

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

**Preamble**

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

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

The framework is designed to:

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

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

State/Territory: Tennessee  
(Name of State/Territory)

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

\_\_\_\_\_  
(Signature of Agency Head)

SCHIP Program Name (s) TennCare

SCHIP Program Type  Medicaid SCHIP Expansion Only  
 Separate SCHIP Program Only  
 Combination of the above

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

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Submission Date \_\_\_\_\_

## **SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS**

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

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

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

No changes have been made to the MCHIP program since it was approved on September 3, 1999.

1. Program eligibility
2. Enrollment process
3. Presumptive eligibility
4. Continuous eligibility
5. Outreach/marketing campaigns
6. Eligibility determination process
7. Eligibility redetermination process
8. Benefit structure
9. Cost-sharing policies
10. Crowd-out policies
11. Delivery system
12. Coordination with other programs (especially private insurance and Medicaid)
13. Screen and enroll process

14. Application

15. Other

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

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

A September, 2000 report from the Center on Budget and Policy Priorities in Washington, DC, concluded that in the three states that were early to expand Medicaid coverage to parents – Tennessee, Oregon and Hawaii – coverage of eligible young children rose by 16 percent between 1990 and 1998. The Center reported that Tennessee’s Medicaid expansions increased the use of preventive health services like Pap smears for women and dental checkups for children. (View the report on-line at <http://www.cbpp.org/9-5-00health.htm>).

Tennessee’s success in expanding coverage to uninsured and uninsurable children is particularly relevant right now, as coverage for children is expanding nationwide through the implementation of the State Children’s Health Insurance Program (SCHIP). As a precursor to SCHIP, TennCare demonstrates the feasibility of implementing a coverage expansion for children that is popular and improves access to care. TennCare, as the largest family-based expansion of health insurance coverage for low-income persons in recent history, corroborates the findings from dozens of studies that have addressed whether providing insurance coverage to the uninsured makes a difference. Although the findings are specific to Tennessee, they demonstrate that a Medicaid expansion model, the model that twenty-six states plus the District of Columbia have adopted for their SCHIP programs can greatly improve children’s access to care. (Source: “State Children’s Health Insurance Program (SCHIP) Status Report,” updated as of 27 October 1999, [www.hcfa.gov/init/chstatus.htm](http://www.hcfa.gov/init/chstatus.htm) (21 August 2000)).

The Center for Business and Economic Research (CBER) at the University of Tennessee conducts an annual survey of Tennesseans to determine their insurance status, perceptions about quality of medical care, satisfaction with insurance (including TennCare), and use of medical facilities. According to the CBER, the uninsured rate for children is 4.12 percent of the 2000 population (5,623,784). Tennessee has made progress in providing insurance for individuals under age 18. Currently, there are approximately 550,000 children on TennCare. The number of children enrolled on TennCare is taken from the TennCare Management Information System (TCMIS).

The Center for Business and Economic Research at the University of Tennessee and the Social Science Research Institute in consultation with the Bureau of TennCare prepared a survey instrument. A target sample size of 5,000 participants was chosen. The survey was conducted between May 15

and June 30, 2000, using a random-digit dialing based sample and a Computer Assisted Telephone Interviewing System. Four calls were made at staggered times to each residence to minimize non-respondent bias. The design chosen was a "household sample" with the interview conducted with the head of the household.

Approximately 60% of all the households contacted agreed to participate in the survey, and as a general rule, the demographics of the random sample closely mirrored those that were obtained for Tennessee during the most recent census.

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

In Tennessee, outreach activities are centered around eligibility for the entire TennCare program. These efforts are not categorized as Medicaid and MCHIP activities; therefore, we are unable to quantify how many children enrolled in Medicaid as a result of MCHIP outreach activities.

There are approximately 550,000 children under age 18 on TennCare. Of the 550,000 children with TennCare, about 340,000 are Medicaid-eligible and the remaining 210,000 are enrolled as Uninsureds (meaning those who lack access to insurance through a family member's employer) or Uninsurables (meaning those who were turned down for insurance because of a medical condition. The number of children enrolled in TennCare is taken from the TCMIS.

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

Tennessee has moved aggressively to identify and enroll uninsured children who are eligible to participate in TennCare. For the first year of the TennCare Program (1994), there was an Uninsured eligibility category, which was open to individuals (both children and adults) who did not have access to health insurance through an employer or family member as of a specified date in the past, which initially was March 1, 1993. There was massive publicity about the new program. The State retained a marketing firm to assist in the preparation of videos, television and radio spots, and other materials to encourage people to enroll. Advocates participated in radio and television interviews all over the State. A large TennCare Information Line was established to help people with questions, and local health departments conducted major enrollment efforts in their communities. Providers such as community hospitals also worked to assist people in enrolling in TennCare.

The success of these efforts is shown by the fact that the Uninsured category had to be closed at the end of December 1994 because the State was nearing its cap on the number of people who could be enrolled in TennCare. (The Uninsured category remained open after 1994 for two distinct groups: people losing Medicaid eligibility and people losing access to COBRA coverage. Individuals in both groups had to lack access to health insurance through an employer or a family member, and they had to apply within specified timeframes after losing coverage.) Even though the Uninsured category was

closed, however, the enrollment of Medicaid-eligibles and Uninsurables (meaning individuals who had been turned down for health insurance because of a medical condition) continued without interruption.

