

# *The Child Health Insurance Project*

Issue Brief • Number 5

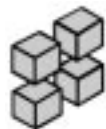
## **An Analysis of States' CHIP Policies Affecting Children with Special Health Care Needs**

Harriette B. Fox

with

Regina R. Graham, Margaret A. McManus, and Christine Y. Chen

April 1999



**MATERNAL & CHILD HEALTH**  
POLICY RESEARCH CENTER

# **AN ANALYSIS OF STATES' CHIP POLICIES AFFECTING CHILDREN WITH SPECIAL HEALTH CARE NEEDS**

Harriette B. Fox

with

Regina R. Graham, Margaret A. McManus, and Christine Y. Chen

Maternal and Child Health Policy Research Center  
Fox Health Policy Consultants  
750 17<sup>th</sup> Street, NW  
Suite 1025  
Washington, D.C. 20006-4607  
202-223-1500

This issue brief was funded by the federal Maternal and Child Health Bureau.

# TABLE OF CONTENTS

Introduction .....	1
Eligibility .....	3
Benefits .....	6
Plan Arrangements .....	12
Cost-Sharing Requirements .....	22
Summary and Conclusions .....	28
Appendices	
I:    Income Eligibility Levels under State CHIP Plans .....	30
II:   Benefit Packages in Non-Medicaid CHIP Plans .....	33
III-A: Insurance Arrangements in Non-Medicaid CHIP Plans .....	43
III-B: Insurance Arrangements in Medicaid CHIP Plans .....	45
IV-A: Services Excluded from States' Fully Capitated Non-Medicaid CHIP Contracts ....	47
IV-B: Services Excluded from States' Fully Capitated Medicaid CHIP Contracts .....	49
V-A: Non-Medicaid Contract Language Pertaining to Children with Special Health Care Needs in CHIP Plans .....	51
V-B: Medicaid Contract Language Pertaining to Children with Special Health Care Needs in CHIP Plans .....	53
VI-A: Cost-Sharing Provisions in Non-Medicaid CHIP Plans .....	55
VI-B: Cost-Sharing Provisions in Medicaid CHIP Plans Operating under Section 1115 Demonstration Waivers .....	61

# AN ANALYSIS OF STATES' CHIP POLICIES AFFECTING CHILDREN WITH SPECIAL HEALTH CARE NEEDS

A large number of children with special health care needs are now being served by the new Children's Health Insurance Program (CHIP). National estimates reveal that 16.9 percent of children in the CHIP-eligible population in families with incomes up to 200 percent of poverty have an existing special health care need.<sup>1</sup> A special health care need has been defined as a chronic physical, developmental, behavioral, or emotional condition requiring health and related services of a type or amount beyond those required by children generally.<sup>2</sup> The types of services that children with special health care needs might require include monitoring by primary care physicians and pediatric subspecialists, prescription medications, ancillary therapies, mental health services, nursing services, durable medical equipment or assistive technologies, and care coordination. As a result, their health care expenses are higher than those for other children.<sup>3</sup>

As of January 31, 1999, all but three states<sup>4</sup> (Tennessee, Washington, and Wyoming) had received approval from the Health Care Financing Administration (HCFA) to implement a CHIP program. These 48 states are pursuing a variety of approaches for expanding health insurance coverage to CHIP-eligible children.

- Twenty-four states (Alaska, Arkansas, District of Columbia, Hawaii, Idaho, Illinois, Indiana, Iowa, Louisiana, Maryland, Minnesota, Mississippi, Missouri, Nebraska,

---

<sup>1</sup> Newacheck P et al: *New Estimates of Children with Special Health Care Needs and Implications for the State Children's Health Insurance Program*. Washington, DC: Maternal and Child Health Policy Research Center, March 1998.

<sup>2</sup> McPherson M et al: A New Definition of Children with Special Health Care Needs. *Pediatrics*. 102: 1137-1140, 1998.

<sup>3</sup> Ireys H et al: Expenditures for Care of Children with Chronic Illnesses Enrolled in the Washington State Medicaid Program, Fiscal Year 1993. *Pediatrics*. 100: 197-2-4, 1997.

<sup>4</sup> The District of Columbia is considered a state for this analysis.

New Mexico, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Texas, West Virginia, and Wisconsin) are enrolling children into their Medicaid programs. In 13 of these states, Medicaid programs are operating under Section 1115 demonstration waivers.

- Fourteen states (Arizona, Colorado, Delaware, Georgia, Kansas, Montana, North Carolina, Nevada, New York, Oregon, Pennsylvania, Utah, Vermont, and Virginia) are enrolling children into non-Medicaid plans.
- And 10 states (Alabama, California, Connecticut, Florida, Kentucky, Massachusetts, Maine, Michigan, New Hampshire, and New Jersey) are using a combination of Medicaid and non-Medicaid plans to serve children in families at different income levels.

This issue brief was prepared by the Maternal and Child Health Policy Research Center to assess how approved CHIP programs will serve children with special health care needs. In each of four policy areas -- eligibility, benefits, plan design, and cost-sharing -- we briefly review the options available to states for addressing the special coverage requirements of this population, provide an overview of the policies most states have adopted, and then identify the innovative approaches some states have taken to benefit children with special needs. Information for the issue brief is based on our analysis of the 48 approved state CHIP applications, including the state responses to HCFA's questions and conditions; all state CHIP documents constituting the standard insurance contract or request for applications from insurers; and conversations with state CHIP program directors, and sometimes Medicaid staff, to obtain more detailed information or clarify points of confusion. This issue brief is the fifth in our Child Health Insurance Project series. Other CHIP issue briefs and fact sheets can be found on our web site: [www.mchpolicy.org](http://www.mchpolicy.org).

## ELIGIBILITY

In setting eligibility policies under CHIP, states may extend coverage to children in families with incomes as high as 200 percent of poverty or incomes at 50 percentage points above the state's current Medicaid eligibility level, whichever is higher. Those that elect to enroll children into a non-Medicaid program have additional options that could be used to benefit children with special needs. They may use countable income, rather than gross or net income, and may bring higher income children into the CHIP program by disregarding specific amounts of income or types of expenses, such as medical expenses. In addition, they may use the maximum income standard for children with disabilities but not for others, or they may apply more liberal income methodologies for them. In defining which children would be considered disabled, a state could choose the Social Security Administration's disability definition<sup>5</sup> or select a more inclusive criteria based on functional status, special service needs, or anticipated treatment costs. Finally, although children with insurance cannot participate in non-Medicaid CHIP programs, states may elect to require shorter periods of uninsurance for disabled children or to define certain types of insurance as inadequate.

Income eligibility levels among the 48 states with approved CHIP plans range from 100 to 300 percent of poverty but tend to be higher in states that have chosen non-Medicaid programs either alone or in combination with Medicaid. (See Appendix I.) The 24 states enrolling all CHIP-eligible children into Medicaid chose income eligibility levels from as low as 100 to as high as 300 percent of poverty, but half have thresholds that are at or below the 150 percent level. In fact, a significant proportion of states using only Medicaid to insure CHIP-eligible children are either accelerating the phase in of adolescents up to 100 percent of poverty or increasing the income eligibility for some or all children up to the 133 percent or 150 percent level in effect for younger children. Less than a third of the Medicaid states are covering children in families with incomes at or above 200 percent of poverty. Although two of the four states with the option to go to an income level higher than 200

---

<sup>5</sup> The Social Security Administration considers a child to be disabled if he or she has a "medically determinable physical or mental impairment which results in marked and severe functional limitations, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months." *Personal Responsibility and Work Opportunity Reconciliation Act of 1996*, Pub. L. 104-193 § 211.

percent of poverty for most or all children took advantage of it, one of the states actually had adopted this policy prior to the enactment of CHIP.<sup>6</sup> By contrast, the 24 states enrolling CHIP-eligible children into non-Medicaid programs, either alone or in combination with Medicaid, selected income eligibility levels that range from 150 to 300 percent of poverty, and three-quarters of these states are covering children in families with incomes at or above 200 percent of poverty. Moreover, each of the three states able to set their income eligibility thresholds above 200 percent of poverty chose to do so.<sup>7</sup>

With respect to requirements regarding the length of time during which children must be uninsured in order to be CHIP eligible, state policies range from no uninsurance period at all to a period as long as 12 months. However, most states have been fairly liberal in this area. This is particularly true for those that operate Medicaid CHIP programs -- only five of which have any period-of-uninsurance requirement. Among the 48 states overall, 21 require no period of uninsurance, one requires a one-month period, and eight require a three-month period. Still, 13 states are requiring children to be uninsured for as long as six months and five are requiring that they be uninsured for a full year.

No state has set its income eligibility threshold for children with disabilities higher than those for other CHIP-eligible children. In addition, only one state has adopted an income eligibility methodology that would provide greater access to coverage for children with disabilities or special needs. This state, Colorado, is disregarding all incurred medical expenses that require payment within the next 12 months when calculating eligibility for its non-Medicaid CHIP program.

---

<sup>6</sup> Two additional Medicaid states, Minnesota and Missouri, set their income eligibility levels above 200 percent of poverty, but Minnesota only allowed a very small number of young children to participate and Missouri established eligibility at 300 percent of poverty by permitting income disregards.

<sup>7</sup> One additional non-Medicaid state, New York, also set its income eligibility level above 200 percent of poverty, but it did so by obtaining HCFA approval for eligibility at 185 percent of net income -- the estimated equivalent of 222 percent of gross income.

Several states, however, have established exemptions to their required period of uninsurance for children considered to be underinsured. Four states will enroll children into CHIP immediately if the premium cost incurred by families in private health insurance plans is too high -- in two cases, defined as more than 50 percent of the premium charge and in one, more than \$300 a month. More significantly, three additional states will exempt children from a required period of uninsurance if the child has special needs or the scope of coverage is limited.<sup>8</sup>

- Oregon waives its six-month waiting period for insurance if a child has a condition that must be treated to prevent permanent loss of function or disability.
- Connecticut and Kentucky both have exemptions to their required six-month period of uninsurance if there has been a substantial reduction in either lifetime medical benefits or a particular benefit category under the child's existing employer-sponsored coverage.

---

<sup>8</sup> Although New Mexico's approved CHIP plan included an exemption its 12-month period of uninsurance if a child with special needs is underinsured, the state subsequently dropped this provision due to difficulties in operationalizing the exemption.

## BENEFITS

States have a wide range of options for designing their CHIP benefit packages. If they choose to use the Medicaid program for CHIP-eligible children, they must provide the same coverage available to other children enrolled in Medicaid. If they choose a non-Medicaid program, they must provide coverage that is either the same as or actuarially equivalent to the benefits offered under one of three benchmark plans -- the standard BlueCross BlueShield plan available to federal employees, the state employees' plan, or the most popular HMO plan in the state. However, they may include additional benefits that more nearly approximate the Medicaid benefit package. In addition, states may seek approval from the Secretary to design their own coverage. States may select a plan for children with disabilities that is more generous than the benefit package selected for other children.

The 48 CHIP benefit packages thus far approved by HCFA vary considerably. (See Appendix II.) At one extreme are the 29 states providing a full Medicaid benefit package that covers all medically necessary services -- of which 24 are enrolling children into their state Medicaid programs and five are enrolling children in non-Medicaid programs that cover additional diagnostic and treatment services equivalent to the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit under Medicaid. At the other extreme are the four states providing non-Medicaid coverage that does not include over-the-counter drugs, nursing services, case management services, and routine dental services and provides either very limited coverage or no coverage at all for ancillary therapies, outpatient mental health, and inpatient substance abuse services.<sup>9</sup> In general, however, non-Medicaid CHIP programs offer routine care services such as physician services, prescription drugs, laboratory services, and radiological services without stated limits and provide varying degrees of coverage for ancillary therapy, home health, mental health, substance abuse, and other specialized services.

---

<sup>9</sup> One state, Oregon, is not included in our benefit analysis because it limits services in accordance with its own prioritized list of services for covered conditions rather than by specific annual, day, or visit limits. Mental health services, in selected counties, are the only services not subject to the prioritized list.

With the exception of the five states that include EPSDT expanded benefits in their non-Medicaid coverage, the majority of non-Medicaid programs impose amount, duration, or scope restrictions on most services important to children with special needs. For children with complex physical conditions, the extent of coverage for specialized or chronic care services varies significantly from state to state. Physical, occupational, and speech therapy are typically covered for at least 24 visits for all therapies combined, but often are available only for acute episodes and not for children with developmental delays or conditions that will not improve significantly. One state provides no coverage for ancillary therapies. Although home health services are usually covered without visit limits, they are sometimes restricted to skilled nursing and rarely include respite or personal care services. In one state no home health coverage is available. Durable medical equipment is covered in all but one state, although coverage for hearing aids or eyeglasses is excluded in a few states. Case management services for children with complex physical conditions is available in less than half of the states.

Children with mental health or substance abuse conditions also would have highly variable access to needed services under the 19 non-Medicaid programs without EPSDT-like coverage. Outpatient mental health services are typically covered for at least 20 visits in all non-Medicaid CHIP programs.<sup>10</sup> To varying degrees, residential treatment and community-based services<sup>11</sup> are sometimes covered as well. Applicable limits are lifted in two states for children with selected biologically based disorders. Yet, in five states, outpatient mental health treatment is not covered at all for children with certain mental and developmental conditions, such as learning disabilities, mental retardation, conduct disorders, oppositional disorders, or chronic psychosis. Outpatient substance abuse services are generally covered for at least 20 visits, but one state has no outpatient benefit for substance abuse treatment. Inpatient mental health services are typically covered for at least 15 days, and inpatient substance abuse services are typically covered for at least 20 days, but often only for detoxification. One state provides no coverage for inpatient mental health services, however, and

---

<sup>10</sup> In six states, additional outpatient mental health benefits are available through the conversion of inpatient mental health benefits.

<sup>11</sup> Community-based services may include intensive in-home services, crisis stabilization, and day treatment services and are usually furnished through community mental health centers.

three provide no coverage for inpatient substance abuse services. Moreover, coverage for mental health and substance abuse services is frequently combined and subject to a single benefit limit, which poses serious access problems for children with co-existing conditions. Case management services for children with mental health problems are available in just over half of the states.

Importantly, however, a number of states have adopted innovative approaches to augment the benefits available under their non-Medicaid plans for children who meet state-defined criteria. Children with complex physical or behavioral health problems are eligible in four states for a more comprehensive benefit package with services comparable to those available under Medicaid. In two states, however, access to these services appears to be more liberal for children with physical or developmental conditions than for those with mental health or substance abuse problems. The expanded benefits are available to children with severe physical, mental, or developmental conditions in one state; children with moderate to severe physical or developmental conditions and those with serious behavioral disorders in two states; and children with significant physical, behavioral, or developmental conditions or illnesses in another.

