

**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: _____
Texas

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) **Children's Health Insurance Program** _____

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

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

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

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

Note: The following information is provided in relation to Texas' Phase II SCHIP program, which began operation April 3, 2000.

1. Program eligibility-- 200% FPL(net income test).
2. Enrollment process-- Joint with Medicaid and Texas Healthy Kids Corporation referral.
3. Presumptive eligibility-- N/A
4. Continuous eligibility-- 12 Months
5. Outreach/marketing campaigns-- Multi-faceted campaign generic to all three programs (see section 2.4).
6. Eligibility determination process-- Two-page joint application, with only income verification and immigration status required for SCHIP.
7. Eligibility redetermination process-- Simplified renewal process (see section 2.5)
8. Benefit structure-- Comprehensive benefit package designed for both healthy and special needs children.
9. Cost-sharing policies-- Graduated premium and co-payments based on family income.
10. Crowd-out policies-- 90 day waiting period for children dropping private insurance at the time

of application.

1. Delivery system-- HMOs in 84 counties; Exclusive Provider Organization in 170.
2. Coordination with other programs (especially private insurance and Medicaid)-- See above
3. Screen and enroll process-- See above
4. Application -- See above
5. 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.

Results from the last Current Population Survey (CPS) for Texas, conducted in March of 2000, indicate that children under the age of 19 had a rate of uninsurance of 24.6 percent in 1999. On the other hand, the CPS conducted in March of 1999 indicated that children under the age of 19 had a rate of uninsurance of 25.9 percent in 1998.

The CPS data thus indicate that the rate of uninsurance for children under the age of 19 may have dropped by a little over 1 percent during the 1998-1999 period.

At this point, though, the State does not have all the empirical data necessary to determine the extent by which the rate of uninsurance may have changed during FFY 2000. That data will be available once the results from the March of 2001 CPS are published. That having been said, Texas Phase II SCHIP program has reduced the number of uninsured children during FY 2001 enrolling more than 212,000.

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.

Available Texas Department of Human Services (TDHS) data suggest that during FFY 2000 some 4,500 children enrolled in the Medicaid program due to referrals and eligibility screenings generated by the Phase II SCHIP program. Those data currently are under review amid

indications that they understate the increase in Medicaid enrollment directly resulting from the Phase II screening process. In addition, general trends in Medicaid enrollment point to increases that coincide with Phase II implementation in FY 2001, but that cannot be definitively tied to SCHIP outreach efforts.

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

It is expected that growth in SCHIP enrollment will help reduce the rate of uninsurance among Texas children under the age of 19 – assuming all other relevant factors stay equal. However, as mentioned above, the extent of this reduction will not be known with a reliable degree of precision until the results of the March of 2001 CPS are published.

As of the end of December of 2000, Texas had already enrolled over 212,000 children in its Phase II SCHIP program. Those children either were uninsured at the time of enrollment in the Phase II coverage, or could not afford the private coverage they had based on the state statutory standard of 10% of family income. Thus, the vast majority of Phase II enrolled children would have remained uninsured if affordable health coverage were not available through SCHIP.

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 ?NC? (for no change) in column 3.

Note: While outside the scope of this report, progress in relation to Phase II strategic objectives is reported to the extent that data are available.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
To compare annual data on the number and percent of children enrolled in CHIP to the estimated number of potentially eligible children in the state		<p>Data Sources:</p> <ul style="list-style-type: none"> (1) Texas SCHIP program administrative files. (2) Historical data on uninsurance by age group and poverty income status obtained from the March Current Population Survey (CPS) for Texas. (3) Population projections by age group for the year 2000 obtained from the Texas State Data Center at Texas A&M University. <p>Methodology:</p> <ul style="list-style-type: none"> (1) Information on the number of SCHIP enrollees was taken from SCHIP program administrative files. (2) The number of potential eligibles was determined by statistically extrapolating – based on historical CPS data -- the percentage of uninsured children meeting the Texas SCHIP income criteria at the end of FFY 2000. Separate statistical extrapolations were done for Phase I and Phase II of SCHIP (see definitions below). The extrapolated percentages were applied to projections of the Texas population ages 0 – 18, by age group, for the year 2000. The population projections were done by the Texas State Data Center at Texas A&M University. <p>Definitions:</p> <p>In Texas, the SCHIP program was introduced in two phases, or along two separate</p>

