

**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: \_\_\_\_\_ New Mexico \_\_\_\_\_  
(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: 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? *The estimated baseline for the number of children not covered is 94,500. This is the same number as stated on New Mexico's 1115 waiver. New Mexico did not submit a CHIP Annual Report in 1998 as the program did not exist in the state until March of 1999.*

1.1.1 What are the data source(s) and methodology used to make this estimate? *The data source is based on the U.S. Census Bureau Current Population Survey for 1996, which estimated the total number of uninsured children in New Mexico that year to be 108,788. The projected numbers for 1997 of total uninsured children, adjusted for population growth, were 109,926.*

*The percentages of uninsured children above and below 185% federal poverty level (FPL) come from statistical analysis of the 1993 Robert Wood Johnson Foundation Family Survey of Health Insurance in New Mexico. The percentages are applied to the estimates of uninsured children to arrive at the number of uninsured families with income below 185% FPL, and those uninsured children with incomes 185% to 235% FPL.*

*The estimate of 14% of uninsured children in families at or above 185% FPL is generally consistent with the statistics from the Employee Benefits Research Institute which show 14.8% of uninsured children in the U.S. were in families at or above 200% FPL in 1992. The estimate is also generally consistent with the statistics from the State Level Databook on Health Care Access and Financing from the Urban Institute. Their analysis of CSP data for 1991, 1992 and 1993 shows 24% of nonelderly uninsured people (adults and children) were in families at or above 200% FPL.*

*The estimate of 86% of uninsured children in families with incomes below 185% FPL is generally consistent with conjecture among Medicaid professionals that the Medicaid participation rate has been approximately 60%. Information from*

*the Medicaid MARS Eligibility Report (HMRG 152X 6/97) indicates 164,073 children were enrolled in Medicaid in June, 1997. Those are about 63% of 258,610, which is the sum of 164,073 enrolled children and approximately 94,500 children who are estimated to qualify under the 185% FPL guidelines but are not enrolled. Our estimate of the number of children at or below 185% FPL is generally consistent with the 258,610, lending support to the estimates*

- 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 state is reasonably confident in its estimate, based on the explanation given above.*

- 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))

*The state has made excellent progress in increasing the number of insured children. As of February 29, 2000, a total of 204,761 children were enrolled in all Medicaid categories. In the SCHIP program, 2,887 were enrolled.*

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

*The data source is actual Medicaid enrollment count as of February 29, 2000.*

- 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 is highly confident in these numbers as they are based on actual Medicaid enrollment figures.*

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

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

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

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

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<b>Table 1.3</b>		
(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.)
<b>OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN</b>		
94,500 uninsured children to be enrolled		<p>Data Sources: Stated in Section 1.1.1</p> <p>Methodology: Stated in Section 1.1.1</p> <p>Numerator: <i>N/A</i></p> <p>Denominator: <i>N/A</i></p> <p>Progress Summary: <i>Enrollment of children as of February, 2000 is 204,761; indicating that 30,829 have been newly added to the rolls since July 1997.</i></p> <p><i>As a percentage of the state's objective, this represents nearly 41% of the identified number of uninsured children from low-income households.</i></p>

**Table 1.3**

**OBJECTIVES RELATED TO CHIP ENROLLMENT**

SCHIP Enrollment of 5,500		<p>Data Sources: <i>Multiple surveys and population projections and projected growth rate based on past growth history</i></p> <p>Methodology:</p> <p>Numerator:</p> <p>Denominator:</p> <p>Progress Summary: <i>As of February, 2000, 2,887 are enrolled in SCHIP. This represents the New Mexico has enrolled 52% of the potentially eligible SCHIP children in one year.</i></p>
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## SECTION 2. BACKGROUND

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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: State Children's Health Insurance Program (SCHIP)

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

3/1/1999

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

Name of program:

N/A

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

Other - Family Coverage

Name of program: N/A

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

Other - Employer-sponsored Insurance Coverage

Name of program: N/A

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

\_\_\_ Other - Wraparound Benefit Package

Name of program:

N/A

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

\_\_\_ Other (specify) N/A

Name of program:

N/A

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

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. *N/A*

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

2.2 What environmental factors in your State affect your CHIP program? (Section 2108(b)(1)(E)) *2/3 of the state's population live in rural areas – the population is spread out.*

2.2.1 How did pre-existing programs (including Medicaid) affect the design of your CHIP program(s)? *Children's Medicaid already covered children from households whose income fell below 185% of the Federal Poverty Level (FPL).*

*With an existing infrastructure, New Mexico opted to make its CHIP program an expansion of Medicaid. The Children in New Mexico falling under the CHIP category are from families whose income levels fall between 185% and 235% of FPL. Children in this category receive the same coverage and those under 185% of FPL, but with cost sharing in the form of a small co-payment to the provider at the time services are received.*

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

X 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?

