kaiser commission on medicaid and the uninsured

S-CHIP Administration and Accountability

Prepared by
Margaret A. McManus
and Harriette B. Fox
Maternal and Child Health Policy Research Center
for
The Kaiser Commission on
Medicaid and the Uninsured

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THE HENRY J. KAISER FAMILY FOUNDATION

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The Kaiser Commission on Medicaid and the Uninsured serves as a policy institute and forum for analyzing health care coverage and access for the low-income population and assessing options for reform. The Commission, begun in 1991, strives to bring increased public awareness and expanded analytic effort to the policy debate over health coverage and access, with a special focus on Medicaid and the uninsured. The Commission is a major initiative of the Henry J. Kaiser Family Foundation and is based at the Foundation's Washington, D.C. office.

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EXECUTIVE SUMMARY

This issue brief examines the design and implementation of the State Children's Health Insurance Program (S-CHIP) as it affects administration and accountability. The brief is based on a study of S-CHIP programs in five states, of which three—California, Connecticut, and Utah—opted to enroll S-CHIP eligible children into new private health insurance arrangements, and two—Maryland and Missouri—chose to insure them through Medicaid. For each state, we conducted one or more site visits, meeting with the S-CHIP program director and senior staff; the medical director and other key staff from the two managed care organizations with the largest S-CHIP enrollment; key staff from their behavioral health subcontractors or the state's behavioral health plan; a variety of physical and mental health care providers; and families. We also conducted a detailed analysis of all relevant S-CHIP documents and available enrollment, capitation, and quality data.

Our major study findings with respect to administration and accountability suggest non-Medicaid S-CHIP programs faced more administrative challenges than Medicaid S-CHIP programs did. However, all of the programs during their first year of operation were focused primarily on basic design and enrollment activities and gave less attention to administrative functions concerning accountability.

- **Program Design.** Decisions to pursue a Medicaid or non-Medicaid S-CHIP approach were based primarily on states' experiences with their Medicaid program and political pressures for a private option. The three non-Medicaid programs in our study modeled their S-CHIP benefits on their state employees' health benefit packages but charged lower premiums to limit families' out-of-pocket payment liabilities. Concerned with benefit limitations for children with serious physical or mental conditions, however, two of the three programs adopted wrap-around benefit programs.
- **Program Administration.** The three states using non-Medicaid programs selected administrative entities for S-CHIP that they perceived were best able to implement the program quickly and efficiently. Two of the states relied on their Medicaid programs' administrative infrastructure, while the other state, California, used a separate quasi-governmental entity that had previous experience administering subsidized insurance programs.
- **Enrollment.** With respect to specific administrative functions, we found that among our five study states, success with enrollment appeared to be related primarily to a lower band of S-CHIP income eligibility, lack of premiums, and the perceived availability of free care.
- **Cost-sharing.** Premium collection appeared to be accomplished most easily in the states that used third party enrollment brokers, rather than plans. Mechanisms for tracking families' out-of-pocket expenses seemed to work best in the states that chose not to place responsibility on families, although very few families in any of the five states reached the five-percent cost-sharing maximum.

- **Quality Oversight.** With respect to mechanisms for accountability, we found that S-CHIP quality information for year one was unavailable in all five states, even in the two Medicaid states that had extensive quality reporting requirements in place, since data for the S-CHIP children were not separated from data for regular Medicaid children. Although S-CHIP officials in the five states all perceived that families were satisfied with their new coverage and had few complaints, S-CHIP data on complaints and grievances were available only from the non-Medicaid programs.

Introduction and Methods

This report, prepared for The Kaiser Commission on Medicaid and the Uninsured, is part of a larger study focusing on implementation issues and challenges during the first year of S-CHIP operation in five states. Our goal was to understand how program arrangements and plan requirements influence the delivery and quality of care for S-CHIP participants and the ease of program implementation for states. In particular, we wanted to assess the differences between Medicaid and non-Medicaid programs. Other topics addressed in separate reports in this series are state managed care contracting, access to care by adolescents, and access to care by children with special health care needs.

Our study states were California, Connecticut, Maryland, Missouri, and Utah. Three of the five states—California, Connecticut, and Utah—developed non-Medicaid programs. The other two—Maryland and Missouri—chose to serve S-CHIP children through Medicaid. The following is a description of the programs, current as of their first year of S-CHIP implementation.

- **California's** non-Medicaid S-CHIP program, Healthy Families, began offering coverage to children in families with incomes above Medicaid eligibility levels[1] and below 200 percent of the federal poverty level on July 1, 1998. The program is unique in that it is administered by a quasi-governmental entity, the Managed Risk Medical Insurance Board (MRMIB). Healthy Families participants, all of whom are charged monthly premiums and copayments, receive a benefit package modeled after the insurance program for state employees. Children with intensive physical or mental health needs were eligible for supplemental benefits which, along with their other specialty services, were furnished at no cost through two wrap-around programs operated by the state's Title V program, California Children's Services (CCS), and the county mental health systems. At the end of its first year of operation, Healthy Families was serving 138,869 children.
- **Connecticut's** non-Medicaid S-CHIP program, HUSKY B, which serves children in families with incomes above Medicaid eligibility levels,[2] began enrolling them on July 1, 1998. The program is administered by the state Medicaid agency. Its participants, all of whom are charged copayments, receive the state employees' benefit package. Those with incomes above 225 percent of poverty are required to pay monthly premiums; those with incomes above 300 percent of poverty may buy into the program at full cost. Supplemental services furnished through HUSKY Plus Physical or HUSKY Plus Behavioral are available at no cost to children in families with incomes below 300 percent of poverty who have special physical or mental health needs. After one year of operation, 3,543 children were participating in HUSKY B.
- **Utah's** non-Medicaid S-CHIP program, CHIP, opened enrollment on August 1, 1998 to children in families with incomes above Medicaid eligibility levels[3] and below 200 percent of the federal poverty level. The state's Medicaid agency administers the

[1] Prior to S-CHIP, California's Medicaid eligibility levels were set at 200 percent of poverty for infants, 133 percent of poverty for children ages 1 to 6, and 100 percent of poverty for children ages 6 to 15.

[2] Prior to S-CHIP, Connecticut's Medicaid eligibility levels were set at 185 percent of poverty for children up to age 15 and 100 percent of poverty for children ages 15 to 19.

[3] Prior to S-CHIP, Utah's Medicaid eligibility levels were set at 133 percent of poverty for children up to age six and 100 percent of poverty for children up to age 19.

program, which provides benefits actuarially equivalent to the state employees' benefit package. Although the program does not impose any premium charges, it requires all participants to pay copayments and those with higher incomes to pay coinsurance for certain services. One year after implementation, CHIP was serving 10,279 children.