On April 1, 1997, Governor Don Sundquist re-opened the TennCare Uninsured category for children under age 18 who lacked access to health insurance through an employer or a family member. Local health departments were the key players in conducting outreach for this new program. A video was produced (including a version for individuals with hearing impairments) for use in informing families about the new program. Health department staff distributed flyers, posters, signs, and report card inserts to WIC and Head Start programs, offices of the Department of Human Services, Legal Aid offices, churches, schools, day care and family resource centers, after-school programs, health fairs, hospital emergency rooms, children's museums, county hospital carnivals, the circus, fast food/grocery/variety stores used by low-income families, child advocacy groups, minority health coalitions, volunteers, physicians' offices, factories, companies not offering health coverage, and bank drive-in windows. Parenting fairs have been held at schools. Contests have been held among clerks at local health departments to see who could enroll the most children. Presentations have been made at universities and neighborhood associations, and the print and broadcast media have been used as well.

In January 1998, Governor Sundquist expanded the Uninsured category to include children under age 19 whose families have access to health insurance but could not afford it. Uninsured children who have access to health insurance are allowed to enroll in TennCare only if their family incomes do not exceed 200% of poverty.

PHASE I of Tennessee's MCHIP Plan was the extension of Medicaid coverage to children up to the age of 19 whose family incomes do not exceed 100% poverty. As of September 30, 2000, approximately fourteen thousand children have been enrolled who meet the criteria for this category.

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

No, skip to 1.3

Yes, what is the new baseline?

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

What was the justification for adopting a different methodology?

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

Had your state not changed its baseline, how much progress would have been made in reducing

the number of low-income, uninsured children?

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

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

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

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

<b>Table 1.3</b>		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
<b>OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN</b>		
Reduce the number and proportion of uninsured children in Tennessee	1) Conduct outreach for the TennCare for Children Program.	<p>1) Number of counties with health departments which have received training materials to help them enroll children in the TennCare for children/MCHIP program.</p> <p>2) Number of organizations other than TennCare which are conducting TennCare Children/CHIP outreach activities.</p> <p>Data Sources: Key contact persons at the Bureau of TennCare and the Bureau of Health Services Administration (HSA).</p> <p>Progress Summary:</p> <p>By April 1, 1997, all counties with local health departments (95) had received training materials to assist them in enrolling eligible children in the TennCare for Children Program. Besides the health departments two other organizations are conducting outreach activities, the Tennessee Health Care Campaign and the National Health Care for the Homeless Council.</p>
		As of September 30, 2000, 14,044 children were enrolled in Tennessee's MCHIP program. All 95 counties are enrolling children in the TennCare for Children MCHIP program.

(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
<b>OBJECTIVES RELATED TO SCHIP ENROLLMENT</b>		
Reduce the number and proportion of uninsured children in Tennessee.	2) Enroll uninsured children in the TennCare for Children/MCHIP program.	1) Number of uninsured children with family incomes less than 100% poverty who are enrolled in TennCare for Children/MCHIP program.  2) Number of counties with health departments that are enrolling children in the TennCare for children MCHIP program.  Data Sources: TennCare Management Information System (TMIS) and key contact persons at the Bureau of HSA. Progress Summary:
<b>OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT</b>		
		Data Sources:  Methodology:  Progress Summary:
<b>OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)</b>		
Identify and reduce factors that exist in a managed care system which could serve as barriers to delivery of quality health care services to TennCare-	1) Examine all templates of the MCOs' and BHOs' contracts with providers to determine if there are any elements which present potential barriers to EPSDT and require	1) Review all provider contract templates for identification of potential problems with requirements for correction of potential problems. 2) Review of new provider contract templates for identification of potential problems.  Data Sources: TennCare Contract Development and Compliance Unit Progress Summary:

(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
eligible children.	<p>that these elements be corrected.</p> <p>2) Require that the MCOs provide primary care providers with up-to-date lists of specialists to whom children may be referred.</p> <p>3) Review all EPSDT activities at each MCO and BHO, identify deficiencies, and check to see that deficiencies are corrected.</p>	<p>The Tennessee Department of Commerce and Insurance (TDCI) has completed reviews of MCO and BHO provider contracts. The Office of Contract Development and Compliance Unit in conjunction with TDCI continues to monitor new provider contracts.</p> <p>1) Contract requirement. 2) Schedule of quarterly due dates for producing this information. 3) Amendment of contract to include financial consequences for non-compliance with the provision.</p> <p>Data Source: TennCare Contract Development and Compliance Unit.</p> <p>Progress Summary:</p> <p>The Risk Agreements with the managed care organizations have been amended to include the provision that primary care providers are to receive an up-to-date lists of specialists on a quarterly basis.</p> <p>1) Letters sent to MCOs/BHOs about deficiencies found in their EPSDT activities. 2) Corrective action plans returned by MCOs and approved by TennCare. 3) EQRO review of MCOs and BHOs' corrective action activities.</p> <p>Data Source: EQRO EPSDT Activities Report and EQRO Annual Surveys</p> <p>Progress Summary:</p> <p>The EQRO completes an annual review of activities and the MCOs and BHOs submitted corrective action plans as required. The EQRO continues to monitor EPSDT activities</p>