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 *More than 20,000 children enrolled since the inception of Presumptive Eligibility since July 1998.*

\_\_\_ Coverage of Supplemental Security Income (SSI) children

Provision of continuous coverage (specify number of months 12)

Note: *Continuous eligibility regardless of changes in household income.*

Elimination of assets tests

Elimination of face-to-face eligibility interviews *Note: Face-to-face interviews at the local state offices were eliminated – SCHIP Eligibility can be obtained off-site through the schools, FQHCs, Indian Health Services and other providers as part of the Presumptive Eligibility/Medicaid On-Site Application Assistance program.*

\_\_\_ Easing of documentation requirements

Impact of welfare reform on Medicaid enrollment and changes to AFDC/TANF (specify) *Through the “delinking” of cash assistance and Medicaid, individuals who might not otherwise obtain Medicaid coverage due to the stigma of entering a state “welfare” office may apply for Medicaid without ever stepping in a state office through the Presumptive Eligibility/Medicaid On-Site Application Assistance program. Children can apply for Medicaid through the schools, providers, FQHCs, Indian Health Services etc.*

\_\_\_ 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) \_\_\_\_\_
  - \_\_\_ Changes in economic circumstances, such as unemployment rate (specify)
  - \_\_\_ 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.”

	<b>Medicaid CHIP Expansion Program</b>	<b>State-designed CHIP Program</b>	<b>Other CHIP Program*</b>
Geographic area served by the plan (Section 2108(b)(1)(B)(iv))	<i>Entire State</i>	N/A	N/A
Age	<i>Children under age 19</i>	N/A	N/A
Income (define countable income)	<i>Countable Income of parents only if the parents are in the household <u>AND</u> financially responsible for the Child(ren).</i>	N/A	N/A
Resources (including any standards relating to spend downs and disposition of resources)	<i>No Resource test</i>	N/A	N/A
Residency requirements	<i>Must be a resident of the state</i>	N/A	N/A
Disability status	<i>N/A</i>	N/A	N/A
Access to or coverage under other health coverage (Section 2108(b)(1)(B)(i))	<i>Children receiving coverage under a private health insurance policy are not eligible for CHIP. Voluntary cancellation of existing health insurance make the child(ren) ineligible for 12 months.</i>	N/A	N/A

Other standards (identify and describe)	<i>Children in households with income that is 185% of FPL and Less than 235% of FPL qualify for SCHIP. Under 185% qualifies for the children's category of Medicaid coverage.</i>	N/A	N/A
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*\*Make a separate column for each “other” program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.*

3.1.2 How often is eligibility redetermined?

Redetermination	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*
Monthly		N/A	N/A
Every six months		N/A	N/A
Every twelve months	<b>X</b>	N/A	N/A
Other (specify)	<i>12 Months Continuous Eligibility regardless of income changes.</i>	N/A	N/A

\*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  No Which program(s)? **Children’s Medicaid and SCHIP**

For how long? **12 months continuous regardless of income changes**

No

3.1.4 Does the CHIP program provide retroactive eligibility?

Yes  No Which program(s)? **All children’s Medicaid categories -**

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

No

3.1.5 Does the CHIP program have presumptive eligibility?

Yes  No Which program(s)? **All children’s Medicaid categories**

Which populations? **All populations meeting the eligibility criteria**

Who determines? **Certified and trained qualified entities (FOHCs, Schools and Indian Health Services, etc).**

No



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

Yes  No Is the joint application used to determine eligibility for other State programs? If yes, specify. **Application for Children's Medicaid and CHIP are on the same form as used for Pregnant women, and Family planning services for women**

No

3.1.7 Evaluate the strengths and weaknesses of your *eligibility determination* process in increasing creditable health coverage among targeted low-income children? ***The Presumptive Eligibility/Medicaid On-Site Application Assistance program (PE/MOSAA) has been a major factor in helping enroll uninsured children. Presumptive Eligibility covers the child(ren) for up to 60 days. The MOSAA application for Medicaid enrollment is also done at the Presumptive Eligibility sites.***

