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:

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

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

C. Build on data ***already collected*** by CMS quarterly enrollment and expenditure reports, **AND**

D. 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: **CA**
(Name of State/Territory)

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

Signature:

Lesley Cummings, Executive Director

SCHIP Program Name(s): **All, California**

SCHIP Program Type:

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

Reporting Period: **2007** *Note: Federal Fiscal Year 2007 starts 10/1/06 and ends 9/30/07.*

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Submission Date: **1/31/2008**

(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

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.

	SCHIP Medicaid Expansion Program					Separate Child Health Program				
	* Upper % of FPL are defined as Up to and Including									
Eligibility						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 16**	100	% of FPL *	From	100	% of FPL for children ages **6 through 16**	250	% of FPL *
	From	0	% of FPL for children ages **17 and 18**	100	% of FPL *	From	100	% of FPL for children ages **17 and 18**	250	% of FPL *

Is presumptive eligibility provided for children?	☐	No	☐	No
	☒	Yes, for whom and how long? **[1000]** Yes, for whom and how long? 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. In addition, children (ages 0-1 under 200% FPL, 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. [1000]	☒	Yes - Please describe below: For which populations (include the FPL levels) **[1000]** Children screened above Medicaid FPL guidelines up to 200% SCHIP FPL are granted presumptive eligibility. Services are delivered through Medicaid's fee for service delivery system. Average number of presumptive eligibility periods granted per individual and average duration of the presumptive eligibility period **[1000]** Brief description of your presumptive eligibility policies **[1000]**
	☐	N/A	☐	N/A

Is retroactive eligibility available?	☐	No	☒	No
	☒	Yes, for whom and how long? For Children up to 3 months [1000]	☐	Yes, for whom and how long?
	☐	N/A	☐	N/A

Does your State Plan contain authority to implement a waiting list?	Not applicable	☒	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		☒ 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
			To which groups (including FPL levels) does the period of uninsurance apply? **[1000]** Children who have employer sponsored insurance (ESI) within the last 3 months for all FPL levels. If the child 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 **[1000]** 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 contriubutions for one or more categories of employees or 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.	
	☐	N/A	☐	N/A

Does your program match prospective enrollees to a database that details private insurance status?	☒	No	☒	No
	☐	Yes	☐	Yes
			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		Specify number of months	1
	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, no longer a California resident or the applicant requests child's disenrollment.		Turning age 19, non-payment of premiums, death of the child or the applicant requests child's disenrollment from the program.	
	☐	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	
	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)	
			$4-$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).	
	☐	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	
	☐	N/A	☐	N/A

Does your program require income disregards?	☒	No	☐	No
	☐	Yes	☒	Yes
	If Yes, please describe below		If Yes, please describe below	
			Income greater than 200% through 300% FPL.	

	☐	N/A	☐	N/A

Is a preprinted renewal form sent prior to eligibility expiring?	☒	No	☐	No
	☐	Yes	☒	Yes
		☐ 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

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

Title XXI funds children ages 6 through 18 up to 100% FPL in the Medicaid Program for those whose assets are waived. Applicant may pay three months in advance and receive the fourth month free. If the applicant uses Electronic Funds Transfer (EFT) or makes recurring credit card payments, 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 at 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. 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.

Comments on Responses in Table:

Is there an assets test for children in your Medicaid program?	☐	Yes	☒	No	☐	N/A
Is it different from the assets test in your separate child health program? If yes, please describe in the narrative section below the asset test in your program.	☐	Yes	☐	No	☒	N/A
Are there income disregards for your Medicaid program?	☐	Yes	☒	No	☐	N/A
Are they different from the income disregards in your separate child health program? If yes, please describe in the narrative section below the income disregards used in your separate child health program.	☐	Yes	☒	No	☐	N/A

Is a joint application used for your Medicaid and separate child health program? ☒ Yes ☐ No ☐ N/A

7. Indicate what documentation is required at initial application

	Self-Declaration	Documentation Required
Income	☐	☒
Citizenship	☐	☒
Insured Status	☒	☐

8. 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
Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	☐	☒	☐	☐	☒	☐
Application	☐	☒	☐	☐	☒	☐
Application documentation requirements	☐	☒	☐	☐	☒	☐
Benefit structure	☐	☒	☐	☐	☒	☐
Cost sharing (including amounts, populations, & collection process)	☐	☒	☐	☐	☒	☐
Crowd out policies	☐	☒	☐	☐	☒	☐
Delivery system	☐	☒	☐	☐	☒	☐
Eligibility determination process (including implementing a waiting lists or open enrollment periods)	☐	☒	☐	☐	☒	☐
Eligibility levels / target population	☐	☒	☐	☐	☒	☐
Assets test in Medicaid and/or SCHIP	☐	☒	☐	☐	☒	☐
Income disregards in Medicaid and/or SCHIP	☐	☒	☐	☐	☒	☐
Eligibility redetermination process	☐	☒	☐	☒	☐	☐
Enrollment process for health plan selection	☐	☒	☐	☒	☐	☐
Family coverage	☐	☒	☐	☐	☒	☐
Outreach (e.g., decrease funds, target outreach)	☒	☐	☐	☒	☐	☐
Premium assistance	☐	☒	☐	☐	☒	☐

Prenatal Eligibility expansion	☐ ☒ ☐	☐ ☒ ☐
Waiver populations (funded under title XXI)		
Parents	☐ ☒ ☐	☐ ☒ ☐
Pregnant women	☐ ☒ ☐	☐ ☒ ☐
Childless adults	☐ ☒ ☐	☐ ☒ ☐
Methods and procedures for prevention, investigation, and referral of cases of fraud and abuse	☐ ☒ ☐	☐ ☒ ☐
Other – please specify		
_____	☐ ☐ ☐	☐ ☐ ☐
_____	☐ ☐ ☐	☐ ☐ ☐
_____	☐ ☐ ☐	☐ ☐ ☐

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

Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	
Application	
Application documentation requirements	
Benefit structure	
Cost sharing (including amounts, populations, & collection process)	
Crowd out policies	
Delivery system	
Eligibility determination process (including implementing a waiting lists or open enrollment periods)	

Eligibility levels / target population	
Assets test in Medicaid and/or SCHIP	
Income disregards in Medicaid and/or SCHIP	
Eligibility redetermination process	Prior to August 30, 2007, children with household income below SCHIP guidelines during annual redetermination received an additional 2-months of continued eligibility in the SCHIP program. Effective September 1, 2007, children with household income below SCHIP guidelines will no longer receive the 2-months additional SCHIP coverage. These children may qualify and be granted Presumptive Eligibility into Medicaid.
Enrollment process for health plan selection	On December 28, 2006, the SCHIP program implemented a process called “Automatic and Alternate Assignment of Plans.” With the alternate plan assignment process, an application missing health, dental, and/or vision plan selections is no longer denied. The SCHIP program will now automatically assign plans for the eligible children. Missing health plan selections defaults to the Community Provider Health Plan in the county where the child resides.
Family coverage	
Outreach	During the last quarter of FFY 2006, funding for Outreach, Enrollment, Retention and Utilization County Allocation (OERU) Grants were allocated to promote public awareness about the SCHIP and Medicaid programs. However, funding for OERU grants were not reallocated for the State fiscal year 2007/2008.
Premium assistance	
Prenatal Eligibility Expansion	
Waiver populations (funded under title XXI)	
Parents	
Pregnant women	
Childless adults	
Methods and procedures for prevention, investigation, and referral of cases of fraud and abuse	

Other – please specify	
a.	
b.	
c.	

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 is 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 2005 and FFY 2006) 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 2007). 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 2007.
Final: Check this box if the data you are reporting are considered final for FFY 2007.

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 2008, 2009, and 2010. Based on your recent performance on the measure (from FFY 2005 through 2007), 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 2005	FFY 2006	FFY 2007
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*: ☐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*: HEDIS 2007
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*:	**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.
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: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:
Year of Data:	**Year of Data:** 2006	**Year of Data:** 2006

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

FFY 2005	FFY 2006	FFY 2007
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: 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: 3690 Rate: 0.9 4 visits Numerator: 528 Denominator: 3690 Rate: 14.3 1 visit Numerator: 44 Denominator: 3690 Rate: 1.2 5 visits Numerator: 966 Denominator: 3690 Rate: 26.2 2 visits Numerator: 80 Denominator: 3690 Rate: 2.2 6+ visits Numerator: 1807 Denominator: 3690 Rate: 49 3 visits Numerator: 230 Denominator: 3690 Rate: 6.2 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:

How did your performance in 2007 compare with the Annual Performance Objective documented in your 2006 Annual Report? This is the first year that we are reporting on this measure. The 2007 score will be used as a benchmark for future year comparisons and to set performance objectives.

Are there any quality improvement activities that contribute to your progress?

Annual Performance Objective for FFY 2008: To meet or exceed the guidelines set forth in the American Academy of Pediatrics (AAP) Recommendation for Preventive Pediatric Health Care. Participating health plans with higher scores will share best practices and lower scoring plans submit a corrective action plan to improve these scores.

Annual Performance Objective for FFY 2009: To meet or exceed the guidelines set forth in the American Academy of Pediatrics (AAP) Recommendation for Preventive Pediatric Health Care. Participating health plans with higher scores will share best practices and lower scoring plans submit a corrective action plan to improve these scores.

Annual Performance Objective for FFY 2010: To meet or exceed the guidelines set forth in the American Academy of Pediatrics (AAP) Recommendation for Preventive Pediatric Health Care. Participating health plans with higher scores will share best practices and lower scoring plans submit a corrective action plan to improve these scores.

Explain how these objectives were set: MRMIB wants Well-Child Visits in the first 15 months of life to be based on and meet or exceed the American Academy of Pediatrics (AAP) Recommendation for Preventive Pediatric Health Care.

