

Table 1.3 State Progress: Strategic Objectives and Performance Goals		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
Increase in overall access to coverage relative to estimate of number of uninsured children in Pennsylvania	Increase state government participation in and administration of outreach efforts to include public service announcements, inter-agency mutual referrals and revision and distribution of CHIP information.	<p>Data sources: CHIP enrollment data</p> <p>Methodology: Enrollment Growth From May 1998 through September 1999. Enrollment in May 1998 = 54,080 Enrollment in September 1999 = 76,639 Growth in Enrollment = 22,559</p> <p>Formula used: $\frac{(9/99 \text{ Enrollment} - 5/98 \text{ Enrollment})}{5/98 \text{ Enrollment}}$</p> <p>Computation: $\frac{(76,639 - 54,080)}{54,080} = 41.7\%$</p> <p>Numerator: 22,559 Increased enrollment from 5/98 through 9/99</p> <p>Denominator: 54,080 Enrollment in May 1998</p> <p>Progress Summary: In 17 months, CHIP enrollment increased approximately 41.7%</p>

Table 1.3 (cont'd)		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc)
Increase access to coverage children in rural areas, specifically central and northeast Pennsylvania	Seek to establish a working relationship with the Center for Rural Pennsylvania, a not-for-profit organization dedicated to identifying, studying and offering solutions to public policy issues of concern to rural areas of the Commonwealth, to identify barriers to access in central and northeastern Pennsylvania.	<p>Data sources: CHIP enrollment data</p> <p>Methodology: Enrollment growth from May 1998 through September 1999 in 19 rural counties in northeastern and central Pennsylvania (Bedford, Clinton, Columbia, Juniata, Lebanon, Mifflin, Monroe, Montour, Northumberland, Perry, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne, Wyoming).</p> <p>Enrollment in May, 1998 = 4,217 Enrollment in September, 1999 = 6,215</p> <p>Formula used: $\frac{(9/99 \text{ Enrollment} - 5/98 \text{ Enrollment})}{5/98 \text{ Enrollment}}$ </p> <p>Computation: $\frac{(6,215 - 4,217)}{4,217} = 47.3\%$ </p> <p>Numerator: 1,998 Increased enrollment from 5/98 through 9/99</p> <p>Denominator: 4,217 enrollment in 5/98</p> <p>Progress Summary: In 17 months, CHIP enrollment in Pennsylvania's northeastern and central rural counties increased approximately 47.3%. This surpasses the statewide growth of 41.7% during the same time period.</p>

Table 1.3 (cont'd)		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc)
OBJECTIVES RELATED TO CHIP ENROLLMENT		
Increase public awareness of CHIP and other state programs aimed at providing health care assistance.	Increase state government participation in and administration of outreach efforts to include public service announcements, inter-agency mutual referrals and revision, and distribution of CHIP information.	<p>Data sources: Benchmark and Follow-up Telephone Surveys – See Appendix E.</p> <p>Methodology: Realizing the importance of accountability and understanding the target audience of any social marketing efforts, the Pennsylvania Insurance Department asked PPO&S to conduct two telephone surveys—a benchmark survey prior to the launch of the first concerted television advertising outreach campaign and a follow-up survey conducted approximately six months later. In October 1998, 432 interviews were conducted with Pennsylvania parents who met income guidelines closely approximating CHIP requirements, and in April/May 1999, 324 interviews were conducted with parents using the same guidelines. All respondents were parents of children under 20 years of age and were screened for residence in Pennsylvania, income, age of children and number of adults and children in the household. A complex formula was created to qualify respondents for the survey, which closely approximates the requirements for enrollment of children in CHIP.</p> <p>The one requirement for CHIP enrollment, which was purposefully excluded from these screening criteria, was current insurance status of children in the household. While the question was asked and the answers recorded for cross tabulation and analysis purposes, it was decided by the researchers and the client that interviews should be conducted with both currently insured and uninsured children. There were two reasons for this. First, interviewing only parents of uninsured children would have been cost-prohibitive due to their small proportion to the general population. Second, and more importantly, because television and other mass media efforts cannot be targeted at the uninsured, a more useful accountability test of promotional effectiveness would include the entire demographic group targeted by the media outreach campaign. Additionally, it was agreed that, the nature of insurance coverage for this demographic group is such that promoting all Pennsylvania parents who meet the income and family size guidelines would be useful as family circumstances change and insured children become uninsured.</p>

