



THE DISTRICT OF COLUMBIA
WASHINGTON, D.C. 20001

MARION BARRY JR
MAYOR

The Honorable Donna E. Shalala, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Shalala:

Enclosed is the District of Columbia's formal application for the State Children's Health Insurance Program (CHIP) which the Department of Health has recently completed. After extensive public deliberation, the City is proposing to expand Medicaid in order to provide health insurance coverage to uninsured *targeted* low-income children.

As you know, the Medicaid program offers a rich benefit package. Having the ability to access the Early and Periodic Screening, Diagnosis and Treatment Program will give children ongoing access to the highest level of care and significantly improve their health status.

Under the District's expansion, all uninsured children who now live in families with income up to 200 percent of the federal poverty level will be able to enroll in CHIP. The CHIP coverage expansion coupled with extensive outreach activities will allow the District to identify the newly eligible population as well as those children who are currently eligible for but not enrolled in Medicaid. We are delighted that these efforts will allow us to offer health insurance coverage to approximately 10,000 uninsured children.

On behalf of the City, I would like to express our sincere appreciation for all the assistance that the Department of Health staff received from the staffs of Health Care Financing Administration and the Health Resources and Services Administration during the preparation of this application. We join with both administrations in looking forward to the implementation of this important initiative.

Sincerely,

Marion Barry, Jr.,
Mayor

cc: Allan S. Noonan MD, MPH, Director, Department of Health
Claude Earl Fox, MD, MPH, Acting Administrator, HRSA
David Cade, Director, Family and Children's Health Division Group, HCFA
Charlene Brown, Acting Regional Administrator, HCFA, Region III

STATE CHILD HEALTH PLAN
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
STATE CHILDREN'S HEALTH INSURANCE PROGRAM
(Required under **4901** of the Balanced Budget Act of **1997** (New section **2101(b)))**

State/Territory: District of Columbia
State Agency: District of Columbia Department of Health
Address: 800 Ninth Street, SW
Washington, D.C. 20024
Supervising Official: Allan S. Noonan, MD, MPH, Director

As a condition for receipt of Federal funds under Title XXI of the Social Security Act,

(Signature of Governor of State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children's Health Program and hereby agrees to administer the program in accordance with the provisions of the State Child Health Plan, the requirements of Title XXI and XIX of the Act and all applicable Federal regulations and other official issuances of the Department.

According to the Paperwork Reduction Act of **1995**, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid **OMB** control number for this information collection is **0938-0707**. The time required to complete this information collection is estimated to average **160** hours (or minutes) per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, P.O. Box **26684**, Baltimore, Maryland **21207** and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, **D.C. 20503**.

Section 1. General Description and Purpose of the State Child Health Plans (Section 2101)

The state will use funds provided under Title XXI primarily for (Check appropriate box):

- 1.1. Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (Section 2103); **OR**
- 1.2. Providing expanded benefits under the State's Medicaid plan (Title XIX); **OR**
- 1.3. A combination of both of the above.

Section 2. General Background and Description of State Approach to Child Health Coverage

(Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

- 2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in section 2110(c)(2)). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements).

Summary of District's Children Population

- Based upon adjusted Current Population Survey (CPS) data, there were an estimated 112,557 children under age 19 living in the District of Columbia. This number includes District residents and undocumented immigrants living in the District.
- On an average monthly basis, 67,734 (60.2 percent) of the approximately 112,557 children under age 19 living in the District are covered under Medicaid; 30,074 (26.7 percent) are covered under an employer-sponsored plan or some other type of coverage; and about **14,749 children (13.1 percent) are uninsured.**

Summary of Data on Uninsured Children Living in the District

- Of the 14,749 uninsured children under age 19 living in the District, approximately 32.5 percent are under age 6; 52.7 percent are between the ages of 6 and 14; and 14.8 percent are between the ages of 15 and 18.
- About 75.8 percent of the 14,749 uninsured children under age 19 living in the District are reported as African-Americans and 21.2 are reported as white. The remaining 3 percent are reported as "other."
- Based upon estimates provided by the Bureau of the Census and the Immigration and Naturalization Service (INS), an estimated 20,000 undocumented immigrants living in the District of Columbia. Of the 20,000 undocumented immigrants living in the District, 4,407 are under age 19. Of the 4,407 undocumented immigrant children living in the District who are under age 19, about 833 would be CHIP-eligible "but for" their immigration status. Under federal law, these children are not eligible for either Medicaid or CHIP.

- There is no reliable data on the number of legal immigrant children who have arrived in the District since the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (August 22, 1996). These children are statutorily ineligible for Medicaid for their first five years in the country. Thereafter, these children are eligible for Medicaid subject to (a) a state's option, and (b) sponsor deeming rules.

Summary of Current Medicaid Enrollment

- Under the District's current Medicaid eligibility rules, infants are eligible up to 185 percent of poverty; children ages 1 through 5 are eligible up to 133 percent of poverty; children ages 6 through 14 are eligible up to 100 percent of poverty; and children ages 15 through 18 are eligible up to approximately 50 percent of poverty.
- Of the 112,557 children under age 19 living in the District, approximately 73,835 were Medicaid eligible at some point during 1966. This includes all children who qualified for the program under one or more categories of eligibility including: AFDC recipients; medically needy; disabled children; or the federally mandated expansion in eligibility for poverty-related groups.
- Of the 73,835 children who were Medicaid-eligible at some point during 1966, only 67,734 actually enrolled in the program. This represents an overall program enrollment rate of 91.7 percent.
- The enrollment rate for children who were eligible for AFDC cash assistance (typically persons below 40 percent of the federal poverty level) was 97 percent while the enrollment rate for children in non-cash expansion groups (Medicaid only) was 74 percent.
- There were approximately 6,101 children who were eligible for, but not enrolled in Medicaid. Of these, 3,272 (53.6 percent) were uninsured; 2,289 (37.5 percent) had employer-sponsored coverage; and the remaining 540 (8.9 percent) had individually purchased insurance coverage.

Approximate Number of CHIP Eligible Children Among the Total Number of Uninsured

- Of the 14,749 uninsured children living in the District of Columbia, approximately 833 are undocumented immigrant children living in families with incomes less than 200 percent of the federal poverty level. Although these approximately 833 children

meet the income eligibility criteria for CHIP, they are ineligible for CHIP because of their immigration status.

- Of the 14,749 uninsured children living in the District of Columbia, 2,701 are in families with income above 200 percent of the federal poverty level and are therefore ineligible for CHIP.
- Of the 14,749 uninsured children living in the District of Columbia, 3,272 are uninsured, Medicaid-eligible, and not currently enrolled in the Medicaid Program. These 3,272 children are ineligible for CHIP because they are eligible for Medicaid under eligibility rules in effect on March 31, 1997.
- Where one subtracts from the total number of 14,749 uninsured children: (a) the number of children who are not eligible for CHIP because of their immigration status (833); (b) the number of uninsured children who are in families with incomes above 200 percent of the federal poverty level (2,701); and (c) the number of children who are currently eligible for but not currently enrolled in Medicaid (3,272), **there are 7,943 children among those who are currently uninsured in the District who are eligible for CHIP.**

**Approximate Number of CHIP-Eligible Children Expected to Enroll in CHIP
(Including Substitution)**

- The District proposes to increase the Medicaid income eligibility limit for the CHIP program to 200 percent of the federal poverty level (FPL) for all uninsured children living in the District who are under age 19. The benefits provided to these newly eligible children will be the same as those now provided to children currently enrolled in Medicaid.
- There are approximately 7,943 uninsured children who are: (a) District residents; (b) live in families with income below 200 percent of the federal poverty level; and (c) are under age 19. Approximately 6,672 (84 percent) of these 7,943 uninsured children are expected to enroll in CHIP.
- There are approximately 4,322 children living in the District of Columbia who are in families with access employer-sponsored dependent coverage. Approximately 1,729 (40 percent) are expected to drop such coverage and enroll in CHIP.
- There are approximately 1,170 children in the District of Columbia who are in families with income up to 200 percent of the federal poverty level and who are either enrolled in CHAMPUS or Medicare. None of these children are expected to drop their coverage with either CHAMPUS or Medicare to enroll in CHIP.

- The total number of children who are expected to enroll in CHIP is derived as follows: (a) approximately 6,672 (84 percent) of the 7,943 uninsured children; plus (b) 1,729 (40 percent) of the 4,332 children with private insurance coverage who are expected to drop such coverage and enroll in CHIP; plus (c) none of the 1,170 children currently enrolled in CHAMPUS or Medicare; equals a total number of **8,401 children who are expected to enroll in CHIP.**

Impact of CHIP Outreach and Education Efforts on Medicaid Enrollment (The Currently Eligible But Not Enrolled Population)

- There are approximately 6,101 children living in the District who are eligible for but not enrolled in the Medicaid program under March 31, 1997 eligibility criteria. All of these children are eligible to enroll in Medicaid even though a portion of them (46.4 percent) already have some sort of private insurance coverage.
- The District's implementation of CHIP will include an outreach effort designed to encourage enrollment among those who are CHIP-eligible.
- Based upon results from prior outreach programs, we assume that about 20 percent of those who are eligible for but not enrolled in Medicaid will enroll in response to the intensified outreach efforts. We further assume that the entire 20 percent of persons in this category will come from that portion of the total population of 6,101 who are currently uninsured.
- Thus, it is estimated that the outreach initiative will increase Medicaid enrollment by about 1,223 children per year.

Impact of CHIP Enrollment and Outreach on Total Program Numbers

- The number of CHIP-eligible children who are likely to enroll in the program is **8,401**. The number of currently Medicaid-eligible children who are likely to enroll in the program due to outreach activities is **1,223**. Thus overall Medicaid program enrollment will increase from **67,734 to 77,358**.

Impact on the Number of Uninsured Children in the District

- There are currently an estimated 14,749 uninsured children living in the District of Columbia. The combined effect of CHIP and its associated outreach program will be to increase the number of children with Medicaid coverage by 9,624. This number includes the 8,401 children who will enroll in CHIP and the 1,223 children who will

be added to the regular Medicaid program as a result of outreach. Total Medicaid program enrollment (including regular Medicaid and CHIP-Medicaid) will increase from 67,734 to 77,358.

- Approximately 6,854 children are expected to remain uninsured despite the CHIP expansion and vigorous outreach activities. About 2,701 (39.4 percent) of the children who remain uninsured are in families with income in excess of 200 percent of the federal poverty level. Another 833 (12.2 percent) of these children who will remain uninsured, meet the income eligibility criteria under either Medicaid or CHIP, but are ineligible because they are undocumented aliens. About 2,049 of the children who will remain uninsured (29.9 percent) will be children who are eligible for Medicaid under the current program who will not enroll despite vigorous outreach efforts. This is equal to the number of eligible but not enrolled persons who are uninsured (3,272) less the number of eligible non-enrollees who would become covered due to outreach (1,223). All of the eligible but not enrolled children who enroll due to intensified outreach efforts are assumed to be persons who would be otherwise uninsured.
- Finally, 1,271 of those who will remain uninsured are newly eligible CHIP children who, for a variety of possible reasons, will not enroll in the program. Thus, 6,854 children will remain uninsured in the District despite the CHIP expansion and vigorous outreach efforts. (See **Appendix A Discussion Paper: Coverage and Costs under the Children's Health Insurance Program**, revised March 16, 1998, prepared by The Lewin Group, Inc.)

Summary of two Private Initiatives: Capital Community *Kids Care* and the Kaiser *Kids Program*

- There are two privately funded initiatives currently underway in the District to provide health insurance coverage to uninsured children.
- Both of the initiatives are funded by private foundations and sponsored by two local managed care organizations (Capital Community Health Plan and Kaiser Permanente).
- Each plan has 500 slots into which uninsured children may be enrolled. Both plans have expressed that they intend to expand the number of available slots over time.
- The Capital Community *Kids Care* Program covers children in families with income up to 275 percent of the federal poverty level.
- The *Kaiser Kids* Program covers children in families with income up to 200 percent of the federal poverty level.

- Both of the programs require children to be ineligible for Medicaid.
- As of February 1998, there were 500 children enrolled in the Capital Community *Kids* Care Program and 500 children enrolled in the *Kaiser Kids* Program.
- Enrollment criteria for both programs includes: (a) the child may not be eligible for Medicaid; (b) the child must be under age 18; and (c) the child must be a resident of the District of Columbia. (See Appendix B: Description of Capital Community *Kids* Cure Program) (See Appendix C: Description of *Kaiser Kids* Program)

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2)

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance):

Summary of District Activities to Identify and Enroll Medicaid Eligible Children

- The Medical Assistance Program: The Medical Assistance Program (Medicaid) is the only public health insurance program currently available to children who are residents of the District of Columbia.
- Income Maintenance Administration: The Income Maintenance Administration (IMA) is the entity within the Department of Human Services responsible for eligibility determinations for the District's Medicaid program as well as cash assistance, food stamps and other benefits. Individuals can walk into any of the eight (8) IMA service centers at any time and be processed for Medicaid eligibility.
- Income Maintenance Administration Community Outreach: Representatives from IMA give talks to community groups upon request. The purpose of these presentations is to inform the public about: (a) general eligibility requirements for the District's Medicaid program; (b) the requirements for Medicaid eligibility; and (c) the eligibility determination process. Examples of groups addressed include: The Children's Health Coalition, area churches, DSH Hospitals and the District's two federally qualified health centers. East of the River and Upper Cardoza.
- Disproportionate Share Hospitals: All DSH Hospitals in the District conduct the following outreach and enrollment activities: (a) place signs up in their facilities that alert people about Medicaid; (b) provide assistance with completing the Medicaid application; and (c) collect completed applications and deliver them to IMA offices. DSH hospitals include: Children's

Hospital, Hospital for Sick Children, Providence Hospital, Hadley Hospital, Greater Southeast Hospital, DC General Hospital, and Howard University Hospital, and Saint Elizabeth's Hospital. Saint Elizabeth's Hospital and DC General Hospital have District government employed IMA workers on site who accept applications and make final determinations on-site; all other DSH hospitals have contracts with private firms to gather and collect application information and assist with the preparation of Medicaid applications. This information is then forwarded to the central IMA unit on H Street NE. within five days of client signing the application.

- **Public Benefits Corporation Clinics:** The PBC clinics (13 clinics across the District) have their own employees who: (a) collect, gather, and assist with the completion of Medicaid applications and, (b) send the client with the completed application packet to the appropriate service center based on census tract information.
- **Non-DSH Hospitals:** Non-DSH Hospitals in the District (George Washington University Hospital, Georgetown University Hospital, Washington Hospital Center, and Sibley Hospital) either have members of their own staffs or hire contracted staff to assist Medicaid applicants. This staff activity includes: (a) assisting clients with completing applications; (b) assembling completed application packets; and (c) forwarding completed application packets to the central IMA unit on H Street NE.
- **Mary's Center for Maternal and Child Health:** Mary's Center is a non-profit community-based clinic that provides comprehensive health services to low-income women and children. The clinic primarily provides services to Latino, African and Middle Eastern immigrants. An employee of the District government is located at the Center. This individual assists Medicaid applicants with the following: (a) assisting clients with completing applications; (b) assembling completed application packets; and (c) forwarding completed application packets to the central IMA unit on H Street NE. Most of these applications are processed in IMA's Multinational Unit.
- a **Other Hospital-Related Activities:** Many local hospitals hire staff to assist Medicaid-eligible individuals during every phase of the enrollment process. For example, Children's Hospital has contracted with a private organization to: (a) assist self-pay customers with filling out the Medicaid application; (b) obtain the necessary supporting documentation; (c) submit the application to the Income Maintenance Administration; and (d) follow up with eligibility workers until the customer's application is given a final determination.
- **Medical Care Advisory Committee:** Through its Medical Care Advisory Committee, the District's Medicaid program provides ongoing information to Committee members on key program changes and receives guidance on successful outreach strategies.
- **Medical Assistance Program Staff:** Staff of the Medical Assistance Program (Medicaid) give frequent presentations and briefings to consumer and provider groups on Medicaid eligibility rules and other aspects of accessing the program.

- **Section 330 Federally Qualified Health Centers:** The Federally Qualified Health Centers have their own staff to assist Medicaid applicants. Their activities include the following: (a) assisting clients with completing applications; (b) assembling completed application packets; and (c) forwarding completed application packets to the central IMA unit on H Street NE.
- **The Supplemental Food Program For Women, Infants and Children:** The Supplemental Food Program for Women, Infants and Children (WIC) is located within the Department of Health. WIC employees distribute literature on Medicaid and Medicaid eligibility to all WIC applicants. Many WIC sites are located in clinic settings where clients have access to clinic personnel for assistance with applying for Medicaid.
(See Appendix D: Medicaid Outreach Information Distributed by WIC Agencies)
- **Office of Maternal and Child Health:** The District's Office of Maternal and Child Health (OMCH) is located within the Department of Health. Established in 1982, the OMCH is charged with planning, promoting, and coordinating a state-based system of comprehensive health services for all mothers and children, including children with special health care needs, in both the public and private sectors of the District of Columbia. The OMCH integrates Medicaid-related outreach activities into many of their programs. Generally, individuals working in the various programs inform parents and providers about Medicaid eligibility and about Medicaid Managed Care. (See Appendix E: Description of OMCH Outreach Programs Description of HMO Oversight Program)
- **Other Activities:** A number of community clinics, community-based groups, and other nonprofit associations throughout the District conduct the following activities: (a) provide information to consumers about the District's Medicaid program; (b) assist consumers with completing the Medicaid application; (c) assist consumers with locating, assembling and photocopying necessary documentation; (d) provide translation services for non-English speaking or limited-English speaking consumers who are applying for Medicaid; and, (e) interface between eligibility workers and customers when necessary. Examples of some of these groups include:
 - The United Planning Organization (UPO)
 - The Non-Profit Clinic Consortium
 - The 10Non-Profit Clinics
 - The DC Primary Care Association
 - DC Action for Children
 - Children's Health Coalition of DC
 - Chartered Health Plan

- China Town Community Center of the Chinese Community Church
- Planned Parenthood
- Whitman Walker Clinic, Inc.

Summary of District Activities to Assist Non-Medicaid Eligible Children in Enrolling in the Private Initiatives

Representatives from the District’s Department of Health including the District’s Medicaid Program serve on a task force created to identify effective outreach strategies for the District’s two privately funded health insurance initiatives. The District is currently exploring ways to incorporate information about these two initiatives into its outreach and education strategy for CHIP. The Medicaid Assistance Program (Medicaid) is the only publicly-funded health insurance program in the District of Columbia.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

There are no health insurance programs in the District of Columbia that involve a public-private partnership.

2.3. Describe how the new State Title XXI program(s) is(are) designed to be coordinated with such efforts to increase the number of children with creditable health coverage so that only eligible targeted low-income children are covered: (Section 2102)(a)(3)

- **Triage During the Enrollment Process:** Enrollment activities for CHIP will be based on a strategy that is designed to direct families to an appropriate source of health insurance coverage. This means that during the enrollment process eligibility workers will be trained to do CHIP eligibility determinations and income based Medicaid eligibility determinations. **As** individuals come forward to enroll a child in CHIP, the child will first be screened for Medicaid-eligibility prior to being enrolled in CHIP. Individuals who are eligible for regular Medicaid (based solely on income) will be enrolled in the program as part of the same process as that used for CHIP enrollment.
- **Appropriate Referrals:** Individuals who are eligible for Medicaid based upon other criteria (e.g. spend-down) will be referred to appropriate eligibility workers. These individuals will also be referred to appropriate application assistance programs if such assistance is required. In addition, eligibility workers will be trained to refer individuals to either of the two private initiatives (see above) when the individual

would be an appropriate referral.

- a* **Comprehensive Outreach:** Although the primary goals of Title XXI outreach efforts are to identify and enroll CHIP-eligible children (who will be separately tracked once enrolled,) the District is eager to identify and enroll *all* children who are eligible for but not enrolled in the Medicaid program as well as children who are not eligible for Medicaid but may be eligible for one of the two private initiatives. Thus, the District plans to mount a comprehensive outreach strategy designed to reach (a) children who are eligible for but not enrolled in Medicaid and (b) children who are eligible for CHIP. Appropriate referrals will be made for children who are ineligible for Medicaid and CHIP but may be eligible for either of the two private initiatives.
- a* **Provider Education:** The District’s Medicaid Agency will undertake activities to educate providers about CHIP and changes in the enrollment and eligibility determination process. The Agency will work collaboratively with the DC Primary Care Association, the Medical Society of DC, the DC Chapter of the American Academy of Pediatrics, and the DC Hospital Association to ensure that a maximum number of providers are reached.
- a* **Coordination of Department Health Activities:** There will be coordination among all Department of Health Programs (e.g. Maternal and Child Health, Title X Family Planning, Immunizations, etc.). to ensure that each program integrates Medicaid and CHIP outreach strategies and enrollment assistance into their ongoing activities.
- **Coordination with other City Programs:** The Department of Health will work with the City’s School Lunch Program, the Head Start Program, and other City programs serving large numbers of low-income children to ensure that effective outreach occurs among their respective populations.

Section 3. General Contents of State Child Health Plan (Section 2102)(a)(4))

X Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 4.

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children: **(Section 2102)(a)(4)**

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children: **(Section 2102)(a)(4)**

Section 4. Eligibility Standards and Methodology. (Section 2102(b))

X Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. **(Section 2102)(b)(1)(A))**

- 4.1.1. Geographic area served by the Plan: _____
- 4.1.2. Age: _____
- 4.1.3. Income: _____
- 4.1.4. Resources (including any standards relating to spend downs and disposition of resources): _____
- 4.1.5. Residency: _____
- 4.1.6. Disability Status (so long as any standard relating to disability status does not restrict eligibility): _____
- 4.1.7. Access to or coverage under other health coverage: _____
- 4.1.8.** Duration of eligibility _____
- 4.1.9. Other standards (identify and describe): _____

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: **(Section 2102)(b)(1)(B))**

- 4.2.1. These standards do not discriminate on the basis of diagnosis.
- 4.2.2. Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
- 4.2.3. These standards do not deny eligibility based on a child having a pre-existing medical condition.,

4.3. Describe the methods of establishing eligibility and continuing enrollment. **(Section 2102)(b)(2)**

4.4. Describe the procedures that assure:

4.4.1. Through intake and follow up screening, that only targeted low-income children who are ineligible for either Medicaid or other creditable coverage are furnished child health assistance under the state child health plan. **(Section 2102)(b)(3)(A)**

4.4.2. That children found through the screening to be eligible for medical assistance under the state Medicaid plan under Title XIX are enrolled for such assistance under such plan. **(Section 2102)(b)(3)(B)**

4.4.3. That the insurance provided under the state child health plan does not substitute for coverage under group health plans. **(Section 2102)(b)(3)(C)**

4.4.4. The provision of child health assistance to targeted low-income children in the state who are Indians (as defined in section 4 0 of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c). **(Section 2102)(b)(3)(D)**

4.4.5. Coordination with other public and private programs providing creditable coverage for low-income children. **(Section 2102)(b)(3)(E)**

Section 5. Outreach and Coordination (Section 2102(c))

Describe the procedures used by the state to accomplish:

5.1. Outreach to families of children likely to be eligible for assistance or under other public or private health coverage to inform them of the availability of, and to assist them in enrolling their children in such a program: (Section 2102(c)(1))

Basic Outreach Strategy

The District's Comprehensive Outreach Strategy will be developed based on the following guiding principles:

- Outreach efforts will be City-wide
- Outreach efforts will be culturally sensitive, language appropriate, and sensitive to the needs of the blind, hearing impaired and the deaf. Special outreach efforts will be developed and targeted to the following: Children with special health care needs, the Hispanic community, and the homeless community.
- Outreach materials (and other strategies) will utilize a variety of media approaches. Printed materials will be written at appropriate literacy levels updated to reflect program changes.
- The comprehensive outreach strategy will inform parents, teachers, school nurses, community-based organizations, and the community at-large about CHIP eligibility, eligibility for regular Medicaid, and enrollment procedures.
- The outreach strategy will incorporate the Department of Health web page at <http://www.dchealth.com>. The following will be placed on the web page: (a) general information related to CHIP; (b) a copy of the CHIP application; and (c) step-by-step instructions on how to fill out and submit the application. The Department of Health, through its outreach activities, will encourage school nurses, teachers and others to use the web page to assist potential customers.

Outreach Partners

The District will use existing case management structures in place in the Supplemental Food Program for Women, Infants and Children (WIC), Title V Programs, Healthy Start and Title X Programs to inform potential clients about CHIP eligibility. These programs have mechanisms in place that will allow for follow-up to see whether the parent of a potentially eligible child successfully completes the application process.

The District plans to hire an outreach coordinator to assist the City in the development and implementation of a comprehensive outreach plan that is based upon the guiding principles (see

above). Once the overall outreach approach is identified, the District will integrate the following programs into that strategy:

Public Programs

- DC Public Schools–School Health Program
- DC Head Start and DC Early Head Start
- DC Office of Maternal and Child Health
- DC Office of Early Childhood Development--DC Early Intervention Program (Child Find)
- DC Immunization Program
- The Supplemental Food Program for Women, Infants and Children (WIC)
- The DC Public Housing System
- The DC Public Hospitals (Social Workers, Emergency Rooms, and Other Relevant Departments)
- The Public Benefits Corporation Community Clinics
- Section 330 Clinics

Private Programs

- Area Houses of Worship and Representative Organizations
- Managed Care Organizations
- Private Not-For-Profit Community Clinics
- DC Action for Children
- Children's Health Coalition of DC
- Private Hospitals
- The District of Columbia Hospital Association
- Local Chapter of the American Academy of Pediatrics

- Local Businesses
- The DC Primary Care Association
- The Medical Society of the District of Columbia
- Advocacy Organizations
- Immigrant and Ethnic Organizations

New Enrollment Procedures

The District is currently developing an enrollment process for CHIP and income based Medicaid applicants that is: (a) user friendly; (b) timely; (c) accommodates working parent(s); (d) requires less documentation; and (e) is accompanied by appropriate supportive services. To accomplish these goals the District is considering the following:

- Naming the program *Healthy DC Kids*. It is believed that giving the program an appealing name will remove the welfare stigma and encourage enrollment
- Developing a two-page application form that does not include documentation of resources. The new application form will be distributed at the following sites: WIC Centers, Head Start Centers, Title V OMCH Programs, Title X Family Planning Programs, D.C. Public Schools and other appropriate community-based sites.
- Working with the Income Maintenance Administration to implement an efficient eligibility determination process that is dedicated to processing only CHIP and income-based Medicaid applications. The unit will be adequately staffed and trained to ensure quicker application processing
- Hiring and training additional eligibility workers to enroll children in CHIP and regular Medicaid (income-based only). This function will also include ongoing training
- Working to ensure a faster turn-around time in application processing and eligibility determination. The District's goal is to determine eligibility in between seven (7) to ten (10) days. Eligibility workers' caseloads will be continuously monitored and appropriately adjusted to reach this goal.

- Developing and instituting a mail-in application process
- Contracting with community-based entities to assist potential customers with all aspects of application assistance, language access, and other required supportive services
- Distributing printed outreach and education materials as well as program applications among public and private outreach partners

5.2. Coordination of the administration of this program with other public and private health insurance programs: (Section 2102(c)(2))

The District's Medicaid program will keep itself informed on eligibility criteria and enrollment procedures for the two private initiatives currently operating in the District. In addition, the District's Medicaid program will work closely with sponsors of the two private health insurance initiatives to ensure that they are fully informed about: (a) Medicaid and CHIP eligibility requirements; and (b) Medicaid and CHIP enrollment procedures, so that these programs are able to make appropriate referrals to Medicaid. The District's Medicaid program will also inform outreach workers, application assistance workers and eligibility workers about the two private initiatives so that appropriate referrals can be made when individuals are found to be ineligible for Medicaid or CHIP.

- 6.2. The state elects to provide the following forms of coverage to children:
(Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) **(Section 2110(a))**
- 6.2.1. Inpatient services **(Section 2110(a)(1))**
 - 6.2.2. Outpatient services **(Section 2110(a)(2))**
 - 6.2.3. Physician services **(Section 2110(a)(3))**
 - 6.2.4. Surgical services **(Section 2110(a)(4))**
 - 6.2.5. Clinic services (including health center services) and other ambulatory health care services. **(Section 2110(a)(5))**
 - 6.2.6. Prescription drugs **(Section 2110(a)(6))**
 - 6.2.7. Over-the-counter medications **(Section 2110(a)(7))**
 - 6.2.8. Laboratory and radiological services **(Section 2110(a)(8))**
 - 6.2.9. Prenatal care and pregnancy family services and supplies **(Section 2110(a)(9))**
 - 6.2.10.0 Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services **(Section 2110(a)(10))**
 - 6.2.11. Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services **(Section 2110(a)(11))**
 - 6.2.12. Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) **(Section 2110(a)(12))**
 - 6.2.13. Disposable medical supplies **(Section 2110(a)(13))**
 - 6.2.14. Home and community-based health care services (See instructions) **(Section 2110(a)(14))**
 - 6.2.15. Nursing care services (See instructions) **(Section 2110(a)(15))**
 - 6.2.16. Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest **(Section 2110(a)(16))**
 - 6.2.17. Dental services **(Section 2110(a)(17))**
 - 6.2.18. Inpatient substance abuse treatment services and residential substance abuse treatment services **(Section 2110(a)(18))**
 - 6.2.19. Outpatient substance abuse treatment services **(Section 2110(a)(19))**
 - 6.2.20. Case management services **(Section 2110(a)(20))**
 - 6.2.21. Care coordination services **(Section 2110(a)(21))**
 - 6.2.22. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders **(Section 2110(a)(22))**
 - 6.2.23. Hospice care **(Section 2110(a)(23))**
 - 6.2.24. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) **(Section 2110(a)(24))**

- 6.2.25.0 Premiums for private health care insurance coverage (**Section 2110(a)(25)**)
- 6.2.26. Medical transportation (**Section 2110(a)(26)**)
- 6.2.27. Enabling services (such as transportation, translation, and outreach services (See instructions) (**Section 2110(a)(27)**)
- 6.2.28. Any other health care services or items specified by the Secretary and not included under this section (**Section 2110(a)(28)**)

6.3. **Waivers - Additional Purchase Options.** If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate waiver. Review and approval of the waiver application(s) will be distinct from the state plan approval process. To be approved, the state must address the following: **(Section 2105(c)(2) and(3))**

- 6.3.1. **Cost Effective Alternatives.** Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following:
- 6.3.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; **Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(I))**
 - 6.3.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; and **Describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii))**
 - 6.3.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923 of the Social Security Act. **Describe the community based delivery system. (Section 2105(c)(2)(B)(iii))**

6.3.2. **Purchase of Family Coverage.** Describe the plan to provide family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: **(Section 2105(c)(3))**

6.3.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.) (Section 2105(c)(3)(A))**

6.3.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. **(Section 2105(c)(3)(B))**

Section 7. Quality and Appropriateness of Care

X Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 8.

- 7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. **(2102(a)(7)(A))**
-

Will the state utilize any of the following tools to assure quality?

(Check all that apply and describe the activities for any categories utilized.)

- 7.1.1. Quality standards
- 7.1.2. Performance measurement
- 7.1.3. Information strategies
- 7.1.4. Quality improvement strategies

- 7.2. Describe the methods used, including monitoring, to assure access to covered services, including emergency services. **(2102(a)(7)(B))**
-

Section 8. Cost Sharing and Payment (Section 2103(e))

X Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan?

- 8.1.1. YES
8.1.2. NO, skip to question 8.5.

8.2. Describe the amount of cost-sharing and any sliding scale based on income:
(Section 2103(e)(1)(A))

- 8.2.1. Premiums: _____
8.2.2. Deductibles: _____
8.2.3. Coinsurance: _____
8.2.4. Other: _____

8.3. Describe how the public will be notified of this cost-sharing and any differences based on income: _____

8.4. The state assures that it has made the following findings with respect to the cost sharing and payment aspects of its plan: **(Section 2103(e))**

- 8.4.1. Cost-sharing does not favor children from higher income families over lower income families. **(Section 2103(e)(1)(B))**
- 8.4.2. No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. **(Section 2103(e)(2))**
- 8.4.3. No child in a family with income less than 150% of the Federal Poverty Level will incur cost-sharing that is not permitted under 1916(b)(1).
- 8.4.4. No Federal funds will be used toward state matching requirements. **(Section 2105(c)(4))**
- 8.4.5. No premiums or cost-sharing will be used toward state matching requirements. **(Section 2105(c)(5))**
- 8.4.6. No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. **(Section 2105(c)(6)(A))**
- 8.4.7. Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. **(Section 2105(d)(1))**
- 8.4.8. No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. **(Section 2105(c)(7)(B))**
- 8.4.9. No funds provided under this title will be used to pay for any abortion or to

assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). **(Section 2105)(c)(7)(A)**

8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's annual income for the year involved: **(Section 2103(e)(3)(B))** _____

8.6. The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan:

- 8.6.1.** The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services **(Section 2102(b)(1)(B)(ii))**; OR
- 8.6.2.** The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.3.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA **(Section 2109(a)(1),(2))**. Please describe:

Section 9. Strategic Objectives and Performance Goals for the Plan Administration (Section 2107)

- 9.1.** Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children. **(Section 2107(a)(2))**

Strategic Objectives

- **Strategic Objective 1:** The District will achieve at least **5** percent of its projected enrollment of CHIP eligible children within the first year of implementation of the eligibility expansion.
- **Strategic Objective 2:** Within the first year of the eligibility expansion and its associated outreach strategy, the District will identify and enroll at least 35 percent of those children who are: (a) uninsured, and (b) currently Medicaid-eligible but not enrolled.
- **Strategic Objective 3:** Fifty percent of CHIP-enrolled children will have self-selected an HMO and a primary care provider within the first year of enrollment.
- **Strategic Objective 4:** Those newly enrolled in CHIP and regular Medicaid (income based) will express satisfaction with the new enrollment process.
- **Strategic Objective 5:** The District will develop and implement a process for determining the effectiveness of (a) the enrollment process, and (b) the City-wide outreach strategy.

- 9.2.** Specify one or more performance goals for each strategic objective identified: **(Section 2107(a)(3))**

Performance Goals

- **Performance Goal for Strategic Objective 1:** The District will collect data on the number of CHIP-eligible children enrolled in the program on a monthly basis.
- **Performance Goal for Strategic Objective 2:** The District will collect data on the number of new Medicaid-eligible and CHIP eligible enrollees on a monthly basis.
- **Performance Goal for Strategic Objective 3:** The District's Medicaid Agency will monitor data on CHIP enrollees and whether or not they were selected enrollments or default enrollments on a monthly basis.
- **Performance Goal for Strategic Objective 4:** The District will capture information related to consumer satisfaction with the eligibility determination process through its managed care

enrollment broker. The District is considering developing a questionnaire for this purpose.

- **Performance Goal for Strategic Objective 5:** The District will: (a) the District will work through its managed care enrollment broker to elicit information from customers related to satisfaction with the eligibility determination process. The City is considering developing a questionnaire for this purpose; and (b) the City will include a question (or series of questions) on its new Medicaid/CHIP application that will elicit from the applicant how he or she found out about the program and whether he/she received community-based assistance with completing the process. The Medicaid Agency will desk audit enrollment forms for customer responses every six months and tabulate the data.

- 9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops:
(Section 2107(a)(4)(A),(B))

Objective Measurement of Performance Measures

The District's baseline for its performance is those measures as stated in this application and relevant appendixes. The Medical Assistance Administration receives numerical data from the Managed Care Organizations (MCOs) on an ongoing basis. This data is summed and tabulated to determine whether targets have been met and to compare MCO performance. Data used in reports developed by the Medical Assistance Administration is readily verifiable through the contracted Managed Care Organizations and may be independently verified through the MCOs. In addition, the Medical Assistance Administration will employ an External Quality Review Organization (EQRO) to independently verify data received from the MCOs.

The Medical Assistance Administration will work through its independent enrollment broker to capture satisfaction with the eligibility determination process. This information may be independently verified through the enrollment broker.

Performance measures that do not lend themselves to numeric summation will be tabulated and maintained by Medical Assistance Administration personnel. These tabulations, as well as the raw data used to develop them, will be maintained on file by the Medical Assistance Administration, and can be made available for independent verification.

Check the applicable suggested performance measurements listed below that the state plans to use: **(Section 2107(a)(4))**

9.3.1. **X** The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.

9.3.2. **X** The reduction in the percentage of uninsured children.

- 9.3.3. The increase in the percentage of children with a usual source of care.
- 9.3.4. The extent to which outcome measures show progress on one or more of the health problems identified by the state. **Problems Identified:** Asthma and Lead Poisoning
- 9.3.5. HEDIS Measurement Set relevant to children and adolescents younger than 19. **See 9.3.7 below.**
- 9.3.6. Other child appropriate measurement set. List or describe the set used.
- 9.3.7. If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
- 9.3.7.1. Immunizations
- 9.3.7.2. Well child care
- 9.3.7.3. Adolescent well visits
- 9.3.7.4. Satisfaction with care
- 9.3.7.5. Mental health
- 9.3.7.6. Dental care
- 9.3.7.7. Other, please list: EPSDT screening
- 9.3.8. Performance measures for special targeted populations.
- 9.4. The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. **(Section 2107(b)(1))**
- 9.5. The state assures it will comply with the annual assessment and evaluation required under Section 10.1. and 10.2. (See Section 10) Briefly describe the state's plan for these annual assessments and reports. **(Section 2107(b)(2))**

District of Columbia Plan for Annual Assessments

The District of Columbia's Medicaid program will collect data consistent with the reporting requirements of Section 10 of this CHIP application. The District will compile the data into an assessment and evaluation report on an annual basis. Specifically, the District will:

- Track all new Medicaid enrollees along the following indicators: (a) monthly number enrolled; (b) income level; (c) age; (d) race and ethnicity; (e) geographic area of residence with the District; and (f) criteria for Medicaid eligibility
- Collect enrollment information from the two private health insurance initiatives in the District
- Ensure that enrolled children receive Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services consistent with standards set forth in the District's contractual agreement with its Managed Care Organizations. **(See Appendix F: EPSDT Standards set forth in MCO Contracts)**
- Implement an HMO Oversight Program designed to evaluate member satisfaction and quality of care and service delivery. **(See Appendix G: Description of HMO Oversight Program)**

and Quality Measures)

- Evaluate effectiveness of outreach and public education activities

9.6. **X** The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section **2107(b)(3)**)

9.7. **X** The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed.

