FRAMEWORK FOR THE ANNUAL REPORT OF THE 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 CMS quarterly enrollment and expenditure reports, **AND**

- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

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

State/Territory: **AL**
(Name of State/Territory)

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

Signature:

Fern M. Shinbaum

SCHIP Program Name(s): **All kids**

SCHIP Program Type:
______ SCHIP Medicaid Expansion Only
______ Separate Child Health Program Only
______ Combination of the above

Reporting Period: **2003** *Note: Federal Fiscal Year 2002 starts 10/1/01 and ends 9/30/02.*

Contact Person/Title: **Fern M. Shinbaum**

Address: **P.O. Box 303017, Suite 250**

City: **Montgomery** State: **AL** Zip: **36130-3017**

Phone: **(334)206-5568** Fax: **(334)261-1149**

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

Submission Date: **12/30/03**

(Due to your CMS Regional Contact and Central Office Project Officer by January 1st of each year)
Please copy Cynthia Pernice at NASHP (cpernice@nashp.org)

SECTION I: SNAPSHOT OF SCHIP PROGRAM AND CHANGES

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 explain in narrative below this table.

	SCHIP Medicaid Expansion Program						Separate Child Health Program				
Eligibility							From	0	% of FPL for **conception to birth**	0	% of FPL
	From		% of FPL for **infants**		% of FPL		From	134	% of FPL for **infants**	200	% of FPL
	From		% of FPL for children ages **1 through 5**		% of FPL		From	134	% of FPL for children ages **1 through 5**	200	% of FPL
	From		% of FPL for children ages **6 through 16**		% of FPL		From	101	% of FPL for children ages **6 through 16**	200	% of FPL
	From		% of FPL for children ages **17 and 18**		% of FPL		From	101	% of FPL for children ages **17 and 18**	200	% of FPL
Is presumptive eligibility provided for children?		No_						No			
		Yes, for whom and how long?						Yes, for whom and how long?			
Is retroactive eligibility available?		No						No			
		Yes, for whom and how long?						Yes, for whom and how long? For newborns if the parent applies for enrollment for the newborn within 60 days after the birth			
Does your State Plan contain authority to implement a waiting list?	Not applicable							No_			
								Yes			
Does your program have a mail-in application?		No_						No_			
		Yes						Yes			
Can an applicant apply for your program over phone?		No_						No_			
		Yes						Yes			
Does your program have an application on your website that can be printed, completed and mailed in?		No						No			
		Yes						Yes			

	SCHIP Medicaid Expansion Program	Separate Child Health Program
Can an applicant apply for your program on-line?	No Yes – please check all that apply Signature page must be printed and mailed in Family documentation must be mailed (i.e., income documentation) Electronic signature is required	No Yes – please check all that apply Signature page must be printed and mailed in Family documentation must be mailed (i.e., income documentation) Electronic signature is required No Signature is required
Does your program require a face-to-face interview during initial application	No Yes	No Yes
Does your program require a child to be uninsured for a minimum amount of time prior to enrollment (waiting period)?	No Yes Note: this option requires an 1115 waiver Note: Exceptions to waiting period should be listed in Section III, subsection Substitution, question 6 Specify number of months	No Yes Note: Exceptions to waiting period should be listed in Section III, subsection Substitution, question 6 Specify number of months: 3
Does your program provides period of continuous coverage regardless of income changes?	No Yes Specify number of months Explain circumstances when a child would lose eligibility during the time period in the box below	No Yes Specify number of months: 12 Explain circumstances when a child would lose eligibility during the time period in the box below If an enrolled child turns 19 years of age, enrollment ends at the end of the 19th birth month. Enrollment would also end if the custodial parent requests termination in writing.
Does your program require premiums or an enrollment fee?	No Yes Enrollment Fee $ Premium Amount $ Yearly cap $ Briefly explain fee structure in the box below	No Yes Enrollment Fee $ Premium Amount $ Yearly cap $ Briefly explain fee structure in the box below Children with incomes above 150% FPL pay an annual premium of $50. If a family has more than 3 children, the family only has to pay the premiums for three children.
Does your program impose copayments or coinsurance?	No_ Yes	No_ Yes

	SCHIP Medicaid Expansion Program	Separate Child Health Program
Does your program require an assets test?	☐ No ☐ Yes If Yes, please describe below	☐ No ☐ Yes If Yes, please describe below
Is a preprinted renewal form sent prior to eligibility expiring?	☐ No Yes, we send out form to family with their information precompleted and ☐ ask for confirmation ☐ Do not require a response unless income or other circumstances have changed	☐ No Yes, we send out form to family with their information precompleted and ☐ ask for confirmation ☐ do not require a response unless income or other circumstances have changed

Enter any Narrative text below.

With regard to the waiting period before eligible for enrollment: There is no waiting period unless the health insurance on the child was dropped voluntarily in order to enroll in ALL Kids (CHIP separate program). However, this waiting policy does not apply if the coverage that is terminated is a policy with the Alabama Child Caring Foundation, or Medicaid, or COBRA, or if the lifetime policy limit on the exisiting insurance has been met.

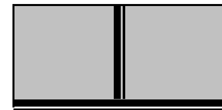
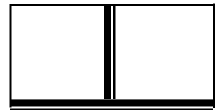
2.Are the income disregards the same for your Medicaid and SCHIP Programs? ☐ Yes ☐ No

2.Is a joint application used for your Medicaid, Medicaid Expansion and SCHIP Programs? ☐ Yes ☐ No

4. Have you made changes to any of the following policy or program areas during the reporting period? Please indicate "yes" or "no change" by marking appropriate column.

	Medicaid Expansion SCHIP Program		Separate Child Health Program	
	Yes	No Change	Yes	No Change
a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)				
b) Application				
c) Benefit structure				
d) Cost sharing structure				
e) Cost sharing collection process				
f) Crowd out policies				
g) Delivery system				
h) Eligibility determination process (including implementing a waiting lists or open enrollment periods)				
i) Eligibility levels / target population				
j) Eligibility redetermination process				
k) Enrollment process for health plan selection				
l) Family coverage				
m) Outreach (add examples, e.g., decrease, funds, target outreach)				
n) Premium assistance				
o) Prenatal eligibility expansion				
p) Waiver populations (funded under title XXI)				
Parents				
Pregnant women				
Childless adults				
a) Other – please specify				
a. Instituted measures to be in compliance with HIPAA				
b. Implemented 2 special grants				

c.

