

**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: Maryland
(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: March 31, 2000

Reporting Period: July 1, 1998 – September 30, 1999

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Developed by the National Academy for State Health Policy

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?

Our estimated baseline for the number of uncovered low-income children is 100,000. Our original estimated baseline for the number of uncovered low-income children submitted in the 1998 annual report was 108,883 uncovered low-income children. We decided that for consistency purposes we would conform our estimate to the HCFA estimate used in distributing the fiscal year 1998 State Children's Health Insurance Program (SCHIP) allotments.

As discussed in Section 1.1.2, we plan to conduct a more valid survey of the uninsured in Maryland to develop a better estimate of uninsured children prior to implementing an expansion of our SCHIP in July of 2001.

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

The data source for this estimate was the Current Population Survey (CPS) data. We used the arithmetic average of the number of low-income children and low-income children with no health insurance as calculated from the three most recent March supplements to the CPS (1994, 1995 and 1996) that were available prior to fiscal year 1998. These data refer to information for calendar years 1993, 1994 and 1995. This estimate represents the number of children in Maryland who are under 19 years of age, whose family income is at or below 200 percent of the poverty threshold appropriate for that family and who are not reported to be covered by health insurance.

- 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.)

The CPS data is considered to have a low reliability due to the limitations inherent in the sampling methodology.

First, the CPS uses a small sample size in Maryland – less than 1,500 individuals. A very small percentage of these individuals surveyed are uninsured. We, therefore, believe that there is a range within which the true percentage of uninsured children lies, and that it is quite wide.

Second, we have found that the CPS estimates of participation in public assistance programs typically understate enrollment when compared to estimates of actual enrollment developed from the Maryland Department of Health and Mental Hygiene (DHMH) administrative files. For example, in 1998, the CPS reported 151,000 children enrolled in Maryland Medicaid programs for the previous year (1997), but in 1999, participation in the previous year (1998) was erroneously estimated at 43,000 children. The actual enrollment data from DHMH, however, showed that average enrollment for children increased from 243,000 in 1997 to 248,000 in 1998.

Third, we have found significant flaws in the most recent CPS questionnaire. We found that the 1999 questionnaire did not mention the “HealthChoice” program when respondents were queried about Medicaid participation. Instead, the CPS used the term “Maryland Access to Care” program. This omission is significant because the Maryland Access to Care program ended in June of 1997, and we have used the term “HealthChoice” since its implementation in July of 1997.

The Department of Health and Mental Hygiene has been working with the Maryland Health Care Commission and the Maryland Health Care Foundation to address the lack of reliable data on the uninsured in Maryland. We believe that we need to commission a study to focus solely on the issue of uninsured in our State. We are discussing our funding needs with various foundations and hope to secure funding for a study by the end of this year. Our goal is to have more accurate information on the uninsured before July of 2001. (Note: This will provide us with a reliable baseline for our current program before we implement any expansion.)

- 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))

Significant progress has been made in Maryland in reducing the number of uninsured children since the State began its outreach efforts for the Maryland Children’s Health Program (MCHP) in July, 1998. We have measured our progress by reporting the total number of children served by the CHIP program as of September 30, 1999. In the future, when more reliable Maryland data are available from our survey of the uninsured, we will compare the current estimate of uninsured children with our baseline estimate.

Our MCHP program includes children that receive enhanced Federal matching who are:

(1) in families with income between 185 and 200 percent of poverty; and (2) born before October 1, 1983 and in families with income above 40 percent of poverty. The MCHP also includes children that receive regular Federal matching who are above the Sixth Omnibus Budget Reconciliation Act (SOBRA) levels but below 185 percent of poverty. As of September 30, 1999, we had enrolled a total of 15,486 children into MCHP at the enhanced match and 42,134 children at the regular match. In addition to almost 58,000 enrollees in MCHP as of September 30, 1999, an estimated 16,000 children became eligible for Medicaid as a result of MCHP outreach activities.

We are quite pleased that within 15 months of implementing our MCHP program we had exceeded our overall MCHP goals. In our SCHIP application, we expected that 46,500 children (75 percent of the newly eligible population) would participate in MCHP in the first year of implementation. Specifically, we estimated that we would enroll 15,500 children eligible for enhanced matching and 31,000 children eligible for regular matching.

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

The estimate of the number of children enrolled in MCHP is based on DHMH administrative data.

The estimate of the additional number of children eligible as a result of MCHP outreach is based on the increase in enrollment over that which would have been expected based on normal projected growth in the SOBRA population prior to when MCHP was initially implemented.

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 State believes the estimate is reliable based on its experience with such estimates.

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

The State has made considerable progress in achieving many of its strategic objectives during the reporting period of this report. Unfortunately, the data is not yet available to address one of the strategic objectives.

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		
<i>Outreach to eligible low-income children</i>	<i>Reduction in the number of non-covered children</i>	Data Sources: <i>Not available at this time.</i> Methodology: Numerator: Denominator: Progress Summary:
OBJECTIVES RELATED TO CHIP ENROLLMENT		
<i>Outreach to eligible low-income children</i>	<i>Number of Medicaid eligibles enrolled in MCHP as compared to projections.</i>	Data Sources: <i>Internal enrollment data</i> Methodology: <i>Number of enrolled children reported by System on 9/30/99.</i> Numerator: <i>57,620 children (9/30/99)</i> Denominator: <i>46,500 (projected in CHIP application based on 75 percent participation rate)</i> Progress Summary: <i>We have met and exceeded our goal by 24 percent.</i>

Table 1.3

	<p>3. <i>Increase in the number of enrollees who indicate that they have improved access to the health care delivery system through satisfaction survey reports.</i></p> <p>4. <i>Increase in satisfaction with specialty health care resources.</i></p>	<p>Numerator:</p> <p>Denominator:</p> <p>Progress Summary:</p> <p>Data Sources: <i>See Narrative</i></p> <p>Methodology:</p> <p>Numerator:</p> <p>Denominator:</p> <p>Progress Summary:</p> <p>Data Sources: <i>See Narrative</i></p> <p>Methodology:</p> <p>Numerator:</p> <p>Denominator:</p> <p>Progress Summary:</p>
<p>OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)</p>		
		<p>Data Sources:</p>

Table 1.3

		Methodology: Numerator: Denominator: Progress Summary:
OTHER OBJECTIVES		
		Data Sources: Methodology: Numerator: Denominator: Progress Summary:

Outreach to eligible low-income children

1. Reduction in the number of non-covered children

The data to measure our progress in reaching this goal is not available. As noted above, we believe the 1999 CPS for Maryland is significantly flawed. The earlier years of the CPS do not cover the time period during which MCHP has been in existence. In the future, we hope to commission a study of the uninsured in Maryland so that we can measure our progress in meeting this goal.

2. Number of Medicaid eligibles enrolled in MCHP as compared to projections

Our internal enrollment data indicate that we had enrolled 57,620 children in MCHP by September 30, 1999. This compares quite favorably with our projected estimate in our CHIP application that we would cover 46,500 children in MCHP in the initial year. We believe that we have exceeded our goal by 24 percent.

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

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

In the HealthChoice program, we have continually monitored primary care provider network capacity through: a) quarterly capacity update reports; and b) through the online complaint system. Attachment A includes the provider network capacity reports showing the network as of June, 1998 and also as of September 1999. These reports demonstrate that provider network capacity remained more than adequate to handle the current enrollment in each local access area during that time period. Furthermore, we believe the low number of complaints (approximately 200 per month in a program with approximately 370,000 current enrollees) related to provider access is an indication that access to care has remained consistently high.

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

We do not have baseline information on the number of dental providers participating in HealthChoice as of July 1997.

A recent analysis from October of 1999 of the MCO dental provider network estimates 648 dental providers participating in the HealthChoice Program. This information is based on the monthly provider file submitted to the Department from each MCO. The analysis of the most current information indicates a state-wide ratio of dentists to children of 1:474 or a

ratio of 1:700 for adults and children. It should be noted, however, that there are fewer dental providers in the rural regions of the State. In addition, some dental providers do not accept new referrals and many limit the number of new referrals that they accept for oral health care. Furthermore, these statistics do not represent the availability of specialists, such as, pediatric dentists who are trained to treat very young children.

