

***EVALUATION of Pennsylvania's
CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT***

Pennsylvania

State/Territory: _____

(Name of State/Territory)

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

**M. Diane Koken
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SECTION 1. SUMMARY OF KEY ACCOMPLISHMENTS

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?

Pennsylvania, at 8.3% is among five states with the lowest rate of uninsured children under the age of nineteen. Only Vermont (6.4%), Hawaii (6.8%), Wisconsin (6.9%) and Rhode Island (7.5%) have a lower percentage of uninsured children. The current baseline estimate of the number of uninsured children is 257,654. This is a revised estimate using a rolling average of U.S. Census Survey data for 1996, 1997 and 1998.

The distribution of those children is:

• Eligible, but not yet enrolled in Medicaid	125,609	49%
• Eligible, but not yet enrolled in CHIP	72,695	28%
*Federally Subsidized CHIP	54,172	
*State-only Funded CHIP	18,523	
• Ineligible for a government funded program	59,350	23%

*Income limit for Federally subsidized CHIP is 200% of the Federal Poverty Guidelines; for State-funded CHIP, 235% of the guidelines.

The methodology for the revised estimate is similar to, but not identical to, that used to determine the estimate included in the 1998 Annual Report. That estimate was derived from a rolling average of survey data for the period 1995, 1996 and 1997 resulting in an estimate of 283,312 uninsured children. With that estimate, it was concluded that approximately one third of the children were potentially eligible for Medicaid; one-third for CHIP; and one third ineligible for a government funded program. However, some refinements were made in the current estimate, which result in a different apportionment of potential eligibility.

Reflected in the changed assumptions used to refine the estimate were:

- The current estimate now takes into consideration the impact of the use of a “net income” methodology for both Medicaid and CHIP (previous estimate considered gross income for both)
- The current estimate takes into consideration a reduction in enrollment in Medicaid during the past year
- The current estimate takes into consideration an increase in enrollment in CHIP during the past year (in both the Federally funded and State-funded components)
- The current estimate takes into consideration the increased age limit covered by Medicaid (through age 16)

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

U.S. Census Survey Data for calendar years 1996, 1997 and 1998. Methodology described above.

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.)

There is a high level of confidence in the methodology used to derive the baseline estimates. This degree of confidence is tempered only by the generally acknowledged limitations of the U.S. Census Survey data (e.g. size of sample). The methodology and assumptions used in apportioning the distribution were agreed upon by the Insurance Department, the Department of Public Welfare and the Pennsylvania Partnerships for Children as being appropriate and acceptable. See Appendix A for a report issued on March 14, 2000 by the Pennsylvania Partnership for Children entitled "Uninsured Children in Pennsylvania".

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, and anti-crowd-out efforts)? How many more children have creditable coverage following the implementation of Title XXI? (Section 2108(b)(1)(A)).

During the month of March 2000, 92,677 children are enrolled in CHIP representing approximately 55% of the universe of potential enrollees:

- 85,732 are enrolled in Federally subsidized CHIP (92.5%)
- 6,945 are enrolled in State funded CHIP (7.5%)

This monthly "point in time" enrollment can be compared with enrollment for the month of May 1998 (the month in which Pennsylvania received approval of its State Plan of Operation). During the month of May 1998, 56,548 children were enrolled in CHIP. A steadily increasing percentage of enrollment has resulted in approximately 63.8% more children being covered in March 2000 than in May 1998.

As indicated in the response contained in Section 1.1, the total number of uninsured children in Pennsylvania dropped from 283,312 to 257,655. It is difficult to ascribe a direct cause and effect relationship between enrollment in a publicly funded program and a reduction in the number of uninsured. Such factors as a consistent rate of employer-based health care coverage (71.5%), a reduction in the unemployment rate (4%) and strong economic conditions must also be considered. However, the following data reveals a steady climb in combined Medicaid and CHIP enrollment that has contributed to the overall decline in the rate of uninsured children.

<u>Children Enrolled</u>	<u>Medicaid*</u>	<u>CHIP</u>	<u>Total</u>
July 1998	699,519	60,902	760,421
August 1998	701,623	60,985	762,608
September 1998	698,817	65,578	764,395
October 1998	698,859	66,305	765,164
November 1998	694,586	66,889	761,475
December 1998	688,968	68,376	757,344
<u>Children Enrolled</u>	<u>Medicaid*</u>	<u>CHIP</u>	<u>Total</u>
January 1999	689,149	70,277	759,426
February 1999	689,241	71,469	760,710
March 1999	693,391	73,158	766,549
April 1999	693,002	74,476	767,478
May 1999	694,439	76,764	771,203
June 1999	692,165	78,998	771,163
July 1999	693,129	80,719	773,848
August 1999	695,628	82,251	777,879
September 1999	691,612	82,963	774,575

*All categories including TANF-related, General Assistance-related, SSI-related, Medically Needy Only and Categorically Needy.

This data demonstrates an overall increase in month to month participation in both Medicaid and CHIP, due in some measure to the constant rate of increase in CHIP. Careful examination of the source data reveals that a reduction did not occur in all categories of Medicaid during this period. Although there was a reduction in the TANF-related category of coverage, there was a steady increase in categorical coverage (i.e. Extended Medical Coverage for families leaving welfare to work and in the child-only group). Notably, in May 1998, 356,804 children received categorical coverage; in September 1999, 413,963 received categorical coverage.

