MCHP Disenrollee Survey Instrument

Interviewer: Hello, this is _______ calling on behalf of the State of Maryland. I am calling because you had a child enrolled in the Maryland Children's Health Program, also known as MCHP. I would like to ask you about recent changes to MCHP and your child's experiences with the program.

Are you the parent or guardian of CHILD'S NAME who knows the most about CHILD'S NAME medical and health care? *(If NO, then ask to speak with the child's appropriate parent or guardian. If parent or guardian is unavailable then ask when would be a better time to call back.)*

Upon reaching the appropriate parent or guardian repeat the introduction and then continue:

If you would like to participate in this interview, I'll ask you some questions. This interview will take only a few minutes.

Your participation is voluntary. Your decision to participate and your answers to my questions will not affect your child's current or future services or benefits.

Your answers will be kept completely confidential and you will not be identified in any way. You do not have to answer all the questions, only those you feel comfortable with.

A. Would you be willing to participate in this brief survey?

YES ρ (proceed with the interview item C below)

NO ρ *ASK THE FOLLOWING QUESTION*

B. Would you be interested in participating on a future date that would be more convenient for you?

YES ρ (reschedule survey)

NO ρ *SAY THE FOLLOWING AND THEN DISCONTINUE THE INTERVIEW*

Thank you for taking the time to speak with me.

C. Our records indicate that CHILD'S NAME is no longer enrolled in MCHP, is that correct?

YES ρ (proceed with question 1 below)

NO ρ
DON'T KNOW ρ
REFUSED ρ

SAY THE FOLLOWING SENTENCE AND THEN SKIP TO QUESTION 1

It is possible that our records have not been updated. However, we still have a few questions for you. ρ (Proceed with question 1 below)

Interviewer: If more than one child in your family disenrolled from MCHP, we are only asking about CHILD'S NAME.

1. In the past few months, did you receive any letters from the State of Maryland's Department of Health and Mental Hygiene about changes in MCHP?

YES (proceed with question 2 below)

NO (skip to question 3 below)

2. Was the letter you received clear and written in a way that was easy to understand?

YES (proceed with question 3 below)

NO (proceed with question 3 below)

3. In the past few months, did you contact anyone about the changes in MCHP or about an MCHP bill you received?

YES	(proceed with question 4 below)
NO	(skip to question 6 below)

4. Who did you contact?
   ____________________ (Interviewer write answer) (proceed with question 5 below)

5. Were you satisfied with the help you received from the individual or agency that you contacted?

   YES (proceed with question 6 below)

   NO (proceed with question 6 below)

6. Were you aware that, beginning in September, it would cost $37 per month for one or more children in a family to participate in MCHP?

   YES (skip to question 9 below)

   NO (proceed with question 7 below)

7. If you had known about the $37 monthly cost, would you have paid that amount in order to keep CHILD'S NAME enrolled in MCHP?

   YES (skip to question 10 below)

   NO (proceed with question 8 below)

8. Do you feel that $37 is an affordable amount to pay each month to participate in MCHP?

   YES (skip to question 10 below)

   NO (skip to question 10 below)

9. How did you learn about the $37 monthly cost? (*more than one response can be accepted)*
   A. The letter you received (proceed with question 10 below)
   B. From your local health department (proceed with question 10 below)
   C. From calling your MCO (proceed with question 10 below)
   D. From your doctor's office (proceed with question 10 below)
   E. Other __________________ (proceed with question 10 below)

10. Which of the following best describes why CHILD'S NAME is no longer in MCHP? (Read all responses first, then ask the respondent to choose the best response)

    A. You obtained other insurance (skip to question 13 below)
    B. $37 was more than you felt that you afford each month (proceed with question 11 below)
    C. You did not understand the letter that you received (proceed with question 11 below)
    D. You were dissatisfied with some part of MCHP (proceed with question 11 below)
    E. You felt that your child did not need insurance (proceed with question 11 below)
    F. You did not know you had to pay the new monthly cost (proceed with question 11 below)
    G. You did not pay the monthly cost on time (proceed with question 11 below)
    H. Other ____

11. Have you obtained any other health insurance for CHILD'S NAME?

    YES (skip to question 13 below)

    NO (proceed with question 12 below)

12. Which of the following describe how you plan to get health services for CHILD'S NAME? (*Check all that apply*)

   A. You will reapply for insurance through MCHP (proceed with question 13 below).
   B. You will purchase other health insurance for your child or obtain insurance through your employer (proceed with question 13 below).
   C. You will use your own money to pay for any health care your child may need (proceed with question 13 below).
   D. You will go to a community clinic for health care your child may need (proceed with question 13 below).
   E. You will take your child to the emergency room if he/she needs health care (proceed with question 13 below).
   F. Your child will have to go without needed health services because you cannot afford to pay for them (proceed with question 13 below).
   G. Other ______________________________

13. While in MCHP, how many times did CHILD'S NAME see a doctor during the year?

   A. 1-2 (proceed with question 14 below)
   B. 3-5 (proceed with question 14 below)
   C. 5 or more times? (proceed with question 14 below)

14. Which of the following services did your child receive? (*Check all that apply*)

   A. Regular check-up (well child or Healthy kids) (proceed with question 15 below)
   B. Doctor's visits while your child was sick (proceed with question 15 below)
   C. Dental Care (proceed with question 15 below)
   D. Hospital or emergency room care (proceed with question 15 below)
   E. Other ____________ (proceed with question 15 below)

15. Was your child taking any medication on a regular basis while in MCHP?

YES (proceed with question 16 below)

NO (skip to question 18 below)

16. Has your child been able to continue taking the medication?

YES (skip to question 18 below)

NO (proceed with question 17 below)

17. Please describe the reason why your child is no longer taking the medication:

A. You cannot afford to pay for the medication. (proceed to question 18 below)

B. Your child no longer needs the medication. (proceed to question 18 below)

C. The prescription ran out and you cannot afford to take your child to the doctor to get it renewed. (proceed to question 18 below)

D. Other ____ (proceed to question 18 below)

18. Were you aware that you could reapply for MCHP at any time?

YES (proceed with question 19 below)

NO (proceed with question 19 below)

19. Is there any other information you would like to share about CHILD'S NAME experience in MCHP?

YES ________________________________

NO

This concludes our questions. If you have questions about MCHP, you may call the MCHP Premium Case Management Unit at 1-866-269-5576.

If you are interested in re-enrolling in MCHP, please contact your local health department or call 1-800-456-8900 for an application.

Thank you for taking the time to speak with me.