Table 1.3 (cont'd)						
OBJECTIVES RELATED TO CHIP ENROLLMENT (cont'd)						
		<p>Methodology (cont'd): The surveys had several primary purposes:</p> <ul style="list-style-type: none"> • To measure gross impact of the outreach campaign on members of the demographic target group as measured by awareness of CHIP • To ascertain a better understanding of how the target audience views and would view government programs such as CHIP • To test the impact of the first six months of media outreach on perceptions of government insurance programs such as CHIP <p>Interviews were conducted by professionally trained and supervised telephone interviewers at a central location. The interviewers used a CATI (Computer Assisted Telephone Interviewing) system, which allowed for automatic and instantaneous screening of prospective respondents for CHIP enrollment criteria. The sample of households to be interviewed was a computer generated random sample of listed households in census tracts, in which a large proportion of residents met the CHIP enrollment requirements according to most currently available census data and estimates.</p> <p>The sampling error at 95% confidence level for these surveys is as follows:</p> <table> <tr> <td>Fall 1998</td> <td>Sampling error = (+/-) 4.7%</td> </tr> <tr> <td>Spring 1999</td> <td>Sampling error = (+/-) 5.4%</td> </tr> </table> <p>Briefly, this means (using the Fall 1998 error as an example) that if this same survey was conducted 100 times at the same time, we would expect that the responses to questions would be plus or minus 4.7% of the response given in this Fall survey.</p> <p>Progress Summary: Prior to the implementation of the media campaign, 41% of the population had an awareness of CHIP. Approximately 6 months after the media campaign began, public awareness of CHIP increased to 67%. Coincidentally, public awareness of Medicaid increased from 87% to 90%. In 17 months, CHIP enrollment increased approximately 41.7%</p>	Fall 1998	Sampling error = (+/-) 4.7%	Spring 1999	Sampling error = (+/-) 5.4%
Fall 1998	Sampling error = (+/-) 4.7%					
Spring 1999	Sampling error = (+/-) 5.4%					

Table 1.3 (cont'd)		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc)
OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		
Increase access to coverage for racial, ethnic, minority and special needs children eligible for CHIP	Require Grantees contractually to increase outreach focus on community-based agencies in predominantly minority, non-English speaking areas.	<p>Data sources: NA</p> <p>Methodology:</p> <p>Numerator:</p> <p>Denominator:</p> <p>Progress Summary: Although data is not currently available by race or ethnicity, overall enrollment increased approximately 41.7% from 5/98 through 9/99. It is reasonable to conclude, based on this rate of growth, that access to coverage for racial, ethnic, minority and special needs children has increased. A new data system is under development that will provide this information in the future.</p>
OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		
NA	NA	<p>Data sources: NA</p> <p>Methodology:</p> <p>Numerator:</p> <p>Denominator:</p> <p>Progress Summary:</p>

Table 1.3 (cont'd)		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc)
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
Increase the percentage of children receiving age appropriate well child care, immunizations and preventive health services.	Ensure by explicit references in contract that Program Grantees provide to CHIP quality improvement plans which will include the process by which Grantees will monitor and quantify quality improvement.	<p>Data sources: NA</p> <p>Methodology:</p> <p>Numerator:</p> <p>Denominator:</p> <p>Progress Summary: Although data is not currently available, overall enrollment increased approximately 41.7% from 5/98 through 9/99. It is reasonable to conclude, based on this rate of growth, that the percentage of children receiving age appropriate well child care, immunization and preventive health services has increased. There is no anecdotal information to suggest otherwise. A new data system and monitoring protocol are under development that will provide this information in the future.</p>