- **Maryland's** Medicaid S-CHIP program, the Maryland Children's Health Insurance Program (MCHIP), began offering coverage to all children below 200 percent of the federal poverty level[4] on July 1, 1998. Participants receive full Medicaid benefits with no cost-sharing obligations. Children with one of 33 physical diagnoses may opt out of managed care enrollment and enroll in the Rare and Expensive Case Management Program. According to the state, approximately 57,000 children were participating at the end of MCHIP's first year of operation; however, because of a previously approved Medicaid waiver program that provided limited benefits, the state receives the enhanced federal match rate for only 14,975 children, those with incomes between 185 and 200 percent of poverty.
- **Missouri's** Medicaid S-CHIP program, MC+ for Kids, became operational on July 1, 1998, offering coverage to all children in families with incomes below 300 percent of the federal poverty level.[5] Because Missouri operates its Medicaid program under an approved section 1115 research and demonstration waiver, the state was allowed to modify its existing Medicaid waiver to include S-CHIP participants. All MC+ for Kids participants are charged copayments, and those in families with incomes above 235 percent of poverty are required to pay monthly premiums. Participants receive full Medicaid benefits, with the exception of nonemergency transportation. At the end of its first year of operation, MC+ for Kids was serving 68,475 children.[6]

In addition to selecting states that would enable us to compare Medicaid and non-Medicaid approaches, we required that the study states be operating their S-CHIP programs for at least one year and that they set their upper income eligibility level no lower than 200 percent of the federal poverty level. We also sought to obtain geographic representation and some variation in covered services, cost-sharing requirements, and administrative structure. For example, California and Connecticut have relatively modest cost-sharing requirements, at least for physical health, under their non-Medicaid programs and supplement their basic benefit package with coverage for children with intensive needs. Utah, by contrast, operates a non-Medicaid program that more closely mirrors traditional health insurance. In addition, California uses a quasi-public entity to administer its program, while the other four states rely on their Medicaid administrative structure.

At the outset of the project, we developed a detailed set of core research questions. These questions primarily addressed the intent and effect of various state and plan policies, such as state contract requirements regarding benefits, provider networks, and quality assurance and plan

[4] Prior to S-CHIP, Maryland's Medicaid eligibility levels were set at 185 percent of poverty for infants, 133 percent of poverty for children ages 1 to 6, 100 percent of poverty for children ages 6 to 16, and 34 percent of poverty for children ages 16 to 19.

[5] Prior to S-CHIP, Missouri's Medicaid eligibility levels were set at 185 percent of poverty for infants, 133 percent of poverty for children ages 1 to 6, and 100 percent of poverty for children ages 6 to 19.

[6] Missouri was the only one of the five states not to serve S-CHIP participants through managed care on a statewide basis. Missouri's program operated on a fee-for-service basis in certain rural areas of the state.

payment and authorization policies for important covered services. From these core questions, we developed a model survey instrument for each of the groups to be interviewed. Based on our analysis of each state's S-CHIP plan and contract documents, we modified each instrument to reflect state-specific program arrangements. Each interview took approximately two hours to conduct and was later followed up by additional telephone interviews and data requests to verify or clarify the information provided.

For each state, we conducted our site visits between September 1999 and February 2000, meeting with the S-CHIP program director and senior staff; the medical director and other key staff from the two managed care plans with the largest S-CHIP enrollment; providers; and families whose children have special needs. Interviews with S-CHIP officials took place in the state agency offices, and other interviews were conducted in the communities where the state's two largest S-CHIP plans were based. Providers and families typically attended the group interviews from surrounding areas. Only in California, because of its size, was our sample of providers and families limited to a certain geographic area (Los Angeles).

The study is essentially a qualitative study that attempts to glean from the various perspectives of the state, the plans, providers, and families what the first year's experience of the five S-CHIP programs has been—what aspects of the program appear to be working well and what aspects are causing difficulties or confusion. Our findings are not based on large administrative data sets, chart reviews, or consumer satisfaction surveys, although we sought to obtain such data when they were available. Rather, the findings are based primarily on the opinions and insights of key decision makers as well as providers and families affected by state and plan policies. Often the responses of different groups were at odds, and understanding the complete picture was difficult. In these instances, we attempted to piece together what were the facts and underlying issues. The reader should keep in mind that our findings are based on a small sample of S-CHIP programs and therefore may not be generalizable to the experiences of other programs. In addition, our findings are current only as of the date of our site visit. All five S-CHIP programs have now begun their third year of operation, and, as enrollment has grown and plans and providers become more experienced with the program, substantial changes have likely occurred.

This issue brief on administration and accountability is divided into three sections. The first addresses how the five S-CHIP programs in our study made their basic program design decisions. The second examines how they chose to have their programs administered. The third discusses their experiences related to the administrative challenges of enrollment, premium collection, tracking mechanisms for cost sharing, quality oversight, and complaints and grievances. The appendix provides a short summary of each state's S-CHIP program and also includes three tables. Appendix Table I provides a summary of the five states' S-CHIP programs, Table II describes their benefits in detail, and Table III describes their cost-sharing requirements.

Program Design Decisions

The five states in our S-CHIP study based their decisions about whether to establish a Medicaid or non-Medicaid S-CHIP program on a variety of factors, the most compelling of which seemed to be the nature of the political climate and their experiences with the Medicaid program. Maryland and Missouri chose a Medicaid approach because of their recently approved section 1115

demonstration waivers. Maryland had implemented its waiver in the summer of 1997, a year before the S-CHIP expansion. Missouri had submitted its section 1115 waiver application to cover uninsured children and adults in 1997, just a few months prior to the enactment of S-CHIP. Other reasons that officials in the two states cited for pursuing a Medicaid option were administrative ease, simplicity, and support by advocates. There was a strong desire in these states to build an S-CHIP program based on their existing Medicaid managed care policies and plans. Both Medicaid states, however, incorporated program components that responded to political pressures for a private option. Maryland's legislature required the S-CHIP program to develop a private option for uninsured children with family incomes between 185 and 200 percent of poverty, and Missouri's legislature required premiums and copayments comparable to those required of its state employees.

California, Connecticut, and Utah adopted a non-Medicaid approach based on the strong preference of each of their governors for a private health insurance option and equity concerns with other employer-based benefit plans. Other reasons cited for using a non-Medicaid approach were concerns about the entitlement nature of Medicaid and the long-term federal funding for S-CHIP, the costs associated with the treatment component of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, the negative associations of Medicaid with welfare, the desire for greater flexibility and less federal oversight, and the belief that individuals should assume responsibility for their own health care coverage.[7]

Among the three non-Medicaid states, S-CHIP benefit packages were closely modeled after those of their state employee health benefit plans (See Appendix Table II). California and Utah, however, added certain services that would not have otherwise been included.[8] With respect to cost sharing, the states largely evolved their own policies primarily to minimize the likelihood that families would reach the federal limit of five-percent of household income for out-of-pocket spending on S-CHIP cost sharing (See Appendix Table III). California imposed premiums and copayments for all S-CHIP participants but reduced the outpatient mental health copayment, while Connecticut imposed premiums and copayments only for children in the highest income group.[9] Utah elected not to charge any premiums; however, it imposed modest copayments on children in the lower income group[10] and copayments and coinsurance equal to those in the private sector[11] for children in the higher income group.[12] The states charging premiums believed

[7] Of our five study states, California was the only one that conducted any actuarial studies comparing the costs of a Medicaid versus a non-Medicaid approach. Two studies in fact were conducted—one sponsored by the state and the other by The Henry J. Kaiser Family Foundation. The state study found that a non-Medicaid option would be less expensive. The foundation study came to the opposite conclusion, primarily because of lower utilization assumptions for the S-CHIP population compared with the Medicaid population.

[8] California added vision and comprehensive dental services; Utah added vision services.

[9] Connecticut imposed $30 and $50 premiums for children in families with incomes above 235 percent and the full premium for those with family incomes above 300 percent of poverty.

[10] Utah charged $2, $5, and $10 copayments depending on the service for children in families with incomes between 100 and 150 percent of the federal poverty level.

[11] The only difference from the state employees health benefit plan was that the prescription coinsurance requirement was changed to a copayment.

