

REPORT

An Implementation Analysis of States' Experiences in Transitioning "Stairstep" Children from Separate CHIP to Medicaid

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I. INTRODUCTION AND KEY FINDINGS

Since 1997, the Children’s Health Insurance Program (CHIP) has provided vital coverage to families that earn too much money to qualify for Medicaid but cannot afford private insurance. CHIP has successfully increased access to care, relieved the financial burden that health care imposes on families, and reduced the number of uninsured children (Harrington and Kenney et al. 2014; Coyer and Kenney 2013; Rosenbach et al. 2007; Wooldridge et al. 2005). CHIP’s future is currently in doubt, as funding for the program is set to expire in September 2017.¹ If funding expires or the program is not reauthorized, states may seek to enact major policy changes to fill the potential coverage gaps for affected families and children, potentially transitioning them to an expanded Medicaid program, creating state-level children’s health programs to cover affected children, or encouraging eligible families to purchase subsidized coverage through the health insurance marketplaces.

To understand states’ experiences in implementing coverage transitions for children, including efforts to make transitions as seamless as possible and to ensure continuity of care, the Medicaid and CHIP Payment and Access Commission (MACPAC) contracted with Mathematica Policy Research to study a specific feature of the Affordable Care Act: the stairstep transition. The ACA required Medicaid to cover all children with incomes up to 138 percent of the federal poverty level (FPL) as of January 2014. Whereas all states were previously required to cover children under age 6 in families with incomes up to 138 percent of FPL and children ages 6 to 18 up to 100 percent of FPL through Medicaid, children ages 6 to 18 with family incomes between 100 and 138 percent of FPL were permitted to be covered through separate CHIP. At the time the ACA was enacted, 21 states covered these so-called stairstep children through separate CHIP and thus needed to transition them to Medicaid in order to comply with the ACA requirement.² Even though the policy change was intended to benefit families—who could now have all of their children enrolled in a single coverage program, receive more comprehensive benefits, and pay less for their children’s care—such a transition raises concerns about continuity of coverage and access for children transitioning, along with concerns about potential confusion for parents and providers.

In this report, we describe 10 states’ approaches to the transition, identifying common challenges and lessons learned that could support future transitions between health coverage programs. Findings are based on interviews with state administrators and other stakeholders, including child health advocates, insurance issuers, and provider groups, within each of the 10 study states. In addition to this implementation assessment, we are conducting a quantitative

¹ Even without new federal funding for CHIP, however, the Affordable Care Act (ACA) imposes maintenance-of-effort (MOE) requirements through September 30, 2019, that require states to maintain children’s income eligibility levels for CHIP as a condition of continuing to receive federal Medicaid payments. MOE requirements will affect Medicaid expansion and separate CHIP programs differently. If federal CHIP funding is exhausted, Medicaid expansion CHIP programs must continue to provide coverage but at the regular Medicaid matching rate. Separate CHIP programs have more flexibility and may (1) impose waiting lists or enrollment caps to limit CHIP expenditures and (2) begin enrolling CHIP-eligible children in the health insurance marketplace when the state’s federal CHIP allotment is exhausted (Mitchell and Baumrucker 2015).

² After the stairstep transition, states continue to receive CHIP’s enhanced Federal Medical Assistance Percentage (FMAP) for these children.

outcomes analysis in which we will assess rigorously how the transition from separate CHIP to Medicaid affected children's access to and use of health care in Colorado and New York.³ Key findings on six research topics include the following:

1. **Planning and operations.** Medicaid and CHIP administrators in most of the study states began planning at least six months before the transition and involved agency staff, health insurance issuers, child health advocates, and provider groups in the planning discussions. Six states transitioned all stairstep children by using a “mass transition” approach (transitioning all children at one time through an administrative function), and four implemented the transition on a rolling basis (transitioning children at renewal). In Colorado, implementation of the transition began in January 2013; in five other states, implementation began on or close to the January 1, 2014 deadline; and CMS gave the remaining four states permission to delay the transition to a later date because of state-specific circumstances.
2. **Continuity of care.** Administrators in four states—Alabama, Florida, Mississippi, and Pennsylvania—adopted procedures to ensure that transitioning children could remain with their primary care providers using two distinct approaches. The administrators either helped families to identify and enroll their children in the Medicaid managed care organization (MCO) in which their existing provider participated (Florida and Pennsylvania) or encouraged CHIP-only providers also to accept Medicaid patients (Alabama and Mississippi). Administrators in the remaining six states did not take explicit steps to mitigate continuity-of-care concerns, mostly because provider networks in the two programs were perceived to be highly similar or because existing continuity-of-care policies offered some degree of protection.
3. **Outreach.** Administrators in all but one state sent mailings to families to alert them to the transition and then conducted additional outreach to health insurance issuers and provider groups to alert them to the upcoming changes. Respondents reported that successful communications were grounded in clear and simple language and allowed for ample lead time to alert families before the transition's implementation. Further, administrators found it necessary to carefully target families that would be affected by the transition and some were able to leverage community-based organizations and provider groups to spread the transition message.
4. **Results.** Administrators in states that conducted a mass transition had an easier time tracking the number of stairstep children transitioning from separate CHIP to Medicaid than those conducting the transition on a rolling basis at renewal. The most commonly cited benefits of the transition included the alignment of coverage for children of different ages within the same family, the elimination of cost sharing, and access to a more comprehensive benefits package. However, respondents cited some drawbacks, including perceived Medicaid stigma

³ These two states were selected for the impact analysis because they transitioned their stairstep populations ahead of the January 1, 2014 deadline and therefore have longer follow-up data available than do other states. New York is not included in this implementation analysis, but other studies document administrators' experiences with the stairstep transition in New York and provide information comparable to that obtained in this study (Silow-Carroll and Rodin 2013; Prater and Alker 2013).

and consumer confusion about the transition. The fiscal impacts of the transition are still undergoing assessment.

5. **Challenges.** The most common challenges state administrators faced when undertaking the transition related to technology, the administrative burden of simultaneously implementing other ACA-related policy changes, and communications. Administrators reported few unexpected challenges, noting that they had anticipated the challenges that they in fact confronted.
6. **Best practices for ensuring smooth transitions.** State administrators believe that several factors contributed to smooth transitions for children and families, including close coordination within and across Medicaid and separate CHIP teams; clear and consistent communication with families, health insurance issuers, providers, and other stakeholders; and implementation of policies that ensure continuity of care. Stakeholder representatives echoed the importance of sending coordinated messages to families and provider groups and suggested that, for future coverage transitions, administrators could extend their outreach efforts to include the offer of additional resources to help families and practices navigate the transition.

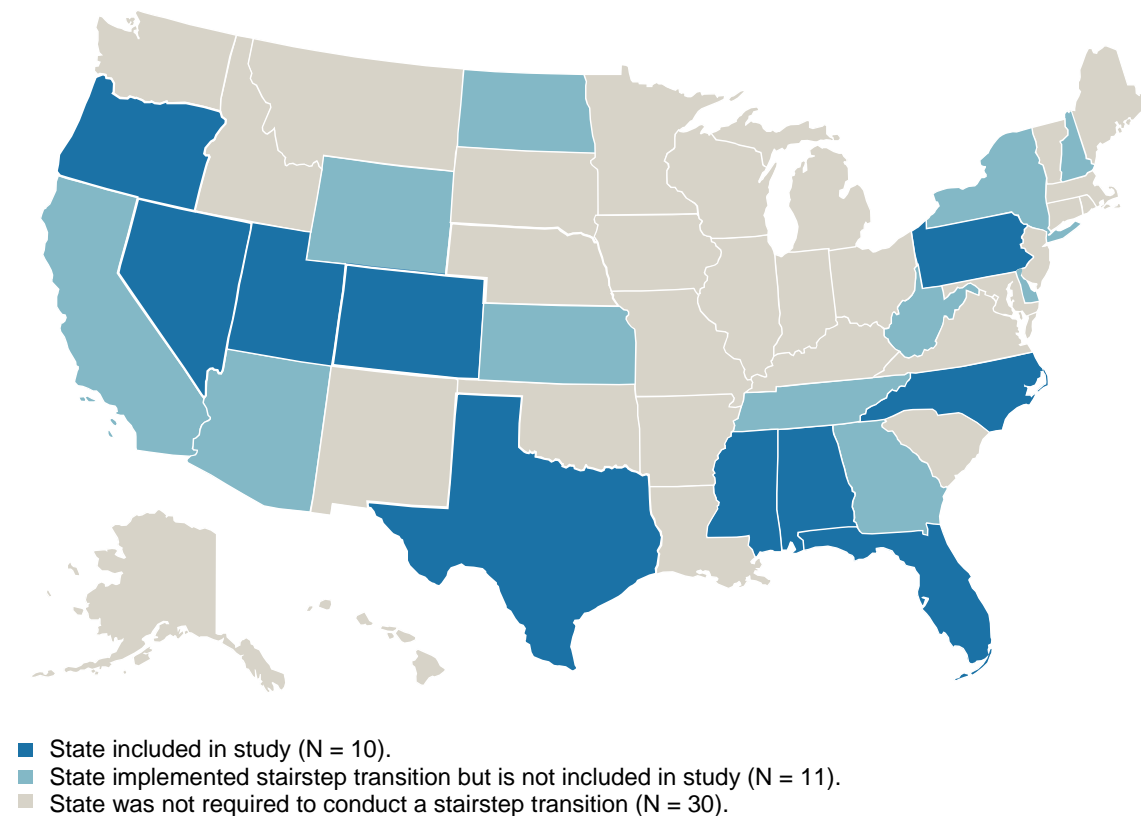
Although transitioning stairstep children from separate CHIP to Medicaid was a significant undertaking, findings from interviews with state administrators and other stakeholders within the 10 study states indicate a relatively smooth transition. State administrators may look to findings from this study about how states implemented the stairstep transition—for example, best practices regarding continuity of care or outreach—as examples of processes worth adopting when approaching future transitions in coverage. Identifying in advance best practices as well as the major challenges faced by state administrators, such as technology and communications, may help state administrators better plan for future coverage transitions. Findings from this implementation assessment will also inform the analysis of the impact of the transition from separate CHIP to Medicaid on children’s access to and use of health care in Colorado and New York.

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II. STUDY STATES

To select the 10 study states, we researched the 21 states required to conduct a stairstep transition by conducting an environmental scan that included a review of salient CHIP and Medicaid program features identified through published literature and reports, state plan amendments, and media releases. We also conducted Google searches to gather additional detail about the transition landscape in each of the 21 potential states. We ultimately selected and secured participation from state administrators in 10 of the 21 states that were required to conduct the stairstep transition (Figure II.1). The selection of the 10 states was based on several factors identified through the environmental scan, including having a large number of children estimated to be in the stairstep population or at least 20 percent of the state's separate CHIP enrollees estimated to qualify for transition. This allowed for inclusion of more populous states with large numbers of affected children (such as Florida and Texas) as well as for inclusion of some less populous states in which more than 50 percent of children in a separate CHIP program were subject to transition (as in Mississippi, Oregon, and Utah). Across the 10 states, an estimated 463,000 children were expected to transition to Medicaid, representing approximately 80 percent of all children expected to be affected by the stairstep provision of the ACA (Prater and Alker 2013).⁴

Figure II.1. Study states and other states required to transition stairstep children



⁴ The calculation excludes California and New Hampshire, which eliminated their separate CHIP programs entirely in advance of the January 1, 2014, deadline and enrolled all CHIP-covered children into Medicaid.

To increase the relevance of findings about states' successes with transitions and other lessons learned, we also sought regional variation and diversity in other characteristics, such as whether states expanded Medicaid for adults. In Table II.1.1, we show key Medicaid and CHIP characteristics in the 10 states. Appendix A describes state selection criteria and study methods in greater detail.

As shown in the table, policies and procedures in Medicaid and separate CHIP sometimes vary within a single state, such as in the types of delivery and eligibility systems used in Medicaid and separate CHIP. In Alabama, Florida, and Pennsylvania, separate agencies administer the two programs. The degree of coordination (or variation) in such policies and procedures across the two programs likely had administrative effects for program leaders and may have personal effects for families subject to the transition. Some of the most salient characteristics expected to affect the transition included the following:

- **Separate CHIP and Medicaid delivery systems.** Differences in delivery systems between the two programs may produce differences in provider networks, which could disrupt continuity of care at transition. Even though most states relied on managed care for both CHIP and Medicaid before 2014, our sample includes one state, Alabama, with fee-for-service in CHIP and primary care case management in Medicaid. For the same period, we observed the opposite in Colorado, Florida, and Mississippi, with managed care in CHIP and primary care case management or fee-for-service in Medicaid.
- **Separate eligibility systems.** A single eligibility system for both Medicaid and separate CHIP programs may simplify transitions by easing data exchange across the two programs. Beginning in 2014, the ACA required all states to operate an integrated eligibility system for Medicaid, CHIP, and the health insurance exchanges, and all states in this study have complied with this requirement. However, as of January 2013, we report the use of a single information system for Medicaid and separate CHIP programs in Colorado, Mississippi, North Carolina, Oregon, and Utah. In states that maintained separate eligibility systems as of January 2013, the implementation of a single eligibility system and the stairstep transition were likely simultaneous, which may have resulted in administrative complications.
- **Enrollment and renewal policies.** Many eligibility and renewal procedures are the same in Medicaid and separate CHIP programs, although differences remain. Separate CHIP policies are generally more generous than corresponding policies in states' Medicaid programs. At the time of transition, Colorado, Florida, Nevada, Pennsylvania, Texas, and Utah had 12-month continuous eligibility regardless of changes in family income in their separate CHIP program, but not in Medicaid; thus, transitioning children will face more frequent and complicated procedures to remain enrolled in Medicaid versus separate CHIP.
- **Cost sharing.** Families with income at or above 101 percent of FPL in Alabama, Florida, Nevada, and Utah had to pay premiums while copayments were required for some services for families with income at or above 101 percent of FPL in Alabama, Colorado, Florida, North Carolina, Texas, and Utah. In these states, the transition to Medicaid, which prohibits most cost sharing for children, would make coverage more affordable compared to separate CHIP.

