kaiser commission on medicaid and the uninsured

S-CHIP Managed Care Contracting

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

December 2000

THE HENRY J. KAISER FAMILY FOUNDATION

kaiser commission on medicaid and the uninsured

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.

kaiser commission on medicaid and the uninsured

S-CHIP Managed Care Contracting

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

December 2000

ACKNOWLEDGMENTS

This study was commissioned by The Henry J. Kaiser Family Foundation. We would especially like to thank Alina Salganicoff and Christina Chang for their assistance and support.

We also wish to thank the staff members of the state agencies and managed care organizations, whose willingness to meet with us and patiently respond to our numerous subsequent research questions were most appreciated. In particular, we extend our gratitude to the Medicaid and S-CHIP staff who shared their experiences with us: Lorraine Brown, John Gregorina, and Sandra Shewry of California; Joanne Aitken, Evelyn Dudley, Larry Kaplan, Linda Mead, David Parella, Yleana Sanchez, Mark Schaefer, and Oralee Wilson of Connecticut; Jennie Bonney, Damion Briggs, Debbie Chang, Mark Coin, Diane Herr, Karen Lane, Joe Millstone, Karen Oliver, Tim Santoni, Susan Tucker, and Ned Wollman of Maryland; Myra Bruning, Judy Muck, Greg Vadner, and Pam Victor of Missouri; Rod Betit, Michael Deily, Roy Dunn, Ed Furia, Robert Rolfs, and Chad Westover of Utah; and all the administrative staff who helped us set up the meetings. We also acknowledge the help of Lisa Davis, George Delavan, and Maridee Gregory of the Title V offices in Connecticut, Utah, and California.

Many other people were invaluable in helping us arrange meetings with providers. We thank the chapter administrators of the American Academy of Pediatrics who helped us identify pediatricians and pediatric subspecialists and in many cases secured their participation: Eve Black of California, Jill Wood of Connecticut, Bobbi Seaboldt of Maryland, Jan Frank of Missouri, and Cathy Oyler of Utah. In addition, many providers merit thanks for their assistance: Paula Armbruster, Connie Cahalan, Joshua Calhoun, Robin Doroshow, Ann Foster, Milton Fujita, Bernard Griesmer, Neal Kaufman, Bill Lewis, Barbara Mason, Aric Schichor, Kathryn Smith, Vera Tait, Edward Vidaurri, and Gerry Waterfield. Finally, we wish to thank all the providers who participated in our meetings and telephone interviews and responded to our additional requests for information.

Families provided an essential perspective to the report, and we are grateful for their generosity in sharing their time and experiences with us. We would like, in particular, to thank those who helped us arrange family meetings: Richard Brown, Molly Cole, Fran Goldfarb, Ana Friendly, Gina Pola-Money, Eileen Rauzi, Susan Tager, and Josie Thomas.

Finally, we want to acknowledge Stephanie Limb, senior policy analyst at the Maternal and Child Health Policy Research Center, for her overall contribution to the project. In addition, we want to acknowledge Margaret Hayden of the Center for her diligent research assistance and efforts to obtain the multiple pieces of information the study required. We also appreciate her tenacity in arranging and organizing the site visits. Also, from the Center, we thank Jonathan Austrian, Christine Chen, and Wesley Hsu for their research assistance and Yun-Yi Hung and Paul Newacheck for their special data analyses.

TABLE of CONTENTS

EXECUTIVE SUMMARY

This issue brief examines the design and implementation of managed care contracting under the State Children's Health Insurance Program (S-CHIP). 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 managed care contracting suggest that states have been able to enter into arrangements with plans to serve the S-CHIP population fairly easily. This was because the S-CHIP programs in the five states we studied relied on existing Medicaid or commercial models of contracting and payment.

- **Plan selection.** The five S-CHIP programs used different approaches in selecting managed care contractors, but they essentially chose plans on the basis of network capacity, administrative ability, financial solvency, and, in some states, cost. Ultimately, all of the states entered into contracts with most of the plans already participating in Medicaid. It was generally perceived that these plans were in the best position to meet contracting requirements and that their participation facilitated S-CHIP implementation.

