

March 31, 2000

Billy Bob Farrell
HCFA, Region VI
Division of Medicaid and State Operations
1301 Young Street, Room 833
Dallas, Texas 75202

Dear Mr. Farrell:

Attached is Arkansas' FFY 1999 CHIP Evaluation report as required by CHIP legislation. Arkansas has used the HCFA approved Framework pre-print document. The State is also sending this report electronically. The report is being submitted to Jennifer Ryan and Joan Peterson in Baltimore, as well.

You may contact me at 501-682-8292 or Joie Wallis at 501-682-5424 (or by e-mail at joie.wallis@Medicaid.state.ar.us) if you have any questions regarding this evaluation report.

Sincerely,

Ray Hanley
Director

RH:jcw

Attachment

c: Jennifer Ryan
Joan Peterson
file

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

(Developed by States, for States to meet requirements under Section 2108(b) of the Social Security Act)

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

The following State Evaluation is submitted in compliance with Title XXI of the Social Security Act (Section 2108(b)).

(Signature of Agency Head)

Date: March 31, 2000

Reporting Period: 10/1/98 – 9/30/99

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SECTION 1. SUMMARY OF KEY ACCOMPLISHMENTS OF YOUR CHIP PROGRAM

This section is designed to highlight the key accomplishments of your CHIP program to date toward increasing the number of children with creditable health coverage (Section 2108(b)(1)(A)). This section also identifies strategic objectives, performance goals, and performance measures for the CHIP program(s), as well as progress and barriers toward meeting those goals. More detailed analysis of program effectiveness in reducing the number of uninsured low-income children is given in sections that follow.

- 1.1 *What is the estimated baseline number of uncovered low-income children? Is this estimated baseline the same number submitted to HCFA in the 1998 annual report? If not, what estimate did you submit, and why is it different?*

Arkansas did not submit a 1998 annual report since its CHIP program did not start until FFY 99. We located two reports regarding the number of uninsured children: one report showed 112,700 and the other showed 99,752.

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

The State located two estimates. (1) The Casey Foundation estimated 112,700 uninsured children. They combined their annual surveys for 1992 through 1996 in order to have a valid sample. (2) The Southern Institute on Children and Families estimated 99,752 uninsured children in Arkansas. The following is from the “Uninsured Children in the South – Second Report” dated November 1996:

The source of the estimates of uninsured children is the Current Population Survey. Uninsured means the lack of any health insurance, including Medicaid, for an entire year. The data were prepared by the Urban Institute using data specifications submitted by the Southern Institute on Children and Families for 1989 and 1993. (Note that Medicaid data, specified above, are point in time numbers.)

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

The State thinks that the estimated number of uninsured children, provided by the Southern Institute, is more reflective of the actual number than the Casey Foundation estimate. However, the methodology used is inherently limited as an estimate for the number of uninsured children in FFY 1999.

There was tremendous Medicaid growth during and since the time of the data used in the Southern Institute's estimate. There were 77,379 Medicaid eligible in September 1989; there were 119,326 Medicaid eligible children in September 1993; there were 129,046 Medicaid eligible in September 1998.

Not only did the number of Medicaid children increase but the State implemented the ARKids First 1115 demonstration on September 1, 1997. There were 30,290 children enrolled in ARKids First as of September 1998.

The State does not have data on the numbers of children who lost other health insurance coverage during the same time.

- 1.2 *How much progress has been made in increasing the number of children with creditable health coverage (for example, changes in uninsured rates, Title XXI enrollment levels, estimates of children enrolled in Medicaid as a result of Title XXI outreach, anti-crowd-out efforts)? How many more children have creditable coverage following the implementation of Title XXI? (Section 2108(b)(1)(A))*

The State ever-enrolled 1,165 children in its CHIP Medicaid expansion; there were 913 CHIP eligible children in the July-September 1999 quarter. During the report period, the total number of Medicaid children grew from 129,046 in September 1998 to 129,930 in September 1999: it would appear that all the growth in the number of Medicaid eligible children during the report period was due to the CHIP Medicaid expansion.

The ARKids First 1115 demonstration eligibles grew from 30,290 in September 1998 to 43,843 in September 1999; an increase of 13,553, or 44%.

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

The number of CHIP ever-enrolled children came from a one-time Decision Support System report from MMIS data. The Medicaid and ARKids First data shown in 1.2 is from a system generated monthly report on the number of Medicaid eligibles. The report provides an unduplicated count of persons who had any eligibility in the month. The data is broken out by adult or children and by Medicaid Aid Category.

- 1.2.2 *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 data reported in 1.2 is accurate. It is actual data from the MMIS system and the Arkansas Client Eligibility System.

1.3 *What progress has been made to achieve the State's strategic objectives and performance goals for its CHIP program(s)?*

Please complete Table 1.3 to summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in the Title XXI State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

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

For each performance goal specified in Table 1.3, please provide additional narrative discussing how actual performance to date compares against performance goals. Please be as specific as possible concerning your findings to date. If performance goals have not been met, indicate the barriers or constraints. The narrative also should discuss future performance measurement activities, including a projection of when additional data are likely to be available.

Table 1.3		
<i>(1) Strategic Objectives (as specified in Title XXI State Plan)</i>	<i>(2) Performance Goals for each Strategic Objective</i>	<i>(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)</i>
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
Previously uninsured children who may be potentially eligible for Arkansas Title XXI Program will be identified through ongoing outreach activities.	By July 1, 1998,* mechanisms to conduct ongoing outreach will have been developed and implemented. * CHIP was implemented 10-1-98 rather than the proposed 7-1-98.	<p><i>Data Sources:</i> The Arkansas Department of Health (ADH) and Arkansas Advocates for Children and Families.</p> <p><i>Methodology:</i> Personal observation, verbal reports and written reports.</p> <p><i>Numerator:/Denominator:</i></p> <p><i>Progress Summary:</i> The Arkansas Department of Human Services (DHS) has a contract with the ADH to develop and air television ads to promote the Medicaid program and the PCCM waiver. The ads tell individuals to contact the DHS County Office if they wish to make an application. Television ads air during the day and prime time. ADH also operates a Medicaid (ConnectCare) Help Line; the Help Line number appears in the TV ads. DHS receives a weekly report on the number of hotline calls. See "Recipient Outreach", page 5, in Attachment A.</p> <p>The Arkansas Advocates for Children and Families had several outreach initiatives in place for Medicaid and ARKids First (1115 demonstration). Those initiatives include: developing a volunteer manual, training volunteers, developing outreach articles, partnering with Community Health Centers, Head Start, Taco Bell, Sonic Drive-In and, schools (PTO, athletic directors, etc.).</p>