Table II.1. Characteristics of study states, January 2013

| | Alabama | Colorado | Florida | Mississippi | Nevada | North Carolina | Oregon | Pennsylvania | Texas | Utah |
|---|---------|----------|---------|-------------|--------|----------------|--------|--------------|----------------|--------|
| Estimated size of stairstep population ^a | 25,000 | 19,000 | 71,000 | 40,000 | 11,000 | 58,000 | 42,000 | 40,000 | 131,000 | 26,000 |
| Estimated size of stairstep population as a percent of total separate CHIP population | 29 | 23 | 28 | 57 | 46 | 30 | 59 | 21 | 23 | 70 |
| Separate CHIP and Medicaid administered by same agency | N | Y | N | Y | Y | Y | Y | N | Y | Y |
| Medicaid delivery system ^b | PCCM | FFS | PCCM | FFS | MC | PCCM | MC | MC | MC | MC |
| Separate CHIP delivery system ^b | FFS | MC | MC | MC | MC | PCCM | MC | MC | MC | MC |
| Same eligibility system for Medicaid and separate CHIP ^b | N | Y | N | Y | N | Y | Y | N | N | Y |
| 12-month continuous eligibility (Medicaid) ^b | Y | N | N | Y | N | Y | Y | N | N | N |
| 12-month continuous eligibility (separate CHIP) ^b | Y | Y | Y | Y | Y | Y | Y | Y | Y ^c | Y |
| Separate CHIP premium at 101 percent of FPL ^b | Y | N | Y | N | Y | N | N | N | N ^d | Y |
| Separate CHIP co-payments at 101 percent of FPL ^b | Y | Y | Y | N | N | Y | N | N | Y | Y |
| Medicaid expansion for newly eligible adults ^e | N | Y | N | N | Y | N | Y | N | N | N |

Sources: Prater and Alker 2013; Centers for Medicare & Medicaid Services 2015a; Centers for Medicare & Medicaid Services 2015b; Energy and Commerce Committee 2014; Kaiser Family Foundation 2015; Hoag et al. 2011; Centers for Medicare & Medicaid Services 2012; Heberlein et al. 2013; interviews with state administrators (April–June 2015).

Note: Y = Yes; N = No; MC = managed care; PCCM = primary care case management; FFS = fee for service; FPL = federal poverty level.

^a Calculation of the estimates from Prater and Alker (2013) was based on the number of estimated stairstep children collected from state officials and state advocates and with the June 2012 CHIP monthly enrollment data provided to Health Management Associates for the Kaiser Commission on Medicaid and the Uninsured. These estimates may lack precision for the following reasons: (1) estimates cited by state officials and state advocates may vary, with estimates from state advocates potentially less accurate than those from state officials; (2) data were collected several years in advance of the transition in January 2014 and thus may be outdated; (3) children aging out of or otherwise becoming ineligible for the program may not be appropriately accounted for; or (4) children projected to transfer may have lost coverage during the transition despite the automatic transfer. Despite their limitations, we cite these estimates because they are the only published estimates of the numbers of stairstep children.

^b Program features are shown for January 2013 to simulate the environment for children before the stairstep transition occurred, when states were planning for the transition. In several states, changes occurred after January 1, 2013, but before the stairstep transition: Florida Medicaid changed from PCCM to statewide Medicaid managed care. Beginning in 2014, the ACA required all states to operate an integrated eligibility system for Medicaid, CHIP, and the health insurance marketplace. All states in this study have complied with this requirement.

^c In Texas, children in separate CHIP with incomes below 185 percent of the FPL receive 12 months of continuous eligibility. Children in families at or above 185 percent of the FPL receive 6 months of continuous eligibility. After 6 months, they are eligible for another 6 months of continuous eligibility if they remain financially eligible.

^d After the ACA was implemented in Texas, children in separate CHIP at or above 151 percent of FPL are required to pay an annual enrollment premium.

^e Medicaid expansion for adults is shown as of January 1, 2014. Pennsylvania has since implemented a Medicaid expansion for adults (January 1, 2015).

- Medicaid expansion for adults.** States' administrative capacity to manage the stairstep transition was influenced by concurrent changes to their Medicaid programs, such as expansion of Medicaid to those adults newly eligible under the ACA. The decision to implement Medicaid expansion for adults does not affect stairstep children's eligibility, but the expansion decision did affect administrative resources at the time of the stairstep transition. Nevada and Oregon implemented an adult Medicaid expansion effective January 1, 2014, at the same time that they were to transition stairstep children. Colorado also implemented an adult Medicaid expansion but, as described in detail later, transitioned stairstep children well in advance of the January 1, 2014 deadline; thus, the stairstep transition and adult Medicaid expansion did not occur simultaneously. Pennsylvania implemented Medicaid expansion for adults under a federal waiver on January 1, 2015, which coincided with their stairstep transition.

Within each state, we began by conducting interviews with state Medicaid and CHIP administrators. We then interviewed other stakeholders, including child health advocates, provider group representatives, and health insurance issuers. In Table II.2, we show the number of interviews conducted, by state and type of respondent.

Table II.2. Interviews conducted across 10 states, by respondent type

| State | State administrators | Advocates | Insurance issuers | Provider groups | Total |
|----------------|----------------------|-----------|-------------------|-----------------|-----------|
| Alabama | 1 | 1 | 1 | 2 | 5 |
| Colorado | 1 | 2 | 1 | 0 | 4 |
| Florida | 2 | 2 | 0 | 0 | 4 |
| Mississippi | 1 | 2 | 0 | 1 | 4 |
| Nevada | 2 | 0 | 0 | 1 | 3 |
| North Carolina | 2 | 1 | 1 | 1 | 5 |
| Oregon | 3 | 0 | 0 | 1 | 4 |
| Pennsylvania | 1 | 1 | 2 | 1 | 5 |
| Texas | 1 | 1 | 2 | 1 | 5 |
| Utah | 1 | 1 | 1 | 1 | 4 |
| Totals | 15 | 11 | 8 | 9 | 43 |

Note: In all states except Pennsylvania, administrators representing both Medicaid and separate CHIP were interviewed. In Pennsylvania, only separate CHIP administrators were interviewed.

III. SYNTHESIS OF KEY FINDINGS

In this chapter, we present major findings on six research topics related to the transition: (1) planning and operations; (2) continuity of care; (3) outreach to families; (4) results; (5) challenges; and (6) best practices for ensuring smooth transitions.

*1. **Planning and operations.** When did states begin planning for the transition, and who were the key players? How did states operationalize the stairstep transition?*

Administrators in most of the study states began planning at least six months before the transition. They developed cross-agency working groups, communicated regularly with CMS, and hosted meetings and forums with relevant stakeholders to discuss transition policies. Most of the nine study states that transitioned children at or after the January 1, 2014 deadline⁵ began planning for the transition by mid-2013, with Alabama and North Carolina starting their planning the earliest (fall 2012). Activity in most states accelerated in fall 2013 as the January 1, 2014 deadline approached. States' general approach to planning and executing the transition involved the convening of "working groups" that included representatives from several departments and/or agencies charged with developing and coordinating activities related to program eligibility, services/benefits, policy, budget, and information technology (IT) systems. Typically led by the state agency overseeing the Medicaid program, the working groups generally held standing meetings every two weeks or more frequently. Their main agenda focused on (1) the development of the technical approach for transferring children across the two programs; (2) the development of notices to be sent to families explaining the change in federal law and what it meant for them; and (3) an analysis of utilization patterns and the development of algorithms to transfer children to the same insurance issuer and/or primary care provider, if available, in Medicaid.

State administrators viewed the Centers for Medicare & Medicaid Services (CMS) staff as a key partner. CMS staff provided important direction to states' planning efforts by answering questions, issuing two rounds of guidance in fall 2013 (CMS 2013a; CMS 2013b), approving state plan amendments for Medicaid and CHIP (required of all states transitioning children), and providing feedback on state notices to families of enrollees. As an administrator in Florida described, "*We talked about our transition plan and so [CMS staff] knew the timing of the statewide Medicaid managed care rollout. And that's how we were able to very easily have a discussion with them about how the CHIP transition was going to dovetail with that, and how to make that the least interruptive transition that it could be. We were committed to that, they were committed to that—it was very easy after that, from a Federal permission perspective.*"

Medicaid and CHIP agency administrators received input from other stakeholders, including third-party administrators and health insurance issuers, to help plan for the transition. In many states, state administrators secured the involvement of the state information system vendors (such as HP in Alabama and Deloitte in Nevada) responsible for developing changes to eligibility or claims system business rules and executing the actual the transition.

⁵ The count of nine excludes Colorado, which transitioned its stairstep population earlier, as described later.

Health insurance issuers were also integral participants; these groups helped many states think through how to operationalize the transition, analyzing network differences and developing the process by which children were default-assigned to certain MCOs and providers. In Alabama, Florida, Mississippi, Pennsylvania, Texas, and Utah, health insurance issuers were involved in transition planning from the start. For example, a state administrator in Mississippi said, “[*The health insurance issuers were*] in the room during the entire process. . . . They were a partner in planning and identifying areas of concern around this transition. . . . They were involved from the very beginning, because we needed it to be a very smooth transition.” Issuers in two of these states (Alabama and Mississippi) helped state administrators analyze provider network differences.

Outside stakeholders, such as advocacy groups and local chapters of the American Academy of Pediatrics, participated in transition planning discussions, although they were not necessarily involved in deciding which processes would be adopted. In helping to guide transition plans, state administrators turned to existing Medicaid advisory boards and committees (such as medical care advisory committees) to solicit early feedback and ideas from the health professional and child and family interest groups that are represented on these boards and committees. In Alabama, Colorado, Florida, Pennsylvania, and Texas, existing coalitions dedicated to ensuring children’s health insurance coverage played an important role in furthering state efforts to disseminate information about the transition to child and family advocacy organizations. Coalition meetings in these states provided community partners with a regular forum in which to receive updates from state administrators about the transition, raise questions about state plans for the transition, and provide insights into issues and challenges from the perspective of their constituents.

Representatives from outside stakeholder groups were largely satisfied with state administrators’ planning and communication efforts. Most groups believed that they were reasonably well informed about the transition process, saying that they were kept aware of states’ steps in notifying families about the transition, its timing, and implementation. However, some advocacy and provider groups in some states felt that they could have been involved at an earlier stage. Wider dissemination of the details of the transition plans to some stakeholder types generally occurred after the formulation of transition plans or closer to implementation of the plans, thereby limiting the amount of stakeholder input into the structure and timing of notices to families and the transition. As one provider group representative in Mississippi stated, “[*They do listen to our advice and our input. But I don’t think we’re intricately involved in a lot of their planning and details about [the] transition. We’re there to comment on their decisions, but. . . . I don’t remember them ever really asking us how we would like to see it designed.*”

State administrators used either a mass transition or transition-at-renewal approach; their decisions on the type and timing of their stairstep transition were largely a function of state-specific factors, such as the degree of existing alignment between the two programs and whether other program, administrative, or service delivery changes were occurring simultaneously. In 6 of 10 states (Alabama, Mississippi, North Carolina, Oregon, Pennsylvania, and Utah), administrators implemented a “mass transition”; they used information already available to them to transition all stairstep children administratively from separate CHIP to

Medicaid on a set date (Table III.1).⁶ Administrators cited two overall benefits to this approach: families did not have to undertake any actions, and transition through administrative action averted the state’s need to manage stairstep children in two separate programs over time. For some of these states, such as North Carolina and Oregon, mass transition was regarded as the simplest option—execution of the transition at the “flip of a switch.” As a North Carolina administrator described, *“It was an automated process. The [Medicaid eligibility] staff didn’t have to do anything. We identified those individuals, we changed [their] program classification and category, and then effective January 2014, they were in the new classification which was our M-CHIP [Medicaid expansion CHIP].”*

Table III.1. Key stairstep transition decisions, by state

| State | Transition type | | Transition timing | | |
|----------------|-----------------|-----------------------|------------------------------|--------------------------|---|
| | Mass transition | Transition at renewal | Before January 2014 deadline | On January 2014 deadline | After January 2014 deadline (with CMS approval) |
| Total | 6 | 4 | 1 | 5 | 4 |
| Alabama | √ | | | √ | |
| Colorado | | √ | √ (January 2013) | | |
| Florida | | √ | | | √ (December 2014) |
| Mississippi | √ | | | | √ (January 2015) |
| Nevada | | √ | | | √ (October 2014) |
| North Carolina | √ | | | √ | |
| Oregon | √ | | | √ | |
| Pennsylvania | √ ^a | | | | √ (January 2015) |
| Texas | | √ | | √ | |
| Utah | √ | | | √ | |

Source: Interviews with state administrators, April through June 2015.

^a Pennsylvania offered families the option of transitioning stairstep children to Medicaid at renewal throughout 2014, and any stairstep children remaining in separate CHIP as of December 31, 2014 were administratively transitioned to Medicaid. Fewer than 300 stairstep children opted to move to Medicaid early, and Pennsylvania is thus characterized as a “mass transition” state.

For some states, the decision to undertake a mass transition presented drawbacks. For example, in the six mass transition states, children retained their previous (separate CHIP) renewal date so some children had to renew coverage in Medicaid soon after the transition, a process that some families and providers found confusing. Unlike the case of other mass transition states, which used an automated approach to switch children from CHIP to Medicaid, Utah administrators had to review the state’s stairstep population manually, approving each individually. As one state administrator explained, *“Our system wasn’t able to automate any of this, so it was all a manual process for [the department] to follow through with, and so they had pulled an ad hoc report to identify these children who would be Medicaid and they actually went through each case to transition.”* This labor-intensive process took approximately three months,

⁶ Pennsylvania offered families the option of transitioning stairstep children to Medicaid at renewal throughout 2014, and any stairstep children remaining in separate CHIP as of December 31, 2014 were administratively transitioned to Medicaid. Fewer than 300 stairstep children opted to move to Medicaid early, and Pennsylvania is thus characterized as a “mass transition” state.

during which time CMS required the state to waive CHIP premiums for all children under 150 percent of FPL.

