

***Federal Fiscal Year 2001
FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT***

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

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

(James K. Haveman, Jr.)

SCHIP Program Name(s): MIChild and Healthy Kids

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

Reporting Period: Federal Fiscal Year 2001 (10/1/2000-9/30/2001)

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Submission Date: _____

*(Due to your CMS Regional Contact and Central Office Project Officer by January 1, 2002)
Please cc Cynthia Pernice at NASHP (cpernice@nashp.org)*

SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This sections has been designed to allow you to report on your SCHIP program changes and progress during Federal fiscal year 2001 (September 30, 2000 to October 1, 2001).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 2000 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, 2000, 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.

- A. Program eligibility - NC
- B. Enrollment process - NC
- C. Presumptive eligibility - Michigan is in the final stages of testing and implementation of an electronic application for presumptive determination of eligibility. Initially, this e-application will be implemented at a few sites in the state during the Winter of 2001. This process will expand to statewide promotion by February 2002. Applicants will be able to apply at any computer terminal and receive a presumptive eligibility determination within a minute of electronically submitting a completed application. Those eligible for MICHild will receive a printout of their coverage begin date, a signature page to sign and return to continue coverage for a full year and, if applicable, a set of payment coupons. Those eligible for Healthy Kids (Medicaid) and who have application assistance will receive a printout advising them of their coverage begin date and a signature page to sign and return to continue coverage beyond the initial two months. It is anticipated that this process will be used primarily by Health Departments around the State, where staff will be trained to assist the applicants in this electronic process. Those who apply without application assistance must send in the signature page before eligibility can begin.
- D. Continuous eligibility - NC
- E. Outreach/marketing campaigns - Michigan continues to provide extensive outreach and marketing for the MICHild/Healthy Kids programs to increase enrollment and decrease the number of uninsured children in Michigan.

Outreach Incentive Payments- The Department of Community Health (DCH) continued the \$25 incentive payment to local health departments (LHDs) for each person assisted with completion of a MICHild/Healthy Kids application. For fiscal year 2001, this payment was made for 24,601 children and pregnant women, an increase from the 18,927 applicants assisted in fiscal year 2000.

Training - Twenty-seven update training sessions were held by the Training unit of DCH during fiscal year 2001 (the initial statewide training sessions were held during fiscal year 2000). DCH also provides training, upon request, to any community-based organization that requests it.

Rural Health Initiatives - DCH has worked with the Michigan Center for Rural Health and the Rural Development Council of Michigan on the federal grant funding outreach in three rural sites to work with grass roots community partners to increase enrollment in MICHild and Healthy Kids. MICHild and/or Healthy Kids program materials continue to be distributed at the Indian Health Centers. Eligibility workers at Federally Qualified Health Centers continue to assist Tribal members with the MICHild/Healthy Kids joint application.

School Outreach -The Education and Outreach Staff at DCH met with the Michigan Department of Education and fourteen local districts to discuss piloting outreach through the school lunch program. Although the schools were interested in participating, the requirements for state agreements with individual school districts was determined too cumbersome to implement this project at this time. Michigan continues to have effective school outreach by working with local agencies to provide school outreach.

Ongoing contact/collaboration with state education-related associations continues. This includes:

- Michigan Association of School Nurses
- Michigan School Counselor Association
- Michigan Association of School Social Workers
- Michigan Association of Secondary School Principals
- Michigan Elementary and Middle School Principals Association
- Michigan School Food Service Association

The associations were provided with information, education, and printed program materials. These collaborations have resulted in invitations to participate in school-related conferences, health fairs, and community events.

Media Campaign -An extensive media campaign continues to provide information on MICHild/Healthy Kids, including television, radio, print and posters.

Employer-Based Outreach - Michigan continues to seek out small businesses, associations and agencies that offer individuals jobs, training or employment information. Many individuals associated with these companies are in transition from assistance toward self-sufficiency. MICHild information is presented as possible health care for family members.

Employment-related collaboration has begun with:

- Michigan Department of Career Development- Site visits were completed at the 26 Michigan Works! Agencies who oversee workforce development programs, and to the local Work First offices these agencies oversee.
- Small Business Association of Michigan- Conducted an on-site visit and received a referral to the Michigan Small Business Development Centers (12 regional offices with approximately 60 satellite offices). Provided the state director with information to be shared with the directors of each of the regional offices. Follow-up with the regional offices has begun.
- Cascade Engineering- A small business in Grand Rapids, Michigan, integrated the MICHild information into their orientation programs for new employees to consider during the three-month waiting period before the employer health insurance becomes effective.
- Referrals have been received to other agencies and businesses, such as Grand Rapids Opportunities for Women who serve many women starting up a business.