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

The data represented above is actual (rather than estimated) data for the period specified. The data is taken from monthly reports prepared by the Department of Public Welfare for Medicaid; and the Insurance Department, for CHIP. Please refer to Appendix B for copies of the reports for the subject period which contain the data specific to Medicaid and to CHIP.

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 interval if available).

Data taken from actual enrollment and therefore merits a high level of confidence.

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

See Table 1.3 - State Progress: Strategic Objectives and Performance Goals

SECTION 2. BACKGROUND

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: _____

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

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

Name of program: *Pennsylvania Children's Health Insurance Program (CHIP)*

Date enrollment began (i.e., when children first became eligible to receive services): *May 1993 (Federal Financial Participation began effective May 28, 1998)*

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.

NA. Family Coverage is not offered.

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.

NA. Buy-in for employer-sponsored insurance is not offered.

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

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

Medicaid

From its earliest days, Pennsylvania established and funded medical services for the poor and disabled. As evidence of its historical and continuing commitment, on January 1, 1966, the Commonwealth had the distinction of being one of the first six states in the nation to accept Federal funds for Medicaid- the earliest possible date that Federal Title XIX funds were made available. In addition, state-funded medical assistance continued to be made available to persons who did not categorically qualify for a Federally-funded program. Pennsylvania also kept pace with the evolution of Medicaid as it continued to change and expand, offering an increasing array of services, especially those targeted at pregnant women, children, the elderly and the disabled.

Evidence can be seen of this commitment in such initiatives as:

- Eliminating the eligibility asset test for all households containing children
- Developing a “child only” application to simplify the enrollment process

- Electing the option to cover pregnant women at the Federally approved maximum level of 185% of the poverty guidelines
- Implementing presumptive eligibility for pregnant women
- Maximizing the availability of Medicaid to children with disabilities
- Implementing a successful managed care program which notably improves access to service

More recently, with the passage and implementation of welfare reform, Pennsylvania has been recognized nationally for its initiative to ensure continued enrollment in Medicaid when a family leaves welfare for work.

Children's Health Insurance Program

Legislation creating the Children's Health Insurance Program (CHIP) was passed by the General Assembly in December 1992 (the Children's Health Insurance Act, 62 P.S. 5001.101). Enrollment of children began in May 1993. It was the intent of the legislation that CHIP provide access to primary and preventative care to children who were not eligible for Medicaid and to those who were not covered by either private or employer-based health insurance. Coverage was to be provided in a cost-effective manner by insurers under contract with the Pennsylvania Insurance Department.

CHIP was initially funded by a 2 cents per pack tax on cigarettes and a special fund was created for the purpose of purchasing health care coverage for children. In the first year of the program, free insurance was provided to children under the age of 13 in families with income less than 185% of the Federal poverty guidelines. An additional age group was added for coverage each year thereafter. Subsidized insurance was provided to children under the age six in families with income between 186% and 235% of the Federal poverty guidelines. A monthly premium was charged for participation in the subsidized component, along with a co-payment requirement of \$5.00 for prescriptions (no other co-payment requirement for other services).

The benefit package included:

- Preventative care (e.g. well child visits, immunizations, health education, tuberculosis testing, and developmental screening)
- Diagnosis and treatment of illness or injury, including all medically necessary services related to illness or injury
- Injections and medications
- Emergency accident and emergency medical care
- Prescription drugs (with \$5.00 co-pay)
- Emergency, preventative and routine dental care

- Vision care
- Hearing care
- Inpatient hospital care (90 days per year for children who did not qualify for the “spend-down” provisions of Medicaid)

CHIP- The State and Federal Partnership

The passage of the Federal Balanced Budget Act of 1997 provided Pennsylvania with the opportunity to continue and expand its legacy of providing health care coverage for children. The Pennsylvania CHIP served as a model for the Act and was specifically cited as exemplary and meeting the Congressionally established program requirements.

The Federal statute allows states a great deal of flexibility in the design and operation of an insurance program for children. However, certain provisions of the statute necessitated corresponding amendment to State law in order to maximize the availability of Federal funds. On June 17, 1998, Governor Tom Ridge signed into law Act 68 of 1998, (P.L. 464) which contained the conforming amendments. Included were:

- Expansion of the age limits to include all children under the age of nineteen (for both free and subsidized CHIP)
- Expansion of the income limits from 185% to 200% of the Federal poverty guidelines (free program)
- Elimination of the \$5.00 co-payment for prescription medications
- Imposition of a citizenship requirement consistent with that for Medicaid

These statutory changes enabled the Commonwealth to move forward with full implementation of the expanded and improved Children’s Health Insurance Program.

It also should be noted that subsidized coverage continues to be provided for children under the age of nineteen with family income between 201% and 235% of the Federal poverty guidelines. The subsidized component of the program is funded by state funds alone. The benefit package is the same as that of the free component and there are no co-payment requirements.