Other Comments on Measure:

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

FFY 2005	FFY 2006	FFY 2007
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*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2004	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2005	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2007
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 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: Plans provide a random sample of summary data as well as member level data that is certified by an independent auditor. The random sample is of HFP members who were three,four,five,or six years old during the measurement yr 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 yr. MRMIB calculates percentages and	**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: Plans provide a random sample of summary data as well as member level data that is certified by an independent auditor. The random sample is of HFP members who were three, four, five, or six years old during the measurement yr who were continuously enrolled in the plan during the measurement yr and who received one or more well-child visit(s) with a primary care provider during the measurement year. MRMIB calculates percentages and	**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:

FFY 2005	FFY 2006	FFY 2007
compares the results with those submitted by the health plans.	compares the results with those submitted by the hlth plans.	
Year of Data: 2005	**Year of Data:** 2006	**Year of Data:** 2006
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Percent with 1+ visits Numerator: 11274 Denominator: 17291 Rate: 65.2 Additional notes on measure: The numerator and denominator are based upon a sample of children as required by the NCQA for this HEDIS measure. The numerator and denominator are not reflective of the entire HFP population.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with 1+ visits Numerator: 15643 Denominator: 24121 Rate: 64.9 Additional notes on measure: The numerator and denominator are based upon a sample of children as required by the NCQA for this HEDIS measure. The numerator and denominator are not reflective of the entire HFP population.	**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.

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

FFY 2005	FFY 2006	FFY 2007
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:

How did your performance in 2007 compare with the Annual Performance Objective documented in your 2006 Annual Report? Scores continue to steadily improve each year and we continue to work with plans that have scores below the average.

Are there any quality improvement activities that contribute to your progress?

Annual Performance Objective for FFY 2008: Continued increase of 2% for 2008.

Annual Performance Objective for FFY 2009: Continued increase of 2% for 2009.

Annual Performance Objective for FFY 2010: Continued increase of 2% for 2010.

Explain how these objectives were set: MRMIB wants a continued annual increase of 2% for Well-Child Visits in children in the 3rd, 4th, 5th, and 6th years of Life.

Other Comments on Measure: Based on the sample submitted by the plans, the mean score across health plans in 2006 was 72%. For the last three measurement years there was a 2% increase each year in the number of HFP enrollees who had a well-child visit.

MEASURE: Use of Appropriate Medications for Children with Asthma

FFY 2005	FFY 2006	FFY 2007
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*: ☐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*: 2006	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2007
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*:	**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.
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: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:
Year of Data: 2005	**Year of Data:** 2006	**Year of Data:** 2006

Use of Appropriate Medications for Children with Asthma (continued)

FFY 2005	FFY 2006	FFY 2007
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Percent receiving appropriate medications 5-9 years Numerator: Denominator: Rate: 10-17 years Numerator: Denominator: Rate: Combined rate (5-17 years) Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent receiving appropriate medications 5-9 years Numerator: 2182 Denominator: 2392 Rate: 91.2 10-17 years Numerator: 2399 Denominator: 2711 Rate: 88.5 Combined rate (5-17 years) Numerator: 4728 Denominator: 5284 Rate: 89.5 Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent receiving appropriate medications 5-9 years Numerator: 2566 Denominator: 2673 Rate: 96 10-17 years Numerator: 2829 Denominator: 3047 Rate: 92.8 Combined rate (5-17 years) Numerator: 5549 Denominator: 5907 Rate: 93.9 Additional notes on measure:
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: Percent receiving appropriate medications	**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:

How did your performance in 2007 compare with the Annual Performance Objective documented in your 2006 Annual Report? Scores continue to steadily improve each year and we continue to work with plans that have scores below the average.

Are there any quality improvement activities that contribute to your progress?

Annual Performance Objective for FFY 2008: Improved performance rate for the 5-18 year old group as well as a 2% increase in each age group.

Annual Performance Objective for FFY 2009: A 2% increase in each age group.

Annual Performance Objective for FFY 2010: A 2% increase in each age group.

Explain how these objectives were set: MRMIB wants improved performance in the use of Appropriate Mediaton for Children with Asthma for the 5-18 year old group as well as a 2% increase in each age group.

Other Comments on Measure: Based upon the data submitted by the plans, it can be imputed that 94% of all applicable HFP enrollees who were identified as having persistent asthma were appropriately prescribed medication during the measurement year. This represents a 5% increase from the previous measurement year.

MEASURE: Children's Access to Primary Care Practitioners

FFY 2005	FFY 2006	FFY 2007
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*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2004	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2005	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2007
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 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: Plans provide a random sample of summary data as well as member level data that is certified by an independent auditor. The random sample is 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. MRMIB calculates percentages and compares the results with those submitted by the 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 numerator: Plans provide a random sample of summary data as well as member level data that is certified by an independent auditor. The random sample is 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. MRMIB calculates percentages and compares the results with those submitted by the 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:

FFY 2005	FFY 2006	FFY 2007
Year of Data: 2005	**Year of Data:** 2006	**Year of Data:** 2006

FFY 2005	FFY 2006	FFY 2007
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Percent with a PCP visit 12-24 months Numerator: 8129 Denominator: 8904 Rate: 91.3 25 months-6 years Numerator: 92350 Denominator: 113441 Rate: 81.4 7-11 years Numerator: 79199 Denominator: 97579 Rate: 81.2 12-19 years Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with a PCP visit 12-24 months Numerator: 7868 Denominator: 8476 Rate: 92.8 25 months-6 years Numerator: 102489 Denominator: 117196 Rate: 87.5 7-11 years Numerator: Denominator: Rate: 12-19 years Numerator: Denominator: Rate: Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with a PCP visit 12-24 months Numerator: 17815 Denominator: 18605 Rate: 95.8 25 months-6 years Numerator: 105679 Denominator: 119202 Rate: 88.7 7-11 years Numerator: 108008 Denominator: 121337 Rate: 89 12-19 years Numerator: 139907 Denominator: 162411 Rate: 86.1 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:

How did your performance in 2007 compare with the Annual Performance Objective documented in your 2006 Annual Report? Scores continue to steadily improve each year and we continue to work with plans that have scores below the average.

Are there any quality improvement activities that contribute to your progress?

Annual Performance Objective for FFY 2008: A 2% increase in each age group.

Annual Performance Objective for FFY 2009: A 2% increase in each age group.

Annual Performance Objective for FFY 2010: A 2% increase in each age group.

Explain how these objectives were set: MRMIB wants continued improvement in HFP subscriber Access to Primary Care Practitioners.

Other Comments on Measure: Based upon the data submitted by the plans, it can be imputed that 88% of all applicable HFP enrollees had a visit with a primary care practitioner during the measurement year. This represents a 4% increase from the previous measurement year.

SECTION IIB: ENROLLMENT AND UNINSURED DATA

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

Program	FFY 2006	FFY 2007	Percent change FFY 2006-2007
SCHIP Medicaid Expansion Program	214216	265057	23.73
Separate Child Health Program	1177189	1273359	8.17

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

SCHIP Medicaid Expansion Program: One month bridge caseload continues to grow as a result of implementation of performance standards in July 2005, from 5,221 children in June 2006 to 10,493 children in June 2007. Medicaid expansion caseload grew from 103,091 children in June 2006 to 132,207 children in June 2007. Regular Medi-Cal caseload decreased from 3,161,437 in June 2006 to 3,130,407 in June 2007. 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. We attribute the recent higher growth to the decrease of children in the Regular Medicaid Program. Some children have been placed in different eligibility categories related to the new automated eligibility systems in the counties.

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 2004-2006. 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 2007 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	Std. Error	Rate	Std. Error
1996 - 1998	1,258	82.5	13.1	.9
1998 - 2000	1,164	79.3	11.8	.8

2000 - 2002	968	66.5	9.6	.6
2002 - 2004	848	62.0	8.5	.6
2003 - 2005	835	55.8	8.3	.5
2004 - 2006	829	53.0	8.2	.5
Percent change 1996-1998 vs. 2004-2006	-34.1%	NA	-37.4%	NA

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

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

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.

☒ 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	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
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

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 isued 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.

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

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.

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.

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.

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

During the last quarter of FFY 2006, outreach funding was appropriated to promote public awareness of the SCHIP and Medicaid programs. A $22 million funding allocation was made to those counties where the highest number of eligible (but not enrolled) children resided and to counties that had the highest number of SCHIP and Medicaid enrollment in order to promote retention. The county allocation was to build on the existing local structures, experience and knowledge gained by counties in their efforts to increase enrollment of uninsured children and program retention. County outreach utilizes a wide variety of community-based organizations that perform targeted outreach and enrollment activities to reach large number of children. Targeted, grassroots outreach activities require the counties to provide innovative and culturally appropriate outreach and enrollment approaches. While outreach funding was allocated during FFY 2007, funding was not distributed to the counties.

During FFY 2007 outreach grant funds were awarded to 32 counties to promote outreach, enrollment, retention, and utilization (OERU). A total of 244 Enrollment Entities (EE) participated in OERU. Of the 244, 83 were blocked from regular EE reimbursement payments because their focus was to conduct outreach in enrolling children into the programs. The remaining 161 EEs performed other non-enrollment activities (such as promoting the access and utilization of benefits, etc.). The

2007/08 State Budget did not re-allocate the outreach grant funds and all participating EEs were restored to full payment status for application assistance, effective July 1, 2007.

During the 2006 FFY, 84,059 applications and 78,573 annual renewals were assisted by Certified Application Assistants (CAAs) and approximately $2.8 million was paid to EEs. For the 2007 FFY, 88,317 applications and 88,616 annual renewals were assisted by CAAs and approximately $3.4 million was paid to EEs. Close to 4,300 additional applications and over 10,000 Annual Eligibility Reviews (AERS) were assisted by CAAs. The numbers of applications assisted by CAAs increased by 5% while the number of AERS assisted by CAA increased by 12.8%. The increase in assisted applications and AER forms is attributed, in part, to the increased EE reimbursement.

The number of children enrolled due to CAA help totaled 96,321. This represents 37.2% of the SCHIP eligible children. The number of children that continued to qualify through the help of CAAs at AER totaled 81,524. This represents 15.5% of the SCHIP eligible children at the AER and is a 12.6% increase compared to the 72,424 children that continued to qualify through the help of CAAs at AER in the previous reporting period.