OBJECTIVES RELATED TO CHIP ENROLLMENT

<p>Low-income children who were previously without health insurance coverage will have health insurance coverage through Arkansas' Title XXI Program.</p>	<p>Within 60 days of implementing the CHIP Medicaid expansion, DHS will notify the families of ARKids children, who are potentially eligible for chip Medicaid of the Medicaid expansion and their potential eligibility. A Medicaid application form will be included with the notice. Through this effort and other outreach efforts, the State expects to enroll approximately 3800 children by the end of the first year of the CHIP Medicaid expansion</p>	<p><i>Data Sources:</i> Division of County Operations, ARKids First Central Eligibility Unit.</p> <p><i>Methodology:</i> The Arkansas Client Eligibility System identified 2200 families with children receiving ARKids First benefits who had at least one child who was born after September 30, 1982 and before October 30,1983.</p> <p><i>Numerator:</i></p> <p><i>Denominator:</i></p> <p><i>Progress Summary:</i> Letters and a Medicaid application were mailed to 2200 families in November 1998 informing them that their child(ren) might now be eligible for Medicaid, which offers greater benefits which are provided without co-payments. Of the CHIP eligibles in 1999, 169 had ARKids First eligibility prior to their CHIP eligibility.</p>
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OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT

The infrastructure of the Arkansas Department of Human Services (DHS), Division of Medical Services (DMS) and Division of County Operations, will be able to accommodate all critical facets of Phase I of Arkansas' Title XXI program. In Phase I, we will adopt the Medicaid expansion option by offering Medicaid to children born after 9-30-82, and prior to 10-1-83, who have incomes equal to or less than 100% of the federal poverty level. A resource test (e.g., \$3200 for a family of 4) must also be met.

By July 1, 1998, DHS will have the following in place: (1) data systems modifications with regard to eligibility determination, enrollment, participant information, health service utilization, billing, provider information, etc; (2) personnel to implement the expansion (i.e. eligibility workers, administrative staff, and support staff); and (3) publications such as eligibility and provider manual issuances to implement the expansion.

Data Sources:
Division of County Operations (DCO) and the Division of Medical Services (DMS)

Methodology:
Reports

Numerator:

Denominator:

Progress Summary:

The State received HCFA approval in August 1998 for its CHIP Medicaid expansion; the State decided to implement the Medicaid expansion on 10-1-98. The system was in place to accept and dispose of applications in the Medicaid expansion. Since this was a small expansion, the current DCO County Office staff performed the eligibility, administrative and support tasks. The DCO Medical Services Policy Manual (MSP) (eligibility manual) was issued with an effective date of 10-01-98. A copy of the MSP Issuance 98-5 is attached. See Attachment B.

OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)

<p>Children enrolled in Arkansas' Title XXI Program will have access to health care.</p>	<p>As children are enrolled in the CHIP Medicaid expansion, their parents will be asked to select a primary care physician (PCP) of their choice. The DMS Primary Care Case Management Program, ConnectCare, offers 1800 physicians statewide, who have a caseload availability of approximately 1,000,000 patients. Access availability is five to one. For those children whose parents do not immediately select a PCP, the system will require such selection at the first attempt to access medical care at a doctor's office or emergency room.</p>	<p><i>Data Sources:</i></p> <p>MMIS</p> <p><i>Methodology:</i></p> <p>MMIS PCP reports</p> <p><i>Numerator:</i></p> <p><i>Denominator:</i></p> <p><i>Progress Summary:</i></p> <p>87% of Medicaid recipients, who are required to have a PCP, have a PCP on file.</p>
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OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
<p>Arkansas' Title XXI Program will improve the health status of children enrolled in the program as well as improve the overall health care system accessed through the program.</p>	<p>Beginning July 1, 1998, the following health status and health care system measures for the Arkansas Medicaid expansion will show acceptable incremental improvements for at least the following data elements: immunization status, adolescent well visits, satisfaction with care.</p>	<p><i>Data Sources:</i> Internal reports and reports from contractors</p> <p><i>Methodology:</i></p> <p><i>Numerator:</i></p> <p><i>Denominator:</i></p> <p><i>Progress Summary:</i> The State is currently analyzing immunization data. The State is still collecting data on adolescent well visits. Attached is a Medicaid Recipient Survey (the CHIP Medicaid expansion is not broken out). See Attachment C.</p>
OTHER OBJECTIVES		
<p>N/A</p>		<p><i>Data Sources:</i></p> <p><i>Methodology:</i></p> <p><i>Numerator:</i></p> <p><i>Denominator:</i></p> <p><i>Progress Summary:</i></p>

SECTION 2. BACKGROUND

This section is designed to provide background information on CHIP program(s) funded through Title XXI.

2.1 *How are Title XXI funds being used in your State?*

2.1.1 *List all programs in your State that are funded through Title XXI. (Check all that apply.)*

Providing expanded eligibility under the State's Medicaid plan (Medicaid CHIP expansion)

Name of program: Arkansas Medicaid Program

Date enrollment began (i.e., when children first became eligible to receive services):

October 1, 1998

Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (State-designed CHIP program)

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

Other - Family Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

Other - Employer-sponsored Insurance Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ *Other - Wraparound Benefit Package*

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ *Other (specify)* _____

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

2.1.2 If State offers family coverage: Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

N/A

2.1.3 If State has a buy-in program for employer-sponsored insurance: Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

N/A

2.2 What environmental factors in your State affect your CHIP program?
(Section 2108(b)(1)(E))

2.2.1 How did pre-existing programs (including Medicaid) affect the design of your CHIP program(s)?

Since Arkansas' CHIP program is a Medicaid expansion, the CHIP program had to be a Medicaid option, which we did not already cover.

