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 and Territories* must assess the operation of the State child health plan in each Federal fiscal year, and report to the Secretary, by January 1 following the end of the Federal 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. The State is out of compliance with SCHIP statute and regulations if the report is not submitted by January 1. The State is also out of compliance if any section of this report relevant to the State's program is incomplete.

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.

* - When "State" is referenced throughout this template, "State" is defined as either a state or a territory.

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DO NOT CERTIFY YOUR REPORT UNTIL ALL SECTIONS ARE COMPLETE.

State/Territory: **California**
(Name of State/Territory)

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

Signature:

SCHIP Program Name(s): **Healthy Families Program**

SCHIP Program Type:

- ☐ SCHIP Medicaid Expansion Only
- ☐ Separate Child Health Program Only
- ☒ Combination of the above

Reporting Period: ***2008*** *Note: Federal Fiscal Year 2008 starts 10/1/07 and ends 9/30/08.*

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Submission Date: **February 11, 2009**

(Due to your CMS Regional Contact and Central Office Project Officer by January 1st of each year)

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**				
	*** Upper % of FPL are defined as Up to and Including**									
	Gross or Net Income: ALL Age Groups as indicated below									
	Is income calculated as gross or net income?		☐	Gross Income		**Is income calculated as gross or net income?**		☐	Gross Income	
			☒	Income Net of Disregards				☒	Income Net of Disregards	
Eligibility	From 0 to 200% of FPL conception to birth for undocumented pregnant women					**From**	200	% of FPL conception to birth	300	% of FPL *
	From	0	% of FPL for **infants****	200	% of FPL*	**From**	200	% of FPL for **infants**	250	% of FPL *
	From	0	% of FPL for children ages **1 through 5****	133	% of FPL*	**From**	133	% of FPL for children ages **1 through 5**	250	% of FPL *
	From	0	% of FPL for children ages **6 through 18****	100	% of FPL*	**From**	100	% of FPL for children ages **6 through 18**	250	% of FPL *
			**-Covers only children that become eligible for Medicaid due to the asset waiver and are not previously covered under Title XIX			**From**	200	% of FPL for AIM-linked infants through 2	300	% of FPL
						From	250	% of FPL for infants through 18 for County/SCHIP	300	% of FPL

Is presumptive eligibility provided for children?	☐	No	☐	No
	☒	Yes, for whom and how long? Children under 200% FPL receiving services from a Child Health & Disability Prevention Program (CHDP) provider are enrolled in the no-cost Medi-Cal program (California's Medicaid Program) via the CHDP Gateway for two (2) months. In addition, children, (ages 1-5 under 133% FPL and ages 6-18 under 100% FPL) screened to the Medi-cal program are granted presumptive eligibility into California's Medicaid program until final eligibility determinations are made. (Children ages 0-1 under 200% FPL are covered under Title XIX funding.) **[1000]**	☐	Yes – Please describe below **[1000]** For which populations (include the FPL levels) Children under 200% receiving services from a Child Health & Disability Prevention Program (CHDP) provider are enrolled in the no-cost Medi-Cal program (California's Medicaid Program) via the CHDP Gateway for two (2) months. This includes children ages 1-5 from 133% FPL to 200% FPL and ages 6-18 from 100% FPL to 200% FPL. Children screened below SCHIP FPL guidelines are granted presumptive eligibility into Medicaid. To qualify for presumptive eligibility, children's income must be as follows: 1) ages 0-1 under 200% FPL, 2) ages 1-5 under 133% FPL and 3) ages 6-18 under 100% FPL). Average number of presumptive eligibility periods granted per individual and average duration of the presumptive eligibility period Presumptive eligibility occurs at the initial application process and during the SCHIP Annual Eligibility Review (AER) process, if the child appears to be eligible for Medicaid because the family's income is below SCHIP guidelines. Presumptive eligibility is typically granted until Medicaid makes a final eligibility determination. Brief description of your presumptive eligibility policies During the initial application at SPE or during the SCHIP AER processes, subscribers whose household income is below SCHIP guidelines may be granted presumptive eligibility into Medicaid.
	☐	N/A	☐	N/A

Is retroactive eligibility	☐	No	☐	No

available?	☒	Yes, for whom and how long? Retroactive eligibility may be granted for up to 3 months prior to the month of application for children. **[1000]**	**X**	Yes, for whom and how long? **AIM linked infants are enrolled retroactively in SCHIP back to the infants date of birth.**
	☐	N/A	☐	N/A

Does your State Plan contain authority to implement a waiting list?	Not applicable	**X**	No
			Yes
		☐	N/A

Does your program have a mail-in application?	☐	No	☐	No
	☒	Yes	☒	Yes
	☐	N/A	☐	N/A

Can an applicant apply for your program over the phone?	☐	No	☐	No
	☒	Yes	☒	Yes
	☐	N/A	☐	N/A

Does your program have an application on your website that can be printed, completed and mailed in?	☐	No	☐	No
	☒	Yes	☒	Yes
	☐	N/A	☐	N/A

Can an applicant apply for your program on-line?	☐	No		☐	No	
	☒	Yes – please check all that apply		☒	Yes – please check all that apply	
		☒	Signature page must be printed and mailed in		☒	Signature page must be printed and mailed in
		☒	Family documentation must be mailed (i.e., income documentation)		☒	Family documentation must be mailed (i.e., income documentation)
		☒	Electronic signature is required Certified Application Assistants submit applications for Medicaid and SCHIP on-line through the Health-e-App application process.		☒	Electronic signature is required
					☐	No Signature is required
	☐	N/A		☐	N/A	

Does your program require a face-to-face interview during initial application	☒	No	☒	No
	☐	Yes	☐	Yes
	☐	N/A	☐	N/A

Does your program require a child to be uninsured for a minimum amount of time prior to enrollment (waiting period)?	☒	No	☐	No
	☐	Yes	☒	Yes
	Specify number of months		Specify number of months	3 months
			To which groups (including FPL levels) does the period of uninsurance apply? Children who currently have or have had employer sponsored insurance (ESI) within the last 3 months for all FPL levels. If the child has or had ESI coverage, the child may become eligible for SCHIP 3 months after the ESI coverage ends. **[1000]**	
			List all exemptions to imposing the period of uninsurance The 3-month waiting period may be waived. Exemption occurs if the person through whom the ESI had been available: a) lost employment or experienced a change in employment status, b) changed/moved to an address that is not covered by the ESI, c) lost health benefits due to employer discontinuing health benefits to all employees or dependents, or ceased to provide coverage or contributions for one or more categories of employees, d) lost coverage due to death of individual through whom the children were covered or a legal separation or divorce from the individual through whom the children were covered or e) COBRA coverage ended.	
	☐	N/A	☐	N/A

Does your program match prospective enrollees to a database that details private insurance status?	☐	No	☒	No
	☒	Yes	☐	Yes
		Medicaid beneficiary records are matched with information received from several health insurance providers after enrollment to identify individuals who have other health insurance coverage.	If yes, what database? **[1000]**	
	☐	N/A	☐	N/A

Does your program provide period of continuous coverage <u>regardless of income changes?</u>	☐	No	☐	No
	☒	Yes	☒	Yes
	Specify number of months	12	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	
	Death of the child, child no longer a California resident or the applicant requests child's disenrollment. **[1000]**		Turning age 19, non-payment of premiums, death of the child, the applicant requests child's disenrollment from the program or the family requests a re-evaluation of eligibility due to a reduction in income. **[1000]**	
	☐	N/A	☐	N/A

Does your program require premiums or an enrollment fee?	☒	No	☐	No
	☐	Yes	☒	Yes
	Enrollment fee amount		Enrollment fee amount	$0
	Premium amount		Premium amount	$4 to $15 per month for each child, up to $45 per month for a family.
	Yearly cap		Yearly cap	$250
	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]		$4 to $15 per month per child with a maximum of $45 per month for a family. There are three categories of premiums. They include Category A for incomes above 100% FPL up to 150% FPL ($4-$7 per child per month; maximum of $14 per family); Category B for incomes above 150% FPL up to 200% FPL ($6-$9 per child per month; maximum of $27 per family); and Category C for incomes above 200% FPL up to 250% FPL ($12-$15 per child per month; maximum of $45 per family). Maximums are dependent upon the number of children enrolled and the plan chosen. Please see narrative for discount information. **[500]**	
	☐	N/A	☐	N/A

Does your program impose copayments or coinsurance?	☒	No	☐	No
	☐	Yes	☒	Yes
	☐	N/A	☐	N/A

Does your program impose deductibles?	☒	No	☒	No
	☐	Yes	☐	Yes
	☐	N/A	☐	N/A

Does your program require an assets test?	☒	No	☒	No
	☐	Yes	☐	Yes
	If Yes, please describe below		If Yes, please describe below	
	[500]		**[500]**	
	☐	N/A	☐	N/A

Does your program require income disregards? **(Note: if you checked off net income in the eligibility question, you must complete this question)**	☐	No	☐	No
	☒	Yes	☒	Yes
	If Yes, please describe below		If Yes, please describe below	
	The monthly income disregards are as follows: $90 for each working person, up to $200 for childcare expenses for each child under the age of 2, up to $175 for childcare expenses for each child age 2 or older or for disabled dependent care expenses, first $50 of child/spousal support received, or the full amount of court-ordered child support or spousal support paid which ever is less. Income disregards are specified in the California Code of Regulations, Title 22, Division 3, Subdivision 1, Chapter 2, Article 10, Sections 50547 through 50555.2. **[1000]**		The monthly income disregards are as follows: $90 for each working person, up to $200 for childcare expenses for each child under the age of 2, up to $175 for childcare expenses for each child age 2 or older or for disabled dependent care expenses, first $50 of child/spousal support received, or the full amount of court-ordered child support or spousal support paid which ever is less. In addition to the income disregards noted above, SCHIP also applies other income disregards, where incomes greater than 200% up to 300% FPL are disregarded. For example, 1) Statewide SCHIP Program – Disregard income greater than 200% FPL up to 250% FPL, 2) SCHIP Infants Born to Access for Infants & Mothers (AIM) Subscribers – Disregard income greater than 200% FPL up to 300% FPL, and 3) C-CHIP Counties (4 counties) – If SCHIP eligible child, disregard income greater than 200% FPL up to 300% FPL. **[1000]**	
	☐	N/A	☐	N/A

Which delivery system(s) does your program use?	☒	Managed Care	☒	Managed Care
	☐	Primary Care Case Management	☐	Primary Care Case Management
	☒	Fee for Service	☐	Fee for Service
	Please describe which groups receive which delivery system FPL Children residing in managed care counties are required to get care through the county's managed care plan. Those children residing in counties not participating in managed care receive care through the fee-for-service delivery system. Children who are in Presumptive Eligibility are also receiving fee-for-service delivery. **[500]**		Please describe which groups receive which delivery system All children in the separate SCHIP program are in managed care. SCHIP presumptive eligibility via the CHDP Gateway is delivered through the Medicaid Fee for Service system. **[500]**	

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
	☐	We send out form to family with their information pre-completed and ask for confirmation	☒	We send out form to family with their information pre-completed and ask for confirmation
	☐	We send out form but do not require a response unless income or other circumstances have changed	☐	We send out form but do not require a response unless income or other circumstances have changed
	☐	N/A	☐	N/A

Comments on Responses in Table:

2. Is there an assets test for children in your Medicaid program? ☐ Yes ☒ No ☐ N/A
3. Is it different from the assets test in your separate child health program? ☐ Yes ☐ No ☒ N/A
4. Are there income disregards for your Medicaid program? ☒ Yes ☐ No ☐ N/A
5. Are they different from the income disregards in your separate child health program? ☐ Yes ☒ No ☐ N/A
6. Is a joint application (i.e., the same, single application) used for your Medicaid and separate child health program? ☒ Yes ☐ No ☐ N/A

7. If you have a joint application, is the application sufficient to determine eligibility for both Medicaid and SCHIP? ☒ Yes ☐ No ☐ N/A

8. Indicate what documentation is required at initial application

	Self-Declaration	Self-Declaration with internal verification	Documentation Required
Income	☐	☐	☒
Citizenship	☐	☐	☒
Insured Status	☒	☐	☐

Enter any Narrative text below.

Medicaid beneficiary records are matched with information received from several health insurance providers after enrollment to identify individuals who have other health insurance coverage.

Title XXI funds children who are granted presumptive eligibility into Medicaid whose assets are waived. Children eligible for presumptive eligibility are those ages 0-1 under 200%FPL, ages 1-5 under 133% FPL, and ages 6-18 under 100% FPL.

Applicant may pay three months premiums in advance and receive the fourth month free. If the applicant uses Electronic Funds Transfer (EFT) or makes recurring credit card payments for premiums, the applicant receives a 25% discount. The $250 yearly cap only applies to health benefit co-payments for all subscribers who reside in one household. In the event the $250 yearly co-payment cap is met, the applicant is still required to make monthly premium payments.

Applicants may apply for the SCHIP and Medicaid programs on-line through the assistance of a Certified Application Assistant (CAA) or County Eligibility Worker (EW). Only CAAs and EWs have access to the on-line electronic application process. The on-line application process for public use is in the beginning stages of development and will be a future accomplishment.

Under the provision of the AB 495 SPA, Section 1.1, four counties are authorized to serve eligible children with incomes between 250-300% FPL. This program is known as the Healthy Kids Program. These counties comply with the 3-month substitution coverage provision for ESI coverage and other SCHIP eligibility requirements.

Documentation for any US citizen, national or legal immigrant applying for health coverage is required to be SCHIP eligible. This documentation can be sent with the application or within 2 months of enrollment. **[7500]**

9. 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	N/A	Yes	No Change	N/A
a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	☐	☒	☐	☐	☒	☐
b) Application		X	☐	☒	☐	☐
c) Application documentation requirements	☐	☒	☐	☐	☒	☐

	Medicaid Expansion SCHIP Program			Separate Child Health Program		
	Yes	No Change	N/A	Yes	No Change	N/A
d) Benefit structure	☐	☒	☐	☐	☒	☐
e) Cost sharing (including amounts, populations, & collection process)	☐	☐	☒	☐	☒	☐
f) Crowd out policies	☐	☒	☐	☐	☒	☐
g) Delivery system	☐	☒	☐	☐	☒	☐
h) Eligibility determination process (including implementing a waiting lists or open enrollment periods)	☐	☒	☐	☒	☐	☐
i) Eligibility levels / target population	☐	☒	☐	☐	☒	☐
j) Assets test in Medicaid and/or SCHIP	☐	☒	☐	☐	☒	☐
k) Income disregards in Medicaid and/or SCHIP	☐	☒	☐	☐	☒	☐
l) Eligibility redetermination process	☐	☒	☐	☐	☒	☐
m) Enrollment process for health plan selection	☐	☒	☐	☐	☒	☐
n) Family coverage	☐	☒	☐	☐	☒	☐
o) Outreach (e.g., decrease funds, target outreach)	☐	☒	☐	☒	☐	☐
p) Premium assistance	☐	☐	☒	☐	☒	☐
q) Prenatal Eligibility expansion	☐	☒	☐	☐	☒	☐
r) Waiver populations (funded under title XXI)						
Parents	☐	☐	☒	☐		**X**
Pregnant women	☐	☐	☒	☐		**X**
Childless adults	☐	☐	☒	☐		**X**
s) Methods and procedures for prevention, investigation, and referral of cases of fraud and abuse	☐	☒	☐	☐	☒	☐
t) 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	On April 1, 2008, the State launched a revised joint application for the SCHIP and Medicaid programs. Changes include using more simplified language; reducing the reading grade level; more effectively communicating and presenting important program information, including a document check list to ensure that the applicant provides the necessary information needed to ensure that the application is complete; and making the application more visually appealing for the target population. The application was changed to eliminate any barriers that discourage individuals from applying for the SCHIP and Medicaid programs by making it easier to read and understand. The previous joint application was at a 10th grade reading level. The new application is at a 7th grade reading level.
c) Application documentation requirements	
d) Benefit structure	
e) Cost sharing (including amounts, populations, & collection process)	
f) Crowd out policies	
g) Delivery system	
h) Eligibility determination process (including implementing a waiting lists or open enrollment periods)	On 11/5/07, the MRMIB adopted emergency regulations to ensure that SCHIP expenditures do not exceed amounts available. The adopted regulations give the Board the authority to establish a waiting list for new children applying for the program, in the event there is not sufficient SCHIP funding. If the waiting list does not adequately limit SCHIP funding, the Board can also direct the program to disenroll subscriber children during the Annual Eligibility Review. The disenrolled children would be placed on the waiting list. While regulations give the Board the authority to establish a waiting list or authorize disenrollments, a wait list or disenrollments have not been implemented. The State Budget was passed on 9/23/08. Open Enrollment (OE) for the State Fiscal Year (SFY) 2008-2009 was delayed, due to the State Budget. OE typically occurs April 15th through May 31st each year which would have occurred during the 2008 FFY. OE will occur 11/15/08 - 12/31/08. Therefore, OE will be reported in the 2009 FFY Federal Annual Report.
i) Eligibility levels / target population	

j) Assets test in Medicaid and/or SCHIP	
k) Income disregards in Medicaid and/or SCHIP	
l) Eligibility redetermination process	
m) Enrollment process for health plan selection	
n) Family coverage	
o) Outreach	During the third quarter of FFY 2008, school based outreach through the Connecting Kids To Health Care Through Schools Program ended on April 1, 2008. School based outreach activities were funded through grants from the David and Lucille Packard Foundation. MRMIB continues to support several of the activities previously supported by the Connecting Kids to Health Care Through Schools Program. This includes the Request For Information (RFI) Flyers. The RFI templates have been posted on the MRMIB and the HFP websites for continued use by school based organizations. MRMIB is currently developing a customized on-line RFI process for the HFP website. During the reporting period, 333,343 RFIs were printed and distributed by school-based organizations. In addition, MRMIB continues to distribute Connecting Kids collateral materials to the top producing Enrollment Entities.
p) Premium assistance	
q) Prenatal Eligibility Expansion	
r) Waiver populations (funded under title XXI)	
Parents	
Pregnant women	
Childless adults	

s) Methods and procedures for prevention, investigation, and referral of cases of fraud and abuse	
t) Other – please specify	
a. **[50]**	
b. **[50]**	
c. **[50]**	

Enter any Narrative text below. **[7500**

SECTION II: PROGRAM'S PERFORMANCE MEASUREMENT AND PROGRESS

This section consists of three subsections 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.

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 core 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

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.

This section contains templates for reporting performance measurement data for each of the core child health measures. Please report performance measurement data for the three most recent years (to the extent that data are available). In the first and second column, data from the previous two years' annual reports (FFY 2006 and FFY 2007) will be populated with data from previously reported data in SARTS, enter data in these columns only if changes must be made. If you previously reported no data for either of those years, but you now have recent data available for them, please enter the data. In the third column, please report the most recent data available at the time you are submitting the current annual report (FFY 2008). Additional instructions for completing each row of the table are provided below.

If Data Not Reported, Please Explain Why:
If you cannot provide a specific measure, please check the box that applies 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.
- 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.
- 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.

Status of Data Reported:
Please indicate the status of the data you are reporting, as follows:

- Provisional: Check this box if you are reporting data for a measure, but the data are currently being modified, verified, or may change in any other way before you finalize them for FFY 2008.
- Final: Check this box if the data you are reporting are considered final for FFY 2008.
- Same data as reported in a previous year's annual report: Check this box if the data you are reporting are the same data that your State reported in another annual report. Indicate in which year's annual report you previously reported the data.

Measurement Specification:
For each performance measure, 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® 2007). If using HEDIS®-like specifications, please explain how HEDIS® was modified.

Data Source:
For each performance measure, please indicate the source of data – administrative data (claims) (specify the kind of administrative data used), hybrid data (claims and medical records) (specify how the two were used to create the data source), survey data (specify the survey used), or other source (specify the other source). If another data source was used, please explain the source.

Definition of Population included in the Measure:
Please indicate the definition of the population included in the denominator for each measure (such as age, continuous enrollment, type of delivery system). Check one box to indicate whether the data are for the SCHIP population only, or include both SCHIP and Medicaid (Title XIX) children combined. Also provide a definition of the numerator (such as the number of visits required for inclusion).