5. For each topic you responded yes to above, please explain the change and why the change was made, below.

a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law) b)	
c) Application d)	Changes were made to the application in order to include application information for Medicaid for Low Income Families as well as changes which were made merely for cosmetic purposes and ease of computer entry. Other changes were made to accommodate lower literacy applicants and to request additional information needed to better manage the program. A family friendly cover page was also added.
e) Benefit structure f)	Changes were made to the benefit structure due to program maturation and needs expressed by providers and consumers. These changes were as follows: 1. CHIP began paying dentists for nitrous oxide; 2. CHIP began omitting charges for diagnostic/preventive care from the $1000 annualmaximum for dental coverage; and 3. CHIP increased the amount it pays for eye glasses.
g) Cost sharing structure h)	
i) Cost sharing collection process j)	
k) Crowd out policies l)	
m) Delivery system n)	
o) Eligibility determination process (including implementing a waiting lists or open enrollment periods) p)	
q) Eligibility levels / target population r)	
s) Eligibility redetermination process t)	

u) Enrollment process for health plan selection v)	
w) Family coverage x)	
y) Outreach (add examples, e.g., decrease, funds, target outreach) z)	CHIP completed hiring 12 regional coordinators & a Hispanic Coordinator. CHIP developed targeted outreach to ages 0-5. CHIP developed an outreach system with the AL Department of Economic and Community Affairs, to make information about health insurance for children available to individuals who are being dislocated due to lay offs. With the Office of Children's Affairs a parenting kit was developed. Due to budget restrictions, CHIP curtailed statewide media campaigns.
aa) Premium assistance ab)	
ac) Prenatal eligibility expansion ad)	
ae) Waiver populations (funded under title XXI)	
Parents	
Pregnant women	
Childless adults	
AF) Other – please specify	
a. Instituted measures to be in compliance with HIPAA	A HIPAA compliance officer was designated within the CHIP Central Office. Plans to revise the benefit book to include HIPAA information were made. All CHIP staff received training so that all CHIP activities were conducted in compliance with HIPAA. Electronic transactions were reviewed to insure HIPAA compliance.
b. Implemented 2 special grants	CHIP implemented 2 special grants. During FY 03 the 1st grant, Supporting Families after Welfare Reform, sought to coordinate the CHIP & Medicaid computer files so as to streamline referrals as well as to support the transition of the MLIF from DHR to the Medicaid Agency. The 2nd grant, a State Planning Grant, sought to identify & describe the uninsured in AL. The project further researched & identified health insurance options for these populations which the state is studying further.

c.	

SECTION II: PROGRAM'S STRATEGIC OBJECTIVES AND PERFORMANCE GOALS

1. In the table below, 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.

Column 2: List the performance goals for each strategic objective.

Column 3: For each performance goal, indicate how performance is being measured and progress toward meeting the goal. Specify if the strategic objective listed is new/revised or continuing, the data sources, the methodology and specific measurement approaches (e.g., numerator and denominator). Please attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was previously reported, please complete columns 1 and 2 and enter "NC" (for no change) in column 3.*

Strategic Objectives	(1) **Performance Goals for each Strategic Objective**	(1) **Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)**
Objectives related to Reducing the Number of Uninsured Children		

Strategic Objectives	(1) **Performance Goals for each Strategic Objective**	(1) **Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)**
1. The number of low-income (< 200% FPL), uninsured children in AL will be reduced each year.	A. The number of low-income uninsured children in AL will be reduced by 1% each year until the number of low-income uninsured children is no larger than 10% of the children in the state. B. A tracking system will be established by April 2004, which will track applicants referred among ALL Kids, SOBRA Medicaid, and the Alabama Child Caring Foundation.	New/Revised ☐ Continuing ☐ Data Sources: CPS and/or NSAF and state data survey; Tracking system. Methodology: Retrieve data from CPS and/or NSAF and, beginning FY 2003 report, state data survey. Progress Summary: A. The number of low-income uninsured children in Alabama has decreased since the implementation of Alabama SCHIP. According to the 2003 Alabama Health Care Insurance and Access Survey, of those children at or below 200% of poverty, approximately 12.1% are uninsured. This number indicates a decline from last year's estimate of 15.9% based on the 2000, 2001 and 2002 Current Population Survey. Overall, the 2003 Alabama Health Care Insurance and Access Survey estimated that approximately 78,805 (6.6%) children in Alabama are uninsured, which indicates significant decline from our baseline estimate of 173,012 from the Urban Institute's 1997 National Survey of America's Families (NSAF.) Nevertheless, it should be noted that the Alabama Health Care Insurance and Access Survey uninsurance estimates have been lower than Census and NSAF estimations. The CHIP program will continue to monitor these data sources in order to document any significant changes that may occur in the future. B. The CHIP data system enhancements continue to capture 100% of the information submitted on the paper application, thereby allowing continued sharing of data electronically among ALL Kids, SOBRA Medicaid and the Alabama Child Caring Foundation. Eligibility determination data are retained at the child level and continue to be transmitted nightly to the Alabama Medicaid Agency for use by SOBRA Medicaid eligibility workers.
Objectives Related to SCHIP Enrollment		

Strategic Objectives	(1) **Performance Goals for each Strategic Objective**	(1) **Performance Measures and Progress** **(Specify Data Sources, methodology, time period, etc.)**
2. Given available funding, the number of low income (between the Medicaid eligibility upper income levels and 200% FPL) children enrolled in ALL Kids will be maintained at at least 50,000 (current enrollment) at any given time.	A. The percentage information indicate. B. A higher percentage of families with ALL Kids enrolled child(ren), report that financial barriers to accessing care have been reduced since enrollment in ALL Kids in comparison to the	New/Revised ☐ Continuin g ☐ Data Sources: : Renewal database, New Enrollee survey database, administrative files, Enrollment Data Management system Methodology: : Comparison of the number of non-renewals who owed premiums to the number who were due to renew.