Other -

- Information and Referral Informational booths, attended by providers, professionals, agency staff, school employees, and families, were provided at nine statewide conferences for a variety of state associations and agencies including:
 - Michigan Head Start Training Conference
 - WIC Spring Conference 2001
 - Michigan Association of School Nurses 2001 Annual State Conference
 - Michigan Rural Health Association Conference
 - Michigan School Food Service Association Annual Conference
 - Prosperity Institute for Michigan Women
 - Michigan Healthy Mothers, Healthy Babies Conference
 - American Academy of Pediatrics Annual Meeting
 - Michigan Primary Care Association Conference
- Newsletters - MICHild information was contributed to the newsletters of the Division of Child Day Care Licensing, for distribution to 22, 000 licensed day care providers, and to the Center for Rural Health, with a circulation of approximately 2400 state association members, healthcare professionals and public officials involved with Rural Health.
- Educational Sessions -
 - On-site sessions providing program updates and new employee education have been conducted for two of the eleven MICHild health plans. Health plan staff from Member Services and Provider Services attended the sessions. Additional educational sessions are currently being scheduled for the remaining MICHild health plans.
 - A MICHild/Healthy Kids presentation was given to the Office of Multi-Cultural Services, a state agency that that serves the minority population in Michigan.

Printed materials were provided at this presentation and for subsequent quarterly meetings of the agency.

- Printed materials - Requests for brochures, applications, and posters are received on an on-going basis from community agencies, associations, and schools. We provide these materials in three languages- English, Spanish, and Arabic.
- Michigan joined a national campaign by Wal-Mart stores called “Babies First.” It was designed to bring awareness to the need for child health and safety. Printed MICHild materials were sent to Wal-Mart’s distribution center to be packaged with products for the fifty-nine stores in Michigan. Many stores conducted weeklong promotions for this campaign.
- Local contacts - A MICHild outreach contacts list is continually maintained and updated that includes, by county, local public health and community agency outreach and application assistance. Contacts for the Covering Kids program are also included. This unit also responded to all requests for presentations, referring to local contacts whenever possible.
- Web information - Information on MICHild and Healthy Kids is on the department web site. Michigan also developed with Michigan Virtual University a free web-based course that details the Medicaid program, including Healthy Kids. It explains who is covered, how to apply, what is covered, and how to receive health care. It has a link to the department’s MICHild web site. Audio text is played for each screen of information.
- Media Campaign - An extensive media campaign continues to provide information on MICHild and Healthy Kids. The media campaign, coordinated by Health Promotions and Publications, includes television, radio, print, and transit posters.

- F. Eligibility determination process - Implementation of presumptive eligibility, as explained above.
- G. Eligibility redetermination process- Effective September 2000, the redetermination process was modified. At redetermination, enrollees now receive a preprinted form listing the eligibility information on file. If there are no changes, the cover letter is signed and returned to process for another 12 months of coverage. Any changes are indicated on the preprinted form, which is signed and returned for eligibility determination. This simplification of the redetermination process has significantly reduced the number of enrollees lost at redetermination. The retention rate was 31 percent prior to this change, and now the retention rate is 47 percent.
- H. Benefit structure - NC
- I. Cost-sharing policies- Effective June 2001, MICHild enrollees who live in households with members who are American Indian or Alaska Native are exempt from payment of the \$5 MICHild premium.
- J. Crowd-out policies- NC

- K. Delivery system- NC
- L. Coordination with other programs (especially private insurance and Medicaid) -NC
- M. Screen and enroll process - NC
- N. Application - The application has been further revised to make the reporting of income easier for applicants. At audit, it was found that some applicants were confused about the meaning of 'gross income.' The application now resolves this issue by requesting both the 'gross' and 'net' income amounts.
- O. Other - NC

1.2 Please report how much progress has been made during FFY 2001 in reducing the number of uncovered low-income children.

- A. **Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2001. Describe the data source and method used to derive this information.** In October 2000, there were 26,574 sixteen to eighteen year olds enrolled in the Healthy Kids Medicaid Expansion. In September 2001, there was an increase to 30,892 in this same age group, and increase of 4,318 children, or 16 percent. In October 2000, there were 15,006 children enrolled in MICHild, which increased to 23,577. This is an increase of 8,571 children, or 57 percent.
- B. **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.** As of September 2001, there were 340,000 children and pregnant women enrolled in Healthy Kids, per CIS (Client Information System, Michigan's Medicaid database). This is a 14 percent increase in the number of Medicaid enrollees that were active per CIS in October 2000. Michigan does not separately track persons enrolled solely due to outreach efforts, but we are confident that the outreach efforts described in Section 1.1 contributed significantly to this success.
- C. **Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.**
NC
- D. **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 2001 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 and denominator). Please attach additional narrative if necessary.