- In Connecticut, children with physical or developmental problems or serious mental or substance abuse disorders are eligible for services additional to those offered through the state's standard non-Medicaid CHIP program, HUSKY Part B. Those who have or are at risk for any of a broad range of physical or developmental conditions that are covered by the Title V program and associated with elevated service needs, or who are identified through one of three screening tools, qualify for the HUSKY Plus Plan for Children with Special Physical Health Needs. The plan constitutes a broad benefit package that includes assessment services, ancillary therapy services, medical devices and equipment, home health services, pharmacy services, and orthodontia. Those who have severe mental health or substance abuse problems that have caused substantial long-standing impairments, who have heavily utilized<sup>12</sup> the basic benefit package's behavioral health services, and who can be expected to improve significantly with intensive treatment

---

<sup>12</sup> Heavy utilization refers to at least 20 outpatient visits and five hospital days through the basic benefit package. However, the behavioral health plan may waive this policy under special circumstances.

qualify for the HUSKY Plus Behavioral Health Plan. This plan delivers assessment services, case management services, mobile crisis services, intensive in-home child and adolescent psychiatric services, and extended coverage for outpatient mental health visits. The mental health and substance abuse benefits available under HUSKY Part B appear to provide adequate coverage for most children with behavioral health problems not serious enough to qualify them for the specialized plan.

- In North Carolina, which uses a non-Medicaid program for all CHIP-eligible children, those with physical, developmental, mental health, or substance abuse conditions that meet specific criteria have access to expanded coverage equivalent to the full package of benefits available under Medicaid. Physical and developmental health services might include nutrition services, specialized durable medical equipment, or ancillary therapies. Behavioral health services might include outpatient and inpatient mental health or substance abuse services and community-based services. To be eligible, a child may have any physician-diagnosed birth defect, developmental disability, behavioral disorder, or chronic and complex illness that is likely to continue indefinitely, interfere with daily routines, and require extensive medical intervention and family management.<sup>13</sup>
- In Massachusetts, all children with physical, mental, or developmental conditions that meet the Social Security Administration's definition of disability are enrolled into the Medicaid program, regardless of whether their family income would otherwise qualify them for non-Medicaid CHIP coverage. As Medicaid beneficiaries, they become participants in the state's 1115 demonstration waiver program for persons with disabilities. Their coverage includes the full package of Medicaid benefits but, unlike other Medicaid child beneficiaries, they are not enrolled in managed care organizations.

---

<sup>13</sup> Physical and developmental services are furnished through the Title V program, while behavioral health services are provided by the private insurance carrier administering the basic benefit package. All expanded coverage is reimbursed by the CHIP program on a fee-for-service basis, subject to a fixed budget. See the section on Plan Arrangements for provider and reimbursement information on the Connecticut and Florida plans serving children with special needs.

- In Florida, all children enrolled in the non-Medicaid CHIP program with chronic or potentially chronic physical or developmental conditions and a capped number of enrolled children with serious emotional disturbances or substance dependency (approximately 300) will receive the same benefit package available to Medicaid beneficiaries. These are children who would qualify for services under the state's Title V program or the children's mental health program. Children with mild to moderate mental health or substance abuse problems that do not qualify for the enhanced benefit plan will receive coverage that probably meets their needs under the regular non-Medicaid CHIP program.

There are also two states in which children with serious emotional disturbances who meet state-specific criteria are eligible for expanded mental health benefits. In both states, these expanded benefits are community-based services available to children with such conditions as schizophrenia, manic depressive disorder, and conduct disorder. One of these states provides community-based service benefits for children with severe chemical dependency problems as well.

- In Montana, children with serious emotional disturbances are eligible for additional mental health services including outpatient services, inpatient services, residential treatment services, case management services, crisis intervention services, and prescription drugs.
- In Georgia, children with severe emotional disturbances or substance abuse problems are offered expanded behavioral health services such as day treatment services, crisis intervention services, recreational therapy services, family and group counseling services, residential treatment services, occupational therapy services, ambulatory detoxification services, nursing services, and prescription drugs.

Among the remaining 13 non-Medicaid CHIP programs without any EPSDT requirements or wraparound arrangements, two have stipulated that children eligible for certain public programs will receive additional benefits through them, without CHIP funding. Both programs have referral relationships with the Title V program and one also has a referral relationship with county mental health departments. While the specialty services offered through these Title V and mental health

programs are extensive, Title V eligibility is fairly restrictive in one of the states and mental health service eligibility is open only to those with the most severe problems. In addition, of course, these programs operate under limited budgets.

- Colorado's CHIP program provides that children with chronic physical conditions be referred to the state's Title V program, which offers services such as specialized medical equipment, ancillary therapies, and inpatient hospital care. Children with moderate to severe physical conditions, except for diabetes or asthma, are eligible.
- California's CHIP program provides that children with severe physical conditions be referred to the Title V agency, which offers specialized medical services including equipment and supplies, ancillary therapies, prescription drugs, and inpatient hospital care, and that children with serious emotional disturbances be referred to the county mental health department, which provides specialized behavioral health services such as psychological evaluations and counseling, prescription drugs, crisis intervention, and residential services. Since both programs serve only children with serious conditions, children with moderate conditions might be ineligible for the public programs and not have coverage for all of their specialty services through the non-Medicaid CHIP program.

## PLAN ARRANGEMENTS

In addition to the latitude states have in designing the benefit package that CHIP-eligible children will receive, they also have broad discretion in structuring the insurance arrangements for furnishing these services. In states operating Medicaid CHIP programs, Medicaid's existing plan arrangements would be used, but in those operating non-Medicaid programs, choices would have to be made about the type of insurance arrangement, whether services would be excluded from capitation and reimbursed separately, and the extent of service access and quality requirements. In structuring these requirements, states have the opportunity to address the special care requirements of children with chronic conditions. Separate plans could be established to furnish their care, or selected specialty services could be financed on a fee-for-service basis if a general managed care organization was not equipped to deliver them. Provider network requirements could stipulate specialty providers with pediatric expertise; access guidelines could include liberal medical necessity criteria and flexible service authorization policies; and quality of care requirements could call for patient satisfaction surveys, clinical effectiveness measures, and service utilization data specific to children with special needs.

For the most part, CHIP-eligible children in states that operate non-Medicaid programs will be far more likely than those in states that only operate Medicaid programs to be enrolled in managed care organizations and to have all of their services capitated.<sup>14</sup> (See Appendices III A & B and Appendices IV A & B.) All but one<sup>15</sup> of the 24 non-Medicaid programs are requiring children, typically on a statewide basis, to obtain their coverage through private insurers that employ a high degree of managed care controls, although two are using plans that assume no financial risk.<sup>16</sup>

---

<sup>14</sup> States that use Medicaid CHIP programs in combination with non-Medicaid CHIP programs were not included in our analysis of Medicaid CHIP programs because in most instances a relatively small proportion of CHIP-eligible children are being enrolled into Medicaid.

<sup>15</sup> In Georgia, CHIP-eligible children are enrolled with a primary care case manager who functions as a gatekeeper for some or all covered services. In the future, Georgia intends to offer children who reside in the metropolitan Atlanta area the option of enrolling into capitated plans.

<sup>16</sup> In Alabama, CHIP-eligible children are enrolled into one of two plans, BlueCross BlueShield or Prime Health, both of which have their own provider networks but provide administrative services only. These plans are self-insured by the state. In North Carolina, all CHIP-eligible children are enrolled into an indemnity plan known as the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan, which was established as one of the insurance options for state employees. It has no preferred provider network. BlueCross BlueShield

By contrast, only 13 of the 24 Medicaid programs are requiring mandatory managed care enrollment, most often in limited jurisdictions rather than statewide -- while an additional six states are enrolling children into managed care organizations on a voluntary basis in some or all counties, and five are using primary care case management (PCCM) or other non-capitated arrangements exclusively.<sup>17</sup> Moreover, only half of the non-Medicaid programs exclude a covered service from their capitated arrangements, while all but one of the Medicaid programs using managed care organizations have carved out at least one pediatric service, and usually many more, to be financed fee for service or through separate capitated arrangements. In addition, non-Medicaid programs tend to place fewer contractual requirements on plans to collect service utilization data, monitor clinical effectiveness, meet access standards,<sup>18</sup> and evaluate member satisfaction. They also have fewer stipulations regarding the use of various types of qualified primary care providers, including safety net providers. Finally, their contracts are less likely to provide plans with a state-established definition of medical necessity.

Not surprisingly, CHIP programs, whether Medicaid or non-Medicaid, rarely structure capitated arrangements specifically for children who have special needs. Among states with non-Medicaid CHIP programs, one is enrolling children with chronic conditions into a separate comprehensive health plan. Two other states have separate plans for specialty services. Although nine of the remaining states with non-Medicaid programs carve out certain services utilized by all children (usually dental services, behavioral health services, or both services), only six carve out a specialty service intended for children with special needs. Among states with Medicaid CHIP programs, one enrolls children and adults who meet SSI-disability criteria into a special plan and another enrolls children who receive SSI assistance into a separate plan; however, in both cases enrollment is voluntary and unlikely to include a significant number of CHIP-eligible children with

---

provides administrative services only for basic medical services, and Value Options provides administrative services only for behavioral health services.

<sup>17</sup> The five Medicaid programs are in Alaska, Arkansas, Idaho, Louisiana, and South Dakota. Alaska does not use any form of managed care, while the other four states use PCCMs.

<sup>18</sup> Access standards include minimum waiting times for appointments, distance requirements for providers, and ratios for primary care providers to beneficiaries.

disabilities.<sup>19</sup> Yet more than three-quarters of Medicaid programs exclude from their general capitated arrangements one or more services important to children with special needs. Such carve-out policies are in place for health-related special education services in 11 states, early intervention services in nine states, and targeted case management in eight states.

- Florida's non-Medicaid CHIP program requires all children who have chronic or potentially chronic physical or developmental problems and a specified number of children with severe emotional disturbances or chemical dependency to enroll into a special managed care plan able to furnish all of their primary, specialty, and long term care services. Like Medicaid enrollees with the same conditions, these CHIP-eligible children receive covered services through the Children's Medical Services Network, a plan originally developed as a PCCM under an 1915(b) demonstration waiver. The plan is administrated by the state Title V program and uses the approved provider networks of that program and county mental health departments. For each CHIP-eligible child, it receives a monthly capitation rate based on historic cost experience from the Medicaid program and adjusted for diagnosis, age, and geographical location. Providers are paid on a fee-for-service basis.
- Connecticut's non-Medicaid CHIP program enrolls children with physical or developmental problems and those with severe mental or substance abuse disorders into two different plans that provide specialty services. The HUSKY Plus Physical Plan is administered by the Yale Children's Hospital and Connecticut Children's Medical Center which contracts with Title V providers. The HUSKY Plus Behavioral Plan is administered by the Yale Child Study Center, which contracts with a variety of community-based providers. Under both supplemental plans, providers are reimbursed on a fee-for-service basis, although CHIP funding is capped and delivery sites operate under fixed budgets.

---

<sup>19</sup> Importantly, however, only three of the 13 Medicaid CHIP programs require that children who receive SSI assistance enroll into managed care organizations. (See Appendix III B.)

- Montana's non-Medicaid CHIP program serves children with serious emotional disturbances through the Mental Health Access Plan, which is operated by Montana Community Partners, a behavioral health organization comprised of non-profit providers and a commercial plan.<sup>20</sup> Montana Community Partners is capitated by the state to furnish specialized mental health services, including both community-based and residential services.
- Vermont's non-Medicaid CHIP program does not have any specialty plans, but it excludes from its capitated arrangements behavioral health services for children with serious emotional disturbances or severe chemical dependency problems, health-related special education services, early intervention services, and eyeglasses. These services are all paid by the state on a fee-for-service basis.
- South Carolina is the strongest example of a Medicaid CHIP program with extensive carve-out protections for children with special needs. The program excludes intensive behavioral health services for all children, community-based behavioral health services for those with serious emotional disturbances or severe chemical dependency problems, health-related special education services, and early intervention services from its managed care contracts and pays providers on a fee-for-service basis.

Among the 39 CHIP programs enrolling children into managed care organizations,<sup>21</sup> the

---

<sup>20</sup> This plan also is capitated to serve all children enrolled in the Medicaid program. At the request of the plan, however, the state Medicaid and CHIP programs intend to terminate their current contracts with the plan. The state hopes to have a new relationship established with another behavioral health organization shortly. If necessary, however, the CHIP program will pay providers on a fee-for-service basis for specialized mental health services during the transition. (Montana Managed Care Officials Bust Deadlines to Replace Troubled Behavioral Health Care Vendor. *State Health Watch*. 6: 10-11, April 1999.)

<sup>21</sup> The CHIP Medicaid programs in Alaska, Arkansas, Idaho, Louisiana, and South Dakota were not enrolling any CHIP-eligible children into capitated plans as of January 31, 1999. The non-Medicaid CHIP programs in Alabama, Georgia, and North Carolina were not enrolling any CHIP-eligible children into capitated arrangements as of January 31, 1999. All of these CHIP programs were therefore excluded from our contract analysis. In addition, the non-Medicaid CHIP program in Massachusetts was excluded because it primarily subsidizes premium charges for families with access to employer-sponsored insurance in which employers contribute at least 50 percent of premium costs, the benefit package meets the state's standard criteria, and the cost of coverage to the state is less than the cost of enrollment into a Medicaid HMO for the child or children alone. Children with employer-sponsored coverage

standard contracts and requests for applications that have been issued vary widely in terms of the type and extent of the requirements placed on plans for serving children with special needs but, except for medical necessity language, non-Medicaid documents tend to have more special provisions for chronic care than Medicaid documents. (See Appendices V A & B.) In most instances where detailed requirements regarding children with special needs were included in the contracts of non-Medicaid CHIP programs, the language appears to have been drawn from the state's Medicaid managed care contract. Among the seven non-Medicaid CHIP programs that adopted their states' Medicaid managed care contracts in full,<sup>22</sup> however, only half imposed three or more contractual requirements related to the care of children with special needs.

Importantly, a significant number of CHIP programs, but particularly non-Medicaid CHIP programs, are requiring plans to include in their networks the kind of specialty providers that children with special needs require. Of the 20 non-Medicaid CHIP contract documents and the 19 Medicaid contract documents, nine non-Medicaid and five Medicaid stipulate the participation of public program providers of children's physical or mental health services, and 12 non-Medicaid and eight Medicaid stipulate the participation of pediatric subspecialists and others with pediatric expertise. In addition, there are provisions regarding the selection of specialists as primary care providers in six non-Medicaid and nine Medicaid contracts, and provisions facilitating referrals for specialists' services for children with special needs in eight non-Medicaid and seven Medicaid contracts. Access

---

constitute the majority of non-Medicaid CHIP participants, according to the state's responses to HCFA's questions on April 27, 1998. Thus, plan arrangements for this CHIP program vary considerably from employer to employer. Moreover, children who have no access to employer-sponsored insurance that meets the state's requirements for premium assistance have the option to enroll into either a Medicaid PCCM or managed care organization.

Wisconsin's Medicaid CHIP program also subsidizes premium charges for families with access to employer-sponsored insurance. However, it does so only for families with access to coverage in which the employer pays between 60 and 80 percent of the premium and costs to the state for the premium subsidy, uncovered services that would be available through Medicaid, and administrative expenses together are less than the cost of enrolling the child or children into a Medicaid HMO. Because of the stringency of this cost-effectiveness test, Wisconsin's Medicaid CHIP program which requires enrollment into managed care organizations is included in our contract analysis.

<sup>22</sup> These seven programs are in Arizona, Delaware, Nevada, New Jersey, Oregon, Vermont, and Virginia, and they are all administered by their state Medicaid agencies. There are eight additional non-Medicaid programs, a total of 16, that are also administered by their state Medicaid agencies. The remaining five non-Medicaid programs not administered by their Medicaid agencies are California, Florida, Michigan, New Hampshire, and Pennsylvania.

requirements pertaining to specialty services are contained in eight non-Medicaid and eight Medicaid contracts.