- 9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e))**
- 9.8.1. **X** Section 1902(a)(4)(C) (relating to conflict of interest standards)
 - 9.8.2. **X** Paragraphs (2), (16) and (17) of Section 1903(I) (relating to limitations on payment)
 - 9.8.3. **X** Section 1903(w) (relating to limitations on provider donations and taxes)
 - 9.8.4. **X** Section 1115 (relating to waiver authority)
 - 9.8.5. **X** Section 1116 (relating to administrative and judicial review), but only insofar as consistent with Title XXI
 - 9.8.6. **X** Section 1124 (relating to disclosure of ownership and related information)
 - 9.8.7. **X** Section 1126 (relating to disclosure of information about certain convicted individuals)
 - 9.8.8. **X** Section 1128A (relating to civil monetary penalties)
 - 9.8.9. **X** Section 1128B(d) (relating to criminal penalties for certain additional charges)
 - 9.8.10. **X** Section 1132 (relating to periods within which claims must be filed)
- 9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. **(Section 2107(c))**

Summary of the District’s Comprehensive Strategy to Include the Public in its Decisionmaking Process

- The public process for discussing issues related to the development of the District’s CHIP plan is an ongoing one that has been city-wide, open and inclusive.
- All meetings that have been held related to CHIP have been open to the community.
- An article, *DC Seeks to Expand Health Care for Needy Children*, appeared in the Washington Post on December 9, 1997. **(See Appendix H: December 9, 1997 Washington Post Article)**
- Specific efforts were made to include members and representatives from the District’s immigrant communities in the planning process. These include: working with the Mayor’s Office of Diversity, the Mayor’s Office of Asian and Pacific Islanders Affairs and the Mayor’s Office of Latino Affairs to ensure that members of these communities were aware of CHIP and that they would send representatives to the public forums.
- Translation services and signing for the hearing impaired were made available at several of the public forums. Specifically, Chinese, Vietnamese and Spanish translators were available.

Public Involvement in Program Design

- The Medicaid Managed Care and Eligibility Committee (MMCEC) of the Mayor's Health Policy Council took the lead in the District's public process to involve the community in planning for CHIP. The membership of the MMCEC includes, but is not limited to representatives from the following organizations: The Department of Health, including the DC Medical Assistance Administration (Medicaid), D.C. Dental Association, D.C. Hospital Association, Blue Cross Blue Shield of the National Capitol Area, and the Medical Society of the District of Columbia.
- The Committee process was, and continues to be, open to all interested community members. **(See Appendix I: Summary of Health Policy Council (including background on members)).**
- For the purpose of discussing issues related to the District's CHIP plan, the Committee was divided into three Work Groups: (1) The Coverage and Benefits Work Group; (2) The Structure and Administration Work Group; and (3) The Outreach and Education Work Group.
- The Committee and its component Work Groups met several times between September 1997 and December 1998 to evaluate the policy options associated with the development of a CHIP plan. On December 9, 1998, the Committee made final recommendations to the Mayor's Health Policy Council.
- Upon approval of the Committee's recommendation (as amended) by the Health Policy Council (December 9, 1997) the Committee proceeded with a series of public forums related to CHIP. **(See Appendix J: Medicaid Managed Care and Eligibility Committee Consensus Report; Health Policy Council Recommendation; and Comments of Families USA on Recommendations of the Medicaid Managed Care and Eligibility Committee)**
- The Medicaid Managed Care and Eligibility Subcommittee of the Mayor's Health Policy Council conducted five public forums between January 12, 1998 and January 28, 1998. The purpose of the meetings were: (a) to inform the public about CHIP and options given to states under federal law; (b) to inform the public that the District is planning to expand Medicaid to implement CHIP; (c) to solicit public input related to effective enrollment processes; and (d) to solicit public input related to effective public education and outreach strategies. **(See Appendix K: Summary of Health Policy Council and Flyers and Handouts for Public Hearings Conducted by the Medicaid Managed Care and Eligibility Committee of the Mayor's Health Policy Council)**

- e A Public Roundtable sponsored by Councilmember Sandra Allen (Ward 8), Chair of the Committee on Human Services was held in the City Council Chambers on January 27, 1998. A number of groups and some private individuals offered testimony at the Roundtable. (See Appendix L: Flyer Announcing Public Hearings; Statement of Allan S. Noonan, MD, MPH, Director, Department of Health; Statement of Bailus Walker, Jr., PhD, MPH, Chair, Mayor's Health Policy Council; Statement of Brenda Richardson, Chair, Outreach and Education Work Group; Statement of Jesse Price, Consumer; Statement of Diane Bernstein, President, DC Action for Children; and Statement of Hanita Schreiber, President, Capital Community Health Plan)

- e The Department of Health, in partnership with City Councilmembers, conducted a series of public forums between February 12, 1998 and March 16, 1998 in seven of the City's eight wards. The forums were advertised in the Washington Post on February 12, 1998. (See Appendix M: February 12, 1998 Washington Post Article) Representatives from the Department of Health and the City Council provided information at the meetings. The purpose of these forums was: (a) to ensure city-wide in-put in the **CHIP** planning process; (b) to inform the public about CHIP and options given to states under federal law; (c) to inform the public that the District is planning to expand Medicaid to implement CHIP; (d) to solicit public input relative to effective enrollment processes; and (e) to solicit public input relative to effective public education and outreach strategies. (See Appendix N: Flyers and News Release Advertising Public Hearings Conducted by the Department of Health and the City Council)

- e Representatives from the District's Medicaid Agency have made themselves available to make presentations upon request. Thus far, approximately six presentations have been made to such groups as: The Use Your Power Parent Group, The Welfare Reform Collaborative, The Washington Parent Group Fund, and DC Foster Care Social Workers.

Public Involvement in Program Implementation

- e The Director of the Department of Health and members of the Managed Care and Eligibility Committee of the Mayor's Health Policy Council will share ongoing oversight responsibilities for CHIP.

- The Outreach and Education Work Group of the Medicaid Managed Care and Eligibility Committee will have continued involvement in the development, implementation and ongoing oversight of the City's outreach plan as will representatives from key City agencies.

Mechanism for Ongoing Public Involvement

- The District will conduct periodic focus group sessions with consumer groups to evaluate the effectiveness of CHIP and the level of satisfaction with changes in the enrollment process.
- Consumers, providers and other concerned parties will be encouraged to give their input to the Medical Care Advisory Committee which meets on a monthly basis.
- The Managed Care and Eligibility Committee will continue to review CHIP activities during regular meetings.

9.10. Provide a budget for this program. Include details on the planned use of funds and sources of the non-Federal share of plan expenditures. **(Section 2107(d))**

A financial form for the budget is being developed, with input from all interested parties, for states to utilize.

BUDGET PRINCIPLES

The District's CHIP Program--Healthy *DC Kids*--will provide health insurance coverage to all uninsured children who: (a) are under age 19; (b) are District residents; (c) who live in families with income up to 200 percent of the federal poverty level (FPL); (d) who are not Medicaid eligible under current eligibility criteria; and (e) who meet all other statutory eligibility requirements.

It is estimated that approximately 8,401 children will enroll in CHIP. CHIP enrollees will receive the same benefits package as that received by children enrolled in the regular Medicaid Program. In addition, the District plans to provide services to CHIP-enrolleesthrough the same delivery model designed for TANF and TANF-related mothers and children--managed care. As in the regular Medicaid program, behavioral health services and long-term care services will be carved out and reimbursed on a fee-for-service basis.

Using a per-capita cost for covering children under the existing Medicaid managed care plans for AFDC and AFDC-related persons (plus an allowance for mental health services and other costs not included under capitation), it is estimated that the average per person per month cost of providing coverage to CHIP-enrolled children is \$110 per month in fiscal year 1998.

An average annual rate of growth in per-capita costs for this group--3.75 percent--was arrived at based on the estimated average annual rate of growth in per-capita costs for children in the District's Medicaid Program between 1993 through 1997. Thus total costs over fiscal years 1998through 2003 will be an estimated \$62.7 million, of which, 79 percent (\$49.5 million) will be paid by the federal government. The District's share of program costs are approximately \$13.2 million over the same period of time.

The District plans to begin enrolling children in CHIP in early August. Therefore, we expect an average monthly enrollment of 1,063 children in FN 1998 at an average per person per month cost of \$110. The City

plans to spend the full 10 percent (the maximum allowed by federal law) of the total amount of benefits expenditures on some combination of the following: (a) costs associated with operating CHIP; (b) costs associated with making changes in the eligibility determination system; and (c) costs associated with the development and implementation of an outreach and education strategy.

In **FN** 1999 we expect average monthly enrollments of 7,723 children and a per member per month coverage rate of \$1 14. Again, we plan to spend 10 percent of the total amount of benefits expenditures on activities as cited above. In **FN** 2000 we expect average monthly enrollments of 8,346 and a per member per month coverage rate of \$1 18. (See **Appendix A Discussion Paper: Coverage and Costs under the Children's Health Insurance Program, Revised March 16, 1998, prepared by The Lewin Group, Inc. for a complete discussion of costs associated with CHIP and average monthly enrollments for F N 2001-2003**)

Fiscal Year 1998 CHIP Budget

Benefits Expenditures ¹	\$233,860
Administrative Expenditures ²	<u>\$ 23,386</u>
Total Expenditures	\$257,246
Federal Share of Total Expenditures	\$203,224
State Share of Total Expenditures	\$ 54,022

¹Benefit expenditures derived as follows: Projected average monthly enrollment of 1,063 children x 2 months in **FN** 1998 x \$1 10 per person per month cost of providing coverage = \$233,860.

²Administrative expenditures consists of: (a) costs associated with operating **CHIP**; (b) costs associated with making changes in the eligibility determination system, including development of new enrollment form; and (c) costs associated with the development and implementation of an outreach and education strategy.

Fiscal Year 1999 CHIP Budget

Benefits Expenditures ³	\$10,565,064
Administrative Expenditures	<u>\$ 1,056,506</u>
Total Expenditures	\$11,621,570
Federal Share of Expenditures	\$ 9,181,040
State Share of Expenditures	\$ 2,440,530

Fiscal Year 2000 CHIP Budget

Benefits Expenditures ⁴	\$11,816,520
Administrative Expenditures	<u>\$ 1,181,652</u>
Total Expenditures	\$12,998,172
Federal Share of Expenditures	\$10,268,555
State Share of Expenditures	\$ 2,729,617

³Benefit expenditures derived as follows: Projected average monthly enrollment of 7,723 children x 12 months in **FN** 1999 x \$114 per person per month cost of providing coverage = \$10,565,064.

⁴Benefit expenditures derived as follows: Projected average monthly enrollment of 8,346 children x 12 months in **FN** 2000 x \$118 per person per month cost of providing coverage = \$11,817,936.

Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: (Section **2108(a)(1),(2)**)

10.1.1. X The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.1.2. X Report to the Secretary, January 1 following the end of the fiscal year, on the result of the assessment.

Below is a chart listing the types of information that the state's annual report might include. Submission of such information will allow comparisons to be made between states and on a nationwide basis.

Attributes of Population	Number of Children with Creditable Coverage	Number of Children without Creditable Coverage	TOTAL
	<u>XIX</u> OTHERCHIP		
Income Level:			
< 100%			
≤ 133%			
≤ 185%			
≤ 200%			
> 200%			
<u>Age</u>			
0 - 1			
1 - 5			
6 - 12			
13 - 18			
<u>Race and Ethnicity</u>			
American Indian or Alaskan Native			
Asian or Pacific Islander			
Black, not of Hispanic origin			
Hispanic			
White, not of Hispanic origin			
<u>Location</u>			
MSA			
Non-MSA			

10.2. X State Evaluations. The state assures that by March 31, 2000 it will submit to the

--	--

Secretary an evaluation of each of the items described and listed below: (Section **2108(b)(A)-(H)**)

- 10.2.1. X** An assessment of the effectiveness of the state plan in increasing the number of children with creditable health coverage.
- 10.2.2.** A description and analysis of the effectiveness of elements of the state plan, including:
 - 10.2.2.1.X** The characteristics of the children and families assisted under the state plan including age of the children, family income, and the assisted child's access to or coverage by other health insurance prior to the state plan and after eligibility for the state plan ends;
 - 10.2.2.2. X** The quality of health coverage provided including the types of benefits provided;
 - 10.2.2.3. X** The amount and level (including payment of part or all of any premium) of assistance provided by the state;
 - 10.2.2.4. X** The service area of the state plan;
 - 10.2.2.5. X** The time limits for coverage of a child under the state plan;
 - 10.2.2.6. X** The state's choice of health benefits coverage and other methods used for providing child health assistance, and
 - 10.2.2.7. X** The sources of non-Federal funding used in the state plan.
- 10.2.3. X** An assessment of 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.

- 10.2.4. X A review and assessment of state activities to coordinate the plan under this Title with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services.
- 10.2.5. X An analysis of changes and trends in the state that affect the provision of accessible, affordable, quality health insurance and health care to children.
- 10.2.6. X A description of any plans the state has for improving the availability of health insurance and health care for children.
- 10.2.7. X** Recommendations for improving the program under this Title.
- 10.2.8. X Any other matters the state and the Secretary consider appropriate.
- 10.3. X** The state assures it will comply with future reporting requirements as they are developed.
- 10.4. X The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

LIST OF APPENDIXES

- APPENDIX A: Discussion Paper: *Coverage and Costs under the Children's Health Insurance Program* prepared by The Lewin Group
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APPENDIX A

**Coverage and Costs under the
Children's Health Insurance Program
(CHIP) as Recommended by The
Managed Care and Eligibility
Committee of the Health Policy
Council**

Final Report

Prepared for:

**The Office of the Commissioner,
District of Columbia Medicaid Program**

December 22, 1997
Revised: March 16, 1998

By:

The Lewin Group, Inc.

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EXECUTIVE SUMMARY

In **this** analysis, we developed estimates of the impact of the Children's Health Insurance Program (CHIP) design recommended by The Managed Care and Eligibility Committee of the District of Columbia Health Policy Council. The children's initiative passed by Congress as part of the Balanced Budget Act of **1997** has two components. **First**, it provides **funding** to states and the District of Columbia to expand coverage for children under CHIP. The District's share of **this** funding is **\$12.4** million in **1998**. The second part of the initiative is designed to deal with the fact that there are many children who **are** already eligible for Medicaid under current program designs and are not enrolled. **This** part of the program includes **an** outreach program designed to encourage these persons to enroll.

The primary **data** source used in **this** analysis **was** the District of Columbia subsample of the Current Population Survey (CPS) for **1995** and **1996**. These are the only data available for the District of Columbia that provided the income and health insurance coverage data required to estimate the number of persons who would become eligible under an expansion in coverage. However, the CPS **data**, which overestimates the District of Columbia population by up to **20** percent, were adjusted to reflect the **most** recently available information on: the number of adults and children living in the District; and Medicaid program **data** on the number of Medicaid enrollees in **1996**. Based upon these **adjusted** CPS data, we estimated the number of children who would become eligible under an illustrative version of the CHIP program. These estimates were developed using the Lewin Group State Medicaid Eligibility Model (SMEM), which is specifically designed to estimate the number of persons meeting alternative program eligibility criteria.

Children's Population

Based on these adjusted CPS **data**, we estimate that there **are** about **112,557** children under age 19 living in the District. **This** includes District residents and undocumented aliens living in the District. The key demographic characteristics of these children include:

- Of the **112,557** children in the District, on average about **67,734** children are enrolled in Medicaid each month. Thus, about **60.2** percent of all children in the District are covered under Medicaid. About **26.7** percent (**30,074**) are covered under **an** employer plan or some other type of coverage.
- There are about **14,749** uninsured children in the District (13.1 percent of children).
- About 32.5 percent of all uninsured children in the District are under age 6 while **52.7** percent are between the ages of **6** and **14**. **Only 14.8** percent are between the ages of **15** and **18**.
- About **75.8** percent of uninsured children are African-Americans while **21.2** percent are white. About 31.6 percent of the uninsured report themselves to be Hispanic.
- Based upon estimates provided by the Bureau of the Census and the Immigration and Naturalization Service, we estimate that there are about **4,407** children living in the District

who are undocumented aliens. By federal law, these **persons** are not eligible for either Medicaid or the CHIP program.

Medicaid Eligibility

Using the **data** and model discussed above, we estimate that there are about **73,835** children who were eligible for Medicaid in the District of Columbia in **1996**. **This** includes all children **who** qualified for the program under one or more categories of eligibility including: **AFDC** recipients; medically needy; disabled children; or the federally mandated expansion in eligibility for the poverty population. Key findings include:

- Of the **73,835** children who were eligible for Medicaid, only **67,734** children were enrolled. **This** represents an overall enrollment rate of **91.7** percent.
- The enrollment rate for children who are also eligible for cash assistance under AFDC was **97** percent while the enrollment rate for persons who qualify for Medicaid health benefits only was about **74** percent.
- There were about **6,101** children who were eligible for the program that had not enrolled. Of these, **3,272 (53.6** percent) were uninsured. The remainder (**2,829**) were covered under **some** form of private coverage.

Eligibility Expansion

The proposed **CHIP** program would increase the income eligibility level for children to **200** percent of the federal poverty level (FPL). **The** program would be implemented **as** an extension of the existing Medicaid program and that the benefits provided would be the same **as** those now provided under Medicaid. Based upon **our** analysis of program participation under Medicaid in the District, we **assume** that **84** percent of newly eligible children who do not have private coverage would enroll in the program and that **40** percent of newly eligible children who have private coverage would **shift** to Medicaid to take advantage of the fact that Medicaid does not require premium contributions. We **assume** that no one would **shift** from **CHAMPUS** to Medicaid because comprehensive coverage **is** available to these persons without a premium. These assumptions are based upon enrollment rates in the District of Columbia under the existing Medicaid program for persons with and without employer coverage alternatives. **Our** key findings are:

- If eligibility were expanded to 200 percent of the **FPL**, about **13,435** children would be eligible for **CHIP**. Of these, **8,401 (62.5** percent) would enroll (**assuming** no lags in enrollment).
- Using per-capita costs for covering children under the existing Medicaid managed care plans for AFDC and related persons (plus **an** allowance for mental health and other costs not included under capitation), **we** estimate that the program would cost **an** average of **\$110** per person per month.

-
- **Total** costs over the **1998 through 2003** period would be **\$62.7** million of which **79** percent (**\$49.5** million) would be paid by the federal government. The District's **share** of program costs would be \$13.2 million.

Enrollment Initiative

As discussed above, the program would include **an** outreach program designed to encourage increased enrollment among those who **are** already eligible for the program. Based upon **results from** prior outreach programs, we assumed that about **20** percent of those who **are** eligible for Medicaid but not enrolled would enroll in Medicaid in response to the outreach program for **as long as** the outreach program is in operation. The key findings of **our** analysis included:

- Under these assumptions, we estimate that the outreach initiative will increase enrollment in the program by about **1,223** children per year.
- **This** increase in coverage will cost about \$10 million over the **1998 through 2003** period. The federal government would pay **\$7.0** million and the District would pay \$3.0 million.

Changes in Insurance Coverage

The combined effect of the CHIP program **and** the outreach program will be to increase the number of children with Medicaid coverage by **9,624** persons. **This** includes **8,401** children enrolled **in** the CHIP program and **1,223** persons added **through** the outreach initiative. **Total** Medicaid enrollment for children would increase **from 67,734** under current policy to **77,358**. Our key findings are:

- Of the **9,624** children who take coverage under these initiative, about **7,895 (82.2)** percent will be persons who otherwise would have been uninsured. The remaining **1,729** newly enrolled children who take coverage under the program will be persons who had private coverage **through** another source, such **as** employer-based dependent coverage, who switch to Medicaid. **This** is likely to happen frequently because Medicaid does not require a premium payment while most employer plans do.
- The initiative will reduce the number of uninsured children in the District of Columbia by **7,895** persons. The number of uninsured children would drop from **14,749** under current law to **6,854** persons under the children's initiative.
- Of the **6,854** children who remain uninsured, about **2,701** have incomes above the income eligibility threshold under **CHIP** (i.e., 200 percent of the **FPL**). About **3,320** of those who remain uninsured are children who are eligible under either the **CHIP** or Medicaid programs but have not enrolled. About 833 of these uninsured children are undocumented aliens who otherwise would have been eligible under either the CHIP or **the** Medicaid programs.

I. INTRODUCTION

The Children's Health Insurance Program (**CHIP**) that was passed by Congress as part of the Balanced Budget Act of 1997 (**BBA**) provides federal funds to states and the District of Columbia to expand coverage for children. The initiative includes two components. First, the District will be able to cover children with incomes above the current Medicaid income eligibility criteria under a new program established in the **BBA** called the Children's Health Insurance Program (**CHIP**). The District's program will cover all children under the age of 19 in families with incomes below 200 percent of the poverty level who are uninsured (excluding undocumented residents). The second component of the program includes federal funds to assist states in conducting outreach programs designed to increase enrollment among persons who are already eligible but are not participating in the Medicaid program. These two components of the program should result in a substantial increase in coverage among children.

The federal government has allocated \$12.4 million in funding to the District for CHIP. The District is permitted a great deal of flexibility in designing the program in terms of income eligibility and benefits. In this study, we examine the impact of the CHIP program proposed by The Managed Care and Eligibility Committee of the District of Columbia Health Policy Council. The **CHIP** program for the District will cover all uninsured children not otherwise eligible for Medicaid with incomes below 200 percent of the federal poverty level (FPL). The program would be operated as an extension of the existing Medicaid program and the benefits provided to CHIP enrollees would be the same as those provided under the current Medicaid program. As required by Congress in the **BBA**, coverage under **CHIP** is not available to undocumented aliens. Other variations in the design of the CHIP program could also be evaluated with the data and methods used in this analysis.

In this report, we provide basic information on the number of uninsured children in the District of Columbia and an analysis of their demographic characteristics. Our estimates for the District of Columbia have been adjusted to be consistent with the findings of various demographic researchers including the Grier Partnership. We also show the cost and impacts of expanding coverage to children under the CHIP program. We estimate the number of persons who become eligible and enrolled under the program and estimate the resulting change in the number of uninsured. These results and the data and methods used are presented below.

II. DATA AND METHODS USED

The primary database used in this analysis was the District of Columbia Current Population Survey (CPS) for 1995 and 1996 conducted by the Bureau of the Census. Although there are more authoritative sources on the size of the District population of adults and children, the CPS is the only data source available that provides the income and insurance coverage data required to analyze programs to expand coverage. Consequently, we adjusted the CPS data to reflect other population control totals where available. We then estimated the number of persons who would become eligible and enrolled in the program under an expansion in eligibility. Our estimates of the number persons who would become eligible were derived from the District of Columbia CPS data using the Lewin Group State Medicaid Eligibility Model (SMEM), which is specifically designed to model changes in eligibility under public programs.

A. Population Data

Our analysis of the demographic characteristics of children in the District of Columbia and the number of children potentially affected by the children's initiative are based upon the March Current Population Survey (CPS) data for 1995 and 1996 developed by the Bureau of the Census.¹ These survey data are based upon a representative sample of the US population, which provides information on the demographic, economic and the insurance coverage characteristics of the population. The District of Columbia subsample of these data provides a representative sample of the District's population that can be used to estimate the number of children who would be potentially eligible for coverage under the children's initiative. However, there is a concern over the sample size of the CPS at the state level. To account for this, we pooled the District of Columbia subsamples of the CPS over the two most recent survey years (i.e., 1995 and 1996), each of which provides an independent sample of households in the District.² This approach increases the sample size so that we can improve the reliability of our estimates for narrowly defined classes of individual such as low-income children.

The Bureau of the Census attempts to construct the CPS survey so that it includes all persons in the District, including the homeless and undocumented aliens.³ The only groups omitted from the survey are institutionalized persons (i.e., nursing home residents, people in prisons, etc.). The survey also excludes persons living in group quarters (facilities with 10 or more residents). This means that students living in dormitories are not included in our sample. This is appropriate because these persons are typically considered dependents of parents living in other states.

¹ The Bureau of the Census is an agency within the US Department of Commerce responsible for conducting the decennial census and several population surveys.

² In the pooled sample, all households surveyed in the District of Columbia in 1995 are added to the District subsample for 1996 to create a single database for the District with twice the number of observations than if only the 1996 data were used. The sample weights for each District household in the database were reduced by half so that the pooled database reports the number of persons in the District.

³ These groups are included in the sample partly through adjustments based upon Bureau of the Census initiatives to count the number of persons in the homeless and undocumented populations.

B. Adjustments to CPS Data

It was necessary to make certain adjustments to the District subsample of the CPS to correct for certain problems with these **data**. **First**, as Mr. George Grier of the Grier Partnership **has** shown, the numbers of children and adults reported in the CPS for the District of Columbia are **as much as** 20 percent higher than what **current** research indicates is the true population in the District. In fact, the population counts in the **CPS data are actually** higher than the Bureau of the Census's official projections of the District's population! Moreover, the **CPS data** show a steady increase in the population in the District since **1990** even though the official Bureau of the Census population projections show a decline the District's population. (The Bureau of the **Census** has not published **an** explanation for these discrepancies in their population projections.) The estimates of the number of children **in** the District developed by the Grier Partnership also show a reduction in population in the District although they estimate **even** fewer children than in the Bureau of the Census population projections.

Based upon consultations with both **Grier** and the Bureau of the Census, we adjusted the population counts for the District of Columbia reported in the CPS to replicate Bureau of the Census population projections for the District. These estimates **are** somewhat higher **than** Grier's population estimates for children in the District. They **also** reflect the trend towards **further** declines in the District's population, which both the Bureau of the Census and Grier **are** projecting.

Second, the CPS **data underreports** the number of persons who are enrolled in the District's Medicaid program. **This** reflects the fact that when interviewed, some Medicaid recipients **are** either unable or unwilling to provide information on **their** participation in public programs. Consequently, we adjusted the CPS data to reflect the actual level of Medicaid enrollment for children in the District of Columbia.

Third, we estimated the number of undocumented aliens in the **CPS data** for the District of Columbia **so** that we are able to reflect the impact of excluding undocumented aliens **from** the **CHIP** program. Based upon data provided by various government agencies, we estimate that there were about 20,000 undocumented aliens living in the District in **1996**. **This** is based upon the estimated number of expired visas for District residents provided by the US Immigration and Naturalization Service and Bureau of the Census studies on the number of undocumented persons living in each state and the District of Columbia. Based upon CPS **data** on the percentage of foreign-born persons living in the District who were under the age of **19**, we estimated that about **4,407** of these 20,000 undocumented persons are children. About 20,000 persons in the **CPS** who reported that they were not US citizens, which includes both legal and illegal aliens, were randomly assigned to undocumented alien **status**, and these individuals were considered ineligible for either Medicaid or the CHIP program.

⁴ The Bureau of the Census is aware of this problem and recommends using their official District population projections for total population counts by age rather than the CPS data.

C. Simulation of Eligibility

We estimated the number of children who would become covered under the CHIP program using the Lewin Group State Medicaid Eligibility Model (**SMEM**). This model uses the CPS data to: 1.) Identify those persons who meet the age and residency requirements to be eligible for CHIP; and 2.) Determine children's eligibility based upon their family's reported incomes. The model also estimates the number of these eligible persons who would enroll in the program. The model also includes certain data enhancements designed to more accurately represent the eligibility determination process.

For example, income eligibility for Medicaid is based upon the monthly income of the applicant filing unit rather than annual income. This is important because a family with annual income in excess of a given income eligibility limit, such as the poverty level, may have had several months during the year where their income was below the eligibility limit and other months when it was above the eligibility limit. We account for this by spreading income for filing unit members across the months during the year in which income is received (i.e., earning during periods of employment, etc.) and estimating the number of eligible persons during each month of the year to develop average monthly eligibility estimates. The steps involved in this estimation process include:

- **Number of Potentially Eligible Persons:** The model estimates the number of persons that would meet the income and categorical eligibility criteria specified under the expansion. This is done using the District subsample of the pooled CPS data, which includes the detailed income and family characteristics data required to develop these estimates. The model also estimates the number of persons who are already eligible for the program but are not enrolled so that these individuals are not counted as newly eligible.
- **Unique Program Definitions:** The model reflects unique aspects of the Medicaid eligibility determination process. For example, the model simulates the unique definition of a family unit used under the program. It also models the program's monthly income eligibility determination process under which individuals may be eligible for only certain months during the year.
- **Program Enrollment:** Not all persons who are eligible for Medicaid enroll. Nationwide, only about 76 percent of eligible persons enroll in the program. Enrollment rates decline even more as income rises. The model uses these data to estimate the portion of the newly eligible population that will enroll in the program. Based upon an evaluation of program participation rates in the existing District of Columbia Medicaid program for children, we assume that 84 percent of newly eligible children who do not have private coverage will enroll in the program. Among newly eligible children with private coverage (includes employer and non-group coverage) as a dependent, 40 percent will drop their private coverage and enroll in Medicaid to take advantage of the fact that Medicaid does not require premium contributions. (The derivation of these assumptions is presented in Attachment A.) We assume that no one would shift from CHAMPUS to Medicaid because comprehensive coverage is available to these persons without a premium. The remainder would not enroll in the program.

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- **Impact of Outreach Program:** The expansion in coverage will be associated with **an** outreach program to increase enrollment among eligible individuals. We assume that **as long as this** outreach program is in effect, about **20** percent of all persons who are eligible but not enrolled **will** sign up for the program. **This** assumption is based upon an analysis of the effects of other outreach programs.
 - **Enrollment Lags:** Experience with prior Medicaid expansions indicates **that** it will often **take** several months for newly eligible persons **to learn of** their eligibility for the program. **This** results in a lag in the rate at which newly eligible persons will enroll in the program which tends to keep costs low in the **initial** months of the program. Proper **estimation** of these lags is necessary to accurately estimate program costs. We **assume** that about **25** percent of those **who would** enroll in the program do not enroll until the next year. **This** assumption is based upon observed lags in the rate at which newly eligible persons enrolled under prior expansions in Medicaid eligibility.
 - **Costs per Enrollee:** The model estimates program costs by multiplying the average monthly number of persons enrolled in the program in each month by the average **cost** per member per month (PMPM) for each eligibility group. The PMPM estimates **by** eligibility group **are** based upon actual capitation payments for persons currently covered under the Medicaid managed care program for **AFDC and** AFDC-related groups, which we adjusted to include costs for mental health, long-term care and retrospective eligibility months for newly eligible persons. Separate actuarial estimates **are** used for population groups that **are** not currently enrolled in the program.

III. UNINSURED CHILDREN IN THE DISTRICT

Our analysis indicates that in 1996 there were about 112,557 children under the age of 19 in the District of Columbia (Table I). On an average monthly basis, about 60 percent (67,734) were already enrolled in the District's existing Medicaid program. Another 26.7 percent (30,074) had coverage from some other source such as employer-sponsored coverage. Overall, there were 14,749 children without insurance on an average monthly basis. These data indicate that about 4,793 of the uninsured children in the District were under age 6 (Table 2). There are 7,777 uninsured children aged 6 through 14, and about 2,179 uninsured children aged 15 to 18.

a/

	Number of Children in the District	Average Monthly Medicaid Enrollment	Average Monthly Other Coverage	Average Monthly Uninsured
Under Age 6	48,185	32,862	10,530	4,793
Percent	100.0%	60.2%	21.9%	9.9%
Age 6 - 14	48,080	27,822	12,481	7,777
Percent	100.0%	57.9%	26.0%	16.2%
Age 15 - 18	16,292	7,050	7,063	2,179
Percent	100.0%	43.3%	43.4%	13.4%
All Under Age 19	112,557	67,734	30,074	14,749
Percent	100.0%	60.2%	26.7%	13.1%

	Number of Uninsured Children	Percent of Uninsured Children
Age		
Under Age 6	4,793	32.5%
6 - 14	7,777	52.7%
15 - 18	2,179	14.0%
Race		
white	3,131	21.2%
African-American	11,182	75.8%
Asian	220	1.5%
Other	216	1.5%
Hispanic	4,665	31.6%
TOTAL	14,749	100.0%

IV. ELIGIBILITY FOR MEDICAID

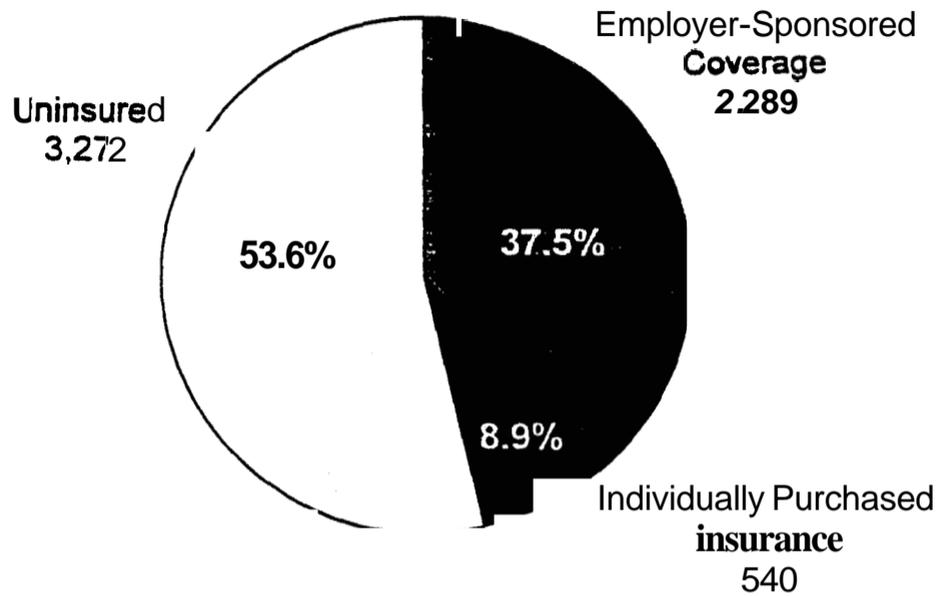
The District of Columbia **HCFA 2082** reports that there **was an** average of **67,734** children enrolled in the District's Medicaid program in **1996** (Table 3). The income eligibility levels under Medicaid vary with the age of the child. In general: infants are eligible **through** 185 percent of poverty; children age **1 through 5** are eligible to **133** percent of poverty; children age **6 through 14** are eligible **through** **100** percent of poverty; and children age **15** through **18** are eligible up to about **50** percent of the poverty level. However, children can enter the program **through** several eligibility processes.

Table 3
Average Monthly Enrollment and Eligibility for Children under Age 19 by Eligibility Category in 1996

Eligibility Group	Enrolled ^a	Eligible ^b	Eligible but Not Enrolled	Percent Enrolled
AFDC and AFDC-Related Children	56,660	58,379	1,719	97.1%
Expansion Children	3,019	4,079	1,060	74.0%
Medically Needy	2,414	3,931	1,517	61.4%
Other Children	5,641	7,446	1,805	75.8%
TOTAL	67,734	73,835	6,101	91.7%

Overall, there were about 6,101 children eligible but not enrolled in the program (*Figure 1*). Of these, 3,272 (53.6 percent) were uninsured. Of the remainder, about 2,289 were covered under an employer-sponsored plan and about 540 were covered under individually purchased non-group private insurance.

Figure 1
Distribution of Eligible but not Enrolled Children under the District's Current Medicaid Program by Source of Coverage^{a/}



Children Eligible but Not Enrolled = 6,101

a/ Estimates based upon the pooled March 1995 and 1996 District of Columbia subsamples of the Current Population Survey (CPS) data recalibrated to match Bureau of the Census population projections for the District of Columbia.

Source: Lewin Group estimates using the State Medicaid Eligibility Model (SMEM).

V. CHILDREN'S ELIGIBILITY EXPANSION

The proposed CHIP program would extend eligibility to all children in families with incomes below 200 percent of poverty. All of these children would be covered under the managed care programs already established to cover AFDC and AFDC-related groups. The benefits provided to these newly eligible groups would be the same as those now provided to children currently enrolled in Medicaid. Upon being certified as eligible, children would be given coverage providing 12 months of continuous coverage. We assume that the initiative will go into effect on April 1, 1998.

We used the SMEM model described above to estimate the number of children who would be eligible for coverage under the CHIP program based upon the pooled District of Columbia subsamples of the CPS data. This involved estimating the number of children who are in families with incomes between the eligibility amounts under the current program and 200 percent of the FPL. Using this process, we estimated that there are 13,435 children who would become eligible for coverage under CHIP. This includes all children in families who have incomes below 200 percent of poverty who are not eligible under the current Medicaid program. (Some of these children are uninsured while some are already covered under a private employer plan.) This estimate excludes children in the District who are undocumented aliens.

However, not all of these newly eligible persons will enroll in the program. We used program enrollment rates for children eligible under the recent children's eligibility expansion (i.e., children under 6 through 133 percent of poverty and children age 6 to 14 through the poverty level) as a basis for estimating enrollment rates under CHIP. We estimated that 84 percent of newly eligible persons who are uninsured would enroll in the program. We also assumed that 40 percent of newly eligible persons who already have private coverage (employer-sponsored or non-group) would drop their private coverage and enroll in Medicaid (the derivation of these assumptions is presented in Attachment A).⁵ We assume that no one would shift from CHAMPUS to Medicaid because comprehensive coverage is already available to them without a premium requirement. We expect some newly eligible persons to switch from employer coverage to Medicaid because Medicaid does not require the family to pay a premium while employer plans typically require a premium contribution from workers for dependent coverage.

We assume that enrollment in the CHIP program will commence on August 1, 1998. We estimate that CHIP would cover about 8,425 children per month by February 1, 1999. We also assume that there will be lags in the time it will take for newly eligible persons to learn of their eligibility. Therefore, average monthly enrollment would be only 1,063 in fiscal year 1998 and 7,723 in fiscal year 1999 (Table 4). These estimates were adjusted in each year to reflect Bureau of the Census projections showing declining population in the District through 2000 followed by slow population increases in each year thereafter.

⁵ These assumptions are based upon a Lewin Group analysis of participation in the existing children's Medicaid expansion group for otherwise uninsured children and children who have access to employer-based coverage using the pooled CPS data. Children are assumed to have access to employer coverage if one or more parents have coverage through their employer. This assumption is consistent with recent employer health plan data showing that virtually all firms that offer insurance also provide family coverage.