Further Enhancement

Benefits

In recognition of the needs of older children and those with more serious or chronic health conditions, the benefit package for CHIP was enhanced effective September 1, 1999. Included in the benefit package were:

- Substance Abuse Treatment
- Durable Medical Equipment
- Rehabilitative Therapies
- Partial Hospital Treatment for Mental Health Services
- Home Health Care

Eligibility Methodology

The method of determining eligibility was changed effective September 1, 1999. The previous “gross” income test was eliminated and a new “net” income test adopted which credits families with a \$90 monthly work expense deduction and incurred child care expenses. Several important goals were considered in modifying the income methodology:

- Establishing and maintaining comparable eligibility methodologies between CHIP and Medicaid
- Coordinating with Medicaid and fulfilling the “screen and enroll” requirements of the Balanced Budget Act of 1997
- Creating a seamless continuum of coverage for targeted low-income children (i.e. Medicaid, Free CHIP, Subsidized CHIP)
- Providing access to coverage for the maximum number of children within allocated State and Federal funds

Consumer Choice

The number of insurers from which consumers could choose their coverage increased from five to seven, effective September 1, 1999. In some areas of the Commonwealth, consumers have as many as three managed-care organizations from which to make their choice. The Department has entered into three-year contracts for coverage with:

- Aetna USHealthcare
- Three Rivers Health Plan
- HMA Health Plan
- Highmark, Inc.
- Capital Blue with Pennsylvania Blue Shield

- Independence Blue Cross with Pennsylvania Blue Shield
- Blue Cross of Northeastern Pennsylvania with Pennsylvania Blue Shield

Please see Appendix D for a map of the contracted coverage areas for each insurer.

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?**

Please see Section 2.2.1 for a description of the pre-existing State only program and enhancements made thereto.

With the approval of the State Plan by the Health Care Financing Administration (HCFA), Pennsylvania began to claim enhanced Federal match for the free component of the program enabling increased enrollment and program enhancement. Children enrolled in the free component are now funded by a combination of Federal and State funds; children enrolled in the subsidized component continued to be funded by State funds alone.

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.

- Changes to the Medicaid program
- Presumptive eligibility for children
- Coverage of Supplemental Security Income (SSI) children
- Provision of continuous coverage (specify number of months ___)
- Elimination of assets tests
- Elimination of face-to-face eligibility interviews
- Easing of documentation requirements**
- Impact of welfare reform on Medicaid enrollment and changes to AFDC/TANF (specify)**

With the implementation of welfare reform, Pennsylvania did experience a temporary decrease in Medicaid enrollment. Recently, however, despite the fact that families continue to transition from welfare to work, Medicaid enrollment is no longer declining. With the emphasis on employment as a

component of welfare reform, many families have found employment and moved off cash assistance. Many of these families are eligible for and receiving Extended Medical Care. Other children remain eligible in the categorical groups.

Pennsylvania has initiated an extensive outreach plan to maintain and increase enrollment in Medicaid, not only this year, but in future years as a result of available Federal funding.

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

X Health insurance premium rate increases

Pennsylvania is fortunate to have a strong private health insurance market. Most privately insured Pennsylvanians are insured by their employer. The Commonwealth's under age 65 uninsured rate is 12% compared with a national rate of 18%. This high insured rate comes at the same time as Pennsylvania's overall unemployment rate has declined to approximately 4%, the lowest rate in nearly three decades.

Health insurance premium rates have been increasing in Pennsylvania and nationally for the last several years. Rate increases have been averaging up to 8% to 10%. This is similar to national averages. However, even with these rate increases, Pennsylvania's overall insured rate has remained in the top ten in the country.

X Legal or regulatory changes related to insurance

Effective January 1, 1999, Pennsylvania enacted Act 68 of 1998, the Commonwealth's managed care patients' protection legislation. This legislation implemented a number of consumer protections including continuity of care, the prudent layperson standard for emergency services, direct access to OB/GYN providers, disclosure of important information to plan enrollees and prompt payment requirements for provider claims.

X Changes in insurance carrier participation (e.g., new carriers entering market or existing carriers exiting market)

Pennsylvania's group and individual health insurance markets have been fairly stable over the last several years. Some smaller carriers have exited the market however they all had very small market shares and their exit did not adversely impact the marketplace.

- ___ Changes in employee cost-sharing for insurance
- ___ Availability of subsidies for adult coverage
- ___ Other (specify) _____

X Changes in the delivery system

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

Managed care penetration in Pennsylvania continues to increase while overall enrollment in traditional indemnity health coverage continues to decline. Currently over 5.25 million Pennsylvanians (almost 45% of the population) receive their health care coverage from a health maintenance organization (HMO) or a gatekeeper preferred provider organization (PPO) (point of service (POS) plans). This includes commercial, Medicare and Medical Assistance populations.

In the hospital sector, there have been major acquisitions/mergers in both Philadelphia and Pittsburgh. In Philadelphia, the Allegheny Health, Education and Research Foundation (AHERF) facilities went bankrupt and were acquired by Tenet Health, a for-profit hospital company. Tenet is the first for-profit hospital owner in Pennsylvania. In Pittsburgh, the AHERF facilities are also facing bankruptcy and are scheduled to be acquired by the West Penn Hospital System, a local, not-for-profit hospital system.