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

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
Objectives related to Reducing the Number of Uninsured Children		
1. To increase the number of low-income children in Michigan with creditable health insurance coverage by	Goal 1: Enroll the estimated number of uninsured, low-income children in Michigan in either the Medicaid	Data Sources: For numerator, MICHild enrollment file and count of MICHild/Healthy Kids common applications processed; for denominator, number of uninsured children under age 19 based on the Urban Institute’s National Survey of American Families. Methodology: Count number of MICHild applicants enrolled through 9/2001 (23,577); count

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means of moving children under age 19 without health insurance into either accessible, quality Medicaid or MICHild coverage while not simultaneously crowding out private coverage	program or the MICHild program, as appropriate.	<p>estimated number of Healthy Kids enrollees based on number of applications found likely to represent Medicaid eligibles at initial eligibility screening x 1.8 children per application (70,381 x 1.8 = 126,685).</p> <p>Numerator: MICHild enrollees as of 9/30/2001 (23,577) + HK enrollees added since beginning of SCHIP program (126,685) = 150,262</p> <p>Denominator: 106,000 children under age 19 whose family income is at or below 200 percent of FPL.</p> <p>Progress Summary: 150,262/106,000 = 141 percent of potentially eligible children are now insured. Increase in enrollment during FY 2000 = 150,262 - 98,049 = 52,213 or 53 percent increase during FY 2001.</p>
Objectives Related to SCHIP Enrollment		
	Goal 2: Enroll in the MICHild program 100% of eligible children who participate in the Caring Program for Children	N/C
Objectives Related to Increasing Medicaid Enrollment		
	Goal 3: Local agencies and programs will contact low-income families	<p>Data Sources: Reports of local agencies under contract to the Department during CY 2001.</p> <p>Methodology: Total counts of outreach contacts made by contracted agencies based on incentive</p>

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	representing 106,000 uninsured children and make known to the families the availability of Medicaid and MICHild health coverage.	payment reporting. Contacts Made: Applications submitted for 24,601 children who appeared to be eligible for either MICHild or Healthy Kids. Progress Summary: The extent of agencies' efforts was even more far-reaching than the statistics alone indicate. The number of children enrolled in MICHild/Healthy Kids suggests this goal continues to be substantially met.
Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)		
	Goal 4: Obtain accurate usable HEDIS® reports from MICHild providers and monitor the following outcomes with emphasis on: a. well-child exams b. immunizations c. receipt of at least one physician visit per MICHild enrollee annually. d. receipt of at least one dental exam per MICHild enrollee annually	Michigan believes that the quality studies performed during the year demonstrate our progress towards monitoring MICHild access and quality outcomes. Although Goal 4 is measured with HEDIS®-Like Reports, we have included the 2001 CAHPS™ 2.0H Surveys and other satisfaction surveys which evaluate the satisfaction of the MICHild members with their MICHild benefits. HEDIS®-Like Reports Data Sources: Blue Cross Blue Shield of Michigan (BCBSM) HEDIS®-like data reports for Measurement Year 2000. HMOs did not meet the 1,000 continuous enrollment numbers necessary for HEDIS®. Methodology: Standard HEDIS® methodology applied to HEDIS®-like reports. BCBSM pulled all facility, pharmacy, and professional claims incurred in 2000 for these continuously enrolled MICHild members. Summary data was produced for use of services, access, and cost reporting and to determine which effectiveness of care measures were feasible. Numerator and Denominator (Sample): All MICHild members (group 31295) were identified from

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		<p>the BCBSM membership files. All members included in HEDIS® measures were verified for continuous enrollment. The total MICHild health enrollment on January 1, 2000 was 10,401. By January 1, 2001 enrollment was 15,041, a 31 percent increase, but only 4,718 members met HEDIS® continuous enrollment criteria for the measurement year.</p> <p>HEDIS®-like Data Report Progress Summary: BCBSM's 2001 findings are as follows:</p> <p>Effectiveness of Care Measure: Childhood Immunization/Adolescent Immunization. Rates are not presented, because BCBSM does not pay a significant volume of claims for childhood immunizations to make valid conclusions regarding the utilization. BCBSM has taken steps to improve immunization rates.</p> <p>Access and Availability of Care Measure: Children's Access to Primary Care Providers. 86 percent of children 12 to 24 months, 80 percent of children 25 months to 6 years, and 72 percent of children 7 to 11 years received a visit with a primary care provider.</p> <p>Initiation of Prenatal Care. Seven live deliveries to MICHild members.</p> <p>Annual Dental Visit. Sixty-three percent between ages 4 and 19 had at least one claim for a dental visit.</p> <p>Use of Services Measure:</p> <p>Well-Child Visits in the First 15 Months of Life. Of the 83 members who met HEDIS® specifications for this measure, 56 (sixty-seven percent) had at least one comprehensive well child</p>

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		<p>visit. In 1999, no members met these specifications.</p> <p>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life. Thirty-seven percent of the children had at least one comprehensive well-care visit in 2000.</p> <p>Adolescent Well-Care Visits. An increase to 19 percent (up from fourteen percent) of enrollees between the ages of 12 and 19 had at least one comprehensive well-care visit in 2000.</p> <p>Myringotomy is again the most frequently performed procedure with 1.17 procedures per 1000 member months.</p> <p>Outpatient Drug Utilization: The average number of prescriptions per year increased to 5.8 (up from 4.4) for children ages 0-9 during 2000. The average number of prescriptions per year increase to 7.2, up from 5.1 for children ages 10-19.</p> <p>Other BCBSM Quality Studies:</p> <p>Use of Appropriate Medications for People With Asthma: A total of 27 MICHild members with persistent asthma were identified and 70 percent received appropriate prescription drug therapy. The statewide BCBSM overall rate is 68 percent.</p> <p>Eleven MICHild members were identified as diabetic. 82 percent received at least one HbA1c test during 2000, which exceeds the overall BCBSM rate of 60 percent for the same time period.</p>

