United States General Accounting Office

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Report to the Ranking Minority Member, Committee on Energy and Commerce, House of Representatives

September 2001

MEDICAID AND SCHIP

States' Enrollment and Payment Policies Can Affect Children's Access to Care

GAO-01-883

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Abbreviations

AFDC	Aid to Families With Dependent Children
CMS	Centers for Medicare and Medicaid Services
CPT 4	Current Procedural Terminology, 4th edition
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
FFS	Fee-For-Service
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HRSA	Health Resources and Service Administration
PCCM	Primary Care Case Management
PMPM	Per-Member-Per-Month
PPO	Preferred Provider Organization
SCHIP	State Children's Health Insurance Program
SSI	Supplemental Security Income
TANF	Tempory Assistance for Needy Families

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United States General Accounting Office
Washington, D.C. 20548

September 10, 2001

The Honorable John D. Dingell
Ranking Minority Member
Committee on Energy and Commerce
House of Representatives

Dear Mr. Dingell:

States provide health care coverage to low-income uninsured children largely through two federal-state programs—Medicaid and the State Children's Health Insurance Program (SCHIP). Medicaid was established in 1965 to provide health care coverage to certain categories of low-income adults and children; in 1998, Medicaid expenditures for health services to about 22.3 million children totaled $32.4 billion.[1] The Congress established SCHIP in 1997 to provide health care coverage to children living in low-income families whose incomes exceed the eligibility requirements for Medicaid; in 1999, SCHIP expenditures for health services to nearly 2 million children totaled $2 billion.[2] In implementing SCHIP, states could choose to expand their Medicaid programs, thus affording SCHIP-eligible children the same benefits and services that the state Medicaid program provides. Alternatively, states could construct a separate child health program distinct from Medicaid that uses specified public or private insurance plans offering a minimum benefit package. Thirty-five states have chosen SCHIP approaches that are, to varying degrees, separate from their Medicaid programs.

In April 2000, we reported to you that Medicaid and SCHIP programs in 10 states that have separate SCHIP programs have differences in the way the programs enroll children and in the scope of benefits they offer.[3] In particular, we noted that 5 of the 10 states had more requirements for Medicaid than for SCHIP, which increased the burden for families applying for Medicaid. For example, Alabama Medicaid required applicants to

[1]The most recent Medicaid enrollment and expenditure data for children are for 1998.

[2]These figures are for children covered from October 1, 1998, through September 30, 1999. SCHIP enrolled over 3 million children from October 1, 1999, through September 30, 2000.

[3]See *Medicaid and SCHIP: Comparisons of Outreach, Enrollment Practices, and Benefits* (GAO/HEHS-00-86, Apr. 14, 2000). The 10 states reviewed in that report were Alabama, Arkansas, California, Colorado, Florida, Kansas, North Carolina, New York, Pennsylvania, and Utah.

submit proof of income (such as pay stubs), while Alabama SCHIP allowed applicants to self-report their income without documentation. Because eligibility for Medicaid and SCHIP can vary with a child's age, children may, at different ages, need to move from one program to the other. Therefore, coordination between Medicaid and SCHIP—which is required under the SCHIP statute—can be critical to ensuring that children are promptly enrolled in the appropriate program so they have access to necessary health care. Access to care, however, is also affected by the extent to which health plans and providers are available and participate in Medicaid and SCHIP. Because of your concern that differences between the programs may limit children's access to care, you asked us to analyze, for selected states' Medicaid and SCHIP programs, differences in (1) states' enrollment requirements, particularly application requirements and eligibility determination practices, and (2) health plan and provider participation and program payments to plans and providers. With regard to both objectives, you also asked that we examine the implications that these differences might have for children's access to care.

To address differences in states' enrollment requirements, we analyzed the application requirements for Medicaid and SCHIP for 10 states with SCHIP separate child health programs. These 10 states were Alabama, California, Colorado, Florida, Kansas, Michigan, New York, North Carolina, Pennsylvania, and Utah. We chose states with programs that had a mixture of administrative structures, ranging from SCHIP programs that were administered by the states' Medicaid program to those that were operated separately. In addition, we selected states whose SCHIP programs had been in operation since January 1999 and that represented a range of geographic locations. We selected 4 of the 10 states for site visits (California, Colorado, Michigan, and New York), based in part on the number of enrollees in both programs and variation in administrative structure. In our site visits, we obtained supporting data on Medicaid and SCHIP application and eligibility determination practices and interviewed representatives of programs, including state, county, and private sector officials, as well as health plan officials, child health advocates, and representatives of provider organizations. We reviewed with these groups the steps necessary for beneficiaries to obtain, maintain, and renew their eligibility. To obtain broader information about health plan and provider participation in the two programs, we interviewed Medicaid and SCHIP officials in the 10 states. We also collected and analyzed information and data on payments in the four states we visited. In conducting our payment analysis, we focused on comparing the two programs' (1) physician fees for primary care services and (2) plan capitation rates, which are paid to health

plans prospectively on a per-member-per-month (PMPM) basis. Finally, we conducted interviews with officials from the Department of Health and Human Services (HHS), including the Centers for Medicare and Medicaid Services (CMS), formerly called the Health Care Financing Administration (HCFA),[4] which has oversight responsibilities for both programs, and the Health Resources and Services Administration (HRSA), which shares oversight responsibilities for SCHIP with CMS. We performed our work from June 2000 through July 2001 in accordance with generally accepted government auditing standards. (See app. I for details on our scope and methodology.)

Results in Brief

Differences in Medicaid and SCHIP enrollment requirements—particularly application requirements and eligibility determination practices—can affect beneficiaries' ability to obtain and keep coverage. To help simplify the process for applicants, 8 of the 10 states we reviewed used joint applications that had similar—but not always identical—requirements for Medicaid and SCHIP applicants. When application requirements differed, Medicaid applicants had to provide additional information or documentation, including items such as proof of types of income or assets, or participate in interviews. The extent of coordination between the programs affected applicants' ability to enroll because joint applications often were transferred between the Medicaid and SCHIP offices to ensure enrollment in the appropriate program. Delays in these transfers or in identifying applications as missing required information could also delay eligibility determination and program enrollment. In two of the four states we visited, where comparable data were available, the average processing time for applications was longer for Medicaid than for SCHIP. While differences in processing times could be affected by poor coordination, other factors, such as additional time allowed to process applications for individuals with special needs, can contribute to Medicaid's longer average processing times. Once enrolled, Medicaid and SCHIP families faced different requirements for maintaining coverage, such as a more complex redetermination process for Medicaid, and monthly premiums or an annual enrollment fee in SCHIP. A family's failure to pay required SCHIP premiums can result in the loss of coverage for children, which happened for 10 percent of enrolled children in one state.

[4]In June 2001, HCFA's name was changed to the Centers for Medicare and Medicaid Services (CMS). Since our fieldwork was conducted while the agency was known as HCFA, we are referring to it in the report findings section by its former name.

Differences in the health plans and providers that participate in Medicaid and SCHIP, as well as differences in the payments they receive, have implications for beneficiaries' access to care. In the 10 states we reviewed, SCHIP often required enrollees to join a managed care plan and sometimes did not offer a choice of plans, while Medicaid offered families a choice of two or more plans or of care on a fee-for-service (FFS) basis, including primary care case management. However, having such choices did not necessarily give beneficiaries greater access to providers because plan choices may be limited to a number of smaller plans—and exclude larger plans with more extensive networks. Plans that do not participate in both Medicaid and SCHIP can create problems with continuity of care, since children can shift between programs as family income or a child's age changes. Where differences in health plan and physician participation existed, a family with children in both programs—possible in all 10 states we reviewed—potentially had to use two different sets of providers for its children. Some states did not know the extent to which physicians participated in both programs. Payment disparities between Medicaid and SCHIP also could affect access to care, and low payments have been a long-standing issue affecting provider participation in Medicaid. In two of the four states we visited, where comparisons between Medicaid and SCHIP physician fees were possible, the fees were consistently lower in Medicaid than in SCHIP. Comparisons of plan capitation rates were more difficult because of differences in the benefits included in these rates. In one state with comparable benefits, SCHIP paid more than Medicaid; in the remaining three states, capitation rates were less comparable because of differences in the benefits or the populations included in the capitation rate, or both.

In commenting on a draft of this report, HHS generally concurred with our observations, also noting the important policy considerations associated with differences in physician participation and payment rates between Medicaid and SCHIP, and their comparability with other payers for similar services.

Background

For over 35 years, Medicaid has operated as a joint federal-state entitlement program to finance health care coverage for certain categories of low-income individuals. Medicaid eligibility is based in part on a family's income in relation to the federal poverty level. Federal law requires states to extend Medicaid eligibility to children aged 5 and under if their family income is at or below 133 percent of the federal poverty level and to children aged 6 to 16 in families with incomes at or below the federal

poverty level.[5] At their discretion, most states have set income eligibility thresholds that expand their Medicaid programs beyond the minimum federal statutory levels.

For most populations, state Medicaid programs must offer certain benefits, such as physician services, inpatient and outpatient hospital services, and nursing facility and home health services. In addition to the benefits that are federally mandated, states may offer optional services, such as dental, physical and occupational therapy, prescription drugs, and case management services. For most children, states must provide Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.[6] These services are intended to provide comprehensive, periodic evaluations of health and developmental history, as well as vision, hearing, and dental screening services, to most Medicaid-eligible children. States are required to cover any service or item that is necessary to correct or ameliorate a condition detected through an EPSDT screening, regardless of whether the service is otherwise covered under a state's Medicaid program.

Across the nation, 48 states and the District of Columbia have Medicaid managed care programs, which require approval from CMS. These managed care programs can be targeted to specific geographic areas within a state or can be statewide. As of June 2000, 36 states and the District of Columbia had Medicaid mandatory managed care programs. In such programs, certain beneficiaries may choose between at least two capitated managed care plans, and states pay prospectively for each enrolled beneficiary on a PMPM basis. As a part of their managed care programs, states can provide beneficiaries a FFS based alternative, such as primary care case management (PCCM). Under PCCM, primary care providers are paid a nominal fee to manage the care of beneficiaries, and all services received are paid on a FFS basis.[7] The remaining 12 states have managed

[5]Medicaid eligibility is mandatory for all children born after September 30, 1983 whose family incomes are less than or equal to the poverty level. By September 2002, mandatory Medicaid eligibility will apply to all children (up to age 19) who meet the income requirements. See 42 U.S.C. § 1396a(a)(10)(A)(i)(VII), (l)(1)(D), (l)(2)(C).

[6]EPSDT is optional for the medically needy population, a category of individuals who generally have too much income to qualify for Medicaid but have "spent down" their income by incurring medical and/or remedial care expenses. See 42 U.S.C. § 1396(a)(10)(C).

[7]For this report, we included PCCM as a FFS-based arrangement because PCCM arrangements pay providers predominantly on a FFS basis.

care programs that are voluntary for beneficiaries, including a FFS-based alternative (such as PCCM), or both.

The Congress created SCHIP in 1997 as a means of providing health benefits coverage to children living in families whose incomes exceed the eligibility limits for Medicaid.[8] Although SCHIP is generally targeted to families with incomes at or below 200 percent of the federal poverty level, each state may set its own income eligibility limits, within certain guidelines.[9] Using the flexibility built into the statute, states' upper income eligibility for SCHIP ranged from 133 percent to 350 percent of the federal poverty level for separate SCHIP programs as of October 2000.[10] States have three options in designing SCHIP: they may expand their Medicaid programs, develop a separate child health program that functions independently of the Medicaid program, or do a combination of both.[11] Fifteen states and the District of Columbia have created Medicaid expansion programs, 16 states have separate child health programs, and 19 states have a combination Medicaid expansion and separate child health component. (See app. II for a summary of states' SCHIP design choices and app. III for states' income eligibility levels in SCHIP and Medicaid.)

