

***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.

SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This section 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:** The state dropped the requirement that Native American children show verification of tribal affiliation in order for their application to be considered complete and processed for eligibility. Reason 1: the state surveyed other states with larger Native American populations and discovered that they did not require verifications. Reason 2: Too many Native American children applying did not attach verifications, which caused their applications to be incomplete and delayed their enrollment into CHIP.

B. **Enrollment process:** NC

C. **Presumptive eligibility:** NC

D. **Continuous eligibility:** NC

E. **Outreach/marketing campaigns--** Outreach/marketing campaigns (log on to www.texasnewsroom.com/TexCareCreative.htm to view Texas' marketing materials)

Marketing materials were modified to include specific price information about SCHIP. For example, prior to the change the tag line "Children's Health Insurance to Fit Your Budget" was used. The tag line was changed to say "\$18 per month or less buys health insurance for all your children."

Print newspaper ads were purchased in local ethnic community newspapers.

Television ads were made in English and Spanish with actual SCHIP families. The families gave "testimonials" about how the program has helped them. The TV buy was significant and the ads ran every other week with at least 25% of them during prime time.

F. Contracted community-based organizations were given an increase in their funding to offer application assistance and to follow-up on incomplete applications in their local communities.

G. **Eligibility determination process:** NC

H. **Eligibility redetermination process:**

This policy was implemented for the first time in TX CHIP starting February 1, 2001. No change since implementation on that date.

I. **Benefit structure:** NC

J. **Cost-sharing policies:** NC

K. **Crowd-out policies:** NC

L. **Delivery system:** NC

M. **Coordination with other programs (especially private insurance and Medicaid):**

The TX CHIP dental services provider, United Concordia Companies, Inc., began coordination of benefits with private dental insurance coverage. Reason: We determined that a number of CHIP enrollees had private dental insurance plans and declared those plans to be primary and CHIP secondary.

The CHIP administrative contractor (Birch & Davis) resolved some problems with technical interfaces with the Medicaid agency (Dept of Human Services) regarding children deemed from and to Medicaid and CHIP. Reason: problems with interfaces were causing some children to have gaps in services when being transferred from one program to another.

N. **Screen and enroll process:** NC

O. **Application:** NC

P. **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.**

It is estimated that in the absence of CHIP -- and assuming there had not been any additional growth in the Medicaid program since May 2000 -- the potential number of low-income ($\leq 200\%$ of FPL) uninsured children under the age of 19 could have reached 1,117,000 as of the end of FFY 2001 (September 2001). That translates into a potential rate of uninsurance of 37% among low-income children. The number of low-income children was estimated at 3,022,000.

Based on analysis of CHIP and Medicaid enrollment trends, it is estimated that the potential population of low-income uninsured children had been reduced by about 446,000 as of September 2001 -- down to about 671,000 from a potential 1,117,000.

Data Sources:

(1) U.S. Census Bureau. March of 1998, 1999, and 2000 Current Population Survey (CPS) for Texas. Texas State Data Center (TXSDC). Population Projections by Age Group for Texas for 2001.

Method:

(A) Estimate of Potential Uninsured and Uninsured Rate as of end of FFY 2001:

Direct application / extrapolation of CPS-derived rates of uninsurance by age and poverty income group against population projections obtained from the TXSDC.

(B) Revised Estimate (after accounting for CHIP) of Uninsured Rate as of end of FFY 2001:

This estimate was done as follows: (1) Taking 90% of the total CHIP enrollment; (2) adding to the figure obtained in step (1) 90% of the estimated additional enrollment in Medicaid not attributed to population growth, and; (3) subtracting the figure obtained in step (2) from the baseline estimate of number of potential low-income uninsured children (n=1,117,000).

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.

It is estimated that - if - after May of 2000 (start-up month for Phase II of CHIP) the population of children enrolled in Medicaid had grown at the exact same rate as the child population as a whole, the number of children enrolled by September of 2001 would have been about 1,010,000. Instead, the actual number of children enrolled was 1,077,000. The latter figure is about 67,000 above the projected 1,010,000.

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

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?

The new baseline is 1,117,000 potentially low-income uninsured children as of September of 2001.