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.

Year of Data:
Please report the year of data for each performance measure. The year (or months) should correspond to the *period in which utilization took place*. Do *not* report the year in which data were collected for the measure, or the version of HEDIS® used to calculate the measure, both of which may be different from the period corresponding to utilization of services.

Performance Measurement Data (HEDIS® or Other):
In this section, please report the numerators, denominators, and rates for each measure (or component). The template provides two sections for entering the performance measurement data, depending on whether you are reporting using HEDIS® or HEDIS®-like methodology or a methodology other than HEDIS®. The form fields have been set up to facilitate entering numerators, denominators, and rates for each measure. If the form fields do not give you enough space to fully report on your measure, please use the "additional notes" section.

Note: SARTS will calculate the rate if you enter the numerator and denominator. Otherwise, if you only have the rate, enter it in the rate box.

If you typically calculate separate rates for each health plan, report the aggregate state-level rate for each measure (or component). The preferred method is to calculate a "weighted rate" by summing the numerators and denominators across plans, and then deriving a single state-level rate based on the ratio of the numerator to the denominator. Alternatively, if numerators and denominators are not available, you may calculate an "unweighted average" by taking the mean rate across health plans.

Explanation of Progress:
The intent of this section is to allow your State to highlight progress and describe any quality improvement activities that may have contributed to your progress. If improvement has not occurred over time, this section can be used to discuss potential reasons for why progress was not seen and to describe future quality improvement plans. In this section, your State is also asked to set annual performance objectives for FFY 2009, 2010, and 2011. Based on your recent performance on the measure (from FFY 2006 through 2008), use a combination of expert opinion and "best guesses" to set objectives for the next three years. Please explain your rationale for setting these objectives. For example, if your rate has been increasing by 3 or 4 percentage points per year, you might project future increases at a similar rate. On the other hand, if your rate has been stable over time, you might set a target that projects a small increase over time. If the rate has been fluctuating over time, you might look more closely at the data to ensure that the fluctuations are not an artifact of the data or the methods used to construct a rate. You might set an initial target that is an average of the recent rates, with slight increases in subsequent years.

In future annual reports, you will be asked to comment on how your actual performance compares to the objective your State set for the year, as well as any quality improvement activities that have helped or could help your State meet future objectives.

Other Comments on Measure:
Please use this section to provide any other comments on the measure, such as data limitations or plans to report on a measure in the future.

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: Well Child Visits in the First 15 Months of Life

FFY 2006	FFY 2007	FFY 2008
Did you report on this goal? ☐ Yes ☒ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☒ Data not available. *Explain*: The Managed Risk Medical Insurance Board's contract with participating health plans did not require the plans to collect this information when it was first requested by CMS. Data was collected in 2006 and reported for 2007. ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**Did you report on this goal?** ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**Did you report on this goal?** ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: 2007 ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: 2008 ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:
Data Source: ☐ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☒ Other. *Specify*: Participating Healthy Families Program (HFP) health plans.	**Data Source:** ☐ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☒ Other. *Specify*: Participating HFP health plans.

FFY 2006	FFY 2007	FFY 2008
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of denominator: Plans provide a random sample of summary data of HFP members who turned 15 months old during the measurement year who were continuously enrolled in the plan between 31 days to 15 months and who had one, two, three, four, five or six or more well-child visit(s) with a primary care practitioner during the measurement year. MRMIB calculates percentages and compares the results with those submitted by the health plans. ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: HFP members who had one, two, three, four, five or six well-child visits with a primary care practitioner during the measurement year.	**Definition of Population Included in the Measure:** Definition of denominator: A random sample of HFP members who turned 15 months old during the measurement year and who were continuously enrolled in the plan between 31 days to 15 months of age. ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: HFP members who had one, two, three, four, five or six well-child visits with a primary care practitioner during the measurement year.
Year of Data:	**Year of Data:** January – December 2006	**Year of Data: January - December 2007**

Well Child Visits in the First 15 Months of Life (continued)

FFY 2006	FFY 2007	FFY 2008
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Percent with specified number of visits 0 visits Numerator: Denominator: Rate: 4 visits Numerator: Denominator: Rate: 1 visit Numerator: Denominator: Rate: 5 visits Numerator: Denominator: Rate: 2 visits Numerator: Denominator: Rate: 6+ visits Numerator: Denominator: Rate: 3 visits Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with specified number of visits 0 visits Numerator: 35 Denominator: 3,690 Rate: 1% 4 visits Numerator: 528 Denominator: 3,690 Rate: 14% 1 visit Numerator: 44 Denominator: 3,690 Rate: 1% 5 visits Numerator: 966 Denominator: 3,690 Rate: 26% 2 visits Numerator: 80 Denominator: 3,690 Rate: 2% 6+ visits Numerator: 1,807 Denominator: 3,690 Rate: 49% 3 visits Numerator: 230 Denominator: 3,690 Rate: 6% Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with specified number of visits 0 visits Numerator: 3 Denominator: 4,643 Rate: 1% 4 visits Numerator: 613 Denominator: 4,643 Rate: 13% 1 visit Numerator: 52 Denominator: 4,643 Rate: 1% 5 visits Numerator: 1,137 Denominator: 4,643 Rate: 24% 2 visits Numerator: 83 Denominator: 4,643 Rate: 2% 6+ visits Numerator: 2,509 Denominator: 4,643 Rate: 54% 3 visits Numerator: 216 Denominator: 4,643 Rate: 5% Additional notes on measure:
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:

Explanation of Progress:
Approximately 54% of HFP children who turned 15 months old during the measurement year received at least 6 well-child visits during the measurement year. This represents a 5% increase over the weighted measure from the previous measurement year.

How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?
Our 2007 rate exceeded our Annual Performance Objective of 2% by an additional 5%, for a total increase of 7% from the previous measurement year.
What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal? Public reporting of plan performance and comparison to state and national Medicaid and commercial scores.

Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.

Annual Performance Objective for FFY 2009: A 5% increase in the number of Well Child Visits in the First 15 Months of Life

Annual Performance Objective for FFY 2010: A 5% increase in the number of Well Child Visits in the First 15 Months of Life

Annual Performance Objective for FFY 2011: A 5% increase in the number of Well Child Visits in the First 15 Months of Life

Explain how these objectives were set: The American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care recommends that children receive 6 physical examinations by 15 months of age. MRMIB's objective is for the majority of children in HFP to receive at least six well-child visits in the first 15 months of life.

Other Comments on Measure:

MEASURE: Well-Child Visits in Children the 3rd, 4th, 5th, and 6th Years of Life

FFY 2006	FFY 2007	FFY 2008
Did you report on this goal? ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**Did you report on this goal?** ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**Did you report on this goal?** ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: 2005. ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: 2007 ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: 2008 ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:
Data Source: ☐ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☒ Other. *Specify*: Participating Healthy Families Program (HFP) health plans.	**Data Source:** ☐ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☒ Other. *Specify*: Participating Healthy Families Program (HFP) health plans.	**Data Source:** ☐ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☒ Other. *Specify*: Participating HFP health plans.

Definition of Population Included in the Measure: Plans provide a random sample of summary data of HFP members who were 3, 4, 5, or 6 years old during the measurement year who were continuously enrolled in the plan during the measurement year and who received one or more well-child visit(s) with a primary care provider during the measurement year. MRMIB calculates percentages and compares the results with those submitted by the health plans. Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Plans provide a random sample of summary data of HFP members who were 3, 4, 5, or 6 years old during the measurement year who were continuously enrolled in the plan during the measurement year and who received one or more well-child visit(s) with a primary care provider during the measurement year. MRMIB calculates percentages and compares the results with those submitted by the health plans. Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: HFP members who were 3, 4, 5 or 6 years old during the measurement year and who were continuously enrolled during the measurement year. ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: HFP members who received one or more well-child visit(s) with a primary care practitioner during the measurement year.
Year of Data: January – December 2005	**Year of Data:** January – December 2006	**Year of Data:** January – December 2007
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology* Percent with 1+ visits Numerator: Denominator: Rate: 70% Additional notes on measure: The rate reported for FFY 2006 was updated to reflect an "unweighted average" of the health plans. The rate previous reported was an inaccurate weighted average. Due to differences in collection of source data by the health plans, some plans were given an unfair influence on the weighted average previously reported.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with 1+ visits Numerator: Denominator: Rate: 72% Additional notes on measure: The rate reported for FFY 2007 is an "unweighted average" of the health plans and was calculated by taking the mean across the health plans.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with 1+ visits Numerator: Denominator: Rate: 73% Additional notes on measure: The rate reported for CY 2007 is a weighted average.

Well-Child Visits in Children the 3rd, 4th, 5th, and 6th Years of Life (continued)

FFY 2006	FFY 2007	FFY 2008
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:

Explanation of Progress:

Approximately 73% of HFP children ages 3 to 6 years old received at least one well-child visit during 2007. This represents a 2% increase over the weighted average of the previous year. For the last 4 measurement years, there has been at least a 2% increase each year in the number of HFP children ages 3 to 6 who received a well-child visit.

How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?
Our 2007 rate met our Annual Performance Objective of at least a 2% increase each year.

What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal? Public reporting of plan performance and comparison to state and national Medicaid and commercial scores.

Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.

Annual Performance Objective for FFY 2009: A 2% increase for Well-Child Visits in Children the 3rd, 4th, 5th, and 6th Years of Life.

Annual Performance Objective for FFY 2010: A 2% increase for Well-Child Visits in Children the 3rd, 4th, 5th, and 6th Years of Life.

Annual Performance Objective for FFY 2011: A 2% increase for Well-Child Visits in Children the 3rd, 4th, 5th, and 6th Years of Life.

Explain how these objectives were set: Based on past performance, MRMIB expects a continued increase of 2% for well-child visits in children ages 3 to 6 years old.

Other Comments on Measure:

MEASURE: Use of Appropriate Medications for Children with Asthma

FFY 2006	FFY 2007	FFY 2008
Did you report on this goal? ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**Did you report on this goal?** ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**Did you report on this goal?** ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: 2006 ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: 2007 ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: 2008 ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:
Data Source: ☐ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☒ Other. *Specify*: Participating HFP health plans.	**Data Source:** ☐ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☒ Other. *Specify* Participating HFP health plans.	**Data Source:** ☐ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☒ Other. *Specify*: Participating HFP health plans.
Definition of Population Included in the Measure: Definition of denominator: : Plans identify the number of children ages five through 18 years who were continuously enrolled during the measurement year and the prior calendar year, were identified as having persistent asthma, and who were appropriately prescribed medication. ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: : Plans identify the number of children ages five through 18 years who were continuously enrolled during the measurement year and the prior calendar year, were identified as having persistent asthma, and who were appropriately prescribed medication. ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: HFP members ages 5 through 18 years who were continuously enrolled during the measurement year and the prior calendar year and were identified as having persistent asthma. ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: HFP members who were appropriately prescribed asthma medication.
Year of Data: January – December 2005	**Year of Data:** January – December 2006	**Year of Data:** January – December 2007

Use of Appropriate Medications for Children with Asthma (continued)

FFY 2006	FFY 2007	FFY 2008
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Percent receiving appropriate medications 5-9 years: Numerator: 2,182 Denominator: 2,392 Rate: 91% 10-17 years: Numerator: 2,399 Denominator: 2,711 Rate: 88% 18 years: Numerator: 147 Denominator: 181 Rate: 81% Combined rate (5-18 years): Numerator: 4,728 Denominator: 5,284 Rate: 89%	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent receiving appropriate medications 5-9 years Numerator: 2,566 Denominator: 2,673 Rate: 96% 10-17 years Numerator: 2,829 Denominator: 3,047 Rate: 93% 18 years: Numerator: 154 Denominator: 187 Rate: 82% Combined rate (5-18 years) Numerator: 5,549 Denominator: 5,907 Rate: 94% Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent receiving appropriate medications 5-9 years Numerator: 2,950 Denominator: 3,076 Rate: 96% 10-17 years Numerator: 3,346 Denominator: 3,601 Rate: 93% 18 years Numerator: 199 Denominator: 234 Rate: 85% Combined rate (5-17 years) Numerator: 6,495 Denominator: 6,911 Rate: 94% Additional notes on measure:
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:

Explanation of Progress:
Approximately 94% of HFP children ages 5 to 18 years who were identified as having persistent asthma received appropriately prescribed asthma medication.

How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?
Our 2007 combined rate was the same as the previous measurement year at an overall rate of 94%. Children ages 5-9 and ages 10-17 maintained consistently high rates of 96% and 93% respectively. Although the Annual Performance Objective of a 2% increase in each age group was not achieved, HFP has a high compliance rate. We are pleased to report that the score for 18 year olds increased by 3% from the previous measurement year.

What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal? Public reporting of plan performance and comparison to state and national Medicaid and commercial scores.

Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.

Annual Performance Objective for FFY 2009: A 2% increase in each age group for the Use of Appropriate Medications for Children with Asthma.

Annual Performance Objective for FFY 2010: A 2% increase in each age group for the Use of Appropriate Medications for Children with Asthma.

Annual Performance Objective for FFY 2011: A 2% increase in each age group for the Use of Appropriate Medications for Children with Asthma.

Explain how these objectives were set: MRMIB wants improved performance in the use of appropriate medication for children ages 5 – 18 who have persistent asthma.

Other Comments on Measure:

MEASURE: Children's Access to Primary Care Practitioners

FFY 2006	FFY 2007	FFY 2008
Did you report on this goal? ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**Did you report on this goal?** ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:	**Did you report on this goal?** ☒ Yes ☐ No **If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: 2006 ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: 2007 ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: 2008 ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:
Data Source: ☐ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☒ Other. *Specify*: Participating HFP health plans.	**Data Source:** ☐ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☒ Other. *Specify*: Participating HFP health plans.	**Data Source:** ☐ Administrative (claims data). *Specify*: ☐ Hybrid (claims and medical record data). *Specify*: ☐ Survey data. *Specify*: ☒ Other. *Specify*: Participating HFP health plans.

FFY 2006	FFY 2007	FFY 2008
Definition of Population Included in the Measure: Definition of denominator: Plans identify the continuously enrolled children ages 12 months through 6 years who had a visit with a primary care physician during the measurement year and the continuously enrolled children ages 7 through 18 years who had a visit with a primary care physician during the measurement year or the year preceding the measurement year. ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Plans identify the continuously enrolled children ages 12 months through 6 years who had a visit with a primary care physician during the measurement year and the continuously enrolled children ages 7 through 18 years who had a visit with a primary care physician during the measurement year or the year preceding the measurement year. ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: HFP members ages 12 months to 18 years who were continuously enrolled during the measurement year. ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: HFP members who had a visit with a primary care physician during the measurement year.
Year of Data: January – December 2005	**Year of Data: January – December 2006**	**Year of Data:** January – December 2007
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Percent with a PCP visit 12-24 months: Numerator: 7,868 Denominator: 8,476 Rate: 93% 7-11 years Numerator: 94,510 Denominator: 111,271 Rate: 85% 25 months-6 years: Numerator: 102,489 Denominator: 117,196 Rate: 87% 12-19 years Numerator: 113,865 Denominator: 140,735 Rate: 81% Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with a PCP visit 12-24 months Numerator: 17,815 Denominator: 18,605 Rate: 96% 7-11 years Numerator: 108,008 Denominator: 121,337 Rate: 89% 25 months-6 years Numerator: 105,679 Denominator: 119,202 Rate: 89% 12-19 years Numerator: 139,907 Denominator: 162,411 Rate: 86% Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with a PCP visit 12-24 months Numerator: 15,103 Denominator: 15,584 Rate: 97% 7-11 years Numerator: 123,169 Denominator: 138,657 Rate: 89% 25 months-6 years Numerator: 128,385 Denominator: 143,570 Rate: 89% 12-19 years Numerator: 163,678 Denominator: 19,1406 Rate: 86% Additional notes on measure:
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:

FFY 2006	FFY 2007	FFY 2008

Explanation of Progress:

Approximately 88% of HFP member's ages 12 months to 18 years had a visit with a primary care practitioner during 2007.

How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?
Rates had consistently improved over the last several years and the 2007 rate remains the same as the previous measurement year. MRMIB continues to work with plans that have rates that are significantly below the program average.

What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal? Public reporting of plan performance and comparison to state and national Medicaid and commercial scores.

Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.

Annual Performance Objective for FFY 2009: A 2% increase in each age group for Children's Access to Primary Care Practitioners.

Annual Performance Objective for FFY 2010: A 2% increase in each age group for Children's Access to Primary Care Practitioners.

Annual Performance Objective for FFY 2011: A 2% increase in each age group for Children's Access to Primary Care Practitioners.

Explain how these objectives were set: MRMIB wants continued improvement in the number of HFP members who see their primary care practitioner each year, particularly those members over 2 years of age, with a goal of 100 % of covered children ages 12 months to 6 years being seen by a primary care practitioner annually and with a goal of 100% of covered children ages 7 to 19 years being seen by a primary care practitioner every two years.

Other Comments on Measure:

SECTION IIB: ENROLLMENT AND UNINSURED DATA

1. 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 2007	FFY 2008	Percent change FFY 2007-2008
SCHIP Medicaid Expansion Program	265,057	290,810	9.71
Separate Child Health Program	1,273,359	1,377,973	8.21

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

2. The table below shows trends in the three-year averages for the number and rate of uninsured children in your State based on the Current Population Survey (CPS), along with the percent change between 1996-1998 and 2005-2007. 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, but in the meantime, please refer to the CPS data attachment that was sent with the FFY 2008 Annual Report Template.

	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	
Period	Number (In Thousands)	Std. Error	Rate	Std. Error
1996-1998				
1998-2000				
2000-2002				
2002-2004				

2003-2005				
2004-2006				
2005-2007				
Percent change 1996-1998 vs. 2005-2007				

A. Please explain any activities or factors that may account for increases or decreases in your number and/or rate of uninsured children.

[7500]

B. Please note any comments here concerning CPS data limitations that may affect the reliability or precision of these estimates. **[7500]**

3. Please indicate by checking the box below whether your State has an alternate data source and/or methodology for measuring the change in the number and/or rate of uninsured children.

X Yes (please report your data in the table below)

☐ No (skip to Question #4)

Please report your alternate data 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)	California Health Interview Survey (CHIS)
Reporting period (2 or more points in time)	2001, 2003 and 2005
Methodology	The baseline for 2001 and 2003 was calculated by using Medi-Cal and HFP enrollment data and the 2000 Current Population Survey (CPS) as analyzed by the UCLA Center for Health Policy Research. Technical notes can be found in *The State of Health Insurance in California: Recent Trends, Future Prospects* and at the UCLA Centers website: www.healthpolicy.ucla.edu. The methodology used for estimating the baseline did not change. The baseline for 2005 was calculated by using Medi-Cal and HFP enrollment data and the 2005 Current Population Survey (CPS) as analyzed by the UCLA Center for Health Policy Research. Technical notes can be found in *The State of Health Insurance in California: Findings from the 2005 California Health Interview Survey* and at the UCLA Centers website: www.healthpolicy.ucla.edu. The methodology used for estimating the baseline did not change.
Population (Please include ages and income levels)	CHIS is a general population survey that examines health insurance coverage, as well as numerous other issues. It surveys households through random selection and does so in five languages.
Sample sizes	2001 Survey: 55,000 households with over samples of Asian Pacific Islanders and American Indian/Alaska Natives. This sample included 5,000-6,000 adolescents and 14,000 children by proxy. 2003 Survey: 40,000 households with 4,000 adolescents and 9,000 children by proxy. Over samples were done of Koreans and Vietnamese. 2005 Survey: 45,649 households with 4,029 adolescents, and 11,358

	children.
Number and/or rate for two or more points in time	Coverage of children enrolled under Medi-Cal and HFP continues to increase: 2001 - 24.2%; 2003 - 29.2%; and 2005: 30.9%. The percentage of uninsured children decreased from 2001 (14.8%) to 2003 (11.3%) to 2005 (10.7%). The number of children with employer sponsored coverage decreased from 2001 (55.1%) to 2003 (50.8%) to 2005 (50.3%).
Statistical significance of results	• Increases in the number of children enrolled in HFP or Medi-Cal are statistically significant both for 2001-2003 and 2003-2005. • Decreases in the percentage of uninsured children were statistically significant between 2001-2003. • Decreases in the percentage of employer sponsored coverage were statistically significant between 2001 and 2003.

