed workers who rotate their time among 140 outreach sites statewide, including hospitals and community health centers, to support outreach efforts. Out-stationed outreach workers are also available, upon request, to meet with families as well as small groups that often serve as support groups for families with children with special needs, to explain MassHealth benefits, eligibility and the application process. The Division employs a number of outreach strategies to reach MassHealth eligible families and individuals as summarized in Section 3.4. of the Framework response.

5.1.3. Benefit Structure

MassHealth expansion and Title XXI initiatives are based on the same benefit structure, with a few exceptions in Family Assistance Direct Coverage.

The uniformity of benefits in MassHealth among the Medicaid expansion, 1115 Waiver Demonstration and Title XXI initiative has been very important in outreach activities and in marketing the benefits of MassHealth to a multi-dimensional population without

having to segment messages for different eligibility sectors. This ability to widely target different population groups under the broad MassHealth banner has increased the efficiency with which marketing and outreach activities are offered.

In another area, however, the Division is reassessing the effectiveness of its current approach to determining whether employer sponsored health insurance (ESI) meets the benchmark standard. Based on experience to date the Division is concerned that ESI policies that were in essence equivalent to the benchmark were excluded because an inflexible matrix approach was used to assess benefit equivalency with the result that from an actuarial perspective some of the exclusions may not have been warranted. The Division is looking to restructure its approach to determining ESI equivalency to the benchmark. The restructured process will provide the availability of both the matrix and actuarial options for use in assessing equivalency.

5.1.4. Cost Sharing

In developing its approach to cost sharing, the Division determined that it was appropriate to require that families at higher income pay a share of premium costs for coverage. It further determined that all families at those income levels should be charged a premium share regardless of how the coverage was provided (i.e. through buy-in to employer sponsored insurance through Family Assistance/Premium Assistance, or the direct coverage of children through Family Assistance/Direct Coverage). The determination to charge premiums for families above 150% of the FPL was based on several policy goals. These included the desire to maintain families at this income level who had employer sponsored insurance (ESI) coverage, or who had access to ESI in the ESI market. In addition, the Division wanted to ensure that there was equity in cost sharing for families in ESI or direct coverage. Cost sharing is structured to keep premium share payments within a 1 ½ to 2 percent range for those in Family Assistance. This has been translated to \$10 per child per month, up to a maximum of \$30, whether the family is receiving premium assistance for ESI coverage or direct coverage. Overall there is a 5% cap for all cost-sharing including premium costs and co-pays or deductibles charged through ESI (with the exception of well child visits for which families have no co-pay responsibility). The Division will cover cost sharing for well baby and well child care services by paying the provider or the family for any well child or well baby co-payments and/or deductibles. Once families have incurred and paid bills on behalf of their children exceeding 5% of the family income, they will cease to be responsible for any additional co-payments or deductible relative to their children's health care for that eligibility year. For families enrolled in MassHealth Family Assistance the Division has prepared a packet entitled: *MassHealth Family Assistance C.A.R.E. Kit (Children's Allowable Receipts and Expenses)* to help families track their children's medical expenses. MassHealth helps families in MassHealth Family Assistance (the only coverage group with cost-sharing responsibilities) pay for copays, deductibles, and coinsurance when they are provided to eligible children under age 19.

The Division’s experience with premiums to date has shown that 7% of families are disenrolled because of their failure to pay premiums.

To date only 9 claims have been filed from families seeking reimbursement for claims for well child care. There may be various reasons for this. The most likely scenario is that providers are writing off the co-payment for well-child visits, or that the member is paying and is not filing a claim with DMA. There is also a possibility that people are not accessing care. While we cannot monitor the quality of care of those in ESI as we do with our direct coverage plans, because we have no authority over ESI, we do have experience through our PCC Plan and MCO programs with a population similar to this one, i.e. those in Family Assistance Direct Coverage. Based on that experience, we know that our immunization rates for the MassHealth members utilizing the PCC and MCO service delivery systems were at 93%. (See Section 1.3) In addition, Massachusetts HMOs participate in Commercial HEDIS and a comparison of their performance with HMOs nationally shows that Massachusetts HMO’s are on par with the MassHealth Mean for HEDIS in measuring Children’s Access to Primary Care Providers as presented below.

Measure Children’s Access to PCPs	MassHealth Mean	MassHealth Median	HEDIS Massachusetts	HEDIS National
12-24 months	93.6%	91.4%	94.7%	91.7%
25 Mo –6 Yrs	88.5%	85.0%	90.0%	82.1%
7-11 Yrs	89.5%	93.1%	92.5%	82.9%

5.1.5. Delivery System

With the exception of families enrolled in Family Assistance Premium Assistance and most CommonHealth members who utilize the service delivery system that their employer’s coverage prescribes, all MassHealth members have the same choice of service delivery options, the Division’s PCC Plan or a choice of Managed Care Organizations.

