

WE COVER



"She's eligible? Wonderful!"



"My kid's insured? Super!"



"My boy's covered? Awesome!"

2005 ANNUAL REPORT



**FRAMEWORK FOR THE ANNUAL REPORT OF
THE 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 and CMS over the years to design and revise this Annual Report Template. Over time, the framework has been updated to reflect program maturation and corrected where difficulties with reporting have been identified.

The framework is designed to:

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

SECTION I: SNAPSHOT OF SCHIP PROGRAM AND CHANGES

- 1) To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. You are encouraged to complete this table for the different SCHIP programs within your state, e.g., if you have two types of separate child health programs within your state with different eligibility rules. If you would like to make any comments on your responses, please explain in narrative below this table. Please note that the numbers in brackets, e.g., **[500]** are character limits in the State Annual Report Template System (SARTS). You will not be able to enter responses with characters greater than the limit indicated in the brackets.

	SCHIP Medicaid Expansion Program				Separate Child Health Program				
	From		% of FPL for infants	% of FPL	From		% of FPL conception to birth		% of FPL
Eligibility	From		% of FPL for children ages 1 through 5	% of FPL	From	185	% of FPL for infants	200	% of FPL
	From		% of FPL for children ages 6 through 16	% of FPL	From	133	% of FPL for 1 through 5	200	% of FPL
	From		% of FPL for children ages 17 and 18	% of FPL	From	100	% of FPL for children ages 6 through 16	200	% of FPL
	From		% of FPL for children ages 17 and 18	% of FPL	From	100	% of FPL for children ages 17 and 18	200	% of FPL

Is presumptive eligibility provided for children?	No	<input checked="" type="checkbox"/>	No
	Yes, for whom and how long? [1000]		Yes, for whom and how long? [1000]

Is retroactive eligibility available?	No		No
	Yes, for whom and how long? [1000]	<input checked="" type="checkbox"/>	Yes, for whom and how long? Children who are disenrolled from Medicaid because of a change in family circumstances and who are eligible for CHIP may be retroactively enrolled to avoid a gap in health care coverage.

Does your State Plan contain authority to implement a waiting list?	Not applicable	<input checked="" type="checkbox"/>	No
			Yes

Does your program have a mail-in application?	No		No
	Yes	<input checked="" type="checkbox"/>	Yes

Can an applicant apply for your program over the phone?	<input type="checkbox"/>	No	<input type="checkbox"/>	No
	<input type="checkbox"/>	Yes	<input checked="" type="checkbox"/>	Yes. Applications may be filed over the telephone by calling the CHIP Helpline. Helpline counselors use the so-called "Power User" version of Commonwealth of Pennsylvania Application for Social Services (COMPASS) to enter applicant information. COMPASS performs an eligibility review for both CHIP and Medicaid and forwards the data to the appropriate administrative entity to complete enrollment. Additionally, several of our contractors, through their help desks, provide assistance to applicants having difficulty filling out the applications, but not to the point of accepting an application over the phone.

Does your program have an application on your website that can be printed, completed and mailed in?	<input type="checkbox"/>	No	<input type="checkbox"/>	No
	<input type="checkbox"/>	Yes	<input checked="" type="checkbox"/>	Yes

Can an applicant apply for your program on-line?	<input type="checkbox"/>	No	<input type="checkbox"/>	No
	<input type="checkbox"/> Yes – please check all that apply		<input type="checkbox"/> Yes – please check all that apply	
	<input type="checkbox"/>	<input type="checkbox"/> Signature page must be printed and mailed in	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> Signature page must be printed and mailed in
	<input type="checkbox"/>	<input type="checkbox"/> Family documentation must be mailed (i.e., income documentation)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> Family documentation must be mailed (i.e., income documentation)
	<input type="checkbox"/>	<input type="checkbox"/> Electronic signature is required	<input type="checkbox"/>	<input type="checkbox"/> Electronic signature is required
	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/> No Signature is required

Does your program require a face-to-face interview during initial application	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>	No
	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Yes

Does your program require a child to be uninsured for a minimum amount of time prior to enrollment (waiting period)?	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>	No
	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Yes
	<input type="checkbox"/>	Specify number of months	<input type="checkbox"/>	Specify number of months

Does your program provide period of continuous coverage <u>regardless of income changes?</u>		No		No
		Yes	X	Yes
	Specify number of months		Specify number of months	
			12	
	Explain circumstances when a child would lose eligibility during the time period in the box below		Explain circumstances when a child would lose eligibility during the time period in the box below	
	[1000]	<ul style="list-style-type: none"> • Moves to another state • Reaches 19 years of age • Obtains private health insurance or is enrolled in Medicaid • Becomes an inmate of a public institution or a patient in an institution for mental diseases • Death of the child • Misinformation provided at application which would have resulted in a determination of ineligibility had the correct information been known • Voluntary termination requested 		

Does your program require premiums or an enrollment fee?		No	X	No
		Yes		Yes
	Enrollment fee amount		Enrollment fee amount	
	Premium amount		Premium amount	
	Yearly cap		Yearly cap	
	If yes, briefly explain fee structure in the box below		If yes, briefly explain fee structure in the box below (including premium/enrollment fee amounts and include Federal poverty levels where appropriate)	
		[500]	[500]	

Does your program impose copayments or coinsurance?		No	X	No
		Yes		Yes

Does your program impose deductibles?		No	X	No
		Yes		Yes

Does your program require an assets test?		No	X	No
		Yes		Yes
	If Yes, please describe below		If Yes, please describe below	
		[500]	[500]	

Does your program require income disregards?		No		No
		Yes	X	Yes

		If Yes, please describe below
		<ul style="list-style-type: none"> • Standard Earned Income Deduction of \$120/month for each family member who is working • Dependent Care Deduction of \$175/month for each child two years of age or older or incapacitated adult, or \$200/month for each child under age two

Is a preprinted renewal form sent prior to eligibility expiring?		No		No
		Yes, we send out form to family with their information pre-completed and		Yes, we send out form to family with their information pre-completed and
	<input type="checkbox"/>	We send out form to family with their information pre-completed and ask for confirmation	<input checked="" type="checkbox"/>	We send out form to family with their information pre-completed and ask for confirmation. Two of our seven contractors are currently using preprinted renewal forms. The capability exists for the other five and expect many of them to provide this in the future.
	<input type="checkbox"/>	We send out form but do not require a response unless income or other circumstances have changed	<input type="checkbox"/>	We send out form but do not require a response unless income or other circumstances have changed

Comments on Responses in Table:

2. Is there an assets test for children in your Medicaid program? Yes No
3. Is it different from the assets test in your separate child health program? **N/A** Yes No
4. Are there income disregards for your Medicaid program? Yes No
5. Are they different from the income disregards in your separate child health program? Yes No
6. Is a joint application used for your Medicaid and separate child health program? Yes No

7. Have you made changes to any of the following policy or program areas during the reporting period? Please indicate "yes" or "no change" by marking appropriate column.

	Medicaid Expansion SCHIP Program		Separate Child Health Program	
	Yes	No Change	Yes	No Change
a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)				X
b) Application			X	
c) Benefit structure				X
d) Cost sharing (including amounts, populations, & collection process)				X
e) Crowd out policies				X
f) Delivery system				X
g) Eligibility determination process (including implementing a waiting lists or open enrollment periods)				X
h) Eligibility levels / target population				X
i) Assets test in Medicaid and/or SCHIP				X
j) Income disregards in Medicaid and/or SCHIP				X
k) Eligibility redetermination process				X
l) Enrollment process for health plan selection				X
m) Family coverage				X
n) Outreach (e.g., decrease funds, target outreach)			X	
o) Premium assistance				X
p) Prenatal Eligibility expansion				X

q) Waiver populations (funded under title XXI)

Parents

Pregnant women

Childless adults

			X
			X
			X

r) Other – please specify

a. [50]

b. [50]

c. [50]

8. For each topic you responded yes to above, please explain the change and why the change was made, below:

a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	
b) Application	Our applications were modified to capture additional information regarding existing disabilities, enrollment in or application for SSI/SSD, and to gather the number of hours worked per month by members of the household. We also added a short survey for those choosing not to renew.
c) Benefit structure	
d) Cost sharing (including amounts, populations, & collection process)	
e) Crowd out policies	
f) Delivery system	
g) Eligibility determination process (including implementing a waiting lists or open enrollment periods)	
h) Eligibility levels / target population	
i) Assets test in Medicaid and/or SCHIP	
j) Income disregards in Medicaid and/or SCHIP	

k) Eligibility redetermination process	
l) Enrollment process for health plan selection	
m) Family coverage	
n) Outreach	See Section III "Outreach" for detailed description of outreach activities during the reporting period.
o) Premium assistance	
p) Prenatal Eligibility Expansion	
q) Waiver populations (funded under title XXI)	
Parents	
Pregnant women	
Childless adults	
r) Other – please specify	
a. [50]	
b. [50]	
c. [50]	

SECTION II: PROGRAM'S PERFORMANCE MEASUREMENT AND PROGRESS

This section consists of three sub sections that gather information on the core performance measures for the SCHIP program as well as your State's progress toward meeting its general program strategic objectives and performance goals. Section IIA captures data on the core performance measures to the extent data are available. Section IIB captures your enrollment progress as well as changes in the number and/or rate of uninsured children in your State. Section IIC captures progress towards meeting your State's general strategic objectives and performance goals.

Please note that the numbers in brackets, e.g., [500] are character limits in the State Annual Report Template System (SARTS). You will not be able to enter responses with characters greater than the limit indicated in the brackets.

SECTION IIA: REPORTING OF CORE PERFORMANCE MEASURES

CMS is directed to examine national performance measures by the SCHIP Final Rules of January 11, 2001. To address this SCHIP directive, and to address the need for performance measurement in Medicaid, CMS, along with other Federal and State officials, developed a core set of performance measures for Medicaid and SCHIP. The group focused on well-established measures whose results could motivate agencies, providers, and health plans to improve the quality of care delivered to enrollees. After receiving comments from Medicaid and SCHIP officials on an initial list of 19 measures, the group recommended seven core measures, including four child health measures and three adult measures:

Child Health Measures

- Well child visits in the first 15 months of life
- Well child visits in the 3rd, 4th, 5th, and 6th years of life
- Use of appropriate medications for children with asthma
- Children's access to primary care practitioners

Adult Measures

- Comprehensive diabetes care (hemoglobin A1c tests)
- Adult access to preventive/ambulatory health services
- Prenatal and postpartum care (prenatal visits)

These measures are based on specifications provided by the Health Plan Employer Data and Information Set (HEDIS®). HEDIS® provides a useful framework for defining and measuring performance. However, use of HEDIS® methodology is not required for reporting on your measures. The HEDIS® methodology can also be modified based on the availability of data in your State.

The table should be completed as follows:

- Column 1: If you cannot provide a specific measure, please check the boxes that apply to your State for each performance measure, as follows:
- Population not covered: Check this box if your program does not cover the population included in the measure. For example, if your State does not cover adults under SCHIP, check the box indicating, "population not covered" for the three adult measures.
 - Data not available: Check this box if data are not available for a particular measure in your State. Please provide an explanation of why the data are currently not available.
 - Not able to report due to small sample size: Check this box if the sample size (i.e., denominator) for a particular measure is **less than 30**. If the sample size is less than 30, your State is not required to report data on the measure. However, please indicate the exact sample size in the space provided.
 - Other: Please specify if there is another reason why your state cannot report the measure.

Column 2: For each performance measure listed in Column 1, please indicate the measurement specification (i.e., were the measures calculated using the HEDIS® technical specifications, HEDIS®-like specifications, or some other source with measurement specifications unrelated to HEDIS®). If the measures were calculated using HEDIS® or HEDIS®-like specifications, please indicate which version was used (e.g., HEDIS® 2004).

Column 3: For each performance measure listed in Column 1, please indicate the data source(s); the definition of the population included in the measure (such as age, continuous enrollment, type of delivery system); the baseline measurement and baseline year; and your current performance, including the date of the most recent data reported. For rates, please specify the numerator and denominator that were used to calculate the rates. Please also note any comments on the performance measures or progress, such as data limitations, comparisons with external benchmarks, etc. and an explanation for changes from the baseline. Note: you do not need to report data for all delivery system types. You may choose to report data for only the delivery system with the most enrollees in your program.

NOTE: Please do not reference attachments in this table. If details about a particular measure are located in an attachment, please summarize the relevant information from the attachment in the space provided for each measure.

Measure	Measurement Specification	Performance Measures and Progress
<p>Well child visits in the first 15 months of life</p> <p>Not Reported Because:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Population not covered <input type="checkbox"/> Data not available <input type="checkbox"/> Not able to report due to small sample size (less than 30) <input type="checkbox"/> Other <p>Specify sample size:</p> <p>Explain:</p> <p>[500]</p>	<p>X HEDIS Specify version of HEDIS used: 2005</p> <p><input type="checkbox"/> HEDIS-Like Explain how HEDIS was modified:</p> <p>Specify version of HEDIS used:</p> <p><input type="checkbox"/> Other Explain:</p> <p>[7500]</p>	<p>Data Source(s): HEDIS®</p> <p>During the reporting period, PA CHIP contracted with the National Committee for Quality Assurance (NCQA) to collect and analyze Health Employer Data Information Set® (HEDIS)/Consumer Assessment of health Plans Survey (CAHPS)CAHPS.</p> <p>CHIP contracts with seven managed care organizations (MCOs) – five Commercial and two Medicaid MCOs. The two Medicaid MCOs were excluded from measurement this year because their respective CHIP enrollments are too low to adequately measure performance using HEDIS sampling methodology. The PA CHIP averages, therefore, reflect the Commercial product.</p> <p>Definition of Population Included in Measure:</p> <p>The population for this measure includes all children 15 months of age during 2004 with 31 days of continuous enrollment. This measure determines the percentage of eligible children who received six or more well-child visits with a PCP in 2004.</p>

Measure	Measurement Specification	Performance Measures and Progress
		<p>Baseline / Year: 2004</p> <p>MCO 1: non-reportable denominator 29</p> <p>MCO 2: non-reportable Denominator 21</p> <p>MCO 3: non-reportable Denominator 13</p> <p>MCO 4: 69.4% Numerator 25 Denominator 36</p> <p>MCO 5: non-reportable Denominator 2 (Specify numerator and denominator for rates)</p> <p>Performance Progress/Year: 2005 (Specify numerator and denominator for rates)</p> <p>This is the second year this measure was reviewed. Only MCO #4 met the requirement of an eligible denominator population above 30.</p> <p>2005:</p> <p>MCO 1: non-reportable Denominator 28</p> <p>MCO 2: non-reportable Denominator 19</p> <p>MCO 3: non-reportable Denominator 11</p> <p>MCO 4: 66.1% Numerator 39 Denominator 59</p> <p>MCO 5: non-reportable Denominator 19</p> <p>[7500]</p>