Strategic Objectives	(1) **Performance Goals for each Strategic Objective**	(1) **Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)**
		Progress Summary: As of September 30, 2003 there were 62,449 enrollees in the ALL Kids program. A. During FY03 the cumulative rate of Disenrollment due to non-payment of past due premiums was 0.59%. The highest month reported was June 2003 with 1.04% of cancellations due to non-payment of premium and the lowest month reported was November 2002 with 0.11%. B. Based on the data reported in the New Enrollee Survey, prior to obtaining ALL Kids insurance, 27% needed medical care but could not get it due to expense; 40% waited longer than should have due to expense; and 76% worried a great deal about their ability to pay for healthcare. In contrast, data reported in the Continuous Enrollee Survey (while enrolled in ALL Kids), 95% of enrollees received care when it was needed; 91% did not wait longer than necessary to seek care; and when making a final optional comment, 19% felt relief and/or security in the ability to have affordable care for their children. C-D. In FY 2003 ALL Kids the outreach plans for special populations which were developed by consultants during the previous year were evaluated and used to inform outreach activities at both the regional level and the central office level. E. The ALL Kids program continued to employ a Hispanic Regional Coordinator who provided outreach services to Hispanics statewide. The Coordinator also provided cultural awareness inservices for the ALL Kids central office staff. With regard to the birth-to-five providers, outreach plans were evaluated and used to inform outreach activities at both the regional level and the central office level. F. See C-E above. G. . In FY 2003, CHIP implemented a HRSA State Planning Grant which identified other broad areas for outreach. As these populations are further defined, outreach efforts will be developed. H. During FY 2003, the ADPH contracted with Bell South for a language translation telephone line. Additionally, CHIP employed a Hispanic outreach consultant to identify ways to promote the program within this population. I. Throughout FY03, the CHIP Data Management Unit has monitored the frequency of cancellations due to non-participation in the renewal process.

Strategic Objectives	(1) Performance Goals for each Strategic Objective	(1) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
3. The number of low-income children (incomes in the Medicaid income eligibility ranges) enrolled in SOBRA Medicaid will be maintained at at least 300,000.	There will be maintenance of effort or an increase, on the part of CHIP, to decrease the number of low-income (Medicaid eligible) children as evidenced by at least the following: 1. Continued use of a joint application form. 2. Continued use of joint renewal form. 3. Continued referral, without any barriers, of applications and renewal between ALL Kids and SOBRA Medicaid. 4. Continued outreach efforts by CHIP staff for network building with community groups, professionals (individual and in groups), child care providers, schools, etc. 5. Continued evaluation and monitoring of the application transfer/referral process between ALL Kids and Medicaid. 6. Continued computer enhancements to improve the communication with other agencies and current and potential ALL Kids enrollees.	New/Revised ☐ Continuin g ☐ Data Sources: Use of a joint application form; Use of a joint renewal form; policy for seamless referral between ALL Kids and SOBRA Medicaid; documentation in administrative outreach and application transfer and referral processes files Methodology: : Seamless referral policy in place; outreach/marketing files reflect outreach conducted by central office staff, regional staff, and federal program office; Meeting minutes, which reflect the continued evaluation and monitoring of the application transfer/referral process between ALL Kids and Medicaid will be on file; Computer enhancements are in place Progress Summary: ALL Kids has continued all performance goals as outlined in this section. Of particular note is the continuation of a Medicaid eligibility unit co-located with the All Kids Enrollment Unit. These outstationed SOBRA Medicaid staff are tasked with eligibility determination for applications referred by the ALL Kids Enrollment Unit in pre-designated geographic regions. This arrangement has fostered and facilitated improved communication between the agencies regarding eligibility determination policies as well as individual children's determination of eligibility. Additionally, enhancements to the CHIP Eligibility and Enrollment system have been made through the Supporting Families after Welfare Reform Project which has enabled communication between the ALL Kids computer system and the Medicaid computer system.
Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)		

Strategic Objectives	(1) **Performance Goals for each Strategic Objective**	(1) **Performance Measures and Progress** **(Specify Data Sources, methodology, time period, etc.)**
4. Enrollment in ALL Kids will result in more children having a medical home.	A. A higher percentage of families report that their ALL Kids enrolled child(ren) have a usual source of care since enrollment in ALL Kids than before enrollment in ALL Kids. B. A lower percentage of families report that their ALL Kids enrolled child(ren) have used a hospital emergency room since enrollment in ALL Kids than before enrollment in ALL Kids.	New/Revised ☐ Continuin g ☐ Data Sources: New Enrollee and Continuous Enrollee Surveys Methodology: Reported usual source of care; reported ER use. Progress Summary: A. Data from the ALL Kids New Enrollee Survey show that approximately 79% of parents report their child had a usual source of care prior to enrollment in ALL Kids. The ALL Kids Continuous Enrollee Survey shows that parents report a higher level of having a usual source of care for their child once enrolled in the program. In fact, 92% of parents reported a usual source of care for their child as part of this survey. B. According to the 9/03 New Enrollee Survey Report, 46.9% of new enrollees had at least 1 ER visit prior to CHIP enrollment whereas, according to the 9/03 Continuous Enrollee Survey Report 37% of enrollees had an ER visit during CHIP enrollment.
Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)		

Strategic Objectives	(1) **Performance Goals for each Strategic Objective**	(1) **Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)**
5. Enrollment in ALL Kids will result in a higher usage of preventive care	A. A higher percentage of families report that their ALL Kids enrolled child(ren) have had a well child check-up in the past year since enrollment in ALL Kids than before enrollment in ALL Kids. B. A higher percentage of families report that their ALL Kids enrolled child(ren) have had a dental visit in the past year since enrollment in ALL Kids than before enrollment in ALL Kids. C. A higher percentage of families report that their ALL Kids enrolled child(ren) have had a vision screening in the past year since enrollment in ALL Kids than before enrollment in ALL Kids.	New/Revised ☐ Continuing ☐ Data Sources: Pediatric Health History and Continuous Enrollee Surveys Methodology: Reported use of well-child check-up; reported dental visit; reported vision screening. Progress Summary: A. Of those enrollees providing a Pediatric Health History at enrollment, 59% reported having received a preventive medical check-up in the twelve months preceding enrollment in ALL Kids. Data from the ALL Kids Continuous Enrollee Survey shows that approximately 92% of enrollees received at least one preventive/routine care medical service in the previous twelve months of enrollment. B. Of those enrollees providing a Pediatric Health History at enrollment, approximately 38% reported receiving a preventive dental visit in the twelve months preceding enrollment. Data from the ALL Kids Continuous Enrollee Survey shows that approximately 75% of enrollees received at least one preventive dental visit within the previous twelve months of enrollment. C. Data from the Pediatric Health History (PHH) database was used to determine the number of enrollees that reported obtaining preventative vision care within the twelve months preceding ALL Kids enrollment. Of those that provided a PHH at enrollment, 33.6% in FY02 and 43% in FY03, reported receiving a preventative vision screening within the twelve months prior to ALL Kids enrollment. In FY04, CHIP will examine the feasibility of using claims data to determine the percentage of children enrolled who receive this service in their enrollment year.
Other Objectives		

