FRAMEWORK FOR ANNUAL REPORT OF STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**
- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**
- Build on data ***already collected*** by HCFA quarterly enrollment and expenditure reports, **AND**
- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

FRAMEWORK FOR ANNUAL REPORT OF STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory:

Alabama

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

_____

(Signature of Agency Head)

SCHIP Program Name (s): ***Phase I – Medicaid Expansion, Phase II – ALL Kids***

SCHIP Program Type ____Medicaid SCHIP Expansion Only
____Separate SCHIP Program Only
_***X***_Combination of the above

Reporting Period: **Federal Fiscal Year 2000 (10/1/99-9/30/00)**

Contact Person/Title: ***Cathy Caldwell, Data Manager***
Children's Health Insurance Program

Address: ***201 Monroe St***
Montgomery, AL. 36104

Phone ***(334) 206-5568*** Fax : ***(334) 206-2950***

Email: ***ccaldwell@adph.state.al.us***

Submission Date: ***January 1, 2001***

SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This sections has been designed to allow you to report on your SCHIP program=s changes and progress during Federal fiscal year 2000 (September 30, 1999 to October 1, 2000).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 1999 in the following areas and explain the reason(s) the changes were implemented.

Note: If no new policies or procedures have been implemented since September 30, 1999, please enter ›NC= for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

1. Program eligibility:

- ***In November 1999 a policy was adopted by the ALL Kids program to place all American Indian enrollees in the No Fee category. The decision was also made to have this apply to both federal and state recognized tribes.***
- ***In February 2000 Amendment #3 was made to Alabama's CHIP Plan to allow for income from temporary work with the U S Census Bureau to be disregarded when applying for ALL Kids.***
- ***Procedures were enacted to allow for transition between ALL Kids, SOBRA Medicaid and the Alabama Child Caring Foundation (ACCF) (a private philanthropic organization) without a lapse in coverage when an individual's eligibility status changes at annual renewal.***

2. Enrollment process:

- ***The Alabama Child Caring Foundation (ACCF) has been added to the joint ALL Kids/SOBRA Medicaid application. When an application is reviewed by either SOBRA Medicaid or ALL Kids and the children are not Medicaid or ALL Kids eligible the application is then forwarded to ACCF.***

3. Presumptive eligibility: ***NC***

4. Continuous eligibility: ***NC***

5. Outreach/marketing campaigns:

- ***School outreach continues. In October 1998 joint Medicaid / ALL Kids applications were sent out to every child in public school in the state. In October of 1999 as part of the Statewide Parenting Day, an ALL Kids informational brochure was sent out to every child in the state. Posters were sent to each to school to be displayed. Applications were also sent to each school to be distributed to interested parents.***

- ***We have intensified outreach efforts through the public school system by exhibiting at regional and annual School Nurse conferences. Made overview presentations at the new school nurse orientation and training conferences and to the Department of Education Child Nutrition Directors. Exhibited at the annual Mega-Conference attended by an overwhelming majority of the states' teachers, principals, assistant principals, and guidance counselors sponsored by the Alabama Department of Education's Health Education Department. Have distributed CHIP information and specialty items to support school-sponsored events and participated in numerous school-hosted health fairs around the state. The strong success of outreach through the school system, as evidenced by the percentage of applications the enrollment office receives stating schools as the source of information and / or application, confirms school outreach as the most effective tool we have used so far.***
- ***The use of specialty items bearing the ALL Kids toll-free number has increased information and application request calls because individuals have access to the toll-free number in a form that remains in the home or office.***
- ***Strengthened outreach to hospitals, doctor's offices and other healthcare providers to encourage them to identify families with uninsured children who use their services, to equip them to educate caregivers as to the importance of health insurance and a medical home. Attended appropriate association meetings to support this effort.***
- ***Accelerated the growth of partnerships with associations and organizations around the state that have embraced "getting Alabama's children insured" as their mission. Increased in-service trainings to these groups to empower them to successfully carry out outreach activities in their communities.***

6. Eligibility determination process: ***NC***

7. Eligibility redetermination process:

    - ***The ALL Kids Program began in October 1998. Children enrolled are awarded twelve months of continuous eligibility, unless they turn 19 years of age prior to that time. Therefore, the first ALL Kids renewal process began in October 1999. Data from the ongoing renewal process will be discussed later in this document.***

8. Benefit structure:

    - ***Alabama's CHIP Plan Amendment II- ALL Kids Plus was approved by HCFA September 24, 1999. All Kids Plus will provide for expanded services for Children with Special Healthcare Needs and Conditions (CSHNC). Implementation of ALL Kids Plus began in FY 2000 with the signing of the contract with Alabama Department of Rehabilitative Services (ADRS). Further efforts are being made to finalize contracts and plans for implementation with two additional state agencies, Department of Mental Health Mental Retardation and the University of Alabama Sparks Center.***

9. Cost-sharing policies:

- ***A change was made to the ALL Kids premium structure during FY 2000. Previously, for ALL Kids enrollees whose family income was above 150 up to 200% FPL there was a $50 per year per child premium if paid in one payment or a $60 per year per child premium if divided into multiple payments, with a maximum of $150 per year per family. There were a substantial number of families who paid the $60 per child premium in one payment. This created administrative confusion and the need to provide refunds to the families that over paid. The decision was made to charge a $50 per year per child premium with a maximum of $150 per family whether the payment is made in one or multiple payments (for enrollees whose family income is above 150 up to 200% FPL).***
- ***As noted in #1 of this section, all American Indian ALL Kids enrollees are placed in the no-fee category. This was enacted with the submission to HCFA of Amendment 3 to the Alabama's CHIP Plan.***

Crowd-out policies: ***NC***

10. Delivery system:

- ***There were no changes to the delivery system in FY99, but at the beginning of FY 2000 Prime Health was terminated as an insurance vendor in the ALL Kids Program. This was a joint decision made by the Department of Public Health and Prime Health based on an analysis of enrollment and utilization.***

11. Coordination with other programs (especially private insurance and Medicaid):

- ***There is ongoing coordination between Medicaid and ALL Kids. This coordination has resulted in continual refinement of the joint application.***
- ***As noted in #2 of section 1.1 the Alabama Child Caring Foundation has been added to the joint application. This allows for the forwarding of the application to ACCF on children who are not eligible for Medicaid or ALL Kids.***

12. Screen and enroll process: ***NC***

13. Application:

- ***At the beginning of FY 2000 the joint Medicaid / ALL Kids application was revised, adding the ACCF and making the form more "family friendly". The new form collects the same basic information as the old form but the questions on the new form are grouped together in a more logical order with some simple language allowing families to more easily complete the application.***

- ***Translation into Spanish of the revised application and revised brochures was begun in FY 2000 and will be completed soon.***
- A***ll program out reach materials have been refined, including the application, to make them more culturally sensitive i.e. eliminating the term "illegal alien". Added the phrase, "Se Habla Espanol" to all ALL Kids out reach materials while simplifying language.***

14. Other

- ***A formal grievance procedure was developed for the ALL Kids Program. In addition to this, a networked database was developed to record client contact information as well as resolutions to problems situations.***
- ***The CHIP Program has added staff, which includes a Marketing and Outreach Coordinator, an Administrator and a Data Manager, as well as additional clerical support.***
- ***The ALL Kids enrollment contractor, the State Employees Insurance Board (SEIB), has added additional enrollment workers and clerical staff.***

1.2 Please report how much progress has been made during FFY 2000 in reducing the number of uncovered, low-income children.

1. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2000. Describe the data source and method used to derive this information.

- ***The CHIP Phase I - Medicaid Expansion began February 2, 1998. As of September 30, 2000, 7,948 children were enrolled in CHIP Phase I.***
- ***CHIP Phase II - ALL Kids, began October 1, 1998. As of September 30, 2000, 29,064 children were enrolled in ALL Kids.***
- ***Due to the "woodwork effect" from the Chip outreach it is estimated that an additional 43,504 children have been added to the SOBRA Medicaid program.***
- ***These enrollment numbers indicate 80,516 children who were previously uninsured are currently enrolled in these programs.***
- ***In addition to the children enrolled in Phase I, ALL Kids and SOBRA Medicaid there are 6,347 currently enrolled in the Alabama Child Caring Foundation (ACCF). This is a philanthropic organization that provides out patient insurance coverage for uninsured children who are not eligible for Medicaid or ALL Kids.***

Data sources:

- ***The total number of children enrolled in CHIP Phase I – Medicaid Expansion and the number of additional children enrolled in SOBRA Medicaid are obtained from monthly enrollment reports and estimates provided by the Alabama Medicaid Agency (AMA). These estimates are based on current and historic Medicaid enrollment.***

- ***The total number of children enrolled in ALL Kids is obtained from the weekly and monthly enrollment reports provided to the CHIP staff by the enrollment contractor. Monthly enrollment reports are also provided by Blue Cross and Blue Shield of Alabama (BCBS), the major insurance vendor, and are used to periodically validate enrollment counts.***

2. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information**.**

   - ***An estimated additional 43,504 children have been enrolled in the SOBRA Medicaid Program since the beginning of CHIP outreach. Prior to the initiation of CHIP outreach SOBRA enrollment had remained constant. After the start of CHIP outreach SOBRA enrolment showed a sharp increase and the upward trend has continued.***
   - ***The Alabama Medicaid Agency (AMA), using both current and historical enrollment data, provided this estimate.***

3. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

   - ***According to the "Snapshots of America's Families II: A View of the Nation and 13 States from the National Survey of America's Families", an Urban Institute Program, the rate of uninsured children in Alabama was reduced from 14.6% to 9%.***

4. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

   ____ No, skip to 1.3

   X Yes, what is the new baseline?

   - ***Based on estimates from the 1997 round of National Survey of America's Families (NSAF) there were 173,012 uninsured children in Alabama. Of these, 91,209 were <u>≤</u> 100% Federal Poverty Level (FPL), 49,579 were above 100 up to 200% FPL and 32,224 were >200% FPL.***

What are the data source(s) and methodology used to make this estimate?

   - ***This estimate is based on data from the 1997 round of NSAF which is a household survey conducted as part of the Urban Institute's Assessing the New Federalism (ANF) project.***

What was the justification for adopting a different methodology?

- ***The NSAF sample was designed to provide reliable national estimates but also state-representative estimates for the 13 ANF States. Alabama is one of the 13 ANF states.***
- ***The approach to measuring insurance coverage in NSAF differs from that used in the Current Population Survey (CPS) - the source of Alabama's original estimate - in several important ways. These differences were designed to address some of the concerns that have been expressed about the CPS related to potential recall problems, the treatment of uninsurance as a residual, and identification of coverage through state programs. First, insurance coverage was measured at the time of the survey as opposed to the CPS approach of asking respondents to recall coverage from the previous calendar year. Second, a question was used to confirm that people for whom no coverage has been reported during the main battery of questions on health insurance are actually uninsured. Finally, separate questions are included that ask about coverage related to SCHIP or state programs. All of these features of NSAF are designed to avoid missing identification of insurance coverage.***

What is the State=s assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

- ***For the reasons stated above, it is felt that the baseline estimate derived from the NSAF is the most reliable estimate currently available.***
- ***Even though the NSAF provides a reliable state specific estimate it cannot provide county specific estimates of the number of uninsured children. There is a need for these data so that outreach can be more targeted and effective. These data are also needed as an evaluative tool to assess the effectiveness of targeted outreach activities.***

Confidence intervals by income of new baseline estimates of the number of uninsured children:

Income	*Est. # Uninsured Children*	*90% Confidence*	*Interval*
<100% FPL	*91,209*		
101-200% FPL	*49,579*		
>200% FPL	*32,224*		
Totals	*173,012*		

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

- ***Alabama's original baseline estimate showed 112,900 uninsured children less than***

200% FPL. If current enrollment numbers of 80,516 (Phase I, ALL Kids and additional children enrolled in SOBRA) are compared to the original baseline Alabama has made greater progress in reducing the percent of uninsured children than compared to the new baseline. The decision was made to adopt the new baseline because it is felt to be more accurate.

Below is a table showing Alabama's original baseline estimate from The Southern Institute on Families and Children, Alabama's new baseline estimate from the National Survey of America's Families (NSAF) and enrollment (as of September 30,2000) in CHIP Phase I – Medicaid Expansion, CHIP Phase II - ALL Kids and additional children enrolled in SOBRA Medicaid.

Income	*Southern Institute on Families and Children**	*National Survey of America's Families***	*Enrollment as of September 30, 2000*
≤ 100% FPL	*64,000*	*91,209*	*Phase I – Medicaid Expansion: 7,948 Additional enrolled in SOBRA Medicaid: 43,504*
101 – 200% FPL	*48,900*	*49,579*	*ALL Kids: 29,064*
Total ≤ 200% FPL	*112,900 (10.4%)*	*140,788 (12.4%)*	*80,516*
> 200% FPL	*55,600*	*32,224*	
Totals	*168,500 (15%)*	*173,012 (15.2%)*	

"Uninsured Children in the South, Second Report, November 1996", which is based on the 1994 Census Bureau's Current Population Survey (CPS), reflecting 1993 data.
****A household survey conducted as part of the Urban Institute's Assessing the New Federalism (ANF) project. These data were collected on the 1997 round of NSAF.***

1.3 Complete Table 1.3 to show what progress has been made during FFY 2000 toward achieving your State=s strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State=s strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List your State=s strategic objectives for your SCHIP program, as specified in your State Plan.
Column 2: List the performance goals for each strategic objective.
Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator,

denominator). Please attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter ANC@ (for no change) in column 3.*

Table 1.3

(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
Objective 1 Low-income children who were previously without health insurance coverage will have health insurance coverage through Alabama's Title XXI Program.	***By October 1, 1999, 17,000 previously uninsured low-income children will have or have had health insurance coverage through Phase I CHIP – Medicaid Expansion.***	Data Sources: Alabama Medicaid Agency enrollment data Methodology: • ***Medicaid enrollment records were examined to provide an estimate of the unduplicated number of children ever enrolled in CHIP Phase I – Medicaid Expansion since the beginning of the CHIP program. This number was compared to the target enrollment stated in the performance goal.*** Progress Summary: • ***As of September 30, 2000 Medicaid estimates there have been 17,346 children enrolled in CHIP phase I.*** ***This Goal has been achieved.***
OBJECTIVES RELATED TO SCHIP ENROLLMENT		