- **Contract provisions.** There was significant variation in the provider network, access, and quality reporting provisions that states included in their contracts. The two Medicaid S-CHIP programs tended to include more specifications in their contracts than the three non-Medicaid programs. However, two of the three drew heavily on their state Medicaid contracts in establishing requirements for S-CHIP plans. The other state, California, which had the fewest requirements, drew from its public employees' contract.

- **Capitation rates.** Capitation rates paid to participating S-CHIP plans as well as overall per-child expenditures—which included any additional costs for mental health, dental, or other specialty services—varied across the five states. Except in one state, S-CHIP rates were either the same as or lower than those for Medicaid. Most plans perceived that the rates were adequate to meet the contract requirements, although all plan officials noted that it was too soon to judge.

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 administration and accountability, 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 are eligible for supplemental benefits which, along with their other specialty services, are 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.

[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.

- **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 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 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.

---

[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.

[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.

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 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 managed care contracting is divided into three sections. The first addresses the plan selection process used by the five S-CHIP programs in our study. The second examines the managed care contract provisions established by the programs regarding provider networks, access, and quality reporting. The third describes each study states S-CHIP capitation rates and the approaches used to establish the rates. 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.

Plan Selection Process

The five S-CHIP programs we studied used a variety of approaches to selecting managed care contractors. Yet, putting price issues aside, they all appeared to base their selections on essentially similar evaluation criteria: network capacity, administrative ability, and financial solvency. Both Medicaid S-CHIP programs relied on their existing Medicaid contractors, having determined that the plans had sufficient capacity to serve additional enrollees. In Maryland—which had based its Medicaid plan selection on the plan's ability to meet its regulatory requirements for managed care providers—plans were required to accept S-CHIP enrollees. In Missouri—which originally used a rating scheme that allocated points for expertise of personnel, proposed method of performance, experience, and cost—plans were given the option to enroll S-CHIP children. Among the three non-Medicaid S-CHIP programs, California's and Connecticut's both solicited bids from all interested parties. California selected plans that had adequate provider networks, were financially solvent, and had the capacity to perform the contract requirements.[7] Connecticut rated plans based on points for provider networks, ability to provide covered services, ability to perform administrative and management functions, and financial viability. Utah's non-Medicaid program determined that (with the exception of one plan legislatively required to participate) it would accept bids only from existing Medicaid contractors. This was a way of speeding the contracting process, and, at the same time, assuring the state that it would receive bids from contractors with proven experience and ability.

Moreover, regardless of the process used, the five S-CHIP programs ultimately entered into contracts with nearly all of the plans serving the Medicaid population. In the two Medicaid states, S-CHIP children were being enrolled into all but one of each state's Medicaid plans—seven in Maryland[8] and nine in Missouri.[9] The situation was not that dissimilar in the non-Medicaid states. Connecticut was contracting with four plans that included all but one of the state's Medicaid contractors. Utah was contracting with five plans that included three of the state's five Medicaid contractors and one plan that was, in many respects, a commercial version of a plan participating in Medicaid. Even in California, where the S-CHIP program is privately administered, the 26 S-CHIP plans included 20 of the state's 24 Medicaid contractors and four plans serving the Medicaid population as subcontractors.[10]

Plan officials perceived that historic Medicaid contractors were in the best position to meet the kind of requirements imposed by the state programs. These were thought to be the only plans that had the necessary infrastructure in place to comply with enrollment verification, new member outreach, quality reporting, and complaint and grievance procedures. It was mentioned repeatedly that projected S-CHIP enrollment was too small to make the product viable, except as an extension of Medicaid business. In fact, staff from the only plan we interviewed without any

---

[7] The California S-CHIP contract incorporates the regulatory requirements of the Department of Corporations. All participating plans were expected to meet these requirements and obtain what is referred to as a "Knox-Keene" license by July 1, 2000. Only one plan chose not to pursue a Knox-Keene license and did not continue participating in S-CHIP when the new contract period began July 1, 2000.

