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 and CMS over the years to design and revise this Annual Report Template. Over time, the framework has been updated to reflect program maturation and corrected where difficulties with reporting have been identified.

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**

SCHIP Program Type:

_____ SCHIP Medicaid Expansion Only
_____ Separate Child Health Program Only
_____ Combination of the above

Reporting Period: **2004** *Note: Federal Fiscal Year 2004 starts 10/1/03 and ends 9/30/04.*

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Submission Date: **12/29/04**

(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. You are encouraged to complete this table for the different SCHIP programs within your state, e.g., if you have two types of separate child health programs within your state with different eligibility rules. If you would like to make any comments on your responses, please explain in narrative below this table.

	SCHIP Medicaid Expansion Program					Separate Child Health Program				
Eligibility						From	0	% of FPL 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 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?
		N/A		N/A

Is retroactive eligibility available?		No		No
		Yes, for whom and how long?		Yes, for whom and how long?
		N/A		N/A

Does your State Plan contain authority to implement a waiting list?	Not applicable		No_
			Yes
			N/A

Does your program have a mail-in application?		No_		No_
		Yes		Yes
		N/A		N/A

Can an applicant apply for your program over the phone?		No_		No_
		Yes		Yes
		N/A		N/A

Does your program have an application on your website that can be printed, completed and mailed in?		No		No
		Yes		Yes
		N/A		N/A

Can an applicant apply for your program on-line?		No		No
		Yes – please check all that apply		Yes – please check all that apply
		Signature page must be printed and mailed in		Signature page must be printed and mailed in
		Family documentation must be mailed (i.e., income documentation)		Family documentation must be mailed (i.e., income documentation)
		Electronic signature is required		Electronic signature is required
				No Signature is required
		N/A		N/A

Does your program require a face-to-face interview during initial application		No		No
		Yes		Yes
		N/A		N/A

Does your program require a child to be uninsured for a minimum amount of time prior to enrollment (waiting period)?		No		No
		Yes		Yes
	Specify number of months		Specify number of months	3
		N/A		N/A

Does your program provide period of continuous coverage <u>regardless of income changes?</u>		No		No
		Yes		Yes
	Specify number of months		Specify number of months	12
	Explain circumstances when a child would lose eligibility during the time period in the box below		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.	
		N/A		N/A

Does your program require premiums or an enrollment fee?		No		No
		Yes		Yes
	Enrollment fee amount		Enrollment fee amount	
	Premium amount		Premium amount	
	Yearly cap		Yearly cap	
	If yes, briefly explain fee structure in the box below		If yes, briefly explain fee structure in the box below (including premium/enrollment fee amounts and include Federal poverty levels where appropriate)	
			Children with incomes up to and including 150%FPL pay an annual premium of $50. Children with incomes above 150% FPL pay an annual premium of $100. If a family has more than 3 children, the family only has to pay the premiums for 3 children. Native Americans pay no premiums and no co-pays.	
		N/A		N/A

Does your program impose copayments or coinsurance?		No_		No_
		Yes		Yes
		N/A		N/A

Does your program impose deductibles?		No_		No_
		Yes		Yes
		N/A		N/A

Does your program require an assets test?		No		No
		Yes		Yes
	If Yes, please describe below		If Yes, please describe below	
		N/A		N/A

Does your program require income disregards?		No		No
		Yes		Yes
	If Yes, please describe below		If Yes, please describe below	
			Three disregards are applied to the monthly family income when applicable: (1)$90 for each working adult applied to earned income; (2) up to $50 of child support payments received; and, (3) up to $200 and $175 for each child or dependent adult in day care for ages 0-23 months and 2 years and over, respectively.	
		N/A		N/A

Is a preprinted renewal form sent prior to eligibility expiring?		No		No
		Yes, we send out form to family with their information pre-completed and		Yes, we send out form to family with their information pre-completed and
		We send out form to family with their information pre-completed and ask for confirmation		We send out form to family with their information pre-completed and ask for confirmation
		We send out form but do not require a response unless income or other circumstances have changed		We send out form but do not require a response unless income or other circumstances have changed
		N/A		N/A

Comments on Responses in Table:

2.Is there an assets test for children in your Medicaid program? Yes No N/A

2.Is it different from the assets test in your separate child health program? Yes No N/A

2.Are there income disregards for your Medicaid program? Yes No N/A

2.Are they different from the income disregards in your separate child health program? Yes No N/A

3.

2.Is a joint application used for your Medicaid and separate child health program? Yes No N/A

3.

Enter any Narrative text below.
Attached is a schedule of co-pays.

7. 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.

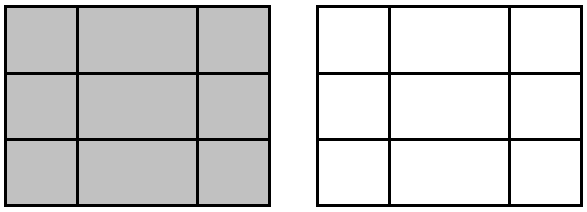
	Medicaid Expansion SCHIP Program			Separate Child Health Program		
	Yes	No Change	N/A	Yes	No Change	N/A
a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)						
b) Application						
c) Benefit structure						
d) Cost sharing (including amounts, populations, & collection process)						
e) Crowd out policies						
f) Delivery system						
g) Eligibility determination process (including implementing a waiting lists or open enrollment periods)						
h) Eligibility levels / target population						
i) Assets test in Medicaid and/or SCHIP						
j) Income disregards in Medicaid and/or SCHIP						
k) Eligibility redetermination process						
l) Enrollment process for health plan selection						
m) Family coverage						
n) Outreach (e.g., decrease funds, target outreach)						
o) Premium assistance						
p) Prenatal Eligibility expansion						
q) Waiver populations (funded under title XXI)						
Parents						
Pregnant women						
Childless adults						

a) Other – please specify

a. _____

b. _____

c. _____



8. 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) a)	
a) Application b)	Beginning in July 2004, a web-based joint application was piloted for ALL Kids, SOBRA Medicaid, MLIF (Medicaid for Low-Income Families), and ACCF (Alabama Child Caring Foundation). Following the pilot, the application was made available statewide in Sept. 2004. Web applications were initiated on 800 children. Web applications were submitted to one of these programs for 589 children.
a) Benefit structure b)	
d) Cost sharing (including amounts, populations, & collection process) e)	Oct. 2003, premiums were instituted for enrollees below 150% FPL ($50 per child for the first 3 children in a family only) & raised for enrollees > 150%FPL through 200%FPL ($100 per child for the first 3 children in a family only). Co-pays were also raised for these 2 groups ((see attachment 1). Pharmacy co-pays were also raised and set in a 3-tiered system (generic [lowest co-payment], preferred brand, non-preferred brand [highest co-pay]). Native Americans pay no premiums and no co-pays.
d) Crowd out policies e)	
d) Delivery system e)	