(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
	1) Identify an "EPSDT Liaison" at each MCO/BHO who can serve as a focal point for information about EPSDT within the MCO/ BHO and who can report to TennCare on activities and concerns.	<p>during their annual surveys. The Quality Oversight Division conducts regular medical record reviews and requires each managed care organizations to submit a quarterly report of EPSDT activities.</p> <p>1) Identification of EPSDT Liaisons by the MCOs/BHOs.</p> <p>Data Sources: Key contact persons at the Bureau of TennCare.</p> <p>Progress Summary:</p> <p>Each MCO and BHO has appointed and EPSDT Liaison for their organization. A representative from TennCare meets with the EPSDT liaisons on a quarterly basis to discuss the progress being made to meet the goals of the EPSDT program.</p>
<b>OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)</b>		
Increase the percentage of children in theTenn- Care program who have had appropriate EPSDT screenings.	1) Develop improved EPSDT clinical screening guidelines in the areas of vision, hearing, child development, and behavioral health.	<p>1) Establishment of EPSDT Screening Guidelines Committee composed of physicians and nurses representing various professional organizations in Tennessee.</p> <p>2) Completion of draft guidelines.</p> <p>3) Pilot testing of guidelines in a pediatric practice in Tennessee.</p> <p>4) Refinement and distribution of guidelines.</p> <p>Data Sources: Key contact persons at the Bureau of TennCare.</p> <p>Progress Summary:</p> <p>The EPSDT Screening Guidelines Committee was established in June of 1998. The screening guidelines have been completed, tested and widely distributed to MCOs/BHOs ad providers. Currently, the Bureau of TennCare is in the process of developing a video for providers on the EPSDT screening guidelines.</p>

(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
	<p>2) Conduct annual measurements of the percentage of TennCare children who have had appropriate screens which include all 7 required components, and use the results of these measurements to communicate with the MCOs about improvements needed.</p> <p>3) Conduct annual measurements of compliance with dental screening requirements and use the results of the measurements to communicate with the MCOs about improvements method.</p>	<p>1) Screening ratio 2) Percentage of the 7 required components contained in EPSDT screens 3) Adjusted periodic screening percentage (APSP (annual periodic screening percentage multiplied by the percentage of screens with required 7 components present)</p> <p>Data Source: HCFA 416 report and annual medical record review of a statistically significant sample of screening visits.</p> <p>Progress Summary: The baseline screening ratio for FFY 2000 was 45%. We contribute this increase to the massive outreach efforts conducted by the MCOs and the local health departments. The APSP for 2000 will be determined this month. The percentage of the 7 required components contained in EPSDT screens.</p> <p>1) Percentage of TennCare children receiving dental screens.</p> <p>Data Source: HCFA 416 report and TCMIS for dental encounter codes.</p> <p>Progress Summary: Dental screenings have increased from 28.2% in FFY 96 to 31.1% in FFY 97. Dental screening percentages have increased every year since the baseline percentage was calculated in FFY 96. For FFY 2000, the dental screening percentage was 33%.</p>
<b>OTHER OBJECTIVES</b>		
		Data Sources:

		Methodology: Progress Summary:
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**Strategic Objective 1:** Reduce the number and proportion of uninsured children in Tennessee.

Performance Goal 1.1: Conduct outreach for the TennCare for Children Program.

Performance Measures:

- 1) Number of counties with health departments, which have received training materials to help them enroll children in the TennCare for Children/CHIP program.

**Baseline:** 0 (FFY 96)

**Target:** 95 (FFY97)

- 2) Number of organizations other than TennCare, which are conducting TennCare for Children/CHIP outreach activities.

**Baseline:** 0 (FFY 96)

**Target:** 3 (FFY 99)

*Progress Summary*

*This performance measure has been met. By April 1, 1997, all counties with local health departments (95) had received training materials to assist them in enrolling eligible children into the TennCare for Children Program. Besides the health departments two other organizations are conducting outreach activities.*

*In the fall of 1998, the Robert Wood Johnson Foundation awarded a grant of \$991,648 to the Tennessee Health Care Campaign (THCC), a statewide coalition of grassroots consumer organizations, to support activities especially designed to increase enrollment of children in TennCare. One urban and four rural counties serve as pilot sites for this project. The THCC is utilizing the Social Marketing "Logic Model" for outlining the steps to achieve their goals.*

*The National Health Care for the Homeless Council administers the TennCare Shelter Enrollment Project. This program is currently the only source of direct training and technical support available in the state to facilitate TennCare enrollment of homeless children. Since 1998, the Project has provided TennCare outreach and enrollment training to more than one hundred emergency shelter staff in twenty-two Tennessee counties, both rural and urban.*

Performance Goal 1.2 Enroll uninsured children in the TennCare for Children/MCHIP program.

## Performance Measures

- 1) Number of uninsured children with family incomes less than 100% poverty who are enrolled in the TennCare for Children/CHIP program.

**Baseline:** 0 (FFY 96)

**Target:** 10,000 (FFY 99)

- 2) Number of counties with health departments that are enrolling children in the TennCare for Children/CHIP program

**Baseline:** 0 (FFY 96)

**Target:** 95 (FFY 97)

## Progress Summary

*As of September 30, 2000, there were 14,044 children enrolled in Tennessee's MCHIP program. We have far exceeded our target and all 95 counties are enrolling children in the TennCare for Children/MCHIP program.*

**Strategic Objective 2:** Increase the percentage of children in the TennCare program who have had appropriate EPSDT screenings.

Performance Goal 2.1: Develop improved EPSDT clinical screening guidelines in the areas of vision, hearing, child development, and behavioral health.

## Performance Measures:

- 1) Establishment of EPSDT Screening Guidelines Committee composed of physicians and nurses representing various professional organizations in Tennessee.

**Timeframe:** Fall 1998

- 2) Completion of draft guidelines

**Timeframe:** Summer 1999

- 3) Pilot testing of guidelines in a pediatric practice in Tennessee.