The Department is committed to making sure children with Medical Assistance coverage have access to comprehensive dental services. Our strategy is to work collaboratively with all parties (including the State's Oral Health Advisory Committee, dentists, MCOs, advocates, parents, the dental school, and local health departments) to make sure that children with Medicaid coverage in Maryland access their covered dental benefit.

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

The Satisfaction Survey includes the CHIP population as part of the overall HealthChoice program. The 1999 Satisfaction Survey (using CAHPS instrument) had a response rate of 22 percent. In 1998, 63 percent of respondents indicated that they always got regular care for their children as soon as they wanted. In 1999, the response was similar with 61 percent of respondents giving this answer. In another question, 59 percent of respondents in 1998 indicated that their children always got urgent care as soon as they wanted and this increased to 73 percent in 1999.

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

The Satisfaction Survey included a question on satisfaction with specialty care. In 1998, 73 percent of children in HealthChoice felt that specialty care was very good/excellent and this increased to 78 percent in 1999.

SECTION 2. BACKGROUND

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

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

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

- Providing expanded eligibility under the State's Medicaid plan (Medicaid CHIP expansion)

Name of program: Maryland Children's Health Program

Date enrollment began (i.e., when children first became eligible to receive services): July 1, 1998

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

Name of program: _____

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

- Other - Family Coverage

Name of program: _____

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

- Other - Employer-sponsored Insurance Coverage

Name of program: _____

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

- Other - Wraparound Benefit Package

Name of program: _____

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

___ Other (specify) _____

Name of program: _____

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

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 CHIP programs.

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 CHIP programs.

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

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

The Maryland Children's Health Program benefited from the State's experience and history with Medicaid managed care program through a Section 1115 demonstration waiver. Of 485,000 total Medicaid enrollees in September of 1999, 355,296 were served by managed care organizations in HealthChoice. Maryland's Title XXI population also is served through HealthChoice.

Eligible children are enrolled in Maryland's HealthChoice Program, which provides a comprehensive package of benefits and, most importantly, a medical home for all eligible children. With the implementation of HealthChoice in July of 1997, the responsibility for eligibility determinations for SOBRA eligibility poverty level pregnant women and children was given to local health departments throughout the State. MCHP benefited from this arrangement when it began in July of 1998. The expansion of coverage for children was easily accommodated by local health departments and the managed care organizations in which they enrolled.

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 CHIP?

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

Children’s Medical Services (CMS). The CMS program is the Title V Program in Maryland that has traditionally assisted families in planning and obtaining specialty medical and rehabilitative care. The program has provided for both direct and wrap around specialty care services to eligible children with special health care needs. Program activities have concentrated on the purchase of direct care services through community providers, local health departments and academic institutions through both fee-for-service reimbursement and grants.

Children historically served by the program are now eligible for the Maryland Children’s Health Insurance Program and, as a result, the program’s focus is shifting from that of providing direct and wrap around services to that of systems building activities. The program is moving in several new directions including:

- *The development of a regional approach to program activities;*
- *The development of a system to provide respite and other enabling services; and*
- *The development of services supporting State level activities.*

During the transition, the program will continue to pay for direct and wrap around services for underinsured children who meet the program’s eligibility criteria including:

- *Children who have or who are at risk for disabilities, chronic illnesses or health related educational problems; and*
- *Children in families with adjusted income under 200 percent of the federal poverty level.*

In addition, children who are aged 19 to 22 who are uninsured also are eligible.

Prior to MCHP, the CMS program provided specialty care services to approximately 6,500 children. Most of these children have been transitioned into MCHP. At this time, CMS provides services to approximately 1,500 children. These children are uninsured (children who age out of MCHP), underinsured and undocumented. Services are provided directly through hospital and community-based specialty care providers and local health department-based specialty clinics.

Carroll County Children's Fund Health and Wellness Care Program. The Carroll County children's Fund Health and Wellness Care Program is designed to provide primary and preventive health care for children ages birth to age 18 who do not qualify for Medicaid or any other publicly funded program. It is targeted at families that are not able to afford health insurance either on their own or through their employer. Eligibility is determined at the local level through the Carroll County Health Department. The program includes access to primary and preventive care, limited pharmacy assistance, basic diagnostic x-ray and laboratory services. The services provided to children are delivered through a partnership with Carroll County General Hospital, New American Health, LLC, and providers who participate in the Carroll County Contract Management Organization. Approximately 75 children were served in 1999.

The Anne Arundel County Caring Program for Children. Tailored to meet the needs of young children, the Caring Program for children offers access to preventive and primary care, prescriptions, eye exams and glasses, and selected outpatient surgeries. The program is intended to support the needs of children whose parents earn too much to qualify them for Medicaid but who cannot afford private insurance. To be eligible, a child must be:

- Unmarried;
- Between the ages of 16 (born before 9/30/83) and 19 years of age;
- A resident of Anne Arundel County;
- A full-time student if school age; and

- Uninsured.

This program no longer serves children and none were seen in 1999.

Allegany Health Right. *Allegany Health Right is a non-profit program providing limited medical care to low-income individuals unable to afford the cost of physician services or prescription medications. Eligibility determination is made through the Allegany County Department of Social Services. Cost for services is tailored to the individual's budget. Services include: physician care, prescriptions, diagnostic services, hospital sliding scale payments and advocacy services. This program no longer provides services to children and none were seen in 1999.*

Montgomery County. *The Care For Kids program served approximately 1,800 undocumented children in 1999.*

Prince George's County. *The Medical Care for Children Partnership (a Catholic Charities Program) served approximately 300 children in 1999. These children were between 200 and 250 percent of poverty. It serves children from birth to age 18 and undocumented children.*

- 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 CHIP program.

Changes to the Medicaid program

- Presumptive eligibility for children
- Coverage of Supplemental Security Income (SSI) children
- Provision of continuous coverage (specify number of months ___)
Enrollees in HealthChoice receive a guarantee of Medicaid eligibility for 6 months at their initial determination of eligibility. If there is a gap in coverage for more than one month, children are provided another 6 months of guaranteed eligibility.

- Elimination of assets tests
- Elimination of face-to-face eligibility interviews
- Easing of documentation requirements

Maryland allows self-declaration of income for MCHP.

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

To address any negative impact that Welfare Reform and the “delinking” of Medicaid may have had on Maryland residents, the State took major steps to ensure that persons denied cash assistance, or losing cash assistance, would be tested for any Medicaid eligibility or eligibility for the Maryland Children’s Health Program. These steps have resulted in an increase in enrollment for families and children.

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

- 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) _____

- 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) _____

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

- Changes in the demographic or socioeconomic context

- Changes in population characteristics, such as racial/ethnic mix or immigrant status (specify) _____
- X** Changes in economic circumstances, such as unemployment rate (specify) *The unemployment rate in Maryland decreased from 4.7 in July of 1998 to 4.1 percent in September of 1999.*
- Other (specify) _____
- Other (specify) _____

SECTION 3. PROGRAM DESIGN

This section is designed to provide a description of the elements of your State Plan, including eligibility, benefits, delivery system, cost-sharing, outreach, coordination with other programs, and anti-crowd-out provisions.

3.1 Who is eligible?

3.1.1 Describe the standards used to determine eligibility of targeted low-income children for child health assistance under the plan. For each standard, describe the criteria used to apply the standard. If not applicable, enter “NA.”

	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*
Geographic area served by the plan (Section 2108(b)(1)(B)(iv))	<i>Statewide</i>		
Age	<i>< 19 years</i>		
Income (define countable income)	<i>Earned and unearned income less \$90 earned income disregard, \$175/\$100 of child care expenses, \$50 of child support received, child support and alimony paid.</i>		
Resources (including any standards relating to spend downs and disposition of resources)	<i>No resource test</i>		
Residency requirements	<i>Maryland resident, no durational requirement</i>		
Disability status	<i>N/A</i>		

Access to or coverage under other health coverage (Section 2108(b)(1)(B)(i))	<i>For title XXI: applicant may not have employer sponsored insurance or have been voluntarily terminated within 6 months of application</i>		
Other standards (identify and describe)			

**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”.*

****Please see attachment B for addendum to Table 3.1.1.**

3.1.2 How often is eligibility redetermined?

Table 3.1.2			
Redetermination	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*
Monthly			
Every six months			
Every twelve months	X <i>Or when a recipient reports a change in circumstances.</i>		
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”.