2.2.2 Were any of the preexisting programs "State-only" and if so what has happened to that program?

No pre-existing programs were "State-only"

___ *One or more pre-existing programs were "State only" Describe current status of program(s): Is it still enrolling children? What is its target group? Was it folded into CHIP?*

2.2.3 Describe changes and trends in the State since implementation of your Title XXI program that “affect the provision of accessible, affordable, quality health insurance and healthcare for children.” (Section 2108(b)(1)(E))

Examples are listed below. Check all that apply and provide descriptive narrative if applicable. Please indicate source of information (e.g., news account, evaluation study) and, where available, provide quantitative measures about the effects on your CHIP program.

___ Changes to the Medicaid program

- ___ Presumptive eligibility for children
- ___ Coverage of Supplemental Security Income (SSI) children
- ___ Provision of continuous coverage (specify number of months ___)
- ___ Elimination of assets tests
- ___ Elimination of face-to-face eligibility interviews
- ___ Easing of documentation requirements

___ Impact of welfare reform on Medicaid enrollment and changes to AFDC/TANF (specify)

Arkansas has seen a shift of children moving from AFDC/1931 Medicaid to other categories of Medicaid since the beginning of the TANF program in July 1997. The number of children in the 1931 group has decreased by over 14,000. Overall though, the number of children covered today under Medicaid and the ARKids First demonstration has increased by 55,000 since the beginning of the Arkansas TANF Program. This has been an increase of approximately 42%.

___ Changes in the private insurance market that could affect affordability of or accessibility to private health insurance

- X___ Health insurance premium rate increases
- ___ Legal or regulatory changes related to insurance
- ___ Changes in insurance carrier participation (e.g., new carriers entering market or existing carriers exiting market)
- X___ Changes in employee cost-sharing for insurance
- ___ Availability of subsidies for adult coverage
- ___ Other (specify) _____

- ___ *Changes in the delivery system*
 - ___ *Changes in extent of managed care penetration (e.g., changes in HMO, IPA, PPO activity)*
 - ___ *Changes in hospital marketplace (e.g., closure, conversion, merger)*
 - ___ *Other (specify) _____*

- ___ *Development of new health care programs or services for targeted low-income children (specify) _____*

- ___ *Changes in the demographic or socioeconomic context*
 - ___ *Changes in population characteristics, such as racial/ethnic mix or immigrant status (specify) _____*
 - ___ *Changes in economic circumstances, such as unemployment rate (specify) _____*
 - ___ *Other (specify) _____*
 - ___ *Other (specify) _____*

SECTION 3. PROGRAM DESIGN

This section is designed to provide a description of the elements of your State Plan, including eligibility, benefits, delivery system, cost-sharing, outreach, coordination with other programs, and anti-crowd-out provisions.

3.1 Who is eligible?

3.1.1 Describe the standards used to determine eligibility of targeted low-income children for child health assistance under the plan. For each standard, describe the criteria used to apply the standard. If not applicable, enter "NA."

	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* ___
<i>Geographic area served by the plan (Section 2108(b)(1)(B)(iv))</i>	Statewide		
<i>Age</i>	Children born after 9-1-82 and before 10-1-83		
<i>Income (define countable income)</i>	100% of the Federal Poverty Level		
<i>Resources (including any standards relating to spend downs and disposition of resources)</i>	1 person = \$2000 2 persons = \$3000 3 persons = \$3100 Add \$100 for each additional family member		
<i>Residency requirements</i>	Current State Resident		
<i>Disability status</i>	N/A		
<i>Access to or coverage under other health coverage (Section 2108(b)(1)(B)(i))</i>	N/A		
<i>Other standards (identify and describe)</i>	N/A		

**Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".*

3.1.2 How often is eligibility redetermined?

Table 3.1.2			
<i>Redetermination</i>	<i>Medicaid CHIP Expansion Program</i>	<i>State-designed CHIP Program</i>	<i>Other CHIP Program*</i>
<i>Monthly</i>			
<i>Every six months</i>			
<i>Every twelve months</i>	X		
<i>Other (specify)</i>			

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.1.3 Is eligibility guaranteed for a specified period of time regardless of income changes? (Section 2108(b)(1)(B)(v))

Yes Which program(s)?
For how long?
 No

3.1.4 Does the CHIP program provide retroactive eligibility?

Yes Which program(s)? Medicaid Expansion

How many months look-back?

Up to 3 months prior to the date of application, provided all eligibility requirements are met during the retroactive period.

No

3.1.5 Does the CHIP program have presumptive eligibility?

Yes Which program(s)?

Which populations?
Who determines?

No

3.1.6 *Do your Medicaid program and CHIP program have a joint application?*

X__ Yes Is the joint application used to determine eligibility for other State programs? If yes, specify.

The same application is used for family Medicaid categories (adult Medicaid categories use a different application).

___ No

3.1.7 *Evaluate the strengths and weaknesses of your eligibility determination process in increasing creditable health coverage among targeted low-income children.*

Initial eligibility determination is completed by the local DHS county office and outstationed workers. The application is four pages. The fourth page is a signature page with a list of rights and responsibilities. An initial face-to-face interview is required. Most eligibility requirements must be verified and documented. A determination is made on the application within 45 days from receipt. Once approved, the recipient will receive a letter within 2 to 3 days providing instructions on how to obtain a photo Medicaid card.

Strengths: Short, simplified application.

Weaknesses: Face-to-face interview and stringent documentation, although these are considered strengths in ensuring program integrity.

3.1.8 *Evaluate the strengths and weaknesses of your eligibility redetermination process in increasing creditable health coverage among targeted low-income children. How does the redetermination process differ from the initial eligibility determination process?*

For eligibility redeterminations, the same form that is used for initial applications is mailed to the recipient, by the local DHS county office, requesting completion and verification of current income and assets. Redeterminations do not require a face-to-face interview. If there is no response from the recipient within the timeframe on the original notice, a second notice is sent to the recipient, allowing 10 days to provide the information. If the recipient provides the requested information, eligibility will continue with no lapse in eligibility. If there is no response, the case will be closed at the end of the 10-day notice period.

Strengths: Short, simplified form with no face-to-face interview requirement.