Table 4
The Cost of Covering Children through 200 Percent of Poverty in the District under the Children's Health Insurance Program (CHIP)

	Assumptions			Total Spending (In thousands)	Federal Share (In thousands)	District Share (In thousands)
	Average Monthly Number of Children ^{a/}	Per Member Per Month Cost ^{b/}	Percent Growth in Per-Capita Costs ^{c/}			
1997	--	\$115	--	--	--	--
1998	1,063 ^{d/}	\$110	-4.44%	\$1,403	\$1,108	\$295
1999	7,723 ^{d/}	\$114	3.75%	\$10,565	\$8,346	\$2,219
2000	8,346	\$118	3.75%	\$11,818	\$9,336	\$2,482
2001	8,429	\$123	3.75%	\$12,441	\$9,828	\$2,613
2002	8,513	\$127	3.75%	\$12,974	\$10,249	\$2,725
2003	8,499	\$132	3.75%	\$13,462	\$10,635	\$2,827
1998 - 2003				\$62,663	\$49,504	\$13,159

- a/ Lewin Group estimates using the District of Columbia subsample of a pooled cross-section of Current Population Survey (CPS) data for 1995 and 1996, developed by the Bureau of the Census. Enrollment is adjusted in each year to reflect Bureau of the Census projections showing a trend towards reduced population in the District through the year 2000 followed by slow population growth thereafter.
- b/ Per-capita costs in 1998 were estimated based upon actual District managed care payment rates in 1998 adjusted to reflect the actual age composition of the newly eligible population. These rates were adjusted further to include mental health, long-term care, and retrospective eligibility month costs. Estimates also include an allowance for program administrative costs equal to 3.41 percent of benefits costs.
- c/ Per-capita costs were assumed to grow at the average annual rate of growth in costs over the 1993 through 1997 period for children in the District of Columbia (3.75 percent).
- d/ Enrollment is assumed to begin on August 1, 1998. We assume that enrollment in the initiative will reach 8,424 children by February 1, 1999. Enrollment is expected to lag as newly eligible persons learn of their eligibility between August 1, 1998 and January 31, 1999.
- Source: Lewin Group estimates using the State Medicaid Eligibility Model (SMEM).

We estimated the average cost per person per month based upon the per-capita premiums negotiated by the District with the managed care plans that are now serving the AFDC and AFDC-related groups in the District. We adjusted these per-capita rates to include mental health and long-term care services not included in the capitation amount, and the fee-for-service costs associated with retrospective eligibility for months of enrollment prior to enrolling in the managed care program. Using this method, we estimate that the average monthly cost per newly enrolled child will be \$110 per month in 1998.

We assume that the average annual rate of growth in per-capita costs for this group will be 3.75 percent per year. This is the estimated average annual rate of growth in per-capita costs for children in the District Medicaid program over the 1993 through 1997 period. Under these assumptions, we estimate that total Medicaid spending over the 1998 through 2003 period for this group would be \$62.7 million (see Table 4). The federal government's share of these costs would be 79 percent of total costs (\$49.5 million), leaving the District with \$13.2 million in costs over the 1998 through 2003 period.

In addition to the eligibility expansion, the children's initiative includes funding for increased outreach to enroll children who are currently eligible for Medicaid but not enrolled. Because many of those who are eligible but not enrolled have coverage from some other source, the impact of this outreach on Medicaid enrollment may be small. As discussed above, we assumed that about 20 percent of those children who are eligible but not currently enrolled in the program would sign up for Medicaid due to the outreach program.⁶ This outreach will increase enrollment among currently eligible children by about 1,223. This will cost \$10.0 million over the 1998 through 2003 period with \$7.0 million paid by the federal government and \$3.0 million paid by the District (Table 5).

The combined effect of the CHIP program and the outreach program would be to increase the number of persons covered under the District's Medicaid program by 9,624 persons. This includes the 8,401 children added by the children's expansion and the 1,223 currently eligible persons who will enroll due to outreach. This would increase the number of children enrolled in Medicaid from 67,734 children to 77,358 children (Table 6).

Table 7 presents our estimates of the number of children who would be eligible and enrolled under the children's initiative by current insurance status. Of the 13,435 children who would be eligible under the CHIP program, about 7,943 would be uninsured. About 4,322 of these eligible children will be covered under a spouse or parent's private health insurance plan. Another 1,170 of the eligible children will be persons who are already covered by CHAMPUS. As discussed above, we assume that 84 percent of eligible persons who are uninsured will enroll and that none of those who are already covered by CHAMPUS enroll. In addition, we assume that 40 percent of those with private coverage (1,729) will switch to Medicaid. These 1,729 children include about 1,577 children who will drop employer-sponsored coverage to enroll and about 152 children who will drop their individually purchased non-group coverage to join CHIP.

⁶ As discussed above, this assumption is based upon observed increases in enrollment under other outreach efforts. We assume that all of those who would become insured due to outreach are persons who otherwise would be uninsured.

	Assumptions			Total Spending (in thousands)	Federal Share (in thousands)	District Share (in thousands)
	Average Monthly Number of Children ^{b/}	Per Member Per Month Cost ^{b/}	Percent Growth In Per-Capita Costs ^{c/}			
1997	--	\$115	--	--	--	--
1998	463	\$110	-4.44%	\$611	\$427	\$183
1999	1,223	\$114	3.75%	\$1,673	\$1,171	\$502
2000	1,212	\$118	3.75%	\$1,720	\$1,204	\$516
2001	1,224	\$123	3.75%	\$1,803	\$1,262	\$541
2002	1,346	\$127	3.75%	\$2,057	\$1,440	\$617
2003	1,359	\$132	3.75%	\$2,154	\$1,508	\$646
1998 - 2003				\$10,018	\$7,012	\$3,005

	Enrollment under Current Medicaid Program	Number Newly Eligible for CHIP ^{b/}	Eligibility Expansions		
			Number Enrolled in CHIP ^{c/}	Currently Eligible Persons Enrolling Due to Outreach ^{d/}	Total Enrollment under Medicaid and CHIP ^{e/}
Under Age 6	32,862	3,176	1,894	593	35,349
6-14	27,822	4,509	3,436	502	31,760
15-18	7,050	5,750	3,071	128	10,249
All Under 19	67,734	13,435	8,401	1,223	77,358

- a/ Estimates based upon March 1995 and 1996 Current Population Survey (CPS) data recalibrated to match Bureau of the Census population projections for the District of Columbia
 - b/ Includes children who meet both the income eligibility criteria and the citizenship/residency requirement.
 - c/ Average monthly number of newly eligible persons who would enroll in the program in 1998 assuming no lags in enrollment due to the time it takes for individuals to learn of the program and apply.
 - d/ Number of currently eligible children who enroll due to new outreach programs to find and enroll eligible children.
 - e/ Includes currently eligible persons plus the newly enrolled and the number who enroll due to outreach.
- Source: Lewin Group estimates using the State Medicaid Eligibility Model (SMEM).

**Table 7
Distribution of Eligible and Enrolled Children by Current Insured Status in the CHIP Eligibility Simulation**

	Number of Eligible Persons	Number of Eligible Persons Who Enroll	Percent Enrolled
Children Eligible for CHIP Expansion			
CHIP Expansion			
Uninsured Children	7,943	6,672	84.0%
Children with Private Coverage	4,322	1,729	40.0%
Children with CHAMPUS	1,170	0	0.0%
Total CHIP Expansion	13,435	8,401	62.5%
Medicaid Eligible Non-Enrollees Who Enroll Due to Outreach	6,101	1,223	20.0%

Source: Lewin Group estimates using the State Medicaid Eligibility Model (SMEM).

VI. IMPACT ON THE NUMBER OF UNINSURED

As discussed above, we estimate that there are currently 14,749 children in the District of Columbia who are uninsured. Under the children's initiative, the number of uninsured children in the District would fall to 6,854 (Table 8). This is a reduction in the number of uninsured children in the District of 7,895 persons.

Table 8
Average Monthly Number of Uninsured Persons Before and After the Eligibility Expansion^{a/}

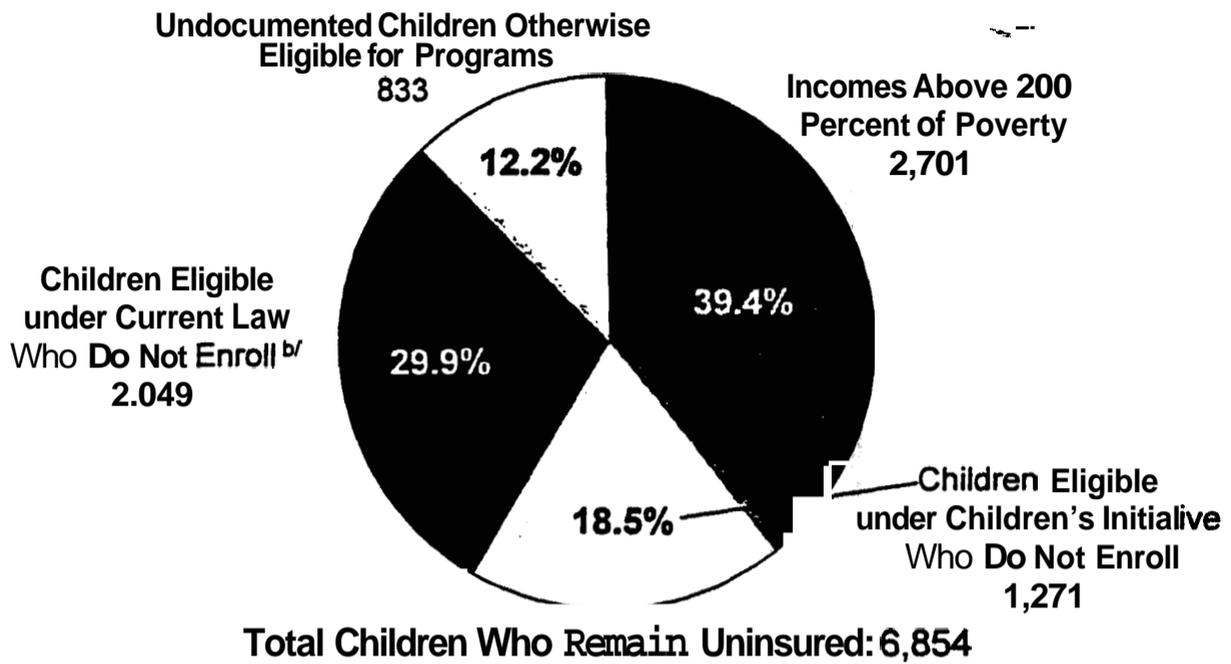
	Uninsured Under Current Policy	Children with Children's Initiative	Number of Uninsured
Under Age 6	4,783	2,402	2,391
6 - 14	7,777	3,683	4,094
15 - 18	2,179	769	1,410
All Under 19	14,749	6,854	7,895

a/ Estimates based upon the pooled March 1995 and 1996 District of Columbia subsamples of the Current Population Survey (CPS) data recalibrated to match Bureau of the Census population projections for the District of Columbia.

Source: Lewin Group estimates using the State Medicaid Eligibility Model (SMEM).

The children who remain uninsured will include persons who are either not eligible for the program or are eligible but decline to enroll. About **2,701 (39.4 percent)** of the children who remain uninsured are in families with incomes in excess of the income eligibility level of **200 percent of poverty (Figure 2)**. Another **833** of these uninsured children (**12.2 percent**) meet the income eligibility criteria for either the current Medicaid program or **CHIP**, but are ineligible because they are undocumented aliens. About **2,049** of those who remain uninsured (**29.9 percent**) will be children who are eligible for Medicaid under the current program who will remain uninsured despite outreach efforts to encourage these individuals to enroll. In addition, **1,271** of those who will remain uninsured are newly eligible children under the initiative who will not enroll.

Figure 2
Program Eligibility Characteristics of Persons Who Remain Uninsured in the District under the Children's Initiative: Average Monthly Persons^{a/}



a/ Estimates based upon the pooled March 1995 and 1996 District of Columbia subsamples of the Current Population Survey (CPS) data recalibrated to match Bureau of the Census population projections for the District of Columbia.

b/ After adjustment for outreach. This is equal to the number of eligible but not enrolled persons in the program who are uninsured (3,272) less the number of eligible non-enrollees who would become covered due to outreach (1,223). (All of those who enroll due to outreach are assumed to be persons who otherwise would be uninsured.)

Source: Lewin Group estimates using the State Medicaid Eligibility Model (SMEM).

VII.CAVEATS

Throughout **this analysis**, we have used the **most** appropriate **data** available for the District of Columbia. However, we **have** had to **adjust** some of these **data** sources to reflect the **most** recently available **data on** the number of children and **adults** living in the District. We **have also** adjusted these **data** to reflect the **most** recent **HCFA 2082 data** on the number of enrollees by age and class of eligibility in the District's Medicaid program. Thus, the **data** used in **this** analysis reflect adjustments that have had a **significant** impact on our estimates. Consequently, **our** estimates of the impact of **the** children's initiative **are likely to** change as more accurate **data** are collected. However, by **cross-checking** our data **against** other sources of data for the District of Columbia, **we feel** that the adjusted **CPS data** used in **this** analysis **are** sufficient to estimate **the** number of persons who would become eligible and enroll in the **CHIP** program.

This report **summarizes** the major findings of one potential option for expanded coverage under **the** children's initiative. Other children's initiative proposals could be analyzed with the **data** and models developed **on this** project.

Attachment A:
Derivation of Enrollment Assumptions

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ATTACHMENT A: DERIVATION OF ENROLLMENT ASSUMPTIONS

In **this** analysis, we needed to develop assumptions on the rate at which eligible **persons will** enroll in **CHIP**. In particular, we needed to develop **an** assumption on **the** extent to which parents will switch eligible children **from** employer-sponsored coverage to publicly subsidized insurance under CHIP. Unfortunately, **little** information is available on rates of participation in the Medicaid program, particularly for those who could potentially substitute **CHIP** for employer coverage. **Our** approach **was** to estimate participation rates for **non-disabled** children in the current Medicaid program and use **them as** a basis for estimating the percentage of eligible **persons** enrolling in **CHIP**.

As discussed above, we used the Lewin Group State Medicaid Eligibility Model (**SMEM**) to estimate the number of persons meeting the District's income eligibility levels under the current Medicaid program by category of eligibility. We then calculated participation rates by dividing the number of persons in these categories who received benefits **over** the number of persons that we estimate are eligible in these categories. We developed these estimates separately for children with parents who have employer-based insurance and those who do not. **This** provides **an** estimate of the percentage of children who could have **obtained** employer coverage **as** a dependent who enrolled in Medicaid.' **This also** provides **an estimate** of enrollment rates for children who do not have access to employer coverage.

Table A - I presents **our** estimated enrollment rates for these two groups nationally and for the District of Columbia. These **data** show that enrollment rates for these children in the District **are** substantially higher **than** the **national** average. They **also** show **that**, in the District, enrollment rates for children without access to employer coverage were **83.6** percent compared with **72.3** percent for children in families where the child could have been enrolled in **an** employer plan. We originally used these assumptions **to** estimate enrollment in **CHIP**.

However, the estimated participation rate for children **with** access to coverage probably overstates the percentage of persons who would discontinue their employer coverage to enroll in Medicaid. **This** is because not all of the parents of children who **had** access to employer-sponsored coverage would have been covered under the employer plan even if Medicaid coverage were not available. For example, in **a** recent Lewin Group analysis of the **CPS data**, we estimated that among children in poverty whose **parent(s)** **are** covered by **an** employer plan, only about **55** percent have dependent coverage.* **Also**, parents at **higher** income levels **are** expected to be less likely to **shift** their children **from an** employer plan to Medicaid due to Medicaid *stigma* and **a** perceived benefit in retaining private coverage. Consequently, we revised **our** assumptions so that the percentage of children with employer-sponsored coverage would be **40** percent and that **84** percent of those **who** do not have access to employer coverage would enroll.

⁷ Because recent employer surveys show that virtually all employers that offer coverage also offer family coverage, we assume that all parents who have employer coverage could enroll their children as a dependent.

⁸ The Lewin Group, Inc. "Exploring the Question of Substitution," (Forthcoming Report to the US Department of Health and Human Services (HHS)).

Table A - 1
Children's Participation in Medicaid for Persons Eligible under AFDC and the Children's Expansion Groups in 1996^{a/}

	United States	District of Columbia
One or More Parents with Employer Coverage^{b/}		
Enrolled	2,169,493	5,028
Eligible	4,315,032	6,959
Percent Participation	50.3%	72.3%
Other Children		
Enrolled	12,426,545	55,701
Eligible	18,442,896	66,660
Percent Participation	67.4%	83.6%
All Children		
Enrolled	14,596,038	60,729
Eligible	22,757,928	73,619
Percent Participation	64.1%	82.5%

a/ includes children eligible under TANF and children who are eligible under the Medicaid expansion.

b/ includes children where one or more parent(s) have coverage on their own job.

Source: Lewin Group analysis of the CPS data using the State Medicaid Eligibility Model (SMEM).

APPENDIX B

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CAPITAL COMMUNITY KIDS CARE

A Pilot Program Sponsored by
Capital Community Health Plan, United HealthCare Corporation
and The Alliance for Medical Care

Background Information

- Health care coverage for children who reside in **the District of Columbia** who are 18 years of age and under and who are not eligible for any other **form** of health insurance coverage.
- Families whose income is under **275%** of federal **poverty** guidelines will **be eligible**
- Monthly premiums to cost **\$63.60** with families paying a sliding scale fee ranging from **\$10 - \$25** per child per month based on income level. **If a family** has more than four children enrolled with the program, monthly contributions **will be** capped and no additional premiums **collected**.
- Capital Community Health Plan, United Healthcare Corporation and the Alliance for Medical Care **will** provide funding to cover the remaining balance **of the cost of the** monthly **premium for** each enrolled child.
- Health care **services** will be delivered through the broad network of Capital Community Health Plan hospitals, community clinics **and** community based physicians. The network includes over **175** primary care physicians, **735** specialists and **five of the leading** hospitals in the **District of Columbia**: Children's National Medical Center, Greater Southeast Community Hospital, Howard University Hospital, Providence Hospital and Washington Hospital Center
- **Benefits** include well child **visits**, inpatient hospital care, outpatient surgery, prescription drugs, diagnostic and laboratory tests, therapeutic services, home health care, durable medical equipment and prosthetic devices, emergency medical services, maternity care, mental health and substance services, vision services and dental care in connection with an accident
- Individuals will be responsible for **\$3** copayments for physician **visits**, outpatient mental health and substance abuse visits, and prescriptions. There **will no** copayments for well child visits. A **535** copayment will be charged for inappropriate emergency room use

Capital Community Kids Care is a health care program sponsored by Capital Community Health Plan and United HealthCare Corporation

HOW DO I JOIN?

For more Information or to request an application, call us at **1-800-731-2247** or (202) 898-4850. Send us your completed application and mail us one month's premium by the 10th of the month. If approved, your child's coverage will start the following month.

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CAPITAL COMMUNITY KIDS CARE is a pilot program sponsored by Capital Community Health Plan and United HealthCare Corporation and is made possible through contributions from the Alliance for Medical Care and other private donation. United HealthCare Corporation is a national leader in health care management, serving purchasers, consumers, managers and providers of health care since 1974. Capital Community Health Plan has been providing health plan benefits to District of Columbia residents since June of 1996.



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**SPECIAL PROGRAMS THAT
ARE PART OF CAPITAL
COMMUNITY KIDS CARE**

Optum® NurseLine
You can call our 24-hour NurseLine at 1-800-411-024 any time to talk to a registered nurse about a health care question or concern, and it's free!

Discounted Dental Services
Capital Community Kids Care members will receive special pricing on dental services when using CCHP's network of dental providers.

WHAT IS CAPITAL COMMUNITY KIDS CARE?

Capital Community Kids Care is a low-cost program offered by Capital Community Health Plan (CCHP) and designed to help families provide health insurance coverage for their children. Healthcare services for Kids Care members will be provided by CCHP's network of doctors that includes more than 100 pediatric primary care doctors and specialists.

CCHP is a health plan owned by five of the leading hospitals in the District of Columbia: Children's National Medical Center, Greater Southeast Community Hospital, Howard Hospital, Providence Hospital and Washington Hospital Center. CCHP physicians and community-based clinics have been caring for District residents for many years. We offer many specialized services for children and adolescents.

WHO CAN JOIN?

TO BE A MEMBER OF CAPITAL COMMUNITY KIDS CARE, CHILDREN MUST:

- Be under 19 years of age
- Not be eligible for or have any other insurance
- Reside in the District of Columbia
- Be without health insurance coverage for 3 months except for disenrolled Medicaid recipients

ORDER TO QUALIFY FAMILIES MUST:

Apply to cover all eligible children in the family. Meet certain income requirements based on family size.

There are no exclusions for preexisting conditions. If you have more than one child you must apply to enroll all of them in Capital Community Kids Care.

PREMIUMS ARE BASED ON YOUR ABILITY TO PAY

You will be responsible to pay a small portion of the monthly premium based on your income level. There are annual income limits based on family size. The monthly premiums will range from \$10-\$25 per month per child, not to exceed a maximum payment of \$100 per month. See the chart below to find out if you qualify for this program.

Number of family members	\$10 per child	\$17 per child	\$25 per child	
2	under \$16,552	\$16,533 - \$23,554	\$23,555 - \$35,013	Please call our Member Services Department to find out if your child is eligible to join: (202) 898-4850 1-800-731-2247 (202) 218-6999 (TDD)
3	under \$20,795	\$20,795 - \$29,593	\$29,594 - \$43,989	
4	under \$25,038	\$25,038 - \$35,631	\$35,632 - \$52,965	
5	under \$29,281	\$29,281 - \$41,669	\$41,670 - \$61,941	
6	under \$33,524	\$33,524 - \$47,708	\$47,709 - \$70,917	
7	under \$37,768	\$37,768 - \$53,746	\$53,747 - \$79,893	
8	under \$42,011	\$42,011 - \$59,785	\$59,786 - \$88,869	

WHAT HEALTH CARE SERVICES ARE COVERED BY CAPITAL COMMUNITY KIDS CARE?

- Well Child Visits and Routine checkups
- Immunizations
- Inpatient Hospital Care
- Physician Services
- Lab and X-ray
- Outpatient Surgery
- Prescription Drugs
- Mental Health and Substance Abuse Services
- Vision Services
- Therapeutic Services
- Emergency Medical Services
- Access to Discounted Dental Services



WHAT WILL FAMILIES BE RESPONSIBLE FOR PAYING?

Besides the monthly premium, you will be asked to pay a small fee (co-payment) when you use health care services:

- \$3 per physician visit (except for well child visits)
- \$3 per outpatient mental health or substance abuse visit
- \$3 per prescription
- \$35 for inappropriate use of emergency room (i.e. failure to notify us within 24 hours of an emergency room visit or for using the emergency room for non-emergency care)

CAPITAL COMMUNITY KIDS CARE

BACKGROUND INFORMATION

Need for the Program: Statistics on Uninsured Children

- in the District of Columbia, 39% of children were without health insurance for at least one month over a two-year period in 1995-96.
- Currently, approximately **18,654** children have **no** health insurance.
- **Most** uninsured children **live** in homes that have working families with incomes **less** than \$26,000.
- **Thirty percent** of uninsured children are Medicaid eligible but **not** enrolled.
- Nationally, ten million children are uninsured, 500,000 are under the age of one, and **34%** are teenagers.
- Uninsured children make up **25%** of the nation's **40** million people without health coverage.

Background on Capital Community Kids Care

- A program sponsored by Capital Community Health Plan, United Healthcare Corporation and The Alliance for Medical Care.
- Comprehensive healthcare benefits **for** children under the age of **18**.
- Commitment **by** five of Washington's leading hospitals; Children's National **Medical** Center, Greater **Southeast** Community Hospital, Howard University Hospital, Providence Hospital, and Washington Hospital Center.
- Example of a public-private **partnership** that will benefit the residents of the District of Columbia.
- Capital Community Health Plan currently **serves** 7,000 Medicaid recipients in the District of Columbia.
- Capital Community Health Plan has been **selected as** one of the default plans in the District's "new" Medicaid Managed Care Program.

STATISTICS ON UNINSURED CHILDREN

- 10 million children are without health insurance this year, the highest level since the U.S. Census began consistently tracking health coverage statistics (*General Accounting Office*).
- 23 million American children were without health insurance coverage for at least one month during a recent two year period (*Families USA, 1995-96*).
- In the District of Columbia 59% of children were without health insurance for at least one month over a two-year period in 1995-96 (*Families USA*).
- In the District of Columbia, 18,654 children - or 1 in 6 - had no health insurance in 1995 (*Children's Defense Fund*)
- 7 million uninsured children live in homes with incomes of less than \$26,000, most of them working families (*National Association of Children's Hospitals*)
- 9 out of 10 uninsured children have working parents and two-thirds are in two-parent families (*Families USA*)
- 1 in 7 children in the United States lacked health insurance in 1995 (*Children's Defense Fund*)
- Nationally, the number of uninsured children has risen by nearly 2 million since 1987
- 3 out of 4 parents of uninsured children postpone going to the doctor themselves, preferring to save that cost to pay for medical care for their children (*University of Pittsburgh*)
- in 1995, 9.8 million children, almost 14% of children under 18, were uninsured for the entire year. This number rose from 8.2 million in 1987, an increase of nearly 17% (*U.S. Census Bureau*)
- Of the nation's 10 million uninsured children.
 - ⇒ 34% are teen-agers
 - ⇒ 500,000 are under the age of one
 - ⇒ 86% live in families with at least one working parent
 - ⇒ 65% live in families with annual incomes of \$25,000 or less
 - ⇒ 63% live in two-parent families; 37% live with one parent
 (*Employee Benefits Research Institute*)

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- 12% of uninsured children are forced to restrict activities such as bike riding and ball playing because parents feared they would get hurt (*University of Pittsburgh*).
- Uninsured children make up one fourth of the nation's 40 million people without health coverage. (*Employee Benefits Research Institute*).
- 30% of uninsured children are Medicaid-eligible but not enrolled (*General Accounting Office*).

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FOR IMMEDIATE RELEASE

Contact: Deena Barghothi
(202) 383-9700

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**New Health Care Program Ready to Provide Coverage
for Uninsured Children in Washington, D.C.**
*Capital Community Health Plan and United HealthCare Develop
Capital Community Kids Care*

Washington, D.C., August 12, 1997 - Uninsured children of the District of Columbia are the focus of a creative new program launched today that will provide health care coverage for eligible children living in Washington, D.C. for a modest family contribution.

"The historic expansion of funding for children's health services approved last week gives Capital Community Kids Care a pivotal role in developing and testing programs for uninsured children throughout the country," said Hanita Schreiber, CEO of Capital Community Health Plan (CCHP). "We hope the District and states can learn from our program as a potential model for public-private partnerships."

Capital Community Kids Care was developed by CCHP and United HealthCare Corporation. Beginning this October, it will provide health care coverage for children including physician care, inpatient and outpatient care, diagnostic and laboratory tests, prescription drugs and emergency services. Family contributions will be based on a sliding scale with small copayments for some services (see attached program guidelines). Capital Community Kids Care premiums are being subsidized by The Alliance for Medical Care, Capital Community Health Plan and United HealthCare.

United HealthCare has a long-standing commitment to promote access to health care for medically underserved children," said William W. McGuire, M.D., President and CEO of United HealthCare Corporation. "We see this program as a potential blueprint that can be duplicated across the country. Capital Community Kids Care combines our resources and experience in children's health programs with CCHP's knowledge of the local population and its pediatric care network. This is an example of the private sector working to meet a public health need."

--more--

Capital Community Kids Care is a health care program sponsored by Capital Community Health Plan and United HealthCare Corporation

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United HealthCare Corporation serves more than 14 million people, through its health plans and other network-based health insurance products. United HealthCare helps improve people's health-and well-being by designing and organizing health care services that help people access the care they need, when they need it.

###

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CEO, Children's National
Medical Center
Vice Chairman:
Sister Carol Keehan
CEO, Providence Hospital
Board Members:
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Healthcare System
Executive Director/CEO
Sherman McCoy
Howard University Hospital
Kenneth A. Samet
President, Washington Hospital Center
Michael P. O'Boyle, Treasurer
CFO, Washington Hospital Center

Staff:
Haika Schreiber, President/CEO
Tamara A. Smith, VP, Marketing & Government
Relations
John Dell'Erba, CFO
Al Perkins, VP, Network Development &
Operations

Model Type:
Mixed - IPA & Group
Service Areas: Washington, DC
Enrollment: 1/1/98 10,450.

Miscellaneous:

For Profit	Yes
Federally Qualified	No
Accepts Medicaid	Yes
Accepts Medicare	No
NCQA Accredited	No
Number of Hospitals:	5
Number of Physicians:	
Primary Care	240
Specialists	998

Capital Community Health Plan is an HMO owned by five of the leading hospitals in the District of Columbia: Children's National Medical Center, Greater Southeast Community Hospital, Howard University Hospital, Providence Hospital and Washington Hospital Center. These hospitals are all recognized providers in the District's Medicaid Program and together they account for nearly 75 percent of the current Medicaid admissions.

CCHP began operation in June of 1996 and has over 10,000 AFDC and related Medicaid members that are residents of the District of Columbia. CCHP is committed to providing exceptional quality care and customer service to its members. It offers the city's most complete range of high quality, coordinated health care services in convenient locations. CCHP has a well organized provider network with over 1200 physicians and community based clinics who have been caring for the Medicaid population for many years.

CCHP has been organized and financed to operate successfully under a risk based capitated reimbursement system and has contracted with United HealthCare of the Mid-Atlantic (UHC Mid-Atlantic) to provide management and administrative services. UHC Mid-Atlantic has more than twenty years of solid experience in managed care and has been contracting with the State of Maryland to serve its Medicaid population since 1974. UHC Mid-Atlantic provides access to state of the art MIS systems, claims processing, customer service, cost containment and quality assurance systems.

UHC Mid-Atlantic is a subsidiary of United HealthCare (UHC), one of the largest national health care providers serving more than 4 million individuals through a broad continuum of products including HMOs, PPOs, and Indemnity programs. UHC has 600,000 Medicaid members with contracts in 13 states and Puerto Rico. UHC provides access to extensive management and clinical support systems and highly qualified health care professionals with experience in Medicaid managed care, regulatory compliance, EBP/SDT education and outreach, medical management, clinical practice standards and reporting systems. The corporate staff of UHC is available to CCHP for advice and consultation in building a strong and effective Medicaid program.

Capital Community Kids Care is a health care program sponsored by Capital Community Health Plan and United HealthCare Corporation

Washington
POST
8/13/97



Hanita Schreiber is president of Capital Community Health Plan, which sponsors the Capital Community Kids Care program.

Children Get a Health Care Safety Net

Two D.C. Programs to Provide Services to Poor Are Announced

By Todd Bearman
Washington Post Staff Writer

Yohannes Solomon's 7-year-old son needs throat surgery. His 14-year-old son needs hepatitis shots. His 1-year-old son needs the general care associated with a toddler.

Solomon, 40, a hot dog vendor who lives in Northwest Washington, says he cannot get the medical care his family needs because he lacks health insurance.

"He can't sleep at night because of the problems," Solomon said of his 7-year-old, Robel. "We had him in for surgery in May but my Medicaid ran out. I don't have anything now."

But Solomon soon will be among the parents of 1,000 children in the District who will be able to get medical insurance under two year-long programs announced yesterday.

One program, Capital Community Kids Care, is sponsored by the Capital Community Health Plan (CCHP), a health maintenance organization involving five D.C. hospitals and United

Healthcare Corp., a Minneapolis-based provider. The other effort involves Kaiser Permanente, an HMO with 529,000 members in the Washington-Baltimore area. Both programs are in partnership with the Alliance for Medical Care, a nonprofit foundation that provides health care programs for D.C. residents.

"The goal is to get the children that fall between the safety nets so that they will be able to get coverage, and with that coverage their parents will seek preventive care for their children and not turn up in an emergency room," said Edwin K. Zechman Jr., CCHP's chairman and president and chief executive of Children's Hospital, one of the five CCHP members.

The foundation recently received a city contract to provide Medicaid services to D.C. residents.

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ard University Hospital, Providence Hospital and Washington Hospital Center.

The cost of the plan will range from \$10 to \$17 per child per month, with family maximums of \$40 to \$100 a month, all based on income. Fees will range from \$3 for physicians' visits and prescriptions, to \$35 for inappropriate uses of hospital emergency rooms.

The Kaiser Permanente program, expected to begin enrollment within weeks, will serve 500 children at the HMO's two health care centers in the District. Families will pay \$10 per child a month up to a maximum of \$20 per month, with no co-payments. The company does not serve Medicaid patients.

United Healthcare, with 94 million customers nationwide, is contributing \$125,000 to Capital Kids. The grants from the Alliance for Medical Care—\$125,000 to CCHP and \$180,000 to the Kaiser Permanente effort—are contributions from Donald de Laski, who co-founded the alliance last year.

Programa para niños alivia gastos de salud

KIDS CARE

Viene de la Página 1

ninguna otra alternativa. Son gente que algunas veces son orgullosos y aunque necesitan ayuda médica no van a pedirle a un programa del gobierno."

Sigue Guzmán: "Esta es la gente que está olvidada en el sistema de cuidado de salud y nadie habla de ella. Nosotros nos dirigimos a este público para responder a sus necesidades de seguro de salud y desarrollar un producto que les proporcione la cobertura que ellos necesitan. Al mismo tiempo, al recibir cobertura médica para sus hijos, estos padres pueden ejercer medicina preventiva. Este programa, sobre todo, busca promover la medicina preventiva"

Wensi es de Nueva York, donde pasó cuatro años montando clínicas de salud en los colegios para proveer atención médica a los niños que la necesitan. Tiene amplia experiencia en este tema, y gran entusiasmo en llegar a todos los niños cuyos padres no tienen seguro médico en Washington, para facilitarles el acceso a este plan de salud.

"Yo hablo con muchas familias cuando las atiendo para tramitar la solicitud, y muchos me dicen, entre ellos abuelos, que estaban rezando

por un programa de este tipo para sus hijos y sus nietos." Según el gobierno federal, 10 millones de niños en este país no tienen seguro médico. El número de niños sin seguro ha crecido por casi 2 millones desde 1987. El programa para los niños es un programa piloto subvencionado por CCHP y "United Health Care Corporation" y ha sido posible gracias a contribuciones del "Alliance for Medical Care" (Alianza para Cuidado Médico) y otras donaciones privadas. Cinco de los más importantes hospitales de Washington son dueños de CCHP y por lo tanto se encuentran entre los hospitales que proveen el servicio a Capital Community Kids Care, los hospitales que participan son: Children's National Medical Center, Greater Southeast Community Hospital, Howard University Hospital, Providence Hospital and Washington Hospital Center.

Cuáles son los requisitos para ser miembro? Tener menos de 19 años, no tener otro seguro o calificar para otro seguro, residir en el Distrito de Columbia, no haber tenido seguro médico por los últimos tres meses. Para calificar, las familias necesitan concordar con ciertos requerimientos de sueldo y cantidad de miembros en

nes por condiciones preexistentes. Si Ud. tiene más de un hijo, puede enrolar a toda la familia. Las primas mensuales se establecen entre \$10-\$25 dólares por mes por niño, de manera que incluso con una familia numerosa, los padres no tienen que pagar más de \$100 dólares al mes.

Además de las primas mensuales, Ud. deberá pagar un pequeño pago cuando utilice los servicios: \$3 por visita al médico, \$3 por visita de salud mental o drogas, \$35 por uso inapropiado de la sala de emergencia.

¿Qué servicios cubre "Capital Community Kids Care"?; visitas médicas, y examen general rutinario, servicio hospitalario interno, laboratorio, rayos X, cirugía, recetas médicas, servicios terapéuticos, emergencias, vista y acceso a servicios dentales con descuento.

Al ser un programa piloto, preguntamos con qué continuidad contamos. Wensi nos explica que el pre-

suuesto que firmó el P. Clinton, exige a los estados seguro de salud a los niños de 18 años y dedica 64 mil dólares para este cometido nacional. De esta manera e de Columbia tiene tiempo verano de 1998 para desah plan de salud. CCHP ha i iniciativa de buscar capita dos para iniciar la tarea un y luego asociarse con el cuando llegue el momento.

Nos asegura Wensi q de ser un plan piloto, con año que viene con dmer También nos informa q momento no se pide com tener residencia. Por lo ta mos a todos los padres de edad latina que no tengan salud para sus hijos, a llam R. Guzmán al (202) 218-(202) 898-4850. Wensi hal y en el otro teléfono, tambi darán en español se Ud. lo

Salud al alcance de todos los niños

Por Luz María Aguirre
LA NACION

¿Tiene Ud. niños y no tiene seguro de salud...? ¡No se preocupe! ¡Ahora puede conseguir atención médica para sus hijos, con un programa nuevo, llamado "Kids Care"! Con este mensaje se encabeza el folleto de



Wensi R. Guzmán, Director de Proyectos de CCHP Kids Care.

propaganda de "Capital Community Kids Care" (CCKC), un programa establecido en el Distrito de Columbia dirigido concretamente a proveer a seguro de salud para niños recién nacidos hasta los 18 años que carezcan de dicho beneficio.

Wensi Guzmán, Director de Proyectos para "Kids Care", del "Capital Community Health Plan" (CCHP) nos comenta que "este programa se ha iniciado al determinar la necesidad que hay, no solo en Washington sino en los diferentes estados, de atender con este servicio a ese sector de la población que no califica para Medicaid, trabaja, pero no puede afrontar el gasto de un seguro regular y está atrapado en el medio, a

KIDS CARE

**Kaiser Kids Program
Kaiser Permanente Medical Center
1011 North Capitol Street, NE
Washington, DC 20002**

Dear Director:

Please find **information** attached describing the **Kaiser Kids Program**, a program sponsored by the **Alliance for Medical Care** and **Kaiser Permanente**. The **Alliance for Medical Care** is a **non-profit organization** that is assisting low-income parents by subsidizing **health insurance policies** for families that are ineligible for Medicaid but are **currently** unable to finance the cost of an independent **insurance** policy for their children. **Kaiser Permanente** and the **Alliance for Medical Care** have joined together for the purpose of **offering** this program to 500 uninsured children in the **District of Columbia**.

The comprehensive **health insurance** policies cost **\$10** per month to enroll one child and **\$20** per month to enroll two or more children in a family. **Eligibility** for the program is based on residence in the **District**, age of the child, **insurance status** of the child and **income** of the family.

Currently, the **Kaiser Kids Program** has enrolled 500 children and the sponsors are considering **expanding** the program to include additional children. Consideration is also being given to include children from a higher income bracket.

The attached information includes an article from the **Washington Post** describing the program, a fact sheet and press release on the **Kaiser Kids Program** and a copy of one of the flyers used to publicize the program. If you would like additional information please contact me at (202) 898-5173.

Sincerely,

Abbie Mae Buck Miller
Program Coordinator
Alliance for **Medical Care**

Fact Sheet: Kaiser Kids Program

Kaiser Permanente/Alliance for Medical Care Child Health Care Program

- Comprehensive health care coverage will be provided by Kaiser Permanente with families paying \$10 per child per month (\$20 maximum a family per month). The balance of the cost of coverage will be shared by the Alliance and Kaiser. No co-pay will be expected for medical services.