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
Objective 2 Previously uninsured children who may potentially be eligible for Alabama's Title XXI Program will be identified through ongoing outreach activities	***By February 1, 1999, mechanisms to conduct ongoing outreach will have been developed and implemented in the three broad areas (1) an increase in the number of eligibility workers so that at least 14,000 previously uninsured children will be identified as potential Title XXI eligibles in Phase I. (2) update/expansion of existing outreach activities;(3) activities to identify, enroll, and serve Alabama's growing qualified Hispanic population***	***Performance Goal #1: NC*** ***This objective had been obtained during FY 98, which was reported in the Evaluation submitted March 2000.*** ***Performance goal #2:*** Data Sources: • ***AMA files and ADPH files which reflect CHIP outreach activities*** Methodology: • ***AMA and ADPH files will be reviewed to evaluate the increase in outreach activities.*** Progress Summary: • ***The program has dramatically increased it's presence at regional and statewide conferences in both exhibits and presentations to members, to agency and professional organizations who have front-line relationships with families with children who may be eligible for CHIP.*** • ***Redesigned all outreach materials to be easier to use, lowering the literacy levels of the text and including family friendly graphics and layout. Designed companion out reach materials to distribute to partnering outreach and enrollment resources i.e. rolodex cards, program summaries and business cards. The most effective of these***

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
		has been the FAX BACK FORM (attachment--), which facilitates quick, direct contact with the ALL Kids program office when requesting or reordering resource supplies. This is a simple form distributed to every outreach point. It includes our program contact information, an outreach supplies order section and a section for comments or special requests. The program's toll-free number is printed at the top. All one has to do is fill it out and fax or mail it to the ALL Kids office. Orders for support materials are shipped out immediately. • ***A number of specialty items such as pencils, note pads, bubble pens, frisbees and beverage cups have been used to promote the program at statewide and community events and educational presentations. All items are imprinted with the ALL Kids logo, tag line and toll-free telephone number.*** • ***Created a Speakers Bureau comprised of people of all walks of life who are intimately familiar with the program and eager to educate others on the program's behalf.*** • ***Increased public awareness through the use of television and radio talk shows, newspaper articles and organization newsletters.*** • ***Actively participated in strategic planning with the Alabama Hospital Association to help hospital staff identify and enroll children and teens as they come through Alabama's hospitals. Focused on multiple points of contact including the Labor and Delivery, Neonatal, Emergency Room, Admissions and Accounting departments.*** • ***Strengthened coordination and support of community based outreach***

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
		via county coalition groups comprised of community leaders, local and state agencies and civic and Faith-based organizations. These coalitions tailor outreach efforts to fit their own community needs and make-up. • ***Staffed the Governor's Task Force on Children's Health Insurance. The Outreach Workgroup had members from numerous and varied fields of interest and experience: CHIP, Covering Alabama's Kids, The Alabama Department of Public Health, education and child care agencies, health and hospital providers, government program agencies, community and minority advocacy groups and civic group volunteers.*** • ***Organized and staffed booth and exhibits at school health fairs held across the state in support of the State Parenting Day declared by the Governor's office.*** ***Performance Goal #3*** Data Sources: • ***AMA files and ADPH files which reflect CHIP outreach activities to Alabama's Hispanic population*** Methodology: • ***AMA and ADPH files will be reviewed to evaluate the increase in outreach activities for Alabama's Hispanic Population.***

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
		Progress Summary: • ***Translation into Spanish of the revised application and revised brochures was begun in FY 2000 and will be completed soon.*** • ***Have refined all program outreach materials, including the application, to make them more culturally sensitive i.e. eliminating the term "illegal alien". Added the phrase, "Se Habla Espanol" to all ALL Kids outreach materials.*** • ***Have provided translated materials to any and all public and private organizations and associations in support of their outreach efforts and in support of the America's Promise initiative.*** • ***Increased presence at Hispanic festivals and attended Hispanic events such as Cinco de Mayo. Provided information to all immigration lawyers in the state.*** • ***State and County Health Departments are working with Hispanic health providers and Hispanic faith community leaders to bring health care to areas, which have growing Hispanic populations.*** • ***Supported Covering Alabama's Kids, which has worked diligently and successfully to increase their bilingual staff, in areas of high Hispanic concentrations, by maintaining their supplies of translated materials for their outreach efforts.*** • ***Participated in the first statewide Hispanic coalition meeting coordinated by the Alabama Department of Public Health. Attendance at this included staff from many programs of the Department of Public***

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
		Health including Family Health Services, Diabetes, Tuberculoses, STD/HIV, Maternity Waiver, CHIP, Area and county Health Departments, clinical nurses, social workers, Hispanic faith-community leaders, Hispanic and American physicians, healthcare organizations, Medicaid, Hispanic educators from institutions of higher learning, Catholic Social Services and others.

OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		
Objective 3 ***Children enrolled in Alabama's Title XXI***	***By February 1, 1999, 100% of those children enrolled in Alabama's***	***Phase I –Medicaid Expansion*** ***NC. This objective had been obtained during FY 98, which was reported in the***

Program will have a usual source of health care.	***Title XXI Program (except those exempted from participation in managed care such as children in foster care) will have a medical home as evidenced by documented assignment of a provider for Phase I enrollees or a usual source of care for each child enrolled in ALL Kids.***	***Evaluation submitted March 2000.*** ***Phase II – ALL Kids*** Date Sources***:*** • ***Enrollment records obtained from ALL Kids, BCBS and Prime Health, University of Alabama at Birmingham, School of Public Health (UAB) Access to Care/ First Year Retrospective Survey (attachment--)*** Methodology: • ***ALL Kids, BCBS and Prime Health enrollment reports will be used to determine ALL Kids enrollment.*** • ***UAB's Access to Care/ First Year Retrospective Survey contains questions concerning usual source of care, both before and after ALL Kids. This information will be used to assess usual sources of care for ALL Kids enrollees.*** Progress Summary: • ***ALL Kids enrollees enrolled with Prime Health (less than 1% of the ALL Kids population) are assigned to a gatekeeper physician.*** • ***ALL Kids enrollees enrolled with BCBS are not assigned to a gatekeeper physician. ALL Kids strongly recommends that every enrolled child receives a well doctor check up and a preventive dental check up as soon as possible after enrollment. All children enrolled in ALL Kids are mailed a post card reminding their parent of the importance of these preventive visits along with encouragement to schedule the appropriate appointments. If the child has not had both visits within the first 120 days of enrollment their name and identifying information is forwarded to Intracorp for follow up. Intracorp is a medical management company which has been contracted by BCBS to place out bound calls as a means of follow up for children who have not received both a well doctor and a preventive dental visit.***