- ___ 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.”

See Table 3.1.1 - Eligibility Standards

3.1.2 How often is eligibility redetermined?

See Table 3.1.2 – Determination of Eligibility

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)? *State-designed CHIP program*

For how long? *12 months from the date of enrollment*

No

3.1.4 Does the CHIP program provide retroactive eligibility?

Yes Which program(s)?

How many months look-back?

No

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 See 3.1.7 for information regarding procedure: “Any Form is a Good Form”.

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

Applying for CHIP is simple! To apply, a parent or guardian need only fill out a two page application, attach income verification and forward to the CHIP insurer of their choice. The parent need not go anywhere and may complete the application in the privacy of their own home. Assistance with questions may be secured through contacting the toll-free number of the insurer or the central toll-free number (1-800-986-KIDS).

A process dubbed “Any Form is a Good Form” was adopted in February 1999 which facilitates enrollment in both CHIP and Medicaid. Application materials for children determined ineligible for CHIP because family income is within the Medicaid range are automatically sent to the appropriate County Assistance Office for a determination of eligibility for Medicaid. Application materials for children determined ineligible for Medicaid because family income is within the CHIP range are sent to a CHIP insurer for a determination of eligibility for CHIP.

Strengths in the Application Process include:

- Families are able to apply for benefits for their children utilizing a short and simple application.
- Families are able to mail-in the CHIP application to the CHIP contractor of choice for the determination of eligibility.
- Families are able to call a toll-free telephone number to inquire about the program. Families are able to speak with a “live” voice who will screen them for CHIP or Medicaid; appropriate applications are provided to callers.
- The eligibility criteria for CHIP is modest (income, age of child, citizenship, uncovered by healthcare coverage).
- The verification requirements are minimal (income only).

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?

Renewal of CHIP eligibility is simple! Renewal of eligibility is completed annually by the CHIP contractors for children who are enrolled in their plan. The process is simple in that the only verification that is required is the submission of current income information.

Contractors are required to start the renewal process no fewer than 60 days in advance of the date that eligibility will expire. Most contractors start at least 90 days in advance by issuing the renewal form followed by warning letters, if appropriate.

Despite the ease of the renewal process, a significant number of children lose coverage each month simply because there is a failure to respond to the renewal notice. In an attempt to learn more about this issue, focus groups were conducted to determine the reason(s) for failure to renew. Focus group participants shared a common belief that insurance coverage is important for their children and generally expressed positive opinions regarding their coverage under CHIP. Reasons given for failure to renew mostly related to life style. Many parents stated that “they meant to do it”, but did not follow up on the renewal because they were too busy or forgot to send it in by the deadline.

New methods of increasing retention are presently being tested. Included are:

- changing the appearance of the renewal notices
- conducting personal telephone calls as a reminder
- reducing the amount of income verification required (to one paystub rather than a full month work of documentation)

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

3.2.1 Benefits

See Table 3.2.1 – Benefit Package

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

The primary purposes and focus of CHIP is to provide comprehensive preventive health care. Providers are required to provide preventive services to enrolled children during regular periodic preventive health visits. The periodicity and content of preventive health maintenance visits are consistent with standards recommended by the American Academy of Pediatrics which currently include the following services:

- Health history (individual and family)
- Complete initial unclothed physical examination and periodic physical assessments as needed
- Immunizations (including Hepatitis B immunization)
- Physical growth measurements
- Nutritional assessment
- Individual and family psychosocial assessment
- Preventive oral/dental screening
- Tuberculosis screening in accordance with Department of Health screening standards
- Vision screening
- Audiometric screening
- Developmental/behavioral screening
- Blood lead screening in accordance with Center for Disease Control (CDC) screening standards set forth in Section III, Management Standards
- Age-appropriate laboratory tests and clinical screening procedures for iron deficiency, sickle cell anemia, lead poisoning (in accordance with procedures described in Section III, glucosuria, albuminuria, tuberculosis, strep throat, hypertension, and substance abuse
- Comprehensive physical examination including x-rays if necessary to diagnose/confirm a suspected case of child abuse, shall be covered for any child in which such abuse is suspected
- Appropriate Services for appointment scheduling, reminders and cancellations
- Follow-up for missed appointments and referrals. Insurers must shall develop and implement detailed procedures for follow-up of missed appointments, follow-up for clients who repeatedly cancel appointments for preventive services and/or who fail to complete referrals for additional services; and follow-up/tracking to determine status of referrals and result of services received.

As noted in Table 3.2.1 (CHIP Program Type), CHIP also provides benefits beyond those for preventive care. As noted in Section 2.2.1, Pennsylvania's CHIP benefit package was one of three grandfathered by the Balanced Budget Act of 1997. Effective September 1, 1999, five new benefits have been included in the CHIP benefit package and approved by the Health Care Financing Administration. Those benefits include:

- Substance abuse treatment
- Durable medical equipment
- Physical, speech, occupational, and respiratory therapies
- Partial hospitalization for mental health services
- Home health care

These services meet the needs of older children and those with more serious or chronic health conditions.

No CHIP benefit requires a co-payment or deductible.

3.2.3 Delivery System

See Table 3.2.3 – Delivery System

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

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

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?