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
		<p>tracks.</p> <p>What is known as Phase I of SCHIP was officially introduced on July 1, 1998. This phase targets uninsured children younger than 19 born before 10/1/1983 and who come from families with incomes at/or below 100% of FPL. Additionally, children targeted under Phase I do not qualify for Medicaid through the TANF program. This program expires at the end of FFY 2002.</p> <p>What is known as Phase II of SCHIP was officially introduced on May 1, 2000. This phase targets uninsured children under the age of 19 who do not qualify for Medicaid and who come from families with incomes at or below 200% of FPL.</p> <p>Progress Summary:</p> <p>(1) Phase I: It is estimated that by the end of FFY 2000 (September of 2000) there were 50,000 children potentially eligible under Phase I of SCHIP. Of those, the state enrolled (as of September of 2000) a total of 17,085. This translates into a participation rate of 34 percent.</p> <p>(2) Phase II: It is estimated that in the year 2000 there are, on a monthly average basis, about 460,000 children potentially eligible under Phase II of SCHIP. As of the end of FFY 2000 (September of 2000), a total of 83,538 children were enrolled under phase II, which is the equivalent of 18% of the estimated target population. It should be noted this reflects on the number of children receiving services as of 9/30/00. The total number of children enrolled as of that date, including children whose coverage was to begin 11/1/00, was 116,520.</p> <p><i>But It also should be noted that by December 21 of 2000 the total enrollment under</i></p>

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
		<i>Phase II of SCHIP had grown to 212,063. The more current enrollment figures are the equivalent of 46% of the estimated target population.</i>
OBJECTIVES RELATED TO SCHIP ENROLLMENT		
		Data Sources: Methodology: Progress Summary:
OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		
		Data Sources: Methodology: Progress Summary:
OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		
		Data Sources: Methodology:

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
		Progress Summary:
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
Phases I & II: Previously uninsured children ages 0 through 18 enrolled in the Texas Phase I program have access to quality preventative and comprehensive diagnostic/treatment services by maximizing the use of primary prevention, early detection and management of health care through participating health plans. Phase I children, those aged 15 through 18, receive similar	Phase I: During the fiscal year ending September 30, 2000 65% of all children 15-18 enrolled in Phase I will have had their THS (EPSDT) screens	Data Sources: Phase I—Eligibility and Paid Claims data located on the Ad Hoc Query Platform. Phase II--Three data sources are used to calculate compliance with well child care visit and immunization guidelines. These are (1) enrollment records, (2) claims and encounter data, and (3) telephone survey data obtained from families whose children are enrolled in the Children's Health Insurance Program. Methodology: Phase I—Divide the unduplicated number of CHIP enrollees into the number of enrollees who had at least one screen during FY 2000. Numerator—The number of enrollees who had at least one screen: 33,545. Denominator—The number of unduplicated enrollees: 39,618. Phase II--The American Academy of Pediatrics (AAP) guidelines are used as the standard for determining compliance or non-compliance with well child care visits and immunizations. A computer algorithm as developed at the Institute for Child Health Policy that takes into consideration the child's age and the number of well child visits and

Table 1.3		
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services via Texas Health Steps (EPSDT).		<p>immunizations expected for that child's age. In addition, the algorithm takes into consideration various immunization schedules and manufacturers. For example, one schedule of immunizations might be expected if the initial immunization was given at birth versus if the immunization was initiated at 1 month of age. Immunization schedules also can also vary depending on the manufacturer of the vaccine. Institute staff developed the algorithm in collaboration with two general pediatricians who are at the University of Florida, College of Medicine.</p> <p>The computer algorithm is then applied to the claims and encounter data and compliance is calculated for well child visits and the following immunizations: Diptheria, tetanus, pertussis (DPT), Hepatitis A, Hepatitis B, H. <i>influenzae</i>, type b, Polio, Measles, Mumps Rubella (MMR), and Varicella. Claims and encounter data provide useful information. However, it is recognized that parents may go out-of-plan to obtain immunizations for their children. Therefore, telephone interviews are being conducted with a random sample of families whose children are newly enrolled and with families whose children have been in the program for at least 6 months to assess parent self report of well child care and immunization compliance. The immunization questions used on the surveys were taken from the National Immunization Survey. Parent report would incorporate out-of-plan health care use. The results from the claims and encounter data will be compared to the results obtained from parent surveys. The percentage of children in compliance with well child visit recommendations and with each immunization will be reported for each approach (claims/encounter versus survey data). Compliance also will be reported by age cohort (i.e., less than 1 year 1 to 3 years, and so on).</p>