**Timeframe:** Late summer 1999

- 4) Refinement and distribution of guidelines

**Timeframe:** Fall 1999

**Progress Summary:**

*In June 1998, the Bureau of TennCare appointed an EPSDT Screening Guidelines Committee. The Committee is composed of physicians and nurses representing various professional organizations, and the managed care organization's (MCOs) and behavioral health organization's (BHOs) medical directors. The committee completed the hearing and vision guidelines in the fall of 1998. The behavioral and developmental guidelines were completed early summer 1999. A contract with Le Bonheur Children's Medical Center was executed and finalized in order to field test the hearing, vision, behavioral and developmental guidelines. The pilot study began mid-July and was completed August 1999. The study was conducted in two local pediatric practices in Shelby County, Tennessee, to examine, in clinical practices, the subjective and objective recommendations of the screening instruments proposed by the EPSDT Screening Guidelines Committee. The guidelines have been widely distributed to MCO/BHO medical directors, EPSDT coordinators at each MCO/BHO, the Pediatric Society of Tennessee and to the Tennessee Nursing Association (TNA). The guidelines have also been included in past EPSDT semi-annual progress reports, and in TennCare Standard Operating Procedures (TSOPs), both of which are distributed to the MCOs/BHOs, their providers and other state agencies such as the Department of Health (DOH), Department of Human Services (DHS), Department of Children Services (DCS), and Department of Mental Health and Developmental Disabilities (TDMHDD). Currently, the Bureau of TennCare is in the process of developing a video for providers to educate them on the EPSDT Screening Guidelines.*

Performance Goal 2.2: Conduct annual measurements of the percentage of TennCare children who have had appropriate screens which include all seven required components, and use the results of these measurements to communicate with the MCOs about improvements needed.

Performance Measures:

1) Screening ratio

**Baseline:** .39 (FFY 96)  
**Target:** 1.00 (FFY 01)

2) Percentage of the 7 required components contained in EPSDT screens

**Baseline:** 56.2% (FFY 96)  
**Target:** 80% (FFY 01)

3) Adjusted periodic screening percentage (APSP) (annual periodic screening percentage multiplied by the percentage of screens with required 7

components present)

**Baseline:** 21.9% (FFY 96)  
**Target:** 80% (FFY 01)

***Progress Summary:***

***This performance measure is ongoing. The screening ratio for FFY 2000 was 45%. We contribute this increase to the continued outreach activities of the state, the MCOs/BHOs and the local health departments. The APSP for FFY 2000 has not been calculated. It is expected to be completed by the end of April. Each MCO/BHO is notified of their individual screening results and when there are deficiencies they are required to submit corrective actions plans to the Bureau of TennCare. TennCare's Quality Oversight Unit reviews, accepts and monitors the plans of corrections.***

Performance Goal 2.3: Conduct annual measurements of compliance with dental screening requirements and use the results of these measurements to communicate with the MCOs about improvements needed.

Performance Measure:

- 1) Percentage of TennCare children receiving dental screens

**Baseline:** 28.2% (FFY 96)  
**Target:** 80% (FFY 03)

***Progress Summary:***

***This performance measure is ongoing. The dental screening percentage for FFY 2000 was 33%. The dental screening percentage has increased every year since the baseline percentage was calculated. Each MCO/BHO is notified of their individual screening results and when there are deficiencies they are required to submit corrective actions plans to the Bureau of TennCare. TennCare's Quality Improvement Unit reviews, accepts and monitors the plans of corrections.***

**Strategic Objective 3:** Identify and reduce factors that exist in a managed care system which could serve as barriers to delivery of quality health care services to TennCare children.

Performance Goal 3.1: Examine all templates of the Managed Care Organization's and Behavioral Health Organization's contracts with providers to determine if there are any elements which present potential barriers to EPSDT and require that these elements be corrected.

Performance Measure:

- 1) Review of all provider contract templates and identification of potential problems, with requirements for correction of potential problems

**Timeframe:** Summer and fall 1998

- 2) Review of new provider contract templates for identification of potential problems

**Timeframe:** Ongoing

***Progress Summary:***

***During the summer and fall of 1998, the Tennessee Department of Commerce and Insurance completed a review of MCO and BHO contracts. Where potential problems were identified the MCOs/BHOs were required to submit corrective action plans. TennCare's Office of Contract Development and Compliance Unit in conjunction with TDCI continues to monitor new provider contracts for identification of potential problems.***

Performance Goal 3.2: Require that the MCOs provide primary care providers with up-to-date list of specialists to whom children may be referred.

Performance Measure:

- 1) Contract requirement in place

**Timeframe:** Fall of 1998

- 2) Schedule of quarterly due dates for producing this information

**Timeframe:** June 1999

- 3) Amendment of contract to include financial consequences for non-compliance with this provision

**Timeframe:** July 2000

***Progress Summary:***

***By Amendment, on February 1, 1998, TennCare required MCOs to provide primary care providers with up-to-date lists of specialists to whom children may be referred. In July 1998, the contract was further amended to require that the MCOs implement the schedule of quarterly listings by September 1998, and supplements be provided on a quarterly basis thereafter.***

Performance Goal 3.3: Review all EPSDT activities at each MCO and BHO, identify deficiencies, and check to see that deficiencies are corrected.