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

The data sources are the March 1998, 1999, and 2000 Current Population Survey (CPS) for Texas and population projections by age group obtained from the Texas State Data Center (TXSDC).

The methodology consists of applying CPS-derived rates of uninsurance by age and poverty income group to population projections by age group obtained from the TXSDC.

What was the justification for adopting a different methodology?

The U.S. Census Bureau released additional and more up-to-date CPS data.

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.)

The estimates are regarded as moderately reliable; generally, CPS samples are not large enough for doing statistical estimates involving subpopulations within a state.

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

According to the revised estimates, the potential number of low-income uninsured children is higher by about 28,000 as compared to the prior baseline estimate (1,117,000 versus 1,089,000).

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		
Provide increased access to health care coverage for the new CHIP-enrolled Texas children in families with incomes at or below 200% of poverty	To compare annual data on the number and percent of children enrolled in CHIP to the estimated number of potentially eligible children in the state	<p>Data Sources: (1) U.S. Census Bureau. March of 1998, 1999, and 2000 Current Population Survey (CPS) for Texas. (2) Texas State Data Center (TXSDC). Texas Population Projections by Age Group for 2001. (3) Texas CHIP program administrative / client files</p> <p>Methodology: Direct application / extrapolation of percent of uninsured children by age and poverty income group based on the CPS data against population projections, by age group, obtained from the TXSDC.</p> <p>Progress Summary: It had been estimated that by the end of FFY 2001 (September of 2001) about 474,000 potentially uninsured children would meet the CHIP income eligibility criteria. Those children would be from families with incomes at/below 200% of poverty who could not qualify for Texas’ Medicaid.</p> <p>As of September of 2001, enrollment in CHIP was 429,000. It is calculated that 69% of the enrollees met the CHIP income eligibility criteria, while the remainder 31% were Medicaid-</p>

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		<p>income eligible children who failed to pass Texas' Medicaid assets test. The latter percent translates into some 133,000 out of 429,000 total enrollees.</p> <p>For September of 2001, it is estimated that about 62% of potentially CHIP income eligible children were enrolled -- 296,000 out of 474,000.</p> <p>Compared to the figures reported in the evaluation covering FFY 2000, total CHIP enrollment has increased by 233% -- from 184,000 to 429,000.</p>
Objectives Related to SCHIP Enrollment		
Number of children insured by Texas CHIP program	The Texas Health and Human Services Commission set a goal of 428, 000 children enrolled in CHIP by September 1, 2001	<p>Data Sources: CHIP application and enrollment data</p> <p>Methodology: Tracking of enrollment numbers or bi-weekly reports</p> <p>Progress Summary: The Texas CHIP Program met and surpassed the HHSC goal with 429,066 children enrolled and receiving CHIP health care services on September 1, 2001</p>
Objectives Related to Increasing Medicaid Enrollment		
		<p>Data Sources:</p> <p>Methodology:</p> <p>Progress Summary:</p>
Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)		
		<p>Data Sources:</p> <p>Methodology:</p> <p>Progress Summary:</p>
Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)		
Previously uninsured children ages 0 through 18 enrolled in Texas have access to quality preventive and comprehensive diagnostic treatment services by maximizing the use of primary prevention, early detection and management of health care through participating health plans.		<p>Data Sources: Parent surveys are used to address issues related to the children's access to care. Currently telephone surveys are being conducted with families whose children have been enrolled in CHIP for at least 12 months. Sample sizes were calculated to ensure that they would be adequate to allow for comparisons between each of the participating health plans and between certain rural areas of the state. The telephone survey contains extensive questions about the children's usual source of care, the type of usual source of care (i.e., doctor's office, clinic, and so on), and other information. In addition, there is an extensive section asking about the children's unmet health care needs.</p> <p>Methodology: Children were randomly selected from each health plan and from several rural regions in the state. Their</p>