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
		<p>Progress Summary: Phase I—nearly 85% (84.7%) of CHIP Phase I enrollees had at least one screen during FY 2000. This indicates that CHIP Phase I enrollees have access to quality preventative and comprehensive diagnostic/treatment services.</p> <p>In Phase II, there has been insufficient Phase II program experience during FY 2001 to judge program progress in this area.</p>
OTHER OBJECTIVES		
		<p>Data Sources:</p> <p>Methodology:</p> <p>Progress Summary:</p>

- 1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.** Not applicable.
- 1.5 Discuss your States progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.** Not applicable.
- 1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.** Performance standards in relation to Phase II strategic objectives will be developed during FY 2001-02 once data baselines are established during that period.
- 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.** Not applicable.

SECTION 2. AREAS OF SPECIAL INTEREST

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

2.1 Family coverage: Not applicable.

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

Number of adults _____

Number of children _____

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

2.2 Employer-sponsored insurance buy-in: Not applicable.

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

Number of adults _____

Number of children _____

2.3 Crowd-out:

1. How do you define crowd-out in your SCHIP program? Because Texas Medicaid operates a HIPP program, crowd-out is not an issue in Phase I.
2. How do you monitor and measure whether crowd-out is occurring? In Phase II, crowd-out is deterred by the requirement that children be uninsured at the time of enrollment with an exception for children whose families are paying more than 10% of family income for private coverage. The

extent to which the latter exception is exercised is recorded by the Phase II eligibility and enrollment system.

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

2.4 Outreach:

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

The TexCare Partnership outreach plan is broad and comprehensive, including hundreds of community-based organizations, free and paid media, public relations, and corporate involvement. At the most basic level, we measure effectiveness by tracking application and enrollment volume at the statewide level, county level, and zip code level. We link application trends over a particular period of time to specific outreach activities like paid media or a telethon in a particular community. We also track the relationship between CBO application assistance activities and application trends.

Data collected through a variety of program means show that many families indicate that they heard about TexCare Partnership through a variety of means, with television advertising being the most common means followed by school-based outreach.

Because many families come in contact with our outreach plan through a variety of means, it is not easy to isolate the impact of any particular activity or strategy. For example, a family that applies through a community-based organization like a school or church (CBO) has likely already been exposed to the program through paid and free media as well as word of mouth. It is difficult, if not impossible, to determine in a situation like this which piece of the outreach puzzle is decisive in producing an application contact either through the mail or the hotline.

While robust application volume is positive, ultimately the most important measure of the effectiveness of an outreach effort is the volume of completed applications. This is a significant distinction because an SCHIP eligibility determination or a referral to Medicaid is not possible without receipt of all required information and verifications. Our data shows that the activity most

likely to result in a complete application is direct application assistance at the community level. We have determined this by comparing the proportion of written and phone applications that result in eligibility determinations or referrals and further determining the impact of CBO involvement.

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?

We measure the effectiveness of particular outreach strategies by analyzing application and enrollment volume in particular communities or regions or in relation to timeframes that coincide with specific types of outreach activities.

Our experience suggests that one of the most successful means of reaching Hispanic and immigrant families is through the involvement of trusted individuals at the community level. One of our most successful outreach efforts is in Webb County (Laredo), which has a very high proportion of immigrant and Hispanic families. The success in this community is a reflection of a very active and trusted CBO. Similarly, our success in El Paso County is a reflection of a high level of community commitment involving trusted individuals and organizations.