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		<p>2001 CAHPS™ 2.0H Member Satisfaction Surveys were conducted by BCBSM and Market Facts:</p> <p>Data Sources: BCBSM 2001 CAHPS™ 2.0H Member Satisfaction Survey was conducted by MORPACE International, A National Committee on Quality Assurance (NCQA) certified survey research provider.</p> <p>Methodology: The BCBSM CAHPS™ 2.0H survey focused on the 12-month period prior to the administration of the survey. This corresponds to the 2000 NCQA Quality compass reporting year of January 1, 2000 to December 31, 2000. The questions, their placement in the survey tool, and the response options, the mailing and telephone methodology are mandated by NCQA. Data selection was a stratified random sampling. 1,050 BCBSM members were selected for sampling in February 2001, with results for 670 respondents. Response rate was 65 percent.</p> <p>Numerator and Denominator (Sample): All MICHild members who were eligible were included in the population from which survey members were selected. Eligible members are defined as members who are covered by BCBSM MICHild Health Plan. Members must be 12 years or younger as of December 31 of the measurement year and must have been continuously enrolled for the HEDIS® reporting year. Continuous enrollment allows for one coverage lapse of up to 45 days during the reporting year.</p> <p>BCBSM 2001 CAHPS™ 2.0H Progress Summary:</p> <p>89 percent of respondents felt that getting care that was needed was not a problem. 87 percent of respondents felt that they usually/always could get care quickly. 95 percent of respondents were usually/always satisfied with provider communication and the courteous office staff (composite</p>

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		<p>measures).</p> <p>89 percent of respondents rate the experience with the child’s health plan as 8, 9, or 10 (with 10 being the highest possible). 82 percent of respondents rate their experience with their child’s doctor or nurse as 8, 9, or 10. 81 percent rate the specialist seen the most often by their child as 8, 9, or 10 (overall rating measure).</p> <p>Data Sources: Market Facts 2001 CAHPS™ 2.0H Survey</p> <p>Methodology: CAHPS™ 2.0H survey is considered valid and reliable when obtained from a period of twelve consecutive months of managed care enrollment for the enrollee studied.</p> <p>Numerator and Denominator (Sample): The child identified must be MICHild eligible for 5 of last 6 months of calendar year 2000.</p> <p>Market Facts 2001 CAHPS™ 2.0H Survey Progress Summary: Market Facts' raw data for fiscal year 2000 has been analyzed and evaluated for this report. The initial result of the May 2001 CAHPS™, with 51 percent response rate. 97 percent rated the health of the children as "excellent" to "good". Over 50 percent of the children needed immediate care for illness or injury and almost 50 percent went to a doctor's office more than three times. Nearly 90 percent reported that getting care quickly was not a problem.</p> <p>Data Source: 2001 MICHild Satisfaction Survey Administrative Contractor (Maximus) in October 2001.</p>

<p>Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)</p>	<p>(2) Performance Goals for each Strategic Objective</p>	<p>(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)</p>
		<p>Methodology: This is the third annual MICHild Satisfaction Survey administered by the Administrative Contractor. 363 MICHild families were chosen at random. Sixteen-to-eighteen year-olds, who are State Children’s Health Insurance Program eligible, receiving services through Healthy Kids were not subject to being interviewed.</p> <p>Numerator and Denominator (Sample): All of the families surveyed received MICHild benefits for at least six months prior to the interview and were active in October. There were approximately 550 children in the households interviewed.</p> <p>October 2001 MICHild Satisfaction Survey Progress Summary: Nearly 95 percent of the families have seen a doctor, and over three quarters of the families have seen a dentist. Over 76 percent of the families took their child to the doctor for well-child checkups or immunizations. A small percentage of families utilized mental health or substance abuse services. 73 percent of the families that received these services indicated the service was good to excellent.</p> <p>Dental Satisfaction Survey was conducted by BCBSM:</p> <p>Data Sources: July 2001 BCBSM Dental Satisfaction Survey</p> <p>Methodology: The survey instrument was limited to a one-page survey form. The dental survey was conducted during the period from June 1 through July 6, 2001. The survey was mailed to the MICHild families and follow-up post cards were sent two weeks later. It was limited to 1,193 MICHild families. The survey response rate was 21 percent (253 families). BCBSM commercial response is comparable at 20 percent.</p>