Measure	Measurement Specification	Performance Measures and Progress
		<p>Explanation of Progress:</p> <p>MCO #4 experienced a slight decrease in the number of 15-month-old enrollees who received six or more well-child visits with a PCP in 2005 (66.1%) from 2004 (69.4%). The denominator for MCO #4 increased somewhat but remained low at 59. Since this measure includes 15 month olds with only one month or more of enrollment, it is likely some of these children were behind on their well-child checks prior to enrollment. This may also be influenced by the fact that a portion of CHIP infants are on Medicaid for the first few months to the first year of life prior to their enrollment in CHIP. The MA average is noted to be significantly lower than the Commercial or PA averages. We will continue to monitor these issues.</p> <p>Other Comments on Measure:</p> <p>At 66.1%, the rate for MCO #4 is significantly higher than the Medicaid National (48%) and Regional (52.2%) averages but is lower than the Commercial National (68.7%), Regional (75.6%) and PA (78.5%) averages.</p>

Measure	Measurement Specification	Performance Measures and Progress
<p>Well-child visits in children the 3rd, 4th, 5th, and 6th years of life</p> <p>Not Reported Because:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Population not covered <input type="checkbox"/> Data not available <input type="checkbox"/> Not able to report due to small sample size (less than 30) <ul style="list-style-type: none"> Explain: <input type="checkbox"/> Other <ul style="list-style-type: none"> Specify sample size: Explain: <p>[500]</p>	<p>X HEDIS Specify version of HEDIS used: 2005</p> <p><input type="checkbox"/> HEDIS-Like Explain how HEDIS was modified:</p> <p>Specify version of HEDIS used:</p> <p><input type="checkbox"/> Other Explain:</p> <p>[7500]</p>	<p>Data Source(s): HEDIS®</p> <p>During the reporting period, PA CHIP contracted with NCQA to collect and analyze HEDIS®/CAHPS as explained in the measure Well-child Visits in the First 15 Months of Life.</p> <p>Definition of Population Included in Measure:</p> <p>The population for this measure includes 3, 4, 5, or 6 year olds enrolled as of December 31, 2004, with no more than one gap in enrollment up to 45 days during the continuous enrollment period, who received one or more well-child visit(s) with a Primary Care Practitioner during the measurement year.</p> <p>Baseline / Year: 2002</p> <p>MCO 1: 57.7% Numerator 1,211 Denominator 2,099</p> <p>MCO 2: 65.2% Numerator 479 Denominator 735</p> <p>MCO 3: 65.9% Numerator 271 Denominator 411</p> <p>MCO 4: 74.2% Numerator 336 Denominator 453</p> <p>MCO 5: 70.1% Numerator 272 Denominator 388</p> <p>PA CHIP average: 66.6% (Specify numerator and denominator for rates) [500]</p>

Measure	Measurement Specification	Performance Measures and Progress
		<p>Performance Progress/Year: 2005 (Specify numerator and denominator for rates)</p> <p>Year: 2005 MCO 1: 64.2% Numerator 1,237 Denominator 1,927</p> <p>MCO 2: 63.8% Numerator 557 Denominator 873</p> <p>MCO 3: 75.4% Numerator 310 Denominator 411</p> <p>MCO 4: 79% Numerator 350 Denominator 443</p> <p>MCO 5: 72.5% Numerator 261 Denominator 360</p> <p>PA CHIP average: 71%</p> <p>Explanation of Progress:</p> <p>On average, 71% of enrollees, 3 to 6 years of age, received one or more well-child visit(s) with a Primary Care Practitioner in 2004. The 2005 PA CHIP average (71%) reflects an increase of 6.2 percentage points from the 2004 PA CHIP average (64.8%). All five plans either maintained or improved their rates from 2004.</p> <p>The 2004 PA CHIP average was slightly lower than the 2003 average due to a 16.2 percentage point drop by one plan; this same plan improved by 21 percentage points for 2005.</p> <p>Other Comments on Measure:</p> <p>At 71%, the PA CHIP average is higher than the Medicaid National (62.7%) and Regional (67.9%) averages, and more than six percentage points higher than the Commercial National average (64.4%) but lower than the Commercial PA (76.2%) and Regional (72.6%) averages.</p>

Measure	Measurement Specification	Performance Measures and Progress
<p>Use of appropriate medications for children with asthma</p> <p>Not Reported Because:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Population not covered <input type="checkbox"/> Data not available <input type="checkbox"/> Not able to report due to small sample size (less than 30) <input type="checkbox"/> Other <p>Explain:</p> <p>Specify sample size:</p> <p>Explain:</p> <p>[500]</p>	<p>X HEDIS 2005</p> <p>Specify version of HEDIS used: 2005</p> <ul style="list-style-type: none"> <input type="checkbox"/> HEDIS-Like <input type="checkbox"/> Other <p>Explain how HEDIS was modified:</p> <p>Specify version of HEDIS used:</p> <p>Explain:</p> <p>[7500]</p>	<p>Data Source(s): HEDIS®</p> <p>During the reporting period, PA CHIP contracted with NCQA to collect and analyze HEDIS®/CAHPS as explained in the measure Well-child Visits in the First 15 Months of Life.</p> <p>Definition of Population Included in Measure:</p> <p>The population for this measure includes children, ages 5-17, with persistent asthma (according to HEDIS criteria) who were prescribed medications acceptable as primary therapy for long-term control of asthma.</p> <p>Baseline / Year: 2002</p> <p>MCO 1: 72.1% Numerator 196 Denominator 272</p> <p>MCO 2: 66.7% Numerator 96 Denominator 144</p> <p>MCO 3: 70.6% Numerator 125 Denominator 177</p> <p>MCO 4: 67.7% Numerator 283 Denominator 418</p> <p>MCO 5: 67.1% Numerator 348 Denominator 519</p> <p>PA CHIP average: 68.8%</p>

Measure	Measurement Specification	Performance Measures and Progress
		<p>Performance Progress/Year: 2005 (Specify numerator and denominator for rates)</p> <p>Year 2005: MCO 1: 72.7% Numerator 331 Denominator 455</p> <p>MCO 2: 71.4% Numerator 185 Denominator 259</p> <p>MCO 3: 76.1% Numerator 271 Denominator 356</p> <p>MCO 4: 67.5% Numerator 444 Denominator 658</p> <p>MCO 5: 75.5% Numerator 472 Denominator 625</p> <p>PA CHIP average: 72.7%</p> <p>Explanation of Progress: On average, 72.7% of PA CHIP enrollees (ages 5-17 years) were prescribed appropriate medications for long-term control of asthma in 2004. The 2005 PA CHIP average (72.7%) shows a steady yearly improvement from the 2002 baseline year (68.8%) and a 2.4 percentage point increase from the 2004 PA CHIP average (70.3%). Three MCOs showed improvement in their rates and two MCOs showed a slight decrease.</p> <p>Other Comments on Measure:</p> <p>At 72.7%, the PA CHIP average is higher than the Commercial National (71.5%) and Commercial Regional (72%) averages and higher than the Medicaid National (62.8%) and Medicaid Regional (66.7%) averages, and less than one percentage point lower than the Commercial PA average (73.1%).</p>
<p>Children's access to primary care practitioners</p> <p>Not Reported Because:</p> <p><input type="checkbox"/> Population not covered</p> <p><input type="checkbox"/> Data not available</p> <p>Explain:</p>	<p><input checked="" type="checkbox"/> HEDIS Specify version of HEDIS used: 2005</p> <p><input type="checkbox"/> HEDIS-Like Explain how HEDIS was modified:</p> <p>Specify version of HEDIS used:</p>	<p>Data Source(s): HEDIS®</p> <p>During the reporting period, PA CHIP contracted with NCQA to collect and analyze HEDIS®/CAHPS as explained in the measure Well-child Visits in the First 15 Months of Life.</p>

Measure	Measurement Specification	Performance Measures and Progress
<input type="checkbox"/> Not able to report due to small sample size (less than 30) Specify sample size: <input type="checkbox"/> Other Explain: [500]	<input type="checkbox"/> Other Explain: [7500]	Definition of Population Included in Measure: The population for this measure includes enrollees, ages 2-11 years, with no more than a 45-day gap continuous enrollment in 2004. The measure determines the percentage of enrollees, ages 2-11 years, who visited with a PCP in 2004. Baseline / Year: 2002 MCO 1: 85.8% Numerator 4,136 Denominator 4,821 MCO 2: 92.1% Numerator 1,867 Denominator 2,028 MCO 3: 89.8% Numerator 3,195 Denominator 3,558 MCO 4: 86.9% Numerator 4,663 Denominator 5,367 MCO 5: 91.0% Numerator 8,305 Denominator 9,124 PA CHIP average: 89.1%

Measure	Measurement Specification	Performance Measures and Progress
		<p>Performance Progress/Year: 2005 (Specify numerator and denominator for rates)</p> <p>Year 2005: MCO 1: 88.7% Numerator 4,624 Denominator 5,216</p> <p>MCO 2: 89.6% Numerator 2,208 Denominator 2,463</p> <p>MCO 3: 90.7% Numerator 3,779 Denominator 4,166</p> <p>MCO 4: 88.9% Numerator 5,494 Denominator 6,182</p> <p>MCO 5: 91.8% Numerator 9,113 Denominator 9,925</p> <p>PA CHIP average: 89.9%</p> <p>Explanation of Progress:</p> <p>On average, 89.9% of PA CHIP enrollees, ages 2-11, had a visit with a Primary Care Practitioner in 2004. The PA CHIP average has gradually increased since the baseline year, with the exception of a slight drop in 2003 which can be attributed to one MCO. With that exception, all plans have consistently averaged between 88.1% and 91.8% since 2003, most showing gradual increases in this measure.</p> <p>Other Comments on Measure:</p> <p>At 89.9%, the 2005 PA CHIP average is comparable to the averages of the Commercial National (88.3%), Regional (90.3%), and PA (90.6%) averages and the PA CHIP average is higher than Medicaid National (82.4%) and Regional (84%) by several percentage points.</p>
<p>Adult Comprehensive diabetes care (hemoglobin A1c tests)</p> <p>Not Reported Because:</p> <p><input checked="" type="checkbox"/> Population not covered</p> <p><input type="checkbox"/> Data not available</p>	<p><input type="checkbox"/> HEDIS Specify version of HEDIS used:</p> <p><input type="checkbox"/> HEDIS-Like Explain how HEDIS was modified:</p>	<p>Data Source(s): [500]</p> <p>Definition of Population Included in Measure: [700]</p>

Measure	Measurement Specification	Performance Measures and Progress
<p>Explain:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Not able to report due to small sample size (less than 30) Specify sample size: <input type="checkbox"/> Other Explain: <p>[500]</p>	<p>Specify version of HEDIS used:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Other Explain: <p>[7500]</p>	<p>Baseline / Year: (Specify numerator and denominator for rates) [500]</p> <p>Performance Progress/Year: (Specify numerator and denominator for rates) [7500]</p> <p>Explanation of Progress: [700]</p> <p>Other Comments on Measure: [700]</p>
<p>Adult access to preventive/ambulatory health services</p> <p>Not Reported Because:</p> <p>X Population not covered</p> <ul style="list-style-type: none"> <input type="checkbox"/> Data not available Explain: <input type="checkbox"/> Not able to report due to small sample size (less than 30) Specify sample size: <input type="checkbox"/> Other Explain: <p>[500]</p>	<ul style="list-style-type: none"> <input type="checkbox"/> HEDIS Specify version of HEDIS used: <input type="checkbox"/> HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: <input type="checkbox"/> Other Explain: <p>[7500]</p>	<p>Data Source(s): [500]</p> <p>Definition of Population Included in Measure: [700]</p> <p>Baseline / Year: (Specify numerator and denominator for rates) [500]</p> <p>Performance Progress/Year: (Specify numerator and denominator for rates) [7500]</p> <p>Explanation of Progress: [700]</p> <p>Other Comments on Measure: [700]</p>
<p>Adult Prenatal and postpartum care (prenatal visits):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Coverage for pregnant women over age 19 through a demonstration <input type="checkbox"/> Coverage for unborn children through the SCHIP state plan <input type="checkbox"/> Coverage for pregnant women under age 19 through the SCHIP state plan 	<ul style="list-style-type: none"> <input type="checkbox"/> HEDIS Specify version of HEDIS used: <input type="checkbox"/> HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: 	<p>Data Source(s): [500]</p> <p>Definition of Population Included in Measure: [700]</p>

Measure	Measurement Specification	Performance Measures and Progress
<p>Not Reported Because:</p> <p><input checked="" type="checkbox"/> Population not covered</p> <p><input type="checkbox"/> Data not available Explain:</p> <p><input type="checkbox"/> Not able to report due to small sample size (less than 30) Specify sample size:</p> <p><input type="checkbox"/> Other Explain:</p> <p>[500]</p>	<p><input type="checkbox"/> Other Explain:</p> <p>[7500]</p>	<p>Baseline / Year: (Specify numerator and denominator for rates) [500]</p> <p>Performance Progress/Year: (Specify numerator and denominator for rates) [7500]</p> <p>Explanation of Progress: [700]</p> <p>Other Comments on Measure: [700]</p>

SECTION IIB: ENROLLMENT AND UNINSURED DATA

- The information in the table below is the Unduplicated Number of Children Ever Enrolled in SCHIP in your State for the two most recent reporting periods. The enrollment numbers reported below should correspond to line 7 in your State's 4th quarter data report (submitted in October) in the SCHIP Statistical Enrollment Data System (SEDS). The percent change column reflects the percent change in enrollment over the two-year period. If the percent change exceeds 10 percent (increase or decrease), please explain in letter A below any factors that may account for these changes (such as decreases due to elimination of outreach or increases due to program expansions). This information will be filled in automatically by SARTS through a link to SEDS. Please wait until you have an enrollment number from SEDS before you complete this response.

Program	FFY 2004	FFY 2005	Percent change FFY 2004-2005
SCHIP Medicaid Expansion Program			
Separate Child Health Program	177,415	179,807	1.35%

- Please explain any factors that may account for enrollment increases or decreases exceeding 10 percent.

[7500]

- Three-year averages in the number and/or rate of uninsured children in each state based on the Current Population Survey (CPS) are shown in the table below, along with the percent change between 1996-1998 and 2001-2004. Significant changes are denoted with an asterisk (*). If your state uses an alternate data source and/or methodology for measuring change in the number and/or rate of uninsured children, please explain in Question #3. SARTS will fill in this information automatically.

3.

Period	Uninsured Children Under Age 19 Below 200 Percent of Poverty		Uninsured Children Under Age 19 Below 200 Percent of Poverty as a Percent of Total Children Under Age 19	
	Number	Std. Error	Rate	Std. Error
1996-1998	157	25.1	5.1	.8
1998-2000	115	21.5	3.7	.7
2000-2002	162	21.2	5.5	.7
2002-2004	195	23.3	6.5	.8
Percent change 1996-1998 vs. 2001-2004	24.2	NA	27.5	NA

- A. Please note any comments here concerning CPS data limitations that may affect the reliability or precision of these estimates.