- In West Virginia, the Medicaid CHIP contract offers financial incentives to plans that contract with the Title V Handicapped Children's Service providers. If a plan does not contract with these providers, it must provide the same level and types of services, including multidisciplinary care.
- In Utah, the standard contract for its non-Medicaid program specifies that children with special needs must have access to appropriate pediatric specialists, even if they are only available outside of the plan's provider network, and that providers cannot be penalized for making such referrals.
- In Connecticut, the non-Medicaid CHIP contract requires plans to include sufficient numbers of appropriately trained and certified clinicians of pediatric care, including primary, medical subspecialty, and surgical specialty physicians as well as providers of related services such as dental, mental health, social work, developmental evaluation, therapy, school-linked clinic, and other public health services. Plans must submit quarterly reports on provider network capacity, and where capacity is exceeded, the state will suspend new enrollment. Connecticut also requires plans to stipulate in their applications the specialists to whom members will be permitted to self-refer, the number of specialty visits that will be allowed without re-authorization or without initial authorization by a primary care provider, the procedures for referral if appropriate specialists are not available in the plan's network, and the specialist's latitude in prescribing medications and referring to subspecialists or other providers.
- In Michigan, the non-Medicaid CHIP program uses contractual language requiring that children with chronic conditions be allowed to choose a pediatric specialist as their primary care physician.

- In Missouri, the Medicaid CHIP contract requires plans to assure that treatment regimens involving physical, occupational, and speech therapy; psychological counseling; or home health care are not interrupted or delayed by the prior authorization process. The contract also requires plans to monitor the number of requests for specialists to serve as primary care providers along with the frequency with which the request is granted.
- In Colorado, the non-Medicaid CHIP contract requires primary care physicians to grant specialist referrals, renewable for up to one year, for children who qualify under the program's definition of special health care needs.<sup>23</sup>

Not all CHIP contracts, however, direct plans to use medical necessity standards that would assure access to specialty services for children with special needs. Medicaid contracts are far more likely to contain a definition of medical necessity and thereby preclude plans from adopting a medical necessity standard that limits coverage to treatment of an illness or injury. Only one Medicaid contract, compared with 12 non-Medicaid contracts, is silent on the issue of medical necessity. Among the 26 CHIP contracts that do contain medical necessity standards -- 18 Medicaid and eight non-Medicaid -- the language provides for the treatment of a condition or disability in addition to an illness or injury in about three-quarters of states, and would allow for interventions to achieve optimal functioning or prevent the worsening of a disability in about one-third of states. Yet nine contracts, seven of which are Medicaid, include one or more qualifying provisions that would restrict specialty service access: two require that the disease, illness, or injury be expected to cause significant disability or significant or severe pain; three require that there be evidence of effectiveness for the intervention; and six require that either the treatment or the level of service be the least costly alternative.<sup>24</sup>

---

<sup>23</sup> Special health care needs are defined in the CHIP contract as conditions that have a biological, physiological, or cognitive basis; have lasted or are likely to last for more than one year; and produced functional impairments or reliance on special services or assistive devices.

<sup>24</sup> The ninth state also stipulates that the service be the least costly but only if it is equally effective to the alternatives.

- Texas' Medicaid CHIP program uses two separate medical necessity definitions -- one for behavioral health services and one for all other health services. With respect to behavioral health, medically necessary services include diagnosis and treatment services to improve, maintain, or prevent deterioration of a mental health or substance abuse condition. With respect to all other types of health care, medically necessary services include preventive, screening, and treatment services for conditions that cause limitations in function or threaten to cause or worsen a handicap.
- Delaware's non-Medicaid CHIP contract stipulates as part of its medical necessity definition that services be rendered in response to pain; to treat an illness, injury, or other diagnosed condition; or to treat the effects of a diagnosed condition that has resulted in or could result in a physical or mental limitation including loss of physical or mental functionality or developmental delay. Delaware's contract also stipulates that services be appropriate to the comprehensive profile -- needs, aptitudes, abilities, and environment-- of the beneficiary and the beneficiary's family.
- Connecticut's non-Medicaid CHIP contract defines medical necessary services as care provided to correct or diminish the adverse effects of a medical condition or mental illness and to assist an individual in attaining or maintaining an optimal level of health.<sup>25</sup>

Although Medicaid CHIP programs are as likely as non-Medicaid CHIP programs to have at least one quality performance measure for children with special health care needs, more than a third of CHIP contracts have no utilization, clinical effectiveness, or consumer satisfaction reporting requirements pertaining to children with chronic conditions. This is largely because the state of the art in quality measurement for children with chronic conditions is not well developed and the quality requirements specified in the Title XXI legislation address only preventive care and immunizations.

---

<sup>25</sup> Colorado previously had defined medical necessity for non-Medicaid CHIP beneficiaries as services that would aid in the overall physical and mental growth and development of the child. However, the state elected to substitute more restrictive language.

As many as 15 CHIP contracts -- nine of which are non-Medicaid -- include chronic care utilization measures, primarily for mental health services and specialist referrals. Yet, no CHIP contract requires managed care organizations to compare overall service utilization among children with and without chronic conditions, despite the fact that 17 CHIP contracts require managed care organizations to identify children with special needs.<sup>26</sup> Fourteen CHIP contracts -- 10 of which are Medicaid -- require plans to report on clinical effectiveness measures. Asthma treatment is by far the most common measure, although mental health treatment is sometimes mentioned as well. Finally, seven CHIP contracts -- including six non-Medicaid -- require plans to conduct member satisfaction surveys that specifically address access to specialist services.

- The Texas Medicaid CHIP contract specifies reporting requirements for several chronic care measures as well as a mechanism for identifying members with chronic or disabling conditions. For clinical effectiveness, plans are required to conduct focused studies on asthma or another chronic condition and to report scores on two functional assessment scales for children with a variety of mental health conditions, including mood and affective disorders, anxiety and phobia disorders, schizophrenia and other psychoses, and attention deficit hyperactivity disorder. For service utilization, plans are required to report chronic care use including home health encounters, private duty nursing services, ancillary therapies, and durable medical equipment and to report on behavioral health service use including inpatient hospitalizations and readmissions, outpatient services, partial hospitalizations, intensive outpatient services, emergency room services, and referrals to the local mental health authority.
- The Wisconsin non-Medicaid CHIP contract specifies that plans must monitor both clinical effectiveness and use of services for children with chronic conditions. Clinical effectiveness measures are required for asthma as well as mental health and substance abuse treatment. For mental health and substance abuse follow-up care, there is a state-established goal that plans are expected to meet. In addition, Wisconsin requires plans to

---

<sup>26</sup> Only two of the 17 states, Connecticut and Florida, specify the screening instrument that plans are to use to identify children with special needs.

conduct two focused studies on children with special health care needs, specialty services, outpatient asthma management, nutritional services, lead screening, diabetic care, or alcohol and drug abuse services. Utilization measures are required for the following services: diagnosis and treatment as a result of an EPSDT screen (excluding vision, dental, and hearing services); hospitalization for failure to thrive and asthma; and mental health and substance abuse outpatient evaluation, day treatment, detoxification, rehabilitation therapy, and hospitalization.

- The Rhode Island Medicaid CHIP contract not only requires plans to report on performance measures that focus on the clinical effectiveness of care for children with chronic conditions, it also has standards for each measure. Plans must report readmission rates for mental health hospitalizations and attempt to meet the state's standard of less than 20 percent. Also, they must monitor asthma hospitalization rates with the goal of decreasing their previous rate by 10 percent. Finally, plans are required to report the number of children who have elevated blood lead levels of 20 mg/dl or greater and refer at least 90 percent of these cases to the state's lead centers for treatment.
- The New Hampshire non-Medicaid CHIP contract stipulates clinical effectiveness and satisfaction survey requirements. Plans must initiate two clinical focused studies, which may include lead toxicity screening and treatment, pediatric asthma, attention deficit disorder, adolescent counseling on smoking and substance abuse, or behavioral health screening and treatment. In addition, provider satisfaction and enrollee satisfaction surveys, using questions from the Consumer Assessment of Health Plans (CAHPS) instrument, must be conducted.
- The Kansas non-Medicaid CHIP contract includes requirements for conducting consumer satisfaction surveys. Core questions for children from CAHPS must be included along with supplemental questions that address mental health and other chronic conditions.

## COST-SHARING REQUIREMENTS

States are permitted to impose cost-sharing requirements -- premiums, deductibles, copayments, or coinsurance -- on families whose children participate in the CHIP program, provided that the requirements are consistent with federal guidelines. For children in families with incomes at or below 150 percent of poverty who are enrolled in non-Medicaid CHIP programs, and all those enrolled in regular Medicaid CHIP programs, only nominal cost-sharing is allowed.<sup>27</sup> However, more significant charges are permissible for children in families with incomes above 150 percent of poverty who are enrolled in non-Medicaid CHIP programs and those enrolled in Medicaid CHIP programs operating under 1115 demonstration waivers.<sup>28</sup> Cost-sharing amounts may be set as sliding-scale or flat charges but cannot favor higher income families over those with lower incomes and cannot exceed the five percent out-of-pocket limit.<sup>29</sup> States concerned about the financial burden on families whose children heavily utilize health services have the option to keep deductibles, copayments, and coinsurance as low as possible. Alternatively, they may place a cap on these charges, or set the overall cost-sharing limit at an amount lower than the Congressionally established five-percent cap, and also assure that responsibility for tracking cost-sharing payments is not left with the family.

---

<sup>27</sup> The nominal cost-sharing charges for children in families living at or below 150 percent of poverty and enrolled in non-Medicaid programs are those established by the Secretary for medically needy individuals. The maximum allowable premium amounts that states may charge vary by family size as well as income. Currently, the maximum allowable monthly premium charge for a single child in a two-parent family with a gross income that places them between 75 and 150 percent of poverty ranges from \$13 to \$16. Charges for each health service may only be of one type -- deductible, coinsurance, or copayment. However, deductibles may not exceed \$2 per month per family, coinsurance may not exceed five percent of the state Medicaid agency's payment for the service, and copayments for outpatient services cannot exceed those in the HCFA schedule for services of different costs. HCFA's proposed regulations, already in effect, set copayments at \$1 for services reimbursed at \$15 or less; \$2 for services reimbursed at between \$15.01 and \$40; \$3 for services reimbursed at between \$40.01 and \$80; and \$5 for services reimbursed at more than \$80. (Health Care Financing Administration: State Official Letter, Children's Health Insurance Program, February 13, 1998 and personal communications with HCFA staff during March 1999).

<sup>28</sup> For children in families with incomes above 150 percent of poverty who are enrolled in non-Medicaid programs, states are able to charge premiums, apply deductibles, and also require copayments or coinsurance for any service except preventive care. Where 1115 demonstration waiver programs are in place, states may impose these charges on expanded eligibility groups who are not categorically needy.

<sup>29</sup> The total charges (including premiums, deductibles, coinsurance, and copayments) for families participating in CHIP cannot exceed five percent of the family's gross income. (HCFA is considering a formal rule-making process to lower the level of the cap on cost-sharing. Amendment to Florida's Title XXI Child Health Insurance Plan: State Responses to Questions from the Health Care Financing Administration, August 20, 1998.)

Twenty of the 24 non-Medicaid programs are requiring cost-sharing for CHIP-eligible children, while only four of the 12 Medicaid demonstration waiver programs are. (See Appendices VI A & B.) Most non-Medicaid CHIP programs with cost-sharing requirements are structuring them to include both premium and copayment charges, although seven are applying premium charges only, and one is using a combination of coinsurance and copayments. None imposes deductibles. Premiums are imposed in 19 non-Medicaid CHIP programs, 16 of which have some rate adjustments for amount of family income, number of enrolled siblings, or, more commonly, both factors. More than half of these states impose premium charges only on families with incomes above 150 percent of poverty or some higher income threshold. Monthly premium rates for families at 101 percent of poverty with one child range from a low of \$1 to a high of \$10; at 151 percent of poverty, from \$4 to \$20; and, at 185 percent of poverty, from \$4 up to \$25. Most states' monthly premium charges for a single child do not exceed \$15. Copayments are imposed in 12 non-Medicaid CHIP programs,<sup>30</sup> with eight states making some adjustments based on family income. Almost a third of these states have copayment requirements only for families with incomes above 150 percent of poverty. Although copayments are always applied to non-preventive physician visits and prescription drugs (usually with higher charges for brand names), many non-Medicaid CHIP programs also require copayments for outpatient mental health and substance abuse services, ancillary therapy services, optometry services, dental services, and emergency services, particularly if used inappropriately. Copayment charges range from \$1 for generic prescription drugs in three states to \$50 for outpatient mental health services over 20 visits in one state, but most services do not carry copayments greater than \$5.

Among the four Medicaid demonstration waiver programs that have cost-sharing requirements, one requires both premiums and copayments, two require either premiums or copayments, and one offers premium and copayment options; however, none imposes charges on

---

<sup>30</sup> Massachusetts' non-Medicaid CHIP program was excluded from the analysis of coinsurance and copayments because it offers premium assistance to finance employer-based coverage that meets state-established criteria, and qualifying plans carry various cost-sharing policies that would apply to CHIP-eligible children. Children who have no access to acceptable employer-sponsored insurance receive coverage through Medicaid's PCCMs and managed care organizations and are not subject to any copayments or coinsurance requirements. Vermont's non-Medicaid CHIP program also is not included in the analysis of coinsurance and copayments. It has approval to apply copayment charges to families with incomes above 225 percent of poverty; however, the charges will not be implemented until July 1, 1999.

families with incomes at or below 150 percent of poverty. States' policies regarding premium charges vary widely. At 151 percent of poverty, the only state that has a premium requirement charges \$52 per month. Copayments are far more consistent across the states. At 186 percent of poverty, the point at which copayments apply in three states, charges range from \$2 for prescription drugs to \$15 for outpatient hospital services, but are typically \$5.

Given that they have elevated service needs, children with chronic conditions are more affected by copayment or coinsurance requirements than other children. By estimating the charges that non-Medicaid CHIP programs requiring copayments or coinsurance would likely impose on three hypothetical children -- one without a chronic condition,<sup>31</sup> one with a neuromuscular condition,<sup>32</sup> and one with a psychiatric disorder<sup>33</sup> -- we found, not surprisingly, that a family whose child had a chronic condition would almost always incur higher out-of-pocket costs for covered services. For the child with a neuromuscular condition in a family whose income is at 151 percent of poverty, these costs would be somewhat higher than those for the child without a chronic condition (an amount equal to between 0.5 and 0.9 percent of their income) in four states, and significantly higher (an amount equal to between 1 and 3.7 percent of their income) in two states. For the child with a psychiatric disorder at the same income level, service costs would be somewhat higher in three states and significantly higher in four.<sup>34</sup> The child with a psychiatric disorder also would be more likely to need services that would not be covered by the plan and for which full costs -- more than 10

---

<sup>31</sup> We assumed that a child without a chronic condition would receive: one preventive office visit; two physician visits; three prescriptions, including refills; and two dental visits.