Data source: Administrative Vendor

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 Section 9 of your SCHIP State Plan has changed, please indicate when it changed, and how the goals and objectives in Section 9 of your State Plan and the goals reported in this section of the annual report are different. 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 2005 and FFY 2006) 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 2007).

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 2007.

Final: Check this box if the data you are reporting are considered final for FFY 2007.

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® 2007). 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. 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 2008, 2009, and 2010. Based on your recent performance on the measure (from FFY 2005 through 2007), 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.

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

FFY 2005	FFY 2006	FFY 2007
Goal #1 (Describe) Increase the percentage of Medi-Cal eligible children who are enrolled in the Medi-Cal program.	**Goal #1 (Describe)** Increase the percentage of Medi-Cal eligible children who are enrolled in the Medi-Cal program.	**Goal #1 (Describe)** Increase the percentage of Medi-Cal eligible children who are enrolled in the Medi-Cal program.
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*: Department of Health Services.	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☒ Other. *Specify*: California Department of Health Care Services.
Definition of Population Included in the Measure: Definition of denominator: Eligible children in Medicaid in FFY 2004-2005 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:** 2006
Performance Measurement Data: Described what is being measured: 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: 224000 (# eligible for but not enrolled in HFP in 2001) Denominator: 301000 (# eligible for but not enrolled in HFP in 2003) Rate: 25%; estimated reduction in the percentage of uninsured children in target income families that have family income above no-cost Medi-Cal. Numerator: 224000	**Performance Measurement Data:** Described what is being measured: 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:** Described what is being measured: Analyze changes in number of eligible children in Medicaid in FFY 2006 and 2007. Numerator: Denominator: Rate: Additional notes on measure:

FFY 2005	FFY 2006	FFY 2007
Denominator: 301000 Rate: 74.4 Additional notes on measure:		
	Explanation of Progress: **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **Are there any quality improvement activities that contribute to your progress?**	**Explanation of Progress:** **How did your performance in 2007 compare with the Annual Performance Objective documented in your 2006 Annual Report?** Overall, enrollment in Medi-Cal increased by .001% over 2006. One month bridge caseload continues to grow as a result of implementation of performance standards in July 2005, from 5,221 children in June 2006 to 10, 493 children in June 2007. Medicaid expanision caseload grew from 103,091 children in June 2006 to 132,207 children in June 2007. Regular Medi-Cal caseload decreased from 3,161,437 in June 2006 to 3,130,407 in June 2007. 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. We attribute the recent higher growth in the M-SCHIP Medicaid Expansion Program to the decrease of children in the Regular Medicaid Program. Some children have been placed in different eligibility categories related to the new automated eligibility systems in the counties. **Are there any quality improvement activities that contribute to your progress?**
	Annual Performance Objective for FFY 2007: Achieve improvements in enrolling eligible children. **Annual Performance Objective for FFY 2008:** Achieve improvements in enrolling eligible children. **Annual Performance Objective for FFY 2009:** Achieve improvements in enrolling eligible children. *Explain how these objectives were set:* For 2005: There has been an overall increase of 31,525 in the total number of children in Medi-Cal between June 2004 and June 2005. In the Regular Medi-Cal program, the number of children enrolled increased by 22,592 from 3,178,470 to 3,201,062. In the Medi-Cal Expansion program, the number of children increased by 7,156 from 81,352 to 88,508. In California's One-Month Bridge Program, the number of children enrolled increased by 1,777 from 2,545 to 4,322.	**Annual Performance Objective for FFY 2008:** Achieve improvements in enrolling eligible children. **Annual Performance Objective for FFY 2009:** Achieve improvements in enrolling eligible children. **Annual Performance Objective for FFY 2010:** Achieve improvements in enrolling eligible children. *Explain how these objectives were set:*

FFY 2005	FFY 2006	FFY 2007
Other Comments on Measure: For 2005:The increase in the number of children in the regular Medi-Cal program is due to continuing minor growth in coverage for low-income families (Section 1931(b) of the Social Security Act) and efforts to facilitate the Medi-Cal application process for children through the Child Health and Disability Prevention Program (CHDP) Gateway, Express Lane application through the schools for children eligible for the National School Lunch Prog, and accelerated enrollment for children through the SPE	**Other Comments on Measure:** For 2005:The increase in the number of children in the regular Medi-Cal program is due to continuing minor growth in coverage for low-income families (Section 1931(b) of the Social Security Act) and efforts to facilitate the Medi-Cal application process for children through the Child Health and Disability Prevention Program (CHDP) Gateway, Express Lane application through the schools for children eligible for the National School Lunch Program, and accelerated enrollment for children	**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 2005	FFY 2006	FFY 2007
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 aboe 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:* 2004	**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*: Preview of 2005 CHIS data for report to be issued at the end of January 2007.	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☒ Other. *Specify*: "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:	**Year of Data:**	**Year of Data:**
Performance Measurement Data: Described what is being measured: 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: 224000 (# eligible for but not enrolled in HFP in 2001) Denominator: 301000 (# eligible for but not enrolled in HFP in 2003) Rate: 25%; estimated reduction in the percentage of uninsured children in target income families that have family income above no-cost Medi-Cal.	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described 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: 301000 Denominator: 200000 Rate: 150.5 Additional notes on measure: The numerator is the # eligible for but not enrolled in HFP in 2003. The Denominator is the #eligible for but not enrolled in HFP in 2005). Rate: 30% estimated reduction in the percentage of uninsured children in target income families that have family income above no-cost Medi-Cal.

FFY 2005	FFY 2006	FFY 2007
Numerator: 224000 Denominator: 301000 Rate: 74.4 Additional notes on measure:		
	Explanation of Progress: **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **Are there any quality improvement activities that contribute to your progress?**	**Explanation of Progress:** **How did your performance in 2007 compare with the Annual Performance Objective documented in your 2006 Annual Report?** There is a continued reduction in the percentage of uninsured children in target income families that have family income above no-cost Medi-Cal. **Are there any quality improvement activities that contribute to your progress?**
	Annual Performance Objective for FFY 2007: **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** *Explain how these objectives were set:*	**Annual Performance Objective for FFY 2008:** Continued reduction in the percentage of uninsured children in target income families that have income above no-cost Medi-Cal. **Annual Performance Objective for FFY 2009:** Continued reduction in the percentage of uninsured children in target income families that have 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 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.
Other Comments on Measure: For 2005: According to the 2003 CHIS, only 9.1% of parents were unaware of HFP, compared to 23.3% who were unaware in 2001. California plans to continue utilizing CHIS to measure changes in the number of uninsured children. Collection of new data for the 2005-2007 CHIS survey began in July 2005 and will be completed in December 2005. Data from the 2005 survey should be available beginning in early 2007.	**Other Comments on Measure:**	**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 2005	FFY 2006	FFY 2007
Goal #3 (Describe) Reduce the percentage of children using the emergency room as their usual source of primary care.	**Goal #3 (Describe)** Reduce the percentage of children using the emergency room as their usual source of primary care.	**Goal #3 (Describe)**
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☒ Discontinued. *Explain*: Program does not currently encounter data; therefore, cannot determine if EF utilization is excessive.	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☒ Discontinued. *Explain*: Program does not currently encounter data; therefore, cannot determine if EF utilization is excessive.	**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: Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:
	Explanation of Progress: **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **Are there any quality improvement activities that contribute to your progress?**	**Explanation of Progress:** **How did your performance in 2007 compare with the Annual Performance Objective documented in your 2006 Annual Report?** **Are there any quality improvement activities that contribute to your progress?**

FFY 2005	FFY 2006	FFY 2007
	Annual Performance Objective for FFY 2007: Achieve improvements in enrolling eligible children. **Annual Performance Objective for FFY 2008:** Achieve improvements in enrolling eligible children. **Annual Performance Objective for FFY 2009:** Achieve improvements in enrolling eligible children. *Explain how these objectives were set:*	**Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** **Annual Performance Objective for FFY 2010:** *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:** For 2005: According to the 2003 CHIS, only 9.1% of parents were unaware of HFP, compared to 23.3% who were unaware in 2001. California plans to continue utilizing CHIS to measure changes in the number of uninsured children. Collection of new data for the 2005-2007 CHIS survey began in July 2005 and will be completed in December 2005. Data from the 2005 survey should be available beginning in early 2007.	**Other Comments on Measure:**

Objectives Related to SCHIP Enrollment

FFY 2005	FFY 2006	FFY 2007
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 proces 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: N/A Definition of numerator: N/A	**Definition of Population Included in the Measure:** Definition of denominator: N/A Definition of numerator: N/A	**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: Described 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:	**Performance Measurement Data:** Described 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:	**Performance Measurement Data:** Described 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:

FFY 2005	FFY 2006	FFY 2007
	Explanation of Progress: **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **Are there any quality improvement activities that contribute to your progress?**	**Explanation of Progress:** **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** In FFY 2007, the State streamlined the enrollment process by no longer requiring initial premium payments and applicants' plan selections to be included with the applications. Eligible children are no longer denied SCHIP coverage when payments and plan selections are not provided during the application process. Instead, applicants receive a monthly billing statement for the child's first full month's coverage. in the event the applicant does not provide plan selections, SCHIP contacts the applicant and requests the information. However, if the applicant does not provide the plan selections, the eligible child is assigned to the community provider plan and alternately assigned to the dental and vision plans. In the past, an estimated 140,000 eligible children did not get enrolled or experienced delay in enrollment into SCHIP as a result of not providing the premium payments or identifying plan selections. **Are there any quality improvement activities that contribute to your progress?** 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, in November 2006, the SCHIP Administrative Vendor was 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.