One of the issues with the CPS data is the relatively high variability in the estimates of the number of uninsured children.

4. If your State has an alternate data source and/or methodology for measuring change in the number and/or rate of uninsured children, please report in the table below. Data are required for two or more points in time to demonstrate change (or lack of change). Please be as specific and detailed as possible about the method used to measure progress toward covering the uninsured.

Data source(s)	[500]
Reporting period (2 or more points in time)	[200]
Methodology	[7500]
Population	[500]
Sample sizes	[200]
Number and/or rate for two or more points in time	[200]
Statistical significance of results	[200]

- A. Please explain why the state chose to adopt a different methodology to measure changes in the number and/or rate of uninsured children.

In order to obtain more detailed information, compared to the CPS data, the Pennsylvania Insurance Department initiated a state-specific survey in January 2004 to evaluate the health insurance status of the Commonwealth's residents. The results of this survey have already been used to make detailed analysis of various characteristics of insured, as well as uninsured, residents of the Commonwealth.

The study conducted in 2004 was the first of its kind. Therefore, using the results to determine changes in the number of uninsured children is not possible at this time. To analyze trends, the program office has requested funding to repeat the survey in the 2006-2007 state fiscal year.

- B. What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Provide a numerical range or confidence intervals if available.)
[7500]

5. How many children do you estimate 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. ***(States with only a SCHIP Medicaid Expansion Program should skip this question)***

Since September 2004, the number of children enrolled in Medicaid has increased from 863,606 to 910,202 (an increase of 46,596). While no exact figure is available, it is reasonable to assume that a portion of the increase is caused by CHIP outreach activities.

In addition, each month approximately 18.6% of applicants for CHIP are screened as potentially eligible for Medicaid. Applications associated with these children are automatically sent to Medicaid for disposition.

SECTION IIC: STATE STRATEGIC OBJECTIVES AND PERFORMANCE GOALS

In the table below, summarize your State's general strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Use additional pages as necessary. **Please do not reference attachments in this table. If details about a particular measure are located in an attachment, please summarize the relevant information from the attachment in the space provided for each measure.** The table should be completed as follows:

Column 1: List your State's general strategic objectives for your SCHIP program and indicate if the strategic objective listed is new/revised or continuing. If you have met your goal and/or are discontinuing a strategic objective or goal, please continue to list the objective/goal in the space provided below, and indicate that it has been discontinued, and provide the reason why it was discontinued. Also, if you have revised a goal, please check "new/revised" and explain how and why it was revised.

Note: States are required to report objectives related to reducing the number of uninsured children. (This/these measure(s) should reflect what was reported in Section IIB, Question(s) 2 and 3. Progress towards reducing the number of uninsured children should be reported in this section.)

Column 2: List the performance goals for each strategic objective. Where applicable, provide the measurement specification (i.e., were the measures calculated using the HEDIS® technical specifications, HEDIS®-like specifications, or some other source with measurement specifications unrelated to HEDIS®).

Column 3: For each performance goal listed in Column 1, please indicate the data source(s); the definition of the population included in the measure (such as age, continuous enrollment, type of delivery system); the methodology used; the baseline measurement and baseline year; and your current performance, including the date of the most recent data reported. For rates, please specify the numerator and denominator that were used to calculate the rates. Please note any comments on the performance measures or progress, such as data limitations, comparisons with external benchmarks, or the like.

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(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 (Mandatory for all states for each reporting year) (This/these measure(s) should reflect what was reported in Section IIB, Question(s) 2 and 3.)		
<input type="checkbox"/> New/revised <input checked="" type="checkbox"/> Continuing <input type="checkbox"/> Discontinued Explain: Increase in overall access to coverage relative to estimated number of uninsured children in Pennsylvania.	Goal #1: Increase state government participation in and administration of outreach efforts and include public service announcements, inter-agency mutual referrals, and revision and distribution of CHIP information.	Data Source(s): Medicaid and CHIP enrollment records Definition of Population Included in Measure: Children meeting eligibility guidelines for each program. Methodology: Enrollment growth in CHIP, Medicaid, and combined programs from May 1998 through September 2005. Baseline / Year: Children enrolled in Medicaid, May 1998 = 703,311 Children enrolled in CHIP, May 1998 = 54,080 Children enrolled in Medicaid, September 2004 = 910,202 Children enrolled in CHIP, September 2004 = 136,470

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		<p>Performance Progress / Year: Numerator: (9/05 Enrollment – 5/98 Enrollment) Denominator: 5/98 Enrollment</p> <p>Percent increase in Medicaid enrollment = $\frac{(910,202-703,311)}{703,311} = 29.4\%$</p> <p>Percent increase in CHIP enrollment = $\frac{(136,470-54,080)}{54,080} = 152.3\%$</p> <p>Percent increase in combined enrollment = $\frac{((910,202+136,470)-(703,311+54,080))}{(703,311+54,080)} = 38.2\%$</p> <p>Explanation of Progress: Since approval of the Pennsylvania state CHIP plan in May 1998, the Pennsylvania Insurance Department's CHIP and the Department of Public Welfare's Medicaid offices have worked together to increase the number of children covered by one program or the other by over 38%.</p> <p>Other Comments on Measure:</p>
<input type="checkbox"/> New/revised <input type="checkbox"/> Continuing <input type="checkbox"/> Discontinued Explain:	Goal #2:	Data Source(s): Definition of Population Included in Measure: Methodology: Baseline / Year: Performance Progress / Year: Explanation of Progress: Other Comments on Measure:
<input type="checkbox"/> New/revised <input type="checkbox"/> Continuing <input type="checkbox"/> Discontinued Explain: [500]	Goal #3: [7500]	Data Source(s): [500] Definition of Population Included in Measure: [700] Methodology: [500] Baseline / Year: (Specify numerator and denominator for rates) [500]

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		Performance Progress / Year: (Specify numerator and denominator for rates) [7500] Explanation of Progress: [700] Other Comments on Measure: [700]

Objectives Related to SCHIP Enrollment		
(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
<input type="checkbox"/> New/revised <input checked="" type="checkbox"/> Continuing <input type="checkbox"/> Discontinued Explain: Increase access to coverage for children in rural areas and northeast Pennsylvania.	Goal #1: 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, and to identify barriers to access in central and northeastern Pennsylvania.	Data Source(s): CHIP enrollment data Definition of Population Included in Measure: Enrollment in CHIP in the 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, and Wyoming). Methodology: Calculate percent change in enrollment in the defined counties since May 1998, the month the state plan was approved. Baseline / Year: Enrollment in May 1998 = 4,217 Performance Progress / Year: Enrollment in September 2005 = 13,322 Numerator: (9/05 Enrollment – 5/98 Enrollment) Denominator: 5/98 Enrollment Percent increase in enrollment = $\frac{(13,322 - 4,217)}{4,217} = 215.9\%$ Explanation of Progress: Since May 1998, when Pennsylvania's state CHIP plan was approved, enrollment in the target counties has increased by 215.9%. This increase surpasses the statewide growth of 152.3% during the same period. Other Comments on Measure:

<p> <input type="checkbox"/> New/revised <input checked="" type="checkbox"/> Continuing <input type="checkbox"/> Discontinued Explain: Increase access to coverage for racial, ethnic, minority, and special needs children eligible for CHIP. </p>	<p> Goal #2: Contractually require insurance contractors to increase outreach focus on community-based agencies in predominantly minority or non-English speaking areas. </p>	<p> Data Source(s): Data available from CHIP enrollment records and the U.S. Census Bureau. </p> <p> Definition of Population Included in Measure: All enrollees in Pennsylvania's CHIP program </p> <p> Methodology: Compare the proportion of CHIP enrollees that fall into various race and ethnic categories to U.S. Census Bureau data for the general population in Pennsylvania. </p> <p> Baseline / Year: CHIP data based on CMS 21 E report from 4th quarter FFY 2005. U.S. Census Bureau estimates are from the 2004 American Community Survey and were retrieved October 28, 2005. </p> <p> Performance Progress / Year: </p> <table border="1" data-bbox="959 764 1560 1314"> <thead> <tr> <th>Race</th> <th>PA General Population</th> <th>CHIP</th> </tr> </thead> <tbody> <tr> <td>Native Hawaiian or Other Pacific Islander</td> <td>0.0%</td> <td>0.0%</td> </tr> <tr> <td>American Indian or Alaska Native</td> <td>0.1%</td> <td>0.2%</td> </tr> <tr> <td>Asian</td> <td>2.2%</td> <td>2.6%</td> </tr> <tr> <td>Black or African American</td> <td>10.0%</td> <td>12.8%</td> </tr> <tr> <td>White</td> <td>84.8%</td> <td>51.2%</td> </tr> <tr> <td>Two or More Races</td> <td>1.1%</td> <td>1.3%</td> </tr> <tr> <td>Unspecified Race</td> <td>N/A</td> <td>31.9%</td> </tr> </tbody> </table> <table border="1" data-bbox="959 1346 1560 1509"> <thead> <tr> <th>Ethnicity</th> <th>PA General Population</th> <th>CHIP</th> </tr> </thead> <tbody> <tr> <td>Hispanic or Latino</td> <td>3.7%</td> <td>2.3%</td> </tr> <tr> <td>Unspecified Ethnicity</td> <td>96.3%</td> <td>97.7%</td> </tr> </tbody> </table> <p> Explanation of Progress: The population of CHIP enrollees is reflective of the general population in Pennsylvania. </p> <p> Other Comments on Measure: </p>	Race	PA General Population	CHIP	Native Hawaiian or Other Pacific Islander	0.0%	0.0%	American Indian or Alaska Native	0.1%	0.2%	Asian	2.2%	2.6%	Black or African American	10.0%	12.8%	White	84.8%	51.2%	Two or More Races	1.1%	1.3%	Unspecified Race	N/A	31.9%	Ethnicity	PA General Population	CHIP	Hispanic or Latino	3.7%	2.3%	Unspecified Ethnicity	96.3%	97.7%
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(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
<input type="checkbox"/> New/revised <input type="checkbox"/> Continuing <input type="checkbox"/> Discontinued Explain: [500]	Goal #3: [7500]	Data Source(s): [500] Definition of Population Included in Measure: [700] Methodology: [500] Baseline / Year: (Specify numerator and denominator for rates) [500] Performance Progress / Year: (Specify numerator and denominator for rates) [7500] Explanation of Progress: [700] Other Comments on Measure: [700]
Objectives Related to Medicaid Enrollment		
<input type="checkbox"/> New/revised <input type="checkbox"/> Continuing <input type="checkbox"/> Discontinued Explain: [500]	Goal #1: [7500]	Data Source(s): [500] Definition of Population Included in Measure: [700] Methodology: [500] Baseline / Year: (Specify numerator and denominator for rates) [500] Performance Progress / Year: (Specify numerator and denominator for rates) [7500] Explanation of Progress: [700] Other Comments on Measure: [700]
<input type="checkbox"/> New/revised <input type="checkbox"/> Continuing <input type="checkbox"/> Discontinued Explain: [500]	Goal #2: [7500]	Data Source(s): [500] Definition of Population Included in Measure: [700] Methodology: [500]

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		Baseline / Year: (Specify numerator and denominator for rates) [500] Performance Progress / Year: (Specify numerator and denominator for rates) [7500] Explanation of Progress: [700] Other Comments on Measure: [700]
<input type="checkbox"/> New/revised <input type="checkbox"/> Continuing <input type="checkbox"/> Discontinued Explain: [500]	Goal #3: [7500]	Data Source(s): [500] Definition of Population Included in Measure: [700] Methodology: [500] Baseline / Year: (Specify numerator and denominator for rates) [500] Performance Progress / Year: (Specify numerator and denominator for rates) [7500] Explanation of Progress: [700] Other Comments on Measure: [700]
Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)		
<input type="checkbox"/> New/revised <input checked="" type="checkbox"/> Continuing <input type="checkbox"/> Discontinued Explain: [500]	Goal #1: Increase rate for Children’s Access to Primary Care Practitioners, ages 2-11. <input checked="" type="checkbox"/> HEDIS Specify version of HEDIS used: HEDIS@2005/ CAHPS 3.0H Child (with Chronic Care Conditions) <input type="checkbox"/> HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: <input type="checkbox"/> Other Explain:	Data Source(s): [500] HEDIS@/CAHPS HEDIS@ measure for Children’s Access to Primary Care Practitioners, ages 2-11. CHIP contracts with seven managed care organizations (MCOs), but only five have been included in the review because the CHIP enrollment of two of the MCOs is too small to adequately measure performance using the HEDIS sampling methodology CAHPS 3.0H Child (with Chronic Care Conditions). Definition of Population Included in Measure: HEDIS: The percent of enrollees ages 2-11 years who had at least one visit with a Primary Care Practitioner (PCP). CAHPS: 3,025 respondents from five MCOs completed the CAHPS@3.0H Questionnaire. 700]

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
	[7500]	<p>Methodology: [500] Comparison of HEDIS measure on primary care access and CAHPS health care access indicator regarding child having a personal doctor or nurse.</p> <p>HEDIS: Baseline / Year: 2002 MCO 1: 85.8% Numerator 4,136 Denominator 4,821</p> <p>MCO 2: 92.1% Numerator 1,867 Denominator 2,028</p> <p>MCO 3: 89.8% Numerator 3,195 Denominator 3,558</p> <p>MCO 4: 86.9% Numerator 4,663 Denominator 5,367</p> <p>MCO 5: 91.0% Numerator 8,305 Denominator 9,124</p> <p>PA CHIP average: 89.1%</p> <p>(Specify numerator and denominator for rates) [500]</p>

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		<p>Performance Progress / Year: (Specify numerator and denominator for rates) Year 2005:</p> <p>MCO 1: 88.7% Numerator 4,624 Denominator 5,216</p> <p>MCO 2: 89.6% Numerator 2,208 Denominator 2,463</p> <p>MCO 3: 90.7% Numerator 3,779 Denominator 4,166</p> <p>MCO 4: 88.9% Numerator 5,494 Denominator 6,182</p> <p>MCO 5: 91.8% Numerator 9,113 Denominator 9,925</p> <p>PA CHIP average: 89.9%</p> <p>CAHPS: Health Care Access Indicator "Child has a personal doctor or nurse" Year 2005:</p> <p>MCO 1: 85.5% Numerator 376 Denominator 452</p> <p>MCO 2: 95.3% Numerator 490 Denominator 521</p> <p>MCO 3: 89.9% Numerator 508 Denominator 572</p> <p>MCO 4: 91.0% Numerator 233 Denominator 262</p> <p>MCO 5: 94.6% Numerator 491 Denominator 526</p> <p>PA CHIP average: 91.3%</p>

