

***Federal Fiscal Year 2001
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:

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

**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: Rhode Island

(Name of State/Territory)

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

(Signature of Agency Head)

SCHIP Program Name(s): RIte Care

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: 12/31/01

(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—Effective January 1, 2001, Family Coverage extended to Section 1931 expansion parents and relative caretakers between 100 and 185% of the FPL and pregnant women between 185 and 250% of the FPL
- B. Enrollment process—NC
- C. Presumptive eligibility—Not applicable
- D. Continuous eligibility—NC
- E. Outreach/marketing campaigns—See Section 2.4
- F. Eligibility determination process—NC
- G. Eligibility redetermination process—NC
- H. Benefit structure—Effective January 1, 2001, retroactive eligibility for medical expenses incurred prior to the month of application was eliminated for certain categories of recipients.
- I. Cost-sharing policies—NC
- J. Crowd-out policies—Effective April 1, 2001 Phase 1 of RIte Share Premium Assistance Program was implemented with voluntary employer enrollment.
- K. Delivery system—Effective July 1, 2001, all three participating Health Plans are open to new enrollment
- L. Coordination with other programs (especially private insurance and Medicaid)—See J. above
- M. Screen and enroll process—NC
- N. Application —NC
- O. Other—Not applicable

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. According to the most recent Current Population Survey, the rate of uninsured children is the lowest in the nation –2.4 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.
See Section 2.4
- C. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.
See Section 2.4
- 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. Improve Outreach efforts 2. Provide family coverage 3. Implement the Rite Share premium assistance program	Reduce the percentage of uninsured children	Data Sources: Current Population Surveys (CPS) Methodology: Progress Summary: CPS data for 2000 indicates that the rate of uninsurance for children has declined to 2.4 percent. (see attached Percent Uninsured Children in RI 1994 – 2000)
Objectives Related to SCHIP Enrollment		
1. Improve Outreach efforts 2. Provide family coverage 3. Implement the Rite Share premium assistance program		Data Sources: Eligibility and enrollment system Methodology: Progress Summary: See Rite Care Outreach Report and Adults And Children Enrolled In Rite Care 1995 to 2001
Objectives Related to Increasing Medicaid Enrollment		
1. Improve Outreach efforts 2. Provide family coverage 3. Implement the Rite Share premium assistance program		Data Sources: Eligibility and enrollment system Methodology: Progress Summary: See Rite Care Outreach Report and Adults And Children Enrolled In Rite Care 1995 to 2001
Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)		
Rite Care Performance Incentive Program (see attached)		Data Sources: Encounter Data Methodology: Progress Summary: See attached Rite Care Program Results and Rite Care Performance Incentive Program

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 Use of Preventative Care (Immunizations, Well Child Care)		
Rite Care Performance Incentive Program (see attached)		Data Sources: Encounter Data Methodology: Progress Summary: See attached Rite Care Program Results and Rite Care Performance Incentive Program
Other Objectives		
		Data Sources: Methodology: Progress Summary:

- 1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.**
- 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.**
Not Applicable
- 1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.**
 The process is ongoing (see below)
- 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.**

Rite Care Outreach Report, Oct. 2000
Rite Stats Volumes 1 and 2
SFY 2001 Rite Care Member Satisfaction Survey
A Statewide Assessment Of Lead Screening Histories Of Preschool Children Enrolled In A Medicaid Managed Care Program, Aug 2001, by Patrick Vivier MD, PhD et al
The Impact of Rite Care on Adequacy of Prenatal Care and the Health of Newborns
The Effect of Rite Care on Teen Births in RI 1993 - 1999
Rhode Island's Rite Care Program Results

CEDARR Family Centers
Rite Share Fact Sheet and Rite Share Employer Packet
Profiles and Trends of Uninsured in RI, 1996 – 1999
Rite Care Enrollment 1994 – 2001
Adults and Children Enrolled in Rite Care 1995 to 2001
Rite Care Performance Incentive Program
Rhode Island's Rite Share Program: Unique Design Features
NHPRI Medicaid/SCHIP Survey
Percent Uninsured Children in RI 1994 - 2000

Studies are attached. Also it should be noted that Rhode Island received a national award from the National Health Care Purchasing Institute for improving quality care for its Rite Care members.

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:

- 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.
- On November 1, 1998, Rhode Island expanded RItE Care coverage to parents up to 185% FPL under the 1931 provision. Effective January 18, 2001, parents in this group who are between 100 – 185% FPL are covered under a SCHIP 1115 parent coverage waiver. Parents under 100% FPL are covered under Medicaid. All eligible families are enrolled in RItE Care or RItE Share.
- B. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2001 (10/1/00 - 9/30/01)?
- 17,946 Number of adults _____
- 17,398 Number of children _____
- C. How do you monitor cost-effectiveness of family coverage?
- See attached Rhode Island's RItE Share Program: Unique Design Features

2.2 Employer-sponsored insurance buy-in:

- 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).
- RItE Share, Rhode Island's new Premium Assistance Program, helps low and middle-income families obtain health insurance coverage through their employer by paying the employee's share of monthly premiums. This new program ensures that Medicaid eligible employees can remain in their employer-sponsored health insurance (ESI).