d) Eligibility determination process (including implementing a waiting lists or open enrollment periods) e)	Beginning Oct. 2003 a waiting list for enrollment was instituted. During this time all applications received were reviewed for Medicaid and Alabama Child Caring eligibility & applications were forwarded to these programs as appropriate. The waiting list was opened 7 times during FY 2004 and a total of 14,476 children were enrolled during these times. No child stayed on the waiting list more than 4½ months. However, the average wait time was 1-2 months.
d) Eligibility levels / target population e)	
d) Assets test in Medicaid and/or SCHIP e)	
d) Income disregards in Medicaid and/or SCHIP e)	
d) Eligibility redetermination process e)	Instead of sending blank renewal forms to families, the program began to send out preprinted renewals began with the renewal packets in November 2003.
d) Enrollment process for health plan selection e)	
d) Family coverage e)	
d) Outreach e)	The waiting list caused the outreach message to shift to enrollment renewal, & injury prevention. With the end of the waiting list, the emphasis shifted back to outreach & enrollment. At this time, radio & television campaigns were reinstated. CHIP targeted outreach to adolescents involved in school sponsored sports programs. CHIP increased outreach to providers. Trainings on the web application were held. CHIP continued to tailor outreach initiatives to Native Americans, Hispanics, & Asians.
d) Premium assistance e)	

d) Prenatal Eligibility Expansion	
e)	

d) Waiver populations (funded under title XXI)	
Parents	
Pregnant women	
Childless adults	

D) Other – please specify	
a.	In the State Planning Grant 4 health plans were subjected to economic modeling. Also a publication on the uninsured in Alabama was printed & distributed. The Health Dept. was awarded a RWJF Covering Kids& Families (CAKF)grant. CAKF supported the Cover the Uninsured Week & assisted with regard to coordination, simplification, & enrollment in the CHIP & Medicaid programs. In the RWJF Supporting Families project, the state implemented a web-based application process.
b.	
c.	

Enter any Narrative text below.

SECTION II: PROGRAM'S PERFORMANCE MEASUREMENT AND PROGRESS

This section consists of three sub sections that gather information on the core performance measures for the SCHIP program as well as your State's progress toward meeting its general program strategic objectives and performance goals. Section IIA captures data on the core performance measures to the extent data are available. Section IIB captures your enrollment progress as well as changes in the number and/or rate of uninsured children in your State. Section IIC captures progress towards meeting your State's general strategic objectives and performance goals.

SECTION IIA: REPORTING OF CORE PERFORMANCE MEASURES

CMS is directed to examine national performance measures by the SCHIP Final Rules of January 11, 2001. To address this SCHIP directive, and to address the need for performance measurement in Medicaid, CMS, along with other Federal and State officials, developed a core set of performance measures for 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 19 measures, the group recommended seven core measures, including four child health measures and three adult measures:

Child Health Measures
- Well child visits 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
- Children's access to primary care practitioners

Adult Measures
- Comprehensive diabetes care (hemoglobin A1c tests)
- Adult access to preventive/ambulatory health services
- Prenatal and postpartum care (prenatal visits)

These measures are based on specifications provided by the Health Plan Employer Data and Information Set (HEDIS®). HEDIS® provides a useful framework for defining and measuring performance. However, use of HEDIS® methodology is not required for reporting on your measures. The HEDIS® methodology can also be modified based on the availability of data in your State.

The table should be completed as follows:

Column 1: If you cannot provide a specific measure, please check the boxes that apply to your State for each performance measure, as follows:
- Population not covered: Check this box if your program does not cover the population included in the measure. For example, if your State does not cover adults under SCHIP, check the box indicating, "population not covered" for the three adult measures.
- Data not available: Check this box if data are not available for a particular measure in your State. Please provide an explanation of why the data are currently not available.
- Not able to report due to small sample size: Check this box if the sample size (i.e., denominator) for a particular measure is **less than 30**. If the sample size is less 30, your State is not required to report data on the measure. However, please indicate the exact sample size in the space provided.
- Other: Please specify if there is another reason why your state cannot report the measure.

Column 2: For each performance measure listed in Column 1, please indicate the measurement specification (i.e., were the measures calculated using the HEDIS® technical specifications, HEDIS®-like specifications, or some other source with measurement specifications unrelated to HEDIS®). If the measures were calculated using HEDIS® or

HEDIS®-like specifications, please indicate which version was used (e.g., HEDIS® 2004).

Column 3: For each performance measure listed in Column 1, please indicate the data source(s); the definition of the population included in the measure (such as age, continuous enrollment, type of delivery system); the baseline measurement and baseline year; and your current performance, including the date of the most recent data reported. For rates, please specify the numerator and denominator that were used to calculate the rates. Please also note any comments on the performance measures or progress, such as data limitations, comparisons with external benchmarks, etc. and an explanation for changes from the baseline. Note: you do not need to report data for all delivery system types. You may choose to report data for only the delivery system with the most enrollees in your program.

NOTE: Please do not reference attachments in this table. If details about a particular measure are located in an attachment, please summarize the relevant information from the attachment in the space provided for each measure.

Measure	Measurement Specification	Performance Measures and Progress

Measure	Measurement Specification	Performance Measures and Progress
Well child visits in the first 15 months of life Not Reported Because: Population not covered. Data not available. *Explain*. Not able to report due to small sample size (less than 30.) *Specify sample size.* Other. *Explain*.	HEDIS. *Specify version of HEDIS used.* HEDIS-Like. *Explain how HEDIS was modified.* *Specify version of HEDIS used.* Other. *Explain*.	Data Source(s): Administrative (claims) data Definition of Population Included in Measure: The percentage of enrolled members who turned 15 months old during the measurement year, who were continuously enrolled from 31 days of age and who received either zero, one, two, three, four, five, six or more well child visits with a PCP during their first 15 months of life. Baseline / Year: (Specify numerator and denominator for rates) Baseline year - 2004 Numerator: Seven separate numerators are calculated corresponding to the number of members who had received: zero, one, two, three, four, five, six or more well child visits with a PCP during their first 15 months of life. The PCP is not assigned to the member. Denominator: See "Definition of Population Included in Measure" above. Performance Progress/Year: (Specify numerator and denominator for rates) Well Child Visit=WCV 0 WCV: 18% 49/271 1 WCV: 2% 5/271 2 WCV: 7% 20/271 3 WCV: 9% 25/271 4 WCV: 17% 46/271 5 WCV: 20% 53/271 6+ WCV: 27% 73/271 TOTAL: 82% of enrollees had a well child visit within the first 15 months of life.

