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

Preamble

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**

- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**

- Build on data ***already collected*** by HCFA quarterly enrollment and expenditure reports, **AND**

- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

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

State/Territory: _____
OKLAHOMA

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

_____
(Signature of Agency Head)

SCHIP Program Name (s) **SOONERCARE**

SCHIP Program Type **X** Medicaid SCHIP Expansion Only
____ Separate SCHIP Program Only
____ Combination of the above

Reporting Period **Federal Fiscal Year 2000 (10/1/99-9/30/00)**

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SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This sections has been designed to allow you to report on your SCHIP program=s changes and progress during Federal fiscal year 2000 (September 30, 1999 to October 1, 2000).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 1999 in the following areas and explain the reason(s) the changes were implemented.

Note: If no new policies or procedures have been implemented since September 30, 1999, please enter ›NC= for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

1. Program eligibility **NC**
2. Enrollment process **NC**
3. Presumptive eligibility **NC**
4. Continuous eligibility **NC**
5. Outreach/marketing campaigns **NC**
6. Eligibility determination process **NC**
7. Eligibility redetermination process **NC**
8. Benefit structure **NC**
9. Cost-sharing policies **NC**
10. Crowd-out policies **NC**
11. Delivery system **NC**
12. Coordination with other programs (especially private insurance and Medicaid) **NC**
13. Screen and enroll process **NC**
14. Application **NC**
15. Other **NC**

1.2 Please report how much progress has been made during FFY 2000 in reducing the number of uncovered, low-income children.

Oklahoma has had phenomenal success in increasing the number of children with creditable health coverage. On September 30, 2000 we had total 37,321 (versus 30,127 in FFY 1999) enrolled in SCHIP and 86,1829 (versus 65,696 in FFY 1999) additional children enrolled in Medicaid as a result of Title XXI outreach (point in time) since our expansion in December 1997.

1. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2000. Describe the data source and method used to derive this information.

On September 30, 2000 we had 37,321 children enrolled in SCHIP (point in time internal eligibility data, Medicaid enrollment data) since our expansion which is 91% of total SCHIP eligibles. This is an increase of 7,194 children enrolled in SCHIP over the previous Federal fiscal year. In terms of percentage, our SCHIP enrollment increased from 73% to 91% over the previous Federal fiscal year. As a result of Title XXI outreach we had 86,182 additional children enrolled in Medicaid (point in time internal eligibility data, Medicaid enrollment data).

2. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

As a result of Title XXI outreach we had 86,182 additional children enrolled in Medicaid (point in time internal eligibility data, Medicaid enrollment data).

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

4. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

   ___✓___ No, skip to 1.3

   ____ Yes, what is the new baseline?

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

What was the justification for adopting a different methodology?

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

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

1.3 Complete Table 1.3 to show what progress has been made during FFY 2000 toward achieving your State=s strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State=s strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

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

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

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
1. Decrease the number of children in the State who lack creditable health insurance coverage.	**By the end of FFY 1998, the State hopes to have forty-five (45%) percent of the newly eligible uninsured children enrolled, and, by the end of FFY 1999, 75%.**	Data Sources: **Current Population Survey, internal eligibility data, Medicaid enrollment data** Methodology: **Compare number of uninsured enrolled children reported by the system on September 30, 2000 to baseline estimate of uninsured children.** Numerator**: Number of newly eligible uninsured enrolled children** Denominator: **Baseline estimate of newly eligible uninsured children.** Progress Summary: **The State is pleased to report that it enrolled 37,321 (91%) newly eligible uninsured children by September 30, 2000 (out of 40,995 newly eligible uninsured children).**
OBJECTIVES RELATED TO SCHIP ENROLLMENT		
2. Monitor Program participation so that	**Survey in the short run**	Data Sources: **Data from survey**