The goals of the RItE Share Program are to:

- Create the capacity within the Department of Human Services to help pay premiums,
- Support families in their efforts to obtain or maintain private, employer-sponsored health insurance and
- Decrease the number of individuals on RItE Care that have access to employer-sponsored health insurance.

Under the RItE Share Program, individuals who are eligible for Medical Assistance and employed by an employer that offers a "qualified" plan, will enroll in their employer-sponsored health insurance through the employer.

In order for an applicant to be enrolled in RItE Share:

- The parents and/or their children are determined eligible for Medical Assistance (RItE Care), and
- One of the parents has access to employer-sponsored health insurance and works for an employer that offers an approved health plan.

The employer contribution to the cost of coverage remains unchanged. The state will pay for the employee's health insurance premium cost. RItE Share members are also eligible for payment of

copays and for "wrap-around" health care services which are Medicaid required services not included in the employer's health plan

- B. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2001?
 55 Number of adults _____
 145 Number of children _____
(Combined Medicaid and SCHIP enrollment)

2.3 **Crowd-out:**

- A. How do you define crowd-out in your SCHIP program?
 Crowd-out is defined by not having had employer-sponsored health insurance for the previous six months that would have cost less than \$50 per month in premiums per family.
- B. How do you monitor and measure whether crowd-out is occurring?
 The State obtains information about previous coverage as part of the application process
- C. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.
 Crowd-out occurred when the State expanded to family coverage beginning in 1998. This led the State to establish its RItE Share premium assistance program
- 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.
 It is too early to tell, as RItE Share is just beginning implementation

2.4 **Outreach:**

- A. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?
 The State's primary outreach strategies during the last Federal Fiscal year included: hospital-based outreach, school-based outreach, and immigrant (mostly Latino) outreach. The Medicaid/SCHIP program (RItE Care) coordinates with Covering Kids Rhode Island, a grant-funded project, in implementing these strategies. The most effective activities include: finding out about health insurance through "word-of-mouth", working with community-based agencies to reach certain populations, ensuring enrollment in hospital outpatient settings, the emergency room and in primary health care sites. In addition, Rhode Island funds the Family Resource Counselors (or FRCs) who are located at hospitals and community health centers. The FRCs help families with applying for health insurance
- We track effectiveness by collecting information at the site of outreach (i.e., hospital, emergency room, dental clinic) and also by strategy codes that are written on each application by the coordinators of the three Covering Kids sites.
- 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?
 Yes. In the immigrant population (mostly Latino) word-of-mouth is the best way to let other families know about health insurance. Also, working with community-based agencies that the immigrant population uses and trusts is key.

The coordinators of the Covering Kids pilot sites keep detailed information on what activities or strategies they are using. Over time they can determine which strategies were most effective based on how many person-hours it took to complete and also the sustainability of the outreach strategy.

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

Currently, we are working closely with our Covering Kids Rhode Island partners. Its three pilot sites include outreach in schools, outreach to the immigrant population and outreach in hospitals.

In outreach immigrants (mostly Latino), the most effective strategy was spreading the word about health insurance through families who had had a positive experience with enrollment and the resulting coverage. Immigrant families also looked to community-based agencies for assistance and this was a great place to coordinate with agency staff to help families enroll.

In school-based outreach, many strategies were time intensive and even though the schools are a place that families trust, several of the strategies took an enormous amount of time and sustainability was questionable.

In hospital-based outreach, there were many effective strategies. They have included: training all hospital staff from doctors to billing clerks to administrators; including messages about free or low-cost health insurance on bills that go to families that have no insurance; and accessing uninsured children through hospital-based clinics, e.g. dental, immunization, and the general pediatric clinic.

2.5 Retention:

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

The State has been working on a streamlined RIte Care recertification initiative that has not yet been implemented. The State has also been working with Neighborhood Health Plan of Rhode Island Member Services to identify and reach out to pending recertifications. Finally, since foster children are now enrolled in RIte Care, DHS has been working with the Department of Children, Youth and Families to improve continuity of coverage for children moving back and forth between foster care and their family.

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—In FY2002, RI's new recertification form will include member information and require the member to only list info that has changed since the last recertification. _____

Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe-- In FY2002, the State will conduct surveys and focus groups on families who leave the program. _____

Other, please explain _____

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

D. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?
Health Plan outreach to members who are due to recertify.