FFY 2005	FFY 2006	FFY 2007
	Annual Performance Objective for FFY 2007: Currently, the existing application is close to a 10th grade reading level. The State has developed an application that is easier to understand and read 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, effectively communicating/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. **Annual Performance Objective for FFY 2008:** California is partnering with two private philanthropic foundations to expand the access of the existing on-line electronic application process for general public use. When the on-line application is used, the overall amount of missing information is reduced dramatically because of the step-by-step process required to complete the application. For example, the electronic application provides automated 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. **Annual Performance Objective for FFY 2009:** To be determined *Explain how these objectives were set:* Applicants can receive enrollment instructions, applications, and handbooks in 10 languages. These languages include English, Spanish, Vietnamese, Khmer (Cambodian), Armenian, Cantonese, Korean, Russian, Hmong and Farsi. In addition, HFP has all correspondence, billing invoices, and other program notification materials available in 5 languages: English, Spanish, Chinese, Korean, and Vietnamese.	**Annual Performance Objective for FFY 2008:** The existing application is at a 10th grade reading level. The State has developed an application that is easier to understand and read 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. **Annual Performance Objective for FFY 2009:** 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. 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 a pay stubs or tax forms. Electronic verification of self-declared income will be instituted. This process is aimed at increasing retention and program effeciency. **Annual Performance Objective for FFY 2010:** TBD. *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to SCHIP Enrollment (Continued)

FFY 2005	FFY 2006	FFY 2007
Goal #2 (Describe) Ensure the participation of community-based organizations in outreach/education activities.	**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/CAA's in the application and retention processes and community-based organization.
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 and HFP Enrollment Data..	**Data Source:** ☒ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☒ Other. *Specify*: Enrollment Entity Agreements and HFP Enrollment Data.	**Data Source:** ☒ Eligibility/Enrollment data. ☐ Survey data. *Specify*: ☒ Other. *Specify*: Enrollment Entity Agreements and HFP Enrollment Data.
Definition of Population Included in the Measure: Definition of denominator: N/A Definition of numerator: N/A	**Definition of Population Included in the Measure:** Definition of denominator: N/A Definition of numerator: N/A	**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: Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Increased number of EE/CAAs providing application assistance to families. Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Increased number of EE/CAAs providing application assistance to families. Numerator: Denominator: Rate: Additional notes on measure:

FFY 2005	FFY 2006	FFY 2007
	Explanation of Progress: **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **Are there any quality improvement activities that contribute to your progress?**	**Explanation of Progress:** **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** Since the increase in the amount of payments to Enrollment Entities (EEs) for assisted applications, on-line applications and Annual Eligibility Review (AER) forms on July 1, 2006, EE participation increased steadily since the last reporting period. The number of EEs increased from 2,037 to 2,630. This is a 23% increase in the number of participating EEs. In addition, 18,862 CAAs were available to assist families in applying for the SCHIP and Medicaid programs as of September 2007. With approximately 1,800 new CAA's since the last reporting period, this is a 10% increase in CAA participation. This is an average of 150 new CAAs being trained each month. A total of 309,661 applications were received at the Single Point of Entry (SPE) Of the applications received at SPE, a total of 88,371 applications were assisted by Certified Application Assistants (CAA's). This represents 29% of all applications received at SPE. **Are there any quality improvement activities that contribute to your progress?**
	Annual Performance Objective for FFY 2007: Although there was significant increase in the number of EEs/CAAs providing assistance to families compared to the previous reporting period, the State's objective is to increase the number of EE/CAA participation. EEs/CAAs assist families in filling out the applications and SCHIP AER forms, ensuring that all necessary documentation is included in order for the applications to be considered complete. The level of EE/CAA participation typically results in more complete applications 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 process. **Annual Performance Objective for FFY 2008:** 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 2008:** Although there was 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. **Annual Performance Objective for FFY 2009:** Continue to encourage and increase community-based organizations' and EEs/CAAs participation in outreach for the Medicaid and SCHIP programs.

FFY 2005	FFY 2006	FFY 2007
	Annual Performance Objective for FFY 2009: Continue to encourage and increase community-based organizations' and EEs/CAAs' participation in outreach for the Medicaid and SCHIP programs. *Explain how these objectives were set:*	**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. *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:** Effective July 1, 2005, the EE/CAA reimbursement process was restored for each successful application where a child(ren) is enrolled. Effective July 1, 2006, the EE/CAA reimbursement process increased the amount for on-line applications submitted. For each successful on-line application where a child(ren) is enrolled (in SCHIP and for each application forwarded to the Medi-Cal program, the amount increased from $50 to $60.	**Other Comments on Measure:**

Objectives Related to SCHIP Enrollment (Continued)

FFY 2005	FFY 2006	FFY 2007
Goal #3 (Describe)	**Goal #3 (Describe)**	**Goal #3 (Describe)** Streamling 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: Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:
	Explanation of Progress: **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **Are there any quality improvement activities that contribute to your progress?**	**Explanation of Progress:** **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** Not applicable. New goal, thus not previously identified in prior report **Are there any quality improvement activities that contribute to your progress?** Not applicable. New goal, thus not previously identified in prior report

FFY 2005	FFY 2006	FFY 2007
	Annual Performance Objective for FFY 2007: Currently, the existing application is close to a 10th grade reading level. The State has developed an application that is easier to understand and read 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, effectively communicating/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. **Annual Performance Objective for FFY 2008:** California is partnering with two private philanthropic foundations to expand the access of the existing on-line electronic application process for general public use. When the on-line application is used, the overall amount of missing information is reduced dramatically because of the step-by-step process required to complete the application. For example, the electronic application provides automated 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. **Annual Performance Objective for FFY 2009:** To be determined *Explain how these objectives were set:* Applicants can receive enrollment instructions, applications, and handbooks in 10 languages. These languages include English, Spanish, Vietnamese, Khmer (Cambodian), Armenian, Cantonese, Korean, Russian, Hmong and Farsi. In addition, HFP has all correspondence, billing invoices, and other program notification materials available in 5 languages: English, Spanish, Chinese, Korean, and Vietnamese.	**Annual Performance Objective for FFY 2008:** Continue to streamline the enrollment process between Medicaid and SCHIP. While the State implemented a paper process for the counties to forward annual re-determiniation information to SCHIP when children no longer qualify for Medicaid, the State plans on implementing an electronic process in receiving the information from the counties. **Annual Performance Objective for FFY 2009:** In FFY 2007, the State delayed for one year, due to Budget constraints, the implementation an 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 until an SCHIP eligbility determination is made. The new process will replace Medicaid one-month bridge coverage with SCHIP Presumtive Eligibility until SCHIP makes an eligibility determination. **Annual Performance Objective for FFY 2010:** TBD *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to Medicaid Enrollment

FFY 2005	FFY 2006	FFY 2007
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: Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:
	Explanation of Progress: **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **Are there any quality improvement activities that contribute to your progress?**	**Explanation of Progress:** **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **Are there any quality improvement activities that contribute to your progress?**

FFY 2005	FFY 2006	FFY 2007
	Annual Performance Objective for FFY 2007: **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** *Explain how these objectives were set:*	**Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** **Annual Performance Objective for FFY 2010:** *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to Medicaid Enrollment (Continued)

FFY 2005	FFY 2006	FFY 2007
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: Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:
	Explanation of Progress: **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **Are there any quality improvement activities that contribute to your progress?**	**Explanation of Progress:** **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **Are there any quality improvement activities that contribute to your progress?**

FFY 2005	FFY 2006	FFY 2007
	Annual Performance Objective for FFY 2007: **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** *Explain how these objectives were set:*	**Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** **Annual Performance Objective for FFY 2010:** *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

Objectives Related to Medicaid Enrollment (Continued)

FFY 2005	FFY 2006	FFY 2007
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: Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:	**Performance Measurement Data:** Described what is being measured: Numerator: Denominator: Rate: Additional notes on measure:
	Explanation of Progress: **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **Are there any quality improvement activities that contribute to your progress?**	**Explanation of Progress:** **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **Are there any quality improvement activities that contribute to your progress?**

FFY 2005	FFY 2006	FFY 2007
	Annual Performance Objective for FFY 2007: **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** *Explain how these objectives were set:*	**Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** **Annual Performance Objective for FFY 2010:** *Explain how these objectives were set:*
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

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

FFY 2005	FFY 2006	FFY 2007
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. *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*: 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: ☒ 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:** 2006
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:

FFY 2005	FFY 2006	FFY 2007
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: 0.30 Additional notes on measure:
	Explanation of Progress: **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **Are there any quality improvement activities that contribute to your progress?** **Annual Performance Objective for FFY 2007:** MRMIB will continue to offer a broad range of options to subscribers across the State **Annual Performance Objective for FFY 2008:** MRMIB will continue to offer a broad range of options to subscribers across the State **Annual Performance Objective for FFY 2009:** MRMIB will continue to offer a broad range of options to subscribers across the State *Explain how these objectives were set:*	**Explanation of Progress:** **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** There were fewer subscribers who had a choice of only one health plan and there were more counties where subscribers had the choice of 3 or more health plans. **Are there any quality improvement activities that contribute to your progress?** **Annual Performance Objective for FFY 2008:** At Least 95% of HFP subscribers will have a choice of two or more health plans. **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. *Explain how these objectives were set:* This was an original and is an ongoing objective of the HFP program.
Other Comments on Measure: For 2005: A total of 26 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 who had a choice of only one health plan mostly resided in rural areas of the state where access to health care services are limited. These subscribers were enrolled in exclusive provider organization plans (EPO) that provide a broad network of providers.	**Other Comments on Measure:** 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 0.30% of subscribers who have a choice of only one health plan mostly reside in rural areas of the state where access to health care services are limited. These subscribers are enrolled in exclusive provider organization plans (EPO) that provide a broad network of providers.	**Other Comments on Measure:**

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

FFY 2005	FFY 2006	FFY 2007
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 providers for all Healthy Families Program Members.	**Goal #2 (Describe)** Ensure broad access in each county to Traditional and Safety Net Providers for all Healthy Families Program members.
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-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 Healthy Families Program (HFP) health plans.	**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: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:
Year of Data: 2005	**Year of Data:** 2006	**Year of Data:** 2006
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: 62 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:

FFY 2005	FFY 2006	FFY 2007
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: Rate: The data is being analyzed.
	Explanation of Progress: **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **Are there any quality improvement activities that contribute to your progress?** **Annual Performance Objective for FFY 2007:** We will continue to measure levels of TS&N Providers participating in HFP and continue to provide subscribers with the option of choosing TS&N providers. **Annual Performance Objective for FFY 2008:** We will continue to measure levels of TS&N Providers participating in HFP and continue to provide subscribers with the option of choosing TS&N providers. **Annual Performance Objective for FFY 2009:** We will continue to measure levels of TS&N Providers participating in HFP and continue to provide subscribers with the option of choosing TS&N providers. *Explain how these objectives were set:*	**Explanation of Progress:** **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** Data for 2006 will not be released until next year because data is being analyzed every other year. **Are there any quality improvement activities that contribute to your progress?** **Annual Performance Objective for FFY 2008:** Continue to encourage health plans to contract with T&SN providers. **Annual Performance Objective for FFY 2009:** Continue to encourage health plans to contract with T&SN providers. **Annual Performance Objective for FFY 2010:** Continue to encourage health plans to contract with T&SN providers. *Explain how these objectives were set:* This was an original and is an ongoing objective of the HFP program.
Other Comments on Measure: For 2004, 2005 and 2006: HFP participating health plans continue to include T&SN providers in their network and to participate in the competition for the one designated plan allowed to offer the HFP product at a discount. For both 2004 and 2005, 62% of HFP members either selected or were assigned a TSN primary care physician. Data for 2006 will not be released until next year. This rate has remained consistent from 2002 through 2005.	**Other Comments on Measure:** For 2004, 2005 and 2006: HFP participating health plans continue to include T&SN providers in their network and to participate in the competition for the one designated plan allowed to offer the HFP product at a discount. For both 2004 and 2005, 62% of HFP members either selected or were assigned a TSN primary care physician. Data for 2006 will not be released until next year. This rate has remained consistent from 2002 through 2005.	**Other Comments on Measure:**

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

FFY 2005	FFY 2006	FFY 2007
Goal #3 (Describe)	**Goal #3 (Describe)**	**Goal #3 (Describe)** Improve the percentage of children receiving serious emotional disorder (SED) specialized services.
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*: MRMIB is unable to predict the number of children receiving CCS services because the percentage of children receiving these services depends on the number of children with illnesses that meet CCS requirements. However, MRMIB is using CAHPS to provide information aobut the satisfaction of parents who have children receiving CCS services. MRMIB will report the results in the 2008 Federal Annual Report.
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-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*: HFP enrollment, CCS, and County Mental Health Data.
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*: 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:	**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:
Year of Data:	**Year of Data:** 2006	**Year of Data:** 2004
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:

FFY 2005	FFY 2006	FFY 2007
Additional notes on measure:	Additional notes on measure:	Additional notes on measure:
Other Performance Measurement Data: 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: Numerator: Number of Children receiving SED services. Denominator: Total HFP population. Rate: Data not yet available.
	Explanation of Progress: **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **Are there any quality improvement activities that contribute to your progress?** **Annual Performance Objective for FFY 2007:** **Annual Performance Objective for FFY 2008:**	**Explanation of Progress:** **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** The percentage of children receiving CCS services remained the same. **Are there any quality improvement activities that contribute to your progress?** **Annual Performance Objective for FFY 2008:** The utilization rates for SED services will increase by 1%. MRMIB is conducting a study of how health plans provide mental health and substance abuse services to HFP subscribers, as well as how they coordinate services with providers. The study will also have focus groups that will ask parents about the quality of mental health or substance abuse services received by their children. The results of the 2 year study will provide MRMIB the information it needs to work with the plans and the counties to ensure proper coordination of services and ensure increased utilization of services by HFP subscribers. **Annual Performance Objective for FFY 2009:** The utilization rates for SED services will increase by 1%. We 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 programs regarding barriers to access, referral issues, subscriber complaints, and treatment/payment coverage. Identify and resolve at least two issues per year.

FFY 2005	FFY 2006	FFY 2007
	Annual Performance Objective for FFY 2009: *Explain how these objectives were set:*	**Annual Performance Objective for FFY 2010:** The utilization rates for SED services will increase by 1%. We 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 programs regarding barriers to access, referral issues, subscriber complaints, and treatmentment/payment coverage. Identify and resolve at least two issues per year. *Explain how these objectives were set:* MRMIB wants increases in the number of HFP children receiving SED services.
Other Comments on Measure:	**Other Comments on Measure:**	**Other Comments on Measure:**

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

FFY 2005	FFY 2006	FFY 2007
Goal #1 (Describe) Maintain or improve the percentage of children receiving CCS and mental health (SED) speacialized services	**Goal #1 (Describe)** Maintain or improve the percentage of children receiving CCS and mental health (SED specialized services	**Goal #1 (Describe)** Ensure all HFP children receive an annual dental 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*: 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.
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*: 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, 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*: HEDIS 2007
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☒ Other. *Specify*: HFP enrollment, CCS, and County mental health data.	**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) dental 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: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: The number of children ages 2 through 18 years who were continuously enrolled during the measurement year and had at least one dental visit.
Year of Data: 2004	**Year of Data:** 2005	**Year of Data:** 2006
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: 197133 Denominator: 305200 Rate: 64.6

FFY 2005	FFY 2006	FFY 2007
Additional notes on measure:	Additional notes on measure:	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: Numerator: Number of Children Receiving CCS or SED Services Denominator: Total HFP population Rate: CCS: 3%; SED: Data not yet available.	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:
	Explanation of Progress: **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **Are there any quality improvement activities that contribute to your progress?** **Annual Performance Objective for FFY 2007:** Assure children needing these services receive them. We will continue to monitor rates of children receiving these services and work with stakeholders to see if rates improve service levels. **Annual Performance Objective for FFY 2008:** Assure children needing these services receive them. We will continue to monitor rates of children receiving these services and work with stakeholders to see if rates improve service levels. **Annual Performance Objective for FFY 2009:** Assure children needing these services receive them. We will continue to monitor rates of children receiving these services and work with stakeholders to see if rates improve service levels. *Explain how these objectives were set:*	**Explanation of Progress:** **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** This is the first year the scores for Annual Dental Visit were reported in the Annual Report. **Are there any quality improvement activities that contribute to your progress?** **Annual Performance Objective for FFY 2008:** Revise the dental quality measures reported by the dental plans. **Annual Performance Objective for FFY 2009:** A 2% increase each year. **Annual Performance Objective for FFY 2010:** A 2% increase each year. *Explain how these objectives were set:* MRMIB wants increases in the number of HFP children who receive an annual dental visit.

FFY 2005	FFY 2006	FFY 2007
Other Comments on Measure: Numberator: Number of children receiving CCS or SED Services. Denominator: Total HFP Population. Rate: CCS: 2.5%, SED 0.7%	**Other Comments on Measure:** The percentage of children receiving CCS services has remained constant over the last 2 reporting periods (July 03-June 04; July 04-June05). The percentage of children receiving SED services has increased slightly over 2 reporting periods (July 02-June 03; July 03-June 04).	**Other Comments on Measure:**

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

FFY 2005	FFY 2006	FFY 2007
Goal #2 (Describe) Ensure no break in coverage for children who access CCS and SED specialized services	**Goal #2 (Describe)** Ensure no break in coverage for children who access CCS and SED specialized services	**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:*
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-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*: HFP enrollment, CCS and County mental health data.	**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*:
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: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:
Year of Data: 2003	**Year of Data:** 2004	**Year of Data:**
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:

FFY 2005	FFY 2006	FFY 2007
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: **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **Are there any quality improvement activities that contribute to your progress?** **Annual Performance Objective for FFY 2007:** Implementation of recommendations from an evaluation of SED/Mental Health Services in Healthy Families such as: Creation of state-wide forum of health plans and county mental health departments to discuss issues related to referrals, assessment and treatment Redesign of referral process Research and Development of standardized assessment tool; Emphasis on early and periodic screening; Increased Communication between counties, plans and providers Continuous communication between State, health, dental and vision plans and the county CCS and MH programs regarding barriers to access, referral issues, subscriber complaints, and treatment/payment coverage **Annual Performance Objective for FFY 2008:** Continuous communication between State, health, dental and vision plans and the county programs regarding barriers to access, referral issues, subscriber complaints, and treatment/payment coverage **Annual Performance Objective for FFY 2009:** Continuous communication between State, health, dental and vision plans and the county programs regarding barriers to access, referral issues, subscriber complaints, and treatment/payment coverage *Explain how these objectives were set:*	**Explanation of Progress:** **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **Are there any quality improvement activities that contribute to your progress?** **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** **Annual Performance Objective for FFY 2010:** *Explain how these objectives were set:*

FFY 2005	FFY 2006	FFY 2007
Other Comments on Measure: For 2005: The State continues to monitor access to services for children with special health care needs as it has since the inception of the program. To ensure coordination of care for HFP subscribers who are eligible for the CCS and county mental health services, the Managed Risk Medical Insurance Board (MRMIB) developed a Memorandum of Understanding (MOU) for use by HFP participating plans and county CCS and mental health programs.	**Other Comments on Measure:** For 2006: Memorandums of Understanding (MOUs) between participating HFP plans and county CCS and mental health plans and county CCS and mental health programs ensure the coordination of care for HFP subscribers. In addition, ongoing meetings and the use of newsletters allow the State, health, dental and vision plans and the county programs to maintain open communication on such topics as barriers to access, referral issues, subscriber complaints, and treatment/payment coverage.	**Other Comments on Measure:**

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

FFY 2005	FFY 2006	FFY 2007
Goal #3 (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 #3 (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 #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:*
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: 2005 measure of access.	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: 2005 measure of access.	**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 Healthy Families Program (HFP) health plans.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. *Specify*: ☐ Other. *Specify*:
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: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator:
Year of Data: 2004	**Year of Data:** 2005	**Year of Data:**
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:

FFY 2005	FFY 2006	FFY 2007
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: **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **Are there any quality improvement activities that contribute to your progress?** **Annual Performance Objective for FFY 2007:** Working with plans to improve scores via Quality Performance Improvement Project. Participating health plans with higher scores will share best practices and lower scoring plans submit a corrective action plan to improve these scores **Annual Performance Objective for FFY 2008:** Working with plans to improve scores via Quality Performance Improvement Project. Participating health plans with higher scores will share best practices and lower scoring plans submit a corrective action plan to improve these scores **Annual Performance Objective for FFY 2009:** Working with plans to improve scores via Quality Performance Improvement Project. Participating health plans with higher scores will share best practices and lower scoring plans submit a corrective action plan to improve these scores *Explain how these objectives were set:*	**Explanation of Progress:** **How did your performance in 2006 compare with the Annual Performance Objective documented in your 2005 Annual Report?** **Are there any quality improvement activities that contribute to your progress?** **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** **Annual Performance Objective for FFY 2010:** *Explain how these objectives were set:*
Other Comments on Measure: For 2005: Based upon findings, plans with low scores continue to improve. Some scores have been impacted by poor methods of collecting data. Plans with scores above 80% on HEDIS measures continue to have somewhat consistent high scores. Health plans are contacted for clarification if there is more than a 10% change and an explanation has not already been provided.	**Other Comments on Measure:** For 2006: Based upon the data submitted by the plans, it can be imputed that 87% of all applicable HFP enrollees had access to a primary care physician in the measurement year, an improvement of 7 percentage points from 2005.	**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: Fact Sheets: Fact Sheets are submitted annually by each health, dental and vision plan interested in participating in the Healthy Families Program (HFP). Fact Sheets request information about the organization of the plans and the provision of health, dental and vision care services. 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, heathcare effectiveness, and access because these areas are vital to young children and are the cornerstone of the HFP. The HEDIS (Healthcare Effectiveness Data Information Set) is used as a basis for the current measures. The measures collected in 2006-07 were: Childhood Immunization Status, Well Child Visits in the 3rd, 4th, 5th, and 6th years of life, Well-Child Visits during the First 15 months of Life, Adolescent Well-Care Visits, Children's and Adolescent's Access to Primary Care Practitioners, Use of Appropriate Medications for People with Asthma, Mental health Utilization, Identification of Alcohol and Other Drug Services. The following HEDIS measures have been added to the 2007-08 Health Plan data reporting requirements: Chlamydia Screening for Women, Appropriate Treatment for Children with Upper Respiratory Infection, Appropriate Testing for Children with Pharyngitis, and Lead Screening (for reporting in 2009). HFP plan scores remain better than Medicaid and comparable commercial plans for several years with the exception of scores for the Follow-up after Hospitalization for Mental Illness HEDIS measure. In 2006-07 the Follow-up after Hospitalization for Mental illness HEDIS measure was replaced with the Mental Health Utilization (Inpatient, Intermediate, and Ambulatory Services)HEDIS measure. MRMIB believes the new measure will provide a more complete and accurate picture of the utilization of mental health services by HFP subscribers. Member Satisfaction Surveys: MRMIB collects data on HFP subscriber satisfaction though satisfactions and by monitoring subscriber complaints. Consumer satisfaction surveys for both health and dental plans are conducted each year that 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). The surveys were administered in five languages-English, Spanish, Chinese, Korean, and Vietnamese. The CAHPS survey results reveal that the program has maintained virtually the same level of satisfaction since the survey was done in 2003. The 2006 CAHPS survey overall scores are comparable to other SCHIP and Medicaid programs. The D-CAHPS survey provides information on access to care and levels of satisfaction with dental plans, dental providers and overall dental care. Scores in the 2006 D-CAHPS survey generally remained the same from 2003. The results of the 2006 survey indicate that members continue to report lower levels of satisfaction with Dental Maintenance Organizations (DMO's) compared to dental Exclusive Provider Organizations (EPO's). The YAHCSsurvey results will provide a 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. Disenrollment surveys, subscriber complaints, California Children Services, Mental Health Referral Reports, Cultural and Linguistic Services Reports, Group needs assessments, are additional strategies used by MRMIB.

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?

MRMIB has added the following HEDIS® performance measures to the 2005-2008 health and dental plan contracts for reporting in 2008-09: Appropriate Treatment for Children with Upper Respiratory Infection,Appropriate Testing for Children with Pharyngitis, Chlamydia Screening for Women, Lead Screening (for reporting in 2009). The data for these performance measures will be reported in the 2008 Federal Annual Report. Encounter/Claims Data: MRMIB is developing an encounter/claims database that will 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. Plans will begin reporting data in mid-2008. Dental Quality Measures: A recent Dental Plan Quality Measurement Report identified low percentages of HFP subscribers receiving a number of dental services, including an initial dental visit, periodic dental visits, prophylaxis (preventive care), and dental sealants. Quality Performance Improvement - MRMIB contacted each participating dental plan to discuss what may be causing the low percentage scores reported in the Dental Plan Quality Measurement

Report. Plans were asked to provide corrective action strategies and timelines for implementation of those strategies. MRMIB also identified best practices among the participating dental plans and shared those best practices as part of the feedback to the plans. New Dental Quality Measures - 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 final recommendations for new dental measures will be reported by plans in 2009 for the 2008 reporting year.

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. 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 by researchers from the University of California, San Francisco. This Phase consisted of an evaluation of Serious Emotional Disturbance (SED) services provided through county mental health programs. The focus of this evaluation was to determine whether HFP subscribers are receiving adequate treatment for SED and to assess the adequacy of coordination of services between health plans and counties. The Phase I study results provide MRMIB the opportunity to promote coordination and communication between the health plans and the counties and to more accurately monitor the extent to which HFP SED children are receiving needed care.

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 12/1/07.

Mental Health Workgroup

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

- HFP plan and county mental health liaisons
- MRMIB staff
- Members of the County Mental Health Directors Association
- 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.

Young Adult Health Care Survey (YAHCS): Administered for the first time in 2006, the YAHCS provides information about the experiences of teens in HFP and their unique health care needs. The young adult survey assesses the degree to which teens aged 14 through 18 receive recommended preventive counseling and screening.

Data collection for the 2007 survey began in September 2007 and will provide trend data for comparison. Information about the 2007 young adult survey will be included in the 2008 Federal Annual Report.

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.

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

SECTION III: ASSESSMENT OF STATE PLAN AND PROGRAM OPERATION

Please reference and summarize attachments that are relevant to specific questions

OUTREACH

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

During the last quarter of FFY 2006, outreach funding was appropriated to promote public awareness of the SCHIP and Medicaid programs. A $22 million funding allocation was made to those counties where the highest number of eligible (but not enrolled) children resided and to counties that had the highest number of SCHIP and Medicaid enrollment in order to promote retention. The county allocation was to build on the existing local structures, experience and knowledge gained by counties in their efforts to increase enrollment of uninsured children and program retention. County outreach utilizes a wide variety of community-based organizations that perform targeted outreach and enrollment activities to reach large number of children. Targeted, grassroots outreach activities require the counties to provide innovative and culturally appropriate outreach and enrollment approaches. While outreach funding was allocated during FFY 2007, funding was not distributed to the counties.

During FFY 2007, outreach grant funds were awarded to 32 counties to promote outreach, enrollment, retention, and utilization (OERU). A total of 244 Enrollment Entities (EE) participated in OERU. Of the 244, 83 were blocked from regular EE reimbursement payments because their focus was to conduct outreach in enrolling children into the programs. The remaining 161 EEs performed other non-enrollment activities (such as promoting the access and utilization of benefits, etc.). The 2007/08 State Budget did not re-allocate the outreach grant funds and all participating EEs were restored to full payment status for application assistance, effective July 1, 2007.

During the 2006 FFY, 84,059 applications and 78,573 annual renewals were assisted by Certified Application Assistants (CAAs) and approximately $2.8 million was paid to EEs. For the 2007 FFY, 88,317 applications and 88,616 annual renewals were assisted by CAAs and approximately $3.4 million was paid to EEs. Close to 4,300 additional applications and over 10,000 Annual Eligibility Reviews (AERS) were assisted by CAAs. The numbers of applications assisted by CAAs increased by 5% while the number of AERS assisted by CAA increased by 12.8%. The increase in assisted applications and AER forms is attributed, in part, to the increased EE reimbursement.

The number of children enrolled due to CAA help totaled 96,321. This represents 37.2% of the SCHIP eligible children. The number of children that continued to qualify through the help of CAAs at AER totaled 81,524. This represents 15.5% of the SCHIP eligible children at the AER and is a 12.6% increase compared to the 72,424 children that continued to qualify through the help of CAAs at AER in the previous reporting period.

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? **Would you consider this a best practice? [7500]**

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. 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 309,661 applications were received at the Single Point of Entry (SPE). Of the applications received at SPE, a total of 88,317 applications were assisted by CAAs. This represents 29% of all applications received at SPE.

In addition, a total of 88,616 annual eligibility review forms received were assisted by CAAs. This is a 12.8% increase over the 78,573 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), a total of $5,085,960 was approved for payment to the EEs. 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.

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

A small portion of the outreach funding was allocated to the counties for specific target populations. The counties developed their own approaches in promoting program awareness and retention. Past outreach efforts resulted in increased enrollment in the SCHIP and Medicaid programs.

During the last quarter of the previous reporting period, outreach grant funds were awarded to 32 counties to promote outreach, enrollment, retention, and utilization (OERU). However, due to budget constraints the 2007/08 State Budget did not re-allocate these outreach grant funds.

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). **[7500]**

As policy makers know, the percentage varies by data source used and these sources have their strengths and weaknesses. California uses the California Health Interview Survey (CHIS), which is a state survey, because its sample size is higher than Current Population Survey (CPS), and this allows for better estimates of subgroups. The 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) suggests adjusting CHIS estimates of uninsured children by a factor of 1.6 when absolute size matters. The percentage listed above is not adjusted. For cross state comparison, either CPS should be used or an adjusted CHIS estimate.

Recent economic downturns and recent state population growth were not part of the 2005 CHIS survey. The economic downturns and state population growth will both contribute to a larger number of uninsured than was reported by the 2005 CHIS.