Table 3.1.1 Eligibility Standards			
	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*
Geographic areas served by the plan (Section 2108(b)(1)(B)(iv))		Statewide	
Age		Under 19	
Income (define countable income)		0-200% FPL - All income is considered except for income that is excluded by federal or state law from consideration for means-tested programs or is otherwise excluded from consideration by Pennsylvania's Medicaid program. Two deductions from income are allowed: 1) a \$90 per month standard earned income disregard for employed persons, and 2) a child care/adult dependent care deduction of up to \$200 per month per child or adult dependent.	
Resources (including any standards relating to spend downs and disposition of resources)		NA	
Residency requirements		Except for newborns, must be a resident of Pennsylvania for 30 days.	
Disability status		NA	
Access to or coverage under other health coverage (Section 2108(b)(1)(B)(I))		Must not be covered at time of application	
Other standards (identify and describe)			

Addendum to Table 3.1.1

The questions below ask for countable income levels for your Title XXI programs (Medicaid SCHIP expansion and State-designed SCHIP program), as well as for the Title XIX child poverty-related groups. Please report your eligibility criteria as of **September 30, 1999**.

3.1.1.1 For each program, do you use a gross income test or a net income test or both?

Title XIX Child Poverty-related Groups	<input type="checkbox"/> Gross	<input checked="" type="checkbox"/> Net	<input type="checkbox"/> Both
Title XXI Medicaid SCHIP Expansion	<input type="checkbox"/> Gross	<input type="checkbox"/> Net	<input type="checkbox"/> Both
Title XXI State-Designed SCHIP Program	<input type="checkbox"/> Gross	<input checked="" type="checkbox"/> Net	<input type="checkbox"/> Both
Other SCHIP program _____	<input type="checkbox"/> Gross	<input type="checkbox"/> Net	<input type="checkbox"/> Both

3.1.1.2 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.

Title XIX Child Poverty-related Groups	185% of FPL for children under age 0-1
	133 % of FPL for children aged 1-5
	100 % of FPL for children aged 6-16
	*average approximately 41% - 62% of FPL for children age 17-18

*Income limits for Medically Needy Only

1 person	\$425 monthly	\$2,550 semi-annually
2 persons	442	2,650
3 persons	467	2,800
4 persons	567	3,400
5 persons	675	4,050
6 persons	758	4,550
each additional person	92	550

Title XXI State-Designed SCHIP program **No**

Yes (complete
column C in
3.1.1.7)

Other SCHIP program _____ **No**

Yes (complete
column D in
3.1.1.7)

3.1.1.7 How do you treat assets/resources?

See Table 3.1.1.7 – Treatment of Assets/Resources

NA – Assets/resources do not count towards eligibility for CHIP.

3.1.1.8 Have any of the eligibility rules changed since September 30, 1999?

Yes **No**

Earnings from individuals temporarily employed by the Census Bureau for Census 2000 activities have been disregarded

Table 3.1.1.3 – Whose Income Counts				
	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP program	Other SCHIP Program*
Family Composition				
Child, siblings, and legally responsible adults living in the household	D		D	
All relatives living in the household	D		D	
All individuals living in the household	D		D	
Other (specify)				

Table 3.1.1.4 – Countable Income				
	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Programs
Type of income				
Earnings	C		C	
Earnings of dependent children				
Earnings of students	NC		NC	
Earnings from job placement programs	NC		NC	
Earnings from community service programs under Title I of the National and Community Service Act of 1990 (e.g., Serve America)	NC *unless the income exceeds minimum wage		NC*	
Earnings from volunteer programs under the Domestic Volunteer Service Act of 1973 (e.g., AmeriCorps, Vista)	NC		NC	
Education Related Income	NC		NC	
Income from college work-study programs				
Assistance from programs administered by the Department of Education	NC		NC	
Education loans and awards	NC		NC	
Other Income	NC		NC	
Earned income tax credit (EITC)				
Alimony payments received	C		C	