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		<p>parents are currently being asked to participate in a 45 minute telephone interview about their children's health care. Data collected include information about usual source of care, unmet need, the child's health status, and family satisfaction with care using the Consumer Assessment of Health Plans Survey (CAHPS). Statistical analyses will be conducted when the data collection is complete that will include plan comparisons, rural/urban comparisons, and analyses about differing experiences for those from varying racial and ethnic groups</p> <p>Progress Summary: Fielding of the survey just began with a target completion of over 4,000 interviews. Data collection will be complete by January 2002 with an initial report available by March 1, 2002.</p>
		<p>Data Sources: Three data sources are used to calculate compliance with well childcare visit and immunization guidelines. These are 1. enrollment records, 2. claims and encounter data, and 3. telephone survey data obtained from families whose children are enrolled in the SCHIP Program.</p> <p>Methodology: The American Academy of Pediatrics (AAP) guidelines are used as the standard for determining compliance or non-compliance with well childcare visits and immunizations. In addition, HEDIS 2002 guidelines are also used. A computer algorithm was developed at the Institute for Child Health Policy that takes into consideration the child's age and the number of well child visits and immunizations expected for that child's age. In addition, the algorithm takes into consideration various immunization schedules and manufacturers. For example, one schedule of immunizations might be expected if the initial immunization was given at birth versus if the immunization was initiated at 1 month of age. Immunization schedules also can vary depending on the manufacturer of the vaccine. Institute staff developed the algorithm in collaboration with two general pediatricians who are at the University of Florida College of Medicine.</p> <p>The computer algorithm is then applied to the claims and encounter data and compliance is calculated for well child visits and the following immunizations: Diphtheria, tetanus, pertussis (DPT), Hepatitis A, Hepatitis B, H. <i>influenzae</i>, type b, Polio, Measles, Mumps Rubella (MMR), and Varicella. Claims and encounter data provide useful information. However, it is recognized that parents may go out-of-plan to obtain immunizations for their children. Therefore, telephone interviews are being conducted with a random sample of families whose children are newly enrolled and with families whose children have been in the program for at least 12 months to assess parent self report of well child care and immunization compliance. The immunization questions used on the surveys were taken from the National Immunization Survey. Parent report would incorporate out-of-plan health care use. The results from the claims and encounter data will be compared to the results obtained from parent surveys. The percentage of children in compliance with well child visit recommendations and with each immunization will be reported for each approach (claims/encounter versus survey data).</p>

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		Compliance also will be reported by age cohort (i.e., less than 1 year 1 to 3 years, and so on). Progress Summary:
Other Objectives		

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.

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

The state is in the process of collecting baseline patient-level encounter data for the CHIP population. Once enrollment stabilizes, the state will begin comparing program performance against other state Title XXI and commercial health plan quality of care benchmarks, including HEDIS. As noted above, the state is already tracking immunization rates, well-child and well-baby visits and other preventive measures. Reliable judgments about performance, however, require more data than is currently available.

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.

Institute for Child Health Policy Studies: Elizabeth Shenkman & Jana Col, *Children’s Health Insurance Program in Texas: The New Enrollee Survey Report* (January 2001); Elizabeth Shenkman & Jana Col, *Children’s Health Insurance Program in Texas: Applied But Not Yet Enrolled* (May 2001); Elizabeth Shenkman & Jana Col, *Children’s Health Insurance Program in Texas: Preliminary Report on the Enrollee’s Health Care Use*

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:

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

Under the state's S-CHIP implementing legislation, S.B. 445, a child with prior health insurance coverage must wait 90 days from the date that coverage terminated before applying for CHIP. The purpose of this provision is to discourage crowd-out.

Crowd out would be considered to be occurring if the state allowed CHIP eligible children who are covered by commercial insurance to enroll in CHIP even though they do not qualify for a good cause exception to the normal enrollment bar.

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

Texas also uses surveys of enrollees and applicants.

We ask on the TCP application if an applying child is covered by commercial insurance. In addition, we ask if the applying child has been covered by commercial insurance within the past 90 days. If the Texas CHIP program confirms simultaneous coverage with a private insurance carrier the applicants claims to the contrary notwithstanding the child's CHIP coverage is terminated.

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

A January, 2001 survey of new enrollees found that 4% had had coverage three months prior to enrollment. A survey of those who had applied but not yet enrolled released in June 2001 found that 11% had coverage three months prior to the potential enrollment date. These reports are attached and are cited in the answer to 1.7 above.