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

California uses a state survey, the California Health Interview Survey (CHIS) because its sample size is higher than CPS, which allows for better estimates of subgroups. CHIS also asks more detailed questions about eligibility for public programs (Medi-Cal /HFP). However, a 2004 report issued by the California Healthcare Foundation (CHCF) *Memorandum on Data Guide: Analysis Results for Understanding Survey Estimates of California's Uninsured and Medi-Cal Populations* (Feldman, Schur, Berk and Kintala) suggest adjusting CHIS estimates of uninsured children by a factor of 1.6 when absolute size matters. Figures detailed above are not adjusted.

B. What is your State's assessment of the reliability of the estimate? Please provide standard errors, confidence intervals, and/or p-values if available.

Given its larger sample size, and greater precision asking eligibility questions, California considers the estimate reliable. However, for cross state comparison, either CPS should be used or an adjusted CHIS estimate. As noted above, the report suggests adjusting CHIS estimates of uninsured children by a factor of 1.6.

C. What are the limitations of the data or estimation methodology?

CHIS is a telephone survey, not an in-person survey which could produce some bias. This issue will be explored in the 2007 CHIS. Also, state surveys generally tend to produce lower estimates of the uninsured. As noted above, the CHCF study suggests adjusting estimates of uninsured children by a factor of 1.6.

D. How does your State use this alternate data source in SCHIP program planning?

California uses CHIS to benchmark enrollment. Local jurisdictions use it to target outreach.

4. 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.

California does not actively collect data to evaluate the impact of outreach and enrollment simplification. The State, however, believes outreach and enrollment simplification played a major role in the continuing increase in enrollment for the SCHIP and Medicaid.

The State funding for statewide media outreach campaigns stopped on July 1, 2003. However, the State continued to work closely with the David and Lucille Packard Foundation and Public Health Institute to sponsor the Connecting Kids to Healthcare Through Schools Project. This Project focused on statewide school-based outreach and enrollment for the SCHIP, Medicaid and Children's Expansion Programs (e.g. Healthy Kids Programs). Although this project ended in April 2008, the State continues to support certain school-based outreach efforts.

As a result of the school based outreach over 300,000 outreach materials were distributed to schools during this reporting period. Over 70,000 outreach materials were distributed after the close of the Connecting Kids Project ended. The schools disseminated the materials to parents with their Back-to-School packets, at Back-to-School Nights, Parent/Teacher Conferences, and with school lunch menus. The dissemination of outreach materials resulted in over 17,319 requests for applications to be mailed to prospective applicants. Many of the outreach materials were customized with local contact information, so the number of applications requested is understated for this outreach goal.

In addition, outreach still exists at the local levels for a wide variety of Children's Expansion Programs. For many of these programs outreach and enrollment is privately funded through Foundations and Local First 5 Commissions. In those counties with Children's Expansion Programs, there have been positive impacts on both the Medicaid and SCHIP Programs in California.

The EE/CAA reimbursement process continues for each successful application where a child is enrolled. In FFY 2006, the EE/CAA reimbursement process increased the amount for on-line applications submitted from $50 to $60. This reimbursement is paid for each successful on-line application where a child is enrolled in SCHIP and for each application forwarded to the Medicaid Program where a child is granted presumptive Medicaid eligibility. In addition, for each successful Annual Eligibility Review form where a child continues to be eligible for SCHIP, the EE receives $50 instead of $25.

In addition, 20,480 CAAs were available to assist families in applying for the SCHIP and Medicaid programs as of September 2008. With approximately 1,600 new CAAs since the last reporting period, this is an 8% increase in CAA participation. This is an average of 133 new CAAs being trained each month.

The number of applications assisted by CAAs increased approximately 23%. During the initial application process, 118,375 of SCHIP eligible children obtained assistance from CAAs. During the Annual Eligibility Review process, 91,802 children continued to be eligible for SCHIP through the assistance of CAAs. This is a 12% increase from the previous reporting period.

SECTION IIC: STATE STRATEGIC OBJECTIVES AND PERFORMANCE GOALS

This subsection gathers information on your State's general strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. (If your goals reported in the annual report now differ from Section 9 of your SCHIP state plan, please indicate how they differ in "Other Comments on Measure." Also, the state plan should be amended to reconcile these differences). The format of this section provides your State with an opportunity to track progress over time. This section contains templates for reporting performance measurement data for each of five categories of strategic objectives, related to:

- Reducing the number of uninsured children
- SCHIP enrollment
- Medicaid enrollment
- Increasing access to care
- Use of preventative care (immunizations, well child care)

Please report performance measurement data for the three most recent years for which data are available (to the extent that data are available). In the first two columns, report data from the previous two years' annual reports (FFY 2006 and FFY 2008) will be populated with data from previously reported data in SARTS, enter data in these columns only if changes must be made. If you previously reported no data for either of those years, but you now have recent data available for them, please enter the data. In the third column, please report the most recent data available at the time you are submitting the current annual report (FFY 2008).

Note that the term *performance measure* is used differently in Section IIA versus IIC. In Section IIA, the term refers to the four core child health measures. In this section, the term is used more broadly, to refer to any data your State provides as evidence towards a particular goal within a strategic objective. For the purpose of this section, "objectives" refer to the five broad categories listed above, while "goals" are State-specific, and should be listed in the appropriate subsections within the space provided for each objective.

NOTES: Please do not reference attachments in this section. 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.

In addition, please do not report the same data that were reported in Sections IIA or IIB. The intent of this section is to capture goals and measures that your State did not report elsewhere in Section II.

Additional instructions for completing each row of the table are provided below.

Goal:

For each objective, space has been provided to report up to three goals. Use this section to provide a brief description of each goal you are reporting within a given strategic objective. **All new goals should include a direction and a target. For clarification only, an example goal would be**: "Increase (direction) by 5 percent (target) the number of SCHIP beneficiaries who turned 13 years old during the measurement year who had a second dose of MMR, three hepatitis B vaccinations and one varicella vaccination by their 13th birthday."

Type of Goal:

For each goal you are reporting within a given strategic objective, please indicate the type of goal, as follows:

- New/revised: Check this box if you have revised or added a goal. Please explain how and why the goal was revised.

- Continuing: Check this box if the goal you are reporting is the same one you have reported in previous annual reports.

- Discontinued: Check this box if you have met your goal and/or are discontinuing a goal. Please explain why the goal was discontinued.

Status of Data Reported:

Please indicate the status of the data you are reporting for each goal, as follows:

- Provisional: Check this box if you are reporting performance measure data for a goal, but the data are currently being modified, verified, or may change in any other way before you finalize them for FFY 2008.

- Final: Check this box if the data you are reporting are considered final for FFY 2008.

- Same data as reported in a previous year's annual report: Check this box if the data you are reporting are the same data that your State reported for the goal in another annual report. Indicate in which year's annual report you previously reported the data.

Measurement Specification:

This section is included for only two of the objectives— objectives related to increasing access to care, and objectives related to use of preventative care—because these are the two objectives for which States may report using the HEDIS® measurement specification. In this section, for each goal, please indicate the measurement specification used to calculate your performance measure data (i.e., were the measures calculated using the HEDIS® specifications, HEDIS®-like specifications, or some other method unrelated to HEDIS®). If the measures were calculated using HEDIS® or HEDIS®-like specifications, please indicate which version was used (e.g., HEDIS® 2008). If using HEDIS®-like specifications, please explain how HEDIS® was modified.

Data Source:

For each performance measure, please indicate the source of data. The categories provided in this section vary by objective. For the objectives related to reducing the number of uninsured children and SCHIP or Medicaid enrollment, please indicate whether you have used eligibility/enrollment data, survey data (specify the survey used), or other source (specify the other source). For the objectives related to access to care and use of preventative care, please indicate whether you used administrative data (claims) (specify the kind of administrative data used), hybrid data (claims and medical records) (specify how the two were used to create the data source), survey data (specify the survey used), or other source (specify the other source). In all cases, if another data source was used, please explain the source.

Definition of Population Included in Measure:

Please indicate the definition of the population included in the denominator for each measure (such as age, continuous enrollment, type of delivery system). Also provide a definition of the numerator (such as the number of visits required for inclusion, e.g., one or more visits in the past year).

For measures related to increasing access to care and use of preventative care, please also check one box to indicate whether the data are for the SCHIP population only, or include both SCHIP and Medicaid (Title XIX) children combined.

Year of Data:

Please report the year of data for each performance measure. The year (or months) should correspond to the *period in which enrollment or utilization took place*. Do *not* report the year in which data were collected for the measure, or the version of HEDIS® used to calculate the measure, both of which may be different from the period corresponding to enrollment or utilization of services.

Performance Measurement Data:

Describe what is being measured: Please provide a brief explanation of the information you intend to capture through the performance measure.

Numerator, Denominator, and Rate: Please report the numerators, denominators, and rates for each measure (or component). For the objectives related to increasing access to care and use of preventative care, the template provides two sections for entering the performance measurement data, depending on whether you are reporting using HEDIS® or HEDIS®-like methodology or a methodology other than HEDIS®. The form fields have been set up to facilitate entering numerators, denominators, and rates for each measure. If the form fields do not give you enough space to fully report on your measure, please use the "additional notes" section.

If you typically calculate separate rates for each health plan, report the aggregate state-level rate for each measure (or component). The preferred method is to calculate a "weighted rate" by summing the numerators and denominators across plans, and then deriving a single state-level rate based on the ratio of the numerator to the denominator. Alternatively, if numerators and denominators are not available, you may calculate an "unweighted average" by taking the mean rate across health plans.

Explanation of Progress:

The intent of this section is to allow your State to highlight progress and describe any quality improvement activities that may have contributed to your progress. Any quality improvement activity described should involve the SCHIP program, benefit SCHIP enrollees, and relate to the performance measure and your progress. An example of a quality improvement activity is a state-wide initiative to inform individual families directly of their children's immunization status with the goal of increasing immunization rates. SCHIP would either be the primary lead or substantially involved in the project. If improvement has not occurred over time, this section can be used to discuss potential reasons for why progress was not seen and to describe future quality improvement plans. In this section, your State is also asked to set annual performance objectives for FFY 2009, 2010 and 2011. Based on your recent performance on the measure (from FFY 2006 through 2008), use a combination of expert opinion and "best guesses" to set objectives for the next three years. Please explain your rationale for setting these objectives. For example, if your rate has been increasing by 3 or 4 percentage points per year, you might project future increases at a similar rate. On the other hand, if your rate has been stable over time, you might set a target that projects a small increase over time. If the rate has been fluctuating over time, you might look more closely at the data to ensure that the fluctuations are not an artifact of the data or the methods used to construct a rate. You might set an initial target that is an average of the recent rates, with slight increases in subsequent years. In future annual reports, you will be asked to comment on how your actual performance compares to the objective your State set for the year, as well as any quality improvement activities that have helped or could help your State meet future objectives.

Other Comments on Measure:

Please use this section to provide any other comments on the measure, such as data limitations, plans to report on a measure in the future, or differences between performance measures reported here and those discussed in Section 9 of the SCHIP state plan.

Objectives Related to Reducing the Number of Uninsured Children (Do not report data that was reported in Section IIB, Questions 2 and 3)

FFY 2006	FFY 2007	FFY 2008
Goal #1 Increase the percentage of Medi-Cal eligible children who are enrolled in the Medi-Cal Program.	**Goal #1** Increase the percentage of Medi-Cal eligible children who are enrolled in the Medi-Cal Program.	**Goal #1**) Increase the percentage of Medi-Cal eligible children who are enrolled in the Medi-Cal Program.
Type of Goal: ☐ New/revised. *Explain*: X Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: XContinuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: XContinuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. XFinal. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. X Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. XFinal. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: X Other. *Specify*: California Dept. of Health Care Services	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: X Other. *Specify*: California Dept. of Health Care Services	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: XOther. *Specify*: California Dept. of Health Care Services
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:**
Performance Measurement Data: Describe what is being measured: Analyze changes in number of eligible children in Medicaid in FFY 2005 and 2006. Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Describe what is being measured: Analyze changes in number of eligible children in Medicaid in FFY 2005 and 2006. Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Describe what is being measured: Analyze changes in number of eligible children in Medicaid in FFY 2005 and 2006. Numerator: Denominator: Rate: Additional notes on measure:

FFY 2006	FFY 2007	FFY 2008

Explanation of Progress:

How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?

Overall, enrollment in Medi-Cal increased over 2007. One-month bridge caseload continues to grow as a result of implementation of performance standards in July 2005, from 10,493 children in June 2007 to 10,791 children in June 2008. Medicaid expansion caseload grew from 132,207 children in June 2007 to 148,121 children in June 2008. Regular Medicaid caseload increased from 3,130,407 in June 2007 to 3,189,183 in June 2008. The number of children in the one-Month Bridge Program continues to increase due to counties implementing new automated eligibility determination systems or upgrading current systems and the implementation of performance standards.

What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?

Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.

Annual Performance Objective for FFY 2009: Achieve improvements in enrolling eligible children

Annual Performance Objective for FFY 2010: Achieve improvements in enrolling eligible children

Annual Performance Objective for FFY 2011: Achieve improvements in enrolling eligible children

Explain how these objectives were set:

Other Comments on Measure:

Objectives Related to Reducing the Number of Uninsured Children (Do not report data that was reported in Section IIB, Questions 2 and 3) (Continued)

FFY 2006	FFY 2007	FFY 2008
Goal #2 (Describe) Reduce the percentage of uninsured children in target income families that have family income above no-cost Medi-Cal.	**Goal #2 (Describe)** Reduce the percentage of uninsured children in target income families that have family income above no-cost Medi-Cal.	**Goal #2 (Describe)** Reduce the percentage of uninsured children in target income families that have family income above no-cost Medi-Cal.
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☒ Other. "The State of Health Insurance in California: Findings from the 2003 California Health Interview Survey" (Brown, et.al, UCLA 2005)	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☒ Other. "The State of Health Insurance in California: Findings from the 2005 California Health Interview Survey" (Brown, et.al, UCLA 2007)	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☒ Other. "The State of Health Insurance in California: Findings from the 2005 California Health Interview Survey" (Brown, et.al, UCLA 2007)
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Year of Data: 2001 and 2003	**Year of Data: 2003 and 2005**	**Year of Data: 2005 and 2007**

Performance Measurement Data: Describe what is being measured: Analyze changes in number of eligible uninsured children between 2001 and 2003 who were eligible for Medi-Cal or Healthy Families Program. Numerator: 224,000 (# eligible for but not enrolled in HFP in 2001) Denominator: 301,000 (# eligible for but not enrolled in HFP in 2003) Rate: 25%; estimated reduction in the percentage of	**Performance Measurement Data:** Describe what is being measured: Analyze changes in number of eligible uninsured children between 2003 and 2005 who were eligible for Medi-Cal or Healthy Families Program. Numerator: 301,000 (# eligible for but not enrolled in HFP in 2003) Denominator: 200,000 (# eligible for but not enrolled in HFP in 2005)	**Performance Measurement Data:** Describe what is being measured: Analyze changes in number of eligible uninsured children between 2003 and 2005 who were eligible for Medi-Cal or Healthy Families Program. Numerator: 200,000 (# eligible for but not enrolled in HFP in 2005) Denominator: 180,000 (# eligible for but not enrolled in HFP in 2007)

uninsured children in target income families that have family income above no-cost Medi-Cal.	Rate: 30%; estimated reduction in the percentage of uninsured children in target income families that have family income above no-cost Medi-Cal.	Rate: 10%; estimated reduction in the percentage of uninsured children in target income families that have family income above no-cost Medi-Cal.

Explanation of Progress:

How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?

At the end of the FFY 2008, 884,524 children were enrolled in SCHIP. This is a 10% increase from FFY 2007 when 835,981 children were enrolled in SCHIP.

What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?

In April 2008, the state implemented a revised joint application that is at a 7th grade reading level. The previous application that it replaced was at a 10th grade reading level. The State developed an application that is easier to read and understand, in order to eliminate any barriers that discourage individuals from applying for the SCHIP and Medicaid programs. Improvements include using more simplified language, reducing the reading grade level, more effectively communicating and presenting important program information, including a document check list to ensure that the application provides the necessary information needed to ensure that the application is complete, and making the application more visually appealing for the target population. In addition, 2 new languages, Tagalog and Arabic, were added.

Applicants may apply for the SCHIP and Medicaid programs on-line through the assistance of Certified Application Assistants (CAAs) or County Eligibility Workers (EWs). Currently, only CAAs and EWs are authorized to access and utilize the on-line electronic application process. When the on-line application is used, the missing information is reduced because of the step-by-step process required to complete the application. For example, the electronic application provides context-based assistance when filling out the application. The application cannot be submitted unless all required information is entered into the electronic form. All information on the forms is automatically captured and electronically transmitted to the eligibility system. California has seen a steady growth in the number of participating CAAs using the on-line application during FFY 2008. A similar growth has been experienced in the volume of the on-line applications.

During FFY 2007, a total of 43,741 on-line applications were assisted by CAAs. This is a monthly average of 3,645 on-line applications submitted to the Single Point of Entry (SPE). During the FFY 2008, a total of 57,754 on-line applications were submitted to SPE. This is a monthly average of 4,813 on-line applications submitted to the SPE. In September 2008, the on-line application reached an all time high with 7,398 on-line applications which equals approximately 25% of all applications received at SPE during this month.

During the FFY 2007, SCHIP waiver allowing the 2-month SCHIP bridge expired. In the last quarter of FFY 2007, the State implemented a Presumptive Eligibility Medicaid Program to ensure that children maintain access to health care while they are being processed for eligibility into Medicaid. The 2-month SCHIP bridge was eliminated and children with household income below SCHIP guidelines during the annual eligibility review (AER) process no longer receive the two-month bridge in SCHIP. They may qualify for and be granted presumptive eligibility into Medicaid. Presumptive Medicaid gives children free temporary Medicaid health coverage while Medicaid completes an eligibility determination for the Medicaid Program.

Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data

Annual Performance Objective for FFY 2009: Continued reduction in the percentage of uninsured children in target income families that have family income above no-cost Medi-Cal.

Annual Performance Objective for FFY 2010: Continued reduction in the percentage of uninsured children in target income families that have family income above no-cost Medi-Cal.

Annual Performance Objective for FFY 2011: Continued reduction in the percentage of uninsured children in target income families that have family income above no-cost Medi-Cal.

Explain how these objectives were set: MRMIB wants the continued reduction in the number of uninsured children in California.

In August 2008, the SCHIP AER form was revised and the family no longer needs to provide authorization to forward the application to Medicaid. If children are determined to have income below the SCHIP income guidelines during the AER process, they are granted presumptive eligibility. Since the implementation of the revised AER form, over 1,900 children were determined to have income below SCHIP guidelines and were granted presumptive eligibility and their application was forwarded to Medicaid without a break in health coverage.

Other Comments on Measure:

Objectives Related to Reducing the Number of Uninsured Children (Do not report data that was reported in Section IIB, Questions 2 and 3) (Continued)

FFY 2006	FFY 2007	FFY 2008
Goal #3 (Describe)	**Goal #3 (Describe)**	**Goal #3 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:**
Performance Measurement Data: Describe what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Describe what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Describe what is being measured: Numerator: Denominator: Rate: Additional notes on measure:

FFY 2006	FFY 2007	FFY 2008
Explanation of Progress: **How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?** **What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2009:** **Annual Performance Objective for FFY 2010:** **Annual Performance Objective for FFY 2011:** *Explain how these objectives were set:*		
Other Comments on Measure:		

Objectives Related to SCHIP Enrollment

FFY 2006	FFY 2007	FFY 2008
Goal #1 (Describe) Provide an application and enrollment process which is easy to understand and use.	**Goal #1 (Describe)** Provide an application and enrollment process which is easy to understand and use.	**Goal #1 (Describe)** Provide an application and enrollment process which is easy to understand and use.
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☒ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☒ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☒ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:**

FFY 2006	FFY 2007	FFY 2008
Performance Measurement Data: Describe what is being measured: Ensuring that written and telephone services are provided in the appropriate languages for the target population. Numerator: Denominator: Rate: Additional notes on measure: The joint application captures information on language read and spoken by the applicant to ensure that program and its contracted providers have that information readily available to provide information in the appropriate languages.	**Performance Measurement Data:** Describe what is being measured: Ensuring that written and telephone services are provided in the appropriate languages for the target population. Numerator: Denominator: Rate: Additional notes on measure: The joint application captures information on language read and spoken by the applicant to ensure that program and its contracted providers have that information readily available to provide information in the appropriate languages.	**Performance Measurement Data:** Describe what is being measured: Ensuring that written and telephone services are provided in the appropriate languages for the target population. Numerator: Denominator: Rate: Additional notes on measure: The joint application captures information on language read and spoken by the applicant to ensure that program and its contracted providers have that information readily available to provide information in the appropriate languages.