3.1.3 Is eligibility guaranteed for a specified period of time regardless of income changes? (Section 2108(b)(1)(B)(v))

Yes Which program(s)? *Enrollees in HealthChoice are guaranteed eligibility for 6 months when initially determined eligible for the program.*

For how long?

No

3.1.4 Does the CHIP program provide retroactive eligibility?

Yes Which program(s)?
Medicaid.

How many months look-back? *3 months.*

No

We will make sure that we are meeting this requirement.

3.1.5 Does the CHIP program have presumptive eligibility?

Yes Which program(s)?

Which populations?

Who determines?

No

3.1.6 Do your Medicaid program and CHIP program have a joint application?

Yes Is the joint application used to determine eligibility for other State programs? If yes, specify.

No

Maryland's SCHIP is a Medicaid expansion. We use a short, 3-page application form for all children applying for MCHP, which includes both children receiving enhanced Federal matching and children receiving regular Federal matching.

3.1.7 Evaluate the strengths and weaknesses of your *eligibility determination* process in increasing creditable health coverage among targeted low-income children

*The **strengths** of the eligibility determination process include: a shortened and simplified application form (3 pages); applications may be mailed by the applicant to the local department of health; self-declaration of income (no verifications are required); there is no assets test; and local health departments are required to determine eligibility within 10 days of the receipt of a completed application. Recent program data indicate that 68 percent of applications are processed by local health departments in 10 days or less; 17 percent are processed in 11 to 20 days; 7.5 percent are processed in 21 to 30 days; and 7.5 percent are processed in 30 or more days. Local health department staff indicate that most of the delays in processing applications are due to incomplete submissions by applicants.*

*A **weakness** exists in processing those applications that have an associated Food Stamp case at the local department of social services. Such cases must be transferred to the applicant's local department of social services for processing. This frequently results in a delay in processing eligibility for such cases.*

We are addressing this weakness in two ways. First, we worked with advocates and developed a plan to extend our expedited eligibility process to cases associated cases. This process will ensure that all applications are processed in 10 days or less. We plan to first implement this process in Baltimore City and then extend it Statewide. Second, we are applying for the Robert Wood Johnson grant on "Supporting Families after Welfare Reform" to evaluate our eligibility

processes and develop a plan of action to correct any deficiencies in our process.

- 3.1.8 Evaluate the strengths and weaknesses of your *eligibility redetermination* process in increasing creditable health coverage among targeted low-income children. How does the redetermination process differ from the initial eligibility determination process?

*We use the same 3-page, mail-in application form for eligibility redeterminations. Approximately 45 days before the end of the recipient's 12 month certification, an application is sent out with a letter requesting the recipient to complete the application and return it to the local health department to allow a redetermination of continuing eligibility prior to the expiration of the current period of eligibility. A **weakness** of this process is that families may delay or forget to follow through with the redetermination and a lapse in eligibility may occur pending the completion of the process. Those individuals who complete the application the month after it was due, however, have an effective date back to the first of the month so that there is no lapse in coverage.*

We will develop a plan to address this weakness. As noted above in Section 3.1.7, DHMH is applying for the Robert Wood Johnson grant called "Supporting Families after Welfare Reform." This grant also would provide us the opportunity to review our eligibility redetermination process and develop a plan of action to address any deficiencies.

- 3.2 What benefits do children receive and how is the delivery system structured?
(Section 2108(b)(1)(B)(vi))

3.2.1 Benefits

Please complete Table 3.2.1 for each of your CHIP programs, showing which benefits are covered, the extent of cost sharing (if any), and benefit limits (if any).

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 3.2.1 CHIP Program Type Medicaid expansion			
Benefit	Is Service Covered? (T = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Inpatient hospital services	Y		
Emergency hospital services	Y		
Outpatient hospital services	Y		
Physician services	Y		
Clinic services	Y		
Prescription drugs	Y		
Over-the-counter medications	Y		
Outpatient laboratory and radiology services	Y		
Prenatal care	Y		
Family planning services	Y		
Inpatient mental health services	Y		
Outpatient mental health services	Y		
Inpatient substance abuse treatment services	Y		
Residential substance abuse treatment services	Y		
Outpatient substance abuse treatment services	Y		
Durable medical equipment	Y		
Disposable medical supplies	Y		

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Preventive dental services	Y		
Restorative dental services	Y		
Hearing screening	Y		
Hearing aids	Y		
Vision screening	Y		
Corrective lenses (including eyeglasses)	Y		
Developmental assessment	Y		
Immunizations	Y		
Well-baby visits	Y		
Well-child visits	Y		
Physical therapy	Y		
Speech therapy	Y		
Occupational therapy	Y		
Physical rehabilitation services	Y		
Podiatric services	Y		
Chiropractic services	Y		
Medical transportation	Y		
Home health services	Y		
Nursing facility	Y		
ICF/MR	Y		

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Hospice care	Y		
Private duty nursing	Y		
Personal care services	Y		
Habilitative services	Y		
Case management/Care coordination	Y		
Non-emergency transportation	Y		
Interpreter services	Y		
Other (Specify)			
Other (Specify)			
Other (Specify)			

3.2.2 Scope and Range of Health Benefits (Section 2108(b)(1)(B)(ii))

Please comment on the scope and range of health coverage provided, including the types of benefits provided and cost-sharing requirements. Please highlight the level of preventive services offered and services available to children with special health care needs. Also, describe any enabling services offered to CHIP enrollees. (Enabling services include non-emergency transportation, interpretation, individual needs assessment, home visits, community outreach, translation of written materials, and other services designed to facilitate access to care.)

The scope and range of the health benefits for CHIP enrollees is the same as that provided to the HealthChoice enrollee. The State has been continually committed to ensuring the provision of a complete and comprehensive benefit package, equivalent to the benefits that have been available to Maryland Medicaid recipients through the fee-for-service delivery system. The managed care organization (MCO) may not charge its enrollees any co-payments, premiums or cost sharing of any kind.

Services provided include all services that are determined medically necessary and appropriate, Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT), which includes case management and care coordination for Special Need Populations. An MCO also is responsible for providing appropriate referrals to Head Start, the WIC nutritional program, School Health-Related Special Education Services, vocational rehabilitation, and Maternal and Child Health Services.

In addition to the minimum benefit package, the MCOs also are required to ensure that their adult and pediatric primary care, specialty, and sub-specialty providers are clinically qualified to provide service to members of special needs populations. Members of special needs populations are to be treated with a continuous case management approach, which includes a comprehensive plan of care that is family focused, case management, home visits, outreach and educational programs as appropriate. A Special Needs Coordinator in each MCO must serve as a resource for health care services information and referral, and for information on the requirements of the Americans with Disabilities Act.

MCOs are required to provide "enabling" services, defined as those service that assist in the provision of medical treatment and care. Some of these enabling services include: Health Risk Assessments to identify special needs at the time of enrollment; non-emergency transportation; and written or verbal information that provides instruction and/or education to enrollees with additional communication needs. This may include written materials in other languages, braille, or communication assistance for individuals who are hearing impaired.

Finally, DHMH administers the Rare and Expensive Case Management (REM) programs as a component of the HealthChoice program. The REM program is an intensive case management program for individuals who meet specific diagnostic criteria. These diagnoses include diseases of the nervous system, digestive and genitourinary system, with age limitations ranging from 0 to 20 years old. Cystic fibrosis, spina bifida, hemophilia and non-neonate ventilator dependency are the main diagnoses for individuals through age 64. Currently, there are 2,440 individuals enrolled in REM, of which 87 percent are children.

Case management services are provided by licensed nurses and social workers to assist REM eligible individuals in receiving health services. Case managers are responsible for providing comprehensive needs assessments, assisting REM enrollees in identifying appropriate providers, coordinating care and services from other programs and/or agencies, monitoring service delivery and documenting the REM enrollees' plan of care. Case managers are required to conduct face-to-face on-site assessments for each REM recipient. A detailed plan of care is developed during this process. It is in this planning that the case manager is able to assist the recipient in coordinating his/her care, provide education regarding specific conditions and preventative measures for complications.