In the remaining four states (Colorado, Florida, Nevada, and Texas), administrators chose to transition stairstep children to Medicaid during the renewal process rather than through mass transition.⁷ In Colorado and Texas, administrators viewed this approach as administratively less burdensome: children's eligibility would already be re-determined at renewal, and transitioning children at this time allowed the states to spread out the administration of the transition over time. As an advocate from Colorado said, *"I don't think that all-at-once transitions happen very well. . . . And so the opportunity to phase it in over time probably created some confusion for providers who didn't know when their clients' renewal [dates] were and where their client was in that process. But I think in terms of managing workload for the [state] agency and avoiding significant problems impacting large portions of the population, it was probably [a] good choice."* Florida's and Nevada's decision to use renewal dates to transition children was largely a function of the desire to balance the timing of the transition with concurrent changes in the states' Medicaid programs (the statewide managed care rollout in Florida and implementation of a new eligibility system and adult Medicaid expansion in Nevada, described in more detail below). In addition, existing enrollment and renewal policies in place in the four states conducting transitions at renewal, including 12-month continuous coverage in separate CHIP (Colorado, Florida, Nevada, and Texas) and a yearly premium payment (Texas), made it more beneficial to enrollees to execute the transition at the end of the child's CHIP eligibility period.

In general, states in which separate CHIP largely mirrors Medicaid (for example, the same delivery system, benefits package, and provider networks), the transition was especially straightforward. Based on our interviews, Nevada's, North Carolina's, and Oregon's separate CHIP programs closely resemble Medicaid. Because of the similarities among programs, the states may have had fewer complexities to manage during the transition.

Timing of the stairstep transition varied across states. In Colorado, implementation took place in advance of the January 1, 2014 deadline, five states met the deadline, and it occurred after the deadline in four states. Administrators in Colorado reported widespread support among legislators and advocates to move the stairstep children from separate CHIP to Medicaid sooner rather than later because of the transition's perceived benefits. Legislation signed into law in Colorado in April 2011 allowed the stairstep transition to begin later that year, although the transition was eventually pushed back from a fall 2011 start date to January 2013 because of systems issues (Table III.1). Administrators and advocates alike saw the early transition as a win-win situation for the state, providers, and families. The state realized significant cost savings from the transition for several reasons: (1) children in Colorado's separate CHIP are more expensive to cover than children in Medicaid,⁸ (2) the state would

⁷ In Texas, families of stairstep children had the opportunity to apply for Medicaid at any time in order to transition early; families were notified of this option through a written notice.

⁸ For fiscal year 2011–2012, the estimated per capita cost for each child in Colorado's Medicaid program was \$1,835; the estimated per capita cost for each child in Colorado's CHIP was \$2,364 (Colorado Legislative Council Staff 2011). CHIP operates through managed care in Colorado, and the per member per month rates paid through this delivery system are, on average, higher than the amounts paid for each child enrolled in the fee-for-service delivery system used in Medicaid.

continue to receive CHIP's enhanced FMAP for these children once they transitioned to Medicaid, and (3) elimination of the stairstep transition would reduce administrative red tape. Unlike in the case of separate CHIP, primary care providers seeing Medicaid patients would receive the temporary enhanced Medicaid reimbursement rate authorized by the ACA, and stairstep children would receive access to enhanced services through Medicaid's early and periodic screening, diagnostic, and treatment (EPSDT) benefit.⁹

In Florida, Mississippi, Nevada, and Pennsylvania, administrators postponed their stairstep transitions until after the January 1, 2014 deadline. CMS granted Florida and Nevada waivers to freeze renewals for all separate CHIP enrollees (not just stairstep children), thereby maintaining children's coverage status, until the timing of the transition could be aligned with concurrent changes in the states' Medicaid programs. For Florida, the transition's timing coincided with the switch from a primary care case management (PCCM) delivery system to Medicaid managed care in August 2014. Administrators in Nevada delayed the transition to permit ample time to phase out a separate CHIP eligibility system and implement Medicaid expansion for adults, thereby preventing the "swamping" of the eligibility process. Administrators in both Florida and Nevada chose a rolling renewal approach—Florida, starting in August 2014 and Nevada starting in October 2014—as they restarted separate CHIP renewals, transitioning stairstep children to Medicaid over subsequent months during redetermination of eligibility for coverage.

In Mississippi and Pennsylvania, CMS granted waivers to delay the stairstep transition until January 2015. When Mississippi administrators were planning for the transition in late fall 2013, they recognized a need for greater provider overlap between the two programs (in its guidance to states, CMS recommended but did not require states to review provider overlap). As such, Mississippi administrators requested and were granted a waiver to delay implementation so that they could work with providers and health insurance issuers to ensure more provider overlap across the two programs. In Pennsylvania, opposition to the transition of children from separate CHIP to Medicaid by the governor at the time was particularly strong. State administrators cited the governor's strong preference to keep children enrolled in CHIP as the reason for the waiver request, and other evidence suggests that the additional time was needed to prepare for the transition and keep children with their providers for as long as possible (Energy and Commerce Committee 2014).

In the four states with implementation dates after the January 1, 2014 deadline, CMS required the states to waive premium payments for children identified by the states as potentially subject to the stairstep transition; only Florida and Nevada required premium payments for children at this income level and were thus affected by this policy. CMS then required the states to give families written notice of the option of transitioning to Medicaid any time after January 1, 2014. Under this option, very few families made the early transition. For example, in Florida, only 55 families out of 38,000 notified of the option called the state call center to request transitioning ahead of the state's planned transition date.

⁹ The ACA implemented a temporary bump in Medicaid payments for primary care providers. Section 1202 of the ACA required states to increase Medicaid primary care provider payments to equal Medicare Part B payment levels between January 1, 2013, and December 31, 2014 (Medicaid.gov 2015). Although the reimbursement rate officially expired, Colorado (among other states) has continued to keep the reimbursement rate at the Medicare level (Advisory Board Company 2015).

2. *Continuity of care. What steps were taken to ensure provider continuity for children at the time of the transition? Were any policies adopted to ensure continuity of care for children undergoing treatment at the time of the transition?*

Administrators in Alabama, Florida, Mississippi, and Pennsylvania adopted procedures to ensure that transitioning children could remain with their primary care provider. Administrators in the four states expressed concern about primary care continuity and took two distinct approaches to mitigate interruptions in care. In Florida and Pennsylvania, administrators attempted to maximize care continuity by helping children enroll in Medicaid MCOs that included their CHIP primary care provider. In both states, administrators first analyzed primary care provider overlap between the Medicaid and CHIP programs. In Pennsylvania, administrators sorted children into three categories: (1) children who could remain with the same health insurance issuer (with their Medicaid MCO) and could continue to see the same primary care provider, (2) children who could remain with the same primary care provider if they switched insurance issuers, and (3) children who would need to change primary care providers. Each affected family in Pennsylvania received a verification letter that varied with the child’s category. Children in the first category were automatically enrolled in the default MCO. Parents of children in the other two groups had to select an MCO, although families of children in the second category were informed as to the MCO(s) in which their primary care provider participated. An enrollment broker—whom families could call (the verification letter included broker contact information)—provided additional support, such as by helping them identify a new MCO or primary care provider. Pennsylvania administrators also made certain that that any pre-authorization status was transferred to Medicaid for 30 to 60 days (with the length of time dependent on the policy for that particular service). In Florida, administrators also conducted a provider gap analysis in order to identify which children would be able to stay with their primary care provider after transitioning to Medicaid. Administrators made the resultant information available to the Medicaid choice counseling staff, who, in turn, selected a default MCO for all transitioning children; the MCO included a child’s current primary care provider when that provider was available in a participating Medicaid MCO.

In contrast, administrators in Alabama and Mississippi attempted to mitigate continuity-of-care issues by encouraging stairstep children’s primary care providers to participate in Medicaid if they did not already do so. Alabama CHIP administrators created a list of all primary care providers currently serving stairstep children and presented it to the state’s Medicaid agency. The Medicaid agency then contacted any providers not already participating in Medicaid to encourage their participation. Mississippi’s approach was similar, although administrators contacted only those CHIP primary care providers with the highest volume of children enrolled in CHIP (as determined by state administrators) who were not already participating in Medicaid. Administrators reported both strategies to be at least somewhat successful, although work to increase Medicaid provider access continues. As a Mississippi state administrator reported, *“For the most part, they worked out pretty well. We did end up enrolling some additional providers. We allowed them to [open] their panels to just those [transitioning stairstep] members if they so choose. It wasn’t 100 percent effective—there’s still several large pediatrician groups that chose not to enroll as Medicaid providers, but that outreach is ongoing.”* Mississippi administrators developed a waiver so that transition children could continue seeing their CHIP provider if the provider were not participating in the Medicaid program for 90 days without a new prior authorization.

In the remaining six states, administrators did not take explicit steps to mitigate continuity-of-care concerns, mostly because provider networks in Medicaid and separate CHIP were already identical or perceived to be highly similar. Administrators in Nevada and Oregon reported that Medicaid and CHIP had identical provider networks and that continuity of care was not a concern. North Carolina, Texas, and Utah administrators stated that provider networks across the two programs were similar, although a slightly higher number of providers were available in CHIP. Given the similarities in North Carolina's, Texas's, and Utah's networks and the protection provided by existing continuity-of-care laws, administrators in these states did not express any concerns or think that the transition required additional continuity-of-care policy. For example, Medicaid MCO contracts in Texas require a 90-day continuity-of-care period for new clients, during which time the new MCO must honor any pre-authorized services; state administrators relied on this existing law to help protect transitioning stairstep children. In Colorado, administrators reported that, because children were moving from a restricted provider network in CHIP MCOs to a predominantly fee-for-service Medicaid program in which any willing provider may participate, they had few concerns about children losing access to their current providers. Further, some state administrators said that they were willing to work with families on a case-by-case basis to resolve transition problems, but they reported that they did not receive many complaints.

In several states, administrators and other stakeholders said that they were less concerned about continuity-of-care issues during the stairstep transition as compared to earlier transitions because of improvements in Medicaid access. Four state administrators and provider group respondents from four states noted that the number of primary care providers accepting both Medicaid and CHIP has increased in recent years, with the Medicaid increase potentially related to the ACA's requirement for higher Medicaid reimbursement rates. For example, a representative from a provider group in Utah reported, *"I know that some [primary care providers] who only took CHIP and didn't take Medicaid, but then the problem sort of went away. . . . because of the increased medical payments. The number of providers who are willing to take Medicaid increased by about 30 percent when they did the payment increase."* These reimbursement rates were temporary and affected rates only in 2013 and 2014, although policymakers in Alabama, Colorado, and Mississippi opted to maintain the reimbursement increases, and policymakers in Nevada opted to continue reimbursing physicians at rates higher than previous rates but lower than under the ACA requirement (Advisory Board Company 2015). The rate increases affected only primary care reimbursement, not specialty care.

Some insurance issuers and provider groups also encouraged Medicaid participation among their providers even though state administrators did not require them to do so. One insurance issuer in Colorado whose networks were not identical noted that it contacted the few providers who did not already participate in Medicaid and therefore would not be able to continue serving their CHIP-enrolled patients after the transition. The insurance issuer stated, *"We did a very active comparison of who [stairstep children] had selected as their primary care provider, did that provider also accept Medicaid. . . . We did outreach to both; to the practices to say would you be willing to accept Medicaid to keep these patients that are already on your panel and then checking with families to make sure that they knew their ability to access that provider was dependent on their willingness to accept Medicaid."* Provider groups in Mississippi and Pennsylvania reported that they encouraged practices to participate in Medicaid, citing the primary care reimbursement increase as a reason to consider participation. In Mississippi, where

the transition did not occur until 2015, representatives from the provider group interviewed for this study reported that the group continues lobbying providers to accept Medicaid and they believe that some providers may be willing to do so because the state has continued to reimburse Medicaid at Medicare levels.

Most continuity-of-care efforts focused on primary care; however, behavioral health was one area of specialty care that gave rise to respondents' concerns in three states. In general, state administrators did not voice strong concerns regarding care continuity for most specialty services, although several noted taking steps to mitigate concerns about access to behavioral health. Behavioral health was a particular concern in states that use different delivery systems in Medicaid and CHIP to provide these services. For example, Alabama administrators developed a list of children who would be transitioning and provided the list to insurance issuers, who identified and notified the behavioral health providers that saw those patients. Providers were then encouraged to discuss options with transitioning clients, such as how to find a Medicaid provider if they themselves did not accept Medicaid. In Utah, administrators worked with county systems (Medicaid's behavioral health delivery system) either to ensure that children began treatment with the county before the transition or to negotiate single service agreements with CHIP behavioral health providers so that the transition would not disrupt care for children already in treatment. Even though state administrators did not express concerns regarding continuity of care for most specialty services, an advocate in Florida pointed out that failure to examine specialty care providers during the transition had some caused some continuity-of-care problems for children with special health care needs.