- Comprehensive health care includes health education, preventive care, emergency care, hospital and office visits, medically necessary laboratory costs and x-ray services, short-term physical therapy (not to exceed two months in duration), annual vision exams, unlimited doctor's visits for short-term and crisis intervention mental health and substance abuse services and 45 days of hospital or residential mental health care, maternity and newborn coverage, and free prescription drugs and prescribed health accessories at Kaiser pharmacies.

- Kaiser Permanente and the Alliance for Medical Care have initially Committed funding for a maximum of 500 uninsured children from the District of Columbia through this program. The first year of the renewable agreement is 8/1/97 to 7/31/98.

- The program will be administered by the Alliance for Medical Care staff from an office in the Kaiser Permanente North Capitol Medical Center, 1011 N. Capitol Street, NE. Health Care services also will be provided at the Kaiser Permanente West End Medical Center, 2100 Pennsylvania Avenue, NW. Reginald Brown is the executive director of the Alliance for Medical Care and can be contacted at (703)671-3837. Abbie Miller is the Alliance for Medical Care Kaiser Kids Program Coordinator at the North Capitol Medical Center, (202)898-5173.

Criteria for Enrollment in Child Health Care Program

- Participants shall be children under the age of 18 who are resident in the District of Columbia.

- Participants shall be in families with income less than 200% of the federal poverty level.

- Participants shall not have (or be eligible for) health benefits coverage under any other private or public program or policy providing health insurance, health coverage or health services, including but not limited to Medicaid.

For More Information Please Contact:

Abbie Miller, Program Coordinator (202) 898-5173

NEWS



Media Relations • Mid-Atlantic States • 2101 East Jefferson Street • Rockville, Maryland 20852

For Immediate Release
Tuesday, August 12, 1997

Contact:

Reginald Brown
Alliance for Medical Care
703-671-3837

KAISER PERMANENTE AND ALLIANCE FOR MEDICAL CARE WILL PROVIDE COMPREHENSIVE HEALTH CARE FOR 500 UNINSURED DC CHILDREN

ROCKVILLE, MARYLAND—Kaiser Permanente and the Alliance for Medical Care today announced an agreement to provide comprehensive health care for 500 uninsured children in the District of Columbia. Qualified families will pay \$10 a month per child or a maximum \$20 a month per family. The balance of the cost of coverage will be shared by these two non-profit organizations to help meet a pressing community need while new health care programs for uninsured children are developed with recently authorized federal funding.

The Alliance for Medical Care will enroll eligible children and administer the program from an office at the Kaiser Permanente North Capitol Medical Center. Participants will receive Kaiser Permanente membership cards and most health care will be provided at the HMO's North Capitol Medical Center and West End Medical Center, both in Washington, DC. The two partners expect to renew the agreement after the first year.

The new program will be the second children's health care initiative in the District of Columbia for the Alliance for Medical Care, a charitable organization founded in June 1996 and based in Alexandria, Virginia. Last year, the Alliance created a program to provide ambulatory medical care for up to 150 DC children with asthma. The original program is based on agreements to reimburse health care providers at Howard University College of Medicine and George Washington University Medical Center.

"Earlier this year, we decided to expand our investment of private-sector capital in the health of DC children by helping to pay for comprehensive health insurance through Kaiser Permanente and other established health maintenance organizations," said Donald deLaski, chairman of the board and cofounder of the Alliance for Medical Care. "We're also announcing a partnership today with Capital Community Health Plan, a Medicaid managed care contractor

Kaiser Permanente/Alliance for Medical Care Partnership for Uninsured Children

for the District of Columbia. The complementary programs of these health plans will improve children's quality of life in more DC neighborhoods."

"Over the next five years, new federal funding will provide urgently needed health coverage for children of low-income working families through the balanced budget legislation signed earlier this month. We expect our partnership with the Alliance for Medical Care to serve uninsured DC children well as new public programs are developed. We want to demonstrate effective ways to meet part of this great need with compassionate, quality care for each child," said Robert Pfotenhauer, vice president and executive director of Kaiser Permanente's Washington, D.C. market.

Kaiser Permanente, with 529,000 health plan members in the Washington-Baltimore metro area, already participates in two major programs that provide 3,185 subsidized health care slots for uninsured families and children in Virginia, Maryland and the District of Columbia (see fact sheet).

Under this partnership agreement, the Alliance for Medical Care will pay Kaiser Permanente \$30 per child per month, participants will pay Kaiser Permanente \$10 per child per month (up to \$20 maximum per family per month), and Kaiser Permanente will subsidize the balance of the monthly cost of coverage.

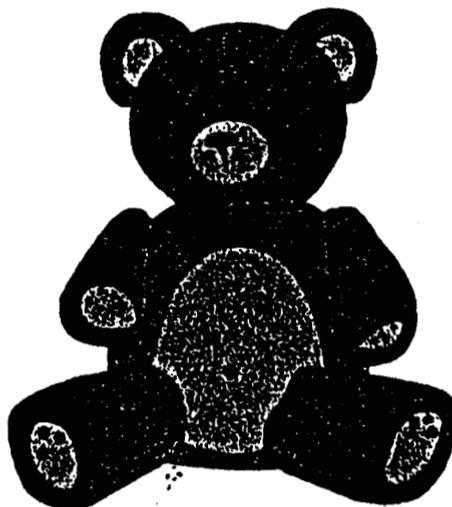
Kaiser Permanente will provide participants basic health care services including health education, preventive care, emergency care, inpatient and outpatient physician care, diagnostic laboratory and radiological services, short-term physical therapy, annual vision exams, mental health and substance abuse services, maternity and newborn coverage, and prescription drugs and accessories at no cost through Kaiser Permanente pharmacies. All services must be authorized by Kaiser Permanente health care providers according to terms of the agreement.

Participants may live anywhere in the District of Columbia, but recruitment efforts will focus on Ward 2 and Ward 6, where Kaiser Permanente has medical centers. Under the basic eligibility criteria, participants must be under age 18; be residents of the District of Columbia; have household income less than 200% of federal poverty level; and not have or be eligible for health benefits coverage under any private or public program or policy providing health insurance, health coverage or health services, including but not limited to Medicaid. In general, eligible children will be accepted on a first come, first served basis regardless of current health status subject to terms and limitations of the program.

For detailed information and an application to enroll in the new program for uninsured DC children, interested families may contact Abbie Millet, program coordinator for the Alliance for Medical Care, by calling 202-898-5173.

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**Kaiser Kids Program
Alliance for Medical Care/ Kaiser Permanente**



Is your child without health insurance?

Does your child live in the District?

Is your child unable to receive Medicaid?

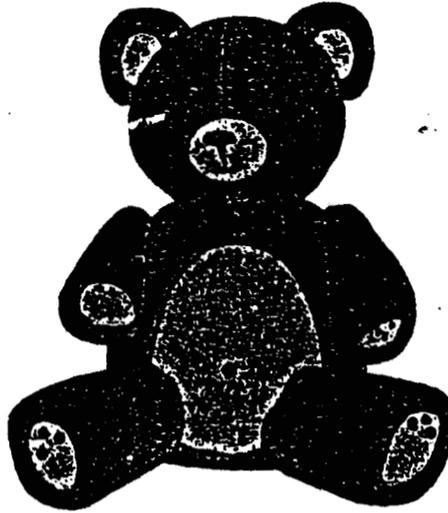
If you answered Yes to these three questions your child may be **eligible** for the Kaiser Kids Program sponsored by the Alliance for Medical Care and Kaiser Permanente.

The Kaiser Kids Program will **Help** low-income parents who are ineligible for the Medicaid program **pay** the cost of a **health insurance** policy for their children. The Alliance for Medical Care has joined with Kaiser **Permanente** to **offer** complete health insurance policies to **500** uninsured District children this year. **The** policies will cost **\$10.00** a month to cover one child or **\$20.00** a month to cover more than **one** child in a family.

If you have any questions or you **would** like to apply **for** the program please contact the Program Coordinator, Abbie **Miller** at

(202) 898-5173

El Proyecto Kaiser Kids
La Alianza para Servicios Médicos / Kaiser Permanente



Está su niño sin seguro médico?

Vive su niño en el Distrito de Columbia?

Tiene usted un niño que no califica para Medicaid?

Sí respondió "sí" a estas tres preguntas, es posible que su niño sea elegible para el Proyecto Kaiser Kids de La Alianza para Servicios Médicos y Kaiser Permanente.

El Proyecto Kaiser Kids ayudará a padres de bajos ingresos que no son elegibles para Medicaid pagar el seguro médico de sus niños. La Alianza Para Servicios Médicos junta con Kaiser Permanents ofrecerán pólizas de seguro médico completo a 500 niños del Distrito de Colombia este año. La póliza de seguro va a costar \$10.00 cada mes para cubrir a un niño o \$20.00 cada mes para más de un niño por familia.

Sí tiene cualquier pregunta o quisiera una solicitud para el proyecto, favor de ponerse en contacto Abbie Miller a

(202) 898-5173



BY LARRY MORRIS—THE WASHINGTON POST

Hanita Schreiber is president of Capital Community Health Plan, which sponsors the Capital Community Kids Care program.

Children Get a Health Care Safety Net

Two D.C. Programs to Provide Services to Poor Are Announced

By Todd Beamon
Washington Post Staff Writer

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APPENDIX D

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DO YOU NEED THESE SERVICES?

MEDICAID

The Medicaid Program helps qualified persons pay for medical services. Family income and resources are used to determine eligibility. You do not have to be on welfare to qualify for Medicaid. Current income limits for Medicaid are given below. If you do not meet these limits but have large medical expenses, you should still contact a Medicaid Office to see if you qualify. The addresses are at the bottom of this page.

MEDICAID INCOME ELIGIBILITY LIMITS (District of Columbia, 1994)¹

MONTHLY GROSS INCOME²

FAMILY SIZE	PREGNANT WOMEN	INFANTS (under 1 yrs old)	CHILDREN (1-5 yrs old)
1	1,183.25	1,183.25	867.85
2 ³	1,597.17	1,597.17	1,148.23
3	2,001.09	2,001.09	1,438.62
4	2,405.00	2,405.00	1,728.00
5	2,808.92	2,808.92	2,018.38
6	3,212.83	3,212.83	2,308.77

For each person over 6 family members add:

403.82

403.82

290.38

FOOD STAMPS

The Food Stamp Program provides food assistance to low-income households with certain income limits. The Program is intended to stretch a family's food dollars. Food Stamps can be used to purchase food from approved grocery stores and markets. You do not have to be on welfare to qualify for Food Stamps.

AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)

Aid to Families with Dependent Children (AFDC) provides money to low income families with dependent children who lack parental support. Lack of parental support means one or both parents are dead, disabled, unemployed, or continuously absent from the home. The family income and resources are used to determine who qualifies. In some cases, AFDC may assist a family in collecting child support payments, finding work or training for work. People on AFDC are eligible for Medicaid.

MEDICAID, AFDC AND FOOD STAMP OFFICES

Apply for AFDC or Public Assistance, Food Stamps and Medicaid at these Service Centers. They are open Monday-Friday from 8:15 am to 4:45 pm. Call first to find out what documents to bring.

NORTHEAST

M Street Service Center
645 M Street, NE
Call: 724-5188

Capitol East Service Center
1326 Independence Ave., SE
Call: 727-0624 or 727-0608

Eckington Service Center
80 Florida Avenue, NE
Call: 673-7440

Edgewood Service Center
801 Edgewood Terrace, NE
Call: 578-8629

Northeast Service Center
4313 Nannie M. Burroughs Ave, NE
Call: 727-0338

NORTHWEST

Kennedy Service Center
508 Kennedy Street, NW
Call: 578-8908

SOUTHEAST

Anacostia Service Center
2100 M.L. King Jr. Ave., SE
Call: 645-4614

Capitol View Service Center
5928 East Capitol Street, SE
Call: 645-4588

Congress Heights Service Center
840 Valley Avenue, SE
Call: 645-4525

HEARING IMPAIRED

Call 727-DEAF
Leave your name and TTY number

¹ Effective February 1994.

² These figures are 185% of poverty for pregnant women and infants, and 133% of poverty for children.

³ Pregnant women are counted as two persons.

CHILD SUPPORT ENFORCEMENT SERVICES

The Child Support Enforcement Program helps people obtain payments from an absent parent who is not contributing to the support of his child. Services include establishing legal parenthood, locating absent parents, obtaining legal support orders from the court and collecting child support payments. Call 646-6330, Paternity & Child Support Enforcement, 800 8th Street, SW, 3rd Floor, Washington, DC 20004.

COMMODITY SUPPLEMENTAL FOOD PROGRAM (CSFP)

CSFP is available to pregnant women, infants, children under 6 and senior citizens. If you are not on WIC you may be eligible. Most distribution sites are open from 8:30 am to 4:00 pm Monday-Friday. Call 645-5518 for the distribution site closest to your home.

OTHER FOOD ASSISTANCE RESOURCES

The places below provide food assistance to women, infants, children and others in need. Call for more information on what is offered.

NORTHWEST

Bread for the City
1305 14th Street, NW
332-0440

Christian Action Center
1201 T Street, NW
Call: 332-3721 & 265-4494

Northwest Pregnancy Center
1314 14th Street, NW Suite #4
Call: 483-7008
Open Mon.-Fri., 12 noon-4 pm

The Family Place

3309 18th Street, NW
Call 265-0149
Open Mon.-Fri., 9 am-5 pm

SOUTHEAST

Catholic Charities
Assumption Church
3401 Martin Luther King Jr.
Avenue, SE
Call: 526-4100; Mon., Wed., Thr.,
Fri.; 10 am-12 pm and 1 pm-3 pm
Infant Formula Available

Southeast Teen Crisis Center

220 High View Place, SE
Call: 574-3880
Infant Formula Available

SOUTHWEST

Southwest Health Center
850 Delaware Avenue, SW
Call: 727-9122
Tues., Wed., & Thurs..
8:30 am to 4 pm

Bread for the City
3845 South Capitol Street, SW
Call: 561-8587

ALCOHOL AND DRUG ABUSE TREATMENT

The Addiction, Prevention and Recovery Administration (APRA) will help anyone who wants counseling and treatment for alcohol or drug abuse. The central intake phone number will provide information on all available services. Take the first step - call 727-5163. *If you are pregnant with a alcohol or drug problem - DO NOT wait, call 727-5163 TODAY!!!!*

OTHER SUBSTANCE ABUSE TREATMENT SERVICES

The places below offer substance abuse counseling and treatment. Call for more information.

Women's Services Clinic
1905 E Street, SE
Building # 13
Washington, DC 20003
Call: 727-5166 (ext. 671)

Second Genesis
1320 Harvard Street, NW
Washington, DC
Call: 234-6800

Andromeda Hispano Mental Health
Foundation
1400 Decatur Street, NW
Washington, DC 20011
Call: 291-4707;
Mon. - Fri. 9 a.m. - 5 p.m.

United Planning Organization (UPO)
Substance Abuse Program
941 N. Capitol St., N.E.
Washington, DC 20002
Call: 289-9100, ext. 216

CHILDHOOD IMMUNIZATIONS

Protect your infant or young child from preventable diseases like measles, mumps, polio and rubella. Ask your child's doctor about the immunizations your child needs or call 547-BABY for the public health clinic nearest you. Prepared by the Government of the District of Columbia's WIC Program. The WIC Program does not discriminate on the basis of race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, family responsibilities, handicap, matriculation or political affiliation.

APPENDIXE

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Fact Sheet

Department of Human Services
Commission of Public Health

THE MISSION

The Office of Maternal and Child Health (OMCH), established October 1, 1982, is charged with planning, promoting, and coordinating a state-based system of comprehensive health services for all mothers and children, including children with special health care needs in both the public and private sectors of the District of Columbia. As the single state agency, OMCH administers the Title V Maternal and Child Health Services Block Grant. The office is also responsible for developing and assuring the implementation of programs for the reduction of infant mortality and teen pregnancy prevention.

ACTIVITIES

D.C. Healthy Start Project is one of 15 designated Healthy Start Communities nationwide, charged with mobilizing collaborative community efforts to focus on the comprehensive needs of pregnant women and infants. The goal of these efforts is to reduce infant mortality 50% by September 1996, in Wards 7 & 8. Special initiatives funded by this project include: Patient Incentive Program; Sister Friends Program; Evening and Weekend Clinic; two Maternity Outreach Mobiles; and H.D. Woodson Senior High School Adolescent Wellness Center.

Comprehensive HIV Intervention and Prevention Services (CHIPS) for Families' mission is to improve the capacity of primary care health and social service systems to assure the delivery of community-based, family-centered care for parents, infants, children, and youth affected by the HIV/AIDS epidemic in the District of Columbia. CHIPS for Families also delivers comprehensive, family-centered case management services to over 170 families affected by HIV disease annually.

SYNERGY is an adolescent health coalition working to strengthen and enhance the Commission of Public Health and community-based organization's capacity to provide prevention, education, outreach and treatment services to youth in high risk situations.

The Pregnancy Risk Assessment Monitoring System (PRAMS) collaborates with District hospitals to conduct hospital-based data collection. As a state reproductive health surveillance tool, PRAMS may be used to monitor maternal behaviors and risk factors, provide statewide prevalence rates for maternal risk factors, identify gaps in health care system delivery and utilization, provide data for needs assessments, program planning, and evaluation, and assess the impact of behavioral risk factors and health care problems on pregnancy outcome.

The Pregnancy Nutrition Surveillance System (PNSS) examines the relationship between factors associated with nutritional status during pregnancy and birthweight. The data collected from District residents include weight gain during pregnancy, smoking and drinking behavior before and during pregnancy, hematocrit and hemoglobin levels, and birth outcome, which is analyzed to better understand the prevalence and trends of risk factors associated with low birthweight and adverse pregnancy outcomes.

D.C. Systems Development Initiative (DCSDI) advocates for the development of a coordinated system of primary health care for women and children in the District of Columbia, including children with special needs and especially in Wards 6, 7, and 8. During this era of restructuring, DCSDI's focus is consumer and provider education regarding Medicaid Managed Care.

Newborn Screening Program provides screening of every birth occurring in the District of Columbia for certain metabolic and sickle cell disorders for which early and appropriate treatment can prevent death or substantially ameliorate mental retardation, physical handicaps and developmental disabilities.

Genetic Services provides clinical genetic services to pediatric and prenatal clients of the Ambulatory Health Care Administrations' Neighborhood Health Centers. Services provided include: Genetic counseling and education; family history; physical examinations; diagnostic procedures; laboratory screening and testing; evaluation and diagnosis; treatment and management; referrals; and follow-up services.

Government of the District of Columbia

The NIE-DC Initiative to Reduce Infant Mortality is a five year collaborative between the National Institute of Child Health and Development, the National Institutes of Health, Office of Research on Minority Populations, the National Institute for Nursing Research, the D.C. Commission of Public Health, and five of the city's most prominent health care and research centers. Its tasks include designing and evaluating interventions aimed at reducing the Infant Mortality Rate (IMR); increasing public understanding of health risks to pregnant women; encouraging high-risk women to obtain prenatal care as well as assume responsibility for their health.

Baby Hotline is a 24 hour telephone answering service to callers in need of information, counseling, and referrals on maternal and child health concerns and problems. The toll free hotline number is 1-800-MOM-BABY.

Teen Tips Hotline, a 24 hour telephone information and referral service for teenagers. The number is 1-800-656-2229.

PRINTED MATERIALS/RESOURCES

At Your Fingertips: MOM'S RESOURCE BOOK, available in English and Spanish, is a listing of local services of interest to pregnant women and mothers. This manual is small in size, designed for easy use by clients, listing 12 major categories of services with a description of each service offered and how to access the services. Copies available from OMCH.

MCH ALERT, a quarterly newsletter produced by OMCH staff and distributed to local MCH providers.

HIV Primary Care Protocols for Providers is a manual designed by the CHIPS for Families Project to maximize the ability of the Ambulatory Health Care Administration clinical staff and other front-line providers to deliver high-quality primary care services for pregnant and non-pregnant women with HIV infection and for antibody-positive, or infected, infants and children.

Healthy Start Infant Mortality Review Update, a quarterly newsletter produced by OMCH staff and distributed to local MCH providers and clients.

Healthy Start Resource Center, a library and on-line computer service to provide information on maternal and child health issues and other health care concerns to parents and community groups. Also available through the Center are: **Healthy Start Newsletter**, produced quarterly and distributed to MCH providers and consumers; **Resource Parents Trainers and Trainees Manuals**, including **Home Visiting Guide**; and **Case Management Manual**, including **Protocols**.

Guide to Maternal and Child Health Services by Ward in the District of Columbia provides a comprehensive, up-to-date resource listing of maternal and child health services offered within the District of Columbia. The guide is user friendly for easy reference, designed to familiarize service providers with the spectrum of existing services, and to facilitate cooperation among providers whose services may be complementary. Copies available from OMCH.

Maternal and Child Health Programs and Special Projects, a comprehensive listing of citywide program goals and objectives under four major subheadings: Maternal and Infant Health, Children and Adolescents, Children with Special Health Care Needs, and MCH-Related Programs and Projects. The Appendices provide information on issues that range from key resources outside of Title V, to locations of health facilities that offer prenatal care services.

For information call the **Baby Hotline, 1-800-MOM-BABY.**

APPENDIX F

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(3) minutes from the Medicaid Advisory Committee meetings; and

(4) corrective action plans developed for individual providers concerning care provided under this contract.

b. Minutes from the Provider's Quality Assurance **Committee** meetings shall be made available upon request **by** the District for review at Provider's site. All such minutes shall be kept **confidential** by reviewing parties **as** required under the District's **Health** Maintenance Organization Act of 1996.

6. **EPSDT-related Information**

a. Provider shall produce summary and enrollee specific data **from** the claims and medical records of its enrollees on EPSDT **services**, described in paragraph 2.a.(9) of Section H **and/or** from the EPSDT tracking system, described in paragraph 6 of Section I for the District **as** requested.

b. Provider shall submit aggregate information collected on **EPSDT** activity in the same format **as** the annual HCFA-4 16 report, ninety days after the end of each calendar quarter or **as** requested by the District.

7. **Operational Indicators of Provider Performance and Encounter Data**

Measures" and Attachment III to this contract.

b. Provider's **description** of its method for **providing the** District with aggregate performance **and** outcome measures, **as well as** its **description** of policies for transmission of data from network members in response **to** Sections **C.9.2** and **C.9.3** of Solicitation No. 7010-AA-NS-2-CR shall be incorporated into this contract **as** a performance specification.

d. Provider shall submit additional aggregate outcome measures, **as requested by the** District. These aggregate outcome measures shall **be** developed by the District **in**

10. EPSDT Outreach Activities

- a. Provider shall conduct outreach activities to assist enrollees make and keep EPSDT appointments for eligible children. The outreach activities shall include every reasonable effort, including telephone calls, scheduling of appointments for recipients, mailed reminders and personal visits, to contact parents, guardians of children, or the children themselves, if appropriate, based on the child's age, who are due for, or who have failed to keep appointments for, EPSDT screens and laboratory tests set forth in the District's periodicity schedule, immunizations, or follow-up treatment to correct or ameliorate a defect identified during an EPSDT screen or laboratory test, or have otherwise not obtained EPSDT screens laboratory tests, immunizations, follow-up treatment or other services, in order to assist them to obtain such services.
- b. Provider shall offer scheduling and transportation assistance prior to the due date of each eligible child's periodic screening, laboratory tests and immunizations, when this assistance is requested and necessary as required by 42 CFR 440.170.

11. EPSDT Education for Members of Provider Network

Provider shall train all physicians providing EPSDT, at least annually, about the current requirements for EPSDT and shall develop a monitoring program to ensure, on at least an annual basis, that each physician providing EPSDT services has the necessary equipment and knowledge to perform such services in accordance with standard medical practice.

H. COVERAGE AND BENEFITS

1. Covered Services

- a. This contract provides for coverage and provision by Provider of all medical assistance benefits and services that are listed in Attachment I, which is incorporated herein as part of this contract.
 - b. In making determinations regarding the minimum amount, duration and scope of coverage with respect to any service identified in Attachment I, Provider shall be bound by the same service definitions and coverage requirements which apply to
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the District Medicaid program under federal **and** District law, 42 U.S.C. § 1396 et. seq.; 42 C.F.R. § 431 et. seq.

2. **Early and Periodic Screening Diagnosis and Treatment Services (EPSDT) for Enrollees Under 21 Years of Age**
- a. The EPSDT program is the pediatric component of Medicaid and requires coverage of periodic and interperiodic screens, vision, dental, and hearing care, diagnostic services needed to confirm the existence of a physical or mental illness or condition and all medical assistance services that are recognized under Section 1905 of the **Social Security Act**, even if not offered under the state plan to persons age **21** and older. In operating the EPSDT program, Provider shall be bound by all federal laws applicable to the program (including 42 U.S.C. §§ **1396a(a)(43)**, **1396d(a)(4)(B)**, and 1396d(r)).
- (1) Provider shall be responsible for coverage and provision of all periodic screening services in accordance with the Department's periodicity schedule, as well as interperiodic screening services, which shall be furnished to any child who is suspected by a health care provider or any person authorized to make decisions regarding the child's health of having a physical or mental health problem.
 - (2) Provider shall be responsible for coverage and provision of all EPSDT dental services set forth in Attachment I.
 - (3) Provider shall be responsible for coverage and provision of all EPSDT vision services set forth in Attachment I.
 - (4) Provider shall be responsible for coverage and provision of all **EPSDT** hearing services set forth in Attachment I.
 - (5) Provider shall be responsible for coverage and provision of all services required to diagnose a condition other than mental illness or addiction disorder diagnostic services. In the case of services required to diagnose a mental health condition in an individual under age **21**, Provider shall arrange for such diagnostic services but is not responsible for the **cost** of providing such diagnostic services.

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- c. Provider shall ensure that effective communication is provided for deaf persons in its **administrative** and medical services, in accordance with Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act of 1990.42 USC § 12112 - 14, including the availability of qualified sign language interpreters.

5. **Transportation and Scheduling Assistance Requirements**

- a. Provider shall furnish all transportation for emergency services as defined in Article XXII.
- b. Provider shall furnish all medically necessary transportation for non-emergency situations.
- c. Provider shall offer and provide, if requested and necessary, transportation to EPSDT services.
- d. Provider shall offer and provide, if requested and necessary, assistance with scheduling EPSDT appointments.

6. **EPSDT Tracking System**

- a. Provider shall operate a system that tracks the following **EPSDT** activities for each **enrollee**:
 - (1) the EPSDT screens, immunizations, and laboratory tests that the enrollee is **due** to receive;
 - (2) the EPSDT screens, immunizations, and laboratory tests that the enrollee **has** received and the dates that the screens, immunizations and laboratory tests **occurred**;
 - (3) whether the enrollee has been referred for corrective treatment as a result of an EPSDT screen or laboratory test and the date that any such **referral** occurred;
 - (4) whether the enrollee has received the corrective treatment and the date that the corrective treatment occurred; and

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- (5) the outreach activities described in section G. 10 that have been performed ~~with respect~~ to the enrollee and the dates that each of the outreach activities occurred.

7. **EPSDT Performance Standards**

- a. Provider shall meet the EPSDT participation ratio, as defined by the HCFA State Medicaid Manual, Section 5360.B (November 1993) for Provider's enrollees according to the following schedule:
- (1) 75% for 1998, and
 - (2) 80% for 1999.
- b. If Provider fails to meet or show progress toward meeting the EPSDT performance standards in paragraph "a" of this section or ensure that children have their age-appropriate screens updated for missed opportunities, the District shall take any or all of the following actions (depending on the extent of the failure to comply or to demonstrate progress with the standards):
- (1) require the Provider to develop and implement a corrective action plan, that is approved by the District and is designed to increase Provider's EPSDT participation ratio;
 - (2) require the Provider to utilize the Department's EPSDT case management program; or
 - (3) withheld an amount from the Provider's payment, pursuant to Article XI, section A3 at a rate of \$45 for each enrollee that is required to be added to the numerator in Provider's EPSDT participation ratio to comply with the performance standards in paragraph "a" of this section.

J. **ADVANCE DIRECTIVES**

1. Provider shall comply with the requirements of 42 C.F.R.Ch. IV, subpart I of part 489 relating to maintaining written policies and procedures concerning advance directives.
2. Provider shall ensure compliance with requirements of State law (whether statutory or recognized by the courts of the State) regarding advance directives. Provider shall

APPENDIX G

District of Columbia Medicaid Managed Care Program
Commission on Health Care Finance
HMO Oversight Program

The Commission on Health Care Finance ("Commission") has received approval from the Department of Health and Human Services to enroll all TANF and TANF-related Medicaid enrollees into HMOs. The Commission is selecting HMOs to participate in the program.

Each HMO that participates in the mandatory HMO program enters into a full-risk contract to provide the full scope of Medicaid services, except for *mental* health, substance abuse, long-term care and inpatient transplant services, for a negotiated capitation rate payable for each member. The contract includes: (1) Covered services; (2) Enrollment policies; (3) Marketing limitations; (4) Escrow and equity balance; (5) Physician incentive plan and stop-loss requirements, (6) Network provider sub-contract terms; (7) Member education and outreach requirements, and (8) Minimum performance standards for network composition, service time lines, EPSDT encounter rates and quality assurance program activities.

The Office of Managed Care (OMC), within the Commission is responsible for ensuring that each HMO complies with the terms of the contract. The OMC performs a readiness review prior to the plan's receipt of its first member and monitors compliance with the contract throughout the contract's term. To augment the specific contract compliance activities, the Commission, as purchaser of care for Medicaid recipients, continually evaluates the HMOs, through its oversight program, to assure that the services purchased result in improvements in access to high quality care. The Commission determines whether baseline performance levels for delivery of health care services are met, checks to see why the performance level has not been met, and periodically raises the baseline threshold.

Several sources provide information about an HMO's performance, including: administration of a 24 hour hotline by the Commission to receive enrollee complaints; self reporting of performance measures by the HMOs; probes into self-reported data by the Commission or its contractors; early warning system proxy calls; and surveys of enrollees, providers, and other District agencies. More information about the specific activities that are performed within each of the five broad elements are described below. Some of the sources produce information that may lead to contract compliance issues immediately, while other sources produce more global information that needs to be analyzed before patterns are identified.

Each quarter the Commission meets with each HMO individually to discuss the findings or questions raised during the course of the oversight activities. Areas of concern are identified when care and service levels become unacceptable. The Commission and the HMO then must focus their attention on these particular areas to probe for the underlying reasons for the poor performance. Effective methods of probing include surveys of enrollees to gather information about the prevalence of certain factors, requests for more specific (possibly individual) data,

reviews of medical charts, or interviews with other District agencies. These focused studies, or probes can be performed by either the HMO or the Commission, or a combination of the two. When enough information has been gathered to uncover the underlying reason, a plan to improve performance is developed in collaboration with the HMO, and is monitored continually by the Commission until sufficient progress is made in the level of care or service.

The Commission's oversight program has been designed to achieve its goals without overburdening or micro-managing the care providers and requiring an unrealistic level of Commission resources. This means that the Commission continually reviews the oversight activities to ensure their effectiveness and specific activities may be curtailed if the activity is not producing useful information. To prevent needless redundancy of oversight processes and further the conservation of resources, the specific activities may be substituted for HMOs that have attained full NCQA accreditation or have received positive evaluations in relevant program areas over a period of time. In this way the plans have an additional incentive to perform well and to cooperate with the collection of the information.

To improve contract compliance and overall performance of the plans, the Commission hosts monthly meetings with all of the participating HMOs to discuss a variety of topics. Topics discussed in previous meetings are the District's Title V and special education agencies; Medicaid eligibility criteria; special needs of persons with HIV/AIDS and developmental disabilities; roles of various non-profit community agencies that serve the health care needs of the indigent population in the District; and HMO responsibilities under the Salazar court order. At least once a year, the Commission hosts a meeting between the HMOs and recipient advocacy groups to discuss their issues of concern.

The oversight program consists of the five broad elements of evaluation: (1) delivery of technical quality of care and service; (2) member satisfaction; (3) provider satisfaction; (4) compliance with HMO certification requirements; and (5) effectiveness as a business partner. The activities associated with each of the five broad elements are more thoroughly described below:

I. Evaluation of an HMO's delivery of quality care and service

GOALS:

- A To ensure a minimum level of medical care is delivered to Medicaid recipients within each HMO
- B To ensure a minimum level of services is delivered to Medicaid recipients within each HMO.
- C To achieve selected care and service goals for the entire recipient population.

Activities:

1. Develop and maintain an assessment tool for collection of performance measures - The Commission contracted with a consultant to develop the overall list of performance measures that will be submitted by the HMOs. An assessment tool was developed that allows a third

party to objectively assess care and services and hold the HMO accountable for medical care performance levels. Comparative analysis of the HMOs is also possible. The Commission is using a combination of structure, process and outcome measures that have been developed and tested on a national basis, whenever possible (i.e. HEDIS measures). See attached list. Using these valid and tested measures increases the confidence of the Commission that it is collecting measures that will be effective indicators of plan performance. The measures will need to be continually monitored to ensure that the data collected is uniform across the plans and is an effective measure of the specific area of concern. Other areas of concern identified from the oversight program may warrant the addition of new measures to the list.

2. Collect, Collate and analyze the data - The measures described in #1 are collected from two sources, the HMOs and the Commission. Data from each source are collected on a monthly, quarterly, and annual basis. One of the program analyst positions in the OMC is responsible for the collection, collation and first level analysis of the measures. This first level analysis is performed to identify problems associated with poor retrieval of the data by the HMOs or possibly, inadequate instructions on how to collect the data. Charts, graphs, and tables are created to report the measures to various interested parties, including the HMOs.
3. Identify outliers from data collected - To identify areas of concern, outliers of performance are identified by comparing the measures collected from each plan to measures from other District Medicaid HMOs, other State Medicaid HMOs, or national industry standards.
4. Develop or determine minimal performance levels - To encourage and assure continuous quality improvement, minimum standards of performance levels are established for the measures by the OMC and are based on standards developed by comparing the measures across the HMOs, or can be national or state Medicaid-specific performance standards. Through the terms of the contracts, HMOs may be held accountable for meeting the performance levels established. Sanctions, including the development of corrective action plans and the cessation of default assignments, could be applied to the plans that fail to meet the minimal performance standards.
5. Develop and coordinate focused activities that improve the level of care or service to the entire recipient population - As a broader objective than individual HMO performance, where performance across all plans need to improve, focused studies of the area of concern are used to probe for specific causes. If immunization rates of all of the managed care population is lower than desired, a focused study of the causes of this phenomenon is performed in conjunction with the Department of Health and specific activities that will cause an improvement are identified and implemented.
6. Design and monitor the EPSDT case management program - One of the requirements of the Salazar Court Order is to implement an individualized case management program to assist individuals in receiving their appropriate EPSDT services, when the HMO's efforts at case management have failed. The purpose of the program is to encourage the child's parent.

guardian or caretaker to bring the child into compliance with the EPSDT periodicity schedule and to ensure that barriers to accessing the EPSDT services have been resolved. The Commission is hiring an outside vendor to perform the case management duties. The high level of interaction between the Commission's case manager and the HMOs will provide insights into the procedures that the HMOs have in place to comply with the EPSDT contract requirements.

7. Provide technical assistance to the HMOs on data collection - Education is ongoing to the plans on how to collect the data. The Commission assists or identifies other organizations that can assist the plans to accurately collect the requested data.
8. Audit the data - An important element in the collection of self-reported measures is the auditing of the plans methods and systems to verify the data that has been collected. By validating the data, we verify that the measures were calculated as instructed and that the HMO's data sources, its process for collecting claims, encounters, member, and provider information, are sound.
9. Make proxy calls as a component of an Early Warning System - Given that an adverse impact on quality may be more likely to occur during the startup phase of a new HMO or when there is a rapid increase in membership for an existing HMO, the Commission, in cooperation with HCFA is developing an early warning system. Designed to screen for problems within the first two to four months of operations the system consists of proxy phone calls to provider offices requesting appointments for a range of services and phone calls to pediatrician's offices verifying that newborns have been seen within three months following the birth. The proxy calls measure the 24 hour availability of providers and the access to timely appointments. The calls to pediatricians provide an insight into a plan's effectiveness at outreach for the critical newborn EPSDT screens. Where problems with access are found, extension of this activity beyond the initial two-to four month period may be required.
10. Review the HMO's Quality Management and Utilization Management processes - A review of the plan's adherence to HCFA's guidelines for quality assurance programs (QAPs) is performed to gauge how well the plans are monitoring their own performance. Compared to the paper reviews of the QAPs that use a checklist approach and are performed during the review of the application or bid and the readiness review, an annual review of the QAP is meant to be functional review of the HMO programs that improve quality of care.
11. Link with other District agencies to ensure Public Health goals are met - This activity is much broader in scope and involves the Department of Health in analyzing broad public Health goals with other sources of data. One example of this activity is to review birth and death certificates to study the difference in birth outcomes and reasons for deaths between Medicaid beneficiaries in HMOs and those in fee-for-service and those not covered by Medicaid.

II. Evaluation of an HMO's member satisfaction

GOAL: To ensure a minimum level of recipient satisfaction with HMO's services.

Activities:

- I. Enrollee satisfaction with ——— - Surveys of enrollees can be valuable in two ways: (1) to gain insights on plan performance from the perspective of the enrollees; and (2) to help beneficiaries make informed enrollment decisions by publishing the results of the surveys. A new tool is available for use that has been specifically designed for the Medicaid population. The Consumer Assessment of Health Plan Study (CAHPS) is currently used by three states for similar purposes. Using the quality and service questions from CAHPS is an efficient and cost effective method for capturing quality performance results. An outside contractor would conduct the survey across the entire Medicaid HMO population.
2. Collection and comparison of HMO satisfaction surveys - According to the contract, the HMOs must conduct two enrollee satisfaction surveys each year. The results of the surveys are forwarded to the OMC for analysis. A specific area of concern can be targeted through these surveys, by requesting the plan (or plans) to ask specific questions as a part of their survey. In many cases, results can be obtained more quickly than waiting for the annual external survey. Or in the case, where an area of concern is identified with one HMO only, this is an effective method of probing for the underlying cause.
3. Administration of the HELPLINE - An effective and timely way to determine an area of concern about a plan's performance is the monitoring of the calls that come into the 24 hour managed care hotline. First Health, the contractor that administers the District's hotline, called the HELPLINE, reports to the OMC the total number and type of calls received each week. Although the calls are reported in fairly broad categories and the number of calls in each category is not specified by plan, in the past, the HELPLINE calls have proven to be a good early indicator of potential program problems.
4. Complaints, Grievances, and Appeals - Any call into the HELPLINE that needs additional research or cannot be resolved on the phone, is documented and faxed to the OMC on a daily basis. The complaint is then researched and responded to by OMC staff. The Commission has its own formal grievance and appeals procedures in addition to those at each of the plans. Meetings with advocates is another way to learn of complaints with individual HMOs. Compared to the broad results derived from a satisfaction survey, the review of enrollee complaints is an individual consumer protection that yields helpful insights into potential problems with the plans.