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

As noted above, community-based outreach involving active and committed organizations is particularly effective in reaching immigrant and Hispanic populations, particularly along the Texas/Mexico border. The relatively higher proportion of completed applications generated through community-based application assistance compared to other outreach approaches is also indicative of the value of this approach across all population groups.

Because the application and enrollment volume for the TexCare Partnership is strong across most rural and urban communities throughout Texas, and because the outreach effort is so multi-faceted and broad, it is difficult to isolate the impact of specific strategies on particular ethnic, geographic, or cultural groups. For instance, while our African-American application volume in the Houston area is strong, it is difficult to ascertain the extent to which that success is attributable to the involvement of black churches as opposed to television advertising that includes African-American children. The most obvious lesson from our first eight months of outreach experience is that successful outreach cannot be built on a foundation of relatively few strategies.

2.5 Retention:

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

Texas' Phase II SCHIP program is relatively young, and our first re-enrollments will not occur until March at the earliest. But in designing our re-enrollment policy, we have taken some steps that we believe will result in a high rate of retention among children who remain eligible.

The most important criterion is simplicity. A renewing family receives a printout of the most recent eligibility information. If nothing has changed, all that is required is the return of the form with a dated signature. No further documentation is required. If something has changed, the change can be noted on the renewal form and returned with any required verification.

The policy assumes that a renewing child will remain in the current health plan which means a family need take no action to maintain continuous coverage once eligibility has been re-confirmed. Any payment that is owed is not due at the time of renewal but within the first two months of the next coverage period.

A renewing child's health plan is notified when the renewal process is beginning for that child so that health plan marketing can occur. Similarly, a contracted CBO in the child's area is also notified if the family does not respond to the renewal notice in the first month.

Non-responding families are sent a second renewal form in the eleventh month of coverage. This follow-up notice, combined with CBO and health plan marketing, means most renewing families with have several opportunities and reminders to complete this very simple process.

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

To date, very few disenrolling children remain eligible for SCHIP in Texas. The most common reasons for disenrollment are "aging out" (turning 19), or dual coverage by another form of insurance. It is too early to have any experience with families who disenroll for failure to renew. At the present time, the only common situation in which a family is involuntarily disenrolled without a change in eligibility is cost-sharing delinquency. And the incidence of this situation is very low to date.

For these reasons, none of the following steps have been taken to date.

- Follow-up by caseworkers/outreach workers
- 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.
4. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

As noted above, the Texas Phase II SCHIP program has no experience with re-enrollment and our enrollment retention rate to date among eligible children is extremely high.

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 have not made any evaluations in this area to date.

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.

The TexCare Partnership application is a joint application for Phase II SCHIP and Medicaid. Families of uninsured children complete the joint application without reference to either program. The verifications that are accepted through TexCare Partnership are valid for Medicaid and SCHIP. An SCHIP eligibility determination or Medicaid referral is made based on the information on the application. While the application meets many of the program requirements for Medicaid and all of the program requirements for SCHIP, there are ways in which the application requirements and application processes for the respective programs differ.

Consistent with the federally approved state option, Medicaid screens for resources (assets) while there is no resource test in SCHIP. The resources screen occurs separate from the joint application and is an intermediate step that occurs prior to a Medicaid referral. However, a face-to-face interview at a local Department of Human Services Office is required to complete the Medicaid eligibility determination process while no face-to-face interview is required for SCHIP applicants.

The Medicaid interview is a function of pre-SCHIP policy, which places a premium on applicant convenience in applying for other services, including food stamps. The interview is a federal requirement in the food stamp program.

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

The process is a combination of electronic and paper referrals. Whether a child is transferred from Medicaid to SCHIP or vice versa, the information is conveyed using an electronic interface that includes all information relevant to an eligibility determination (family size, gross income minus disregards, children's names and ages, etc.). When a transfer is made from SCHIP to Medicaid, the electronic information is accompanied by the paper documentation which is sent to the appropriate local Department of Human Services office via overnight courier.