91% - of children below 200% FPL eligible for Medicaid or SCHIP were enrolled according to the 2005 CHIS "The State of Health Insurance in California: Findings from the 2005 California Health Interview Survey" and the California Health Insurance Survey website: http://www.chis.ucla.edu.

SUBSTITUTION OF COVERAGE (CROWD-OUT)

States with a separate child health program up to and including 200% of FPL must complete question 1.

Is your state's eligibility level up to and including 200 percent of the FPL?

- ☒ Yes
- ☐ No
- ☐ N/A

If yes, if you have substitution prevention policies in place, please identify those strategies. **[7500]**

SCHIP precludes enrollment within 3 months of a child having Employer Sponsored Insurance (ESI).

States with a separate child health program above 200 through 250% of FPL must complete question 2. All other states with trigger mechanisms should also answer this question.

Is your state's eligibility level above 200 and up to and including 250 percent of the FPL?

- ☒ Yes
- ☐ No
- ☐ N/A

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

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.

States with separate child health programs over 250% of FPL must complete question 3. All other states with substitution prevention provisions should also answer this question.

Does your state cover children above 250 percent of the FPL or does it employ substitution prevention provisions?

☒ Yes
☐ No
☐ N/A

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

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.

All States must complete the following 3 questions

Describe how substitution of coverage is monitored and measured and how the State evaluates the effectiveness of its policies. **[7500]**

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.

At the time of application, what percent of applicants are found to have insurance? **[7500]**

During the period of October 1, 2006 through September 30, 2007, over 6.8% of the children were determined to be ineligible at the time of initial application, as a result of having other insurance coverage. Of the 6.8% that had other insurance coverage, less than 0.5% had employer-sponsored insurance and 6.3% were receiving health coverage through the Medicaid programs

Describe the incidence of substitution. What percent of applicants drop group health plan coverage to enroll in SCHIP? **[7500]**

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. State data shows that for the period October 2006 through September 2007, less than 0.5% of ineligible children were denied SCHIP coverage due coverage in Employer Sponsored Insurance within the prior three (3) months of applying for coverage.

COORDINATION BETWEEN SCHIP AND MEDICAID

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

Do you have the same redetermination procedures to renew eligibility for Medicaid and SCHIP (e.g., the same verification and interview requirements)? Please explain. **[7500]**

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.

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 for a Medicaid eligibility determination. 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. Up until August 30, 2007, in these cases, coordination between the two programs and continuity of care were ensured by the State granting two additional months of SCHIP "bridge coverage" while the application was being processed for Medicaid eligibility or where the SCHIP is obtaining the applicant's consent to forward the AER application to the CWD.

Effective August 30, 2007, this "bridge coverage" was replaced with Medicaid Presumptive Eligibility. To continue the coordination between the two programs and ensure continuity of care, the Medicaid Presumptive Eligibility places subscribers in Medicaid, if a subscriber is determined ineligible due to income being too low at AER and the applicant has provided consent to forward to 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.

Are the same delivery systems (including 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.

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

ELIGIBILITY REDETERMINATION AND RETENTION

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? **[500]**

At least 3 notifications are sent to the 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, phone calls are also made to the families.

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?) **[500]**

AER packet is sent 60 days before due date, 30-day reminder post-card is sent, courtesy calls are made if an AER is not returned in 30 days prior to the due date and a pending disenrollment letter is sent 15 days prior to disenrollment. 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.

☐ 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) **[500]**

Customized, pre-printed re-enrollment forms are available in 5 languages. 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.

☒ Conducts surveys or focus groups with disenrollees to learn more about reasons for disenrollment *please describe:* **[500]**

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.

☐ Other, *please explain*: **[500]**

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. **[7500]**

Currently, SCHIP does not have data measuring the effectiveness of strategies to retain eligible children.

SCHIP has shown significant retention of eligible children. 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 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.

What percentage of children in the program are retained in the program at redetermination? What percentage of children in the program are disenrolled at redetermination? **[500]**

The 2007 Annual Retention Report shows that of the children enrolled in 2004, 90% continued to be enrolled until they reached the annual eligibility review process. 10% were disenrolled prior to AER as a result of turning 19, nonpayment of premiums, or because applicants requested to disenroll the children from the SCHIP. For calendar year 2005, the retention rate was 78%. In 2004, 77% of the children remained enrolled in SCHIP. In 2003, 70% maintained enrollment.

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 2007 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 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 2006 through September 2007, the number of children disenrolled totaled 265,028. Of this total, approximately 151,699 children were disenrolled during the annual eligibility review process. This represents 57.2% of the total disenrolled. Of the 151,699 children disenrolled at the annual review process, 53,505 children (35%) were disenrolled due to avoidable reasons and 98,103 children (65%) were disenrolled due to unavoidable reasons. Of the total 57.2% disenrolled at annual review, 3.3% obtained employer-sponsored insurance or children were enrolled in Medicaid, while 16.8% were disenrolled due to household income above or below SCHIP guidelines. Additionally, 11.9% were disenrolled due to incomplete annual review information not completed and 25.2% did not return annual review information for processing.

Additionally, of the 265,028 children disenrolled, 113,329 children were disenrolled during the non-AER process. This represents 42.8% of the total disenrolled. Of the 113,329 disenrolled during the non-AER process, 23,235 children (21%) were disenrolled due to avoidable reasons and 65,774 children (79%) were disenrolled due to unavoidable reasons. Of the total 42.8% disenrolled during the non-AER process, 1.4% did not provide citizenship or immigration documentation within the 2 months of enrollment while 7.3% requested disenrollment from SCHIP. Additionally, 9.2% turned 19 and aged-out of SCHIP and 24.9% were disenrolled due to non-payment of premium.

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

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

Total Number of Dis-enrollees	**Obtain other public or private coverage**		**Remain uninsured**		**Age-out**		**Move to new geographic area**		**Other**	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
265028	8800	3			24319	9				

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 related information on the

MRMIB 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 different 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.

COST SHARING

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

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.

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

The State has not conducted an assessment of the effect of cost sharing on utilization of health services. However, many services provided in the SCHIP do not require copayments. The program was designed with this feature to eliminate a potential barrier to services. Preventative health and dental services and all inpatient services are provided without co-payment. Copayments 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 are Seriously Emotionally Disturbed (SED).

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

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

Adults

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

☐ Family Coverage Waiver under the State Plan
☐ SCHIP Section 1115 Demonstration
☐ Health Insurance Flexibility & Accountability Demonstration
☐ Premium Assistance under the Medicaid State Plan (Section 1906 HIPP)

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

☐ Parents and Caretaker Relatives
☐ Childless Adults
☐ Pregnant Women

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, etc.) **[7500]**

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

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

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

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. **(For states offering premium assistance under a family coverage waiver or for states offering employer sponsored insurance or premium assistance under a demonstration.) [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]**

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

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]**

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.

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

29 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 : **[7500]**

The State 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.

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

SECTION IV: PROGRAM FINANCING FOR STATE PLAN

1. Please complete the following table to provide budget information. Describe in narrative any details of your planned use of funds below, including the assumptions on which this budget was based (per member/per month rate, estimated enrollment and source of non-Federal funds). (*Note: This reporting period =Federal Fiscal Year 2007. 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	**2007**	**2008**	**2009**
Insurance payments			
Managed Care	848137470	1191741693	1243226590
Fee for Service	653295380	770768562	805270154
Total Benefit Costs	1501432850	1962510255	2048496744
(Offsetting beneficiary cost sharing payments)	-69404804	-83782723	-113359512
Net Benefit Costs	$ 1432028046	$ 1878727532	$ 1935137232

Administration Costs

Personnel			
General Administration	105650521	98248505	100223502
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/Marketing costs	739552	7936313	6666709
Other (e.g., indirect costs)			
Health Services Initiatives			
Total Administration Costs	106390073	106184818	106890211
10% Administrative Cap (net benefit costs ÷ 9)	159114227	208747504	215015248

Federal Title XXI Share	999971777	1290193028	1327317838
State Share	538446342	694719322	714709605

TOTAL COSTS OF APPROVED SCHIP PLAN	1538418119	1984912350	2042027443

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

- ☒ State appropriations
- ☒ County/local funds
- ☐ Employer contributions
- ☒ Foundation grants
- ☐ Private donations
- ☐ Tobacco settlement
- ☐ Other (specify) **[500]**

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? **[1500]**

no

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.

	2007		2008		2009	
	# of eligibles	$ PMPM	# of eligibles	$ PMPM	# of eligibles	$ PMPM
Managed Care	779784	$ 92	876226	$ 101	928438	$ 96
Fee for Service		$		$		$

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

SECTION V: 1115 DEMONSTRATION WAIVERS (FINANCED BY SCHIP)

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

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

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]**

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)	**2007**	**2008**	**2009**	**2010**	**2011**
Benefit Costs for Demonstration Population #1 (e.g., children)					
Insurance Payments					
Managed care per member/per month rate @ # of eligibles					
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. **[500]**

Other notes relevant to the budget: **[7500]**

SECTION VI: PROGRAM CHALLENGES AND ACCOMPLISHMENTS

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 interest and support for coverage for children, both in the Administration and the Legislature even during a difficult fiscal situation. Governor Schwarzenegger's top priority is ensuring Californians have access to affordable health care with particular emphasis on children.

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

Three significant challenges include:

- The CMS August 17, 2007 letter that, 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%, called for in the Governor's health care reform proposal and included in ABX 1X, 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's SCHIP Parental Waiver that includes the authority to operate a SCHIP 2-Month Bridge Program into Medicaid Program expired in March 2007. The federal Centers for Medicare and Medicaid Services (CMS) informed the Managed Risk Medical Insurance Board (MRMIB) that the waiver would not be renewed. This waiver allowed uninterrupted health coverage for children who lost SCHIP eligibility during the annual eligibility review (AER) for an additional 2 months. Therefore, due to the State's goal to streamline children's enrollment process into the Medicaid Program, the State implemented a new program for those children who were enrolled in the SCHIP program but whose family income level decreased below the SCHIP income guidelines. After being disenrolled from SCHIP, these children may be enrolled into the Medicaid Presumptive Eligibility Program until Medicaid completes the children's eligibility determinations.