Strategic Objectives	(1) **Performance Goals for each Strategic Objective**	(1) **Performance Measures and Progress** **(Specify Data Sources, methodology, time period, etc.)**
6. Specialty services beyond the basic ALL Kids coverage package will be available for ALL Kids enrolled children with special health care needs.	A. Contracts with state agencies which serve children with special health care needs will be maintained for the purpose of providing specialty services beyond the basic ALL Kids coverage package for these children. B. Exploration of the feasibility of establishing contracts with other state agencies that serve children with special health care needs. C. Continued monitoring of access to specialty care for children with special health care needs.	New/Revised ☐ Continuin g ☐ Data Sources: Administrative files; New Enrollee Survey Methodology: Contracts are on file; documentation on file of exploration of feasibility for establishing contracts with other CSHCN state agencies; data on access to care for CSHCN. Progress Summary: A. ALL Kids maintained an ALL Kids PLUS contract with the Dep't of Rehabilitation Services for providing specialty services beyond the basic ALL Kids coverage package. B. ALL Kids signed a PLUS contract with the Alabama Department of Mental Health and Mental Retardation. ALL Kids continued to explore a PLUS contract with the Alabama Institute for the Deaf and Blind. C. ALL Kids continued to monitor access to specialty care for CSHCN through claims data and meetings with program staff.

2. How are you measuring the access to, or the quality or outcomes of care received by your SCHIP population? What have you found?

   The Alabama SCHIP program partners with the University of Alabama at Birmingham School of Public Health to evaluate SCHIP enrollees' experiences with the program and their access to and utilization of health services while enrolled. In particular, UAB School of Public Health distributes and analyzes three surveys: a New Enrollee Survey, a Continuous Enrollee Survey and a Disenrollee Survey.

   The Continuous Enrollee Survey began in October 1999 and provides ongoing feedback to the program regarding enrollees' access to and utilization of health services. The survey captures data from children who have been enrolled in ALL Kids for at least twelve months. The response rate has averaged 55% over the life of the survey. Fourty-eight percent (48%) of respondents have been on the program twelve to twenty four months, and 38% have been enrolled greater than two years.

   Specific questions address the enrollees' access to a medical home. Over 90% of respondents indicate that they have either one provider or group of providers they use for sick or routine health care. Ninety percent (90%) say that they have no problem finding a doctor that accepts ALL Kids and 85% rate their satisfaction with their child's personal doctor as "high". Similarly, parents report receiving routine medical and dental care according to recommended schedules (79% and 76% respectively). Ninety-five percent (95%) report no problems or barriers to obtaining needed prescriptions. Parents also report high levels of access for specialty services. In fact, 96% report that there was no time in the previous twelve months when their child needed specialty care and they could not access these services.

3. What plans does your SCHIP program have for future measurement of the access to, or the quality or outcomes of care received by your SCHIP population? When will data be available?

The Alabama CHIP program will continue to conduct surveys in collaboration with the University of Alabama at Birmingham School of Public Health, Department of Maternal and Child Health. These surveys mainly provide measurements of access to care and to a more limited degree, quality of care and health outcomes.

In addition, CHIP will continue to be an active participant in a multi-state work group focused on ways to utilize claims data to generate meaningful outcome and quality measures. In the upcoming year, options will be analyzed and examined to further evaluate access and quality of care within the program.

Beginning October 2003, Alabama CHIP will be participating in the Centers for Medicare and Medicaid's Payment Accuracy Measurement Demonstration (PAM) project. In the project, CHIP claims will be examined to confirm the accuracy of the claims payment system. If inaccuracies are revealed, then efforts will be directed to study the origin of the problem(s) and to develop greater focus on strengthening the internal controls to eliminate the problem(s). The study consists of three components: a process review, eligibility review and medical necessity review. These reviews will allow us to examine the impact of our internal processes on healthcare quality, outcomes and access. Final results will be available in September 2004.

4. Have you conducted any focused quality studies on your SCHIP population, e.g., adolescents, attention deficit disorder, substance abuse, special heath care needs or other emerging health care needs? What have you found?

   ADOLESCENTS

   There is an adolescent supplement to the continuous enrollee survey, approximately 54% of enrollees receiving the survey also receive this component. All recipients are twelve years of age and older and the survey supplement may be filled out by either the parent, the adolescent or the parent may work in conjunction with their child to answer the survey questions. The majority of surveys are filled out either by the parent or the parent and the adolescent together. However, 20% indicate that the adolescent only filled out the survey. The survey focuses on adolescent issues such as emotional and behavioral concerns. To date, there has been a 53% response rate.

   The survey results show that over half (52%) of adolescents report calling their health care provider for advice. Of those that did call, 68% said they usually or always got the help or advice that they were seeking. Thirty-two percent (32%) of adolescents reported that their health care provider has discussed with them taking responsibility for their own health. Similarly, thirty-four percent said the provider gave them reassurance and support about taking responsibility for their own health. However, only 37% of adolescents responding to the survey reported having the opportunity to speak with their provider privately.

   CSHCN

   Alabama's SCHIP program is extremely interested in how children with special health care needs fare when in a private health insurance modeled program. To this end, they have worked with UAB School of Public Health in the publication of papers and presentations regarding the effects of disability status, age and race on access to care and unmet need. Through this endeavor, respondents from the first year retrospective survey of children enrolled in ALL Kids during FY99 were again surveyed to determine if their child had a special health care need. Five screener questions were used and twenty-seven percent of respondents answered yes to at least one of these questions. These data showed that while all enrollees indicated an improvement in access to care after enrolling in CHIP, those children with a special health care need indicated even greater improvement.

5. 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 and summarize findings or list main findings.

The summary information from the Continuous Enrollee Survey, the New Enrollee Survey and the Disenrollee Survey can be found in the responses to questions 1-4 above. More extensive summaries can be found in the 3 attachments containing reports of these surveys.

Reporting of National Performance Measures

The Centers for Medicare & Medicaid Services (CMS) convened the Performance Measurement Partnership Project (PMPP) as a collaborative effort between Federal and state officials to develop a national set of performance measures for Medicaid and the State Children's Health Insurance Programs (SCHIP). CMS is directed to examine national performance measures by the SCHIP Final Rules of January 11, 2001 and the Medicaid Final Rules of June 14, 2002 on managed care.