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? ***It is too early to evaluate as the program was implemented in March of 1999. Preliminary data should be available in April, 2000.***

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 Managed Care**

Benefit	Is Service Covered? (T = yes)	Cost-Sharing (Specify)*  *Cost-Sharing in the form of co-payment only applies to those between 185% & 235% FPL (CHIP), no cost sharing for below 185% FPL. There is no co-payment for services received through Indian Health Services (IHS)	Benefit Limits (Specify)
Inpatient hospital services	T	\$25	
Emergency hospital services	T	\$15	
Outpatient hospital services	T	\$15	
Physician services	T	\$5	
Clinic services	T	\$5	
Prescription drugs	T	\$2	
Over-the-counter medications	T	\$2	Therapeutic classes covered are: analgesics, topical antiinfectives and antifungals, antiulcer drugs, vitamins and minerals, stool softeners and laxatives.
Outpatient laboratory and radiology services	T	\$5	
Prenatal care	T	Waived	
Family planning services	T	Waived	
Inpatient mental health services	T	\$25	
Outpatient mental health services	T	\$5	
Inpatient substance abuse treatment services	T	\$25	
Residential substance abuse treatment services	T	\$25	

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Outpatient substance abuse treatment services	T	\$5	
Durable medical equipment	T		
Disposable medical supplies	T		
Preventive dental services	T	\$5	
Restorative dental services	T	\$5	
Hearing screening	T	\$5	
Hearing aids	T		
Vision screening	T	\$5	
Corrective lenses (including eyeglasses)	T		
Developmental assessment	T		
Immunizations	T	\$5	
Well-baby visits	T		
Well-child visits	T		
Physical therapy	T	\$5	
Speech therapy	T	\$5	
Occupational therapy	T	\$5	
Physical rehabilitation services	T	\$5	
Podiatric services	T	\$5	
Chiropractic services	No	N/A	
Medical transportation	T		
Home health services	T		

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Nursing facility	T*	\$25	*For interim or non-permanent placement only
ICF/MR	No	N/A	Under a different Medicaid Category
Hospice care	T		
Private duty nursing	T		
Personal care services	T		
Habilitative services	No		
Case management/Care coordination	T		CM for: Pregnant Women and Their Children, EPSDT, and Children Up To Age Three
Non-emergency transportation	T		
Interpreter services	No		
Other (Specify) <u>Enhanced Benefits</u>			The MCOs offer enhanced benefits outside of the NM Medicaid benefit package. These services vary among the MCOs.
Other (Specify) Nutrition Services			
Other (Specify) Prosthetics and Orthotics			

<b>Table 3.2.1 CHIP Program Type Fee for Service</b>			
Benefit	Is Service Covered? (T = yes)	Cost-Sharing (Specify)*  *Cost-Sharing in the form of co-payment only applies to those between 185% & 235% FPL (CHIP), no cost sharing for below 185% FPL. There is no co-payment for services received through Indian Health Services (IHS)	Benefit Limits (Specify)
Inpatient hospital services	T	\$25	
Emergency hospital services	T	\$15	
Outpatient hospital services	T	\$15	
Physician services	T	\$5	
Clinic services	T	\$5	
Prescription drugs	T	\$2	
Over-the-counter medications	T	\$2	
Outpatient laboratory and radiology services	T	\$5	
Prenatal care	T	Waived	
Family planning services	T	Waived	
Inpatient mental health services	T	\$25	
Outpatient mental health services	T	\$5	

Inpatient substance abuse treatment services	T	\$25	<i>Inpatient substance abuse treatment is covered in residential treatment centers (RTCs) and in-patient psych. Hospitals (where indicated). We do not cover free standing inpatient substance abuse treatment centers</i>
Residential substance abuse treatment services	T	\$25	<i>Residential substance abuse treatment is covered in residential treatment centers (RTCs) and in-patient psych. Hospitals (where indicated).</i>
Outpatient substance abuse treatment services	T	\$5	
Durable medical equipment	T		
Disposable medical supplies	T		
Preventive dental services	T	\$5	
Restorative dental services	T	\$5	<i>If medically necessary and identified as the result of an EPSDT screen.</i>
Hearing screening	T	\$5	
Hearing aids	T		
Vision screening	T	\$5	
Corrective lenses (including eyeglasses)	T		
Developmental assessment	T		
Immunizations	T	\$5	
Well-baby visits	T		
Well-child visits	T		
Physical therapy	T	\$5	
Speech therapy	T	\$5	