[8]Established as title XXI of the Social Security Act by P.L. 105-33, SCHIP is codified as 42 U.S.C. § 1397aa *et seq.*

[9]In general, the SCHIP statute targets children in families with incomes at or below 200 percent of the poverty level—$35,300 for a family of four in 2001. Recognizing the variability in state Medicaid programs, the statute allows a state to expand eligibility up to 50 percentage points above its Medicaid income eligibility standard in 1997. See 42 U.S.C. § 1397jj(b)(1)(B)(ii)(I).

[10]Neither Medicaid nor SCHIP dictates how a state defines income for purposes of eligibility determination. Thus, some states have expanded income eligibility levels for families through "income disregards," which ignore certain types of family income for purposes of determining eligibility. For instance, one state has imposed income disregards as high as 100 percent of the federal poverty level, which means that a family with an income equal to 200 percent of the federal poverty level is treated as if its income were equal to the federal poverty level. See 42 U.S.C. § 1396u-1(b)(2).

[11]States' SCHIP programs that expand Medicaid and create a separate component are termed combination programs. Combination programs can involve small increases in eligibility for states' Medicaid programs. For example, five states added coverage only for children aged 17 and 18 in families with incomes at or below the federal poverty level. This group is already being phased into mandatory Medicaid coverage under current federal law; consequently, these Medicaid expansions will not exist after September 2002. See 42 U.S.C. § 1396a(a)(10)(A)(i)(VII), (l)(1)(D), (l)(2)(C).

While Medicaid expansion programs under SCHIP must use Medicaid's enrollment structures, benefit packages, and provider networks, SCHIP separate child health programs may depart from Medicaid requirements, particularly with regard to benefits and the plans, providers, and delivery systems available to enrollees. SCHIP separate child health programs generally cover basic benefits, such as physician services, inpatient and outpatient hospital services, and laboratory and radiological services, and may provide other benefits at the state's discretion, such as prescription drugs and hearing, mental health, dental, and vision services. In contrast to Medicaid, SCHIP does not require that beneficiaries have freedom to choose among providers or plans, and permits states to implement mandatory managed care; thus, states may place SCHIP enrollees in a single managed care plan without an alternative.

Medicaid and SCHIP separate child health programs may differ in other respects, particularly in terms of their application requirements, eligibility determination processes, cost-sharing requirements, and periods of eligibility. Some of these differences are based in federal statute, while others are the result of federal regulations. For example, federal law has been interpreted to require that public employees determine Medicaid eligibility,[12] while SCHIP contains no such requirement; consequently, states are currently permitted to use private contractors to determine SCHIP eligibility. Also, while federal Medicaid regulations generally do not permit cost-sharing for children, the SCHIP statute allows states to require beneficiary cost-sharing, which some states have implemented as a way to mirror private insurance and encourage appropriate use of services. (See table 1.)

[12]By statute, a state or local agency must determine Medicaid eligibility. See 42 U.S.C. § 1396a(a)(5).

Table 1: Key Differences in Federal Eligibility Requirements Between Medicaid and SCHIP Separate Child Health Programs, as of June 2001

Element	Medicaid	SCHIP separate child health program
Application requirements	Social Security number required.	Social Security number not required.[a]
Eligibility determination	Public employee must determine eligibility.	Private entities may determine eligibility and conduct other administrative functions.
	States must have a system in place to verify family's income after eligibility determination.	Income verification not required.
Cost-sharing	Generally, no cost-sharing allowed for children.[b]	Cost-sharing, such as premiums or annual enrollment fees, allowed for children in families with incomes above 150 percent of the poverty level, up to 5 percent of family income. For children in families with incomes below 150 percent of the poverty level, nominal cost-sharing is allowed.

[a]Effective August 24, 2001, states may choose to require a Social Security number for children applying for SCHIP.

[b]In general, Medicaid does not allow premiums, deductibles, copayments, or other charges for children. However, CMS may waive these restrictions and allow states to require nominal cost-sharing.

Source: GAO analysis.

Medicaid and SCHIP also differ in terms of the proportion of their program expenditures that come from federal funds and in whether eligible individuals are considered entitled to the program benefits and services. State expenditures for Medicaid are matched by the federal government using a formula that results in federal shares ranging from 50 to 77 percent of expenditures, depending on a state's per capita income in relationship to the national average. The national average federal share of Medicaid expenditures is about 57 percent. The SCHIP statute provides for an "enhanced" federal matching rate, with each states' SCHIP rate exceeding its Medicaid rate. Federal shares of SCHIP expenditures range from 65 to 84 percent with the national average federal share equaling about 72

percent.[13] In the Medicaid program, all eligible individuals are entitled to program benefits. No overall federal budget limit exists for the Medicaid program. In contrast, for SCHIP, federal matching for each state is limited. The Congress appropriated $40 billion over 10 years (from fiscal year 1998 to 2007), with a specified amount allocated annually to each of the 50 states, the District of Columbia, Puerto Rico, and the U.S. territories. States' choices to operate a Medicaid expansion or separate child health program determine whether eligible individuals are entitled to receive the benefits and services offered. States opting for a Medicaid expansion under SCHIP must provide Medicaid benefits to all eligible children. The state must continue to serve those children even if its allocated federal funds are exhausted.[14] In contrast, SCHIP separate child health programs are not entitlements to coverage or services; once federal funds are exhausted, states have the option to discontinue providing services or cover the services with other funds.

Both statutory and regulatory requirements for coordination between Medicaid and SCHIP exist at the federal level. The SCHIP statute requires the program to coordinate with Medicaid, including first screening SCHIP applicants for Medicaid eligibility.[15] On the basis of this initial screen, applications (which in most states are the joint Medicaid/SCHIP applications) are directed to either Medicaid or SCHIP, where each program is responsible for final eligibility determination and enrollment. (See fig. 1.) In addition, as of August 24, 2001, SCHIP regulations also require that state Medicaid agencies adopt a process that facilitates enrollment in a state child health program when a child is determined ineligible for Medicaid.[16]

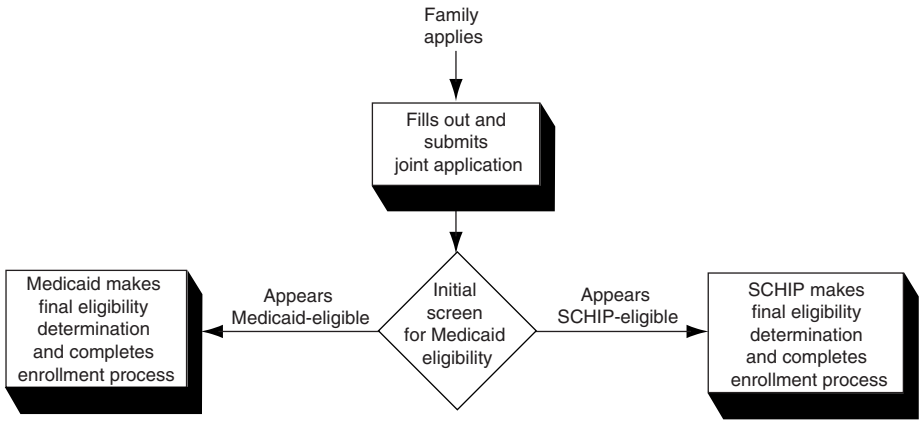
[13]Each state's SCHIP enhanced match is equal to 70 percent of its Medicaid matching rate plus 30 percentage points, not to exceed a federal share of 85 percent. Thus, a state with the minimum 50-percent Medicaid match receives a 65-percent match under SCHIP.

[14]However, states that expend their available SCHIP funds may then claim a Medicaid matching rate for benefits and services provided under a Medicaid expansion.

[15]See 42 U.S.C. § 1397bb(b)(3).

[16] See 42 C.F.R. § 431.636.

Figure 1: Medicaid/SCHIP Initial Screening Process for States With Joint Applications



Source: GAO analysis.

In part because Medicaid and SCHIP eligibility represent a continuum of income levels, coordination between the programs is important. Several states have found that many families applying for SCHIP actually have incomes that qualify them for Medicaid.[17] In addition, families may need to apply to both Medicaid and SCHIP to obtain health care coverage for all of their children because Medicaid eligibility standards can vary according to the age of the child. Table 2 illustrates for two states (Florida and Vermont), how income eligibility can—but does not always—vary by age. (App. III shows the eligibility standards for SCHIP and Medicaid in the 35 states with SCHIP separate child health programs.)

[17]See *Children's Health Insurance Program: State Implementation Approaches Are Evolving* (GAO/HEHS-99-65, May 14, 1999).

Table 2: Income Eligibility for Medicaid and SCHIP, by Age Group, in Florida and Vermont

	Florida income eligibility as a percentage of federal poverty level		Vermont income eligibility as a percentage of federal poverty level	
Age group	**Medicaid**	**SCHIP**	**Medicaid**	**SCHIP**
Infants	Up to 185	Over 185 to 200[a]	Up to 225	Over 225 to 300
1-5 years	Up to 133	Over 133 to 200	Up to 225	Over 225 to 300
6-16 years	Up to 100	Over 100 to 200	Up to 225	Over 225 to 300
17-18 years	Up to 28	Over 28 to 200[b]	Up to 225	Over 225 to 300

[a]Infants in this income eligibility range are covered under Florida's Medicaid expansion component of its SCHIP program.

[b]Children aged 17 to18 in families with incomes ranging from above 28 percent to 100 percent of the federal poverty level are covered under Florida's Medicaid expansion component of its SCHIP program. The remaining children are covered under the state's SCHIP separate child health program.

While Similarities Often Exist, Enrollment Differences Can Affect Ability to Obtain and Keep Coverage

Differences in Medicaid and SCHIP enrollment requirements—particularly application requirements and eligibility determination practices—can affect beneficiaries' ability to obtain and keep coverage. To help simplify the process for applicants, 8 of the 10 states we reviewed used joint applications that had similar—but not always identical—requirements for Medicaid and SCHIP applicants. When application requirements differed, Medicaid applicants had to provide additional information or documentation. The extent and effectiveness of coordination between the programs affected applicants' ability to obtain coverage because joint applications often were transferred between the Medicaid and SCHIP offices to ensure that applicants were enrolled in the appropriate program. Poor coordination meant that applications that were transferred or incomplete risked being delayed or denied. In two of the four states we reviewed, Medicaid applications generally took more time to process. However, different processing times could not be attributed solely to lack of coordination efforts because other factors may affect processing times as well. Once enrolled, Medicaid and SCHIP families faced different requirements for maintaining coverage, such as a more complex redetermination process for Medicaid, and premium and annual fee requirements in SCHIP.

Joint Applications Had Similar, but Not Always Identical, Requirements

Joint Medicaid/SCHIP applications are used widely—31 of the 35 states with SCHIP separate child health programs (including 8 of the 10 states we reviewed) have them.[18] In most states, joint applications are the primary method for applying for SCHIP; however, families applying for Medicaid and other public programs may be required to use a separate, different application form.[19] Joint application forms have helped simplify application and eligibility determination for both programs. When an applicant is found ineligible for one program, the joint form can minimize or eliminate the follow-up needed to determine eligibility for the other program. While the 10 states we reviewed generally had similar information and documentation requirements for both programs, some differences remained with regard to income deductions, asset information, and interview requirements.