See Table 3.4.1 - Education and Outreach Approach

3.4.2 Where does your CHIP program conduct client education and outreach?

See Table 3.4.2 – Education and Outreach Setting

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.

The Commonwealth is committed to providing access to quality health care coverage and to improving the health status of children. To achieve this goal, the Commonwealth brought together a unique interagency consortium dedicated to increasing public awareness of and enrollment in both CHIP and Medicaid. Senior Management staff and others in the Departments of Insurance, Public Welfare and Health meet together twice monthly to do strategic planning, to monitor progress, and to problem solve. In addition to time and effort, the three agencies have also jointly committed funding to a multi-media and multi-faceted public awareness campaign for CHIP, Medicaid and Maternal and Child Health services. This unique consortium has recently been cited by the Health Care Financing Administration as a best practice to be emulated by other states.

The agenda for increasing awareness and enrollment includes but is not limited to:

- Establishing a single statewide toll-free number (1-800-986-KIDS) to provide access to helpline staff who inform, refer and assist in applying for CHIP and Medicaid
- Jointly funding a multiyear contract with a media consultant
- Developing complementary media messages about the availability of health care coverage and the importance of preventative care
- Increasing access to coverage by improving eligibility and enrollment practices
- Conducting market research regarding special populations to improve targeted marketing and outreach
- Measuring the effectiveness of all efforts by gathering and analyzing available data

Measuring the effectiveness of outreach and marketing continues to be a challenge. Through surveys, focus groups, and the analysis of data linking media play of advertisement to calls to the Helpline we are increasing our understanding of the impact of marketing on enrollment patterns in CHIP. Examples of methods and indicators used and the resultant findings include:

- A benchmark and follow-up telephone survey of callers to the Helpline to determine the impact of media marketing on such things as

awareness of CHIP and the perception of government programs. See Appendix E for a copy of the Benchmark Survey report.

- Monthly analysis of data relating to calls to the Helpline including such things as the total number of calls received each week; total number of CHIP or Medicaid referrals resulting from the calls; and the relationship between the calls and the placement of media advertising (e.g. time of day, area of the state). See Appendix F a sample copies of documentation relating to calls to the Helpline.
- The creation of a means of “geo-mapping” the relationship between enrollment patterns, media advertising and other economic factors that provide an indication of market penetration for CHIP. See Appendix G for a sample copy of a geo-map relating to market penetration.

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

As the fifth most populous state, Pennsylvania has a distinctive population distribution and composition. As summarized in “The State of the Commonwealth: 1998” issued by the Pennsylvania State Data Center, the Commonwealth is characterized by its major urban centers, such as Philadelphia and Pittsburgh, that represent almost 2 million of the 11,881,643 total state population. However, Pennsylvania also has the largest percentage of residents identified as rural at 31.1 percent.

The racial composition of rural and urban populations is very different. It has been established that rural Pennsylvania is very homogenous, with a 98% white population. This is in contrast to the diversity of the urban areas, which have 86.2 percent white, 11.8% black and 2.0% other. In addition, 92% of the Hispanic population reside in urban areas.

Immigration statistics for Pennsylvania during 1996 showed a 12% increase in the number of immigrants since 1995. Forty percent of these immigrants originated from India, Mainland China, the Caribbean and the former Soviet Union.

Language patterns at home further illustrate the diversity in Pennsylvania. Over 10 million residents, or 93% of residents, speak only English, but a large number of the population speaks Spanish, 213,096; Italian, 103,844; or German, 78,499 at home. All of these factors need to be considered in the preparation and dissemination of information about CHIP to the residents of Pennsylvania.

Media materials have been prepared with sensitivity to minority populations. Television and radio ads are available in English as well as Spanish. African-American and Hispanic newspapers are also effective mediums for reaching

CHIP's target demographics. The media messages that are directed to various ethnic groups are supported by focus group testing. Future plans include media messages to the Asian population.

Many Community Based Organizations have staff of varying minority and ethnic backgrounds that support operations to reach out, to communicate and to assist families in the application process as well as ensuring they receive health care services. CHIP contractors work closely with the Community Based Organizations to assist in the application process as well as keeping abreast of ethnic-related needs. CHIP contractors also provide translation for many languages through their own staff or accessing translation services as needed.

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.

Since October 1998, CHIP has engaged in a statewide media campaign to promote the program, using television, radio and newspaper ads. This campaign, according to a telephone survey conducted in the Fall of 1998 and Spring of 1999, and anecdotal information from community based organizations, has been effective in achieving widespread familiarity with CHIP. See Appendix E. The media materials have been culturally sensitive and are available in English as well as Spanish.

A variety of data sources have been relied upon to evaluate what methodologies are successful with dealing with several populations. The CHIP/Healthy Babies/Health Kids Helpline maintains an excellent database and reporting system to facilitate follow-up with families.

Examples of data captured by the database include:

- the type of call e.g., insurance, suspected pregnancy
- the caller language
- gender
- race
- how the caller learned about the Helpline.

Implementation of CHIP's planned central database will link enrollment data with Helpline data to enable more complete analysis of the relationships between advertising, calls to the Helpline and actual enrollment. In addition to the systems development, CHIP has also engaged the services of the social marketing contractor to conduct a study of the different Hispanic cultures and their acceptance of health insurance and response to media messages.