3. ***Outreach to families.** How did state administrators notify families and other stakeholders, such as providers and insurance issuers, of the transition? What types of outreach strategies were most successful?*

Administrators in 9 of 10 study states conducted outreach to families to alert them to the effects of the transition, with mailings the predominant method in all 9 states and website announcements in 2 states. CMS provided states with guidance on outreach, advising them to conduct "proper and timely notification to families, including detailed information on changes related to MCOs, providers, benefits and cost sharing and what families can expect and need to do in preparation for the transition" (CMS 2013a). State administrators often collaborated with advocates, advisory committees, health insurance issuers, and provider groups to review various communications. In addition, these groups sometimes conducted outreach directly to families. In states implementing the staircase transition by the January 1, 2014 deadline, families received mailed notices one to three times between January 2013 and March 2014; in other words, families received a communication from any time between a year in advance to after the transition had begun. Oregon administrators did not engage in any outreach for the transition, stating that outreach would cause unnecessary confusion because Medicaid and CHIP are virtually indistinguishable in Oregon and because families were exempt from any meaningful changes or action. Stakeholders in Oregon noted that families and providers reported little to no confusion about the transition.

Administrators in all 10 states in the study reported that they notified health insurance issuers and provider association groups about the transition; those issuers and groups in turn alerted individual providers. Administrators in Alabama, Colorado, Florida,

Mississippi, and North Carolina also reached out directly to providers. To notify insurance issuers and provider groups, administrators discussed the transition during regular standing meetings or during transition-specific planning meetings and distributed fact sheets and state bulletins (a normal method for distributing information to such groups). These groups would then reach out to their provider networks to pass along messages by newsletters, emails, and other means of communication. This indirect outreach approach proved beneficial in some states. For example, in Mississippi, state administrators thought that providers would be more receptive to hearing messages from provider associations instead of from the state agency. For the states that reached out directly to providers, one benefit was that state administrators could actively encourage providers to participate in Medicaid. Stakeholders in Alabama also reported that the “Q&A” document for providers on the state’s website—designed to answer common questions—was particularly helpful and engaging. Oregon was the only study state in which only state administrators reached out to providers. Administrators there noted that other groups probably did not reach out to providers because they deferred to the state and because nothing for providers changed as a result of the transition, including the reimbursement fee schedule.

Some advocates felt that messages may have been better received by families when the source of the messages was trusted community resources. As one Colorado advocate stated, “*We find that communication that comes from providers or community-based outreach enrollment specialists or folks who have personal relationships with clients tends to be better heard and better received than impersonal communication through the state.*” The involvement of health insurance issuers and provider groups in conducting outreach to families made sense, however, only if these groups were able to identify which children were transitioning; in fact, many groups lacked such capacity. Concerned that the state was not reaching out to families and lacking information about which members were likely to transition, a health insurance issuer interviewed in Texas reported conducting extensive (but non-targeted) outreach about the transition to its members. Insurance issuers in Pennsylvania reported that they worked with the state to identify which children were transitioning and which children could stay with their current primary care provider and MCO.

Factors that were perceived to facilitate successful outreach strategies included having ample lead time before implementation, targeted outreach to the stairstep population, clear communication, and leveraging child health advocates, insurance issuers, and provider associations to spread the transition message. Almost all interviewees agreed about the importance of giving families sufficient notice of the transition so that they were not caught off guard. In all states except Texas, administrators provided notices in advance of the transition. Texas administrators reported being prepared to notify families as of January 1, 2014 but, due to federal delays in approving its transition notices, the notices were not sent until after the rolling transition had begun, a concern cited by some stakeholders. Given that the transitioning stairstep population was relatively small, state administrators and child health advocates across study states noted the importance of targeted outreach to the affected population rather than blanket radio or television advertisements. Further, most state administrators recognized that (like all letters issued by the state to beneficiaries), communication materials had to be written clearly and concisely to ensure that families would understand how the policy change would affect them.

4. **Results.** *What share of all stairstep children successfully transitioned? What were the major benefits of the transition for children and their families? What were the perceived drawbacks?*

Administrators in states that conducted an administrative or mass transition had an easier time tracking the number of children who transitioned from separate CHIP to Medicaid than those conducting the transition at renewal. We asked administrators in all study states to provide the number of stairstep children who transitioned from separate CHIP to Medicaid (Table III.2). In states with an administrative or mass transfer, it was generally easier to track the number of transitioning stairstep children because the transition took place automatically and without an eligibility redetermination. Administrators in some states transitioning children at renewal (Colorado, Nevada, and Texas) or in conjunction with other program changes (Oregon, Texas, and Utah) were unable to identify the number of children who transitioned. Colorado and Oregon administrators provided the estimated number of children in the stairstep age and income bracket at the time of the interview, and Nevada, Texas, and Utah administrators provided the estimated number of stairstep children identified before the transition. Transitioning at renewal meant that children's eligibility was already being redetermined and that other factors (such as changes in age, family size, or income) may have affected the children's eligibility outside the stairstep transition. The simultaneous implementation of other policy changes, such as IT system updates, the implementation of modified adjusted gross income (MAGI) eligibility determinations, or the elimination of an asset test (Texas and Utah), would further affect whether the children changed programs and thus compromised states' ability to track the stairstep population.

None of the administrators in the study states tracked what happened to stairstep children if they did not transition to Medicaid, such as whether they received another source of coverage or became uninsured. CMS did not require states to track the results of the transition, although it did recommend that states create a transition monitoring plan that would include a number of elements, such as the number of children who were expected to transition but did not and the reasons (CMS 2013b).

Table III.2. Type of stairstep transition and estimated number of stairstep children who transitioned from separate CHIP to Medicaid

| State | Transition type | | Data provided by state administrators | | |
|---------------------------|-----------------|-----------------------|---|---|---|
| | Mass transition | Transition at renewal | Approximate number of stairstep children who transitioned | Estimated number of stairstep children identified before transition | Estimated number of children in stairstep age/income bracket at time of interview |
| Alabama | √ | | 23,000 | | |
| Colorado | | √ | | | 56,156 |
| Florida ^a | | √ | 27,000 | 51,000 | |
| Mississippi | √ | | 23,000–24,000 | | |
| Nevada | | √ | | 11,000 ^b | |
| North Carolina | √ | | 70,000 | | |
| Oregon | √ | | | | 6,429 |
| Pennsylvania ^c | √ ^d | | 7,000 | 30,000 | |
| Texas | | √ | | 201,000 ^e | |
| Utah | √ | | | 10,000–14,000 ^f | |

Sources: Interviews with state administrators (April—June 2015).

Note: Numbers of children reported by states to have transitioned should not be compared to the estimates presented in Table II.1 (Prater and Alker 2013). The estimates cited in that table may lack precision because of the source of the data, old or inaccurate data, children aging out of or otherwise becoming ineligible for the program, or children getting lost in the system and losing coverage despite the automatic transfer.

^a Florida administrators identified 51,000 potential stairstep children; of these 51,000 children, 27,000 enrolled in Medicaid, 16,000 remained in separate CHIP, and the remaining 8,000 became unenrolled (potentially because they aged out, did not comply with renewal, or gained other sources of coverage).

^b Number of stairstep children identified by Prater and Alker (2013) and cited in state administrators' interview.

^c Pennsylvania administrators identified 30,000 children in the stairstep age and income bracket as of December 31, 2013; of these 30,000 children, approximately 7,000 were transitioned from separate CHIP to Medicaid. The remaining children were no longer subject to the transition due to a variety of factors, including income changes, terminations, aging out, and so on.

^d Pennsylvania offered families the option of transitioning stairstep children to Medicaid at renewal throughout 2014, and any stairstep children remaining in separate CHIP as of December 31, 2014 were administratively transitioned to Medicaid. Fewer than 300 stairstep children opted to move to Medicaid early, and Pennsylvania is thus characterized as a "mass transition" state.

^e Number of stairstep children identified as of December 2013 by Texas administrators; the transition occurred on a rolling basis and simultaneously with other program eligibility changes, including the implementation of federally-required MAGI rules. The simultaneous implementation of these changes (including eliminating the assets tests, removing a number of income disregards, and changing numerous countable income types) compromised Texas administrators' ability to isolate the number of children transitioning as a result of CHIP and Medicaid income limit changes from children transitioning as a result of MAGI changes.

^f Number of stairstep children identified before the transition; the transition occurred simultaneously with the elimination of an asset test, and the state was unable to disentangle those two numbers.

State administrators, advocates, and provider groups perceived that the transition went relatively smoothly for families because of efforts conducted in advance of the transition to ensure care continuity and because families were likely to be familiar with Medicaid. Even though none of the state administrators reported conducting surveys to determine families' experience with the transition, they cited the lack of complaints by families as evidence that the

transfer went smoothly. Advocates and provider groups may have been more likely to hear about the problems facing families, but representatives of these groups also reported that families found the transition relatively smooth. Respondents attributed the ease of the transition to two main factors. First, many state administrators worked in advance of the transition to ensure care continuity. Second, for two reasons, most families' stairstep children already had experience as Medicaid beneficiaries: (1) other children in the same family were also Medicaid recipients, or (2) family income fluctuations led to the child's previous enrollment in Medicaid. As one state administrator in Alabama noted, *"Of all the things we did and had to do with ACA, [the stairstep transition] wasn't a big issue because we let people know ahead of time and walked them through what to expect. . . . And I think a lot of the recipients. . . . were used to going on and off Medicaid. Maybe one year they would be on Medicaid and then one year they weren't, or maybe they were on Medicaid before they were on CHIP. So they were used to it."*

The potential benefits of the transition most commonly cited by respondents included aligning coverage within families, eliminating cost sharing, and providing access to a more comprehensive benefits package. Five state administrators, advocates, and provider group representatives from four states (out of 18 total respondents answering the question about benefits of the transition)¹⁰ reported that the major benefit of the transition was its potential to align coverage for different-aged children within the same family, thereby offering children of different ages in the same family access to the same provider networks and the same benefits. As a state administrator in Colorado noted, *"Families aren't having to navigate two different health coverage scenarios for two children in the exact same family. Pediatricians aren't having to figure out who can get what as they're looking at kids."* As noted in Chapter II, cost sharing in CHIP is more common for families at higher income levels. However, in four study states, stairstep children were liable for premiums, and in six study states, children were liable for copayments for some services. Four advocates and provider group representatives from three states (again out of 18 total respondents) noted that the elimination of these cost-sharing responsibilities was one of the major benefits of transitioning stairstep children to Medicaid.

Four advocates and insurance issuer representatives from four states (out of 18 respondents) reported that children who transitioned to Medicaid would, if needed, be entitled to more generous benefits than those offered through separate CHIP; the exception was Oregon, whose Medicaid and CHIP benefits packages are identical. The most commonly cited extra Medicaid benefits included Medicaid coverage of EPSDT benefits, non-emergency transportation, physical or occupational therapy, orthodontia, and minor differences in prescription drug formularies. In most cases, respondents did not know whether families were aware of the more generous Medicaid coverage. In Utah, however, state administrators reported an increase post-transition in the use of certain orthodontia services, which the separate CHIP program did not cover, suggesting that families in that state knew about the difference.

Finally, two advocates in Colorado and North Carolina reported the movement from separate CHIP to Medicaid as a long-term benefit to children because Medicaid is an entitlement

¹⁰ Respondents to this question could give any response (they did not choose from among a preset list of categories), and they could cite more than one answer. Not all respondents answered the question; some reported no answer, others were not asked because of time constraints.

program, whereas separate CHIP is not.¹¹ As a North Carolina advocate noted, *“Since we run the program so much the same, I don’t know that [families] are seeing anything better. It’s of course an entitlement, and so it’s more stable. . . . I don’t think families think about that.”*

Respondents reported several perceived drawbacks of the transition, some of which are presumably short-term, such as consumer confusion, while others like are likely to be long-term, such as perceived Medicaid stigma and reduced access to care. Although they noted confusion as likely a short-term issue, seven state administrators, advocates, and insurance issuer representatives from five states (out of 27 total respondents answering the question about drawbacks of the transition)¹² reported confusion among families, especially related to the need to change coverage programs even though their income had not changed. Another source of confusion cited by the respondents was the perceived lack of information available to consumers during the transition. As one advocate in Florida described, *“I think that the biggest issue tends to be. . . . confusion. . . . Some of the stuff is not necessarily innate information to people and when you start messing around with their health insurance coverage, it gets confusing and when they get confused, they get frustrated.”* Despite states’ and other stakeholders’ engagement in outreach, respondents reported that is not unusual for families to ignore or misunderstand mass mailings. For example, some respondents felt that families may have benefited from individual explanations about how to be more proactive in selecting the appropriate MCO for their situation. Five advocates and provider group representatives in four states (again out of 27 respondents answering the question) pointed to disruption in care or changes to providers as another short-term concern. Even amid states’ efforts to maintain provider continuity, some children had to change providers and experienced a disruption in care. Part of the disruption may have resulted from delivery system changes, which posed a problem in Alabama and Florida. These two states had either different delivery systems (Alabama) or different contracting processes for separate CHIP and Medicaid within the same delivery systems, resulting in different health insurance issuers and provider networks (Florida). Changes in delivery systems may require families to adapt to new insurance issuers, different care arrangements (such as the need to obtain a referral from a primary care physician for specialty care), and/or new providers.

Despite the states’ ongoing efforts to minimize Medicaid stigma, eight state administrators, advocates, insurance issuers, and provider group representatives from seven states (out of 27 respondents) perceived a continuing stigma associated with enrollment in Medicaid instead of in separate CHIP. As one insurance issuer in Pennsylvania noted, *“There’s a lot of horror stories about dealing with [Medicaid] offices and providing information, getting things done timely. It’s just CHIP has always worked so well. . . . for families that a lot of people don’t want to have to go the route with Medical Assistance because they’ve heard so many bad things about it.”* Four

¹¹ Medicaid is an entitlement program, meaning that anyone who meets eligibility rules has a right to enroll and that states operate with guaranteed federal financial support for part of the cost of their Medicaid programs (Center on Budget and Policy Priorities 2015). In contrast, separate CHIP is not an entitlement program, meaning that states may impose enrollment caps or waiting lists and that, once the state has spent its federal CHIP allotment, it must use its own funds if it wishes to continue financing CHIP coverage through a separate CHIP program (Rudowitz et al. 2014).