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		<p>Numerator and Denominator (Sample): Children who have only dental coverage through BCBSM, have been enrolled for at least 6 months, and were at least 3 years old by April 1, 2001., plus families from among those with both health and dental coverage who have been enrolled for at least 6 months and who have children aged 12 and older. It is possible that a family with children both over 12 and under 12 could receive both surveys using this approach.</p> <p>July 2001 BCBSM Dental Satisfaction Survey Progress Summary: Overall satisfaction with the dentist was 95 percent. Overall satisfaction with the hygienist was 97 percent. MICHild members were very satisfied with the cleanliness (97 percent), time spent in the waiting room (90 percent), and most members were satisfied with the length of time needed to make an appointment (84 percent).</p> <p>Data Source: Michigan Dental Satisfaction Survey administered by Market Facts.</p> <p>Methodology: The Market Facts Dental Satisfaction Survey tool was prepared in collaboration with the Department of Community Health. The survey was administered in the Spring of 2001. The same survey tool was sent to three groups; the MICHild BCBSM enrollees, Delta Dental enrollees and the Healthy Kids Dental enrollees.</p> <p>Numerator and Denominator: The Market Facts Dental Satisfaction Survey sample is a random sample of eligibles from each group. The Administrative Contractor generated the file of eligibles. Of 1,937 respondents, 1,199 (61.9 percent) had been to a dentist or dental clinic in the last six months.</p> <p>Market Facts Dental Satisfaction Survey Progress Summary: 50.5 percent rated their experience with the plan as best possible (score of 10), with an additional 32.5 percent rated their experience with the plan as an 8 or 9.</p>

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Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)		
	See Goal 3	BCBSM Quality Improvement Measures: NC
Other Objectives		
	<p>Goal 5: Provide an application and enrollment process that is easy for families to understand and use.</p> <p>Provide a re-enrollment process that is easy for families to understand and use.</p>	<p>Data Sources: Administrative Contractor Satisfaction Survey, Weekly/Monthly reports from the Administrative Contractor</p> <p>Methodology: Satisfaction Survey: Random sample of MICHild families were asked whether the enrollment and eligibility determination process was easy.</p> <p>October 2001 MICHild Satisfaction Survey Progress Summary: Actual monthly number of applications submitted using the MICHild/Healthy Kids combined application. Actual numbers of follow-up letters and calls made regarding incomplete applications. 90 percent of the MICHild households rated the application process as good to excellent; while another 9 percent rated the process as average.</p> <p>Weekly/Monthly Reports from the Administrative Contractor Progress Summary: The rate of</p>

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		<p>incomplete applications continues at 20 percent. Further, the number of applications submitted continues to average 4,000 monthly.</p> <p>Data Sources: Weekly/Monthly Reports from the Administrative Contractor</p> <p>Progress Summary: From November 1999-January 2000, the rate of retention of MICHild enrollees was 33 percent. Use of a re-enrollment form with pre-printed information about the family from the database of the Administrative contractor was instituted, rather than requiring each family to fill out a blank application. From November 2000 - January 2001, the rate of retention of MICHild enrollees rose to 47 percent.</p>
	<p>Goal 6: Obtain participation of community-based organizations in outreach and education activities</p>	<p>Data Sources: LHDs, Medical Services Administration Division (MSA) of the DCH, Training Unit, Administrative Contractor, MSA's Education and Outreach Section</p> <p>Methodology: Number and amount of outreach incentive payments for the fiscal year; informal reports from the multi-purpose collaborative bodies; number and types of trainings requested; number, types, and, origin of requests for information from the Administrative Contractor; reports from the Education and Outreach Section</p> <p>Progress Summary: All but one of the LHD's participated in the outreach incentive payments. Twenty seven training sessions were held by the Training Unit (the initial statewide training sessions were held the previous year, these additional sessions were held for new employees); the Education and Outreach Section held numerous sessions throughout the state. Site visits were made to the 26 Michigan Works! Agencies who oversee workforce development programs, and to the local Work First offices these agencies oversee.</p>

- 1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.**
NC
- 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.**
NC
- 1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.**
The following are annual reports:
 Administrative Contractor's Satisfaction Survey/October 2001
 MarketFacts 2000 Consumer Satisfaction Survey Report/May 2001
 BCBSM 2001 HEDIS® Report
 BCBSM 2001 CAHPS™ 2.0H Report/MORPACE
 BCBSM 2001 MICHild Dental Provider Satisfaction Survey
 MarketFacts Michigan Children's Dental Survey/Spring 2002
 The following reports are available as indicated:
 Administrative Contractor Weekly and Monthly Executive Summary Reports
 Outreach Reports/various times during the year
- 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.**
 Administrative Contractor's Satisfaction Survey/October 2001
 MarketFacts 2000 Consumer Satisfaction Survey Report/May 2001
 BCBSM 2001 HEDIS® Report
 BCBSM 2001 CAHPS™ 2.0H Report/MORPACE
 BCBSM 2001 MICHild Dental Provider Satisfaction Survey
 MarketFacts Michigan Children's Dental Survey/Spring 2002
 Administrative Contractor Executive Summary Reports
 Outreach Reports
 Delta Dental Paid Claims Reports

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: N/A

- 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.

- B. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2001 (10/1/00 - 9/30/01)?
 - _____ Number of adults
 - _____ Number of children

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

2.2 Employer-sponsored insurance buy-in: N/A

- A. 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).