Measure	Measurement Specification	Performance Measures and Progress
		Explanation of Progress: Beginning with this annual report, the method of measuring this objective and goal was changed. FY 2004 is the baseline year. Therefore no comparison showing progress is made. However, For most of the measures within this objective and overall for the objective, CHIP compared favorably to the Blue Cross Blue Shield of Alabama (BCBSAL) book of business. BCBSAL book of business percentages: 0 WCV: 22% 1 WCV: 4% 2 WCV: 4% 3 WCV: 5% 4 WCV: 9% 5 WCV: 17% 6+ WCV: 39% TOTAL: 78% of enrollees had a well child visit within the first 15 months of life. Other Comments on Measure:

Measure	Measurement Specification	Performance Measures and Progress
Well child visits in children the 3rd, 4th, 5th, and 6th years of life Not Reported Because: Population not covered. Data not available. *Explain*. Not able to report due to small sample size (less than 30.) *Specify sample size.* Other. *Explain*.	HEDIS. *Specify version of HEDIS used.* HEDIS-Like. *Explain how HEDIS was modified.* *Specify version of HEDIS used.* Other. *Explain*.	Data Source(s): Administrative (claims) data Definition of Population Included in Measure: The percentage of members who were 3, 4, 5, or 6 years of age during the measurement year, who were continuously enrolled, who received one or more well-child visits with a PCP during the measurement year with no gap in enrollment greater than 45 days and were enrolled on the last day of the measurement year. Baseline / Year: (Specify numerator and denominator for rates) Baseline / Year: FY 2004 Numerator: Members who had at least one well-child visit with a PCP during the measurement year. The PCP is not assigned to the member. Denominator: See "Definition of Population Included in Measure" above. Performance Progress/Year: (Specify numerator and denominator for rates) Num. Denom. WCV: 31% 1,522 4,972 Explanation of Progress: This is the first year that we have reported the measure in this way. Therefore, it is not possible to compare the progress in FY 2004 to the previous year. However, CHIP was comparable to the BCBSAL book of business percentage for this measure which was 33%. Other Comments on Measure: It is believed that the reported 31% is lower than the actual percentage of children who received well child visits due to CPT coding issues. Historically well child visits have not been a reimbursable service in Alabama fee for service plans (such as CHIP) and physicians have tended to code these visits to any reasonable sick child code. It is thought that this coding habit continues even though well child visits are now covered in most, if not all, health plans sold in Alabama.

Measure	Measurement Specification	Performance Measures and Progress
Use of appropriate medications for children with asthma Not Reported Because: Population not covered. Data not available. *Explain*. Not able to report due to small sample size (less than 30.) *Specify sample size.* Other. *Explain*.	HEDIS. *Specify version of HEDIS used.* HEDIS-Like. *Explain how HEDIS was modified.* *Specify version of HEDIS used.* Other. *Explain*.	Data Source(s): Administrative (claims) data Definition of Population Included in Measure: The percentage of enrolled members 5-58 years of age (see other comments below) during the measurement year who were identified as having persistent asthma during the year prior to the measurement year and who were appropriately prescribed medication during the measurement year. Baseline / Year: (Specify numerator and denominator for rates) Baseline / Year: FY 2004 Numerator: For each member in the denominator, those who have had at least one dispensed prescription for inhaled corticosteroids, cromolyn sodium and nedocromil, leukotriene modifiers, or methylxanthines in the measurement year. The list of NDCs provided at the http://www.ncqa.org was used to identify appropriate prescriptions. Denominator: See "Definition of Population Included in Measure" above. Performance Progress/Year: (Specify numerator and denominator for rates) Performance Progress/Year: FY 2004 Age % Num. Denom. 5-9 74% 239 322 10-17 71% 491 691 18-19 57% 24 42 TOTAL 71% 754 1,055 Explanation of Progress: This is the first year that we have reported data for this measure. Therefore, it is not possible to compare the progress in FY 2004 to the previous year. However, it should be noted that CHIP compared favorably with the BCBSAL book of business for this measure. BCBSAL book of business: Age % 5-9 67% 10-17 63% 18-19 61% TOTAL 62%

Measure	Measurement Specification	Performance Measures and Progress
		Other Comments on Measure: The program used the exact HEDIS definition for this measure which allows for enrollees up to age 58 years. However, Alabama's CHIP only serves children through age 18 years of age. (Some children are enrolled through the end of the birth month of the 19th year). Therefore the upper age through which data was collected for this measure is 19 years (not 58).

Measure	Measurement Specification	Performance Measures and Progress
Children's access to primary care practitioners Not Reported Because: Population not covered. Data not available. *Explain*. Not able to report due to small sample size (less than 30.) *Specify sample size.* Other. *Explain*.	HEDIS. *Specify version of HEDIS used.* HEDIS-Like. *Explain how HEDIS was modified.* *Specify version of HEDIS used.* Other. *Explain*.	Data Source(s): Administrative (claims) data Definition of Population Included in Measure: The percentage of enrollees: 1) 12-24 months, 25 months-6 years who were continuously enrolled during the measurement year, had a visit with a PCP during the measurement year, and had no more than 1 gap in enrollment of up to 45 days during the measurement year, 2) enrollees 7-11 years and 12-19 years of age who were continuously enrolled during the measurement year and the year prior to the measurement year, had a visit with a PCP during the measurement year or the year prior to the measurement year, and had no more than one gap in enrollment of up to 45 days during each year of continuous enrollment. Baseline / Year: (Specify numerator and denominator for rates) Baseline / Year: 2004 Numerator: Age 12-24 months and 25 months-6 years of age with at least one visit with a PCP in the measurement year, 7-11 and 12-19 years of age with at least one visit with a PCP in the measurement year or in the year prior to the measurement year. To count towards the measure, the visit must be with an identified PCP. Denominator: The eligible population. Performance Progress/Year: (Specify numerator and denominator for rates) Performance Progress/Year: 2004 Cohorts % Num. Denom. 7-11yrs 81% 6,545 8,036 12-19yrs 78% 10,549 13,584 12-24 mo.88% 390 445 25mo-6yrs78% 4,556 5,828

Measure	Measurement Specification	Performance Measures and Progress
		Explanation of Progress: This is the first year that we have reported data for this measure. Therefore, it is not possible to compare the progress in FY 2004 to the previous year. However, it should be noted that CHIP compared favorably with the BCBSAL book of business for this measure. BCBSAL book of business: Age Group % 7-11 years 72% 12-19 years 66% 12-24 mo. 82% 25 mo-6 yrs 73% Other Comments on Measure:
Adult Comprehensive diabetes care (hemoglobin A1c tests) Not Reported Because: Population not covered. Data not available. *Explain*. Not able to report due to small sample size (less than 30.) *Specify sample size.* Other. *Explain*.	HEDIS. *Specify version of HEDIS used.* HEDIS-Like. *Explain how HEDIS was modified.* *Specify version of HEDIS used.* Other. *Explain*.	Data Source(s): Definition of Population Included in Measure: Baseline / Year: (Specify numerator and denominator for rates) Performance Progress/Year: (Specify numerator and denominator for rates) Explanation of Progress: Other Comments on Measure:

Measure	Measurement Specification	Performance Measures and Progress
Adult access to preventive/ambulatory health services Not Reported Because: Population not covered. Data not available. *Explain*. Not able to report due to small sample size (less than 30.) *Specify sample size.* Other. *Explain*.	HEDIS. *Specify version of HEDIS used.* HEDIS-Like. *Explain how HEDIS was modified.* *Specify version of HEDIS used.* Other. *Explain*.	Data Source(s): Definition of Population Included in Measure: Baseline / Year: (Specify numerator and denominator for rates) Performance Progress/Year: (Specify numerator and denominator for rates) Explanation of Progress: Other Comments on Measure:

Measure	Measurement Specification	Performance Measures and Progress
Adult Prenatal and postpartum care (prenatal visits): **Coverage for pregnant women over age 19 through a demonstration** **Coverage for unborn children through the SCHIP state plan** **Coverage for pregnant women under age 19 through the SCHIP state plan** Not Reported Because: Population not covered. Data not available. *Explain*. Not able to report due to small sample size (less than 30.) *Specify sample size.* Other. *Explain*. Because AL does not cover adults and the number of enrollees having obstetrical services was small, the program was advised, by Mathematica, to leave this portion of the report blank.	HEDIS. *Specify version of HEDIS used.* HEDIS-Like. *Explain how HEDIS was modified.* *Specify version of HEDIS used.* Other. *Explain*.	Data Source(s): Definition of Population Included in Measure: Baseline / Year: (Specify numerator and denominator for rates) Performance Progress/Year: (Specify numerator and denominator for rates) Explanation of Progress: Other Comments on Measure:

SECTION IIB: ENROLLMENT AND UNINSURED DATA

1. The information in the table below is the Unduplicated Number of Children Ever Enrolled in SCHIP in your State for the two most recent reporting periods. 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). The percent change column reflects the percent change in enrollment over the two-year period. If the percent change exceeds 10 percent (increase or decrease), please explain in letter A below any factors that may account for these changes (such as decreases due to elimination of outreach or increases due to program expansions). This information will be filled in automatically by SARTS through a link to SEDS. Please wait until you have an enrollment number from SEDS before you complete this response.

Program	FFY 2003	FFY 2004	Percent change FFY 2003-2004
SCHIP Medicaid Expansion Program			
Separate Child Health Program			

   A. Please explain any factors that may account for enrollment increases or decreases exceeding 10 percent.

2. Three-year averages in the number and/or rate of uninsured children in each state based on the Current Population Survey (CPS) are shown in the table below, along with the percent change between 1996-1998 and 2001-2003. Significant changes are denoted with an asterisk (*). If your state uses an alternate data source and/or methodology for measuring change in the number and/or rate of uninsured children, please explain in Question #3. SARTS will fill in this information automatically, but in the meantime, please refer to the CPS data attachment that was sent with the FY 2004 Annual Report Template.

	Uninsured Children Under Age 19 Below 200 Percent of Poverty		Uninsured Children Under Age 19 Below 200 Percent of Poverty as a Percent of Total Children Under Age 19	
Period	Number	Std. Error	Rate	Std. Error
1996-1998				
1997-1999				
2000-2002				
2001-2003				
Percent change 1996-1998 vs. 2001-2003	%	NA	%**	NA

** Significantly different from zero at the .10 level, two-tailed [or one-tailed] test.

A. Please note any comments here concerning CPS data limitations that may affect the reliability or precision of these estimates.

It should be noted that Alabama's sample size is very small and this may affect the reliability and precision of the estimates.

3. If your State has an alternate data source and/or methodology for measuring change in the number and/or rate of uninsured children, please report in the table below. Data are required for two or more points in time to demonstrate change (or lack of change). Please be as specific and detailed as possible about the method used to measure progress toward covering the uninsured.

Data source(s)	
Reporting period (2 or more points in time)	
Methodology	
Population	
Sample sizes	
Number and/or rate for two or more points in time	
Statistical significance of results	

A. Please explain why the state chose to adopt a different methodology to measure changes in the number and/or rate of uninsured children.

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.)

4. 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 should skip this question.)***

It is estimated that approximately 120,000 children have been enrolled in SOBRA Medicaid as a result of CHIP. This number has been estimated using the knowledge that SOBRA Medicaid enrollment was essentially flat prior to CHIP. This estimated number represents the increase in SOBRA Medicaid since the implementation of CHIP.

SECTION IIC: STATE STRATEGIC OBJECTIVES AND PERFORMANCE GOALS

In the table below, summarize your State's general strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Use additional pages as necessary. **Please do not reference attachments in this table. If details about a particular measure are located in an attachment, please summarize the relevant information from the attachment in the space provided for each measure.** The table should be completed as follows:

Column 1: List your State's general strategic objectives for your SCHIP program and indicate if the strategic objective listed is new/revised or continuing. If you have met your goal and/or are discontinuing a strategic objective or goal, please continue to list the objective/goal in the space provided below, and indicate that it has been discontinued, and provide the reason why it was discontinued. Also, if you have revised a goal, please check "new/revised" and explain how and why it was revised.

Note: States are required to report objectives related to reducing the number of uninsured children. (This/these measure(s) should reflect what was reported in Section IIB, Question(s) 2 and 3. Progress towards reducing the number of uninsured children should be reported in this section.)

Column 2: List the performance goals for each strategic objective. Where applicable, provide the measurement specification (i.e., were the measures calculated using the HEDIS® technical specifications, HEDIS®-like specifications, or some other source with measurement specifications unrelated to HEDIS®).

Column 3: For each performance goal listed in Column 1, please indicate the data source(s); the definition of the population included in the measure (such as age, continuous enrollment, type of delivery system); the methodology used; the baseline measurement and baseline year; and your current performance, including the date of the most recent data reported. For rates, please specify the numerator and denominator that were used to calculate the rates. Please note any comments on the performance measures or progress, such as data limitations, comparisons with external benchmarks, or the like.

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	**(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 ***(Mandatory for all states for each reporting year) (This/these measure(s) should reflect what was reported in Section IIB, Question(s) 2 and 3.)***		

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
New/revised Continuing Discontinued Explain:	Goal #1: 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.	Data Source(s): CPS Definition of Population Included in Measure: Children under 19 years of age at or below 200% FPL. Methodology: CPS Report Analysis 3 year averages Baseline / Year: (Specify numerator and denominator for rates) Baseline / Year: 1996-1998: 10.5% 115,000/1,095,000 Performance Progress / Year: (Specify numerator and denominator for rates) Performance Progress / Year: A) 2001-2003: 6.5% 76,000/1,170,000 Explanation of Progress: The decrease in the number of low-income uninsured children is due to the continued successes of each of the components of the program: outreach, enrollment, service delivery. Other Comments on Measure:
New/revised Continuing Discontinued Explain:	Goal #2: 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.	Data Source(s): Administrative files Definition of Population Included in Measure: Referrals of new applications and renewals among ALL Kids, SOBRA Medicaid, and the Alabama Child Caring Foundation. Methodology: Review of administrative files Baseline / Year: (Specify numerator and denominator for rates) N/A Performance Progress / Year: (Specify numerator and denominator for rates) N/A Explanation of Progress: In FY 2004, the program used Robert Wood Johnson Foundation grant funds to build an interface among the Medicaid, ALL Kids. In 2005, the program plans to build a reporting mechanism to track applications as well as an interface with the Alabama Child Caring Foundation. Other Comments on Measure:

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
New/revised Continuing Discontinued Explain:	Goal #3:	Data Source(s): Definition of Population Included in Measure: Methodology: Baseline / Year: (Specify numerator and denominator for rates) Performance Progress / Year: (Specify numerator and denominator for rates) Explanation of Progress: Other Comments on Measure:

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	**(2) Performance Goals for each Strategic Objective**	(1) **(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)**
New/revised Continuing Discontinued Explain:	Goal #1: The percentage of families who do not renew their children's ALL Kids coverage due to a financial barrier (owing past premiums) will not be more than 3% annually. ** Please see	Data Source(s): CHIP Data System Definition of Population Included in Measure: Enrollees who did not renew due to non-payment of premium. Methodology: The number of ALL Kids enrollees who disenroll for non-payment of premium divided by the number of enrollees who were due to renew. Baseline / Year: (Specify numerator and denominator for rates) Not applicable Performance Progress / Year: (Specify numerator and denominator for rates)) In FY2004, less than 1% of ALL Kids enrollees disenrolled due to non-payment of premiums. Explanation of Progress: Due to successes in the outreach, enrollment, and service delivery sections of the program and adequate funding, the program has been able to sustain an enrollment above 50,000 children at any given time and has had the successes detailed above and below. Other Comments on Measure:

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(1) (3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
New/revised Continuing Discontinued Explain:	Goal #1: The percentage of families who do not renew their children's ALL Kids coverage due to a financial barrier (owing past premiums) will not be more than 3% annually. ** Please see	Data Source(s): CHIP Data System Definition of Population Included in Measure: Enrollees who did not renew due to non-payment of premium. Methodology: The number of ALL Kids enrollees who disenroll for non-payment of premium divided by the number of enrollees who were due to renew. Baseline / Year: (Specify numerator and denominator for rates) Not applicable Performance Progress / Year: (Specify numerator and denominator for rates)) In FY2004, less than 1% of ALL Kids enrollees disenrolled due to non-payment of premiums. Explanation of Progress: Due to successes in the outreach, enrollment, and service delivery sections of the program and adequate funding, the program has been able to sustain an enrollment above 50,000 children at any given time and has had the successes detailed above and below. Other Comments on Measure:
New/revised Continuing Discontinued Explain:	Goal #2: 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 time before enrollment in ALL Kids.	Data Source(s): New Enrollees Survey and Continuous Enrollees Survey Definition of Population Included in Measure: Enrollees who completed the applicable questions on the New Enrollees Survey and Continuous Enrollees Survey. Methodology: The number of families with ALL Kids enrolled children who report financial barriers to accessing care since enrollment in ALL Kids in comparison to their experience before enrollment. Baseline / Year: (Specify numerator and denominator for rates) Not applicable Performance Progress / Year: (Specify numerator and denominator for rates) Before enrollment, 30% of the families reported that they could not afford care. After enrollment only 3.2% reported that they could not afford care.

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	**(2) Performance Goals for each Strategic Objective**	(1) **(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)**
New/revised Continuing Discontinued Explain:	Goal #1: The percentage of families who do not renew their children's ALL Kids coverage due to a financial barrier (owing past premiums) will not be more than 3% annually. ** Please see	Data Source(s): CHIP Data System Definition of Population Included in Measure: Enrollees who did not renew due to non-payment of premium. Methodology: The number of ALL Kids enrollees who disenroll for non-payment of premium divided by the number of enrollees who were due to renew. Baseline / Year: (Specify numerator and denominator for rates) Not applicable Performance Progress / Year: (Specify numerator and denominator for rates)) In FY2004, less than 1% of ALL Kids enrollees disenrolled due to non-payment of premiums. Explanation of Progress: Due to successes in the outreach, enrollment, and service delivery sections of the program and adequate funding, the program has been able to sustain an enrollment above 50,000 children at any given time and has had the successes detailed above and below. Other Comments on Measure:
		Explanation of Progress: Progress is due to success in the outreach, enrollment, and service delivery sections of the program and adequate funding. Other Comments on Measure:

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
New/revised Continuing Discontinued Explain: This was accomplished in FY 2003.	Goal #3: Plans which target outreach activities toward specific populations: (adolescents, Native Americans, and faith-based organizations) will be developed by October, 2002.	Data Source(s): Review of appropriate administrative files. Definition of Population Included in Measure: Not applicable Methodology: Review of appropriate administrative files. Baseline / Year: (Specify numerator and denominator for rates) Completed in FY 2003 Performance Progress / Year: (Specify numerator and denominator for rates) Completed in FY 2003 Explanation of Progress: Not Applicable Other Comments on Measure: This measure is being discontinued because it was met in 2003.
Objectives Related to Medicaid Enrollment		

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
New/revised Continuing Discontinued Explain:	Goal #1: There will be a maintenance of effort or an increase, on the part of CHIP, to decrease the # of uninsured, low-income (Medicaid eligible) children as evidenced by at the least the following: (a) Continuted use of a joint applicatoins form. (b) Continued use of a joint renewal form. (c) Continued referral, without any barriers, of applications & renewals between CHIP and Medicaid. (d) Continued outreach efforts by CHIP staff for network building with community groups, prefessionals (individually & in groups), child care providers, schools, etc. (e) Continued evaluation & monitoring of the application transfer/referral process between CHIP and Medicaid. (f) Continued computer enhancements to improve the ecommunication with other agencies & current potential CHIP enrollees.	Data Source(s): Medicaid enrollment data, administrative files, evidence of use of jiont application and renewal forms. Definition of Population Included in Measure: Not applicable Methodology: Review of administrative files & forms used for applicatoin & renewal. Baseline / Year: (Specify numerator and denominator for rates) Not applicable Performance Progress / Year: (Specify numerator and denominator for rates) SOBRA Medicaid enrollment during FY 2004 ws at least 300,000. (a-b) Joint application & renewal forms continued to be used. (c) Monthly meetings between CHIP & Medicaid staff revealed that referral between the 2 programs continued with minimal barriers. Barriers were addressed at each monthly meeting & actions to reduce/eliminate these barriers were taken. (d) Outreach activities continued through the work of the Regional CHIP staff & central office staff directing special projects. (e) see c above. (f) An Automated Data Integration (ADI) system was put into place during FY 2004. The ADI system allowed for a seamless, automated, transfer of application information to be transferred between CHIP & Medicaid. A Web-based application was put into place during the year whch enhanced the application process for potential CHIP & Medicaid enrollees. Other CHIP computer systems continued to be refined by the Health Department's Computer Systems Center during the year. Explanation of Progress: Other Comments on Measure:

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
New/revised Continuing Discontinued Explain:	Goal #2:	Data Source(s): Definition of Population Included in Measure: Methodology: Baseline / Year: (Specify numerator and denominator for rates) Performance Progress / Year: (Specify numerator and denominator for rates) Explanation of Progress: Other Comments on Measure:
New/revised Continuing Discontinued Explain:	Goal #3:	Data Source(s): Definition of Population Included in Measure: Methodology: Baseline / Year: (Specify numerator and denominator for rates) Performance Progress / Year: (Specify numerator and denominator for rates) Explanation of Progress: Other Comments on Measure:
Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)		