III. Evaluation of an HMO's provider satisfaction

GOAL To ensure a minimum level of provider satisfaction with plan processes.

Commission on Health Care Finance
Office of Managed Care

Activity:

1. **External survey of HMO network providers** - Surveying providers is a useful method to evaluate the effectiveness of the HMO systems. An annual survey of the plan's network providers and their administrative staff, performed by an outside contractor, provides insights into the effectiveness of the plans' provider education program, policy and procedure manuals, utilization management processes, claims payment system, and methods for reducing the number of missed appointments. Since many of the providers in the District contract with more than one of the HMOs, this type of focused survey provides an objective evaluation from the provider's perspective.
2. **Monitor provider complaints** - First Health and the Commission takes calls from and meets frequently with providers and provider groups that may be experiencing problems with individual HMOs. Similar to complaints from individual enrollees, these calls and meetings produce insights into potential problems with the plans.

III. Evaluation of the HMO's compliance with the District's HMO certification requirements

GOAL: To ensure that the minimum requirements under the District's HMO Act of 1996 are met.

Activities:

1. **Review and assessment by the Insurance Administration** - HMOs are required to comply with the HMO Act of 1996 throughout the term of the contract. The Insurance Administration (IA) has authority to regulate this Act. After an initial review and approval of the application, the IA issues a certificate of authority to operate as an HMO in the District. HMOs submit financial reports to the IA quarterly, that are reviewed and approved by the IA. The Commission is notified of all concerns, deficiencies, and approvals of the Medicaid plans.
2. **Exception review by IA as requested by the Commission** - The HMOs are required to submit financial information on their Medicaid operations to the Commission quarterly. If concerns are raised during the Commission's review about the plan's financial stability, the Commission notifies the IA and the IA investigates the concerns.

V. Evaluation of the HMO's effectiveness as a business partner

GOAL: To demonstrate skills as an effective contractor and business partner,

Activities:

1. **Develop and maintain an assessment tool** - To evaluate each plan on their overall

performance as a contractor, an assessment tool will be developed. The assessment tool will detail a series of issues that relate to the contractor's operations in terms of the efficiency, responsiveness, and professionalism demonstrated during the term of the contract. Areas to be evaluated are: responsiveness to the Commission's requests for information, attendance at meetings, professionalism in dealing with the Commission and other District agency staff, cooperation, compliance with deadlines, and relationship and cooperation with community agencies. Similar tools and evaluations have been utilized in other state's Medicaid programs with positive results on their usefulness.

2. Administer survey of District agencies and contractors - Using the tool described above, the Office of Managed Care staff will survey Commission and other District agencies. After careful review of the results of the survey, an report of the findings will be issued to each HMO and other interested parties. The HMO is requested to respond to the findings. The survey findings will be used as part of the Commission's overall evaluation of HMO performance.

Commission On Health Care Finance
Medicaid Managed Care Program
Performance Indicators for HMOs

Assessment of HMO's Capacity to Provide Services:

1.a.	Number of PCPs and Dentists	Quarterly
1.b.	Number of PCPs and Dentists with fully open panels.	Quarterly
1.c.	Number of PCPs and Dentists with partially restricted panels.	Quarterly
1.d.	Number of PCPs and Dentists with closed panels.	Quarterly
1.e.	Number of members assigned to each PCP	Monthly
2.	Total HMO enrollment	Monthly
3.	Total number of providers, by specialty	Quarterly
4.	Number of members autoassigned to a PCP by the HMO	Monthly

Assessment of Access to and the Process of Care:

5.	Number of Adult encounters for preventive/ambulatory health	Quarterly	HCFA
6.	Number of Children encounters for preventive care	Quarterly	HCFA
7.	Number of referrals from PCPs to specialists, by type	Quarterly	HCFA
8.	Number and type of denials of service	Quarterly	HCFA
9.	Time between request for services and a denial decision.	Quarterly	HCFA
10.	Time between enrollment and first PCP encounter.	Quarterly	HCFA
11.	Time between birth and first ambulatory PCP encounter.	Quarterly	HCFA
12.	Number of members receiving EPSDT services.	Quarterly	Salazar
13.	Number of women who receive first prenatal visit in first trimester.	Annually	HEDIS
14.	Length of time between enrollment and first prenatal visit	Quarterly	HEDIS
15.	Percent of members who received postpartum visit by 42 nd day.	Quarterly	HEDIS
16.	Number of births and average length of stay.	Monthly	HEDIS
17.	Cesarean section rate, Days and average length of stay.	Quarterly	

18.	Number and percent of low birth weight babies.	Annually	HEDIS
19.	Number of eye exams for people with diabetes.	Annually	HEDIS
20.	Number and percent of lead assessments for 12 month and 2 year olds.	Annually	
21.	<i>Undefined.</i>		
22.	Hospitalizations for asthma care.	Quarterly	HCFA
23.	Number and percent of childhood immunizations.	Annually	HEDIS
24.	Percent of immunizations for 13 year olds.	Annually	HEDIS
25.	Number of inpatient days and average length of stay.	Quarterly	HCFA
26.	Number of denied inpatient days.	Quarterly	HCFA
27.	Number of ER approvals.	Quarterly	HCFA

Assessment of HMO's Financial Status

28.	Medicaid only income statement line items.	Quarterly
29.	Total cash payouts for medical expenses.	Quarterly
30.	Plan wide income statement line items.	Quarterly
31.	Annual audited financial statements.	Annual

32.	Number and rate of members who change PCPs.	Quarterly
33.	Number of member complaints, by type.	Quarterly
34.	Number of grievances and appeals filed.	Quarterly
35.	Number of expedited grievances and appeals requested.	Quarterly
36.	Average length of time to process grievances and appeals.	Quarterly
37.	Member services telephone abandonment rate.	Quarterly
38.	Member services telephone average speed of answer.	Quarterly
39.	Changes made to plan policies and procedures.	Quarterly

I. ASSESSMENT OF MCO'S CAPACITY TO PROVIDE SERVICES

Measure: Number of Primary Care Physicians and Dentists

A. Reporting frequency: Quarterly (i.e. will be requested monthly during first six month of program) Instructions: Use HEDIS 3.0 specifications (p. 75 for PCPs and p. 95 for Dentists) to report data for elements 1.a. through 1.d. Follow HEDIS instructions except for the designated reporting period (e.g., reporting year is converted to reporting quarter for the CHCF).

- 1.a. Total number of network Primary Care Physicians (PCPs):
 Are OB/GYNs included in this number? _____ **Yes**
 If yes, record the number of OB/GYNs serving as PCPs: _____
 Total number of network Dentists: _____
- 1.b. Number of PCPs from 1.a. with no restrictions on the number of new plan members accepted (completely open panels): _____
 Number of Dentists from 1.a. with no restrictions on the number of new plan members accepted (completely open panels): _____
- 1.c. Number of PCPs from 1.a. with some restrictions on number of new plan members accepted: _____
 Number of Dentists from 1.a. with some restrictions on number of new plan members accepted: _____
- 1.d. Number of PCPs from 1.a. with no new plan members accepted (completely closed panels): _____
 Number of Dentists from 1.a. with no new plan members accepted (completely closed panels): _____
- 1.e. Attach a list of contracted PCPs. For each PCP, list the total number of D.C. Medicaid members enrolled in the panel of each PCP. Also, indicate if each PCP's panel is open, open with some restrictions or closed. **List Attached?**
Yes No

Measure: Total HMO Enrollment

A. Reporting frequency: Monthly
 B. Instructions: For the reporting month, list the total number of plan enrollees for all lines of business for the contracted corporation. Also list the total Medicaid enrollment in all service areas for the contracted corporation.

- 2.a. Total HMO enrollment (all lines of business): _____
- 2.b. Total Medicaid enrollment in all service areas: _____

Measure: Total Number of Providers, By Specialty

- A. Reporting frequency: Quarterly
- B. Instructions: For the reporting quarter, list the number of contracted/employed providers, by type and board specialty certification. Physicians who are board eligible are acceptable for this measure. Do not include the hospital-based specialists of Radiology, Anesthesiology, Pathology and Emergency Medicine physicians. Because mental health services are "carved out" of the Medicaid contract, they should not be included in this report.

If providers are listed both under a primary care and specialty area, assign them to the area that constitutes the majority of their practice (using claims/encounter data or a comparable method, to determine the dominate area of practice).

Note: Board certification refers to the various specialty certification programs of the American Board of Medical Specialties and the American Osteopathic Association.

- 3.a. Total number of contracted/employed providers: _____
- 3.b. Total number of Medical Doctors and Doctors of Osteopathy: _____
- 3.c. Total number of General Practitioners (non-board certified physicians): _____
- 3.d. Total number of board certified physicians: _____

(List the number of board certified physicians in the appropriate categories below. The total number of physicians listed in the categories below should equal the number in 3.d. above.)

- Allergy and Immunology: _____
- Dentistry: _____
- Dermatology: _____
- Family Practice: _____
- General Internal Medicine (without subspecialty): _____

Physical Medicine:

Preventive Medicine:

Neurology:

General Surgery (without subspecialty):

Surgery Subspecialists(Total):

• **Cardiovascular:**

o **Colon & Rectal Surgery:**

• **General Surgery:**

• **Neurological Surgery:**

o **Ophthalmology:**

a **Oral & Maxofacial Surgery:**

• **Orthopedic Surgery:**

o **Otolaryngology:**

o **Plastic Surgery:**

• **Thoracic Surgery:**

• **Urology:**

a **Vascular Surgery:**

Other Physician Specialties (Total):

Specify Specialty:

3.e. Total number of advance practice practitioners (Total):
(e.g., Nurse Practitioners, Nurse Midwives, Physician Assistants, etc.
Exclude mental health practitioners):

Specify categories below (The total number of advance practitioners listed
in the categories below should equal the number in 3.e. above):

3.f. Nurse Practitioners:

3.g. Nurse Midwives:

3.h. Physician Assistants:

3.i. Other Advance Practitioners, Total (exclude mental health practitioners):
Specify categories:

Report the total number of "in network" facilities:

3.j. Hospitals

3.k. Pharmacies

3.l. Laboratories (non-hospital affiliated)

3.m. Radiology Centers (non-hospital affiliated)

3.n. Clinics

Reminder: Report to CHCF all terminations and additions of PCPs,
hospitals, clinics, pharmacies, laboratories or radiology services:

Measure: Number of Members "Autoassigned" to a PCP by the MCO

- A. Reporting frequency: Monthly
- B. Instructions: Report the total number of Medicaid members who were newly enrolled in the plan in the reporting month who did not choose a PCP and were therefore, automatically assigned to a plan PCP. Include newborns in this number. Exclude re-enrollees to the plan who had previously lost eligibility for Medicaid, and thus disenrolled from the plan, at any time in the past.

4.a. Total number of newly enrolled Medicaid enrollees in the reporting month (as defined in the instructions): _____

4.b. Number of Medicaid enrollees in 4.a who voluntarily selected the MCO: _____

4.c. Number of members in 4.b. who selected a PCP: _____

4.d. Number in 4.b. who were autoassigned to a PCP: _____

4.e. Number of Medicaid members in 4.a who were autoassigned to the MCO: _____

4.f. Number in 4.e. who selected a PCP: _____

4.g. Number in 4.e. who were autoassigned to a PCP: _____

II. ASSESSMENT OF ACCESS TO AND THE PROCESS OF CARE

Measure: Adults' Access to Preventive/Ambulatory Health Services

- A. Reporting frequency: Quarterly
- B. Instructions; Record the number of encounters Medicaid members received for the eight services listed below. Refer to the instructions contained in HEDIS 3.0, page 69 for the technical specifications for measure calculation for 5.a. through 5.f. Limit calculations to only the age categories listed below (age ranges 20 through 44 and 45 through 65 years).

For 5.g., 5.h., and 5.i. use the following CPT-4 codes to obtain the data requested for the two age groups:

5.g. Occupational Therapy: 97770.

5.h. Speech Therapy: 92506.92507.92508.

5.i. Physical Therapy: 97110,97112,97113,97114,97115,97116,97117,97118,97119,97120,97121,97122,97123,97124,97125,97126,97127,97128,97129,97130,97131,97132,97133,97134,97135,97136,97137,97138,97139,97140,97141,97142,97143,97144,97145,97146,97147,97148,97149,97150,97151,97152,97153,97154,97155,97156,97157,97158,97159,97160,97161,97162,97163,97164,97165,97166,97167,97168,97169,97170,97171,97172,97173,97174,97175,97176,97177,97178,97179,97180,97181,97182,97183,97184,97185,97186,97187,97188,97189,97190,97191,97192,97193,97194,97195,97196,97197,97198,97199,97200,97201,97202,97203,97204,97205,97206,97207,97208,97209,97210,97211,97212,97213,97214,97215,97216,97217,97218,97219,97220,97221,97222,97223,97224,97225,97226,97227,97228,97229,97230,97231,97232,97233,97234,97235,97236,97237,97238,97239,97240,97241,97242,97243,97244,97245,97246,97247,97248,97249,97250,97251,97252,97253,97254,97255,97256,97257,97258,97259,97260,97261,97262,97263,97264,97265,97266,97267,97268,97269,97270,97271,97272,97273,97274,97275,97276,97277,97278,97279,97280,97281,97282,97283,97284,97285,97286,97287,97288,97289,97290,97291,97292,97293,97294,97295,97296,97297,97298,97299,97300,97301,97302,97303,97304,97305,97306,97307,97308,97309,97310,97311,97312,97313,97314,97315,97316,97317,97318,97319,97320,97321,97322,97323,97324,97325,97326,97327,97328,97329,97330,97331,97332,97333,97334,97335,97336,97337,97338,97339,97340,97341,97342,97343,97344,97345,97346,97347,97348,97349,97350,97351,97352,97353,97354,97355,97356,97357,97358,97359,97360,97361,97362,97363,97364,97365,97366,97367,97368,97369,97370,97371,97372,97373,97374,97375,97376,97377,97378,97379,97380,97381,97382,97383,97384,97385,97386,97387,97388,97389,97390,97391,97392,97393,97394,97395,97396,97397,97398,97399,97400,97401,97402,97403,97404,97405,97406,97407,97408,97409,97410,97411,97412,97413,97414,97415,97416,97417,97418,97419,97420,97421,97422,97423,97424,97425,97426,97427,97428,97429,97430,97431,97432,97433,97434,97435,97436,97437,97438,97439,97440,97441,97442,97443,97444,97445,97446,97447,97448,97449,97450,97451,97452,97453,97454,97455,97456,97457,97458,97459,97460,97461,97462,97463,97464,97465,97466,97467,97468,97469,97470,97471,97472,97473,97474,97475,97476,97477,97478,97479,97480,97481,97482,97483,97484,97485,97486,97487,97488,97489,97490,97491,97492,97493,97494,97495,97496,97497,97498,97499,97500,97501,97502,97503,97504,97505,97506,97507,97508,97509,97510,97511,97512,97513,97514,97515,97516,97517,97518,97519,97520,97521,97522,97523,97524,97525,97526,97527,97528,97529,97530,97531,97532,97533,97534,97535,97536,97537,97538,97539,97540,97541,97542,97543,97544,97545,97546,97547,97548,97549,97550,97551,97552,97553,97554,97555,97556,97557,97558,97559,97560,97561,97562,97563,97564,97565,97566,97567,97568,97569,97570,97571,97572,97573,97574,97575,97576,97577,97578,97579,97580,97581,97582,97583,97584,97585,97586,97587,97588,97589,97590,97591,97592,97593,97594,97595,97596,97597,97598,97599,97600,97601,97602,97603,97604,97605,97606,97607,97608,97609,97610,97611,97612,97613,97614,97615,97616,97617,97618,97619,97620,97621,97622,97623,97624,97625,97626,97627,97628,97629,97630,97631,97632,97633,97634,97635,97636,97637,97638,97639,97640,97641,97642,97643,97644,97645,97646,97647,97648,97649,97650,97651,97652,97653,97654,97655,97656,97657,97658,97659,97660,97661,97662,97663,97664,97665,97666,97667,97668,97669,97670,97671,97672,97673,97674,97675,97676,97677,97678,97679,97680,97681,97682,97683,97684,97685,97686,97687,97688,97689,97690,97691,97692,97693,97694,97695,97696,97697,97698,97699,97700,97701,97702,97703,97704,97705,97706,97707,97708,97709,97710,97711,97712,97713,97714,97715,97716,97717,97718,97719,97720,97721,97722,97723,97724,97725,97726,97727,97728,97729,97730,97731,97732,97733,97734,97735,97736,97737,97738,97739,97740,97741,97742,97743,97744,97745,97746,97747,97748,97749,97750,97751,97752,97753,97754,97755,97756,97757,97758,97759,97760,97761,97762,97763,97764,97765,97766,97767,97768,97769,97770,97771,97772,97773,97774,97775,97776,97777,97778,97779,97780,97781,97782,97783,97784,97785,97786,97787,97788,97789,97790,97791,97792,97793,97794,97795,97796,97797,97798,97799,97800,97801,97802,97803,97804,97805,97806,97807,97808,97809,97810,97811,97812,97813,97814,97815,97816,97817,97818,97819,97820,97821,97822,97823,97824,97825,97826,97827,97828,97829,97830,97831,97832,97833,97834,97835,97836,97837,97838,97839,97840,97841,97842,97843,97844,97845,97846,97847,97848,97849,97850,97851,97852,97853,97854,97855,97856,97857,97858,97859,97860,97861,97862,97863,97864,97865,97866,97867,97868,97869,97870,97871,97872,97873,97874,97875,97876,97877,97878,97879,97880,97881,97882,97883,97884,97885,97886,97887,97888,97889,97890,97891,97892,97893,97894,97895,97896,97897,97898,97899,97900,97901,97902,97903,97904,97905,97906,97907,97908,97909,97910,97911,97912,97913,97914,97915,97916,97917,97918,97919,97920,97921,97922,97923,97924,97925,97926,97927,97928,97929,97930,97931,97932,97933,97934,97935,97936,97937,97938,97939,97940,97941,97942,97943,97944,97945,97946,97947,97948,97949,97950,97951,97952,97953,97954,97955,97956,97957,97958,97959,97960,97961,97962,97963,97964,97965,97966,97967,97968,97969,97970,97971,97972,97973,97974,97975,97976,97977,97978,97979,97980,97981,97982,97983,97984,97985,97986,97987,97988,97989,97990,97991,97992,97993,97994,97995,97996,97997,97998,97999,98000,98001,98002,98003,98004,98005,98006,98007,98008,98009,98010,98011,98012,98013,98014,98015,98016,98017,98018,98019,98020,98021,98022,98023,98024,98025,98026,98027,98028,98029,98030,98031,98032,98033,98034,98035,98036,98037,98038,98039,98040,98041,98042,98043,98044,98045,98046,98047,98048,98049,98050,98051,98052,98053,98054,98055,98056,98057,98058,98059,98060,98061,98062,98063,98064,98065,98066,98067,98068,98069,98070,98071,98072,98073,98074,98075,98076,98077,98078,98079,98080,98081,98082,98083,98084,98085,98086,98087,98088,98089,98090,98091,98092,98093,98094,98095,98096,98097,98098,98099,98100,98101,98102,98103,98104,98105,98106,98107,98108,98109,98110,98111,98112,98113,98114,98115,98116,98117,98118,98119,98120,98121,98122,98123,98124,98125,98126,98127,98128,98129,98130,98131,98132,98133,98134,98135,98136,98137,98138,98139,98140,98141,98142,98143,98144,98145,98146,98147,98148,98149,98150,98151,98152,98153,98154,98155,98156,98157,98158,98159,98160,98161,98162,98163,98164,98165,98166,98167,98168,98169,98170,98171,98172,98173,98174,98175,98176,98177,98178,98179,98180,98181,98182,98183,98184,98185,98186,98187,98188,98189,98190,98191,98192,98193,98194,98195,98196,98197,98198,98199,98200,98201,98202,98203,98204,98205,98206,98207,98208,98209,98210,98211,98212,98213,98214,98215,98216,98217,98218,98219,98220,98221,98222,98223,98224,98225,98226,98227,98228,98229,98230,98231,98232,98233,98234,98235,98236,98237,98238,98239,98240,98241,98242,98243,98244,98245,98246,98247,98248,98249,98250,98251,98252,98253,98254,98255,98256,98257,98258,98259,98260,98261,98262,98263,98264,98265,98266,98267,98268,98269,98270,98271,98272,98273,98274,98275,98276,98277,98278,98279,98280,98281,98282,98283,98284,98285,98286,98287,98288,98289,98290,98291,98292,98293,98294,98295,98296,98297,98298,98299,98300,98301,98302,98303,98304,98305,98306,98307,98308,98309,98310,98311,98312,98313,98314,98315,98316,98317,98318,98319,98320,98321,98322,98323,98324,98325,98326,98327,98328,98329,98330,98331,98332,98333,98334,98335,98336,98337,98338,98339,98340,98341,98342,98343,98344,98345,98346,98347,98348,98349,98350,98351,98352,98353,98354,98355,98356,98357,98358,98359,98360,98361,98362,98363,98364,98365,98366,98367,98368,98369,98370,98371,98372,98373,98374,98375,98376,98377,98378,98379,98380,98381,98382,98383,98384,98385,98386,98387,98388,98389,98390,98391,98392,98393,98394,98395,98396,98397,98398,98399,98400,98401,98402,98403,98404,98405,98406,98407,98408,98409,98410,98411,98412,98413,98414,98415,98416,98417,98418,98419,98420,98421,98422,98423,98424,98425,98426,98427,98428,98429,98430,98431,98432,98433,98434,98435,98436,98437,98438,98439,98440,98441,98442,98443,98444,98445,98446,98447,98448,98449,98450,98451,98452,98453,98454,98455,98456,98457,98458,98459,98460,98461,98462,98463,98464,98465,98466,98467,98468,98469,98470,98471,98472,98473,98474,98475,98476,98477,98478,98479,98480,98481,98482,98483,98484,98485,98486,98487,98488,98489,98490,98491,98492,98493,98494,98495,98496,98497,98498,98499,98500,98501,98502,98503,98504,98505,98506,98507,98508,98509,98510,98511,98512,98513,98514,98515,98516,98517,98518,98519,98520,98521,98522,98523,98524,98525,98526,98527,98528,98529,98530,98531,98532,98533,98534,98535,98536,98537,98538,98539,98540,98541,98542,98543,98544,98545,98546,98547,98548,98549,98550,98551,98552,98553,98554,98555,98556,98557,98558,98559,98560,98561,98562,98563,98564,98565,98566,98567,98568,98569,98570,98571,98572,98573,98574,98575,98576,98577,98578,98579,98580,98581,98582,98583,98584,98585,98586,98587,98588,98589,98590,98591,98592,98593,98594,98595,98596,98597,98598,98599,98600,98601,98602,98603,98604,98605,98606,98607,98608,98609,98610,98611,98612,98613,98614,98615,98616,98617,98618,98619,98620,98621,98622,98623,98624,98625,98626,98627,98628,98629,98630,98631,98632,98633,98634,98635,98636,98637,98638,98639,98640,98641,98642,98643,98644,98645,98646,98647,98648,98649,98650,98651,98652,98653,98654,98655,98656,98657,98658,98659,98660,98661,98662,98663,98664,98665,98666,98667,98668,98669,98670,98671,98672,98673,98674,98675,98676,98677,98678,98679,98680,98681,98682,98683,98684,98685,98686,98687,98688,98689,98690,98691,98692,98693,98694,98695,98696,98697,98698,98699,98700,98701,98702,98703,98704,98705,98706,98707,98708,98709,98710,98711,98712,98713,98714,98715,98716,98717,98718,98719,98720,98721,98722,98723,98724,98725,98726,98727,98728,98729,98730,98731,98732,98733,98734,98735,98736,98737,98738,98739,98740,98741,98742,98743,98744,98745,98746,98747,98748,98749,98750,98751,98752,98753,98754,98755,98756,98757,98758,98759,98760,98761,98762,98763,98764,98765,98766,98767,98768,98769,98770,98771,98772,98773,98774,98775,98776,98777,98778,98779,98780,98781,98782,98783,98784,98785,98786,98787,98788,98789,98790,98791,98792,98793,98794,98795,98796,98797,98798,98799,98800,98801,98802,98803,98804,98805,98806,98807,98808,98809,98810,98811,98812,98813,98814,98815,98816,98817,98818,98819,98820,98821,98822,98823,98824,98825,98826,98827,98828,98829,98830,98831,98832,98833,98834,98835,98836,98837,98838,98839,98840,98841,98842,98843,98844,98845,98846,98847,98848,98849,98850,98851,98852,98853,98854,98855,98856,98857,98858,98859,98860,98861,98862,98863,98864,98865,98866,98867,98868,98869,98870,98871,98872,98873,98874,98875,98876,98877,98878,98879,98880,98881,98882,98883,98884,98885,98886,98887,98888,98889,98890,98891,98892,98893,98894,98895,98896,98897,98898,98899,98900,98901,98902,98903,98904,98905,98906,98907,98908,98909,98910,98911,98912,98913,98914,98915,98916,98917,98918,98919,98920,98921,98922,98923,98924,98925,98926,98927,98928,98929,98930,98931,98932,98933,98934,98935,98936,98937,98938,98939,98940,98941,98942,98943,98944,98945,98946,98947,98948,98949,98950,98951,98952,98953,98954,98955,98956,98957,98958,98959,98960,98961,98962,98963,98964,98965,98966,98967,98968,98969,98970,98971,98972,98973,98974,98975,98976,98977,98978,98979,98980,98981,98982,98983,98984,98985,98986,98987,98988,98989,98990,98991,98992,98993,98994,98995,98996,98997,98998,98999,99000,99001,99002,99003,99004,99005,99006,9900

- 5.b. Home Services: _____
- 5.d. Preventive Medicine: _____
- 5.e. Other Evaluation and Management Services: _____
- 5.f. Ophthalmology and Optometry: _____
- 5.g. Occupational Therapy: _____
- 5.h. Speech Therapy: _____
- 5.i. Physical Therapy: _____

;

Measure: Children's Access to Primary Care Providers

- A. Reporting Frequency: Quarterly
- B. Instructions: Record the number of encounters Medicaid members received for the two services listed below. Refer to the instructions contained in HEDIS 3.0, page 72 for the technical specifications for measure calculation. Limit calculations to only the categories listed below for age ranges 12 through 24 months and 25 months through 6 years.

12-24 25 months -
months 6 years

- 6.a. Evaluation and Management: _____
- 6.b. Preventive Medicine: _____

Measure: Number of Referrals to Specialists, by Type of Specialty

- A. Reporting Frequency: Quarterly
- B. Instructions: Categorize and record all referrals (not encounters) made in the reporting quarter from PCPs to medical and surgical specialists. Referrals include care in either the inpatient or outpatient setting. Report referrals for two age groups: newborn through 20 years and 21 through 64 years.

	<u>Age <1-20</u>	<u>Age 21-64</u>
7a Total number of specialist referrals:		
 <i>Number of referrals by specialty:</i>		
	<u>Age 4-20</u>	<u>Age 21-64</u>
7b Allergy and Immunology:		
7c Dermatology:		
7d Internal Medicine: (Cardiovascular Disease, Endocrinology and Metabolism, Gastroenterology, Hematology, Infectious Disease, Medical Oncology, Nephrology, Pulmonary Disease, Rheumatology, Nuclear Medicine)		
7e Pediatrics: (Neonatal-Perinatal Medicine, Pediatric Cardiology, Pediatric Endocrinology, Pediatric Hematology-Oncology, Pediatric Intensivists, Pediatric Nephrology)		
7f Physical Medicine (physician visits only):		
7g Neurology:		
7h Surgery: (Cardiovascular, Colon & Rectal Surgery, General Surgery, Neurological Surgery, Ophthalmology, Oral & Maxofacial Surgery, Orthopedic Surgery, Otolaryngology, Plastic Surgery, Thoracic Surgery, Urology, Vascular Surgery)		
7i Obstetrics/Gynecology:		
7j Other: Total		
Specify:		

Number of referrals by specialty:

Age <1-20

Age 21-64

Measure: Number and Type of Denials of Service

A. Reporting Frequency: **Quarterly**

B. Instructions: Record the **total number** and type of Medicaid denials rendered by the **plan for medical necessity and benefits**, in the reporting quarter. Include prior authorization, concurrent review and **retrospective review** denials in these **numbers**. Exclude **administrative denials**.

- 8.a. **Total** number of denials for medical necessity and benefits in the reporting quarter: _____
- 8.b. **From** the total included in 8.a., number of outpatient procedures that were denied: _____
- 8.c. **From** the total included in 8.a., number of inpatient denials: _____
- 8.d. **From** the total included in 8.a., number of specialist referrals that were denied _____
- 8.e. **From** the total included in 8.a., number of Occupational Therapy sessions denied: _____
- 8.f. **From** the total included in 8.a., number of Speech Therapy sessions denied: _____
- 8.g. **From** the total included in 8.a., number of Physical Therapy sessions denied: _____
- 8.h. **From** the total included in 8.a., number of home health visits denied: _____

Measure: Denial Time Frames

A. Reporting Frequency: **Quarterly**

B. Instructions: For the reporting quarter, **average the number** of business days from request for services to decision. Include only the requests for services from question 8. above. Report **average** time in business days for prior authorization, concurrent review and retrospective review decisions.

- 9.a. Average length of time between request and decision for prior authorization services: _____ days
- 9.b. Average length of time for inpatient concurrent review decisions: _____ days
- 9.c. Average length of time for retrospective review decisions: _____ days

Measure: time Between Enrollment and First PCP Encounter

A. Reporting Frequency: Quarterly

B. Instructions: For the year-to-date, record the average length of time between a Medicaid member's enrollment and first PCP encounter. * Categorize each member's experience into the time periods listed below. Record the number of members in each category, percent of the total for each category and the cumulative percent for the year-to-date.

*Plans may eliminate from the denominator members who meet the following criteria:

- age 12-24 months who received a PCP visit in the six months prior to enrollment, or
- age 3 years and older who received a PCP visit within the year prior to enrollment.

To establish receipt of a PCP visit within these timeframes, plans must verify the information directly from the PCP provider or the member. In the event a plan chooses to eliminate enrollees from its denominator, they are required to provide the data requested in 10.b. through 10.e. If enrollees are not eliminated from the denominator, items 10.b. through 10.e. do not apply.

10.a. Total number of year-to-date enrollees: _____

Fill in this box only if the denominator (10.a.) will be adjusted

10.b. Total number of enrollees eliminated from the denominator in 10.a.: _____

10.c. • Number of enrollees eliminated who were age 12-24 months and received a PCP visit in the six months prior to enrollment: _____

10.d. • Number of enrollees eliminated who were age three years and older who received a PCP visit one year prior to enrollment: _____

10.e. Revised denominator. with the total in 10.b. eliminated: _____

For reporting items 10.f through 10.o., use 10.a. as the denominator, if no members are eliminated from the denominator. If members are eliminated from the denominator consistent with the instructions above, use 10.e. as the denominator.

Below, categorize the members in the denominators by time from enrollment to first PCP encounter. Total the numbers in the categories listed below.

	Number	Percent	Cumulative Percent
10.f. Four weeks after enrollment:	_____	_____	_____

10.g.	Eight weeks after enrollment:	_____	_____
10.h.	12 weeks after enrollment:	_____	_____
10.i.	16 weeks after enrollment:	_____	_____
10.j.	20 weeks after enrollment:	_____	_____
10.k.	24 weeks after enrollment:	_____	_____
10.l.	36 weeks after enrollment:	_____	_____
10.m.	52 weeks after enrollment:	_____	_____
10.n.	Greater than 53 weeks after enrollment:	_____	_____
<hr/>			
10.o.	Average time between enrollment and first PCP encounter for all enrollees in the denominator:	_____	

Measure: Number of Members Receiving Selected EPSDT Screening Services

- A. Reporting Frequency: **Quarterly**
- B. Instructions: Report the number of unduplicated Medicaid members age newborn through age 20 who were enrolled in the reporting quarter. For further information on items 12a through 12g., refer to the State Medicaid Manual, the chapter entitled State Organization and General Administration, Section 2700.4.

	Total	Age Group			
		<1	2-5	6-14	15-20
11.a. Number of enrolled individuals eligible for EPSDT services in the reporting quarter (e.g., total Medicaid membership in the age ranges defined):					
11.b. Number of eligibles in 11.a. who received at least one screening service in the reporting quarter:					
11.c. Number of screens received by eligibles in 11.a. in the reporting quarter:					
11.d. Number of eligibles in 11.a. referred for corrective treatment:					
11.e. Number of eligibles in receiving a vision assessment:					
11.f. Number of eligibles in 11.a. who received a dental assessment:					

11.g. Number of eligibles in 11.a. who received a hearing assessment:					
11.h. Of the number of enrollees in 11.a., report the number due for an EPSDT service in the reporting quarter:					
11.i. Number of eligibles in 11.h. who received all scheduled EPSDT services:					
11.j. Number of enrollees in 11.a. who were fully up-to-date with all EPSDT services at the end of the reporting quarter:					

Prenatal, Perinatal and Newborns

Measure: Prenatal Care Visit in the First Trimester of Pregnancy

- A. Reporting Frequency: Annually
- B. Instructions: To determine the number and percentage of pregnant Medicaid members who received a prenatal care visit in the first trimester of pregnancy, use the measurement specifications contained in HEDIS 3.0, page 34. Also, specify the method chosen for production of the data (administrative approach or hybrid approach).

	<u>Number</u>	<u>Percent</u>
12.a. Pregnant members who received a prenatal care visit in the first trimester of pregnancy:	_____	_____
12.b. Method of data production (administrative or hybrid):		Admin. or Hybrid

Measure: First Prenatal Care Visit Within Six Weeks of Enrollment

- A. Reporting Frequency: Quarterly
- B. Instructions: For all pregnant Medicaid members who enrolled in the reporting quarter, determine the length of time that lapsed between enrollment and first prenatal care visit. For definitions of prenatal care visit, coding and member exclusions, see the HEDIS 3.0, page 84: Initiation of Prenatal Care. (Note that the HEDIS specification requires annual reporting. The CHCF altered this

measure only in the area of reporting frequency, where quarterly reporting is required.)

	<u>Number</u>	<u>Percent</u>
13. Pregnant members enrolled in the reporting quarter who received a prenatal care visit within six weeks of enrollment:		

Measure: Check-Ups After Delivery

A. Reporting Frequency: Quarterly

B. Instructions: To determine the percent of Medicaid members who delivered a live birth and received a postpartum visit within 42 days of delivery, see the HEDIS 3.0 specifications, page 44. Calculate this measure on a cumulative basis, including all year-to-date (YTD) Medicaid deliveries (for Year 1, include all deliveries from October 1997).

	<u>YTD Number</u>	<u>YTD Percent</u>
14.a. Medicaid women who delivered a live birth during the reporting year who had a postpartum visit by the 42 nd day after delivery:		
13.b. Method of data production (administrative or hybrid):		Admin. or Hybrid

Measure: Number of Live Births and Average Length of Stay for All, Well and Complex Newborns

A. Reporting frequency: Monthly

B. Instructions: Include only Medicaid newborn. Follow the instructions contained in the HEDIS 3.0 Births and Average Length of Stay measure (p. 181). Report the following data from HEDIS 3.0 Template Table 51-1.

15.a. Number of newborns, all newborns	
15.b. Number of newborns, well newborns	
15.c. Number of newborns, complex newborns	
<hr/>	
15.d. Newborns/1000 female member months (age 10-49), all newborns	
15.e. Newborns/1000 female member months (age 10-49), well newborns	

15.f. Newborns/1000 female member months (age 10-49), complex newborns _____

15.g. Average length of stay, all newborns _____

15.h. Average length of stay, well newborns _____

15.i. Average length of stay, complex newborns _____

Measure: Cesarean Section Rate and Vaginal Birth After Cesarean Section Rate

A. Reporting Frequency: Quarterly

B. Instructions: Follow the instructions contained in the HEDIS 3.0 Cesarean Section (C/S) Rate and Vaginal Birth After Cesarean Section (VBAC) Rate measure (p. 178). Report the all the data listed in HEDIS 3.0 Table 5H.

Age	Discharges: C/S Deliveries (i.) 16.a.	Days 16.b.	ALOS 16.c.	Discharges: Total Deliveries (ii.) 16.d.	C/S Rate (i./ii.) 16.e.	Discharges: VBAC Deliveries (iii.) 16.f.	Days 16.g.	ALOS 16.h.	Discharges: Total Deliveries with prior C/S (iv.) 16.i.	VBAC Rate (iii./iv.) 16.j.
10-14										
15-19										
20-34										
35-49										
Other*										
Total										

* "Other" includes females age 0-9 and 50+ and of unknown age.

Measure: Low Birth Weight Babies

- A. Reporting Frequency: **Annually**
- B. Instructions: Follow the instructions contained in the HEDIS 3.0 Low Birth Weight Babies measure, page 40. Report numbers and rates for Medicaid enrollees only.

	<u>Number</u>	<u>Percent</u>
17.a. Infants whose birth weight was less than 1,500 grams:	_____	_____
17.b. infants whose birth weight was less than 2,500 grams:	_____	_____

Diabetes Care

Measure: Eye Exams for People with Diabetes

- A. Reporting Frequency: **Annually**
- B. Instructions: Follow the instructions contained in the HEDIS 3.0 Eye Exams for People with Diabetes measure, page 56. Report two numbers below: the number of Diabetic members identified and 2) percent screened with an eye exam for retinal disease.

	<u>Number of Medicaid Diabetics</u>	<u>Percent With Eye Exam</u>
18. Eye exams for people with diabetes:	_____	_____

Lead Scretning

Measure: Lead Screening

- A. Reporting Frequency: **Annually**
- B. instructions: Blood lead assessment is recommended at age 12 months and at age two. Assessment of blood lead at other ages is subject to member risk status and medical history. Therefore, two separate measures for compliance with blood lead screening are required: blood lead screening at age 12 months and at age two.