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		<p>Explanation of Progress: [700]</p> <p><u>HEDIS:</u> On average, 89.9% of PA CHIP enrollees, ages 2-11, had a visit with a Primary Care Practitioner in 2004 (HEDIS 2005). The PA CHIP average has gradually increased since the baseline year, with the exception of a slight drop in 2003 which can be attributed to one MCO. With that exception, all plans have consistently averaged between 88.1% and 91.8% since 2003, most showing gradual increases in this measure.</p> <p><u>CAHPS Survey:</u> The 2005 CAHPS survey shows 91.3% of respondents reported having a personal doctor or nurse, which is comparable to the 91.5% reported in 2004. This is up from 84% in 2002 to approximately 87% in 2003.</p> <p>Approximately 90% of PA CHIP enrollees, ages 2-11, report having a personal doctor or nurse and are noted to have had a visit with a PCP in 2004.</p> <p>Other Comments on Measure: [700]</p> <p>At 89.9%, the 2005 PA CHIP average is comparable to the Commercial National (88.3%), Regional (90.3%), and PA (90.6%) averages and the PA CHIP average is higher than Medicaid National (82.4%) and Regional (84%) by several percentage points.</p>
<p><input type="checkbox"/> New/revised <input checked="" type="checkbox"/> Continuing <input type="checkbox"/> Discontinued Explain:</p> <p>[500]</p>	<p>Goal #2: Decrease number of children utilizing emergency room services</p> <p><input checked="" type="checkbox"/> HEDIS Specify version of HEDIS used: HEDIS@2005</p> <p><input type="checkbox"/> HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used:</p> <p><input type="checkbox"/> Other Explain:</p> <p>[7500]</p>	<p>Data Source(s): [500] HEDIS@/CAHPS HEDIS@ Ambulatory Care Measure. CHIP contracts with seven managed care organizations (MCOs), but only five have been included in the review because the CHIP enrollment of two of the MCOs is too small to adequately measure performance using the HEDIS sampling methodology.</p> <p>Definition of Population Included in Measure: Enrollee use of ambulatory services for emergency department visits for the age group “under 1 year of age.” [700]</p> <p>Methodology: [500]</p> <p>Measure of each visit to an emergency department by an enrollee under 1 year of age that does not result in an inpatient stay.</p>

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		<p>(Specify numerator and denominator for rates) Baseline / Year: 2004</p> <p>MCO 1: 637.6 visits per 1,000 enrollees Numerator 50 Denominator 941</p> <p>MCO 2: 1,435.4 visits per 1,000 enrollees Numerator 25 Denominator 209</p> <p>MCO 3: 243.4 visits per 1,000 enrollees Numerator 23 Denominator 1,134</p> <p>MCO 4: 615.8 visits per 1,000 enrollees Numerator 142 Denominator 2,767</p> <p>MCO 5: 544.4 visits per 1,000 enrollees Numerator 167 Denominator 3,681</p> <p>PA CHIP 695.3 visits per 1,000 enrollees [500]</p> <p>Performance Progress / Year: (Specify numerator and denominator for rates)</p> <p>2005:</p> <p>MCO 1: 290.3 visits per 1,000 enrollees Numerator/Denominator not available</p> <p>MCO 2: 783.9 visits per 1,000 enrollees Numerator/Denominator not available</p> <p>MCO 3: 285.2 visits per 1,000 enrollees Numerator/Denominator not available</p> <p>MCO 4: 543.4 visits per 1,000 enrollees Numerator/Denominator not available</p> <p>MCO 5: 543.5 visits per 1,000 enrollees Numerator/Denominator not available</p> <p>PA CHIP 489.3 visits per 1,000 enrollees [7500]</p>

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		<p>Explanation of Progress: [700]</p> <p>The 2005 PA CHIP average is 489.3 visits per 1,000 enrollees while the 2004 PA CHIP average was 695.3 per 1,000 enrollees, showing a significant decrease in the number of emergency department visits for the age group “under 1 year of age.” All MCOs reported decreased utilization, except for a very slight increase in MCO #3 (the MCO with the lowest utilization rate for HEDIS 2004 and 2005). The utilization for MCO #2, the highest utilization numbers for HEDIS 2003, 2004, and 2005, decreased significantly from 1,435.4 visits per 1,000 enrollees for HEDIS 2004 to 783.9 visits in HEDIS 2005.</p> <p>Other Comments on Measure: [700]</p> <p>At 489.3 visits per 1,000 enrollees, the 2005 PA CHIP is slightly higher than the Commercial National (309.4), Regional (338), and PA (344.8) averages. The Commercial averages greatly exceed the Medicaid National (87.1) and Regional (90.8) averages.</p> <p>This reflects a marked improvement but warrants further monitoring.</p>
<input type="checkbox"/> New/revised <input type="checkbox"/> Continuing <input type="checkbox"/> Discontinued Explain: [500]	<p>Goal #3:</p> <p><input type="checkbox"/> HEDIS Specify version of HEDIS used:</p> <p><input type="checkbox"/> HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used:</p> <p><input type="checkbox"/> Other Explain: [7500]</p>	<p>Data Source(s): [500]</p> <p>Definition of Population Included in Measure: [700]</p> <p>Methodology: [500]</p> <p>Baseline / Year: (Specify numerator and denominator for rates) [500]</p> <p>Performance Progress / Year: (Specify numerator and denominator for rates) [7500]</p> <p>Explanation of Progress: [700]</p> <p>Other Comments on Measure: [700]</p>

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)		
(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
<input type="checkbox"/> New/revised <input type="checkbox"/> Continuing <input type="checkbox"/> Discontinued Explain: [500]	Goal #1: <input type="checkbox"/> HEDIS Specify version of HEDIS used: <input type="checkbox"/> HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: <input type="checkbox"/> Other Explain: [7500]	Data Source(s): [500] Definition of Population Included in Measure: [700] Methodology: [500] Baseline / Year: (Specify numerator and denominator for rates) [500] Performance Progress / Year: (Specify numerator and denominator for rates) [7500] Explanation of Progress: [700] Other Comments on Measure: [700]
<input type="checkbox"/> New/revised <input type="checkbox"/> Continuing <input type="checkbox"/> Discontinued Explain: [500]	Goal #2: <input type="checkbox"/> HEDIS Specify version of HEDIS used: <input type="checkbox"/> HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: <input type="checkbox"/> Other Explain: [7500]	Data Source(s): [500] Definition of Population Included in Measure: [700] Methodology: [500] Baseline / Year: (Specify numerator and denominator for rates) [500] Performance Progress / Year: (Specify numerator and denominator for rates) [7500] Explanation of Progress: [700] Other Comments on Measure: [700]

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
<input type="checkbox"/> New/revised <input type="checkbox"/> Continuing <input type="checkbox"/> Discontinued Explain: [500]	Goal #3: <input type="checkbox"/> HEDIS Specify version of HEDIS used: <input type="checkbox"/> HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: <input type="checkbox"/> Other Explain: [7500]	Data Source(s): [500] Definition of Population Included in Measure: [700] Methodology: [500] Baseline / Year: (Specify numerator and denominator for rates) [500] Performance Progress / Year: (Specify numerator and denominator for rates) [7500] Explanation of Progress: [700] Other Comments on Measure: [700]

1. What other strategies does your state use to measure and report on access to, quality, or outcomes of care received by your SCHIP population? What have you found?

HEDIS/CAHPS is used as the primary measurement tool. In addition, CHIP Managed Care Organizations (MCOs) are contractually required to submit quarterly and annual reports that provide aggregated data.

In general, HEDIS findings indicate that PA CHIP comparably compares to the commercial and Medicaid populations for many of the reported Effectiveness of Care, Access/Availability of Care, and Use of Care measures. PA CHIP enrollees continue to utilize emergency room services at a higher rate than the commercial populations of the MCOs. HEDIS data also indicates that inpatient mental health utilization continues to be higher than our commercial counterparts and Medicaid, although the number of inpatient discharges has decreased since 2002. It is important to note that the denominators for our CHIP population for these measures are small in comparison to the entire commercial and Medicaid populations and may be a primary factor for this variance. Further investigation will aid in determining the factors.

An approach to studying emergency room usage is currently under development to determine if there is, in fact, over-utilization and what may be the contributing factors. The 2005 HEDIS measures show a slight decrease in utilization for several of the age groups, but still warrants further investigation.

2. What strategies does your SCHIP program have for future measurement and reporting on access to, quality, or outcomes of care received by your SCHIP population? When will data be available? **[7500]**

In February 2004, the development of a data warehouse to provide more immediate and detailed access to claims and utilization data began. (Such data is currently only available in aggregate form from reports provided by the MCOs.) Phase 2 of the data warehouse was expected to go live as of January 2006 but multiple reporting formats utilized by each of the contracted MCOs has delayed the timeframe. We anticipate approximately six to eight months before the data will be considered reliable for internal and external purposes.

3. Have you conducted any focused quality studies on your SCHIP population, e.g., adolescents, attention deficit disorder, substance abuse, special health care needs, or other emerging health care needs? What have you found?

Over the past year, the Insurance Department has been actively involved in a number of health care initiatives under the aegis of the Governor's Office of Health Care Reform. Among the most significant initiatives are an assessment of the mental health and substance abuse service delivery systems and a task force to address the issue of childhood obesity. These efforts include all state agencies that have programs that provide health care services, including the Insurance Department (CHIP Program), Department of Public Welfare (Medicaid Program), and the Department of Health (Bureau of Family Health). These initiatives, which began during the past eight months, are still in the fact-finding stage.

The Insurance Department is currently partnering with Medicaid in a targeted childhood obesity effort for Medicaid and CHIP enrollees. We are also coordinating efforts with the Pennsylvania Medical Society to disseminate information to healthcare providers across the state.

4. Please attach any additional 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 and summarize findings or list main findings.

2005 CAHPS®3.0 Child Survey Summary, CAHPS® 3.0H Child (with Chronic Care Conditions) Questionnaire. The CAHPS Child Survey Summary measures the level of consumer satisfaction for the program as an entity, for each individual MCO, and in regard to enrollee experience with the care provided by doctors and nurses providing service through the insurers. A draft copy of the survey is available as Attachment 1. Unfortunately, the final version will not be available prior to the December 31 deadline for inclusion with this report.

SECTION III: ASSESSMENT OF STATE PLAN AND PROGRAM OPERATION

Please reference and summarize attachments that are relevant to specific questions

Please note that the numbers in brackets, e.g., [7500] are character limits in the State Annual Report Template System (SARTS). You will not be able to enter responses with characters greater than the limit indicated in the brackets.

OUTREACH

1. How have you redirected/changed your outreach strategies during the reporting period? [7500]

MARKETING

Market Study

Based on the Melior study the Department commissioned in the summer of 2003 that affirmed the validity that there is a high level of public awareness of CHIP, the Department worked on messaging that was specifically directed toward motivating a parent to begin the enrollment process. In addition, it was recommended that the development of specific messages directed at targeted market segments be undertaken because a single, broader message does not resonate across all audiences.

The market segments that the Department focused its outreach efforts included:

- **The Not Me's** - people who don't think that their children would qualify. The message for this group is "You may not have thought CHIP is for families just like yours."
- **Transitional Families** - people whose lives and insurance status has changed (e.g., divorce, loss of employment, etc.). The message for this group is "When change leaves your kids uninsured, CHIP can help."

Two television advertisements were developed that feature sports-related themes (skateboarding and a child attempting to play basketball in a suit of armor). The messaging conveys that CHIP lets "kids be kids" and that "we cover" unexpected life events. The television ads were augmented by radio spots that tell parents that their children "really could" qualify for CHIP. One such message is particularly noteworthy in that it features a friend (an **Influencer**) telling a young mother (a **Not Me**) about the generous income limits for CHIP.

The advertising campaign ran intermittently throughout 2005 as a component of the annual back-to-school effort and during the holiday-season (2004 and 2005). A testament to their impact can be seen in the fact that the call volume to the Helpline almost doubled when the ads were run.

Collateral marketing materials (brochures and posters) that complement the television and radio themes were developed and continue to be distributed across the Commonwealth. Print ads were also published in the newspapers of counties with the highest rates of unemployment throughout the state.

OUTREACH THROUGH TECHNOLOGY

COMPASS/*Applying for Coverage*

The Commonwealth of Pennsylvania Access to Social Services (COMPASS) web-based application system (www.COMPASS.state.pa.us) continues to be a well-used tool by consumers seeking to apply for health care coverage and other supportive social service programs. In the past 12 months, more than 75,000 applications for the many available services have been submitted via COMPASS by either consumers or community partners. Of the 75,000, more than 66,700 have been for health care-related services (9,400 applications for CHIP have been submitted, more than 4,300 for adultBasic, and over 53,000 have been submitted for Medicaid). Approximately 7 percent of all CHIP applications and 9 percent of CHIP renewals are completed on-line; approximately 6 percent of all Medicaid applications are completed on-line.

COMPASS/Renewing Coverage

COMPASS utilization numbers increased with the ability to renew coverage for CHIP, adultBasic and Medicaid on-line (established in 2004). Enrollees receive information about the option to renew on-line in their renewal notices and reminders. They are provided with security protection information to access their individual data. An important feature of this enhancement to COMPASS was the concept of an electronic signature. In 2005, a new component called "My COMPASS Account" was created to provide enrolled consumers a roster of all services in which they are enrolled and an account balance where appropriate (e.g., food stamps, cash assistance).

COMPASS/Vehicle for Accessing Coverage Over the Telephone

Throughout 2005, Helpline counselors have been taking applications and processing renewals for CHIP, adultBasic, and Medicaid over the telephone. Counselors enter the information provided by the caller by utilizing the so-called Power User version of COMPASS. In late 2005, the Helpline will begin a new renewal initiative of contacting families who have not renewed their CHIP benefits and have received a termination notice. Designated Helpline staff will call up to 2,500 families a month to determine if they need assistance in renewing CHIP benefits or if they are letting their benefits lapse and for what reason they are doing so.

COMPASS/Future Enhancements

Future releases of COMPASS are slated to include application for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and the Pharmaceutical Assistance Contract for the Elderly (PACE). The Department is reaching out to other Commonwealth agencies to establish other possible COMPASS connections and partnerships, such as Unemployment Compensation. In addition, a pilot program in select school districts tested the use of COMPASS to apply for free and reduced price lunches and is expected to be made available in all schools next year. The use of electronic signatures with COMPASS applications is set to begin in 2006.

Website Improvements

The Department is working with an information technology company to provide a new and more user-friendly CHIP website. The new site, which is scheduled to be unveiled in early 2006, will contain a full array of information including eligibility requirements, benefit information, how to apply, how to secure brochures and other outreach materials, and the SCHIP Annual Report.

GRASS ROOTS INITIATIVES

CHIP Pool Patrols

During the summer of 2005, "CHIP pool patrols" visited community pools across the Commonwealth to talk to families about CHIP and educate them about the need for quality health insurance for their kids. The teams handed out sunscreens to families with the CHIP "We Cover" motto printed on them, along with CHIP brochures and applications. In total, the pool patrols visited over 110 community pools and five Erie beaches, also stopping off at parks, recreation centers, Boys and Girls Clubs, YMCAs and food banks along the way. In total, the pool patrols handed out 9,000 "We Cover" sunscreens.