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
"crowd-out" does not become problematic.	**to assess crowd-out.**	Methodology: **Survey (CAHPS methodology)** Numerator: **SCHIP enrollees who dropped private employer/individual insurance.** Denominator: **SCHIP enrollees** Progress Summary: **The crowd out rate was only 5.2%.**
OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		
3. Increase the enrollment of currently-eligible (but not participating) AFDC and AFDC-related Children in the Medicaid Program.	**Through a statewide outreach effort, the State hopes to increase Medicaid participation by the end of FFY 1998 to 70%, and, by the end of FFY 1999, to 75%.**	Data Sources: **Current Population Survey, internal eligibility data, Medicaid enrollment data** Methodology: **Compare number of enrolled children reported on HCFA 2082 on September 30, 2000 to baseline estimate of eligible children.** Numerator: **Number of Medicaid enrolled children**

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
		Denominator: **Baseline estimate of Medicaid eligible children.** Progress Summary: **The State is pleased to report that it enrolled 281,589 children in the Medicaid Program by September 30, 2000. Through a statewide outreach effort, the State increased the enrollment of currently-eligible (but not participating) AFDC and AFDC-related Children in the Medicaid Program to 76% by September 30, 2000.**
OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		
		Data Sources: Methodology: Progress Summary:
OTHER OBJECTIVES		

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
4. Ensure that the Medicaid enrollment (participation) percentages are the same for both the rural SoonerCare Choice and urban SoonerCare Plus Programs. **Cumulative enrollment percentages for the affected urban and rural eligibles will be the same by the end of FFY 1999.**	**Cumulative enrollment percentages for the affected urban and rural eligibles will be the same by the end of FFY 1999.**	Data Sources: **Current Population Survey, internal eligibility data, SoonerCare enrollment data** Methodology: **Compare SoonerCare Choice and SoonerCare Plus Programs enrollment data** Numerator: **SoonerCare Choice enrollees and SoonerCare Plus enrollees** Denominator: **SoonerCare Choice eligibles and SoonerCare Plus eligibles** Progress Summary: **At the end of September 2000, approximately 60% of the SoonerCare Plus urban eligibles were enrolled in the program while 82% of the SoonerCare Choice rural eligibles were enrolled in the program.**

OTHER OBJECTIVES

5. Reduce the number of short-term ("medical") enrollments into the Medicaid program which result in periods of retroactive eligibility.	**Reduce such (after-the-fact) enrollments from 90% to (50%) by the end of FFY 1999.**	Data Sources: **Medicaid eligibility data (data extract from Dept. of Human Services).** Methodology: **Count all children with certification dates earlier than application dates and compare with number of all children enrolled.** Numerator: **Number of children with certification dates earlier than application dates and compare with number of all children enrolled.** Denominator: **All children enrolled.** Progress Summary: **The number of short-term ("medical") enrollments into the Medicaid program which result in periods of retroactive eligibility was reduced to 49.17%.**

6. Minimize the autoassignment rate for newly-enrolled individuals (for both the existing unenrolled eligibles and the new eligibles) in the selection of a PCCM or MCO.	**Enrollment autoassignment rates will be less than (50%) by the end of FFY 1998 and less than 40% by the end of FFY 1999.**	Data Sources: **Medicaid enrollment data** Methodology: **Compare the number of enrollees with the number of children autoassigned** Numerator: **The number of children autoassigned** Denominator: **The number of children enrolled in SoonerCare** Progress Summary: **By September 30, 2000 autoassignment rates were down to 50%.**

1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.

1.5 Discuss your State=s progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.

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

1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program=s performance. Please list attachments here.

See Attachment A : crowd out survey

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family coverage:

A. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out. **NA**

2. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2000 (10/1/99 -9/30/00)?

   Number of adults_____
   Number of children_____

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

2.2 Employer-sponsored insurance buy-in:

1. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s). **NA**

2. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2000?

   Number of adults_____
   Number of children_____

2.3 Crowd-out:

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

   We define crowd out as the number of SCHIP enrollees who voluntarily dropped private employer/individual insurance prior to enrolling in SCHIP out of (divided by) the total number of SCHIP enrollees.