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Occupational therapy	T	\$5	
Physical rehabilitation services	T	\$5	
Podiatric services	T	\$5	<i>Under EPSDT, individuals under 21 years of age may receive podiatric services if medically necessary, that are not available to adults.</i>
Chiropractic services	No	N/A	
Medical transportation	T		
Home health services	T		
Nursing facility	T	\$25	<i>While children may be eligible for NF services, it is optimal to provide services to this population in a less restrictive setting</i>
ICF/MR	T		<i>While children may be eligible for ICF/MR services, it is optimal to provide services to this population in a less restrictive setting.</i>
Hospice care	T		
Private duty nursing	T		
Personal care services	T		
Habilitative services	No		
Case management/Care coordination	T		
Non-emergency transportation	T		
Interpreter services	No		<i>We are currently exploring adding interpreter services to the benefit package. If medically necessary and identified as the result of an EPSDT screen, this service would be available to children, even if not currently in the benefit package.</i>

Other (Specify) Treatment Foster care	T		
Other (Specify) <u>Outpatient and partial hospitalization in a free standing psychiatric hospital</u>	T		
Other (Specify) <u>Home and Community-Based Waiver programs</u>	T		

### 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.)

### 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.

<b>Table 3.2.3</b>			
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 <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mandatory enrollment?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Number of MCOs	3		
B. Primary care case management (PCCM) program			
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)			
D. Indemnity/fee-for-service (specify services that are carved out to FFS, if applicable)	<i>Presumptive eligibility period coverage, Native Americans, members enrolled in HIPP, members in NF's or ICF/MRs, children and adolescents in out of state foster care or adoption placement</i>		
E. Other (specify)			
F. Other (specify)			
G. 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”.

3.3 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

Type of cost-sharing	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Premiums			
Enrollment fee			
Deductibles			
Coinsurance/copayments**	<b>X</b>		
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? *N/A*

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

- 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

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does it vary by program, income, family size, or other criteria? *N/A*

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? ***Families are notified on their Medicaid Card what the co-payment requirements are, and are informed they must save their documentation of making co-payments. Upon presentation of documentation for reaching the co-payment maximum, a notation is made in the case file on the system, and subsequent Medicaid cards issued have the co-payment information removed.***

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.) ***To date, no families have reported reaching the co-payment cap.***

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? *N/A*

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						
Brochures/flyers	T	5				
Direct mail by State/enrollment broker/administrative contractor	T	5				
Education sessions	T	5				
Home visits by State/enrollment broker/administrative contractor	N/A					
Hotline	T	5				
Incentives for education/outreach staff	T	2				
Incentives for enrollees	T	5				
Incentives for insurance agents	N/A					
Non-traditional hours for application intake	T	3				
Prime-time TV advertisements	T	5				
Public access cable TV	N/A					
Public transportation ads						

Radio/newspaper/TV advertisement and PSAs	T	5				
Signs/posters	T	5				
State/broker initiated phone calls	N/A					
Other (specify) <u>3 SPECIAL NEEDS CONTRACTORS</u> *	T	5				
Other (specify) <u>3 STATEWIDE ROBERT WOOD JOHNSON FOUNDATION COVERING KIDS PROJECT</u> **	T	5				

\*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”

\*Three special needs contractors for statewide educational outreach

- ARC OF NEW MEXICO = ASSOCIATION FOR RETARDED CITIZENS
- NEW MEXICO AMI = ALLIANCE FOR MENTALLY ILL
- PRO = PARENTS REACHING OUT

\*\* Statewide Robert Wood Johnson Foundation Covering Kids Project (Educational outreach, door-to-door visits, undocumented children)

3.4.2 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.

<b>Table 3.4.2</b>						
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	T	3				
Community sponsored events	T	5				
Beneficiary's home	T	5				
Day care centers	T	4				
Faith communities	T	5				
Fast food restaurants	T	3				
Grocery stores	T	3				
Homeless shelters	T	5				
Job training centers	T	5				
Laundromats	T	4				
Libraries	T	4				
Local/community health centers	T	5				
Point of service/provider locations	T	5				
Public meetings/health fairs	T	5				
Public housing						

Developed by the National Academy for State Health Policy

Refugee resettlement programs	T	5				
Schools/adult education sites	T	5				
Senior centers	T	5				
Social service agency	T	5				
Workplace	T	5				
Other (specify) <u>59 Chambers of Commerce through the State</u> *	T	5				
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”.