The PMPP's stated goal is to create a short list of performance measures relevant to those enrolled in Medicaid and SCHIP. The group focused on well-established measures whose results could motivate agencies, providers, and health plans to improve the quality of care delivered to enrollees. After receiving comments from Medicaid and SCHIP officials on an initial list of some 19 measures, the PMPP group trimmed the list to the following seven core measures (SCHIP states should report on all applicable measures for covered populations to the extent that data is available):

- Well child visits for children in the first 15 months of life
- Well child visits in the 3rd, 4th, 5th, and 6th years of life
- Use of appropriate medications for children with asthma
- Comprehensive diabetes care (hemoglobin A1c tests)
- Children's access to primary care services
- Adult access to preventive/ambulatory health services
- Prenatal and postpartum care (prenatal visits)

Work remains to resolve technical issues related to implementing the collection, analysis, and reporting of the measures. If your State currently has data on any of these measures, please report them using the format below. Indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator and denominator). Please attach additional narrative if necessary.

Performance Measure	Describe How It Was Measured	Performance Measures and Progress
Well child visits for children in the first 15 months of life	This measure is for the percentage of enrolled members who were 15 months old or less. The measure addresses the percentage of members with one to eight well child visits during this age span.	Data Sources: Blue Cross Blue Shield of Alabama ALL Kids Annual Report
		Methodology: The percentage of CHIP enrollees in the first 15 months of life who had at least one well child visit during the year
		Progress Summary: 76.1% of CHIP enrollees in the first 15 months of life had at least one well child visit during the year. It should be noted that because ALL Kids uses a fee-for-service reimbursement system instead of a capitated or managed care system, the ALL Kids Program's ability to obtain reliable data for this performance measure is questionable due to the fact that reporting of a well child visit can be obscured by the coding of a sick child visit which may be reimbursed at a higher rate.

Performance Measure	Describe How It Was Measured	Performance Measures and Progress
Well child visits in the 3rd, 4th, 5th, and 6th years of life	This measure is for the percentage of enrolled members who were in the 3rd, 4th, 5th, and 6th years of life. The measure addresses the percentage of members with at least one well child visit during this age span.	Data Sources: Blue Cross Blue Shield of Alabama ALL Kids Annual Report Methodology: The percentage of CHIP enrollees who had at least one well child visit during the 3rd, 4th, 5th, and 6th years of life. Progress Summary: 30.3% of enrollees in the 3rd year of life had at least one well child visit during the year. 40.2% of enrollees in the 4th year of life had at least one well child visit during the year. 44.3% of enrollees in the 5th year of life had at least one well child visit during the year. 12.6% of enrollees in the 6th year of life had at least one well child visit during the year. It should be noted that because ALL Kids uses a fee-for-service reimbursement system instead of a capitated or managed care system, the ALL Kids Program's ability to obtain reliable data for this performance measure is questionable due to the fact that reporting of a well child visit can be obscured by the coding of a sick child visit which may be reimbursed at a higher rate.
Use of appropriate medications for children with asthma	Not reportable at this time	Data Sources: Methodology: Progress Summary:
Comprehensive diabetes care (hemoglobin A1c tests)	Percentage of diabetic enrollees who had a HbA1c test at any time during the year.	Data Sources: Blue Cross Blue Shield of Alabama ALL Kids Annual Report Methodology: # of diabetic enrollees with a HbA1c test over the # of diabetic enrollees Progress Summary: 33% of diabetic enrollees had at least once HbA1c test during the year.
Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)	See first and second national objectives above.	Data Sources: Methodology: Progress Summary:
Adult access to preventive/ambulatory health services	Not applicable	Data Sources: Methodology: Progress Summary:
Prenatal and postpartum care (prenatal visits)	Unable to be reported at this time.	Data Sources: Methodology: Progress Summary: ALL Kids reimburses physicians for obstetrical services via a global rate which bundles prenatal services, delivery, and post partum services together. Therefore, the number of pre-natal visits is not captured in ALL Kids utilization data. During FY 2003, the program paid for 255 births.

SECTION III: ASSESSMENT OF STATE PLAN AND PROGRAM OPERATION

ENROLLMENT

1. Please provide the Unduplicated Number of Children Ever Enrolled in SCHIP in your State for the reporting period. The enrollment numbers reported below should correspond to line 7 in your State's 4th quarter data report (submitted in October) in the SCHIP Statistical Enrollment Data System (SEDS).

________________	SCHIP Medicaid Expansion Program (SEDS form 64.21E)	________________	Separate Child Health Program (SEDS form 21E)

2. Please report any evidence of change in the number or rate of uninsured, low-income children in your State that has occurred during the reporting period. Describe the data source and method used to derive this information.

   The number of uninsured children less than 19 years of age has decreased significantly since the implementation of Alabama SCHIP. Alabama SCHIP 's baseline estimate, which is based on the Urban Institute's 1997 National Survey of America's Families (NSAF), indicated that there were 173,012 uninsured children in Alabama. Of these, 91,209 were Medicaid-eligible, 49,579 were All Kids eligible and 32,223 were in families with incomes above 200% FPL. Six years later, the 2003 Alabama Health Care Insurance and Access Survey, funded by Health Resources and Services Administration (HRSA), estimated that approximately 78,805 (6.6%) children in Alabama are uninsured. Of these, roughly 21,513 are potentially eligible for CHIP.

3. How many children do you estimate 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. ***(States with only a SCHIP Medicaid Expansion Program, please skip to #4)***

   Alabama Medicaid, SCHIP, and the Alabama Child Caring Foundation (ACCF) use a common application enabling children identified as potentially eligible for Medicaid or ACCF to be referred without delay for eligibility determination and enrollment. Therefore, the availability of SCHIP funding for marketing and outreach activities translates to increased enrollment in all three programs.

   Since its inception in 1998, the Alabama SOBRA Medicaid program has seen a net increase of approximately 156,556 children. It is estimated that approximately 60-70,000 of these new enrollees were referred by ALL Kids. Both the Alabama Medicaid program and the ALL Kids program provide enrollment data on a quarterly basis. These data, in conjunction with ALL Kids internal eligibility and enrollment system data are used to determine the effect of ALL Kids marketing and outreach on SOBRA Medicaid enrollment. Systems enhancements are currently under development to enable both programs to link eligibility determination systems in a way that will allow for more precise measurement of this effect.