¹² Respondents to this question could give any response (they did not choose from among a preset list of categories), and they could cite more than one answer. Not all respondents answered the question; some reported no answer, others were not asked because of time constraints.

provider group representatives from four states (out of 27 total respondents) pointed to reduced access to care in Medicaid, particularly among specialists, as a drawback of the transition. In Alabama, for example, the separate CHIP provider network covers 98 percent of the state's providers, whereas Medicaid provider networks are narrower. Differences in Alabama's reimbursement rates were reported to be the primary reason for variation in provider participation, although more burdensome reporting and compliance requirements were also reasons that providers preferred to participate in separate CHIP rather than in Medicaid.

Fiscal impacts of the stairstep transition are still undergoing assessment such that administrators in 6 of 10 study states were either unsure about the nature of the impact or have not yet seen much impact. In the other 4 states, administrators report that fiscal impacts vary based on differences in per member per month costs, lost revenue from waiving premiums, and inability to collect the enhanced FMAP. Administrators in North Carolina, Pennsylvania, and Texas reported that they did not have enough data to determine the impact of the change (either because not enough time had elapsed since the transition or because the simultaneous implementation of MAGI rules compromised their ability to capture the necessary data), and administrators in Mississippi, Nevada, and Oregon reported no major fiscal impacts as a result of the transition. Among states that reported a fiscal impact thus far:

- Alabama and Colorado administrators reported that they have realized savings, with lower costs per member per month in Medicaid and the continued receipt of the enhanced federal CHIP match for affected children producing a net gain in state revenue. Administrators in Alabama also noted that lower service utilization for stairstep children since the transition has led to cost savings, although they expected the savings eventually to level out. In Colorado, the per capita cost in Medicaid's fee-for-service delivery system is lower, on average, than the per capita cost in separate CHIP's managed care delivery system, thus resulting in net savings after the transition.
- Florida and Utah administrators noted the transition's negative fiscal impacts, although for different reasons. Given that children in Florida remained in separate CHIP for nearly a year absent the collection of premiums (because the state delayed implementation, as described earlier), the separate CHIP program lost out on significant premium revenue. In Utah, administrators knew that—on average—per capita costs in Medicaid were higher than in CHIP, but the difference between the numbers has thus far been greater than expected. Part of the issue is that Utah administrators are not currently collecting the enhanced federal CHIP match for the affected population. They implemented the stairstep transition amid other eligibility changes (as described earlier) that have prevented them from tracking children in a way that would allow them to collect the enhanced federal CHIP match. Federal regulations give states up to two years to claim the enhanced match. Therefore, state administrators are still trying to implement the necessary IT systems changes to claim those funds.

Transitions of stairstep children and the subsequent reduction in size of states' separate CHIP programs have not led to discussions about eliminating states' separate CHIP programs, according to state administrators. Of the 10 states in the study, administrators in Alabama, Florida, Mississippi, Pennsylvania, Texas, and Utah said that they would retain the separate CHIP program because of its popularity among legislators and families. As a Texas

state administrator noted, *“I think [legislators] like that people pay a low enrollment fee and some very minimal copayments. And they view it as a mechanism of insuring children at a higher income level, so it tends to be something they're in support of.”* Although some state administrators could envision efficiencies if the program were rolled into Medicaid, none wanted to broach the idea during a time of so many other program changes. Despite identical or nearly identical Medicaid and separate CHIP programs in Nevada, North Carolina, and Oregon, administrators in these states said that maintaining a separate CHIP program gave legislators greater flexibility if CHIP were not reauthorized or state legislators needed to make changes to balance a budget (once the program converts to Medicaid, it is harder to make changes). Administrators in Colorado reported some discussion about eliminating the state’s separate CHIP, though not directly in response to the stairstep transition. Colorado administrators have slowly taken steps to streamline the two programs and may continue to do so for administrative efficiencies.

5. **Challenges.** *What were the most common challenges for administrators during the transitions, and how were they addressed?*

State administrators in Alabama, Florida, Mississippi, Nevada, Oregon, and Pennsylvania viewed IT as the greatest challenge to undertaking the transition; accordingly, they worked in advance to ensure that IT systems would be capable of handling the transition. Systems challenges varied but included the need to build a new eligibility system (not a requirement of the stairstep transition, but a need that arose simultaneously in several states), the need to incorporate the stairstep change into the existing eligibility system, and, in some states, the need to address system capabilities stretched thin by the large volume of children transitioning. State administrators conducted significant work in advance of the transition to ensure that systems challenges did not create problems for families. For example, Alabama reported conducting numerous tests in advance of the transition to make sure everything operated as expected. As an administrator in Pennsylvania described, *“Whenever you deal with that large amount of kids, you have a ton of systemic issues that could possibly go wrong. So, it was just a constant day-to-day struggle to make sure that everything was no less than perfect, because if it wouldn’t have been, then we would have had a lot of complaints because people would have been overlooked or missed.”* Although Colorado administrators implemented the transition ahead of the required January 1, 2014 deadline, they delayed the original implementation date to make sure the necessary IT systems changes were in place.

According to administrators in Alabama, Florida, and Utah, external factors, especially deadlines for implementing other ACA-related policy changes, limited the time and resources available to focus on the stairstep transition and posed major barriers to timely implementation. The stairstep transition occurred within the broader context of other ACA-related changes; for example, January 1, 2014 (the date the change was required, although states enacted the change at various times) fell in the midst of the first marketplace open enrollment period. It was also the date on which many states expanded Medicaid to newly eligible adults as well as the date on which the MAGI methodology took effect. As one state administrator in Utah noted, *“This is a significant change to these kids and their environment, but it was just one of several significant changes that were going on all at the same time. . . . There’s a lot of stuff going on at that period of time and trying to make all of those changes at the same time, I think, was confusing for a lot of people.”*

State administrators interviewed in Colorado, Florida, and Nevada viewed communication as a major challenge, and this resonated as a challenge in the outside stakeholder community. Seven advocates and insurance issuers from six states (out of 15 respondents answering the question about major challenges to the transition)¹³ also reported communications as one of the biggest challenges. Administrators in the three states concerned with communication challenges reported that one of their primary challenges related to notification of the appropriate families and engagement in strategic communications with outside stakeholders. For example, in Nevada, the transition required children to be assigned new ID numbers that had to be communicated to families and providers by a certain date in order for the transition to occur smoothly. Other types of respondents cited communication—both communication from the state and the other stakeholders’ communication with families—as significant challenges associated with the transition. For example, an insurance issuer in Texas, perceiving a lack of transparency from the state about the transition, stated, “*There wasn’t really any sort of policy communication plan. We knew that this was happening. . . . But essentially we just waited.*” In Pennsylvania, stakeholders perceived that the political uncertainty about whether the state would implement the stairstep transition hampered state administrators’ ability to plan thoroughly for the transition, which they believed hampered the quality of the state’s communications with them and the affected families. Stakeholders in the other states did not perceive the respective states’ communication to be inadequate, but they did experience a challenge in explaining the transition and the reasons for it to affected families while reassuring the same families that their coverage would not terminate.

Few unexpected challenges arose. In general, most state administrators reported that they expected the challenges that they in fact confronted. As for the few unexpected issues that did arise, they tended to be state-specific. In Florida, for example, families had the option of transitioning to Medicaid early, but most families elected to remain in separate CHIP with waived premiums. If families were due for an eligibility redetermination for the Supplemental Nutrition Assistance Program (SNAP) within the transition period, however, their SNAP redetermination may have initiated them to move to Medicaid, despite their ability and perhaps desire to remain in separate CHIP.

6. *Best practices for ensuring smooth transitions. What do states and other stakeholders believe to be best practices for ensuring smooth transitions?*

State administrators cited three common best practices for smoothing coverage transitions: close coordination within and across Medicaid and separate CHIP teams, clear and consistent communication with families and outside stakeholders, and policies and procedures to ensure continuity of care. Administrators in Alabama, Colorado, Florida, North Carolina, and Pennsylvania reported that engaging team members from all divisions with a role in the transition enhanced their ability to smooth beneficiaries’ transitions. Team members include IT programmers, eligibility policy officials, and financial staff across Medicaid and separate CHIP departments. State administrators saw their ability to eliminate internal silos and tackle the transition together as essential to their ultimate success. In states with previously

¹³ Respondents to this question could give any response (they did not choose from among a preset list of categories), and they could cite more than one answer. Not all respondents answered the question; some reported no answer, others were not asked because of time constraints.

established relationships between Medicaid and separate CHIP, coordination was significantly easier because communications across functions and departments were already in place. For example, an administrator in North Carolina noted that *“We just have a lot of streamlined functions in our state. There’s one universal application; we have a shared claims processor contractor; we have the identical preferred drug lists for beneficiaries in both programs; we have identical reimbursement rates; and so there are many things that are streamlined and run parallel in both programs.”* States that made efforts to have the right people at the table early on reported being able to anticipate and overcome challenges more quickly than if their processes had been more dispersed.

State administrators reported that they exerted considerable effort to keep the focus of the transition on the affected families and children, and administrators in Alabama, Florida, Mississippi, Pennsylvania, and Utah viewed their communications and outreach efforts with families as a best practice. In general, state administrators were able to undertake the transition without requiring additional paperwork from families beyond what they would have needed for a standard renewal. As described earlier, state administrators reached out to families early and often via various media (e.g. standard mail and website announcements). Respondents believed that these early alerts to the transition probably minimized the number of complaints. As an administrator in Alabama stated, *“Sending that letter [to families] was key. I think our families can handle change, but keeping them in the loop and keeping them aware that this change is coming, that was so appreciated [by] the parents. I think it helped make the transition a lot smoother.”* In addition to communicating directly with families, state administrators relied on outside stakeholders to function as trusted messengers in spreading the word. For example, administrators in Mississippi reported leveraging provider groups to communicate to providers about the transition.

Even though the federal government did not require the development of continuity-of-care provisions for the study population, administrators in four of the study states, as noted earlier, developed processes to minimize the impact of the transition on beneficiaries’ care, and the remaining states relied on existing laws or contracts to protect children’s continuity of care. Administrators in Alabama, Florida, Mississippi, Texas, and Utah recommended the adoption of such practices or the continuation of such policies for future transitions. For example, Florida administrators helped families enroll their children in Medicaid MCOs that already included the children’s established primary care provider, and Mississippi administrators encouraged primary care providers to participate in Medicaid. The efforts in Mississippi were perceived to be at least somewhat successful, although work to increase access to Medicaid providers continues.

Best practices described by other stakeholder groups varied by stakeholder type. Advocates focused on the importance of coordinated messaging to families, insurance issuers advised about conducting outreach and working closely with members, and provider associations said that it is important to support practices as they navigate the transition. Advocates often serve as front-line messengers, both distributing information to families and elevating concerns raised by families to their contacts in the state. Advocates in this study served both purposes. For example, one Mississippi advocate cited advocates’ ability to spread messages in the community by leveraging contacts at Head Starts, child care centers, health ministries, and schools, further amplifying messages about the stairstep transition as a best practice. An advocate in Colorado echoed this sentiment, stating, *“The important takeaway from*

this policy implementation and others we have done in partnership with the state is the importance of getting the information out through those community-based organizations so that they can both train their professionals and also communicate about that effectively with their clients.” Finally, a Florida advocate reported filtering on-the-ground information back to the state and their organization’s ability to react quickly as a significant benefit, *“We’re catching problems as they’re coming up. If we start to see a trend in some issues, I make sure our state folks know it right away, and they’re able to address them very quickly. We’ve gotten really good about that, and I think we were able to do that really well even through this transition.”* Some other stakeholders validated advocates’ views. For example, one insurance issuer in Colorado remarked, *“I think really being hand in hand with the advocacy community, really leaning on their connections and their PR and outreach campaigns was important. They did a lot of that community education and preparation and stuff that didn’t cost the state anything, it didn’t cost the plans anything. It was just everybody was kind of collectively moving and leveraging the available resources to get information out in a really collaborative way.”*

As a best practice in some states, insurance issuers also identified efforts to match providers across programs. Insurance issuers offering both Medicaid and separate CHIP policies reported that they were able to advance efforts with their members to ensure smooth access and transitions by encouraging members to maintain their MCO when transitioning. For example, an insurance issuer in Pennsylvania noted that state administrators’ commitment to categorizing children based on whether they could keep their insurance issuers and/or primary care providers allowed them greater flexibility to work directly with transitioning members to encourage them to maintain MCOs and primary care providers.

Similar to advocates, provider group representatives viewed their best practices as twofold: to offer resources and support to practices affected by the transition and to give feedback to state administrators. First, provider groups reported that communication with their providers was critical. They spread the states’ messages about the transition and, as a provider group in Pennsylvania stated, kept *“practices ahead of the curve.”* The provider group in Pennsylvania asked the state for a copy of the letter to be mailed to families in advance so that it could distribute it to providers within its network. The early release of the letter gave providers a sneak peek at what the affected families were receiving in the mail, thus allowing the providers to anticipate potential questions. Other provider groups cited the strong working relationship between state government and pediatricians. For example, several state Medicaid and/or CHIP advisory councils included pediatricians as members, and, in Texas, a provider group noted that it provided feedback to the state on its messages, noting *“I think the big piece is when you have a coverage transition like this through the state and provider and consumer groups, to be able to offer feedback to the state before communications are sent out, given that we know the types of questions that clients are going to ask.”*

IV. LESSONS FROM THE STAIRSTEP TRANSITION

Transitioning stairstep children from separate CHIP to Medicaid was a significant undertaking, and state administrators and stakeholders in the 10 study states reported the completion of a relatively smooth transition. If federal funding for CHIP is not renewed after 2017 or other changes to the program are mandated, states may look to the stairstep transition as a model for how to approach future coverage transitions for children enrolled in CHIP or for broader coverage transitions.