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

Refer to Table 3.5 – Coordination Between Health Care Programs

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)

Information on current or previous health insurance gathered on application (specify) *Every applicant must answer whether they have current health insurance*

Information verified with employer (specify)

Records match (specify) *All applications are matched with Medicaid prior to enrollment in CHIP, and with private insurance files.*

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.

Pennsylvania has taken a number of steps to guard against crowd-out. Questions regarding insurance coverage along with matches against Medicaid and private insurance files help to assure that only uninsured children are enrolled. Examples of data available regarding this issue are:

- Approximately 24% of all applications for CHIP were rejected for any reason (e.g. insurance, income, failure to provide documentation, etc.)
- Of the applications rejected for any reason, an average of 5% were rejected because the child had private insurance.
- Of the applications rejected for any reason, an average of 15% were rejected because the family income was within Medicaid range

(application forwarded to the appropriate County Assistance Office per the “Any Form is a Good Form” practice).

- Less than .01% were found to have been enrolled in a commercial product of a CHIP contractor when a match was completed. Please note that in the case of one contractor, their computer system automatically checks for enrollment in a commercial product making it virtually impossible for a child to be enrolled if there is private coverage.
- For the period July 1999 through January 2000, an average of 9% of cases terminated at time of recertification lost CHIP eligibility because private insurance was now available to the child(ren).
- For the period July 1999 through January 2000, only 13 children were found to have active Medicaid status. (Appropriate corrective action was taken on those cases).
- For the period July 1999 through January 2000, an average of 15% of all cases due for recertification were terminated from CHIP because the result of a referral made for Medicaid was that the child(ren) was found eligible (for Medicaid).

It should also be noted that, at 71.5% Pennsylvania continues to enjoy one of the nations highest rates of the persons insured by employer based coverage. The national average is 62.6%. The stability of the rate of employer based coverage supports the hypothesis that no serious degree of “crowd out” has or is occurring as the result of expansion of publicly funded health care programs. See Appendix H for additional information about the rate of employer based coverage for Pennsylvania and the nation.

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))

See Table 4.1.1 – CHIP Characteristics

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))

Information not available.

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))

The percentage of uninsured children has been reduced from 9.3% (1 in 11 children) to 8.3% (1 in 12 children).

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?

Estimated disenrollment for the period is 36,086. This estimate is derived from summing four quarters of HCFA 21E submitted data. The result is slightly higher than terminations reported by contractors (33,934). The difference can be attributed to the lack of a centralized database, monthly manual adjustments and some difference in definition of a termination. These issues are being addressed with the creation of a centralized system.

The Department of Public Welfare does not collect data about medical terminations; therefore, no data were available for this comparison.

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?

Information not available. This issue is being addressed in the design of a centralized database.

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

See Table 4.2.3 - Reasons for Discontinuance of Coverage.

The information provided is from the summed four quarters of data from the FFY 1999 HCFA 21E. Although CHIP contractors are presently submitting monthly data regarding reasons for termination, the data is flawed and will therefore not be reported. Contractors have maintained separate data systems with differing reason codes and definitions. This issue is being addressed in the design of a central data base.

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

See Section 3.1.8 regarding efforts to reduce the rate of non-renewal.

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 \$38,068,233

FFY 1999 \$59,807,263

See Table 4.3.1 – CHIP Total Expenditures

What proportion was spent on purchasing private health insurance premiums versus purchasing direct services? 100%

4.3.2 What were the total expenditures that applied to the 10 percent limit?

See Table 4.3.2 – CHIP Administration and Outreach Expenditures

What types of activities were funded under the 10 percent cap?

Funds subject to the 10% cap supported various administrative and outreach projects such as:

- A state-wide media campaign
- Development of an eligibility and enrollment system
- Staff salary and benefits
- Behavioral Risk Factor Surveillance Survey questions directed towards CHIP population

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

To date, the 10% cap has not affected the program design of Pennsylvania CHIP. However, we have been prudent in our expenditures and are carefully monitoring our administrative costs in the event that the 10% cap poses a challenge in the future.

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

- State appropriations**
State cigarette and general fund revenues
- 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.’

See Table 4.4.1 – Approaches to Monitoring Access

All CHIP insurance contractors have full National Committee for Quality Assurance (NCQA) accreditation. See Appendix I, HEDIS report cards. Health Plan Employer Data and Information Set (HEDIS) measurements grade all Managed Care Organizations (MCOs) on access to care. The Department of

Health (DOH) accompanies NCQA on all accreditation audits, as well. Any deficiencies found during the review must be addressed by the MCO in a corrective action plan. DOH follows up, thereafter, on the progress the MCO has made towards remedying deficiencies.

By Pennsylvania law, all MCOs are required to submit quarterly and annual reports to the DOH. See Appendix J, Quarterly and Annual Report Instructions. The quarterly reports contain data on membership, utilization, personnel provider notability, compliant and grievances. The annual reports contain data on the MCO's delivery system, including a quality assurance report, plan standards, medical complement, grievance resolution system, calendar year grievances, disenrollment by termination reason, consumer satisfaction, and utilization data. See Appendix K for actual reports submitted by MCO's contracted to serve CHIP enrollees. Please note that, because of its volume, not all attachments referenced within the MCO's report are attached hereto. The only referenced attachment relates to the delivery system, "Quality Management Program".