[8] In Maryland, one of the Medicaid contractors was in receivership and could not enroll additional members.

[9] In Missouri, Prudential elected not to take any S-CHIP children because its parent company (Aetna) was not interested in taking on any new public-sector business.

[10] Two Medicaid plans in the Two-Plan Model—one in Los Angeles County, and the other in Orange County—contracted with other plans to serve Medicaid enrollees.

Medicaid experience mentioned that the contract requirements were not well matched to what the plan could initially provide and that, as a consequence, the liberal risk-sharing arrangement established for this plan was essential.[11]

States also perceived that using Medicaid contractors for S-CHIP had obvious advantages. S-CHIP staff in each of the five states reported that using the same plans made S-CHIP implementation easier. Those operating non-Medicaid programs emphasized that managed care contracting was accomplished more quickly and those operating Medicaid programs emphasized that money was saved as well. Equally important, S-CHIP staff consistently mentioned that using Medicaid contractors to serve the S-CHIP population was better for families transitioning between Medicaid and S-CHIP and, in California and Utah, for families who might have children enrolled in both programs.

Contracting Provisions

State contracting requirements for the five S-CHIP programs varied significantly, not just between but among the Medicaid and non-Medicaid programs we studied. Overall, Maryland's Medicaid S-CHIP program, which established its managed care policies through regulations issued by the Department of Health and Mental Hygiene, had the most extensive set of managed care requirements. California's non-Medicaid program, which relied in part on regulations for commercial HMOs issued by the Department of Corporations, had the least extensive set. Programs in the other three states fell somewhere in between. Connecticut, however, presented a special case: as of June 1999, nearly one year after its program was implemented, Connecticut had not actually developed an S-CHIP contract and was assuming that plans understood the requirements contained in its request for proposals constituted the terms of the contract.[12]

With respect to **provider network requirements** specifically, contract language, where it was included, served to provide only general guidance to plans about the characteristics of the networks that states intended to be available for S-CHIP enrollees. All five states addressed the adequacy of primary care providers in some way, and all but California included some guidance regarding specialty providers as well.

- California, Maryland, and Missouri established numerical ratios for primary care providers, but they appear high[13]—either 1,500 or 2,000 children for every provider—while Connecticut

[11] This plan was a public employees' health benefit plan statutorily required by the state to participate in S-CHIP but unable to assume financial risk.

[12] Plans, however, found this arrangement unsatisfactory. They believed that without a detailed contract, plans were operating under different assumptions, particularly about the scope of coverage for undefined benefits. The state, as of May 2000, still did not have a contract document for plans to sign.

[13] Using data available for current staffing patterns in HMOs and private practices, the American Academy of Pediatrics reports an "ideal" practice ratio of one pediatrician per 1,200 to 1,400 children. Future of Pediatric Education II: Organizing Pediatric Education to Meet the Needs of Infants, Children, Adolescents, and Young Adults in the 21st Century. *Pediatrics.* 105(1 pt 2):163-212, 2000.

required that plans have sufficient numbers of appropriately trained pediatric clinicians.[14] Maryland and Utah both specified that specialists could serve as primary care providers, when appropriate, and Utah also required that plans have primary care providers experienced in serving children with special needs.

- None of the five states established any specialty provider-to-child ratios. Connecticut and Maryland, however, did include language to the effect that plans must have a sufficient number and mix of pediatric medical subspecialists, surgical specialists, and ancillary therapists to meet the population's needs. Maryland provided the most detail on specialty providers, stipulating, for example, that networks include specialty and subspecialty providers experienced in interdisciplinary medical management, but Connecticut was the only state that required plans to include pediatric mental health providers and social workers in their behavioral health networks.[15]
- Maryland, Missouri, and Utah each stipulated that enrollees be permitted to see an out-of-network provider if the plan did not have one with similar training and expertise. Maryland also stipulated that plans contract with any historical provider[16] that the state assigned to them.[17]

With respect to **access requirements**, there was significant variation in the types of contract provisions used by the five states, but the provisions constituted fairly specific directives to plans, as shown in Table I. Four states (all but California) had appointment standards, and three states (all but California and Utah) had distance standards.