[12] Utah charged $4, $10, and $30 copayments and 10 percent, 20 percent, and 50 percent coinsurance depending on the service for children in families with incomes between 151 and 200 percent of the federal poverty level.

that paying for coverage would permit greater public acceptance, deter "crowd-out," or substitution, of private coverage, and allow more eligible children to be served with the available funding. The states charging copayments or coinsurance were motivated by the desire to establish equity with privately insured children and the perception that higher income families would be more comfortable contributing to the cost of their children's care.

Still, among the states that chose the non-Medicaid S-CHIP option, there was some concern about the comprehensiveness of the benefits for children with special needs. Both California and Connecticut elected to offer extensive supplemental or wrap-around benefit packages for children with serious physical and behavioral health conditions, although the design and administration of the two wrap-around programs differed to some extent.[13] S-CHIP officials in the two states believed they could control costs by applying specific medical eligibility criteria. Utah chose not to provide additional benefits to children with special needs because of concerns about inequities for most employed families in the state. It did require in its contract, however, that managed care plans allow one out-of-network outpatient team evaluation and one follow-up visit for Title V services[14] without prior authorization requirements.

Overall, state S-CHIP officials perceived that the program choices they made were appropriate and cost-effective. In California and Utah, officials were satisfied with the separate non-Medicaid approach, despite the relatively small size of the participating population. They believed that the ability to require managed care enrollment statewide contributed to their programs' efficiency. Only Connecticut staff thought that a different choice might have been more economical. This was because the state experienced such low enrollment for S-CHIP, with most of the respondents to its outreach efforts found eligible for Medicaid.

Administrative Decisions

To administer their non-Medicaid S-CHIP programs, Connecticut and Utah relied on their Medicaid programs' administrative infrastructure. Connecticut officials wanted to implement S-CHIP quickly, and they saw in the Medicaid program the availability of experienced staff and proven operational systems. By drawing on Medicaid program resources, they presumed they would be in the best position to initiate plan selection and contracting and to create a seamless system for eligibility determinations and enrollment verifications. They expected too that this approach would be the least costly. Utah, also looking to control costs, chose to issue a request for proposals to administer S-CHIP. Bids were received from a private insurer as well as the state Medicaid program, but the private insurer, which would have had to set up a completely new infrastructure to meet state requirements, could not match Medicaid's administrative costs.

[13] Connecticut opted to create separate plans—one for special physical health care needs and the other for behavioral health needs—and to contract directly with its major centers of excellence to manage the provider networks. California did not establish separate plans, but instead contracted directly with its existing state Title V program and its state/county mental health departments to deliver the supplemental services.

[14] Title V of the Social Security Act provides federal block grant funds to the states for child health services. At least 30 percent of each state's block grant must go towards services for children with special health care needs, although states are able to define their own medical criteria and establish their own policies for covered services.

California chose to use a quasi-governmental entity—the Managed Risk Medical Insurance Board (MRMIB)—to administer S-CHIP. The legislature made the decision not to use the Medicaid infrastructure purportedly because it was viewed as large and unwieldy. It selected MRMIB because of its more efficient management style and prior experience operating two other public insurance programs, one for low-income mothers and infants and one for persons considered to be high insurance risks.

In general, the outcomes of administrative decisions made by the five states reflect tradeoffs between costs and effectiveness. In California, a separate administrative entity with a fairly large staff may have cost the state more money, but it appears to have evolved as a well-organized, self-contained entity able to carry out its required functions. The S-CHIP programs in Connecticut and Utah, which have relatively small numbers of dedicated staff working out of the Medicaid offices, may actually have more difficulties accomplishing S-CHIP functions because the Medicaid staff they rely on are already committed to other tasks. By contrast, the S-CHIP programs in Maryland and Missouri have the least complicated administrative structure, but they also have the least information on the S-CHIP population distinct from regular Medicaid-eligible children.

Implementation Challenges

Enrollment

Among the five states in our study, enrollment of potentially eligible S-CHIP children varied considerably at the end of year one, as shown in Table I. Based on estimates of the actual-to-expected number of enrollees, S-CHIP enrollment rates appeared to have had more to do with income eligibility levels, use of premiums, and perceptions regarding the availability of low-cost or free care, than they did with the type of program approach used.[15] Assuming that states' projections were accurate, Maryland enrolled the largest proportion of potentially eligible S-CHIP children, while Connecticut enrolled the smallest proportion. Utah attributed its success to the absence of premiums, use of a private versus a Medicaid option, effective outreach and enrollment strategies, a simplified application form, and the lack of alternative forms of affordable health insurance coverage. Connecticut's lower enrollment rate was attributed to the ready availability of free care at hospitals, the requirement to pay premiums, and possibly also to the fact that higher income families may choose to purchase care as needed rather than become insured. The required six-month period of uninsurance was another factor reported to have caused low enrollment in Connecticut, as it was in Missouri.

The three states in our study operating non-Medicaid S-CHIP programs initially encountered more challenges in setting up their enrollment system than Medicaid states did. In these states, S-CHIP staff had to establish linked eligibility determination processes and mechanisms for notifying ineligible families about their potential eligibility for Medicaid, and Medicaid staff also had to develop a comparable system for notifying the S-CHIP program about potentially eligible

[15]Not until state or national household surveys are analyzed for the period between 1998 and 1999 will a definitive assessment of states' enrollment success be available.

Table I

S-CHIP Enrollment Estimates in the Five Study States During the First Year of S-CHIP Implementation

	California	Connecticut	Maryland	Missouri	Utah
S-CHIP Start Date	7/1/98	7/1/98	7/1/98	7/1/98	8/1/98
S-CHIP Eligibility Levels					
Infants	200–250%	185–300%	185–200%	185–300%	133–200%
Children Ages 1–6	133–200%	185–300%	133–200%	133–300%	133–200%
Older Children	100–200%	185–300%	100–200%	100–300%	100–200%
Number of S-CHIP Enrollees	138,869	3,543	57,000	42,251	10,729
Number of State-Projected S-CHIP Enrollees	200,400	15,000	46,500	68,475	10,000
Percentage of Actual-to-Projected Enrollees	69.3%	25.1%	123%	61.7%	107%

Source: Information obtained by the Maternal and Child Health Policy Research Center through detailed on-site and follow-up telephone interviews with S-CHIP officials.

Notes: *Maryland data include infants in families with incomes between 185 and 200 percent of poverty, children ages 1 to 6 with family incomes between 133 and 200 percent of poverty, children ages 6 to 16 with family incomes between 100 and 200 percent of poverty, and children ages 16 to 19 with family incomes between 34 and 200 percent of poverty.

families. Connecticut and Utah used the same enrollment brokers for the S-CHIP and Medicaid programs, which facilitated the exchange of information. California, by contrast, used separate administrative vendors for S-CHIP and Medicaid and required families either to apply separately or consent formally to have their applications shared between the two programs.

Premium Collection

In California, Connecticut, and Missouri, state officials had to establish a mechanism for collecting monthly premiums. From the states' perspective, monthly premium amounts, which ranged from $4 to $194 depending on the state and the family's level of income, as shown in Appendix Table III, were fair. Only staff from Missouri's Medicaid S-CHIP program expressed concerns about the premium amount possibly being too high.[16] In the non-Medicaid states, California[17] and Connecticut,[18] S-CHIP staff considered premiums to be both affordable and a good value. Although nonpayment of premiums was the leading reason for disenrollment in the three states charging

[16] Missouri's premium was $65 per family with incomes above 225 percent of poverty.