- B. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2001?
 - _____ Number of adults
 - _____ Number of children

2.3 Crowd-out: NC

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

Crowd-out is when a family voluntarily drops employer-sponsored dependent health coverage and enrolls their children in MICHild.

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

During the application process, applicants are asked if the children have other insurance through the employment of a parent. If the children are insured, or have had employer-sponsored health coverage in the preceding 6 months, the children are not eligible for MICHild. Exceptions are granted when the coverage was lost through no fault of the family (e.g., employer dropped dependent coverage, family member lost job) or in cases where coverage is not accessible (e.g., coverage provided by a non-custodial parent is an HMO whose coverage area does not include the child's home). Employer coverage does not preclude MICHild enrollment if it does not meet the state's definition of comprehensive coverage.

Occasionally, a contracted HMO may indicate that a child has other insurance at the

time of application, which the family failed to disclose. In most of the cases, it was determined that the dual coverage occurred after MICHild enrollment, which is permissible per our policy.

- C. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.
Crowd-out does not appear to be a problem in Michigan.
- D. 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.
Michigan has only one crowd-out policy (the six month penalty).

2.4 Outreach:

- A. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?
The most effective outreach mechanism has been the combined MICHild/Healthy Kids media campaign implemented by the state. This media campaign is run statewide.

Each person who contacts the Administrative Contractor for a MICHild/Healthy Kids application is asked where they heard about the programs. Over 40 percent consistently respond that they heard about the program from the media. Friends and Family consistently averages 20 percent, except for late fall when School briefly replaces Friends and Family at 20 percent. The majority of the year, School averages 6 percent of responses.

- B. 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?

The media campaign has been consistently the most effective, as it is broadcast statewide and is accessible by most of the population.

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

The applications are not tracked to determine the specific source of where the applicant heard about the program. However, when families call the toll-free line to receive an application, they are asked where they heard about the program. Typically, the number of applicants who respond that they heard about the program through the school system increases during the fall months. Our informal conclusion is that after a combination of methods of receiving information about MICHild/Healthy kids, an application is eventually filed.

2.5 Retention:

A. What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?
Michigan has adopted an easier method for redeterminations, which has increased retention at redetermination from 31 percent in 2000 to 47 percent in 2001. This is discussed under Section.1.1.

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

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

See 1.1, 1.3

Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe

The Administrative Contractor conducts telephone surveys of a subset of the SCHIP population who fail to renew their MICHild enrollment. The primary reason given by respondents continues to be that the children are now covered by other insurance or Medicaid.

Other, please explain

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

NC. The same measures are not used in Medicaid. Medicaid does not use the simplified redetermination form and no telephone survey is conducted. For Medicaid redeterminations, a new application is sent to the family annually. Due to the volume of applications/redeterminations that FIA must handle every month for welfare programs and Medicaid, it is not feasible to follow-up on each disenrollment from Healthy Kids.

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

Michigan has adopted an easier method for redeterminations. This is discussed under Section 1.1 and 1.3, Goal 5.

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

The monthly telephone survey conducted by the Administrative Contractor (discussed in 2.5.A.) provides information on a sampling of disenrolled children who have obtained other health coverage. The reason cited by the vast majority of families who do not reenroll children in the MICHild program is that the children are now covered through employer-based coverage, and some are now covered through Medicaid.

2.6 Coordination between SCHIP and Medicaid:

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

The same application is used for MICHild and Healthy Kids. The combined application, (DCH-0373D), is the primary application for MICHild and Healthy Kids. The family may also apply for coverage for the children using the FIA-1171 (used for all Medicaid and welfare programs). There is no interview requirement for MICHild or Healthy Kids, and both programs use self-declaration for verification of income.

The redetermination process is different. The MICHild redetermination form is a preprint of the information currently on file for the family. If the information has changed, the family notes that on the form, signs it and returns it to the Administrative Contractor. For Healthy Kids, the family must complete a new FIA-1171 application and return it to the county FIA office.

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

If the child is active Healthy Kids but determined to be SCHIP eligible, the application and budget are sent to the Administrative Contractor with a notation of when the Healthy Kids coverage will end. These applications are reviewed on a priority basis to ensure continuity of coverage between the two programs.

If a MICHild enrollee at redetermination appears to be eligible for Healthy Kids, the application is hand-carried to the co-located FIA staff for opening. This assures continuity of coverage. The application is then sent to the appropriate local FIA office.

Both the Administrative Contractor and FIA have been instructed to accept the other agency's budget. This provides seamless coverage and resolves the issue of "bouncing" between agencies as a result of possible misinterpretation of policy between the programs.

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

The delivery systems for MICHild and Healthy Kids are not identical – although there is some overlap among HMOs serving both programs. The MICHild plan selected by eighty percent of the families is Blue Cross and Blue Shield of Michigan (BCBSM). BCBSM does not participate in the Medicaid program. Even though BCBSM does not participate in Medicaid, many of the enrolled providers do participate. This fact makes it relatively easy for families to find a health plan in either MICHild or Medicaid that includes the family's children's doctor.