In addition, CHIP contractors are required to submit quarterly and annual reports on service utilization and encounters, data on the number of providers by type, and CHIP specific grievance data. A full analysis of this information is not presently available.

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 question 4.4.3.

See Table 4.4.2 – Managed Care Utilization Data

See response to question 4.4.1

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

See response to question 4.4.1

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?

As a condition of the contract, insurers are expected to fulfill certain Quality Management and Utilization requirements. See Appendix L. A full review of contractor compliance with these requirements will be conducted in January 2001, covering the period September 1, 1999 through August 30, 2000 (the first full year of the current contract).

In the second contract year, insurers will be required to provide unvalidated HEDIS data for both their commercial subscribers and for CHIP (calendar year

2000). It is our intent to seek assistance from NCQA and HCFA in the analysis of this data. However, it will not be reported. In the third contract year, validated HEDIS data will be expected (calendar year 2001) and reported upon by the Commonwealth.

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.’

See Table 4.5.1 – Measuring Quality

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.

Please refer to Section 4.4.1

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?

Please refer to Section 4.4.4

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.

Appendix I: Individual MCO HEDIS report cards referenced in Section 4.4

Appendix J: Department of Health quarterly and annual utilization and quality assurance instructions to MCOs

Appendix K: Individual MCO annual reports to Department of Health

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.)

5.1.1 Eligibility Determination/Redetermination and Enrollment

The Pennsylvania CHIP model (a public/private partnership) is distinguishable from that of other States in several significant ways. This is especially true in the area of eligibility determination and enrollment. The seven CHIP contractors are responsible not only for providing health care coverage to children, but also for eligibility determination and enrollment.

All applications are filed through the mail directly with the insurer that the parent has chosen to provide coverage for their child(ren). The application document completed by the consumer is uniquely designed by the insurer and is not the standard government fare. Each application bears the unique corporate logo of the individual insurer.

Anecdotally, if not empirically, we have learned about the positive impact of this direct relationship. Consumers relate the sense of being a customer of their insurer (e.g. Capital Blue Cross, Aetna US Healthcare, etc) rather than the recipient of a government-funded program. Identification cards issued by the insurer resemble cards that are issued to persons covered by commercial coverage. All interactions, whether they be eligibility or service related, are with the insurer. Consumers express satisfaction with this relationship in surveys and focus groups.

5.1.2 Outreach

Pennsylvania has experienced a steady increase in enrollment since the approval of its State Plan. The addition of Federal funds has enabled the Department to:

- Engage in a statewide marketing campaign (paid media advertising, etc.) to increase public awareness and encourage eligible families to apply for CHIP.

- Work with other State agencies, CHIP contractors and Community Based Organizations to develop and implement locally based outreach strategies.

The impact of these efforts has been encouraging and monthly enrollment has increased an average of 2% each month (92,677 children in March 2000). These results compare favorably with reported nationwide data which placed Pennsylvania fifth in the nation for total number of children enrolled in a SCHIP; and first among “stand alone” programs.

Marketing

Significant effort and resources have been devoted to marketing CHIP and to measuring the impact of the statewide media campaign. Demographic profiles and market segmentation tell us what television shows will reach the targeted audience (i.e. adults age 18 through 49 who are the parents of children who are uninsured). We have learned that:

- Saturday Night Live is a good vehicle to reach parents in Erie
- Oprah reaches 19,000 adult viewers daily in the Harrisburg market; 118,000 in the Philadelphia market
- The Today Show tops the morning show line-up in Pittsburgh

Ads placed on these shows make the phones ring! Reports from the AT&T phone system tell us how many calls are received per day (300-400 daily when ads are running), the area code of call origin, the time of day, the number of repeated call attempts and the length of each call. These factors can be compared against the time placement and media market of ads. Comparisons are also made for time periods when no ads are being run (i.e. call volume drops by half).

Important lessons have been learned, both through experience and through data collection. One practical lesson was learned almost immediately after the statewide campaign was launched in October 1998. The volume of 33,000 calls received during the first six weeks exceeded all possible expectations (by a factor of ten) totally overwhelmed the phone system and the eight Helpline staff members! From this we confirmed that:

- There had been a lack of general awareness of CHIP
- There was pent up demand for CHIP
- That there was no reluctance on the part of families to seek out information and apply for CHIP

Importantly, we learned never to run ads in all media markets at the same time again!! However, these valuable lessons prompted us to fund eight new positions for the Helpline, to vary the placement of the ads (as to time and location) and to improve our monitoring tools. One emerging objective is to link Helpline data

with that from our central data system (when implemented) so we might learn how many callers apply for coverage, how many are determined eligible, and how long the process takes.