FFY 2006	FFY 2007	FFY 2008

Explanation of Progress:

Applicants can receive enrollment instructions, applications and handbooks in 12 languages. These languages include English, Spanish, Vietnamese, Khmer (Cambodian), Hmong, Armenian, Chinese, Korean, Russian, Farsi, Tagalog and Arabic. In addition, HFP has all correspondence, billing invoices and other program notification materials available in 5 languages: English, Spanish, Chinese, Korean and Vietnamese. The program's administrative vendor maintains 3 toll-free lines to provide pre- and post-enrollment assistance. These lines operate Monday through Friday from 8:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m. The toll-free SCHIP information line (800-880-5305) and the Medicaid outreach line (888-747-1222) are staffed with enrollment specialists who can provide SCHIP and Medicaid information, provide enrollment assistance, give families information on the status of their application and provide support to Enrollment Entities and Certified Application Assistants. The lines are staffed by a team of operators proficient in the 12 designated languages in which campaign materials are published. A special toll-free SCHIP member services number (866-848-9166) is also available to assist members with inquiries about changes to their account and provide members with information about eligibility appeals. The line is staffed with operators proficient in all of the 12 languages.

How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?

In April 2008, the state implemented a revised joint application that is at a 7th grade reading level. The previous application that it replaced was at a 10th grade reading level. The State developed an application that is easier to read and understand, in order to eliminate any barriers that discourage individuals from applying for the SCHIP and Medicaid programs. Improvements include using more simplified language, reducing the reading grade level, more effectively communicating and presenting important program information, including a document check list to ensure that the application provides the necessary information needed to ensure that the application is complete, and making the application more visually appealing for the target population. In addition, 2 new languages, Tagalog and Arabic, were added.

Applicants may apply for the SCHIP and Medicaid programs on-line through the assistance of Certified Application Assistants (CAAs) or County Eligibility Workers (EWs). Currently, only CAAs and EWs are authorized to access and utilize the on-line electronic application process. When the on-line application is used, the missing information is reduced because of the step-by-step process required to complete the application. For example, the electronic application provides context-based assistance when filling out the application. The application cannot be submitted unless all required information is entered into the electronic form. All information on the forms is automatically captured and electronically transmitted to the eligibility system. California has seen a steady growth in the number of participating CAAs using the on-line application during FFY 2008. A similar growth has been experienced in the volume of the on-line applications.

During FFY 2007, a total of 43,741 on-line applications were assisted by CAAs. This is a monthly average of 3,645 on-line applications submitted to the Single Point of Entry (SPE). During the FFY 07/08, a total of 57,754 on-line applications were submitted to SPE. This is a monthly average of 4,813 on-line applications submitted to the SPE. In September 2008, the on-line application reached an all time high with 7,398 on-line applications which equals approximately 25% of all applications received at SPE during this month.

California continues to partner with two private philanthropic foundations to expand the access of the existing on-line electronic application process for general public use, where families can apply on-line without the help of CAAs and EWs. During FFY 2008, California completed the requirements assessment phase of the on-line public access project. The assessment phase identified the technical requirements, enhanced features, additional functions, additional programs, estimated costs and resources and development phase timeline required to take the on-line application to world wide web.

FFY 2006	FFY 2007	FFY 2008

What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?

Since January 2004, the SCHIP Administrative Vendor has performance standards including the timely screening of applications to either Medicaid or SCHIP, determining the completeness of applications, processing program reviews and appeals timely, sending data transmissions to participating plans and assisting members on the customer toll-free lines. The contracted level that must be met is between 98% and 100%. These are measured monthly. In addition, as of November 2006, the SCHIP Administrative vendor is required to meet performance standards in assuring quality and accuracy in the areas of applicants being screened to the appropriate program(s), SCHIP eligibility determinations at both initial application and the Annual Eligibility Review, accurate adjudication of appeals and program reviews, accurate data transmissions for individual eligibility triggering events, accurate generating and posting of SCHIP daily enrollment files for the plans based on the prior days events, and accuracy of monthly capitation payment determinations for plans and the monthly generation of the capitation files. The contracted level that must be met is 98%, which is measured on a monthly basis. These standards are the highest performance and quality and accuracy standards for SCHIP nationwide.

Since January 2004, the SCHIP Administrative Vendor has met the 11 monthly performance standards 99.4% (459 out of 462 standard measurements) of the time. Also, since November 2006 the SCHIP Administrative Vendor has met the 7 accuracy standards 100% (102 out of 102 standard measurements) of the time.

Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.

Annual Performance Objective for FFY 2009:

Since the State implemented a revised application that is at a 7th grade reading grade level during the third quarter of this Federal Fiscal Year, the State will assess whether or not additional changes to the application needs to be considered, in order for it to be more user friendly and easier to understand. The State will assess the effectiveness of the new application and will report the findings in next year's Federal Annual Report. Also, the revised application eliminated the authorization to share information between Medicaid and SCHIP by asserting that information will be shared between programs to improve program communication and coordination. This is to ensure that children are forwarded to the program for which they qualify.

Continue to encourage and increase the CAAs' and EWs' participation in the use of the on-line application process when assisting families to apply for the SCHIP or Medicaid programs.

The State will begin the development phase of the on-line application public access project during FFY 2009.

Annual Performance Objective for FFY 2010:

Annual Performance Objective for FFY 2011:

TBD

Explain how these objectives were set:

Objectives Related to SCHIP Enrollment (Continued)

FFY 2006	FFY 2007	FFY 2008
Goal #2 (Describe) Encourage and increase the participation of EEs/CAAs in the application and retention processes, enhance EE/CAA incentives by increasing the reimbursement amount, and community-based organization and county outreach grants.	**Goal #2 (Describe)** Encourage and increase the participation of EEs/CAAs in the application and retention processes and community-based organization and county outreach grants.	**Goal #2 (Describe)** Encourage and increase the participation of EEs/CAAs in the application and retention processes and community-based organization and county outreach grants.
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☒ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☒ Other. *Specify* Enrollment Entity Agreements	**Data Source:** ☒ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☒ Other. *Specify*: Enrollment Entity Agreements	**Data Source:** ☒ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☒ Other. *Specify*: Enrollment Entity Agreements
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:**
Performance Measurement Data: Describe what is being measured: Increased number of EE/CAAs providing application assistance to families Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Describe what is being measured: Increased number of EE/CAAs providing application assistance to families Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Describe what is being measured: Increased number of EE/CAAs providing application assistance to families Numerator: Denominator: Rate: Additional notes on measure:

FFY 2006	FFY 2007	FFY 2008

Explanation of Progress:

How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?

Since the increase in the amount of payments to Enrollment Entities (EEs) for assisted applications and Annual Eligibility Review (AER) forms, on July 1, 2006, EE participation increased steadily since the last reporting period. As of September 2007, the number of EEs was 2,630. As of September 2008, the number of EEs increased to 3,244. This is a 23% increase in the number of participating EEs.

In addition, 20,480 CAAs were available to assist families in applying for the SCHIP and Medicaid programs as of September 2008. With almost 2,182 new CAAs since the last reporting period, this is a 12% increase in CAA participation. This is an average of 182 new CAAs being trained each month.

Much of the increase in new CAAs is due to the CAA Web Based Training (WBT) curriculum. Since the WBT was implemented in February 2005, 4,317 new CAAs successfully completed the WBT. Since the last reporting period, 1,539 CAAs completed the WBT. This was a 55% increase with 128 new CAAs passing the WBT each month. The on-line training curriculum is available in English and Spanish 24 hours a day for CAA candidates to take the CAA certification curriculum. If the CAA candidate successfully completes the WBT, they receive their CAA Certificate and are qualified to assist families with applications. Since the last reporting period, 1,539 new CAAs were trained through the on-line WBT with an average passing score of over 90%. This was a 2% increase in the number of CAAs trained through the on-line WBT, with an average of 128 new CAAs passing the WBT each month.
A total of 347,070 applications were received at the Single Point of Entry (SPE) since the last reporting period. Of the applications received at SPE, a total of 109,211 applications were assisted by Certified Application Assistants (CAAs). This represents 31% of all applications received at SPE. The number of applications assisted by CAAs increased from 88,317 to 109,211, an increase of 23% compared to the previous reporting period. The number of children enrolled due to CAA help totaled 118,375. This represents 43% of the SCHIP eligible children. Correspondingly, for the applications assisted by CAAs at SPE, EE reimbursement totaled $4,318,430. This is a 29% increase compared to the $3,340,910 EE reimbursement paid in the previous reporting period.

In addition, a total of 100,224 AER forms received were assisted by CAAs. This is a 13 % increase over the 88,616 AER forms assisted by CAAs in the previous reporting period. The number of children that continued to qualify through the help of CAAs at AER totaled 91,802. This represents 5% increase of SCHIP eligible children at AER and a 12% increase compared to the 81,524 children that continued to qualify through the help of CAAs at AER in the previous reporting period. EE reimbursement for CAAs assisting with AER forms totaled $2,223,300, an increase of 22% over the previous year's reimbursement. EE reimbursements paid in the previous year totaled $1,745,050.

FFY 2006	FFY 2007	FFY 2008

What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?

Through the use of the on-line Web Based Training, California has the ability to effectively track the number of new CAAs that become certified on a monthly basis and to compare this information throughout the federal reporting period for any trends. Currently we have three complete FFY for this type of data from which we can compare and analyze. As stated in this report, through the assistance of CAAs, California has seen a steady growth in the number of children that qualify and get enrolled in the Medicaid and SCHIP program, as well as an increasing number of children that re-qualify for SCHIP when the families are assisted during the annual eligibility review process.

Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.

Annual Performance Objective for FFY 2009:

Although there was a steady increase in the number of EEs and CAAs providing assistance to families compared to the previous reporting period, the State's objective is to continue to increase the number of EEs and CAAs. EEs and CAAs assist families in filling out the application and SCHIP AER forms, ensuring that all necessary documentation is included in order for the application to be considered complete.

The level of EE and CAA participation typically results in more complete application and AER forms being received. A complete application expedites the enrollment process for eligible children and prevents eligible children from being disenrolled from SCHIP during the AER. Incomplete applications and AER forms require significant follow-up with the families to obtain the missing information and may delay the enrollment or may result in the disenrollment of eligible children.

Annual Performance Objective for FFY 2010:

Continue to encourage and increase community-based organizations' and EEs/CAAs' participation in outreach for the Medicaid and SCHIP Programs.

Annual Performance Objective for FFY 2011:

Continue to encourage and increase community-based organizations' and EEs/CAAs' participation in outreach for the Medicaid and SCHIP Programs.

Other Comments on Measure:

Explain how these objectives were set:

Objectives Related to SCHIP Enrollment (Continued)

FFY 2006	FFY 2007	FFY 2008
Goal #3 (Describe) None previously	**Goal #3 (Describe)** Streamlining the enrollment process between Medicaid and SCHIP.	**Goal #3 (Describe)** Streamlining the enrollment process between Medicaid and SCHIP.
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☒ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☒ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☒ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:**
Performance Measurement Data: Describe what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Describe what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Describe what is being measured: Numerator: Denominator: Rate: Additional notes on measure:

Explanation of Progress:

During FFY 2007, the State implemented a paper process for counties to submit applications and documentation to SCHIP. The objective of the process is to streamline the enrollment process from Medicaid to SCHIP. The process targets families who no longer qualify for Medicaid at their annual re-determination and may qualify for SCHIP because their income is above Medicaid guidelines. Minimal additional information is needed from the applicants to make eligibility determinations, since the counties provide the proof of income used to determine that the children no longer qualified for Medicaid. Prior to being implemented, the monthly average number of county referrals was 1,454. For the FFY 2007 reporting period, the monthly average number of county referrals increased from 1,454 to 3,430, which was an increase of 135% during that period.

During the FFY 2007, SCHIP waiver allowing the 2-month SCHIP bridge expired. In the last quarter of FFY 2007, the State implemented a Presumptive Eligibility Medicaid Program to ensure that children maintain access to health care while they are being processed for eligibility into Medicaid. The 2-month SCHIP bridge was eliminated and children with household income below SCHIP guidelines during the annual eligibility review (AER) process no longer receive the two-month bridge in SCHIP. They may qualify for and be granted presumptive eligibility into Medicaid. Presumptive Medicaid gives children free temporary Medicaid health coverage while Medicaid completes an eligibility determination for the Medicaid Program.

How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?

The State implemented a paper process for the counties to forward annual re-determination information of Medicaid enrollees to SCHIP when children no longer qualify for Medicaid. For the FFY 2008, the monthly average number of county referrals increased to approximately 3,916 from the last reporting period. This is an increase of approximately 14% for the FFY 2008 reporting period and an increase of 169% since implementation. During the FFY 2008, the State began system changes and implementation plans for an electronic process in receiving the information from the counties. The state anticipates implementation of the electronic process for receiving the re-determination information from the counties during FFY 2009.

For the FFY 2008, approximately 48,620 children's household income was below SCHIP guidelines during the AER process. During the reporting period, when a child's household income is determined to be below SCHIP guidelines, the applicant must provide authorization for SCHIP to forward the application to Medicaid. Of these 48,620 children determined to be below SCHIP income guidelines, 31,403 children (65%) provided authorization to forward their information to Medicaid. Of the subscriber's that provided authorization to forward their application to Medicaid, 24,427 children (78%) were granted presumptive eligibility for Medicaid. Of the children granted presumptive eligibility into Medicaid, 20,639 children (85%) did not experience a break in health coverage. In August 2008, the SCHIP AER form was revised and the family no longer needs to provide authorization to forward the application to Medicaid. If children are determined to have income below the SCHIP income guidelines during the AER process, they are granted presumptive eligibility. Since the implementation of the revised AER form, over 1,900 children were determined to have income below SCHIP guidelines and were granted presumptive eligibility and their application was forwarded to Medicaid without a break in health coverage.

What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?

In order to ensure that children are enrolled in the program that they truly qualify for, the SCHIP Annual Eligibility Review (AER) Form was revised. The SCHIP AER Form is an application that is also used by the Medicaid Program. During the last quarter of this FFY, the AER Form was modified, where families are no longer required to provide consent to forward the AER information to the Medicaid Program. Instead, the AER Form asserts that information will be shared between programs (similar to the revised application) and income documentation will automatically be sent to the Medicaid Program when children's income qualifies them for Medicaid. If eligible for presumptive eligibility, the children will automatically be granted presumptive eligibility into Medicaid, which will eliminate lapse in health care coverage between SCHIP and Medicaid.

Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.

Annual Performance Objective for FFY 2009:

Continue to streamline the enrollment process between Medicaid and SCHIP. While the State implemented a paper process for the counties to forward annual re-determination information to SCHIP where children no longer qualify for Medicaid, the State continues to work closely with the Medicaid Program to implement an electronic process in receiving the information from the counties.

Annual Performance Objective for FFY 2010:

In FFY 2007 and 2008, the State delayed due to Budget constraints, the implementation of SCHIP presumptive eligibility process to replace the Medicaid to SCHIP one-month bridge coverage. Currently, when a child enrolled in Medicaid no longer qualifies for the program, the child remains enrolled in Medicaid for one additional month while a SCHIP eligibility determination is made. The new process will replace Medicaid one-month bridge coverage with the SCHIP Presumptive Eligibility until SCHIP makes an eligibility determination.

Other projects include implementing county pilot projects for Medicaid and establishing an electronic gateway for the Women, Infants & Children (WIC) program as well as working with Medicaid in establishing a SCHIP Presumptive Eligibility Program for children whose incomes are above Medicaid guidelines during the initial application process.

Annual Performance Objective for FFY 2011:

Electronic transmission of application data and supporting documentation from the Medicaid Program to the SCHIP Program and from the SCHIP Program to the Medicaid Program to improve the coordination between the programs. This will simplify the application process and reduce potential barriers for the enrollment of uninsured eligible children.

Explain how these objectives were set:

Objectives Related to SCHIP Enrollment (Continued)

FFY 2006	FFY 2007	FFY 2008
Goal #4 (Describe) None previously	**Goal #4 (Describe)** Allow applicants to self-declare income during their Annual Eligibility Review (AER)	**Goal #4 (Describe)** Allow applicants to self-declare income during their Annual Eligibility Review (AER)
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☒ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐Final. ☐ *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐Final. ☐ *Specify year of annual report in which data previously reported:* FFY 2007
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** X Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** X Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Self-declaration of income will be offered to existing SCHIP families. Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Self-declaration of income will be offered to existing SCHIP families. Definition of denominator: Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:**

FFY 2006	FFY 2007	FFY 2008
Performance Measurement Data: Describe what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Describe what is being measured: Numerator: Denominator: Rate: Additional notes on measure: The state will measure the effectiveness of allowing families to use self-declaration and the impact it has on increasing SCHIP retention levels.	**Performance Measurement Data:** Describe what is being measured: Numerator: Denominator: Rate: Additional notes on measure: The state will measure the effectiveness of allowing families to use self-declaration and the impact it has on increasing SCHIP retention levels.

Explanation of Progress:

SCHIP families must renew their eligibility on an annual basis. This process is known as the Annual Eligibility Review (AER) process. Families are mailed a pre-printed AER package at least 60 days prior to their anniversary month. In addition, SCHIP reminds the family to submit their AER forms through reminders letters, post cards and courtesy calls. The family confirms the information on the AER form is current and correct. They may also make correction directly on the pre-printed form. Each AER package also included an Add A Person Form which can be used to add additional children to the family's case. During the AER, the family must provide proof of qualifying income in order to re-establish eligibility for another 12 months of coverage.

How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?

In FFY 2007, the State passed into law a self-declaration of income at the annual eligibility review (AER) process for SCHIP applicants. However, the State has delayed implementation due to the State Budget deficits.

What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?

Self-declaration of income will be offered to existing SCHIP families and allows families, who choose to do so, to "self-declare" household income during the AER process without the requirement of documentation such as pay stubs or tax forms. This process is aimed at increasing retention and program efficiency. Electronic verification of self-declared income will have to be implemented. However, if a family chooses to provide income verification instead of self-declaration their incomes, they may do so.

Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.

The State is closely monitoring national Health Care Reform bills that will provide the infrastructure to implement universal coverage for all children. The framework provided by the national children's reform(s) will help the State design and develop similar state-level initiatives.

Annual Performance Objective for FFY 2009:

Annual Performance Objective for FFY 2010:
In FFY 2009, the State will pursue Health Care Reform initiatives to provide coverage for all children. These initiatives will require the Legislature authority and Governor's approval. If passed, the initiative(s) would be implemented in FFY 2011. This will be a challenge to the State as it would be our goal to create a seamless and transparent transfer children from one program to another (e.g., Medicaid with a share of cost to SCHIP, Children's County Health Initiatives to SCHIP, etc.) with minimal additional application information and/or disruption of established health care relationships.