2.7 Cost Sharing:

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

Michigan's only form of cost sharing in the MICHild program is a \$5 per family monthly premium. Families with a household member who is American Indian/Alaska Native are exempt from payment of this premium. The monthly telephone survey conducted by the Administrative Contractor of disenrolled families does ask if the amount of the premium was responsible for the child's disenrollment from MICHild. The results of the survey have not shown the premium to be a factor in disenrollment.

- B. 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?

Michigan does not impose cost sharing in the form of copayments.

2.8 Assessment and Monitoring of Quality of Care:

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

HEDIS® Report for measurement year 2000. HMOs did not submit HEDIS® reports because their number of enrollees did not reach this threshold. See Table 1.3, Goal 3 for a summary of results.

Other BCBSM Quality Studies included in the HEDIS®-like report. See Table 1.3, Goal 3 for a summary of results

2000 CAHPS™ 2.0H Member Satisfaction Surveys by BCBSM, Market Facts, and Administrative Contractor. See Table 1.3, Goal 3 for a summary of the survey results.

Dental Satisfaction Surveys by BCBSM, Delta Dental, and Market Facts. See Table 1.3, Goal 3 for a summary of the survey results.

Complaints and Grievances for fiscal year 2001. Three complaints were reported by the health plans. Two were billing issues, one was a complaint about a long office wait. All three were resolved at the customer service level.

- B. 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 Table 1.3, Goal 4. Michigan used the HEDIS®-like reports to monitor and assess the well-baby care, well-child care, and immunizations provided by the BCBSM network. We also submit a copy of the 2001 CAHPS™ Member Satisfaction Survey performed by BCBSM and Market Facts, and the 2001 MICHild Satisfaction Survey completed by the Administrative Contractor in October, 2001, as evidence of Michigan's monitoring and assessing the quality of preventive care received by MICHild enrollees.

Dental care is monitored through the July 2001 BCBSM Dental Satisfaction Survey.

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

The above studies will continue on an annual basis.

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 2001 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.

- A. Eligibility - See Section 1.1 C for a description of the electronic application Michigan is implementing Winter, 2001. See Section 1.1 N for information regarding changes to Michigan's application form.
- B. Outreach - The \$25 outreach incentive payment described in 1.1(E) was again highly successful. This fiscal year, 29 percent more applicants were assisted with the application process by local health department staff, compared to the previous fiscal year.

A barrier to outreach within the school systems was the state requirement that state agreements be signed with individual school districts, rather than a statewide program. Michigan will continue to support local school outreach efforts.
- C. Enrollment - In October 2000, there were 15,006 MICHild enrollees. By September 2001, this number had increased to 23,577 (57 percent).
- D. Retention/disenrollment - Progress Summary: From November 1999-January 2000, the rate of retention of MICHild enrollees was 33 percent. Use of a re-enrollment form with pre-printed information about the family from the database of the Administrative contractor was instituted in September 2000, rather than requiring each family to fill out a blank application. From November 2000 - January 2001, the rate of retention of MICHild enrollees rose to 47 percent.
- E. Benefit structure - N/A

- F. Cost-sharing - Effective June 2001, MICHild enrollees who live in households with members who are American Indian or Alaska Native are exempt from payment of the \$5 MICHild premium.
- G. Delivery system - N/A
- H. Coordination with other programs - N/A
- I. Crowd-out - N/A
- J. Other - N/A

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 2001, your current fiscal year budget, and FFY 2003-projected budget. Please describe in narrative any details of your planned use of funds.**

Note: Federal Fiscal Year 2001 starts 10/1/00 and ends 9/30/01).

	Federal Fiscal Year 2001 costs	Federal Fiscal Year 2002	Federal Fiscal Year 2003
Benefit Costs			
Insurance payments			
Managed care			
per member/per month rate X # of eligibles	39,726,113	50,155,000	58,895,000
Fee for Service	12,300,810	13,216,000	13,216,000
Total Benefit Costs	52,026,923	63,371,000	72,111,000
(Offsetting beneficiary cost sharing payments)	(825,455)	(1,150,000)	(1,450,000)
Net Benefit Costs	51,201,468	62,221,000	70,661,000
Administration Costs			
Personnel	0	0	0
General administration	0	0	0
Contractors/Brokers(e.g.,enrollment contractors)	1,865,364	2,695,000	3,000,000
Claims Processing	0	0	0
Outreach/marketing costs	0	2,218,000	2,851,000
Other	0	2,000,000	2,000,000
Total Administration Costs	1,865,364	6,913,000	7,851,000
10% Administrative Cost Ceiling	5,689,052	6,913,000	7,851,000
Federal Share (multiplied by enhanced FMAP rate)	36,791,234	48,014,000	54,527,000
State Share	16,879,113	21,120,000	23,985,000
TOTAL PROGRAM COSTS	53,171,121	69,134,000	78,512,000

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2001.