[17] California's premium in year one was $7 per child and $14 for two or more children in families with incomes between 101 and 150 percent of the federal poverty level. For children in families with incomes between 151 and 200 percent of the federal poverty level, the premium was $9 per child and $27 for three or more children. Families choosing the community provider plan in their county paid a reduced premium of $4–$8 or $6–$18, depending on family income and size.

[18] Connecticut's premium was $30 per child and $50 for two or more children in families with incomes above 235 to 300 percent of the federal poverty level. Families with incomes over 300 percent of the federal poverty level paid the full group rate with no state subsidies. These monthly rates, depending on the plan, ranged from $113.87 to $194.37.

premiums, the proportion that had disenrolled in the first year was very low. Whether premium amounts factor into reenrollment is an issue that our study could not address.

Premium collection, according to S-CHIP officials, had gone relatively well, particularly in California and Missouri where third party enrollment brokers collected premiums. Connecticut, which assigned this responsibility to its managed care plans, reported that plans found premium collection expensive and burdensome, given the small amount of money collected each month and the need to maintain records of family size and income as well as premium payments. Each of the three states established grace periods for late payments (ranging from 60 to 90 days),[19] but only California instituted a special administrative mechanism to facilitate the collection of premiums. It allowed families to pay their premiums for three months at a time and receive the fourth month at no cost, a policy that reportedly has been quite popular among S-CHIP families and minimized administrative burdens for the state.

Tracking Cost Sharing

Another administrative challenge for the four states (all but Maryland) that had cost-sharing requirements was tracking families' out-of-pocket expenditures to determine if they reached the federally required five-percent limit of household income. Although the four states had ultimate responsibility for assuring that families with incomes over 150 percent of poverty did not exceed the out-of-pocket maximum, each adopted different policies for tracking and notification, with very different implications for plans, providers, and families. California and Missouri both relied on families to track their own out-of-pocket expenses. However, in California, families were expected to notify the plans when they met the out-of-pocket limit of $250, at which point the plan would inform providers when they called to verify enrollment and adjust their reimbursement amount accordingly. In Missouri—where copayments were additional to providers' regular Medicaid payments and were not consistently collected—families were expected to send their out-of-pocket expense information directly to the state S-CHIP office. When the five-percent maximum had been reached, the state would modify its provider swipe card system to indicate that copayments would no longer be charged. In both states, the extent to which families understood the system was unclear. Those we interviewed were either confused about the maximum cost-sharing requirement or unaware of their maximum obligation or even that tracking was their responsibility.

Neither Connecticut nor Utah placed any tracking responsibilities on families. Connecticut relied instead on plans, given that they were responsible for furnishing all covered services and could make assumptions about copayment amounts based on utilization data. When the maximum was reached, plans were expected to notify families and (through the enrollment broker) the state as well, but only one of the two largest plans had intended to adjust provider payments. Utah maintained tracking responsibility at the state level so that it could merge utilization data submitted separately by medical and dental plans. When out-of-pocket liabilities were met, the S-CHIP program would forward the file to the plans, which then would adjust provider reimbursements and notify the families. During the lag period between the time families reached their limits and the S-CHIP program made its notifications, families could be reimbursed for any out-of-pocket outlays they incurred. Families in these states also were not clear about the maximum out-of-pocket policies.

[19] In each state, the grace periods were followed by lock-out periods of three to six months.

Regardless of the tracking approach used, however, states perceived that their methods for complying with the maximum cost-sharing requirement were sufficient, given that few families would likely reach their limits since premiums, copayments, and coinsurance charges were generally so low. In fact, only a very small number of families reportedly met the five-percent maximum in the first year of S-CHIP implementation,[20] even in Utah where copayments and coinsurance were the highest in the country.[21] Overall, it appeared, though, that plans were best able to track utilization and out-of-pocket expenditures. Approaches that relied on families were more problematic.

Quality Oversight

Quality monitoring approaches differed between the Medicaid and non-Medicaid states in our study, but all five states at the end of the first year of operation had limited or no information with which to evaluate plan performance in serving S-CHIP enrolled children. This was largely because of the small number of children enrolled in S-CHIP, the requirement for 12-month continuous eligibility for many HEDIS[22] measures, and the desire to make S-CHIP reporting timetables coincide with those used by Medicaid and commercial plans. Maryland and Missouri had collected extensive internal and external quality performance information from plans in the first year but had not separated the S-CHIP population from the regular Medicaid child population.[23] California, Connecticut, and Utah also did not have information available for the first year. Although the three non-Medicaid programs had some indication of their quality reporting requirements in their contract, each worked with an advisory group and coordinated with their Medicaid programs before finalizing their measures. This delayed the release of the final reporting requirements in these states; in Connecticut, the delay was almost a year after the program's start-up. Connecticut, though, did collect some pediatric quality data from plans in 1998, but it determined that the data could be analyzed only for plans as a whole, not individually.

The two Medicaid S-CHIP programs both established fairly extensive performance reporting requirements, which were viewed by plans and providers as burdensome. These requirements included several early detection and screening measures, EPSDT performance evaluations, and focused studies on chronic conditions.[24] In Maryland, plans had to participate in the state's external quality evaluation, which involved a series of six focused medical record reviews.[25] Plans questioned the methodologies used, which, in some instances, differed from HEDIS specifications. More importantly, they perceived that the standards for plan performance were unrealistic and the use of financial penalties was onerous. In Missouri, plans were required to monitor sentinel events, conduct a focused study,[26] and participate in HEDIS audits, all of which required detailed

[20] There were 11 families in California who reached the five-percent maximum and one child in Utah. In Connecticut and Missouri, no children reached the maximum.

[21] Fox HB, Graham RG, McManus MA, Chen CY. *An Analysis of States' CHIP Policies Affecting Children with Special Health Care Needs.* Washington, DC: Maternal and Child Health Policy Research Center, April 1999.

[22] HEDIS (the Health Plan Employer Data and Information Set) is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA). HEDIS provides purchasers and consumers the ability to evaluate the quality of different plans among a variety of dimensions, including effectiveness of care and use of services.

[23] Maryland and Missouri noted, however, that this could be done only with some difficulty.

[24] See separate issue brief on S-CHIP managed care contracting for a table summarizing each state's quality performance measures.

[25] Maryland's focused studies were on diabetes, immunization status at 24 months, pediatric asthma, prenatal care, EPSDT, and somatic mental health.

[26] In Missouri, the sentinel events that the state required the plans to monitor were sickle cell anemia and AIDS, and the plans could choose two of their own. The state also required a focused study on asthma and external HEDIS audits.

chart reviews. Plans reported that these requirements were excessively time consuming for providers. Both Medicaid states were pursuing a variety of strategies to address the concerns of plans and providers. Maryland was modifying its audit specifications to be more consistent with HEDIS and was assessing its experience with the use of financial penalties. Missouri was relying more on EPSDT administrative data and was also considering having each of the plans contract with a single quality review firm to conduct the requisite chart reviews from all plans at one time.

The extent of quality reporting requirements among the three non-Medicaid S-CHIP programs was more variable, with Utah having the largest number and California the fewest. Overall, they relied on a subset of measures that were used by their Medicaid programs to permit comparisons of utilization, access to care, and satisfaction between the S-CHIP and Medicaid populations. California and Connecticut, in fact, elected not to require any encounter data for S-CHIP, although these data were required for Medicaid. Plans in these states were generally pleased with the states' approach to quality monitoring.