Texas CHIP will begin collecting SSN data for children January 1, 2002. Which will enhance the state's ability to further analyze the relationship between SCHIP enrollment and secular insurance market trends.

- 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.

The Texas CHIP program utilizes two methods for preventing crowd out. First, a child with current insurance is prohibited from enrolling in CHIP, even if they are otherwise eligible for the program. The lone exception to this policy is if the family pays 10% or more of its CHIP net income toward costs related to providing its children with the other insurance. If the family meets this "good cause exception", the Texas CHIP Program will enroll the family's children. Secondly, any child for whom the family declares it has had coverage in the past 90 days must wait a total of 90 days from the cancellation of that previous coverage before enrolling in CHIP.

The waiting period appears to be effective. The data supporting this conclusion can be found in the survey of new enrollees cited above.

2.4 Outreach:

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

The TexCare Partnership outreach plan is broad and comprehensive, including hundreds of community-based organizations, free and paid media, media relations, and corporate involvement. At the most basic level, we measure effectiveness by tracking application and enrollment volume at the statewide level, county level and zip code level. We can link application trends over a particular period of time to specific outreach activities like paid media, back-to-school activities or a telethon in a particular community. We also track the relationship between CBO application assistance activities and application trends. The data from the survey of new enrollees and applied but not enrolled clearly identify those strategies which have been most effective.

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

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

- 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?

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

Our experience suggests that one of the most successful means of reaching Hispanic and immigrant families is through the involvement of trusted individuals at the community level.

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

As noted above, community-based outreach involving active and committed organizations is particularly effective in reaching immigrant and Hispanic populations, particularly along the Texas/Mexico border.

Because the application and enrollment volume for the TexCare Partnership is strong across most rural and urban communities throughout Texas, and because the outreach effort is so multi-faceted and broad, it is difficult to isolate the impact of specific strategies on particular ethnic, geographic, or cultural groups.

2.5 Retention:

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

Follow up by caseworkers/outreach workers
Renewal Reminder Notices to all families
Information campaigns
Simplification of renewal process
Surveys with disenrollees to learn more about reasons for disenrollment.

- 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
CHIP families are allowed to indicate that no changes in income expenses of family size have occurred since initial enrollment. Thus they renew without having to submit new information if they state their circumstances have remained the same. Families who have changes to report may report only those changes and avoid going through a re- application process.
 Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe
Surveys of this kind are currently being undertaken by the CHIP Quality Assurance Contractor. Complete data are not available at this time.
 Other, please explain

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

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

The Texas CHIP program has not yet completed its second year of operations. We do not have enough program data at this point to reach any firm conclusions in this regard

- 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 Texas CHIP Quality Assurance Contractor is conducting a survey that will help us understand the insurance status of children who disenroll.

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.

Despite the use of a single application (TCP application) which a Texas resident may use for applying for both CHIP and Medicaid, differences do exist between the two programs in initial application intake and re determination.

Medicaid requires a face-to-face interview for initial certification and re certification. Residents may secure CHIP coverage via an exchange of information over the phone and mail. Medicaid requires re-certification every 3 months while CHIP offers 12 months of continuous eligibility. Determination of Medicaid eligibility requires a more thorough review of family assets than the CHIP eligibility determination process where assets are self-declared. As of January 1, 2002, initial determination and recertification processes for the two programs will be identical.

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

If a child's eligibility status changes from Medicaid to CHIP, or vice versa, one program electronically refers data regarding the child to the other. Upon receiving a referral from the Medicaid program, CHIP immediately initiates the enrollment process for the transferring child (i.e., mails an enrollment packet to the child's family). If Medicaid receives the referral from CHIP, it must still conclusively determine whether the child is eligible for Medicaid. Again, beginning January 1, 2002, each program will be able to deem children eligible for the other.

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

About one-half of health plans that offer Medicaid coverage also offer CHIP coverage. However, networks and other delivery systems operated by the plans are not necessarily the same for both programs only in certain parts of the state. CHIP offers managed care coverage to CHIP children statewide, while Medicaid offers managed care only in certain parts of the state.

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?