A blood lead screen/assessment consists of a blood test for quantitative lead. Plans may obtain the data using one of two methods:

- 1) **Administrative data systems method.** Plans may identify the presence of a blood lead screen for individuals in the denominator population from laboratory data available in computer systems. If this method is used, assessment of the presence of a blood lead test for the entire denominator is required. *The CPT-4 code for the blood lead quantitative screen procedure is 83655.*
- 2) **Hybrid method.** For denominator individuals who do not show a blood lead screen in administrative data within the study time frame, a medical record review may be performed to determine the presence or absence of the blood test. Page 8 of HEDIS 3.0 instructions exist for the production of rates based in the hybrid methodology.

C. Calculations

19.a. *Percent of eligible 12-month olds who received a blood lead screen by age 15 months.*

- Denominator: Medicaid enrollees who reached age one in the reporting year.
- Numerator: Number of individuals in denominator with record of at least one quantitative blood lead screen by, and including, the individual's 15th month of life.

19.b. *Percent of eligible two year olds who received a blood lead screen by age 25 months.*

- Denominator: Medicaid enrollees who reached age two in the reporting year.
- Numerator: Number of individuals in denominator with record of at least one quantitative blood lead screen between the individual's 15th and 27th month of life.

	<u>Numerator</u>	<u>Denominator</u>	<u>Percent</u>
19.a. Number and percent of eligible 12-month olds who received a blood lead screen by age 15 months.			%
19.b. Method of data production (administrative or hybrid) for 19.a.:			Admin. or Hybrid
19.c. Number and percent of eligible two-year-olds that received a blood lead screen between the 16 th and 27 th months of life.			%
19.d. Method of data production (administrative or hybrid) for 19.c.:			Admin. or Hybrid

Measure: Hospitalizations for Asthma

- A. Reporting Frequency: Monthly
- B. Instructions: From hospital admission records, determine the number of Medicaid members age 2 through 19 years who were admitted with a diagnosis of asthma

Denominator: The number of Medicaid members aged 2 through 19 years at the end of the reporting month.

Numerator: From the denominator, identify the number of inpatient admissions with a diagnosis of asthma (ICD-9 code 493.xx) during the reporting month.

	<u>Number of Members Age 2-19</u>	<u>Number of Asthma Admissions</u>	<u>Rate of Asthma Admissions</u>
20. Hospitalization for asthma:			

Childhood Immunizations

Measure: Childhood immunizations

- A. Reporting Frequency: Annually
- B. Instructions: Follow the instructions from HEDIS 3.0, page 19. Report the following data for the Medicaid population only.

- 21.a. Number of eligible children surveyed (denominator): _____
- 21.b. Percent of denominator who received at least four DTP or DTaP: _____
- 21.c. Percent of denominator who received at least three polio vaccines: _____
- 21.d. Percent of denominator who received at least one MMR _____
- 21.e. Percent of denominator who received at least one H influenza type b: _____
- 21.f. Percent of denominator who received at least two hepatitis vaccines: _____
- 21.g. Percent of denominator who received all of the vaccines listed above: _____

Measure: Adolescent Immunization Status

- A. Reporting Frequency: Annually
- B. Instructions: Follow the instructions from HEDIS 3.0, page 23. Report the following data for the Medicaid population only.

22. Percent of 13-year-olds who received a second dose of MMR by age 13: _____

Hospital Care

Measure: Hospital Discharges/1000

- A. Reporting Frequency: Quarterly
- B. Instructions: Follow the instructions from HEDIS 3.0, page 155. Report the data from HEIDS Table 5D-1 for the Medicaid population only..

Abbreviations: Member Months = MM;
Average Length of Stay = ALOS.

3 a. Total Inpatient Discharges and Days

MM	Discharges	Discharges/ 1000 MM	Days	Days/1000 MM	ALOS
<1					
1-9					
10-19					
20-44					
45-64					
65-74					
75-84					
85+					
unknown					
Total					

Total Member Months: _____

23b. Medicine Discharges and Days

MM	Discharges	Discharges/ 1000 MM	Days	Days/1000 MM	ALOS
<1					
1-9					
10-19					
20-44					
45-64					
65-74					
75-84					
85+					
Unknown					
Total					

23.c. Surgery Discharges and Days

MM	Discharges	Discharges/ 1000 MM	Days	Days/1000 MM	ALOS
<1					
1-9					
10-19					
20-44					
45-64					
65-74					
75-84					
85+					
Unknown					
Total					

23. d. Maternity Discharges and Days

MM	Discharges	Discharges/ 1000 MM	Days	Days/1000 MM	ALOS
<1					
1-9					
10-19					
20-44					
43-64					
65-74					
75-84					
85+					
Unknown					
Total					

Measure: Number of Denied inpatient Days/1000 Member Months

- A. Reponing Frequency: Quarterly
- B. Instructions: Report the number and rate/1000 member months of Medicaid inpatient days that were denied during either concurrent review or retrospective review, in the reporting quarter. Report the number for children (newborn through 20 years of age (<21 years)) and adults (21 through 64 years of age (>21 - 64 years)).

	<u>Number</u>	<u>Number/ 1000 MM</u>
24.a. Number and rate of denied inpatient days, age <21 years:		
21.b. Number and rate of denied inpatient days, age >=21 years:		

Emergency Room Approvals and Denials

- A. Reporting Frequency: Quarterly
- B. Instructions: Report the number of Medicaid emergency room approvals and denials for the reporting quarter. If a triage fee was paid the hospital ER, the encounter is not considered either an approval or a denial of an ER service.

	<u>Number</u>
25.a. Number and rate of ER approvals:	
25.b. Number and rate of denied ER visits:	

III. ASSESSMENT OF MCO FINANCIAL STATUS

Please see the definition attachment to this reporting template for more explicit definitions of the terms used below.

Measure: Financial Data, Plan-Wide and D.C. Medicaid Members

- A. Reporting Frequency: Quarterly
- B. Instructions: For items 26.a. through 26.g. report the requested information for the entire plan (Plan-Wide Statistics) and for District of Columbia Medicaid members only (D.C. Medicaid).

	<u>plan-Wide Statistics</u>	<u>D.C. Medicaid Only</u>
26.a. Total revenues:	\$	\$
26.b. Medical expenses:	\$	\$
26.c. Administrative expenses:	\$	\$
26.d. Total expenses ((26.b.)+(26.c.)):	\$	\$
26.e. Administrative expense ratio ((26.c.)/(26.a.)):		
26.f. Net excess (deficit) of revenues over expenses:	\$	\$
26.g. Margin ((26.f.)/26.a.):		

Measure: Financial Data, D.C. Medicaid Only

A. Reporting Frequency: Quarterly

B. Instructions: For items 27.a. through 27.c. report the requested information for District of Columbia Medicaid members only.

		<u>D.C. Medicaid Only</u>
27.a.	Total cash payouts for medical expenses:	\$ _____
		Number <u>Amount</u>
27.b.	Number and amount of received and unpaid claims for medical expenses at end of quarter:	\$ _____
27.c.	Amount of incurred but not reported claims for medical expenses at end of quarter:	\$ _____

Measure: Financial Data, Plan-Wide Only

A. Reporting Frequency: Quarterly

B. Instructions: For items 28.a. through 28.e. report the requested information for the entire plan.

		<u>plan-Wide Statistics</u>
28.a.	Net worth:	\$ _____
28.b.	Total Medicare enrollees:	_____
28.c.	Total Medicaid enrollees:	_____
28.d.	Total District of Columbia Medicaid Managed Care Program enrollees:	_____
28.e.	Total other enrollees:	_____

Measure: Financial Statement

- A. Reporting Frequency: **Annually**
- B. Instructions: **Attach to this data reporting** tool the MCO's **annual financial statement** Report to be **submitted** within **90 days** of close of MCOs **fiscal year**.

29. Attached quarterly audited financial statement?: **Yes**

ASSESSMENT OF MEMBER SATISFACTION WITH MCO SERVICES

Measure: Number and Rate of Members Who Changed PCPs

- A. Reporting Frequency: **Quarterly**
- B. Instructions: Report the number of Medicaid **members who** changed PCPs in the reporting quarter. Also report the rate **per 1000 member months (MM)**.

	<u>Number</u>	<u>Rate/1000</u> <u>MM</u>
30. Number and rate/1000 member months of Medicaid members who changed PCPs		

Measure: Number of Member Complaints Received by the MCO, by Type

- A. Reporting Frequency: **Quarterly**
- B. Instructions: The definition of a complaint is an expression of dissatisfaction by a Medicaid recipient or recipient's representative, Complaints **must be** accepted by **MCOs** in either oral or written form.

Record the total number of calls (inquiries and complaints) received from or on behalf of Medicaid members. identify and record the number of complaints in the reporting quarter. and categorize and record them by type.

31.a. Total number of inquiries and complaints received from or on behalf of Medicaid members in the reporting quarter:	
• Total number of verbal complaints received from or on behalf of members in the reporting quarter:	
• Total number of written complaints received from or on behalf of members in the reporting quarter:	

From the complaints reported in 31.a. record the type of complaints received below.

Type of Complaints

Number

Complaints Regarding Telephone Access

31.b.	Provider—telephone always busy/unable to reach by phone:	_____
31.c.	Provider—wait time on phone excessive:	_____
31.d.	Provider—no or excessive wait for a return call:	_____
31.e.	Provider—other telephone access or service issue:	_____
31.f.	Dental Provider—telephone access:	_____
31.g.	Transportation—telephone always busy/unable to reach by phone:	_____
31.h.	Transportation—wait time on phone excessive:	_____
31.i.	Transportation—no or excessive wait for a return call:	_____
31.j.	Transportation—other telephone access or service issue:	_____
31.k.	Plan—telephone always busy/unable to reach by phone:	_____
31.l.	Plan—Wait time on phone excessive:	_____
31.m.	Plan—no or excessive wait for a return call:	_____
31.n.	Plan—other telephone access or service issue:	_____

Complaints Regarding Access to Care

31.o.	Provider—unable to get appointment with primary care provider:	_____
31.p.	Provider—unable to get appointment with specialty provider:	_____
31.q.	Provider—excessive wait to get an appointment with primary care provider:	_____
31.r.	Provider—excessive wait to get an appointment with specialty provider: Dental Provider—access issues.	_____
31.s.	Plan—denial of care.	_____
31.t.	Plan—assignment to PCP.	_____
31.u.	Transportation—scheduling problems:	_____
31.v.	Transportation—excessive wait time once scheduled:	_____
31.w.	Transportation—no pick-up:	_____
31.x.	Transportation—other issue:	_____

Complaints Regarding the Quality of Care and Service

31.y.	Provider—rude:	_____
31.z.	Provider—office staff was rude:	_____
31.aa.	Provider—dissatisfaction with treatment:	_____
31.bb.	Dental Provider—quality of care or service issues.	_____

31.cc.	Transportation— rude :	_____
31.dd.	Lab— dissatisfaction with service/treatment:	_____
31.ee.	Pharmacy— dissatisfaction with service/treatment:	_____
31. ff.	Hospital— dissatisfaction with service/treatment:	_____
31.gg.	Other Total:	_____
	Specify type:	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

Measure: Number of Grievances and Appeals Filed

- A. Reporting Frequency: Quarterly
- B. Instructions: For the purposes of this report, a grievance is the first request for reconsideration of a prior plan decision (in some organizations, these may be referred to as a first level appeal). An "appeal" is the second request for reconsideration of a prior plan decision (in some organizations, these may be referred to as second level appeals).

Record the total number of grievances and appeals filed in the reporting quarter.

32.a. Number of grievances (or first level appeals) filed in the reporting quarter: _____

32.b. Number of appeals (or second level appeals) filed in the reporting quarter: _____

Measure: Number of Expedited Grievances and Appeals Requested

- A. Reporting Frequency: Quarterly
- B. Instructions: An expedited grievance or appeal is any request for reconsideration of a plan decision with a process that is more expedient than the routine grievance and appeal process timeframe. Record below the total number of expedited grievances filed in the reporting quarter.

33. Number of expedited grievances and appeals filed in the reporting quarter: _____

Measure: Average Length of Time Required to Process Expedited Grievances or Appeals

- A. Reporting Frequency: Quarterly
B. Instructions: Average the length of time for processing expedited grievances filed in the reporting quarter. Record the average length of time in business days.

34. Average length of time required to process expedited grievances and appeals, in days: _____ **days**

Measure: Health Plan Member Services Telephone Abandonment Rate

- A. Reporting Frequency: Quarterly
B. Instructions: Report the percentage of total calls received by the plan's Member Services Department that were abandoned at any time during the call. Report the average abandonment rate for the quarter.

35. Member Services Department average telephone abandonment rate: _____

Measure: Health Plan Member Services Telephone Average Speed of Answer

- A. Reporting Frequency: Quarterly
B. Instructions: Report the average speed of answer of calls incoming to the plan Member Services Department.

36. Member Services Department average speed of call answer: _____

Measure: Changes Made to Plan Policies and Procedures

- A. Reporting Frequency: Quarterly
B. Instructions: Report and attach any changes to existing plan policies and procedures related to the following areas:
• Utilization review activities
• Provider procedure manuals
• Quality assurance program
• Access standards, and
• Claims payment.

37. Changes made to any of the areas listed above in the last quarter?: **Yes No**
If yes, please attach relevant documents.

**DEFINITIONS FOR USE WITH THE
COMMISSION ON HEALTH CARE FINANCE REPORTING TEMPLATE FOR
MCO PERFORMANCE MEASURES**

Administrative expenses—includes all costs associated with the overall management and operation of the plan, including compensation, interest expense, occupancy, depreciation and amortization directly associated with administrative services, marketing and aggregate write-ins for other administrative expenses.

Medical expenses—all expenses for the medical assistance items and services which are covered in this contract, included in the District's premium paid to Provider, and for which Provider has financial responsibility under this contract including physician and professional service costs, hospital inpatient and outpatient costs, supply costs, costs associated with outside referrals, emergency department and out-of-area care, costs associated with physician financial incentive deposits and withdrawal adjustments, reinsurance expenses net of recoveries, occupancy, depreciation and amortization directly associated with the delivery of medical assistance services. Such term includes costs that are reduced by copayments, revenues received from third party liability collection and subrogation.

Total revenues—premiums from public and private sources, investment earned during the period and aggregate income from other sources.

Provider—managed care organization participating in the District's managed care program for AFDC and AFDC-related persons authorized under D.C. Code section 1-359(d).

Net excess or deficit of revenues over expenses—total revenues minus total expenses plus or minus extraordinary items and provision for federal income taxes.

Net worth—total net worth at the start of the year plus the increases or decreases in capital, retained earnings, reserves and restricted funds, and unassigned surplus.

Complain!—an expression of dissatisfaction by a recipient or the recipient's representative, either oral or written.

Grievance—A written or verbal request for reconsideration of a prior health plan decision by an enrollee or an enrollee's personal representative. For the purposes of this report, a grievance is the first request for reconsideration of a prior plan decision (in some organizations, these may be referred to as a first level appeal).

Appeal—a formal request for reconsideration of the final grievance decision rendered by a health plan. For the purposes of this report, an "appeal" is the second request for

reconsideration of a prior plan decision (in some organizations, these may be referred to as second level appeals).

Members—*individuals* for whom the managed care organization has a contractual obligation to provide, or arrange for the provision of, health services.

Providers—*individuals* licensed, certified, or authorized by law to render professional health services directly to members. For example, physicians, physicians' assistants, nurse practitioners, chiropractors, and dentists are included in the term.

APPENDIX H

1

D.C. Seeks to Expand Health Care for Needy Children

By Avram Goldstein
Washington Post Staff Writer

In the first stage of what they hope will be a dramatic expansion of the beleaguered D.C. Medicaid program, District officials are putting the finishing touches on a plan to extend health insurance coverage to 8,300 children of the working poor.

The plan will cost \$15 million, will be financed largely by new federal money available for children's health programs and could be the precursor to a much bigger plan being developed by city officials: bringing an additional 30,000 uninsured adults under the Medicaid umbrella.

"This is a program that was ignored for 30 years," said D.C. health care finance commissioner Paul Offner. "We have a coherent plan to move this program into the 21st century, and it's working."

To some critics, the concept of adding about 40,000 adults and children to the 130,000 people already on the D.C. Medicaid rolls seems dubious, given the city's fiscal condition and years of management inefficiency within the federally supported health insurance program for the District's poor and disabled.

Last year, a federal judge presiding over a class-action lawsuit lambasted D.C. Medicaid administrators for failing to follow their own rules, processing applications too slowly, kicking people out of the program without notice and denying preventive care to children who are entitled to it. The human impact has been severe, the judge said.

Meanwhile, a long-planned shift of 4,000 current Medicaid recipients into health maintenance organizations has been held up for months by a separate court battle over how to contracts were awarded leaving thousands of Medicaid enrollees confused about who their doctors are



JOHN W. HILL JR.

... a potential "win-win situation"

A lawyer who sued the city in the class-action case says she supports the administration's idea of mending health coverage to as many uninsured residents as possible, but she worries that it could overburden the system.

"I understand they are trying to make managerial improvements, but we aren't there yet," said Kathleen Millian, who represents Medicaid recipients.

But Offner, who was hired to clean up the troubled agency two years ago, said he is making progress in banishing inefficiencies. For example, he said, his administration had begun steering severely disabled residents away from Medicaid group homes that are the most expensive in the nation. Savings from such managerial changes will fund expanded coverage, he said, noting also that Medicaid inflation already has slowed considerably.

From 1990 to 1996, D.C. Medicaid expenditures were growing at a staggering rate, from 54 percent to

21.6 percent a year. This year's \$843 million D.C. Medicaid budget grew by only 0.2 percent from last year, a time when national health cost inflation surpassed 6 percent, Offner said.

"I can understand people being skeptical, but all I can say is we have one of the most expensive Medicaid programs in the country," he said.

Money for the new children's plan is to come mostly from a five-year, \$24 billion pot Congress created last summer to cover 5 million children nationwide. The D.C. children's initiative would cost a relatively modest \$12 million in federal funds plus a \$3 million city match each year, Offner said.

The new program is expected to be approved this evening by the public-private D.C. Health Policy Council and must then go to the D.C. financial control board.

Some states already have launched children's plans, and officials in the rest are working on proposals to submit to the U.S. Health Care Financing Administration. Maryland and Virginia officials are still deciding how to structure their programs to take advantage of the money.

The children in Washington would join a Medicaid program that already covers 68,000 children. Because income eligibility limits decline as they age, younger children in some families are on Medicaid while their older brothers and sisters are disqualified. Expansion would end that, officials say.

Under the District plan, eligibility for Medicaid would include any resident younger than 19 whose household income is less than 200 percent of poverty levels—a much more generous limit than is now in effect. For a family of four, children would be covered up to a maximum household income of about \$32,000.

The biggest problem for the children's program will be persuading

parents to sign up their newly eligible youngsters, Offner said. "A lot of people don't like walking into a welfare office," he said.

The D.C. Health Care Financing Commission wants to put registration sites in other settings throughout the District to overcome the problem, but that entails additional computer networking costs, he said.

Some health officials see the children's plan as an important test: The District must demonstrate that it has the systems in place to take on 8,300 more children before it can attempt to absorb an influx of adults, the health officials say.

D.C. officials also must get federal officials to waive rules before they can extend coverage to more adults.

Offner offered few details about funding for the adult plan, but he did offer a prediction: "We won't have to ask for more local tax money. We can finance this, in my opinion, mostly through efficiencies and transfers within the budget."

So far, the control board has supported Offner, said control board executive director John W. Hill Jr.

"Clearly, to the extent that all those numbers work out and you are able to increase services without reducing costs, that's the kind of win-win situation everyone is looking for," Hill said.

Activists said they were delighted with the children's plan. "It's terrific," said Claudia Schlosberg, of the National Health Law Program's D.C. office. "Early treatment is critically important in terms of the ability of these children to develop and thrive and do well in school, and ultimately it saves the city a lot of money."

Offner said the \$15 million price tag for the children's initiative was impossible to pass up.

"One of the most interesting realizations for me and everyone else is how cheap it is," Offner said.

APPENDIX I

Transforming The District's Health Care System
HEALTH POLICY COUNCIL and RELATED ACTIVITIES
- A Public/Private Partnership -
(December 1997)

1. **Mayor's Health Policy Council**
 - Chair, Bailus Walker, Jr., PhD, MPH (Private Sector)
 - Vice Chair, Jearline Williams, (DC Government Senior Official)
 - Council (100 members; 8 of 10 from the private sector)
 - Assists the City in Developing Health Policy Options
 - Options Consistent with Improving Health Care Delivery System
 - Goal is to Improve the Health Status of District Residents
 - Council meet.. 2nd Tuesday of Every Month from 6:30 PM - 8:30 PM
 - Council has 10 major current Committees (plus 1 retired and 2 pending)
 - Committees have private sector Chair and public sector So-Chair
 - Ten Committa Chairs bring Recommendations before Council for Debate
 - Approved Recommendations Move to Management Reform Team(s)

2. **Mayor's Health Policy (Council) office.**
 - Location: 441 4th Street, NW, Suite 1000, Washington, DC 20001
 - Telephone: 202-727-9239/9243; Fax: 202-727-0165.
 - Provides Advice to the Mayor and Executive Branch
 - Focal Point for Health Transformation Initiatives
 - Facilitates Technical Assistance from the Federal Government
 - Provides Administrative/Technical Support to Health Policy Council
 - Coordinates weekly, monthly, quarterly District and Federal meetings

3. **Level of DC Cooperation: Direct Access; Supportive; involved.**
 - Mayor
 - City Administrator's Office
 - Chief of Staff
 - Various City Council Members
 - The DC Financial Authority (Control Board)
 - Chief Financial Officer
 - Corporation Counsel
 - Boards and Commissions Director
 - Office of Communications Director
 - Office of Insurance and Securities Regulation
 - Office of Intergovernmental Relations Director
 - Office of Policy and Evaluation Director
 - Department of Health Director
 - Department of Human Services Director
 - Correctional Health Care Director
 - Emergency Medical Services Director
 - Public Benefit Corporation CEO

4. **Level of DC Government Support.**
 - **Mayoral Order Establishing Health Policy Office**
 - **Mayoral Order Establishing Health Policy Council**
 - **Funding and District Staff Support from Health the Department**
 - **Federal Assistance from DHHS under the "DC/DHHS Initiative"**
 - **Five Offices, Open Areas, Meeting and Conference Rooms**
 - **Telephones and Fax Machines (including long-distance access)**
 - **Equipment and Supplies**

5. **Health Policy Council and Health Policy Office Focus:**
 - a. **Creation of a Health Department that combines the state agency functions of public health and health care finance (and also in the very near future some environmental and regulatory functions): *Announced January 13, 1997***

 - b. **Implement Medicaid managed care to reduce cost/improve quality: *(progress)*.**

 - e. **Transformation of mental health (and substance abuse) services, resulting in improved accessibility and more community-based services: *Pilots were proposed and under consideration by Receiver***

 - d. **Establishment of a Public Benefits Corporation to serve as the health delivery arm for primary, acute, and long-term care: *Board established December 96. PBC to be operational within 180 days of Board establishment (completed)***

 - e. **Institution/coordination of a management information system to monitor health care delivery. *Recommendations developed.***

 - f. **Development of a Primary Care Network which integrates public and private sector primary care clinics: *(Progressing)*.**

 - g. **Creating purchasing arrangements to leverage the city's purchasing power ADAP purchases (November 96). *PSC/District Agreement for selected contracts and grants (February 97). Anticipating eventual use of Federal Prime Vendor or FSS for all pharmaceuticals and medical supplies.***

 - h. **Improvement of Correctional Health Services: *Selected privatization. Actions to consolidate court orders. Health Policy Council recommendations.***

 - i. **Improvement of Emergency Medical Services: *Training, improved communication, and piloting of rapid response vehicles.***

 - j. **Development of educational materials to better inform and encourage consumer participation in their own health care *Immediate plans for collaborative partnerships between District, Federal, and private sector***

6. **Mayor's Health Policy Council Committees.**
 - Correctional Health
 - Department of Health
 - Emergency Medical Services
 - Environmental Health (*Proposed and Under Consideration*)
 - Long Term Care
 - Management Information System
 - Medicaid Managed Care
 - Mental Health Managed Care
 - Primary Care Network Development
 - Public Benefits Corporation (*Work Completed, Retired Committee 1-14-97*)
 - Public Information Education
 - Substance Abuse Prevention and Recovery (*Pending*)
 - Value Purchasing

7. **District of Columbia Health Transformation Team.**
 - Chaired by Dr. Bailus Walker
 - Materials and Background Work by Health Policy (Council) office staff
 - Meets Every Tuesday from 8:00 AM to 9:00 AM
 - Purpose: to identify issues, resolve problems, and facilitate change
 - Participants are Public Sector Members:
 - * Asst. Director for Health Services, Corrections Department
 - * Commissioner of Health Care Finance, Department of Health
 - * Commissioner, Insurance and Securities Regulation
 - * Commission on Mental Health Services (*active history*)
 - * Director, Department of Health
 - * Director, Department of Human Services
 - * Director, Mayor's Health Policy Office
 - * Executive Director, DC General Hospital
 - * Medical Director, Office of Emergency Medical Services
 - * Staff of Mayor's Health Policy Office

8. **Other Areas of Active Involvement:**
 - Providing Advice, Recommendations, Testimony to Elected Officials
 - Facilitating Collaboration between DC, Federal Govt, and Private Sector
 - Assisting with Follow-up on Selected DC/Federal Agreements

APPENDIX J

CHILDREN'S HEALTH INITIATIVE FOR THE DISTRICT OF COLUMBIA

RECOMMENDATIONS OF THE MEDICAID MANAGED CARE AND ELIGIBILITY COMMITTEE TO THE MAYOR'S HEALTH POLICY COUNCIL

December 9, 1997

Introduction

The Balanced Budget Act of 1997 creates a new program—the State Children's Health Insurance Program (CHIP). The purpose of the new program is "to provide funds to states to enable them to initiate and expand the provision of child health assistance to uninsured low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children."

The District of Columbia is eligible to receive approximately \$12 million annually in CHIP funds. The District must provide approximately \$3 million annually in appropriated funds as a match for the federal dollars. Under the program, the federal medical assistance percentage (FMAP) is 79 percent. Thus, the federal government will provide 79 cents of every dollar spent on providing allowable services and outreach activities to CHIP children.

In order for the District to receive its F/Y 1998 federal allotment, it must submit a plan to the federal government by the end of June 1998. To receive federal approval the District must submit a plan that describes how the program will be structured and implemented, any limitations on children covered by the program, and how the District will monitor certain quality standards.

The Managed Care and Eligibility Committee

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in September 1997, the Mayor's Health Policy Council, under the leadership of Dr. Bailus Walker, commissioned the Medicaid Managed Care and Eligibility Committee to spearhead planning for the District's CHIP program. The Committee divided into three work groups in order to address specific issues related to the development of the District's CHIP plan. They are: (a) The Structure and Administration Work Group; (b) The Coverage and Benefits Work Group; and (c) The Outreach and Education Work Group. The Committee, and its three component work groups have assessed various policy options and have reached consensus on several key aspects of the CHIP plan. This report summarizes the issues on which the work groups have reached consensus and offers recommendations to the Mayor's Health Policy Council.

Eligible Children in the District

Only targeted low-income children are eligible for coverage under the CHIP program. A targeted low-income child is one: (a) who is under age 19; (b) whose annual family income is less than 200 percent of poverty for a family of its size; (c) who does not have other insurance; and (d) who has been determined eligible for child health assistance under the CHIP plan.

A child is not a targeted low-income child and is thus ineligible for the CHIP program if: (a) the child is an inmate of a public institution or a patient in an institution for mental diseases; (b) the child is a member of a family that is eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State; or (c) the child is covered under a group health plan. Newly arriving legal immigrant children (e.g. those arriving in the U.S. on or after August 22, 1997) who have been in the country for less than 5 years and undocumented immigrant children are not eligible for the CHIP program.

Note: If States, and the District, expand Medicaid to provide coverage to targeted low-income children, the child may be a member of a family that is eligible for a State health benefits plan and be eligible for the CHIP program. This is not the case if a separate program option is elected.

The District currently provides Medicaid to low-income children as follows: pregnant women and children up to age 1 year with incomes up to 185 percent of the federal poverty level (FPL); children aged 1-5 years with incomes up to 133 percent of the FPL; children aged 6-14 with incomes up to 100 percent of the FPL; and children aged 15-19 with incomes up to 50 percent of the FPL. In 1997, 200 percent of the FPL for a family of three is \$26,660.

The Lewin Group, under contract with the Medicaid Agency, has conducted extensive research on the number of uninsured children in the District of Columbia. Based upon Lewin's analysis, the following numbers have emerged:

- There are approximately 112,557 children under the age of 19 in the District of Columbia;
- Approximately 67,734 (60.2 percent) of the 112,557 children are currently enrolled in Medicaid;
- Approximately 30,074 (26.7 percent) have insurance coverage from some other source, such as employer-sponsored coverage;
- Approximately 14,749 (13.1 percent) are uninsured;
- Approximately 3,404 of uninsured children are in households with incomes at or above 200 percent of poverty; and,
- Based upon a 76 percent enrollment rate for uninsured eligible children and a 20 percent enrollment rate for children transferring from other insurance programs, approximately 8,282 children will enroll in the new CHIP program during its first full year.

Committee Recommendations

PROGRAM STRUCTURE

States and the District may spend CHIP funds to: (1) expand Medicaid coverage to targeted low-income children; (2) support a separate state child health insurance program to cover targeted low-income children; or, (3) combine both approaches. The Committee recommends that the District begin the CHIP program with a Medicaid expansion. The Committee further recommends that the CHIP Program be incorporated into the managed care service delivery structure.

Selecting a Medicaid expansion initially does not preclude the District from developing a separate program should the Medicaid option prove inadequate to meet the needs of CHIP children. The Committee recognized and extensively debated two concerns about choosing the Medicaid expansion option: (1) current problems with the

...may prevent effective enrollment of CHIP children; and, (2) ensuring support for the participation of traditional community providers in the new system. Both of these concerns are addressed in the "Outstanding Issues" section below. Despite these concerns, the following advantages of an initial Medicaid expansion were persuasive:

- **A Medicaid expansion will enable families to obtain a single source of health insurance coverage for their children.** It is possible to have one child in a family unit who is eligible for Medicaid under current eligibility rules and another child in that same family who is not eligible for Medicaid (under current rules) but is eligible for the CHIP program. A Medicaid expansion allows a family such as the one described to obtain a single source of coverage for all children in the family. This approach is less confusing for families and ensures that families have access to a single set of providers.
- **A Medicaid expansion maximizes the District's ability to offer continuity of care to vulnerable children.** Many low-income families have income fluctuations over relatively short periods of time. Establishing a separate program for CHIP eligible children creates the potential for children being moved between a new CHIP program and Medicaid when family income changes. Under a Medicaid expansion, continuous and seamless coverage of children is simplified and readily assured.
- **The Medicaid benefit package is relatively generous compared with benefits offered through private sector plans.** Two features of the Medicaid benefit package for children make it superior to most private plans. The first is EPSDT, which covers comprehensive, ongoing preventive and well-child care and all treatments that are medically necessary as a follow-up to that care. Second, the Medicaid package provides comprehensive long-term care services to children who need them. Neither EPSDT nor long-term care services are part of a typical private insurance package.
- **A Medicaid expansion builds upon an existing infrastructure.** Medicaid has well developed structures, processes, and existing rules for activities such as claims payment, provider certification, provider relations, and program operation. Thus costly and time-consuming start-up and infrastructure development activities will be eliminated if the District elects to expand Medicaid.
- **Children covered under a Medicaid expansion remain eligible for Medicaid if the federal allotment of CHIP funds is depleted.** Because Medicaid is an entitlement to the individual, federal funds will continue to be available at the District's regular 70 percent FMAP should the District use its full allotment of CHIP funds (with a FMAP of 79). As long as a child meets the financial criteria for Medicaid eligibility (whether regular Medicaid or CHIP) the child would be entitled to receive Medicaid-reimbursed services. Under a separate insurance program, the District would have the option to stop enrolling eligible children and establish waiting lists once its allotment of federal funds is depleted.

COVERAGE

If the District elects to provide health insurance coverage to CHIP children by expanding Medicaid, the City is required to cover all children who meet the income and asset criteria. If the District decides to develop a separate program, it may restrict CHIP enrollment based upon geography, age, income and resources, residency, disability status (could set higher level), and access to other health insurance. Pre-existing condition limitations are prohibited under both the Medicaid and separate program option.

In general, States and the District are allowed to cover eligible children in families with incomes up to 200 percent of the FPL (\$26,660 for a family of three). The annual cost of Medicaid coverage per eligible child ranges from between \$1400 and \$1800. Estimates are that approximately 8282 eligible children will enroll in the new program. The Committee recommends that the CHIP program cover all eligible children with no limitations

... program participation. Based upon current budget projections, the Committee believes that there are enough available funds (both Federal and District) to cover all eligible children.

THE 12-MONTH CONTINUOUS ELIGIBILITY OPTION

States that cover CHIP children through a Medicaid expansion may grant 12 months of continuous Medicaid eligibility to children up to age 19. If the District elects the 12-month continuous eligibility option, extended eligibility must be available to children in the regular Medicaid program as well as children eligible for Medicaid through the CHIP program. The District would receive its regular 70 percent FMAP for providing 12 months of continuous coverage to children in the regular Medicaid program and an enhanced 75 percent FMAP for providing such coverage to Medicaid-eligible children enrolled as CHIP children. In order to foster continuity of care for all Medicaid-eligible children (regular Medicaid and CHIP) the Committee recommends that the District elect the 12-month continuous eligibility option.

BENEFITS

If the District elects to provide coverage to targeted low-income children by expanding Medicaid, the full range of approved Medicaid State plan benefits, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) that are available to categorically needy Medicaid recipients must be available to the CHIP children. EPSDT is a mandatory Medicaid benefit that provides periodic and regular health screening to eligible children and any medically necessary treatments that result from the screening.

Although the District would be required to meet federally defined minimum coverage standards under a separate CHIP program, the District would have considerable flexibility, within broad federal guidelines, to define the benefit package if it elects to develop a separate program. For example, the District would not be required to provide the EPSDT benefit to CHIP children under a separate program option although it could elect to do so. Federal law requires the benefits package under a separate program option to meet one of four standards: benchmark coverage; coverage that is actuarially equivalent to benchmark coverage, state-based program coverage, or other coverage subject to HHS approval.

The Committee recognizes that by initially expanding Medicaid, the full array of Medicaid State plan services are available to CHIP children. Behavioral health services should continue to be "carved out" of the managed care delivery system and reimbursed on a fee-for-service basis. Should the District opt to develop a separate CHIP Program at a later date, the Committee recommends that the program be structured to offer a benefits package equal to that offered by Medicaid.

USE OF ADMINISTRATIVE FUNDS

Although the primary intent of the CHIP law is to obtain health coverage for low-income children who would not otherwise have insurance, states and the District are permitted to spend up to 10 percent of their expended funds on one or more of the following activities: (1) outreach; (2) direct purchase or provision of health services for targeted low-income children; (3) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income and other low-income children); and (4) administration of the CHIP program.

States may obtain a waiver of the 10 percent limit for cost effective alternatives if: (a) the additional expenditure provides targeted low-income children with coverage of benefits consistent with the requirements of the program; and (b) the average per child cost is not greater than the cost of coverage that would otherwise be provided through a community-based health delivery system. Such systems might include contracts with community clinics or with disproportionate share hospitals as long as they can be demonstrated to be cost effective.

The Committee recommends using a significant portion of the administrative funds to support public and private community-based providers that are effectively engaged in the following activities: (a) outreach;

COST SHARING

States and the District may impose cost sharing on CHIP children within specified limitations, both under a Medicaid expansion and under a separate CHIP program. The amount of a state's expenditures, which serves as the basis for calculating the amount of the state's federal payment, is reduced by the amount of any premiums or other cost sharing received by a state.

If the District uses the new funds to expand Medicaid, Medicaid law applies with respect to enrollment fees, premiums, deductions, cost sharing, and other charges. While the Medicaid statute permits limited cost sharing under certain circumstances, it contains strong beneficiary protections with respect to cost sharing. Currently, the District's Medicaid cost sharing requirements are limited to a \$1 co-payment for prescription drugs and a \$2 co-payment for eyeglasses. The committee supports cost-sharing rules for the CHIP program that are consistent with current Medicaid cost sharing rules.

OUTREACH AND EDUCATION

Several outreach strategies were discussed. They include: (a) out-stationing eligibility workers at Head Start Centers; targeted schools, grocery stores, churches, and other places around the community; (b) establishing evening hours for eligibility determinations; (c) coordinating with existing outreach efforts of MCH, WIC, UPO and other groups; (d) developing public service announcements for local radio and television distribution; (e) developing user-friendly, easily understandable, educational materials such as comic books, flyers and videos; and (f) developing culturally sensitive, language appropriate community education videos for city-wide distribution.

The Committee recommends an outreach and education strategy that is: (a) City-wide; (b) culturally sensitive; (c) language appropriate; and, (d) has a multi-media approach. It is recommended that a public relations expert be recruited to assist with the development of a multi-media campaign. It is further recommended that the City develop and identify private sources of funding for outreach activities. Finally, the Committee recommends that the City form partnerships with local universities to develop and implement a plan to evaluate outreach and education activities related to the CHIP program.

COMMUNITY FORUMS

In order for the new program to achieve its enrollment and program participation goals, it is imperative that the design of the CHIP program have widespread community support. The group recognizes that many immigrants may be reluctant to attend community forums because of fear of detection by immigration authorities. The Committee recommends that four City-wide Community Forums be held between December and the end of January in order to solicit community input in the development of a final CHIP plan. The Committee further recommends that special efforts be made to invite representatives from immigrant communities to participate in the community forums.

Outstanding Issues

STATUTORILY INELIGIBLE CHILDREN

Legal immigrant children who have not been in the U.S. for at least 5 years and undocumented immigrant children are not eligible to participate in the CHIP program. The Lewin Group estimates that there are approximately 4,000 undocumented immigrant children living in the District. The Committee underscores the importance of the role of traditional safety-net providers in providing limited amounts of care to this population. The Committee is committed to the continued viability of the District's safety-net.

TRADITIONAL COMMUNITY-BASED PROVIDERS

Several options for expanding the role of public and private traditional community-based providers were identified. They include: (a) out stationing eligibility workers in community-based service settings; (b) delegating eligibility determination functions to persons who work for community-based agencies; (c) using school-based nursing programs to identify and enroll eligible children; and (d) contracting with a private vendor to conduct eligibility. The Committee recommends that each of these options be explored for legality, feasibility, and affordability.

Traditional community-based providers, both public and private, have begun to develop productive relationships with managed care organizations. In some instances these providers do not have adequate resources to be competitive in the new managed care environment. The Committee underscores the importance of supporting the Public Benefits Corporation as well as other private and public traditional community-based providers in order to maintain an adequate safety net in the District. The Committee recommends that the District formulate a stronger role for traditional community-based providers within the managed care plans, both as contracted service providers and as access points for beneficiaries.