Pennsylvania Farm Show

The Pennsylvania Farm Show is the largest indoor agricultural event in America, housing 25 acres under roof, spread throughout 11 buildings including three arenas. In 2005, nearly 500,000 visitors packed the aisles of this free event to view the many farm equipment displays, livestock and educational exhibits and agricultural demonstrations participating in this "Winter Extravaganza".

The CHIP program sponsored a booth at the 2005 Farm Show. The booth was manned by CHIP and adultBasic staff and outreach staff from several of the CHIP contractors. Brochures, posters, applications and palm cards were distributed by staff as well as young teens dressed in armor to reflect the new CHIP television commercials, which played on a continuous loop at the booth. Contractors also provided fun giveaways to attract visitors to the booth. Many families with no insurance for their children or themselves stopped by the booth seeking information. Also, many families who have CHIP coverage shared positive stories about their children's coverage.

2. What methods have you found most effective in reaching low-income, uninsured children (e.g., T.V., school outreach, word-of-mouth)? How have you measured effectiveness? **[7500]**

It is difficult, if not impossible, to point to any single outreach effort that has the greatest impact on enrollment. The Department worked closely with its Helpline contractor in 2005 to measure how callers heard about the CHIP program. Television and radio advertising continue to reach the broadest audience, resulting in ever-increasing public awareness of CHIP. Flyers distributed through schools and County Assistance Offices also drew many CHIP calls. Finding that word of mouth and community events continue to strongly fuel awareness, the Department and its insurance company contractors continuously engage in a host of special activities, events, meetings and festivals in communities across the Commonwealth. Examples of those that occurred during this reporting period include:

School-Based Outreach

Annual Distribution of CHIP Information

Pursuant to state statute, passed in December 2002 (Act 153 of 2002, 24 P.S. §14-1406), the Department distributed information about the existence of and eligibility for CHIP to all children enrolled in public schools and offered the information for distribution to private schools. A bright orange flyer with the marketing message “REALLY...even a family of four with annual income of \$45,000 could qualify for CHIP” was distributed to all public and private schools in Pennsylvania. A total of 2.2 million flyers were distributed.

The Department used experience gained from past years to improve the distribution. Based on recommendations from school districts and the state’s Department of Education, the flyers were made available to the schools in June to enable local school personnel to insert them in parent-information packets that are distributed at the beginning of the school year. The Department of Education also sent a broadcast message via e-mail to its 501 school districts to alert them that the CHIP flyers were being sent and a reminder that they were to be distributed to all students. The Department of Education also added a link from their website to the CHIP website and included an electronic version of the CHIP flyer to their website for schools that wished to incorporate the flyer in student booklets and other printed materials.

School Nurse Consultants

Training sessions were again held with state school nurse consultants so that they might be better informed about CHIP and so that they could disseminate information to all school nurses throughout the Commonwealth. The information included how they might encourage or assist the parents of uninsured children to apply for CHIP and the new messaging focus (in particular, the use of COMPASS for on-line, in-school enrollment and telephonic applications were recommended as new options). School nurses were also encouraged to include information about CHIP with kindergarten registration materials and to document health insurance status information in school health records.

Partnership with Boscov’s/Public Service Announcement (PSA) with COMCAST

Boscov’s, a Pennsylvania-based chain of retail stores, stepped forward for a second year to invite CHIP to be an integral part of its annual back-to-school effort. During the weekend prior to the opening of the school year, Boscov’s included CHIP information in newspaper ads and hosted back-to-school events in most of its 25 stores through the state. COMCAST Cable Network also promoted CHIP on their cable channels by airing a series of PSAs featuring Governor Edward G. Rendell. In total, four different PSAs featuring CHIP were run on all Pennsylvania channels during 2005, including a tax season PSA, a summer/outdoor PSA, a back to school PSA and a holiday PSA.

Helpline Call Center

Policy Studies Incorporated (PSI) —Connecting Citizens with CHIP

In 2004, the Commonwealth launched an exciting new public/private partnership project called the Health and Human Services Call Center (HHSCC). The HHSCC comprises a unique multi-agency collaboration among five state agencies that support seven different statewide information and referral helplines: the Pennsylvania Insurance Department, and the Departments of Health, Aging, Public Welfare and General Services. While this integrated call center has saved the Commonwealth more than \$2 million in operating costs, it has also expanded services for callers by providing a “one stop shop” for social services in Pennsylvania. Center information and referral specialists are cross-trained to handle calls from each of the helplines – from Medicaid and CHIP help to brain injury information, from assistance for kids with special needs to long-term care resources, and from what to do about lead in the house to finding a doctor when you’re pregnant - to maximize resources and offer the full range of available services and information to citizens on one call.

The Commonwealth's partner in the HHSCC is Policy Studies Inc. (PSI). PSI has more than 20 years experience in managing health and human services programs such as the HHSCC for federal, state, and local government. Its health services include SCHIP eligibility and enrollment, Medicaid health benefits management (enrollment broker), provider network management, and public health consulting.

PSI has a distinct history of involvement with public programs and provides a full range of consulting, outsourcing, and technology services in health services, child support enforcement, workforce development, justice services, and health and human services technology support. PSI has large-scale call center operations and smaller customer service units in many public health insurance and child support programs across the country.

The Commonwealth and PSI have developed a set of high-quality standards for HHSCC operations and constantly monitor those performance standards to ensure a consistent level of service excellence for Pennsylvania. Quality assurance monitoring is conducted to ensure excellence in customer service. This includes call monitoring and evaluations with each Helpline counselor and for each line. The key performance indicators for the call center are:

- Average speed of answer of <30 seconds
- 95% service level
- Abandoned call rate of <5%
- Live answer rate of 95% or greater
- Average hold time of <30 seconds

Despite heavy call volume (especially when CHIP television ads are on air), the HHSCC consistently met and exceeded these performance standards across all lines.

Application and Renewal Assistance

In addition to information and referral services, the call center is providing application assistance services for callers. Callers are given the option to: receive a paper application; apply or renew over the phone with the assistance of a Helpline counselor; or receive the COMPASS website address to apply on their own over the web. The counselor uses the Power User version of COMPASS to record the application information provided by the caller. The counselor shares the results of the program screening performed by COMPASS with the caller and completes the electronic application for enrollment in the appropriate Commonwealth program. The call center also maintains a list of applications submitted and conducts follow-up calls to ensure that a "result" has occurred with each caller.

Application and Renewal Assistance

While the HHSCC provides callers with valuable information and referrals, staff also are trained to identify anyone without insurance and offer them information and assistance with programs such as Medicaid, CHIP, and PACE (the state's prescription assistance program). For callers who ask specifically for help with Medicaid and CHIP applications, center information and referral specialists offer three options: to mail a paper application, give the Commonwealth of Pennsylvania Access to Social Services (COMPASS) website so they can go on their own to fill out an application, or fill out the application in COMPASS for them while they are on the telephone.

In SFY 2004-05, the center:

- Mailed 9,397 Medicaid applications
- Mailed 37,750 CHIP and adultBasic applications
- Made 7,134 COMPASS referrals
- Completed 3,446 COMPASS applications on-line

Two months after sending an application or completing one online, center staff follow-up with callers to see if they mailed in their completed application or received information about the program for which they applied. Starting just recently, the center began making follow-up calls for individuals whose membership is up for renewal in CHIP. The center works closely with the Pennsylvania Insurance Department and the managed care plans to target families who will lose coverage if they do not get renewal paperwork done on time. Each family receives at least two calls, and staff leaves messages when they are not able to reach someone directly. It is expected that this initiative will help to reduce the number of families who

lose CHIP benefits because they forget to renew or do not complete the renewal process before their coverage ends.

Interagency Initiatives

The work of the nationally recognized interagency work group continues. Key initiatives undertaken during the reporting period include:

Newly Formed Interagency COMPASS Workgroup

Recognizing the interconnectedness of social service programs and the communities they serve, the CHIP program created an interagency COMPASS workgroup in September 2005 to explore and implement ways to continually improve communications and outreach to families in need of CHIP and other Commonwealth social service programs through the use of the COMPASS online application. Outreach will not only include citizens, but also community organization partners who are vital to the people we all serve.

CHIP Information with Birth Certificates

The Department of Health supports the CHIP outreach effort by issuing a specially designed CHIP brochure with each birth certificate they issue. The special brochure was updated this year to reflect the revised messaging of the new CHIP collateral materials.

CHIP Information with Child Support Enforcement

The Child Support Enforcement Unit of the Department of Public Welfare (DPW) sought help in developing a training module about CHIP for the Domestic Relations staff in all Pennsylvania counties. Collateral materials are in the packets provided to families when they have initial contact with the Domestic Relations Office. CHIP also has been included as a link on the DPW child support website.

Transition Checklist for Health Care Planning

CHIP outreach staff supported an effort spearheaded by the Department of Education and DPW to prepare a "Transition Checklist for Health Care Planning" to be used by youth and young adults who have disabilities to achieve successful health outcomes. The checklist was provided to community partners and families of children with disabilities at a series of seminars held throughout the state.

CareerLink Symposiums

Throughout September 2005, the CHIP Outreach Coordinator delivered a series of presentations across the Commonwealth at regional CareerLink conferences. Pennsylvania CareerLink is a cooperative effort that provides one-stop delivery of career services and other needed services to job seekers, employers and other interested individuals through their local county Pennsylvania CareerLink office. The topic of the presentations focused on the interconnection between the CHIP program and the Commonwealth of Pennsylvania Access to Social Services (COMPASS), with explanations on how to become a COMPASS Community Partner. Each of the Commonwealth's 79 CareerLink centers has Internet access and computer labs available to the public. Most already partner with CHIP contractors to provide CHIP information and are looking for additional social service resources and assistance they can provide to people in transition who need healthcare benefits. Based on the response to the presentations from various CareerLink centers, CHIP staff will continue to work with Pennsylvania's Department of Labor and Industry to explore further partnership opportunities.

Covering Kids and Families

Continued Collaboration

Pennsylvania Partnerships for Children (PPC), as the lead agency for the *Covering Kids and Families* (CKF) Coalition, continues to engage in a mutually respectful and productive relationship with CHIP. Consumer advocates are viewed as important contributors in the development of new outreach and enrollment strategies and their input is regularly encouraged by the CHIP staff. PPC brings the knowledge gained through the four local CKF projects as well as the experience of more than 70 CKF Statewide Coalition members.

Staff from the Insurance Department, as well as the CHIP contractors, continue to participate in the CKF Coalition, serving on the Steering Committee. The CHIP staff provide regular updates on the CHIP and adultBasic program structure, enrollment and outreach strategies and engage in development of Coalition

activities and tactics. CHIP staff regularly seek input from CKF Coalition members in developing new policies, strategies and tactics.

CKF and the CHIP and Medicaid programs have collaborated on a number of projects through this past year. Notably, the Insurance Department has encouraged the CKF Back to School concept.

This year, the Deputy Commissioner for CHIP and adultBasic participated in a press conference held in Philadelphia to kick off the Annual Back to School Campaign. The Deputy Commissioner spoke at the press conference along with elected officials, a family receiving CHIP, the Deputy Health Commissioner and the Philly Phanatic (Philadelphia Phillies mascot). Coverage of the event was carried on local affiliates of CBS, ABC, WB and *Telemundo*. Print coverage was carried in the Philadelphia Inquirer. In addition, the Department also coordinated its advertising to complement the start of the Back to School period.

The Insurance Department is an active participant in the second year of the CKF Process Improvement Collaborative. The CKF Process Improvement Collaborative (PIC) is a Robert Wood Johnson Foundation funded project engaging 14 states in a year-long effort to identify and implement specific small scale tests to improve the effectiveness and efficiency of administrative procedures. Pennsylvania's PIC team included a CHIP outreach representative and the Deputy Commissioner for CHIP and adultBasic along with representatives from Department of Public Welfare operations and eligibility staff and CKF Project Director. Pennsylvania's project assessed two areas of customer service for families enrolling in or renewing their health coverage through Medicaid or CHIP.

The first test measured the transfer of applications and renewal forms between Medicaid and CHIP when families were ineligible for the program they first applied to but appeared eligible for the other program. Initially, the team looked at initial applications and then examined renewals. Initial applications appear to transfer correctly, but more assessment is needed to ascertain correct transfer at renewal.

The second test of customer service was inspired by PIC projects in other states. The Helpline will make outbound calls to families who have been sent notices that they are due to lose coverage within 30 days. The Helpline will make three attempts to reach the family to remind them of the renewal deadline, to offer to take a renewal over the phone and to conduct a brief survey if families have decided to leave the CHIP program. Using the small scale test strategy, the Helpline has adjusted their scripts, their call timing and measured their outcomes through rapid turnaround to assess the efficacy of this strategy.

The Departments of Public Welfare and Insurance collaborated on a pilot test of self-declaration of income in three sites in Philadelphia. This project allowed families who received specific application assistance to self-declare their income if they applied through City Health Center #9, Temple Children's Hospital or Philadelphia Citizens for Children and Youth. Program eligibility for Medicaid or CHIP was determined based on the self-declaration and third-party verification of their income was obtained subsequent to authorization of coverage.

PPC has been pleased to work with CHIP and adultBasic staff through a number of transitions this year. Patricia Stromberg will be missed, but the appointment of George Hoover as Deputy Commissioner has been well-received by the CKF Statewide Coalition. Deputy Commissioner Hoover is a trusted partner who has worked closely with PPC staff on a number of projects and initiatives during his tenure in the Department of Public Welfare. That partnership continues to be solidly effective in his new role.

The Insurance Department and the CHIP program staff continue to engage in remarkably cordial and collaborative partnerships with CKF. This ongoing openness to the national expertise available through CKF as well as the willingness to seek input from CKF, the Coalition, and the four local projects has continuously enhanced and improved the outreach, enrollment and renewal efforts in both CHIP and Medicaid.

3. Is your state targeting outreach to specific populations (e.g., minorities, immigrants, and children living in rural areas)? Have these efforts been successful, and how have you measured effectiveness? **[7500]**

Background

U.S. Census figures indicated that Pennsylvania's Hispanic population increased from two percent in 1990 to 3.4 percent in 2003. Acknowledging this growth and knowing that one in four Hispanic children is uninsured nationally, the Department sought to continue its strategy of targeting the fast-growing Hispanic community. The Mendoza Group, a for-profit Hispanic agency that has a history of health marketing initiatives within the Latino community, was again selected based on its successful work in 2004 of focusing on two demographic segments of the market, those unaware of CHIP and those who do not think that they qualify for CHIP.

The overall strategy for 2005 was designed to allow continuous opportunities for more information and more education that were implemented through an aggressive grassroots tactical approach and one that empowered Spanish-speaking and bilingual Hispanic families to take the next steps towards enrolling their uninsured children in the CHIP program.