With regard to income reporting, 9 of the 10 states we reviewed established identical requirements for both Medicaid and SCHIP. Some of the 10 states in our sample have taken other steps to make application requirements consistent between the programs. For example, most of the states we reviewed did not ask for information about assets or require the applicant to complete an interview. California eliminated its former requirement for an in-person interview as part of the Medicaid application process and allowed Medicaid applications to be mailed in like SCHIP applications. (See table 3.)

[18]The remaining four states—Nevada, North Dakota, Texas, and Utah—did not have joint applications in place as of July 2000. See The Kaiser Commission on Medicaid and the Uninsured, *Making It Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures* (Oct. 2000).

[19]While joint applications can be used for children applying for Medicaid, a state may have a number of different Medicaid application forms. For example, in addition to its joint Medicaid/SCHIP application for children, Florida has a Medicaid application for families that includes food stamps and cash assistance; similarly Utah and Michigan have more extensive application forms for families that are applying for Medicaid and other programs.

Table 3: Information and Documentation Requirements for Medicaid and SCHIP Applications in 10 States

	Income		Income deductions[a]		Assets		Interview	
State	**Medicaid**	**SCHIP**	**Medicaid**	**SCHIP**	**Medicaid**	**SCHIP**	**Medicaid**	**SCHIP**
Alabama	✔	●	✔	●	-	-	●[b]	-
California	✔	✔	✔	✔	-	-	-	-
Colorado	✔	✔	●	●	●	-	-	-
Florida	●	●	●	●	-	-	-	-
Kansas	✔	✔	-	-	-	-	-	-
Michigan	●	●	●	●	-	-	-	-
New York	✔	✔	✔	-	-	-	●[b]	-
North Carolina	✔	✔	●	●	-	-	-	-
Pennsylvania	✔	✔	●	●	-	-	-	-
Utah	✔	✔	✔	-	✔	-	●[b]	●
Number of states with different requirements	1		3		2		2	

Legend

✔= Information and documentation required.

● = Information required, documentation not required.

- = Information not asked for or required.

[a]Income deductions allow families to deduct from the family's monthly income a portion of work-related expenses, out-of-pocket child care costs, and child support received.

[b]Alabama and Utah interviews can be conducted over the telephone; New York interviews are face-to-face.

Source: GAO analyses of states' joint applications and eligibility practices as of March 2001.

Documenting income and income-related information has been cited as a barrier to program eligibility—but also as a means of ensuring that only eligible individuals are enrolled in the appropriate program. In particular, the need to offer documentation, such as pay stubs or proof of child care expenses, can be problematic for families. For instance, families that do not receive regular paychecks can have difficulty showing several months of pay stubs. Similarly, child care expenses can be difficult to document, particularly if an individual pays cash or with a money order. Seven of the 10 states we reviewed were consistent in requiring applicants to document their income for both programs. However, individuals in four states could report income deduction information for both programs, such as child support or day care expenses, without supplying proof. Only one state required both Medicaid and SCHIP applicants to document income

deductions, while three states required documentation for Medicaid applicants but not for SCHIP.

Of the 10 states we reviewed, 2 states—Florida and Michigan—had no income documentation requirements for Medicaid or SCHIP. For example, Medicaid and SCHIP officials in Michigan told us that they eliminated documentation requirements because they were a barrier to application and enrollment. Before the state eliminated the documentation requirements, Michigan officials reported that 75 percent of the applications received were incomplete because individuals failed to provide adequate documentation. Michigan eliminated income documentation for both programs and, as a result, the proportion of incomplete applications received for both programs dropped to below 20 percent.[20]

While application requirements for both Medicaid and SCHIP in the 10 states we reviewed were generally similar, they were not always identical. Where differences existed, Medicaid required more information or documentation, particularly with regard to income deductions, assets, or the need to participate in an in-person interview. For example, Colorado required applicants to report income deductions and assets for Medicaid but not for SCHIP, and New York required in-person interviews and proof of income deductions for Medicaid applicants but not for SCHIP. (See table 3.) New York's Medicaid interview requirement was part of its facilitated enrollment strategy intended to assist applicants in completing the enrollment process. This strategy uses community-based organizations (such as hospitals, clinics, schools, and libraries) as sites where such interviews can be conducted. SCHIP applicants can also use the facilitated enrollment process for assistance in applying for the program, but they are not subject to the in-person interview requirement.

The states we visited had various strategies for addressing the differences between Medicaid and SCHIP requirements on their joint applications. In California, application questions that were Medicaid-specific—such as the need for a Social Security number—were clearly marked as not required for a SCHIP applicant. Colorado joint applications, on the other hand,

[20]Michigan officials asserted that self-reported income has not resulted in a high error rate for Medicaid and SCHIP applications. In particular, an official told us that posteligibility audits, which are conducted by taking a sample of Medicaid and SCHIP applications and verifying the information reported by applicants, showed an error rate of 3 percent. These posteligibility reviews began in October 2000. Data on prior error rates were not available.

asked for information without differentiating between items required by one program versus another. For example, its joint application asked for information about assets, although this was only required for Medicaid, to lessen the need for additional information if an applicant appeared Medicaid-eligible. Both policies have implications for applicants—either the applicant submits information that may not be necessary or risks having to provide additional information later, which could prolong the approval process.

Delayed or Denied Coverage Often Linked to Coordination and Processing Issues

Delayed or denied coverage often was associated with a lack of coordination between the programs and other processing issues. In particular, delays or denials were at risk when Medicaid and SCHIP applications were transferred between programs, or when applications were deemed incomplete. The amount of risk depended on how closely the programs coordinated. Generally, states that had identical Medicaid and SCHIP application requirements and that maintained geographically close or colocated eligibility determination offices for both programs, reduced the risk of delayed or denied coverage. However, different application requirements for Medicaid and SCHIP, as well as poor coordination between the programs could delay coverage for families. In two of the four states we visited where we could obtain comparable data, processing Medicaid applications took longer than for SCHIP; however, longer processing times could be due to a variety of factors besides differences in application requirements and insufficient coordination.

Application Transfers Between Programs Increased the Need for Coordination

Increased coordination between Medicaid and SCHIP was important in part because joint applications were often transferred between programs. Application and eligibility determination processes for Medicaid and SCHIP include an initial eligibility screen for Medicaid and a final eligibility determination in the appropriate program.[21] Across the four states we visited, the initial eligibility screening generally took place when an applicant submitted a joint application to a SCHIP processing location.[22] SCHIP eligibility determination officials were responsible for performing the initial screen; applications deemed potentially Medicaid-eligible were typically sent to the Medicaid office in the county where the applicant resided, while those deemed potentially SCHIP-eligible remained at the SCHIP office for final eligibility determination.

In the four states we visited, the proportion of joint applications transferred between the programs was substantial. For example, Michigan officials reported that one-half of the applications submitted to SCHIP were determined to be potentially Medicaid-eligible and were forwarded to Medicaid, and California SCHIP officials estimated that about 30 percent of the applications received by mail were eligible for Medicaid and thus required transfer. Applications could also flow in the opposite direction. For example, SCHIP application processing sites for Colorado and Michigan each reported that about 20 percent of their applications were transferred from county offices that determine Medicaid eligibility to the SCHIP processing location. Colorado officials estimated that, although average times were not available, such transfers could take anywhere from 2 weeks to 6 months.

[21]Across the 10 states we reviewed, the applications were sent to various locations. For example, states instructed applicants to mail their applications directly to health plans, to county-based Medicaid eligibility determination offices, to SCHIP, or gave them a choice of locations.

[22]In California, Colorado, and Michigan, families mailed joint applications to a single location within the state that was run by SCHIP workers. In New York, an applicant for SCHIP could mail in the application to the health plan he or she selected; applicants for Medicaid submitted their applications at the time of the required in-person interview.

Application transfers took less time if the program offices were geographically close or colocated. For example, Michigan established a state-operated Medicaid eligibility determination office in the same building as the SCHIP enrollment contractor responsible for processing joint applications. At this SCHIP processing center, joint applications that appeared Medicaid eligible were to be transferred immediately to this Medicaid office instead of being sent to various county Medicaid offices for eligibility determination.[23]

Different Application Requirements Increased the Risk of Incomplete Applications

When joint applications ask for different information for Medicaid and SCHIP, applications transferred between programs can be considered incomplete, which will delay processing until the needed information is supplied. For instance, if required Medicaid information, such as a Social Security number, is missing from a joint application, Medicaid processing can be delayed because the application is incomplete.[24] When applications were incomplete for these or other reasons, it increased the likelihood of follow-up and often prolonged the completion of the eligibility determination process. For example, community assistance workers in California told us that families who were required to supply additional information or documentation did not always return to complete the application process, and many applications were ultimately denied because they remained incomplete.[25] California officials noted that it is unknown whether these families were deterred by the requirements or they did not follow through because they believed they were not eligible for the program.

While incomplete information on applications resulted in some denials, states varied in the extent to which they could provide data on denials. For example, California and Colorado were able to provide data on SCHIP

[23]A Michigan State official noted that, despite this centralized processing of Medicaid applications, about 25 percent of applications that appeared Medicaid-eligible were still sent from the colocated Medicaid office to the county offices for processing. Under certain circumstances, the joint applications that appear Medicaid-eligible are sent to the Medicaid office in the county where the applicant lives. For example, when a family that is already receiving Medicaid or whose enrollment is under review in Medicaid submits a joint application for a child, the case will be flagged and sent to the county office.

[24]California allows applicants that appear Medicaid-eligible 60 days to submit their Social Security number.

[25]Some states denied coverage after a certain time period if the information was not provided.

denials that resulted from incomplete information. California indicated that 27 percent of applications received are denied; of these, almost half were denied because of incomplete information. In 2000, Colorado reported that 31 percent of all applications received were denied because they were incomplete. Beginning January 2001, however, the state changed its application, which an official told us reduced the percentage of denials due to incomplete applications to about 24 percent. In contrast, Michigan indicated that less than 3 percent of applications were denied for incomplete information. A Michigan official attributed this low denial rate to the state's policy to minimize the amount of required documentation for both Medicaid and SCHIP, which has reduced the number of applications that are incomplete and require follow-up.

Better Program Coordination Helped Avoid Delays

Officials gave us examples of poor coordination between the programs that resulted in delayed coverage or inconvenience to families. In California, application assistants reported that SCHIP coverage could be denied if the family had not been promptly taken off Medicaid's rolls after becoming ineligible. For example, when a Medicaid family's income rose enough to make the family ineligible for Medicaid but eligible for SCHIP, as long as the family was still recorded as enrolled in Medicaid, its SCHIP application would be denied. Other difficulties could occur if program eligibility information was not provided to the family. For example, some Colorado families that were denied Medicaid were not informed that their applications had been sent to SCHIP and only discovered they were eligible for SCHIP when they received a notice that SCHIP premiums were due.

Michigan has made efforts to improve coordination between the programs by avoiding repeated transfers of the same application that occurred when Medicaid and SCHIP eligibility workers disagreed on an applicant's eligibility. To address this, the state developed a policy in which Medicaid and SCHIP eligibility workers accept each other's calculations for purposes of determining program eligibility. To ensure that only eligible individuals are enrolled in the appropriate program, the state checks applications for calculation errors. If any problems consistently occur with workers from either program, the state conducts eligibility worker training to minimize the incidence of errors.