Complaints and Grievances

All of our study states had systems in place for complaints and grievances,[27] and none reported any difficulties in establishing or operating their systems. The procedures for handling complaints and grievances differed substantially between the Medicaid and non-Medicaid S-CHIP programs, however. Maryland and Missouri had more extensive procedures in place than California, Connecticut, and Utah. The Medicaid programs both allowed enrollees to file their complaints and grievances simultaneously with the state and plan, while still encouraging complaint resolution at the plan level. The non-Medicaid programs all required S-CHIP enrollees to exhaust their plan's internal process first before appealing to the state. In addition, Maryland and Missouri required more frequent and detailed reports of complaints and grievances and their resolution. Plans in Connecticut and Utah were required to submit reports on complaints and grievances and their resolution semiannually and those in California were required only to submit information on benefit grievances annually. Maryland's system for complaints and grievances was unique among the five states in our study in that it included a central unit to assist families in filing and also local ombudsmen that could be called in as needed.

While the establishment of complaints and grievance systems are important to assuring plan accountability, they may not actually provide an accurate indication of problems in plan operations at this early stage in S-CHIP implementation. State and plan officials alike reported that S-CHIP enrollees appeared to be very satisfied with their new coverage. The three non-Medicaid programs based this assessment on the small number of complaints and even smaller

[27] HCFA's Notice of Proposed Rulemaking, published in September 1998, implementing the Medicaid managed care provisions of the Balanced Budget Act of 1997, defines a complaint as "any oral or written communication, made by or on behalf of an enrollee expressing dissatisfaction with any aspect of an MCO's or provider's operations, activities, or behavior, regardless of whether remedial action is sought." A grievance is defined as "written communications explicitly addressing dissatisfaction with the following: availability, delivery, or quality; payment, treatment, or reimbursement of claims for services; or issues unresolved through the complaint process."

number of grievances they received—(mostly related to enrollees' requests to switch plans, their confusion over benefits and cost sharing, or other administrative issues)—while the two Medicaid programs in fact had not yet analyzed information for the S-CHIP population apart from Medicaid participants overall. The families we interviewed reported being grateful for S-CHIP coverage. Those experiencing difficulties, however, were either reticent to complain or not yet knowledgeable about the procedures for filing complaints and grievances. Only two S-CHIP programs, those in California and Missouri, included information about the complaints and grievance process in materials given to families. All plans in the five states outlined the complaints and grievance procedures in their handbooks, but with varying detail and clarity.

Conclusions

State officials in the three non-Medicaid states we studied all were satisfied with the S-CHIP administration entity they selected—Medicaid agencies in Connecticut and Utah, and a separate, quasi-governmental agency in California. In each case they perceived that their choice assured that S-CHIP administration was handled most efficiently. Yet, plans in non-Medicaid states using Medicaid agencies reported that the S-CHIP officials sometimes failed to appreciate that S-CHIP was intended to be a commercial product. This was not the case in California, where plans were pleased with the separate administrative agency and its ability to operate the program distinct from Medicaid.

Our study states' focus in the first year of S-CHIP operation was more on administration than on accountability. Compared to the states that chose Medicaid programs, those that chose non-Medicaid programs faced a greater administrative burden in assuring that uninsured children were enrolled into Medicaid, when appropriate. Yet, all of the states had to focus significant resources on start-up tasks. The three non-Medicaid states, and Missouri as well, had to establish new mechanisms for premium collection and tracking families' cost sharing. Even in Maryland, program officials spent time dealing with new program elements. For the most part, each of the states met these challenges, but they were time-consuming and, predictably, left states with limited resources to focus on quality assurance and other accountability activities. As states' S-CHIP programs become more established, they are likely to begin to demand more of plans, in particular, turning their attention to monitoring plans' quality performance, comparing Medicaid and S-CHIP program participants' satisfaction with care, and developing new quality improvement initiatives for children.

APPENDIX

Overview of the Five Study States' S-CHIP Programs

California

California structured its S-CHIP program as a private initiative but also included a small S-CHIP expansion of Medicaid. Concerns that the stigma of Medicaid's association with welfare would discourage enrollment, former Governor Wilson (R) insisted that the S-CHIP program not be affiliated with Medicaid, either in terms of benefits or administration. The state implemented its new program, known as Healthy Families, in July 1998, with the expectation that 328,000 children would be eligible. At the end of the first year, 138,869 children were participating.

Eligibility. California provides S-CHIP eligibility under Medicaid to uninsured adolescents ages 16 to 19 in families with incomes up to 100 percent of the federal poverty level and S-CHIP eligibility under Healthy Families to all uninsured children in families with incomes up to 250 percent of the federal poverty level. During the first year of implementation, however, S-CHIP eligible children ages 14 to 19 in families with incomes up to 100 percent of poverty were covered under Medicaid and under Healthy Families at family income levels up to 200 percent of poverty.[1] To qualify as uninsured, participants must not have had insurance for three months prior to applying, although they can qualify immediately if they have reached the maximum benefit limits offered under employer-sponsored coverage.

Cost sharing is required for all Healthy Families enrollees. Families pay small monthly premiums that vary slightly depending on family income and are charged standard, private sector copayments for certain services.

Coverage. Healthy Families coverage is modeled after CalPERS, the benefit package available through the health insurance program for state employees and retirees. In addition to hospital and physician services, prescription drugs, vision services, and dental care, the benefits include various services offered with specific limitations. These are: skilled nursing care up to 100 days per benefit year; ancillary therapy services up to 60 consecutive calendar days per condition; outpatient mental health services up to 20 visits; inpatient mental health services up to 30 days; outpatient substance abuse crisis intervention and services up to 20 visits; inpatient detoxification; durable medical equipment that primarily serves a medical purpose; and home health care services with the exception of custodial care and long-term physical therapy and rehabilitation.

Enrollees who meet the medical eligibility criteria for California Children's Services (CCS), the Title V program for Children with Special Needs, or who are determined to be seriously emotionally disturbed by the county mental health system receive additional services outside of their managed care plan. Among CCS' benefits are physician subspecialty services, hospital services, ancillary therapy services, prescription drugs, durable medical equipment, medical nutrition therapy, specialty care center services, care coordination, and nonemergency

[1] Prior to S-CHIP, California's Medicaid eligibility levels were set at 200 percent of poverty for infants, 133 percent of poverty for children ages 1 to 6, and 100 percent of poverty for children ages 6 to 15.

transportation. The county mental health systems offer outpatient services, residential treatment services, intensive day treatment, medication support services, crisis intervention services, and targeted case management.

Managed Care Arrangements. Healthy Families is a statewide managed care program that requires all participants to enroll in a health maintenance organization (HMO) or exclusive provider organization (EPO), in addition to separate vision and dental plans. Carved out of the managed care contracts are all wrap-around services as well as dental and vision contracts. Rates for the capitated services vary by region but not age or gender. In most counties, enrollees have a choice of at least two plans, although seven counties have only one EPO available, and three have nine plans from which to choose.

Enrollees eligible for wrap-around benefits receive these services through different arrangements. The CCS programs in each county have their own providers that have met board certification and experience requirements, and the county mental health systems have their own providers—community agencies that contract with or are operated by the counties. In the program's first year, the CCS program received an annual appropriation of $9.7 million and the county mental health systems received an annual appropriation of $9.8 million.