Pennsylvania's dominant Hispanic populations fall into three groups:

- Puerto Rican – More acculturated
- Mexican – Newly arrived and Non-acculturated
- Other (Includes Dominican, Central and South American) – Less acculturated

The “newly arrived” have less than five years in this country; “less acculturated” have been in this country five to ten years; and “more acculturated” have been in this country more than ten years. With acculturation comes increased ability to understand and function independently with public systems. Based on the acculturation levels, marketing efforts needed to be adjusted to effectively reach each grouping.

Strategic Plan

Community-Based Organizations (CBOs) provide a significant point of entry into the Hispanic market, and the best way to reach the Hispanic community is to work with them. For the past 30 years, these organizations have served as the frontline advocates for and providers of Hispanic health care and social services. It was this network that was targeted in 2005 as the most appropriate and sensible entry point for designing and implementing health outreach programs for Latino communities.

In 2005, Mendoza Group interviewed and selected seven key CHIP nonprofit provider organizations as enrollment team partners during the campaign. These partners would serve not only as points of distribution but would be the core venues for media-driven enrollment drives. Seven counties were targeted within the Commonwealth for the rollout of the multi-tiered plan: Philadelphia, Berks, Lehigh, Bucks, Montgomery, Chester and Lancaster. The implementation of the strategic plan was formed around four key tactical approaches that were managed by a CHIP-trained bilingual street team hired by Mendoza Group:

- Media Briefings
- Presentations and Distribution of the Spanish-language CHIP documentary
- Enrollment Drives
- Health Fairs and culturally-relevant Community Events

Media Briefings

Immediate awareness of the CHIP Latino campaign was proven by the successful coverage provided by Hispanic and non-Hispanic media in the three designated counties for the media briefings – Philadelphia, Lehigh and Berks. Mendoza selected Dr. Ivan Lugo, Associate Dean at Temple University's School of Dentistry and an endearing “celebrity” to the Hispanic media, as their ambassador for the CHIP campaign in Spanish. Newspapers praised the Commonwealth's efforts in rolling out a bilingual initiative, which Dr. Lugo touted as “*the first...primarily because of partnerships with Latino social service agencies in places like Lehigh Valley, Philadelphia and Reading to promote it.*” Dr. Lugo's call to action to Latino consumers through the media yielded positive feedback evidenced by significant media headline coverage, and also served to spread the powerful “word-of-mouth” message through a highly trusted symbol of the Latino community.

CHIP Documentary

Mendoza utilized a docu-video about CHIP that provided an emotional and testimonial call to action to uninsured families, and one that would also be useful in motivating influencers in the community who work with or can identify potential CHIP families.

To date, 4,592 docu-videos have been distributed and 205 community organizations have participated in Mendoza's workshop presentations of the docu-video. While the grassroots approach was aggressive, the message was sustained through a frequently played two-minute vignette of the video aired on local Spanish-language stations.

Enrollment Drives

Seven provider venues were selected for broadcast-driven Latino enrollment drives. The enrollment drives proved to be an extremely effective method of reaching potential CHIP families in a highly personalized way. Some highlighted outcomes of the enrollment drives included:

- 70 families who visited community-based organizations (CBOs) inquired about CHIP
- 60 families applied for CHIP
- 40 families applied on-site with the assistance of a bilingual CHIP street team and/or provider specialist
- A slight increase in calls to the CHIP hotline during the media campaign period
- Anecdotal and qualitative research that would help in the overall analysis

Health Fairs and Community Events

Approximately 50,000+ Latinos were directly reached through CHIP's branding message at certain key events from March through September 2005. The estimated media impressions for the same events were 575,000. Mendoza's criteria in selecting these events focused on identifying grassroots activities that allowed more opportunity for personalized interaction with a smaller audience size to extend beyond the CHIP brand. This strategy allowed Mendoza to invest in affordable activities by way of sponsorship and/or "community working dollars."

Results

The consistent observation that became obvious early in the implementation of the tactical plan was the need to focus on two general themes: (1) spend more time explaining what CHIP's health insurance is and who may qualify; and (2) community organization intake specialists spend more time taking care of the technical business (completing the appropriate enrollment documentation) and have less time available for the individual questions and answers. Overall, the 2005 outreach campaign reinforced that education of the CHIP program and personal contact with families continue to be vital in the Latino community.

SUBSTITUTION OF COVERAGE (CROWD-OUT)

States with a separate child health program above 200 through 250% of FPL must complete question 1. All other states with trigger mechanisms should also answer this question.

1. Does your state cover children between 200 and 250 percent of the FPL or does it identify a trigger mechanism or point at which a substitution prevention policy is instituted? Yes _____ No X

If yes, please identify the trigger mechanisms or point at which your substitution prevention policy is instituted. [7500]

States with separate child health programs over 250% of FPL must complete question 2. All other states with substitution prevention provisions should also answer this question.

2. Does your state cover children above 250 percent of the FPL or does it employ substitution prevention provisions? Yes _____ No X

If yes, identify your substitution prevention provisions (waiting periods, etc.). [7500]

All States must complete the following 3 questions

3. Describe how substitution of coverage is monitored and measured and the effectiveness of your policies.

Pennsylvania has taken a number of steps to guard against “crowd-out.” Applications for CHIP coverage include questions relating to other forms of health insurance coverage. Applicants reporting that they have other types of health insurance are denied coverage through Pennsylvania’s CHIP program. In addition, electronic cross-matches with Medicaid and private insurance occur to help assure that only uninsured children are covered by CHIP.

4. At the time of application, what percent of applicants are found to have insurance?

Approximately 9.3% of applicants are found to have health insurance at the time of application.

5. Describe the incidence of substitution. What percent of applicants drop group health plan coverage to enroll in SCHIP?

According to CPS data from 2004, 86% of all Pennsylvanians under age 65 had health insurance. In 2004, nearly 76% of Pennsylvanians under age 65 had employer-based or private coverage, compared to the national average of 69%. The stability of the percentage of private coverage and the constancy of employer-provided coverage continue to support the hypothesis that no significant degree of crowd-out has occurred as a result of the expansion of publicly-funded health care programs.

Examples of data related to this issue include:

- Approximately 21.9% of applicants processed during the reporting period were found ineligible because they were already receiving Medicaid or the family income was in the Medicaid range
- Nearly 6% of applicants were denied CHIP coverage during the reporting period because the child had employer-based or private coverage
- An average of 34% of cases terminated at the time of renewal lost eligibility for CHIP because the child was determined to be eligible for Medicaid

COORDINATION BETWEEN SCHIP AND MEDICAID

(This subsection should be completed by States with a Separate Child Health Program)

1. Do you have the same redetermination procedures to renew eligibility for Medicaid and SCHIP (e.g., the same verification and interview requirements)? Please explain.

The processes for renewing eligibility for CHIP and redetermining eligibility for Medicaid are alike. Both programs require renewal every 12 months. Neither requires an interview. Both programs review factors that may have changed since the application was filed or the last renewal. CHIP and Medicaid have aligned their requirements as described in the next section, Eligibility Redetermination and Retention.

2. Please explain the process that occurs when a child's eligibility status changes from Medicaid to SCHIP and from SCHIP to Medicaid. Have you identified any challenges? If so, please explain.

Children who are being disenrolled from Medicaid because of a change in family circumstances and who are eligible for CHIP can be enrolled in CHIP retroactively to the first of the month in which disenrollment from Medicaid occurred to avoid a gap in health care coverage. (Previously, all CHIP applicants were enrolled effective the 1st day of the next calendar month.)

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

Of the seven CHIP contractors that provide coverage, two participate in Medicaid Managed Care. However, many providers participate in more than one insurer's provider network, which usually allows a child to continue receiving treatment from the same physician when the child's coverage shifts from Medicaid to CHIP, and vice versa. Medicaid continues to utilize fee-for-service in areas of the state where managed care is not available. CHIP uses managed care programs statewide (either traditional HMO or PPO).

ELIGIBILITY REDETERMINATION AND RETENTION

1. What measures does your State employ to retain eligible children in SCHIP? Please check all that apply and provide descriptions as requested.

Conducts follow-up with clients through caseworkers/outreach workers

Sends renewal reminder notices to all families

How many notices are sent to the family prior to disenrolling the child from the program?

Three

At what intervals are reminder notices sent to families (e.g., how many weeks before the end of the current eligibility period is a follow-up letter sent if the renewal has not been received by the State?)

The first renewal notice is mailed 90 days prior to the end of a child's enrollment period. Additional notices are sent 60 days and 30 days prior to termination if the renewal has not been completed. Telephone outreach at the 60- and 30-day points is often provided.

Sends targeted mailings to selected populations
Please specify population(s) (e.g., lower income eligibility groups) [500]

Holds information campaigns

Provides a simplified reenrollment process,
Please describe efforts (e.g., reducing the length of the application, creating combined Medicaid/SCHIP application)

Renewal letters and forms have been revised to a more user-friendly format. Renewal forms are pre-populated with the applicant's information to the extent that the systems will allow.

Use of COMPASS, the Commonwealth of Pennsylvania Access to Social Services, allows for electronic renewal. COMPASS is a web-based application used to apply for many of the social services, including CHIP, offered by the Commonwealth.

E-signature is authorized for COMPASS renewals. E-signed renewals now eliminate the need to fax or mail in a signature page to CHIP contractors.

Use of telephone for renewal. New this year, enrollees are able to call the CHIP Helpline and renew over the phone. Helpline representatives key an applicant's information into COMPASS and submit with e-signature.

X

Conducts surveys or focus groups with disenrollees to learn more about reasons for disenrollment *please describe:*

The Department tracks the disenrollment population and reviews this data on a monthly basis with CHIP contractors. Through a joint effort between CHIP and its contractors, the rate of disenrollment has stabilized. (See Attachment 2.)

A survey targeting disenrollees is in development. The intent is to determine why a child disenrolled, their current health insurance status, and potential process improvements.

Other, *please explain:*

The CHIP program implemented the following improvements to its renewal process:

- Implemented e-signature capability in November 2004 to enrollees who renew online, thus eliminating the need to fax or mail in a signature page
- Developed a pilot to have the CHIP Helpline contractor initiate outbound calls to up to 2,000 households who failed to respond to the 90- and 60-day renewal letters. The persons to contact are identified through the 'Pending Termination for Non-renewal Report' available through our CAPS system. The Helpline can take a renewal over the phone. If the family is not interested in renewing, the Helpline will conduct a brief survey to try to determine why the family is not renewing.

In a continuing effort to narrow differences between the eligibility requirements and procedures for CHIP and Medicaid:

- The amount of income verification required was reduced from a full month's verification to verification that is reasonably representative of the applicant's circumstances (e.g., single pay stub for a person who routinely receives the same amount of wages each pay period) for both new applications and renewals
- The validity period for income verification was changed from 90 days to 60 days to accommodate a corresponding change made in the Medicaid program
- The income calculation methodology was revised to simplify the calculation by reducing the number of steps in the conversion process. The method of determining monthly income for persons with weekly earnings was changed from using a multiplying factor of 4.3 to a new factor of 4.0. In addition, the new conversion factor has the practical impact of creating a result that is the equivalent of a 48-week earning year. The revision reduced the "net" income of applicants, thus allowing applicants who would have previously been ineligible for subsidized CHIP to be eligible; some who would have previously been eligible for subsidized CHIP to be eligible for free CHIP; and some who would have previously been eligible for free CHIP to be eligible for Medicaid.

-
2. Which of the above strategies appear to be the most effective? Have you evaluated the effectiveness of any strategies? If so, please describe the evaluation, including data sources and methodology.

The number of enrollees who do not respond or fail to complete renewals continues to decline since tracking and monthly discussions/reviews began with CHIP contractors. In January 2004 the rate of

completed CHIP renewals was 76%. In 2005, the CHIP renewals completed averaged 82%. All of the above strategies have contributed to this decrease in disenrollments. To date, we have not formally evaluated any of the initiatives. The out-bound call initiative is being closely tracked and monitored and we should be able to measure its effectiveness over the coming year.

- Does your State generate monthly reports or conduct assessments that track the outcomes of individuals who disenroll, or do not reenroll, in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured, how many age-out, how many move to a new geographic area)

Yes

No

When was the monthly report or assessment last conducted? **[7500]**

The monthly assessment reflects information from October 2005.

If you responded yes to the question above, please provide a summary of the most recent findings (in the table below) from these reports and/or assessments. **[7500]**

Findings from Report/Assessment on Individuals Who Disenroll, or Do Not Reenroll in SCHIP

Total Number of Dis-enrollees	Obtain other public or private coverage		Remain uninsured UNKNOWN*		Age-out		Move to new geographic area		Other *	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
5,050	998	20%	-----	-----	483	9%	54	1%	3,515	70%

* We do not specifically track the number who remain uninsured.

The Other column includes:

- Failure to complete renewal; 2,052 (41%)
- Failed to respond to renewal notice; 10 (.2%)
- High income; 239 (5%)
- Misc. includes; individual's request, changes in families' eligibility and other miscellaneous reasons. 1,214 (24%)

Please describe the data source (e.g., telephone or mail survey, focus groups) used to derive this information.

The data source is our Data Warehouse. **[7500]**

COST SHARING

- Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found? **[7500]**

N/A

- Has your State undertaken any assessment of the effects of cost sharing on utilization of health services in SCHIP? If so, what have you found? **[7500]**

N/A

3. If your state has increased or decreased cost sharing in the past federal fiscal year, has the state undertaken any assessment of the impact of these changes on application, enrollment, disenrollment, and utilization of health services in SCHIP. If so, what have you found? **[7500]**

N/A

PREMIUM ASSISTANCE PROGRAM(S) UNDER SCHIP STATE PLAN

1. Does your State offer a premium assistance program for children and/or adults using Title XXI funds under any of the following authorities?

Yes _____ please answer questions below.

X No _____ skip to Section IV.

Children

_____ Yes, Check all that apply and complete each question for each authority.

_____ Premium Assistance under the State Plan

_____ Family Coverage Waiver under the State Plan

_____ SCHIP Section 1115 Demonstration

_____ Medicaid Section 1115 Demonstration

_____ Health Insurance Flexibility & Accountability Demonstration

_____ Premium Assistance under the Medicaid State Plan (Section 1906 HIPP)

Adults

_____ Yes, Check all that apply and complete each question for each authority.

_____ Premium Assistance under the State Plan (Incidentally)

_____ Family Coverage Waiver under the State Plan

_____ SCHIP Section 1115 Demonstration

_____ Medicaid Section 1115 Demonstration

_____ Health Insurance Flexibility & Accountability Demonstration

_____ Premium Assistance under the Medicaid State Plan (Section 1906 HIPP)

2. Please indicate which adults your State covers with premium assistance. (Check all that apply.)

_____ Parents and Caretaker Relatives

_____ Childless Adults

3. Briefly describe your program (including current status, progress, difficulties, etc.) **[7500]**

4. What benefit package does the program use? **[7500]**

5. Does the program provide wrap-around coverage for benefits or cost sharing? **[7500]**

6. Identify the total number of children and adults enrolled in the premium assistance program for whom Title XXI funds are used during the reporting period (provide the number of adults enrolled in premium assistance even if they were covered incidentally and not via the SCHIP family coverage provision).