Table 3.1.1.4 (cont'd)				
Child support payments received	C		C	
Roomer/boarder income	C		C	
Income from individual development accounts	C *except for Education Savings Accounts		C*	
Gifts	NC		NC	
In-kind income	NC		NC	
Program Benefits Welfare cash benefits (TANF)	NC		NC	
Supplemental Security Income (SSI) cash benefits	NC		NC	
Social Security cash benefits	C		C	
Housing subsidies	NC		NC	
Foster care cash benefits	NC		NC	
Adoption assistance cash benefits	NC		NC	
Veterans benefits	C		C	
Emergency or disaster relief benefits	NC		NC	
Low income energy assistance payments	NC		NC	
Native American tribal benefits	NC		NC	
Other Types of Income:				
Income tax refunds	NC		NC	
Relocation assistance	NC		NC	
Payments from the Family Caregiver Support Program	NC		NC	
Japanese-American and Aleut restitution payments	NC		NC	

Table 3.1.1.4 (cont'd)				
Donations from public or private agencies	NC		NC	
Day care payments in an approved family day care home	NC		C	
Alaska Native Claims	NC		NC	
Agent Orange Settlement Payments	NC		NC	
Any other income excluded by Federal or State law from consideration for means-tested programs	NC		NC	

Table 3.1.1.5 – Income Disregards/Deductions				
Type of Disregard/Deduction	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program *
Earnings	\$90/month or 50% of earnings if applicant was a recipient of TANF or TANF-related Medicaid in one of the four calendar months prior to the month of application	\$	\$90/month	\$
Self-employment expenses	Profit from self-employment is counted as defined by the Department of Public Welfare	\$	IRS-recognized business expenses	\$
Alimony payments received	NA	\$	NA	\$
Paid	NA	\$	NA	\$
Child support payments received	NA	\$	NA	\$
Paid	NA	\$	NA	\$
Child care expenses	Up to \$175/month for child aged 2 or older Up to \$200/month for child under age 2	\$	Up to \$175/month for child aged 2 or older Up to \$200/month for child under age 2	\$
Medical care expenses	NA	\$	NA	\$
Gifts	NA	\$	NA	\$
Other types of disregards/deductions (specify) Adult Dependent Care	Up to \$175 per month	\$	Up to \$175 per month	\$

Table 3.1.1.7 – Treatment of Assets/Resources				
Treatment of Assets/Resources	Title XIX Child Poverty-related Groups (A)	Title XXI Medicaid SCHIP Expansion (B)	Title XXI State-designed SCHIP Program (C)	Other SCHIP Program* _____
Countable or allowable level of asset/resource test	NA		NA	
Treatment of vehicles: Are one or more vehicles disregarded? <i>Yes or No</i>	NA		NA	
What is the value of the disregard for vehicles?	NA		NA	
When the value exceeds the limit, is the child ineligible (“I”) or is the excess applied (“A”) to the threshold allowable amount for other assets? <i>(Enter I or A)</i>	NA		NA	

Table 3.1.2 Determination of Eligibility			
	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Redetermination			
Monthly			
Every six months			
Every twelve months		X	
Other (specify) _____			

Table 3.2.1 Benefit Package			
Benefit	Is Service Covered? ✓ = Yes	Cost-Sharing (Specify)	Benefit Limits (Specify)
Inpatient hospital services	✓	NA	90 days per year
Emergency hospital services	✓	NA	NA
Outpatient hospital services	✓	NA	NA
Physician services	✓	NA	NA
Clinic services			
Prescription drugs	✓	NA	NA
Over-the-counter medications			
Outpatient laboratory and radiology services	✓	NA	NA
Prenatal care			
Family planning services			
Inpatient mental health services	✓	NA	90 days per year in conjunction with limit on inpatient hospital services
Outpatient mental health services	✓	NA	50 visits per year
Inpatient substance abuse treatment services	✓	NA	7 days of treatment per admission; lifetime limit of 4 admissions
Residential substance abuse treatment	✓	NA	30 days per year; lifetime limit of 90 days
Outpatient substance abuse treatment services	✓	NA	30 full session visits or equivalent partial visits per year; lifetime limit of 120 days