Performance Measure:

- 1) Letters sent to MCOs/BHOs about deficiencies found in their EPSDT activities

**Timeframe:** Winter 1998

- 2) Corrective action plans returned by MCOs and approved by TennCare

**Timeframe:** Spring 1999

- 3) EQRO review of MCO's and BHO's corrective action activities

**Timeframe:** Fall 1999

***Progress Summary:***

*This performance measure has been met. The Bureau of TennCare requested for the External Quality Review Organization (EQRO) to conduct a review of EPSDT activities at each MCO/BHO as a part of their 1998 fall focus review survey. The EQRO report titled, MCO/BHO EPSDT Activities Report was submitted to TennCare in February 1999. The EQRO developed recommendations specific to each MCO regarding modifications that they might make in their programs; these recommendations were sent to the MCOs and corrective action plans were requested from the MCOs/BHOs. TennCare's Quality Oversight Division continues to monitor the progress and implementation of the corrective action plans and the EQRO completed a follow-up review of the MCO's and BHO's corrective activities in the fall of 1999. The EQRO will continue to monitor the MCO's and BHO's operational activities in an effort to identify and remove elements which may be potential barriers to EPSDT. The Quality Oversight Division also conducts regular medical record reviews and requires each MCO to submit a quarterly report of EPSDT activities.*

Performance Goal 3.4: Identify an EPSDT Liaison at each MCO/BHO who can serve as a focal point for information about EPSDT within the MCO/BHO and who can report to TennCare on activities and concerns.

Performance Measure:

- 1) Identification of EPSDT Liaisons by the MCOs/BHOs

**Timeframe:** Fall 1998

***Progress Summary:***

*In the fall of 1998, each MCO and BHO was asked to appoint an EPSDT representative to serve as*

*a contact person for their organization. A representative from TennCare meets with the EPSDT liaisons on a quarterly basis to discuss the progress being made to meet the goals of the EPSDT program.*

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
<b>OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN</b>		
Reduce the number and proportion of uninsured children in Tennessee	1) Conduct outreach for the TennCare for Children Program.	<p>1) Number of counties with health departments which have received training materials to help them enroll children in the TennCare for children/MCHIP program.</p> <p>2) Number of organizations other than TennCare which are conducting TennCare for Children/CHIP outreach activities.</p> <p>Data Sources: Key contact persons at the Bureau of TennCare and the Bureau of Health Services Administration (HSA).</p> <p>Progress Summary:</p> <p>By April 1, 1997, all counties with local health departments (95) had received training materials to assist them in enrolling eligible children in the TennCare for Children Program. Besides the health departments two other organizations are conducting outreach activities.</p>
	2) Enroll uninsured children in the TennCare for Children/MCHIP program.	<p>1) Number of uninsured children with family incomes less than 100% poverty who are enrolled in TennCare for Children/MCHIP program.</p> <p>2) Number of counties with health departments that are enrolling children in the TennCare for Children/CHIP program</p> <p>Data Sources: TennCare Management Information System (TMIS) and key contact persons at the Bureau of HSA.</p>

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2)Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
		<p>Progress Summary:</p> <p>As of September 30, 1999, 17,046 children were enrolled in Tennessee’s MCHIP program. All 95 counties are enrolling children in the TennCare for Children/MCHIP program.</p>
<b>OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)</b>		
Increase the percentage of children in the TennCare program who have had appropriate EPSDT screenings.	1) Develop improved EPSDT clinical screening guidelines in the areas of vision, hearing, child development, and behavioral health.	<p>1) Establishment of EPSDT Screening Guidelines Committee composed of physicians and nurses representing various professional organizations in Tennessee.</p> <p>2) Completion of draft guidelines.</p> <p>3) Pilot testing of guidelines in a pediatric practice in Tennessee.</p> <p>4) Refinement and distribution of guidelines.</p> <p>Data Sources: Key contact persons at the Bureau of TennCare.</p> <p>Progress Summary:</p> <p>The EPSDT Screening Guidelines Committee was established in June of 1998. The screening guidelines have been completed, tested and widely distributed to MCOs/BHOs and providers.</p>



Table 1.3		
Identify and reduce factors that exist in a managed care system which could serve as barriers to delivery of quality health care services to TennCare-eligible children.	1) Examine all template of the MCOs' and BHOs' contracts with providers to determine if there are any elements which present potential barriers to EPSDT and require that these elements be corrected.	<p>1) Review all provider contract templates for identification of potential problems with requirements for correction of potential problems.</p> <p>2) Review of new provider contract templates for identification of potential problems.</p> <p>Data Sources: TennCare Contract Development and Compliance Unit</p> <p>Progress Summary:</p> <p>The Tennessee Department of Commerce and Insurance (TDCI) has completed reviews of MCO and BHO provider contracts. The Office of Contract</p>
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)

Table 1.3

	<p>2) Require that the MCOs provide primary care providers with up-to-date lists of specialists to whom children may be referred.</p> <p>3) Review all EPSDT activities at each MCO and BHO, identify deficiencies, and check to see that deficiencies are corrected.</p>	<p>Development and Compliance Unit in conjunction with TDCI monitors new provider contracts.</p> <ol style="list-style-type: none"> <li>1) Contract requirement</li> <li>2) Schedule of quarterly due dates for producing this information</li> <li>3) Amendment of contract to include financial consequences for non-compliance with this provision.</li> </ol> <p>Data Source: TennCare Contract Development and Compliance Unit.</p> <p>Progress Summary: The Risk Agreements with the managed care organizations have been amended to include the provision that primary care providers are to receive an up-to-date lists of specialists on a quarterly basis.</p> <ol style="list-style-type: none"> <li>1) Letters sent to MCOs/BHOs about deficiencies found in their EPSDT activities</li> <li>2) Corrective action plans returned by MCOs and approved by TennCare</li> <li>3) EQRO review of MCOs and BHOs' corrective action activities</li> </ol> <p>Data Source: EQRO EPSDT Activities Report and EQRO Annual Surveys</p> <p>Progress Summary: The EQRO completed a review of activities in the fall of 1998 and the MCOs and BHOs submitted corrective action plans as required. The EQRO continues to monitor EPSDT activities during their annual surveys.</p>
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(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
<b>OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)</b>		
	1) Identify an “EPSDT Liaison” at each MCO/BHO who can serve as a focal point for information about EPSDT within the MCO/BHO and who can report to TennCare on activities and concerns.	1) Identification of EPSDT Liaisons by the MCOs/BHOs.  Data Sources: Key contact persons at the Bureau of TennCare.  Progress Summary: Each MCO and BHO has appointed an EPSDT Liaison for their organization.