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

   We survey SCHIP enrollees to monitor and measure whether crowd-out is occurring.

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

The crowd out rate was only 5.2 (see-attached survey).

4. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

NA

2.4 Outreach:

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

Based on monthly telephone surveys we find that the Department of Human Service eligibility workers and family/friends were the most effective in providing information about the program.

2. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

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

2.5 Retention:

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

Eligibility rules have been revised in 1999 to establish a new eligibility process that applies specifically to categorically needy pregnant women and families with children that allows an eligibility re-determination process eliminating the automatic case closure at the end of the certification period. Earlier, rules required categorically needy families with children who do not receive cash assistance to be certified for Medicaid for a six-month period. The eligibility period terminated automatically at the end of the six-month period and the case closed without worker action or notice to the client. In order to continue Medicaid coverage, the client had to re-apply. This put the client back into fee-for-service for one to three of the six months of eligibility, thus causing a break

in the continuity of care.

The new rules eliminated automatic case closure and replaced the closure with a redetermination process. The eligibility worker has to take an action in order for the case to close. This revision maintains the medical home model for Medicaid clients.

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

__✓__ Follow-up by caseworkers/outreach workers
__✓__ Renewal reminder notices to all families
___ Targeted mailing to selected populations, specify population _____
__✓__ Information campaigns
__✓__ Simplification of re-enrollment process, please describe**___see above in 2.5 A_____**
___
___ Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe_____
___ Other, please explain_____

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

Yes.

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

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

2.6 Coordination between SCHIP and Medicaid:

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

Yes-Oklahoma has done a Medicaid expansion under SCHIP.

2. Explain how children are transferred between Medicaid and SCHIP when a child=s eligibility status changes.

The enrollees' insurance/income status is monitored and the federal financial match is appropriately claimed.

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

Yes.

2.7 Cost Sharing:

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

NA

2. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?

2.8 Assessment and Monitoring of Quality of Care:

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

The Oklahoma Medicaid program has used the HCFA designed Quality Assurance Reform Initiative (QARI) as a tool for monitoring quality of care for the Medicaid managed care programs (SoonerCare) covered under the Oklahoma 1115 Waiver. In July of 1999, Oklahoma began implementation of the HCFA Quality Improvement System for Managed Care (QISMC). In July of 2000, the first QISMC reports for all SoonerCare programs were released. These reports indicate that all SoonerCare products have performed exceptionally well for the first year of QISMC implementation. The SoonerCare QISMC reports have been included for further detailed information.

Oklahoma had used the Consumer Assessment of Health Plan Surveys (CAHPS) as the tool for monitoring satisfaction with all SoonerCare products. The CAHPS surveys administered are as follows:

1. **CAHPS Adult**
2. **CAHPS Child**
3. **CAHPS SSI Adult**
4. **CAHPS Children with Special Health Care Needs (a preliminary of the Child SSI survey)**
5. **Pediatric modification of the Adult Behavioral Health Survey (a preliminary of the CAHPS ECHO Survey)**

The results have indicated a high level of satisfaction across all products, with satisfaction

with services to children remaining consistently higher than services to adults. The CAHPS Child, Children with Special Health Care Needs, and Pediatric Behavioral Health surveys have been included for further detailed information.

Oklahoma has collected Healthplan Employer Data Information Set (HEDIS) measures from participating HMOs for several years. HEDIS measures have remained difficult to interpret across all measures due to some remaining problems with the HMO ability to collect administrative data. This is particularly problematic with immunization and well child data. Other measures, such as utilization measures, are much more stable. Oklahoma has conducted Immunization and EPSDT focused studies under QISMC, which have indicated much higher measures for Immunizations and well child screens than indicated in HEDIS measures. HCCA 416 EPSDT measures have also been higher. This has indicated a systematic under reporting of HEDIS measures for Immunizations and well child screens. The most recent HEDIS measures have been included for more detailed information.

2. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?