3.2.3 Delivery System

Identify in Table 3.2.3 the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Check all that apply.

Type of delivery system	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*
A. Comprehensive risk managed care organizations (MCOs)			
Statewide?	<input checked="" type="checkbox"/> Yes ___ No	___ Yes ___ No	___ Yes ___ No
Mandatory enrollment?	<input checked="" type="checkbox"/> Yes ___ No	___ Yes ___ No	___ Yes ___ No
Number of MCOs	8		
B. Primary care case management (PCCM) program	No		

C. Non-comprehensive risk contractors for selected services such as mental health, dental, or vision (specify services that are carved out to managed care, if applicable)	Mental Health		
D. Indemnity/fee-for-service (specify services that are carved out to FFS, if applicable)	IEP/IFSP(see note#1),OT, PT, Speech, Audiology, Personal Care, Medical Day Care, Transportation.		
E. Other (<i>Rare and Expensive Case Management – See note#2</i>)			
F. Other (specify)			
G. Other (specify)			

Note #1: IEP/IFSP services are health-related specialty services for children with Individualized Education Plans or infants and toddlers with Individualized Family Service Plans. Examples of such services include: occupational therapy, physical therapy, speech therapy and audiology.

Note #2: The Rare and Expensive Case Management (REM) program is an intensive care management program for individuals who meet specific diagnostic criteria. See Section 3.2.2 for more details.

*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”.

3.3 How much does CHIP cost families?

3.3.1 Is cost sharing imposed on any of the families covered under the plan? (Cost sharing includes premiums, enrollment fees, deductibles, coinsurance/copayments, or other out-of-pocket expenses paid by the family.)

No, skip to section 3.4

Yes, check all that apply in Table 3.3.1

Table 3.3.1

Type of cost-sharing	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____ _____
Premiums			
Enrollment fee			
Deductibles			
Coinsurance/copayments**			
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”.

**See Table 3.2.1 for detailed information.

3.3.2 **If premiums are charged:** What is the level of premiums and how do they vary by program, income, family size, or other criteria? (Describe criteria and attach schedule.) How often are premiums collected? What do you do if families fail to pay the premium? Is there a waiting period (lock-out) before a family can re-enroll? Do you have any innovative approaches to premium collection?

3.3.3 **If premiums are charged:** Who may pay for the premium? Check all that apply. (Section 2108(b)(1)(B)(iii))

- Employer
- Family
- Absent parent
- Private donations/sponsorship
- Other (specify) _____

3.3.4 **If enrollment fee is charged:** What is the amount of the enrollment fee and how does it vary by program, income, family size, or other criteria?

3.3.5 **If deductibles are charged:** What is the amount of deductibles (specify, including variations by program, health plan, type of service, and other criteria)?

3.3.6 How are families notified of their cost-sharing requirements under CHIP, including the 5 percent cap?

3.3.7 How is your CHIP program monitoring that annual aggregate cost-sharing does not exceed 5 percent of family income? Check all that apply below and include a narrative providing further details on the approach.

Shoebox method (families save records documenting cumulative level of cost sharing)

Health plan administration (health plans track cumulative level of cost sharing)

Audit and reconciliation (State performs audit of utilization and cost sharing)

Other (specify)_____

3.3.8 What percent of families hit the 5 percent cap since your CHIP program was implemented? (If more than one CHIP program with cost sharing, specify for each program.)

3.3.9 Has your State undertaken any assessment of the effects of premiums on participation or the effects of cost sharing on utilization, and if so, what have you found?

3.4 How do you reach and inform potential enrollees?

3.4.1 What client education and outreach approaches does your CHIP program use?

Please complete Table 3.4.1. Identify all of the client education and outreach approaches used by your CHIP program(s). Specify which approaches are used (T=yes) and then rate the effectiveness of each approach on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.1

Approach	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program*	
	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)
Billboards	Y	4				
Brochures/flyers	Y	3				
Direct mail by State/enrollment broker/administrative contractor						
Education sessions	Y	3				
Home visits by State/enrollment broker/administrative contractor	Y	4				
Hotline	Y	5				
Incentives for education/outreach staff						
Incentives for enrollees						
Incentives for insurance agents						
Non-traditional hours for application intake						
Prime-time TV advertisements						
Public access cable TV	Y	4				
Public transportation ads	Y	4				
Radio/newspaper/TV advertisement and PSAs	Y	4				
Signs/posters	Y	3				

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State/broker initiated phone calls						
Other (specify)						
Other (specify)						

Where does your CHIP program conduct client education and outreach?

Please complete Table 3.4.2. Identify all the settings used by your CHIP program(s) for client education and outreach. Specify which settings are used (**T**=yes) and then rate the effectiveness of each setting on a scale of 1 to 5, where 1=least effective and 5=most effective.

Setting	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program*	
	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)
Battered women shelters	Y	2				
Community sponsored events	Y	2				
Beneficiary's home	Y	4				
Day care centers	Y	3				
Faith communities	Y	2				
Fast food restaurants	Y	3				
Grocery stores	Y	3				
Homeless shelters	Y	2				
Job training centers	Y	3				
Laundromats	Y	2				
Libraries	Y	1				
Local/community health centers	Y	5				
Point of service/provider locations	Y	4				
Public meetings/health fairs	Y	2				
Public housing	Y	3				
Refugee resettlement programs	Y	1				

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Schools/adult education sites	Y	3				
Senior centers	Y	1				
Social service agency	Y	3				
Workplace	Y	2				
Other (specify) __ <i>Unemployment office</i>	Y	4				
Other (specify)___ <i>gas and electric bills</i>	Y	3				

- 3.4.3 Describe methods and indicators used to assess outreach effectiveness, such as the number of children enrolled relative to the particular target population. Please be as specific and detailed as possible. Attach reports or other documentation where available.

Maryland has been extremely successful in enrolling children in MCHP. The enrollment success can be attributed to the Program's simplicity of design, ease of access, and the communication of the MCHP message around the state through extensive outreach and enrollment efforts. The focus of outreach and enrollment efforts has been local health departments throughout the State. Each local health department has worked with and through its community's public and private resources to reach and enroll children in MCHP. Attachment C provides a comprehensive summary of all MCHP outreach activities conducted by the local health departments as of September 30, 1999.

We are lacking, however, a comprehensive analysis and evaluation of the effectiveness and inclusiveness of each of the many outreach programs and activities throughout the state. Plans are now underway to develop a monitoring and evaluation program so that enrollment continues to increase and, as importantly, we can be assured that effective outreach reaches all socioeconomic, ethnic and cultural elements of Maryland's eligible population. Please see 3.4.4.

- 3.4.4 What communication approaches are being used to reach families of varying ethnic backgrounds?

Local health departments have directly, and indirectly through community organizations, targeted communications to families of varying ethnic backgrounds. Also, one of the sub-grantees of the RWJ Covering Kids Program is targeting a large portion of the Hispanic community in the Metro Washington, D.C. counties of Maryland.

Our MCHP application is available in Spanish. We also contract with a translation service so our staff that work on the toll-free line can answer questions in any language needed. When a person needs translation services, we call this service and they have translators on stand-by ready to assist our callers. In addition, some of our local health departments have bilingual eligibility workers.

- 3.4.5 Have any of the outreach activities been more successful in reaching certain populations? Which methods best reached which populations? How have you measured their effectiveness? Please present quantitative findings where available.

Although Maryland currently lacks data to rate the effectiveness of the various outreach activities, we have applied for a technical assistance grant with the Health Resources and Services Administration to help evaluate our outreach program. We have had several preliminary calls and had our first face-to-face meeting with the contractor on March 29, 2000. We have requested technical assistance in developing options for determining what methods were most effective in enrolling current enrollees in the MCHP. We also have asked for the contractor to develop options so that we can monitor which strategies are most effective in enrolling children when we expand our current MCHP.