Surveys are currently being undertaken to study this. No final data are available as of yet.

- 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?

Same as "A" above.

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.

The state receives quarterly patient-level encounter data files from each contracted health plan. The state has also completed surveys of enrollees and applicants. Two additional surveys are currently in the field: one is a CAHPS enrollee survey and the other is a survey of disenrollees.

While it is still early to draw many conclusions from the encounter data, the following trends seem apparent: (1) about ten percent of CHIP enrollees have special needs as identified using the National Association of Children's Hospitals and Related Institutions diagnosis list; (2) about 40 percent of the program's encounters involve asthma; (3) use rates for physician visits, hospital admissions, and average length of stay per 1,000 members are in line with other Title XXI programs at a similar point in their development.

Survey data suggest that enrollees are generally pleased with their care and that they are seeking preventive care services from physicians rather than the emergency room.

- 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 the answer to "A" above.

- 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?

See the answer to "A" above. Aside from the surveys, we plan to continue our encounter data analysis and begin to measure the program's performance against state and national quality of care benchmarks.

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:

No significant barriers were encountered in the Texas SCHIP eligibility determination system. Generally, the TexCare Partnership application and determination process worked well as evidenced by the state's success in meeting an ambitious end of SFY 2001 enrollment goal. (See "C" below).

B. Outreach: N/A

C. Enrollment:

Texas SCHIP's enrollment goal for the end of SFY 2001 (16 months since start-up) was set at 428,000, a level generally regarded as very ambitious. Actual enrollment at the end of SFY 2001 (end of August 2001) was 429,066, 1066 children over the goal. Please see the attached enrollment chart.

D. Retention/disenrollment:

Texas SCHIP implemented a streamlined renewal process, for the first group of renewal children, in May of 2001. The renewal process begins in the 10th month of continuous eligibility. Families are sent a preprinted renewal application and asked to mark through and change any out of date information. If no information has changed, the family simply signs and dates the renewal application. Non-responding families are sent a second complete renewal packet. Overall retention in CHIP (renewal among those who could renew) has been about 72%. Others who completed process, but were no longer eligible for CHIP were deemed to Medicaid or referred to commercial insurance options.

E. Benefit structure: N/A

F. Cost-sharing: N/A

G. Delivery system: N/A

H. Coordination with other programs: N/A

I. Crowd-out: N/A

J. Other

SECTION 4: PROGRAM FINANCING

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

4.1 Please complete Table 4.1 to provide your budget for FFY 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	\$326,512,930	\$610,248,600	\$519,752,000
Managed care	\$312,696,539	\$605,165,300	\$519,752,000
per member/per month rate X # of eligibles			
Fee for Service	\$13,816,391	\$5,083,300	-
Total Benefit Costs	\$326,512,930	\$610,248,600	\$519,752,000
(Offsetting beneficiary cost sharing payments)	\$9,267,815	\$14,837,000	\$12,288,000
Net Benefit Costs *	\$317,245,115	\$595,411,600	\$507,464,000
*Note that SCHIP and Schip II Benefit Costs are combined, and those costs include only insurance payments.			
Administration Costs			
Personnel	\$8,083,335	\$1,788,400	\$1,440,000
General administration	\$2,475,492	\$470,000	\$350,000
Contractors/Brokers (e.g., enrollment contractors)	\$25,186,866	\$27,515,000	\$34,854,000
Claims Processing	-	-	-
Outreach/marketing costs	\$11,198,432	\$5,500,000	\$5,500,000
Other	-	-	-
Total Administration Costs	\$46,944,125	\$35,273,400	\$42,144,000
10% Administrative Cost Ceiling	\$35,249,457	\$66,156,844	\$56,384,889
Federal Share (multiplied by enhanced FMAP rate)	\$265,676,051	\$456,615,940	\$396,377,290
State Share	\$98,513,189	\$174,069,060	\$153,230,710
TOTAL PROGRAM COSTS	\$364,189,240	\$630,685,000	\$549,608,000

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

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.

Texas anticipates using public funds, other than state appropriations, to finance part of the state's share.