ELIGIBILITY DETERMINATION

Recently the Commission on Health Care Finance (CHCF) and the American Health Care Association (AHC) agreed to work collaboratively with the Maximus Company to provide the District with a viable plan for eligibility determination and enrollment of eligible children in the CHIP program. Maximus began work on this project in late October and will complete its work in six weeks. The Committee recommends that the District: final decisions related to eligibility determination after a complete analysis of Maximus's findings.

Specifically, Maximus will:

Identify and assess operational barriers to outreach, intake, and enrollment in the existing eligibility system;

Identify and assess possible approaches to carrying out intake and enrollment in the CHIP program within the current system vs. a new system;

Determine the best option for structuring outreach, intake and enrollment community-based organizations; and, for the CHIP program (including a complete assessment of the feasibility of out-stationing

eligibility at community-based organizations); and,

Develop a road-map for establishing an efficient intake and enrollment system, identifying the most appropriate option.

PRELIMINARY ELIGIBILITY DETERMINATION

Participating states to extend immediate, short-term eligibility—and thus Medicaid reimbursed care—to all Medicaid-eligible children. *Qualified entities* include: (a) Medicaid providers; and, (b) entities authorized to determine a child's eligibility for services under the Head Start Act, the Child Care and Development Block Grant, and the WIC program if these entities are determined by the state to be capable of making the necessary income determinations. The District may extend presumptive eligibility to children under age 19. The duration of the PE period is between 30 and 60 days.

...the District elects the option. The District would receive federal payments at the enhanced FMAP of 79 percent for services provided during the presumptive eligibility period to targeted low-income children (e.g. CHIP children). The District would receive federal payments at its regular 70 percent FMAP for services provided to all other Medicaid-eligible children during the PE period. Any amounts that are paid to the District for services provided to children during the PE period would be deducted from the City's allotment of CHIP funds. The federal government is considering whether states, and the District, will be able to limit PE to one period per child. It is not clear to what extent a limitation will be administratively feasible.

The Committee favors any option that allows children to receive health care sooner rather than later. The Committee recommends that full support of this option be reserved until it can be reviewed in conjunction with larger eligibility issues to be discussed in the report by Maxima.

ACCESS TO CARE

Despite the availability of health care provided to children through a new CHIP program, the Committee identified several barriers that often preclude meaningful access to health care. These barriers include: (a) problem with the Medicaid eligibility determination system; (b) insufficient and/or ineffective outreach and education efforts; and (c) language and cultural barriers. The Committee recommends that administrative funds available through the new CHIP program be directed towards overcoming these barriers.



GOVERNMENT OF THE DISTRICT OF COLUMBIA
HEALTH POLICY COUNCIL

MARION BARRY, JR.
MAYOR

BAILUS WALKER, JR., PhD
CHAIR

Memorandum

DATE: December 24, 1997

TO: The Honorable Marion Barry, Jr., Mayor
Andrew Brimmer, PhD, Chairman, Control Authority
The Honorable Linda Cropp, Chairman, Council of the District of Columbia
Joyce Ladner, PhD, Member, Control Authority
Allan Noonan, MD, MPH, Director, Department of Health

FROM: Bailus Walker, Jr., PhD, MPH
Chair, Health Policy Council

SUBJECT: Health Policy Council Recommendation to Expedite Process to Access Federal Funding to Cover Large Numbers of Uninsured Children in the District

On December 9, 1997, the Health Policy Council approved a recommendation for the Department of Health to proceed with all appropriate action to develop an application for the State Child Health Insurance Program (S-CHIP). The details of the recommendation, including background information, are attached for your review.

As you well know, the Health Policy Council is a public and private collaborative initiative that focuses on developing health policy options to address pressing issues. The Council has around one hundred members with ten specialized Committees. More than eighty percent of the members are volunteers from the private sector, and the Council counts among its members consumers, community advocates, service providers, religious leaders, youth and elderly, labor, academia, and policy makers.

This recommendation was developed by the Health Policy Council's Medicaid Managed Care and Eligibility Committee. It was not generated rapidly nor by a selective group, but was developed over a period of several months and during many committee meetings. The meetings were open to all Health Policy Council members and a good number of them chose to participate. Non-members from the public and private sectors also attended. The Medicaid Managed Care and Eligibility Committee now intends to move forward with public hearings by the end of January 1998.

We believe it extremely important for the Department of Health to move rapidly and aggressively in developing the necessary documents to take full advantage of the available funds for this children's health initiative. In fact, many States are in the process of developing their programs or have already submitted plans. We strongly urge you endorse the position taken by the Health Policy Council.



GOVERNMENT OF THE DISTRICT OF COLUMBIA
HEALTH POLICY COUNCIL

MARION BARRY, R.
MAYOR

BARBARA WALKER, R., PhD
CHAIR

**Health Policy Council Recommendation
for Consideration by
Department of Health Management Reform Team**

Committee: Medicaid Managed Care and Eligibility

Date: December 9, 1997

Issue: The District is eligible to receive 12 million dollars per year from the Federal government to develop a State Child Health Insurance Program ("S-CHIP") to provide health insurance coverage to uninsured children in families with income up to 200 percent of the federal poverty level. The District must provide approximately \$3 million annually in appropriated funds as a match for the federal dollars. Up to ten percent of the expended funds may be used for program administration, public education, and outreach activities. The Commission on Health Care Finance has funds in its approved F/Y 1998 budget to provide the city match for the federal dollars. There are over 8,000 children currently living in the District who would be eligible for and enroll in the new program.

In order to receive Federal funds for the program the District must have a plan approved by the Federal government that: (a) describes how the program will be structured (e.g. Medicaid vs. separate program); and (b) identifies the children who will be covered under the program. The District may also include a provision in the plan that allows the City to provide Medicaid coverage to all eligible children for a full year regardless of fluctuations in family income. By expanding Medicaid—at least initially—the District would be able to provide health care to low-income children without undue delay. Should the District elect to cover S-CHIP children by expanding Medicaid initially, the law permits the City to develop a separate program at some later point if the Medicaid expansion does not adequately meet the needs of the S-CHIP children.

Recommendation: Between now and the end of January, the Medicaid Managed Care and Eligibility Committee of the Mayor's Health Policy Council ("the Council") should conduct a series of public forums to present a S-CHIP plan, approved by the Council, that includes the following provisions: (a) Expand Medicaid eligibility up to 200 percent of the federal poverty level for all eligible uninsured children in the District; (b) provide coverage to all eligible children; (c) provide 12-months of continuous Medicaid eligibility to all eligible children in the District (regular Medicaid and S-CHIP); (d) limit cost sharing to current Medicaid rules; and, (e) use a significant portion of the allowable administrative funds to support the appropriate outreach, education, enrollment, and health services initiatives of public and private community-based providers. The Medicaid Managed Care and Eligibility Committee will continue activities related to: (a) oversight of the Medicaid expansion for S-CHIP children; and, (b) review of other options for program structure to ensure that all S-CHIP eligible children are receiving appropriate services.

(see page 2 for benefits)

Benefit(s): By taking this action the District will be able to develop broad-based community support for: (a) providing access to health care to over 8,000 uninsured children currently living in the District without undue delay; (b) giving City policymakers no more than six (6) months following implementation of the S-CHIP program to fully explore feasible alternatives to covering targeted low-income children through an alternative program structure if necessary; (c) developing and adequately funding an effective outreach and education strategy that builds upon the activities of public and private traditional community-based providers; (d) providing one full year of uninterrupted health insurance coverage to all Medicaid eligible children (regular Medicaid and S-CHIP children); and, (e) supporting continued oversight and evaluation of the S-CHIP program by the Medicaid Managed Care and Eligibility Committee.

On behalf of the Health Policy Council, a one hundred member public and private sector body, we transmit this recommendation to the Department of Health Management Reform Team and recommend your expedited approval so the Department of Health may initiate the process with the federal Government (i.e., Department of Health and Human Services, Health Care Financing Administration) to expand child health assistance to many additional uninsured, low-income children in the District of Columbia.

In order to receive funds, a State must submit and obtain approval of its State Child Health Plan from the Secretary of the Department of Health and Human Services. A State may submit an amendment to its Child Health Plan at any time. A State Child Health Plan or amendment is deemed approved unless the Secretary notifies the State in writing within 90 days after receiving the plan or amendment, that it is disapproved or that additional information is needed. Funds for this initiative became available October 1, 1997. Any amounts unused after 3 years will be redistributed to States that have fully spent their allotments.

As public hearings are scheduled to be carried out before the end of January and continued progress is needed to assure that the District can take full advantage of its allotment, we would sincerely appreciate your quick reaction to this recommendation.

Bailus Walker, Jr., PhD. MPH
Chair, Mayor's Health Policy Council

Dec 24, 1997
Date



CHILDREN'S HEALTH INITIATIVE FOR THE DISTRICT OF COLUMBIA

Comments of **Families USA** on the **Recommendations**
Of the Medicaid Managed Care and Eligibility Committee
To the Mayor's Health Policy Council
January 20, 1998

We endorse the recommendations of the Task Force regarding Medicaid expansion and urge the Mayor's Health Policy Council to adopt them. With over 65,000 children now in the District's Medicaid program, it makes sense to add the 8,000 children expected to enroll in CHIP to the existing system rather than creating a new bureaucracy.

Election of the 12-month eligibility option for all children in Medicaid similarly makes sense. It will facilitate continuity of care, free eligibility workers from interim determinations, and encourage employment. 12-month continuous eligibility is particularly useful in managed care settings by giving MCOs a financial incentive to provide cost-effective preventive services. The following comments address the outstanding issues identified by the Task Force.

Eligibility determination. There are many ways the District can redesign its Medicaid/CHIP application process to make the process easier and faster for both applicants and eligibility workers.

- Traditional community-based providers: Taking applications in settings other than the welfare office can be a very effective strategy for identifying children in working poor families who will be the primary beneficiaries of the CHIP program. The District should include such arrangements in its CHIP plan. The HCFA rules on "outstationing" permit the District to contract with non-state workers to engage in "initial processing" of applications, but the actual eligibility determination must be made by a state employee. There are several models from other states of community-based organizations assisting applicants in filling out application forms and gathering necessary verification without any formal contractual relationship with the state e.g. Philadelphia Citizens for Children and Youth. There are also models of states which have hired and trained workers specifically to work in the community to take

applications and promote the program e.g. Georgia's Right from the Start Medicaid Project. In addition, several states have successfully enlisted providers in outreach and eligibility efforts e.g. Greenville Memorial Hospital, Greenville, SC.

- **Application streamlining:** Two good ways of simplifying and speeding-up the eligibility process are to shorten the application form, eliminate unnecessary verification requirements, and allow mail-in applications without requiring a face to face interview. Several states have developed two-three page forms for their children's Medicaid program, e.g. South Carolina, Washington, Pennsylvania, and Vermont. Several states also rely largely on the applicant's self-declaration and do not require the applicant to provide third party verification. Georgia, for example, does not even require the applicant to provide income verification. The state does do a computer cross-match of quarterly earnings reported to its Labor Department and has found little evidence of applicant misrepresentation of income.
- **Outreach:** Up to ten percent of program expenditures can be used for outreach services. The District should enlist the help of the community in devising new outreach strategies geared to the diverse populations within the District, in addition to using the services of marketing professionals to design an advertising campaign to publicize the program.
- **Presumptive eligibility:** The District should adopt this option which enables earlier access to services for children. If presumptive eligibility is combined with a shorter, simpler application form, fewer verification requirements and mail-in applications, it can also improve the application and enrollment process.
- **Statutorily ineligible children.** Most immigrant children who entered the country after August 22, 1996 are ineligible for Medicaid or CHIP. These children form a natural coverage group for the KIDS CARE programs offered by Capital Community Health Plan and Kaiser Permanente. Such charitable undertaking cannot substitute for public programs, but they can serve an important function in filling some of the gaps in the public system. The District should encourage the continuation of these private initiatives for this purpose.

Prepared by Victoria Pulos

APPENDIX K

10/1/2018

10/1/2018

10/1/2018

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10/1/2018

10/1/2018

Transforming The District's Health Care System
HEALTH POLICY COUNCIL and RELATED ACTIVITIES
- A Public/Private Partnership -
(December 1997)

1. **Mayor's Health Policy Council**
 - Chair, **Bailus Walker, Jr., PhD, MPH (Private Sector)**
 - Vice Chair, **Jearline Williams, (DC Government Senior Official)**
 - Council (100 members; 8 of 10 from the private sector)
 - Assist. the City in Developing Health Policy Options
 - Options Consistent with Improving Health Care Delivery System
 - Goal is to Improve the Health Status of District Residents
 - Council meets 2nd Tuesday of Every Month from 6:30 PM - 8:30 PM
 - Council has 10 major current Committees (plus 1 retired and 2 pending)
 - Committees have private sector Chair and public sector Co-Chair
 - Ten Committee Chairs bring Recommendations before Council for Debate
 - Approved Recommendations Move to Management Reform Team(s)

2. **Mayor's Health Policy (Council) Office.**
 - Location: 441 4th Street, NW, Suite 1000, Washington, DC 20001
 - Telephone: 202-727-9239/9243; Fax: 202-727-0165.
 - Provides Advice to the Mayor and Executive Branch
 - Focal Point for Health Transformation Initiatives
 - Facilitates Technical Assistance from the Federal Government
 - Provides Administrative/Technical Support to Health Policy Council
 - Coordinates weekly, monthly, quarterly District and Federal meetings

3. **Level of DC Cooperation: Direct Access; Supportive; Involved.**
 - Mayor
 - City Administrator's Office
 - Chief of Staff
 - Various City Council Members
 - The DC Financial Authority (Control Board)
 - Chief Financial Officer
 - Corporation Counsel
 - Boards and Commissions Director
 - Office of Communications Director
 - Office of Insurance and Securities Regulation
 - Office of Intergovernmental Relations Director
 - Office of Policy and Evaluation Director
 - Department of Health Director
 - Department of Human Services Director
 - Correctional Health Care Director
 - Emergency Medical Services Director
 - Public Benefit Corporation CEO

4. **Level of DC Government Support.**
 - Mayoral Order Establishing Health Policy Office
 - Mayoral Order Establishing Health Policy Council
 - Funding and District Staff Support from Health the Department
 - Federal Assistance from DHHS under the "DC/DIHS Initiative"
 - Five offices, Open Areas, Mating and Conference Rooms
 - Telephones and Fax Machines (including long-distance access)
 - Equipment and Supplies

5. **Health Policy Council and Health Policy Office Focus:**
 - a. Creation of a Health Department that combines the state agency functions of public health and health care finance (and also in the very near future some environmental and regulatory functions): *Announced January 13, 1997*
 - b. implement Medicaid managed care to reduce cost/improve quality; *(progress)*.
 - c. Transformation of mental health (and substance abuse) services. resulting in improved accessibility and more community-based services: *Pilots were proposed and under consideration by Receiver*
 - d. Establishment of a Public Benefits Corporation to serve as the health delivery arm for primary, acute, and long-term care: *Board established December 96. PBC to be operational within 180 days of Board establishment (completed)*.
 - e. Institution/coordination of a management information system to monitor health care delivery. *Recommendations developed.*
 - f. Development of a Primary Care Network which integrates public and private sector primary care clinics: *(Progressing)*.
 - g. Creating purchasing arrangements to leverage the city's purchasing power: *ADAP purchases (November 96). PSC/District Agreement for selected contracts and grants (February 97). Anticipating eventual use of Federal Prime Vendor or FSS for all pharmaceuticals and medical supplies.*
 - h. Improvement of Correctional Health Services: *Selected privatization. Actions to consolidate court orders. Health Policy Council recommendations.*
 - i. Improvement of Emergency Medical Services: *Training, improved communication, and piloting of rapid response vehicles.*
 - j. Development of educational materials to better inform and encourage consumer participation in their own health care: *Immediate plans for collaborative partnerships between District, Federal, and private sector*

6. **Mayor's Health Policy Council Committees.**
 - Correctional Health
 - Department of Health
 - Emergency Medical Services
 - Environmental Health (*Proposed and Under Consideration*)
 - Long Term Care
 - Management Information System
 - Medicaid Managed Care
 - Mental Health Managed Care
 - Primary Care Network Development
 - Public Benefits Corporation (*Work Completed, Retired Committee 1-14-97*)
 - Public Information Education
 - Substance Abuse Prevention and Recovery (*Pending*)
 - Value Purchasing

7. **District of Columbia Health Transformation Team.**
 - Chaired by Dr. Bailus Walker
 - Materials and **Background** Work by Health Policy (Council) Office Staff
 - Meets Every Tuesday from 8:00 AM to 9:00 AM
 - **Purpose:** to identify issues, resolve problems, and facilitate change
 - Participants are Public Sector **Members:**
 - * Asst. Director for Health Services, Corrections Department
 - * Commissioner of Health Care Finance, Department of Health
 - * Commissioner, Insurance and Securities Regulation
 - * Commission on Mental Health Services (*active history*)
 - * Director, Department of Health
 - * Director, Department of Human Services
 - * Director, Mayor's Health Policy Office
 - * Executive Director, DC General Hospital
 - * Medical Director, Office of Emergency Medical Services
 - * Staff of Mayor's Health Policy Office

8. **Other Areas of Active Involvement:**
 - Providing Advice, Recommendations, Testimony to Elected Officials
 - Facilitating Collaboration between DC, Federal Govt. and Private Sector
 - Assisting with Follow-up on Selected DC/Federal Agreements

Nonprofit Clinic Consortium

1470 Irving Street NW Washington DC 20010 202-667-4378 202-332-0085 (fax)

December 10, 1997

Paul Offner
Commission on Health Care Finance
2100 Martin Luther King Jr. Ave. SE, Suite 302
Washington, DC 20020

Dear Dr. Offner,

On behalf of the Nonprofit Clinic Consortium I congratulate you on the completion of the recommendations for the State Child Health Insurance Program. The NPCC is pleased to see our positions reflected in your recommendation — namely to administer the program through existing Medicaid structures and to creatively use the administrative funds to do outreach and education through public and private community-based providers. Our clinics anticipate helping your office work through the implementation details.

We look forward to supporting your recommendation at the upcoming public forums. Please alert Amy Houser at the NPCC office (202-667-4378 phone, 202-332-0085 fax) of your forum dates, times and locations.

Thank you again for your hard work on SCHIP.

Sincerely,

Andrew Schamess, M.D.
Chair, NPCC Board of Directors
Medical Director, La Clinica del Pueblo

cc: <i>Allan Noonan</i>	<i>Linda Cropp</i>	<i>Sue Brown</i>
<i>Bailus Walker</i>	<i>Frank Smith</i>	<i>Edward Singletary</i>
<i>Sharon Ambrose</i>	<i>Joyce Ladner</i>	<i>Jearline Williams</i>
<i>Sandy Allen</i>	<i>Virginia Fleming</i>	<i>Denise Savage</i>

RECEIVED COMMISSION ON
HEALTH CARE FINANCE
97 DEC 17 AM 11 10

Bread for the City & Zachaeus Free Clinic Community of Hope Health Services
Community Medical Care DC Spanish Catholic Center Family & Medical Counseling Services
La Clinica del Pueblo Mary's Center for Maternal and Child Care So Others Might Eat Medical Clinic
Washington Free Clinic Whitman-Walker Clinic

**CHILDREN'S HEALTH INSURANCE PROGRAM
COMMUNITY FORUM**



Are your children uninsured?

Are you working with no health benefits for your children?

Are you unemployed with no health coverage for the kids?

**JOIN US & LEARN MORE ABOUT
THE "CHIP" PROGRAM**

*Monday, January 12, 1998
Bethlehem Baptist Church
2458 MLK Jr. Avenue, S.E.
Washington, DC*

*Tuesday, January 13, 1998
Calvary Baptist Church
755 8th Street, N.W.
Washington, DC*

*Wednesday, January 14, 1998
First Baptist Church
3440 Minnesota Avenue, S.E.
Washington, DC*

*Tuesday, January 20, 1998
Sacred Heart Church
Corner of 16th and Park Road, N.W.
Washington, DC*

TIME: 6:00 p.m. - 8:00 p.m.

A Forum in the Northeast Quadrant of the City is being planned. Information on that forum will be distributed soon!

For more information, please call Karla Simmons on 727-3685.

Sponsored by: The Mayor's Health Policy Council

**FORO COMMUNITARIO DEL PROGRAMA
INICIATIVAS PARA LA SALUD DEL NIÑO**

*Están sus niños sin seguro?
Está usted trabajando sin beneficios
de salud para sus niños?
Está usted sin trabajo y sin cobertura
de salud para sus niños?*



**ÚNASE A NOSOTROS Y APRENDA ACERCA DEL PROGRAMA
INICIATIVAS PARA LA SALUD DEL NIÑOS**

*Enero 12, 1998 a las 6:00 p.m.
Iglesia Bautista Bethlehem
2458 MLK Jr., Avenue. S.E.
Washington, D.C.*

*Enero 13, 1998 a las 6:00 p.m.
Iglesia Bautista Calvario
755- 8^a Street, N. W.
Washington, D. C.*

*Enero 14, 1998 a las 6:00 p.m.
Primera Iglesia Bautista
3440 Minnesota Avenue. S.E.
Washington, D. C.*

*Enero 20, 1998 a las 6:00 p.m.
Iglesia Sagrado Corazón
16^a & Park Road, N. W.
Washington, D.C.*

Para más información, por favor llame a Karla Simmons al (202) 727-3688

Patrocinado por: Consejo Póliza de Salud del Alcalde

EL NUEVO PLAN DE SALUD
THE NEW
CHILDREN'S HEALTH INSURANCE PROGRAM

CONFERENCIA DE LOS PADRES Y PROFESIONALES DE ATENCIÓN A NIÑOS
A FORUM AT CHILDREN'S HOSPITAL

- **DOES YOUR CHILD NEED HEALTH INSURANCE**
- **ARE YOU A PEDIATRICIAN, SOCIAL WORKER OR OTHER PROFESSIONAL WORKING WITH FAMILIES WITH UNINSURED CHILDREN**
- **ARE YOU A CHILD ADVOCATE**

LEARN MORE ABOUT "CHIP" ON 1/28 AT CHILDREN'S AUDITORIUM

**WHEN: WEDNESDAY JANUARY 28, 1998
FROM 6:00 P.M. TO 8:00 P.M.**

**WHERE: CHILDREN'S HOSPITAL AUDITORIUM
111 MICHIGAN AVENUE, NW
WASHINGTON, D.C. 20010
(202) 884-4930**

**Sponsors: Mayor's Health Policy Council and the Children's National Medical Center.
Interpreting Services: Spanish Language and Hearing Impaired**

**EL NUEVO PROGRAMA DE SALUD
PARA NIÑOS/AS
UN FORO EN EL CHILDREN'S HOSPITAL**

¿ NECESITA SU NIÑO/A SEGURO MÉDICO?

¿ ES UD PEDIATRA, TRABAJADORA/A SOCIAL U OTRO PROFESIONAL QUE TRABAJA CON FAMILIAS SIN SEGURO MEDICO?

¿ ES UD. UNA PERSONA QUE DEFIENDE LOS DERECHOS DE LOS NIÑOS/AS?

APRENDA MAS SOBRE EL PROGRAMA "CHIP" EL 28 DE ENERO DE 1998

**EN EL AUDITORIUM DEL "CHILDREN'S"
SEGUNDA PLANTA**

**CUANDO: MIERCOLES 28 DE ENERO, 1998
6:00 A 8:00 P.M.**

**DONDE: CHILDREN'S HOSPITAL
AUDITORIUM
111 Michigan Avenue, N.W.
Washington, DC 20010
(202) 884-4930**

**AUSPICIADO POR: EL CONSEJO DE POLITICAS DE SALUD DEL ALCALDE DE D.C.
(MAYOR'S HEALTH POLICY COUNCIL) Y EL HOSPITAL MEDICO NACIONAL DE
NIÑOS/AS (CHILDREN'S HOSPITAL NATIONAL MEDICAL CENTER)**

ESTE FORO SERA INTERPRETADO SIMULTANEAMENTE EN ESPAÑOL E IDIOMA DE SEÑAS PARA PERSONAS CON PROBLEMAS DE AUDICIÓN.

FREQUENTLY ASKED QUESTIONS ABOUT CHIP

Q. What do the letters **CHIP** stand for?

A. **CHIP** stands for Children's Health Insurance Program.

Q. What *is* the **CHIP** Program?

A. The **CHIP** program is a new children's health insurance program that will begin in the District of Columbia soon. The District's Medicaid program already covers about 67,000 children in the District and private insurance covers many others. However, over 10,000 children currently living in the District have no health insurance. Under a recently enacted federal law, all states and the District of Columbia are eligible to receive special federal funding to develop and implement an insurance Programs for uninsured children.

Q. Who will be eligible to participate in the **CHIP** program?

A. All children who (a) live in the District; (b) are citizens or lawful permanent residents of the U.S.; (c) are uninsured; (d) are under age 19; (e) are not currently eligible for Medicaid; and, (f) are in families with incomes up to 200 percent of the federal poverty level.

Q. Will the parents of CHIP children be eligible for coverage?

A. No Federal law does not permit such coverage. Parents who are otherwise eligible for Medicaid will continue to be eligible.

Q. When will the CHIP Program begin?

A. In order to begin the CHIP Program, the District has to submit a plan to City policymakers for approval. Once approved by City policymakers, the plan must be submitted to the Federal government for approval. The District may begin the CHIP Program any time after approval of the plan by the Federal government.

Q. How will the CHIP program be funded?

A. CHIP will be funded with a combination of federal and District of Columbia funds. The District is eligible to receive up to \$12 million per year in federal funds. Approximately \$3 million per year in District funds will be required to match the federal monies.

Q. What does it mean to have a family income "up to 200 percent of the federal poverty level"?

A. Most Medicaid eligibility criteria related to income levels are determined by federal poverty guidelines established by the U.S. Department of Health and Human Services. Federal poverty guidelines are prospective estimates for a given year used to determine eligibility for certain means-tested programs such as Medicaid. (See: attached income chart)

Q. How many children will be eligible for the new program?

A. Estimates are that there are approximately 8,282 children who are eligible for and will enroll in the new CHIP program.

Q. How will the District's CHIP Program be set up?

A. The District has two choices in how it sets up the new CHIP Program. It can either expand the Medicaid program to cover more children; or it can develop a new program to cover the CHIP kids. A committee of District officials and private citizens is recommending a Medicaid expansion for the following reasons: (a) expanding Medicaid will allow the District to begin the CHIP program within a short period of time; (b) the Medicaid benefits package (including EPSDT) is more generous compared with private plans; (c) expanding Medicaid will allow the District to develop the CHIP program on a well established administrative structure; (d) families that include both Medicaid enrollees and Child Health enrollees will be able to use a single set of providers; and (e) children covered under a Medicaid expansion remain eligible for Medicaid even if the new allotment of federal funds is depleted

Q. Once enrolled in **CHIP**, how long will a child remain eligible until recertification is required?

A. The District has the option of allowing all children, **regular** Medicaid and **CHIP**, to remain on Medicaid for 12 months with uninterrupted coverage.

Q. If the District expands Medicaid for the **CHIP** Program, will the **CHIP** benefits be the same as the benefits available under regular **Medicaid**?

A. Yes. If the District develops a **CHIP/Medicaid** expansion, all regular Medicaid benefits, including **EPSDT**, will be available for children enrolled in **CHIP**.

Q. What is **EPSDT**?

A. **EPSDT** stands for Early and Periodic Screening, Diagnosis and Treatment. **EPSDT** is a mandatory Medicaid service for all children who are enrolled in Medicaid. Under **EPSDT**, children receive regular and periodic comprehensive health screening, vision, dental, and hearing services. Medicaid provides all necessary health care, diagnostic services, and treatment(s) required to correct or ameliorate any defects found during regular screening(s) regardless of whether the follow-up services are generally covered under a state's Medicaid plan.

Q. What types of outreach activities are being planned to tell people about the new program?

A. The specifics of an outreach strategy are currently being developed. However, any strategy that is finally adopted will be: (a) city-wide; (b) culturally sensitive; (c) language appropriate; (d) based upon a multi-media approach. If you have suggestions and/or ideas related to outreach, please write them down on the attached piece of paper and turn them in at the end of this meeting.

1/12/98

Are Your Children Likely to Qualify for CHIP?*

Number of People in Family (count parents and children)**	Monthly Income Level to Qualify for CHIP (200 percent of poverty)	Annual (Yearly) Income Level to Qualify for CHIP (200 percent of poverty)
1	\$1,315.00	\$15,780.00
2	\$1,768.33	\$21,219.96
3	\$2,221.67	\$26,660.04
4	\$2,675.00	\$32,100.00
5	\$3,128.33	\$37,539.96
6	\$3,581.67	\$42,980.04
7	\$4,035.00	\$48,420.00

Note: These figures are only rough estimates intended to give you an idea of whether your children may qualify for CHIP. If your income is less than the figures represented on this chart, your children may be eligible for regular Medicaid. Contact your local service center.

****Note** Parents are counted in family size even though they will not be eligible for the CHIP program.

Memorandum

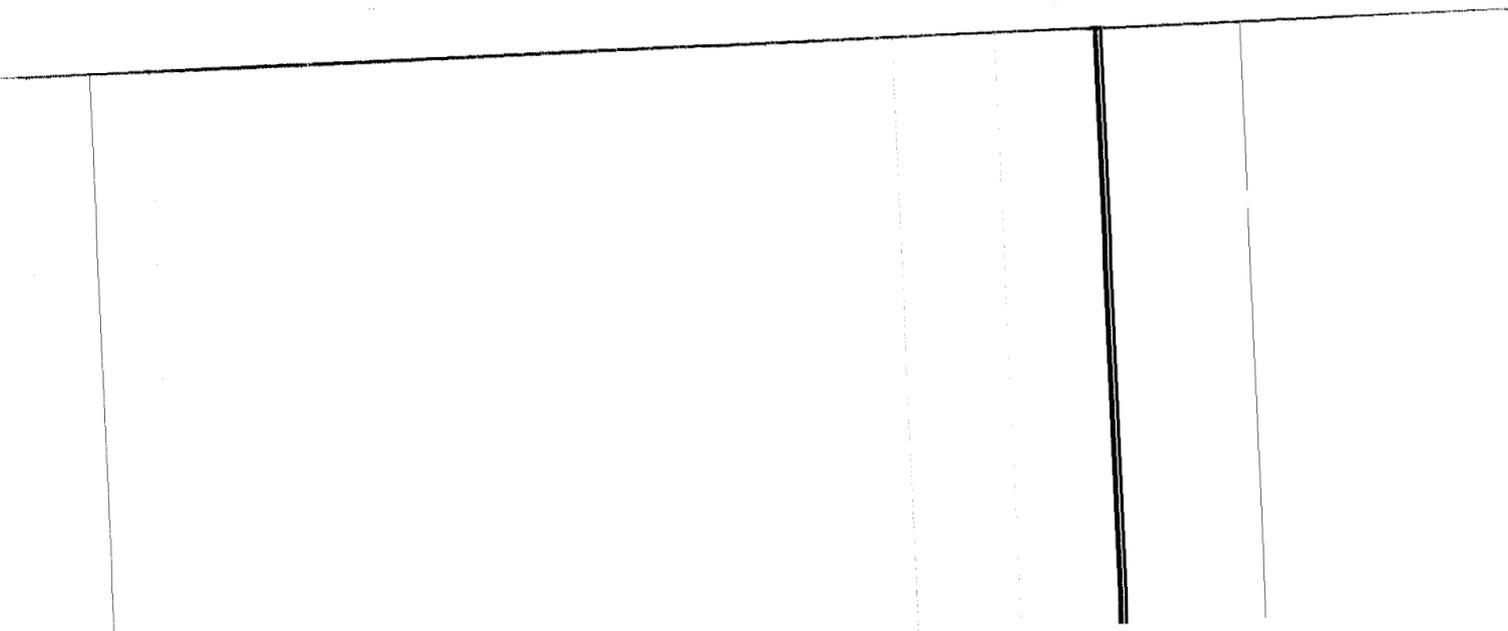
Date: January 1998
To: Concerned Consumers
From: The Medicaid Managed Care and ~~Eligibility~~ Committee
Re: Your Enrollment. Education and Outreach Ideas for CHIP

In order for city policymakers to design a **CHIP** program that meets **your** needs, it **is** important that we hear your ideas for effective enrollment, education, and outreach. Please take the time to write your comments on this form and mail or **FAX** them to **us**. Your participation is appreciated!

The *following* are my ideas related to outreach **and** education activities for CHIP.

Message: _____

**Mail to: Commission on Health Care Finance
2100 MLK Jr. Ave., SE. Suite 401
Washington, D.C. 20020
Attn: Karla Simmons
or
FAX to: (202) 727-2739**



DISCUSSION QUESTIONS FOR COMMUNITY FORUMS ON CHIP

- I. DO YOU RECOMMEND CHANGE(S) IN THE MEDICAID APPLICATION AND/OR ENROLLMENT PROCESS? IF SO, PLEASE DESCRIBE THE CHANCES.**

- II. WHAT ARE YOUR IDEAS CONCERNING OUTREACH AND PUBLIC EDUCATION?**

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Overview of the State Children's Health Insurance Program (S-CHIP) enabled by Title XXI of the Social Security Act

- **Who:** Children under age 19 not eligible for Medicaid with family incomes below 200% poverty or 50 percentage points above the state (District) Medicaid limit
- **What:** State Children's Health Insurance Program (S-CHIP) enables states to implement plans to initiate and expand the provision of health care assistance to uninsured, low-income children via Medicaid expansion or a separate State Insurance Program
- **How :** \$24 Billion over five years (1998 - 2002) Grant spending \$20 billion; other spending \$4 Billion
- **When:** May begin expansions as early as October 1, 1997

Federal and State Funding

- **State Allotment: Each state will receive a portion of the total block grant, D.C. Allotment = \$14 million/year**
- **Use of funds for purposes of administration, outreach, and purchasing direct services may not exceed 10% of the amount used for providing coverage**
- **Allotments remain available for three years**
- **Federal matching rate increased for the District for this program to 79%**
- **Cannot change Medicaid eligibility from level as of June 1, 1997 and must enroll eligible children in Medicaid**

E

Matching Rate

- The enhanced federal matching rate is available only up to the District's yearly allotment
- The enhanced match reduces the District's cost of financing children's health insurance by 30%
 - States who have chosen the Medicaid expansion option are eligible for additional funding at the regular match rate if they exhaust the funds provided by the enhanced rate
 - There is no additional federal money above the allotment if the District chooses to provide coverage under a separate program



Eligibility Criteria

- A separate District **Program could limit eligibility by: geography, age, income and resources, residency, disability status (could set higher level), and access to other health insurance**
- Separate program **must be coordinated with Medicaid**
District could limit **enrollment and create waiting lists**
- There can be **no pre-existing condition limitations**
- District **would have full responsibility for determining how to administer program and how to deliver care**

Program Eligibility Requirements

- Procedures established for **eligibility must ensure the following:**
 - Only **low-income children** are permitted to receive assistance under Title XXI
 - Children found to be Medicaid eligible should be enrolled in the Medicaid program
 - Coverage is not to substitute for existing group health plan insurance
 - Child health assistance is to be provided to low-income children who are Native American as defined in the Indian Health Care Improvement Act
 - There must be coordination with other public and private programs providing appropriate health insurance coverage to low-income children

Covered Benefits

- the legislation defines the following four options for a minimum benefit package:
 - coverage of benefits equivalent to those provided in a benchmark benefit package
 - coverage of benefits actuarially equivalent to one of the benchmark benefit packages
 - coverage of comprehensive benefits provided by an existing children's health program
 - other health plans that the Secretary deems adequate for a low-income population

Covered Benefits (Continued)

- If the actuarially equivalence option is taken, states must provide the following:
 - four basic services (inpatient/outpatient hospital services, surgical and medical services, laboratory and x-ray, and well-baby/well-child care)
 - aggregate value must be actuarially equivalent to the benchmark plan
 - mental health, vision, hearing and prescription benefits must have at least 75% the value of these services in the benchmark plan
- A benchmark benefit package may consist of one of the following:
- Standard BC/BS preferred provider option offered by FEHBP
 - Health coverage generally offered to District employees
 - health coverage by the HMO with the largest commercial, non-Medicaid enrollment in the state

Cost Sharing

- The District plan is **required to include a description of the amount of premiums, deductibles, or other cost sharing arrangements instituted by a separate child health program**
- **Cost sharing is limited based on total family income**
 - **Families below 150% of poverty: cost sharing must be consistent with Medicaid and premiums cannot exceed amounts imposed on Medicaid beneficiaries**
 - **Families above 150% of poverty: premiums, deductibles, and other cost sharing to be based on a sliding fee schedule and is not to exceed 5% of the family income**

Plan Requirements

When applying for funding under Title XXI the District



must submit a plan with the following information:

- the current insurance status of children, including low-income and uninsured children
- efforts to insure low-income and uninsured children
- efforts to coordinate with existing programs
- outline of child health assistance to be provided under the plan including a description of the delivery and utilization control systems
- eligibility criteria
- outreach activities
- quality assurance

Additional Requirements

- **Maintenance of effort: The District may not change Medicaid eligibility standards as of June 1, 1997, must continue to enroll eligible children into Medicaid programs, and must maintain the current level of spending on non-federal health insurance programs**
- **Substitution: The District must submit in its plan a process by which they will assure that they are not replacing existing insurance coverage**
- **Reporting and Evaluation: District must report annually on their progress at insuring low-income and uninsured children**
- **Fraud and Abuse: Specific Medicaid and Medicare sanctions apply to programs accepting Title XXI funding**

Medicaid Expansion

- If the District chooses this option, it is subject to the federal Medicaid rules relating to entitlement, benefits, cost sharing, and delivery for all additional children covered under the expansion
- As the Separate Insurance option provides states with substantial flexibility, this option provides the following:
 - assurance of a broad range of services
 - protections under the federal Medicaid law
 - purchasing power offered by state Medicaid programs
 - developed

Presumptive Eligibility Provisions

- Under Title XXI, states have the option to establish or extend presumptive eligibility within their programs (30 states have already implemented this for pregnant women)
- the District may allow community health centers, Head Start Programs, WIC providers, child care programs, and other "qualified entities" to enroll children in Medicaid expansion programs on a temporary basis based on information provided by the family
- Families must then submit a formal application and be determined as eligible
- This allows providers to become involved in outreach processes ensuring timely enrollment

Presumptive Eligibility (Continued)

- Presumptive eligibility also allows providers to enroll children who are difficult to reach (e.g. low-income children not enrolled in welfare)
- Title XXI has considered the funding of presumptive eligibility
 - The federal share of the cost of presumptive eligibility is offset by the block grant allocation to the states
 - Once children are found to be eligible, the Medicaid program will pick up the cost of their ongoing services



Continuous Coverage Provisions

- The District has **the option under Title XXI** to guarantee **12 months of coverage** for children enrolled in Medicaid **regardless of fluctuations in income during the year**
- However, this does **not apply to children who lose coverage because they have reached the age of 19**
- Continuous **coverage provides stability in coverage** for children **enrolled in programs** and will assist to minimize **disruptions in eligibility** and access to **timely and appropriate health care**

Important Decisions for The District:

- How does the District want to provide health coverage to children under the new program? Medicaid expansion? Obtain health insurance from private health plans? Pay some providers directly? (not more than 10%) Combination of above?
- Who will be eligible for the new program?
- What benefits will the children receive?
- What Medicaid options will the District choose? Presumptive eligibility? 12 month continuous eligibility?
- What will the impact be of any program expansion on the District's eligibility system due to increased demands and complexity?