We are currently exploring several efforts to obtain data that will allow us to assess the effectiveness of various outreach activities. First, we are attempting obtain funding to conduct focus groups with potential eligibles to determine any barriers to enrollment. Second, we are considering bar coding our applications so that we can determine the locations or types of entities that are most effective in producing applicants. We also may do a zip code analysis of HealthChoice enrollees to determine if there are any jurisdictions that appear to be underrepresented. Third, we may commence asking our toll free line operators to ask callers where they heard about the program. Before implementing any of these strategies, we would like to assess all of the options that will be presented to us by the HRSA contractor and discuss them with our partners in the community to obtain as much input as possible from individuals who work at the local level.

3.5 What other health programs are available to CHIP eligibles and how do you coordinate with them? (Section 2108(b)(1)(D))

Describe procedures to coordinate among CHIP programs, other health care programs, and non-health care programs. Table 3.5 identifies possible areas of coordination between CHIP and other programs (such as Medicaid, MCH, WIC, School Lunch). Check all areas in which coordination takes place and specify the nature of coordination in narrative text, either on the table or in an attachment.

Table 3.5				
Type of coordination	Medicaid*	Maternal and child health	Other (specify) WIC	Other (specify)
Administration				
Outreach		Program outreach and enrollment support (see note #1)	Program outreach and enrollment support (see note#2)	
Eligibility determination				
Service delivery				
Procurement				
Contracting				
Data collection				
Quality assurance				
Other (specify)				
Other (specify)				

*Note: This column is not applicable for States with a Medicaid CHIP expansion program only.

Note #1: In order to receive services paid for by CMS, a child must first apply for Medicaid/MCHP and be determined ineligible. CMS mailed a letter to all children who received services through CMS and provided a copy of the short, 3-page MCHP application.

Note #2: WIC helps distribute MCHP applications and materials and helps potential applicants complete the application.

3.6 How do you avoid crowd-out of private insurance?

3.6.1 Describe anti-crowd-out policies implemented by your CHIP program. If there are differences across programs, please describe for each program separately. Check all that apply and describe.

Eligibility determination process:

Waiting period without health insurance (specify)

Maryland imposes a 6 month waiting period for individuals who dropped employer sponsored insurance.

Information on current or previous health insurance gathered on application (specify)

Maryland asks applicants three questions: (1) does anyone applying for MCHP have any health insurance? (2) Has anyone applying for MCHP dropped health insurance coverage in the past six months? (3) If yes, the applicant is asked several questions about the type of insurance, the insurance company name and the duration of coverage.

Information verified with employer (specify)

Records match (specify)

Applicant identification is run against database of major insurers in the State through the Medicaid Program's Division of Medicaid Recoveries.

Other (specify)

Other (specify)

Benefit package design:

Benefit limits (specify)

Cost-sharing (specify)

Other (specify)

Other (specify)

Other policies intended to avoid crowd out (e.g., insurance reform):

Other (specify)

Other (specify)

3.6.2 How do you monitor crowd-out? What have you found? Please attach any available reports or other documentation.

Maryland established an anti-crowd out policy of a 6 month waiting period for individuals who dropped employer sponsored health benefits. See Section 4.1.2.

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.

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 CHIP Program Type : Medicaid Expansion						
Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998**	FFY 1999	FFY 1998	FFY 1999
All Children	6326	18072	2.4	8.5	37	1107
Age						
Under 1	163	478	2.4	8.5	0	6
1-5	509	2206	2.5	7.5	9	135
6-12	531	2271	2.5	7.3	3	120
13-18	5123	13117	2.3	8.9	25	846

Countable Income Level*						
At or below 150% FPL	6294	13703	2.4	9.3	36	921
Above 150% FPL	32	4369	2.0	6.0	1	186
Age and Income						
Under 1						
At or below 150% FPL	159	346	2.4	9.1	0	5
Above 150% FPL	4	127	1.5	6.9	0	1
1-5						
At or below 150% FPL	497	936	2.5	9.0	9	96
Above 150% FPL	12	1112	1.8	6.1	0	39
6-12						
At or below 150% FPL	524	736	2.5	9.9	3	53
Above 150% FPL	7	1351	2.4	5.7	0	67
13-18						
At or below 150% FPL	5114	10450	2.3	9.3	24	767
Above 150% FPL	9	1599	2.1	6.1	1	79
Type of plan						
Fee-for-service	2480	1424	1.7	8.0	20	31
Managed care	3846	16648	2.8	8.5	17	1076
PCCM	0	0	0	0	0	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.

**MCHP was only in operation for one quarter during Federal Fiscal Year 1998.

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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))

Our Maryland Children's Health Program application asks whether individuals dropped health insurance coverage in the past six months. If the answer is yes, they must complete information about the insurer, policy number, group number, effective date and end date. Any child who dropped employer sponsored health insurance within the past 6 months prior to application will be denied coverage. As a result of applying this anti-crowd out strategy, we were not required to monitor the extent of crowd out.

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

We plan to take two steps to improve our knowledge about these two issues. First, we will amend our application to ask additional questions about when the child last had insurance, what type of insurance the child had most recently and what reason best characterizes why they no longer have the insurance today. Second, we will begin monitoring crowd out through periodic audits of applications to determine the actual number of CHIP enrollees who had coverage and the reasons they cite for dropping coverage. If we determine a problem, we will consider more stringent strategies for preventing crowd out.

- 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))

Unknown at this time.

- 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?

Attachment D shows enrollment and disenrollment by month between July 1998 and September 1999 for the eligibility category of children receiving the enhanced Federal match. The “case closed” category represents the children that disenrolled from the category during the particular month. These children may, however, have maintained Medicaid coverage under a different eligibility category.

- 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?

Unknown at this time, but we will develop a plan to determine this information in the future.

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

Unknown at this time, but we will develop a plan to determine this information in the future.

Table 4.2.3

Reason for discontinuation of coverage	Medicaid CHIP Expansion Program		State-designed CHIP Program		Other CHIP Program*	
	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total
Total						
Access to commercial insurance						
Eligible for Medicaid						
Income too high						
Aged out of program						
Moved/died						
Nonpayment of premium						
Incomplete documentation						

Did not reply/unable to contact						
Other (specify)						
Other (specify)						
Don't know						

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

Some local health departments contact the family to see if they may still be eligible. We understand that providers often encourage families to apply on behalf of their children. We will develop a plan to address this issue. For example, one option that we have considered is to send a letter to families when the children have not reenrolled three months later.

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 \$1,064,922

FFY 1999 \$20,666,510

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?

Table 4.3.1 CHIP Program Type Medicaid Expansion

Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures	\$969,704	\$19,647,842	\$630,308	\$12,771,098
Premiums for private health insurance (net of cost-sharing offsets)*	834,112	14,547,195	542,173	9,455,676

Fee-for-service expenditures (subtotal)				
Inpatient hospital services	43,353	1,679,496	28,179	1,091,672
Inpatient mental health facility services	4,999	630,113	3,249	409,573
Nursing care services	0	12,917	0	8,396
Physician and surgical services	9,987	156,832	6492	101,941
Outpatient hospital services	52,285	476,040	33,985	309,426
Outpatient mental health facility services	0	1,040,096	0	676,062
Prescribed drugs	19,450	265,818	12,643	172,781
Vision Services	332	2,584	216	1679
Dental Services	535	4,341	348	2822
Other practitioners' services	91	17,368	59	11,290
Clinic services	1489	88,127	968	57,282
Therapy and rehabilitation services	0	290,526	0	188,842
Laboratory and radiological services	4,972	43,860	3232	28,509
Durable and disposable medical equipment	922	18,403	599	11,962
Family planning	0	0	0	0
Abortions	0	0	0	0
Screening services	2,645	15,253	1,719	9915
Home health	0	0	0	0
Home and community-based services	0	14,482	0	9414
Hospice	0	0	0	0
Medical transportation	575	68,874	374	44,769
Case management	0	550	0	358
Other services	3,724	603,506	2,421	392,279
Less Collections	<9767>	<328,538>	<6,349>	<213,550>
TOTAL	969,704	19,647,842	630,308	12,771,098

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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?

Outreach and administration.

What role did the 10 percent cap have in program design?

The 10 percent cap was not a major limiting factor in the design of our Medicaid expansion because we built upon the benefits, provider network and delivery system and outreach mechanisms in our existing Medicaid program. We do anticipate, however, that the administrative costs associated with designing our “private option” expansion of MCHP will come close, if not exceed, the 10 percent cap especially in the early years of implementation.