Limited Data Indicated Longer Medicaid Processing Times

Differences in the application requirements and processes could affect how long it took children to obtain coverage in the two programs. However, only SCHIP offices were able to provide information on application and eligibility determination processing times in all four states; for Medicaid in these states, comparable processing times were only available in Colorado and Michigan.[26] In these two states, Medicaid application and eligibility determination processing generally took longer than SCHIP. For example, Colorado reported statewide average processing times that were longer for Medicaid (38 days) than for SCHIP (14 days for a completed application and 30 days for those requiring follow-up). Michigan reported that average processing times were 19 days for Medicaid and 8 days for SCHIP.[27] While differences in processing times could be affected by poor coordination, other factors can contribute to Medicaid's longer average processing times. For example, the Medicaid eligible population includes adults and individuals with special needs in addition to children, which also can affect how quickly applications are processed.

[26]We did not include Medicaid processing times from California and New York because the data received were not comparable to SCHIP data. For example, in California, Los Angeles County provided an average processing time for Medicaid that included eligibility determinations for applicants with disabilities, while SCHIP reported an average processing time for joint applications only. Under Medicaid, states have 90 days to determine Medicaid eligibility for disability-related coverage. See 42 C.F.R. § 435.911(a)(1), (2). While New York actually provided a shorter average processing time for Medicaid eligibility determinations than for SCHIP, Medicaid's processing times did not include the time it took to complete the requirement for an in-person interview.

[27]The state's average Medicaid application processing time was shortened to fewer than 10 days for applications processed at the Medicaid office that was colocated with the SCHIP eligibility processing center.

States may allow families to receive covered services while applications are being processed by adopting a presumptive eligibility policy, an option available to states under both programs. Presumptive eligibility allows a child to receive coverage immediately while eligibility determination is in process. Nationally, however, few states have opted for presumptive eligibility in their Medicaid and SCHIP programs. As of July 2000,[28] five states had adopted and implemented presumptive eligibility in their Medicaid programs—Massachusetts, Nebraska, New Hampshire, New Jersey, and New Mexico, while three states—Massachusetts, New Jersey, and New York—had adopted and implemented presumptive eligibility for SCHIP. A Michigan official told us that although the state has allowed health plans to adopt presumptive eligibility, none of the plans had done so as of May 2001.

Differing Program Requirements Affected Families' Abilities to Maintain Coverage

Once enrolled, Medicaid and SCHIP families faced different requirements for maintaining coverage. SCHIP children were generally guaranteed a longer period of eligibility regardless of changes in income or family size, while Medicaid children could lose coverage sooner because of requirements to report such changes. Also, Medicaid enrollees faced a more complex redetermination process than SCHIP children did. In contrast, SCHIP children risked losing coverage for their families' failure to pay required premiums or enrollment fees, while Medicaid generally did not have such cost-sharing requirements.

[28]The Kaiser Commission on Medicaid and the Uninsured, *Making It Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures.*

The four states we visited generally required redetermination of eligibility after 12 months for both programs. To maintain coverage during the eligibility period, two states—Michigan and Colorado—required Medicaid families to report any significant changes, such as income or family status, and the families could lose coverage if changes made them ineligible.[29] In contrast, SCHIP families in these two states had "continuous eligibility," meaning they remained covered for the full 12 months regardless of changes in income or family status.[30] New York did the opposite: Medicaid families had continuous eligibility, while SCHIP families did not.

At the end of the coverage period, the programs redetermine enrollees' eligibility for coverage. Medicaid families in California, Michigan, and New York faced a more complex redetermination process than SCHIP families. For example, to begin Medicaid redetermination, Michigan mailed families a new Medicaid application, but it was a 10-page form, not the 4-page joint application. In contrast, the state's SCHIP beneficiaries were mailed a summary of the information on their last application and asked to update information that had changed. In New York, families completed redetermination forms for both Medicaid and SCHIP, but Medicaid again required an in-person interview. In contrast, Medicaid redetermination in Colorado may be less burdensome than SCHIP redetermination, depending on the information the state is able to collect before contacting the family. The state first searches other program files, such as Food Stamps and Temporary Assistance for Needy Families (TANF), to determine whether it already has the necessary application information. If the state does not find the information with this process, it sends families a redetermination form that essentially has the same information requirements as the joint application. For SCHIP redetermination, families must submit another joint application.

While Medicaid, under federal law, generally does not allow premiums or fees for children under age 18,[31] the SCHIP legislation permits states to

[29]In June 2001, California changed its Medicaid program to allow eligible children to remain covered for at least 1 year, regardless of changes in family circumstance, income, or resources.

[30]Continuous eligibility is available for children as a state option in both Medicaid and SCHIP. This option guarantees coverage for 12 months, or a designated eligibility period, regardless of changes in family income or composition. Without continuous eligibility, families are required to report any significant changes in income or household status.

[31]See 42 U.S.C. § 1396o.

require limited cost-sharing. SCHIP families in the four states we visited faced varying degrees of risk of losing coverage for failure to pay monthly premiums or annual enrollment fees. The percentage of children who lost SCHIP coverage because of their families' failure to pay premiums ranged from 0 percent in Colorado to 10 percent in Michigan. (See table 4.)

Table 4: Four States' Policies on Payment of SCHIP Premiums

State	Premium[a]	Maximum family premium	Is coverage lost upon failure to pay?	Time allowed for premium payment	Percentage of children who lost coverage[b]
California	$4-$9/child/month	$27/month	Yes	60 days	9
Colorado	$0-$25/child/year[c]	$35/year[c]	Yes	30 days[c]	0[d]
Michigan	$5/month	$5/month	Yes	30 days	10
New York	$0-$15/child/month	$45/month	Yes	30 days	4

[a]In some states, premiums can vary per child based on family income, household size, and, in one state, (California) by the health plan in which the child is enrolled.

[b]Loss-of-coverage data is expressed as a percentage of total enrollment. The data represented different time frames, depending on what the state was able to provide. The percentages represented 11 months of data in California, over 24 months in Colorado, 12 months in Michigan, and 3 months in New York.

[c]Data represent a new state policy instituted in spring 2001, when Colorado began charging SCHIP families an annual enrollment fee. Before this, the state had charged certain SCHIP families monthly premiums that ranged from $9 to $30, depending on a family's income and number of children.

[d]Data represent disenrollment activity under the former policy of monthly premiums. According to a state auditor's report, the state never put a policy in place to make collections on premiums, so no families lost coverage for failure to pay.

Source: State information.

Health Plan and Physician Participation, and Payment Differences Can Affect Access to Care

Differences in the plans and physicians that participate in Medicaid and SCHIP and in payments the programs make to these plans and physicians have implications for beneficiaries' choices and access to care. In the 10 states we reviewed, SCHIP often required enrollees to join a managed care plan and sometimes did not provide a choice of plans. In contrast, Medicaid beneficiaries had a choice of at least two capitated plans in locations offering managed care or could receive care on a FFS basis, including through PCCM.[32] However, having such choices did not necessarily mean greater access to providers. For example, FFS options do not necessarily provide greater access to physicians than managed care plans do, since physicians may choose to limit participation or not participate in Medicaid. Similarly, one program may have a number of smaller plans, while larger plans with more extensive provider networks may not participate in the program. Payment disparities between Medicaid and SCHIP also had the potential to affect access to care. In two states where comparable data were available, Medicaid FFS payments to physicians for children's preventive services were lower than the rates physicians were paid for the same services in SCHIP. We also compared Medicaid and SCHIP physician fees with those of Medicare and found Medicaid fees consistently lower in all four states, while our comparison of SCHIP and Medicare fees showed a less consistent relationship. Comparisons of capitation rates were difficult because of differences in the benefits included within these rates. In one state with comparable benefits covered by the capitation rate, SCHIP paid more than Medicaid. In the remaining three states, capitation rate comparisons were not feasible because of differences in the benefits or populations covered, or both.

[32]Capitated managed care plans are paid on a PMPM basis, while a PCCM pays primary care physicians a nominal fee to manage beneficiary care and makes FFS payments for services provided.

Medicaid Offered Families More Choice Between FFS and Managed Care Plans

In terms of the broad choices available—obtaining health care through FFS or enrollment in a managed care plan—families with children in Medicaid generally had more choice than SCHIP families. In the 10 states we reviewed, Medicaid generally offered families a choice of receiving services on a FFS basis;[33] selecting between a capitated managed care plan and FFS, including PCCM; or choosing from at least two capitated plans. Across the nine states with capitated managed care, enrollment of Medicaid beneficiaries in capitated plans ranged from 4 percent to 75 percent.[34] In contrast, virtually all children enrolled in SCHIP in 8 of the 10 states were enrolled in capitated managed care plans; the remaining two states offered only FFS care.[35] (See table 5.)

Table 5: Use of FFS and Capitated Plans in Medicaid and SCHIP in 10 States

	Option				Percentage of beneficiaries enrolled in capitated plans	
	FFS[a]		Capitated			
State	Medicaid	SCHIP	Medicaid	SCHIP	Medicaid[b]	SCHIP
Alabama	●[c]	●	○	○	0	0
California	◗	○	◗[d]	●	54	100
Colorado	◗	○	◗[d]	●	40	100[e]
Florida	●	○[e]	●	●	37	98[f]
Kansas	●	○	◗	●	26	100
Michigan	◗	○	●[d]	●	67	100
New York	◗	○	◗[d]	●	32	100
North Carolina	●	●	○[g]	○	4[g]	0
Pennsylvania	◗	○	◗[d]	●	70	100
Utah	◗	○	◗[d]	●	75	100

[33]To participate in Medicaid, providers must have a provider agreement with the state Medicaid agency; the availability of FFS providers is based on the number of agreements a state has in place, as well as how many of these providers are currently accepting patients.

[34]We did not include Alabama among these states because both Medicaid and SCHIP are FFS programs. We included North Carolina Medicaid—although its Medicaid and SCHIP programs are predominantly FFS—because the state does enroll Medicaid beneficiaries in one county in capitated plans.

[35]Capitated managed care plans refers to how states pay health plans in Medicaid and SCHIP, which is on a PMPM, capitated basis. Managed care plans participating in Medicaid or SCHIP may choose to pay their providers on a capitated or FFS basis.

Legend

● - Option is available for nearly all beneficiaries.

❍ - Option is rarely or not available to beneficiaries.

◗ - The extent to which option is available varies across the state.

Note: This table refers to the financial relationship between the state and participating plans or providers. Under FFS, the state pays providers directly for services delivered to eligible beneficiaries. Under capitation, the state pays managed care plans on a capitated PMPM basis, and the managed care plans are responsible for paying providers.

[a]FFS here includes PCCM programs and preferred provider organization (PPO) arrangements that are not capitated.

[b]With the exception of Colorado Medicaid, all Medicaid capitation percentages include adults as well as children.

[c]While Alabama's Medicaid is primarily FFS-based, inpatient hospital services are provided on a capitated basis. Since the focus of this study is on primary care, we classified this program as FFS.

[d]The state requires Medicaid beneficiaries in some geographic areas—but not others—to enroll in capitated plans.

[e]May include some beneficiaries whose physicians are paid on a FFS basis.

[f]A small portion of SCHIP children in this state—those under age 5—must use Medicaid plans and PCCM physicians.

[g]North Carolina Medicaid enrolls beneficiaries in one county in capitated plans.

Source: GAO analysis.

Medicaid beneficiaries' choices within a state depended on where they lived. The Medicaid programs in seven states—California, Colorado, Michigan, New York, North Carolina, Pennsylvania, and Utah—mandated that certain Medicaid beneficiaries enroll in capitated health plans,[36] but the extensiveness of mandatory enrollment within a state varied greatly. [37] In certain areas of these states, enrollment in a capitated Medicaid plan was mandatory for most children:

- in 22 of 58 counties in California,
- in urban areas of Colorado,
- in 73 of 83 counties in Michigan,
- in 16 of 57 counties in New York and in parts of New York City,
- in one county in North Carolina,

[36]Medicaid programs typically target certain beneficiary groups, such as families in TANF, for enrollment in mandatory managed care programs. Sometimes other groups, such as certain children with special health care needs, are exempted or excluded from mandatory enrollment in managed care.