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

The state has not met the target EPSDT screening performance goals as outlined in the MCHIP Plan; however, the state is taking all reasonable steps to reach these goals. Last fall the Quality Oversight Division completed an extensive survey of the MCOs' outreach and informing activities. The External Quality Review Organization (EQRO) continues to monitor MCO activities related to EPSDT services as a part of the annual surveys and the Quality Oversight Division will continue to conduct medical record reviews and periodically review the outreach and informing activities of each managed care organization.

The state is planning to implement a massive EPSDT screening campaign utilizing the local, county, health departments in an effort to increase EPSDT screening percentages.

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

N/A

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

N/A

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

N/A

## **SECTION 2. AREAS OF SPECIAL INTEREST**

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

### **2.1 Family coverage:**

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

TennCare does not offer family coverage through the MCHIP program, however, the Title XXI program is an expansion of the existing TennCare Program. The Medicaid program is provided through a Section 1115a waiver called TennCare. TennCare covers individuals who are Medicaid-eligible, Uninsured or Uninsurable. Often family members meet the criteria of eligibility, thus providing coverage for family members.

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

Number of adults     N/A    

Number of children   14,044  

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

N/A

### **2.2 Employer-sponsored insurance buy-in:**

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

N/A

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

N/A

Number of adults \_\_\_\_\_  
Number of children \_\_\_\_\_

### **2.3 Crowd-out:**

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

Tennessee defines "crowd-out" as the movement of children out of private insurance plans into the TennCare MCHIP program. Since our MCHIP program is limited to children in families at or below 100% of poverty, most of those families would not likely be in the private insurance market and are therefore not subject to "crowd out". Families present for services at local health departments (including those interested in TennCare) are routinely asked whether all of their children are insured. Tennessee will continue to monitor the enrollment of uninsured children in TennCare to make certain that "crowd out" does not become a factor.

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

See question 2.3.

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

See question 2.3.

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

See question 2.3.

### **2.4 Outreach:**

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

While Tennessee has conducted numerous outreach activities very few of them have been monitored for effectiveness. There are two organizations that collaborate with TennCare, which have begun to track preliminary results of their activities.

The Robert Wood Johnson Foundation (RWJ) awarded a grant of \$991,648 to the Tennessee Health Care Campaign (THCC) to support activities especially designed to increase enrollment of children

in TennCare. Four rural and one urban county serve as research sites for this project. THCC is utilizing the Social Marketing "Logic Model" for outlining the steps to achieve their goals. This model is aimed at trying to reach individuals whom we have failed to reach through more traditional outreach and marketing strategies.

The National Health Care for the Homeless Council administers the TennCare Shelter Enrollment Project. This program is currently the only source of direct training and technical support available in the state to facilitate TennCare enrollment of homeless children. Since 1998, the Project has provided TennCare outreach enrollment training to more than one hundred emergency shelter staff in twenty-two Tennessee counties, both rural and urban.

The THCC and the TennCare Shelter Enrollment Project are both devising mechanisms to track the effectiveness of their outreach efforts.

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

Our local health departments have taken the lead in tailoring outreach activities to meet the needs of their specific counties. Effective social marketing strategies developed through the RWJ pilot sites will be shared with health departments and other agencies throughout the state in hopes of determining which activities are more effective and successful.

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

Again, we have little quantitative results of the effectiveness of our outreach activities at this time, but we anticipate having preliminary results quantified from the RWS pilot sites in the near future.

## 2.5 **Retention:**

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

Local health departments conduct outreach to encourage families of children who may continue to be eligible for TennCare to complete the reverification process. The Tennessee Health Care Campaign (THCC) and the TennCare Shelter Enrollment Project have a component of their outreach efforts that are targeted to those families whose children who may have lost their TennCare coverage because the reverification process was not completed. Children, who lose coverage, yet continue to meet the eligibility requirements of the TennCare program will be allowed to re-enroll.

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

     Follow-up by caseworkers/outreach workers

  X   Renewal reminder notices to all families

\_\_\_ 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 \_\_\_\_\_
- \_\_\_ Other, please explain \_\_\_\_\_

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

Yes

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

While we are collaboratively working with the local health departments and advocacy agencies to ensure that eligible children stay enrolled, we do not have any quantitative data that would support which is most effective at this time.

5. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.

We do not have access to this information.

## 2.6 Coordination between SCHIP and Medicaid:

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

Children seeking to enroll in the TennCare for Children program do so by completing a one page TennCare enrollment form. The forms are widely available throughout the State - at State offices including all local health departments and through statewide hotlines.

The completed forms are mailed to the Bureau of TennCare where they are keyed in and the social security numbers are verified with the Social Security Administration. Within 7-10 days a notice is sent to the child's family instructing them to go to their local health department to complete the enrollment process. Applicants must have a social security number or have applied for one and proof of income and insurance status is required to complete the enrollment process. If there is inaccurate information on the application, corrections and updates can be made at the local health department immediately and not delay enrollment. During the visit, health department staff provides information regarding benefits as well as the enrollee's rights/responsibilities as a TennCare member.

The MCO and BHO in which the child is to be enrolled are notified of their eligibility and those organizations send the child a card and a Member Handbook. Additional mailings from TennCare and the MCOs/BHOs occur periodically throughout the year.