- Appointment standards for emergent, urgent, and routine care were established in each of the four states for primary care. In addition, Maryland, Missouri, and Utah specified appointment standards for specialists; Connecticut and Maryland specified them for dental services; and Maryland and Missouri specified them for mental health.
- In the three states where distance standards were established, they too always addressed primary care. However, Connecticut and Maryland also included distance standards for dental services; Maryland and Missouri included them for pharmacy services; and Connecticut included them for mental health.

---

[14] Missouri contractually required plans to subcontract with federally qualified health centers and rural health clinics unless they could demonstrate that their networks had a sufficient capacity to deliver the same services. Connecticut required in its request for proposals that plans contract with school-linked clinics; however, the state elected not to maintain this requirement.

[15] Maryland and Missouri had more extensive requirements regarding the specific types of mental health providers that were to be included in the plans' networks, but neither state required that they be pediatric providers.

[16] State regulations governing the Maryland Medicaid managed care program define an historical provider as someone who provided a certain number of units of service to Medicaid participants, who received a particular amount of Medicaid payments, or who served a particular number of Medicaid participants between July 1994 and July 1995. The particular amount of service units, payments, and recipients varied depending on whether the provider had participated in the state's voluntary HMO or primary care case management systems.

[17] No other state required plans to contract with safety net providers. However, California offered plans an incentive (the ability to offer a discounted premium) to include in their networks the most traditional and safety net providers in the county, and Missouri gave preference in the contracting process to plans that included community mental health centers.

Table 1

S-CHIP Contract Requirements Pertaining to Access to Care in the Five Study States During the First Year of S-CHIP Implementation

	California	Connecticut	Maryland	Missouri	Utah
Appointment Standards					
1. Primary Care					
—Emergency		same day		same day	
—Urgent		2 days	2 days	2 days	2 days
—Routine		10 days	30 days	30 days	21 days
2. Medical Specialists/ Chronic Care					
—Emergency				same day	
—Urgent				3 days	2 days
—Routine			30 days	30 days	30 days
3. Mental Health					
—Emergency				same day[1]	
—Urgent				3 days[2]	2 days
—Routine			10–30 days	30 days[2]	30 days
4. Dental Care					
—Emergency					
—Urgent			2 days		
—Routine		6 weeks	30 days		
Distance Standards[3]					
1. Primary Care		15 miles or 30 minutes	10 miles or 30 minutes	20 miles	
2. Medical Specialists					
3. Mental Health Care		20 miles			
4. Dental Care		20 miles	10 miles or 30 minutes		
5. Pharmacies			5 miles or 10 minutes	20 miles	
Other Access Requirements					
1. Multidisciplinary Care			✔		✔
2. Initial Mental Health Services			✔		
3. School-Based Clinics[4]			✔		
4. Title V Services					✔
5. Self-Referral for Family Planning			✔	✔	
6. Time Limits on Authorization Decisions			✔	✔	

Source: Information obtained by the Maternal and Child Health Policy Research Center through detailed on-site and follow-up telephone interviews and an analysis of the S-CHIP contracts in effect during the first year of S-CHIP implementation.

Notes: [1]Missouri requires that emergency care for non-seriously mentally ill individuals be provided within 24 hours.

[2]Missouri requires that non-emergency care be available within 30 days, unless requested by a PCP, in which case, services must be available within 72 hours.

[3]All of the distance standards are only for urban areas.

[4]Maryland requires plans to waive authorization only for acute care visits.

- Other types of access requirements were sometimes established as well. For example, Maryland and Utah both required that children with special needs have access to multidisciplinary care teams. Maryland also established that plans' usual authorization and primary care referral requirements be waived for initial mental health services[18] and for acute care visits to school-based clinics, while Utah stipulated that they be waived for initial Title V services.[19] In addition, Maryland and Missouri both stipulated, as federally required under Medicaid, that plans could not have referral or authorization policies pertaining to family planning services, and both set limits on the time frame in which authorization decisions must be made for certain services.