In addition to the information contained above, Oklahoma has conducted Focused studies under QARI for EPSDT Immunizations and, Pediatric Asthma. Under QISMC, the responsibility for conducting Quality Improvement Projects (QIPs) shifted to the HMOs. The State did, however designate and design a QIP for EPSDT. The study design and year one implementation of the EPSDT study is contained in the year one QISMC assessment.

Well child, immunization, behavioral health and substance abuse, dental, and vision data are available in HEDIS. Satisfaction with these services is assessed regularly in the various CAHPS surveys.

The State is participating in the Government Performance and Results Act (GPRA) Immunization Performance Improvement Project in conjunction with the Oklahoma State Department of Health. This is a collaborative effort to improve and monitor the immunization status of all children, as well as the Medicaid population specifically. Ongoing data are collected and available annually.

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

Oklahoma will continue with QISMC monitoring and CAHPS surveys. These results will be available on an annual basis. As a part of QISMC. The Oklahoma EPSDT QIP study

will be completed after year two of QISMC, July of 2001. Oklahoma will also continue with annual administration of CAHPS surveys. These results will be available on an annual basis. Oklahoma will also continue to collect selected HEDIS measures to be available on an annual basis.

SECTION 3. SUCCESSES AND BARRIERS

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

3.1 Please highlight successes and barriers you encountered during FFY 2000 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.

Note: If there is nothing to highlight as a success or barrier, Please enter ›NA: for not applicable.

1. Eligibility

2. Outreach

3. Enrollment

4. Retention/disenrollment

5. Benefit structure

6. Cost-sharing

7. Delivery systems

8. Coordination with other programs

9. Crowd-out

10. Other

SECTION 4. PROGRAM FINANCING

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

4.1 Please complete Table 4.1 to provide your budget for FFY 2000, your current fiscal year budget, and FFY 2002 projected budget. Please describe in narrative any details of your planned use of funds.

Note: Federal Fiscal Year 2000 starts 10/1/99 and ends 9/30/00).

Since we are at 91% participation for SCHIP, we expect our enrollment to stabilize at these levels. Hence the budget projections for the next 2 years are at FFY 2000 levels.

	Federal Fiscal Year 2000 costs	Federal Fiscal Year 2001	Federal Fiscal Year 2002
Benefit Costs			
Insurance payments			
Managed care			
per member/per month rate X # of eligibles			
Fee for Service			
Total Benefit Costs			
(Offsetting beneficiary cost sharing payments)			
Net Benefit Costs	37,040,620	37,040,620	37,040,620
Administration Costs			
Personnel			
General administration			
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/marketing costs			
Other			
Total Administration Costs	1,444,350	1,444,350	1,444,350
10% Administrative Cost Ceiling			
Federal Share (multiplied by enhanced FMAP rate)	30,695,720	30,695,720	30,695,720
State Share	7,789,250	7,789,250	7,789,250
TOTAL PROGRAM COSTS	**38,484,970**	**38,484,970**	**38,484,970**

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2000.

NA

4.3 What were the non-Federal sources of funds spent on your CHIP program during FFY 2000?

___✓___State appropriations
_____County/local funds
_____Employer contributions
_____Foundation grants
_____Private donations (such as United Way, sponsorship)
_____Other (specify) _____

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

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

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

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

Table 5.1	**Medicaid Expansion SCHIP program**	**Separate SCHIP program**
Program Name		
Provides presumptive eligibility for children	✓ No _____Yes, for whom and how long?	_____No _____Yes, for whom and how long?
Provides retroactive eligibility	_____No ✓ **-for 90 days** Yes, for whom and how long?	_____No _____Yes, for whom and how long?
Makes eligibility determination	✓ **(Dept. of Human Services)** State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)* _____	_____State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)* _____
Average length of stay on program	Specify months **8.995 months in Medicaid (7.56 months in Soonercare)**	Specify months _____
Has joint application for Medicaid and SCHIP	_____No ✓ Yes	_____No _____Yes
Has a mail-in application	_____No ✓ Yes	_____No _____Yes
Can apply for program over phone	_____No ✓ Yes	_____No _____Yes