[37]In Florida and Kansas, Medicaid programs required beneficiaries to enroll in managed care but included a PCCM option in most counties.

- in the Pittsburgh and Philadelphia areas of Pennsylvania,[38] and
- in 4 urban counties in Utah.

While enrollment was mandatory in these locations, Medicaid beneficiaries could still choose among two or more capitated plans. For example Medicaid beneficiaries could choose among 9 capitated plans in Wayne County, Michigan, and among 13 to16 plans in New York City, depending on the area in which they live.

SCHIP beneficiaries generally had less choice between managed care plans and FFS than Medicaid beneficiaries, and these choices also depended on where the beneficiaries lived. Four of the states we reviewed with capitated managed care plans in SCHIP—Colorado, Florida, New York, and Pennsylvania—had geographic regions in which the SCHIP program offered a single managed care plan and no FFS option. In addition, SCHIP children throughout Kansas were enrolled in the single available plan in their area and did not have a FFS option, while Medicaid children were enrolled in either a PCCM or a capitated plan. While SCHIP children did not always have a choice of FFS, this did not mean that choices were necessarily limited. For example, California SCHIP officials noted that in the five counties with the largest enrollment (over 60 percent of the SCHIP enrollment statewide), SCHIP beneficiaries have between 7 and 9 health plan choices. Similarly, in New York City, SCHIP beneficiaries have between 10 and 15 plan choices, depending on where they live.

Degree to Which Plans and Physicians Participated in Both Programs Varied Among States

The degree to which health plans and physicians participated in both Medicaid and SCHIP varied among the 10 states we reviewed. Several states, such as Colorado, Kansas, New York, and Utah, reported that generally the same health plans participated in both programs, but in Florida, Michigan, and Pennsylvania, there was limited overlap between the health plans participating in Medicaid and those participating in SCHIP. (See table 6.) This difference was especially pronounced in Michigan, where 80 percent of SCHIP beneficiaries were enrolled in a single capitated plan that did not participate in Medicaid and that contracted with over 95 percent of the physicians in the state. Michigan officials told us that in one quarter, 27 percent of children that reapplied for SCHIP were eligible for Medicaid; to the extent that these children were enrolled in the plan that

[38]Pennsylvania officials noted that Medicaid beneficiaries are required to enroll in mandatory managed care as soon as managed care plans become available in their area.

did not participate in Medicaid, the transfer to Medicaid would require that they select a new health plan.

Table 6: Health Plan Participation in Medicaid and SCHIP in 10 States

	Number of capitated managed care plans		
State	**Medicaid**	**SCHIP**	**Participation in both programs**
Alabama	[a]	[a]	[a]
California	27[b]	26	22
Colorado	5	6[c]	5
Florida	14	15	6
Kansas	1	2	1
Michigan	26	14	10
New York	29	31	29
North Carolina	3[a]	[a]	[a]
Pennsylvania	6	7	2
Utah	4	3	3

Note: The table above represents the number of capitated managed care plans that participate in a state, and does not reflect the choices available to beneficiaries in any particular location. Across these 10 states, the number of plans available to beneficiaries in a single area ranged from 1 plan for Medicaid and SCHIP in various states and counties to 13 to 16 plans for Medicaid and 10 to 15 for SCHIP in New York City, depending on the borough.

[a]The program is largely FFS for beneficiaries in this state.

[b]This number represents an unduplicated count of the capitated plans that participate in Medicaid. In California, the Medicaid managed care program known as the "two-plan model" limits 12 counties in the state to having two health plans per county participating in the Medicaid program. Within these 12 counties, however, the two health plans sometimes subcontract with additional managed care plans. For example, in Los Angeles County, 10 plans participate in Medicaid either directly or through subcontracts.

[c]This number does not include Colorado's state managed care network, where the state pays primary care providers on a capitated basis. However, we did not include this plan in the table because the state's insurance department does not recognize this entity as a health plan.

Source: State data.

When plans do not participate in both programs, continuity-of-care problems can arise as beneficiaries shift between programs because of changes in family income or children's ages. For example, because Medicaid eligibility changes with a child's age in all 10 of the states we reviewed, a child may have to move from Medicaid to SCHIP at certain ages even when family income remains constant. (See app. III.) Losing eligibility in one program and becoming eligible for the other can therefore mean joining a new plan and possibly seeing a new physician. In addition, a family with more than one child could have children enrolled in each program, so having the same providers in both programs would make obtaining health care easier for the family as a whole.[39]

To facilitate continuity of care, a few states reported taking action to ensure that plans and physicians participated in both Medicaid and SCHIP. For example, in 1998, New York began requiring that new plans participate in both programs and that existing plans serve both Medicaid and SCHIP in any new service areas. Similarly, Colorado required managed care plans contracting with SCHIP to be willing to contract with Medicaid, and it has allowed only one exception to this requirement. Colorado state officials reported that they also intend to request that health plans submit Medicaid and SCHIP physician networks for review so that the state can independently determine the degree of participation in both programs. The remaining six states we reviewed with Medicaid and SCHIP capitated programs did not require health plans to participate in both programs. However, officials in one of the six states—Kansas—said that in the future they intend to require plans' participation in both Medicaid and SCHIP.

Neither requiring health plan participation in both programs nor having FFS options can guarantee, however, that the two programs will have the same physicians, since physicians may choose not to participate in one or the other program or plans may establish different physician networks for each program.[40] Medicaid and SCHIP officials in the 10 states seldom were able to report whether physicians participated in both programs—and the

[39]For additional information on differences in provider networks and complexities for "split" families (that is, families with a child (or children) in each program), see *Implementation of the State Children's Health Insurance Program: Momentum Is Increasing After a Modest Start, First Annual Report* (Mathematica Policy Research Inc. for HCFA, Jan. 2001).

[40]Moreover, the level of physician participation in each program also can vary. For example, physicians may participate fully in Medicaid or SCHIP, accepting all patients that present themselves; participation could be less extensive if a physician limits the number of patients he or she accepts, or if the physician refuses to take new patients from either program.

extent of their participation. A few states-such as Michigan and New York noted that their state insurance departments were responsible for reviewing network adequacy. In most cases, however, states did not have the data needed to compare physician participation in both Medicaid and SCHIP, particularly where a significant portion of care was provided by capitated plans. Colorado officials noted that provider data systems in Medicaid and SCHIP were not comparable and that comparisons also would be difficult because provider participation changes frequently within and between networks.

Payment Rates Can Affect Physician Participation and, Ultimately, Access to Care

Payment rates—whether they are physician fees or capitation rates to health plans—can affect the degree to which physicians and health plans participate in Medicaid and SCHIP, and thereby affect beneficiaries' choices and access to care. The relative fees paid by different insurers—Medicare,[41] Medicaid, SCHIP, and private health plans—can also affect providers' willingness to participate.[42] Nationally, low Medicaid physician fees and physician participation have been long-standing areas of concern. In a recent national survey, pediatricians cited low fees as one of the most important factors in their decision to limit participation in Medicaid.[43] In three of the four states we visited—California, Colorado, and Michigan—the percentage of pediatricians accepting Medicaid patients was below the national average of 67 percent. Some plans and physicians have demonstrated their dissatisfaction with Medicaid's fees by taking legal action. In New York, for example, two provider groups recently initiated lawsuits that resulted in increases in Medicaid dental fees, and physician fees for office visits were increased from $7 to $30. In both cases, these were the first Medicaid fee increases in more than 30 years.

[41]Medicare is a federal health insurance program for elderly and disabled persons and persons with end-stage renal disease; about 4,000 children also are enrolled in the program. Private insurance companies have often based their payments to physicians on Medicare rates.

[42]Stephen Norton, *Recent Trends in Medicaid Physician Fees, 1993 –1998*, The Urban Institute, Assessing the New Federalism (Washington, D.C.: Sept. 1999), p. 1. Some evidence also exists to show that fees must increase to a certain level before participation is affected; see *Oral Health: Factors Contributing to Low Use of Dental Services by Low-Income Populations* (GAO/HEHS-00-149, Sept. 11, 2000).

[43]Yudkowsky, Tang, and Siston, American Academy of Pediatrics, Division of Health Policy Research, *Pediatric Participation in Medicaid/SCHIP: Survey of Fellows of the American Academy of Pediatrics, 2000* (Chicago, Ill.: American Academy of Pediatrics, n.d.).

Across the four states we visited, Medicaid fees were consistently lower than Medicare fees for the same preventive services for children, while SCHIP and Medicare fees had a less consistent relationship in the two states where comparable data were available.[44] Medicaid fees ranged from 29 percent to 61 percent of what Medicare would pay for selected preventive medical services for children. SCHIP fees as a percentage of Medicare fees varied, with two large health plans in California paying 44 to 72 percent of what Medicare would pay and one large health plan in Michigan paying 103 to 124 percent of what Medicare would pay.[45] (See table 7.)

Table 7: Medicaid and SCHIP Physician Fees as a Percentage of Medicare Fees for Selected Preventive Medical Services for Children in Four States

	Physician fees as a percentage of Medicare fees	
State	**Medicaid[a]**	**SCHIP[b]**
California	42 – 55	44 – 72
Colorado	42 – 58	[c]
Michigan	56 – 61	103 – 124
New York	29 – 39	[c]

Note: The range of Medicaid, SCHIP, and Medicare FFS ratios are based on fees paid for seven preventive medical services for children, by age group. These services are listed in app. I, table 10.

[a]We obtained Medicare fees for preventive medical services for children for calendar year 2000 and, where there was geographical variation, we used the lowest payment for Medicare in the state. Within a state, Medicaid fees did not vary by geographic location.

[b]SCHIP fee comparisons are based on what two health plans in California enrolling about 40 percent of the SCHIP children statewide and one large plan in Michigan enrolling about 80 percent of SCHIP children paid their physicians on a FFS basis.

[c]We were unable to make FFS comparisons in Colorado and New York. In Colorado, the state paid fewer than 1 percent of physicians for SCHIP beneficiaries on a FFS basis, and the plan we visited did

[44]We were unable to make FFS comparisons for Colorado's or New York's SCHIP programs. Colorado had a small percentage of providers—less than 1 percent—who provided services to SCHIP beneficiaries on a FFS basis. In New York, SCHIP was entirely a capitated program. Among the three plans we visited in New York, only one paid its providers on a FFS basis. Since this plan enrolled only 4 percent of all SCHIP children in New York, we did not include these data in our analysis.

[45]Even though SCHIP programs in California and Michigan were 100 percent capitated managed care, we were able to compare fees in SCHIP because a large health plan in each state paid providers on a FFS basis. Two plans in California served approximately 40 percent of SCHIP beneficiaries in the state, while a plan in Michigan served approximately 80 percent of the SCHIP beneficiaries in the state.

not pay its physicians on a FFS basis. In New York, where SCHIP was entirely a capitated program, only one of the three plans we visited paid its providers on a FFS basis. This plan enrolled only 4 percent of all SCHIP children in New York.

Source: GAO analysis of FFS payments, March 2001.

In comparing Medicaid and SCHIP fees for the same children's preventive medical services, Medicaid fees in two states—California and Michigan—were consistently lower than what physicians were paid for the same services in SCHIP. Medicaid fees were 46 percent to 58 percent of what one dominant health plan in Michigan paid SCHIP physicians and 83 percent of what a large plan in California paid SCHIP physicians. (See table 8.)