Weaknesses: Stringent verification, although again, it is a strength in ensuring program integrity.

3.2 *What benefits do children receive and how is the delivery system structured?*
(Section 2108(b)(1)(B)(vi))

3.2.1 *Benefits*

Please complete Table 3.2.1 for each of your CHIP programs, showing which benefits are covered, the extent of cost sharing (if any), and benefit limits (if any).

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose “select” “table.” Once the table is highlighted, copy it by selecting “copy” in the Edit menu and then “paste” it under the first table.

Table 3.2.1 CHIP Program Type Medicaid Expansion			
Benefit	Is Service Covered? (✓ = yes)	Cost-Sharing (Specify) N/A	Benefit Limits (Specify)
Inpatient hospital services	✓		Medical Necessity
Emergency hospital services	✓		Medical Necessity
Outpatient hospital services	✓		Medical Necessity
Physician services	✓		Medical Necessity
Clinic services	✓		Medical Necessity
Prescription drugs	✓		With physician prescription, no limit
Over-the-counter medications	✓		Specified cough and cold preparations and limited other OTC
Outpatient laboratory and radiology services	✓		Medical Necessity
Prenatal care	✓		Medical Necessity
Family planning services	✓		1 basic FP exam and 3 periodic FP visits per SFY* (FP prescriptions are unlimited)
Inpatient mental health services	✓		Medical Necessity
Outpatient mental health services	✓		Medical Necessity
Inpatient substance abuse treatment services	✓		Covered in an acute care hospital, based on medical necessity
Residential substance abuse treatment services			
Outpatient substance abuse treatment services			
Durable medical equipment	✓		Medical Necessity; limited to specific equipment

Disposable medical supplies	✓		\$250 per month; may be extended based on medical necessity
Preventive dental services	✓		1 phophlaxis and flouride per SFY; may be extended based on medical necessity
Restorative dental services	✓		Requires Prior Authorization based on medical necessity
Hearing screening	✓		Medical Necessity
Hearing aids	✓		2 appliances per 6 mo. period; additional services be be available with a Prior Authorization based on medical necessity
Vision screening	✓		Medical Necessity
Corrective lenses (including eyeglasses)	✓		1 pair eyeglasses every 12 months, if medically indicated; may be extended based on medical necessity.
Developmental assessment	✓		Medical Necessity
Immunizations	✓		All per protocol, as recommended by the American Academy of Pediatrics
Well-baby visits	✓		Medical Necessity
Well-child visits	✓		Medical Necessity
Physical therapy	✓		<u>Evaluation:</u> Four 30 min. units per SFY. <u>Treatment:</u> Maximum of four 15 min. units per day each for Individual Therapy and Group Therapy. Limits may be extended based on medical necessity.
Speech therapy	✓		<u>Evaluation:</u> Four 30 min. units per SFY. <u>Treatment:</u> Maximum of four 15 min. units per day each for Individual Therapy and Group Therapy. Limits may be extended based on medical necessity.
Occupational therapy	✓		<u>Evaluation:</u> Four 30 min. units per SFY. <u>Treatment:</u> Maximum of four 15 min. units per day each for Individual Therapy and Group Therapy. Limits may be extended based on medical necessity.

Physical rehabilitation services	✓		Medical Necessity
Podiatric services	✓		Medical Necessity
Chiropractic services	✓		Medical Necessity
Medical transportation	✓		Medical Necessity
Home health services	✓		50 visits per SFY*; may be extended based on medical necessity
Nursing facility	✓		Medical Necessity
ICF/MR	✓		Medical Necessity
Hospice care	✓		Medical Necessity
Private duty nursing	✓		For ventilator dependent and for high technology non-ventilator with a Prior Authorization based on medical necessity
Personal care services	✓		With Prior Authorization, based on medical necessity
Habilitative services	✓		Medical Necessity
Case management/Care coordination	✓		Targeted case management with Prior Authorization based on medical necessity
Non-emergency transportation	✓		Provided under 1915(b) waiver – a broker transportation system
Interpreter services	✓*		* Will pay for case manager services to arrange for interpreter services but Arkansas Medicaid does not cover the interpreter services
Other: Domiciliary Care	✓		Medical Necessity
Other: End State Renal Services	✓		Medical Necessity
Other: Hyperalimentation	✓		Medical Necessity
Other: Orthotics and Prosthetics	✓		Limited to specific items; based on medical necessity

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose “select” “table.” Once the table is highlighted, copy it by selecting “copy” in the Edit menu and then “paste” it under the first table.

3.2.2 *Scope and Range of Health Benefits (Section 2108(b)(1)(B)(ii))*

Please comment on the scope and range of health coverage provided, including the types of benefits provided and cost-sharing requirements. Please highlight the level of preventive services offered and services available to children with special health care needs. Also, describe any enabling services offered to CHIP enrollees. (Enabling services include non-emergency transportation, interpretation, individual needs assessment, home visits, community outreach, translation of written materials, and other services designed to facilitate access to care.)

3.2.3 Delivery System

Identify in Table 3.2.3 the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Check all that apply.

Table 3.2.3			
Type of delivery system	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*
A. Comprehensive risk managed care organizations (MCOs)	N/A		
Statewide?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mandatory enrollment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Number of MCOs			
B. Primary care case management (PCCM) program	PCCM		
C. Non-comprehensive risk contractors for selected services such as mental health, dental, or vision (specify services that are carved out to managed care, if applicable)	Transportation services are provided through transportation broker contracts under a 1915(b) waiver.		
D. Indemnity/fee-for-service (specify services that are carved out to FFS, if applicable)	N/A		
E. Other (specify)	N/A		
F. Other (specify)	N/A		
G. Other (specify)	N/A		

*Make a separate column for each “other” program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

3.3 *How much does CHIP cost families?*

3.3.1 *Is cost sharing imposed on any of the families covered under the plan? (Cost sharing includes premiums, enrollment fees, deductibles, coinsurance/copayments, or other out-of-pocket expenses paid by the family.)*

No, skip to section 3.4

Yes, check all that apply in Table 3.3.1

Table 3.3.1			
Type of cost-sharing	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Premiums	N/A		
Enrollment fee	N/A		
Deductibles	N/A		
Coinsurance/copayments**	N/A		
Other (specify) _____	N/A		

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

**See Table 3.2.1 for detailed information.

3.3.2 ***If premiums are charged:*** *What is the level of premiums and how do they vary by program, income, family size, or other criteria? (Describe criteria and attach schedule.) How often are premiums collected? What do you do if families fail to pay the premium? Is there a waiting period (lock-out) before a family can re-enroll? Do you have any innovative approaches to premium collection?*

3.3.3 ***If premiums are charged:*** *Who may pay for the premium? Check all that apply. (Section 2108(b)(1)(B)(iii))*

Employer

Family

Absent parent

Private donations/sponsorship

Other (specify) _____

3.3.4 ***If enrollment fee is charged:*** What is the amount of the enrollment fee and how does it vary by program, income, family size, or other criteria?