Annual Performance Objective for FFY 2011:

Explain how these objectives were set:

Objectives Related to Medicaid Enrollment

FFY 2006	FFY 2007	FFY 2008
Goal #1 (Describe)	**Goal #1 (Describe)**	**Goal #1 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:**
Performance Measurement Data: Describe what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Describe what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Describe what is being measured: Numerator: Denominator: Rate: Additional notes on measure:

FFY 2006	FFY 2007	FFY 2008
Explanation of Progress: **How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?** **What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2009:** **Annual Performance Objective for FFY 2010:** **Annual Performance Objective for FFY 2011:** *Explain how these objectives were set:*		
Other Comments on Measure:		

Objectives Related to Medicaid Enrollment (Continued)

FFY 2006	FFY 2007	FFY 2008
Goal #2 (Describe)	**Goal #2 (Describe)**	**Goal #2 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:**
Performance Measurement Data: Describe what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Describe what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Describe what is being measured: Numerator: Denominator: Rate: Additional notes on measure:

FFY 2006	FFY 2007	FFY 2008
Explanation of Progress: **How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?** **What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2009:** **Annual Performance Objective for FFY 2010:** **Annual Performance Objective for FFY 2011:** *Explain how these objectives were set:*		
Other Comments on Measure:		

Objectives Related to Medicaid Enrollment (Continued)

FFY 2006	FFY 2007	FFY 2008
Goal #3 (Describe)	**Goal #3 (Describe)**	**Goal #3 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☐ Other. *Specify*:
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Definition of numerator:
Year of Data:	**Year of Data:**	**Year of Data:**
Performance Measurement Data: Describe what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Describe what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Describe what is being measured: Numerator: Denominator: Rate: Additional notes on measure:

FFY 2006	FFY 2007	FFY 2008
Explanation of Progress: **How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?** **What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** **Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.** **Annual Performance Objective for FFY 2009:** **Annual Performance Objective for FFY 2010:** **Annual Performance Objective for FFY 2011:** *Explain how these objectives were set:*		
Other Comments on Measure:		

Objectives Increasing Access to Care (Usual Source of Care, Unmet Need)

FFY 2006	FFY 2007	FFY 2008
Goal #1 (Describe) Provide each family with two or more health plan choices for their children.	**Goal #1 (Describe)** Provide each family with two or more health plan choices for their children.	**Goal #1 (Describe)** Provide each family with two or more health plan choices for their children.
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. Number of health plans in each county.	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. Number of health plans in each county.	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other.*Explain*: Number of health plans in each county
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☒ Other. *Specify*: Enrollment data from the HFP Administrative Vendor, MAXIMUS.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☒ Other. *Specify*: Enrollment data from the HFP Administrative Vendor, MAXIMUS.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☒ Other. *Specify*: Enrollment data from the HFP Administrative Vendor, MAXIMUS.
Definition of Population Included in the Measure: Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: The number of children enrolled in HFP. ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: The number of HFP subscribers in those counties with only 1 HFP health plan.

Year of Data: 2005	**Year of Data: 2006**	**Year of Data: 2007**
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:
Other Performance Measurement Data: *(If reporting with another methodology)* Describe what is being measured: The number of counties that have less than 2 plans available to each subscriber. Numerator: The number of HFP subscribers in those counties with only 1 HFP health plan. Denominator: The total number of HFP subscribers. Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Describe what is being measured: The number of counties that have less than 2 plans available to each subscriber. Numerator: The number of HFP subscribers in those counties with only 1 HFP health plan. Denominator: The total number of HFP subscribers. Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Describe what is being measured: The number of counties that have less than 2 plans available to each subscriber. Numerator: The number of HFP subscribers in those counties with only 1 HFP health plan. Denominator: The total number of HFP subscribers. Rate: Additional notes on measure:

Explanation of Progress: For FFY 2006: A total of 27 health plans participated in the program during the reporting period. Over 99.6% of subscribers have a choice of at least two health plans from which to select. The 0.40% of subscribers only having one health plan mostly reside in rural areas of the state where access to health care services are limited. . In 40 of 58 counties, subscribers have a choice of up to 3 or more health plans. In 2 of 58 counties, members had a choice of at least 7 health plans. In 4 of these 39 counties, members can choose from up to 6 health plans.

For FFY 2007: A total of 24 health plans participated in the program during the reporting period. Over 99.70% of subscribers had a choice of at least two health plans from which to select. The 0.30% of subscribers only having one health plan reside in 7 in rural counties of the state where access to health care services are limited and where health plans typically do not have networks. . 3.7% of HFP subscribers had a choice of 2 plans in eleven counties that are located in rural areas of the state. In 41 of 58 counties, subscribers had a choice of up to 3 or more health plans. In 3 of the largest counties, members could choose from up to 8 health plans.

For FFY 2008:

How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?

A total of 24 health plans participated in the program during the reporting period. 99.75% of subscribers had a choice of at least two health plans from which to select. The 0.25% of subscribers only having one health plan reside in 7 rural counties of the state where access to health care services are limited and where health plans typically do not have networks. 3.8% of HFP subscribers had a choice of 2 plans in eleven counties that are located in rural areas of the state. In 40 of 58 counties, subscribers had a choice of up to 3 or more health plans. In 3 of the largest counties, members could choose from up to 10 health plans.

However, due to California's budget challenges, MRMIB was directed to reduce rates to health plans by 5%. As a result, 3 health plans exited 23 counties and reduced the number of plan choices in these counties.

What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal? Ensuring that subscribers are aware of the health plan choices in their county through the use of an annual handbook that is mailed to subscribers and through the use of information on the MRMIB website.

Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.

Annual Performance Objective for FFY 2009:
At least 95% of HFP subscribers will have a choice of two or more health plans.

Annual Performance Objective for FFY 2010:
At least 95% of HFP subscribers will have a choice of two or more health plans.

Annual Performance Objective for FFY 2011:
At least 95% of HFP subscribers will have a choice of two or more health plans.

Explain how these objectives were set: This was an original and is an ongoing objective of the HFP program.

Other Comments on Measure:

Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need) (Continued)

FFY 2006	FFY 2007	FFY 2008
Goal #2 (Describe) : Ensure broad access in each county to Traditional and Safety Net providers for all Healthy Families Program Members.	**Goal #2 (Describe)** Ensure broad access in each county to Traditional and Safety Net (T&SN) providers for all HFP members	**Goal #2 (Describe)** Increase the number of children that choose a Traditional and Safety Net Provider (T&SN) or are assigned a T&SN provider as their PCP
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. Members established with T&SN provider	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. Members established with T&SN provider	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*: Members established with T&SN provider
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☒ Other. *Specify*: Participating Healthy Families Program (HFP) health plans.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☒ Other. *Specify*: Participating HFP health plans.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☒ Other. *Specify*: Participating HFP health plans
Definition of Population Included in the Measure: Traditional and Safety Net providers (clinics, CHDP providers and hospitals) in each county, as defined in Section 12693.21 of the Insurance Code. Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Traditional and Safety Net providers (clinics, CHDP providers and hospitals) in each county, as defined in Section 12693.21 of the Insurance Code. Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: Number of children enrolled in HFP. ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Children who selected or were assigned to a T&SN provider as their PCP.
Year of Data: 2005	**Year of Data:** 2006	**Year of Data:** January – December 2007
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator:

FFY 2006	FFY 2007	FFY 2008
Denominator: Rate: Additional notes on measure:	Denominator: Rate: Additional notes on measure:	Denominator: Rate: Additional notes on measure:
Other Performance Measurement Data: *(If reporting with another methodology)* Describe what is being measured: The Traditional and Safety Net (T&SN) Providers in each county by plan. Health plans use a list supplied by MRMIB to report the number of T&SN providers in their network. Health plans with the highest T&SN participation are given a $3 discount on each member's monthly premium. Numerator: Members established with T&SN provider Denominator: Total HFP membership Rate: 62% Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Describe what is being measured: The Traditional and Safety Net (T&SN) Providers in each county by plan. Health plans use a list supplied by MRMIB to report the number of T&SN providers in their network. Health plans with the highest T&SN participation are given a $3 discount on each member's monthly premium. Numerator: Members established with T&SN provider Denominator: Total HFP membership Rate: The data is being analyzed. Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Describe what is being measured: The number of children who selected or were assigned to a T&SN provider as their PCP. Numerator: Members established with a T&SN provider Denominator: Total HFP Population Rate: 57% Additional notes on measure:

Explanation of Progress:

For 2005: HFP participating health plans continue to include T&SN providers in their network and to compete to be designated as the plan in a county allowed to offer the HFP product at a discount. For 2005, 62% of HFP members either selected or were assigned a TSN primary care physician. This rate has remained consistent from 2002 through 2005.

For 2007, HFP participating health plans continue to include T&SN providers in their network and to compete to be designated as the plan in each county that is offered at a discount to HFP members. During 2007, 57% of HFP members either selected or were assigned to a T&SN primary care physician. This is a decrease from the rate of 62% that was previously reported for the last 3 years. Of those who had a T&SN provider, approximately two-thirds selected the provider themselves. The 2007 T&SN report is contained in Attachment 1.

How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?
In 2007, the percentage of HFP members who either selected or were assigned to a T&SN primary care physician decreased by 5%. The cause of this decrease is unknown.

What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal? Public reporting of plan performance.

Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.

Annual Performance Objective for FFY 2009: MRMIB will continue to encourage health plans to contract with T&SN providers.

Annual Performance Objective for FFY 2010: MRMIB will continue to encourage health plans to contract with T&SN providers.

Annual Performance Objective for FFY 2011: MRMIB will continue to encourage health plans to contract with T&SN providers.

Explain how these objectives were set: This is an original and ongoing objective of the HFP program.

FFY 2006	FFY 2007	FFY 2008
Other Comments on Measure:		

Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need) (Continued)

FFY 2006	FFY 2007	FFY 2008
Goal #3 (Describe) Maintain or improve the percentage of children receiving CCS and mental health (SED) specialized services.	**Goal #3 (Describe)** Improve the percentage of children receiving CCS and serious emotional disorder (SED) specialized services.	**Goal #3 (Describe)** Improve subscriber access to serious emotional disorder (SED) specialized services.
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☒ Discontinued. *Explain*: MRMIB is unable to predict the number of children receiving CCS services because the percentage of children receiving these services fluctuate depending on the number of children with illnesses that meet CCS requirements. However, MRMIB is using CAHPS to provide information about the satisfaction of parents who have children receiving CCS services. MRMIB will report the results in the 2008 Federal Annual Report. MRMIB does not have any indication that CCS services are being under-utilized. MRMIB does, however, believe that SED services are being under-utilized and will continue to measure the number of children receiving SED services.	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. HFP enrollment, CCS, and County mental health data.	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*: HFP enrollment, County Mental Health Data	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*: HFP enrollment, County Mental Health data.
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☒ Other. HFP enrollment, CCS, and County mental	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☒ Other. *Specify*: HFP enrollment, County Mental	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☒ Other. *Specify*:

FFY 2006	FFY 2007	FFY 2008
health data.	Health Data	HFP enrollment and County Mental Health data.
Definition of Population Included in the Measure: Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Number of HFP children who received CCS and SED services.	**Definition of Population Included in the Measure:** Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Number of HFP children who received SED services.	**Definition of Population Included in the Measure:** Definition of denominator: Number of children in HFP. ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Number of HFP children who received SED services.
Year of Data: July 1 2003-June 30, 2004	**Year of Data: July 1, 2006-June 30, 2007**	**Year of Data: July 1, 2007-June 30, 2008**
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:
Other Performance Measurement Data: *(If reporting with another methodology)* Describe what is being measured: Numerator: Number of Children Receiving CCS or SED Services Denominator: Total HFP population Rate: CCS 3%; SED 0.87%. Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Describe what is being measured: Numerator: Number of Children Receiving SED Services Denominator: Total HFP population Rate: SED: 1% Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Describe what is being measured: Numerator: Number of children receiving SED services Denominator: Total HFP population Rate: SED data not yet available Additional notes on measure:

FFY 2006	FFY 2007	FFY 2008

Explanation of Progress:

The percentage of children receiving SED services has increased slightly over 2 reporting periods (July 05-June 06, July 06-June 07).

How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?
SED data is being analyzed and is not yet available for comparison.

What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal? Public reporting of plan performance.

Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.

Annual Performance Objective for FFY 2009:

The utilization rates for SED services will increase by 1% and the utilization for basic mental health services will increase by 1%.

Annual Performance Objective for FFY 2010:
The utilization rates for SED and basic mental health services will increase by 1%. MRMIB will continue to monitor rates of children receiving these services and work with stakeholders to see if rates improve service levels.

Hold quarterly meetings between State, health, dental and vision plans and the County Mental Health Departments regarding barriers to access, referral issues, subscriber complaints, and treatment/payment coverage. Identify and resolve at least two issues per year.

Annual Performance Objective for FFY 2011:
The utilization rates for SED and basic mental health services will increase by 1%. MRMIB will continue to monitor rates of children receiving these services and work with stakeholders to see if rates improve service levels.

Hold quarterly meetings between State, health, dental and vision plans and the County Mental Health Departments regarding barriers to access, referral issues, subscriber complaints, and treatment/payment coverage. Identify and resolve at least two issues per year.

Explain how these objectives were set: MRMIB is concerned about the low rates of utilization of basic mental health services provided by HFP plans as well as the low number of HFP children receiving SED services.

Other Comments on Measure:

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)

FFY 2006	FFY 2007	FFY 2008
Goal #1 (Describe): Achieve year to year improvements in the number of children that have had a visit to a primary care physician during the year.	**Goal #1 (Describe)** Ensure all HFP children receive an annual dental visit	**Goal #1 (Describe)** Ensure all HFP children receive an annual dental visit
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☒ Discontinued. The measure of children having a visit to a primary care physician during the year has been discontinued because this measure is reported in another section of the Federal Annual Report	**Type of Goal:** ☒ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2007
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: 2005 Measure of Access. ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☒ Other. *Specify*: Participating Healthy Families Program (HFP) health plans.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☒ Other. *Specify*: Participating HFP dental plans.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☒ Other. *Specify*: Participating HFP dental plans.
Definition of Population Included in the Measure: A random sample of HFP members, ages 12 months through 18 years who were continuously enrolled in the plan during the measurement year and who had access to a primary care physician. Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: The number of children ages 2 through 18 who were continuously enrolled during the measurement year and had at least one dental visit	**Definition of Population Included in the Measure:** Definition of denominator: All HFP children. ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: The number of children ages 2 through 18 who were continuously enrolled during the measurement year and had at least one dental visit.
Year of Data: 2005	**Year of Data: 2006**	**Year of Data: 2007**

FFY 2006		FFY 2007	FFY 2008
12-24 months Numerator: 7,868 Denominator: 8,476 Rate: 93% 25 months-6 years Numerator: 102,489 Denominator: 117,196 Rate: 87%	7-11 years Numerator: 94,510 Denominator: 111,271 Rate: 85% 12-19 years Numerator: 113,865 Denominator: 140,735 Rate: 81%	(Combined Rate): 2-18 years Numerator: 197,133 Denominator: 305,200 Rate: 65%	(Combined Rate): 2-18 years Numerator: 275,928Denominator: 468,221 Rate: 59%
Other Performance Measurement Data: *(If reporting with another methodology)* Describe what is being measured: Numerator: Denominator: Rate: Additional notes on measure:		**Other Performance Measurement Data:** *(If reporting with another methodology)* Describe what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Describe what is being measured: Numerator: Denominator: Rate: Additional notes on measure:

FFY 2006	FFY 2007	FFY 2008

Explanation of Progress: Based upon the data submitted by the plans, approximately 59% of all applicable HFP enrollees had a visit with a dentist during the measurement year. This represents a 6% decrease from measurement years 2006 and 2007.

Dental Quality Measures: MRMIB is aware and concerned about the small percentage of members getting an annual dental visit. As a result, in addition to the HEDIS Annual Dental Visit measure, MRMIB has added the following dental performance measures to the dental plan contracts for reporting in 2008-09:

- Overall Utilization of Dental Services
- Preventive Dental Services
- Use of Dental Treatment Services
- Examinations/Oral Health Evaluations
- Treatment/Prevention of Caries
- Filling to Preventive Services Ratio
- Continuity of Care

Data for these measures will be reported in the 2009 Federal Annual Report.

MRMIB will use the above measures to determine which dental plans are deficient in providing needed dental care to members, including the annual dental visit. MRMIB will work with those plans to determine why the plans are not providing the needed dental care. MRMIB will also review D-CAHPS data to determine what issues members are having in accessing needed dental services.

How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report? There was a 6% decrease in the number of members receiving an annual dental visit during the measurement years 2006 and 2007.

What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal? In 2007, the Board established a dental advisory committee to evaluate whether the current dental measures provide the information MRMIB needed to determine if HFP subscribers were receiving appropriate dental services. The committee was comprised of plan dental directors, practicing dentists, and other dental experts with extensive knowledge in dental quality measurement. The group evaluated and recommended dental quality measures that MRMIB will use to monitor quality in dental care plans. The new dental measures will be reported to MRMIB in 2009 for CY 2008 and results will be reported in the 2009 Federal Annual Report.

Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.

Annual Performance Objective for FFY 2009: Using the results from the new measures collected in 2008, identify areas for improvement.

Annual Performance Objective for FFY 2010: A 2% increase in each of the dental quality measures, including the annual dental visit.

Annual Performance Objective for FFY 2011: A 2% increase in each of the dental quality measures, including the annual dental visit.

Explain how these objectives were set: MRMIB wants to ensure that HFP children receive an annual dental visit to help reduce caries and other dental conditions.

Other Comments on Measure:

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care) (Continued)

FFY 2006	FFY 2007	FFY 2008
Goal #2 (Describe)	**Goal #2 (Describe)**	**Goal #2 (Describe)** Ensure all HFP children receive recommended immunizations.
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☒ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: HEDIS 2008 ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☒ Other. *Specify*: Participating Healthy Families Program (HFP) health plans.
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: HFP members who were two years old and were continuously enrolled during the measurement year. ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: HFP members who received all of the recommended immunizations.
Year of Data:	**Year of Data:**	**Year of Data:** January – December 2007
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: 79% (Combo 2) & 73% (Combo 3)

FFY 2006	FFY 2007	FFY 2008
Additional notes on measure:	Additional notes on measure:	Additional notes on measure:
Other Performance Measurement Data: *(If reporting with another methodology)* Describe what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Describe what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Describe what is being measured: Numerator: Denominator: Rate: Additional notes on measure:

Explanation of Progress: Based on the data submitted by the plans, approximately 79% of HFP enrollees received all of the Combination 2 immunizations and 73% received all of the Combination 3 immunizations.

How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?
This is the first year the scores for Childhood Immunization Status are being reported in the Annual Report. The Combination 2 rate increased by 2% from the previous measurement year and the Combination 3 rate increased by 6%.

What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal? Public reporting of plan performance and comparison to state and national Medicaid and commercial scores.

Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.

Annual Performance Objective for FFY 2009: A 2% increase each year in the number of HFP enrollees receiving all of the Combination 2 immunizations and all of the Combination 3 immunizations.

Annual Performance Objective for FFY 2010: A 2% increase each year in the number of HFP enrollees receiving all of the Combination 2 immunizations and all of the Combination 3 immunizations.

Annual Performance Objective for FFY 2011: A 2% increase each year in the number of HFP enrollees receiving all of the Combination 2 immunizations and all of the Combination 3 immunizations.

Explain how these objectives were set: MRMIB wants to ensure that all HFP enrollees receive their recommended immunizations.

Other Comments on Measure:

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care) (Continued)

FFY 2006	FFY 2007	FFY 2008
Goal #3 (Describe)	**Goal #3 (Describe)**	**Goal #3 (Describe)** Ensure all HFP adolescents receive an annual well-care visit
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☒ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: HEDIS 2008 ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*:
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☒ Other. *Specify*: Participating Healthy Families Program (HFP) health plans.
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:	**Definition of Population Included in the Measure:** Definition of denominator: HFP members ages 12 to 18 years of age who were continuously enrolled during the measurement year. ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: HFP members ages 12 to 18 who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.
Year of Data:	**Year of Data:**	**Year of Data:** January – December 2007

FFY 2006	FFY 2007	FFY 2008
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: 44% Additional notes on measure:
Other Performance Measurement Data: *(If reporting with another methodology)* Describe what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Describe what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Describe what is being measured: Numerator: Denominator: Rate: Additional notes on measure:

Explanation of Progress: Based on the data submitted by the plans, approximately 44% of HFP adolescents received a well-care visit during the measurement year. This represents a 4% increase from the previous measurement year and a 7% increase from 2005.