Generally, the application process can be completed within two to three weeks. However, in an emergency situation the health department can enroll a child immediately, provided technical requirements of the program are met and proof of income and insurance availability is documented and verified.

Shortening the enrollment process and developing a joint Medicaid-CHIP application are areas that may be explored in the future.

Eligibility determination for Medicaid is determined through the Department of Human Services and the re-certification process for Medicaid-eligible individuals is also completed by the Department of Human Services.

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

Our MCHIP program extends Medicaid coverage to children who would not otherwise qualify for Medicaid and includes children born before October 1, 1998, who have not yet attained the age of 19 years and whose family incomes are below 100% poverty.

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

Tennessee's MCHIP program is a Medicaid expansion, which means that all TennCare covered benefits are available for children in the expansion population and the same delivery systems used under the TennCare program are used for the children in the MCHIP program.

## **2.7 Cost Sharing:**

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

There are no cost sharing responsibilities for the children in the MCHIP program.

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

N/A

## 2.8 Assessment and Monitoring of Quality of Care:

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

Services for children under the Medicaid expansion will be evaluated in the same manner as for other TennCare members. This will be accomplished through our Quality Oversight Program.

In order to assure that all TennCare enrollees have access to the full range of covered health care services and that those services are of a high quality, quality assurance activities are undertaken at three different levels in the TennCare program. First, each MCO and BHO is required to have an internal quality assurance program. Second, the Bureau of TennCare contracts with an External Quality Review Organization (EQRO) to ensure that the MCOs' and BHOs' internal quality assurance program is operating effectively. Finally, the TennCare Bureau, either directly or through contracts with other agencies such as universities, assesses plan-specific and overall program performance.

Active oversight of MCO/BHO internal quality assurance activities is provided by the EQRO. A team from the EQRO makes an onsite visit to each MCO/BHO during the first six months of the year. MCO/BHO performance is reviewed in the areas of utilization management, preventive services, coordination of services, management information systems, network adequacy, provider credentialing, member services, and quality improvement.

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

See above.

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

Given our commitment to quality of care issues, TennCare will continue to fund studies and conduct data validation activities. The EQRO conducts an annual medical record review to compare information in the record to information reported by the MCO in the form of encounter data. TennCare monitors submission of encounter data on an ongoing basis and takes action in the form of retention of a withhold of 10% of the monthly capitation payment whenever it is determined that a contractor is not in compliance.

## SECTION 3. SUCCESSES AND BARRIERS

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

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

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

1. Eligibility
2. Outreach
3. Enrollment
4. Retention/disenrollment
5. Benefit structure
6. Cost-sharing
7. Delivery systems
8. Coordination with other programs
9. Crowd-out
10. Other

Tennessee's original MCHIP plan included uninsured children under the age of 18 who enrolled in the TennCare for Children Program on or after April 1, 1997, and whose family incomes were below 200% of poverty. There were two provisions (cost-sharing and premium revenue match) in the previously approved Section 1115a waiver that were not in sync with CHIP requirements. In an effort to address the cost-sharing requirements under our current waiver, we *reduced* the cost-sharing arrangements for uninsured children with family incomes between 100% and 200% poverty, but we have not eliminated cost-sharing responsibilities altogether. To change the existing cost-sharing requirements beyond what we have already done would change the terms of the waiver and create unnecessary confusion in the TennCare program. Additionally, cost-sharing is one of the measures that we feel helps combat "crowd out". To change the current arrangement for the premium revenues associated with CHIP children would change the terms of the waiver and therefore create unnecessary

administrative burden for Tennessee.

Tennessee's "best practices" are outreach, informing, and enrolling uninsured children into the TennCare program. We've been enrolling uninsured children and adults since 1994. As a result of our successful efforts we had to close enrollment to the Uninsured population (except for certain groups) January 1995, because we were nearing our enrollment cap.

The TennCare program relies heavily on the Title V agency to coordinate outreach and eligibility determination for the title XXI program. The Healthy Start program and the Child Health and Development (CHAD) programs are intensive case management and outreach home visiting programs. The nurses/case workers that visit homes regularly check with their clients to ensure that they have health insurance. In cases where the child is not covered, the caseworkers assist the parent in completing the application process for TennCare. The caseworker will also assist the parent in scheduling EPSDT appointments. Caseworkers also are currently required to monitor the rates of EPSDT appointments for their caseloads.

The Children's Special Services (CSS) program is another intensive case management program for special needs children. The caseworker ensures that every child applies for TennCare and they assist the family in accessing care for the child. Caseworkers provide education on how to access care and explain the TennCare benefits package to families and children.

## SECTION 4. PROGRAM FINANCING

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

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

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

	Federal Fiscal Year 2000 costs	Federal Fiscal Year 2001	Federal Fiscal Year 2002
<b>Benefit Costs</b>			
<b>Insurance payments</b>			
<b>Managed care</b>	26,024,558	27,337,000	27,337,000
per member/per month rate X # of eligibles			
<b>Fee for Service</b>			
<b>Total Benefit Costs</b>			
<b>(Offsetting beneficiary cost sharing payments)</b>			
<b>Net Benefit Costs</b>	26,024,558	27,337,000	27,337,000
<b>Administration Costs</b>			
<b>Personnel</b>			
<b>General administration</b>			
<b>Contractors/Brokers (e.g., enrollment contractors)</b>			
<b>Claims Processing</b>			
<b>Outreach/marketing costs</b>			
<b>Other</b>			
<b>Total Administration Costs</b>	1,744,108	1,622,000	1,622,000
<b>10% Administrative Cost Ceiling</b>	2,602,452	2,733,700	2,733,700
<b>Federal Share (multiplied by enhanced FMAP rate)</b>	20,596,019	21,588,935	21,588,935
<b>State Share</b>	7,172,647	7,370,065	7,370,065
<b>TOTAL PROGRAM COSTS</b>	27,768,636	28,959,000	28,959,000