<sup>32</sup> We assumed that a child with a neuromuscular condition would receive: two preventive office visits; three physician visits; three specialist visits; one emergency room visit; 24 prescriptions, including refills; 20 occupational therapy, physical therapy, and speech therapy visits; two dental visits; one durable medical equipment (wheelchair); and one vision exam and eyeglasses.

<sup>33</sup> We assumed that a child with a psychiatric disorder would receive: one preventive office visit; three physician visits; one specialist visit; 18 prescriptions, including refills; one emergency room visit; 50 outpatient mental health visits; and two dental visits.

<sup>34</sup> We assumed that in Connecticut and Florida the child with a neuromuscular condition would meet the eligibility criteria for an augmented benefit package, but that the child with a psychiatric disorder would not meet the eligibility criteria because only children with serious emotional disturbances qualify. Similarly, in Montana, the child with a psychiatric disorder would not meet the eligibility criteria for augmented benefits.

percent of the family income in two states -- would have to be borne by the family.<sup>35</sup> Regardless of the type of condition, though, family contributions for covered services would be largest in the one state that has elected to enroll most of its CHIP-eligible children into a traditional insurance plan with coinsurance as well as copayment requirements.<sup>36</sup>

Another issue for families whose children have serious chronic conditions is their CHIP program's policy for tracking whether the five percent cost-sharing limit has been reached. Among the 12 non-Medicaid programs charging coinsurance or copayments, half place this responsibility on families, not on plans. Families must keep a record of their premium payments and service contributions, request that cost-sharing charges be discontinued when the limit is reached, and, if necessary, seek reimbursement for outlays that exceed the limit.

For the most part, however, states operating non-Medicaid CHIP programs have tended to impose relatively modest cost-sharing charges, and it appears unlikely that under any CHIP program out-of-pocket expenses would reach the five-percent cap. Not only do four programs have no cost-sharing requirements, one has no premium charge and seven have no coinsurance or copayments. The premiums imposed are generally affordable and, except for behavioral health services in a couple of states, copayments appear reasonable as well. Moreover, a number of states have adopted cost-sharing policies intended to minimize the financial burden on families whose children have special needs. Three of the programs that provide enhanced benefits for children with special needs make them available without any cost-sharing obligation. In addition, copayments are not imposed on

---

<sup>35</sup> Among the nine states that cover children in families at 151 percent of poverty and impose copayment charges, out-of-pocket expenses for necessary services not covered by the CHIP plan would range from an amount equal to: 0 to 15 percent of family income for the child with a psychiatric disorder; 0 to 1.5 percent of family income for the child with a neuromuscular disorder; and 0 to 1 percent of family income for the child without a chronic condition. Among the nine states that cover children in this income group but have no copayment or coinsurance charges, families would incur out-of-pocket expenses for uncovered necessary services only in one state: an amount equal to 1 percent of family income for the child with a psychiatric disorder, the child with a neuromuscular disorder, and for the child without a chronic condition.

<sup>36</sup> For a family with a child who had either a neuromuscular or psychiatric condition, copayment and coinsurance costs could equal 3.88 percent of income. Even though the state does not charge premiums for its non-Medicaid CHIP program, the cost-sharing obligations for a family whose child has special needs are very likely to be higher than those for other states that do charge premiums.

home health care services and durable medical equipment (usually with the exception of eyeglasses) in all but two states; on hospital services in most states; and on ancillary therapies, outpatient mental health services, and outpatient substance abuse treatment in several states. There are also a handful of states that have either modified their copayment policies somewhat so that children with chronic conditions would have reduced financial obligations for certain items or services or have set an affordable cap on copayments overall.<sup>37</sup>

- Under Florida's non-Medicaid CHIP program, children with special health care needs who are participating in the specialty managed care organization are not charged copayments or coinsurance for either primary or specialty care services.
- Under both North Carolina's and Connecticut's non-Medicaid programs, children with special health care needs who are eligible for enhanced benefits have no coinsurance or copayment obligations for these services. Copayment requirements for services furnished under North Carolina's basic benefit plans essentially apply to physician visits and prescription drugs only.
- Under Montana's non-Medicaid CHIP program, although the benefit package is limited, copayments are capped at \$200 annually for all families with incomes at or below 150 percent of poverty. Also, for children with severe emotional disturbances who are eligible for additional mental health services, copayments are not imposed.
- Under Alabama's non-Medicaid program, copayments are not applied to occupational therapy, physical therapy, speech therapy, outpatient mental health services, outpatient substance abuse treatment, optometry services, home health care, and durable medical equipment.

---

<sup>37</sup> Three additional states have placed caps on copayments, but the maximum amount still permits a large differential in outlays for families with a child who has a chronic condition compared with one with a child who does not.

- Under California's non-Medicaid CHIP program, copayments are capped at \$250 annually for all families with incomes at or below 200 percent of poverty. Additionally, children who are prescribed medications for chronic conditions are charged only \$5 for up to a 100-day supply, while other children are charged the same amount for a monthly supply.
- Under the non-Medicaid CHIP program in New Jersey, copayment charges for ancillary therapy services are capped, so that families with incomes above 150 percent of poverty incur cost-sharing obligations only for 20 of 60 covered visits.

## SUMMARY AND CONCLUSIONS

State CHIP programs can address the care requirements of children with special health care needs in a variety of ways. They have the option to make children with disabilities eligible for CHIP at higher income levels than other children, to assure access to a broad scope of specialty services with reasonable cost-sharing, and to establish contract provisions for an appropriate and effective system to deliver services for children with chronic conditions.

Many states have structured their CHIP programs with particular attention to children with special needs. A few, in fact, have pursued innovative plan strategies for this population. The most comprehensive is Florida's non-Medicaid CHIP program, which enrolls children with chronic physical, developmental, or serious behavioral conditions into a special capitated managed care plan offering benefits comparable to Medicaid's that are delivered by an approved network of pediatric primary and specialty care providers. Connecticut furnishes the same population of children with extensive wraparound benefits to augment its basic benefit package and requires that these services be delivered through an approved network of specialty providers. North Carolina has a wraparound benefit package for children with physical or developmental problems. Massachusetts enrolls all children who qualify as disabled into the state Medicaid program but exempts them from managed care.

Also, a significant number of states have crafted benefit packages, cost-sharing protections, and contract specifications to assure that children with special needs receive appropriate care. We found that non-Medicaid CHIP programs were surprisingly strong in these areas. Almost half of the non-Medicaid programs offer specialty care benefits that are considerably more extensive than those available through a standard commercial plan, and almost all of these have limited or no copayment requirements for these services. With respect to managed care arrangements, contract protections for children with special needs are included to some extent in many non-Medicaid and Medicaid programs. Yet, Medicaid CHIP programs are far more likely to have broad medical necessity standards, to require clinical effectiveness measures for chronic care, and to have separate financing

arrangements for one or more services important to children with special needs, while non-Medicaid programs are more likely to require the participation of providers with pediatric expertise.

Despite the efforts on the part of many states to address in some way the needs of children with chronic conditions, numerous opportunities still exist to strengthen state Medicaid CHIP and non-Medicaid CHIP programs for this population. Many CHIP programs, but primarily Medicaid programs, could expand income eligibility up to 200 percent of poverty or higher and make coverage available for the vast majority of currently uninsured children with special needs. Access to CHIP could also be improved by eliminating requirements for periods of uninsurance or establishing exemptions for children with access to private coverage that fails to provide adequate chronic care benefits. Some non-Medicaid programs could enrich their benefit offerings for behavioral health, ancillary therapies, and home health care through their basic benefit packages or the introduction of wraparound coverage. Finally, both Medicaid and non-Medicaid CHIP programs could add greater specificity to contract requirements affecting children with special needs. Depending on the state, these requirements might address pediatric specialty provider participation, medical necessity language, service authorization and access provisions, or chronic care performance measures.

## Appendix I

### Income Eligibility Levels under State CHIP Plans Approved as of January 31, 1999 and State Medicaid Programs

States	CHIP Eligibility Levels Based on Gross Income		Medicaid Eligibility Levels Based on Gross Income		
	Medicaid Programs <sup>1</sup>	Non-Medicaid Programs <sup>1</sup>	Infants	Children Ages One to Six	Older Children <sup>1</sup>
<b>Alaska</b>	200% (0-18) <sup>2</sup>	–	185%	133%	100% (6-19)
<b>Arizona</b>	–	150% (0-19) <sup>3</sup>	140%	133%	100% (6-15)
<b>Arkansas</b>	100% (15-16)	–	200%	200%	200% (6-15) <sup>4</sup>
<b>California</b>	100% (15-19)	200% (1-19) 250% (0-1)	200%	133%	100% (6-15)
<b>Colorado</b>	–	185% (0-19)	133%	133%	100% (6-15)
<b>Connecticut</b>	185% (15-19)	300% (1-19) <sup>5</sup>	185%	185%	185% (6-15)
<b>District of Columbia</b>	200% (0-19)	–	185%	133%	100% (6-15)
<b>Delaware</b>	–	200% (0-19)	185%	133%	100% (6-19)
<b>Florida</b>	100% (15-19)	200% (0-19) <sup>6</sup>	185%	133%	100% (6-15)
<b>Georgia</b>	–	200% (0-19)	185%	133%	100% (6-19)
<b>Hawaii*</b>	185% (1-6)	–	185% <sup>7</sup>	133% <sup>7</sup>	100% (6-19) <sup>7</sup>
<b>Idaho</b>	150% (0-19)	–	133%	133%	100% (6-15)
<b>Illinois</b>	133% (6-19)	–	133%	133%	100% (6-15)
<b>Indiana</b>	150% (1-19)	–	150%	133%	100% (6-19)
<b>Iowa</b>	133% (6-19)	–	185%	133%	100% (6-15)
<b>Kansas</b>	–	200% (0-19)	150%	133%	100% (6-19)
<b>Kentucky*</b>	100% (15-19)	200% (0-19)	185%	133%	100% (6-15)
<b>Louisiana</b>	133% (6-19)	–	133%	133%	100% (6-15)
<b>Maine</b>	150% (1-19)	185% (1-19)	185%	133%	125% (6-19)
<b>Maryland*</b>	200% (0-19)	–	185% <sup>8</sup>	133% <sup>8</sup>	100% (6-15) <sup>8</sup>
<b>Massachu- setts*</b>	150% (1-19) 200% (0-19:disabled)	200% (0-19: non-disabled)	185%	133%	133% (6-19)
<b>Michigan</b>	150% (16-19)	200% (0-19)	185%	150%	150% (6-16)
<b>Minnesota*</b>	280% (0-2)	–	275%	275%	275% (6-19)
<b>Mississippi</b>	100% (15-19)	–	185%	133%	100% (6-15)
<b>Missouri*</b>	300% (0-19) <sup>9</sup>	–	185%	133%	100% (6-19)
<b>Montana</b>	–	150% (0-19)	133%	133%	100% (6-15)

## Appendix I (Cont.)

States	CHIP Eligibility Levels Based on Gross Income		Medicaid Eligibility Levels Based on Gross Income		
	Medicaid Programs <sup>1</sup>	Non-Medicaid Programs <sup>1</sup>	Infants	Children Ages One to Six	Older Children <sup>1</sup>
Nebraska	185% (0-19)	–	150%	133%	100% (6-15)
Nevada	–	200% (0-19)	133%	133%	100% (6-15)
New Hampshire	300% (0-1) <sup>10</sup>	300% (1-19) <sup>10</sup>	185%	185%	185% (6-19)
New Jersey*	133% (6-19)	200% (0-19)	185%	133%	100% (6-15)
New Mexico*	235% (0-19)	–	185%	185%	185% (6-19)
New York	–	222% (0-19) <sup>11</sup>	185%	133%	100% (6-15)
North Carolina	–	200% (0-19)	185%	133%	100% (6-19)
North Dakota	100% (18-19)	–	133%	133%	100% (6-18)
Ohio*	150% (0-19)	–	133%	133%	100% (6-15)
Oklahoma*	185% (0-15) <sup>12</sup>	–	150%	133%	100% (6-15)
Oregon	–	170% (0-18)	133%	133%	100% (6-18)
Pennsylvania	–	200% (0-18)	185%	133%	100% (6-15)
Rhode Island*	250% (8-18)	–	250%	250%	250% (6-8)
South Carolina	150% (1-19)	–	185%	133%	100% (6-15)
South Dakota	133% (6-19)	–	133%	133%	100% (6-19)
Texas	100% (15-19)	–	185%	133%	100% (6-15)
Utah	–	200% (0-19)	133%	133%	100% (6-19)
Vermont	–	300% (0-19) <sup>13</sup>	225%	225%	225% (6-19)
Virginia	–	185% (0-19)	133%	133%	100% (6-19)
West Virginia	150% (1-6)	–	150%	133%	100% (6-19)
Wisconsin*	185% (6-19) <sup>14</sup>	–	185 %	185%	100% (6-15)

\* In these states, CHIP-eligible children are enrolled into existing 1115 demonstration waiver programs.

<sup>1</sup> States were able to make children up to age 19 in families who were not eligible for Medicaid as of March 15, 1997 eligible for CHIP on October 1, 1997, the effective date of the CHIP legislation. However, the federal requirement that states phase in Medicaid eligibility for all children up to age 19 in families with incomes up to the poverty level remains in effect. As a result, the upper age limit for Medicaid eligibility at the poverty level will continue to increase until October 1, 2002 when all children up to age 19 in families with incomes at the poverty level will be enrolled in Medicaid. At the same time, the lower age limit for children in families with incomes up to the poverty level will decrease for CHIP.

<sup>2</sup> Alaska will finance Medicaid coverage for children with family incomes up to 150 percent of poverty through Title XIX in instances where these children have access to creditable insurance; otherwise coverage is funded through Title XXI.

<sup>3</sup> Arizona's income eligibility for its non-Medicaid CHIP program will be expanded to 175 percent of poverty on July 1, 1999 and to 200 percent of poverty on July 1, 2000.

## Appendix I (Cont.)

<sup>4</sup> Arkansas' Medicaid CHIP program only covers children born between October 1, 1982 and October 1, 1983. Children under age 19 with family incomes below 200 percent of poverty are eligible for a limited Medicaid benefit package through an 1115 demonstration waiver program.

<sup>5</sup> Connecticut's non-Medicaid CHIP program disregards up to 65 percent of family income for children ages 13 and under and up to 100 percent of family income for children between ages 14 and 18, which extends CHIP eligibility to 300 percent of poverty.

<sup>6</sup> Florida's non-Medicaid program places children in families with incomes under 200 percent of poverty in 2 different plans depending on the child's age. Children up to age 5 are enrolled in the MediKids program, which offers Medicaid benefits, and children between the ages of 6 and 19 are enrolled in the Healthy Kids program, which offers a narrower benefit package.

<sup>7</sup> Hawaii had provided children under age 19 in families with incomes below 300 percent of poverty eligibility for Medicaid through an 1115 demonstration waiver program until February 1996, when enrollment was capped. On January 1, 1998 the state officially amended its waiver and lowered the eligibility level to the income thresholds listed.

<sup>8</sup> Maryland previously had provided Medicaid eligibility with a limited benefit package to children under age 15 in families with incomes below 200 percent of poverty through an 1115 demonstration waiver program.

<sup>9</sup> Missouri's Medicaid CHIP program disregards up to 100 percent of family income, which extends CHIP eligibility to 300 percent of poverty.