Table 3.2.1 (cont'd)			
Durable medical equipment	✓	NA	Must primarily usually be used to serve a medical purpose and is appropriate for use in the home
Disposable medical supplies	✓	NA	NA
Preventive dental services	✓	NA	NA
Restorative dental services	✓	NA	2 exams per year
Hearing screening	✓	NA	NA
Hearing aids	✓	NA	1 device every 2 years
Vision screening	✓	NA	1 exam per year
Corrective lenses (including eyeglasses)	✓	NA	Maximum of 2 pair per year
Developmental assessment	✓	NA	NA
Immunizations	✓	NA	NA
Well-baby visits	✓	NA	NA
Well-child visits	✓	NA	NA
Physical therapy	✓	NA	60 visits per year
Speech therapy	✓	NA	60 visits per year
Occupational therapy	✓	NA	60 visits per year
Physical rehabilitation services	✓	NA	60 visits per year
Podiatric services			
Chiropractic services			
Medical transportation	✓	NA	Emergency ambulance service only
Home health services	✓	NA	60 visits per year
Nursing facility			
Hospice care			
Private duty nursing			

Table 3.2.1 (cont'd)			
Personal care services			
Habilitative services			
Case management/care coordination			
Non-emergency transportation			
Interpreter services			
Other (Specify) _____			

Table 3.2.3 Delivery System			
Type of delivery system	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*
A. Comprehensive risk managed care organizations (MCOs)			
Statewide?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input checked="" 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 checked="" type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Number of MCOs		5	
B. Primary care case management (PCCM) program		No	
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)		No*	
D. Indemnity/fee-for-service (specify services that are carved out to FFS, if applicable)		No	
E. Other (specify) PPO		Yes**	
F. Other (specify) _____			
G. Other (specify) _____			

*The CHIP program contracts directly with MCOs to provide all medical services. Contracted MCOs, however, can and do subcontract with other MCOs for services such as mental health, dental or vision.

**The CHIP program is a managed care program. The PPO noted is for one CHIP contractor who operates in 21 counties in the central part of Pennsylvania. Approximately five of the 21 counties are PPOs due to the lack of managed care arrangements in those counties. Contractually, this CHIP contractor is required to provide all the same safety nets and services in the PPO areas as is provided in the managed care arrangements.

Table 3.4.1 Education and Outreach Approach						
Approach	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program*	
	✓ = Yes	Rating (1-5)	✓ = Yes	Rating (1-5)	✓ = Yes	Rating (1-5)
Billboards			✓ Contractors	2		
Brochures/flyers			✓ State	3		
			✓ Contractor	3		
			✓ Community Based Organizations	3		
Direct mail by State/enrollment broker/administrative contractor			✓ Contractor	3		
Education sessions			✓ State	4		
			✓ Contractor	4		
			✓ Community Based Organizations	4		
Home visits by State/enrollment broker/administrative contractor			✓ Community Based Organizations	3		
Hotline			✓ State	5		
Incentives for education/outreach staff			✓ Community Based Organizations	2		
Incentives for enrollees						
Incentives for insurance agents						

Table 3.4.1 (cont'd)						
Non-traditional hours for application intake			✓ Contractor	3		
Prime-time TV advertisements			✓ State	5		
			✓ Contractor	5		
Public access cable TV			✓ State	5		
			✓ Contractor	5		
Public transportation ads			✓ State	4		
			✓ Contractor	4		
Radio/newspaper/TV advertisement and PSAs			✓ State	4		
			✓ Contractor	4		
Signs/posers			✓ State	3		
			✓ Contractor	3		
			✓ Community Based Organizations	3		
State/broker initiated phone calls						
Other (specify) Community Based Organizations initiated phone calls			✓ Community Based Organizations	2		