- 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.
Neighborhood Health Plan of Rhode Island did a joint Medicaid/SCHIP survey, the results of which are attached. In addition, Issue 2 of RIte Stats (attached) provides an analysis of enrollees who return to the program and those who do not return.

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.
Yes; see Section 1.5.2 of January 2001 SCHIP Waiver request.
- B. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes.
The only applicable transfer (which is seamless to enrollees) is between "aid categories" as changes occur.
- C. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.
Yes; Medicaid and SCHIP members are enrolled in the same HMOs.

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?
No
- 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?
No

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.
For children, no distinction has been made for SCHIP-eligible RIte Care enrollees. See attached "Program Results" and "Health Plan specific Quality Improvement Study Summary".
- 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 2.8.A
- 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 State will measure trends in the number of enrolled low income children in non-FIP families with (a) uninsured parents, (b) parents with Medicaid coverage, pre and post demonstration (from 1997 to 2003) to assess whether providing coverage for parents increased enrollment of children (using program enrollment files).

The State will also measure the number of uninsured children within these same income brackets. That is, between 100% and 185% of the FPL to assess whether covering parents reduced uninsurance in children (using BRFSS data).

Using public health data sets (e.g., Behavioral Risk Factor Surveillance System) the State will measure and track changes in health care access and health status for the demonstration population. This report

will provide baseline health access and utilization measures as well as trend changes after implementation of the demonstration.

Several data sets that are available at the Department will be used for the analysis of the evaluation. Health indicators from these data sets will be used to track the health outcomes of Rhode Islanders by insurance status. Data sets include existing public health and program data sets. Special evaluation studies will be conducted to answer the research hypotheses. All data sets selected are reliable, well-documented and collect age, sex, race/ethnicity, census tract of residence, insurance status, utilization and health outcome. The following is a list of the data sets that will be used.

Existing Statewide public health population data sets include:

- Hospital Discharge
- Vital Statistics-Birth Record
- Behavioral Risk Factor Surveillance System (BRFSS)
- Rhode Island Health Interview Survey (RHIS)
- Medicaid Management Information System (MMIS)

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.

At the end of December 2000, the month before the demonstration began, there were 17,819 parents or relative caretakers enrolled in RIte Care. Until February 2001, the State did not have the capability to partition these enrollees by income level. Therefore, it is the State’s best estimate that one-half of these individuals were between 100 and 185 percent of the FPL, or 8,910 individuals* Compared to the information presented in Chapter II that there were 12,511 individuals in this “aid category” as of September 30, 2001, this means that there was a **net gain in enrollment of 3,601** for this group since the Waiver was implemented.

The population group of pregnant women between 185 and 250 percent of the FPL enrolled in RIte Care has been more stable. As of December 31, 2000, there were 71 women enrolled in RIte Care in this aid category. As of September 30, 2001 (as shown in Chapter II), there were 73 women enrolled in RIte Care in this aid category.

In Chapter IV, information is presented on the State’s progress in reducing uninsurance in the State – a primary goal to which this Waiver is directed. Information is presented on the State’s progress in implementing other elements of the evaluation of the this demonstration.

- A. Eligibility—HCFA (CMS) approval of parents of eligible children and pregnant women has enhanced enrollment of eligible children. Please refer to the attached charts: RIte Care Enrollment 1994 – 2001 and Adults and Children Enrolled in RIte Care 1995 – 2001, which shows child enrollment staying flat during the child expansions of 94 and 96, and child enrollment growing dramatically when percent eligibility was expanded in Nov 98.
- B. Outreach—See A above
- C. Enrollment—Expanded enrollment has resulted in approximately 2,000 children who came in concurrently with their parents
- D. Retention/disenrollment—Collaboration with NHPRI has been useful in identifying barriers to retention.
- E. Benefit structure—NA
- F. Cost-sharing—NC

* * That this is a reasonable estimate for the pre-demonstration time period is borne out by the actual results from the first month in which partitioned data were available. As of February 28, 2001, there were 9,653 RIte Care enrollees over age 18 between 100 and 185 percent of the FPL. Given the continual growth in the enrollment of adults up to and through January and February 2001, one would have expected several hundred adults between 100 and 185 of the FPL to have enrolled in each of these months.