3.3.5 ***If deductibles are charged:*** What is the amount of deductibles (specify, including variations by program, health plan, type of service, and other criteria)?

3.3.6 How are families notified of their cost-sharing requirements under CHIP, including the 5 percent cap?

3.3.7 How is your CHIP program monitoring that annual aggregate cost-sharing does not exceed 5 percent of family income? Check all that apply below and include a narrative providing further details on the approach.

Shoebox method (families save records documenting cumulative level of cost sharing)

Health plan administration (health plans track cumulative level of cost sharing)

Audit and reconciliation (State performs audit of utilization and cost sharing)

Other (specify)_____

3.3.8 What percent of families hit the 5 percent cap since your CHIP program was implemented? (If more than one CHIP program with cost sharing, specify for each program.)

3.3.9 Has your State undertaken any assessment of the effects of premiums on participation or the effects of cost sharing on utilization, and if so, what have you found?

3.4 How do you reach and inform potential enrollees?

3.4.1 What client education and outreach approaches does your CHIP program use?

Please complete Table 3.4.1. Identify all of the client education and outreach approaches used by your CHIP program(s). Specify which approaches are used (✓ =yes) and then rate the effectiveness of each approach on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.1

Approach	Medicaid CHIP Expansion		State-Designed CHIP Program N/A		Other CHIP Program* N/A	
	✓ = Yes	Rating (1-5)	✓ = Yes	Rating (1-5)	✓ = Yes	Rating (1-5)
Billboards						
Brochures/flyers						
Direct mail by State/enrollment broker/administrative contractor	✓	3				
Education sessions						
Home visits by State/enrollment broker/administrative contractor						
Hotline	✓	2				
Incentives for education/outreach staff						
Incentives for enrollees						
Incentives for insurance agents						
Non-traditional hours for application intake						
Prime-time TV advertisements	✓	3				
Public access cable TV						
Public transportation ads						

Radio/newspaper/TV advertisement and PSAs						
Signs/posters						
State/broker initiated phone calls						
Other (specify)						
Other (specify)						

**Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.*

3.4.2 *Where does your CHIP program conduct client education and outreach?*

Please complete Table 3.4.2. Identify all the settings used by your CHIP program(s) for client education and outreach. Specify which settings are used (✓ =yes) and then rate the effectiveness of each setting on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.2						
Setting	Medicaid CHIP Expansion		State-Designed CHIP Program N/A		Other CHIP Program* <u>N/A</u>	
	✓ = Yes	Rating (1-5)	✓ = Yes	Rating (1-5)	✓ = Yes	Rating (1-5)
Battered women shelters						
Community sponsored events						
Beneficiary's home						
Day care centers	✓	3				
Faith communities						
Fast food restaurants	✓	2				
Grocery stores						
Homeless shelters						
Job training centers						
Laundromats						
Libraries						
Local/community health centers	✓	3				
Point of service/provider locations	✓	3				
Public meetings/health fairs	✓	2				
Public housing						

Refugee resettlement programs						
Schools/adult education sites	✓	3				
Senior centers						
Social service agency						
Workplace						
Other (specify)						
Other (specify)						

**Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.*

3.4.3 *Describe methods and indicators used to assess outreach effectiveness, such as the number of children enrolled relative to the particular target population. Please be as specific and detailed as possible. Attach reports or other documentation where available.*

D/K

3.4.4 *What communication approaches are being used to reach families of varying ethnic backgrounds?*

Medicaid applications, notices and other forms, which are read by and completed by applicants/recipients are available in Spanish. Television ads feature an ethnic/racial mix, which is reflective of the ethnic/racial mix in the state.

3.4.5 *Have any of the outreach activities been more successful in reaching certain populations? Which methods best reached which populations? How have you measured their effectiveness? Please present quantitative findings where available.*

The Division of County Operations conducted a direct mail effort targeted to the families of children in the ARKids First 1115 demonstration whose birth dates fell within the CHIP range. These families were targeted because the Medicaid benefit package is richer than the ARKids First benefit package and because the ARKids First program requires co-payments on most services which are not considered to be well-health services.

3.5 What other health programs are available to CHIP eligibles and how do you coordinate with them? (Section 2108(b)(1)(D))

Describe procedures to coordinate among CHIP programs, other health care programs, and non-health care programs. Table 3.5 identifies possible areas of coordination between CHIP and other programs (such as Medicaid, MCH, WIC, School Lunch). Check all areas in which coordination takes place and specify the nature of coordination in narrative text, either on the table or in an attachment.

Table 3.5				
Type of coordination	Medicaid*	Maternal and child health	Other (specify) <u>WIC</u>	Other (specify)
	N/A			
Administration				
Outreach		✓	✓	
Eligibility determination				
Service delivery				
Procurement				
Contracting				
Data collection				
Quality assurance				
Other (specify)				
Other (specify)				

**Note: This column is not applicable for States with a Medicaid CHIP expansion program only.*

The Arkansas Department of Health serves as an application point for Medicaid and thus their MCH and WIC programs serve as outreach by bringing individuals in who also apply for Medicaid. Also the Children’s Medical Services Section (CMS), Division of Medical Services, receives MCH funds. They encourage families who receive services through their MCH program to apply for Medicaid.