_____ Number of adults ever-enrolled during the reporting period

_____ Number of children ever-enrolled during the reporting period

7. Identify the estimated amount of substitution, if any, that occurred or was prevented as a result of your premium assistance program. How was this measured? **[7500]**

8. During the reporting period, what has been the greatest challenge your premium assistance program has experienced? **[7500]**

9. During the reporting period, what accomplishments have been achieved in your premium assistance program? **[7500]**

10. What changes have you made or are planning to make in your premium assistance program during the next fiscal year? Please comment on why the changes are planned. **[7500]**

11. Indicate the effect of your premium assistance program on access to coverage. How was this measured? **[7500]**

12. What do you estimate is the impact of premium assistance on enrollment and retention of children? How was this measured? **[7500]**

13. Identify the total state expenditures for family coverage during the reporting period. **(For states offering premium assistance under a family coverage waiver only.) [7500]**

SECTION IV: PROGRAM FINANCING FOR STATE PLAN

1. Please complete the following table to provide budget information. Describe in narrative any details of your planned use of funds below, including the assumptions on which this budget was based (per member/per month rate, estimated enrollment and source of non-Federal funds). (Note: This reporting period = Federal Fiscal Year 2005. If you have a combination program you need only submit one budget; programs do not need to be reported separately.)

COST OF APPROVED SCHIP PLAN

Benefit Costs	2005	2006	2007
Insurance payments			
Managed Care	201,095,973	223,122,148	251,539,579
per member/per month rate @ # of eligibles	See note 1 below	See note 2 below	See note 3 below
Fee for Service			
Total Benefit Costs	201,095,973	223,122,148	251,539,579
<i>(Offsetting beneficiary cost sharing payments)</i>			
Net Benefit Costs	\$201,095,973	\$223,122,148	\$251,539,579

Administration Costs

Personnel	957,000	995,000	1,035,000
General Administration	3,335,373	4,005,000	4,125,000
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/Marketing costs	2,755,308	2,500,000	2,500,000
Other [500]			
Health Services Initiatives			
Total Administration Costs	7,047,681	7,500,000	7,660,000
10% Administrative Cap (net benefit costs ÷ 9)	22,343,997	24,791,350	27,948,842

Federal Title XXI Share	140,892,439	158,068,420	177,655,391
State Share	67,251,215	72,553,728	81,544,188

TOTAL COSTS OF APPROVED SCHIP PLAN	208,143,654	230,622,148	259,199,579
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Note 1: 127,814 (avg. enrollment) x \$131.11 (avg. rate) x 12 months

Note 2: 133,567 (avg. enrollment) x \$139.21 (avg. rate) x 12 months

Note 3: 140,762 (avg. enrollment) x \$148.92 (avg. rate) x 12 months

2. What were the sources of non-Federal funding used for State match during the reporting period?

- State appropriations
- County/local funds
- Employer contributions
- Foundation grants
- Private donations

_____ Tobacco settlement
 _____ Other (specify) [500]

SECTION V: 1115 DEMONSTRATION WAIVERS (FINANCED BY SCHIP)

Please reference and summarize attachments that are relevant to specific questions.

1. If you do not have a Demonstration Waiver financed with SCHIP funds skip to Section VI. If you do, please complete the following table showing whom you provide coverage to.

	SCHIP Non-HIFA Demonstration Eligibility					HIFA Waiver Demonstration Eligibility				
Children	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Parents	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Childless Adults	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Pregnant Women	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL

2. Identify the total number of children and adults ever enrolled (an unduplicated enrollment count) in your SCHIP demonstration during the reporting period.

_____ Number of **children** ever enrolled during the reporting period in the demonstration
 _____ Number of **parents** ever enrolled during the reporting period in the demonstration
 _____ Number of **pregnant women** ever enrolled during the reporting period in the demonstration
 _____ Number of **childless adults** ever enrolled during the reporting period in the demonstration

3. What have you found about the impact of covering adults on enrollment, retention, and access to care of children?

4. Please provide budget information in the following table for the years in which the demonstration is approved. *Note: This reporting period (Federal Fiscal Year 2005 starts 10/1/04 and ends 9/30/05).*

COST PROJECTIONS OF DEMONSTRATION (SECTION 1115 or HIFA)	2005	2006	2007	2008	2009
Benefit Costs for Demonstration Population #1 (e.g., children)					
Insurance Payments					
Managed care					
per member/per month rate @ # of eligibles					
Fee for Service					
Total Benefit Costs for Waiver Population #1					

**Benefit Costs for Demonstration Population #2
(e.g., parents)**

Insurance Payments					
Managed care					
per member/per month rate @ # of eligibles					
Fee for Service					
Total Benefit Costs for Waiver Population #2					

**Benefit Costs for Demonstration Population #3
(e.g., pregnant women)**

Insurance Payments					
Managed care					
per member/per month rate @ # of eligibles					
Fee for Service					
Total Benefit Costs for Waiver Population #3					

**Benefit Costs for Demonstration Population #4
(e.g., childless adults)**

Insurance Payments					
Managed care					
per member/per month rate @ # of eligibles					
Fee for Service					
Total Benefit Costs for Waiver Population #3					

Total Benefit Costs					
(Offsetting Beneficiary Cost Sharing Payments)					
Net Benefit Costs (Total Benefit Costs - Offsetting Beneficiary Cost Sharing Payments)					

Administration Costs

Personnel					
General Administration					
Contractors/Brokers (e.g., enrollment contractors)					
Claims Processing					
Outreach/Marketing costs					
Other (specify) [500]					
Total Administration Costs					
10% Administrative Cap (net benefit costs ÷ 9)					

Federal Title XXI Share					
State Share					

TOTAL COSTS OF DEMONSTRATION					
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When was your budget last updated (please include month, day and year)? [500]

Please provide a description of any assumptions that are included in your calculations. [7500]

Other notes relevant to the budget: [7500]

SECTION VI: PROGRAM CHALLENGES AND ACCOMPLISHMENTS

1. For the reporting period, please provide an overview of your state's political and fiscal environment as it relates to health care for low income, uninsured children and families, and how this environment impacted SCHIP. **[7500]**

Pennsylvania continues to face similar challenges as the rest of the nation: health care costs are growing twice as fast as state revenues; many sources of federal aid for medical and social service programs are decreasing; there is a significant reduction in the number of employers offering employer sponsored insurance; and the number of uninsured or under-insured across the state are increasing.

The Rendell Administration has chosen to respond to these enormous pressures in a way that protects those in need while preserving the Commonwealth's fiscal integrity. By restructuring and reforming the social welfare programs, the administration is striving to make them more efficient and effective while maintaining coverage for all who currently receive it. The Administration has made it a priority to protect those who most need our help and support. Implemented changes do not adversely affect the array of health services and social services provided to children.

As noted above, Pennsylvania has maintained existing public coverage for children in both CHIP and Medicaid and there is no intention of negatively impacting these programs in the upcoming year. In fact, it is more just the opposite. In the face of ongoing budget difficulties, the Governor requested and the Legislature approved an increase in the state budget to enroll an additional 10,000 children in CHIP.

Strategic Planning

The Governor's Office of Health Care Reform (GOHCR) applied for and was granted a state-planning grant through the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA). The overall goal of the planning effort is to develop a strategic plan for providing access to affordable, quality health care for every citizen in Pennsylvania. Staff in the Office of CHIP and adultBasic has been fully engaged in this planning effort.

The strategic plan made possible by the HRSA grant will include recommendations about how access may be increased by integrating new programs with existing public and private programs; restructuring of current programs that provide coverage to the uninsured; possible interaction with employer-sponsored insurance; and increasing the portability and developing mechanisms to spread the risk.

The Health Insurance Status of Pennsylvanians

The Rendell Administration remains committed to health care reform and efforts to address the uninsured residents of the Commonwealth. In 2004, the Pennsylvania Insurance Department contracted with Market Decisions, LLC, to conduct a statewide survey aimed at better understanding the health insurance status of all Pennsylvanians.

In the past, the Department relied on national census data. National census data can provide good benchmarking information, but more often than not, the census data does not provide the level of detail needed to understand the demographics of the uninsured population. For our purposes, the census data did not provide the level of detail necessary to shape health-related policy decisions and to aid in such things as outreach for publicly funded health insurance programs like CHIP or adultBasic. The collected data provides a description of both the insured and uninsured people in Pennsylvania, and more detailed information is now available for factors such as age groups, income groups, gender, race, employment status and employer-provided healthcare coverage. A synopsis of the study is available on the Department's website at www.ins.state.pa.us.

Interagency Efforts

The Governor's Cabinet on Children and Families has vigorously engaged state agencies directly involved in public health programs in discussions on comprehensive strategies to improve childhood nutrition and fitness, the next steps, and how to build on these strategies as well as policy and legislative recommendations. New CHIP contracts, which became effective December 1, 2005, require contractors to place special emphasis on periodic health screens including those for obesity prevention. As a result of the Governor's Health Care Reform initiatives, specifically in the realm of obesity, the departments of Public Welfare, Health, and Insurance, under the auspices of the PA Medical Society, participated in the

kick-off of a health care summit on obesity in June of 2005. The Pennsylvania Medical Society will be coordinating efforts with the state agencies on various obesity initiatives aimed primarily at educating and assisting medical professionals in detecting and effectively treating childhood obesity through use of specially designed toolkits, listed referrals sources, and access to PMS' website which provides the most current data on obesity research and treatment.

2. During the reporting period, what has been the greatest challenge your program has experienced? **[7500]**

The single greatest challenge over the reporting period has been efforts directed at increasing enrollment in CHIP. With approximately 96 percent of the state's children currently having either private or public health insurance, it is proving difficult to enroll the approximately 55,000 CHIP eligible children across the state that are currently reported as uninsured. As stated above, the Governor tasked the CHIP office to increase enrollment by 10,000 children during this fiscal year. An extensive outreach effort is being conducted in targeted areas to attract as many children to the program as possible. Additionally, pilot programs are being conducted in some areas to determine what changes to the application process have the greatest impact on attracting new enrollees.

3. During the reporting period, what accomplishments have been achieved in your program? **[7500]**

Reduction in disenrollments

During the reporting period, we have seen a reduction in the number of disenrollments from the program. We are currently experiencing a greater than 80 percent rate of response to renewals over the reporting period. This is up from approximately 72 percent reported last year. Many efforts have contributed to this success.

- Redesigned and simplified renewal forms
- Online renewals through COMPASS
- E-signature accepted for online renewals
- Diminished minor differences between CHIP and Medicaid eligibility requirements
- Initiated telephonic renewals through our help line
- Pre-populated renewal forms

We are not resting on our laurels. In October of this year, we initiated outbound calls to those individuals who have not responded to the 90- and 60-day renewal notices. If an enrollee decides not to renew, data is collected as to the reason for non-renewal. Data regarding the impact of the outbound calls should be available for the next annual report.

Data Warehouse – Phase II

We continue to expand our emphasis beyond enrollment and retention and are focusing more on utilization of services and quality of care. We are on track to have the CHIP data warehouse phase II operational by the end of January 2006. We anticipate approximately six to eight months before the data will be considered reliable for internal and external purposes. The collection of data in three areas (Professional, Institutional, and Dental) is nearly complete. The two other areas (Providers and Pharmaceuticals) still have issues to be addressed.

The initiation and implementation of Phase II of the data warehouse will permit the Department to better track and report on utilization and quality of care. The program anticipates that data in the warehouse will require some additional refinements and will take approximately six months before data can be considered reliable for internal and external purposes. The challenge remains in interpreting this data and properly using it to undertake system and program improvement as determined necessary. To that end, the Department has requested state funding for the next fiscal year 2006-07 for hiring an external review organization to augment staffing expertise.

The Health Insurance Status of Pennsylvanians

As stated above, the Department completed the statewide survey aimed at better understanding the health insurance status of all Pennsylvanians. More than nine out of 10 Pennsylvanians - 92 percent - have some type of healthcare coverage. Coverage is provided by either private health insurance or

publicly-funded healthcare coverage such as CHIP, adultBasic, Medicaid or Medicare. The majority of healthcare coverage, 66 percent, is from private health insurance. Healthcare coverage from publicly funded programs is roughly 29 percent. The demographic information regarding the uninsured will be used to help target our outreach and marketing efforts over the next year.

Commonwealth of Pennsylvania Access to Social Services (COMPASS)

Advances continue to be made in the Insurance Department's and Department of Public Welfare's joint electronic application and enrollment processes. COMPASS continues to grow in use each month with more than 160,000 applications and renewals submitted electronically since its inception. COMPASS continues to be an effective conduit to many of the social service offered in Pennsylvania and provides a seamless application process for Medical Assistance and CHIP. COMPASS is in the process of adding additional services, encompassing programs from other agencies that have means tested programs (Education, Aging, and the like).

COMPASS Community Partners - The COMPASS Community Partner View allows organizations to initiate and actively track applications they submit. Community Partners also have access to Power User, which is a streamlined version of the COMPASS application. Organizations such as hospitals, church groups and other community based groups that help Pennsylvania residents apply for social services can apply to be a COMPASS Community Partner. Less traditional groups are now being recruited to be community partners/power users. These groups include Career Centers, Family Court Judges, etc.

Pilot Projects

In conjunction with the Department of Public Welfare, we are conducting a self-declaration of income pilot at three locations in the Philadelphia Region. During the approximate 1 year of operation, only 178 CHIP applications/renewals have been submitted using self-declaration of income.

We continue to work with our contractors to develop creative pilot projects that focus on improving eligibility and enrollment processes. In addition, we continually meet with various advocacy groups to entertain any ideas that they may have to make the application and renewal processes more efficient and user friendly for the applicants.

4. What changes have you made or are planning to make in your SCHIP program during the next fiscal year? Please comment on why the changes are planned. [7500]

Strategic Sourcing

In last year's report, the Department mentioned the possibility of "carving out" prescription drugs from the composite benefit package and providing this service through the state's Pharmaceutical Assistance Contract for the Elderly (PACE) program to provide this benefit. The PACE program provides prescriptions drugs to senior citizens in Pennsylvania via funds derived from the Pennsylvania lottery. This initiative is in keeping with the Governor's Office of Health Care Reform review of prescription drugs and the Governor's interest in maximizing the Commonwealth's overall purchasing power. Since that time, legislation has been introduced to address this issue. Consequently, the Department has curtailed its individual efforts in this regard and is awaiting the outcome of this legislation.

Outreach

We are in the process of launching a new and more aggressive outreach and marketing campaign. The campaign is starting out with billboards and posters on the subway, buses and subway platforms. The locations for the advertisements were selected in neighborhoods/areas with targeted income levels, African American neighborhoods and areas with a high ratio of service/retail employees. The campaign will be expanded to include television spots and use of the Internet. Longer range plans are still in the formulation stage.