<sup>10</sup> New Hampshire's CHIP program disregards up to 65 percent of income for families whose income is greater than 185 percent of poverty, which extends CHIP eligibility to 300 percent of poverty.

<sup>11</sup> New York's approved income eligibility level for its non-Medicaid CHIP program is 185 percent of poverty based on net income, which amounts to 222 percent of poverty based on gross income.

<sup>12</sup> Oklahoma's Medicaid CHIP program covers children up to age 19 who were born after October 1, 1983 with family incomes up to 185 percent of poverty. Older children are being phased in.

<sup>13</sup> Vermont's non-Medicaid CHIP program covers children in families with incomes at or below 275 percent of poverty but, through the application of income disregard rules, extends CHIP income eligibility to 300 percent of poverty.

<sup>14</sup> Wisconsin's Medicaid CHIP program permits families enrolled in CHIP to remain in the program until their income reaches 200 percent of poverty.

**Source:** Information obtained by Fox Health Policy Consultants through an analysis of CHIP plan applications and amendments approved by HCFA as of January 31, 1999 and supplemented with data from the National Governors' Association: *Early State Trends in Setting Eligibility Levels for Children and Pregnant Women*, Washington, DC: NGA, September 2, 1998.

## Appendix II

### Benefit Packages in Non-Medicaid CHIP Plans Approved as of January 31, 1999

Services Authorized Under Title XXI	Alabama ALL-Kids (Largest HMO plan)	Arizona KidsCare (State employees' plan)	California Healthy Families (State employees' plan)
<b>Prescription drugs</b>	Covered only for generics when brand name equivalents are available	Covered	Covered
<b>Over-the-counter drugs<sup>1</sup></b>	Not covered	Covered	Not covered
<b>Inpatient mental health<sup>2</sup> services</b>	Covered up to 30 days/year	Covered including residential facilities up to 30 days/year in combination with inpatient SA services	Covered up to 30 days/year
<b>Outpatient mental health services<sup>3</sup></b>	Covered including community-based services, but excluding services for children with mental retardation, up to 20 visits/year in combination with outpatient SA services	Covered including community-based services up to 30 visits/year in combination with outpatient SA services	Covered, but excluding conditions such as chronic psychosis, chronic brain syndrome, intractable personality disorder, and mental retardation, and only if amendable to significant improvement through short-term therapy, up to 20 visits/year, with additional days available through conversion of inpatient MH visits <sup>10</sup>
<b>DME and other devices<sup>4</sup></b>	Covered except for hearing aids	Covered for eyeglasses	Covered except for therapeutic footwear
<b>Disposable medical supplies</b>	Covered	Covered	Covered for diabetic supplies
<b>Home health services<sup>5</sup></b>	Covered for skilled nursing services and home health aide services up to 60 visits/year	Covered for skilled nursing services, home health aide services, and personal care services	Covered for skilled nursing services and home health aide services
<b>Nursing care services</b>	Covered for nurse practitioner services	Covered for nurse midwife services, nurse practitioner services, and private duty nursing services	Covered for nurse midwife services, nurse practitioner services, and private duty nursing services
<b>Dental services<sup>6</sup></b>	Covered up to \$1,000/year	Covered	Covered
<b>Inpatient substance abuse treatment services<sup>2</sup></b>	Covered up to 3 days/episode and up to 20 days/year	Covered for detoxification up to 30 days/year in combination with inpatient MH services	Covered for detoxification
<b>Outpatient substance abuse treatment services<sup>3</sup></b>	Covered including community-based services up to 20 visits/year in combination with outpatient MH services <sup>9</sup>	Covered including residential facilities up to 30 visits/year in combination with outpatient MH services	Covered up to 20 visits/year
<b>Case management services<sup>7</sup></b>	Covered	Covered for MH case management	Covered
<b>Physical, occupational, and speech therapy</b>	Covered only if condition will improve	Covered	Covered for a 60-day period/condition, additional visits available if condition will improve significantly
<b>Other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services<sup>8</sup></b>	Covered for chiropractic services up to 12 visits/year or \$400/year; covered for optometry services; covered for SNFs up to 100 days/lifetime	Covered for audiology services; covered for nutrition services; covered for optometry services; covered for podiatry services; covered for respiratory therapy; covered for SNFs up to 90 days/year	Covered for acupuncture up to 20 visits/year; covered for chiropractic services up to 20 visits/year; covered for optometry services including low vision therapy up to \$1,000/2-year period; covered for short-term respiratory therapy at home; covered for SNFs up to 100 days/year
<b>Medical transportation</b>	Covered for emergencies	Covered for emergencies	Covered
<b>Enabling services</b>	Covered	Covered for outreach services	Covered for translation services

## Appendix II (Cont.)

<b>Services Authorized Under Title XXI</b>	<b>Colorado</b> Child Health Plan Plus (State employees' plan & largest HMO plan-equivalent)	<b>Connecticut</b> HUSKY Part B and HUSKY Plus (State employees' plan)	<b>Delaware</b> Delaware Healthy Children Program (State employees' plan)
<b>Prescription drugs</b>	Covered	Covered	Covered
<b>Over-the-counter drugs<sup>1</sup></b>	Not covered	Not covered	Covered
<b>Inpatient mental health<sup>2</sup> services</b>	Covered without limits for certain neurobiologically based MH conditions <sup>11</sup> and up to 45 days for all other MH conditions	Covered up to 60 days/year	Covered up to 31 days/year in combination with inpatient SA services and additional outpatient MH and SA services
<b>Outpatient mental health services<sup>3</sup></b>	Covered without limits for certain neurobiologically based mental conditions <sup>11</sup> and covered up to 20 visits/year for all other MH condition; day treatment services available through conversion of inpatient days <sup>12</sup>	Covered up to 30 visits/year, additional visits available through conversion of inpatient days <sup>13</sup>	Covered including community-based services up to 30 visits/year in combination with outpatient SA services, with additional services available up to 31 days in combination with inpatient MH and SA services and additional outpatient SA services
<b>DME and other devices<sup>4</sup></b>	Covered up to \$2,000/year, but covered without limits for diabetic devices	Covered	Covered
<b>Disposable medical supplies</b>	Not covered	Covered	Covered
<b>Home health services<sup>5</sup></b>	Covered for skilled nursing services	Covered for skilled nursing services and home health aide services	Covered for skilled nursing services and home health aide services
<b>Nursing care services</b>	Not covered	Covered for nurse midwife services and nurse practitioner services	Covered for private duty nursing up to 28 hours/week
<b>Dental services<sup>6</sup></b>	Covered for treatment of injury	Covered	Not covered
<b>Inpatient substance abuse treatment services<sup>2</sup></b>	Not covered	Covered for drug abuse up to 60 days/year and for alcohol abuse up to 45 days/year	Covered up to 31 days/year in combination with inpatient MH services and additional outpatient MH and SA services
<b>Outpatient substance abuse treatment services<sup>3</sup></b>	Covered up to 20 visits/year	Covered up to 60 visits/year	Covered including community-based services up to 30 visits/year in combination with outpatient MH services, with additional services available up to 31 days in combination with inpatient MH and SA services and additional outpatient MH services
<b>Case management services<sup>7</sup></b>	Not covered	Not covered	Covered
<b>Physical, occupational, and speech therapy</b>	Covered up to 30 visits/year/condition	Covered	Covered
<b>Other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services<sup>8</sup></b>	Covered for audiology services up to \$800/year; covered for autism services; covered for treatment of intractable pain; covered for nutrition services; covered for optometry services including vision therapy; covered for short-term SNFs	Covered for chiropractic services; covered for naturopathic services; covered for optometry services; covered for podiatry services; <b>and covered for additional specialty services as medically necessary if child meets state-defined criteria</b>	Covered for optometry services; covered for SNFs up to 30 days
<b>Medical transportation</b>	Covered	Covered only for children who meet CSHCN criteria, otherwise covered only for emergencies	Covered for emergencies
<b>Enabling services</b>	Not covered	Covered for translation services and outreach services	Not covered

## Appendix II (Cont.)

Services Authorized Under Title XXI	Florida Healthy Kids <sup>14</sup> (Existing program)	Georgia PeachCare for Kids (Largest HMO plan-equivalent)	Kansas HealthWave (State employees' plan)
<b>Prescription drugs</b>	Covered for generics unless brand names are medically necessary	Covered	Covered
<b>Over-the-counter drugs<sup>1</sup></b>	Not covered	Covered	Covered
<b>Inpatient mental health<sup>2</sup> services</b>	Covered up to 15 days/year <sup>15</sup>	Covered up to 30 days/admission at general hospitals only; and covered for residential programs if child meets SED criteria	Covered only for biologically based mental conditions <sup>20</sup>
<b>Outpatient mental health services<sup>3</sup></b>	Covered up to 20 visits/year <sup>16</sup>	Covered for psychologists up to 24 hours/year and for physicians up to 17 hours/year with additional services available for emergencies, in combination with outpatient SA services; covered for community-based services if child meets SED criteria	Covered only for biologically based mental conditions <sup>20</sup>
<b>DME and other devices<sup>4</sup></b>	Covered	Covered	Covered
<b>Disposable medical supplies</b>	Covered	Covered for diabetic supplies	Covered for diabetic supplies
<b>Home health services<sup>5</sup></b>	Covered for skilled nursing services	Covered for skilled nursing services and home health aide services up to 75 visits/year, with additional visits available with prior authorization from state	Covered for skilled nursing services and home health aide services
<b>Nursing care services</b>	Covered for inpatient private duty nursing services	Covered for nurse midwife services and nurse practitioner services	Covered
<b>Dental services<sup>6</sup></b>	Covered for treatment of injury <sup>17</sup>	Covered	Covered
<b>Inpatient substance abuse treatment services<sup>2</sup></b>	Covered for detoxification only for pregnant adolescents up to 7 days <sup>18</sup>	Covered up to 30 days/admission at general hospitals only	Covered up to 60 days/year
<b>Outpatient substance abuse treatment services<sup>3</sup></b>	Covered only for pregnant adolescents <sup>19</sup>	Covered for psychologists up to 24 hours/year and for physicians up to 17 hours/year, with additional services available for emergencies, in combination with outpatient MH services; covered for community-based services if child meets SCDP criteria	Covered up to 25 visits/year (2 group therapy visits equal 1 individual therapy visit); day treatment services available through conversion of inpatient days <sup>21</sup>
<b>Case management services<sup>7</sup></b>	Not covered	Not covered	Covered
<b>Physical, occupational, and speech therapy</b>	Covered up to 24 visits within a 60-day period/episode or injury and only if condition will improve significantly	Covered up to 1 hour/day and up to 10 hours/month for each type of therapy, with additional visits available with prior authorization from state	Covered for a minimum 180-day period/condition but only if amendable to significant improvement within 60 days and only following an injury, surgery or acute medical conditions
<b>Other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services<sup>8</sup></b>	Covered for chiropractic services up to 12 visits/year; covered for optometry services; covered for podiatry services up to 24 visits/year; covered for SNFs up to 100 days/year; <b>and covered for additional specialty services if child meets state-defined criteria</b>	Covered for audiology services; covered for early intervention services; covered for nutrition services; covered for optometry services; covered for podiatry services; covered for school-based rehabilitation services	Covered for audiology services; covered for chiropractic services; covered for nutrition services; covered for optometry services; covered for podiatry services; <b>and covered for additional diagnostic and treatment services as medically necessary (EPSDT)</b>
<b>Medical transportation</b>	Covered for emergencies	Covered for emergencies	Covered
<b>Enabling services</b>	Not covered	Not covered	Covered

## Appendix II (Cont.)

Services Authorized Under Title XXI	Kentucky Kentucky CHIP (State employees' plan-equivalent)	Maine Cub Care (Secretary-approved plan)	Massachusetts MassHealth Family Assistance <sup>22</sup> (FEHBP-equivalent)
Prescription drugs	Covered for generics unless otherwise pre-authorized or if generics are not available	Covered	Covered
Over-the-counter drugs <sup>1</sup>	Not covered	Covered	Not covered
Inpatient mental health <sup>2</sup> services	Covered up to 30 days/episode; covered for residential facilities up to 30 days/episode	Covered	Covered up to 60 days/year in psychiatric hospitals and covered without limits at general hospitals
Outpatient mental health services <sup>3</sup>	Covered including community-based services	Covered for individual therapy up to 2 hours/week (8 visits/emergency) and 1 group session/week	Covered up to 20 visits or \$500/year, whichever is greater; day treatment services available through conversion of inpatient days in psychiatric hospitals <sup>23</sup>
DME and other devices <sup>4</sup>	Covered	Covered	Covered except for eyeglasses, hearing aids, and therapeutic footwear
Disposable medical supplies	Covered	Covered for diabetic supplies	Covered for diabetic supplies
Home health services <sup>5</sup>	Covered for skilled nursing services up to 20 visits/year	Covered for skilled nursing services, home health aide services, and personal care services	Covered for skilled nursing services and home health aide services
Nursing care services	Covered for nurse midwife services and nurse practitioner services	Covered for nurse midwife services, nurse practitioner services, and private duty nursing services	Covered for nurse practitioner services
Dental services <sup>6</sup>	Covered	Covered	Covered only for emergencies
Inpatient substance abuse treatment services <sup>2</sup>	Covered up to 30 days/episode	Covered	Covered up to 30 days/year
Outpatient substance abuse treatment services <sup>3</sup>	Covered	Covered	Covered up to 20 visits or \$500/year, whichever is greater; day treatment services available through conversion of inpatient days <sup>23</sup>
Case management services <sup>7</sup>	Covered only for children with severe or complex MH or SA service needs	Covered	Not covered
Physical, occupational, and speech therapy	Covered up to 24 visits within a 60-day period and up to 60 visits/year for each type of therapy	Covered	Covered without limits for children under the age of 3 and covered up to 90 days/condition for each type of therapy for all other children only if condition will improve significantly within 90 days
Other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services <sup>8</sup>	Covered for audiology services; covered for home visitation of at-risk infants and toddlers up to 40 visits/year; covered for nutrition services; covered for optometry services; covered for SNFs up to 30 days/year	Covered for audiology services; covered for chiropractic services; covered for early intervention; covered for optometry services; covered for podiatry services; covered for psychometric testing up to 4 hours; covered for SNFs; <b>and covered for additional diagnostic and treatment services as medically necessary (EPSDT)</b>	Covered for early intervention services up to \$3,200/year and \$9,600/lifetime; covered for nutrition services; covered for optometry services; covered for rehabilitation facilities up to 100 days/year in combination with SNFs
Medical transportation	Covered for emergencies	Covered	Covered
Enabling services	Covered	Covered for translation services	Not covered