With respect to **quality reporting requirements**, contract provisions also varied considerably across the five study states, with each using a different combination of HEDIS[20] and non-HEDIS measures of effectiveness, utilization, and access to care, as shown in Table II.

- For **effectiveness of care**, the one measure used by all five study states was childhood immunizations, although only California, Maryland, and Utah specified adolescent immunizations. None of the five states included any acute illness measures in their contracts, but California, Maryland, and Missouri did require plans to monitor treatment of chronic physical or mental conditions. Missouri's contract was the most extensive in this area; it incorporated several measures of health promotion and disease prevention, early detection and screening, and chronic physical and mental health treatment.
- For **service utilization**, all states but California and Connecticut required plans to submit encounter data to monitor underutilization and overutilization of certain services, most commonly well child care and general acute inpatient hospital and mental health inpatient hospital services. Utah's contract included reporting requirements for most services, except well child care and chemical dependency services.
- For **access and availability of care**, there were comparatively few quality reporting requirements established. Still, California, Missouri, and Utah required plans to document primary care access, typically by counting the number of enrolled children who had a primary care visit during the reporting period. California and Utah also included contract requirements for dental care access, as did Connecticut, specifying compliance with an annual dental visit. Maryland was the only state with a specialized access to care requirement. All of the study states except California required plans to conduct an annual member satisfaction survey.[21]

---

[18] Missouri permits enrollees to self-refer to the mental health system, but it does not require that authorization policies be waived for any initial evaluation or therapy services.

[19] 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.

[20] HEDIS (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 along a variety of dimensions, including effectiveness of care and use of services.

[21] Maryland required its general managed care plans as well as its Specialty Mental Health System to conduct a member satisfaction survey.

Table 2
S-CHIP Contract Requirements Pertaining to Quality Performance Measures in Five Study States During the First Year of S-CHIP Implementation

	California	Connecticut	Maryland	Missouri	Utah
Effectiveness of Care Measures					
1. Health Promotion and Disease Prevention					
A. Immunications					
—Childhood Immunications	✔	✔	✔	✔	✔
—Adolescent Immunications	✔		✔		✔
2. Early Detection and Screening					
A. Low Birthweight		✔			
B. Cervical Cancer Screening				✔	
C. Lead Screening			✔	✔	
D. Alcohol, Substance Abuse, and Tobacco Screening				✔	
E. Sexually Transmitted Disease Screening				✔	
1. Acute Illness					
A. Otitis Media					
4. Chronic Physical Conditions					
A. Asthma			✔	✔	
B. Diabetes			✔	✔	
C. Sickle Cell Anemia			✔		
5. Chronic Mental Health or Substance Abuse Conditions					
A. Ambulatory Follow-up after Hospitalizaton for Mental Health Disorders	✔			✔	
<u>Utilization of Care Measures</u>					
1. Prevention Services					
A. Well Child Care	✔	✔	✔	✔	
2. Ambulatory Services					
A. Physical Services				✔	✔
B. Physician Specialty Services					✔
C. Outpatient Visits					✔
D. Emergency Room Visits					✔
E. Ambulatory Surgery/ Procedures					
3. Physician Services			✔		✔
4. Inpatient Hospital Services		✔	✔	✔	✔
5. Newborn Hospital Services			✔	✔	✔

(Continued on next page)

Table 2 *(Continued from previous page)*

S-CHIP Contract Requirements Pertaining to Quality Performance Measures in Five Study States During the First Year of S-CHIP Implementation