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						
Outreach	3,442	30,094				
Administration	91,776	988,574				
Other _____						
Federal share						
Outreach	2,237	19,561				
Administration	59,655	642,573				
Other _____						

*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”.

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?

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

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

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

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

HealthChoice Financial Monitoring Report submitted by MCOs quarterly provides information on MCO expenditures by service type for each rate cell;

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

State Complaint and Grievance Process that includes Recipient and Provider Hotlines, Complaint Resolution and provides tracking and

resolving of recipients' complaints including coordination and interacting with MCOs and other internal and external agencies. It includes monthly monitoring for trends and is used to make programmatic changes;

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

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

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

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

EPSDT Nurse Review: provides medical record review for comprehensive health and developmental history, physical exam, immunizations, appropriate laboratory tests, health education, vision, hearing and dental screening;

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

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

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

Public involvement and participation: The HealthChoice Program remains an active partner and seeks information and participation through several ongoing committees. These committees include:

Quality Assurance Liaison Committee: to address topics of general interest concerning quality improvement issues;

Medicaid Advisory Committee: comprised of HealthChoice enrollees, enrollee advocates, providers, representatives from the legislature and MCOs. The main function of this committee is to review and make recommendations on the operation and evaluation of managed care programs under HealthChoice;

Special Needs Children Advisory Council: The mission of this committee is to conduct regular reviews of available data, and participate in the effectiveness study for children with special health care needs; and

Medical Review Panel for the Rare and Expensive Case Management Program: has the purpose of reviewing and recommending changes to the conditions appropriate and eligible for REM.

- 4.4.1 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	Other CHIP Program*
Appointment audits	MCO		
PCP/enrollee ratios	MCO		
Time/distance standards	MCO		
Urgent/routine care access standards	MCO		

Network capacity reviews (rural providers, safety net providers, specialty mix)	MCO		
Complaint/grievance/ disenrollment reviews	MCO		
Case file reviews	MCO		
Beneficiary surveys	MCO		
Utilization analysis (emergency room use, preventive care use)	MCO		
Other (specify) <i>Review EPSDT Records for Compliance</i>	MCO		
Other (specify) _____			
Other (specify) _____			

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	Other CHIP Program* _____
Requiring submission of raw encounter data by health plans	<input checked="" type="checkbox"/> Yes ___ No	___ Yes ___ No	___ Yes ___ No
Requiring submission of aggregate HEDIS data by health plans	<input checked="" type="checkbox"/> Yes ___ No	___ Yes ___ No	___ Yes ___ No
Other (specify) _____	___ Yes ___ No	___ Yes ___ No	___ Yes ___ 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”.

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

All information collected is on the total HealthChoice population, as it is important for the State to assure the standards of care for all Medicaid recipients. Some of the information that is available on access to care for HealthChoice enrollees includes: Annual EQRO Audit; Focused Study Reviews on preventive health studies, diagnosis or demographic specific studies, educational programs and services and clinical reviews on special populations such as children with cerebral palsy; collection of Health Plan Employer Data

and Information Set (HEDIS); cumulative reports from data collected from monitoring programs such as the Enrollee Action Line and Ombudsman Program; Satisfaction Surveys; and, input from committees.

Recipient Satisfaction Surveys: The 1999 Recipient Satisfaction Survey, which was the first survey that included MCHIP enrollees in the sample, asked a representative sample of all eligibility categories in HealthChoice about access to care. The survey found that 62 percent of respondents said that they “usually or always” got regular care as soon as they needed it; 73 percent of respondents said that they “usually or always” got urgent care as soon as they needed it.

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 State continues to monitor the HealthChoice program through the use of satisfaction surveys, the complaint and grievance process, EPSDT, MCO systems operational reviews, and medical record reviews. It is expected that encounter data for the utilization analysis will be available in the summer of 2000. The State will then use the encounter database to analyze a wide variety of performance and outcome measures.

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	Other CHIP Program
Focused studies (specify)	MCO		
Client satisfaction surveys	MCO		
Complaint/grievance/disenrollment reviews	MCO		
Sentinel event reviews	MCO		

Plan site visits	MCO		
Case file reviews	MCO		
Independent peer review	MCO		
HEDIS performance measurement	MCO		
Other performance measurement (specify)			
Other (specify) <u>HCQIS</u>	MCO		
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”.

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.

Maryland does not have a separate quality assurance program for the SCHIP enrollees. We do, however, have a long-standing commitment to ensuring that all children with Maryland Medicaid coverage receive high quality health care services. The following describes some of the features of the Maryland EPSDT Quality Improvement Program:

- *The EPSDT Program in Maryland has conducted quality assurance monitoring visits in providers offices for the last 20 years.*
- *The State is divided in regions and nurse consultants are assigned to cover each region. The nurse consultants are responsible for recruiting and orienting providers and their support staff (since the early nineties - we have had six nurse positions).*
- *In addition, the nurse consultant visits providers offices to conduct quality assurance reviews. During these visits, EPSDT nurses monitor medical records to find if the child received the following services during an EPSDT exam:*
 1. *A comprehensive health and developmental history,*
 2. *A comprehensive unclothed physical exam,*
 3. *Immunizations appropriate to age and health history,*

4. *Age and risk appropriate laboratory tests, including lead,*
 5. *Health education and anticipatory guidance, and*
 6. *Vision, hearing, and dental screening.*
- *In addition, the EPSDT nurse consultant examines whether children receive follow-up diagnostic and treatment services necessary to prevent, treat, or ameliorate physical, developmental, or any other conditions identified by an EPSDT provider.*
 - *These reviews are conducted on:*
 1. *An annual basis for those providers who receive satisfactory reviews (this is the most common outcome of a review),*
 2. *An every two year cycle for providers who receive excellent reviews, and*
 3. *More frequently for those who receive a less than satisfactory review.*
 - *The goal of the quality assurance visits is to assist providers and their staff to improve the quality of care provided in their offices. This on-site review process is labor intensive. Office-based reviews, however, are the best way to directly affect individual office-based practices and continuously improve care for children throughout Maryland. The office-based review model gives the nurse an opportunity to explain the expanded benefits package for children with Medical Assistance coverage and to directly provide educational materials and information on the Medical Assistance eligibility process.*
 - *In many cases, office staff have played a key role in elevating the care provided in the offices. Therefore, the nurse consultants meet with both the provider and their staff.*
 - *HMOs have been an important provider of Medicaid services in Maryland since 1975. Enrollment has been voluntary and members have had the right to disenroll without cause. While enrolled, children receive complete health care services, including EPSDT services.*

- *In 1991, Maryland obtained a Freedom of Choice waiver from HCFA, which allowed the State to require almost all Medicaid beneficiaries to choose an HMO or a Primary Medical Provider (PMP). The PMP was responsible for providing primary care services, including EPSDT, and serves as gatekeeper for the provision of specialty services.*
- *In June 1997, Maryland implemented the HealthChoice Program, a Section 1115 Waiver, which required most Medicaid recipients to enroll in an Managed Care Organization (MCO). The MCOs are responsible for providing the full range of high quality health care services, including EPSDT, for enrollees. They are responsible for providing EPSDT certified providers for children enrolled in the MCOs. The EPSDT nurse team continues to certify, train, and monitor these providers.*
- *The EPSDT Quality Assurance Program has continued as recipients enroll in MCOs. New partnerships have been developed between the State's EPSDT nurse quality assurance team and the nurse quality assurance teams within the MCOs.*
- *The activities that the EPSDT nurse consultants perform do not diminish or supplant any of the activities conducted by the MCO to ensure internal quality assurance. Instead, EPSDT nurse consultants work with MCO staff to assure better access to health care services and to increase the quality of care for children with Medicaid coverage. Examples of collaborations include:*
 1. *Ongoing meetings to exchange information and develop QA plans,*
 2. *Joint orientations for groups of pediatric providers,*
 3. *Working collaboratively to assure that MCO providers are certified to provide EPSDT services, and*
 4. *Reviewing and recommending improvements to each others quality assurance tools.*
- *Maryland Medicaid also provides funding to local health departments throughout the State so that they can assist MCOs in outreaching children in need of health care services. Target populations include:*
 1. *Children less than two years old who miss two EPSDT visits in a row;*
 2. *Children younger than 21 years old who miss two visits in a row for treatment of a condition identified by an MCO provider; and*

3. *Children with special health care needs who need assistance in accessing services.*
- *Maryland Medicaid also conducts focused studies to ensure that certain special populations receive special services. Examples include:*
 1. *A focused review on health care services provided to children with asthma.*
 2. *A focused review on at least one population of children with special health care needs. The topic of this focused review will change over time. During 1998, the Program conducted a focused review of special needs children with cerebral palsy to see if plans of care have been developed and implemented. During 1999, the EPSDT Program studied the care given to children with sickle cell anemia.*

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?