## Appendix II (Cont.)

Services Authorized Under Title XXI	Michigan MICHild (State employees' plan)	Montana <sup>25</sup> Montana's Children's Health Insurance Plan (State employees' plan-equivalent)	Nevada Nevada Check Up (Secretary-approved plan)
Prescription drugs	Covered for generics unless brand names indicated by physician	Covered	Covered
Over-the-counter drugs <sup>1</sup>	Not covered	Not covered	Covered
Inpatient mental health <sup>2</sup> services	Covered	Covered including services in a residential program up to 21 visits/year in combination with inpatient SA services, with additional days if child meets SED criteria	Covered
Outpatient mental health services <sup>3</sup>	Covered including community-based services	Covered up to 20 visits/year; day treatment services available through conversion of inpatient days; <sup>26</sup> covered for community-based services if child meets SED criteria	Covered including community-based services
DME and other devices <sup>4</sup>	Covered	Not covered	Covered
Disposable medical supplies	Covered	Covered for diabetic supplies	Covered
Home health services <sup>5</sup>	Covered for skilled nursing services and home health aide services up to 120 visits/year (1 4-hour visit/day)	Not covered	Covered for skilled nursing services, home health aide services, and personal care services
Nursing care services	Covered for nurse midwife services and private duty nursing services	Not covered	Covered for nurse midwife services, nurse practitioner services, and private duty nursing services
Dental services <sup>6</sup>	Covered up to \$600/year	Not covered	Covered
Inpatient substance abuse treatment services <sup>2</sup>	Covered	Covered up to 21 days/year in combination with inpatient MH services and up to \$4,000/2 years and \$8,000/lifetime	Covered
Outpatient substance abuse treatment services <sup>3</sup>	Covered	Covered up to \$1,000/year	Covered
Case management services <sup>7</sup>	Covered only for MH conditions through CMHCs	Not covered	Covered
Physical, occupational, and speech therapy	Covered	Not covered	Covered
Other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services <sup>8</sup>	Covered for acupuncture up to 20 visits/year for certain conditions; <sup>24</sup> covered for audiology services; covered for chiropractic services; covered for optometry services; covered for SNFs up to 120 days/admission	Covered for audiology services; covered for optometry services	Covered for audiology services; covered for chiropractic services; covered for early intervention services; covered for optometry services; covered for podiatry services; covered for school-based rehabilitation services; covered for SNFs; <b>and covered for additional diagnostic and treatment services as medically necessary (EPSDT)</b>
Medical transportation	Covered	Not covered	Covered
Enabling services	Not covered	Not covered	Not covered

## Appendix II (Cont.)

Services Authorized Under Title XXI	New Hampshire Healthy Kids-Silver (FEHBP-equivalent)	New Jersey NJKidCare Plans B and C (FEHBP)	New York Child Health Plus (Existing program)
<b>Prescription drugs</b>	Covered	Covered	Covered for generics when medically acceptable to plan
<b>Over-the-counter drugs<sup>1</sup></b>	Not covered	Covered	Not covered
<b>Inpatient mental health<sup>2</sup> services</b>	Covered up to 15 days/year	Covered for services in a general hospital	Not covered
<b>Outpatient mental health services<sup>3</sup></b>	Covered primarily for acute episodes of certain neurologically based mental conditions <sup>27</sup> without limits and covered, but excluding conditions such as mental retardation and developmental disabilities, for all other MH conditions up to 20 visits/year in combination with outpatient SA services, with additional days available through conversion of inpatient MH visits <sup>28</sup>	Covered	Covered up to 20 visits/year in combination with outpatient SA services
<b>DME and other devices<sup>4</sup></b>	Covered except for therapeutic footwear	Covered	Covered for commodes, walkers, wheelchairs, and diabetic equipment
<b>Disposable medical supplies</b>	Covered	Covered	Covered for diabetic supplies
<b>Home health services<sup>5</sup></b>	Covered for skilled nursing services and home health aide services up to 20 visits/year	Covered for skilled nursing services and home health aide services	Covered for skilled nursing services and home health aide services in lieu of SNF or hospital care and for at least 40 visits/year
<b>Nursing care services</b>	Not covered	Covered for nurse midwife services, nurse practitioner services, and private duty nursing services	Not covered
<b>Dental services<sup>6</sup></b>	Covered	Covered	Covered for treatment of injury
<b>Inpatient substance abuse treatment services<sup>2</sup></b>	Covered for detoxification	Covered	Not covered
<b>Outpatient substance abuse treatment services<sup>3</sup></b>	Covered primarily for acute episodes up to 20 visits/year in combination with outpatient MH services	Covered	Covered up to 60 visits/year in combination with outpatient MH services, including up to 20 visits/year for family therapy if related to alcohol abuse
<b>Case management services<sup>7</sup></b>	Not covered	Covered only for the chronically mentally ill	Not covered
<b>Physical, occupational, and speech therapy</b>	Covered for acute conditions, but excluding developmental disabilities, up to 24 visits/year for ST and up to 24 visits/year for any combination of PT and OT only if condition will improve significantly	Covered up to 60 visits/year for each type of therapy	Covered for PT and OT but only for a short-term period as defined by provider
<b>Other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services<sup>8</sup></b>	Covered for chiropractic services; covered for diabetic monitoring and nutrition services; covered for optometry services; covered for rehabilitation facilities; covered for SNFs	Covered for audiology services; covered for chiropractic services; covered for optometry services; covered for podiatry services; covered for school-based rehabilitation services; covered for SNFs	Covered for diabetic monitoring, nutrition services, and management through home visitation
<b>Medical transportation</b>	Covered for emergencies	Covered	Not covered
<b>Enabling services</b>	Covered	Not covered	Not covered

## Appendix II (Cont.)

Services Authorized Under Title XXI	North Carolina Health Choice (State employees' plan)	Oregon Oregon Health Plan (Secretary-approved plan)	Pennsylvania Pennsylvania Child Health Insurance Plan (Existing program)
Prescription drugs	Covered	Covered, but excluding certain conditions <sup>29</sup>	Covered
Over-the-counter drugs <sup>1</sup>	Not covered	Covered, but excluding certain conditions <sup>29</sup>	Not covered
Inpatient mental health <sup>2</sup> services	Covered including services in a residential program	Covered including services in a residential program, but excluding certain conditions <sup>29</sup>	Covered, but excluding conditions such as mental retardation, autism, neuropsychiatric disorders, and sleep disorders, up to 90 days/year
Outpatient mental health services <sup>3</sup>	Covered up to 26 visits/year in combination with outpatient SA services	Covered, but excluding certain conditions <sup>29</sup>	Covered, but excluding conditions such as mental retardation, autism, neuropsychiatric disorders, and sleep disorders, up to 50 visits/year; day treatment services available through conversion of inpatient days <sup>30</sup>
DME and other devices <sup>4</sup>	Covered	Covered, but excluding certain conditions <sup>29</sup>	Covered
Disposable medical supplies	Covered	Covered, but excluding certain conditions <sup>29</sup>	Not covered
Home health services <sup>5</sup>	Covered for skilled nursing services and home health aide services up to 60 visits/year in lieu of SNF or hospital care and only if condition amendable to rehabilitation	Covered, but excluding certain conditions, <sup>29</sup> for skilled nursing services and home health aide services	Covered for skilled nursing services, home health aide services, and personal care services
Nursing care services	Covered for private duty nursing services	Covered, but excluding certain conditions, <sup>29</sup> for nurse midwife services, nurse practitioner services, and private duty nursing services	Covered for nurse midwife services, nurse practitioner services, and private duty nursing services
Dental services <sup>6</sup>	Covered	Covered, but excluding certain conditions <sup>29</sup>	Covered
Inpatient substance abuse treatment services <sup>2</sup>	Covered including services in a residential program	Covered including services in a residential program, but excluding certain conditions <sup>29</sup>	Not covered
Outpatient substance abuse treatment services <sup>3</sup>	Covered up to 26 visits/year in combination with outpatient MH services	Covered, but excluding certain conditions <sup>29</sup>	Not covered
Case management services <sup>7</sup>	Covered	Covered, but excluding certain conditions <sup>29</sup>	Covered only for MH conditions
Physical, occupational, and speech therapy	Covered	Covered, but excluding certain conditions <sup>29</sup>	Covered for a 60-day period/condition/lifetime and only if condition will improve significantly
Other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services <sup>8</sup>	Covered for acupuncture services; covered for audiology services; covered for chiropractic services up to \$2,000; covered for optometry services; covered for podiatry services; covered for respiratory therapy; covered for psychometric testing; covered for SNFs; <b>and covered for additional specialty services if child meets state-defined criteria</b>	Covered for audiology services, but excluding certain conditions; <sup>29</sup> covered for optometry services, but excluding certain conditions; <sup>29</sup> covered for school-based rehabilitation services <sup>29</sup>	Covered for optometry services
Medical transportation	Covered for emergencies	Covered	Covered
Enabling services	Not covered	Covered for translation services	Not covered

## Appendix II (Cont.)

Services Authorized Under Title XXI	Utah HealthPrint (State employees' plan-equivalent)	Vermont Dr. Dynasaur (Secretary-approved plan)	Virginia Children's Medical Security Insurance Plan (Secretary-approved plan)
Prescription drugs	Covered for generics unless brand names are medically necessary	Covered	Covered for generics unless brand names indicated by physician
Over-the-counter drugs <sup>1</sup>	Not covered	Covered	Covered if designated as a less expensive alternative
Inpatient mental health <sup>2</sup> services	Covered including residential facilities, but excluding conditions such as conduct disorders, oppositional disorders, and learning disabilities, up to 30 days/year in combination with inpatient SA services	Covered	Covered for services in a general hospital
Outpatient mental health services <sup>3</sup>	Covered, but excluding conditions such as conduct disorders, oppositional disorders, and learning disabilities, up to 30 visits/year in combination with outpatient SA services	Covered including community-based services	Covered up to 3 visits within a 7-day period and up to 26 visits/year; and covered for community-based services
DME and other devices <sup>4</sup>	Covered except for eyeglasses and therapeutic footwear	Covered	Covered for eyeglasses and prosthetic devices
Disposable medical supplies	Covered	Covered	Covered
Home health services <sup>5</sup>	Covered for skilled nursing services	Covered for skilled nursing care services, home health aide services, and personal care services up to 60 visits/year	Covered for skilled nursing services up to 32 visits/year and for home health aide services up to 32 visits/year
Nursing care services	Covered for nurse midwife services and nurse practitioner services	Covered	Covered for nurse midwife services
Dental services <sup>6</sup>	Covered	Covered	Covered
Inpatient substance abuse treatment services <sup>2</sup>	Covered up to 30 days/year in combination with inpatient MH services	Covered	Covered only for pregnant adolescents in residential facilities, one treatment/lifetime
Outpatient substance abuse treatment services <sup>3</sup>	Covered up to 30 visits/year in combination with outpatient MH services	Covered	Covered up to 26 visits/year; covered for day treatment services only for pregnant adolescents, one treatment/lifetime
Case management services <sup>7</sup>	Not covered	Covered	Covered only for high-risk pregnant adolescents, high-risk children < 2, and children with mental retardation, with SED, or at risk-for SED
Physical, occupational, and speech therapy	Covered, but excluding therapies for children with developmental delay, for OT and PT up to 16 visits/year in combination with chiropractic services and without limits for ST	Covered, but excluding ST for chronic conditions and developmental delays, up to 4 months of therapy/episode of illness or injury <sup>31</sup>	Covered up to 24 visits for each type of therapy/year
Other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services <sup>8</sup>	Covered for chiropractic services up to 16 visits/year in combination with OT and PT; covered for optometry services up to \$30/2 years for exams and refractions; covered for podiatry services	Covered for audiology services; covered for chiropractic services; <sup>32</sup> covered for nutrition services; covered for optometry services; covered for podiatry services; covered for rehabilitation facilities; covered for SNFs up to 30 days/episode; <b>and covered for additional diagnostic and treatment services as medically necessary (EPSDT)</b>	Covered for audiology services; covered for early intervention services; covered for nutrition services; covered for optometry services; covered for podiatry services; covered for rehabilitation facilities; covered for school-based rehabilitation services; covered for SNFs; <b>and covered for additional diagnostic and treatment services as medically necessary (EPSDT)</b>
Medical transportation	Covered for emergencies	Covered	Covered
Enabling services	Not covered	Covered	Not covered

## Appendix II (Cont.)

Covered = Benefits available with no limits specified  
Equivalent = Actuarially equivalent

CMHCs = Community mental health centers  
CSHCN = Children with special health care needs  
DME = Durable medical equipment  
EPSDT = Early and periodic screening, diagnosis, and treatment  
FEHBP = Federal employees' health benefit program  
MH = Mental health  
OT = Occupational therapy  
PT = Physical therapy  
SA = Substance abuse  
SCDP = Severe chemical dependency problems  
SED = Severe emotional disturbances  
SNFs = Skilled nursing facilities  
ST = Speech therapy or speech language and pathology services

<sup>1</sup>Over-the-counter drugs are assumed not to include any disposable medical supplies such as needles and diabetic testing strips.

<sup>2</sup>As part of inpatient psychiatric services, a state CHIP program may choose to cover treatment services in a residential program or the full cost of a stay in a residential facility (including room and board). There has been confusion among states concerning payment for residential facilities and in 1998 HCFA issued new rules to clarify this issue with respect to Medicaid. (Health Care Financing Administration's Final Rule on Inpatient Psychiatric Services Benefit for Individuals Under Age 21. *Federal Register*. 63: 64195-64199, November 19, 1998.)

<sup>3</sup>Community-based services typically include day treatment services, intensive in-home services, and crisis stabilization as well as additional outpatient therapy visits and usually are furnished through community mental health centers.

<sup>4</sup>DME and other devices, as defined in the Title XXI statute, include eyeglasses and hearing aids.

<sup>5</sup>Home health services include, in addition to skilled nursing services, home health aides, personal care services, and respite care services. Skilled nursing services, according to the American Nurses Association, includes services provided by registered nurses, licensed practical nurses, licensed vocational nurses, and advanced practice registered nurses (nurse midwives, nurse practitioners, and clinical nurse specialists).

<sup>6</sup>Dental services are assumed to include preventive, diagnostic, and restorative services for oral health.

<sup>7</sup>Case management services are assumed to include care coordination services for identified child populations only.

<sup>8</sup>Optometry services are assumed to be vision examinations beyond the vision screening performed in a primary care physician's office and not to include eyeglasses.

<sup>9</sup>In Alabama, 1 inpatient hospital day may be converted to 2 outpatient visits.

<sup>10</sup>In California, 1 inpatient hospital day may be converted to 2 day treatment services, 3 to 4 outpatient visits, or 2 to 3 residential treatment days.

<sup>11</sup>In Colorado, neurologically based mental conditions are defined as schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive compulsive disorder, and panic disorder. Neurobiologically based mental illness is required to be treated as any other illness or condition under Colorado's parity law.

<sup>12</sup>In Colorado, 1 inpatient hospital day may be converted to 2 day treatment services.

<sup>13</sup>In Connecticut, 1 inpatient hospital day can be converted to 1 sub-acute day, 2 day treatment services, 2 intensive outpatient visits, or 3 outpatient visits, however only up to 35 of the 60 inpatient days may be converted.

<sup>14</sup>In Florida, the lifetime maximum benefit is \$1 million.

<sup>15</sup>In Florida, on July 1, 2000, the inpatient mental health benefit will be increased to 30 days/year, including up to 20 days for residential facilities treatment.

<sup>16</sup>In Florida, on July 1, 2000, the outpatient mental health benefit will be increased to 40 visits/year.

<sup>17</sup>In Florida, preventive and diagnostic dental services are optionally furnished by plans, however these benefits are not financed by Title XXI funds.

<sup>18</sup>In Florida, on July 1, 2000, the inpatient substance abuse benefit will be available to all children and will be increased to include 30 residential treatment days/year.

<sup>19</sup>In Florida, on July 1, 2000, the outpatient substance abuse benefit will be available to all children up to 40 visits/year.