   Prior to SCHIP, enrollment in the ACCF had been stable at around 6,000. With the establishment of SCHIP, ACCF saw its enrollment grow from 5,968 in the first quarter of FY 1998 to 8,011 in the fourth quarter of FY 2002. In fact, ACCF had to suspend enrollment during January - February 2003, due to the overwhelming numbers. As a result, enrollment declined from 8,011 in the fourth quarter FY 2002, to 6,476 in the fourth quarter FY 2003. About 25% of ACCF's total enrollees in FY 2003 are Hispanic children.

4. Has your State changed its baseline of uncovered, low-income children from the number reported in your previously submitted Annual Report?

   Note: The baseline is the initial estimate of the number of low-income uninsured children in the State against which the State's progress toward covering the uninsured is measured. Examples of why a State may want to change the baseline include if CPS estimate of the number of uninsured at the start of the program changes

or if the program eligibility levels used to determine the baseline have changed.

_____ No, skip to the Outreach subsection, below

_____ Yes, please provide your new baseline ________________ And continue on to question 5

5. On which source does your State currently base its baseline estimate of uninsured children?

______ The March supplement to the Current Population Survey (CPS)

______ A State-specific survey

______ A statistically adjusted CPS

______ Another appropriate source

A. What was the justification for adopting a different methodology?

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

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

OUTREACH

1. How have you redirected/changed your outreach strategies during the reporting period?

   With the completion of Regional Coordinator placement CHIP has decentralized most education and outreach to a regional level. These coordinators are based across the state and serve as liaisons between the CHIP program and local communities. In addition, they provide outreach, education, and community development and facilitate problem resolution. This has allowed all outreach activities to be more responsive to the needs of the community.

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

   ALL Kids captures information on the distribution of printed and other informational materials via a distribution database. The program tracks the quantities, destinations, and reasons for requests enabling staff to run monthly reports on the number of applications and other materials distributed. The information in this report accurately reflects the number of applications distributed to any sector, organization or outreach effort. This report can be queried by shipping date, county, agency or program, in order to evaluate the success of any given outreach effort or event.

   Increased participation in community events, health fairs, etc., where program staff have direct

contact with families has proven to have positive results. These events give Regional Coordinators and other program staff the opportunity to give parents a clear understanding of the options available to them, how to access these options, correct any program misunderstandings and assist families with completing applications. These efforts have been measured by the number of applications distributed/completed at the event and the number of applications that are requested via telephone and on printed materials order forms.

CHIP continues to make significant progress in reaching low-income, uninsured children through several avenues. The program continues to participate in an extensive network with other agencies and programs already serving the same or over-lapping populations. Many families receive information about CHIP, applications, and application assistance through Child Care Management Agencies, targeted daycare centers, Maternal and Child Health Block Grant Program clinics, WIC clinics, community health centers, school nurse programs, Early Intervention Programs, after-school programs and smaller nonprofit programs whose goals are the improvement of the health, education and welfare of children and teens.

3. 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?

Measurements are still mostly anecdotal at this point.

ALL Kids has found that dissemination of program information to minorities, and residents of rural areas is best received when delivered by a trusted member of the community already ensconced in the child health arena.(i.e., Having school nurses, local health department social workers, Family Service Centers, etc., involved in and doing outreach as part of their ongoing agency work).

ALL Kids has found that outreach efforts that partner with other planned events are more successful than enrollment-type events which have not proven very successful in reaching target populations.

A full time CHIP Hispanic Coordinator has significantly increased outreach and education resulting in higher numbers of insured Hispanic children and teens. Activities include attendance at many Hispanic oriented events such as health fairs and cultural festivals and active involvement with several of the Hispanic coalitions and advocacy groups that have emerged around the state. As a result, the CHIP Hispanic Coordinator, through education, enables community leaders and other agency personnel to be able to assist Hispanic families in obtaining health coverage for their children. Realizing that lack of cultural understanding was a big barrier for health providers and agencies, she has developed a presentation related to Understanding and Reaching the Hispanic Population. Contact hour approval was obtained for both nurses and social workers. This has provided an opening to reach many individuals who are health and social service providers with the cultural sensitivity message as well as information about the health coverage programs.

SUBSTITUTION OF COVERAGE (CROWD-OUT)

All States must complete the following 3 questions

1. Describe how substitution of coverage is monitored and measured.

ALL Kids application materials require that the parent provide detailed information on current health

insurance coverage for children and explain any coverage that has ended in the previous three months. This information is captured in the CHIP eligibility and enrollment data system and is reviewed at initial eligibility determination by Enrollment Unit staff to ensure that children ineligible for CHIP coverage due to having or recently voluntarily terminating other health insurance are not enrolled. If a child appears eligible for ALL Kids coverage, and is uninsured or meets one of the criteria for exception to the ALL Kids crowd-out policy, the information is transmitted to the insurance vendor for enrollment in the program.

This nightly enrollment transmittal to Blue Cross and Blue Shield of Alabama (the vendor for CHIP in Alabama) is then filtered against other Blue Cross Blue Shield policies in order to identify children with other BCBS coverage in effect or that has been terminated less than 90 days from the date of enrollment indicated on the file. This is a highly effective strategy because BCBS insures about 85% of the covered lives in Alabama. A system generated report is returned from BCBS daily to the CHIP Enrollment Unit indicting those potential enrollees filtered as insured. Each case is investigated and the family notified of the indicated other coverage and appropriate waiting periods for enrollment.

The CHIP eligibility and enrollment data system provides program management with monthly reports on these children as well as those that were exempted from any waiting periods based on program policy.

2. Describe the effectiveness of your substitution policies and the incidence of substitution. What percent of applicants, if any, drop group health plan coverage to enroll in SCHIP?

   Due to the reasons stated above, the ALL Kids crowd-out policies are quite effective. The percent of applicants who drop group health plan coverage to enroll in ALL Kids is unknown at this time.

3. At the time of application, what percent of applicants are found to have insurance?

   At the time of application, approximately 2.6% of applicants are found to have current or recent health insurance, which precludes them from enrollment.

   States with separate child health programs over 200% of FPL must complete question 4

4. Identify your substitution prevention provisions (waiting periods, etc.).

   States with a separate child health program between 201% of FFP and 250% of FPL must complete question 5.