		• ***The UAB Access to Care/ First Year Retrospective Survey began September 1999 and ended June 2000. This survey was mailed to a random sample (6,200) of the households of the 26,213 children enrolled in ALL Kids from October 1, 1998 to September 30, 1999. The methodology used in collecting the data included: 1) mailing of an initial survey 2) mailing of a post card reminder 3) mailing of a second survey 4) telephone follow up. The primary purpose of this first year survey was to determine the difference in access to care before the child was enrolled in ALL Kids and after the child enrolled in ALL Kids. Of the 6,200 surveys mailed, 83 were returned with undeliverable addresses. Sixty percent of the surveys were returned (3,739).*** • ***The Survey results indicate that the number of children who have a usual source of care increased after enrollment in ALL Kids. Parents reported that before ALL Kids, 32% of children did not have a personal doctor or group of doctors they saw when sick. After enrolling in ALL Kids, only 9% did not have a personal doctor. When asked if the children had a usual source of care for vaccinations or routine care, 32% did not have a usual source for routine care before ALL Kids as opposed to 8% after enrolling in ALL Kids. Nineteen percent of respondents said it was a big problem to get a personal doctor before enrolling in ALL Kids. After enrolling in ALL Kids only 7% said it was a big problem. Sixteen percent said they did not get a personal doctor for their child before ALL Kids; only 5% did not get a personal doctor or nurse after enrolling in ALL Kids.***
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		

Objective 4 ***Alabama's title XXI Program will improve the health status of children enrolled in the program as well as improve the overall health care system accessed through the program.***	***By February 1, 1999, the following health status and health care system measures for Alabama's Title XXI Program will show acceptable incremental improvements for at least the following data elements: immunization status, adolescent well visits, satisfaction with care***	***Immunization Status:*** ***Query Pediatric Health History*** Data Sources: Methodology: Progress Summary: ***Adolescent well visits:*** Data Sources: • ***UAB's Access to Care/First Year Retrospective Survey*** Methodology: • ***UAB's Access to Care/First Year Retrospective Survey contains questions concerning well doctor visits, both before and after ALL Kids. This information will be used to assess the rate of adolescent well visits before and after ALL Kids coverage.*** Progress Summary: • ***UAB's Access to Care/First Year Retrospective Survey (described in objective 3) indicates that the adolescents (13-18 years of age) that were enrolled in ALL Kids between October 1, 1998 and September 30, 1999 received more adequate well visit care after enrolling in ALL Kids. Before enrolling in ALL Kids, only 30% of adolescents received routine preventive care as soon as the parent wanted. However, that number increased to 82% after enrolling in ALL Kids. Before enrolling in ALL Kids, 40% of adolescents did not have a primary health care provider. After enrolling in ALL Kids, only 18% of adolescents did not have a primary health care provider.*** ***Satisfaction with care:***

		Data Sources: • ***UAB Access to care/First Year Retrospective Survey*** Methodology: • ***Data obtained through the UAB Access to Care/First Year Retrospective Survey will be used to evaluate the ALL Kids enrollee's satisfaction with care since enrolling in the ALL Kids program.*** Progress Summary: • ***Most participation showed a high level of satisfaction with the ALL Kids program. The following table list usage and satisfaction with various aspects of the program.*** *Type of service* *Used at least once* *Satisfied a great deal or somewhat* *Preventive care* *70%* *97%* *Counseling* *13%* -- *Emergency room* *43%* *90%*

		Dental *69%* *94%* *Vision* *41%* *94%* *Care for special health needs* *23%* *90%* *Prescriptions* *81%* *98%* • ***In addition to their level of satisfaction, most (94%) respondents did not have any communication problems with the insurance companies and 90% said they did receive information explaining the insurance plan. Overall, the majority (89%) said they were satisfied 'a great deal' with the ALL Kids Program. Likewise, a very small (<2%) said they were 'not at all' satisfied with the program.*** • ***Sixty percent of the UAB Access to care/First Year Retrospective Survey were completed and returned. This is a higher percentage than would be expected with this type survey. This large return rate indicates satisfaction with the ALL Kids program.*** • ***As part of this survey, respondents were given the opportunity to voice their concerns or express their thoughts on the ALL Kids program. Forty-five percent of those returning surveys made a comment. Of those that responded, almost 16% expressed a sense of relief or security since their child has been enrolled in ALL Kids. Almost 40%***

		expressed praise or thanks for the program. Eleven percent thought their child received better care since being enrolled in ALL Kids. Six percent had questions about ALL Kids coverage. Few expressed complaints about the coverage or the program in general. Overall, ALL Kids received over-whelming positive responses from those surveyed.
OTHER OBJECTIVES		

Objective 5 The infrastructure of the Alabama Department of Public Health (ADPH) and the Alabama Medicaid Agency will be able to accommodate all critical facets of	***By February 1, 1998, the capacity within the Alabama Medicaid Agency, in the following critical areas, will be appropriately expanded to meet the target of enrolling approximately 12,000 children in Year I of***	***NC. All performance goals related to objective 5 were obtained during FY 98, which was reported in the Evaluation, submitted March 2000.***

Phase I of Alabama's Title XXI Program. (Phase I is defined as expanding Medicaid Program eligibility to uninsured children who are less than 19 years of age, born on or before September 30, 1983, and who have incomes equal to or less than 100% of the FPL.)	***Alabama's title XXI Program: (1) data systems with regard to eligibility determination, enrollment, participant information, health service utilization, billing, health status, provider information, etc.: (2) personnel (eligibility workers, administrative staff, and support staff), (3) staff training, (4) publications/documents including program manuals, literature for program personnel, consumers and providers, etc.***	

OTHER OBJECTIVES		
Objective 6 Health care coverage will be expanded as quickly as possible to children between 100% and 200% of the federal poverty	***1. By May 1998, a plan to expand health care coverage to children between 100 and 200% of the federal poverty level will have been submitted to HCFA. 2. By August 1, 1998,***	***NC. All performance goals related to objective 6 were obtained during FY 98, which was reported in the Evaluation, submitted March 2000.***

level.	***health care coverage will be expanded to offer coverage for children between 100 and 200% of the federal poverty level in at least 1/3 of the counties in the state.*** ***3. By April 1, 1999, a plan to insure access to specific services for children with special health care needs will have been developed. One reason the HMO with the largest commercial enrollment in the state was selected as the benchmark coverage is the numerous aspects within the package which will be advantageous to children with special health care needs such as rehabilitation services, home health services, durable medical equipment, skilled nursing care services and others. The Department has***	

	already begun working with other State agencies and members of the CHIP Advisory Council to identify funds and services that could be included in a wrap around (plus) package for children with special health care needs. The Department anticipates a future plan amendment to add this feature. ***(4) By October 1, 1999, 20,000 previously uninsured low-income children will have or have had health insurance coverage through ALL Kids.***	

OTHER OBJECTIVES		
Objective 7 ***ALL Kids enrollees who have special conditions/needs will have sources for coordinated services to meet those conditions/needs.***	***1. By September 30, 2000, 100% of children currently receiving ALL Kids Plus services will have one designated case manager.*** ***2. During FY 2000,***	***Performance Goal # 1:*** Data Sources: • ***Enrollment records from the three state agencies [Alabama Department of Rehabilitative Services (Children's Rehabilitation Services and Early Intervention), Alabama Department of Mental Health Mental Retardation and The University of Alabama Sparks***

	fifty percent of children identified with special health care conditions/need will receive ALL Kids Plus services to meet those needs.	***Center] participating in ALL Kids Plus*** Methodology: • ***Enrollment records from the participating Plus agencies will be examined to ensure that all children receiving ALL Kids Plus services have been assigned a case manager.*** Progress Summary: • ***Children's Rehabilitation Services is currently providing ALL Kids Plus services. All children served by this agency are assigned a case manager.*** ***Performance Goal # 2:*** Data Sources: • ***Enrollment records from the three state agencies [Alabama Department of Rehabilitative Services (Children's Rehabilitation Services (CRS) and Early Intervention), Alabama Department of Mental Health Mental Retardation and The University of Alabama Sparks Center] participating in ALL Kids Plus.*** • ***ALL Kids Pediatric Health History Database*** Methodology: • ***Enrollment data matches will be conducted between the participating agency's enrollment files and ALL Kids enrollment files to identify children who are enrolled in ALL kids and receiving services from one or more of these participating agencies.*** • ***The ALL Kids Pediatric Health History Database will be queried to identify children with special health care needs and conditions.***