Outreach

Some valuable lessons have also been learned through pilot outreach projects overseen by the Pennsylvania Partnerships for Children in the Covering Kids initiative (funded by the Robert Wood Johnson Foundation). The Partnership has shepherded projects in five geographic sites, each testing a slightly different model of outreach. Among the lessons learned during the first year of effort were:

- Families in rural communities respond less well to references to “free or low-cost” insurance. These well-intended phrases may transmit unintended signals about government dependency.
- Families often must deal with daily or immediate crises before they can become interested in meeting longer term needs like health insurance for their children. Securing funds to buy heating oil for a tank that has just run out is of a higher priority than filling out an application for CHIP.
- Families need to hear the messages of available coverage several times, often in several settings before they will act.
- Families need privacy when completing an application. Health Fairs and similar activities are not sites for applying but work well to build awareness.

Future Efforts

Resources will continue to be dedicated to marketing CHIP. Television and radio advertisements will continue to stress the importance of having coverage; however, new ads will also include health-related messages.

Plans also call for us to intensify our local level outreach by granting seed money to grassroots efforts to enroll children in both CHIP and Medicaid. Grants will be targeted at rural sites and other hard-to-reach populations. We are especially interested in reaching the Hispanic and Asian communities and a study is presently underway (includes focus groups, etc.) to help us to better understand what might be effective in reaching these groups.

An on-line application making use of the Internet will also become a reality later in 2000. The combination of available technology and recently enacted “E-Commerce” legislation in Pennsylvania will make a paperless application process a reality. The application will be available to families wherever they might have access to the “net” – in a doctor’s office, a community based organization or in their own home.

5.1.3 Benefit Structure

Effective September 1, 1999, the CHIP benefit package includes services that would better meet the needs of older children and those with special or chronic health care needs. Included were:

- Substance abuse treatment
- Durable medical equipment
- Partial hospitalization for mental health treatment
- Rehabilitative therapies
- Home health care

A data call has been made to each CHIP contractor for the purpose of assessing utilization and the cost of providing both the original benefit package and these additional services. Data is expected to be received on June 15, 2000. Armed with this information, we will be better able to assess the impact of making these additions.

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

NA. There is no cost-sharing in the Federally funded component of Pennsylvania's CHIP.

5.1.5 Delivery System

Approximately 99% of all children enrolled in CHIP receive coverage through a health maintenance organization or a preferred provider organization. The migration toward managed care began in the earliest years of the program to fulfill a statutory mandate that care be provided in a cost-effective manner. Since that time, studies such as that issued in 1999 by the Packard Foundation, have supported the benefit of managed care for children.

It is important to note that CHIP contractors have not established special networks to provide serve to eligible children. CHIP enrollees receive care from the same network of providers that provide care to commercial subscribers. The result is adequate networks (meeting the licensure requirement of the Pennsylvania Department of Health), improved access to care, and enrollee satisfaction.

CHIP enrollees also receive the same consumer protection as the privately insured. Act 1998-68 sets forward the responsibilities of managed care plans and provides such important protections as complaint and grievance procedures and quality health care accountability. CHIP insurers are statutorily and contractually bound to adhere to and uphold these protections because they are licensed insurers.

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

See Section 3.4.3 and Table 3.5 for information regarding coordination with other programs.

There has been no measurable crowd-out experience with Pennsylvania's CHIP.

5.1.7 Evaluation and Monitoring (including data reporting)

It is acknowledged that evaluation and monitoring are very important components in the operation of any publicly funded program. It becomes more critical as the program expands and evolves. A first-year focus on increasing enrollment, completing a competitive procurement and enhancing benefits held priority over meaningful evaluation and monitoring activity. However, several activities are presently underway which will provide increased capacity to engage in both activities.

The most critical is the development and implementation of a central enrollment system and database slated for rollout in July 2000. With this system will come increased accountability and program integrity. The system will compute and validate the eligibility of all enrollees, thus reducing the opportunity for error. Contractors will receive a payment based upon the enrollment data contained in the system thereby assuring the accuracy of expenditures. Importantly, there will be standard statewide statistical and demographic that will reveal much more about program performance.

A request has been approved to hire additional staff for the sole purpose of monitoring program performance and adherence to contractual requirements. Review instruments are being developed which will assess contractor compliance with administrative matters. A request has also been made for approval to hire a person with a medical background for the purpose of managing quality assurance functions.

5.1.8 Other (specify)

NA

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))

No specific response is being provided. The goal of Pennsylvania CHIP is to improve "the availability of health insurance and health care for children".

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

In the Balanced Budget Act of 1997, Congress wisely gave states options for providing increased access to health care coverage for children. Included among the options provided were: the expansion of Medicaid, the establishment of a separate insurance program, or a combination of both. The language of the newly created Title XXI, gives discretion to states in the design and implementation of programs that best meet the needs of its residents. However, there are signs that this degree of flexibility may be at risk.

Repeated examples of erosion of the degree of flexibility intended by Congress can be seen in both the preamble and regulatory text of proposed SCHIP regulations issued by HCFA in November 1999. What is clear throughout those proposed regulations is the intent that states conform their CHIP programs to meet Medicaid requirements. While this direction may seem preferable to Federal policymakers, it may or may not be the choice of state lawmakers or other policymakers throughout the country.

What is best about Title XXI is the opportunity for state experimentation and to learn from it. We urge that such experimentation be supported and encouraged.