\* Over 18,000 private sector businesses.

- 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.
- 3.4.4 What communication approaches are being used to reach families of varying ethnic backgrounds? ***New Mexico has a large Spanish speaking population. All outreach materials are in Spanish as well as English.***
- 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.

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) Providers, FQHC, Indian Health Services	Other (specify) Schools
Administration		X	X	X
Outreach		X	X	X
Eligibility determination		X	X	X
Service delivery			X	
Procurement				
Contracting				
Data collection			X	X (Robert Wood Johnson covering kids contract; special needs outreach contract)
Quality assurance			X	X (see above)
Other (specify)				
Other (specify)				

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

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) 12 Months waiting period for those who voluntarily cancel insurance

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

Information verified with employer (specify)

Records match (specify)

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. ***It is too early to assess as the program was implemented in March of 1999.***

## SECTION 4. PROGRAM ASSESSMENT

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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.

<b>Table 4.1.1 CHIP Program Type</b> — 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
<b>All Children</b>	0	1,908 (period from March 1999 to close of Federal Fiscal year September 1999)	N/A	N/A	N/A	N/A

#### 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))

- 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))
- 4.2 Who disenrolled from your CHIP program and why? *N/A*
- 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?
- 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? ***The Program was implemented in March 1999, consequently, there has been no re-enrollment – children receive twelve months continuous eligibility regardless of income changes.***

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

**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						

\*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”.

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

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 \$0 – Program Began in March 1999

FFY 1999 \$1,045,570

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?

<b>Table 4.3.1 CHIP Program Type</b> <u>Expansion of Medicaid Eligibility</u>				
Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
<b>Total expenditures</b>	\$0	\$1,045,570	\$0	\$847,742
<b>Premiums for private health insurance (net of cost-sharing offsets)*</b>	N/A	N/A	N/A	N/A
<b>Fee-for-service expenditures (subtotal)</b>	\$0	\$1,045,570	\$0	\$847,742
Inpatient hospital services	\$0	\$303,108	\$0	\$245,791
Inpatient mental health facility services	\$0	\$23,476	\$0	\$19,037
Nursing care services	N/A	N/A	N/A	N/A
Physician and surgical services	\$0	\$75,615	\$0	\$61,316
Outpatient hospital services	\$0	\$73,268	\$0	\$59,413
Outpatient mental health facility services	N/A	N/A	N/A	N/A
Prescribed drugs	\$0	\$34,402	\$0	\$27,897

Dental services	\$0	\$7,287	\$0	\$5,909
Vision services	N/A	N/A	N/A	N/A
Other practitioners' services	\$0	\$128,811	\$0	\$104,454
Clinic services	\$0	\$6,768	\$0	\$5,488
Therapy and rehabilitation services	N/A	N/A	N/A	N/A
Laboratory and radiological services	\$0	\$2,409	\$0	\$1,953
Durable and disposable medical equipment	N/A	N/A	N/A	N/A
Family planning	N/A	N/A	N/A	N/A
Abortions	N/A	N/A	N/A	N/A
Screening services	\$0	\$14,988	\$0	\$12,064
Home health	\$0	\$1,649	\$0	\$1,314
Home and community-based services	N/A	N/A	N/A	N/A
Hospice	N/A	N/A	N/A	N/A
Medical transportation	\$0	\$8,594	\$0	\$6,969
Case management	\$0	\$1,497	\$0	\$1,214
Other services	\$0	\$363,698	\$0	\$294,923

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? \_\_\_\_\_

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

<b>Table 4.3.2</b>						
<b>Type of expenditure</b>	Medicaid Chip Expansion Program		State-designed CHIP Program		Other CHIP Program*	
	FY 1998	FY 1999	FY 1998	FY 1999	FY 1998	FY 1999
<b>Total computable share</b>	\$30,700	\$423,700				
Outreach						
Administration						
Other _____						
<b>Federal share</b>						
Outreach						
Administration						
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?

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			
PCP/enrollee ratios			
Time/distance standards			
Urgent/routine care access standards			
Network capacity reviews (rural providers, safety net providers, specialty mix)			
Complaint/grievance/disenrollment reviews	<b>X</b>		
Case file reviews			
Beneficiary surveys	<b>X</b>		
Utilization analysis (emergency room use, preventive care use)			
Other (specify) Routine Quality Assurance as implemented for all Medicaid Categories	<b>X</b>		
Other (specify) <b>I PRO Study</b>	<b>X</b>		
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”.