		Progress Summary: • ***Quarterly enrollment matches are ongoing with CRS these matches have identified 230 children who are receiving services from Children's Rehabilitation Services but had not been previously identified as being ALL Kids enrollees. CRS has also queried their enrollment system to identify uninsured children. Assistance has been provided to the parents of these children to complete a joint SOBRA Medicaid/ALL Kids/Alabama Child Caring Foundation application.*** • ***Training has been provided to CRS staff members to aid them in identifying CHIP eligible children and in assisting families in completing applications.*** • ***The ALL Kids Pediatric Health History Database has been queried to determine the number of children who have special health care needs and conditions that are asked about on the Pediatric Health History form, completed at the time of initial application. ALL Kids in partnership with CRS is working on the development of an outreach plan in order to inform parents of these identified children of the services available through ALL Kids Plus.*** • ***Information has been incorporated into the ALL Kids benefits book to inform parents of the availability of ALL Kids Plus services.***

1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.

1.5 Discuss your State=s progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.

1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.

1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program=s performance. Please list attachments here.

UAB Access to Care/First Year's Retrospective Survey
New Enrollee Survey
Dis-enrollee Survey
BCBS Reports
Urban Institute Data

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family coverage:

A. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.

N/A

2. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2000 (10/1/99 -9/30/00)?

Number of adults_____
Number of children_____

3. How do you monitor cost-effectiveness of family coverage?

2.2 Employer-sponsored insurance buy-in:

1. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).

N/A

2. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2000?

Number of adults_____
Number of children_____

2.3 Crowd-out:

1. How do you define crowd-out in your SCHIP program?

Voluntarily termination of private insurance to enroll in ALL Kids.

2. How do you monitor and measure whether crowd-out is occurring?

- ***As a means of measuring crown-out, questions are asked on the application and on the renewal form about the current insurance status of the child being applied for. At***

initial application and at renewal, ALL Kids enrollment workers check the BCBS enrollment system to see if the applicant is currently enrolled. If found to be currently covered under BCBS the child will not be enrolled in ALL Kids. In addition to this, if insurance coverage has been voluntarily dropped the child cannot be enrolled in ALL Kid s prior to a 90-day waiting period.

3. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

   - ***Based on results from the UAB Dis-enrollee Survey, crowd out does not appear to be a problem. When asked why the child did not have insurance, less than 3% of respondents said that they dropped insurance coverage to enroll in ALL Kids.***

4. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

   - ***Questions on the application, the ability to check the BCBS enrollment system and the three-month waiting period have all been quite effective. In Alabama approximately 85% of all privately insured individuals are insured with BCBS. Having the ability to check the BCBS enrollment system prior to a child's is enrollment or renewal in ALL Kids allows for quite a bit of security in knowing that the child is not enrolled in private insurance. The three-month waiting period is also an effective tool in preventing crowd out. Based on phone conversations with parent's of potential ALL Kids enrollees, most parents who are faced with the decision of their children going three months without coverage chose to continue private insurance coverage.***

2.4 Outreach:

A. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

UAB to provide Narrative
Pediatric Health History- by tracking the number of apps from the listed sources

- ***In the Retrospective Survey, the respondents were asked where they first learned about the ALL Kids program. Schools (40%), Health Departments (17%), and friends and relatives (10%) were the most common responses. When asked where they obtained their ALL Kids application, most also said they got them from schools (41%) and 28% said Health Departments.***
  According to the New Enrollment Survey, 27% said they first learned of ALL Kids from the Health Departments and 18% said schools. When asked where they obtained the ALL Kids application, the most frequent responses were: Health Departments (47%) schools (12%), doctor/dentist offices (10%), and hospitals (7%).

- ***Of the outreach techniques we have used, the most effective avenue to reach low-income, uninsured children is through the public school system. An overwhelming percentage of applications we receive state that the family heard about the program and received their application through the public school system. The initial implementation of the program to the public was conducted by the distribution of 850,000 application packets through the school systems. During the first school year of the program, a complete application packet was sent to schools to be given to every child. Due to the overwhelming success of this initiative, enrollment expectations were surpassed. In 1999, based on the previous years success, ALL Kids brochures were distributed to every child enrolled in the public schools.***

- ***The CHIP program is a 12 month continuous coverage program and the application processing time can get slowed down during the months of September and October due to the vast number re-enrollments. It was decided that the 2000-2001 annual outreach through the schools would be conducted in January 2001 to avoid any additional slowdowns in the enrollment process. Follow-up strategies have also changed for this year.***

2. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

   School aged children- based on the number enrolled

3. Which methods best reached which populations? How have you measured effectiveness?

2.5 Retention:

1. What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

   - ***At ALL Kids renewal a one-page simplified form is sent out to be completed by the parent and returned in the postage paid envelope provided. The renewal process was designed to be as uncomplicated as possible. No documentation is required.***

   - ***During the annual review process for both Medicaid and ALL Kids if a child is found to be ineligible for the program in which they have been enrolled, a letter is sent to the parent informing them of the circumstance along with a new application. The letter encourages the parent to complete the application and submit it to the appropriate program.***

   - ***Information concerning the renewal process is shared with providers and others who may be in contact with ALL Kids enrollees so that they will be aware of and be available to help the family with the renewal process if required.***

- ***Plans are being made to simplify the renewal process for both Medicaid and ALL Kids. These plans will be discussed further in section 7.1.***

2. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

___ Follow-up by case workers/outreach workers
_***X***_ Renewal reminder notices to all families
___ Targeted mailing to selected populations, specify population _____
_***X***_ Information campaigns

- ***Targeted audiences include physicians, support staff, Hospitals, professional organizations and others to assist with educating the families about the renewal process as well the importance of continuation of coverage.***

_***X***_ Simplification of re-enrollment process, please describe

- ***At ALL Kids renewal a one-page form is sent out to be completed by the parent and returned in the postage paid envelope provided. The renewal process was designed to be as uncomplicated as possible. No documentation is required.***

_____
___Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe_____
___ Other, please explain_____

3. Are the same measures being used in Medicaid as well? If not, please describe the differences.

- ***In Medicaid, the renewal form is basically the same as the application. Verification of income is required and either a face to face or a telephone interview is required.***

4. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

- ***Sending out a simplified renewal form followed by a reminder card as well as education of the provider community about the renewal process have been effective in getting a high rate of return of completed renewal forms (80% for ALL Kids). Medicaid and ALL Kids staff are in the process of developing a more seamless system for referral from one program to the other at renewal. This will be discussed further in section 7.1.***

5. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain

uninsured?)? Describe the data source and method used to derive this information.