When a transfer occurs, the receiving entity communicates with the family via the mail. For example, a transfer from Medicaid to SCHIP results in an enrollment packet being generated and sent. This packet includes a welcome letter, a Member Guide, an enrollment form, provider directories, and other important information. A transfer from SCHIP to Medicaid generates a DHS appointment letter that is a pre-requisite to a face-to-face interview. DHS uses the SCHIP joint application and verification to conduct the Medicaid interview and certifies eligible children.

When an applicant applies for Medicaid using the DHS Form 1010 Application for Assistance, if determined ineligible for Medicaid based on assets or income, the DHS advisor determines SCHIP eligibility. The eligibility information is sent electronically to TexCare Partnership (TCP) and TexCare Partnership sends an enrollment packet to the family.

This electronic and paper process is facilitated and monitored through regular meetings that occur between SCHIP, Medicaid, and TexCare Partnership program and information systems staff.

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

The only manner in which the delivery systems for Medicaid and SCHIP clearly overlap is through contracts with identical health plans in certain areas. Provider networks are similar only to the extent that providers who have traditionally offered services to Medicaid members are given preferential status in SCHIP compared to providers who have not traditionally served the Medicaid population. Otherwise, the two programs differ in the following respects:

- The HMO coverage areas are not the same
- SCHIP coverage is based on managed care through the entire state while Medicaid managed care is limited to specific areas of the state
- Medicaid offers a primary care case management (PCCM) model in most areas where managed care is available while there is no PCCM choice in SCHIP.

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? While survey data are expected to assist in this assessment for Phase II the data available at this time are insufficient.
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?

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.

In Phase II Contracted health plans are submitting patient-level encounter/claims data. The dental contractor is submitting aggregate dental encounters by dental procedure code. A survey of new SCHIP enrollees has been completed. The results of each of these data sources are currently being analyzed.

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?

In Phase II, we are analyzing the quarterly encounter/claims data files we receive from contracted health plans to track the delivery of preventive medical services, mental health and substance abuse services and counseling and vision services. Each month we receive aggregate data on the utilization of dental services, including breakouts by dental procedure codes, which we use to measure the provision of dental services.

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?

In Phase II, we plan to continue collecting and analyzing patient-level encounter/claims data and to report on actual versus expected use based upon health status, access to and use of preventive

services, the provision of immunizations, children with special needs access to and use of services, utilization rates and treatment of diabetes and asthma, risky behaviors, including alcohol and drug abuse, and other topics. We also plan to conduct a survey of disenrollees and a survey of those enrolled for more than six months to assess their perceptions of the program and the services they received.

We plan to analyze the provision of preventive dental services through an analysis of the aggregate dental use data.

Results of these various studies will be reported during the Spring of 2001.

SECTION 3. SUCCESSES AND BARRIERS

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

3.1 Please highlight successes and barriers you encountered during FFY 2000 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible. NA (see section 1.1 in relation to Phase II).

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

SECTION 4. PROGRAM FINANCING

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

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

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

	Federal Fiscal Year 2000 costs	Federal Fiscal Year 2001	Federal Fiscal Year 2002
Benefit Costs	*See Attached	Spreadsheets*	
Insurance payments			
Managed care			
per member/per month rate X # of eligibles			
Fee for Service			
Total Benefit Costs			
(Offsetting beneficiary cost sharing payments)			
Net Benefit Costs			
Administration Costs			
Personnel			
General administration			
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/marketing costs			
Other			
Total Administration Costs			
10% Administrative Cost Ceiling			
Federal Share (multiplied by enhanced FMAP rate)			
State Share			
TOTAL PROGRAM COSTS			

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2000. Not applicable.

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. We anticipate submitting for match in FY 2001 funds donated in support of outreach and enrollment activities.