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
New/revised Continuing Discontinued Explain:	Goal #1: HEDIS. *Specify version of HEDIS used.* HEDIS-Like. *Explain how HEDIS was modified.* *Specify version of HEDIS used.* Other. *Explain*. These are state defined objective and goals: Enrollment will result in more children having a medical home. The 2 goals are: (a) A highter percentage of fmailies report that their ALL Kids (CHIP) enrolled child(ren) will 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.	Data Source(s): New and Continuous Enrollee Surveys Definition of Population Included in Measure: a,b) Number of children/families that completed the New and Continuous enrollee surveys. Methodology: a)Comparisons of answers to relevant questions on the New Enrollee survey with answers on the Continuous enrollee survey. Baseline / Year: (Specify numerator and denominator for rates) Not Applicable Performance Progress / Year: (Specify numerator and denominator for rates) a) According to the survey, before enrollment in ALL Kids, 78% of the children/families said that the child had 1 provider that was usually seen for routine care. According to the survey, after enrollment in ALL Kids, 93% of the children/families said that the child had 1 provider that was usually seen for routine care. b) According to the survey in the 12 months prior to ALL Kids, 45% of the children had had an ER visit. After enrollment in ALL Kids, in the most recent 12 months only 33% of the children had used the ER. Explanation of Progress: It is expected that since routine care from a physician's office is accessible for children enrolled in ALL Kids that ER visits would decrease. These decreases are indications that primary and preventive care is accessible for children enrolled in ALL Kids. Other Comments on Measure:

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
New/revised Continuing Discontinued Explain:	Goal #2: HEDIS. *Specify version of HEDIS used.* HEDIS-Like. *Explain how HEDIS was modified.* *Specify version of HEDIS used.* Other. *Explain.*	Data Source(s): Definition of Population Included in Measure: Methodology: Baseline / Year: (Specify numerator and denominator for rates) Performance Progress / Year: (Specify numerator and denominator for rates) Explanation of Progress: Other Comments on Measure:
New/revised Continuing Discontinued Explain:	Goal #3: HEDIS. *Specify version of HEDIS used.* HEDIS-Like. *Explain how HEDIS was modified.* *Specify version of HEDIS used.* Other. *Explain.*	Data Source(s): Definition of Population Included in Measure: Methodology: Baseline / Year: (Specify numerator and denominator for rates) Performance Progress / Year: (Specify numerator and denominator for rates) Explanation of Progress: Other Comments on Measure:
Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)		

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
New/revised Continuing Discontinued Explain:	Goal #1: HEDIS. *Specify version of HEDIS used.* HEDIS-Like. *Explain how HEDIS was modified.* *Specify version of HEDIS used.* Other. *Explain*. These are state defined objective and goals: Enrollment in ALL KIds will result in a higher usage of preventive care. Goals: 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.	Data Source(s): New and Continuous Enrollee Surveys Definition of Population Included in Measure: Children/families who answer the pertinent questions on the New Enrollee Survey & Continuous Enrollee Survey. Methodology:) Percentage of children/families who, on the New Enrollee Survey, answered the questions pertaining to these areas, indicating that they could/did obtain care compared with the percentage of children/families who, on the Continuous Enrollee Survey (children who had been enrolled at least 12 months), answered questions pertaining to these areas indicating that they could/did obtain care. Baseline / Year: (Specify numerator and denominator for rates) Not applicable Performance Progress / Year: (Specify numerator and denominator for rates) a) Before ALL Kids, 67% said they always or usually got routine preventive care. After ALL Kids, 85% said they always or usually got routine preventive care. b) Before ALL Kids. 39.9% said they needed dental care but could not get it and 40.8% of the children had had a dental visit in the 12 months prior to the survey. After ALL Kids, 7.8% reported that they needed dental care but could not get it and 84.8% said that they'd had a dental a visit in the 12 months prior to the survey. c) Before ALL Kids, 13% said that they'd had a need for vision care but could not get it. After ALL Kids, only 2% said that they'd had a need for vision care but could not get it. Explanation of Progress: It is expected that since routine preventive care, dental care and vision care are accessible for children enrolled in ALL Kids that the percentage of children getting these types of care would increase over the percentage receiving these types of care prior to ALL Kids. These percentages are indications that primary and preventive care (including dental and vision) is accessible for children enrolled in ALL Kids. Other Comments on Measure:

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
New/revised Continuing Discontinued Explain:	Goal #2: HEDIS. *Specify version of HEDIS used.* HEDIS-Like. *Explain how HEDIS was modified.* *Specify version of HEDIS used.* Other. *Explain*. The objective in this area, that specialty services beyond the basic ALL Kids package will be available for ALL Kids enrolled children with special health care needs, are as follows: 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.	Data Source(s): Administrative Records Definition of Population Included in Measure: Not Applicable Methodology: Review of Administrative Records Baseline / Year: (Specify numerator and denominator for rates) Baseline year: FY 2002 Performance Progress / Year: (Specify numerator and denominator for rates) a) Contracts with all existing 2004 PLUS agencies were maintained and strengthened through continuous monitoring. b) The feasibility of establishing contracts with other state agencies that serve CSHCN was explored but no additional agency contracts were feasible. c) A specific staff person was assigned to monitor access to specialty care for children with special health care needs. Explanation of Progress: See above Other Comments on Measure:

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
New/revised Continuing Discontinued Explain:	Goal #3: HEDIS. *Specify version of HEDIS used.* HEDIS-Like. *Explain how HEDIS was modified.* *Specify version of HEDIS used.* Other. *Explain.*	Data Source(s): Definition of Population Included in Measure: Methodology: Baseline / Year: (Specify numerator and denominator for rates) Performance Progress / Year: (Specify numerator and denominator for rates) Explanation of Progress: Other Comments on Measure:

2. What other strategies does your state use to measure and report on access to, 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 two surveys for ALL Kids: a New Enrollee Survey and a Continuous Enrollee 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 56% over the life of the survey. Forty-four percent (44%) of respondents have been on the program twelve to twenty four months, and 56% have been enrolled greater than two years.

Specific questions address the enrollees' access to a medical home. Over 93% of respondents indicate that they have either one provider or group of providers they use for sick or routine health care. Ninety-three percent say that they have no problem finding a doctor that accepts ALL Kids and 86% rate their satisfaction with their child's personal doctor as "high". Similarly, after ALL Kids only 11% said they didn't need routine care and 85% said they got it always or usually. Eighty-five percent (85%) reported that they had a dental visit in 12 months prior to survey.

Ninety-five percent report no problems or barriers to obtaining needed prescriptions. Parents also report high levels of access for specialty services. In fact, 97% 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 strategies does your SCHIP program have for future measurement and reporting on access to, 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.

In October 2003, Alabama CHIP began to participate in the Centers for Medicare and Medicaid's Payment Accuracy Measurement Demonstration (PAM) project (later known as the Payment Error Rate Measurement [PERM]). In the project, CHIP claims were 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 were very positive in the areas of process and medical necessity and showed that the program had a 100% accuracy rate in the area of eligibility.

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, 33% 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 49% response rate.

The survey results show that 26% of adolescents report calling their health care provider for advice. Of those that did call, 81% said they usually or always got the help or advice that they were seeking. Forty-nine percent (49%) of adolescents reported that their health care provider has discussed with them taking responsibility for their own health. Similarly, fifty-seven percent said the provider gave them reassurance and support about taking responsibility for their own health. However, only 49% 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, the program has 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 (in 2000) to determine if their child had a special health care need. Five screener questions were used and twenty-one 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 additional 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 New Enrollee Survey Reports and the Continuous Enrollee Survey Reports can be found in the responses to questions 1-4 above. More extensive summaries can be found in Attachment 2.