<sup>20</sup>In Kansas, biologically based mental conditions are defined as schizophrenia, schizoaffective disorder, schizophreniform disorder, brief reactive psychosis, paranoid or delusional disorder, atypical psychosis, major affective disorders (bipolar disorder and major depression), cyclothymic and dysthymic disorders, obsessive compulsive disorder, panic disorder, pervasive developmental disorder (including autism), attention deficit hyperactive disorder, and borderline personality disorder.

## Appendix II (Cont.)

21 In Kansas, 1 inpatient hospital day may be converted to either one or 2 day treatment services, depending on the amount of the allowable charges.

22 In Massachusetts, the non-Medicaid program primarily subsidizes premium charges for families with access to employer-sponsored insurance that includes, at a minimum, the benefits listed. In addition, the employer contribution must be at least 50 percent of premium costs and the cost of coverage to the state must be less than the cost of enrollment into a Medicaid HMO for the child or children alone. Children with employer-sponsored coverage constitute the majority of non-Medicaid CHIP participants, according to the state's responses to HCFA's questions on April 27, 1998. Children who have no access to employer-sponsored insurance that meets the state's requirements for premium assistance receive FEHBP-equivalent coverage.

23 In Massachusetts, 1 inpatient hospital day may be converted to 2 day treatment services.

24 In Michigan, acupuncture is covered for sciatica, neuritis, post-herpetic neuralgia, tic douloureux, chronic headaches, osteoarthritis, rheumatoid arthritis, and myofacial complaints.

25 In Montana, the lifetime maximum on benefit is \$1 million.

26 In Montana, 1 inpatient hospital day may be converted to 2 day treatment services.

27 In New Hampshire, conditions that are covered without limits are schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive compulsive disorder, panic disorder, and pervasive developmental disorder or autism.

28 In New Hampshire, 1 inpatient hospital day may be converted to 2 day treatment services.

29 In Oregon, actual covered services are those that, with the exception of mental health in selected counties, are listed as prioritized services for conditions covered under the state's 1115 Medicaid demonstration waiver program.

30 In Pennsylvania, 1 inpatient hospital day may be converted to 2 day treatment services.

31 In Vermont, up to 1 year of physical, occupational, and speech therapy are available to children with congenital or acquired conditions under the provisions of EPSDT. Services beyond 1 year require prior authorization and are provided on a fee-for-service basis. Outside of the EPSDT arrangement, services beyond 4 months require prior authorization, up to a maximum of 1 year of therapy.

32 In Vermont, chiropractic services are available on a fee-for-service basis to enrollees age 12 and older up to 10 visits/year.

**Source:** Information obtained by Fox Health Policy Consultants through an analysis of CHIP plan applications, state responses to HCFA's questions, and subsequent plan amendments approved by HCFA as of January 31, 1999; state CHIP documents constituting the standard insurance contracts or requests for proposals in effect as of January 31, 1999; and telephone interviews with state Medicaid and CHIP officials when information in the documents was confusing or incomplete.

## Appendix III-A

### Insurance Arrangements in Non-Medicaid CHIP Plans Approved as of January 31, 1999

States	Mandatory Enrollment into Capitated Arrangements		Voluntary Enrollment into Capitated Arrangements <sup>1</sup>		No Capitated Arrangements
	Statewide	Some or Most Counties	Statewide	Some or Most Counties	
Alabama					
Arizona					
California					
Colorado					
Connecticut					
Delaware					
Florida <sup>2</sup>					
Georgia					
Kansas					
Kentucky					
Maine					
Massachusetts <sup>3</sup>					
Michigan					
Montana					
Nevada					
New Hampshire					
New Jersey					
New York					
North Carolina					
Oregon					
Pennsylvania					
Utah					
Vermont					
Virginia					

<sup>1</sup> This category includes states that require automatic enrollment into a capitated plan as the default option if beneficiary fails to make a selection after a specific amount of time between a primary care case management provider, where services are reimbursed on a fee-for-service basis, and a capitated plan.

<sup>2</sup> In Florida, the non-Medicaid CHIP program, Healthy Kids, requires that children between the ages of 6 and 19 enroll into capitated plans. The non-Medicaid CHIP program for children under 6, MediKids, allows for enrollment in either capitated plans or primary care case management systems.

<sup>3</sup> In Massachusetts, the non-Medicaid CHIP program primarily subsidizes premium charges for families with access to employer-sponsored insurance defined as adequate by the state. Children with employer-sponsored coverage constitute the majority of non-Medicaid CHIP participants, according to the state's responses to HCFA's questions on April 27, 1998. Children in families that do not have access to acceptable employer-sponsored insurance have the option to enroll into either a Medicaid PCCM or managed care organization.

## Appendix III-A (Cont.)

**Source:**Information obtained by Fox Health Policy Consultants through an analysis of CHIP plan applications, state responses to HCFA's questions, and subsequent plan amendments approved by HCFA as of January 31, 1999; state CHIP documents constituting the standard insurance contracts or requests for proposals in effect as of January 31, 1999; and telephone interviews with state Medicaid and CHIP officials when information in the documents was confusing or incomplete.

## Appendix III-B

### Insurance Arrangements in Medicaid CHIP Plans Approved as of January 31, 1999

States	Mandatory Enrollment into Capitated Arrangements <sup>1</sup>		Voluntary Enrollment into Capitated Arrangements <sup>2</sup>		No Capitated Arrangements
	Statewide	Some or Most Counties	Statewide	Some or Most Counties	
Alaska					
Arkansas					
District of Columbia <sup>3</sup>					
Hawaii					
Idaho					
Illinois					
Indiana					
Iowa					
Louisiana					
Maryland <sup>4</sup>					
Minnesota					
Mississippi					
Missouri					
Nebraska					
New Mexico					
North Dakota					
Ohio <sup>5</sup>					
Oklahoma					
Rhode Island					
South Carolina					
South Dakota					
Texas					
West Virginia					
Wisconsin <sup>6</sup>					

<sup>1</sup> In the District of Columbia, Hawaii, Minnesota, Missouri, Ohio, Oklahoma, Rhode Island, Texas, West Virginia, and Wisconsin, disabled children receiving Social Security Income (SSI) assistance are exempt from mandatory enrollment into general capitated plans.

<sup>2</sup> This category includes states that require automatic enrollment into a capitated plan as the default option if beneficiary fails to make a selection after a specific amount of time between a primary care case management provider and a capitated plan.

<sup>3</sup> In the District of Columbia, disabled children who receive SSI assistance may enroll into a special capitated plan.

<sup>4</sup> In Maryland, children and adults diagnosed with 1 of 22 severe physical conditions are exempt from mandatory enrollment into capitated plans.

## Appendix III-B (Cont.)

<sup>5</sup> In Ohio, any CHIP-eligible child may voluntarily enroll in a capitated plan in 6 of the 88 counties, while enrollment is required in 10 counties.

<sup>6</sup> In Wisconsin, disabled children and adults who meet SSI disability criteria may enroll into a special capitated plan in one county. Other CHIP-eligible children may receive coverage through employer-sponsored plans, but only if the employer pays between 60 and 80 percent of the premium and the costs to the state for the premium subsidy, uncovered services that would be available through Medicaid, and administrative costs together are less than the cost of enrolling the child or children into a Medicaid HMO.

**Source:** Information obtained by Fox Health Policy Consultants through an analysis of CHIP plan applications, state responses to HCFA's questions, and subsequent plan amendments approved by HCFA as of January 31, 1999; state CHIP documents constituting the standard insurance contracts or requests for proposals in effect as of January 31, 1999; and telephone interviews with state Medicaid and CHIP officials when information in the documents was confusing or incomplete.

**Appendix IV-A**

**Services Excluded from States' Fully Capitated Non-Medicaid CHIP Contracts as of January 31, 1999**

States <sup>1</sup>	Dental	Optometry	Ancillary Therapies	DME		Prescription Drugs	Nursing	Home Health	Mental Health			Case Management	Health-Related Special Education	Early Intervention	Title V/ CSHCN
				All or Most	Int				SED	All or Most	Int				
Arizona															
California															
Colorado															
Connecticut															
Delaware															
Kansas															
Florida <sup>2</sup>															
Kentucky															
Maine															
Massachusetts <sup>3</sup>															
Michigan															
Montana															
Nevada															
New Hampshire															
New Jersey															
New York															
Oregon															
Pennsylvania															
Utah															
Vermont					4										
Virginia															

## Appendix IV-A (Cont.)

CSHCN = Children with special health care needs

DME = Durable medical equipment

CD = Community-based substance abuse services for children with severe chemical dependency problems

Int = Intensive mental health services beyond specified limits

SED = Community-based mental health services primarily or exclusively for children with serious emotional disturbances

<sup>1</sup> Alabama, Georgia, Maine, and North Carolina were excluded from this analysis because these states did not use capitated arrangements to furnish services for CHIP-eligible children as of January 31, 1999.

<sup>2</sup> In Florida, children without special health care needs are enrolled into general capitated plans that furnish all of their covered benefits, while children who have a special health care need may be eligible to enroll in a separate capitated arrangement that provides all primary and specialty services.

<sup>3</sup> In Massachusetts, the majority of CHIP-eligible children are expected to be enrolled into various employer-sponsored insurance plans under which all of their services are capitated.

<sup>4</sup> Vermont pays fee for service for eyeglasses.

**Source:** Information obtained by Fox Health Policy Consultants through an analysis of CHIP plan applications, state responses to HCFA's questions, and subsequent plan amendments approved by HCFA as of January 31, 1999; state CHIP documents constituting the standard insurance contracts or requests for proposals in effect as of January 31, 1999; and telephone interviews with state Medicaid and CHIP officials when information in the documents was confusing or incomplete.

**Appendix IV-B**

**Services Excluded from States' Fully Capitated Medicaid CHIP Contracts as of January 31, 1999**

States <sup>1</sup>	Dental	Optometry	Ancillary Therapies	DME		Prescription Drugs	Nursing	Home Health	Mental Health			Substance Abuse			Case Management	Health-Related Special Education	Early Intervention	Title V/ CSHCN
				All	Some				All or Most	Int	SED	All or Most	Int	CD				
District of Columbia																		
Hawaii																		
Illinois																		
Indiana																		
Iowa				*														
Maryland						2												
Minnesota																		
Mississippi																		
Missouri																		
Nebraska		*																
New Mexico																		
North Dakota																		
Ohio									3			3						
Oklahoma																		
Rhode Island																	4	
South Carolina		*								5		5						
Texas																		
West Virginia																		
Wisconsin	*										6		6					

## Appendix IV-B (Cont.)

CSHCN = Children with special health care needs

DME = Durable medical equipment

CD = Community-based substance abuse services for children with severe chemical dependency problems

Int = Intensive mental health services beyond specified limits

SED = Community-based mental health services primarily or exclusively for children with serious emotional disturbances

\* Optional capitated services

<sup>1</sup> Alaska, Arkansas, Idaho, Louisiana, and South Dakota were excluded from this analysis because these states did not use capitated arrangements to furnish services for CHIP-eligible children as of January 31, 1999.

<sup>2</sup> Maryland includes all prescription drugs in their capitated payment except for those used in the treatment of HIV/AIDS, such as protease inhibitors and non-nucleoside reverse transcriptase inhibitors.

<sup>3</sup> Ohio pays fee for service for behavioral health services received through community mental health centers and all CHIP-eligible children may access these services by self-referrals.

<sup>4</sup> Rhode Island includes all early intervention services in their capitated payment except when the costs exceed \$3,000.

<sup>5</sup> South Carolina pays fee for service for behavioral health services when the costs exceed \$1,000/year.

<sup>6</sup> Wisconsin uses a separate capitated arrangement for furnishing behavioral health services to children with serious emotional disturbances in 2 counties.

**Source:** Information obtained by Fox Health Policy Consultants through an analysis of CHIP plan applications, state responses to HCFA's questions, and subsequent plan amendments approved by HCFA as of January 31, 1999; state CHIP documents constituting the standard insurance contracts or requests for proposals in effect as of January 31, 1999; and telephone interviews with state Medicaid and CHIP officials when information in the documents was confusing or incomplete.

## Appendix V-A

### Non-Medicaid Contract Language Pertaining to Children with Special Health Care Needs in CHIP Plans Approved as of January 31, 1999

States <sup>1</sup>	Elements of Contractual Agreements								
	Network includes public program providers for children	Network includes providers with pediatric expertise	Plans allows specialists as primary care providers	Service authorization requirements include special policies for chronic care	Access requirements include specialty services	Medical necessity language includes conditions, handicaps, or disabilities	Quality of care includes use measures for chronic care	Quality of care includes clinical effectiveness measures for chronic care	Consumer satisfaction surveys include questions related to children with special needs
Arizona									
California									
Colorado									
Connecticut									
Delaware									
Florida									
Kansas									
Kentucky									
Maine									
Michigan									
Montana									
Nevada									
New Hampshire									
New Jersey									
Oregon									
Pennsylvania									
Utah									
Vermont									
Virginia									

## Appendix V-A (Cont.)

<sup>1</sup> Alabama, Georgia, Massachusetts, and North Carolina were excluded from this analysis of non-Medicaid plans because they were not contracting with managed care organizations as of January 31, 1999.

**Source:** Information obtained by Fox Health Policy Consultants through an analysis of CHIP contract documents issued by state non-Medicaid CHIP programs approved by HCFA as of January 31, 1999.

## Appendix V-B

### Medicaid Contract Language Pertaining to Children with Special Health Care Needs in CHIP Plans Approved as of January 31, 1999

States <sup>1</sup>	Elements of Contractual Agreements								
	Network includes public program providers for children	Network includes providers with pediatric expertise	Plan allows specialists as primary care providers	Service authorization requirements include special policies for chronic care	Access requirements include specialty services	Medical necessity language includes conditions, handicaps, or disabilities	Quality of care includes use measures for chronic care	Quality of care includes clinical effectiveness measures for chronic care	Consumer satisfaction surveys include questions related to children with special needs
District of Columbia									
Hawaii									
Illinois									
Indiana									
Iowa									
Maryland									
Minnesota									
Mississippi									
Missouri									
Nebraska									
New Mexico									
North Dakota									
Ohio									
Oklahoma									
Rhode Island									
South Carolina									
Texas									
West Virginia									
Wisconsin									

## Appendix V-B (Cont.)

<sup>1</sup> Alaska, Arkansas, Idaho, Louisiana, and South Dakota were excluded from this analysis of Medicaid plans because they were not contracting with managed care organizations as of January 31, 1999.

**Source:** Information obtained by Fox Health Policy Consultants through an analysis of CHIP contract documents issued by state Medicaid CHIP programs approved by HCFA as of January 31, 1999.