How did your performance in 2008 compare with the Annual Performance Objective documented in your 2007 Annual Report?
This is the first year the scores for Adolescent Well-Care Visits are being reported in the Annual Report.

What quality improvement activities that involve the SCHIP program and benefit SCHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal? Public reporting of plan performance and comparison to state and national Medicaid and commercial scores.

Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.

Annual Performance Objective for FFY 2009: A 2 % increase in HFP adolescents receiving an Adolescent Well-Care Visit each year.

Annual Performance Objective for FFY 2010: A 2% increase in HFP adolescents receiving an Adolescent Well-Care Visit each year.

Annual Performance Objective for FFY 2011: A 2% increase in HFP adolescents receiving an Adolescent Well-Care Visit each year.

Explain how these objectives were set: The American Medical Association's Guidelines for Adolescent Preventive Services recommends that adolescents receive annual check-ups. MRMIB wants to increase the number of adolescents that receive an annual well-care visit to over 50%.

Other Comments on Measure:

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?

MRMIB continues to obtain information on quality of care through health and dental plan reporting requirements and subscriber surveys. The sources of information used to obtain data on the quality of care delivered through health, dental and vision plans include the following:

Annual Quality of Care Reports: Health and dental plans submit quality of care reports each year, as required in their HFP contracts. The measures focus on preventive care, healthcare effectiveness, and access because these areas are vital to young children and are the cornerstone of the HFP. The HEDIS® (Healthcare Effectiveness Data and Information Set) is used as a basis for the current measures. The measures collected in 2007 were:

- Childhood Immunization Status – Combination 2 and 3
- Well-Child Visits during the First 15 Months of Life
- Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
- Adolescent Well-Care Visits
- Children's and Adolescent's Access to Primary Care Practitioners
- Use of Appropriate Medications for People with Asthma
- Appropriate Treatment for Children with Upper Respiratory Infection
- Appropriate Testing for Children with Pharyngitis
- Chlamydia Screening for Women
- Mental Health Utilization
- Identification of Alcohol and Other Drug Services

Lead Screening has been added to the 2008 Health Plan data reporting requirements.

HFP plan scores generally are better than Medicaid nationally and comparable to national commercial plans rates with the exception of scores for Well-Child Visits in the First 15 Months of Life and Appropriate Treatment for Children with Pharyngitis. The rates for these measures are comparable to Medicaid. The results of the 2007 HEDIS® report are contained in Attachment 2.

Member Satisfaction Surveys: MRMIB collects data on HFP subscriber satisfaction with the program and their plans through surveys and by monitoring subscriber complaints.

Consumer satisfaction surveys for both health and dental plans are conducted for the years in which funding is made available. MRMIB has presented the findings of these surveys in prior year Federal Annual Reports.

The following consumer satisfaction surveys were administered in 2007: the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey of health plans, the Dental-CAHPS (D-CAHPS®) survey of dental plans and the Young Adult Health Care Survey (YAHCS®).

In addition, the CAHPS Children with Chronic Conditions (CCC) measurement set was administered to all CAHPS survey participants. MRMIB contracted with DataStat, Inc. to administer the surveys. The surveys were administered in five languages – English, Spanish, Chinese, Korean and Vietnamese.

The CAHPS® survey provides information on access to care, quality of provider communication and members' experience and satisfaction with their health plan, providers and overall health care. Results from this survey reveal key points regarding the Healthy Families Program. The 2007 scores reveal that the Program has maintained virtually the same level of satisfaction compared to 2006. Families continue to report overall positive experiences in the Program and with their health plans.

- Eighty-seven percent (87%) of families surveyed gave their health plans high ratings
- Eighty-three percent (83%) gave their health care a high rating
- Eighty-five percent (85%) gave their personal doctor or nurse a high rating
- Eighty percent (80%) gave their specialist a high rating

The results of the CAHPS CCC measurement set consists of questions that are intended to identify children with chronic conditions and to assess their experience getting needed health care services. The results of the CCC questions indicate:

- Approximately 10.5% of those surveyed had a child with a chronic condition.
- In general, respondents who had a child with a chronic condition reported no statistical difference in their satisfaction levels compared to all respondents, except for "Overall Rating of Health Plan and Getting Needed Care", which had significantly lower rates of satisfaction compared to the general population.
- Respondents who had a child with a chronic condition reported higher levels of satisfaction on the following chronic condition rating: "Doctor or Nurse Who Knows Child" (72% for children with chronic conditions compared to 58.3% in HFP overall).

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The results of the YAHCS® survey provide information on the quantity and quality of recommended counseling and screening services teens receive. The 2007 survey provides second year data about the experience of teens in the HFP and their unique health care needs. The results of the 2007 survey indicate:

- As in the prior year, teens reported very low levels of counseling and screening with the lowest rates for counseling and screening for:
    - Risky behaviors.
    - Unwanted pregnancy and STD's.
    - Depression, mental health and relationships.
- Teens were more likely to get counseling for diet, weight and exercise, although less than half of teens reported receiving such counseling.
- Teens also reported lower scores related to receiving care in a confidential and private setting.
- Overall, teens reported that they were in good health.
- Teens gave their doctors high ratings and though they received counseling or screening at very low rates, they found the counseling to be helpful when they received it.
- Teens who had a routine care visit in the last 12 months reported slightly higher rates of counseling and screening and overall satisfaction with the program.

The results of this report provide the framework for discussion on how the HFP can better support and educate teens as well as addressing important factors such as teen mental health, physical activity and risky behavior.

Reports on the results of the 2007 CAHPS®, and YAHCS® surveys are included as Attachment 3. MRMIB will prepare a report in 2009 summarizing the results of the 2007 D-CAHPS® survey and a copy of the report will be provided in the 2009 Federal Annual Report.

Subscriber Complaints: MRMIB receives direct inquiries and complaints from HFP subscribers. For the reporting period of 10/1/07 - 9/30/08, MRMIB processed approximately 2600 inquiries and complaints.

Cultural and Linguistics Services Report: The survey responses show that most plans are meeting the basic contractual requirements to provide access to cultural and linguistic services. Spanish is language most frequently spoken by HFP families (47.6), followed by English (43.4%) and various Asian languages (5.2%). Asian languages include Vietnamese, Chinese, Japanese, Cambodian, Thai, Tagalog, Hmong, Cantonese, and Korean.
The October 2007 Cultural and Linguistics Survey report found the following:

- Nearly all plans (97%) make information on language assistance services available in information packets and Evidence of Coverage documents sent to members.
- All plans but one use a telephone language line to provide 24-hour access to interpreters.
- About two-thirds (68%) of plans provide face-to-face interpreters.

- Most plans (91%) have a special office and/or designated staff to integrate cultural competency into the organization.
- Only one-third (35%) of plans assess providers' cultural competence on a regular basis.

The results of the 2007 Cultural and Linguistics Services Report are included as Attachment 4.

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?

Health Quality Measures: MRMIB has added Lead Screening to the HEDIS performance measures that the health plans will report in 2008-09. Data for this measure will be reported in the 2009 Federal Annual Report.

Advisory Committee on Quality: In 2008, MRMIB established an Advisory Committee on Quality (ACQ) to advise staff on strategies and methods to monitor and improve the quality of care provided to HFP members. The ACQ is comprised of provider representatives, health plan representatives, researchers, advocacy representatives and a subscriber. The committee will evaluate the quality monitoring tools currently used by MRMIB and make recommendations for quality improvement and setting performance targets. Recommendations from the committee will be reported in the 2009 Federal Annual Report.

Encounter/Claims Data: MRMIB worked on developing an encounter/claims database to collect utilization data from health plans participating in the program. This data will broaden the scope and depth of quality of care information available to MRMIB and is intended for use in a number of reports and projects. MRMIB anticipated having plans report data in 2008. However, MRMIB is unable to receive data at this time due to a California State law called the "Confidentiality of Medical Information Act" which restricts the use and disclosure of information related to a patient's participation in outpatient treatment with a psychotherapist. Because of this restriction, contracted health plans are prohibited from sharing this information without a written authorization from the patient. The contracted plans assert that obtaining such authorizations would place an undue burden on the providers which plans are unwilling to require. The plans also indicate that it would be impossible to separate outpatient mental health treatment from other services.

MRMIB is exploring different options to resolve this setback. MRMIB anticipates being able to report on the Encounter/Claims Data project in the 2010 Federal Annual Report.
Dental Quality Measures: In addition to the HEDIS Annual Dental Visit measure, MRMIB has added the following dental performance measures to the dental plan contracts for reporting in 2008-09:

- Overall Utilization of Dental Services
- Preventive Dental Services
- Use of Dental Treatment Services
- Examinations/Oral Health Evaluations
- Treatment/Prevention of Caries
- Filling to Preventive Services Ratio
- Continuity of Care

Data for these measures will be reported in the 2009 Federal Annual Report.

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

Mental Health/Substance Abuse Study: MRMIB has identified low utilization of mental health and substance abuse treatment services by HFP children as an area of concern. Given the complexity of the HFP delivery system for mental health and substance abuse services, MRMIB is conducting a three-phased project to evaluate the delivery of these services in the HFP:

Phase I analyzed services provided to children with Serious Emotional Disturbance conditions. This phase was completed in 2006.

Phase II and Phase III of the study will be conducted concurrently over a 2 year period.

- Phase II will consist of an evaluation of mental health services provided by health plans, including issues that were identified as needing follow-up in Phase I of the study.

- Phase III will consist of an evaluation of substance abuse services provided by health plans, with special emphasis on services provided for co-occurring disorders.

The start date for Phase II and Phase III of the study is 11/1/08. MRMIB will report the results of Phase II and Phase III in the 2010 Federal Annual Report.

Mental Health Workgroup

MRMIB convened a mental health workgroup in April 2007. The following entities participated in the quarterly workgroup meetings:

- HFP plan and county mental health department liaisons
- MRMIB staff
- Members of the County Mental Health Directors Association
- California Department of Mental Health
- MRMIB HFP Mental Health/Substance Abuse Study contractor

MRMIB will use the workgroup's expertise to identify best practices in the coordination and provision of care to children with serious emotional disturbances (SED) as well as the provision of basic mental health and substance abuse services provided by the HFP health plans.

Children with Chronic Conditions (CCC): For the first time, the CAHPS survey included the Children with Chronic Conditions (CCC) measurement set, which was administered to all survey respondents. This set of questions is designed to identify children with chronic conditions and assess their experience getting needed health care services. Children with chronic conditions are defined as those with a chronic physical, developmental, behavioral, or emotional condition that requires more health care services than generally required. The survey results indicate that approximately 10% of those surveyed had a child with a chronic condition. Overall, they did not have a significantly different experience getting needed health care services compared to the general population.

The results of the CAHPS survey including the CCC questions are contained in Attachment 3.

Young Adult Health Care Survey (YAHCS): The YAHCS provides information about the experiences of teens in HFP and the degree to which teens aged 14 to 18 receive recommended preventive counseling and screening. The survey results indicate that overall teens are in good health and few are engaging in 2 or more risky behaviors. Overall they are happy with their doctors and the care they receive. However, teens continue to report very low levels of counseling and screening to prevent risky behaviors.

The results of the YAHCS are contained in Attachment 3.

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. **[7500]**

Immunization Rates: One of the goals of the MRMIB is to ensure every child enrolled in the Healthy Families Program (HFP) receives all Advisory Committee on Immunization Practices (ACIP) recommended immunizations. To ascertain how HFP plans ensure children receive recommended immunizations, the MRMIB Benefits and Quality Monitoring Division sent an electronic questionnaire to each health plan in July 2007. The purpose of the questionnaire was to obtain information regarding how plans remind members of immunizations and how they collect and use immunization data. A report "Immunization Practices in the Healthy Families Program" (Attachment 5) was developed based on the

data received from the plans. The report also identifies best practices, and compares HFP health plan HEDIS® immunization rates to immunization rates reported by Medi-Cal Managed Care and commercial plans.

HFP Family Out of Pocket Expenditures

Federal law (Title XXI) limits the sum of premiums plus copayment expenses to no more than five percent (5%) of annual household income for children enrolled in the State Children's Health Insurance Program (SCHIP). The HFP has assured compliance with these requirements by limiting the total amount of copayments incurred per family for health services to no more than $250 per benefit year. Each health plan reports annually on the number of HFP subscribers who incurred at least $250 in copayments. MRMIB also requires dental and vision plans to report the amount of copayments incurred for dental and vision services by those HFP members who incurred $250 for health services copayments. The Out of Pocket Expenditures Report for 2004-2006 (Attachment 6) provides information on the out of pocket expenditures for HFP families and shows that no HFP families spent more than 5 % of household income on premiums and copayments. By setting a maximum copayment amount of $250 per family, it is virtually impossible for any family in the HFP to exceed the federal out of pocket maximum of five percent (5%) of household income.

SECTION III: ASSESSMENT OF STATE PLAN AND PROGRAM OPERATION

Please reference and summarize attachments that are relevant to specific questions

OUTREACH

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

During the third quarter of FFY 2008, school based outreach grant funding through the Connecting Kids To Health Care Through Schools Program ended on April 1, 2008. MRMIB continues to support several of the activities previously supported by the Connecting Kids to Health Care Through Schools Program. These include the Request For Information (RFI) Flyers. The RFI Flyers are sent home with students. The parents can provide their contact information and return it to the school coordinator if they are interested in receiving an application for health care coverage. The RFI Flyers also provides parents with contact information if they choose to apply by telephone.

The RFI templates have been posted on the MRMIB and the HFP websites for continued use by school based organizations. MRMIB is currently developing a customized on-line RFI process for the HFP website. During the reporting period, 333,343 RFIs were printed and distributed by school-based organizations. In addition, MRMIB continues to distribute Connecting Kids collateral materials to the top producing Enrollment Entities.

During FFY 2008, 109,211 applications and 100,224 annual renewals were assisted by Certified Application Assistants (CAAs) and approximately $6.5 million was paid to Enrollment Entities (EEs). For the FFY 2007, 88,317 applications and 88,616 annual renewals were assisted by CAAs and approximately $5.1 million was paid to EEs. The number of applications' assisted by CAAs increased by 12% while the number of AERs assisted by CAAs increased by 13%. The increase in assisted applications and AERs is attributed, in part, to the increased EE reimbursement amounts which began in June 2006.

The number of children enrolled by CAA help totaled 118,375. This represents 43% of the SCHIP eligible children. The number of children that continued to qualify through the help of CAAs at AER totaled 91,802. This represents 5% of the SCHIP eligible children at AER and is a 12% increase compared to the 81,524 children that continued to qualify through the help of CAAs at AER in the previous reporting period.

[7500]

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?

The State considers that outreach through local community based organizations (i.e., EEs and CAAs) is one of the most effective and important ways to reach uninsured children and to promote program retention and initial applications. These organizations represent many community partners (e.g., schools, faith-based organizations, social services agencies, health care providers, community clinics, etc.) and they are well placed in the community to establish and maintain relationships with families, promote program awareness, and provide application assistance to apply for the programs.

Since the last reporting period, a total of 347,070 completed applications were received at the Single Point of Entry (SPE). Of the applications received at SPE, a total of 109,211 were assisted by CAAs. This represents 31% of all applications received at SPE.

In addition, a total of 100,224 annual eligibility review forms received were assisted by CAAs. This is a 13% increase over the 88,616 annual eligibility review forms assisted by CAAs in the previous reporting period.

For the applications assisted by CAAs (i.e., paper applications, on-line applications and annual eligibility review forms), paper applications represented 34%, on-line applications represented 30%

and annual eligibility reviews forms represented 36 % of the payments to EEs of the payments for assisted applications. During the last reporting period, paper applications represented 42%, on-line applications represented 24% and annual eligibility review forms represented 34% of the payments to EEs of the payments for assisted applications to EEs. During FFY 07/08, California completed the requirements assessment phase of the on-line public access project. The assessment phase identified the technical requirements, enhanced features, additional functions, additional programs, estimated costs and resources and development phase timeline required to take the on-line application to the world wide web. California expects to begin the development phase of the on-line application public access project during FFY2009.

[7500]

All States must complete the following 3 questions

3. Which of the methods described in Question 2 would you consider a best practice(s)**?**

The State still considers that outreach through local community based organizations (i.e., EEs and CAAs) is one of the most effective and important ways to reach uninsured children and to promote program retention and initial applications. These organizations represent many community partners (e.g., schools, faith-based organizations, social services agencies, health care providers, community clinics, etc.) and they are well placed in the community to establish and maintain relationships with families, promote program awareness, and provide application assistance to apply for the programs.
[7500]

4. 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?

No. However, a portion of the application assistance funding is paid to county and/or regional level collaboratives. The collaboratives developed their own approaches in promoting program awareness and retention, as well as possible targeted populations. Past outreach efforts resulted in increased enrollment in the SCHIP and Medicaid programs. **[7500]**

5. What percentage of children below 200 percent of the Federal poverty level (FPL) who are eligible for Medicaid or SCHIP have been enrolled in those programs? (Identify the data source used).

Based on 2007 CHIS, 89.8% of children below 200 percent of the Federal poverty level who are eligible for Medicaid or SCHIP have been enrolled in those programs.

[7500]

SUBSTITUTION OF COVERAGE (CROWD-OUT)

All states should answer the following question

1. Do you have substitution prevention policies in place?

☒ Yes
☐ No

If yes, indicate if you have the following policies:
☒ Imposing waiting periods between terminating private coverage and enrolling in SCHIP
☐ Imposing cost sharing in approximation to the cost of private coverage
☒ Monitoring health insurance status at the time of application
☐ Other, please explain **[7500]**

States with a separate child health program above 200 through 250% of FPL must complete question 2. All other states should also answer this question if you have a point at which the state will implement or modify a current substitution policy should substitution levels become

unacceptable. .

2. Identify the trigger mechanism or point at which your substitution prevention policy is instituted or modified if you currently have a substitution policy.

   SCHIP precludes enrollment within 3 months of a child having Employer Sponsored Insurance (ESI). For each person for whom application or annual eligibility review is being made, SCHIP requests information for each child if there is current ESI coverage or ESI that was terminated in the last 3 months, including the reason for and date of termination. In addition, participating plans communicate to SCHIP when they discover that a child is or has been covered by ESI within the prior three months. The State makes an initial assessment and determines whether or not to refer to Audits and Investigations for a formal investigation. [7500]

All States must complete the following 3 questions

3. Describe how substitution of coverage is monitored and measured and how the State evaluates the effectiveness of its policies.

   Coverage substitution is monitored through the eligibility determination process and the collection of information regarding employer-sponsored insurance at the time of application data. Applicants are required to answer questions about each child's previous health coverage. The State also monitors this process through the State's plan partners who report and forward information to the State when a child is enrolled in SCHIP and had (or has) employer-sponsored insurance (ESI) within the last 3 months. If the State receives this information, a formal ESI review and assessment is conducted. Children who received ESI 3 months prior to application are not eligible for the HFP, unless they qualify for specific exemptions. These exemptions include the following items listed below.

   • The person or parent providing health coverage lost or changed jobs;

   • The family moved into an area where employer-sponsored coverage is not available;

   • The employer discontinued health benefits to all employees;

   • Coverage was lost because the individual providing the coverage died, legally separated, or divorced;

   • COBRA coverage ended; or

   • The child reached the maximum coverage of benefits allowed in current insurance in which the child is enrolled.

   An independent assessment was conducted by University of California, San Francisco in August 2002 to identify if crowd-out existed in the program. The studies major finding was that crowd-out was minimal (up to 8%) and a major finding was the unaffordability of employer sponsored coverage for families. The report indicated that current program policies were effective in preventing substitution of coverage in the program.

   [7500]

4. At the time of application, what percent of SCHIP applicants are found to have Medicaid [(# applicants found to have Medicaid/total # applicants) * 100] and what percent of applicants are found to have other insurance [(# applicants found to have other insurance/total # applicants) * 100]? Provide a combined percent if you cannot calculate separate percentages.