5.1.6. Coordination with other Programs

MassHealth has achieved a high degree of coordination with CMSP. (See Sections 1.3, 4.1.3).

To avoid crowd out the Division has devised a plan through design of the Family Assistance Premium Assistance program that is based on assisting families buy in to ESI whenever possible. The advantage of this program design includes the fact that families are kept or placed in commercial insurance whenever possible, coverage is provided to the whole family - both adults and children, and families are kept together in one health plan. Crowd out is avoided through this design because part of the eligibility determination process for Family Assistance requires that the applicant indicate both whether the family is currently insured or has access to ESI, and whether there is an employer. The Division confirms the applicant's access to insurance through the employer, and then ascertains whether the employer contributes at least 50%, the coverage meets the Division's benchmark benefit level, and it is cost effective to enroll the family. If these criteria are met, the family must enroll in their employer's coverage. Thus, there is no advantage to dropping coverage because participation in MassHealth will require the family to reenroll in their ESI plan.

5.1.7. Evaluation and Monitoring

For those in direct coverage, evaluation and monitoring is in accordance with the provisions governing the PCC Plan and MCO delivery systems including member satisfaction surveys and HEDIS, as well as all of the other systems in place to monitor MassHealth service delivery. By rolling Title XXI into the MassHealth design, assurances have been achieved that the same high quality oversight and assessment of service delivery and other systems is maintained for the Title XXI population.

Monitoring and evaluation of Family Assistance Premium Assistance, however, has been a challenge. The Division is in the process of developing management reports to oversee operational aspects of the program, and monitoring implementation and determining the profile of those enrolled in the program.

Evaluation of this component of the Title XXI program will be multi-faceted. The characteristics of employees enrolling in Family Assistance Premium Assistance will be assessed. A determination will be made of how many applicants in the income range have access to ESI that meets the benchmark compared to the number who are employed and whose employers offer coverage. A determination of the impact of FA/PA on the employer market, and learning more about the cost of insurance and the range of premium rates will be made. Access to ESI for large versus small employers, and those who are insured and uninsured when they apply will also be assessed.

5.2. Improving availability of health insurance

The Division is pursuing a multi-faceted approach to improving the availability of health insurance for children in the state as highlighted below.

Outreach: The Division has made a significant commitment to developing and promoting effective outreach measures and is working closely with other organizations and entities to improve the availability of health insurance. As described in Section 3.4 the Division is engaged in diverse outreach activities with a range of collaborators including the schools, cities and towns, community based organizations, as well as tailored approaches to reaching targeted groups. Toward this end the Division is working closely with the Covering Kids Initiative, the cities of Boston, Worcester and Springfield, and other local initiatives.

ESI as a Strategy for Increasing Covered Lives: As discussed in Section 4, one of the benefits of providing access for children to health coverage through their parents ESI is that the parents get covered as well. Among the targeted groups are families with low income and access to ESI. The Division is engaged in a number of efforts to learn more about who comprises this group and what approaches are most effective in working with them. Thus, while to date we have enrolled 2,667 children in premium assistance through purchasing 1400 family policies, we estimate that we are covering a total of 5,233 lives.

Children with Special Needs: Other areas we are focusing on include children with special health care needs. We have been working to develop a systematic and encompassing approach for identifying children with special needs and how to support them. In order to continue to learn from other projects serving children with special needs, Division staff participates in a consortium of projects serving children with special needs. Defining these children and their needs is an evolving field, and what the group learns together can continue to guide the Division's efforts to improve care for children with special needs, and increase their access to coverage.

Dental Care: We are also pursuing improving access to dental services for the MassHealth population. A legislative commission on dental needs was convened and has prepared recommendations. The Division is reviewing those recommendations as well as pursuing its plans for meeting the needs of the MassHealth population. Beginning in the winter of 1998 the Division convened 38 dentists to participate in 3 advisory committees across the state to discuss possible strategic approaches to the key issues in the dental program. DMA held nine evening meetings in three parts of the state, meeting three times in each. Meetings were well attended, and some solutions to the problems were identified, which have been incorporated into the Division Dental Reform Plan. These include modifying the current program coverage to be consistent with the American Dental Association's level of dental care that seeks to maintain chewing function. As well, adding coverage for initial and periodic examinations for adult members. With regard to the business environment, reforms were identified to revise and streamline the prior authorization process, make electronic billing easier, and enhance billing assistance. Creating "user friendly" information for dentists on the dental programs was also identified as an important reform agenda, as were special projects that seek to improve the dental service infrastructure in areas of low dental access around the state. Included in the special projects were grants to community health centers to help them expand their dental care services. Another important area of focus is the need to develop a mechanism that assists the Division in assuring an equitable distribution of caseload among dental providers. This includes assessing development of a policy that allows dental practices to establish a caseload capacity, i.e. set a number of MassHealth members for their practice. A budget request to support an increase in fees of \$30 million has been requested for the FY01 budget.