This study found that the close coordination between Medicaid and separate CHIP programs in selected states helped facilitate smooth transitions. Transitioning children from separate CHIP to other programs, such as the health insurance marketplace, may prove more challenging if relationships and systems between the two programs are not as complementary and reinforcing as those between separate CHIP and Medicaid. Families of stairstep children often had experience with Medicaid before the transition because of either different-age siblings enrolled in Medicaid or a stairstep child's previous enrollment in Medicaid. Transitioning to a new program, such as a newly-created state-based children's health program or a health insurance marketplace, may be more challenging for families without a similar level of familiarity. Further, owing to close coordination between Medicaid and separate CHIP, states were able to implement the transition without requiring families to submit additional documentation beyond what is needed for a standard renewal process. Minimizing the burden on families likely eased the transition and is an important consideration for future coverage transitions. In the future, minimizing burden may prove more difficult with programs that are not as closely aligned as Medicaid and separate CHIP or that impose different eligibility requirements.

All types of stakeholders frequently cited strong communication within state government, with outside stakeholders, and with families as a best practice. Although CMS outlined high-level expectations for outreach (including proper and timely notification to families, education and notification to key stakeholders, and the establishment of a help line), state administrators generally described the guidance as minimal. For future coverage transitions, states may benefit from specific guidance related to the timing, notification methods, and other best practices for communicating about the transitions to families and other stakeholders. Further, the federal government did not make any outreach funding available for the purpose of conducting needed outreach. States have made deep cuts to separate CHIP outreach budgets in recent years (Harrington and Kenney et al. 2014), and the financial burden of notifying families and other stakeholders about the transition may have been large. Making funds available to conduct adequate outreach in advance of a transition may help ease the burden on the states, particularly if a future transition in coverage involves a greater volume of children than did the stairstep transition.

States in the study used a variety of strategies to ensure the continuity of children's primary care during the transition. These efforts reportedly benefited some children by allowing them to retain their providers after transitioning. However, the strategies adopted by states might not be feasible if the entire separate CHIP population were to transition to Medicaid, the marketplace, or both, given the large volume of individuals transitioning. For example, matching children with their primary care providers and the effort to ensure that children are assigned to an MCO in which their primary care provider participates is a much bigger challenge if millions of people

are involved, rather than the estimated half-million stairstep children nationally (Prater and Alker 2013). In addition, the longstanding problems with limited Medicaid provider participation might impede children's access to care in the face of a large-scale transition, such as that of all children in separate CHIP. At the least, a best practice for future coverage transitions could be to make it as easy as possible for families and guarantee them the right to switch MCOs or primary care providers for a reasonable period after the transition. In some states, the process to switch Medicaid MCOs or primary care providers reportedly now takes up to 45 days and requires families to complete significant paperwork.

The fact that some insurance issuers and provider associations encouraged CHIP providers to participate in Medicaid suggests that states conducting future transitions could solicit the cooperation of insurance issuers and providers. Communication from trusted sources about the advantages of Medicaid participation, such as the opportunity to retain current patients and receive enhanced Medicaid reimbursement (if relevant), seems to make some difference. Insurance issuers and provider associations could be strong allies in helping providers contact their transitioning patients in order to preserve continuity of care. For example, if provider practices received a list of the transitioning children seen in each practice, providers could be proactive and offer families concrete steps for how to continue to be seen by the same practice. Nonetheless, despite all efforts to preserve children's continuity of care, some disruption is likely to occur during a coverage transition.

During the transition, states struggled with the significant "background noise" of other simultaneously occurring ACA changes, including major eligibility systems changes. Future transitions in coverage may be less affected by concurrent changes, giving state administrators and outside stakeholders more capacity to focus on the transition at hand. In view of other significant changes occurring simultaneously, state administrators reported that they appreciated the leeway accorded them in implementing the stairstep transition. For example, states could implement the transition on their own time line (early, on deadline, or even a delayed transition, with CMS approval) and through the administrative structure that seemed most seamless for their circumstances (mass transition or at renewal). State administrators appreciated the assistance received from and flexibility permitted by the federal government in implementing the transition. For future coverage transitions, similar flexibility may be beneficial.

None of the states in the study dedicated resources to tracking the outcomes of the transition in terms of client satisfaction, ease of transition, or service utilization. Given that the change was mandatory, states may not have sensed the need to study the outcomes of the transition and to revisit their program decisions. However, an investigation into how children fare after a transition in coverage may shed light on important differences between CHIP and Medicaid and whether some stairstep children became uninsured as a result of the transition; these types of findings could be important considerations in future transitions in coverage. In the second part of this stairstep transition study, we are conducting an impact analysis that will rigorously assess changes in stairstep children's access and service utilization after the transition in Colorado and New York, two states that were early implementers of the transition. The information obtained in the first part of the study will provide important context for interpreting the evaluation findings of the impact of the transition on stairstep children in the 10 states in this study as well as nationally.

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APPENDIX A

METHODS

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Appendix A: Methods

To select states for inclusion in the study, we conducted an environmental scan, including a review of salient CHIP and Medicaid program features identified through published literature and reports, state plan amendments, and media releases. We also conducted Google searches to gather additional detail about the transition landscape in each of the 21 potential states. With consultation from MACPAC, we identified six key factors for assessment before recommending states for inclusion in the study: (1) inclusion in an accompanying impact analysis,¹⁴ (2) size of the potential stairstep population, (3) type of transition (such as an all-at-once “mass” transition, a rolling transition at the time of renewal, or some other type of transition),¹⁵ (4) whether the state expanded Medicaid to the newly eligible adult population, (5) separate CHIP and Medicaid delivery systems, and (6) presence of separate CHIP premiums. We prioritized certain criteria (such as size of the stairstep population) and looked to generate diversity in terms of other characteristics (such as an adult Medicaid expansion).¹⁶ Selected states that agreed to participate in the study include Alabama, Colorado, Florida, Mississippi, Nevada, North Carolina, Oregon, Pennsylvania, Texas, and Utah.

To recruit selected states, we began by contacting state Medicaid and separate CHIP administrators, requesting their participation in the study. Once we secured their participation, we scheduled 60-minute interviews with them separately or jointly, depending on the administrative structure of the department and respondent preferences. At the conclusion of the interviews, we asked for interviewees’ recommendations regarding additional state and local stakeholders who would be able to discuss the transition from a different perspective. We identified still other stakeholders through consultation with our project officer and through the environmental scan. We sought stakeholders who represented child health advocates, provider group representatives, and health insurance issuers. We were not able to secure participation from non-state stakeholders in all states; in several states, we found no appropriate stakeholders within a given category; in other states, our attempts to recruit the appropriate individual were unsuccessful.

We conducted interviews from April through July 2015 by telephone, using semistructured interview protocols. Copies of the four protocols are available in Appendix B. In Table II.2 in the main report, we show the number of interviews conducted, by state and type of respondent. We recorded and transcribed interviews; research staff reviewed the transcripts for accuracy and quality. The research team identified the main research themes of interest in order to develop a coding scheme, including code names and definitions. We applied the codes to all transcript notes in Atlas.ti and then analyzed the data, identifying common themes and insights.

¹⁴ In addition to this implementation assessment, we are conducting a quantitative outcomes analysis in which we will assess rigorously how the transition from separate CHIP to Medicaid affected children’s access to and use of health care in Colorado and New York, two states that transitioned their stairstep populations ahead of the deadline and therefore have longer follow-up data available than other states.

¹⁵ Although we aimed to consider type of transition during state selection, we were unable to determine such information for many states during the environmental scan.

¹⁶ Although we had prioritized the inclusion of both Colorado and New York in the implementation assessment due to their inclusion in the impact analysis, we did not include New York for two reasons: existing documentation of New York’s stairstep transition (Silow-Carroll and Rodin 2013; Prater and Alker 2013), and concerns about the burden imposed on state administrators.

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APPENDIX B

PROTOCOLS

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“STAIRSTEP CHILDREN” EVALUATION: STATE OFFICIALS PROTOCOL

Introduction

Introduce ourselves.

Thank you again for taking time to speak with us today. We have been funded by the Medicaid and CHIP Payment and Access Commission, or MACPAC, to learn more about states’ experiences in transitioning “stairstep” children from separate CHIP to Medicaid. These children are ages 6 to 18 whose family income lies between 100 and 138 percent of the federal poverty line; the Affordable Care Act required them to be covered under Medicaid as of January 1, 2014. For this work, we are interviewing key stakeholders in nine target states to more fully understand how states and other stakeholders planned for and implemented the transition, and to highlight particularly successful strategies. *(If asked, the nine states are Alabama, Colorado, Mississippi, New York, North Carolina, Oregon, Pennsylvania, Texas, and Utah. They were chosen based on the size of the population transitioning and diversity of Medicaid and separate CHIP program characteristics).* Information gathered during our interview will be used in a report that will aggregate and synthesize findings from the interviews across all states. *(If asked, MACPAC is interested in this topic because understanding the transition may be instructive as state and federal policymakers consider the future of children’s coverage, including identifying strategies for smoothing transitions from CHIP to other sources of coverage).*

I will be taping the interview today so that we can get it transcribed. We will not quote you directly in any public reporting based on this interview, but in general, we would like to attribute responses to your particular state. As a participating state, you will be given an opportunity to review and comment on project deliverables prior to publication.

Do you have any questions before we start?

A. Background on respondent/role

1. To start, could you please describe your agency and your role within that agency? How long have you been in this position?

B. Medicaid and separate CHIP program features

Next, I’d like to talk about some of the key features of Medicaid and separate CHIP in your state.

2. What are the key differences between the benefits packages children are offered through the separate CHIP and the Medicaid programs? (For example, coverage for EPSDT services, other optional CHIP benefits). From your observations, what types of children are affected by these differences? What are the implications of having different benefit packages offered in Medicaid and separate CHIP? Do children with special health care needs receive a different benefit package?

3. We understand that children enrolled in your separate CHIP program receive care through a **MANAGED CARE/FEE-FOR-SERVICE/COMBINATION** delivery system, and children enrolled in Medicaid receive care through a **MANAGED CARE/FEE-FOR-SERVICE/COMBINATION** delivery system. Is that correct?
 - a. *If interviewee's program uses managed care:* Are there any specific groups or geographic areas that are not covered through managed care, such as children with special health care needs or rural areas of the state? *If so:* Who isn't covered through managed care, and what are the criteria for making this determination?
 - b. *If interviewee's program uses managed care:* Are any services "carved out"? *If so:* How are services provided in those carve-outs: through managed care networks, FFS, or other arrangements?
 - c. *If delivery systems are different:* Why are different delivery systems used in separate CHIP and Medicaid?
 - d. *If both programs use managed care:* We want to understand how much overlap there is in the plans that participate in both programs. Do all of the managed care organizations that participate in **YOUR PROGRAM** also participate in **THE OTHER PROGRAM**? If not, do you know how many participate in **YOUR PROGRAM** but do not participate in **THE OTHER PROGRAM**?
 - e. *If both programs use managed care:* Regarding managed care provider networks, how similar would you say they are between Medicaid and separate CHIP: would you say they are identical or nearly identical; very similar; similar; not very similar; or don't know?

C. Development of stairstep transition policy

Next, I'd like to talk about the major decisions made regarding the stairstep transition, which the ACA required all states to implement by January 2014.

4. The Affordable Care Act passed in March 2010; the Supreme Court ruling in June 2012 did not affect the requirement to transition stairstep children from separate CHIP to Medicaid; and the deadline for the transition was January 2014, although CMS gave some states up to a year to transition children.
 - a. First, I'm wondering when did you first start planning for the transition? In hindsight, was this amount of planning time sufficient?
 - b. When did the transition take place – before January 2014, January 2014 (the required date), or after? Why did you choose this timeframe?
5. Who were the key players in developing **STATE**'s transition policy? (For example, separate CHIP and Medicaid agency staff, state legislature, key advocates). Did you work with staff from **THE OTHER PROGRAM** to develop a plan for undertaking and monitoring the transition? Who did you work with and what role did they play?

6. What efforts were made to ensure children’s continuity of care when transitioning between programs? For example, were any efforts made to align health insurance carriers across programs, or to align their provider networks? How effective were these efforts? What factors affected the success of the efforts? In hindsight, should anything more have been done?
7. Were any policies developed specifically for handling the needs of children who were undergoing treatment at the time of transition, to ensure they could continue treatment with existing providers? If so, what were the policies? How were these children identified? Did you monitor or track the outcomes of these policies at all?
8. What types of policy changes did you make in terms of enrollment and renewal procedures? (For example, revising applications and re-training eligibility and enrollment staff). How were these policy changes implemented? Did you monitor or track the outcomes? Is there anything more that could have been done to make these processes smoother?
9. In your opinion, were there any other critical decisions made when developing the transition policy that we haven’t already talked about? *If so*: Can you talk about those decisions and the rationale behind them? In hindsight, do you think these were the right decisions?
10. Can you give an example of something you planned for in advance that really paid off? (For example, plans for notifying families or development of a system for tracking the enhanced match). Conversely, is there anything you wished you had planned for in advance that you didn’t do?

D. Transition implementation

Now, I’d like to talk about how the transition was actually implemented in **STATE**.

11. How did **STATE** implement the transition—was it phased in at renewal, were all stairstep children transitioned on a particular date, or did you implement it in some other way? Why was this decision made? In hindsight, do you think this was the right decision? Why or why not?
 - a. *If mass transition*: How exactly did the mass transition work? For example, did families have to fill out an application or other additional paperwork during the transfer? How did/will the subsequent renewal process work? How did you ensure that families who needed to renew coverage after the transition occurred would know to renew with Medicaid?