5. Identify the trigger mechanisms or point at which your substitution prevention policy is instituted.

   States with waiting period requirements must complete question 6. (This includes states with SCHIP Medicaid expansion programs with section 1115 demonstrations that allow the State to impose a waiting period.)

6. Identify any exceptions to your waiting period requirement.

   There is no waiting period for children whose health insurance was involuntarily terminated. As a rule, children whose health insurance is voluntarily terminated must wait 3 months from the time of termination before being eligible to enroll in CHIP. There are 4 exceptions to this rule as follows: (1) Terminating COBRA coverage; (2) Terminating Medicaid coverage; (3) Terminating coverage under the Alabama Child Caring Foundation; and (3) Exhausting the lifetime benefits of current coverage.

Coordination between SCHIP and Medicaid

(This subsection should be completed by States with a Separate Child Health Program)

1. Do you have the same redetermination procedures to renew eligibility for Medicaid and SCHIP (e.g., the same verification and interview requirements)? Please explain.

No. Both the ALL Kids and Medicaid programs have the same redetermination procedures as their original determination procedures. Additionally, both programs have the same twelve-month

coverage periods and both use the same renewal form.

2. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes. Have you identified any challenges? If so, please explain.

Yes. When either applications or renewals for children are received by either the ALL Kids or the SOBRA Medicaid program and the eligibility reviewer determines that the applicant does not appear to be eligible for the program in receipt of the application/renewal but appears to meet the income eligibility requirements of the other program, the application/renewal is sent to the other program. This exchange of applications/renewals between the two programs occurs at least weekly.

Periodically there are instances when ALL Kids sends an application to Medicaid and Medicaid reviews and returns the application to ALL Kids. These occurrences are usually due to the fact that ALL Kids accepts the statement of income on the application by declaration and Medicaid requires written verification of income. When this happens, the family has either underestimated the income on the application or the family has variable income which has changed between the time that they applied for ALL Kids and the time that Medicaid requests income verification. During FY 2002 these situations were carefully studied and beginning in early FY 2003, a special procedure was developed so that any application or renewal referred to ALL Kids by Medicaid is expedited once it is received by ALL Kids from Medicaid. ALL applications received at ALL Kids from Medicaid are processed by one designated eligibility worker, for consistency. During FY 2002, two Medicaid eligibility workers and a clerk were outstationed within the ALL Kids Eligibility Unit to assist with referrals from ALL Kids to Medicaid. In FY 2003 there were three Medicaid eligibility workers and a clerk outstationed within the ALL Kids Eligibility Unit.

3. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain

No. Medicaid uses a unique network which the Medicaid Agency manages and ALL Kids uses a preferred provider, discounted fee-for-service network developed by Blue Cross Blue Shield of Alabama.

ELIGIBILITY REDETERMINATION AND RETENTION

1. What measures are being taken to retain eligible children in SCHIP? *Check all that apply*.

____ Follow-up by caseworkers/outreach workers

____ Renewal reminder notices to all families, *specify how many notices and when notified*
Two postcards are sent to each family at ten and six weeks prior to renewal in addition to the renewal form itself, which is sent to each family eight weeks prior to renewal.

____ Targeted mailing to selected populations, *specify population*_ ____________________

____ Information campaigns

____ Simplification of re-enrollment process, *please describe* ____________________

____ Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, *please describe*
During FY 2003, the program administered a ____________________

____ Other, *please explain* During FY 03, 2 similar projects were developed & implemented which focused on retention issues. One project focused on reducing the number of chilren who did not renew & did not give a non-renewal reason. The other project focused on retention of those children due to renew. Both projects used letters & telephone calls to reach these applicants & possibly retain them in ALL Kids. It was found that telephone calls were the most successful in deriving information &/or prompting renewal.

2. Which of the above measures have been effective? Describe the data source and method used to derive this information.

   All of the noted measures above continue to be effective and are continually monitored.

3. Has your State undertaken an assessment of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured, how many age-out, or how many move?) If so, describe the data source and method used to derive this information.

   Since the beginning of the ALL Kids renewal process, Alabama has captured and continuously tracked retention/disenrollment rates and reasons. During this process, all renewal applications are given an eligibility determination - which is named and number coded - and is captured in the CHIP eligibility and enrollment data system. Then, in order to assess these disenrollment determination reasons, disenrollment data is pulled by number code from the CHIP enrollment data system using data reporting software.

   FY03 assessment findings using an average:

   Average retention rate 52.3%

   Reasons for disenrollment:

   Requested by the parent - 0.42%; non-payment of premium - 0.59%; renewal form not received - 20.06%; over income - 2.86%; under income - 13.93%; other insurance - 0.32%; on Medicaid - 0.91%; on State/PEEHIP insurance - 0.15%; out-of-state - 0.02%; past age limit - 0.01%.

   ALL Kids Disenrollee Survey Background and findings:

   The Disenrollment Survey collects information on children disenrolled from ALL Kids. It began with disenrollees from October 1999 and is on-going. A target disenrollee is selected at random from each household with any disenrolled children. The primary purpose of the survey is to determine utilization of services and satisfaction with services while enrolled in ALL Kids.

   The survey is followed up by a reminder postcard and if necessary mailing of a second survey and telephone follow-up. Despite these attempts, the survey has a very low response rate (25%). Therefore it is difficult to generalize the results across all disenrollees.

   Findings from the survey reflect those found in both the new and continuous enrollee surveys. Respondents report high levels of having a usual source of care 80%, receiving dental services 74% and pharmacy services 85%. similarly, there is a high level of satisfaction expressed by respondents. Ninety-four percent (94%) said that participating doctors and dentists were easy to find and 97% reported that they were 'somewhat' or 'a great deal' satisfied with their personal doctor. When asked about their overall opinion of the program 90% said that they were 'a great deal' satisfied with ALL Kids.

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?

   No

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

   No

PREMIUM ASSISTANCE PROGRAM(S) UNDER SCHIP STATE PLAN

1. Does your State offer a premium assistance program using title XXI funds under any of the following authorities?

Note:

Yes, check all that apply and complete each question for each authority.

- State
- Family Coverage
- Section 1115 Demonstration
- Health Insurance Accountability & Flexible Demonstration
- HIPP

No, skip to Section IV.

2. Briefly describe your program (including current status, progress, difficulties, etc.)

3. What benefit package does the program use?

4. Does the program provide wrap-around coverage for benefits? For cost sharing?

5. Identify the total number of children and adults enrolled in the premium assistance program for whom title XXI funds are used during the reporting period (provide the number of adults enrolled in premium assistance even if they were covered incidentally and not via the SCHIP family coverage provision).