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

N/A

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

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

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

No

## SECTION 5: SCHIP PROGRAM AT-A-GLANCE

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

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

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
<b>Program Name</b>	TennCare	
<b>Provides presumptive eligibility for children</b>	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, for whom and how long?	<input type="checkbox"/> No <input type="checkbox"/> Yes, for whom and how long?
<b>Provides retroactive eligibility</b>	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, for whom and how long?	<input type="checkbox"/> No <input type="checkbox"/> Yes, for whom and how long?
<b>Makes eligibility determination</b>	<input type="checkbox"/> State Medicaid eligibility staff <input type="checkbox"/> Contractor <input type="checkbox"/> Community-based organizations <input type="checkbox"/> Insurance agents <input type="checkbox"/> MCO staff <input checked="" type="checkbox"/> Other (specify) <u>Local Health Departments</u> -	<input type="checkbox"/> State Medicaid eligibility staff <input type="checkbox"/> Contractor <input type="checkbox"/> Community-based organizations <input type="checkbox"/> Insurance agents <input type="checkbox"/> MCO staff <input type="checkbox"/> Other (specify) _____
<b>Average length of stay on program</b>	Specify months _____	Specify months _____
<b>Has joint application for Medicaid and SCHIP</b>	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>Has a mail-in application</b>	<input type="checkbox"/> No Eligibility determined and completed at the health department. <input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>Can apply for program over phone</b>	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Can apply for program over internet	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Requires face-to-face interview during initial application	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, specify number of months _____ What exemptions do you provide?	<input type="checkbox"/> No <input type="checkbox"/> Yes, specify number of months _____ What exemptions do you provide?
Provides period of continuous coverage <u>regardless of income changes</u>	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, specify number of months <u>12</u> Explain circumstances when a child would lose eligibility during the time period - when the child obtains other health insurance	<input type="checkbox"/> No <input type="checkbox"/> Yes, specify number of months _____ Explain circumstances when a child would lose eligibility during the time period
Imposes premiums or enrollment fees	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, how much? _____ Who Can Pay? <input type="checkbox"/> Employer <input type="checkbox"/> Family <input type="checkbox"/> Absent parent <input type="checkbox"/> Private donations/sponsorship <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> No <input type="checkbox"/> Yes, how much? _____ Who Can Pay? <input type="checkbox"/> Employer <input type="checkbox"/> Family <input type="checkbox"/> Absent parent <input type="checkbox"/> Private donations/sponsorship <input type="checkbox"/> Other (specify) _____
Imposes copayments or coinsurance	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Provides preprinted redetermination process	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, we send out form to family with their information precompleted and: <input type="checkbox"/> ask for a signed confirmation that information is still correct <input type="checkbox"/> do not request response unless income or other circumstances have changed	<input type="checkbox"/> No <input type="checkbox"/> Yes, we send out form to family with their information and: <input type="checkbox"/> ask for a signed confirmation that information is still correct <input type="checkbox"/> do not request response unless income or other circumstances have changed

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

## SECTION 6: INCOME ELIGIBILITY

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

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

Title XIX Child Poverty-related Groups or  
Section 1931-whichever category is higher

\_\_\_\_\_ % of FPL for children under age \_\_\_\_\_  
\_\_\_\_\_ % of FPL for children aged \_\_\_\_\_  
\_\_\_\_\_ % of FPL for children aged \_\_\_\_\_

Medicaid SCHIP Expansion

100% of FPL for children aged Born before October 1, 1993 who have not yet attained the  
age of 19 years  
\_\_\_\_\_ % of FPL for children aged \_\_\_\_\_  
\_\_\_\_\_ % of FPL for children aged \_\_\_\_\_

State-Designed SCHIP Program

\_\_\_\_\_ % of FPL for children aged \_\_\_\_\_  
\_\_\_\_\_ % of FPL for children aged \_\_\_\_\_  
\_\_\_\_\_ % of FPL for children aged \_\_\_\_\_

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

Do rules differ for applicants and recipients (or between initial enrollment and redetermination)  Yes  No

If yes, please report rules for applicants (initial enrollment).

<b>Table 6.2</b>			
	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	State-designed SCHIP Program
Earnings	\$	\$	\$
Self-employment expenses	\$	\$	\$
Alimony payments Received	\$	\$	\$
Paid	\$	\$	\$
Child support payments Received	\$	\$	\$
Paid	\$	\$	\$
Child care expenses	\$	\$	\$
Medical care expenses	\$	\$	\$
Gifts	\$	\$	\$
Other types of disregards/deductions (specify)	\$	\$	\$

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

Title XIX Poverty-related Groups  No  Yes, specify countable or allowable level of asset test \_\_\_\_\_  
 Medicaid SCHIP Expansion program  No  Yes, specify countable or allowable level of asset test \_\_\_\_\_  
 State-Designed SCHIP program  No  Yes, specify countable or allowable level of asset test \_\_\_\_\_  
 Other SCHIP program \_\_\_\_\_  No  Yes, specify countable or allowable level of asset test \_\_\_\_\_

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

## **SECTION 7: FUTURE PROGRAM CHANGES**

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

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

1. Family coverage
2. Employer sponsored insurance buy-in
3. 1115 waiver
4. Eligibility including presumptive and continuous eligibility
5. Outreach
6. Enrollment/redetermination process
7. Contracting
8. Other

We are not planning to make any changes to the MCHIP program.

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