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

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

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

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Program Name		<i>Children's Health Insurance Program</i>
Provides presumptive eligibility for children	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, for whom and how long?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, for whom and how long?
Provides retroactive eligibility	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, for whom and how long? Three months.	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, for whom and how long?
Makes eligibility determination	<input checked="" 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) _____	<input type="checkbox"/> State Medicaid eligibility staff <input checked="" type="checkbox"/> Contractor <input type="checkbox"/> Community-based organizations <input type="checkbox"/> Insurance agents <input type="checkbox"/> MCO staff <input type="checkbox"/> Other (specify) _____
Average length of stay on program	Specify months _____	Specify months <i>Insufficient experience to judge.</i> _____
Has joint application for Medicaid and SCHIP	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
Has a mail-in application	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Can apply for program over phone	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
Can apply for program over internet	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
Requires face-to-face interview during initial application	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	<input type="checkbox"/> No <input type="checkbox"/> Yes, specify number of months _____ What exemptions do you provide?	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, specify number of months 3 What exemptions do you provide? None
Provides period of continuous coverage regardless of income changes	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, specify number of months _____ Explain circumstances when a child would lose eligibility during the time period	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, specify number of months 12 Explain circumstances when a child would lose eligibility during the time period. <i>Failure to pay premium; leave state.</i>
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 checked="" type="checkbox"/> Yes, how much? \$15 to \$18 per month, depending upon income. _____ Who Can Pay? <input type="checkbox"/> Employer <input checked="" 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 checked="" type="checkbox"/> Yes
Provides preprinted redetermination process	<input 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	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, we send out form to family with their information and: <input checked="" type="checkbox"/> ask for a signed

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
	<p style="text-align: center;">that information is still correct ___ do not request response unless income or other circumstances have changed</p>	<p style="text-align: center;">confirmation that information is still correct ___ do not request response unless income or other circumstances have changed</p>

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

The initial application process starts a new account. Because it is an initial application, CHIP has no information about the household or the individual children. The application must come into the administrative services contractor with all required information and a dated signature. The information is then entered into a system, an account number is generated for the household (with suffixes for each of the children). An eligibility determination is made and the family is either sent CHIP enrollment materials, referred to Medicaid, referred to the Texas Healthy Kids Corporation, or denied. These actions are determined by family size, income, expenses, citizenship status, and insurance status.

The redetermination process (in Texas Phase II SCHIP, this process is called "renewal") is different in the sense that the program already has information in connection with the household and children. A household is sent a form with the most recent application information and is asked to confirm it or change it. The form is then returned with a dated signature. A household that has experienced no change in income, household size, or expenses actually has to do nothing more than peruse the form and sign it and return it. Households that experience changes in income or expenses must indicate those changes on the form and return it with verifications and a dated signature.

Once a signed and dated renewal form is received, the process of eligibility determination as described above occurs again.

SECTION 6: INCOME ELIGIBILITY

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

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

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

185 % of FPL for children under age infants
100 % of FPL for children aged 6-14
133 % of FPL for children aged 1-5

Medicaid SCHIP Expansion

 % of FPL for children aged
 % of FPL for children aged
100 % of FPL for children aged 15-18

State-Designed SCHIP Program

 % of FPL for children aged
 % of FPL for children aged
200 % of FPL for children aged 0-18

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 ?NA.?

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

Table 6.2			
	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	State-designed SCHIP Program
Earnings	\$ 120	\$ 120	\$ 120
Self-employment expenses	\$ 120 + costs of doing business	\$ 120 + costs of doing business	\$ Costs of doing business
Alimony payments Received	\$ 0	\$ 0	\$ 0
Paid	\$ Actual amount	\$ Actual amount	\$ Actual amount
Child support payments Received	\$ 50	\$ 50	\$ 50
Paid	\$ Actual amount	\$ Actual amount	\$ Actual amount
Child care expenses	\$ Up to \$200 for a child < 2 Up to \$175 for a child 2 and over	\$ Up to \$200 for a child < 2 Up to \$175 for a child 2 and over	\$ 200 for a dependent child \$175 for a dependent disabled adult
Medical care expenses	\$ 0	\$ 0	\$ 0

Table 6.2			
	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	State-designed SCHIP Program
Gifts	\$ 0	\$ 0	\$ 0
Other types of disregards/deductions (specify)	\$	\$	\$

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

Title XIX Poverty-related Groups ___ No X Yes, specify countable or allowable level of asset test \$2000

Medicaid SCHIP Expansion program ___ No X Yes, specify countable or allowable level of asset test \$2000

State-Designed SCHIP program X No ___ Yes, specify countable or allowable level of asset test _____

Other SCHIP program _____ X No ___ Yes, specify countable or allowable level of asset test _____

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

SECTION 7: FUTURE PROGRAM CHANGES

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

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2001(10/1/00 through 9/30/01)? Please comment on why the changes are planned. Given that the Phase II program is relatively new, no assessment of needed changes has been completed to date.