Table 8: Medicaid Physician Fees as a Percentage of SCHIP Fees for Selected Preventive Medical Services in California and Michigan

	Medicaid physician fees as a percentage of SCHIP physician fees		
	California[a]		Michigan[b]
Preventive medical service category	Plan A	Plan B	
New patient, under 1 year	83	100	58
New patient, 1 – 4 years	83	100	52
New patient, 5 – 11 years	83	72	51
Established patient, under 1 year	83	92	52
Established patient, 1 – 4 years	83	83	47
Established patient, 5 – 11 years	83	88	47
Established patient, 12 – 17 years	83	92	46

[a]California SCHIP payments are based on what two large plans, enrolling about 40 percent of SCHIP children statewide, paid its FFS physicians.

[b]Michigan SCHIP payments are based on what a large plan, enrolling about 80 percent of SCHIP children statewide, paid its FFS physicians.

Source: State and health plan data.

Just as physician fees can affect physician participation, capitation rates can affect plan participation. Capitation rates can be difficult to compare, however, because the PMPM rates do not always encompass the same benefits. In Michigan, Medicaid capitation rates were lower than SCHIP rates by $26 PMPM, even though the two programs contracted for essentially the same services.[46] In California, differences in benefits and in the populations included in the rates complicated rate comparisons. Medicaid's capitation rate included both adults and children, while SCHIP's rate was limited to children. In the remaining two states, the benefits were not comparable between the two programs, which precluded any conclusions regarding the comparability of capitation rates. (See table 9.)

Table 9: Age-Adjusted Capitation Rates Paid to Health Plans for Children in Medicaid and SCHIP in Four States

State	Medicaid rate[a] (PMPM)	SCHIP rate (PMPM)	Key benefits excluded from capitation rates[b]
California	$95[c]	$80	**Medicaid:** • selected psychiatric and AIDS prescription drugs • mental health benefits • substance abuse treatment
Colorado	$54[d]	$70	**Medicaid:** • most mental health benefits **SCHIP:** • dental benefits
Michigan	$47	$73	**Medicaid:** • mental health benefits • substance abuse treatment • dental benefits **SCHIP:** • mental health benefits • substance abuse treatment • dental benefits
New York	$90[e]	$110	**Medicaid:**[f] • prescription drugs • newborn inpatient hospital costs **SCHIP:** • newborn costs (program starts at 1 mo.)

[46]Responding to concerns regarding Medicaid rates, Michigan's state legislature increased the capitation rates in the fall of 2000. These rate increases are included within our rate analysis.

Note: Medicaid and SCHIP capitation rates are comparable only in Michigan; in the remaining three states, direct comparisons are not feasible because of differences in benefits and populations covered in the capitation rate. Appendix I describes the methods used to develop weighted average capitation rates based on the age distribution of enrollees in each state.

[a]Medicaid rates exclude rates for enrollees receiving Supplemental Security Income (SSI) to achieve a closer match in the health status of Medicaid and SCHIP enrollees for comparison purposes.

[b]Where Medicaid excludes benefits from its capitation rate, such benefits are provided either on a FFS basis or through a separate capitated arrangement. EPSDT benefits are covered under Medicaid but not typically under SCHIP.

[c]The California Medicaid capitation rate is not for children only; it is a family rate that adults, primarily parents who are also eligible for Medicaid under the Temporary Assistance to Needy Families (TANF) program.

[d]These rates are for children up to age 18 in Colorado Medicaid's Baby Care Kids Care, foster care, and Aid to Families With Dependent Children (AFDC) categories. Maternity care was not included in the Medicaid rate; however, a SCHIP official said that very few enrollees in the SCHIP program required maternity benefits.

[e]We excluded a one-time inpatient hospital payment for newborns from the Medicaid weighted average PMPM rate to make it more comparable with New York SCHIP, which does not cover children under 1 month old.

[f]Rates for New York Medicaid include plans' optional benefits, which are dental, emergency transportation, nonemergency transportation, and family planning.

Source: GAO analysis of state data.

Concluding Observations

Although states have a significant amount of flexibility to design their Medicaid and SCHIP programs, differences in enrollment policies have a bearing on how easily children gain and retain access to health care. Differing application requirements and processing times can lead to delayed coverage—and in some cases, to no coverage—if families find the application process too difficult to complete. Well-coordinated programs, however, can minimize the effect of such differences and facilitate enrollment and continuity of care for children.

Differences in provider participation and in the relative payment rates also have implications for children's access to health care. Few states, however, could assess the degree to which the same physicians were available to both Medicaid and SCHIP children. Since physicians decide whether to participate in Medicaid and SCHIP partly on the basis of the payment rates, lower Medicaid payments relative to other payers continue to be a source of concern, although some states have recently increased Medicaid provider payments. While comparing payment rates in a managed care environment is often complicated by differences in covered benefits, differential rates between the two programs can affect plans' and physicians' willingness to participate and, in turn, beneficiaries' access to care.

Agency and State Comments

We provided the Secretary of Health and Human Services an opportunity to comment on a draft of this report. In its comments, HHS generally agreed with our concluding observations that differences in enrollment policies, provider participation, and relative payment rates in Medicaid and SCHIP can have implications for program enrollment as well as access to care. HHS expressed uncertainty, however, about the degree to which our concluding observations provide a national assessment of enrollment and payment policies. The report notes throughout that our findings on enrollment policies and provider participation were based on the experience of 10 states and that our comparisons of payment rates were limited to 4 states. Our intent was not to generalize nationwide, but to illustrate how selected states are addressing challenges that other states might also face in administering their Medicaid and SCHIP programs.

HHS noted that the influence of relative reimbursement levels on physician and dentist participation in the Medicaid program is an important policy consideration. It expressed concern, however, about comparing Medicare physician fees to Medicaid fees for selected pediatric preventive medical services because of differences in the populations eligible for these programs. We made this comparison for several reasons. First, while Medicare is a federal health insurance program primarily for the elderly and persons with disabilities, its fee schedule includes fees for pediatric medical services. Second, both public and private health care insurers often base their payments to physicians on the Medicare fee schedule. For example, in California, Medicare payment levels were used as a benchmark for revisions to the Medicaid fee schedule in August 2000.[47] Finally, research on Medicaid payment frequently considers Medicare fee

[47]In addition, almost half of the Medicaid programs across the country have adopted Medicare's methodology as a benchmark for establishing physician FFS payments. See Sandra Hunt et al, *Applying RBRVS to Medi-Cal*; *Case Studies in Seven States*, PricewaterhouseCoopers (Oakland, Calif.: Medi-Cal Policy Institute, June 2001), pp. 2 and 42.

schedules as a point of comparison for Medicaid rates.[48] While HHS also suggested that a comparative analysis of payment data from commercial plans would be helpful, such an analysis was beyond the scope of this review.

Finally, HHS commented that findings from the American Academy of Pediatrics on physician participation and payments—noted in this report—might warrant further investigation by GAO. We agree that additional analysis of children's access to care and payments to physicians in both Medicaid and SCHIP is warranted, and are continuing to address these issues in other work.

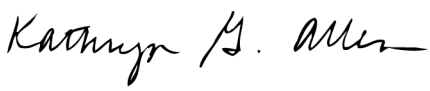
We also provided a copy of our draft report to Medicaid and SCHIP officials in the 10 states included in our analysis. We received comments from the Medicaid and SCHIP programs in California, Colorado, Kansas, Michigan, and Pennsylvania. We also received comments from the Medicaid program in Alabama, and the SCHIP programs in North Carolina and New York. Several states, including Michigan, and Pennsylvania, commented that differences in health plan participation in their Medicaid and SCHIP programs did not necessarily mean that the same physicians do not participate in both programs. We agree that physician participation can be similar even when health plans differ; however, states generally could not provide documentation of the extent of physician participation in both programs. California and Colorado also commented on the difficulty of making capitated payment comparisons between the two programs. We agree that it is difficult to compare Medicaid and SCHIP capitated rates, particularly when program benefits or populations differ. As a result, we noted benefit and population differences throughout the report and did not draw conclusions about comparative payment rates where such differences existed.

[48]See Joel Menges, and others, *Comparing Physician and Dentist Fees Among Medicaid Programs*, The Lewin Group (Oakland, Calif.: Medi-Cal Policy Institute, June 2001); Sandra Hunt, and others, *Comparing CPT Code Payments for Medi-Cal and Other California Payers*, PricewaterhouseCoopers (Oakland, Calif.: Medi-Cal Policy Institute, June 2001); Stephen Norton and Stephen Zuckerman, "Trends in Medicaid Physician Fees, 1993-1998", *Health Affairs*, (Vol. 19, No. 4, July/August 2000); Stephen Norton, *Recent Trends in Medicaid Physician Fees, 1993-1998*, The Urban Institute, Assessing the New Federalism (Washington, D.C.: Sept. 1999). In addition, the American Academy of Pediatrics includes questions about Medicare fees in relation to Medicaid fees in its survey of pediatricians' Medicaid reimbursement rates for 2000.

HHS and the states also provided technical and clarifying comments, which we incorporated where appropriate. (HHS' comments are included in app. IV.)

As arranged with your office, unless you release its contents earlier, we plan no further distribution of this report until 30 days after its issuance date. At that time, we will send copies of this report to the Secretary of Health and Human Services, the Administrators of CMS and HRSA, and other interested parties. We will make copies available to others upon request. If you or your staff have any questions regarding this report, please contact me on (202) 512-7114 or Carolyn Yocom at (202) 512-4931. Key contributors to this report are listed in app. V.

Sincerely yours,



Kathryn G. Allen
Director, Health Care—Medicaid and
Private Health Insurance Issues

Objectives, Scope, and Methodology

The objectives of this report were to analyze, for Medicaid and SCHIP in selected states, differences in (1) enrollment requirements, particularly application and eligibility determination practices, and (2) health plan and physician participation and payments to plans and physicians. With regard to both objectives, we were also asked to consider whether differences between Medicaid and SCHIP might have implications for children's access to care.

To do this, we conducted telephone interviews of Medicaid and SCHIP state, county, and private sector officials responsible for Medicaid and SCHIP administration in 10 states. We visited four states, and we analyzed data from states' programs as well as federal Medicaid and SCHIP program reports and documents. Because states' Medicaid programs varied considerably, data collected from states did not always represent the same time frames. We asked states to provide their latest available data, which ranged from 1999 to the summer of 2001. In addition, we reviewed published studies and reports on application and eligibility determination practices, plan and physician participation, and provider payment issues in Medicaid and SCHIP. We also relied on information from our previous work.[1]

To analyze the extent of programmatic differences for the two reporting objectives, we selected 10 states that had SCHIP programs with separate child health programs. These states were Alabama, California, Colorado, Florida, Kansas, Michigan, New York, North Carolina, Pennsylvania, and Utah. With one exception, these were the same states included in our previous Medicaid and SCHIP comparison report.[2] In selecting these states, we considered attributes of SCHIP separate child health programs, such as administrative structure and the method of providing services (fee-for-service (FFS) or managed care) compared to Medicaid programs in each state. We also selected states whose SCHIP programs had been in operation since January 1999 and represented a range of geographic locations. We made site visits to four of these states (California, Colorado, Michigan, and New York) to probe certain issues more deeply and obtain the multiple perspectives needed. We selected these four states primarily because of their geographic distribution, the varying sizes of their Medicaid

[1]See *Medicaid and SCHIP: Comparisons of Outreach, Enrollment Practices, and Benefits* (GAO/HEHS-00-86, Apr. 14, 2000).