G. Delivery system—NA

H. Coordination with other programs—See Section 2.4

I. Crowd-out—RIte Share should counteract crowd-out

J. Other—Impact on uninsured. See the attached charts: Percent of Uninsured Rhode Islanders 1994 – 2000, Percent of Uninsured Rhode Island Children 1994 – 2000 and Profiles and Trends of the Uninsured in Rhode Island 1996 - 99

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 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 2001 costs	Federal Fiscal Year 2002	Federal Fiscal Year 2003
Benefit Costs			
Insurance payments			
Managed care	\$10,248,088	\$11,913,402	\$12,628,207
per member/per month rate X # of eligibles	\$96.68	\$102.48	\$108.63
Fee for Service	\$1,627,217	\$1,891,640	\$2,005,138
Total Benefit Costs	\$11,875,305	\$13,805,042	\$14,633,453
(Offsetting beneficiary cost sharing payments)	\$307,443	\$357,402	\$378,849
Net Benefit Costs	\$11,567,862	\$13,447,640	\$15,012,302
Administration Costs			
Personnel			
General administration			
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/marketing costs			
Other			
Total Administration Costs			
10% Administrative Cost Ceiling	\$1,285,318	\$1,494,182	\$1,668,034
Federal Share (multiplied by enhanced FMAP rate)	\$8,695,176	\$10,108,143	\$11,284,247
State Share	\$4,158,004	\$4,833,680	\$5,396,089
TOTAL PROGRAM COSTS	\$12,853,181	\$14,941,822	\$16,680,336

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

Family coverage under SCHIP is provided under a separate 1115 SCHIP Waiver. These costs are not included in table 4.1. Total State expenditures for parents covered under the SCHIP family coverage is \$11,398,518 of which \$3,761,511 is State funds for the period 1/2001 through 9/30/2001

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) _____

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	Rlte Care	
Provides presumptive eligibility for children	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, for whom and how long?	<input type="checkbox"/> No <input type="checkbox"/> Yes, for whom and how long?
Provides retroactive eligibility	<input checked="" type="checkbox"/> No As of 1/1/01 <input type="checkbox"/> Yes, for whom and how long?	<input 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 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>34.6 Months</u>	Specify months _____
Has joint application for Medicaid and SCHIP	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Has a mail-in application	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Can apply for program over phone	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Can apply for program over internet	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Requires face-to-face interview during initial application	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, specify number of months <u>6</u> What exemptions do you provide? Only applies to children over 185% FPL	<input type="checkbox"/> No <input type="checkbox"/> Yes, specify number of months _____ What exemptions do you provide?

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Provides period of continuous coverage <u>regardless of income changes</u>	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, specify number of months <u>initial 6 months of enrollment for in-plan benefits only.</u> Explain circumstances when a child would lose eligibility during the time period	<input type="checkbox"/> No <input type="checkbox"/> Yes, specify number of months Explain circumstances when a child would lose eligibility during the time period
Imposes premiums or enrollment fees	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, how much? See attached Schedule of Co-payments _____ 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) Not specified who can pay _____	<input type="checkbox"/> No <input type="checkbox"/> Yes, how much? _____ Who Can Pay? <input type="checkbox"/> Employer <input type="checkbox"/> Family <input type="checkbox"/> Absent parent <input type="checkbox"/> Private donations/sponsorship <input type="checkbox"/> Other (specify) _____
Imposes co-payments or coinsurance	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes or premium share	<input type="checkbox"/> No <input type="checkbox"/> Yes
Provides preprinted redetermination process	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, we send out form to family with their information precompleted and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed	<input type="checkbox"/> No <input type="checkbox"/> Yes, we send out form to family with their information and: ___ ask for a signed confirmation that information is still correct ___ 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.

The redetermination process does not include the Health Plan enrollment choice form.

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
133% of FPL for children aged 1-5
100% of FPL for children aged 6-18

Medicaid SCHIP Expansion

250% of FPL for children aged <1
250% of FPL for children aged 1-7
250% of FPL for children aged 8-18
185% of FPL for parents >18
185-250% of FPL for pregnant women

Separate SCHIP Program

 % of FPL for children aged
 % 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 X 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	\$
Self-employment expenses	\$ allowable directly related to providing goods and services	\$ allowable directly related to providing goods and services	\$
Alimony payments Received	\$	\$	\$
Paid	\$	\$	\$
Child support payments Received	\$ 50	\$ 50	\$
Paid	\$	\$	\$
Child care expenses	\$ 175 mo./child >2 200 mo./child <2	\$ 175 mo./child >2 200 mo./child <2	\$
Medical care expenses	\$	\$	\$
Gifts	\$	\$	\$
Other types of disregards/deductions (specify)	\$	\$	\$

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

Title XIX Poverty-related Groups

No Yes, specify countable or allowable level of asset test _____

Medicaid SCHIP Expansion program

No Yes, specify countable or allowable level of asset test _____

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
- B. Employer sponsored insurance buy-in—Will continue to refine RIte Share program based on results to counteract crowd-out
- C. 1115 waiver
- D. Eligibility including presumptive and continuous eligibility
- E. Outreach
- F. Enrollment/redetermination process—Will implement preprinted redetermination form
- G. Contracting
- H. Other—Will impose monthly premium share payments for all members above 150% FPL ranging from \$43 to \$58 per month per family, depending on income, effective 1-1-02.