________________ Number of adults ever enrolled during the reporting period

________________ Number of children ever enrolled during the reporting period

6. Identify the estimated amount of substitution, if any, that occurred as a result of your premium assistance program. How was this measured?

7. Indicate the effect of your premium assistance program on access to coverage. How was this measured?

8. What do you estimate is the impact of premium assistance on enrollment and retention of

children? How was this measured?

SECTION IV: PROGRAM FINANCING FOR STATE PLAN

1. Please complete the following table to provide budget information. Describe in narrative any details of your planned use of funds below. *Note: This reporting period = Federal Fiscal Year 2002 starts 10/1/01 and ends 9/30/02). If you have a combination program you need only submit one budget; programs do not need to be reported separately.*

COST OF APPROVED SCHIP PLAN

Benefit Costs	**Reporting Period**	**Next Fiscal Year**	**Following Fiscal Year**
Insurance payments			
Managed Care			
Per member/Per month rate @ # of eligibles			
Fee for Service			
Total Benefit Costs			
(Offsetting beneficiary cost sharing payments)			
Net Benefit Costs			
Administration Costs			
Personnel			
General Administration			
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/Marketing costs			
Other			
Total Administration Costs			
10% Administrative Cap (net benefit costs ÷ 9)			
Federal Title XXI Share			
State Share			
TOTAL COSTS OF APPROVED SCHIP PLAN			

Per member/Per month rate @ number of eligibles - $140 @ 672,829 member months.

2. What were the sources of non-Federal funding used for State match during the reporting period?

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

SECTION V: 1115 DEMONSTRATION WAIVERS (FINANCED BY SCHIP)

1. If you do not have a Demonstration Waiver financed with SCHIP funds skip to Section VI. If you do, please complete the following table showing whom you provide coverage to.

	SCHIP Non-HIFA Demonstration Eligibility					**HIFA Waiver Demonstration Eligibility**				
Children	From		% of FPL to		% of FPL	Fro m		% of FPL to		% of FPL
Parents	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Childless Adults	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Pregnant Women	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL

2. Identify the total number of children and adults ever enrolled in your SCHIP demonstration during the reporting period.

_____________ Number of **children** ever enrolled during the reporting period in the demonstration

_____________ Number of **parents** ever enrolled during the reporting period in the demonstration

_____________ Number of **pregnant women** ever enrolled during the reporting period in the demonstration

_____________ Number of **childless adults** ever enrolled during the reporting period in the demonstration

3. What do you estimate is the impact of your State's SCHIP section 1115 demonstration on enrollment, retention, and access to care of children?

4. Please complete the following table to provide budget information. Please describe in narrative any details of your planned use of funds. *Note: This reporting period (Federal Fiscal Year 2002 starts 10/1/01 and ends 9/30/02).*

COST PROJECTIONS OF DEMONSTRATION (SECTION 1115 or HIFA)	**Reporting Period**	**Next Fiscal Year**	**Following Fiscal Year**
Benefit Costs for Demonstration Population #1 (e.g., children)			
Insurance Payments			
Managed care			
per member/per month rate @ # of eligibles			
Fee for Service			
Total Benefit Costs for Waiver Population #1			
Benefit Costs for Demonstration Population #2 (e.g., parents)			
Insurance Payments			
Managed care			
per member/per month rate @ # of eligibles			
Fee for Service			
Total Benefit Costs for Waiver Population #2			
Benefit Costs for Demonstration Population #3 (e.g., pregnant women)			
Insurance Payments			
Managed care			
per member/per month rate @ # of eligibles			
Fee for Service			
Total Benefit Costs for Waiver Population #3			
Total Benefit Costs			
(Offsetting Beneficiary Cost Sharing Payments)			
Net Benefit Costs (Total Benefit Costs - Offsetting Beneficiary Cost Sharing Payments)			
Administration Costs			
Personnel			
General Administration			
Contractors/Brokers *(e.g., enrollment contractors)*			
Claims Processing			
Outreach/Marketing costs			
Other *(specify)*			
Total Administration Costs			
10% Administrative Cap (net benefit costs ÷ 9)			
Federal Title XXI Share			
State Share			
TOTAL COSTS OF DEMONSTRATION			

Section VI: Program Challenges and Accomplishments

1. Please provide an overview of what happened in your State during the reporting period as it relates to health care for low income, uninsured children and families. Include a description of the political and fiscal environment in which your State operated.

   At the beginning of calendar year 2003, the state had a change in governors which resulted in changes in the leadership positions of several state agencies. However, none of these changes had any effect on the depressed economy in the state which overshadowed health care for low income, uninsured children and families during FY 2003 and which will likely continue to adversely affect these populations in FY 2004 and beyond. A referendum, proposed by the new Governor, which would have strengthened state funding failed. Most state agencies were required to cut their budgets by 18% for FY 2004. As a sign of the times, there were a number of large business closings which resulted in a high unemployment number.

2. During the reporting period, what has been the greatest challenge your program has experienced?

   The greatest challenge has been to prepare for the funding shortage in FY 2004. Numerous scenarios were developed in which variables such as waiting lists, premium changes, and co-pay changes were manipulated. This forecasting took an extraodinary amount of attention.

3. During the reporting period, what accomplishments have been achieved in your program?

   The administrative policy manual was finalized. A waiting list for enrollment was established. The program prepared for the implementation of increased cost-sharing by enrollees. The application processing time was greatly reduced. Staffing within the enrollment unit was stabilized. The magnitude of uninsurance in children was decreased. The program implemented 2 important special projects (HRSA State Planning Grant and RWJF Supporting Families After Welfare Reform Implementation Grant).

4. What changes have you made or are planning to make in your SCHIP program during the next fiscal year? Please comment on why the changes are planned.

   Cost-sharing for enrollees will increase. Semi-passive renewal will be implemented in January 2004. A web-based application will be implemented. The waiting-list will be opened for the first time. Enrollees will be able to pay their premiums via a major credit card. State and substate specific data on the uninsured will be refined. The contractor for the program's 24-hour nurse line will be changed from Intracorp to Optum and the line will be marketed differently in an effort to improve its utilization and reduce high-cost benefit usage. All of the above changes are planned to increase fiscal accountability, increase family friendliness, and improve the delivery of services to families.