4.3 What were the non-Federal sources of funds spent on your SCHIP program during FFY 2001?

- State appropriations
- County/local funds
- Employer contributions
- Foundation grants
- Private donations (such as United Way, sponsorship)
- Other (specify) Premium Payments by the families

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

No

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

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

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

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Program Name		
Provides presumptive eligibility for children	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, for whom and how long? Effective Fall of 2001-02 for initial 2 months' eligibility for pregnant women and children under age 19 who apply at a LHD.	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, for whom and how long? Effective Winter of 2001-02, for one month prospective eligibility for pregnant women and children under age 19.
Provides retroactive eligibility	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, for whom and how long? Under age 19 and pregnant women for up to 3 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 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)
Average length of stay on program	Specify months <u>n/a</u>	Specify months <u>6.58</u>
Has joint application for Medicaid and SCHIP	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
Has a mail-in application	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
Can apply for program over phone	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
Can apply for program over internet	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes Effective Winter 2001-02	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes Effective Winter 2001-02
Requires face-to-face interview during initial application	<input checked="" type="checkbox"/> No <input 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 checked="" 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 <u>Six month disqualification period</u> What exemptions do you provide? This applies only to employer-based comprehensive coverage. The disqualification is waived if the loss of coverage was not due to the fault of the employee (lost job, employer cancelled insurance, etc.)

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Provides period of continuous coverage <u>regardless of income changes</u>	<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 <u>12</u> Explain circumstances when a child would lose eligibility during the time period. Only for nonpayment of premiums, eligible for Medicaid, reaches age 19, dies or moves out of state.
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? <u>\$5/MONTH/FAMILY</u> Who Can Pay? <input type="checkbox"/> Employer <input type="checkbox"/> Family <input type="checkbox"/> Absent parent <input type="checkbox"/> Private donations/sponsorship <input checked="" type="checkbox"/> Other (specify) Anyone as long as the payment identifies the family
Imposes copayments or coinsurance	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input checked="" 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 checked="" type="checkbox"/> Yes, we send out form to family with their information and: <input checked="" 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.

For MICHild, the application is the DCH-0373D. It is a 2-page (front and back) application. At redetermination, the family is sent a preprinted redetermination form that they confirm or change information on. The eligibility determination process is the same for both application and redetermination.

For Healthy Kids, the application is either the DCH-0373 or FIA 1171. As noted above, the DCH-0373 is a 2-page application. The FIA-1171 is a seven page (front and back) form for all categories of Medicaid and welfare programs. At redetermination, a new application is required. The eligibility determination process is the same for both application and redetermination.

SECTION 6: INCOME ELIGIBILITY

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

- 6.1 As of September 30, 2001, 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 1
150 % of FPL for children aged 1 to 19
____ % of FPL for children aged _____

Medicaid SCHIP Expansion

150 % of FPL for children aged 16 to 19
____ % of FPL for children aged _____
____ % of FPL for children aged _____

Separate SCHIP Program

200 % of FPL for children aged 0 to 19
____ % of FPL for children aged _____
____ % of FPL for children aged _____

- 6.2 As of September 30, 2001, 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	Separate SCHIP Program
Earnings	\$ 90	\$ 90	\$ 90
Self-employment expenses	\$ As declared	\$As declared	\$As declared
Alimony payments Received	\$N/A	\$ N/A	\$ N/A
Paid	\$ N/A	\$ N/A	\$ N/A
Child support payments Received	\$50	\$50	\$ 50
Paid	\$As declared	\$As declared	\$ As declared
Child care expenses	\$200 per child	\$200 per child	\$200 per child
Medical care expenses	\$ N/A	\$ N/A	\$ N/A
Gifts	\$ N/A	\$ N/A	\$ N/A
Other types of disregards/deductions (specify) \$30 + 1/3 of the earned income if the person has received FIP/LIF in 1 of the 4 calendar months preceding the month being tested	\$30 + 1/3	\$30 + 1/3	\$ N/A

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 _____

Separate 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, 2001?

Yes 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 2002 (10/1/01 through 9/30/02)?** Please comment on why the changes are planned.
- A. Family coverage- N/A
 - B. Employer sponsored insurance buy-in - N/A
 - C. 1115 waiver - N/A
 - D. Eligibility including presumptive and continuous eligibility - During FY 2002, Michigan will fully implement the electronic application (e-application) for SCHIP/Medicaid. Applicants can use the e-application to apply for medical coverage. Those eligible for Healthy Kids/Medicaid will receive presumptive eligibility if they apply at a site staffed with trained personnel to assist in the application process.
 - E. Outreach - Intra-agency Agreement Control Number 01-143 established projects with Indian Health Service (IHS) Community Health Representatives to receive training to perform Medicare and Medicaid/SCHIP enrollment outreach and application assistance. Three tribes in Michigan have received these grants, the Grand Traverse Band of Ottawa and Chippewa, the Little River Band of Ottawa Indians, and the Little Traverse Bay Band of Odawa Indians. The HIS estimates that another 25-35 percent of their active user population may be eligible for enrollment.
 - F. Enrollment/redetermination process - N/A
 - G. Contracting - N/A
 - H. Other - N/A