- b. *If at renewal:* How exactly did the transition at renewal work? Did the family submit their application to renew with separate CHIP and, if found to be between 100 and 138 percent FPL, did they automatically get moved to Medicaid? Were families required to submit additional paperwork or apply separately to Medicaid?
 - c. *If some other way:* Can you please describe how the transition worked? What kind of paperwork did families need to fill out?
12. Regarding outreach to important stakeholders:
 - a. What types of outreach did you do for families? How many months in advance before the policy went into effect were families notified about the transition? Did you send any follow-up reminders? Who could they call with questions? Did you track the number of inquiries received? If so, how many did you receive? What were families most confused about?
 - b. What types of outreach did you do for providers? When and how often did you reach out to providers? What were their main concerns? How did they respond to the transition?
 - c. What types of outreach did you do for insurance carriers? When and how often did you reach out to insurance carriers? What were their main concerns? How did they respond to the transition?
 - d. Overall, what parts of your outreach strategy worked well? Would you do anything differently if you were to undergo another coverage transition here (e.g., mode of communication, frequency, message)?
13. Stairstep children who transitioned to Medicaid continue to receive the enhanced CHIP match from the federal government. How do you track which children in Medicaid are eligible for the enhanced match? Did this require you to make any program eligibility system changes? If so, what? How challenging were those to make?
14. What were the biggest areas of concern or confusion for program administrators in **STATE** when implementing the transition? How did you address these challenges?
15. Thinking back, how easy would you say the transition implementation was for families affected by it—very easy, easy but with some hiccups, difficult, or aren't sure? If there were implementation problems, is there anything you know now that you would have done differently? (For example, notify families sooner, require plans to do outreach to members, etc.)?

E. Transition outcomes

Next, I'd like to talk to you about some of the outcomes of the transition.

16. Of stairstep children who needed to transition from separate CHIP to Medicaid:
- How many actually enrolled in Medicaid?
 - Do you know how many obtained other sources of coverage? What types of coverage?
 - Do you know how many are uninsured? Why do you think these children failed to gain coverage?
17. How many children remain in your S-CHIP program? Were there any discussions in **STATE** about eliminating the separate CHIP program entirely because fewer children would be enrolled?
18. Have you assessed the impact of the transition on families or their satisfaction with coverage?
- If so*: How did you assess that and what you have learned?
 - If not*: If you have not assessed this from the families' perspectives, do you think the transition has benefited eligible children in your state? How so? Do you have any plans to assess the impact on families?
19. With regard to access to care, did you have any specific concerns prior to the transition about areas where the influx of children into Medicaid might be challenging (e.g. particular types of physician specialties or certain geographic areas of the state)? What contingencies did you have in place to help reduce this as an issue? How have these concerns played out?
20. Overall, how effective do you think your efforts to help families and providers ensure smooth transitions and to reduce gaps in coverage or care were?
21. *CHIP director*: What has been the fiscal impact of this transition on the state's separate CHIP budget? How have you dealt with the changes?
- Medicaid director*: What has been the fiscal impact of this transition on the state's Medicaid budget? How have you dealt with the changes?
22. Beyond budget, have there been any other major impacts of this program change at the state level?

F. Lessons learned and best practices

I have just a few final “big picture” questions to wrap up our conversation.

23. Did any unexpected issues or experiences emerge with regard to the transition? What were their effects on the state or on families?
24. What are the biggest challenges in implementing this transition between coverage sources from the perspective of administrators, and how were they overcome? What about for families?
25. After having conducted this transition, did **STATE** or any other stakeholders do anything that you would consider a best practice for ensuring smooth transitions, something that you would highly recommend if other major transitions in coverage were to occur in the future?

I’ve reached the end of my formal questions. Is there anything else you’d like to add to the conversation? Thank you very much for your time.

“STAIRSTEP CHILDREN” EVALUATION: ADVOCATES AND ENROLLMENT SPECIALISTS PROTOCOL

Introduction

Introduce ourselves.

Thank you again for taking time to speak with us today. We have been funded by the Medicaid and CHIP Payment and Access Commission, or MACPAC, to learn more about states’ experiences in transitioning “stairstep” children from separate CHIP to Medicaid. These children are ages 6 to 18 whose family income lies between 100 and 138 percent of the federal poverty line; the Affordable Care Act required them to be covered under Medicaid as of January 1, 2014. For this work, we are interviewing key stakeholders in nine target states to more fully understand how states and other stakeholders planned for and implemented the transition, and to highlight particularly successful strategies. *(If asked, the nine states are Alabama, Colorado, Mississippi, New York, North Carolina, Oregon, Pennsylvania, Texas, and Utah. They were chosen based on the size of the population transitioning and diversity of Medicaid and separate CHIP program characteristics).* Information gathered during our interview will be used in a report that will aggregate and synthesize findings from the interviews across all states. *(If asked, MACPAC is interested in this topic because understanding the transition may be instructive as state and federal policymakers consider the future of children’s coverage, including identifying strategies for smoothing transitions from CHIP to other sources of coverage).*

I will be taping the interview today so that we can get it transcribed. We will not quote you directly in any public reporting based on this interview, but in general, we would like to attribute responses to your particular state.

Do you have any questions before we start?

A. Background on respondent/role

First, I have a few questions about who you are and what you do.

1. To start, could you please describe the mission and activities of your organization? *If unclear:* How do your activities intersect with the separate CHIP and Medicaid programs?
2. What is your position, and how long have you been serving in this role?

B. Medicaid and separate CHIP program features

Next I have a few questions about Medicaid and separate CHIP program features in your state.

3. Are there any key differences between the benefits packages children are offered through the separate CHIP and the Medicaid programs? (For example, coverage for EPSDT services, other optional CHIP benefits **as identified in Medicaid/CHIP director interview**).
 - a. *If yes:* From your observations, what types of children are affected by these differences? What are the implications of having different benefit packages offered in Medicaid and separate CHIP?
4. We understand that children enrolled in Medicaid and separate CHIP use **THE SAME/DIFFERENT** delivery systems in **STATE** (Medicaid uses **XXX**, CHIP uses **XXX**).
 - a. *If same:* Based on your experiences, are the networks of providers in the two programs the same? If not, what are the major differences?
 - b. *If different:* Based on your experiences, how does access to care for children under Medicaid compare to that afforded by separate CHIP?
5. Are you aware of any access problems, either in general, or for specific services, such as dental, behavioral health, or specialty care, in Medicaid? What about in separate CHIP? *If so:* Do you think this is the result of too few providers, too few providers willing to participate in Medicaid and/or separate CHIP, geographic distribution, or some other reason? *If other:* What?

C. Development of stairstep transition policy

Next, I'd like to talk about the timeline and some of the major decisions made regarding the stairstep transition.

6. Did the state engage you in thinking through or planning for the transition? *If so:* What role did you play?
7. From your vantage point, what efforts did the state make to ensure children's continuity of care when transitioning between programs? For example, were any efforts made to align health insurance carriers across programs, or to align their provider networks? How effective were these efforts? What factors affected the success of the efforts? In hindsight, should anything more have been done?
8. Were any policies developed by the state specifically for handling the needs of children who were undergoing treatment at the time of transition, to ensure they could continue treatment with existing providers? How effective were these efforts?
9. In your opinion, were there any other critical decisions made when developing the transition policy that we haven't already talked about? *If so:* What, and why do you think this decision was made? In hindsight, do you think these were the right decisions?

D. Transition implementation

Now, I'd like to talk about how the transition was actually implemented in **STATE**.

10. **Florida** implemented the transition by **PHASING IT IN AT RENEWAL/CONDUCTING A MASS CHANGE ON A SINGLE DATE**. In hindsight, do you think this was the right decision here? Why or why not?
 - a. *If mass transition*: How exactly did the mass transition work? For example, did families have to fill out an application or other additional paperwork during the transfer? How did/will the subsequent renewal process work? How did the state try to ensure that families who needed to renew coverage after the transition occurred know to renew with Medicaid?
 - b. *If at renewal*: How exactly did the transition at renewal work? Did the family submit their application to renew with separate CHIP and, if found to be between 100 and 138 percent FPL, did they automatically get moved to Medicaid? Were families required to submit additional paperwork or apply separately to Medicaid?
 - c. *If some other way*: Can you please describe how the transition worked? What kind of paperwork did families need to fill out?
11. Did your organization play a role in conducting outreach to families or to providers to alert them to the upcoming transition?
 - a. *If so*: What did you do? Did you receive anything from the state to conduct this outreach (materials, messaging, other supports)? Did you develop anything further yourselves? If so, what?
 - b. *If so*: If another coverage transition were to occur, would you make any changes to the types of outreach you conducted or to the information you gave families? If so, what changes would you make?
 - c. *If not*: Who conducted outreach in **STATE** to notify people in advance of the transition? What kinds of information did they provide? Did this seem adequate?
12. How did families respond to the transition? Were families concerned about keeping their coverage? What about provider availability/access to care? Were there any other major areas of concern or confusion?
13. Does your organization help families with enrolling or renewing their coverage? *If so*:
 - a. Did implementation of the stairstep policy introduce any changes to enrollment and renewal procedures, such as revisions to the application, longer processing times, confusion regarding which program a child was eligible for, or others? *If so*: Please discuss those changes and the effects you observed on these processes.

- b. Did your agency's enrollment/renewal staff need to be re-trained in order to adequately assist families? Did the state provide any training? Did your organization or some other group provide training? What types of training were offered?
 - c. Did you observe any common issues or problems with the process? Can you describe those? How were problems resolved?
14. Thinking back, how easy would you say the transition implementation was for families affected by it—very easy, easy but with some hiccups, difficult, or aren't sure? If there were implementation problems, is there anything you know now that you would have wanted done differently? (For example, notify families sooner, require plans to do outreach to members, etc.)?

E. Transition outcomes

Next, I'd like to talk to you about some of the outcomes of the transition.

15. Do you think this transition has benefited the affected families? (For example, aligning coverage for families in Medicaid, giving children access to better benefits package, administrative efficiency, better access to care for children with special health care needs, no out-of-pocket costs). If so, could you describe those benefits? Is this based on data you've collected, on your own observations, or something else?
16. Were there any discussions in **STATE** about eliminating the separate CHIP program entirely because fewer children would be enrolled? Do you think that would be beneficial for children or not?
17. Do you think this transition has had any drawbacks for affected families? (For example, reduced access to providers, continuity of care issues, IT and systems glitches, unnecessary change, confusion about carve-outs). If so, could you describe those? Is this based on data you've collected, on your own observations, or on something else?
18. *If not directly addressed already:* Based on your knowledge of the transition and its impacts, have you seen any early evidence of changes in access to care for stairstep children? If so, what? If not, do you have any speculation about how this transition from Medicaid to separate CHIP will affect children's access to care—will it improve it, worsen it, or have no effect? Why?
19. *If not directly addressed already:* Did you see any evidence of impacts on children's continuity of care, particularly for children undergoing treatment at the time of the transition? If so, what?
20. *If Medicaid and CHIP utilize different delivery systems:* Did the switch from separate CHIP's **MANAGED CARE/FFS** delivery system to Medicaid's **MANAGED CARE/FFS** delivery system pose any problems for families that you're aware of? If so, please describe what you've observed.

21. Overall, how have the families you interact with viewed this policy change? Have they faced challenges since the transition, such as getting enrolled, staying enrolled, or receiving care? Are they satisfied with the switch?
22. Are there any other issues that have emerged due to the transition that we have yet to discuss? If so, what are they? How prevalent and/or persistent is the issue? What could be done to help address this issue?

F. Lessons learned and best practices

I have just a few final “big picture” questions to wrap up our conversation.

23. As an advocate, what are the biggest challenges in helping families navigate the transition and how did you overcome them? What were the biggest challenges for families with this transition?
24. After having undertaken this transition, did **your organization** do anything to help children and families that you would consider a best practice for ensuring smooth transitions, something that you would highly recommend advocates doing if other major transitions in coverage were to occur?

I've reached the end of my formal questions. Is there anything else you'd like to add to the conversation? Thank you very much for your time.

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“STAIRSTEP CHILDREN” EVALUATION: HEALTH INSURANCE ISSUERS PROTOCOL

Introduction

Introduce ourselves.

Thank you again for taking time to speak with us today. We have been funded by the Medicaid and CHIP Payment and Access Commission, or MACPAC, to learn more about states’ experiences in transitioning “stairstep” children from separate CHIP to Medicaid. These children are ages 6 to 18 whose family income lies between 100 and 138 percent of the federal poverty line; the Affordable Care Act required them to be covered under Medicaid as of January 1, 2014. For this work, we are interviewing key stakeholders in nine target states to more fully understand how states and other stakeholders planned for and implemented the transition, and to highlight particularly successful strategies. *(If asked, the nine states are Alabama, Colorado, Mississippi, New York, North Carolina, Oregon, Pennsylvania, Texas, and Utah. They were chosen based on the size of the population transitioning and diversity of Medicaid and separate CHIP program characteristics).* Information gathered during our interview will be used in a report that will aggregate and synthesize findings from the interviews across all states. *(If asked, MACPAC is interested in this topic because understanding the transition may be instructive as state and federal policymakers consider the future of children’s coverage, including identifying strategies for smoothing transitions from CHIP to other sources of coverage).*

I will be taping the interview today so that we can get it transcribed. We will not quote you directly in any public reporting based on this interview, but in general, we would like to attribute responses to your particular state.

Do you have any questions before we start?

A. Background on respondent/role

First, I have a few questions about who you are and what you do.

1. What is your position, and how long have you been serving in this role?
2. Next, I want to learn some basic characteristics about your insurance company. First, are you for-profit or not-for-profit?
3. Do you serve both Medicaid and separate CHIP, or just one of the programs? *If just one of the programs:* Why do you participate in just one program?
 - a. *If offer Medicaid:* How many children are enrolled in your Medicaid plans? Do you know what proportion of Medicaid enrollees in your state choose one of your plans?
 - b. *If offer CHIP:* How many children are enrolled in your CHIP plans? Do you know what proportion of CHIP enrollees in your state choose one of your plans?

4. Did the stairstep transition affect which programs your company offers coverage in? If so, how and why did you make this decision?