	California	Connecticut	Maryland	Missouri	Utah
6. Mental Health Services					
A. Inpatient Hospital Services		✔	✔	✔	✔
B. Day/Night Services		✔			✔
C. Ambulatory Services				✔	✔
D. Hospital Readmissions		✔	✔		
7. Chemical Dependency Services					
A. Inpatient Hospital Services		✔	✔	✔	
B. Day/Night Services		✔	✔		
C. Ambulatory Services			✔	✔	
D. Hospital Readmissions		✔			
8. Other Services					
A. Physical Therapy Services					✔
B. Occupational Therapy Services					✔
C. Speech and Hearing Services					✔
D. Home Health Services				✔	✔
E. Hospice Services					✔
F. Medical Supplies				✔	✔
G. Vision Services				✔	
H. Case Management Services					
Access and Availability of Care Measures					
1. Primary Care Access	✔		✔	✔	✔
A. Primary Care Visits					
2. Specialized Care Access					
A. Low Birthweight Deliveries at Appropriate Facilities					
B. Coordination Between Primary care Providers and Behavioral Health Providers				✔	
3. Dental Care Access					
A. Dental Care Visit	✔	✔			✔
Consumer Satisfaction Survey		✔	✔	✔	✔

Source: Information obtained by the Maternal and Child Health Policy Research Center through detailed on-site and follow-up telephone interviews and an analysis of the S-CHIP contracts in effect during the first year of S-CHIP implementation.

Two of the three non-Medicaid programs, Connecticut's and Utah's, relied heavily on their Medicaid contracts in structuring S-CHIP requirements. In both states, S-CHIP contract provisions concerning such plan functions as marketing, member services, provider services, complaint resolution, and data reporting, as well as those concerning provider network, access, and quality, were either the same or almost the same as those used in their Medicaid contracts. The only major differences pertained to covered services and cost sharing, although in Utah the S-CHIP program also omitted Medicaid's medical necessity definition, its biannual satisfaction survey of children with special needs,[22] and its requirement to allow out-of-network access to family planning providers. California took a very different path, choosing to model its S-CHIP contract on the contract used for the state employees' benefit plan (CalPERS).

Despite other contract similarities with Medicaid, however, all three states operating non-Medicaid S-CHIP programs chose to capitate more of their covered services than they did under their Medicaid programs. For example, California, Connecticut, and Utah all carve early intervention and health-related special education services out of their Medicaid managed care contracts and pay for these services separately, but they did not do the same under S-CHIP. Similarly, under Medicaid, California and Utah both have a separate financing arrangement for all mental health and substance abuse services, and Utah has a separate financing arrangement for prescription drugs, but they did not elect to adopt the same carve-out policies under S-CHIP. The only services that were carved out of both Medicaid and S-CHIP contracts were dental services (in California and Utah) and services for children with special needs (in California).

Capitation Rates

The five states we studied used a variety of approaches to establishing capitation rates for S-CHIP participants. Since Maryland and Missouri were enrolling S-CHIP eligibles into their Medicaid programs, both states based their S-CHIP rates on existing Medicaid rates. Maryland used its Medicaid rate-setting methodology, paying its basic Medicaid rates for 80 percent of the S-CHIP population and paying its adjusted clinical group (ACG)[23] rates for the 20 percent for whom diagnostic claims data were available. Missouri used its regular Medicaid rates, initially derived through a competitive bidding process, in which all offers within a predetermined range for each rate cell were accepted, and then adjusted these rates down slightly to account for differences in the non-emergency transportation benefit. California and Connecticut both established capitation rates for their non-Medicaid S-CHIP programs on the basis of competitive bidding and subsequent negotiation. California calculated an acceptable upper limit for its rates using a formula applied to each area's two lowest bids, while Connecticut simply allowed the highest bidders to resubmit. Unlike these two states, Utah established its non-Medicaid S-CHIP rates using a rate-setting methodology based on the experience of commercial plans.[24]

---

[22] Utah anticipated that there would be too few children with special needs to warrant a separate survey. It was expected that these children would qualify for Medicaid through the medically needy spend-down provision.

[23] The ACG system, developed by researchers at Johns Hopkins School of Public Health, is used in Maryland to set health risk-adjusted capitated rates for Medicaid, and now S-CHIP, participants. Using inpatient and outpatient diagnostic and claims data for a six-month period, patients are assigned one of 52 adjusted clinical groups and are grouped into one of nine risk-adjusted capitation cells.

[24] Utah set its S-CHIP rates based on two actuarial analyses of commercial premiums for children. The public employees' health plan conducted one analysis; PriceWaterhouseCoopers conducted the other.