[2]We substituted Michigan for Arkansas because the latter did not have a separate SCHIP program.

and SCHIP enrollments, and their different program administration structures. For example, the Medicaid program in California operates at the county level, while SCHIP operates statewide; in contrast, Michigan operates both Medicaid and SCHIP out of the same state agency.

During the four site visits, we interviewed representatives of programs—including state, county, and private sector officials—as well as a wide range of groups, including

- state Medicaid and SCHIP directors and their staffs;
- managed care plan officials;
- local organizations responsible for assisting families with applications;
- contractors and other staff responsible for determining eligibility and for enrolling children in Medicaid and SCHIP;
- physician organizations, such as local chapter officials of the American Academy of Pediatrics; and
- child health advocacy organizations.

We also obtained documentation and data from states on application and eligibility determination, plan participation, and plan and physician payments.

To compare application requirements and eligibility determination practices under Medicaid and SCHIP, we analyzed application requirements from the 10 states. Our site visits to four states allowed us to obtain a more in-depth understanding of how Medicaid and SCHIP programs at the state level determined whether applicants were eligible; how the two programs referred ineligible applicants; and how both programs enrolled beneficiaries into managed care plans, where pertinent. In each state we visited, we obtained data and conducted interviews with state, plan, physician, and community groups on Medicaid and SCHIP procedures and requirements, time frames, and coordination efforts.

To obtain information about health plan arrangements and provider participation in the two programs, we conducted semistructured telephone interviews with Medicaid and SCHIP directors or their key staff in the 10 states. These interviews allowed us to capture variations between Medicaid and SCHIP both within and across states. In the four states we visited, we also obtained more extensive information about the degree of beneficiary choice of health plans and physicians in each program, in urban and rural areas and under Medicaid managed care programs. In addition,

we obtained data on the number of plans, degree of plan participation in each program, enrollment by plan, and provider overlap.

Finally, we collected and analyzed information and data on Medicaid and SCHIP payments to managed care plans and FFS providers in the four states we visited. In analyzing payments, we focused on making comparisons within a state regarding Medicaid and SCHIP (1) FFS payments to physicians for services for Medicaid and SCHIP beneficiaries and (2) capitation rates to plans. Plans are paid a fixed amount per member per month (PMPM), regardless of the services provided, while under FFS, physicians are paid a specific amount for each service.

We performed our work from June 2000 through July 2001 in accordance with generally accepted government auditing standards.

Methodology for Comparison of FFS Payment Rates

Since many Medicaid beneficiaries are in a FFS arrangement, we compared Medicaid payments with SCHIP payments for the same preventive services for children. While SCHIP programs do not typically use FFS arrangements, we identified three dominant health plans, two in California and one in Michigan, that served significant numbers of SCHIP beneficiaries and that paid their providers on a FFS basis.[3] We compared Medicaid payments in California and Michigan with the payments that each of these SCHIP plans paid their providers.

[3]We did not make FFS comparisons between Medicaid and SCHIP in Colorado or New York. Colorado has a small percentage of providers—about 1 percent—who provide services to SCHIP beneficiaries in rural areas and are paid on a FFS basis by the state. In New York, SCHIP was entirely a capitated program and the state did not develop FFS rates. Among the three plans we visited in New York, one paid its providers on a FFS basis. Since this plan enrolled only 4 percent of all SCHIP children in New York, we did not include these data in our analysis.

We obtained fee schedules for pediatric medical services using selected codes from the most commonly used procedural coding system in states reporting Medicaid EPSDT services—the standard Physicians Current Procedural Terminology, 4th edition (CPT 4). (See table 10.) These CPT 4 codes were the most commonly used procedural codes for reporting Medicaid's EPSDT services under capitated managed care programs and the second most commonly used codes for reporting these services under FFS.[4]

Table 10: Selected CPT 4 Codes for Preventive Medical Services for Children

CPT 4 codes	Description
99381	New patient, under 1 year
99382	New patient, 1 to 4 years
99383	New patient, 5 to 11 years
99391	Established patient, under 1 year
99392	Established patient, 1 to 4 years
99393	Established patient, 5 to 11 years
99394	Established patient, 12 to 17 years

Source: Current Procedural Terminology, American Medical Association, 4th edition 1999.

Methodology For Comparison of Capitation Rates

Managed care plans often receive different capitation rates for each risk group or category of eligible populations. For example, plans may be paid separate rates for infants and teenagers, or for Supplemental Security Income (SSI) program beneficiaries in Medicaid, who are often more costly to serve because of their complex health needs. The distribution of such population groups and the benefits offered also can differ between Medicaid and SCHIP. Because of this, comparing programs' capitation rates to health plans required analyzing any existing differences between Medicaid and SCHIP rates based on a program's enrollment by age, risk groups, and benefits; where possible, we made adjustments to address the differences we identified.

[4]Elicia J. Herz *Medicaid Services for Children: State Programs Under Early and Periodic Screening, Diagnostic and Treatment (EPSDT)*, Congressional Research Service (Washington, D.C.: Library of Congress, Feb. 11, 1999), p. 21.

In general, to compare capitation rates, we first excluded SSI children from Medicaid's enrollment figures and calculated or obtained weighted average capitation rates for non-SSI children to make the Medicaid rates more comparable to SCHIP.[5] While this approach made the Medicaid and SCHIP populations more similar, the number of beneficiaries in each age group varied by program. To adjust for these differences, we used the SCHIP program's enrollment distribution by age in each state and applied weighted average Medicaid capitation rates, thus calculating a population-adjusted PMPM Medicaid rate that was more comparable to SCHIP. By age-adjusting the two populations, we arrived at more comparable price-to-price evaluations of Medicaid and SCHIP capitation rates.

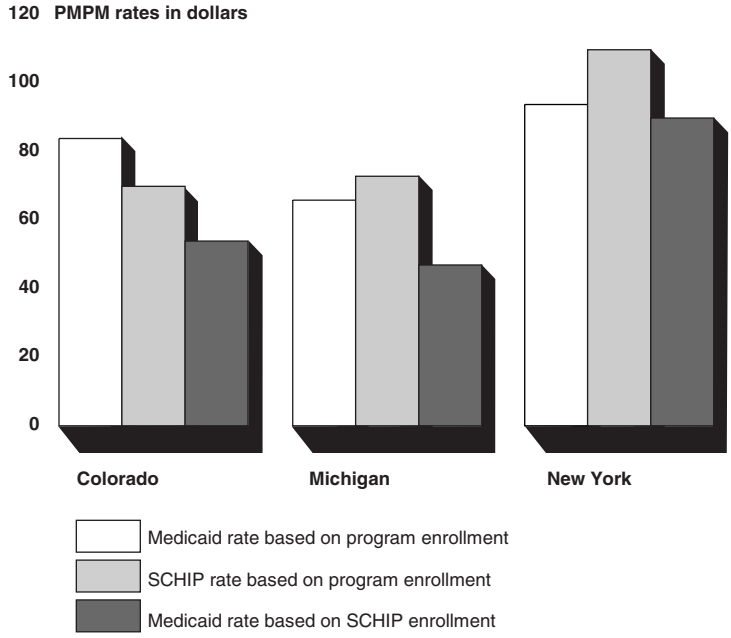
For example, in Colorado, infants (aged 0 to 1) made up 8,236 (15 percent), of all children in Medicaid, while infants composed 633, or 3 percent, of all children in SCHIP. Capitation rates differ by age groupings—with infant rates higher than rates for older children under both programs. For example, the weighted average Medicaid rate for infants in Colorado was $300 PMPM, while the weighted average rate for ages 1 to 18 was $47 PMPM.[6] Given these differences, the weighted average monthly capitation rate for a program enrolling many infants—such as Medicaid—reflects the higher costs of these beneficiaries. This rate is not comparable to the weighted average rate for a program with fewer infants. To adjust for these differences in populations, we used SCHIP's enrollment distribution by age in Colorado and applied Colorado's Medicaid rates to the SCHIP enrollment distribution in order to calculate a population-adjusted PMPM rate. This gave us comparable price-to-price evaluations of Medicaid and SCHIP capitation rates in Colorado of $54 PMPM in Medicaid and $70 PMPM in SCHIP. We also obtained or calculated price-to-price evaluations of

[5]Because SSI eligibility is frequently a criterion for Medicaid eligibility, children with severe disabilities are disproportionately represented within the Medicaid enrollment numbers for children. In addition, Medicaid covers many services that SSI-eligible children would likely use that are not represented in SCHIP benefit packages. Thus, including SSI children would overstate per-child Medicaid expenditures for purposes of comparisons with SCHIP.

[6]These rates are for children up to age 18 in Colorado Medicaid's Baby Care Kids Care, foster care, and Aid to Families With Dependent Children (AFDC).

Medicaid and SCHIP capitation rates for children in Michigan and New York.[7] (Figure 2 shows the original capitation rate for Medicaid and SCHIP, as well as the population-adjusted rate for Medicaid.)

Figure 2: Weighted Average Monthly Capitation Rates in Three States, Adjusted for SCHIP Enrollment Populations



Source: GAO analysis of state data.

[7]We excluded a one-time inpatient hospital payment for newborns in the Medicaid weighted average PMPM rate to make it more comparable with New York SCHIP, which does not cover children under 1 month old.

In California, the Medicaid program developed its capitation rates by eligibility groupings, not by age ranges, and so it could not provide rates for children by age.[8] For our capitation rate comparison, we selected a "family" population grouping that best represented families with children because it included a Medicaid category of eligibility that is based on enrollment in the Temporary Assistance to Needy Families (TANF) program.[9] Within this family rate category, capitation rates were the same, regardless of the age of the child or adult. As a result, creating comparable populations between Medicaid and SCHIP was not possible.[10] The California capitation rates cited represent the weighted averages for Medicaid beneficiaries and for SCHIP beneficiaries in 12 counties that enrolled the majority of Medicaid- and SCHIP-eligible individuals in capitated care.

[8]In contrast, California SCHIP developed different rates for children under 1-year-old ($187.15 PMPM) and for children 1 year and older ($78.66 PMPM).

[9]TANF is a federal grant program operated by states that provides cash assistance and other services to needy families.

[10]California officials noted that the state's Medicaid PMPM capitation rate included both adults and children, thus complicating comparisons with SCHIP's capitation rate, which was limited to children. As a result, we noted population and benefit differences throughout the report and did not draw conclusions where such differences existed.

States' Design Choices Under SCHIP

States are allowed three options in designing SCHIP: expand their Medicaid program, develop a separate child health program that functions independently of the Medicaid program, or combine both approaches. (See table 11.) As of June 2001, 35 states have separate programs or combination programs separate from Medicaid. Fifteen states and the District of Columbia have chosen to create Medicaid expansion programs under SCHIP, 16 states have separate child health programs, and 19 states have programs that combine Medicaid expansion and separate child health programs.

Table 11: States' and the District of Columbia's Choices for SCHIP Programs, as of June 2001

State	Medicaid expansion	Separate program	Combination
Alabama			•
Alaska	•		
Arizona		•	
Arkansas	•		
California			•
Colorado		•	
Connecticut			•
Delaware		•	
District of Columbia	•		
Florida			•
Georgia		•	
Hawaii	•		
Idaho	•		
Illinois			•
Indiana			•
Iowa			•
Kansas		•	
Kentucky			•
Louisiana	•		
Maine			•
Maryland			•
Massachusetts			•
Michigan			•
Minnesota	•		

(Continued From Previous Page)

State	Medicaid expansion	Separate program	Combination
Mississippi			•
Missouri	•		
Montana		•	
Nebraska	•		
Nevada		•	
New Hampshire			•
New Jersey			•
New Mexico	•		
New York			•
North Carolina		•	
North Dakota			•
Ohio	•		
Oklahoma	•		
Oregon		•	
Pennsylvania		•	
Rhode Island	•		
South Carolina	•		
South Dakota			•
Tennessee	•		
Texas			•
Utah		•	
Vermont		•	
Virginia		•	
Washington		•	
West Virginia		•	
Wisconsin	•		
Wyoming		•	
Total	**16**	**16**	**19**

Source: HCFA data.