Table 3.4.2 Education and Outreach Setting						
Setting	Medicaid CHIP Expansion		State Designed CHIP Program		Other CHIP Program*	
Battered women shelters			✓	3		
Community sponsored events			✓	3		
Beneficiary's home			✓	4		
Day care centers			✓	3		
Faith Communities			✓	3		
Fast Food restaurants/other restaurants			✓	1		
Grocery stores			✓	1		
Homeless shelters			✓	3		
Job training centers/employment offices/union cites			✓	1		
Laundromats			✓	1		
Libraries			✓	3		
Local/community health centers			✓	4		
Point of Service/provider locations			✓	4		
Public meetings/health fairs			✓	3		
Public housing			✓	3		
Refugee resettlement programs Migrant programs			✓	1		
Schools/adult education sites			✓	3		
Senior centers			✓	1		
Social service agency/hospitals			✓	3		
Workplace			✓	1		

Table 3.4.2 (cont'd)						
Other (specify) Recreation sites e.g. state parks			✓	1		
Other (specify) Penal institution waiting rooms			✓	1		
Other businesses e.g. hair/nail salons, grocery stores, dry cleaners, car wash, check cashing centers, pharmacies, clothing stores			✓	1		
Other (specify) Federal offices, e.g. Post Office, SSA			✓	1		

Table 3.5 Coordination Between Health Care Programs				
Type of coordination	Medicaid	Maternal and Child Health	Other (specify) Education	Other (specify) PA Partnerships for Children
Administration	<u>1/</u>	<u>1/</u>		
Outreach	<u>1/</u>	<u>1/</u>	<u>1/</u>	
Eligibility determination	<u>2/</u>			
Service delivery				
Procurement				
Contracting				
Data collection	<u>3/</u>			<u>3/</u>
Quality assurance	<u>4/</u>	<u>4/</u>		

1/ Primary program coordination is accomplished through the dynamics of an interagency workgroup in conjunction with a multi-agency social marketing contract and the administration of a shared funded statewide toll-free helpline. The interagency workgroup meets every two weeks and is composed of key officials from the State Departments of Insurance, Public Welfare, Health and Education. The first meeting of the month involves the coordination of program policy. The group then expands every other meeting to include the social marketing contractor, the RWJ Covering Kids grantee and the Helpline staff. The meetings focus on the coordination of program policy and outreach. Examples of these efforts include a coordinated application and eligibility system, the use of a single, statewide social marketing contractor who is responsible for the development and execution of media and other outreach campaigns, and the shared funding of a toll-free helpline.

The CHIP toll-free telephone number is located in the Healthy Babies/Health Kids Helpline, which was originally begun under the auspices of Title V development. The Helpline is jointly funded by the Departments of Insurance, Public Welfare and Health. Initial callers are screened to determine which program they should be appropriately referred to, CHIP or Medicaid. Further services include follow-up with callers to determine if they applied for a program and to assist with the process if necessary. Referrals are also made to necessary providers. The Helpline maintains a database and a reporting system to facilitate the follow-up with families, as well as the coordination with the provider community and the CHIP/Medicaid/Title V agencies.

Many efforts for outreach have been conducted in conjunction with a variety of other agencies. Special mailings have been sent to statewide WIC coordinators, who have distributed CHIP brochures and posters to the WIC sites. The Department of Education, who administers the School Lunch Program, distributed CHIP and Medicaid information to children who participated in the Summer Food and School Lunch Program. Efforts are also being made to ensure that children who may have been in foster care with the Department of Public Welfare and have returned to their families are aware of the CHIP Program.

Table 3.5 Coordination Between Health Care Programs (cont'd)

2/ Coordination with the Medicaid agency, the Department of Public Welfare, has and continues to be essential to ensure that families with children who are denied Medicaid eligibility or terminated from Medicaid are informed about CHIP and either assisted with an application or that information is given to them about CHIP. Pennsylvania initiated a process in February 1999, titled “Any Form is a Good Form”, whereby families who applied for Medicaid and were denied because their income exceeded Medicaid income levels would be automatically referred to a CHIP contractor and vice versa, a family who had applied to CHIP and were found to have income that was below the CHIP income levels would be referred to Medicaid. This practice ensures that families have a single entry point into the health care coverage eligibility system for Pennsylvania. The Department of Public Welfare also provides CHIP information to all families who have had their financial, food stamps or medical case closed.