3.6 *How do you avoid crowd-out of private insurance? N/A*

3.6.1 *Describe anti-crowd-out policies implemented by your CHIP program. If there are differences across programs, please describe for each program separately. Check all that apply and describe.*

____ *Eligibility determination process:*

____ *Waiting period without health insurance (specify)*

____ *Information on current or previous health insurance gathered on application (specify)*

____ *Information verified with employer (specify)*

____ *Records match (specify)*

____ *Other (specify)*

____ *Other (specify)*

____ *Benefit package design:*

____ *Benefit limits (specify)*

____ *Cost-sharing (specify)*

____ *Other (specify)*

____ *Other (specify)*

____ *Other policies intended to avoid crowd out (e.g., insurance reform):*

____ *Other (specify)*

____ *Other (specify)*

3.6.2 *How do you monitor crowd-out? What have you found? Please attach any available reports or other documentation.*

SECTION 4. PROGRAM ASSESSMENT

This section is designed to assess the effectiveness of your CHIP program(s), including enrollment, disenrollment, expenditures, access to care, and quality of care.

4.1 Who is enrolled in your CHIP program?

4.1.1 What are the characteristics of children enrolled in your CHIP program? (Section 2108(b)(1)(B)(i))

Please complete Table 4.1.1 for each of your CHIP programs, based on data from your HCFA quarterly enrollment reports. Summarize the number of children enrolled and their characteristics. Also, discuss average length of enrollment (number of months) and how this varies by characteristics of children and families, as well as across programs.

States are also encouraged to provide additional tables on enrollment by other characteristics, including gender, race, ethnicity, parental employment status, parental marital status, urban/rural location, and immigrant status. Use the same format as Table 4.1.1, if possible.

NOTE: *To duplicate a table: put cursor on desired table go to Edit menu and chose “select” “table.” Once the table is highlighted, copy it by selecting “copy” in the Edit menu and then “paste” it under the first table.*

Table 4.1.1 CHIP Program Type <u>Medicaid Expansion</u>						
Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
	N/A		N/A		N/A	
All Children						
Age						
Under 1		N/A		N/A		N/A
1-5		N/A		N/A		N/A
6-12		N/A		N/A		N/A
13-18		1,165		6.6		340

Countable Income Level*						
At or below 150% FPL		1,165		6.6		340
Above 150% FPL		N/A		N/A		N/A

Age and Income						
Under 1		N/A		N/A		N/A
At or below 150% FPL						
Above 150% FPL						

1-5		N/A		N/A		N/A
At or below 150% FPL						
Above 150% FPL						

6-12		N/A		N/A		N/A
At or below 150% FPL						
Above 150% FPL						

13-18						
At or below 150% FPL		1,165		6.6		340
Above 150% FPL						

Type of plan						
Fee-for-service						
Managed care						
PCCM		1,165		6.6		340

**Countable Income Level is as defined by the states for those that impose premiums at defined levels other than 150% FPL. See the HCFA Quarterly Report instructions for further details.*

SOURCE: HCFA Quarterly Enrollment Reports, Forms HCFA-21E, HCFA-64.21E, HCFA-64EC, HCFA Statistical Information Management System, October 1998

4.1.2 *How many CHIP enrollees had access to or coverage by health insurance prior to enrollment in CHIP? Please indicate the source of these data (e.g., application form, survey). (Section 2108(b)(1)(B)(i))* D/K

4.1.3 *What is the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children? (Section 2108(b)(1)(C))* D/K

4.2 *Who disenrolled from your CHIP program and why?*

4.2.1 *How many children disenrolled from your CHIP program(s)?* 340

Please discuss disenrollment rates presented in Table 4.1.1. Was disenrollment higher or lower than expected?

The disenrollment rate of 29% is about what one might expect for a first year. However, we expect the rate to go up in the next year as the first reevaluations come due and some families fail to complete the process.

How do CHIP disenrollment rates compare to traditional Medicaid disenrollment rates?

The Medicaid disenrollment rate, for the same period, was 34% compared to 29% for the CHIP Medicaid Expansion

4.2.2 *How many children did not re-enroll at renewal? How many of the children who did not re-enroll got other coverage when they left CHIP?*

N/A – The CHIP Medicaid expansion has only been in place for one year. This information should be available in the FFY 2000 report.

4.2.3 *What were the reasons for discontinuation of coverage under CHIP? (Please specify data source, methodologies, and reporting period.)*

Table 4.2.3

Reason for discontinuation of coverage	Medicaid CHIP Expansion Program		State-designed CHIP Program N/A		Other CHIP Program* N/A	
	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total
Total	153					
Access to commercial insurance	N/A					
Eligible for Medicaid**	9					
Income too high	8					
Aged out of program	21					
Moved/died	10					
Nonpayment of premium	N/A					
Incomplete documentation	7					
Did not reply/unable to contact	2					
Other (specify) Need Related	24					
Other (specify) Non-Need Related	55					
Don't know	17					

**Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.*

This information was obtained from the Arkansas Client Eligibility System (ACES): it represents the number of CHIP Medicaid expansion children closed in FFY 1999, for which we still have close data, by reason. The close reason, for children who were closed then later reopened with the same Identification Number, is not available. Therefore the total in this chart is significantly lower than the disenrollment number shown in Table 4.1.1 and in section 4.2.1. **The number reported as disenrolled as “eligible for Medicaid” is under reported.

4.2.4 *What steps is your State taking to ensure that children who disenroll, but are still eligible, re-enroll?*

None at this time.

4.3 *How much did you spend on your CHIP program?*

4.3.1 *What were the total expenditures for your CHIP program in federal fiscal year (FFY) 1998 and 1999?*

FFY 1998 N/A

FFY 1999 \$1,225,512.67

Please complete Table 4.3.1 for each of your CHIP programs and summarize expenditures by category (total computable expenditures and federal share). What proportion was spent on purchasing private health insurance premiums versus purchasing direct services?