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	Medicaid	TexCare Partnership
Provides presumptive eligibility for children	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, for whom and how long? Infants through age 1	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, for whom and how long?
Provides retroactive eligibility	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, for whom and how long? 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 checked="" type="checkbox"/> Contractor <input type="checkbox"/> Community-based organizations <input type="checkbox"/> Insurance agents <input type="checkbox"/> MCO staff <input type="checkbox"/> Other (specify)
Average length of stay on program	Specify months	Specify months
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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
Can apply for program over phone	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
Can apply for program over internet	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
Requires face-to-face interview during initial application	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	<input 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 What exemptions do you provide? 90 days. Exemption for families spending more than 10 percent of income on health insurance. Other exemptions.

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 Enrollment may terminate for failure to pay premium (if required); move from state; fraud.
Imposes premiums or enrollment fees	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, how much? Who Can Pay? <input type="checkbox"/> Employer <input type="checkbox"/> Family <input type="checkbox"/> Absent parent <input type="checkbox"/> Private donations/sponsorship <input type="checkbox"/> Other (specify)	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, how much? \$15-18 depending on income. Who Can Pay? <input type="checkbox"/> Employer <input checked="" type="checkbox"/> Family <input checked="" type="checkbox"/> Absent parent <input type="checkbox"/> Private donations/sponsorship <input type="checkbox"/> Other (specify)
Imposes copayments or coinsurance	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
Provides preprinted redetermination process	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, we send out form to family with their information pre-completed 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.

Redetermination of CHIP eligibility is remarkably simpler than the initial application process. In contrast to completing a two page application and submitting verification of all declare income and expenses, a renewing family has the option of simply stating that nothing has changed in a year’s time that will affect the family’s federal poverty level (FPL) status. If that is the case, they indicate this on the renewal forms and sign the form before mailing back to the program. And, if the family does have changes to report that affect its FPL status they can report those changes on the form, sign the form, and attach verification for only those reported changes.

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 infants
100% of FPL for children aged 6-17
133% of FPL for children aged 1-5

Medicaid SCHIP Expansion

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

Separate SCHIP Program

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

- 6.2 As of September 30, 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	\$ 120	\$ 120	\$ 120
Self-employment expenses	\$ 120 + costs of doing business	\$ 120 + costs of doing business	\$ Costs of doing business
Alimony payments Received	\$ 0	\$ 0	\$ 0
Paid	\$ Actual amount	\$ Actual amount	\$ Actual amount
Child support payments Received	\$ 50	\$ 50	\$ 50
Paid	\$ Actual amount	\$ Actual amount	\$ Actual amount
Child care expenses	\$ Up to \$200 for a child < Up to \$175 for a child 2 and over	\$ Up to \$200 for a child < 2 Up to \$175 for a child 2 and over	\$ 200 for a dependent child \$175 for a dependent disabled adult
Medical care expenses	\$ 0	\$ 0	\$ 0
Gifts	\$ 0	\$ 0	\$ 0
Other types of disregards/deductions (specify)	\$	\$	\$

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

Title XIX Poverty-related Groups

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

Medicaid SCHIP Expansion program

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

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 X No

SECTION 7: FUTURE PROGRAM CHANGES

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

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

A. Family coverage

See "B" below

B. Employer sponsored insurance buy-in

No changes are planned for the report period. However, legislation passed during the report period (House Bill 3038) requires the implementation of a premium assistance program under Texas's SCHIP. Staff are developing options for a program to be implemented in late FFY 2002 or FFY 2003. Proposal could be under a HIFA or an 1115 waiver. The proposed premium assistance may include coverage of other family members if cost-effective.

C. 1115 waiver

None submitted or planned during the report period.

D. Eligibility including presumptive and continuous eligibility

No changes planned or implemented during the reporting period.

E. Outreach

No changes implemented during the report period.

F. Enrollment/redetermination process

Texas SCHIP implemented a streamlined renewal process, for the first group of renewal children, in May of 2001. The renewal process begins in the 10th month of continuous eligibility. Families are sent a preprinted renewal application and asked to mark through and change any out of date information. If no information has changed, the family simply signs and dates the renewal application. Non-responding families are sent a second complete renewal packet.

G. Contracting

H. Other