Maryland does not currently nor does it plan to conduct separate monitoring or evaluation of quality of care for the SCHIP population covered under Medicaid since we have a thorough program. We will continue the quality assurance program outlined in Section 4.5.2 for all children on Medicaid in Maryland.

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.

Attachment E is a report and fact sheet on the HealthChoice Program's Annual Quality of Care Audit.

SECTION 5. REFLECTIONS

This section is designed to identify lessons learned by the State during the early implementation of its CHIP program as well as to discuss ways in which the State plans to improve its CHIP program in the future. The State evaluation should conclude with recommendations of how the Title XXI program could be improved.

- 5.1 What worked and what didn't work when designing and implementing your CHIP program? What lessons have you learned? What are your "best practices"? Where possible, describe what evaluation efforts have been completed, are underway, or planned to analyze what worked and what didn't work. Be as specific and detailed as possible. (Answer all that apply. Enter 'NA' for not applicable.)

We will address each of the specific areas below. One overarching comment is that preparing this evaluation has been a very helpful exercise in focusing our efforts on where we need to strengthen the program. We have spent most of our energy the last year and one half in getting the program up and running. We believe that we have been quite successful in many aspects of implementing the program, but are at the point at which we need to do some strategic planning for the future. For example, the need for better data to support our estimates of the uninsured, assess progress in meeting our stated goals, and to determine which strategies are most effective in enrolling children is abundantly clear. Completing this evaluation protocol has sharpened our awareness of the strengths of our program as well as revealed aspects of the program that require additional attention. As a result of this process, we have a much clearer plan of action for the Maryland Children's Health Program. This next section lays out some of the specific steps we plan to take in the coming year.

5.1.1 Eligibility Determination/Redetermination and Enrollment

The MCHP was up and running 10 weeks after Governor Parris Glendening signed the enabling legislation into law. Effective July 1, 1998, local health departments throughout the State began determining eligibility for MCHP. This successful implementation was the result of a considerable amount of interagency teamwork necessary to make significant changes to systems, regulations, policies and procedures. Other critical work included the development of a simple 3 page application, the development and production of outreach materials, training local staff on determining eligibility and providing training to community-based organizations on outreach to potentially eligible children.

The most important lesson learned is that cooperation and support of many governmental and local organizations is critical to implementation of a major program such as MCHP.

We have not yet evaluated our eligibility or redetermination process. Broad-based program analysis and evaluation is being planning through State Program resources and cooperative efforts with Federal agencies and Foundations. As mentioned in Section 3.1.8, we are developing an application for the Robert Wood Johnson Foundation grant, "Supporting Families after Welfare Reform."

5.1.2 Outreach

We believe that two factors contributed to the success of MCHP: (1) early involvement of the public in development and planning for MCHP; and (2) our guiding principle in implementation of program simplicity.

First, we involved the public early in the process of planning MCHP. The Governor and the Secretary of the Department of Health and Mental Hygiene began an extensive public process to obtain public input into making a decision on program design for SCHIP. The process began with four public hearings held around the State and culminated with the Governor's Roundtable on Children's Health Insurance in Baltimore City, which the Governor personally chaired.

Second, we stressed the importance of designing a program that is easy for the general public to understand and to access. Our message was simple: if you are under 19 and in a family under 200 percent of poverty you are eligible for comprehensive health care benefits through MCHP. In order to streamline the application process, we shortened and simplified the application to 3 pages, we eliminated the face-to-face interview, we eliminated the assets test and we eliminated the requirement for income verification during the application process. In addition, we allowed mail-in applications and the local health departments rather than the welfare offices to determine eligibility to reduce the welfare stigma.

We have not yet completed an evaluation of our outreach process. We have solicited technical assistance through a HRSA grant to help us begin evaluation our outreach strategies.

5.1.3 Benefit Structure

See Section 5.1.5

5.1.4 Cost-Sharing (such as premiums, copayments, compliance with 5% cap)

NA

5.1.5 Delivery System

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

5.1.6 Coordination with Other Programs (especially private insurance and crowd-out)

Maryland currently imposes a 6 month waiting period for children covered by an employer sponsored health benefit plan with dependent coverage that was voluntarily terminated.

5.1.7 Evaluation and Monitoring (including data reporting)

Please see Section 4.4 for fuller description of activities to assure quality of care.

The State has been able to implement and obtain data using the following methods to assure the quality and appropriateness of care: Health Risk Assessments, Recipient and Provider Satisfaction Surveys, Recipient and Provider Hotlines and Complaint Resolution systems, EPSDT, Annual Quality of Care Audit, HEDIS data, Focused clinical reviews and Ombudsman Programs.

The Department continues to be a very active partner in public involvement and participation regarding HealthChoice. Some of the ongoing committees that have assisted in providing monitoring and assurances for the program include:

Quality Assurance Liaison Committee: The purpose is to address topics of

general interest concerning quality improvement issues;

Medicaid Advisory Committee: Comprised of enrollee, enrollee advocates, representatives from the legislature and MCOs, with the main function to review and make recommendations on the operation and evaluation of managed care programs under HealthChoice;

Special Needs Children Advisory Council: The mission is to conduct regular reviews of available data and to participate in the effectiveness study for children with special health care needs;

Medical Review Panel for Rare and Expensive Case Management: The purpose is to review and make recommended changes to the eligibility criteria for REM; and

Bi-Weekly MCO Meetings: A meeting of the 8 MCOs with the purpose of problem solving and offering an opportunity for MCOs to express actual or potential barriers to the successful implementation of HealthChoice.

5.1.8 Other (specify)

5.2 What plans does your State have for “improving the availability of health insurance and health care for children”? (Section 2108(b)(1)(F))

In 1999, the General Assembly directed the Department to study and make recommendations on how to expand the Maryland Children’s Health Program through private market employer-sponsored health benefit plans and individual health benefit plans. The Department convened a Technical Advisory Committee comprised of advocates, insurers, employers, and State agency officials to develop a plan for a private option. We used an open and inclusive process to solicit information and assure that complex design issues were thoroughly reviewed and discussed.

In December 1999, the Department submitted a report to the General Assembly with recommendations on how to implement a workable “private option” program. The House and Senate leadership together with the Governor introduced legislation in January of 2000 based on our recommendations. It moved quickly through the House of Delegates and was adopted.

The legislation has two major provisions. First, it would expand eligibility for children in families with incomes from 200 percent of poverty to 300 percent of poverty. We believe that over 19,000 previously uninsured children would receive health insurance coverage through this expansion of the current program.

Children whose family income is between 200 and 300 percent of poverty would receive

coverage through employer-sponsored insurance if it were available and met the Federal standards. If employer-sponsored insurance were not available, the child would be enrolled in a Medicaid look-alike program with the same benefits and through the same managed care delivery system as enrollees in our HealthChoice program.

The second major provision of the bill would impose a family contribution (premium) on children whose family income is between 200 and 300 percent of poverty. A child whose family income is greater than 200 percent of poverty but at or less than 250 percent would be required to pay \$37.50 per month. A child whose family income is greater than 250 percent of poverty but at or less than 300 percent of poverty would be required to pay \$47 per month. The family contribution would remain the same regardless of how many children are in the family.

More recently, the Senate has adopted a different approach from the House-passed bill and the bill that they originally introduced in January. The Senate passed a bill on March 30, 2000 that would expand Medicaid eligibility to children in families with income up to 250 percent of poverty. It would not provide premium assistance for employer-sponsored insurance, and it would not impose premiums.