Participating plans were paid the same capitation rates, and all but one had the same risk corridor arrangement.[25]

Interestingly, only the two states operating Medicaid S-CHIP programs paid capitation rates that were risk-adjusted in any way. Maryland and Missouri paid rates adjusted for age and gender as well as geographic area and, where historic diagnostic and claims data were available, Maryland also paid ACG rates adjusted for health status. While the three non-Medicaid S-CHIP states all had experience with Medicaid risk-adjustment,[26] they chose to follow a commercial rate-setting approach which typically combines all children ages one to 18 into a single actuarial group. California's rates differed only according to geography, and Connecticut's and Utah's were the same for all S-CHIP children in the same income group.

Capitation amounts paid to plans varied substantially. Among the three non-Medicaid S-CHIP programs in our study, Connecticut's rates were highest. Not counting wrap-around program costs, they were almost double the rates paid in the two other non-Medicaid states. Connecticut was the only one of the three that elected to pay plans more for S-CHIP than Medicaid enrollees. Among the two Medicaid S-CHIP programs, comparisons were difficult because we were unable to obtain per capita expenditures for S-CHIP participants served by Maryland's Specialty Mental Health System. Interestingly, however, Missouri's S-CHIP program paid rates that were not substantially higher than those paid by two of the three non-Medicaid S-CHIP programs.

Some plans in the five S-CHIP programs thought the capitation rates they received were too low for them to meet their contractual obligations. The degree of their discontent did not always correlate to the amount they were paid, however. In one state where capitation rates were comparatively high, staff from a plan that seemed to have liberal service authorization policies were concerned that low enrollment rates made it impossible to spread risk. In another state, paying comparatively low rates, staff from one plan that was apparently providing extensive "non-medical" services to high-risk urban children thought that the capitation rate did not sufficiently compensate them for these services. The other plan we interviewed in that state was not concerned about the urban rate; its position was that the much lower rural rate was inadequate. Overall, the more traditional commercial HMO plans found the capitation rate to be generally reasonable. All plans commented though that it was really too soon to judge the adequacy of S-CHIP rates.

---

[25]Risk corridors are a means of limiting managed care plans' profits and losses. The state reimburses the plan for all or some proportion of losses beyond a set amount and conversely, the plan returns to the state all or some proportion of profits beyond a set amount. In Utah, one plan received full compensation for all losses; the others had a different risk corridor arrangement that the state declined to disclose.

[26]Under their Medicaid programs, California and Connecticut both used capitation rates adjusted for age, gender, and geography. Utah used rates adjusted for geography but also used a modified version of the Chronic Illness and Disability Payment System method to adjust for health status. In addition, the organization administering California's non-Medicaid program also had extensive experience setting health risk-adjusted rates for the state's high-risk pool.

Conclusions

Although states generally have faced significant challenges in reaching their enrollment goals for S-CHIP, none of the five states in our study experienced any significant difficulties in contracting with managed care plans to serve S-CHIP children. This was due to the fact that all five states, including the three non-Medicaid states, found that plans with Medicaid business were receptive to serving the S-CHIP population. Had the S-CHIP programs relied on plans with only commercial business, they would likely have experienced more start-up problems as a result of their unique contract and reporting requirements and the relatively small size of their anticipated S-CHIP populations.

The adequacy of S-CHIP capitation rates in the two Medicaid and three non-Medicaid states was difficult to evaluate at this early stage of implementation. Although there appeared to be substantial variation in capitation rates among the five states, comparisons were complicated by differences in program benefits, including wrap-around services. Given the sizeable proportion of children now covered by public insurance programs, it will be important in the future to assess if payments to plans and providers under S-CHIP as well as Medicaid are sufficient to deliver the full range of covered benefits.

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]

---

[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.

---

[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.

---

[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

Continued on next page

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%

Continued on next page

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.

1450 G Street NW, Suite 250, Washington, DC 20005
Phone: 202-347-5270, *Fax:* 202-347-5274,
Web Site: www.kff.org

Additional free copies of this publication (#2235) are available on our website or by calling our publications request line at 800-656-4533.