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

Workpapers for SCHIP FY 2000 Report - State of Texas-Combined

	FFY 2000	FFY 2001	FFY 2002
Benefits			
Insurance payments	\$ 42,128,611	\$ 348,354,689	\$ 580,628,477
Managed Care (pm/pm rate X number of enrollees)	26,804,815	338,329,164	577,760,900
Fee for service	15,323,796	10,025,526	2,867,577
Total Benefits	42,128,611	348,354,689	580,628,477
less: beneficiary cost sharing	988,377	7,627,000	11,334,105
Net Benefit Costs*	\$ 41,140,234	\$ 340,727,689	\$ 569,294,372

*Note that SCHIP I and SCHIP II Benefit costs are combined, and those costs include only insurance payments.

Administration Costs			
Personnel	\$ 9,550,666	\$ 8,164,040	\$ 2,245,794
General Administration	3,105,540	2,558,239	676,745
Contractors	3,129,250	25,445,282	27,714,711
Claims Processing	-	-	-
Outreach	3,338,061	12,423,380	4,500,000
Other	154,520	145,042	3,936
Total Administration Costs	\$ 19,278,037	\$ 48,735,983	\$ 35,141,186
SCHIP I charged to Title XIX**	10,260,698		
Outreach charge to Title XIX**	3,338,061		
Total Admin Costs charged to Title XIX**	\$ 13,598,759		
<i>10% administrative ceiling</i>	\$ 5,679,275	\$ 40,939,901	\$ 66,538,000
Total Program Costs	\$ 60,418,271	\$ 389,463,672	\$ 604,435,558
Federal Share	\$ 44,075,129	\$ 281,971,699	\$ 435,918,924
State Share	\$ 16,343,142	\$ 107,491,974	\$ 168,516,634

**Note that the total amount of administrative budget and expenditures, attributable to SCHIP are shown. When the administration expenditures exceed the administrative cap, additional administration expenditures have been charged to Title XIX.

Workpapers for SCHIP FY 2000 Report - State of Texas--Phase II

	FFY 2000	FFY 2001	FFY 2002
Benefits			
Insurance payments	18,133,403	332,236,300	575,816,000
Managed Care (pm/pm rate* number of enrollees)	18,133,403	332,236,300	575,816,000
Fee for service	-	-	-
Total Benefits	18,133,403	332,236,300	575,816,000
less: beneficiary cost sharing	988,377	7,627,000	11,334,105
Net Total Benefits	<u>\$ 17,145,026</u>	<u>\$ 324,609,300</u>	<u>\$ 564,481,895</u>

*Note that Benefit costs include only insurance payments and will not match total benefits reported on the FY 2000 HCFA 21 expenditures report.

Administration Costs

Personnel	\$ 188,780	\$ 1,410,000	\$ 1,663,000
General Administration	7,296	481,056	498,000
Contractors	3,129,250	25,445,282	27,714,711
Claims Processing	-	-	-
Outreach	3,338,061	12,423,380	4,500,000
Other	-	11,000	-
Total Administration Costs	<u>\$ 6,663,387</u>	<u>\$ 39,770,718</u>	<u>\$ 34,375,711</u>
<i>10% administrative ceiling</i>	<i>\$ 1,905,000</i>	<i>\$ 37,854,000</i>	<i>\$ 65,515,000</i>
Total Program Costs	<u>\$ 23,808,413</u>	<u>\$ 364,380,018</u>	<u>\$ 598,857,606</u>
Federal Share	\$ 17,368,237	\$ 263,811,133	\$ 431,896,105
State Share	\$ 6,440,176	\$ 100,568,885	\$ 166,961,501