## Appendix VI-A

### Cost-Sharing Provisions in Non-Medicaid CHIP Plans Approved as of January 31, 1999

States	Income Eligibility (% FPL)	Premiums (monthly)	Copayments / Coinsurance
<b>Alabama<sup>1</sup></b> ALL-Kids	≤200%	151 - 200% \$6 for 1 child \$12 for 2 children \$18 for ≥3 children  This fee must be paid in 10 installments annually -- \$60/year, \$120/year or \$180/year	151 - 200%  \$5 Physician visits* Prescription drugs \$1 generics \$3 brand names \$5 ER services (inappropriate) \$5 Inpatient services \$5 Dental services  Copayments are capped at \$500 annually.
<b>Arizona<sup>2</sup></b> KidsCare	≤150%	No premiums	≤150  \$5 ER services (inappropriate)
<b>California<sup>3</sup></b> Healthy Families	≤200%	101 - 150% \$4 for 1 child \$8 for ≥2 children  151 - 200% \$6 for 1 child \$12 for 2 children \$18 for ≥3 children	101 - 200%  \$5 Physician visits* \$5 Prescription drugs \$5 ER services \$5 Outpatient MH services \$5 Outpatient SA services \$5 PT, OT, ST services Varies Dental services \$10 Optometry services \$25 Eyeglasses \$5 Acupuncture services \$5 Chiropractic services  Copayments (except for dental and optometry services) are capped at \$250 annually.
<b>Colorado</b> Child Health Plan Plus	≤185%	101 - 150% \$9 for 1 child \$15 for ≥2 children  151 - 169% \$15 for 1 child \$25 for ≥2 children  170 - 185% \$20 for 1 children \$30 for ≥2 children	101 - 150% 150 - 185%  \$2 \$5 Physician visits* Prescription drugs \$1 generics \$1 brand names \$6 ER transport (inappropriate) \$2 Outpatient MH services \$2 Outpatient SA services \$2 PT, OT, ST services \$2 Dental services \$2 Optometry services

## Appendix VI-A (Cont.)

States	Income Eligibility (% FPL)	Premiums (monthly)		Copayments / Coinsurance	
<b>Connecticut<sup>4</sup></b> HUSKY Part B	≤300%	236 - 300%	\$30 for 1 child \$50 for ≥2 children	186 - 300%	\$5 Physician visits Prescription drugs \$3 generics \$6 brand names \$25 ER services (inappropriate) Outpatient MH services \$25 11-20 visits \$50 or 50% 21-30 visits Varies Dental services \$5 Optometry services \$5 Chiropractic services \$5 Naturopathic services \$5 Podiatry services \$5 Hearing exams
		Premiums and copayments are capped at \$650 annually for families with gross income (before disregards) at or below 235% of FPL. Premiums and copayments are capped at \$1,250 annually for families with gross incomes above 235% of FPL before income disregards.			
<b>Delaware</b> Delaware Healthy Children Program	≤200%	101 - 133%	\$10 per family	101 - 200%	\$10 ER services (inappropriate)
		134 - 166%	\$15 per family		
		167 - 200%	\$25 per family		
<b>Florida<sup>5</sup></b> Healthy Kids	≤200%	101 - 200%	\$15 per family	101 - 200%	\$3 Physician visits*
					\$3 Prescription drugs \$3 generics \$10 ER services (inappropriate) \$10 ER transport (inappropriate) \$3 Outpatient MH services \$3 Outpatient SA services \$3 PT, OT, ST services \$3 Home health services \$3 Optometry services \$10 Eyeglasses \$3 Chiropractic services \$3 Podiatry services
<b>Georgia</b> PeachCare for Kids	≤200%	101 - 200%		No copayments	
		6 - 19	\$7.50 for 1 child \$15 for ≥2 children		
<b>Kansas</b> HealthWave	≤200%	151 - 175%	\$10 per family	No copayments	
		176 - 200%	\$15 per family		

**Appendix VI-A (Cont.)**

<b>States</b>	<b>Income Eligibility (% FPL)</b>	<b>Premiums (monthly)</b>	<b>Copayments / Coinsurance</b>	
<b>Kentucky</b> Kentucky CHIP	≤200%	101 - 133%	\$1.67 per family	101 - 149% 150 - 200%
		134 - 149%	\$3.33 per family	\$3 Physician visits*
		150 - 200%	\$20 per family	\$1 Prescription drugs
		This fee must be paid in 2 installments annually -- \$20/year or \$40/year -- for families with income below 150% of FPL. Families with income at or above 150% of FPL have the option of paying \$240/year in 4, 6, or 12 installments.	\$5 Ambulatory surgery	
			\$10 ER services (inappropriate)	
			\$25 Inpatient services	
			\$5 SNF services	
			\$5 Residential treatment services	
\$3 Outpatient MH services				
\$3 Outpatient SA services				
\$5 Eyeglasses				
\$5 Hearing aids				
<b>Maine</b> Cub Care	≤185%	151 - 160%	\$5 for 1 child \$10 for ≥2 children	No copayments
		161 - 170%	\$10 for 1 child \$20 for ≥2 children	
		171 - 185%	\$15 for 1 child \$30 for ≥2 children	
<b>Massachusetts</b> Family Assistance	≤200%	151 - 200%	\$10 for 1 child \$20 for 2 children \$30 for ≥3 children	Copayments and deductibles may apply, varies by plan.
<b>Michigan</b> MICHild	≤200%	151 - 200%	\$5 per family	No copayments
<b>Montana</b> Montana's Children's Health Insurance Plan	≤150%	100 - 150%	\$1 for 1 child \$1.25 for ≥2 children	100 - 150%
				\$3 Physician visits*
				\$3 Prescription drugs
				\$5 generics
				\$5 brand names
				\$5 ER services
				\$25 Inpatient services
				\$5 Hospital outpatient services
				\$5 Outpatient MH services
				\$5 Outpatient SA services
\$5 Optometry services				
\$5 Audiology services				
This fee must be paid in 1 installment annually -- \$12/year or \$15/year			Copayments are capped at \$200 annually.	

### Appendix VI-A (Cont.)

States	Income Eligibility (% FPL)	Premiums (monthly)		Copayments / Coinsurance					
<b>Nevada</b> Nevada Check Up	≤200%	≤150%	\$3.33 per family	No copayments					
		151 - 175%	\$8.33 per family						
		176 - 200%	\$16.66 per family						
		This fee must be paid in 4 installments annually -- \$40/year, \$100/year, or \$200/years.							
<b>New Hampshire</b> Healthy Kids–Silver	≤300%	186 - 250%	\$20 for 1 child \$40 for 2 children \$60 for 3 children \$80 for 4 children \$100 for ≥5 children	186 - 300%	\$5 Physician visits* Prescription drugs \$5 generics \$10 brand names \$25 ER services (inappropriate) \$5 Outpatient MH services \$5 Outpatient SA services \$5 PT, OT, ST services \$5 Dental services \$5 Optometry services \$5 Eyeglasses \$5 Hearing aids \$5 Audiology services \$5 Chiropractic services				
		251 - 300%	\$40 for 1 child \$80 for 2 children \$100 for ≥3 children						
<b>New Jersey</b> NJKidCare Plans B & C	≤200%	151 - 200%	\$15 per family	151 - 200%	\$5 Physician visits* Prescription drugs \$1 generics \$5 brand names \$10 ER services \$5 Outpatient MH services \$5 Outpatient SA services \$5 PT, OT, ST (1 <sup>st</sup> 20 of 60 visits) \$5 Dental services \$5 Optometry services \$5 Audiology services \$5 Chiropractic services \$5 Podiatry services				
<b>New York</b> Child Health Plus	≤222%	151 - 159%	\$9 for 1 child \$18 for 2 children \$27 for 3 children \$36 for ≥4 children	≤222%	\$2 Physician visits \$1 - 3 Prescription drugs ER services \$10 inappropriate use \$5 appropriate use but failure to notify insurer w/in 24 hrs				
		160 - 222%	\$13 for 1 child \$26 for 2 children \$39 for 3 children \$52 for ≥4 children						



## Appendix VI-A (Cont.)

DME = Durable medical equipment

ER = Emergency room

FEHBP = Federal employees health benefit program

FPL = Federal poverty level

MH = Mental health

OT = Occupational therapy

PT = Physical therapy

SA = Substance abuse

SNF = Skilled nursing facility

ST = Speech therapy or speech language and pathology services

\* Physician visits include physician, nurse practitioner, and physicians assistant services furnished in office or any other outpatient setting.

<sup>1</sup> In Alabama, discounted rates apply if premiums are paid in 1 installment annually -- \$50 for 1 child, \$100 for 2 children, and \$150 for ≥3 children.

<sup>2</sup> In Arizona, income eligibility will be extended up to 175 percent of FPL on July 1, 1999 and up to 200 percent of FPL on July 1, 2000.

<sup>3</sup> In California, various copayment charges apply to some restorations and oral surgeries. Also, a 90-100 day supply of prescription drugs is available for chronic conditions with a single \$5 copayment.

<sup>4</sup> In Connecticut, copayment charges are not imposed on children with special health care needs who are receiving specialty services through HUSKY Plus. For outpatient mental health services beyond 30 visits, copayments are charged at \$50 per visit or 50 percent of the cost of the visit, whichever is less. (See Appendix II.) Dental services that require copayments are bridges and crowns, root canals, dentures (full and partial), extractions, and orthodontia.

<sup>5</sup> In Florida, copayment charges are not imposed on children with special needs who are enrolled in the specialty managed care organization and children under age 5.

<sup>6</sup> In Utah, the coinsurance charges are assessed using 75 percent of the billed amount, except in the case of prescription drugs and durable medical equipment where 100 percent of billed charges is used. For laboratory services, coinsurance charges are only imposed on services over \$50, and for X-ray services, they are only imposed on services greater than \$100. For inpatient mental health and substance abuse services and for residential treatment, the coinsurance rate is 10 percent for the first 10 days, but thereafter the rate increases to 50 percent.

<sup>7</sup> In Vermont, beginning on July 1, 1999, copayments will apply to families above 225 percent of poverty as follows: \$10 for physician visits, outpatient MH, dental services, optometry services, audiology services, chiropractic services, and podiatry services. Copayments are capped at \$950/year, and the medical and dental apportionment is \$650 to \$300, respectively. In addition, a monthly \$20 premium will apply to families above 225 percent of FPL when administratively possible.

**Source:** Information obtained by Fox Health Policy Consultants through an analysis of non-Medicaid CHIP plan applications, state responses to HCFA's questions, and subsequent plan amendments approved by HCFA as of January 31, 1999; state CHIP documents constituting the standard insurance contracts or requests for proposals in effect as of January 31, 1999; and telephone interviews with state Medicaid and CHIP officials when information in the documents was confusing or incomplete.

## Appendix VI-B

### Cost-Sharing Provisions in Medicaid CHIP Plans Operating under Section 1115 Demonstration Waivers Approved as of January 31, 1999

States	Income Eligibility (% FPL)	Premiums (monthly)	Copayments / Coinsurance
<b>Missouri<sup>1</sup></b> MC+ for Kids	300%	226 - 300% \$65 per family	186 - 225% 226 - 300%  \$5            \$10      Physician visits* –             \$5         Prescription drugs \$5            \$10      Ambulatory services \$5            \$10      Inpatient services \$5            \$10      Outpatient services \$5            \$10      PT, OT, ST services \$5            \$10      Community-based MH services \$5            \$10      Home health services \$5            \$10      Dental services \$5            \$10      Audiology services \$5            \$10      Optometry services \$5            \$10      Podiatry services
<b>New Mexico</b> New Mexico Children's Health Insurance Program	235%	No premiums	186 - 235%  \$5            Physician visits* \$2            Prescription drugs \$15          ER and urgent care services \$25          Inpatient services \$15          Hospital outpatient services \$5            Outpatient MH services \$5            Outpatient SA services \$5            PT, OT, ST services \$5            Dental services \$5            Chiropractic services \$5            Audiology services \$5            Podiatry services  Copayments are capped at 3% for families between 186 and 200% of FPL, at 4% for families between 201 and 215% of FPL, and at 5% for families between 216 and 235% of FPL.
<b>Rhode Island<sup>2</sup></b> Rite Care	250%	186 - 250%  <1            \$12.34 - \$12.46  1-5            \$1.94 - \$1.96  6-14          \$1.57 - \$1.58  15-18 male   \$2.48 - \$2.51  15-18 female \$4.01 - \$4.05	186 - 250%  \$5            Physician visits* \$2            Prescription drugs \$35          ER transport (inappropriate) \$25          Inpatient services \$5            SNF services \$15          Ambulatory surgery \$5            Outpatient MH services \$5            Outpatient SA services \$5            PT, OT, ST services \$5            Home health services \$5            Dental services \$5            Optometry services \$5            Audiology services \$5            Podiatry services

## Appendix VI-B (Cont.)

States	Income Eligibility (% FPL)	Premiums (monthly)	Copayments / Coinsurance
Wisconsin <sup>3</sup> BadgerCare	185%	151%  \$52 for 1 child \$70 for 2 or 3 children \$87 for 4 children \$105 for 5 children	No copayments
		185%  \$70 for 1 child \$87 for 2 children \$105 for 3 or 4 children \$123 for 5 children	

ER = Emergency room  
 FPL = Federal poverty level  
 MH = Mental health  
 OT = Occupational therapy  
 PT = Physical therapy  
 SA = Substance abuse  
 SNF = Skilled nursing facility  
 ST = Speech therapy or speech language and pathology services

\* Physician visits include physician, nurse practitioner, physicians assistant services furnished in an office or any other outpatient setting.

<sup>1</sup> Missouri does not apply copayment charges to the following services: case management, emergency room services, personal care, DME, ambulance services, and private duty nursing.

<sup>2</sup> Rhode Island changed their monthly premium rates on 1/5/99 to \$7.56 - \$12.21 for infants less than 12 months old, \$2.16 - \$2.18 for ages 1 to 5 years old, \$1.70 - \$1.72 for ages 6-14, \$2.69 - \$2.72 for males ages 15-18, and \$4.11 - \$4.15 for females ages 15 to 44. The state also raised the income eligibility to 300 percent of poverty. Families with incomes between 185 and 300 percent of poverty still have the option to enroll with either premiums or copayments. Members selecting the premium option are also responsible for a copayment of \$35 for non-emergency use of medical transportation.

<sup>3</sup> In Wisconsin, families with incomes above 150 percent of poverty pay a premium that is equivalent to 3.5 percent of family income. Actual premium amounts therefore vary on the basis of family size and income. However, they do not vary based on the number of family members who choose to enroll. Parents as well as children are eligible. The premiums presented here are for 2-parent families in which only children enroll.

**Source:** Information obtained by Fox Health Policy Consultants through an analysis of 1115 waiver applications and subsequent waiver program amendments approved by HCFA as of January 31, 1999; CHIP plan applications, state responses to HCFA's questions, and subsequent plan amendments approved as of January 31, 1999; and telephone interviews with state Medicaid and CHIP officials.

The Maternal and Child Health Policy Research Center conducts research and analysis on health insurance, managed care, and other financing and delivery issues affecting children. The Center is a collaborative arrangement with four institutions based in Washington, D.C., San Francisco, and Los Angeles. Its co-directors are Harriette Fox of Fox Health Policy Consultants, Neal Halfon of the University of California at Los Angeles, Margaret McManus of McManus Health Policy, and Paul Newacheck of the University of California at San Francisco.

For further information regarding the Child Health Insurance Project, contact Christine Chen at Fox Health Policy Consultants. Address: 750 17<sup>th</sup> Street, NW, Suite 1025, Washington, D.C. 20006-4607. Phone: 202-223-1500. E-mail: [cchen@foxhealth.com](mailto:cchen@foxhealth.com). Also visit the MCH Policy Research Center's web site: [www.mchpolicy.org](http://www.mchpolicy.org).

Copyright © 1999 by Fox Health Policy Consultants  
All Rights Reserved