- During the last quarter of FFY 2006, outreach funding was allocated for public awareness to promote outreach, enrollment, retention and utilization (OERU) for the SCHIP and Medicaid programs. OERU funding allocation occurred at a county level to those counties where the highest number of eligible (but not enrolled) children resided and to counties that had the highest number of SCHIP and Medicaid enrollment in order to promote retention. However, the 2007/2008 State Budget did not re-allocate OERU funding. Thus, counties no longer receive state funding to perform outreach and enrollment activities to promote public awareness.

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

SCHIP Enrollment Continues to Grow: During the end of the last reporting period, there were 760,000 children enrolled in SCHIP. As of September 30, 2007, over 835,900 children were enrolled in SCHIP, a nearly 10% increase.

Enrollment Streamlining (alternate plan assignment and no initial premium requirement): The State streamlined the enrollment process by no longer requiring a premium payment with the initial application process and also eliminated the requirement that the applicant select his/her plans during the initial application process. SCHIP no longer denies applications for being incomplete for these two reasons. If no plans are selected and SCHIP cannot obtain selections from the applicant, SCHIP enrolls the eligible child in the community provider health plan and alternately assigns the dental and vision plan. The new processes significantly reduced delays in enrollment. From January through June 2007, the number of children enrolled without premiums and/or plan selections totaled 107,952. This was a 16% increase in the average monthly enrollment after implementing the program changes.

SCHIP Retention Increase: The SCHIP retention report for 2005 that was conducted in 2007 indicated increased retention rate for SCHIP. The retention rate was 78% for the period of January 2005 - December 2005 which continued to increase from the previous years (2001-69%; 2002-71%, and 2003-70%; and 2004-77%). This may be attributed to enhanced telephone follow-up by the administrative vendor, the outreach efforts by SCHIP plans and local community based organizations, increased Enrollment Entity (EE) and Certified Application Assistant participation, and the increased amount EEs are reimbursed when assisting families during the annual eligibility review process.

Enrollment Entities & Certified Application Assistants Continue to Grow: During this reporting period, the number of Enrollment Entities increased 23% and the number of Certified Application Assistants grew 10% compared to the previous reporting period. Enrollment Entity (EE) Reimbursement Payments Increased: Application assistance reimbursements remain at the increased amount of $50 (instead of $25) for successful Annual Eligibility Review processes when children continue to qualify for SCHIP and $60 for successful initial on-line applications that result in children being enrolled in either SCHIP or Medicaid. In addition, all participating Enrollment Entities were restored to full payment status for application assistance, effective July 1, 2007 when the Outreach, Enrollment, Retention and Utilization (OERU) Grant funding was not re-allocated by the State in its 2007/2008 budget. The amount of EE reimbursements paid during the initial application process increased by 19.5%; whereas during the SCHIP annual eligibility review process, the amount paid to EEs increased 97% compared to the previous reporting period. SCHIP Plan Web-Based Training (WBT): In January 2007, the on-line training for SCHIP health, dental and vision plans was implemented. The WBT is available in English and Spanish. SCHIP Administrative Vendor Performance & Quality and Accuracy Standards: California has enacted the highest performance and quality and accuracy performance standards in the nation on its administrative vendor, at a 98% to 100% accuracy level. Along with the existing administrative performance standards (such as 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 new quality standards assure the accuracy of applicants being screened to the appropriate program(s), SCHIP eligibility determinations at both initial application and the Annual Eligibility Review, adjudication of appeals and program reviews, data transmissions for individual eligibility triggering events, generation and posting of SCHIP daily enrollment files for the plans based on the prior days eligibility triggering events, and monthly capitation payment determinations for plans and the monthly generation of the capitation files the administrative services provided by the vendor. The administrative vendor met all performance and quality standards throughout the reporting period. Transition of SCHIP 2-Month Bridge Coverage to Presumptive Medicaid: SCHIP authorization for the 2-month SCHIP bridge expired. To ensure that children maintain access to health care while they are being processed for eligibility into Medicaid, the State implemented a Presumptive Medicaid Program. Children with household income below SCHIP guidelines during the annual eligibility review process no longer receive the 2-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 decides if the children qualify for the Medicaid Program. SCHIP Open Enrollment (OE) Postcard Process: Less than 4% of SCHIP subscribers change plans during OE annually. The State streamlined the open enrollment process in 2007 (April 15-May 31; with plan changes effective July 1). Members are now sent an OE packet or an OE postcard depending on their particular circumstances. Members received a customized packet showing plan availability for their county if: a) they were required to make new plan selections because of changes in coverage areas for their current plans; or b) their premium changed because they were enrolled in a health plan whose Community Provider Plan (CPP) status changed. In

addition, members whose health, dental and vision plans were still available and their health plan's CPP status did not change in the benefit year received an OE postcard. Members receiving postcards had the option of requesting a customized OE packet in order to change their plans. Instructions for doing so were provided on the OE postcard.

Continuing a Mental Health/Substance Abuse Study, Development of new and revised Dental Quality Measures, Development of Rural Health Demonstration Project Fact Book are also part of the many accomplishments that have been achieved in 2007 by the HFP.

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

HFP/MC Revised Joint Application: The revised joint application for SCHIP/Medicaid will be implemented by March 2008. This is the first major revision process on the joint application since it was revised in April 1999 and the revisions were made to simplify and improve the clarity of the application and documentation required from applicants. The State originally anticipated the revised application being finalize during the last reporting period. However, due to the State's ongoing meetings with the advocacy and stakeholder groups to finalize the application changes during the last quarter of this reporting period, the revised application will be available during the next reporting period.

Health-e-App Public Access: California continues to partner with two private philanthropic foundations to expand the access of the existing electronic application. Currently, only approved county eligibility workers (EWs) and Certified Application Assistants (CAAs) have access to the electronic application. The ongoing project to upgrade the existing electronic application will allow anyone with internet access to use the application to apply for SCHIP/Medicaid. Expanded access plus the system edits that prevent certain application errors is anticipated to improve the success rate for applications submitted electronically. While the State initially experienced road blocks in the development of implementing public access, the on-line application process is at the beginning stages of development and on-going work and activities aimed towards public use will continue throughout the next reporting period.

Self-Certification of Income at SCHIP Annual Eligibility Review Process: Self-declaration of income will be offered to existing SCHIP families and will allow families to "self-declare" household income during the SCHIP annual eligibility review process without the requirement of documentation such as pay stubs or tax forms. Electronic verification of self-declared income will be instituted. This process is aimed at increasing retention and program efficiency. Originally, this program change was going to be implemented during this reporting period. However, due to the State budget, implementation was delayed and is anticipated to occur during the next reporting period.

Electronic Process for Medicaid Referrals: While the State implemented a paper process for the counties to forward annual re-determination information to SCHIP when children no longer qualify for Medicaid because the family's income is above Medicaid guidelines, the State plans on implementing an electronic process in receiving the information from the counties.

SCHIP Presumptive Eligibility at Medicaid Initial Application: The State passed into law a mandate for working with Medicaid in establishing a presumptive eligibility process into SCHIP for children whose incomes are above Medicaid guidelines during the initial Medicaid application process. In addition, the State will work with the Women, Infants & Children (WIC) Program to establish an electronic gateway into SCHIP and Medicaid. Originally, these program changes were going to be implemented during this reporting period. However, due to the State budget, implementation was delayed and is anticipated to occur during the next reporting period.

SCHIP Presumptive Eligibility at Medicaid Annual Re-Determination: The State is scheduled to implement a SCHIP presumptive eligibility process to replace the Medicaid to SCHIP one-month bridge coverage. Currently, in the event a child who is enrolled in Medicaid no longer qualifies for the program because the family's income is above Medicaid requirements, the child remains enrolled in Medicaid for one additional month until an SCHIP eligibility determination is made. The new process will replace the Medicaid one-month bridge coverage with SCHIP presumptive eligibility until SCHIP conducts an eligibility determination. Originally, this program change was going to be implemented during this reporting period. However, due to the State budget, implementation was delayed and is anticipated to occur during the next reporting period.

Increase in SCHIP Subscriber Monthly Premiums and Co-Pays: Based on Governor Schwarzenegger's budget reduction proposal, SCHIP monthly premiums may increase. Families affected by the premium increase are those whose incomes are at a higher FPL. Families whose incomes are below 150% FPL will not experience a change in premiums. Premiums for families with incomes between 150% - 200% FPL will increase from $9 per child per month to $16 per child per month (an increase of $7 per child). Premiums for families with incomes above 200% - 250% will increase from $15 per child per month to $19 per child per month (an increase of $4 per child). In addition, there will be an increase in co-payments for non-preventive services for families whose incomes are above 150% FPL. The $5 co-payment will increase to $7.50. The State anticipates that the premium and co-payment increases will be in effect on July 1, 2008.

SCHIP Children's Expansion: As a result of health care reform and potential changes in the State statutes, SCHIP may expand coverage for children up to 300% FPL statewide. In the event this expansion occurs, the State will need to begin working on policy and program changes during the next reporting period. Implementation for children's expansion is anticipated to occur on July 1, 2009.

Encounter/Claims Data: MRMIB is developing an encounter/claims database that will 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. Plans will begin reporting data in mid-2008ATTACHMENTS

Attachment 1: 2006 Consumer Assessment of Healthcare Providers and Systems (CAHPS®))

Attachment 2: 2006 Dental-CAHPS (D-CAHPS®)

Attachment 3: 2006 Young Adult Health Care Survey (YAHCS®)

Attachment 4: 2007 Open Enrollment Report

Attachment 5: 2006 Cultural and Linguistics Services Report

Attachment 6: Dental Plan Quality Measurement Report

Attachment 7: Proposed Dental Quality Measures

Attachment 8: Phase 1 Mental Health Study

Attachment 9: Plan Performance Profiles

Attachment 10: Rural Health Demonstration Projects (RHDP) Fact Book

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