   During the period of October 1, 2007 through September 30, 2008, 5.7% of the children were determined to be ineligible at the time of initial application, as a result of having other insurance coverage. Of the 5.7% that had other insurance coverage, 5.3% were receiving health coverage through the Medicaid program and 0.4% had employer-sponsored insurance. **[50]**

   a. Of those found to have had other, private insurance and have been uninsured for only a portion of the state's waiting period, what percent meet your state's exemptions to the waiting period (if your state has a waiting period and exemptions) [(# applicants who are exempt/total # applicants who would have to complete a waiting period)*100]?

During the period, October 1, 2007 through September 30, 2008, 76% of those found to have had private insurance met the state's exemptions to the waiting period. The exemptions included: change in job status, COBRA ended, ESI termination due to death, legal separation of divorce, employer ended benefits, lost job and moved and insurance not available.**[50]**

b. Of those found to have other, private insurance, what percent must remain uninsured until the waiting period is met [(# applicants who must complete waiting period/total # applicants who would have to complete a waiting period)*100]?

During the period of October 1, 2007 through September 30, 2008, 24% of those found to have had private insurance had to remain uninsured until the waiting period was met. Of this 24%, 22% was for children at initial application. The other 2% included children determined ineligible at the AER who either had private insurance at the time of AER or obtained other private insurance during the 3 months prior to the AER. **50]**

5. Describe the incidence of substitution. What percent of SCHIP applicants drop group health plan coverage to enroll in SCHIP (i.e., (# applicants who drop coverage/total # applicants) * 100)?

Researchers from the University of California, San Francisco Institute for Health Policy Studies examined the level of substitution coverage for SCHIP. Their August 2002 study concluded that up to 8% of new applicants had employment-related insurance within the 3 months prior to enrolling in the HFP. The researchers found that the highest rate of substitution coverage occurred in the lower income group (below 200%) and that the single largest reason parents dropped employer-sponsored coverage was that it was unaffordable. More than a quarter of the group reported paying more than $75 per month and could no longer afford ESI coverage.

For the period October 1, 2007 through September 30, 2008, State data shows that 0.6% of ineligible children were denied SCHIP coverage due to coverage in Employer Sponsored Insurance within the prior three (3) months of applying for coverage. **[7500]**

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 re-determination processes are similar; however, the re-determination process for Medicaid is separate from SCHIP. For Medicaid, each county welfare department mails a re-determination form to the applicant one month prior to the child's anniversary date. The form must be returned before the end of the annual re-determination month. If the child is found to be eligible for Medicaid, the child will continue to be enrolled in Medicaid for an additional twelve months. If the child is not eligible for Medicaid, the re-determination form is sent to SPE for a SCHIP eligibility determination, as long as there is parental consent. Failure to provide the completed annual re-determination form results in the discontinuance of benefits. However, should the beneficiary complete the annual redetermination required within 30 days of discontinuance, the discontinuance may be rescinded and benefits restored without a break in coverage. Please note that this process has not changed since the 2002 reporting period.

In the SCHIP program, the applicant is mailed a customized, pre-printed Annual Eligibility Review (AER) package at least 60 days prior to their children's anniversary date. The AER package also has an attached Add-A-Person form which is used to apply for any children who now reside in the home but are not enrolled in SCHIP or Medicaid. If the AER package has not been returned within 30 days, the applicant is contacted by telephone to confirm receipt of the AER package, offered assistance to complete the package or to provide a referral to a local entity that can provide direct assistance to complete the AER package. The program also sends a reminder post card to the applicant, explaining that the AER package is due and identifies the deadline date in which the program must receive the information. If the package is not received within 15 days from the deadline date, the applicant is sent a pending disenrollment letter and the reason for the disenrollment (e.g., no package

returned, missing information requested not received, etc.). The pending disenrollment letter includes a Continued Enrollment (CE) form that can be used to appeal the decision. If the CE form is received prior to the prospective disenrollment date, coverage continues for an additional month or until the appeal is adjudicated. If the AER package is not received or is not completed by the end of the anniversary month, the children are disenrolled and the applicants are sent the appropriate disenrollment letters. All denial and disenrollment letters include a Program Review Form to return to the program if the applicant disagrees with the disenrollment action. **[7500]**

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. **[7500]**

   In Medicaid, if a subscriber is determined to be ineligible due to income (being too high) at the redetermination process, the application is forwarded to SCHIP if the applicant has provided consent to forward the form. To improve the coordination between the two programs and ensure continuity of care, the State grants an additional one month of Medicaid continued coverage while the application is being processed for SCHIP eligibility.

   In the SCHIP, if a subscriber is determined ineligible due to income (being too low) at AER and the applicant has provided consent to forward to Medicaid, the AER application is forwarded to the county welfare department (CWD) in the county of the applicant's residence and the subscriber is granted presumptive eligibility into Medicaid, if eligible. The Medicaid Presumptive Eligibility places subscribers in temporary Medicaid until a Medicaid eligibility determination is made. In the event the applicant does not initially provide consent to forward the AER application to the CWD, the SCHIP contacts the applicant to encourage him/her to re-consider Medi-Cal and to submit authorization to forward the AER application to the CWD. If the applicant returns this reconsider letter within ninety days of SCHIP decision notification date, the children are granted presumptive Medicaid in the month the reconsider letter is received.

   On August 15, 2008, SCHIP implemented a revised AER form to make it more like the joint application for Medi-Cal, where SCHIP no longer requires families to opt-in to Medi-Cal in order for the form to be forwarded to the CWD. Instead, children who qualify for Medi-Cal will automatically be forwarded to the CWD. In these cases, coordination between the two programs and continuity of care are ensured by the State granting presumptive eligibility into Medicaid while the application is being processed for Medicaid eligibility. With the revised AER form, the applicant does not have to provide consent to forward the information to Medicaid. This prevents children from experiencing a break in coverage or delay between SCHIP and Medicaid.

   SCHIP uses a detailed transmittal sheet which accompanies each application forwarded to the CWD. This sheet provides detailed subscriber information such as, the income determination used to conclude that the subscriber's income is below SCHIP guidelines, the household composition and family relationships, and the unique identification number assigned to each child on the State's Medi-Cal Eligibility Data System (MEDS). The unique Client Index Number (CIN) provides California the ability to track SCHIP and Medicaid applications, enrollment, and eligibility status of children in either program or those being transferred between programs. If the CWD determines that a child is not eligible for no-cost Medicaid and may be eligible for the SCHIP, the transmittal sheet is returned to SCHIP. The transmittal sheet is accompanied with the application and all documentation for a SCHIP eligibility determination. **[7500]**

3. Are the same delivery systems (such as managed care or fee for service,) or provider networks used in Medicaid and SCHIP? Please explain. **[7500]**

   Medicaid uses both managed care and fee-for-service providers, whereas SCHIP utilizes only managed care providers. There is a significant overlap in the managed care networks between Medicaid and SCHIP. **[7500]**

4. For states that do not use a joint application, please describe the screen and enroll process. **[7500]**

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?

At least 3 notifications are sent to the SCHIP families for the AER process. If families provide insufficient information in order to determine if their children continue to qualify, then letters (in addition to those noted in the bullet below) are mailed to the families, informing them about what other information is needed. In these circumstances, at least five phone calls attempts, including one on Saturday, are also made to the SCHIP families. **[500]**

- 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?)

AER packet is sent 60 days before due date, 30-day reminder post-card is sent, at least five courtesy calls, including one on Saturdays, are made if an AER is not returned 30 days prior to the due date, and a pending disenrollment letter is sent 15 days prior to the disenrollment date. The pending disenrollment letter includes a Continued Enrollment (CE) form that can be used to appeal the decision. If the CE form is received prior to the prospective disenrollment, coverage continues for an additional month or until the appeal is adjudicated. **[500]**

☐ 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)

Customized, pre-printed re-enrollment forms are available in 5 languages for SCHIP families. The customized forms identify each family's information (i.e. known names and relationships of people living in the home). The forms are sent in the families' primary written language. Should an individual choose to reapply for SCHIP, they can call the customer toll-free line and an application will be pre-populated with each family's information and sent to them for completion and submission. This pre-printed application is available in 12 languages. **[500]**

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

Thirty days after children are disenrolled, telephone surveys are made to the families to learn more about the specific reason why the coverage ended. If the families cannot be reached by telephone, then disenrollment surveys are mailed to them. **[500]**

☐ Other, please explain:

[500]

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.

A total of 100,224 AER forms received were assisted by CAAs. This is a 13 % increase over the 88,616 AER forms assisted by CAAs in the previous reporting period. The number of children that continued to qualify through the help of CAAs at AER totaled 91,802. This represents 5% increase of SCHIP eligible children at AER and a 12% increase compared to the 81,524 children that continued to qualify through the help of CAAs at AER in the previous reporting period.

SCHIP has shown significant retention of eligible children since the last reporting period. SCHIP has increased the level of customer service. There is an increase in phone calls to subscribers to obtain necessary information and extensive follow-up. The increase in Enrollment Entity payments from $25 to $50 for the AER has played a part in retention. In addition, the Center for Health Literacy's review of program materials and letters has assisted families with a better understanding of the AER materials. **[7500]**

3. What percentage of children in the program are retained in the program at redetermination (i.e., (# children retained/total # children up for redetermination) * 100)? What percentage of children in the program are disenrolled at redetermination (i.e., (# children disenrolled/total # children up for redetermination) * 100) **[500]**

The State prepares annual reports which are also available through the MRMIB website at www.mrmib.ca.gov . The 2008 Retention Report covers the period from 1/1/06 – 12/31/06 and identifies the percentage of children initially enrolled in SCHIP who continued to qualify for another year. Of the children enrolled in 2006, 90% were still enrolled until they reached the annual eligibility review process. During the AER process, 80% continued to qualify for SCHIP for an additional year. The 2008 Report reflects the highest percentage of children who maintained coverage in the program's history.

[500]

4. 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
☐ N/A

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

September 2008

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]**

SCHIP monthly disenrollment reports are on the MRMIB website (www.mrmib.ca.gov). In addition, charts can be found on avoidable (disenrollments that may be prevented, such as non-payment of premiums or information not provided during annual review) and unavoidable (disenrollments that cannot be prevented such as applicant's request, turning age 19, enrolled in Medicaid or ESI) disenrollments.

It is believed that many of the families that disenroll for non-payment of premiums or due to not submitting their AER information is because they are already enrolled in other health coverage or the Medicaid Program. A future accomplishment will be to enhance the system to accurately report the volume of families actually enrolled in the Medicaid Program.

During the period October 2007 through September 2008, the number of children disenrolled totaled 301,105. Of this total, approximately 166,639 children were disenrolled during the annual eligibility review process. This represents 55.3% of the total disenrolled. Of the 166,639 children disenrolled at the annual review process, 97,139 children (58.3%) were disenrolled due to avoidable reasons and 69,500 children (41.7%) were disenrolled due to unavoidable reasons. Of the total 55.3% disenrolled at the annual eligibility review process, 7.6% no longer lived in the home, obtained employer-sponsored insurance or children were enrolled in Medicaid, while 34.1% were disenrolled due to household income above or below SCHIP guidelines. Additionally, 21.1% were disenrolled due to incomplete annual review information not completed and 37.2% did not return annual review information for processing.

Additionally, of the total 301,105 children disenrolled, 134,466 children were disenrolled during the non-AER process. This represents 44.7% of the total disenrolled. Of the 134,466 disenrolled during the non-AER process, 81,162 children (60.4%) were disenrolled due to avoidable reasons and 53,304 children (39.6%) were disenrolled due to unavoidable reasons. Of the total 44.7% disenrolled during the non-AER process, 3.4% did not provide citizenship or immigration documentation within the 2 months of enrollment while 15.6% requested disenrollment from SCHIP. Additionally 20.6% turned 19 and aged-out of SCHIP and 60.4% were disenrolled due to non-payment of premium. **[7500]**

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

Total Number of Disenrollees	Obtain other public or private coverage		Remain uninsured		Age-out		Move to new geographic area		Other (specify)	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
301,105	12,646	4.2%			27,740	9.2%	n/a	n/a	n/a	n/a

Please describe the data source (e.g., telephone or mail survey, focus groups) used to derive this information. Include the time period reflected in the data (e.g., calendar year, fiscal year, one month, etc.) **[7500]**

The State assesses and reports a wide variety of enrollment and disenrollment information on MRMIB's website (www.mrmib.ca.gov) on a monthly basis. This information also details the number and reasons children disenroll from SCHIP. These reasons include the number of children who are no longer eligible during the AER and the specific reasons for disenrollment (i.e. turned 19 years old, obtained other insurance, income above/below the SCHIP guidelines, etc.). In addition, MRMIB conducts an annual Retention Report which details the reasons subscribers do not stay in the program. This report is also posted on the MRMIB website. **[7500]**

COST SHARING

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

   California continues to use 2 surveys to assess the main reason why children disenroll from the SCHIP due to non-payment of premiums. The first survey is a post card that is mailed to every family after their children are disenrolled from the SCHIP for non-payment of premiums. This survey includes questions about premiums and the cost of SCHIP. The family is asked to indicate which of the following reason best describes the reason they did not pay their premiums: 1) cannot afford payment, 2) lost invoices, 3) never received invoice, and 4) forgot to pay premium.

   The second survey is in conjunction with the non-payment courtesy call initiated by SCHIP 10 days prior to disenrollment for non-payment of premium. During this call, the family is reminded that a premium payment is necessary in order to keep their child enrolled in the SCHIP. If the family

indicates they will not be making the payment, the SCHIP attempts to establish the reason why the family is not able to make the payment. These reasons include those reasons (Items #1 - #4) noted in the above paragraph.

From responses to these surveys, the State has found that it is often the case that families who want to disenroll their child frequently quit paying their premium rather than providing the SCHIP with a formal written request for disenrollment. Both of these surveys are on a voluntary basis. However, based on both surveys, it appears that only a very small percentage of those applicants who do respond are disenrolling from the SCHIP because they cannot afford the cost of the monthly premium. **[7500]**

2. 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?

   The State has not conducted an assessment of the effect of cost sharing on utilization of health services. However, HFP was designed with minimal copayments to eliminate any potential barrier to services. Many preventative services provided in the SCHIP do not require co-payments. Preventive health and dental services and all inpatient services are provided without co-payment. Co-payments are also not required for services provided to children through the California Children's Services (CCS) Program and the county mental health departments for children who have Serious Emotional Disturbances (SED). **[7500]**

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]**

EMPLOYER SPONSORED INSURANCE PROGRAM (INCLUDING PREMIUM ASSISTANCE PROGRAM(S)) UNDER THE SCHIP STATE PLAN OR A SECTION 1115 TITLE XXI DEMONSTRATION

1. Does your State offer an employer sponsored insurance program (including a premium assistance program) for children and/or adults using Title XXI funds?

   ☐ Yes, please answer questions below.
   ☒ No, skip to Program Integrity subsection.

Children

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

☐ Family Coverage Waiver under the State Plan
☐ SCHIP Section 1115 Demonstration
☐ Medicaid Section 1115 Demonstration
☐ Health Insurance Flexibility & Accountability Demonstration (Title XXI)

Adults

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

☐ Family Coverage Waiver under the State Plan (Parents covered incidentally)
☐ SCHIP Section 1115 Demonstration

☐ Health Insurance Flexibility & Accountability Demonstration (Title XXI)

☐ 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
☐ Pregnant Women

3. Briefly describe how your program operates (e.g., is your program an employer sponsored insurance program or a premium assistance program, how do you coordinate assistance between the state and/or employer, who receives the subsidy if a subsidy is provided, etc.) **[7500]**

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

5. Are there any minimum coverage requirements for the benefit package? **[7500]**

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

7. Are there any limits on cost sharing for children in your ESI program? Are there any limits on cost sharing for adults in your ESI program? **[7500]**

8. Identify the total number of children and adults enrolled in the ESI program for whom Title XXI funds are used during the reporting period (provide the number of adults enrolled in this program even if they were covered incidentally, i.e., not explicitly covered through a demonstration).

_____ Number of childless adults ever-enrolled during the reporting period
_____ Number of adults ever-enrolled during the reporting period
_____ Number of children ever-enrolled during the reporting period

9. Identify the estimated amount of substitution, if any, that occurred or was prevented as a result of your employer sponsored insurance program (including premium assistance program). Discuss how was this measured? **[7500]**

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

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

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

13. What do you estimate is the impact of your ESI program (including premium assistance) on enrollment and retention of children? How was this measured? **[7500]**

14. Identify the total state expenditures for providing coverage under your ESI program during the reporting period. **[7500]**

15. Provide the average amount each entity pays towards coverage of the beneficiary under your ESI program:

State: _____

Employer: _____

Employee: _____

16. If you offer a premium assistance program, what, if any, is the minimum employer contribution? **[500]**

17. Do you have a cost effectiveness test that you apply in determining whether an applicant can receive coverage (e.g., the state's share of a premium assistance payment must be less than or equal to the cost of covering the applicant under SCHIP or Medicaid)? **[7500]**

18. Is there a required period of uninsurance before enrolling in your program? If yes, what is the period of uninsurance? **[500]**

19. Do you have a waiting list for your program? Can you cap enrollment for your program? **[500]**

Enter any Narrative text below. **[7500]**

PROGRAM INTEGRITY (COMPLETE ONLY WITH REGARD TO SEPARATE SCHIP PROGRAMS, I.E., THOSE THAT ARE NOT MEDICAID EXPANSIONS)

1. Does your state have a written plan that has safeguards and establishes methods and procedures for:

   (1) prevention;

(2) investigation;

(3) referral of cases of fraud and abuse?

Please explain: **[7500]**

If the state does not have a written plan, do managed health care plans with which your program contracts have written plans? Please Explain:

The State will do an initial review and assessment of reported fraud or abuse and determine whether to refer to Audits and Investigations for a formal investigation. In the event plan partners, government entities or the general public alleges that fraud or abuse is being committed, the procedure is to report the information directly to the State. Most situations where fraud allegations are being made, occur in circumstances where a child is currently enrolled in SCHIP and also has employer-sponsored insurance or when a non-custodial parent (as indicated on the application) indicates that the child actually resides with them. The State requires that the entity or individual reporting the fraud provide the information in writing and to include documentation to substantiate the allegations. The State reviews the allegations, conducts a formal investigation and contacts (by telephone and/or in writing) the individual who is allegedly committing the fraud or abuse.

In 2002, the State conducted an independent fraud risk assessment for the SCHIP program. The assessment concluded that existing HFP rules and procedures are effective in deterring, detecting and controlling fraud and abuse among applicants. The analysis determined that the eligibility determination process establishes safeguards in preserving program integrity. Findings indicated that the applicant's income verification and documentation process reduced the likelihood of inappropriate enrollment. **[7500]**

2. For the reporting period, please indicate the number of cases investigated, and cases referred, regarding fraud and abuse in the following areas:

Provider Credentialing

_____ Number of cases investigated

_____ Number of cases referred to appropriate law enforcement officials

Provider Billing

_____ Number of cases investigated

_____ Number of cases referred to appropriate law enforcement officials

Beneficiary Eligibility

58 Number of cases investigated

0 Number of cases referred to appropriate law enforcement officials

Are these cases for:

SCHIP ☒

Medicaid and SCHIP Combined ☐

3. Does your state rely on contractors to perform the above functions?

☒ Yes, please answer question below.

☐ No

4. If your state relies on contractors to perform the above functions, how does your state provide oversight of those contractors? Please explain:

MRMIB entered into an Interagency Agreement with the California Department of Health Care Services' (SDHCS) Audits and Investigations (A & I) Division to provide investigation services. A & I Division investigates Medicaid fraud and abuse complaints. If SCHIP receives a complaint, it is forwarded to MRMIB and an initial review and assessment of the reported fraud or abuse. If it is determined that additional investigation needs to be conducted, the initial findings are provided to the DHCS A & I staff and a more thorough investigation would be initiated.

In addition, the State also contracts with various health, dental and vision plans that provide services to subscribers through a managed health care model. Each plan establishes safeguards for deterring, detecting and monitoring provider credentialing, fraud and abuse in accordance with State plan licensing statutes. The State pays the plans monthly capitation for each enrolled subscriber. Therefore, State oversight is provided through the plans' licensing agency, either Department of Managed Health Care or Department of Insurance. As stated above, these State agencies will also do an initial assessment and determine whether to refer to Audits and Investigations.