At this time, it is unclear whether the House or Senate version will prevail.

5.2 What recommendations does your State have for improving the Title XXI program?
(Section 2108(b)(1)(G))

Maryland has several suggestions for ways in which the Department of Health and Human Services (DHHS) might improve the Title XXI program. We understand that some of these would require legislative changes. We are hopeful that these initiatives will be pursued both in conversations with Congressional authorizing committees and as DHHS helps in preparing the next Administration's fiscal year 2002 budget.

First, Maryland feels very strongly that States should be able to keep their unspent SCHIP allotments for more than 3 years. Maryland's SCHIP program began in July of 1998. Since that time, we have experienced a steady growth in enrollment. Although we have exceeded our enrollment goal, we are not even close to spending our fiscal year 1998 allotment, which is set to expire in 6 short months. We do believe, however, as our program enrollment continues to grow and with our likely program expansion we will need our full allotment for each fiscal year. States should not be penalized for building their programs slowly rather than prematurely implementing them. For the first few years, in particular (FY98 and 99), we urge your consideration of allowing States to keep their SCHIP allotments for 5 years instead of 3.

Second, we are very concerned that the 10 percent cap on administrative expenses is not sufficient for States that establish separate State programs. We urge you to adopt a modification so that either outreach expenses are not included in the 10 percent cap or

that the 10 percent cap is expanded. We believe that Congress intended some limits on how much States could spend on administration versus benefits, but that the 10 percent cap on administrative costs is unreasonable.

If the Maryland General Assembly adopts a separate State program to provide premium assistance for higher income children, we will need to establish a new unit to undertake many new activities. Some of the functions of this new unit will include: collection of premiums; payment of the State subsidy; ongoing monitoring of employer plans and contributions; outreach and coordination with employers; assessment of large employer benefit packages; and systems development. Maryland already spends about five percent on administrative costs. It is difficult to imagine that we will not exceed the 10 percent cap if we have to undertake a vast number of new administrative changes to implement a premium assistance program.

Third, we urge greater flexibility on issues related to premium assistance programs to encourage employer participation with these programs. Specifically, we believe the Administration's policy requiring an employer contribution of at least 60 percent of the total cost of family coverage is too stringent. We fully support the SCHIP regulation's flexibility to allow a lower amount if the average employer contribution to family coverage is less than 60 percent in the State. Maryland conducted a survey of employers and found that the average employer contribution was lower than 60 percent. If the Maryland General Assembly enacts a program to provide premium assistance for employer-sponsored insurance, we plan to request a waiver of the 60 percent requirement. We urge the Administration's flexibility in reducing the 60 percent requirement based on data demonstrating State variations from the national average.

In addition, we encourage your flexibility on payment of subsidy issues. We believe that employers may be more willing to participate in premium assistance programs if they have limited adjustments to make. If Maryland adopts a premium assistance program, we will be considering paying the State subsidy to families directly on a prospective basis so that employers will not have to make adjustments to their existing withholding arrangements.

Addendum to Table 3.1.1

The following questions and tables are designed to assist states in reporting countable income levels for their Medicaid and SCHIP programs and included in the NASHP SCHIP Evaluation Framework (Table 3.1.1). This technical assistance document is intended to help states present this extremely complex information in a structured format.

The questions below ask for countable income levels for your Title XXI programs (Medicaid SCHIP expansion and State-designed SCHIP program), as well as for the Title XIX child poverty-related groups. Please report your eligibility criteria as of **September 30, 1999**. Also, if the rules are the same for each program, we ask that you enter duplicate information in each column to facilitate analysis across states and across programs.

If you have not completed the Medicaid (Title XIX) portion for the following information and have passed it along to Medicaid, please check here **9** and indicate who you passed it along to. Name _____, phone/email _____

3.1.1.1 For each program, do you use a gross income test or a net income test or both?

Title XIX Child Poverty-related Groups	___ Gross	<u>X</u> Net	___ Both
Title XXI Medicaid SCHIP Expansion	___ Gross	<u>X</u> Net	___ Both
Title XXI State-Designed SCHIP Program	___ Gross	___ Net	___ Both
Other SCHIP program _____	___ Gross	___ Net	___ Both

3.1.1.2 What was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately.

Title XIX Child Poverty-related Groups	185 % of FPL for children under age
___ 1 ___	
	185 % of FPL for children aged ___ 1 -
6 ___	
	185 % of FPL for children aged <u>Born</u>
	after 9/30/83
Title XXI Medicaid SCHIP Expansion	200 % of FPL for children aged <19
<u>yrs but born before 9/30/83 and over 40% FPL</u>	
	200 % of FPL for children aged <19
	<u>yrs but born after 9/30/83 and over 185% FPL</u>
	___ % of FPL for children aged

Title XXI State-Designed SCHIP Program _____ % of FPL for children aged _____

_____ % of FPL for children aged _____

_____ % of FPL for children aged _____

Other SCHIP program _____ % of FPL for children aged _____

_____ % of FPL for children aged _____

_____ % of FPL for children aged _____

3.1.1.3 Complete Table 1.1.1.3 to show whose income you count when determining eligibility for each program and which household members are counted when determining eligibility? (In households with multiple family units, refer to unit with applicant child)

Enter “Y” for yes, “N” for no, or “D” if it depends on the individual circumstances of the case.

	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title X State-des: SCHIP Pr
Family Composition			
Child, siblings, and legally responsible adults living in the household	D	D	
All relatives living in the household	N	N	
All individuals living in the household	N	N	
Other (specify)	N	N	

3.1.1.4 How do you define countable income? For each type of income please indicate whether it is counted, not counted or not recorded.

Enter “C” for counted, “NC” for not counted and “NR” for not recorded.

Table 3.1.1.4			
Type of Income	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title X State-des SCHIP Pr
Earnings	C	C	
Earnings of dependent children			
Earnings of students	C	C	
Earnings from job placement programs	C	C	
Earnings from community service programs under Title I of the National and Community Service Act of 1990 (e.g., Serve America)	C	C	
Earnings from volunteer programs under the Domestic Volunteer Service Act of 1973 (e.g., AmeriCorps, Vista)	C	C	
Education Related Income Income from college work-study programs	C	C	
Assistance from programs administered by the Department of Education	C	C	
Education loans and awards	C	C	
Other Income Earned income tax credit (EITC)	C	C	
Alimony payments received	C	C	
Child support payments received	C	C	
Roomer/boarder income	C	C	
Income from individual development accounts	C	C	
Gifts	C	C	
In-kind income	NC	NC	
Program Benefits Welfare cash benefits (TANF)	NC	NC	

Supplemental Security Income (SSI) cash benefits	NC	NC	
Social Security cash benefits	C	C	
Housing subsidies	NC	NC	
Foster care cash benefits	NC	NC	
Adoption assistance cash benefits	NC	NC	
Veterans benefits	C	C	
Emergency or disaster relief benefits	NC	NC	
Low income energy assistance payments	NC	NC	
Native American tribal benefits	NC	NC	
Other Types of Income (specify) -- Any income not specifically excluded in regulation	C	C	

*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”.

3.1.1.5 What types and *amounts* of disregards and deductions does each program use to arrive at total countable income?

Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter "NA."

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

___ Yes X No

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

Table 3.1.1.5			
Type of Disregard/Deduction	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title X State-des SCHIP Pr
Earnings	\$90/month	\$90/month	\$
Self-employment expenses	\$90/month	\$90/month	\$
Alimony payments Received	\$ -0-	\$ -0-	\$
Paid	\$ ALL	\$ ALL	\$
Child support payments Received	\$50	\$50	\$
Paid	\$ ALL	\$ ALL	\$
Child care expenses	\$175/100*	\$175/100	\$
Medical care expenses	\$0	\$0	\$
Gifts	\$ ALL	\$ ALL	\$
Other types of disregards/deductions (specify)	\$0	\$0	\$

* \$175 is disregarded if parents work more than 100 hours per month/\$100 is disregarded if parents work less than 100 hours per month.

3.1.1.6 For each program, do you use an asset or resource test?

Title XIX Poverty-related Groups X No ___ Yes
(complete column A in 3.1.1.7)