Connecticut

Connecticut's non-Medicaid S-CHIP initiative, known as HUSKY Part B, was implemented in July 1998, along with an S-CHIP expansion of Medicaid, renamed HUSKY Part A. Governor Rowland (R) exerted considerable influence over the program, promoting a primarily private option because of concerns about the scope of EPSDT benefits, the inequity of imposing only nominal cost-sharing charges, and the unpredictability of long-term federal funding. As of June 30, 1999, 3,787 of the estimated 36,700 eligible children were participating in HUSKY B.

Eligibility. Using income disregards, Connecticut's S-CHIP program establishes HUSKY A eligibility for all uninsured adolescents ages 14 to 19 in families with incomes up to 185 percent of the federal poverty level and HUSKY B eligibility for uninsured children up to age 19 in families with incomes between 186 percent and 300 percent of the federal poverty level.[2] To qualify as uninsured, participants must not have had insurance for six months prior to applying for coverage, although there are certain exceptions to this rule, most notably self-employment. Monthly premiums are charged for children in families above 226 percent of poverty. In addition, families with incomes above 300 percent of poverty may purchase HUSKY B coverage for their children at the full group rate negotiated by the state. All HUSKY B participants, regardless of income, are required to pay copayments comparable to the private sector's for most services but higher than usual coinsurance for extended outpatient mental health services.[3]

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[2] Prior to S-CHIP, Connecticut's Medicaid eligibility levels were set at 185 percent of poverty for children up to age 15 and 100 percent of poverty for children ages 15 to 19.

[3] Connecticut has since passed mental health parity legislation that affects the mental health benefit and copayment requirements under S-CHIP. Now there are no inpatient day or outpatient visit limits for mental health services, and the copayment requirement for outpatient mental health services is $5—except for certain conditions: mental retardation; learning, motor skills, and communication disorders; relational problems; and V-codes. For these conditions, the inpatient benefit still is limited to 60 days and the outpatient benefit to 30 visits, and higher copays and coinsurance charges still apply.

Coverage. Children enrolled in HUSKY B receive the state employees' benefit package. In addition to hospital and physician services, skilled nursing, home health, prescription drugs, dental care, and durable medical equipment, the package provides other benefits on a short-term or limited basis. These include: short-term rehabilitation and physical, occupational, and speech therapies; inpatient mental health services up to 60 days; outpatient mental health services up to 30 visits with an option to convert inpatient days; inpatient substance abuse services up to 60 days and for alcohol abuse, 45 days; and outpatient substance abuse services up to 30 visits.

Enrollees who meet certain medical eligibility criteria may receive additional benefits that are limited or not included under the HUSKY B benefit package. These benefits are available through two supplemental "Plus" plans, with no cost-sharing obligations. Children eligible for these benefits remain enrolled in their managed care plans, which continue to be responsible for covered HUSKY B benefits. HUSKY Plus Behavioral offers in-home psychiatric services, mobile crisis services, care coordination, and extended outpatient and day treatment services. HUSKY Plus Physical covers multidisciplinary team consultations, orthodontics, nutritional therapy, hearing aids, specialized medical equipment and supplies, family support services, and extended ancillary therapy, home health, and physician consultation services.

Managed Care Arrangements. During HUSKY B's first year, Connecticut required all children participating in HUSKY B to enroll in one of five managed care plans, all of which are health maintenance organizations and operate statewide. These plans are capitated to provide all services included in the HUSKY B benefit package. The rates they receive vary by plan but not age or other risk factors.

The state has separate contractual arrangements for the Plus programs. Children qualifying for HUSKY Plus Physical receive services from the existing administrators of the Title V program for children with special health care needs. Those who qualify for HUSKY Plus Behavioral receive services from one of 12 child guidance and hospital clinics that contract with the Yale Child Study Center. In the program's first year, the HUSKY Plus programs each received an annual appropriation of $2.5 million.

Maryland

Maryland chose to implement a Medicaid expansion to cover its S-CHIP population because state advocates supported it, and the state Medicaid agency had only recently put into place a section 1115 demonstration waiver program and did not want to start anew with a non-Medicaid approach to S-CHIP. As a condition of approval by the House of Delegates, however, the agency was required to examine the feasibility of eventually developing a private health insurance option for S-CHIP children in families with higher incomes.[4] The state estimated that 60,000 children would become eligible for Medicaid, known as HealthChoice, as a result of S-CHIP and began enrolling the expansion population in July 1998. One year later, 57,000 S-CHIP children had HealthChoice coverage, under the Maryland Children's Health Insurance Program (MCHIP).

[4]The private option has not been implemented, and although the Medicaid agency concluded in December 1998 that the option was not feasible, the House of Delegates required the agency to reconsider its evaluation.

Eligibility. In Maryland, all uninsured children in families up to 200 percent of the federal poverty level are eligible for HealthChoice as S-CHIP participants.[5] However, the level at which S-CHIP eligibility begins, and therefore the size of the S-CHIP population, is viewed differently by the state and the federal government.[6] Prior to the implementation of S-CHIP, Maryland operated a limited-benefit health insurance program, known as KidsCount, under a section 1115 demonstration waiver program for children up to age 15 with family incomes up to 185 percent of poverty. KidsCount ended with the advent of S-CHIP, and participants became eligible for HealthChoice and the full range of Medicaid benefits. The state considers these children to be part of the S-CHIP population. However, despite KidsCount's limited benefits, HCFA does not consider any HealthChoice enrollee with a family income below 185 percent of poverty to be an S-CHIP participant. As a result, the state receives the enhanced matching rate only for enrollees with incomes between 185 and 200 percent of poverty.

Coverage. As HealthChoice participants, MCHIP children receive the full range of Medicaid benefits to which regular Medicaid beneficiaries are entitled. No cost-sharing obligations are imposed.

Managed Care Arrangements. HealthChoice operates as a mandatory, statewide managed care program, and nearly all S-CHIP participants are required to enroll in one of eight managed care organizations. These plans are health maintenance organizations that do not generally operate statewide. Plans contract to provide most Medicaid services. Personal care, early intervention services, and health-related special education services are carved out of capitated contracts and paid for on a fee-for-service basis. In addition, all mental health services are also carved out and paid for under a separate managed care arrangement, called Maryland Health Partners, which the state mental health agency regulates. Beginning in year two, the state also carved out all ancillary therapy services.

Each plan receives the same capitation rate, and the rates vary by enrollees' age, gender, and region. In addition, for S-CHIP participants for whom the state has six months of Medicaid fee-for-service data from 1997—approximately 20 percent of the S-CHIP population—the state uses Adjusted Clinical Groups (ACGs) to adjust rates by diagnosis. Maryland Health Partners is not at financial risk.

The only children excluded from managed care enrollment are those who qualify for the Rare and Expensive Case Management Program (REM).[7] For these children, all care is furnished on a fee-for-service basis.

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[5] Prior to S-CHIP, Maryland's Medicaid eligibility levels were set at 185 percent of poverty for infants, 133 percent of poverty for children ages 1 to 6, 100 percent of poverty for children ages 6 to 16, and 34 percent of poverty for children ages 16 to 19.

[6] Because we were interested in states' perspectives on S-CHIP implementation, we adopted the view of the state government. In our Maryland interviews we inquired about the experiences of newly enrolled children up to age 16 in families with incomes between 100 and 185 percent of the federal poverty level, as well as children in families with incomes between 185 and 200 percent of poverty. Enrollment of S-CHIP participants for whom the state received the enhanced matching rate was 14,975 in July 1999.