- ***The University of Alabama at Birmingham School of Public Health (UAB) has been contracted by the ALL Kids program to conduct a Dis-enrollee Survey.***
- ***The Dis-Enrollment Survey began in October 1999. This survey is ongoing and is sent to all children (one per household) as they dis-enrolled from ALL Kids. From October 1999 to present, 6,379 surveys have been mailed. The response rate is 26%.***
- ***The methodology used in collecting the data includes: 1) mailing of an initial survey, 2) mailing of a post card reminder, 3) mailing of a second survey, 4) telephone follow up. This survey is a tool that is helpful in determining utilization of services and satisfaction with those services.***
- ***The majority of respondents are the mother (86%) or the father (6%). Almost 80% of respondents have at least a high school education. Forty-eight percents of the children dis-enrolling are 13 and older. Thirty-nine percent are in the 6 – 12 years age group.***
- ***The majority (90%) of respondents rated their children's health as good, very good, or excellent.***
- ***Those dis-enrolled were asked if they had insurance at the time they were surveyed. Fifty-six percent said they did not have insurance at the time of survey. Dis-enrollees are survey within 2-6 months of dis-enrollment date. Of the 44% that said they were insured, 17% said the child is now enrolled in Medicaid and almost 4% said the child was enrolled in BCBS Caring Program. Two-thirds of those dis-enrolled left the program because they were over or under the income limit. Almost 10% aged out of the program.***

2.6 Coordination between SCHIP and Medicaid:

Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

- ***A joint application is used for the Alabama SOBRA Medicaid program and the ALL Kids program but enrollment and renewal procedures differ between the two programs.***
- ***For Medicaid, income verification and an interview (either face to face or by telephone) are required at both initial application and at renewal.***
- ***For ALL Kids, there is no requirement for income verification or interview at either initial application or renewal.***
- ***Verification of birth date is required for both programs at initial application.***
- ***Medicaid and ALL Kids staff are in the process of developing a more seamless system for both enrollment and renewal. This will be discussed further in section 7.1.***

1. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes.

- ***During the annual review process for both Medicaid and ALL Kids if a child is found to be ineligible for the program in which they are currently enrolled a letter is sent to the parent informing them of the circumstance along with a new application. The letter encourages the parent to complete the application and submit it to the appropriate program.***

2. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain. ***No***

- ***Medicaid and all kids do not use the same provider network. AMA has its own provider network and fee schedule. ALL Kids utilizes the BCBS Preferred Provider Network. Some providers may be enrolled in both networks.***

2.7 Cost Sharing:

1. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

- ***In the first year, 35% of ALL Kids families were required to pay a fee. The make up of fee versus no-fee dis-enrollees are very similar to the first year participants. Of those dis-enrollees surveyed, 34% were required to pay a fee. The most common reason for dis-enrollment for those who paid a fee is 'over income limit' (20%). Thirteen percent were dis-enrolled for 'non-payment of premiums'. For those that did not pay a fee, the most common reason for dis-enrollment is 'under the income limit' (25%).***

2. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?

Utilization broken down by fee and no-fee:

SERVICE	*% OF NO-FEE THAT USED SERVICE AT LEAST ONCE*	*% OF FEE THAT USED SERVICE AT LEAST ONCE*
Routine care	***79%***	***74%***
Emergency room	***45%***	***40%***
Dental	***71%***	***63%***
Vision	***43%***	***38%***
Care for Special health needs	***23%***	***20%***
Prescriptions	***82%***	***78%***

- ***The table indicates that the no-fee group utilizes services more than the fee group.***

2.8 Assessment and Monitoring of Quality of Care:

1. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.

Quality of Care (self-reporting from Dis-enrollment Survey)

Most participants showed a high level of satisfaction with the ALL Kids program. The following table list usage and satisfaction with various aspects of the program.

Type of service	*Used at least once*	*Satisfied a great deal or somewhat*
Preventive care	***77%***	***97%***
Counseling	***13%***	***--***
Emergency room	***43%***	***90%***
Dental	***69%***	***94%***
Vision	***41%***	***94%***
Care for special health needs	***23%***	***90%***
Prescriptions	***81%***	***98%***

- ***In addition to their level of satisfaction, most (94%) respondents did not have any communication problems with the insurance companies and 90% said they did receive information explaining the insurance plan. Overall, the majority (89%) said they were satisfied 'a great deal' with the ALL Kids Program. Likewise, a very small (<2%) said they were 'not at all' satisfied with the program.***

2. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?

- ***At this time, a dis-enrollment survey is sent to every home, as children are dis-enrolled. They are asked how satisfied they were with services covered by ALL Kids such as: routine care, dental care, and vision care. Beginning January 2001, a survey will be sent to those enrolled for at least twelve continuous months. This Continuous Enrollment Survey will also assess quality of care including mental health and substance abuse for adolescents.***

3. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

- ***Beginning January 2001, Continuous Enrollment Surveys will be sent to those enrollees that have been on the program 12 months or longer. Adolescent supplements will be included in the Continuous Enrollment and the New Enrollment Surveys for***

those children 12 and over. Data should be available by Spring 2001.

SECTION 3. SUCCESSES AND BARRIERS

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

3.1 Please highlight successes and barriers you encountered during FFY 2000 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.

Note: If there is nothing to highlight as a success or barrier, Please enter "NA" for not applicable.

1. Eligibility:

- ***Outreach initiatives have been quite successful in identifying eligible children for both Medicaid and ALL Kids. This has caused application processing time to be more lengthy than ideal. There has been a need to increase staff to process the backlog of applications in both Medicaid and ALL Kids. Obtaining the approval for and acquiring adequate staff has been a significant barrier. This situation appears to be improving so hopefully adequate staff will be in place in the near future.***

2. Outreach:

- ***Outreach efforts in Alabama that have proven to be the most effective are those, which focus on the grassroots, community initiatives, and those, which foster possession of the program by healthcare providers. Successful outreach in Alabama has been accomplished by partnering with the School Nurses in the public school system. These professional workers identify uninsured children in their schools and assist families with the filing of the application. Faith communities outreach through Vacation Bible Schools, the American Lung Association-Alabama Chapter, who screen students in the public school systems, the Alabama Department of Public Health – Vital Statistics Division, who include a brochure with every birth certificate they send out and school and community health fairs across the state are also productive ways to assist families in learning about and enrolling their children in CHIP.***
- ***Of the outreach techniques we have used, the most effective avenue to reach low-income, uninsured children is through the public school system. An overwhelming percentage of applications we receive state that the family heard about the program and received their application through the public school system. The initial implementation of the program to the public was conducted by the distribution of 850,000 application packets to the school systems. During the first school year of the ALL Kids program, a complete application packet was sent to schools to give to every child resulting in enrollment that exceeded expectations. In 1999, based on the previous year's success, ALL Kids brochures were distributed to every child enrolled in the public schools.***