Strategic Planning

Pennsylvania is in the beginning stages of looking at health care issues from a more global view using a State Planning Grant. At the completion of the Strategic Plan, we will know more of any impending changes to the SCHIP program. Many ideas have been discussed, but we do not expect to take any action until the strategic plan is complete. Specific goals of the planning process include:

- Develop options and steps to improve the availability of convenient, affordable access to quality health care for all citizens of Pennsylvania, including a seamless public program of health care coverage for lower income persons and private or public/private options for affordable health care insurance for small and medium sized employers, as well as working families and individuals with higher incomes
- Develop options for reducing the cost of health care, including patient safety efforts, disease management, and the reduction in emergency department utilization
- Develop a strategy for the integration of individual initiatives into a coordinated and staged plan for addressing access, quality and cost issues in Pennsylvania
- Develop comprehensive strategies to improve childhood nutrition and fitness, the next steps and a plan to build on these strategies as well as policy and legislative recommendations
- Expand and standardize quality initiatives for our CHIP and adultBasic programs. Continue ongoing meetings with the Department of Public Welfare to discuss current quality initiatives for their Medical Assistance population, HEDIS measures, and performance-based contracting.

DRAFT
**Pennsylvania Children's
Insurance Program (CHIP)**

CAHPS[®] 2005 Analysis Report

Attachment 1

**Prepared by NCQA for the PA Department of Insurance
December 20, 2005**

CAHPS® 3.0H Child (with Chronic Care Conditions) Questionnaire

From the six CHIP-sponsored plans offered in Pennsylvania, 3,025 respondents completed the CAHPS® 3.0H Questionnaire. For the first time, a Medicaid CHIP plan* submitted data for analysis and reporting in this year's report (*note: data is based on their Medicaid and CHIP populations*). The respondents completed the questionnaire on behalf of a child enrolled in one of the following five commercial HMO plans: Aetna Health Inc. – Pennsylvania, HMO of Northeastern Pennsylvania Inc. d/b/a First Priority Health, Keystone Health Plan Central, Keystone Health Plan East, and Keystone Health Plan West, and one Medicaid plan, Three Rivers Health Plan.

HMO Plan	# of Respondents
Aetna Health Inc. - Pennsylvania	452
HMO of Northeastern Pennsylvania, Inc. d/b/a First Priority Health	521
Keystone Health Plan Central, Inc.	572
Keystone Health Plan East, Inc.	262
Keystone Health Plan West, Inc.	526
Three Rivers Health Plan* (<i>Note: includes MA and CHIP population</i>)	692
<i>Total</i>	<i>3,025</i>

*Three Rivers Health Plan submitted regular CAHPS 3.0 Child Questionnaire (without CCC) data.

Respondent Characteristics

In 2005, more than half of survey respondents were male, continuing the trend of past years. The majority of children enrolled in one of six CHIP plans were white (avg. = 77.8%), and were in “excellent” or “very good” health (63.4%). A high proportion of survey respondents also had a high school diploma or some college education.

Respondent Characteristics	Aetna		FPH		K-Central		K-East		K-West		TRH	
	#	%	#	%	#	%	#	%	#	%	#	%
Gender												
Male	239	53.5%	283	54.8%	320	56.0%	152	58.5%	291	55.9%	353	51.2%
Female	208	46.5%	233	45.2%	251	44.0%	108	41.5%	230	44.1%	336	48.8%
Race/Ethnicity												
White	332	71.7%	497	92.6%	508	85.8%	139	52.5%	491	89.3%	548	75.0%
Black or African American	84	18.1%	16	3.0%	37	6.3%	98	37.0%	36	6.5%	109	15.0%
Asian/Pacific Islander	9	1.9%	1	.19%	3	.51%	8	3.0%	8	1.5%	12	1.6%
American Indian	5	1.1%	9	1.7%	9	1.5%	4	1.5%	6	1.1%	12	1.6%
Hispanic	44	9.9%	21	4.0%	57	10.1%	20	7.9%	11	2.1%	71	10.5%

Health Status												
Excellent or Very Good Health	264	58.7%	310	59.5%	360	63.4%	164	63.1%	317	60.6%	517	75.0%
Good Health	138	30.7%	161	30.9%	161	28.3%	81	31.2%	175	33.5%	132	19.2%
Fair or Poor Health	48	10.7%	50	9.6%	47	8.3%	15	5.8%	31	5.9%	40	5.8%
Education												
Eighth Grade or Less	5	1.1%	5	1.0%	5	0.9%	4	1.5%	6	1.2%	19	2.8%
Some High School	30	6.7%	38	7.3%	34	6.0%	18	6.9%	25	4.8%	139	20.3%
High School Graduate	198	44.1%	245	47.3%	266	46.6%	101	38.7%	224	43.0%	331	48.4%
Some College	170	37.9%	190	36.7%	208	36.4%	99	37.9%	200	38.4%	144	21.1%
College Graduate	32	7.1%	26	5.0%	43	7.5%	26	10%	45	8.6%	38	5.6%
More than College Graduate	14	3.1%	14	2.7%	15	2.6%	13	5.0%	21	4.0%	13	1.9%

Health Care Access Indicators

Aetna Health Inc.

Health Care Access Indicators	#	%
Child has a personal doctor or nurse	376	85.5%
Obtaining a new personal doctor or nurse was not a problem	143	76.5%
Obtaining a specialist referral was not a problem	192	77.7%
Obtaining needed care was not a problem	1,275	85.1%
Impact of child's health from delays in obtaining care was not a problem	141	88.9%

First Priority Health

Health Care Access Indicators	#	%
Child has a personal doctor or nurse	490	95.3%
Obtaining a new personal doctor or nurse was not a problem	162	76.4%
Obtaining a specialist referral was not a problem	231	75.7%
Obtaining needed care was not a problem	353	88.9%
Impact of child's health from delays in obtaining care was not a problem	173	89.8%

Keystone Health Plan Central, Inc.

Health Care Access Indicators	#	%
Child has a personal doctor or nurse	508	89.9%
Obtaining a new personal doctor or nurse was not a problem	NA	0%
Obtaining a specialist referral was not a problem	268	82.5%
Obtaining needed care was not a problem	373	90.8%
Impact of child's health from delays in obtaining care was not a problem	218	92.8%

Keystone Health Plan East, Inc.

Health Care Access Indicators	#	%
Child has a personal doctor or nurse	233	91.0%
Obtaining a new personal doctor or nurse was not a problem	NA	0%
Obtaining a specialist referral was not a problem	96	74.4%
Obtaining needed care was not a problem	144	85.7%
Impact of child's health from delays in obtaining care was not a problem	71	91.6%

Keystone Health Plan West, Inc.

Health Care Access Indicators	#	%
Child has a personal doctor or nurse	491	94.6%
Obtaining a new personal doctor or nurse was not a problem	139	81.8%
Obtaining a specialist referral was not a problem	249	83.3%
Obtaining needed care was not a problem	356	91.5%
Impact of child's health from delays in obtaining care was not a problem	85	96.0%

Three Rivers Health Plan (survey includes MA and CHIP population)*

Health Care Access Indicators	#	%
Child has a personal doctor or nurse (Q4)	593	86.7%
Obtaining a new personal doctor or nurse was not a problem (Q7)	244	78.5%
Seeing a specialist was not a problem (Q10)	127	71.0%
Obtaining needed care was not a problem	NA	NA
Impact of child's health from delays in obtaining care was not a problem	NA	NA

*Questions from CAHPS 3.0H Child Questionnaire (Medicaid, Without CCC Measure)

*Timely Care***Aetna Health Inc.**

Timely Care	#	%
Usually/always obtains routine care appointment as soon as desired	329	88.4%
Usually/always obtains urgent or emergency care as soon as desired	221	91.7%
Usually/always had to wait less than 15 minutes in doctors office for appt	298	68.5%
Usually/always receive help from phoning the doctor during office hours	327	93.1%

First Priority Health

Timely Care	#	%
Usually/always obtains routine care appointment as soon as desired	394	91.8%
Usually/always obtains urgent or emergency care as soon as desired	273	94.1%
Usually/always had to wait less than 15 minutes in doctors office for appt	330	65.0%
Usually/always receive help from phoning the doctor during office hours	385	92.5%

Keystone Health Plan Central, Inc

Timely Care	#	%
Usually/always obtains routine care appointment as soon as desired	462	94.1%
Usually/always obtains urgent or emergency care as soon as desired	287	97.0%
Usually/always had to wait less than 15 minutes in doctors office for appt	396	71.0%
Usually/always receive help from phoning the doctor during office hours	418	97.2%

Keystone Health Plan East, Inc

Timely Care	#	%
Usually/always obtains routine care appointment as soon as desired	184	86.0%
Usually/always obtains urgent or emergency care as soon as desired	132	95.0%
Usually/always had to wait less than 15 minutes in doctors office for appt	145	57.3%
Usually/always receive help from phoning the doctor during office hours	183	90.6%

Keystone Health Plan West, Inc

Timely Care	#	%
Usually/always obtains routine care appointment as soon as desired	421	91.5%
Usually/always obtains urgent or emergency care as soon as desired	249	92.9%
Usually/always had to wait less than 15 minutes in doctors office for appt	344	68.3%
Usually/always receive help from phoning the doctor during office hours	405	94.8%

Three Rivers Health Plan (survey includes MA and CHIP population)*

Timely Care	#	%
Usually/always obtains routine care appointment as soon as desired (Q20)	385	88.3%
Usually/always obtains urgent or emergency care as soon as desired (Q17)	238	90.2%
Usually/always had to wait less than 15 minutes in doctors office for appt (Q28)	346	61.1%
Usually/always receive help from phoning the doctor during office hours (Q15)	356	91.8%

*Questions from CAHPS 3.0H Child Questionnaire (Medicaid, Without CCC Measure)

Satisfaction with Health Care**Aetna Health Inc**

Satisfaction with Health Care	#	%
Clinic staff usually/always treats child with courtesy and respect	420	96.3%
Clinic staff usually/always is as helpful as you thought they would be	407	93.3%
Doctor usually/always listens carefully to you	412	94.7%
Doctor usually/always explains things in a way you can understand	423	97.2%
Doctor usually/always shows respect for what you say	413	94.9%
Providers usually/always explains things so child can understand	367	92.0%
Providers usually/always spends enough time with the child	394	90.8%

First Priority Health

Satisfaction with Health Care	#	%
Clinic staff usually/always treats child with courtesy and respect	490	96.5%
Clinic staff usually/always is as helpful as you thought they would be	477	94.1%
Doctor usually/always listens carefully to you	482	95.4%
Doctor usually/always explains things in a way you can understand	492	96.9%
Doctor usually/always shows respect for what you say	485	95.5%
Providers usually/always explains things so child can understand	437	93.8%
Providers usually/always spends enough time with the child	475	93.8%

Keystone Health Plan Central

Satisfaction with Health Care	#	%
Clinic staff usually/always treats child with courtesy and respect	540	96.4%
Clinic staff usually/always is as helpful as you thought they would be	529	94.6%
Doctor usually/always listens carefully to you	545	97.5%
Doctor usually/always explains things in a way you can understand	548	97.9%
Doctor usually/always shows respect for what you say	541	96.8%
Providers usually/always explains things so child can understand	486	94.0%
Providers usually/always spends enough time with the child	525	94.6%

Keystone Health Plan East

Satisfaction with Health Care	#	%
Clinic staff usually/always treats child with courtesy and respect	239	94.1%
Clinic staff usually/always is as helpful as you thought they would be	230	90.9%
Doctor usually/always listens carefully to you	238	93.7%
Doctor usually/always explains things in a way you can understand	244	96.1%
Doctor usually/always shows respect for what you say	240	94.1%
Providers usually/always explains things so child can understand	212	94.2%
Providers usually/always spends enough time with the child	236	93.3%

Keystone Health Plan West

Satisfaction with Health Care	#	%
Clinic staff usually/always treats child with courtesy and respect	484	96.2%
Clinic staff usually/always is as helpful as you thought they would be	468	93.0%
Doctor usually/always listens carefully to you	469	93.8%
Doctor usually/always explains things in a way you can understand	487	97.0%
Doctor usually/always shows respect for what you say	479	95.0%
Providers usually/always explains things so child can understand	434	92.7%
Providers usually/always spends enough time with the child	464	92.6%

Three Rivers Health Plan (survey includes MA and CHIP population)*

Satisfaction with Health Care	#	%
Clinic staff usually/always treats child with courtesy and respect (Q29)	543	95.1%
Clinic staff usually/always is as helpful as you thought they would be (Q30)	521	91.4%
Doctor usually/always listens carefully to you (Q31)	528	92.6%
Doctor usually/always explains things in a way you can understand (Q33)	527	92.5%
Doctor usually/always shows respect for what you say (Q34)	535	94.0%
Providers usually/always explains things so child can understand (Q37)	338	88.7%
Providers usually/always spends enough time with the child (Q38)	511	90.0%

*Questions from CAHPS 3.0H Child Questionnaire (Medicaid, Without CCC Measure)

CHIP Renewals Due from 2004 and 2005 Year-to-Date

Renewal Due Date	Termination Effective Month	Renewals Due	Terminated for Non-completion of Renewal	Renewals Completed	Percent of Renewals Completed
12/31/2003	2004 Jan	9,250	2,189	7,061	76%
01/31/2004	2004 Feb	10,070	1,864	8,206	81%
02/29/2004	2004 Mar	11,004	2,599	8,405	76%
03/31/2004	2004 Apr	11,129	2,296	8,833	79%
04/30/2004	2004 May	11,835	2,355	9,480	80%
05/31/2004	2004 Jun	11,118	2,286	8,832	79%
06/30/2004	2004 Jul	10,856	2,246	8,610	79%
07/31/2004	2004 Aug	9,290	1,786	7,504	81%
08/31/2004	2004 Sep	9,275	1,671	7,604	82%
09/30/2004	2004 Oct	10,079	1,980	8,099	80%
10/31/2004	2004 Nov	11,212	2,178	9,034	81%
11/30/2004	2004 Dec	10,479	2,028	8,451	81%
12/31/2004	2005 Jan	9,239	1,819	7,420	80%
01/31/2005	2005 Feb	10,046	1,777	8,269	82%
02/28/2005	2005 Mar	10,795	2,053	8,742	81%
03/31/2005	2005 Apr	10,732	1,880	8,852	82%
04/30/2005	2005 May	10,738	1,904	8,834	82%
05/31/2005	2005 Jun	10,510	1,901	8,609	82%
06/30/2005	2005 Jul	10,395	1,883	8,512	82%
07/31/2005	2005 Aug	9,082	1,719	7,363	81%
08/31/2005	2005 Sep	9,793	1,911	7,882	80%
TOTAL		216,927	42,325	174,602	80%