Further coordination efforts will come to fruition as the State’s plan for a single, data element form is put into place. CHIP has traditionally had a different set of managed care plans than Medicaid. Each CHIP contractor has had a unique application and the CHIP eligibility process has been different from Medicaid. Families found that they may have children of varying ages who are eligible for one or both systems, thus they were historically navigating through two systems of application and eligibility. CHIP, as well as Public Welfare staff and representatives from the child advocacy community have been working on a collaborative effort to create a set of common elements that can be used on all applications for either CHIP or Medicaid. This coordinated effort is essential to streamline the eligibility process for Pennsylvania families.

3/ CHIP is also involved in an interagency collaboration with the Department of Public Welfare on data integration. CHIP is engaged in the design and development of a centralized, electronic data system to monitor and analyze performance in order to ensure integrity, efficiency of operations, and quality of care. CHIP is working with the Departments of Public Welfare in the design of the data system, so that the two individual data systems will be able to accomplish data matches on CHIP applicants.

Further efforts for coordination for data collection have evolved as a result of efforts to project the number of uninsured children for Pennsylvania and the appropriate programs for which the children would qualify. The Departments of Insurance and Public Welfare and the Pennsylvania Partnerships for Children, a child advocacy agency, worked together to establish criteria and standards to be utilized in the selection of data for the preparation of the final report of march 2000 titled “Uninsured Children in Pennsylvania”. See Appendix A.

4/ A task force has been convened to assist in the design and development of a quality assurance system that will be executed through CHIP. The system will allow the State to measure and respond to quality of care performance indicators for CHIP. The task force includes medical directors from Medicaid, the Department of Health and CHIP managed care contractors.

Table 4.1.1 CHIP Program Type – Stand Alone Program						
Characteristics	Number of children ever enrolled		Average number of 1 months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children	57,481	81,757	7.42	3.97	7,215	36,085
Age						
Under 1	119	12,782	3.25	2.74	7	135
1-5	8,689	18,804	6.41	3.38	1,152	6,443
6-12	25,492	23,832	9.30	3.93	3,274	16,495
13-18	23,181	26,339	10.71	4.25	2,782	13,012
Countable Income Level*	57,481	81,757	7.42	3.97	7,215	36,085
At or below 150% FPL						
Above 150% FPL	57,481	81,757	7.42	3.97	7,215	36,085
Age and Income						
Under 1	119	12,782	3.25	2.74	7	135
Above 150% FPL	119	12,782	3.25	2.74	7	135
1-5	8,689	18,804	6.41	3.38	1,152	6,443
At or below 150% FPL						
Above 150% FPL	8,689	18,804	6.41	3.38	1,152	6,443
6-12	25,492	23,832	9.30	3.93	3,274	16,495
At or below 150% FPL						
Above 150% FPL	25,492	23,832	9.30	3.93	3,274	16,495

Table 4.1.1 CHIP Program Type – Stand Alone Program						
Characteristics	Number of children ever enrolled		Average number of 1 months of enrollment		Number of disenrollees	
13-18	23,181	26,339	10.71	4.25	2,782	13,012
At or below 150% FPL						
Above 150% FPL	23,181	26,339	10.71	4.25	2,782	13,012
Type of Plan						
Fee-for-service	NA	NA	NA	NA	NA	NA
Managed care	57,481	81,757	7.42	3.97	7,215	36,085
PCCM	NA	NA	NA	NA	NA	NA

*The only characteristics PA CHIP presently have available are the HCFA age categories and the income level at date of application. The federally subsidized portion of the program is above 150% and below 200% of poverty. See Table 4.1.1 – CHIP Characteristics.

Pennsylvania CHIP currently does not have a central database that can unduplicate data state-wide. The method approved by HCFA to complete the HCFA 21E reports is to have contractors perform the calculations for each quarter and PA CHIP takes these individual reports, summarizes them and submits them to HCFA. Contractors do not have the ability to report on enrollments historically. Therefore, once the report period has passed, PA CHIP cannot recapture the data. PA CHIP is in the process of building an electronic central database; however, its current systems are manual. Pennsylvania is committing its resources to building this new system.