[7] REM covers 33 diagnoses, the majority of which are severe physical health problems, such as HIV, spina bifida, hemophilia, ventilator dependent conditions, cystic fibrosis, brain injury, and aplastic anemia.

Missouri

Missouri's S-CHIP program is part of a larger Medicaid expansion covering uninsured adults as well as children. The state had included its current S-CHIP population in a section 1115 demonstration waiver application to HCFA in 1994, although it was never implemented. With the availability of enhanced federal support under S-CHIP, Missouri expanded its Medicaid program, now known as MC+, in September 1999. Eligibility determinations were started several months earlier, and by July 1999, 42,251 of the projected 90,000 children were participating.

Eligibility. Missouri uses income disregards to make all uninsured children in families with incomes up to 300 percent of the federal poverty level eligible for MC+.[8] To qualify as uninsured, participants must not have had insurance for six months prior to the date of application.

Coverage. Children eligible under the expansion are entitled to the complete package of Medicaid benefits, with the exception of nonemergency transportation.[9] However, because S-CHIP participants technically are part of a demonstration waiver, Missouri has been able to require cost sharing greater than what would otherwise be permitted for Medicaid recipients. Beginning in January 1999, families with incomes between 226 percent and 300 percent of poverty are required to pay monthly premiums, identical to those for state employees, and all S-CHIP families are required to pay copayments for office visits and prescription drugs, although the amount varies depending on family income.

Managed Care Arrangements. Missouri does not require all S-CHIP participants to select a managed care organization. Children meeting SSI disability criteria are exempt, as are children living in certain areas of the state. These children, who comprise slightly more than half of the MC+ population, receive Medicaid services on a fee-for-service basis. All other S-CHIP children are required to enroll in one of the three or four managed care organizations that may operate in their region; there are nine operating in the state. All of these plans are health maintenance organizations, and most are provider-sponsored. The plans are capitated to provide nearly all Medicaid benefits; only early intervention services, health-related special education services, certain mental health services for children with severe emotional disturbances, and substance abuse services offered through the state's Comprehensive Substance Abuse and Rehabilitation Program (C-STAR) are carved out of their contracts.

Capitation rates for S-CHIP participants vary according to an enrollee's age, gender, and region, as they do for other Medicaid beneficiaries. The rates are slightly lower than the regular Medicaid rates, however, because the S-CHIP benefits do not include non-emergency transportation.

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[8] Prior to S-CHIP, Missouri's Medicaid eligibility levels were set at 185 percent of poverty for infants, 133 percent of poverty for children ages 1 to 6, and 100 percent of poverty for children ages 6 to 19.

[9] The state excluded this benefit for two reasons: one, it did not want to encourage crowd-out by offering a benefit package that was wholly unlike any offered in the commercial market and two, it reasoned that higher income enrollees would not have the same need for transportation as lower income enrollees.

Utah

Utah implemented a non-Medicaid S-CHIP program in August 1998. Reflecting Governor Leavitt's (R) philosophy that publicly subsidized health insurance should be comparable to private insurance otherwise available to families with similar incomes, the state modeled its program after the private plan for state employees. At the end of the program's first year of operation, the state had 10,729 children participating, more than half of the anticipated 20,000.

Eligibility. Eligibility for S-CHIP is open to all uninsured children up to age 19 in families with incomes at or below 200 percent of the federal poverty level.[10] To qualify as uninsured, a child must not have had insurance during the prior three-month period. Children in families with incomes between 100 and 150 percent of poverty participate in Plan A, and children in families with incomes between 151 and 200 percent of poverty participate in Plan B. Although benefits for both plans are the same, cost-sharing requirements differ. Under Plan A, families are subject to basic copayments for most services. Under Plan B, families are subject to more substantial copayments for office visits and prescription drugs as well as standard, private sector coinsurance for hospital and mental health services. However, neither group is required to pay premiums.

Coverage. Utah provides S-CHIP benefits that are actuarially equivalent to those given to state employees. In addition to hospital and physician services and prescription drugs, the benefit package includes: outpatient mental health treatment up to 30 visits per year for most diagnoses and inpatient mental health treatment up to 30 days per year for most diagnoses;[11] ancillary therapy services up to 16 visits per year to restore speech loss or correct impairments due to congenital defects or injury or sickness; durable medical equipment to assist medical recovery; home health services provided by registered nurses or licensed practical nurses other than custodial care, private duty nursing, and home health aide services; and a limited set of dental services.

Managed Care Arrangements. Children living in urban counties are required to enroll in one of four managed care organizations, each of which is a health maintenance organization. Children living in rural areas must enroll in a single preferred provider organization (PPO), established as one of the plan options for public employees. The PPO also provides dental services to S-CHIP enrollees statewide.

All S-CHIP-covered services, with the exception of dental care, are included in the capitation rate paid to managed care plans for S-CHIP participants. Utah pays a single, average monthly rate for each S-CHIP child, although it has separately negotiated a risk corridor arrangement with each of the five plans to provide a measure of stop-loss protection.

[10] Current Medicaid eligibility in Utah is set at 133 percent of poverty for children up to age six and 100 percent of poverty for children up to age 19.

[11] Diagnoses excluded from mental health coverage are learning disabilities, conduct disorder, and oppositional defiant disorder.

Appendix Table I

Overview of S-CHIP Programs in the Five Study States During the First Year of S-CHIP Implementation

	California	Connecticut	Maryland	Missouri	Utah
Program Name	Healthy Families	HUSKY B	Maryland Children's Health Insurance Program	MC+for Kids	CHIP
Program Type	Non-Medicaid[1]	Non-Medicaid[2]	Medicaid	Medicaid	Non-Medicaid
Implementation Date	7/1/98	7/1/98	7/1/98	7/1/98	8/1/98
Income Eligibility Levels					
Infants	200–250%	185–300%	185–200%	185–300%	133–200%
Children Ages 1–6	133–200%	185–300%	133–200%	133–300%	133–200%
Older Children	100–200%	185–300%	100–200%	100–300%	100–200%
First Year Enrollment	138,869	3,787	57,000	42,251	10,729
Benefit Package	Benchmark Plan (state employees)	Benchmark Plan (state employees)	Medicaid	Medicaid	Benchmark Plan (state employees)
Populations Excluded from MCO Participation	None	None	Children with rare and expensive physical conditions	Children meeting SSI disability criteria and all children in some areas of the state	None
Services Excluded from MCO Contract	Dental, vision, specialty services for children with severe physical health conditions, and non-hospital specialty services for children with severe emotional disturbances	None	Personal care, early intervention, health-related special education, and all mental health	Early intervention, health-related special education, substance abuse, and crisis intervention for children with severe emotional disturbances	Dental

Continued on next page

Appendix Table I *(continued from previous page)*

Overview of S-CHIP Programs in the Five Study States During the First Year of S-CHIP Implementation

	California	Connecticut	Maryland	Missouri	Utah
Wrap-Around Program Services	All specialty services (supplemental and basic) for children with severe physical health conditions, and all non- hospital specialty services (supplemental and basic) for children with severe emotional disturbances	Supplemental specialty services for children with severe physical health conditions (HUSKY Plus Physical), and supplemental specialty services for children with severe emotional disturbances (HUSKY Plus Behavioral)	Not applicable	Not applicable	None
Cost-Sharing Requirements					
Monthly Premiums	Yes	Yes	No	Yes	No
Copayments	Yes	Yes	No	Yes	Yes
Coinsurance	No	No	No	No	Yes
Number of Managed Care Plans	26 MCOs 4 dental plans 1 vision plan	5 MCOs	8 MCOs	9 MCOs	5 MCOs 1 dental plan

Source: Information obtained by the Maternal and Child Health Policy Research Center through analysis of the states' S-CHIP applications and state S-CHIP documents constituting the standard insurance contracts or RFPs and through detailed on-site and follow-up telephone interviews.