Table 4.3.1 CHIP Program Type <u>Medicaid Expansion</u>				
Type of expenditure	Total computable share		Total federal share	
	FFY 1998	N/A	FFY 1998	N/A
Total expenditures			1,225,512.67	
Premiums for private health insurance (net of cost-sharing offsets)*		N/A		N/A
Fee-for-service expenditures (subtotal)				
Inpatient hospital services				
Inpatient mental health facility services				
Nursing care services				
Physician and surgical services				
Outpatient hospital services				

Outpatient mental health facility services				
Prescribed drugs				
Dental services				
Vision services				
Other practitioners' services				
Clinic servicesc				
Therapy and rehabilitation services				
Laboratory and radiological services				
Durable and disposable medical equipment				
Family planning				
Abortions				
Screening services				
Home health				
Home and community-based services				
Hospice				
Medical transportation				
Case management				
Other services				

NOTE: In lieu of completing this table, Arkansas is including its CHIP Medicaid Expansion report using the same State Category of Service used in reporting expenditures in its Medicaid Program.

FFY99 CHIP Expenditures

State Category of Service	Paid Amount	Fed Share
02 - Ambulance	\$7,694.90	\$6,238.26
03 - Ambulatory Surgical Centers	\$665.22	\$539.29
05 - Chiropractor	\$178.29	\$144.54
06 - CRNA	\$4,302.14	\$3,487.74
09 - Maternity/physician program cost	\$92,886.36	\$75,302.97
10 - Dental Services	\$50,548.50	\$40,979.67
11 - Dental Services EPSDT	\$13,024.15	\$10,558.68
14 - EPSDT Immunizations	\$352.62	\$285.87
15 - EPSDT Screening	\$1,826.93	\$1,481.09
16 - Eyeglasses	\$2,470.30	\$2,002.67
17 - Family Planning Clinics	\$10,406.44	\$8,436.50
19 - Family Planning Drugs	\$4,523.94	\$3,667.56
20 - Family Planning Physician	\$1,766.06	\$1,431.74
24 - Home Health Services	\$3,083.21	\$2,499.56
28 - Independent Lab	\$6,408.59	\$5,195.44
31 - Inpatient Acute Care	\$141,684.00	\$114,863.22
33 - Inpatient Psychiatric u-21	\$336,682.27	\$272,948.32
35 - Maternity	\$19,503.92	\$15,811.83
36 - Community Mental Health (RSPMI)	\$103,275.76	\$83,725.66
41 - Nurse Midwife	\$2,404.20	\$1,949.08
42 - Ophthalmologist	\$225.00	\$182.41
43 - Ophthalmologist medical	\$321.00	\$260.23
44 - Optometrist/ Ocularist	\$9,657.22	\$7,829.11
46 - Oral Surgery Dentist (ADA Codes)	\$3,978.70	\$3,225.53
51 - Outpatient Hospital	\$49,244.48	\$39,922.50
52 - Pathologist	\$546.14	\$442.76
55 - Physician Services	\$75,239.76	\$60,996.87
56 - Prescription Services	\$72,591.46	\$58,849.90
65 - Public Transportation	\$53.11	\$43.06
66 - Radiologist	\$13,200.30	\$10,701.48
68 - Rural Health Clinics	\$6,434.61	\$5,216.54
70 - Surgery	\$35,802.46	\$29,025.05
71 - EPSDT CHMS	\$16,162.63	\$13,103.04
72 - EPSDT Podiatry	\$536.00	\$434.54
75 - Pediatric Inpatient	\$6,810.00	\$5,520.87
77 - Rural Inpatient	\$30,605.00	\$24,811.47
80 - Therapy School District/ Esc Group	\$4,000.00	\$3,242.80
81 - Psychologist	\$2,827.88	\$2,292.56
87 - Inpatient AR Teaching	\$16,200.00	\$13,133.34
91 - FQHC Core Services	\$4,803.17	\$3,893.93
93 - EPSDT DMS Expansion	\$258.00	\$209.16
94 - EPSDT Prosthetic Device	\$31.78	\$25.76
95 - EPSDT Orthotic Appliances	\$50.85	\$41.22
F1 - FQHC Dental	\$118.00	\$95.66
FA - Family Planning Waiver	\$141.15	\$114.43
M1 - Managed Care Fees	\$8,445.00	\$6,846.36
N1 - Nurse Practitioner	\$527.31	\$427.49
NT - Net Managed Care Waiver	\$16,601.76	\$13,459.05
P2 - Health Dept Communicable Disease	\$2,649.17	\$2,147.68
PB - Family Planning FQHC	\$138.81	\$112.53
T2 - Case Management DCFS	\$40,252.00	\$32,632.30
T4 -	\$3,372.12	\$2,733.78
Total:	\$1,225,512.67	\$993,523.12

4.3.2 What were the total expenditures that applied to the 10 percent limit? Please complete Table 4.3.2 and summarize expenditures by category.

What types of activities were funded under the 10 percent cap?

We have not claimed administrative expenditures yet but will claim expenditures for eligibility, claims processing, and outreach.

What role did the 10 percent cap have in program design?

None

Table 4.3.2						
Type of expenditure	Medicaid Chip Expansion Program		State-designed CHIP Program		Other CHIP Program*	
	FY 1998	FY 1999	FY 1998	FY 1999	FY 1998	FY 1999
Total computable share						
Outreach						
Administration						
Other _____						
Federal share						
Outreach						
Administration						
Other _____						

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.3.3 What were the non-Federal sources of funds spent on your CHIP program (Section 2108(b)(1)(B)(vii))

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

4.4 How are you assuring CHIP enrollees have access to care?

4.4.1 What processes are being used to monitor and evaluate access to care received by CHIP enrollees? Please specify each delivery system used (from question 3.2.3) if approaches vary by the delivery system within each program. For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in a Primary Care Case Management program, specify 'PCCM.'

Table 4.4.1			
Approaches to monitoring access	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*
Appointment audits	N/A		
PCP/enrollee ratios	PCCM		
Time/distance standards	N/A		
Urgent/routine care access standards	N/A		
Network capacity reviews (rural providers, safety net providers, specialty mix)	N/A		
Complaint/grievance/disenrollment reviews	PCCM		
Case file reviews	PCCM		
Beneficiary surveys	PCCM		
Utilization analysis (emergency room use, preventive care use)	PCCM		
Other (specify) _____	N/A		
Other (specify) _____	N/A		
Other (specify) _____	N/A		

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.4.2 *What kind of managed care utilization data are you collecting for each of your CHIP programs? If your State has no contracts with health plans, skip to section 4.4.3.*

N/A

Table 4.4.2			
Type of utilization data	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*
Requiring submission of raw encounter data by health plans	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No
Requiring submission of aggregate HEDIS data by health plans	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No
Other (specify)_____	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No

**Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.*

4.4.3 *What information (if any) is currently available on access to care by CHIP enrollees in your State? Please summarize the results.*

Although Arkansas does not yet have anything that is specific to the CHIP population, the State does produce, through a contract, annual reports on ConnectCare which address access to care issues.