4.4.2 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.

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? ***A survey instrument will be constructed to gather information from participants and providers.***

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)			
Client satisfaction surveys	<b>X - MCO</b>		
Complaint/grievance/disenrollment reviews	<b>X - MCO &amp; FFS</b>		
Sentinel event reviews			
Plan site visits			
Case file reviews			
Independent peer review			
HEDIS performance measurement	<b>X - MCO</b>		
Other performance measurement (specify)	<b>X - Annual EQRO Evaluation</b>		
Other (specify) <i>Special study (see IPRO attachment)</i>	<b>X</b>		
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. *See attached Salud! Newsletter dated November 1998. New Mexico’s SCHIP enrollees are covered under a Medicaid expansion, and receive the same coverage and quality assurance protections as all Medicaid clients.*

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? *Special Study (see IPRO attachment)*

- 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.

***IPRO Medicaid Salud! Plan Enrollee Satisfaction Survey - 1999***

## **SECTION 5. REFLECTIONS**

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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.

New Mexico implemented SCHIP as a Medicaid expansion with modest copayments in March of 1999. The state was required to submit and administer an 1115 waiver in order to implement cost-sharing in a Medicaid-expansion program. Incorporation of modest cost-sharing was essential to the process of political buy-in necessary for New Mexico's implementation of SCHIP.

New Mexico was disadvantaged by having invoked 1902(r)(2) provisions in 1995 to expand Medicaid eligibility for children in families with incomes between 133% and 185% of income poverty guidelines. Balanced Budget Act of 1997 provisions required New Mexico to use SCHIP funds for the population with incomes from 185-235% of federal poverty guidelines. Due to New Mexico's unique demographics, the entire universe of potential eligibles was approximately 5,500 children. Had New Mexico not voluntarily expanded coverage of children up to 185% on the date of BBA enactment, the SCHIP funding could have been used for the cost of enrolling those uninsured but unenrolled children between 133% and 185% of federal income poverty guidelines.

The state proposed to use SCHIP funding to provide an enhanced benefit package to Medicaid-eligible children, including the SCHIP population. The State Plan Amendment to implement the Phase II services was submitted to the Health Care Financing Administration (HCFA) on April 15, 1999, and was denied by HCFA in a letter that was received by New Mexico on July 8, 1999. New Mexico continues to work with HCFA to resolve the issue of use of SCHIP funds for wrap-around services to the satisfaction of both parties.

As mentioned above, New Mexico submitted an 1115 waiver to allow for modest copayments in its Medicaid-expansion SCHIP program, which was subsequently approved by HCFA. HCFA recently released a policy interpretation that prohibits the imposition of any cost-sharing on Native American SCHIP children, even by states that have approved 1115 waivers. As a result of this policy interpretation, New Mexico is in the process of implementing the necessary policy and system changes to remove the copayment requirement for Native American SCHIP children.

The target date for this policy change is July 1, 2000.

New Mexico has implemented extensive outreach for children via the New Mexikids campaign, 12-month continuous eligibility option for children, and the Presumptive Eligibility and Medicaid On-Site Application Assistance (MOSAA) programs, where close to 1,000 qualified entities that include IHS facilities, schools, primary care providers, public health centers, and others, accept Medicaid applications and do a simplified Medicaid eligibility determination. New Mexico's sharply increasing enrollment numbers speak for themselves on the efficacy of these outreach efforts.

“Crowd-out” in the New Mexico program has been more than adequately addressed. The 12-month waiting period is a significant disincentive for those who consider voluntarily dropping insurance for the purpose of becoming SCHIP eligible. Additionally, New Mexico's demographics render the possibility of significant crowdout on the part of employers very unlikely. New Mexico is an undeveloped, low-income state. It is extremely unlikely that the large employers like the state, the federal Department of Energy, Intel, etc., would drop availability of health insurance coverage for the minute number of SCHIP-eligible children in the state (projected total universe of 5,550). Many small businesses in the state have not found it financially feasible to provide health coverage benefits for their employees. Thus, these businesses are not subject to crowdout issues.

It would be a significant advantage for New Mexico if BBA statutory provisions were amended to allow states like New Mexico to enjoy the benefits afforded to the vast majority of states by allowing use of SCHIP funds for the population of children between 185% and 235% of federal poverty levels, regardless of prior efforts to extend coverage to this group.