Enter any Narrative text below.

Additional performance goals & their measurement & progress objective related to SCHIP enrollment are listed below:

For the objective related to SCHIP Enrollment, goals also included

(1)Continue to develop & implement outreach toward adolescents, Native Americans, Hispanics, birth-to-five care providers, and faith-based orgranizations. These activities were developed and they continued to be implemented in 2004. (2)Develop and implement outreach toward other specific populations at data or other information indicate. During FY 2004, outreach plans began to be developed for Asian populations. (3) Prevent &/or stop language & cultural barriers to enrollment & renewal. The customer service unit continued to use a multi-language telephone assistance service in the cutomers' preferred language & brochures & forms were available in both English & Spanish. The Hispanic Coordinator also provided training on cultural competency for the customer service staff. (4)Annually, reduce the percentage of enrollees cancelling CHIP coverage due to non-participation in the renewal process. In FY 2004, approximately 15.77% of cancellations were due to non-participation in the renewal process as compared to 21.53% in FY 2003.

SECTION III: ASSESSMENT OF STATE PLAN AND PROGRAM OPERATION

Please reference and summarize attachments that are relevant to specific questions

OUTREACH

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

   Radio and television media campaigns were reinstated in June 2004. Outreach messaging shifted focus more heavily on enrollment retention and health education and injury prevention. Cementing a partnership with The Alabama High School Athletic Association, CHIP intensified targeted outreach to the adolescent population involved in school sponsored sports programs. Regional Coordinators based throughout the state have proven to be an invaluable tool for providing outreach, education, and community development and facilitate problem resolution allowing all outreach activities to be more responsive to the needs of the community. The program also secured a Robert Wood Johnson Foundation Covering Alabama Kids and Families grant through which it is anticipated that working relationships with community partners will improve in the areas of outreach coordination and simplification.

2. What methods have you found most effective in reaching low-income, uninsured children (e.g., T.V., school outreach, word-of-mouth)? How have you measured effectiveness?

   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.

   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.

   The CHIP Regional Coordinators compile monthly activity reports which both quantify and evaluate the effectiveness of different outreach activities.

3. Is your state targeting outreach to specific populations (e.g., minorities, immigrants, and children living in rural areas)? Have these efforts been successful, and how have you measured effectiveness?

   CHIP continues to conduct outreach specific to early childhood care providers, faith-based programs and institutions, Native Americans, adolescents, etc. The CHIP Regional Coordinators compile

monthly activity reports which both quantify and evaluate the effectiveness of these outreach activities.

The program 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. The program has also 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.

SUBSTITUTION OF COVERAGE (CROWD-OUT)

States with a separate child health program above 200 through 250% of FPL must complete question 1. All other states with trigger mechanisms should also answer this question.

1. Does your state cover children between 200 and 250 percent of the FPL or does it identify a trigger mechanism or point at which a substitution prevention policy is instituted?

   Yes
   No
   N/A

   If yes, please identify the trigger mechanisms or point at which your substitution prevention policy is instituted.

   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 82% 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. If enrollment in other insurance is dropped voluntarily, there is a 3 month waiting period (during which the child must be uninsured) before the child can be enrolled in CHIP. Exceptions to this waiting period are made for children who have exhausted their lifetime benefits under their other policy, health insurance was involuntarily dropped by the custodial parent, the other heath insurance is one that is limited to catastrophic events or certain diseases (such as a cancer policy).

   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.

States with separate child health programs over 250% of FPL must complete question 2. All other states with substitution prevention provisions should also answer this question.

2. Does your state cover children above 250 percent of the FPL or does it employ substitution prevention provisions?

   Yes
   No
   N/A

   If yes, identify your substitution prevention provisions (waiting periods, etc.).

All States must complete the following 3 questions

3. Describe how substitution of coverage is monitored and measured and the effectiveness of your policies.

   See #1 above.

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

   This information is not available at the time of this report.

5. Describe the incidence of substitution. What percent of applicants 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.

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. However, CHIP has no interview requirements. The only verification requirements in CHIP are for immigrant documentation status and to verify information which is not clear or is contradictory. Since both programs use the same renewal form and since the renewal form is essentially the same as the new application form, when a renewal form is sent by ALL Kids to Medicaid, Medicaid accepts the renewal form as a new application for the program (and vice versa).

2. Please explain the process that occurs when a child's eligibility status changes from Medicaid to SCHIP and from SCHIP to Medicaid. Have you identified any challenges? If so, please explain.

   At the annual renewal time all renewal information is entered into the Automated Data Information (ADI) system. If a child is determined to be ineligible for his current program (CHIP or Medicaid) and probably eligible for the other program (CHIP or Medicaid), the application information is sent electronically to the other program along with all denial documentation. This is explained to the family. Upon receipt of the paper application from the other program, the new program pulls up the renewal information from the ADI system and processes the information as a new application. Monthly CHIP/Medicaid meetings identified a few minor problems that have been successfully dealt with. Such issues have included miscommunications, individual district caseworker problems, consistent interpretations, clarifying what the other program needed in the way of paperwork, etc.

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 does your State employ to retain eligible children in SCHIP? Please check all that apply and provide descriptions as requested.

1.

Conducts follow-up with clients through caseworkers/outreach workers

Sends renewal reminder notices to all families

- How many notices are sent to the family prior to disenrolling the child from the program?
  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.
- At what intervals are reminder notices sent to families (e.g., how many weeks before the end of the current eligibility period is a follow-up letter sent if the renewal has not been received by the State?)
  See above.

Sends targeted mailings to selected populations

- Please specify population(s) (e.g., lower income eligibility groups)

Holds information campaigns

Provides a simplified reenrollment process,

Please describe efforts (e.g., reducing the length of the application, creating combined Medicaid/SCHIP application)

During FY 2004, the renewal form was changed to be a form which is partially pre-printed with the enrollee's information. In addition, the form continues to be a joint form which combines application information for Medicaid, CHIP, and the Alabama Child Caring Foundation and can be moved electronically between the agencies.

Conducts surveys or focus groups with disenrollees to learn more about reasons for disenrollment *please describe:*

Other, *please explain*:

2. Which of the above strategies appear to be the most effective? Have you evaluated the effectiveness of any strategies? If so, please describe the evaluation, including data sources and methodology.

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

3. Does your State generate monthly reports or conduct assessments that track the outcomes of individuals 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, how many move to a new geographic area)

Yes
No
N/A

When was the monthly report or assessment last conducted?

At the time of disenrollment, the program assigns a reason for disenrollment (ie, under income and referred to Medicaid, over income and referred to the Alabama Child Caring Foundation, over age, did not respond, moved out of state, etc.). Reports on this data are run monthly in the middle of the following month. The last monthly report run for FY 2004 was run on October 14, 2004 for enrollees with an effective date of September 1, 2004

If you responded yes to the question above, please provide a summary of the most recent findings (in the table below) from these reports and/or assessments.