- ***Provided outreach and support items to those who come into frontline contact with families and continual presence at school and community events have also helped to break some of the informational barriers.***
- ***The most significant barrier faced in Alabama, program awareness, is two-fold. A large majority of potentially eligible families still were not familiar with the program or if they had heard of it, misunderstood what it was and who was eligible. Continual outreach education and training on a community level is working. The training of all agency staffs, school system staffs, (school nurses, coaches, guidance counselors etc.), child care providers, local health care providers and community and civic organizations and associations, which they share with families, has engendered a greater knowledge and confidence in the program.***
- ***Low functional literacy levels and application complexity is also a barrier. To combat this, ADPH has partnered with the Alabama Medicaid agency to provide application assistance training. This training is now included in the orientation presentations ALL Kids makes to most groups and has been taped for statewide distribution. ALL Kids has worked with Medicaid to lower the language levels and simplify the verification and interview process while maintaining application and enrollment integrity.***
- ***Provided out reach materials and support items to those who come into frontline contact with families and continual presence at school and community events have also helped to break some of the informational barriers.***

3. Enrollment

- ***ALL Kids enrollment continued to increase during FY 2000. Enrollment did not increase at as high a rate as FY 99 due to the number of children leaving the program at disenrollment. Plans are being made to simplify and streamline the renewal process for both Medicaid and ALL Kids. These plans will be discussed further in section 7.1.***

4. Retention/disenrollment:

- ***There are no established baselines of renewal rates. The fact that 80% of the renewal forms are returned completed is considered a success. Additional follow-up is needed on the ones that are not returned and also for those that are found to be ineligible at time of renewal. Below is a breakdown of renewal statistics for FY 2000:***

ALL Kids Renewal Data
October 1999 – September 2000

- Between October 1999 and September 2000, there were 25,699 children due for renewal. Of these, 14,928 (58%) children renewed in ALL Kids and 10,765 (42%) children did not renew.
- 4,828 (19%) did not return renewal forms
- 3,535 (14%) under ALL Kids income level (Medicaid eligible)
- 737 (3%) Over ALL Kids income level (possible eligibility for Alabama Child Caring Foundation)
- 798 (3%) Non-payment of previous year's premium
- 385 (1%) On other insurance

- 213 (<1%) On Medicaid
- 58 (<1%) Dependant of State employee
- 211 (<1%) Moved out of State

5. Benefit structure

6. Cost-sharing:

7. Delivery systems:

- ***As of October 1, 2000 Prime Health was terminated as an insurance vendor in the ALL Kids Program. This was a joint decision made by the Department of Public Health and Prime Health based on an analysis of enrollment and utilization.***

8. Coordination with other programs

9. Crowd-out

10. Other

SECTION 4. PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

4.1 Please complete Table 4.1 to provide your budget for FFY 2000, your current fiscal year budget, and FFY 2002 projected budget. Please describe in narrative any details of your planned use of funds.

Note: Federal Fiscal Year 2000 starts 10/1/99 and ends 9/30/00).

	Federal Fiscal Year 2000 costs	Federal Fiscal Year 2001	Federal Fiscal Year 2002
Benefit Costs			
Insurance payments			
Managed care			
per member/per month rate X # of eligibles			
Fee for Service	39,084,631	55,592,449	68,762,404
Total Benefit Costs	39,084,631	55,592,449	68,762,404
(Offsetting beneficiary cost sharing payments)	430,265	486,303	*Not currently projected*
Net Benefit Costs	38,654,367	55,106,146	"
Administration Costs			
Personnel	561,297	1,077,427	"
General administration	413,836	627,178	"
Contractors/Brokers (e.g., enrollment contractors)	635,548	1, 610,338	"
Claims Processing	111,898		"
Outreach/marketing costs	217,136	1,465,000	"
Other			
Total Administration Costs	1,939,715	4,779,943	"
10% Administrative Cost Ceiling	4,294,930	6,176,939	7,640,267
Federal Share (multiplied by enhanced FMAP rate)	31,947,543	47,304,021	60,128,902
State Share	8,646,539	12,582,067	16,273,769
TOTAL PROGRAM COSTS	**40,594,082**	**59,886,088**	**76,402,671**

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2000.

N/A

4.3 What were the non-Federal sources of funds spent on your CHIP program during FFY 2000?

__***X***__ State appropriations
_____ County/local funds
_____ Employer contributions
_____ Foundation grants
_____ Private donations (such as United Way, sponsorship)
_____ Other (specify) _____

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures?

No

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	**Medicaid Expansion SCHIP program**	**Separate SCHIP program**
Program Name	***Phase I – Medicaid Expansion for 14 – 19 year olds***	***Phase II _ ALL Kids***
Provides presumptive eligibility for children	___X___No _____Yes, for whom and how long?	___X___No _____Yes, for whom and how long?
Provides retroactive eligibility	_____No ___X___Yes, for whom and how long? ---- ***3 Months***	___X___No _____Yes, for whom and how long?
Makes eligibility determination	___X___State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)*	_____State Medicaid eligibility staff ___X___Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)*
Average length of stay on program	Specify months __data not available	Specify months ***_data not available***
Has joint application for Medicaid and SCHIP	_____No ___X___Yes	_____No ___X___Yes
Has a mail-in application	_____No ___X___Yes	_____No ___X___Yes
Can apply for program over phone	___X___No _____Yes	___X___No _____Yes
Can apply for program over internet	___X___No _____Yes	___X___No ***An application can be downloaded from internet but not submitted.***

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
		_____Yes
Requires face-to-face interview during initial application	_____No __*__Yes ***An interview is required but can be done by telephone***	__***X***__No _____Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	__***X***__No _____Yes, specify number of months _____ What exemptions do you provide?	_____No __***X***__Yes, specify number of months ***3*** What exemptions do you provide? ***There is a 3-month waiting period if other insurance is voluntarily dropped. If other insurance is lost involuntarily there is no waiting period.***
Provides period of continuous coverage <u>regardless of income changes</u>	_____No __***X***__ Yes, specify number of months ___***12***_____ Explain circumstances when a child would lose eligibility during the time period***. <u>Coverage would be terminated prior to the end of the 12 months if the child turned 19 years of age or if the parent requested termination of coverage.</u>***	_____No __***X***__Yes, specify number of months __***12***_____ Explain circumstances when a child would lose eligibility during the time period. ***<u>Coverage would be terminated prior to the end of the 12 months if the child turned 19 years of age or if the parent requested termination of coverage.</u>***
Imposes premiums or enrollment fees	__***X***__No _____Yes, how much? _____ Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify) _____	_____No __***X***__Yes, how much? ***<u>For children whose family income is between 100 and 150 % FPL there is no premium. For children who's family income is above 150 up to 200% FPL there is a $50.00 per year per child premium with a maximum of $150.00 per year per family</u>*** _____ Who Can Pay? _***X***__ Employer _***X***__ Family _***X***__ Absent parent _***X***_ Private donations/sponsorship ___ Other (specify) _____
Imposes copayments or coinsurance	__***X****__No ***<u>There are some co-payments for 18 year olds</u>*** _____Yes	_____No __***X***__Yes ***<u>For children whose family income is between 100 and 150 % FPL there are no co-payments. For children who's family income is above 150 up to 200% FPL there are 0 - $5.00 co-payments on some services.</u>*** _____

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Provides preprinted redetermination process	***X*** No _____ Yes, we send out form to family with their information precompleted and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed	***X*** No ***The All Kids renewal form is preprinted with some basic information, including name, address and contract number. The ability to preprint the entire form is not available currently.*** _____ Yes, we send out form to family with their information and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed

5.2 Please explain how the redetermination process differs from the initial application process.

- ***For ALL Kids renewal a one-page form is sent out 60 days prior to the cancellation date. This form is shorter and collects less information than the initial application. The renewal form is not a joint form like the initial application. Therefore if the child is found to be ineligible at renewal and appears to eligible for Medicaid or the Alabama Child Caring Foundation a new application must be submitted and forwarded to either of these programs for enrollment to occur. ALL Kids and Medicaid staff are currently designing a joint renewal for to allow for easier transitioning from one program to the other.***

SECTION 6: INCOME ELIGIBILITY

This section is designed to capture income eligibility information for your SCHIP program.