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Can apply for program over internet	----------No ___✓___✓	_____No _____Yes
Requires face-to-face interview during initial application	___✓___No _____Yes	_____No _____Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	___✓___No _____Yes, specify number of months _____ What exemptions do you provide?	_____No _____Yes, specify number of months _____ What exemptions do you provide?
Provides period of continuous coverage <u>regardless of income changes</u>	---------No _____✓, 6 months_____ Yes, specify number of months _____ Explain circumstances when a child would lose eligibility during the time period	_____No _____Yes, specify number of months _____ Explain circumstances when a child would lose eligibility during the time period
Imposes premiums or enrollment fees	___✓___No _____Yes, how much? _____ Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify) _____	_____No _____Yes, how much? _____ Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify) _____
Imposes copayments or coinsurance	___✓___No _____Yes	_____No _____Yes
Provides preprinted redetermination process	___✓_____ No _____ Yes, we send out form to family with their information precompleted and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed	_____ No _____ Yes, we send out form to family with their information and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed

5.2 Please explain how the redetermination process differs from the initial application process.

Eligibility rules have been revised in 1999 to establish a new eligibility process that applies specifically to categorically needy pregnant women and families with children that allows an eligibility re-determination process eliminating the automatic case closure at the end of the certification period. Earlier, rules required categorically needy families with children who do not receive cash assistance to be certified for Medicaid for a six-month period. The eligibility period terminated automatically at the end of the six-month period. In order to continue Medicaid coverage, the client had to re-apply. This put the client back into fee-for-service for one to three of the six months of eligibility, thus causing a break in the continuity of care.

The new rules eliminated automatic case closure and replaced the closure with a redetermination process. The eligibility worker has to take an action in order for the case to close. This revision maintains the medical home model for Medicaid clients.

SECTION 6: INCOME ELIGIBILITY

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

6.1 As of September 30, 2000, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups or Section 1931-whichever category is higher	**_185%___** of FPL for children under age **__18_____** ____% of FPL for children aged _____ ____% of FPL for children aged _____
Medicaid SCHIP Expansion	**_185%___** of FPL for children under age **__18_____** ____% of FPL for children aged _____ ____% of FPL for children aged _____
State-Designed SCHIP Program	____% of FPL for children aged _____ ____% of FPL for children aged _____ ____% of FPL for children aged _____

6.2 As of September 30, 2000, what types and *amounts* of disregards and deductions does each program use to arrive at total countable income? *Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter ANA.@*

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) ____ Yes ____ No
If yes, please report rules for applicants (initial enrollment).

Table 6.2			
	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	State-designed SCHIP Program
Earnings	**$120**	**$120**	$
Self-employment expenses	$	$	$
Alimony payments Received	$	$	$
Paid	$	$	$
Child support payments Received	**$50**	**$50**	$
Paid	$	$	$
Child care expenses	$	$	$
Medical care expenses	$	$	$
Gifts	$	$	$
Other types of disregards/deductions (specify)	$	$	$

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

Title XIX Poverty-related Groups ✓ No ____Yes, specify countable or allowable level of asset test_____
Medicaid SCHIP Expansion program ✓ No ____Yes, specify countable or allowable level of asset test_____
State-Designed SCHIP program ____No ____Yes, specify countable or allowable level of asset test_____
Other SCHIP program_____ ____No ____Yes, specify countable or allowable level of asset test_____

6.4 Have any of the eligibility rules changed since September 30, 2000? ___ Yes __✓__ No

SECTION 7: FUTURE PROGRAM CHANGES

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

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

1. Family coverage

2. Employer sponsored insurance buy-in

3. 1115 waiver

4. Eligibility including presumptive and continuous eligibility

5. Outreach

6. Enrollment/redetermination process

7. Contracting

8. Other