State Income Eligibility Levels in Medicaid and SCHIP

Because Medicaid and SCHIP income eligibility levels vary by age, children in the same family can qualify for different programs. (See table 12.) Using a family with two children, aged 2 and 7, and an income at 125 percent of the federal poverty level provides an example of how family eligibility can be split between Medicaid and SCHIP. In 21 of the 35 states with separate child health programs, the 2-year-old would be eligible for Medicaid, while the 7-year-old would be eligible for SCHIP.[1] Assuming that the family's income remains at 125 percent of the poverty level, these children would be split between Medicaid and SCHIP for 4 years, until the 2-year-old turned 6 and thus qualified for SCHIP, not Medicaid. Six states have consistent eligibility levels for all ages: four states—Connecticut, Indiana, Maryland, and South Dakota—used SCHIP Medicaid expansions, while two states—Vermont and Washington—already had eligibility levels that were consistent for all children. The remaining eight states have consistent levels for all ages with the exception of infants, which are typically covered at a higher level in Medicaid.

Table 12: Eligibility Standards by Age and Program in States With SCHIP Separate Child Health Programs

		Income as a percentage of federal poverty level, by age[a]			
State	**Program**	**<1**	**1-5**	**6-16**	**17-18**
Alabama					
	Separate SCHIP program	200	200	200	200
	SCHIP Medicaid expansion	[b]	[b]	[b]	100
	Medicaid	133	133	100	15
Arizona					
	Separate SCHIP program	200	200	200	200
	Medicaid	140	133	100	30
California					
	Separate SCHIP program	250	250	250	250
	SCHIP Medicaid expansion	[b]	[b]	[b]	100
	Medicaid	200	133	100	82

[1]The 21 states are Alabama, Arizona, California, Colorado, Delaware, Florida, Georgia, Kansas, Mississippi, Montana, Nevada, New York, North Carolina, North Dakota, Oregon, Pennsylvania, Texas, Utah, Virginia, West Virginia, and Wyoming.

(Continued From Previous Page)

		Income as a percentage of federal poverty level, by age[a]			
State	**Program**	**<1**	**1-5**	**6-16**	**17-18**
Colorado					
	Separate SCHIP program	185	185	185	185
	Medicaid	133	133	100	37
Connecticut					
	Separate SCHIP program	300	300	300	300
	SCHIP Medicaid expansion	[b]	[b]	[b]	185
	Medicaid	185	185	185	100
Delaware					
	Separate SCHIP program	200	200	200	200
	Medicaid	185	133	100	100
Florida					
	Separate SCHIP program	[c]	200	200	200
	SCHIP Medicaid expansion	200	[b]	[b]	100
	Medicaid	185	133	100	28
Georgia					
	Separate SCHIP program	235	235	235	235
	Medicaid	185	133	100	100
Illinois					
	Separate SCHIP program	185	185	185	185
	SCHIP Medicaid expansion	200[d]	[b]	133	133
	Medicaid	133	133	100	46
Indiana					
	Separate SCHIP program	200	200	200	200
	SCHIP Medicaid expansion	[b]	150	150	150
	Medicaid	150	133	100	100
Iowa					
	Separate SCHIP program	[c]	200	200	200
	SCHIP Medicaid expansion	200	[b]	133	133
	Medicaid	185	133	100	37
Kansas					
	Separate SCHIP program	200	200	200	200
	Medicaid	150	133	100	100
Kentucky					
	Separate SCHIP program	200	200	200	200
	SCHIP Medicaid expansion	[b]	150	150	150
	Medicaid	185	133	100	33

(Continued From Previous Page)

State	Program	Income as a percentage of federal poverty level, by age[a] <1	1-5	6-16	17-18
Maine					
	Separate SCHIP program	200	200	200	200
	SCHIP Medicaid expansion	[b]	150	150	150
	Medicaid	185	133	125	125
Maryland					
	Separate SCHIP program	300[e]	300[e]	300[e]	300[e]
	SCHIP Medicaid expansion	200	200	200	200
	Medicaid	185	185	185	40
Massachusetts					
	Separate SCHIP program	[c]	200	200	200
	SCHIP Medicaid expansion	200	150	150	150
	Medicaid	185	133	114	86
Michigan					
	Separate SCHIP program	200	200	200	200
	SCHIP Medicaid expansion	[b]	[b]	[b]	150
	Medicaid	185	150	150	100
Mississippi					
	Separate SCHIP program	200	200	200	200
	SCHIP Medicaid expansion	[b]	[b]	[b]	100
	Medicaid	185	133	100	34
Montana					
	Separate SCHIP program	150	150	150	150
	Medicaid	133	133	100	41
Nevada					
	Separate SCHIP program	200	200	200	200
	Medicaid	133	133	100	31
New Hampshire					
	Separate SCHIP program	[c]	300	300	300
	SCHIP Medicaid expansion	300	[b]	[b]	[b]
	Medicaid	185	185	185	185
New Jersey					
	Separate SCHIP program	350	350	350	350
	SCHIP Medicaid expansion	[b]	133	133	133
	Medicaid	185	133	100	41

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		Income as a percentage of federal poverty level, by age[a]			
State	**Program**	**<1**	**1-5**	**6-16**	**17-18**
New York					
	Separate SCHIP program	250	250	250	250
	SCHIP Medicaid expansion	[b]	[b]	[b]	100
	Medicaid	200[f]	133	100	87
North Carolina					
	Separate SCHIP program	200	200	200	200
	Medicaid	185	133	100	100
North Dakota					
	Separate SCHIP program	140	140	140	140
	SCHIP Medicaid expansion	[b]	[b]	[b]	100[g]
	Medicaid	133	133	100	100[h]
Oregon					
	Separate SCHIP program	170	170	170	170
	Medicaid	133	133	100	100
Pennsylvania					
	Separate SCHIP program	235[i]	235[i]	235[i]	235[i]
	Medicaid	185	133	100	41
South Dakota					
	Separate SCHIP program	200	200	200	200
	SCHIP Medicaid expansion	140	140	140	140
	Medicaid	133	133	100	100
Texas					
	Separate SCHIP program	200	200	200	200
	SCHIP Medicaid expansion	[b]	[b]	[b]	100
	Medicaid	185	133	100	17
Utah					
	Separate SCHIP program	200	200	200	200
	Medicaid	133	133	100	100
Vermont					
	Separate SCHIP program	300	300	300	300
	Medicaid	225	225	225	225
Virginia					
	Separate SCHIP program	185	185	185	185
	Medicaid	133	133	100	100

(Continued From Previous Page)

State	Program	Income as a percentage of federal poverty level, by age[a] <1	1-5	6-16	17-18
Washington					
	Separate SCHIP program	250	250	250	250
	Medicaid	200	200	200	200
West Virginia					
	Separate SCHIP program	200	200	200	200
	Medicaid	150	133	100	100
Wyoming					
	Separate SCHIP program	[c]	[c]	133	133
	Medicaid	133	133	100	55

[a]Unless otherwise noted, Medicaid eligibility levels are reported as of March 31, 1997, while Medicaid expansion and SCHIP eligibility levels are reported as of October 1, 2000.

[b]State has no SCHIP Medicaid expansion category of eligibility for this age group.

[c]State has no SCHIP separate child health category of eligibility for this age group.

[d]Infants born to Medicaid-enrolled mothers are covered up to 200 percent; infants for whom application is made independent of their parents are covered up to 185 percent.

[e]Effective as of July 1, 2001.

[f]Increased from 185 to 200 percent as of November 1, 2000.

[g]Covers age 18 only.

[h]Covers ages 15 through 17.

[i]No federal matching funds are provided for children in families with incomes above 200 to 235 percent of the poverty level. Pennsylvania covers these children with state funds only.

Source: GAO summary of HCFA and state data.

Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

AUG 22 2001

Ms. Kathryn G. Allen
Director, Health Care--Medicaid and
Private Health Insurance Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Ms. Allen:

Enclosed are the Department's comments on your draft report, "Medicaid and SCHIP: States' Enrollment and Payment Policies Can Affect Children's Access to Care." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department also provided extensive technical comments directly to your staff.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely,

Michael Mangano

Michael F. Mangano
Principal Deputy
Inspector General

Enclosure

The Office of Inspector General (OIG) is transmitting the Department's response to this draft report in our capacity as the Department's designated focal point and coordinator for General Accounting Office reports. The OIG has not conducted an independent assessment of these comments and therefore expresses no opinion on them.

Comments of the Department of Health and Human Services on the General Accounting Office Draft Report, "*MEDICAID and SCHIP: States' Enrollment and Payment Policies Can Affect Children's Access to Care*," GAO-01-883

General Comments

Between January 22 and August 4, 2001, the Department's Centers for Medicare and Medicaid Services (CMS) approved 910 new and pending Medicaid and State Children's Health Insurance Program (SCHIP) State plan amendments and waivers. Collectively, these changes have made more than 800,000 additional people eligible for health care coverage across the Nation. In addition, these changes increased benefits for 2.5 million people already covered through Medicaid and SCHIP.

States have significantly improved their programs: 13 States have simplified eligibility, and 34 States are implementing innovative delivery systems. The Health Insurance Flexibility and Accountability Initiative is the most recent step the Department has taken to make it faster and easier for States to expand health insurance coverage to those in need.

While we generally agree with the General Accounting Office's (GAO) concluding observations, it is uncertain that the observations provide an accurate national assessment of enrollment and payment policies that affect access to care in Medicaid and SCHIP.

We are concerned with the limited sample size that was used to compile GAO's report and with the comparison of the Medicare and Medicaid fees for the same preventive services. The GAO analysis states that Medicaid fees are "consistently lower" relative to "...Medicare fees for the same preventive services...." Although the physician current procedural technology codes for this fee-for-service reimbursement comparison are shown in Appendix I, the Medicare and Medicaid programs are serving different populations. Generally when Medicare services are described, people think of services provided to elderly and disabled adults. We suggest that GAO elaborate on their methodology describing how they compare Medicare payment rates to Medicaid payment rates for children. Otherwise, the reader may be confused by the comparison of fee-for-service payment rates between the two programs. It would be helpful if GAO could comment on the availability of data from private commercial plans that could facilitate a more comparable assessment of similar populations.

The report notes that "Payment rates--whether they are physician fees or capitation rates to health plans--can affect the degree to which physicians and health plans participate in Medicaid and SCHIP, and thereby affect beneficiaries' choices and access to care." The influence of relative reimbursement levels on physician and dentist participation in the Medicaid program is an important policy consideration. Furthermore, findings from the American Academy of Pediatrics on this issue may warrant further investigation by GAO.

GAO Contact and Staff Acknowledgments

GAO Contact

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Staff Acknowledgments

Key contributors to this analysis were Joy L. Kraybill, JoAnn Martinez-Shriver, and Deborah A. Signer. In addition, Yorick F. Uzes contributed to the initial design and data collection, Behn Miller provided legal analysis, and Elizabeth T. Morrison assisted in writing the report.

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