Notes: [1]California had a small expansion of its Medicaid program to include adolescents ages 16 to 19 up to 100 percent of the federal poverty level.

[2]Connecticut had a small expansion of its Medicaid program to include adolescents ages 14 to 19 up to 185 percent of the federal poverty level.

Appendix Table II

Benefits Offered by the Five Study States During the First Year of S-CHIP Implementation[1]

	California	Connecticut	Maryland	Missouri	Utah
Physician Services	Covered	Covered	Covered	Covered	Covered
Lab and X-ray Services	Covered	Covered	Covered	Covered	Covered
Preventive Care	Covered	Covered	Covered	Covered	Covered
Prescription Drugs	Covered	Covered	Covered	Covered	Covered
Family Planning Services	Covered except for abortion	Covered except for abortion	Covered	Covered except for abortion	Covered except for routine HIV testing, Norplant, and abortion
Outpatient Hospitalization	Covered	Covered	Covered	Covered	Covered
Inpatient Hospitalization	Covered	Covered	Covered	Covered	Covered
Outpatient Mental Health Services	Covered up to 20 visits/year for conditions that will significantly improve with short-term therapy, with additional visits available through conversion of inpatient mental health days (1:4)	Covered up to 30 visits/year, with additional visits available through conversion of inpatient mental health days (1:3)	Covered	Covered	Covered up to 30 visits/year (in combination with outpatient substance abuse), but excluding conditions such as conduct disorder, oppositional defiant disorder, and learning disabilities
Inpatient Mental Health Services	Covered up to 30 days/year for conditions that will significantly improve with short-term therapy	Covered up to 60 days/year	Covered	Covered	Covered up to 30 days/year (in combination with inpatient substance abuse), but excluding conditions such as conduct disorder, oppositional defiant disorder, and learning disabilities
Residential Treatment Facilities	Covered by converting inpatient mental health days (1:2) for conditions that will significantly improve with short-term therapy	Covered by converting inpatient mental health days (1:1)	Covered	Covered, at plans' option[2]	Covered by converting inpatient mental health days (1:1), but excluding conditions such as conduct disorder, oppositional defiant disorder, and learning disabilities

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Appendix Table II *(continued from previous page)*

Benefits Offered by the Five Study States During the First Year of S-CHIP Implementation[1]

	California	Connecticut	Maryland	Missouri	Utah
Outpatient Substance Abuse Treatment Services	Covered up to 20 visits/year	Covered up to 60 visits/year	Covered	Covered	Covered up to 30 visits/year in combination with outpatient mental health
Inpatient Substance Abuse Treatment Services	Covered for detoxification	Covered for drug abuse up to 60 days/year and for alcohol abuse up to 45 days/year	Covered	Covered	Covered up to 30 days/year in combination with inpatient mental health
Physical, Occupational, and Speech Therapy	Each therapy covered up to 60 consecutive days/ condition, additional visits available if condition will improve significantly	Covered on a short-term basis	Covered	Covered	Covered up to 16 visits/ year, but excluding therapies for children with developmental delay, and excluding speech therapy not required to treat an injury, sickness, or surgically corrected congenital condition
Optometry Services	Covered	Covered	Covered	Covered	Not covered
Eyeglasses	Covered	Covered	Covered	Covered	Not covered
Home Health Services	Covered for skilled nursing services and home health aide services, including PT, OT, and ST	Covered for skilled nursing services and home health aide services	Covered	Covered	Covered for skilled nursing services
Durable Medical Equipment and Other Devices	Covered except for therapeutic footwear and motorized wheelchairs	Covered except for hearing aids and motorized wheelchairs	Covered	Covered	Covered except for eyeglasses and therapeutic footwear
Dental Services	Covered except for orthodontia	Covered	Covered	Covered	Covered except for replacement restorations for other than decay or fracture, orthodontia, sealants except when placed on permanent molars through age 17

Source: Information obtained by the Maternal and Child Health Policy Research Center through analysis of the states' S-CHIP applications and state S-CHIP documents constituting the standard insurance contracts or RFPs.

Notes: [1]The programs were implemented in either July or August of 1998.

[2]Plans in Missouri were only encouraged to provide residential treatment services to avoid inpatient hospitalization; no conversion ratio was provided.

Appendix Table III

Cost-Sharing Requirements for S-CHIP Programs in the Five Study States During the First Year of S-CHIP Implementation[1]

Monthly Premiums	California	Connecticut	Maryland	Missouri		Utah	
101–150% FPL	$7 for 1 child[2] $14 for ≥ 2 children	Not applicable	None	None		None	
151–200% FPL	$9 for 1 child; $18 for 2 children; $27 for ≥ 3 children	None	None	None		None	
200–300% FPL	Not applicable	above 235% FPL: $30 for 1 child; $50 for ≥ 2 children	Not applicable	above 225% FPL: $65 per family		Not applicable	
>300% FPL	Not applicable	$113.87–$194.37, depending on plan selected	Not applicable	Not applicable		Not applicable	
Copayments/Coinsurance	**101–200%**	**>185%**	**None**	**186–225%**	**226–300%**	**101–150%**	**151–200%**
Physician Visits	$5	$5		$5	$10	$5	$10
Prescription Drugs	$5	$3 generic; $6 brand		—	$5	$2	$4; 50% nonformulary
Lab/X-ray	—	—		$5	$10	—	10%
Emergency Room Services	$5	$25		—	—	$5–$10	$30
Inpatient Hospital Services	—	—		$5	$10	—	10%
Outpatient Hospital Services	—	—		$5	$10	—	10%
Mental Health Services							
Outpatient Visits	$5	11–20 visits $25; 21–30 visits $50 or 50%		$5	$10	$5	50%
Inpatient Hospital Services	—	—		$5	$10	—	1–10 days, 10%; 11–30 days, 50%
Substance Abuse Services							
Outpatient Visits	$5	—		—	—	$5	50%
Inpatient Hospital Services	—	—		—	—	—	1–10 days, 10%; 11–30 days, 50%

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Appendix Table III *(continued from previous page)*

Cost-Sharing Requirements for S-CHIP Programs in the Five Study States During the First Year of S-CHIP Implementation[1]

	California	Connecticut	Maryland	Missouri		Utah	
Copayments/Coinsurance	**101–200%**	**>185%**	**None**	**186–225%**	**226–300%**	**101–150%**	**151–200%**
PT, OT, ST Services	$5	—		$5	$10	$5	$10
Audiology Services	—	$5 hearing exams		$5	$10	—	—
Optometry	$10	$5		$5	$10	—	—
Home Health	—	—		$5	$10	—	—
Durable Medical Equipment	—	—		—	—	—	20%
Eyeglasses	$25	lenses covered and up to $50 for frames		—	—	—	—
Dental	varies	varies		$5	$10	—	varies

Source: Information obtained by the Maternal and Child Health Policy Research Center through analysis of the states' S-CHIP applications and state S-CHIP documents constituting the standard insurance contracts or RFPs and through detailed on-site and follow-up telephone interviews.

Notes: [1]The programs were implemented in either July or August of 1998.

[2]California's Healthy Families participants who enroll in a community provider plan receive a discounted premium of $3 per child.

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