Findings from Report/Assessment on Individuals Who Disenroll, or Do Not Reenroll in SCHIP

Total Number of Dis-enrollees	**Obtain other public or private coverage**		**Remain uninsured**		**Age-out**		**Move to new geographic area**		**Other**	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent

Please describe the data source (e.g., telephone or mail survey, focus groups) used to derive this information.

Enrollment Unit data was used to derive the above numbers. It must be noted that the above number for "Other public or private coverage" does not include 697 children who were referred from CHIP to Medicaid because it is not known if the children successfully enrolled in Medicaid. Also, the "Other" category includes 883 applicants who did not respond.

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?

   Currently, Alabama is participating in a National Academy of State Health Policy (NASHP) study with focus groups to evaluate the impact of premiums and co-pays on enrollment and renewal in ALL Kids as well as the utilization of health care services in ALL Kids.

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?

   Yes; see above.

3. If your state has increased or decreased cost sharing in the past federal fiscal year, has the state undertaken any assessment of the impact of these changes on application, enrollment, disenrollment, and utilization of health services in SCHIP. If so, what have you found?

   Yes; see above

PREMIUM ASSISTANCE PROGRAM(S) UNDER SCHIP STATE PLAN

1. Does your State offer a premium assistance program for children and/or adults using Title XXI funds

under any of the following authorities?

Yes, please answer questions below.
No, skip to Section IV.

Children

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

Premium Assistance under the State Plan
Family Coverage Waiver under the State Plan
SCHIP Section 1115 Demonstration
Medicaid Section 1115 Demonstration
Health Insurance Flexibility & Accountability Demonstration
Premium Assistance under the Medicaid State Plan (Section 1906 HIPP)

Adults

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

Premium Assistance under the State Plan (Incidentally)
Family Coverage Waiver under the State Plan
SCHIP Section 1115 Demonstration
Medicaid Section 1115 Demonstration
Health Insurance Flexibility & Accountability Demonstration
Premium Assistance under the Medicaid State Plan (Section 1906 HIPP)

2. Please indicate which adults your State covers with premium assistance. (Check all that apply.)

Parents and Caretaker Relatives
Childless Adults

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

4. What benefit package does the program use?

5. Does the program provide wrap-around coverage for benefits or cost sharing?

6. 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

7. Identify the estimated amount of substitution, if any, that occurred or was prevented as a result of your

premium assistance program. How was this measured?

8. During the reporting period, what has been the greatest challenge your premium assistance program has experienced?

9. During the reporting period, what accomplishments have been achieved in your premium assistance program?

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

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

12. What do you estimate is the impact of premium assistance on enrollment and retention of children? How was this measured?

13. Identify the total state expenditures for family coverage during the reporting period. **(For states offering premium assistance under a family coverage waiver only.)**

Enter any Narrative text below.

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, including the assumptions on which this budget was based (per member/per month rate, estimated enrollment and source of non-Federal funds). (*Note: This reporting period =Federal Fiscal Year 2004. 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	**2004**	**2005**	**2006**
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			
Health Services Initiatives			
Total Administration Costs			
10% Administrative Cap (net benefit costs ÷ 9)			

Federal Title XXI Share			
State Share			

TOTAL COSTS OF APPROVED SCHIP PLAN			

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
Tobacco settlement
Other (specify) Intergovernmental transfers, from other state agencies, of state appropriations.

Enter any Narrative text below.
This form will not allow us to enter an accurate per member per month rate in the manner in which the state calculates it. The following are yearly averages and will not exactly calculate to the insurance payments above. The FY 2004 average PMPM cost was $123.37. The FY 2005 average PMPM cost is projected to be $136.62. The FY 2006 average PMPM cost is projected to be $153.81.

SECTION V: 1115 DEMONSTRATION WAIVERS (FINANCED BY SCHIP)

Please reference and summarize attachments that are relevant to specific questions.

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	From		% 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 (an unduplicated enrollment count) 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 have you found about the impact of covering adults on enrollment, retention, and access to care of children?

4. Please provide budget information in the following table for the years in which the demonstration is approved. *Note: This reporting period (Federal Fiscal Year 2004 starts 10/1/03 and ends 9/30/04).*

COST PROJECTIONS OF DEMONSTRATION (SECTION 1115 or HIFA)	**2004**	**2005**	**2006**	**2007**	**2008**
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					

Benefit Costs for Demonstration Population #4
(e.g., childless adults)

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					

When was your budget last updated (please include month, day and year)?

Please provide a description of any assumptions that are included in your calculations.

Other notes relevant to the budget:

SECTION VI: PROGRAM CHALLENGES AND ACCOMPLISHMENTS

1. For the reporting period, please provide an overview of your state's political and fiscal environment as it relates to health care for low income, uninsured children and families, and how this environment impacted SCHIP.

   During the first part of FY 2004, Alabama continued to follow the previous year's economic decline. This decline was revealed in CHIP's austere state budget which, for the first time in the program's history, required a curbing in the number of new enrollees. The Alabama Medicaid Agency budget also experienced shortfalls. Yet toward the end of FY 2004, the state's depressed economy seemed to have leveled. This leveling was evidenced by a decrease in the number of business closings during the latter half of the year. However, Medicaid predictions for FY2005 still show the agency in a severe financial deficit.

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

   The greatest challenge was determining a balance between anticipated per member per month costs, cost savings due to increased cost sharing, and number of enrollees which could be financially supported. This balancing required continual assessment of expenses and the frequent calculation of cost projections. A secondary challenge was that of communicating information to the public with regard to lifting of enrollment freezes. During FY 2004, the enrollment freeze was lifted seven times. The waiting list process was finally abolished in August, 2004. Enrollment has remained open, with no freezes, since this time. It was difficult to communicate the changing status of the program. It was very difficult to avoid confusion when circumstances required the program to send opposite messages about enrollment openings and freezes, several times during the year.

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

   Success in determining a continual balance between anticipated per member per month costs, cost savings due to increased cost sharing, and number of enrollees which could be financially supported. The program successfully implemented cost sharing changes. The magnitude of uninsurance in children was decreased. The program implemented three important special projects: (1) a HRSA State Planning Grant (continuation), which provided for economic modeling of several health insurance plans; (2) an RWJF Supporting Families After Welfare Reform Implementation Grant which implemented a joint CHIP-Medicaid web-based application; and, (3) a CMS Payment Accuracy Measurement Grant) which audited a sample of transactions to determine the level of accuracy within the program with regard to eligibility determination, benefit administration, claims payment, etc. CHIP also acquired and implemented an RWJF Covering Kids and Families Project.

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.

   1) Smart Pay – This is an individualized strategy for making premium payments throughout the year. Families will be assisted in developing a premium payment schedule and bills will be sent to the family throughout the year. It is hoped that this will decrease the number of children who are disenrolled due to premium payment failure.

   2) Web-based renewal process – A web-based renewal process will be developed during FY 2005. This system will be modeled upon the web-based application process developed in FY 2004.

   3) The program is currently investigating coverage of the unborn child through an expansion of CHIP.

   4) The program plans to implement acceptance of credit card payments for premiums in FY 2005.

   5) The program plans to develop an electronic interface with the Alabama Child Caring Foundation.

Enter any Narrative text below.