APPENDIX L

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Council of the District of Columbia

Notice of Public Roundtable

One Judiciary Square 441 4th Street, NW, Washington, DC 20001

Councilmember Sandra (Sandy) Allen

Announces a Public Roundtable On

The District's Children's Health Initiative

TUESDAY, JANUARY 27, 1998

COUNCIL CHAMBER

ONE JUDICIARY SQUARE

441 4TH STREET, N.W.

10:00 A.M.

Councilmember Sandra (Sandy) Allen, Chairperson of the Council's Committee on Human Services announces a Public Roundtable on the District's Children's Health Initiative on Tuesday, January 27, 1998 at 10:00 a.m. in the Council Chambers, first floor.

The purpose of this Roundtable is to receive comments from the Executive and the public on the District's Children's Health Initiative. Pursuant to the Balanced Budget Act of 1997 the District of Columbia is eligible to receive up to 12 million in new federal funds to develop a State Child Health Insurance Program (CHIP). The purpose of CHIP is to provide Health Insurance to uninsured children in families up to 200 percent below the federal poverty level (currently \$26,660 for a family of three). There are over 8,000 children in the District eligible for the new program.

In order to receive federal funds the District must have a plan approved by the federal government that describes: a) how the program will be structured (e.g. Medicaid vs. a separate program), and (b) the children who will be covered under the program. The District may also include a plan that allows it to provide Medicaid coverage to all eligible children for a full year regardless of fluctuations in family income.

Individuals and representatives of organizations who wish to testify at the public hearing are asked to telephone the Special Assistant to the Committee on Human Services, Roderic Leggins at 724-8045 and furnish their names, addresses, telephone numbers and organizational affiliation, if any, by the close of business on Friday, January 23, 1998. They should also bring with them 20 copies of their written testimony or submit one copy of their written testimony by Monday, January 26, 1998. Individuals will be limited to five minutes and panels will be limited to ten minutes, in order to permit each witness an opportunity to be heard.

Written statements are encouraged and will be made a part of the official record. All statements should be submitted to Mr. Dee Hunter, Committee Counsel, Committee on Human Services, Council of the District of Columbia, One Judiciary Square, 441 4th Street, N.W., Washington, D.C. 20001. The record will officially close on Tuesday, February 3, 1998.

STATEMENT

OF

ALLAN S. NOONAN, M.D., M.P.R.

DIRECTOR

DEPARTMENT OF HEALTH

HEARING

ON

TITLE XXI - CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

BEFORE

THE COMMITTEE ON HUMAN SERVICES

COUNCIL OF THE DISTRICT OF COLUMBIA

COUNCIL CHAMBER

ONE JUDICIARY SQUARE

441 FOURTH STREET, N.W.

JANUARY 27, 1998

10:00 A.M.

Children's Health **Insurance** Program
Testimony of Allan S. Noonan, **MD., MPH**
Public Roundtable
January 27, 1998

Introduction

Good morning. I am pleased to be here today to discuss the Department of Health's activities on the Children's Health Insurance Program (CHIP). During the past five months, the Department of Health has worked actively **with** community groups, advocates, providers and potential recipients to plan for the implementation of **this** Program in the District. Today I will provide some background **on** the program and describe the plans we have underway.

The Federal Balanced **Budget** Act of 1997 created a **new** program—the State Children's Health Insurance Program (CHIP). The purpose of the new program, which we propose to name 'Healthy D. C. Kids', is to provide funds to states to enable them to initiate and expand the provision of child health insurance to uninsured low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.

The District of Columbia is eligible to receive approximately \$12 million annually, beginning in FY 1998, in federal CHIP funds. The District **must** provide approximately \$3 million annually in appropriated funds as a match for the federal dollars. Under the

:

program, the federal government will provide **79 cents** of every dollar spent on providing allowable services and outreach activities to CHIP children.

In order for the District to receive its FY 1998 federal allotment, it must submit a plan to the federal government by the end of June 1998. To receive federal approval, the plan must describe how CHIP will be structured and implemented and how the District will monitor certain quality standards.

The Department of Health is well on its way to completing a plan. We expect to do so by March to insure that there is ample time for the federal government to review the plan. We expect to begin program implementation in August of this year.

Eligible Children

Before I describe our proposed program structure, let me tell you about the children we expect to serve. We are confident that our allocation is large enough to allow us to provide coverage to all children in families with incomes of 200% of poverty or less. (In 1997, 200 percent of the Federal Poverty Level for a family of three was \$25,660.) The new program funds will allow us to provide health insurance protection for approximately 8,200 additional children.

To be eligible for the program, a child must be (a) under age 19; (b) have an annual family income less than 200 percent of poverty, and (c) not have other insurance. A child is ineligible for the program if (a) the child is an inmate of a public institution or a

patient **in an** institution for mental **diseases**; (b) the **child is covered** under a group health plan. **Newly arriving** legal immigrant **children** who **have** been **in the country** for **less** than 5 years and undocumented immigrant children **are not eligible** for **the CHIP** program. **We** know many **of the children who** are not eligible for coverage have severe **health** needs. **The District** must **strengthen** efforts to provide health **services** to these children although **we** are prohibited by law **from** doing so through the **CHIP** program.

The **Lewin** Group, under contract with the Commission on Health **Care Finance**, conducted **extensive** research **on the** number **of** uninsured children in the District of **Columbia**. **Based upon** Lewin's **analysis**, **approximately** 8,282 children **will** be eligible to enroll **in** the new **CHIP** program during its first **full** year.

Program Structure

States and the District **may spend CHIP** funds to: (1) expand **Medicaid** coverage to **targeted** low-income children; (2) support a separate state **child** health insurance program to cover targeted low-income children. or. (3) combine both approaches. The Department of Health is planning to begin the **CHIP** program with **a Medicaid** expansion. **We propose** to incorporate **the CHIP** into Medicaid's **existing health care** financing structure **through which** beneficiaries **receive care** from a variety of service delivery entities

We believe a Medicaid expansion will maximize the District's ability to **offer** continuity of

care to vulnerable children. Many low-income families have income fluctuations over relatively short periods of time. Under a Medicaid expansion, continuous and seamless coverage of children is simplified and readily assured.

The Medicaid benefit package is relatively generous compared with benefits offered through private sector plans. Two features of the Medicaid benefit package for children make it superior to most private plans. The first is EPSDT, which covers comprehensive, ongoing preventive and well-child care and all treatments that are medically necessary as a follow-up to that care. Second, the Medicaid package provides comprehensive long-term care services to children who need them. Neither EPSDT nor long term care services are part of a typical private insurance package. We believe that our first step must be to improve the operation of the existing EPSDT program

A Medicaid expansion builds on an existing infrastructure. Medicaid has well developed structures, processes, and existing rules for activities such as claims payment, provider certification, provider relations, and program operation. Thus costly and time-consuming start-up and infrastructure development activities will be eliminated if the District elects to expand Medicaid. In fact the Department is working on a way to develop a simplified claim form and a form that can be used by different human service provider

Children covered under a Medicaid expansion remain eligible for Medicaid if the federal

allotment of **CHIP** funds is depleted. Because Medicaid **is an entitlement to** the individual, federal funds will continue to be available at the **District's** regular 70 percent match rate if the **District uses** its full allotment of **CHIP funds lists** once its allotment of federal funds is depleted.

Administrative Funds

The District is permitted to spend up to 10 percent of its funds on: outreach and administration of the CHIP program. I am committed to using a significant portion **of** the funds to **support** public and private **community based organizations**. We expect them to be involved in the program through outreach, assistance with eligibility and community education.

We **are** working hard to develop an effective outreach strategy. We will be using the capability of several sections **of** the Department of **Health**, including Maternal and Child Health and WIC **and** we plan to develop relationships with the public schools. We know we will **also** need the help of professional **firms** to develop public service announcements for local **radio and** television distribution and to prepare brochures. We **are** committed to developing **user-friendly, easily understandable, educational materials** and developing **culturally sensitive, language appropriate community education videos** for **city-wide** distribution. We know **that** public funds will be insufficient to **support all** the outreach we need and will be developing partnership with private agencies and funding sources to **support CHIP outreach**. We will **also** form partnerships with local universities to develop and implement a **plan** to evaluate outreach, education and

service delivery activities related to the CHIP program.

We are also considering a variety of approaches to enrollment and eligibility determination, including presumptive eligibility determination contracting with workers at community settings to carry out activities related to enrollment or roving IMA supervisors to determine eligibility quickly at community sites. We are now assessing the feasibility of each of these approaches.

Community Forums

In order for the new program to achieve its enrollment and program participation goals, it is imperative that the design of the CHIP program have widespread community support. As a follow up to the preliminary forums sponsored by the Health Policy Council, the Department of Health will be holding public hearings throughout the city during the next few months to encourage community support and participation in this effort. The first hearing is scheduled for February 12, 1998 in Ward 8. We expect to receive advice on how best to carry out enrollment for the program and how to conduct effective outreach. These ideas will be incorporated into our plan.

Thank you for the opportunity to testify. I look forward to your comments and questions.



GOVERNMENT OF THE DISTRICT OF COLUMBIA
HEALTH POLICY COUNCIL

MARION BARRY, JR.
MAYOR

January 27, 1998

BAILUS WALKER, JR., PhD
CHAIR

The Honorable Sandra (Sandy) Allen
Chairperson, Committee on Human Services
Council of the District of Columbia
441 4th Street, NW, 7th Floor
Washington, DC 20001

Dear chairperson Allen:

Attached is our letter for the record addressing concerns about the prolonged process in moving the District of Columbia's State Children's Health Insurance Program (S-CHIP). We were informed today that additional community forums have been scheduled after the conclusion of today's hearing by the Human Services Committee.

We believe that continued and prolonged delays are unwarranted given the provisions in the law allowing changes in the program at some future date, if needed. We are requesting your support in expediting this program.

Thank you.

Sincerely,

Bailus Walker, Jr., PhD, MPH
Chair, DC Health Policy Council

Enclosure

cc: The Honorable Marion Barry, Jr. Mayor
Andrew Brimmer, PhD, Chairman, Control Authority
The Honorable Linda Cropp, Chairman, Council of the District of Columbia
Joyce Ladner, PhD, Member, Control Authority
Allan Noonan, MD, MPH, Director, Department of Health

Testimony of Bailus Walker, Jr., PhD, MPH
Chair, District of Columbia Health Policy Council
before the
Committee on Human Services
The Honorable Sandra (Sandy) Allen
Tuesday, January 27, 1998

It is **important** that we move expeditiously **to** develop **and** submit to the Federal government the District of Columbia's **State Child Health Insurance Program (S-CHIP)** initiative. Further delay increases the likelihood that the District of Columbia government **will not meet** the specified **deadlines**. Failure to meet the deadline, will mean that the District **allocation** will be distributed among other **states** which are already well ahead of the DC government in **planning** and submission of their **State Child Health** Insurance Programs.

The DC **Health** Policy Council, at its regular **meeting** on December **9**, 1997, approved the proposal **as** submitted by the **Council's** Medicaid Managed Care and Eligibility Committee. The Health Policy Council was well aware of concerns about the organizational placement of the programs (i.e., Medicaid versus a separate entity), but recognized that the **U.S.** Department of Health and Human Services **has** indicated that placement decisions are not irrevocable and **can be** changed at a later date. **As in** any program of this type, midcourse review **will be** necessary to determine modification that **may be** required to ensure that the program meets its objectives.

The Health Policy Council was also thoroughly convinced that obtaining the funds allocated for DC must be our highest priority because of the critical **unmet** needs of the District's children. The Health Policy **Council** went further by approving an addendum to the Council's* Medicaid Managed Care and Eligibility Committee recommendation which will allow the District to revisit the Medicaid expansion component of **the** program within six months, if necessary.

We believe it imperative to move forward with "all deliberate speed" in moving this program forward to ensure access to comprehensive health care. We should not allow the bureaucratic process and special interests to blur the overarching goal of the program, which is to ensure access to comprehensive medical care **by** children who are at highest risk of disease, dysfunction, and premature death.

D.C. CITY COUNCIL TESTIMONY

Good morning, Councilmember Sandra Allen, my name is Brenda Lee Richardson and I am here as the Co-Chair of the Outreach and Education Subcommittee of the Medicaid Managed Care and Eligibility Committee of the Mayor's Health Policy Council. I am delighted to testify before you today on the issue of the Children's Health Insurance Program (CHIP). The Outreach and Education Subcommittee has been meeting for the past few months. In our efforts to ensure that the community is actively engaged in the outreach process, we have had four CHIP forums in the District in Wards 1, 2, 7 and 8.

As you will see in the revised Consensus Report of the Medicaid Managed Care and Eligibility Subcommittee dated December 3, 1997, we have started the outreach and education process by holding these community forums. At the CHIP community forums we discovered that the community was quite thoughtful in helping us to identify effective approaches for outreach and education. For example, at the first forum which was held at Bethlehem Baptist Church in Ward 8, the issue was raised about considering to change the name of the Medicaid program and to be cognizant of the fact that the language needs to be changed as a first step to make the program more appealing. (i.e. a medicaid program vs. a healthcare service) Another issue raised at that forum was how to reach the working class whose children may qualify for CHIP but are fearful of doing business at the IMA offices. A Ward 8 resident recommended that the city partner with grocery stores, banks, pharmacies, etc. in order to get the word out. There was some discussion about the putting a brochure together to educate the public.

There was a second CHIP Forum at Calvary Baptist Church on 8th Street, N.W. The Asian community was represented at this particular forum. We were presented with the issue of addressing language barriers in our outreach and education efforts. A TANF mom also shared that a greater effort has to be made to change perceptions about medicaid because the purpose of the program is to benefit the children and not necessarily an opportunity for parents to determine whether or not they want to deal with a government agency that seemingly has an unpalatable reputation for service delivery.

I also facilitated the CHIP Forum at First Baptist Church on Minnesota Avenue, S.E. with Dr. Paul Offner. There were a lot of critical issues raised

as well as meaningful dialogue on possible measures to be undertaken to reach the public. Location - Location - Location - a very big concern. Where does an applicant go to access this service? Will people who have never had contact with the IMA centers readily go there to apply for services! No. There was much discussion on outstations. They could be located in the schools, at churches, etc. Parents wanted to be able to apply with some anonymity. Here are some of the recommendations that were made:

- Shorten the application form and the process.
- Create a mail-in system for people who don't have the time to leave their jobs.
- Provide training for supervisors and frontline workers.
- Provide training for the doctors who are providing the healthcare.
- Put some commercials on TV and the radio stations.
- Invite churches to put announcements in their Sunday morning bulletins about the program,
- Use D.C.T.V. as a tool to get the word out.
- Conduct intake at school functions
- Send CHIP brochures home in the children's report cards.
- Consider METRO bus advertisements.

We have made diligent efforts to get the word out. Dr. Paul Offner of Healthcare Finance has been quite receptive and open to the recommendations that the various communities have made. Ultimately, this all boils down to trust and changing medicaid's image. Representatives from Washington Sports, PEPCO and Metro have agreed to join our Outreach and Education Subcommittee to help us develop a great marketing campaign for this initiative. The Subcommittee is scheduled to meet again in February after all the forums are over to assess and evaluate what we have learned. The final forum for this month will be hosted by Children's Hospital on Wednesday, January 28th at 6:00 p.m. at the auditorium.

In closing as a businesswoman and resident of Ward 8, I have to honestly congratulate the members of the Medicaid Managed Care and Eligibility Subcommittee for their hard work. This committee is not full of a lot of fluff but is composed of committed people of compassion who are deeply concerned about the welfare of the children of the District of Columbia.

Thank you.

TESTIMONY ON THE CHILDREN'S INITIATIVE

Greetings to the Honorable Chairperson of this committee and to the Honorable Committee Members. My name is Jesse James Price, Sr. I am the father of a twenty-seven year old son Jesse James Price, Jr. born in Washington, DC. I come before this committee today as a private citizen and an interested parent.

Embroided in a major fiscal crisis it is sometimes difficult to see the human misery that grows when we balance the budget on those least able to act on their own behalf. Children do not vote. We as parents and grandparents must act responsibly on their behalf.

There is no greater love we can show children, scarred by poverty, than this initiative to provide health insurance to thousands of children who would otherwise go uninsured. Early intervention and prevention is cost effective. Healthy children grow up to be healthy adults.

Thank you.

TESTIMONY
DC CITY COUNCIL
COUNCILMEMBER SANDRA ALLEN, CHAIRPERSON
COMMITTEE ON HUMAN SERVICES

PUBLIC ROUNDTABLE
on
THE DISTRICT'S CHILDREN'S HEALTH INITIATIVE
TUESDAY, JANUARY 27, 1998
COUNCIL CHAMBER
ONE JUDICIARY SQUARE
441 4TH STREET, NW
10:00 A.M.

Chairwoman Allen. Councilmember Mason, Staff, good afternoon. My name is Diane Bernstein, and I testify today as Coordinator of the Children's Health Care Coalition of DC and President of DC Action for Children. The Coalition, the health arm of DC Action for Children, is a broad-based, public, private initiative whose goal is to ensure that all children in the District of Columbia have access to quality health care.

The Coalition has followed closely the planning of the DC Children's Health Initiative - also known as **CHIP** - by the Medicaid Managed Care and Eligibility Committee of the Mayor's Health Policy Council. We applaud the District's commitment and attempts to involve child advocates, parents, and other interested members of the community in the planning process so that the widest range of perspectives could be considered.

Overall, the Coalition supports the current proposed plan for submission to **HCFA** for the DC **CHIP** program. The decision to go the route of Medicaid expansion initially, while seriously studying the possibility of a separate program down the road, is a prudent one that recognizes the real fiscal and political limitations in the District today. The creation and maintenance of a new bureaucracy to run a separate program is an unwieldy and costly endeavor that would take many months, if not a year, to plan. The District is right to place a higher premium on the urgent need to find health care coverage for children of low-income families now by expanding eligibility of Medicaid than on embarking on a new program that may or may not succeed in the long term.

Importantly, the DC **CHIP** planning committee acknowledges the real fissures in the DC Medicaid program. Indeed, the 1996 *Salazar* class action lawsuit brought to light serious violations of federal Medicaid law by the Income Maintenance Administration, the body charged with Medicaid eligibility determination and recertification, and the Commission on Health Care Finance, which is responsible for the fiscal administration of the Medicaid

prom. Unreasonable congressionally-imposed Full Time Equivalent ceilings have resulted in severely overburdened caseworkers at IMA who, moreover, are underpaid and under-trained to keep abreast of major changes to cash and medical assistance programs in recent years. Mismanagement and low morale have also contributed to debilitating inefficiency within the DC Medicaid program.

We are optimistic that these problems are being addressed by the Salazar Remedial Order, the court-appointed monitor, Thomas Chapman, and consultants' recommendations for improvement at the behest of the DC Financial Authority. Nevertheless, the Coalition was reluctant to endorse any plan to expand the Medicaid program in the District without a real commitment by city officials to take a good, hard look at innovative ways to facilitate the application process and reach out to eligible but unenrolled individuals in the community. The CHIP planning committee, lead by forward-thinking co-chairs Paul Offner and Virginia Fleming, has done just that, hiring the Lewin Group to study the demography of uninsured children in the District and Maximus to consider an alternative eligibility determination system based upon the creative examples of other states. Having done so, we believe the District is in a position to not only absorb an estimated 8,000 new children under the age of 19 living up to 2009 of poverty into a publicly-supponed health care program, but to improve services to the existing Medicaid caseload. The task then will be to focus on the remaining 4,500 uninsured children - according to Lewin Group estimates- who are either undocumented or living above 200% of poverty.

In shon. CHIP presents the District with an exciting opportunity to seize upon federal funding at an enhanced matching rate to cover children who currently fall through the cracks. while better serving those who are already part of the rebounding Medicaid program. On behalf of the Coalition, I urge the Chairwoman and the Council to support the proposed CHIP plan for submission to the feds so that we can take advantage of this historic opportunity to improve the health of our city's children at the earliest possible date.

Thank you for the opportunity to speak on behalf of our children and thank you for your attention.

**TESTIMONY FOR THE
COMMITTEE ON HUMAN SERVICES
COUNCIL OF THE DISTRICT OF COLUMBIA**

**PUBLIC ROUNDTABLE ON THE
DISTRICT'S CHILDREN'S HEALTH INITIATIVE**

Tuesday, January 27, 1998

presented by

Hanita Schreiber, President and CEO

**CAPITAL COMMUNITY HEALTH PLAN
750 First Street, N.E. Washington, DC, 20002
(202) 408-0460**

Good Morning Chairperson Allen, **and members** of the Committee on **Human** Services. My name is **Hanita Schreiber** and I **am** the President and Chief **Executive** Officer of **Capital** Community Health Plan, located at **750** First Street, in **N.E.** Washington, DC. Capital Community Health Plan is a Health Maintenance Organization (HMO) which is owned by five of the leading hospitals **in** the District of Columbia. They are: Children's National Medical Center. Greater Southeast Community Hospital, Howard University Hospital, Providence Hospital, and the Washington Hospital Center. We have been participating in the District's Medicaid Managed Care Program since June of 1996 and currently have over 10,000 AFDC/TANF and Related Medicaid members that are residents of the District of Columbia. Capital Community Health Plan has a solid track record and is committed to providing exceptional quality care and customer service to its members. We provide health care services through a network with broad geographic coverage: access to traditional community based providers; and more than 800 primary care and specialty healthcare providers. Our marketing and outreach staff teach members how to

access and use managed care services and **encourage** early and periodic access to preventive health care services.

In addition to the Medicaid Managed **Care** Program, Capital Community Health **Plan** has developed a pilot-program **for** uninsured children in the District **known as** Capital **Community Kids Care**. The purpose of developing the **Kids Care** program was to provide health insurance coverage to 500 children in the District who currently are not eligible for Medicaid and do not have any other **form** of health care insurance options. The program is funded by private contributions from Capital Community Health Plan, the Alliance for Medical Care and United Healthcare Corporation. United Healthcare Corporation current]: manages Capital Community Health Plan and is a nationally known managed care organization that has extensive experience in Medicaid and programs for uninsured children. We currently has approximately 300 children enrolled in the **Kids Care** program and we have learned many valuable lessons that can be applied to the District's efforts to develop its own CHHP program.

My purpose for providing comments at today's Public Roundtable is to encourage you to move forward rapidly with the development and

implementation of the District's **Children's Health** Initiative. I will also share some of the experiences that we have gained from developing and implementing the Capital Community **Kids Care** program for uninsured children in the District.

Specifically, my comments will address the: 1) Demographics of the population in need; 2) Critical factors for success in program development; and 3) Suggestions for project design and structure.

Demographics Of The Population In Need

Thirty nine percent (39%) of District children were without health insurance for at least one month over a two-year period in 1995-96. There are at least 8,000 children currently living in the District who would be eligible for and enroll in the new **CHIP** program. These children are from working families who do not have access to health insurance options or who cannot afford to purchase health insurance coverage. In addition, there is a large segment of this population that have significant language and cultural barriers to accessing care and health insurance programs for which they would be eligible under the **CHIP** Initiative.

As a result of their lack of access to health insurance coverage, many children do not receive the routine primary care and health screenings necessary for appropriate early childhood development, disease diagnosis and treatment. This can **lead to** unnecessary and prolonged illnesses that are far more costly to treat on an emergency or inpatient basis. One of the significant benefits of **CHIP** program will be to provide children with routine primary care on a cost effective outpatient basis. This in turn will reduce the uncompensated care burden that many District hospitals and other health care providers absorb in caring for uninsured children.

Background on Capital Community Kids Care

Capital Community Health Plan began its pilot-program. **Kids Care** in October of 1997. **Kids Care** is a low-cost program that is designed to help families, whose income is under 275% of poverty, obtain comprehensive health insurance coverage for their children, emphasizing **EPSDT** guidelines. Families contribute a small monthly premium on a sliding scale basis, which ranges from \$10 - \$24 per child per month

■

To be eligible for the program children **must** reside in the District of Columbia; be under 19 years of age; and have been without health insurance coverage for **3** months, except for disenrolled Medicaid recipients. The covered benefits include: well child visits and routine check-ups; immunizations; physician services; lab and **x-rays**; prescription drugs; vision services; discounted dental services; mental health and substance abuse services; and hospital services.

To date, we **have** enrolled almost 300 children in the program and we have learned some interesting facts about **our** members. For example, the average age of our participants is **12** years. Most of our children have been without health insurance coverage for more than **two and a half** years. The average household income is less than \$20,000 for a family of three, and under \$10,000 for a family of two, well within the federal poverty guidelines **that** would make them eligible for the CHIP program.

Lessons Learned/Critical Success Factors

There are several lessons that we have learned from the development and implementation of our **Kids Care** Program. First, there are individuals who seem to be eligible for the current Medicaid

program but who are unaware of their eligibility or do not want to **apply**. One of the primary reasons for this is the issue of documentation of legal status of parents.

Second, there are significant **language and cultural** barriers that hamper individuals from completing the necessary paper work and obtaining the necessary documentation to verify their eligibility for the Kids Care and potentially the **CHIP** program. Many people cannot obtain necessary documentation. Others do not understand the need for health insurance since it is not something they are accustomed to having.

Third, individuals need a significant amount of assistance and face to face support to complete the application, select their primary care physician and understand how to access health care services.

Fourth, a significant amount of time and resources must be dedicated to community based outreach, education and awareness building. We have found that establishing relationships with community based organizations and social service agencies is critical to getting the word out about the program as well as referring individuals who may be eligible for the program. These include organizations such as the: Office of Maternal and Child Health (MCH), Women Infant & Children (WIC)

program, **the** United Planning Organization (UPO), **community** based health centers, churches, schools, day care centers, ANCs, **and** other **groups who** have **long** standing relationships with the residents of the community and **have** an existing level of trust.

Individuals need assistance **with** completing **forms**, submitting applications, and understanding the documents necessary **to** apply for these programs. Obtaining support from individuals in the community where established relationships and trust exist facilitates the enrollment process. The perception and reality of the bureaucracy and red tape that is involved when applying for Medicaid is a factor that deters many individuals from obtaining the benefits that they or their children are eligible for. We have learned that when there are many detailed forms, multiple applications, and supporting documents that have to be submitted, individuals do not understand all of them and do not **take the** time to complete them. One of the **valuable** lessons learned is that it requires a substantial amount of one-on-one, face-to-face support enrollment of individuals in this type of program. It is absolutely essential to use part of the CHIP money to train outreach workers to

provide this assistance. Partnerships **with** existing outreach efforts should be **strongly** considered.

Other strategies that should be **considered** are building partnerships with targeted schools, grocery stores, churches **and** other community organizations. We learned that educational materials **should** be in Spanish as well as English as there **is** a large Hispanic community that **is** eligible for this program. All materials should be easily understandable, with culturally sensitive language appropriate for city-wide distribution. **A very** detailed, well-planned outreach program **is** needed in order for the District's **CHIP** program to be successful. Funding must be allocated for marketing, education and **outreach** activities.

In terms of program evaluation, Capital Community Health Plan **is** currently in the process of collecting baseline data on all of **our** enrollees which we feel may be helpful information for the District. We are working jointly with United Healthcare and Project HOPE to gather and analyze data on participants enrolled in our Kids Care pilot-program.

The goal is to be able to understand the barriers to care and analyze the

health care service use trends prior to **and** after **the** implementation **of** the Kids Care **program**.

Program Structure and Organization

We believe that expanding the current Medicaid Managed Care Program **is** the most cost effective and expedient method to ensuring that eligible children begin receiving health care coverage **as** soon as possible. The Medicaid Managed Care Program has existing staff, information systems and is in the process of establishing performance and quality monitoring standards that **will** enable the required oversight and evaluation of the **CHIP** program.

However, we believe that modifications to the current Medicaid enrollment process, a shortened enrollment form and process, as well as the use of community based enrollment and eligibility outreach workers, are essential for individuals to enroll in the new **CHIP**.

Furthermore, developing the **CHIP** program through the expansion of the Medicaid program will help prevent any undue delay that is usually involved with creating new systems and services. The District may lose access to the federal matching **funds** if the program is not

developed within the very **short** time frame required. Therefore, we support the Medicaid expansion program option.

In conclusion, we support the direction that the District is taking to provide healthcare coverage for uninsured children. Capital Community Health Plan supports the recommendation of the Mayor's Health Policy Council to begin the **CHIP** program with a Medicaid expansion and that the **CHIP** program should be an integral part of the managed care delivery system.

We are very excited about the District's efforts to move forward **quickly** with the **CHIP** Initiative. We are available to offer any **support**, and share our expertise to **your** Committee and the District as you continue to develop the program.

Thank you for the opportunity to provide comments this morning. We will be glad to answer any questions you may have at this time.

APPENDIX M

BULLETIN BOARD

Expanded Health Care for D.C. Children Is Subject of Meetings With City Officials

The D.C. Department of Health and D.C. Council members from seven wards are sponsoring a series of meetings to discuss "Healthy D.C. Kids," a program that will expand health coverage to uninsured youths in the District. Meetings will be held from 6:30 to 8:30 p.m. at locations in each ward except Ward 3.

The Children's Health Insurance Program uses \$12 million a year in federal funds with several million in local matching funds. It will ensure health coverage to children under age 19 whose families earn too much to qualify for Medicaid services but do not have private health insurance coverage. It also will extend health insurance to children whose families have incomes lower than 200 percent of the federal poverty level.

The dates and locations for the meetings include:

Feb. 12 at Rehoboth Baptist Church, 621 Alabama Ave. SE; Feb. 17 at Brookland Manor Boys and Girls Club, 2525 14th St. SE; Feb. 18 at St. Luke's Catholic Church, 4920 East Capitol St. SE; Feb. 19 at Parkside Elementary School, Warder and Newton streets NW; Feb. 23 at the 4th District Police Station, 6001 Georgia Ave. NW; March 2 at St. John's Baptist Church, 610 Ninth St. NW; and March 4 at Hinrichsen High School, Seventh Street and Pennsylvania Avenue SE.



Uninsured DC Children Will Soon Have a New Health Coverage Option

The Balanced Budget Act of 1997 created a new program — the State Children's Health Insurance Program (CHIP). The purpose of this new program is "to provide funds to states to enable them to initiate and expand the provision of child health assistance to uninsured low-income children in an effective and efficient manner that is coordinated with other sources of health benefit coverage for children."

On December 9, 1997, the Mayor's Health Policy Council, a public/private collaborative that focuses on developing health policy options to address pressing issues, approved a recommendation for the Department of Health to start a State Child Health Insurance Program with funds available from the Federal government.

According to the Health Policy Council, the District is eligible to receive 12 million dollars per year to provide health insurance coverage to uninsured children in families with incomes up to 200 percent of the federal poverty level. Accordingly, the District must provide approximately \$3 million annually in appropriated matching funds. Up to 10% of the expended funds are to be used for program administration, public education, and outreach activities. The Commission of Health Care Finance has funds in its approved FY98 budget to provide city matching funds for the federal dollars. Currently, there are over 8,000 children in the District of Columbia who would be eligible to enroll in the new program.

To receive these funds the District must submit a plan to the Federal government by the end of June 1998. To receive federal approval, the plan must describe: (a) how the program will be structured and implemented (e.g. Medicaid vs. separate program); (b) the children who will be covered under the program; and (c) how the District will monitor certain quality standards. The Health Policy Council has also recommended that the District include a provision in the plan that allows the City to provide Medicaid coverage to all eligible children (for a full year) regardless of fluctuations in family income.

States and the District have the option to spend CHIP funds to: (a) expand Medicaid coverage to targeted low-income children; (b) support a separate child health insurance program to cover targeted low-income children; and (c) combine both approaches. The Health Policy Council recommendation was that the District begin the CHIP

program with a Medicaid expansion to later on incorporated into the managed care service delivery system.

The District will take the Medicaid expansion option because: (a) it allows the District to start the CHIP program within a short period of time; (b) the Medicaid benefit package, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is more generous compared with private plans; (c) it allows the District to develop the CHIP program on a well established administrative structure; (d) families that include both Medicaid enrollees and child health enrollees will be able to use a single set of providers; and (e) children covered under a Medicaid expansion remain eligible for Medicaid even if the new allotment of federal funds is depleted.

According to the Lewin Group, who has conducted research on the number of uninsured children in the District under contract with the Medicaid agency, the following numbers have emerged.

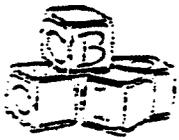
- There are approximately 112,557 children under the age of 19 in the District of Columbia
- Approximately, 67,734 (60.2%) of the 112,557 children are currently enrolled in Medicaid.
- Approximately, 30,074 (26.7%) have insurance coverage from another source, such as an employer-sponsored plan
- Approximately, 3,404 uninsured children are in households at or above 200% of the poverty level.
- Based upon a 76% enrollment rate for uninsured eligible children and 20% enrollment rate for children transferring from other programs, approximately 8,000 children could enroll in the CHIP program during its first full year.

Following the recommendations of the Policy Council, a series of public forums to present the CHIP plan took place at various locations including: Bethlehem Baptist Church (January 12), First Baptist Church (January 14), Calvary Baptist Church (January 13) and Sacred Heart Church (January 20). During these meetings the CHIP program and its eligibility requirements were discussed.

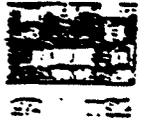
After the community meetings, and to address the issue of Medicaid for immigrants a Task Force was established. The first meeting took place on March 5, 1998 at the Commission of Health Care Finance. For more information on the Task Force call Linda Flowers, Medicaid Policy Analyst at (202) 645-5057.

APPENDIX N

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NOTICE



TO ALL
COMMUNITY LEADERS
AND
HEALTH CARE PROVIDERS
YOU ARE CORDIALLY INVITED TO
ATTEND A COMMUNITY FORUM ON
THE CHILDREN'S
HEALTH INSURANCE
PROGRAM

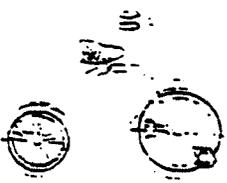
SPONSORED BY
THE DEPARTMENT OF HEALTH
AND COUNCILMEMBER SANDY ALLEN, (WARD 8)

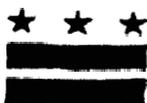
THURSDAY FEBRUARY 12, 1998
REHOBOTH BAPTIST CHURCH
821 ALABAMA AVENUE S.E.
TIME: 8:30 P.M. TIL 9:30 P.M.

IF YOU PLAN TO ATTEND OR NEED FURTHER INFORMATION
CONCERNING THIS IMPORTANT ISSUE..

PLEASE CALL
YVONNE GUEEN DEPARTMENT OF HEALTH

(202) 645-5640





GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH

OFFICE OF DIRECTOR

(202) 645-5556
FAX: 645-0526

MAILING ADDRESS:

800 9TH STREET, S.W.
3RD FLOOR
WASHINGTON, D.C. 20024-2493

NEWS RELEASE

FOR IMMEDIATE RELEASE

February 3, 1998

CONTACT: Phillipa Mezile

202/645-5506

**D.C. HEALTH DEPARTMENT, COUNCILMEMBERS TO CO-HOST CHILDREN'S
HEALTH INSURANCE FORUMS IN SEVEN WARDS**

The D.C. Department of Health and seven Ward Councilmembers will co-host a series of meetings to discuss "Healthy D.C. Kids," a program designed to expand health coverage to 8,000 currently uninsured District youngsters. Each meeting will be held 6:30 p.m. to 8:30 p.m. at various locations and dates between February 12 to March 4, 1998.

The new program, the Children's Health Insurance Program (CHIP), which was created under Title XXI of the Social Security Act, earmarks \$12 million a year in federal funds along with a 43 million local match to implement the program. It will ensure health coverage to children under age 19 whose families earn too much to qualify for traditional Medicaid services, but do not have private health insurance coverage. The new program will extend health insurance coverage to children whose families earn less than 200 percent of the federal poverty level.

"This is a comprehensive health insurance program which will utilize Medicaid funding to provide critical coverage to District youth," said Allan S. Noonan, M.D., M.P.H., Director of the D.C. Department of Health.

Public comment on the plan is invited. The dates and locations for the meetings are as follows:

Ward 1--Thursday, February 19, 1998

Parkview Elementary School, Warder & Newton Sts., N.W.

Contact: Office of Frank Smith, Jr., Ward 1 Councilmember, 724-8024

Ward 2--Monday, March 2, 1998

Shiloh Baptist Church, 610 9th St., N.W.

Contact: Office of Jack Evans, Ward 2 Councilmember, 724-8058

-more-

Children's Health - 2

Ward 4--Monday, February 23, 1998
Fourth District Police **Station**
6001 Georgia Ave., N.W.
Contact: Office of **Charlene Daw Jarvis**, Ward 4 Councilmember, 724-8052

Ward 5 --Tuesday February 17, 1998
Brookland Manor Boys & Girls Club, 2525 14th St., N.E.
Contact: Office of **Harry Thomas**, Ward 5 Councilmember, 724-8024

Ward 6 --March 4
Hine Jr. High School, 7th & Pennsylvania Ave., S.E.
Contact: Office of **Sharon Ambrose**, Ward 6 Councilmember, 724-8072

Ward 7--Wednesday, February 18, 1998
St. Luke's Catholic Church, 4920 East Capitol St., S.E.
Contact: Office of **Kevin Chavous**, Ward 7 Councilmember, 724-8068

Ward 8--Thursday, February 12, 1998
Rehoboth Baptist Church, 621 Alabama Ave., S.E.
Contact: Office of **Sandra Allen**, Ward 8 Councilmember, 724-8045

Please call the Ward offices for specific information. For general information, contact the Department of Health, 645-5640.