6.1 As of September 30, 2000, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups	***133***% of FPL for children under age ***6***
	100% of FPL for children aged 6-***19***
	born after 9/30/83
Title XXI Medicaid SCHIP Expansion	***100% of FPL for children aged under 19 born on or before 9/30/83***
Title XXI State-Designed SCHIP Program	***133***% of FPL for children aged ***0-6***
	100% of FPL for children aged ***6-19***

6.2 As of September 30, 2000, what types and *amounts* of disregards and deductions does each program use to arrive at total countable income? *Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter ANA.@*

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) ____ Yes X No
If yes, please report rules for applicants (initial enrollment).

Table 6.2

	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	State-designed SCHIP Program*
Earnings	$90.00 per worker**	$90.00 per worker**	$ ***NA***
Self-employment expenses	***$90.+ Operating***	***$90. + Operating***	***$ Operating expenses***
Alimony payments Received	$N/A	$N/A	$ ***NA***
Paid	$N/A	$N/A	$ ***NA***
Child support payments Received	$50.00 per family	$50.00 per family	$ ***NA***
Paid	$N/A	$N/A	$ ***NA***
Child care expenses	$200.<age 2 $175age 2 +	$200<age 2 $175 age 2+	$ ***NA***
Medical care expenses	$N/A	$N/A	$ ***NA***
Gifts	$30. Per person per quarter	$30 per person per quarter	$ ***NA***
Other types of disregards/deductions (specify)	$All funds excluded by federal law or regulation	$All funds excluded by federal law or regulation	$ ***Step parent income***

*** Currently there are no disregards in the ALL Kids program. Plans are being made to begin using standard Medicaid disregards for ALL Kids applicants.**

**** Some clients eligible for 30 & 1/3 disregards**

6.3 For each program, do you use an asset test?

Title XIX Poverty-related Groups	***X***	No	____Yes, specify countable or allowable level of asset test_____
Medicaid SCHIP Expansion program	***X***	No	____Yes, specify countable or allowable level of asset test_____
State-Designed SCHIP program	***X***	No	____Yes, specify countable or allowable level of asset test_____
Other SCHIP program_____	***X***	No	____Yes, specify countable or allowable level of asset test_____

6.4 Have any of the eligibility rules changed since September 30, 2000? ___ Yes _X_ No

SECTION 7: FUTURE PROGRAM CHANGES

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2001(10/1/00 through 9/30/01)? Please comment on why the changes are planned.

1. Family coverage: ***None for the near future***

2. Employer sponsored insurance buy-in: ***None for the near future***

3. 1115 waiver: ***None for the near future***

4. Eligibility including presumptive and continuous eligibility:

- ***In April 2000 Governor Don Seigleman established by executive order the Task force on Children's Health Insurance. This Task Force has met monthly with subcommittees meeting bi-weekly. The final Task Force report will be presented to Governor Seigleman in January 2001. Many recommendations dealing with eligibility will be presented in this report. The eligibility recommendations include:***

  Accept self-declaration of income for SOBRA Medicaid
  Remove the interview requirement for SOBRA Medicaid
  Accept self-declaration of age for SOBRA Medicaid, ALL Kids and Medicaid For Low Income Families (MLIF)
  Apply standard Medicaid disregards for ALL Kids applicants
  Accept self-declaration of childcare expenses in SOBRA Medicaid, ALL Kids and MLIF

5. Outreach:

- ***Of the outreach techniques we have used, the most effective avenue to reach low-income, uninsured children is through the public school system. An overwhelming percentage of applications we receive state that the family heard about the program and received their application through the public school system. The initial implementation of the program to the public was conducted by the distribution of 850,000 application packets to the school systems. During the first school year of the ALL Kids program, a complete application packet was sent to schools to give to every child resulting in enrollment that exceeded expectations. In 1999, based on the previous year's success, ALL Kids brochures were distributed to every child enrolled in the public schools.***
- ***Two pilot outreach positions are being developed which will involve collaboration with the ALL Kids, Maternal and Child Health and Women Infants and Children (WIC) programs.***

- ***The CHIP program is a 12-month continuous coverage program and the application processing time can get slowed down during the months of September and October due to the vast number re-enrollments. It was decided that the 2000-2001 annual outreach through the schools would be conducted in January 2001, to avoid any additional slowdowns in the enrollment process.***

- ***In January of 2001, a flyer with ALL Kids information will be distributed to each child in the Alabama public school system. The flyer contains a section at the bottom where a family may fill out contact information if they would like more information about the program and it will be returned to the school nurse of that school. Every flyer that is returned will be individually followed up by the school nurse and support staffing available to them to see that those children are enrolled in CHIP. This change in procedure to more personalized follow-up should result increased enrollment since school nurses know the children and parents view them as trusted members of their community.***

- ***The Children's Health Insurance Program is increasing its staff to include two regional Directors to coordinate the development and implementation of CHIP outreach and enrollment activities in the state. Plans are also in the works for four additional area outreach and enrollment positions focusing, but not limited, efforts in assigned territories.***

- ***The Governor's Task Force on Children's Health Insurance had four workgroups all chaired by CHIP staff. The Outreach Committee proposed many significant recommendations for the Task Force, some of which are already in process and underway. They include: (1) a statewide system for coordinated children's health insurance program outreach, (2) a seamless enrollment process for the state's four children's health insurance programs, (3) the establishment of an official policy an ongoing outreach strategies by hospitals and health care providers to identify, and educate families with uninsured children, (4) the development of an outreach package directed at families with children and providers in the center-based and home-based day-care arena, (5) the development and implementation of education awareness, in-service training and outreach tools for The Department of Education's School Health Cadre and all public school staff, (6) establish "outreach for children's health insurance" as an official policy within the Department of Education, and (7)a recruitment campaign to increase primary care physicians in the Alabama Medicaid Agency's Patient First program.***

- ***The CHIP program has plan to partner with the Department of Public Safety, Department of Industrial Relations' Rapid Response Team, Alabama's electric and gas energy suppliers, The Alabama Judicial College, and state wide media resources for direct and indirect outreach to low income families with children.***

6. Enrollment/redetermination process:

Recommendations concerning enrollment and rederermination are also being presented in the Governor's Task Force report. Many of the recommendations in the eligibility and the outreach category deal with enrollment. Specific redetermination recommendations include:

Design of a joint renewal for to allow for easier transition from one program to the other (SOBRA Medicaid, ALL Kids and ACCF)

7. Contracting:

- ***A Major redesign of both the ALL Kids and Medicaid computer systems are being planned. A contractor has been secured and has begun work on the redesign of the ALL Kids system. This redesign will include a web base enrollment system that can be accessed through many avenues including provider offices, hospitals, and other social services agencies. This system will not only make enrollment easier and quicker it will also allow for collection of more data.***

8. Other