Table 4.2.3 – Reasons for Discontinuation of Coverage

Reason for discontinuation of coverage	Medicaid CHIP Expansion Program		State-designed CHIP Program		Other CHIP Program*	
	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total
Total	N/A	N/A	36,085	12.6%	N/A	N/A
Access to commercial insurance						
Eligible for Medicaid						
Income too high						
Aged out of program						
Moved/died						
Nonpayment of premium						
Incomplete documentation						
Did not reply/unable to contact						
Other (specify)						
Other (specify)						
Don't know			36,085	12.6%		

Table 4.3.1 CHIP Total Expenditures				
Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures	\$38,068,233	\$59,807,263	\$7,271,675	\$40,714,777
Premiums for private health insurance (net of cost-sharing offsets)*	\$37,439,081	\$52,686,854	\$7,271,675	\$38,311,184
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 services				
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				

Table 4.3.2 CHIP – Administrative and Outreach Expenditures						
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	N/A	N/A	\$38,068,233	\$57,117,215	N/A	N/A
Outreach				\$3,794,864		
Administration			\$22,263	\$638,496		
Other__ Benefits_____				\$52,686,854		
Federal share			\$7,271,675	\$40,714,777		
Outreach				\$2,006,112		
Administration				\$397,480		
Other Benefits_____			\$7,271,675	\$38,311,184		

Table 4.4.1 Approaches to Monitoring Access			
Approaches to monitoring access	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*
Appointment audits		MCO	
PCP/enrollee ratios		MCO/PPO	
Time/distance standards		MCO/PPO	
Urgent/routine care access standards		MCO/PPO	
Network capacity reviews (rural providers, safety net providers, specialty mix)		MCO/PPO <u>1/</u>	
Complaint/grievance/disenrollment reviews		MCO/PPO	
Case file reviews		MCO/PPO <u>2/</u>	
Beneficiary surveys		MCO/PPO	
Utilization analysis (emergency room use, preventive care use)		MCO/PPO <u>3/</u>	
Other: High Volume Specialists		MCO <u>4/</u>	
Other: After Hours Survey		MCO <u>5/</u>	
Other: Provider Evaluation Surveys		MCO <u>6/</u>	

Note: The above chart represents company-wide evaluation processes, not CHIP-specific evaluations. CHIP enrollees utilize the same provider networks as commercial subscribers.

1/ Four of the five CHIP MCO's monitor network capacity

2/ Four of the five CHIP MCO's conduct case file reviews

3/ Four of the five CHIP MCO's perform utilization analysis of emergency room use. All five conduct analysis of preventive case usage.

4/ One CHIP MCO monitors "High volume Specialists" reviews.

5/ One CHIP MCO conducts "after hours access" survey.

6/ One CHIP MCO conducts "Provider" evaluation surveys.

Table 4.4.2 Managed Care Utilization Data			
Type of utilization data	Medicaid CHIP Expansion Program	State-designed CHIP program	Other CHIP program*
Requiring submission of raw encounter data by health plans	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Requiring submission of aggregate HEDIS data by health plans	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Other (specify) quarterly and annual reports on encounters by provider type (in the aggregate), hospital utilization, prescription utilization and satisfaction surveys	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

Table 4.5.1 Measuring Quality			
Approaches to monitoring quality	Medicaid CHIP Expansion Program	State-designed CHIP program	Other CHIP program
Focused studies (specify)			
Client satisfaction surveys		MCO*	
Complaint/grievances/disenrollment reviews		MCO*	
Sentinel event reviews		MCO*	
Plan site visits		MCO*	
Case file reviews		MCO*	
Independent peer review		MCO*	
HEDIS performance measurements (specify)		MCO*	
Other performance measurement (specify)			
Other (specify)			
Other (specify)			
Other (specify)			

*The CHIP program is a managed care program. A PPO is used by one CHIP contractor who operates in 21 counties in the central part of Pennsylvania. Approximately five of the 21 counties are PPOs due to the lack of managed care arrangements in those counties. Contractually, this CHIP contractor is required to provide all the same safety nets and services in the PPO areas as is provided in the managed care arrangements.