B. Medicaid and separate CHIP program features

Next I have a few questions about Medicaid and separate CHIP program features in your state.

5. We understand that children enrolled in Medicaid and separate CHIP use **THE SAME/DIFFERENT** delivery systems in **STATE (MEDICAID USES XXX, CHIP USES XXX)**.
 - a. *If delivery systems are different:* How do the differences in delivery systems affect children's access to care?
 - b. *If offer plans in both programs:* Do you know how similar your company's Medicaid and CHIP provider networks are? For example, how do access standards compare for the two types of networks (such as the number of pediatricians per 10,000 enrollees, or the number of children's hospitals included in the networks)?
6. *If offer plans in both programs:* How does access to services for members in Medicaid compare to those in separate CHIP? To what do you attribute those differences? (Possible probes: availability of providers willing to participate in programs, differences in covered benefits, cost-sharing requirements, geography).
7. *If offer plans in one program:* Are you aware of any access challenges for your members, either in general, or for specific services, such as dental, behavioral health, or specialty care? *If so:* Do you think this is the result of too few providers, too few providers willing to participate in (**program they participate in**), geographic distribution, or some other reason? *If other:* What other reason?
8. From your perspective, are there any programmatic differences between Medicaid and separate CHIP that affect providers' willingness to participate? (For example, provider reimbursement rates or the population covered).

C. Development of stairstep transition policy

Next, I'd like to talk about the timeline and some of the major decisions made regarding the stairstep transition.

9. What did you do to prepare for the transition of stairstep kids? Did you need to make any changes to your systems in order to be ready to (**enroll/disenroll/transition**) **stairstep** children?
10. Did the state engage you in thinking through or planning for this transition? *If so:* What role did you play?

11. Did the state require health insurers to do anything special to ensure children's continuity of care when transitioning between programs? For example, were any efforts made to align health insurance carriers across programs or to align their provider networks? Was this a time-limited effort, or are those policies ongoing? What was the impact of those efforts?
12. *If any attempts to align coverage have been made:* What have been the benefits to any attempts to align plans across programs? What do you see as the drawbacks or challenges?
13. Did the state develop any policies specifically for how health insurers should handle the needs of children who were undergoing treatment at the time of transition, to ensure they could continue treatment with existing providers? Was this a time-limited effort, or are those policies ongoing? What was the impact of those efforts?
14. Were there any additional policies your company put in place to handle children's continuity of care and/or the treatment needs of children undergoing treatment at the time of transition? *If so:* What did you do? Was this a time-limited effort, or are those policies ongoing? What was the impact of those efforts? Are there challenges to implementing such policies?
15. What was your greatest concern leading up to the transition (e.g., administrative issues, coverage for certain populations)? How did it play out once the transition occurred?

D. Transition implementation

Now, I'd like to talk about how the transition was actually implemented in **STATE**.

16. Did your company play a role in conducting outreach to families or to providers to alert them to the upcoming transition? *If so:*
 - a. What did you do? What were the main messages? *If conducting outreach to providers:* Was the outreach to providers intended to educate them about the change, or to also try to encourage them to participate in Medicaid?
 - b. Did you receive anything from the state to conduct this outreach (materials, messaging, other supports)? Did you develop anything further yourselves? If so, what?
 - c. If another coverage transition were to occur, would you make any changes to the types of outreach you conducted or to the information you gave families and providers? If so, what changes would you make?
17. How did providers respond to the transition? Were they concerned about provider continuity or access to care for their patients? Were there any other major areas of concern or confusion? How did those concerns play out? What did you do to try to alleviate those concerns? How did the state address these concerns?

18. Are you aware of any providers that previously only accepted separate CHIP who now contract with Medicaid in an effort to maintain their stairstep patients?
19. What about the opposite scenario—separate CHIP providers with stairstep children who did **not** begin contracting with Medicaid after the transition? What happened to patients of those providers? Did you observe any impacts on those children?
20. *If offer plans in both programs:* Were you permitted to make any attempts to encourage transitioning stairstep children to enroll in your Medicaid plan (as opposed to a different insurer’s plan)? *If so:* What did you do? How effective do you think this was?

If offer CHIP only: Were you at all encouraged by the state to begin offering plans in Medicaid, in order to better coordinate coverage and care between the two programs? Is this something you considered or something you would consider in the future? Why or why not?

If offer Medicaid only: Knowing that there would be an increase in the number of children eligible for Medicaid, did you make any attempts to encourage enrollment in your Medicaid plan? For example, did you partner with a CHIP carrier to encourage stairstep kids from their plan to enroll in yours, or reaching out to families enrolled in your Medicaid plan with a stairstep sibling to enroll in the same plan?
21. Did your organization undertake any efforts to help ensure smooth transitions and to reduce gaps in coverage or care that we haven’t already talked about? *If so:* What did you do? How effective do you think these efforts were? Would you do anything differently if another coverage transition were to occur here?

E. Transition outcomes

Next, I’d like to talk to you about some of the outcomes of the transition.

22. *If offer plans in both:* Are you tracking the number of stairstep children that enroll in your Medicaid plans? *If so:* How many stairstep children do you have enrolled? How easy (or difficult) is it to track this population?

If offer plans in only one program: Are you tracking the number of stairstep children that (**disenrolled/enrolled**) in your plans? *If so:* How many stairstep children have been affected? How easy (or difficult) is it to track this population?
23. Are you doing anything (either required by the state or on your own) to specifically track access or utilization grievances by stairstep children? *If so:* What are you doing? What are you learning?
24. Based on your knowledge of the transition and its impacts, have you seen any early evidence of changes in access to care for stairstep children? If so, what? If not, do you have any speculation about how this transition from Medicaid to separate CHIP will affect children’s access to care—will it improve it, reduce it, or have no effect? Why?

25. Did you see any evidence of impacts on children’s continuity of care, particularly for children undergoing treatment at the time of the transition? If so, what?
26. Are there any other issues that have emerged due to the transition that we have yet to discuss? If so, what are they? How prevalent and/or persistent is the issue? What could be done to help address this issue?

F. Lessons learned and best practices

I have just a few final “big picture” questions to wrap up our conversation.

27. As a health insurance carrier, what were the biggest challenges or what didn’t work well in implementing this transition? How were those challenges overcome?
28. After having undertaken this transition, did the state or **your company** do anything to help children, families, or providers that you would consider a best practice, something that you would highly recommend insurers doing if another coverage transition were to occur?
29. Did the state do anything to help health plans undertake this transition?

I’ve reached the end of my formal questions. Is there anything else you’d like to add to the conversation? Thank you very much for your time.

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“STAIRSTEP CHILDREN” EVALUATION: PROVIDER GROUPS PROTOCOL

Introduction

Introduce ourselves.

Thank you again for taking time to speak with us today. We have been funded by the Medicaid and CHIP Payment and Access Commission, or MACPAC, to learn more about states’ experiences in transitioning “stairstep” children from separate CHIP to Medicaid. These children are ages 6 to 18 whose family income lies between 100 and 138 percent of the federal poverty line; the Affordable Care Act required them to be covered under Medicaid as of January 1, 2014. For this work, we are interviewing key stakeholders in nine target states to more fully understand how states and other stakeholders planned for and implemented the transition, and to highlight particularly successful strategies. *(If asked, the nine states are Alabama, Colorado, Mississippi, New York, North Carolina, Oregon, Pennsylvania, Texas, and Utah. They were chosen based on the size of the population transitioning and diversity of Medicaid and separate CHIP program characteristics).* Information gathered during our interview will be used in a report that will aggregate and synthesize findings from the interviews across all states. *(If asked, MACPAC is interested in this topic because understanding the transition may be instructive as state and federal policymakers consider the future of children’s coverage, including identifying strategies for smoothing transitions from CHIP to other sources of coverage).*

I will be taping the interview today so that we can get it transcribed. We will not quote you directly in any public reporting based on this interview, but in general, we would like to attribute responses to your particular state.

Do you have any questions before we start?

A. Background on respondent/role

First, I have a few questions about who you are and what you do.

1. What is the mission of your organization and what is your position there? What kinds of activities does your organization engage in?

B. Medicaid and separate CHIP program features

Next I have a few questions about Medicaid and separate CHIP program features in your state.

2. Are there any key differences between the benefits packages children are offered through the separate CHIP and the Medicaid programs? (For example, coverage for EPSDT services, other optional CHIP benefits **as identified in Medicaid/CHIP director interview**).
 - a. *If yes:* From your observations, do these differences seem to affect children’s use of care when comparing the two programs? If so, what types of patterns have you noticed?

3. We understand that children enrolled in Medicaid and separate CHIP use **THE SAME/DIFFERENT** delivery systems in **STATE** (**MEDICAID USES XXX, separate CHIP USES XXX**).
 - a. *If different:* How do the differences in delivery systems affect children's access to care?
 - b. *If same:* Based on your experiences, how does access to care for children under Medicaid compare to that afforded by separate CHIP?
4. Are you aware of any access problems, either in general, or for specific services, such as dental, behavioral health, or specialty care, in Medicaid? What about in separate CHIP? *If so:* Do you think this is the result of too few providers, too few providers willing to participate in Medicaid and/or separate CHIP, geographic distribution, or some other reason? *If other:* What?
5. From your perspective, are there any programmatic differences between Medicaid and separate CHIP that affect providers' willingness to participate? (For example, provider reimbursement rates or the population covered).

C. Development of stairstep transition policy

Next, I'd like to talk about the timeline and some of the major decisions made regarding the stairstep transition.

6. When did you first become aware that stairstep children would be transitioning from separate CHIP to Medicaid in **STATE**?
7. Did the state engage you or other provider groups in thinking through or planning for this transition? *If so:* What role did you play?
8. Did the Medicaid and separate CHIP health plans engage you or other provider groups in thinking through or planning for this transition? *If so:* What role did you play?
9. From your vantage point, what efforts did the state make to ensure children's continuity of care when transitioning between programs? For example, were any efforts made to align health insurance carriers across programs or their provider networks? In hindsight, should anything more have been done?
10. Were any policies developed by the state specifically for handling the needs of children who were undergoing treatment at the time of transition, to ensure they could continue treatment with existing providers? How effective were these efforts?
11. In your opinion, were there any other critical decisions made when developing the transition policy that we haven't already talked about? *If so:* What, and why do you think this decision was made? In hindsight, do you think these were the right decisions?

D. Transition implementation

Now, I'd like to talk about how the transition was actually implemented in **STATE**.

12. Did your organization play a role in conducting outreach to providers or to families to alert them to the upcoming transition?
 - d. *If so*: Who did you conduct outreach to (providers, families, or both), and what kinds of outreach did you do? What were the main messages? *If conducting outreach to providers*: Was the outreach to providers intended to educate them about the change, or to also try to encourage them to participate in Medicaid?
 - e. *If so*: Did you receive anything from the state or from health plans to conduct this outreach (materials, messaging, other supports)? Did you develop anything further yourselves? If so, what?
 - f. *If so*: If another coverage transition were to occur, would you make any changes to the types of outreach you conducted or to the information you gave to [providers/families—whichever group(s) they said they did outreach for]? What changes would you make?
 - g. *If not*: Who conducted outreach in **STATE** to notify people in advance of the transition? What kinds of information did they offer to providers? What about to families? Did this seem adequate?
13. How did providers respond to the transition? Were they concerned about provider continuity or access to care for their patients? Were there any other major areas of concern or confusion? How did those concerns play out? What was done to address the concerns?
14. Are you aware of any providers that previously only accepted separate CHIP who now contract with Medicaid in an effort to maintain their stairstep patients? *If so*: What do you think influenced them to begin contracting with Medicaid?
15. Did your organization undertake any efforts to help ensure smooth transitions and to reduce gaps in coverage or care that we haven't already talked about? *If so*: What did you do? How effective do you think these efforts were? Would you do anything differently if another coverage transition were to occur here?
16. Thinking back, how easy would you say the transition implementation was for providers—very easy, easy but with some hiccups, difficult, or aren't sure? If there were implementation problems, is there anything you know now that you would have wanted done differently? (For example, notify providers sooner, require plans to do outreach to members, etc.)? What worked well?

E. Transition outcomes

Next, I'd like to talk to you about some of the outcomes of the transition.

17. Do you think this transition has benefited the affected families? (For example, aligning coverage for families in Medicaid, giving children access to better benefits package, administrative efficiency, better access to care for children with special health care needs, no out-of-pocket costs). If so, could you describe those benefits? Is this based on data you've collected, on your own observations, or something else?
18. Do you think this transition has had any drawbacks for affected families? (For example, reduced access to providers, continuity of care issues, IT and systems glitches, unnecessary change, confusion about carve-outs). If so, could you describe those? Is this based on data you've collected, on your own observations, or something else?
19. *If not directly addressed already:* Are you hearing about or seeing any evidence of impacts on children's continuity of care, particularly for children undergoing treatment at the time of the transition? If so, what?
20. Has the transition of stairstep children had any effect on the providers that you work with? What has been the effect?
21. Have you heard about concerns or confusion from families or from your providers, such as calls about questions regarding benefits or in-network providers?
22. Have you or the providers you represent noticed any changes in use of care for stairstep children after the transition, for example an uptick in utilization of services that are covered under Medicaid that are not covered under separate CHIP (or that require cost-sharing in separate CHIP)?
23. Are there any other issues for families or providers that have emerged due to the transition that we have yet to discuss? If so, what are they? How prevalent and/or persistent is the issue? What could be done to help address this issue?

F. Lessons learned and best practices

I have just a few final "big picture" questions to wrap up our conversation.

24. As a provider group, what were the biggest challenges or what didn't work as well for providers in implementing the transition? How were those challenges overcome?
25. Did **your organization** do anything during the transition that was particularly helpful to children, families, or providers that you would highly recommend provider groups do if another coverage transition were to occur?

I've reached the end of my formal questions. Is there anything else you'd like to add to the conversation? Thank you very much for your time.

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