5. Do you contract with managed care health plans and/or a third party contractor to provide this oversight?

☒ Yes

☐ No

Please Explain: Each plan establishes safeguards for deterring, detecting and monitoring provider credentialing, fraud and abuse in accordance with State plan licensing statutes. The State pays the plans monthly capitation for each enrolled subscriber. Therefore, State oversight is provided through the plans' licensing agency, either Department of Managed Health Care or Department of Insurance. **[500]**

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 equals Federal Fiscal Year 2008. 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	**2008**	**2009**	**2010**
Insurance payments	$0	$0	$0
Managed Care	$1,218,043,394	$1,241,769,753	$1,250,688,513
Fee for Service	$733,448,627	$818,393,710	$830,258,960
Total Benefit Costs	$1,951,492,021	$2,060,163,463	$2,080,947,473
(Offsetting beneficiary cost sharing payments)	-$84,137,213	-$81,129,130	-$88,567,639
Net Benefit Costs	$1,867,354,808	$1,979,034,334	$1,992,379,834
Administration Costs			
Personnel	$0	$0	$0
General Administration	$94,252,231	$111,873,042	$100,815,553
Contractors/Brokers (e.g., enrollment contractors)	$0	$0	$0
Claims Processing	$0	$0	$0
Outreach/Marketing costs	$4,922,152	$6,618,252	$7,936,190
Other (e.g., indirect costs)	$0	$0	$0
Health Services Initiatives			
Total Administration Costs	$99,174,383	$118,491,294	$108,751,743
10% Administrative Cap (net benefit costs ÷ 9)			
Federal Title XXI Share	$1,259,347,788	$1,344,267,277	$1,368,939,881
State Share	$707,181,403	$753,258,351	$732,191,696
TOTAL COSTS OF APPROVED SCHIP PLAN	$1,966,529,191	$2,097,525,628	$2,101,131,577

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) **[Proposition 99]**

3. Did you experience a short fall in SCHIP funds this year? If so, what is your analysis for why there were not enough Federal SCHIP funds for your program?

Yes, we had a short fall of $205 million in SCHIP funds for FFY 08. California used carry-over funding from previous years, otherwise, there would not have been enough Federal SCHIP funds.

4. In the table below, enter 1) number of eligibles used to determine per member per month costs for the current year and estimates for the next two years; and, 2) per member per month cost rounded to a whole number. If you have SCHIP enrollees in a fee for service program, per member per month cost will be the average cost per month to provide services to these enrollees.

	2008		2009		2010	
	# of eligibles	$ PMPM	# of eligibles	$ PMPM	# of eligibles	$ PMPM
Managed Care	10,177,445	$120	10,598,414	$117	10,939,910	$114
Fee for Service	3,973,458	$61,120,179	3,982,290	$68,199,476	4,038,972	$69,188,247

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				
	* Upper % of FPL are defined as Up to and Including									
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? You are required to evaluate the effectiveness of your demonstration project, so report here on any progress made in this evaluation, specifically as it relates to enrollment, retention, and access to care for children. **[1000]**

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 2007 starts 10/1/06 and ends 9/30/07).*

COST PROJECTIONS OF DEMONSTRATION (SECTION 1115 or HIFA)	2008	2009	2010	2011	2012
Benefit Costs for Demonstration Population #1 (e.g., children)					
Insurance Payments					
Managed care					
per member/per month rate for managed care					
Fee for Service					
Average cost per enrollee in 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 for managed care					
Fee for Service					
Average cost per enrollee in 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 for managed care					
Fee for Service					
Average cost per enrollee in 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 for managed care					
Fee for Service					
Average cost per enrollee in 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)*					
Total Administration Costs					
10% Administrative Cap (net benefit costs ÷ 9)					

Federal Title XXI Share					
State Share					

TOTAL COSTS OF DEMONSTRATION					

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]**

   There continues to be strong support for insurance coverage for children, both in the Administration and the Legislature.

   SCHIP Funding and Reauthorization: Wait List Regulations Established: Due to the uncertainty regarding SCHIP reauthorization and funding levels during FFY 2008, on November 5, 2007, the MRMIB adopted emergency regulations to ensure that SCHIP expenditures did not exceed amounts available. If sufficient SCHIP funds are not available, the regulations give MRMIB the authority to limit SCHIP enrollment. The adopted regulations give the Board the authority to establish a waiting list for new applications for children applying for the program, in the event there is not sufficient SCHIP funding. If the waiting list does not adequately limit SCHIP expenditures, the Board would have the authority to direct MRMIB to disenroll children during the Annual Eligibility Review. The disenrolled children would be placed on the waiting list. While the program regulations provide the authority to establish a waiting list and to disenroll children, neither feature has been implemented.

   The enactment of short-term extenstion federal legislation provided additional funding for shortfall states in FFY 2008, and MRMIB decided that it did not need to make an insufficient funding determination that would lead to the implementation of a waiting list and possible disenrollment of children. The lack of a long term SCHIP reauthorization continues to present a challenge to MRMIB and could be a reason to potentially freeze enrollment. SCHIP is not an entitlement and state law requires the program to operate within its allocated funding. There are 4 months of SCHIP funding remaining for the states. Waiting until funding runs out to reauthorize makes it difficult to administer the program or assess the adequacy of the state's SCHIP allocation to fully fund the existing and future caseload.

   SCHIP activities,that should have occurred in FFY 2008, but were delayed due to California's State budget reductions include:

   - 2008 Open Enrollment Delay: Open Enrollment (OE) for the State Fiscal Year (SFY) 2008-2009 typically occurs April 15th through May 31st. However, due to the delay in passing the state budget for 2008-09, OE is occurring November 15, 2008 through December 31, 2008. Changes made during OE will take effect February 1, 2009.
   - SCHIP Premium Increases: There is no premium increase for families with income under 150% FPL. Premiums for families with incomes between 150% - 200% FPL will increase $3 per child, with a monthly maximum premium amount of $36 for an entire family. Premiums for families with incomes above 200% - 250% will increase $2 per child, with a family monthly maximum premium amount of $51 for an entire family. The premium increase will be implemented in FFY 2009 (on February 1, 2009). The 2009 Federal Annual Report will provide information on how the premium increase affected families and enrollment in SCHIP.

   Health Care Reform effort: Both the Governor and the Legislature proposed sweeping health care reform packages during the reporting year. Key components included:

- Individual mandate that most Californians must obtain insurance
- Purchasing Pool
- Extending subsidized coverage to children
- Quality Improvement requirements for health insurers
- Changes to health benefit structures

MRMIB would have been responsible for:

- Establishing the new purchasing pool
- Developing various health plan benefit structures
- Administering contracts with health insurers
- Enrolling both subsidized and unsubsidized applicants for coverage

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

CMS August 17, 2007 Directive: As indicated in the 2007 Federal Annual Report, the CMS directive, if applied to our base program, seeks to limit state flexibility for those states that provide SCHIP eligibility for children of families with income levels at or above 250 percent of the Federal poverty level (FPL). It would also make the expansion of coverage for children at 300% FPL, called for in various legislative health care reform bills, more difficult to achieve. The new rules proposed in the letter would reverse longstanding agreements with the states and actually reduce the number of children who receive health care. It will be difficult for any state, including California, to meet all the rules contained in the letter. While California does not concede the legality of the proposed August 17 standards, its terms will impose substantial hardship on the states and the children they serve. The lack of flexibility for the states to determine benefit design, coverage levels, and administration under SCHIP undermines a program that has proven it to be efficient and incredibly valuable to the vulnerable children and pregnant women it currently serves.

California responded to the CMS directive by engaging in conversations with CMS and issuing a response letter, dated August 12, 2008. The response letter explained that California will continue to operate the SCHIP program (including eligibility, benefits and cost-sharing) in accordance with the CMS-approved Title XXI State Plan and will continue to claim federal funds accordingly. California's August 12, 2008 response letter is available on MRMIB's website at www.mrmib.ca.gov .

Encounter/Claims Data: MRMIB worked on developing an encounter/claims database to collect utilization data from health plans participating in the program. This data will broaden the scope and depth of quality of care information available to MRMIB and is intended for use in a number of reports and projects. MRMIB anticipated having plans report data in 2008. However, MRMIB is unable to receive data at this time due to a California State law called the "Confidentiality of Medical Information Act" which restricts the use and disclosure of information related to a patient's participation in outpatient treatment with a psychotherapist. Because of this restriction, contracted health plans are prohibited from sharing this information without a written authorization from the patient. The contracted plans assert that obtaining such authorizations would place an undue burden on the providers which plans are unwilling to require. The plans also indicate that it would be impossible to separate outpatient mental health treatment from other services.

MRMIB is exploring different options to resolve this setback. MRMIB anticipates being able to report on the Encounter/Claims Data Project in the 2010 Federal Annual Report.

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

Office of the Inspector General (OIG) Review of CMS Payment Error Rate Measure(PERM) Audit: California was one of the 17 states selected for the first Payment Error Rate Measurement (PERM) reporting audit for Medicaid and SCHIP fee-for-services and managed care claims. The PERM-calculated error rate of California's SCHIP program administered by the Managed Risk Medical Insurance Board was determined to be .04%. The Statewide error rate was .07% when combined with the Medicaid Expansion cases.

In FFY 2008, the OIG performed a review and validated the California PERM audit and its findings. According to OIG staff, the state had no material finding in its financial reporting for its SCHIP program and the OIG claims reports was able to reconcile the state's SCHIP expenditure reports.

SCHIP Administrative Vendor Performance & Quality and Accuracy Standards: California amended its contract with the HFP Administrative Vendor to require quality and accuracy performance standards. These standards require between a 98-100% accuracy rate for eligibility determinations, screening, data transmissions for eligibility triggering events, monthly plan capitation payments and capitation files for administrative services. The standards are in addition to existing performance standards regarding timeliness of screening and eligibility determinations and prompt telephone service. The vendor met all standards in 2008. The state extended the vendor's contract for an additional year.

Improvement in Plan Quality Performance

MRMIB compared the quality performance of HFP health, dental and vision plans in 2007. The Consumer Assessment of Healthcare Providers and Systems (CAHPS®)) survey of health plans, the Dental-CAHPS (D-CAHPS®) survey of dental plans and the Young Adult Health Care Survey (YAHCS®), as well as HEDIS® measures were used in the comparison. Areas of mixed results, areas for improvement, and areas of achievement were identified for each plan and presented publicly at the September 19, 2007 Board meeting. The plan performance profiles, contained in Attachment 7, will be completed annually.

Plans show improvements in most of the HEDIS® measures and in their CAHPS scores as noted in Section IIC. The 2007 HEDIS Report for the Healthy Families Program is contained in Attachment 2. The CAHPS® and YAHCS® surveys are contained in Attachment 3. Data for the D-CAHPS® survey is not yet available.

Rural Health Demonstration Projects (RHDP):. The RHDP was established to improve access to health care services for medically underserved and uninsured populations in rural areas and special populations who have rural occupations (farm workers, loggers, etc.). In FFY 2008 MRMIB received $ 5.8 million and funded 26 RHDPs.

The funds are used to expand services, extend clinic hours and hire additional providers. The projects provide a number of services, including:

- Nutritional Counseling/Health Education
- Pediatric Surgery Centers
- Mental Health
- Substance Abuse
- Dental Services
- Pediatric Weight Management

Special Advisory Panel (SAP) Focus testing of SCHIP Handbook. The California SCHIP program hosts a series of SAP meetings throughout the year to discuss the language and cultural appropriateness of SCHIP materials, report on feedback from their communities, and make suggestions for improvements. Each meeting has representatives from one of the following language groups: English, Spanish, Vietnamese, Chinese, and Korean. In July 2008, the SAP met and performed focus testing of the SCHIP Handbook. Panel members' suggestions included using simplified language, increasing font size, and replacing the Plan Quality Comparison Guide (PQCG) with one graph showing an overall rating for each participating plan.

SCHIP Enrollment Continues to Grow: During the end of the last reporting period, there were 835,900 children enrolled in SCHIP. As of September 30, 2008, over 884,500 children were enrolled in SCHIP, a 6% increase.

SCHIP Retention Increase: Retention of children in the program continues to improve. The most recent report shows the a year after enrollment in the program and following annual eligibility redetermination, 80% of children remained enrolled, an increase from the previous years (2001-69%; 2002-71%, 2003-70%; 2004-77%; and 2005-78%).

Staff also issued a report looking at longer term retention, since the program's implementation from July 1998 to December 2007. Findings reflect the following:

- Average 1 year retention rate is 80%;
- Average 2 year retention rate is 68%;
- Average 3 year retention rate is close to 60%;
- Average 4 year retention rate is close to 53%;
- Average 5 year retention rate is close to 47%; and
- Average 9 year retention rate is 28%.

Revised Joint Application Implemented: On April 1, 2008, the State launched a revised joint application for the SCHIP and Medicaid programs. Changes include using more simplified language; reducing the reading grade level from a 10th grade reading level to a 7th grade reading level, more effectively communicating and presenting important program information; including a document check list and making the application more visually appealing for the target population. The application was changed to eliminate any barriers that discourage individuals from applying for the SCHIP and Medicaid programs by making it easier to understand and read.

SCHIP to Presumptive Medicaid: In the 2007 report, MRMIB noted that California had implemented presumptive eligibility into Medicaid from SCHIP. During FFY 2008, 48,620 were found at AER to have incomes below HFP requirements. Parents agreed to transfer to Medicaid in 65% of the cases (Note: Overt permission to go to Medicaid is a feature of the renewal form that is being changed. See next topic). Of these 31,403 children, 78% were granted presumptive eligibility for Medicaid. Most of these children (84%) did not have a break in health coverage while transitioning from HFP to Medicaid.

SCHIP Revised AER form: On August 15, 2008, SCHIP released a revised form for use at annual eligibility review (AER). The form deletes the requirement that a family deliberately opt to apply for Medicaid if the children are found ineligible for SCHIP. The change is consistent with the revised joint application. Now children who potentially qualify for Medicaid during the SCHIP AER process will automatically be forwarded to the Medicaid Program because their income falls within the Medicaid Program's guidelines. The State found that close to 16% of children who qualified for presumptive eligibility into Medicaid had a lapse in coverage when they were disenrolled from SCHIP during the AER process.

Enrollment Entities and Certified Application Assistants Continue to Grow. During the reporting period, the number of Enrollment Entities increased from 2,630 to 3,244, a 23% increase from the last reporting period. The number of Certified Application Assistants increased from 18,862 to 20,480, an 8% increase from the last reporting period.

Web-Based Training (WBT) for certified application assistance continues to be a success with 1,539 new Certified Application Assistants completing the WBT with an average passing rate of 90.1%. This is a 55% increase from the last reporting period.

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.

Like many states in the nation, California faced challenges during the reporting period due to the State's difficult fiscal condition. California passed its FY 2008-09 budget in late September 2008, nearly three months late. Despite the dire fiscal condition of the State, there continues to be strong support for coverage for children, both in the Administration and the Legislature. California, like many other states, has experienced a down-turn in the economy resulting in reduced revenues and a projected budget shortfall of over $40 billion through June 2010. A multibillion dollar budget deficit has led to the following General Fund reduction efforts for the program that will be implemented in 2009:

- An increase of certain subscriber premiums. There is no premium increase for families with income under 150% FPL. Premiums for families with incomes between 150% - 200% FPL will increase $3 per child, with a monthly maximum premium amount of $36 for an entire family. Premiums for families with incomes above 200% - 250% will increase $2 per child, with a family monthly maximum premium amount of $51 for an entire family. The premium increase will be implemented in FFY 2009 (on February 1, 2009);
- A five percent reduction in plan rates for 2008-09. This reduction to the 08/09 rates will be effective 2/1/09;
- Deletion of certain vision benefits;
- Establishment of an annual limit on dental benefits; and
- Savings associated with expected enrollment decreases due to the premium increase.

In addition, the MRMIB considered taking the extraordinary precaution of freezing new enrollments. Freezing enrollments in the Healthy Families program would represent the first time the state has limited access to the Healthy Families program after extraordinary efforts to recruit families and significant growth from year-to-year in each of the 10 years since the program began in 1998. However, due to the generosity of the California Children and Families Commission (First 5 Commission) that provided MRMIB with nearly $17 million to cover HFP children ages 0-5 years through June 2009, MRMIB will not have to freeze enrollment in HFP.

Health-e-App Public Access: California continues to partner with two private philanthropic foundations to expand the access of the existing on-line electronic application process for general public use. During FFY 07/08, California completed the requirements assessment phase of the on-line public access project. The assessment phase identified the technical requirements, enhanced features, additional functions, additional programs, estimated costs and resources and development phase timeline required to take the on-line application to the world wide web. California expects to begin the development phase of the on-line application public access project during FFY2009

Electronic Process for Medicaid Referrals: Currently the State has a paper process for the counties to forward annual Medicaid re-determination information to SCHIP when children no longer qualify for Medicaid because the family's income is above Medicaid guidelines. The State is in the process of designing and implementing an electronic process for the Counties to transmit application information to SCHIP.

Assessing Additional Changes to the Revised Joint Application: Since the State implemented a revised application that is at a 7th grade reading grade level during the third quarter of this Federal Fiscal Year, the State will assess whether or not additional changes to the application needs to be considered, in order for it to be more user friendly and easier to understand.

Accessing Birth Record Data During SCHIP Eligibility Determination Process: The Department of Public Health stores all birth records for children born in California. SCHIP will electronically access birth record data when processing applications to determine if a child qualifies for the program. The birth records will be used to assess whether or not a child is a U.S. citizen. If a birth record match is found, the family would not be required to submit hard copies of proof of U.S. citizenship (i.e. birth records or birth certificate), in order to demonstrate that the child is a U.S. citizen.

Mental Health/Substance Abuse Study: MRMIB has identified low utilization of mental health and substance abuse treatment services by HFP children as an area of concern. Given the complexity of the HFP delivery system for mental health and substance abuse services, MRMIB is conducting a three-phased project to evaluate the delivery of these services in the HFP:

Phase I was completed in 2006 and this Phase analyzed services provided to children with Serious Emotional Disturbance conditions.

Phase II and Phase III of the study will be conducted concurrently over a 2 year period.

- Phase II will consist of an evaluation of mental health services provided by health plans, including issues that were identified as needing follow-up in Phase I of the study.

- Phase III will consist of an evaluation of substance abuse services provided by health plans, with special emphasis on services provided for co-occurring disorders.

The start date for Phase II and Phase III of the study was 11/1/08. The results of the study will be reported in the 2010 Federal Annual Report.

Dental Quality Measures: In addition to the HEDIS Annual Dental Visit measure, MRMIB has added the following dental performance measures to the dental plan contracts for reporting in 2008-09:

- Overall Utilization of Dental Services
- Preventive Dental Services
- Use of Dental Treatment Services
- Examinations/Oral Health Evaluations
- Treatment/Prevention of Caries
- Filling to Preventive Services Ratio
- Continuity of Care

Data for these measures will be reported in the 2009 Federal Annual Report.

ATTACHMENTS

1. Traditional and Safety Net Provider Report for 2007:
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_091708/Agenda_Item_7.e_2007_TSN_Report.pdf
2. 2007 Quality Measurement (HEDIS) Report: http://www.mrmib.ca.gov/MRMIB/HFP/HEDIS07.pdf
3. 2007 CAHPS and YAHCS Report:
http://www.mrmib.ca.gov/MRMIB/HFP/2007_Member_Satisfaction_Survey_Report.pdf
4. 2007/08 Cultural and Linguistics Summary: http://www.mrmib.ca.gov/MRMIB/HFP/2007-08_Cultural_Lingustic_Services_Survey.pdf
5. Immunization Practices in the Healthy Families Program:
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_041608/Immunization_Practices_in_the_Healthy_Families_Program_April_2008.pdf
6. Out of Pocket Maximum Report for 2004-05 and 2005-06
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_091708/Agenda_Item_7.f_2004-2006_OOP_Expenditure_Report.pdf
7. Plan Performance Profiles:
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_091907/8d_plan_performance_profiles.pdf