Medicaid Managed Care Services, a division of the Arkansas Foundation for Medical Care, conducts annual comprehensive scientific surveys to measure Medicaid recipient perception of access and satisfaction. Survey results are used to assist Medicaid in evaluating program access and effectiveness and also to identify ways to improve the program. See pages 8, 10 and 11 of Attachment A. Medicaid recipients are overall satisfied with the Arkansas Medicaid program including access to specialists.

The following is excerpted from page 9 of Attachment A. “As of September 1999, the Medicaid caseload was 196,140 recipients. Additionally 1,849 Primary Care Physician had collectively applied for a caseload of 1,035,435 representing four times the physician capacity needed to manage health needs for recipients. By attracting more health care providers into the system, ConnectCare became the state’s largest managed-care program.”

4.4.4 *What plans does your CHIP program have for future monitoring/evaluation of access to care by CHIP enrollees? When will data be available?*

The State will continue to generate the above Medicaid report.

4.5 *How are you measuring the quality of care received by CHIP enrollees?*

4.5.1 *What processes are you using to monitor and evaluate quality of care received by CHIP enrollees, particularly with respect to well-baby care, well-child care, and immunizations? Please specify the approaches used to monitor quality within each delivery system (from question 3.2.3). For example, if an approach is used in managed care, specify ‘MCO.’ If an approach is used in fee-for-service, specify ‘FFS.’ If an approach is used in primary care case management, specify ‘PCCM.’*

Table 4.5.1			
Approaches to monitoring quality	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program
Focused studies (specify)	N/A		
Client satisfaction surveys	N/A		
Complaint/grievance/disenrollment reviews	N/A		
Sentinel event reviews	N/A		
Plan site visits	N/A		
Case file reviews	N/A		
Independent peer review	N/A		
HEDIS performance measurement	PCCM		
Other performance measurement (specify)	N/A		
Other (specify) _____	N/A		
Other (specify) _____	N/A		
Other (specify) _____	N/A		

**Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.*

4.5.2 *What information (if any) is currently available on quality of care received by CHIP enrollees in your State? Please summarize the results.*

This information is not currently available for the CHIP Medicaid expansion population. However, this information is available for Medicaid.

4.5.3 *What plans does your CHIP program have for future monitoring/evaluation of quality of care received by CHIP enrollees? When will data be available?*

The State is developing an on-going immunization and well child evaluation tool and process, which should be available in approximately 12 months.

- 4.6 *Please attach any reports or other documents addressing access, quality, utilization, costs, satisfaction, or other aspects of your CHIP program's performance. Please list attachments here.*

This information is not available at this time for the CHIP Medicaid expansion population. However, the State has this information available for the Medicaid population. Attached are the 1998 Recipient Survey and a ConnectCare report. ConnectCare is Arkansas' PCCM 1915(b) waiver. See Attachments A and C.

SECTION 5. REFLECTIONS

This section is designed to identify lessons learned by the State during the early implementation of its CHIP program as well as to discuss ways in which the State plans to improve its CHIP program in the future. The State evaluation should conclude with recommendations of how the Title XXI program could be improved.

5.1 *What worked and what didn't work when designing and implementing your CHIP program? What lessons have you learned? What are your "best practices"? Where possible, describe what evaluation efforts have been completed, are underway, or planned to analyze what worked and what didn't work. Be as specific and detailed as possible. (Answer all that apply. Enter 'NA' for not applicable.)*

5.1.1 *Eligibility Determination/Redetermination and Enrollment*

N/A – Used the processes and procedures which were in place for Medicaid.

5.1.2 *Outreach*

It appears that the outreach conducted for the ARKids First program was much more effective than the outreach conducted for Medicaid in FFY 1999, since the number of children in the Medicaid program grew by only 884 recipients or .7%, while the ARKids First program grew by 133,553 or 44%.

5.1.3 *Benefit Structure.* N/A

5.1.4 *Cost-Sharing (such as premiums, copayments, compliance with 5% cap)* N/A

5.1.5 *Delivery System* N/A

5.1.6 *Coordination with Other Programs (especially private insurance and crowd-out)*
N/A

5.1.7 *Evaluation and Monitoring (including data reporting)*

5.1.8 *Other (specify)*



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5.2 *What plans does your State have for “improving the availability of health insurance and health care for children”? (Section 2108(b)(1)(F))*

Arkansas has an 1115 demonstration called ARKids First, which has been in place since 9-1-97. This highly successful program now serves approximately 50,000 children. The program is viewed so positively by providers and clients that we now plan to use the ARKids name as an umbrella for ARKids First and ARKids Plus, which will consist of certain children’s Medicaid categories. There will be a combined application form and the ARKids Plus children will receive an ID card, which will look similar to an ARKids First card except the name will be ARKids Plus. The “Plus” lets providers know that these children receive the full range of Medicaid benefits rather than the ARKids First benefit package. Families will be able to apply and have eligibility determined via mail; no office visit will be required. Reevaluations will also be completed through the mail.

The State decided to change the name of the Medicaid program for certain Medicaid categories to ARKids Plus, in part, to take advantage of the ARKids First ad/outreach campaign and the name recognition of ARKids First.

5.3 *What recommendations does your State have for improving the Title XXI program? (Section 2108(b)(1)(G))*

Arkansas wanted to convert approximately half of the ARKids First 1115 demonstration to Title XXI. It appears that due to certain Title XXI regulations, that we should be able to convert only approximately 20% of the caseload. Thus, the State thinks it would improve Title XXI to make the following changes:

1. Change the requirement on co-payments such that the state’s flexibility on the amount of the co-payment would apply to families whose income is above 100% (rather than the current 150%).
2. Remove the exclusion of the children of public employees.