Assisting with Coverage during Gaps in Employment: Massachusetts also provides assistance to those receiving unemployment compensation to help them maintain their health coverage during gaps in employment. Individuals in Massachusetts who are unemployed, with income up to 400% of FPL, and who are eligible for and or receiving Unemployment Compensation Benefits may participate in the Medical Security Plan, offered through the Division of Employment and Training. The Division of Employment and Training contracts with Blue Cross Blue Shield of Massachusetts to administer the program and provide utilization management services. The Medical Security Plan provides two different health insurance programs. Applicants eligible for or receiving health insurance coverage through COBRA, are only eligible for Premium Assistance, which provides partial reimbursement for premiums paid toward the cost of a member's COBRA health plan (up to \$110 per month for an individual and \$270 per month for family coverage). Applicants under Premium Assistance coverage have access to or are receiving COBRA health insurance benefits through a previous employer. Direct coverage is available to income-eligible individuals who have no access to health insurance benefits (COBRA). They are provided with health care services, and pay copays and deductibles. The applicant is enrolled in an indemnity plan and eligible to receive health insurance benefits through Blue Cross Blue Shield of Massachusetts.

Maximizing Integration in Program Design: Because Title XXI offered the states flexibility in the design of their programs Massachusetts was able to create a program that builds on the construct in the 1115 Waiver, by weaving Title XXI into the design in a way that enhances it rather than competes with or undermines it. This has been important, as the Division has worked to advance ESI coverage through its Family Assistance Premium Assistance in conjunction with the Insurance Partnership, which is an 1115 Waiver initiative.

An Advocates Perspective:

We have asked Josh Greenberg of the Massachusetts Covering Kids Initiative to share his thoughts in these Reflections on the progress made in implementing Title XXI and other issues and challenges that remain. His perceptions and comments from his experience with the Massachusetts Covering Kids Initiative are as follows. See Attachment 5 for Mr. Greenberg's comments.

5.3 Recommendations

There are many aspects of the Title XXI program that were good for states, especially in the innovation and flexibility they were allowed in designing their own programs. When Title XXI was authorized, Massachusetts had already given thought to expanding access and was in the process of moving forward. With the new options available under Title XXI, the state was able to pursue these plans even more vigorously.

For states not already planning an expansion it is clear that Title XXI provided the impetus to move in the direction of expanding coverage to children. In addition, the political dynamic encouraged states to take on the challenge of moving forward.

Because of the flexible options that states had to design their own program, it allowed states to be creative in designing a feasible approach for their state. In addition, it allowed the states to take credit for their efforts to expand coverage to children.

Therefore, in thinking about the future of Title XXI it is important that the flexibility that states have had to design their own programs be maintained. We have concern, however, that the direction of the proposed Title XXI regulations would remove some of this flexibility.

Another important perspective is that in the desire to avoid creating another Medicaid type program, there have been many opportunities to be innovative and use the Title XXI experience as an opportunity to improve our Medicaid program, such as in learning to communicate more effectively with the populations we serve. Massachusetts has spent considerable time and energy in developing a member services approach that supports its outreach and marketing efforts.

Our efforts have been focused on a range of issues from creating a system that is responsive to the MassHealth consumer to streamlining the eligibility determination process. Our efforts range from simplifying the application forms and process for applying, to providing well trained telephone contact for those inquiring about MassHealth and a timely response about eligibility, to more complex issues such as developing a cultural competence. Division staff receive ongoing training about eligibility changes, new benefit programs, and implementation phases of all MassHealth expansions. Training enables staff to respond to customer contacts and make appropriate referrals.

The Division defines cultural competency as a developmental process that involves cognitive changes that begin with cultural awareness and end with the attainment of cultural knowledge, adaptation of attitude/behaviors, and the acquisition of skills to work effectively with customers from diverse linguistic and cultural backgrounds. As we work to increase participation in our Insurance Partnership program, we are well aware that our ability to effectively define, identify and communicate with our target population will determine how successful we are in enrolling them in the Family Health Premium Assistance program, and other MassHealth initiatives.
